KENT PUBLIC HEALTH OBSERVATORY

Mental Health Needs Assessment Kent

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Executive Summary:

1. Current Situation and Context

Mental ill health currently represents 23% of the total burden of ill health in the UK and is the largest single cause of disability[1]. Nearly 11% of England's annual secondary health budget is spent on mental health[2] and estimates suggest that the cost of treating mental health problems could double over the next 20 years[3]. Both poverty and exposure to 'adverse childhood experiences' (ACE) contribute and exacerbate a person's mental health (a person's state of mind) and can lead to mental illness (a clinically diagnosable condition that requires treatment). Exposure to four or more ACE's gives a person a 60% chance of having a mental illness that requires specialist treatment. Social Isolation and loneliness also increase the likelihood of depression, multi-morbidity and use of adult acute mental health services. There are also a range of protective factors such as employment, education and social connectedness that can keep people well and improve resilience to breakdown.

In Kent and Medway, there are similar rates of mental illness to the national average. In addition, there are increases in severe depression, complex multiple morbidity, poorer outcomes in both hospital attendances, admissions and premature death in parts of the STP area (notably Medway and Thanet) and higher than national averages of drug and alcohol related deaths, suicides and use of mental health act powers. Transformation will lie both in prevention, social care and pro-active management of mental health as well as embedding high quality specialist mental health care at the heart of Local Care and primary care delivery as outlined by the NHS Long Term Plan.

1.1 Self-Harm and Suicide

Self-harm (requiring hospital admission) and suicide are catastrophic events and markers of mental distress. People completing suicide are typically not known to specialist mental health services. National and local data shows that 70% of suicides are to people not accessing in-patient services although suicides of people known to community mental health services has increased[4]. The Confidential Inquiry into mental health in 2018 found that many of those completing suicide were in contact with primary care. Self-harm is hard

[1] WHO (2008) The Global Burden Of Disease; 2004 update, available at www.who.int/heathinfo/global_burden_disease

[2] Department of Health (2009) Departmental Report 2009: The Health and Personal Social Services available at www.official-documents.gov.uk/document/cm75/7593/7593.pdf

[3] McCrone P, Dhanasiri S, Patel A et al. (2008) Paying the Price; The cost of mental health care in England. London: King‟s Fund, 220 - 226

[4] National Confidential Inqury into mental health : Louis Appleby 2018

to quantify in Kent and Medway and it is not known what proportion of people admitted to hospital for self-harm made intentional attempts at suicide. However, it is known that self-harm behaviour is a significant and costly marker of mental distress.

- The rate of suicide for all persons in Kent and Medway STP area is 10.9 (2015-17) per 100,000. This is higher than the England average rate; 9.6.
- Over the period 2015-17 there were 492 deaths from suicide in Kent and Medway.
- The trend is decreasing locally. However, in 2019 there was a change to the way suicides are classified by coroner's verdicts and in 2019 suicides in England have risen by 12%. Local data is not yet available.
- In Kent and Medway, the male suicide rate is 16.1 (England rate: 14.7) and is higher than the female suicide rate in Kent and Medway of 5.2 (England rate is 4.7).

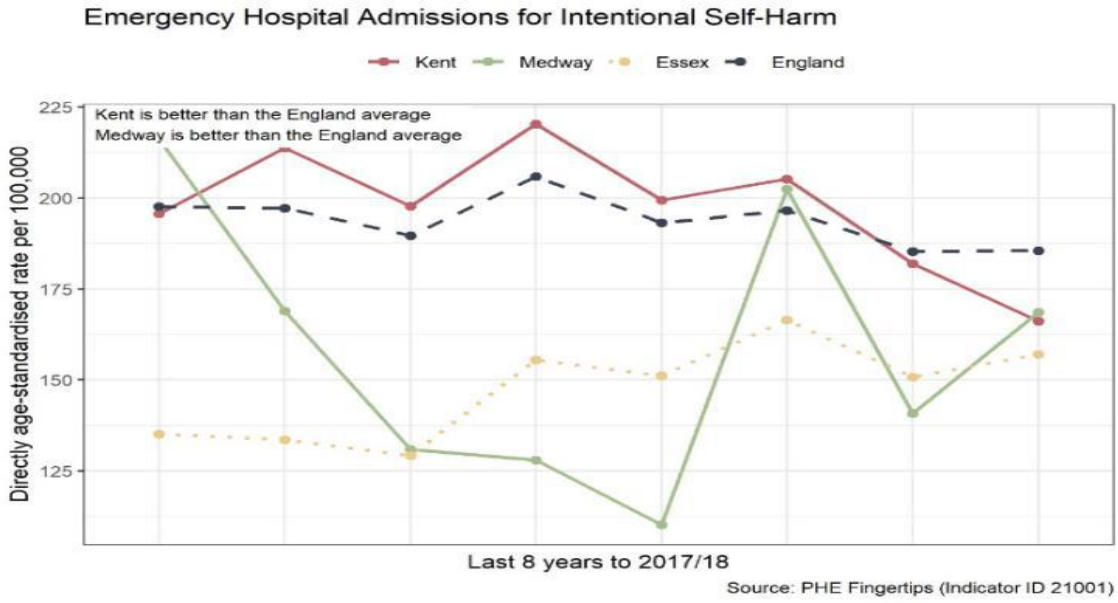
1.2 Self-Harm and Emergency admissions to A&E

In a National study of over 4000 self-harming adults in hospital, 80% had overdosed and around 15% had cut themselves. In the community, it is likely that cutting is a more common way of self-harming than taking an overdose.[5] In Kent and Medway the rates of admission from A&E are now below the England average. Kent's rates were above the national average but have reduced over 8 years and Medway's rates have fluctuated and are now similar to Kent (Figure 1).

It will be important to understand the level of distress leading to self-harm, the links between self-harm and suicide and improve the access for crisis mental health. It is also vital that there is high quality management and resources for self-care and safety netting for people with depression and history of self-harm and suicide attempt.

[5] The epidemiology and management of self-harm among adults in England (2005).Gunnell, D. & Bennewith, O., Journal of Public Health; 27, p.67-73

Figure 1:



2. Summary of Mental Health Prevalence Epidemiology in Kent and Medway (note that in depth Mental Health Needs Assessment are available with data at CCG level).

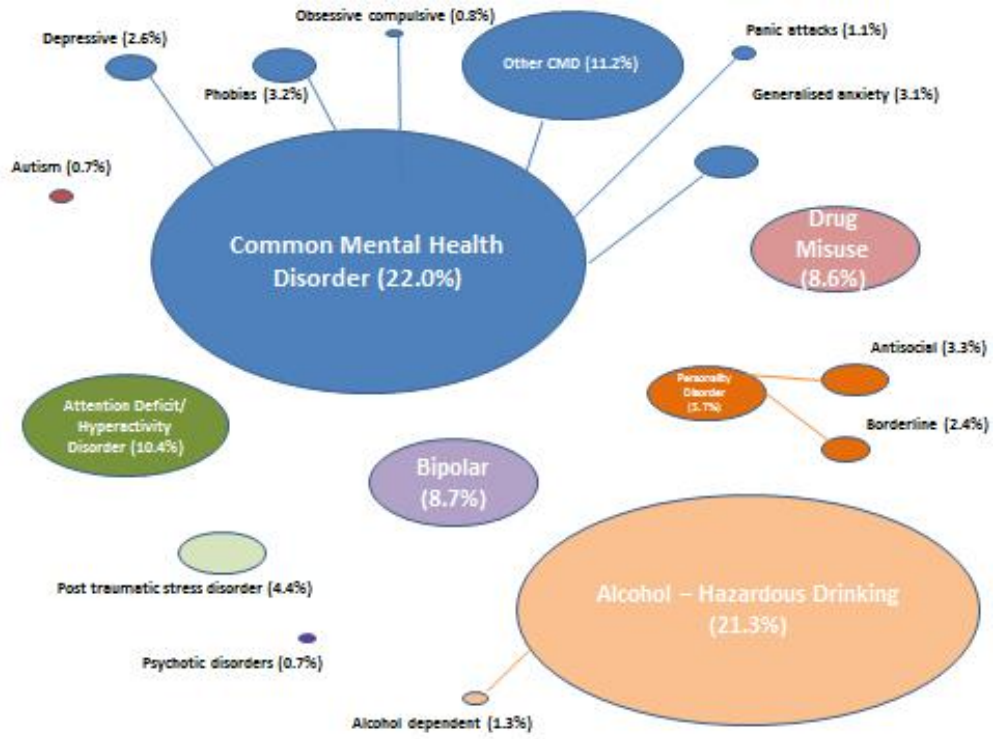
2.1 Mental illnesses are varied and distinct as physical illnesses, with a variety of aetiology and treatments. They typically group into two main types merely describing their prevalence, Common Mental Illnesses (with a prevalence of 1 in 4) or Psychosis (with a prevalence of 0.5- 1 in 100) and Figure 2 gives the estimates for the main range of conditions.

2.2 The most current data for Kent and Medway STP (see separate needs assessments for mental health in Kent and Medway[6]) area shows that an estimated 17% of the population aged 16+ has a common mental illness (CMI) e.g. anxiety and depression. This is estimated at **236,545** people. This is similar to the England benchmark and like the England average the trend is upward. For those people aged 65+ the number is estimated at **35,161** people with a common mental health illness (CMI) (the rate is similar to the England average). For diagnosis of schizophrenia, bipolar affective disorder and other psychoses the APMS reports that the prevalence for this is relatively stable across populations at 0.5- 0.8% of the Adult population. The average onset for psychosis in men is 25 years old and for women, slightly later onset at 35 years. This amounts to **6000** people in Kent with severe psychosis. The APMS also record*s 'sub threshold' psychosis* – which is less serious and enduring but where people still need help in primary care. The estimate for this is 6% of the Adult population and in Kent and Medway is predicted to be **70,680** people. The trend for both England and Kent and Medway is increasing.

[6] Data is from Fingertips PHE and uses 2014 APMS applied to 2017 population data.

2.3 The number of people recorded with psychosis in primary care in Kent and Medway is below the national average. There are **15,420** people in Kent and Medway with a recorded psychosis in primary care. This is 0.8% of the total population of Kent and Medway and considerably below the predicted England average of .94%. The primary care QoF estimate does not take into account the severity e.g severe and enduring vs 'sub threshold'. A snapshot (one quarter) of data for 2018 shows there were 39,140 people in contact with the Specialist Adult Mental Health Services in Kent and Medway. This is above the national average and the trend is increasing.

Figure 2. The Estimated Prevalence of the main Mental Illnesses (relative to each other) in Kent and Medway From APMS (2014).



3. The management of depression (and other common mental illness).

This data (from the Adult Psychiatric Morbidity Study) also shows that of the group of people with CMI, approximately **67,000** people will have high needs and more than one mental health condition. The APMS predicts approximately **7,000** people in this group will have significant substance misuse and self-harm issues and that 0.1% or **1,500** will have severe clinical conditions (notably depression) and recurring suicidal ideation. The APMS shows that in Kent and Medway (like England as whole) the rates of severe depression are increasing – particularly among women (Table 1 & 2). Data from ONS and Coroner's verdicts shows that from 2015-2017 there were **492** deaths from suicide in Kent and Medway. This is a rate of 10.4 per 100,000 and is higher than the England average (9.6). The highest rates are in East Kent, particularly Thanet (14.9 deaths per 100,000 and 55 deaths). It is too early to tell

whether the increasing trend in suicide rates is reducing. A study in the BMJ found that 90% of people who had completed suicide had contacted primary care for help in the previous year. The national confidential enquiry into suicide and self-harm has found that depression and substance misuse are vulnerabilities for completing suicide.

3.1 Good practice in management of depression and anxiety.

The proactive steps to managing depression and anxiety and keeping people out of potential crisis are to a/ encourage help seeking and personal resilience, b/ accurate diagnosis, clear patient information about the condition, and follow up, c/ access to self-help, d/ access to psychological therapies e/ medication and monitoring of medication – alongside other physical health problems f/ access to community assets and safety netting. Good patient and public involvement with advocacy and carer involvement is also necessary.

3.2 Treatment: Good follow up, monitoring and engagement with prevention services.

In Kent and Medway, the recorded prevalence of depression in primary care of **10.6%** amounts to **157,000** people in 2017. This is higher than the national average. This is positive for Kent and Medway as it shows responsible management of patients compared to national. Kent and Medway have an incidence rate of depression in primary care (QoF data 2017) of **1.6% per year**. This is **23,600** new cases in primary care per year. This trend is increasing and is similar to the national average. Of these people 65% were followed up within 3 months and this is both improving and similar to the national average. It is worth noting that some people with depression and multiple conditions may be more difficult to follow up or be less engaged due to their symptoms. Increasing the follow up rate will be an important and proactive step in transforming mental health services for people with severe depression and anxiety. Depression most commonly co-occurs with anxiety (sometimes referred to as Co-thymia) and 13**%** of primary care patients reported this in GP patient survey in 2018. This is an increasing trend. This is important for follow up as the co-occurring mood disorders have counteracting medications (i.e. some depression medications can make people more anxious) thus making monitoring and follow up critical.

Depression and anxiety can lead people to self-medicate and self-neglect making sign posting to prevention services important. People with common mental illness have poorer physical health outcomes resulting from excess weight, alcohol and drugs, pain and poorer immune systems. Trauma informed prevention services that are equipped to understand the issues of self-neglect and poor motivation to self-care are needed. People with severe depression will need easy to access, timely specialist psychological therapy and personal safety and recovery plans (whether via care navigators, peer support or through technology). A report produced by Health Watch in 2019 showed that many patients were unsure what depression was and how to manage the condition.

3.3 Treatment Services: Psychological Services (IAPT)

People experiencing mental distress are encouraged to self-refer to psychological therapies and the services are commissioned by the local NHS. For more severe depression and anxiety specialist services are needed which needs clinical referral. If untreated depression and anxiety can become more severe over time. It is difficult to assess the need and outcomes for the two psychological services, IAPT and specialist psychological counselling together. Given the rise in suicide, self-harm and severe depression it will be important to audit access to specialist counselling services. The graph Figure 3 shows that over the years Kent and Medway have consistently tracked the national average for IAPT (counselling) access. There were **2,385** people accessing IAPT services in March 2019 and that is **20%** of the prevalence of anxiety and depression in Kent. However, given the rise of severe depression commissioners and providers should work to target those at greatest need (Table 1 and 2).

3.4 Medicines

The importance of highlighting following up patients with depression and anxiety is because the majority of people treated in primary care for CMI are prescribed drugs. Figure 4 shows that Kent and Medway maps directly onto the England average for prescribing antidepressants and this is increasing year on year.

Table 1: Estimated Numbers and Rates of Men with Severe CMD (Depression/Anxiety) in Kent

CIS-R score (severity)	2000		2014	
Moderate Severe	6.7%	**28,948**	6.3%	**27,220**
Severe	6.7%	**28,948**	7.3%	**31,540**

Data source : APMS 2014 % applied to Kent Census Data 2011- males over 16 years.

Table 2: Estimated Numbers and Rates of Women with Severe CMD (Depression/Anxiety) in Kent

CIS-R score (severity)	2000		2014	
Moderate Severe	10.2%	**47,386**	10.1%	**46,922**
Severe	9%	**41812**	11.3%	**52,497**

Data source: APMS 2014 % applied to Kent Census Data 2011- females over 16 years.

Figure 3

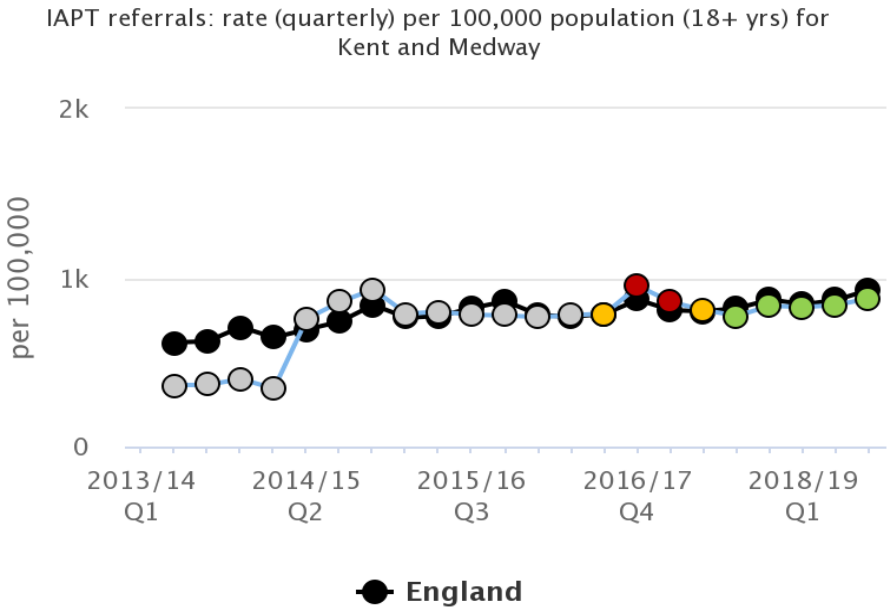
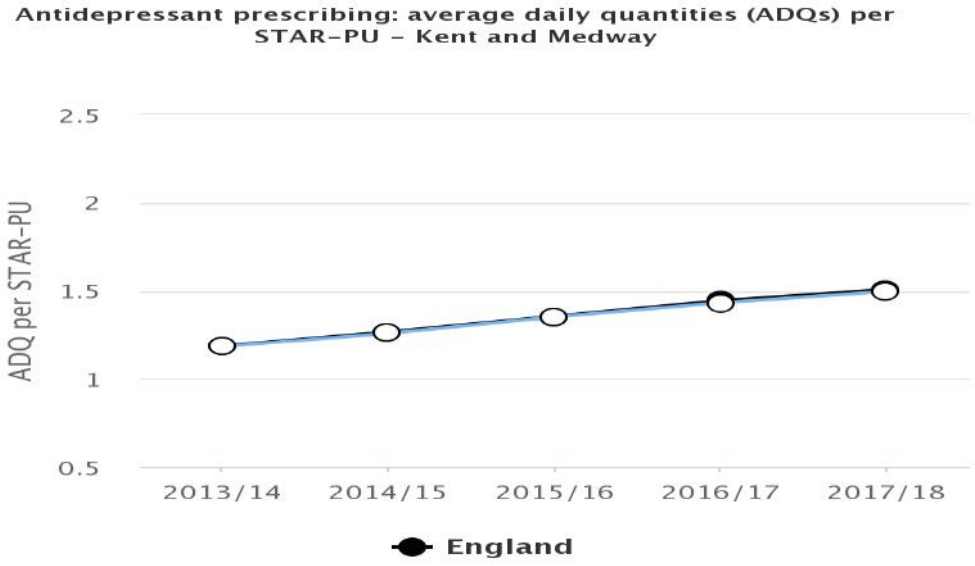


Figure 4



Data source: NHS Business Services Authority (NHSBSA)[7]

4. Management of Psychosis (and other long term relapsing mental illness).

In Kent and Medway 53% of the GP patient population reported having a long-term health condition (either physical and/or mental). It is in this context of long-term health care and treatment that psychosis and other severe mental illness must be managed **as 8.6%** of that population reported having a long-term mental health problem.

[7] *https://apps.nhsbsa.nhs.uk/infosystems/welcome*

In Kent and Medway – there is variation in rates of psychosis where Thanet has the highest rates (Figure 5). In Kent and Medway **2734 per 100,000** people are in contact with specialist mental health services. In 2018 the snapshot quarter data count was **39,150** people and this is **12%** higher than the national average and the trend is increasing (Figure 6). Yet only **7%** of these people are on Care Programmes (compared to 15% nationally). It is important that patients have a good care plan and are able to share these with other professionals and their carers, particularly if the patients will also be in Local care teams and primary care.

In the snapshot quarter 2018/9 in Kent and Medway only 1% of the mental health service users were in hospital. This is well below the national average and seen as a positive indicator. This amounts to **440** patients. In that same quarter the admission rate to hospital was also falling and below the national average. This indicates that there is improving management of patients in crisis in Kent and Medway. The admission rate was **214 per 100,000** and below the national rate of **267 per 100,000**. There were **410** people detained under the mental health in that same snapshot quarter, again below the national average. However, there are local variations and commissioners will need to ensure good crisis care is available over all the patch.

Figure 5: Estimated prevalence of psychotic disorder: % of population aged 16+, 2012

Area	Value	Lower CI	Upper CI
England	0.40*	-	-
Kent and Medway	0.33*	-	-
NHS Ashford CCG	0.28*	-	-
NHS Canterbury And Coas...	0.35*	-	-
NHS Dartford, Gravesham...	0.31*	-	-
NHS Medway CCG	0.28*	-	-
NHS South Kent Coast CC...	0.39*	-	-
NHS Swale CCG	0.34*	-	-
NHS Thanet CCG	0.48*	-	-
NHS West Kent CCG	0.30*	-	-

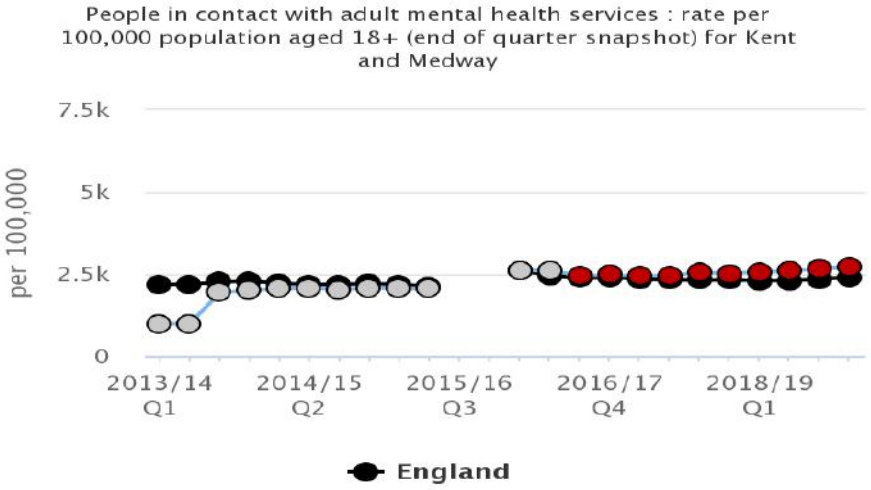
Source: Adult Psychiatric Morbidity Survey (APMS) 2007, ONS population estimates and NHS resource allocation formula

Given Kent and Medway's relative overall population's health – most indicators should be expected to be below the national average in mental health including hospital admission rates. However, this trend is increasing. Kent and Medway's mental health needs are not uniform across the patch and it's size masks important inequalities. The East of the patch has poorer health outcomes overall and Thanet's mental health admission rates are higher than the national average.

A standard was set in the NICE guidance for Psychosis and understood to be best practice to record a diagnosis for each patient in contact with specialist mental health services. It is acknowledged that this is difficult for many reasons – however, it is set in the Long-Term

Plan because it is understood that it will help the person to get access to the right treatment and social care. The England average is not high – it is 21% of patients to have a diagnosis. Kent and Medway is well below this low benchmark at 7% and the trend is falling. This is an important quality measure for local care and important for providers to monitor this alongside the markers for care planning.

Figure 6:



Source: Fingertips PHE 2018/19

The treatment of psychosis in primary care is not straight forward and needs support from specialist psychiatric services. Figure 7 shows that Medway and Thanet have the highest prescribing in primary care.

Figure 7: GP prescribing of drugs for psychoses and related disorders: items (quarterly) per 1,000 population in 2017/18 Q4

Area	Value	Lower CI	Upper CI
England	62.4	62.3	62.4
Kent and Medway	53.7*	53.3	54.1
NHS Ashford CCG	40.9	39.6	42.1
NHS Canterbury And Coas...	43.0	42.0	43.9
NHS Dartford, Gravesham...	54.2	53.2	55.2
NHS Medway CCG	59.9	58.9	60.9
NHS South Kent Coast CC...	52.3	51.2	53.4
NHS Swale CCG	52.4	50.9	53.9
NHS Thanet CCG	69.0	67.5	70.5
NHS West Kent CCG	54.7	53.9	55.4

Source: NHS Digital

5. Crisis Care and Hospital Admissions

Hospital admissions are not a good outcome for patients with mental health problems as it shows that they are in crisis. The data in Fig 7 shows the number and rates of admission to hospital for mental illness (primary diagnosis) per quarter. In 2017/18 there were **3,515** admissions to hospital from Kent and Medway. There are higher admission rates in Thanet, but overall, admission rates are lower than the England average. When Thanet's rates are seen over time (Figure 8) and compared to the England average. It is clear that Thanet is an outlier compared to Kent and Medway. It is encouraging that rates are falling. Thanet will need support and a more tailored approach to transform its mental health system than the rest of Kent and Medway.

6. Health Inequalities and Thanet

Thanet has higher hospital admissions for mental illness, the highest prevalence of psychosis, high rates of prescribing and poor outcomes regarding crisis care and hospital admissions. Thanet has the highest suicide and self-harm rates in Kent and Medway and is the most deprived area in the Kent and Medway STP. It is important that the Integrated Care Systems enable Thanet to meet the needs of it's mental health population by supporting primary and specialist care to work closely together with substance misuse and a variety of social care services. Although the data in Fig 9 is 5 years old it also shows that Thanet has far higher rates of presentation at A&E then any other locality in Kent and Medway and the highest rate of mental health sections. It is difficult to assess from this data how many of the same patients use crisis services disproportionately however where the same people are known to relapse into crisis with high use of ambulance, urgent care and police services – adequate safety nets and services (e.g. safe spaces) should be in place.

Figure 8: Mental health admissions to hospital: rate per 100,000 population in 2018/19 Q2

Area	Value	Lower CI	Upper CI
England	273.5*	270.4	276.6
Kent and Medway	210.9*	196.1	226.5
NHS Ashford CCG	224.2*	168.9	291.8
NHS Canterbury And Coas...	253.6*	208.5	305.7
NHS Dartford, Gravesham...	227.9*	188.2	273.6
NHS Medway CCG	215.3*	177.7	258.4
NHS South Kent Coast CC...	201.7*	161.1	249.4
NHS Swale CCG	178.8*	127.7	243.5
NHS Thanet CCG	304.9*	243.5	377.0
NHS West Kent CCG	159.7*	135.2	187.4

Source: NHS Digital Mental Health Services Data Set monthly reports.

Figure 9: Mental health admissions to hospital: rate per 100,000 population in NHS Thanet CCG

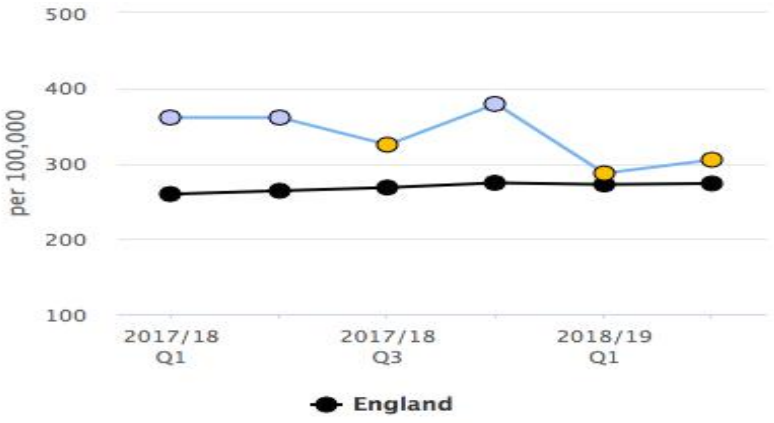


Figure 10: A& E attendances for Mental Illness. 2012 data.

Area	Value	Lower CI	Upper CI
England	243.5	242.2	244.9
Kent and Medway	239.1*	231.9	246.5
NHS Ashford CCG	236.4	209.7	265.6
NHS Canterbury And Coas...	195.2	176.3	215.5
NHS Dartford, Gravesham...	225.9	207.6	245.4
NHS Medway CCG	238.6	220.5	257.8
NHS South Kent Coast CC...	250.3	229.0	273.0
NHS Swale CCG	163.6	140.3	189.5
NHS Thanet CCG	448.2	413.3	485.3
NHS West Kent CCG	217.8	204.6	231.7

Source: Health & Social Care Information Centre (HSCIC) and the Office for National Statistics

7. Premature Mortality, Multiple Morbidity and Co-occurring Condition

A Public Health England report (Figure 11) shows that adults with severe mental illness die younger and from a greater range of health conditions then adults in the general population. People with mental illness are also likely to self-neglect (poor health behaviour) and self-medicate with drugs and alcohol (further exacerbating illness and slowing recovery). Causes of premature death to people with long term mental illness are cancer, CVD, COPD, stroke and liver disease. A study by the Kent public health observatory has shown people with serious and enduring mental illness also suffer multiple morbidities at a greater rate than the general population and these include obesity, hypertension, muscular-skeletal problems, asthma and diabetes. (Figure 12).

Figure: 11

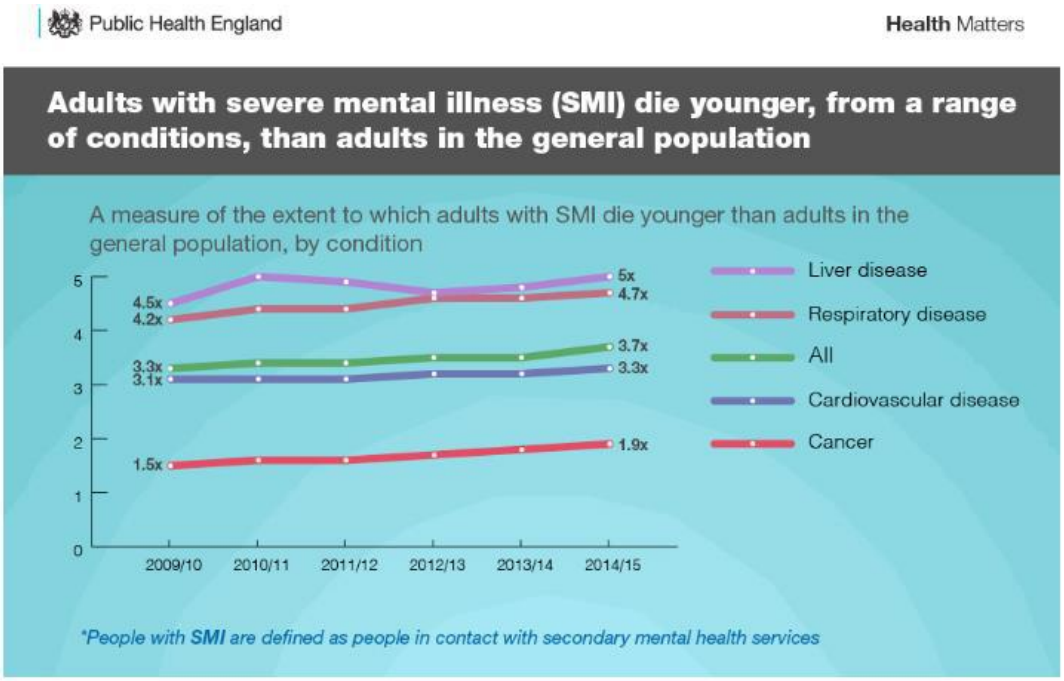
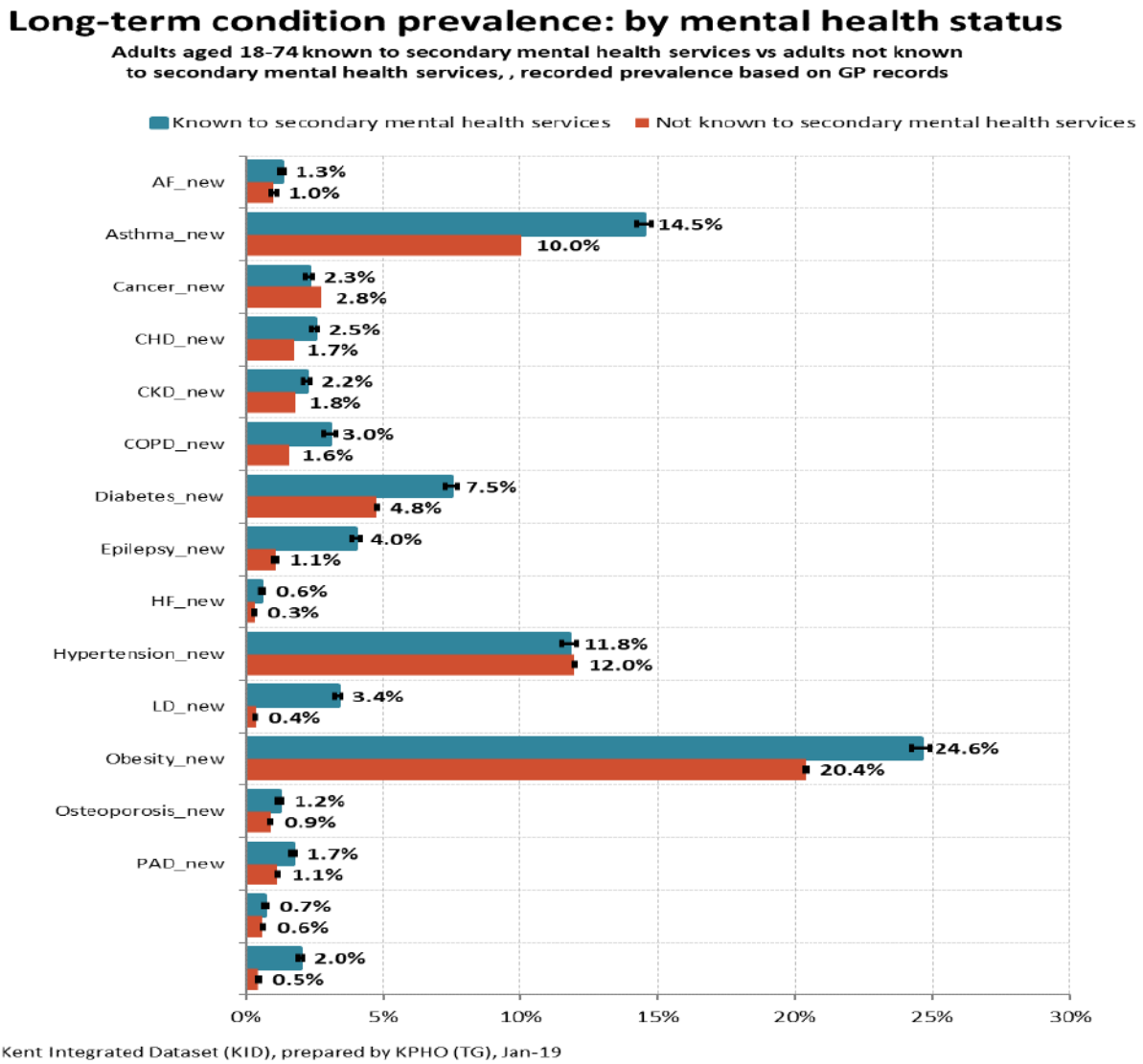


Figure 12:



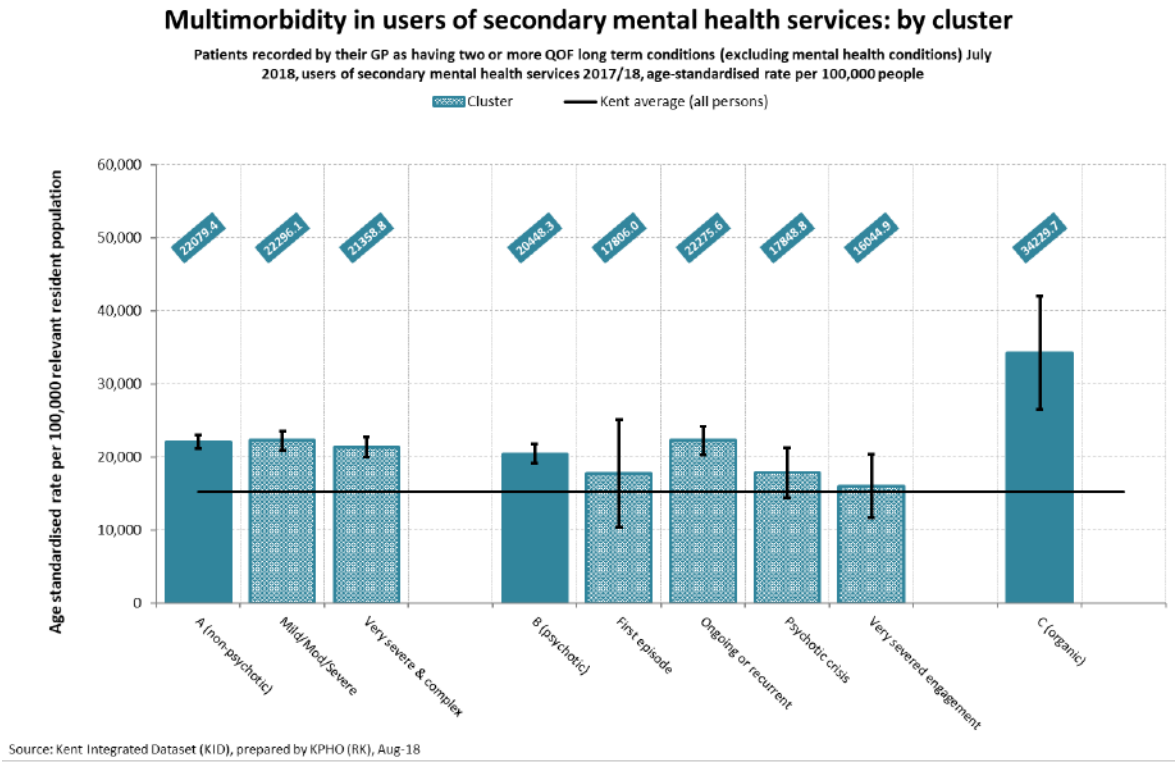
Source: Kent Integrated Dataset (KID), prepared by KPHO (TG), Jan-19

Disease prevalence for adults aged 18-74 with a serious mental illness is particularly high in comparison with their peers for the following conditions:

- Learning Difficulties (odds ratio of 9.5)
- Stroke (odds ratio of 4.3)
- Epilepsy (odds ratio of 3.7)
- COPD (odds ratio of 2.0)
- HF (odds ratio of 1.9)
- Diabetes (odds ratio of 1.6)
- Peripheral Arterial Disease (odds ratio of 1.5)
- Coronary Heart Disease (odds ratio of 1.5)

In addition, people with mental illness are highly likely to have two or more other mental illnesses as the rates of co-morbid mental disorders is common e.g. people with psychosis & PTSD, people with depression, eating disorder and anxiety. Figure 13 shows that all people with serious mental illness in specialist mental health services in Kent and Medway are more likely to have long term physical conditions as well. The multiple, complex and relapsing nature of mental illness makes it important to manage the conditions together and minimise separate pathways of care and ensuring that all people with severe and enduring conditions have adequate care plans, relapse plans and safety nets.

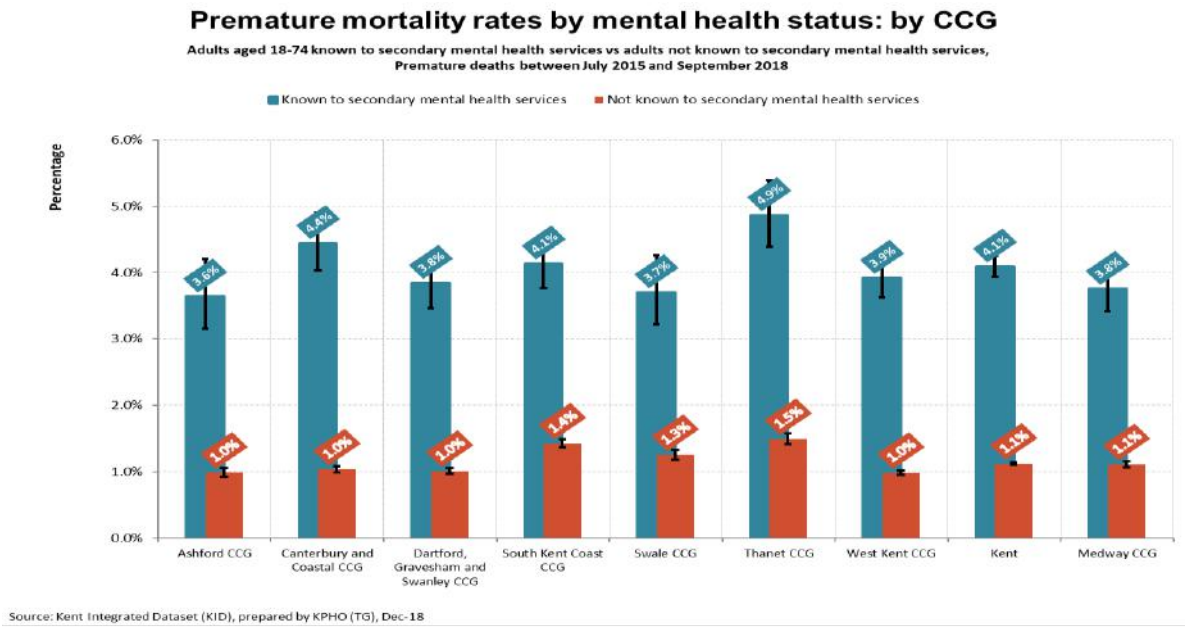
Figure 13:



7.1 Premature Mortality

An analysis based on age, serious mental illness, deprivation and multimorbidity by Kent Public Health Observatory demonstrates that whilst age is the biggest predictor of differences in premature mortality rates, having a serious mental illness is the next most important (of the characteristics considered) for adults aged under 55 and those aged 65-74, i.e. more so than multimorbidity overall and deprivation. For those aged 55-64 multimorbidity is the second biggest predictor, followed by having a serious mental illness. [8](Figure 14)

Figure 14:

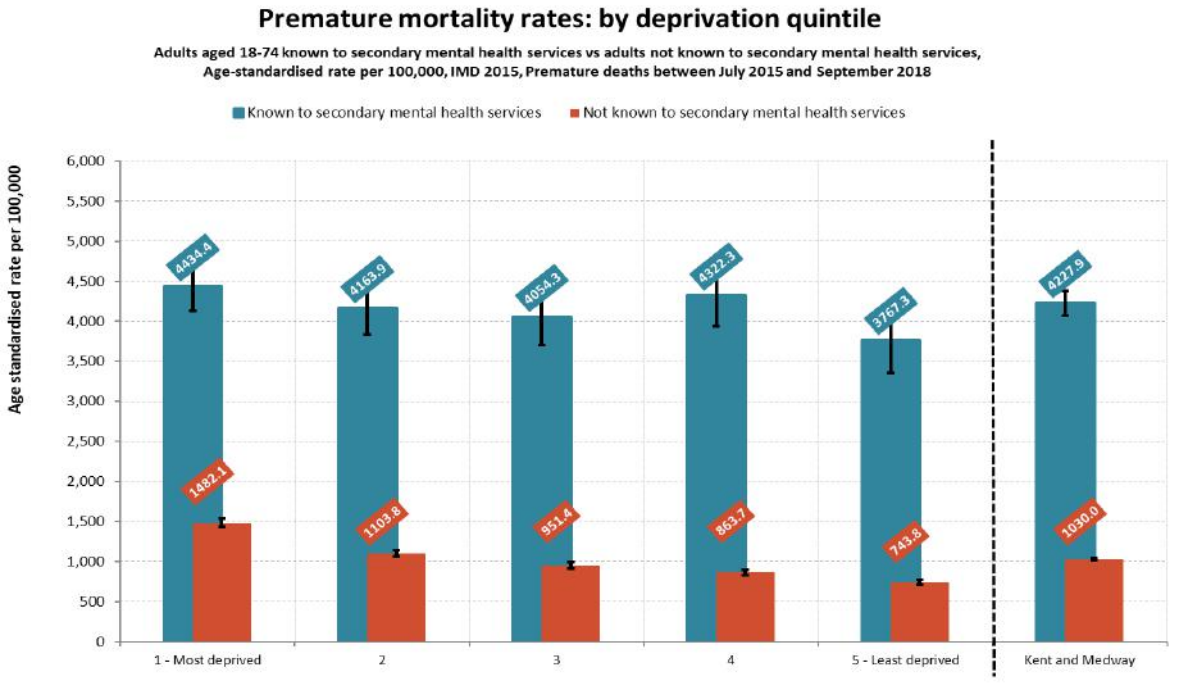


7.2 Mental illness, Health Inequalities and Deprivation

Whilst it is true to say that premature mortality rates amongst those with a serious mental illness are higher for those living in more deprived areas, the gap is far smaller than is the case for the rest of the 18-74 population (Figure 15). Whilst age-standardised premature mortality rates amongst those not known to secondary mental health services are 99% higher (i.e. around double) in the most deprived areas compared with the least deprived, this gap reduces to 18% for those with a serious mental illness. This means that having mental illness is in itself a 'health inequality' regardless of where a person lives and living in a deprived area will exacerbate this.

[8] Public Health England, December 2018, Health Matters: reducing health inequalities in mental illness. https://www.gov.uk/government/publications/health-matters-reducing-health-inequalities-in-mental-illness/health-matters-reducing-health-inequalities-in-mental-illness (Accessed 31st December 2018)

Figure 15



Source: Kent Integrated Dataset (KID), prepared by KPHO (TG), Jan-19

8. Substance Misuse Disorders and Mental Illness (Co-occuring Conditions *formally known as Dual Diagnosis*).

It is not straightforward to set out the policy context in respect of 'dual diagnosis' as no national policy actually exists. The two most relevant dual diagnosis policy drivers are 2002s Department of Health's Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide (May 2002) and Better Care for People with Co-occurring Conditions Mental Health and Substance Misuse': A guide for commissioners (PHE 2018). However, the NHS Long Term Plan clearly states that care wrapped around the patient's needs is the central priority for health care reform.

Currently Co-occurring mental health problems and substance misuse problems are mostly managed in a way which addresses a person's primary problem, followed by the secondary problem; regardless of equity of condition – generally in Kent co-occurring problems are not effectively managed simultaneously. Managing conditions together is important due the scale of the co-morbidity (Table 3) and the risk of not getting timely care e.g. suicide attempt, suicide, longer recovery rates and drug and alcohol related death.

Table 3: Estimated prevalence of mental health problems among people with substance misuse disorder

Condition	% of drug treatment population	% alcohol treatment population
Psychiatric disorder	75	85
Non-substance induced psychosis disorders	8	19
Personality disorder	37	53
Depression &/or anxiety disorder	68	81
Severe depression	27	34
Mild depression	40	47
Severe anxiety	19	32

Source: PHE Guidance 2017

The 2017 PHE guidance (taken from the large-scale London study COSMIC) states: 70% of Drug Users and 86% of Alcohol dependent users in treatment have a mental health problem.[9] This is **1,582 people** (2017/8 numbers in treatment) in Kent substance misuse services with a serious mental health need.

Kent Substance Misuse Treatment Services report that **44%** of their cohort in treatment in 2017/8 entered treatment with an existing mental health diagnosis, of these **24%** were being treated by CMHT and 58% (n=**258**) were being seen in primary care. This is below the expected number from national research. Research by KPHO finds **fewer** service users with a mental health diagnosis being treated in primary care. The 2002 COSMIC study Co-Morbidity of Substance Misuse and Mental Illness Collaborative Study found that 44% of all people in secondary and specialist mental health services had a substance misuse problem. Applying the COSMIC study rates conservatively to the Kent population would estimate that **1000 individuals** in Kent Substance Misuse services are 'complex needs with multi-morbidity'. Across the health care settings, the estimated prevalence of 'dual diagnosis', as a percentage of the Kent Integrated Dataset (sample of **1,221,770** persons aged 14 plus):

- within general practice **0.36%** of persons had evidence of dual diagnosis from recording of harmful and/or dependent drinking **(0.26%)** or drug use and/or opioid substitution treatment (0.10%). [2]
- using hospital admissions **0.14%** of persons had evidence of dual diagnosis from same year admissions for serious mental illness or depression, as well as, alcohol (0.08%) or drug misuse (0.10%).

[9] *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2016: England, Northern Ireland, Scotland and Wales October 2016. University of Manchester.*

0.02% of Community Mental Health Team contacts were flagged with the cluster for dual diagnosis. This is far fewer than predicted both by national estimates and the COSMIC study.

COSMIC prediction of problematic substance misuse in CMHT is 44%. Overall, we identified **5,954** individuals equating to a combined prevalence of **0.49%** of the general adult population. **Less than 0.01% of the individuals identified were known across all the health care settings.** However, 43% of individuals identified from hospital admissions were known to Community Mental Health Teams.

This shows that systematic management of substance misuse and mental illness is not happening. Kent Public Health commissioned substance misuse services are currently not commissioned to treat mental illness. A move to better trauma informed care with integrated therapeutic counselling and case management provision may be more appropriate if costly to commission without integration with NHS services. Reports from serious incidents show barriers in access to mental health care for those people leaving detox and rehabilitation and a lack of care planning.

9. Tackling the physical health of people with mental health problems

This data comes from a cohort study by the Kent Public Health Observatory of two cohorts of patients aged 18-74 registered with one of the Kent & Medway *GPs flowing data into the KID* at the time of the analysis, one cohort who in the *12-month period* between October 2017 and September 2018[10], and another cohort who were still alive at the end of the study period (1,233,847 adults). The aim was to understand the recorded multi-morbidity prevalence in Kent & Medway. The study found it is around **50% higher amongst those with a serious mental illness** than the rest of the population.

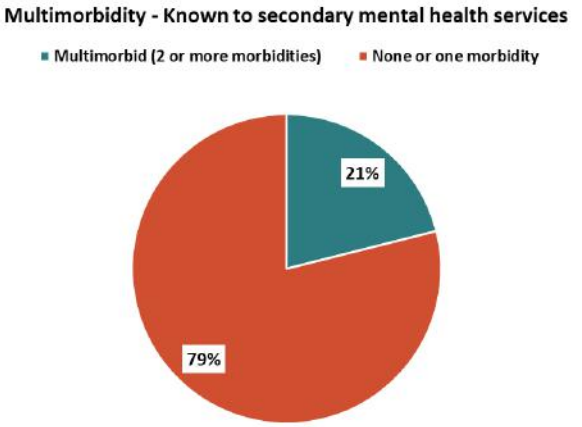
Across Kent and Medway, 21% of adults aged 18-74 with a serious mental illness[11] were recorded as multimorbid[12] by their GP compared to 14% of other adults aged 18-74.

[10] Deaths prior to this date have incomplete GP records associated with them, and so identification of long-term condition and multimorbidity prevalence is not possible.

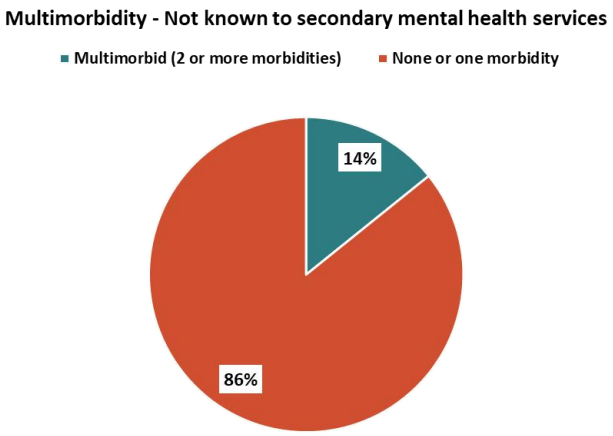
[11] And registered with one of the GPs flowing data into the KID at the time of the analysis.

[12] Patients were considered multimorbid if they had two or more of the following 16 long term conditions: Atrial Fibrillation (AF), Coronary Heart Disease (CHD), Hypertension, Heart Failure (HF), Peripheral Artery Disease (PAD), Stroke, Diabetes, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Cancer, Chronic Kidney Disease, (CKD), Epilepsy, Learning Difficulties (LD), Osteoporosis, Rheumatoid Arthritis (RA), or Obesity.

Figure 16:



Source: Kent Integrated Dataset (KID), prepared by KPHO (TG), Jan-19



Source: Kent Integrated Dataset (KID), prepared by KPHO (TG), Jan-19

9.1 Physical Illness and Early Death in people with mental health problems in Kent and Medway

The more physical illness a person has – the earlier they are predicted to die. The early death rate (that is death before age 75) was 1.4% for those in the study cohort[13] recorded by their GP as having two or more long term conditions including mental illness, this reduces to 0.2% amongst those without two or more long-term conditions recorded. Health Inequalities will be worse where people have a long-term mental illness. Where Health Inequalities and premature mortality exists across Kent, in Kent's most deprived communities, people who are aging (over 50) with a mental illness are likely to be highly vulnerable to premature death. A form of analysis called Discriminant analysis was used to isolate each impact such as age, deprivation and multiple health condition in turn. When this analysis was run on this cohort it showed that serious mental illness is the next most important driver for early death after age. This indicates that people with mental health problems must be targeted for health improvement in order to tackle health inequalities.

Recommendations

- The Mental health of a person must be as serious consideration as their physical health in all health and social care treatments with a particular focus on joint management of mental and physical health conditions at primary care, increasing skills for front line clinical and social care staff in managing mental health and understanding medicines interactions. Prioritising areas of deprivation in Kent for integrated health and mental illness case management is also recommended.

[13] Kent & Medway residents aged 18-74 registered with one of the Kent & Medway *GPs flowing data into the KID* at September 2018 who died in the *12-month period* between October 2017 and September 2018[13], or were still alive at the end of the study period (1,233,847 adults).

Ensuing there is increased and targeted support for lifestyle management in areas of deprivation targeted to people with mental health problems is also recommended – particularly alcohol, obesity and smoking for this group.

- Transformation of mental health services will lie both in prevention, social care and pro-active management of mental health as well as embedding high quality specialist mental health care at the heart of Local Care and primary care delivery as outlined by the NHS Long Term Plan
- Embed learning from Kent and Medway suicide prevention programme into Long Term Plan.
- Commissioners must understand the level of distress leading to self-harm, the links between self-harm and suicide and improve the access for crisis mental health via audit and research.
- Ensure there is high quality management and resources available for self-care and safety netting for people with depression and history of self-harm and suicide attempt.
- Kent and Medway have a greater reliance on specialist mental health providers then the national average in managing psychosis (see data on Qof vs referrals and treatment of psychosis in KMPT). Primary care will need high quality and timely support from psychiatry services to manage people's severe mental health within Local Care Teams.
- Overall in Kent and Medway depression is managed well in primary care – with higher rates of people registered at primary care, high rates of medication and access to counselling services however given the high rates of self-harm and suicide it is advised that better advice and support at diagnosis is given – highlighting the risks and vulnerabilities of depression symptoms and the importance if seeking help.
- In Kent and Medway, it is important to treat a person's mental and physical health together in one care plan and share this with the person requiring support. Commissioner's and providers must also be aware that a person is likely to have more than one mental health condition, and this is key to designing care pathways.
- Given the rise in severe depression and high rates of self-harm, Commissioners must be assured that patients are receiving the correct level of psychological therapy. An equity audit of NHS IAPT and NHS specialist psychology services is advised to ensure services are targeted and marketed appropriately.
- It is vital that people with serious, long term and relapsing mental health conditions have appropriate care plans in place and these plans are shared with the number of people involved with a person's physical and mental health care.
- This is a need for better Population Health Management by using more of locally curated person level linked data from all STP organisations for a range of analytics and adopt a *systems thinking* approach for better population segmentation, demand modelling & capacity planning (including workforce), and 'controlled' evaluation to

understand the effect of existing mental health service change / introduction of new services.

- Kent and Medway are a large and complex STP area and there are important differences within the patch. Thanet is the most deprived area in Kent and Medway and its mental health indicators and outcome differ to the rest of Kent and Medway. It will be important that commissioner's and providers tailor make a system that best serves the unique features of the Thanet population.
- Ensure there is an adequate and easy to access crisis mental health system in place when people are in distress preferably one that diverts people from use of mental health act powers and is pro-active rather than reactive (ie revolving door patients).
- Mental illness is a health inequality *independent* of area of deprivation – however living in an area of deprivation will compound this situation. It is important that tackling mental health feature in any plans to tackle health inequalities – both in the NHS and in KCC.
- Due to high rates of multi morbidity in the population of people with mental illness in Kent it is important to have good access to health checks, health promotion advice and support and trauma informed care at all steps in a person's access to health and social care.
- Due to high rates of co-morbidity between those with an active dependency to substances (drugs and/or alcohol) it is important to remove barriers to mental health care for this group.
- Due to as high death rates due to drug users, suicide rates and alcohol related liver disease for alcohol dependent people - it is important to ensure that care planning, psychological therapy, and risk and relapse plans are shared between agencies and people involved in a person's care.

Summary of Chapter 1

Tackling health inequalities, social isolation and adverse childhood experiences are important to prevent mental health problems in adults. Increasing the access to social and economic assets in a community and ensuring services that provide support are trained in 'trauma informed care' are also some of the ways in which mental well-being can be enhanced. Tackling the stigma and discrimination about mental illness is important because it enables people to seek help and support each other to avoid crisis. Reducing the level of chronic cortisol is possible through a number of actions e.g. mindfulness, physical activity, social connectedness and in October 2019 a new national campaign will be launched enabling the population to take steps to keep well. It will be important for all agencies to promote this campaign.

1 Introduction: Mental Health and Wellbeing in Kent

The Five Year Forward View (2016)[14] and its subsequent mandates pledge progress on the links between mental and physical health, health inequalities and social isolation. To this end there is a national pledge to bring partnerships together to tackle mental health and wellbeing. The direction of policy continues with the NHS 10 Year Plan[15] which continues to focus on reforms of the Mental Health Act detentions: better care for vulnerable groups, better access to preventative mental health services including talking therapies and a reduction in suicide rates.

1.1 Five Year Forward View, Ten Year Plan and Parity of Esteem

This needs assessment is aimed at all agencies whose goal it is to improve the health of Kent's population. It provides an overview of current available data and a deeper dive into the links between physical and mental health of Kent population, particularly focusing on depression.

In 2019, progress towards better mental health for people in Kent must focus on bringing together the health of both body and mind. Since 2011, 'parity of esteem' has been the key term and shows government commitment to mental health at the same level as physical health. The 2016 Task Force that wrote the "Mental Health 5 Year Forward View" underlined that access to mental health services should be as good as access to physical health services. Mental health conditions often bring an enormous degree of co-morbidity which must be tackled together in a systematic way. People who suffer mental illness are often poorly equipped to manage the confusing array of fragmented services and their health outcomes show a 20-year mortality gap compared with those who don't have mental

[14] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

[15] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf

illness.[16] Mental illness is often a long-term, chronic and relapsing condition, therefore, people who are suffering mental health need advocacy, get help with navigation and co-ordination of their care needs, as well as high quality treatment and social empowerment.

The new 10-year plan for NHS Mental Health Services launched in January 2019 is ambitious and challenging (Please see Appendix 1 for more details about who commissions what in mental health). Headlines are:

- Better support for children and young people and transition to adult services
- Better and more access to psychological services (IAPT)
- Better support for alcohol treatment and advice
- Faster urgent and crisis care and places of safety
- Better psychiatric liaison services and co-ordinated care
- Better lifestyle advice and health coaching.

These priorities need to be met in the context of pressures on existing social care and public health needs and a priority to support and train the mental health front line workforce.

1.2 Tackling Health Inequalities

One way to tackle health inequalities in premature death rates across all ages is to understand the way mental health and physical health interact and how this results in sickness and early death. It is widely accepted that social disadvantage increases stress which produce continuous low levels of cortisol in a person's blood stream. The impact of continuous cortisol is corrosive on the body and disabling for mental wellbeing and in part explains the higher premature death rates in people from disadvantaged areas.[17] Having a sense of personal and community resilience can mitigate these problems.

Different experiences of disadvantage and the impact of social determinants such as access to housing and work throughout a person's life links with an increased likelihood of having adverse childhood experiences (e.g. domestic violence, trauma and neglect) and can lead to poorer mental health and poor resilience in adulthood. The Health Inequalities in Kent report[18] highlights the most deprived areas in Kent and describes four distinct groups (group 1 - young people lacking opportunities; group 2 - deprived rural households; group 3 - families in social housing; and group 4/ young people in poor quality accommodation) to enable better targeting of appropriate interventions. Please see Appendix 2 for more details.

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[16] NHS England. Mental Health 5 Year Forward View. https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

[17] Kings Fund. What is happening to life expectancy in the UK? https://www.kingsfund.org.uk/publications/whats-happening-life-expectancy-uk

[18] https://www.kpho.org.uk/__data/assets/pdf_file/0011/58835/Mind-the-Gap-Analytical-Report-D2.pdf

1.2.1 Places and Environment

Certain population subgroups are at higher risk of mental health problems because of greater exposure and vulnerability to unfavourable social, economic and environmental circumstances, which intersect with factors including gender, ethnicity and disability. This needs assessment must be taken in the context of the **Kent Children's Emotional and Mental Health Needs Assessment**[19] as well as the many reports that exist describing the nature and extent of Kent's health inequalities, including *Mind the Gap: Tackling Health Inequalities in Kent*[20], and Kent Local Mental Health & Well Being Tool[21]. The toolkit has been developed by Kent Public Health team to show that wards in local communities all differ in their needs and will need tailored approaches to tackling wellbeing depending on the local environment.

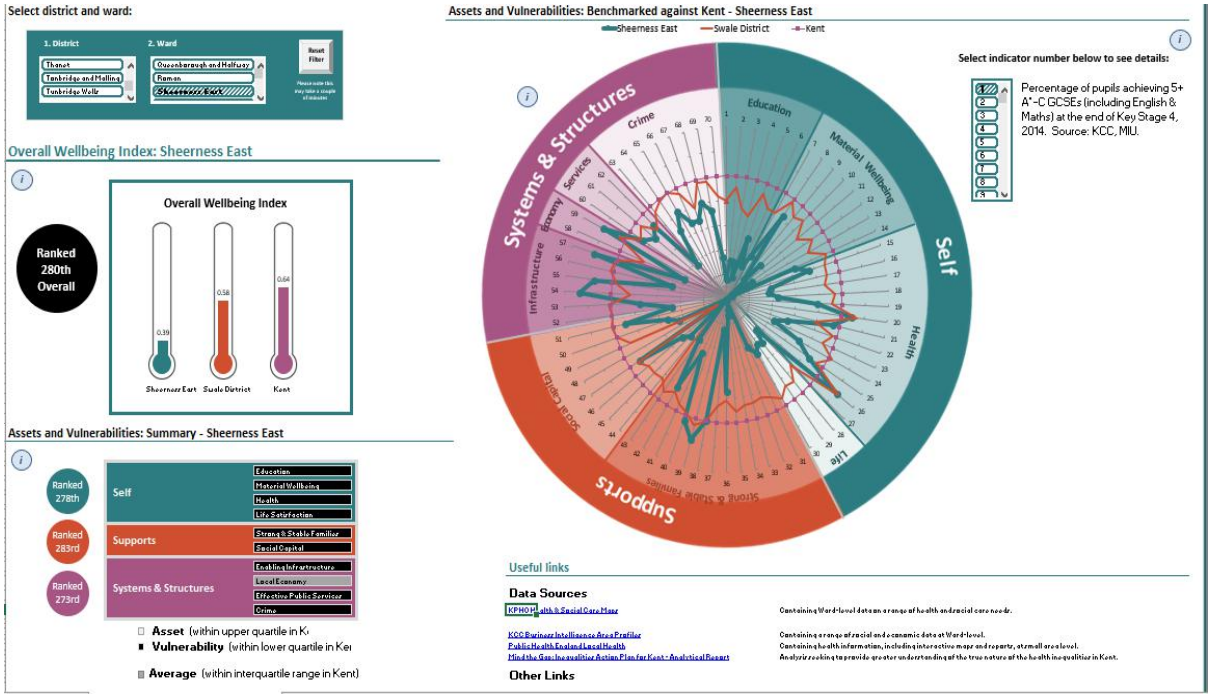
The Kent Mental Health Assets Tool provides a description of a number of indicators (taken as an index) to describe the assets and vulnerabilities of every ward in Kent. Figure 1 is an example of what the tool provides: Sheerness East, and it is compared to Swale and then Kent for overall wellbeing. The graphic below shows that this is an area with some particular issues e.g. higher rate of crime, problems with accessing services and lacking in social support. Many of the local population fall into Group 1 in the health inequalities, that is people facing problems of low income, poor mental health and high mortality from alcohol and smoking.

[19] *https://www.kpho.org.uk/__data/assets/pdf_file/0006/87459/Emotional-and-mental-Health-Needs-Assessment-for-Children-.pdf*

[20] *https://www.kpho.org.uk/health-intelligence/disease-groups/mental-health/kent-mental-health-and-wellbeing-index*

[21] *https://www.kpho.org.uk/__data/assets/pdf_file/0011/58835/Mind-the-Gap-Analytical-Report-D2.pdf*

Figure 1: Snapshot example from Kent Quality of Life and Wellbeing index



Source: Kent public health observatory

1.2.2 Adverse childhood experiences and their impact on adult mental Health: risk factors

The issue of 'Adverse Childhood Experience' is explored as these are risk factors to poor mental wellbeing in adulthood. The reason this is important is that currently services are often poorly equipped to understand the reasons for a person's behaviour and better trauma informed care may help to lesson demand on specialist mental health services and better equip all services to tackle health and wellbeing.

It is well recognised that Adverse Childhood Events (ACEs) can significantly reduce a person's resilience to cope with life events and lead to risk factors of mental illness.

1.2.2.1 Impact of Childhood Trauma

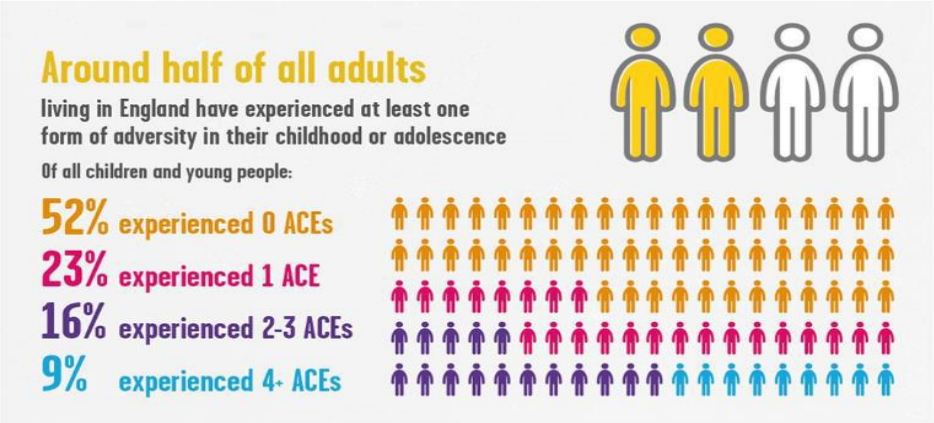
'Adverse Childhood Experiences' is the terminology that explains the cumulative impact of negative experience in childhood that impact on the developing brain that lead to difficulties in later life. New neurological and medical evidence points to changes in brain development from the trauma that will slow down an adult's ability to make changes or take in information. This is why an understanding of these issues in adult services will better equip people to offer help rather than rely on specialist adult mental health services alone. The way to enable services to cope with this new understanding of the impact of trauma on an adult is called 'Trauma Informed Care' or 'Trauma Informed Practice'. Therefore, adults who have had two or more of the issues described in figure 2 will need more time, different behavioural support and care then people who have not experienced such events. These

impacts are cumulative in impact and 16% of the Kent adult population will have trauma resulting from two or more Adverse Childhood Experiences (ACEs) and 9% will be highly impacted by their childhood trauma figure 3.

Figure 2: Forms of adverse childhood experiences

Data source: Bellies 2013[22]

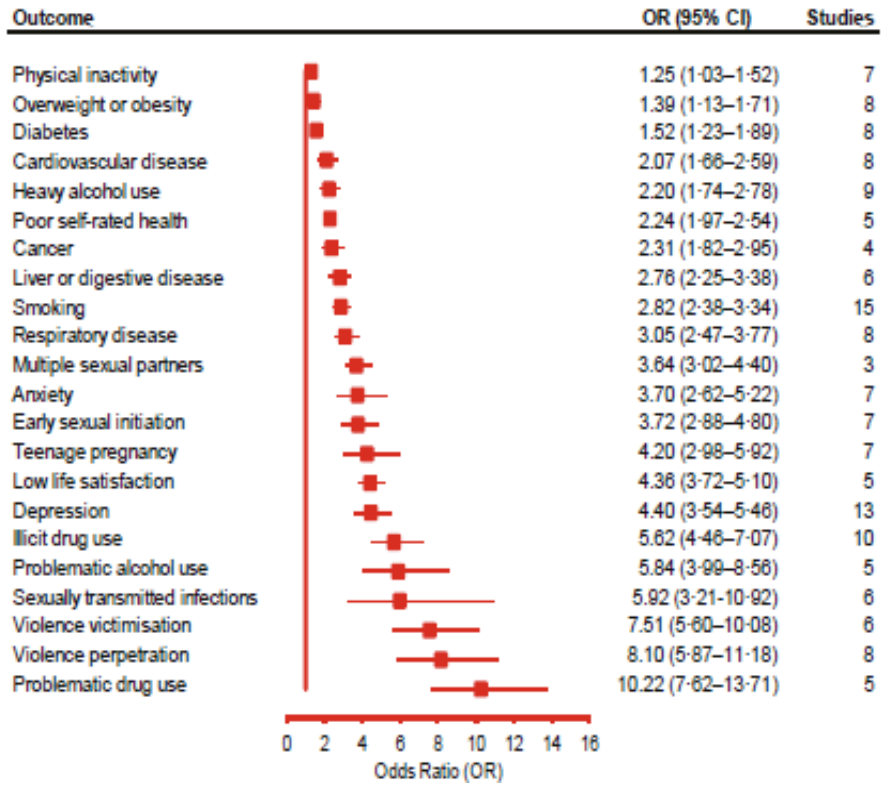
Figure 3: ACEs in adults in England



Data source: Bellies 2013[7]

[22] *http://www.wales.nhs.uk/sitesplus/documents/888/Wales%20Public%20Health%20Conference%20MAB%20Draft%20%5BRe.pdf*

Figure 4: Likelihood and Risks of Poor Outcomes in Adulthood from having 2+ ACE[23]



Source: Hughes *et al* (2017)[8]

1.2.2.2 Risk Factors from Trauma

Recent studies (Fig 4) have found that having multiple ACEs is a major risk factor for many health conditions. The outcomes most strongly associated with multiple ACEs are violence, mental illness, and substance use. To help people suffering these conditions it is important to have interventions that can tackle ACEs such as good staff training and supervision. To sustain improvements in health requires a focus on prevention of ACEs, resilience building as well as ACE-informed service provision. Hughes *et al* (2017)[8] found that by age 69 years old, 80% of people exposed to 4+ ACE had a major mental and physical condition. In a recent public health study in the North of England, many professionals (both outside and inside mental health services) admitted that they did not feel equipped in talking about traumatic events in people's lives and did not feel they had the time to do so. Yet the evidence from service users showed that even a short conversation about what had led up to the situation they were in made a significant difference to their wellbeing (Sweeney et al 2016).[24]

[23] *Hughes et al 2017 https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(17)30118-4/fulltext*

[24] *Sweeney et al 2016 https://www.emeraldinsight.com/doi/full/10.1108/MHRJ-01-2015-0006*

Compared with people with no ACEs, Adults with 4+ ACEs are: [25]

4 times more likely to be a high-risk drinker
6 times more likely to have had or caused unintended teenage pregnancy
6 times more likely to smoke e-cigarettes or tobacco
6 times more likely to have had sex under the age of 16 years
11 times more likely to have smoked cannabis
14 times more likely to have been a victim of violence over the last 12 months
15 times more likely to have committed violence against another person in the last 12 months
16 times more likely to have used crack cocaine or heroin
20 times more likely to have been incarcerated at any point in their lifetime

Table 1: Data from Public Health England's review into ACEs showed the following:

4+ ACES		
Substance Misuse Services	**64%**	**KCC Commissioned**
Mental Health Services	**60%**	**NHS Commissioned**
Employed in Social Care	**16%**	**KCC**
Homeless People	**55%**	**KCC & District**

Research published in the Lancet in 2017 has shown 16% of adults in Kent are suffering from trauma as result of 4+ ACEs. There are also life events in adulthood that can lead to poor mental health and increase the risk of mental illness, e.g. sexual assault, bereavement, debt and social isolation. More recent research is also showing that multiple exposure to trauma in adulthood also increases likelihood of mental and physical illness. [26]

1.2.3 Stigma

There has been much stigma about mental illness in the past, resulting in poor care, neglect and in many cases in the past – cruelty to those suffering mental illness. This is because the causes of mental illness have been poorly understood. The 'Time to Change' movement is now urging people to see mental illness just like physical illness, in that people with mental illness should be treated with care and respect.[27]

[25] *Public Health Wales National Study on ACE 2017*

[27] *https://www.time-to-change.org.uk*

1.2.4 Social Isolation and Loneliness

The issue of social isolation is receiving increasing attention from health and social care professionals and policy-makers due to the negative impact that social isolation is known to have on individual health and wellbeing at different stages of life. Research shows that there is a 26% greater early death rate for people suffering social isolation[28].

1.2.4.1 Definitions[29]

Social isolation: The inadequate quality and quantity of social relations with other people at the different levels where human interaction takes place (individual, group, community and the larger social environment).

Loneliness: An emotional perception that can be experienced by individuals regardless of the breadth of their social networks.

1.2.4.2 Mechanism Evolutionary adaption to stress and cortisol

Stress is central to the mechanisms whereby social isolation can contribute to poor health.[32] [33] Physical or psychosocial stressors (such as social isolation) activate adaptive biological systems in the body (the nervous system, cardiovascular, metabolic and immune systems). While there are personality characteristics, behavioural responses (such as smoking) and psychosocial factors (including social support) that can modulate the perception of stress. Prolonged exposure to stress is damaging to biological systems in the body via the build-up and corrosive action of cortisol in the blood and to the immune system.

1.2.4.3 Consequences

Mental illness: The emotional impact of stress can be a rise in depression and anxiety and poor self-care, self-harm and neglect.

Physical Illness: There is a higher rate of CVD and COPD, inflammation and some cancers.

Addictions: can be both rooted in, and the cause of, social isolation. Adverse social experiences such as isolation, abandonment and neglect, especially during the early stages of life, increase an individual's risk of developing drug addiction.

1.2.4.4 Risk Groups

Social Isolation can occur at all life stages and particularly[30]:

- new and young mothers

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[28] Holt-Lunstad, Julianne. Social Relationships and Mortality Risk: A Meta-analytic Review. 2010

[29] Zavaleta D, Samuel K, Mills C. Social isolation: a conceptual and measurement proposal. POPHI Working Paper No 67, Oxford Poverty and Human Development Initiative, 2014.

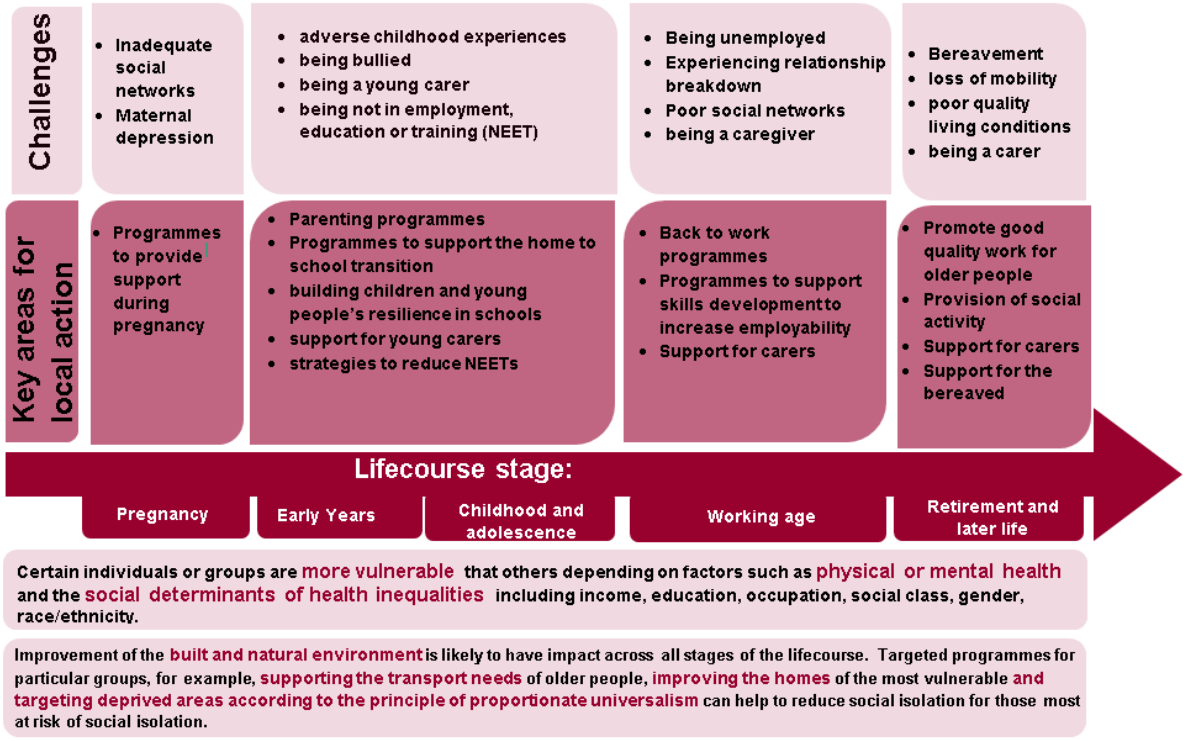
[30] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/461120/3a_Social_isolation-Full-revised.pdf

- minority groups, e.g. LGBTQ and BME where access to a community is missing
- shift workers
- older people.

1.2.4.5 Antidote

Social support is a key aspect of social networks for health and wellbeing.

Figure 5: Tackling social isolation across the Lifecourse



Public Health England have developed the schema in Figure 5 (above) to help develop programmes to tackle social isolation across the life course.[31]

A detailed report developed by Kent County Council identifies the risks to health and wellbeing as a result of social isolation in the population aged 65+. (Figure 6). The Kent residents identified as being in the highest risk group of older people at possibility of social isolation and loneliness *and* found they had the highest levels of multimorbidity, depression, the highest usage of acute and social care services, and the highest levels of frailty.[32]

[31] *PHE England. Local action on health inequalities: reducing social isolation across the lifecourse. Sep 2015*

[32] *https://democracy.kent.gov.uk/documents/s86149/Social%20isolation%20and%20loneliness%20in%20Kent%20-%20Public%20Health.pdf*

Figure 6: % of the population who are older people more likely to be experiencing social isolation/loneliness: by electoral ward

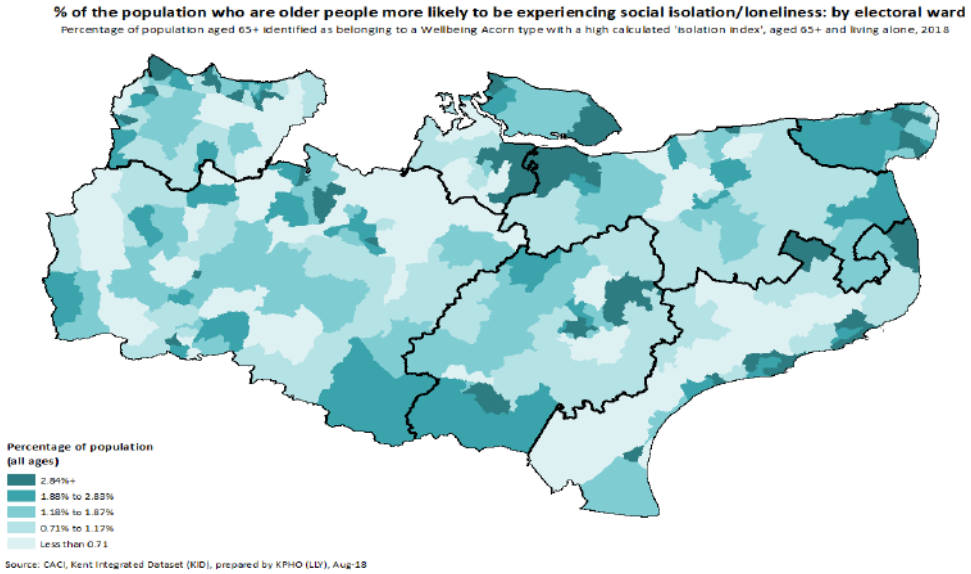
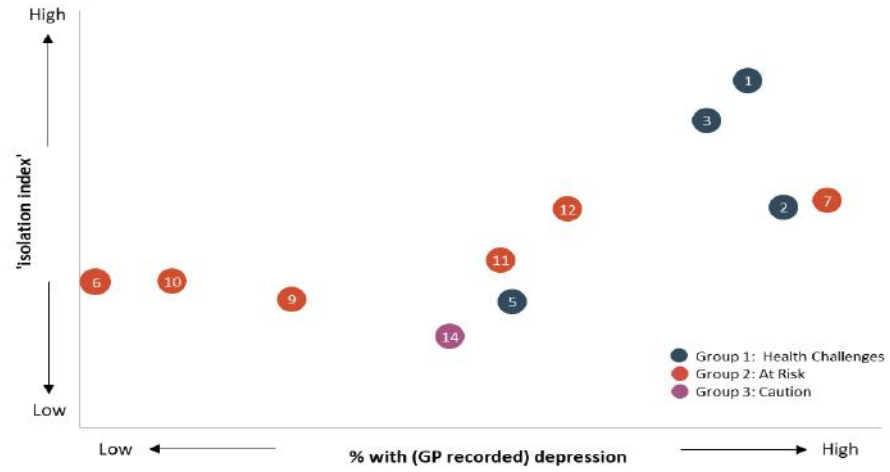


Figure 6 shows all areas in Kent have pockets where people are socially isolated. Rural and coastal areas are most vulnerable.

Figure 7: ACORN (Market research dataset) segmentation of Socially Isolated people aged Over 65 in Kent and QOF depression scores.



Data source: ACORN[33]

Figure 7 shows that people who score high on the 'isolation index' are more likely to see their GP's for depression.

[33] *https://acorn.caci.co.uk/*

Summary of Chapter 2

Mental illnesses are hard to define and quantify epidemiologically. This is due to the sheer range of conditions and the overarching and interacting symptoms e.g. depression. However, the best indication of the extent of the conditions in Kent and Medway is the Adult Psychiatric Morbidity Survey (2007 & 2014). This shows that there has been an increase in severe depression, particularly among women. The APMS predicts 31,540 men and 52497 women with severe depression in Kent and Medway. The prevalence of psychotic conditions is relatively stable from 2007 to 2014 at 0.5% of the adult population. This predicts approximately 5,900 people with psychotic disorder in Kent and Medway. Black men appear to have higher rates than other groups at 3.2%. However, 'sub-threshold' psychosis - which is more prevalent (6%), may be present in people accessing primary care. Living alone is also a predictor of higher rates of psychosis (1.1%). There are 12,231 people in Kent on a GP register for psychosis. This is above the predicted rate for Kent and Medway. It will need to be assessed whether these are people with psychosis or people with other serious and long-term conditions (e.g. substance misuse disorder) placed under this QoF category. There are 2% of people predicted to have Bi-polar disorder. Nationally Bipolar disorder is often misdiagnosed as relapsing depression. It is important to diagnose bipolar as the medication for depression can cause harm in a person with Bipolar Disorder. Personality disorder (PD) is both serious and relatively common. It is estimated that almost 24% of the population accessing primary care may have some form of PD. PD may not be a particularly helpful term as they describe a number of interacting symptoms mainly due to problems in childhood attachment and trauma e.g. child sex abuse and neglect. A national study found that in 2010 40% of people in secondary mental health services had PD. People with PD are more likely to have substance misuse disorders, suicidality, self-harming behaviour and be victims and perpetrators of violence and crime. Eating disorders affect 1.6% of adults in the severe clinical threshold. It impacts women more. Around 31% of adults experience a traumatic event (as an adult) and 1 in 20 is likely to have post-traumatic stress disorder. Pregnancy and motherhood are vulnerable times for a woman's mental health. It is a significant life event, and also subject to enormous hormonal changes. The quality of attachment between mother and infant can also have lasting impact on a person as an adult (see personality / adult attachment disorder). Mental illness in Older age is often masked by physical illness and organic mental incapacity (dementia). However, older age is also significant life stage that can lead to social isolation. Older people also face mental illness e.g. 1% of people over 65 will have psychosis. Carers mental health is also vulnerable as they face a high degree of isolation and stress. It is vital that a person with mental illness has their physical health taken as seriously as their mental health. People with mental illness die on average 20 years earlier of a physical health problem then a person without mental illness.

2 The Extent of Mental Health Problems and Illness in Kent

Mental health problems are a growing public health concern. This chapter provides an overview of the prevalence of mental health problems, it's international and UK wide context and Kent in particular. Where possible data will highlight Kent districts and wards, however data will describe the extent mainly in Kent and Medway, and CCG (pre 2017) localities. This chapter will describe details on the main types of problems and their impact on mortality, disability and suicidal intent.

This chapter will give an overview of prevalence data for mental health in Kent and will then take a 'deeper dive' into two key conditions: depression and psychosis. These have been chosen because the links between depression, suicide and physical health problems and psychosis – because of its links to premature mortality.

A Note of Caution on Data: mental health is a complex field, so statistics have been selected that help to illustrate many of the challenges facing individuals, families, communities and wider society. Reputable sources of data such as government, research and policy organisations and peer reviewed publications, have been used. A word of caution; these are illustrative statistics and not the whole picture. They are drawn from many different sources, collected on different dates, and gathered in different places from people with different characteristics (for example, age, sex and ethnicity).

2.1 International Prevalence, Context & Terminology

According to the 2018 Global Burden of Disease UK Study, depression was the fourth leading cause of years lived with disability, behind low back and neck pain, skin and subcutaneous diseases, and migraine.[34] In 26 countries, depression was the primary driver of disability.[35] After depression, the next most prevalent mental illnesses are anxiety, schizophrenia and bipolar disorder. Depressive disorders also contribute to the burden of suicide and heart disease on mortality and disability; they have both a direct and an indirect impact on the length and quality of life. [36]

[34] *UK GBD 2018. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32207-4/fulltext*

[35] *Vos, T., Barber, RM., Bell, B., Bertozzi-Villa, A., Biryukov,S., Bolliger, I., …Murray, CJ.. (2013). Global, regional, and national incidence, prevalence, and years lived with disability for 301 acute and chronic diseases and injuries in 188 countries, 1990–2013: A systematic analysis for the Global Burden of Disease study. The Lancet, 386(9995), 743–800.*

[36] *Ferrari, A.J., Charlson, F.J., Norman, R.E., Patten, S.B., Freedman, G., Murray, C.J.L., … & Whiteford, H.A. (2013). Burden of Depressive Disorders by Country, Sex, Age, and Year: Findings from the Global Burden of Disease study 2010. PLOS Medicine, 10(11).*

2.2 Common Mental Illness (Disorder) & Serious and Enduring Mental Illness (Disorder)

There are two interacting ways to consider mental health. Just like physical health – there is an every-day, fluctuating sense of 'health' and this can be called 'mental health or mental wellbeing'. Every person has this, and it can fluctuate and be responsive to a person's actions. Most people, with some effort, will achieve a sense of wellbeing. There are life events and 'stressors' that can impact on 'mental wellbeing' that a person can either withstand or become vulnerable to.

2.2.1 The Adult Psychiatric Morbidity Survey for England (APMS)

The Adult Psychiatric Morbidity Survey for England (APMS), which has been carried out every seven years since 1993, offers some of the most reliable data for the trends and prevalence of many different mental health problems and treatments. The survey, carried out in 2014 and published in 2016, is the source of many of the prevalence figures cited in this section and applied to Kent's population. Please see the methodology of APMS in Appendix 3.

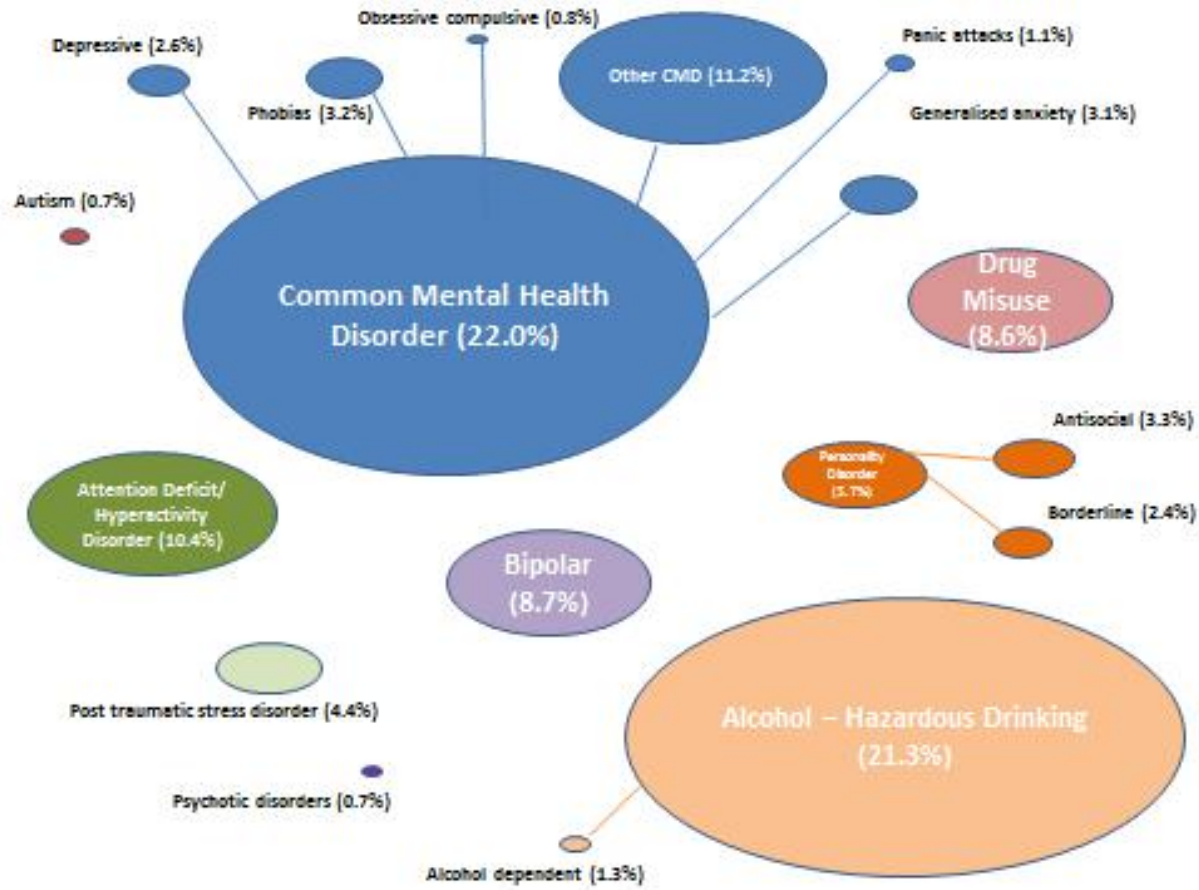
In examining prevalence rates, and to some extent incidence of mental health disorders in Kent, three approaches have been taken; firstly by applying rates taken from APMS secondly from QOF and PHE fingerprints data and finally by looking at data from the Kent Integrated Data set (KID).

The Figure below (Figure 8) sets out the percentage of people with mental health disorders in Kent using data from the 2014 National APMS. The 2014 APMS found that one adult in six had a common mental disorder (CMD): about one woman in five and one man in eight. In Kent, 22% of the general population have a common mental health disorder (Figure 8).

Drug and alcohol problems are prevalent in the population where 21% of the population are drinking at hazardous levels and 8% are misusing drugs. The more serious and persistent conditions can also be seen within the depression category where 2.6% have serious and enduring depression, 8.7% have bi-polar, 10% of adults have attention deficit hyperactivity disorder (ADHD), 4% have post-traumatic stress disorder (PTSD) and less than 1% have psychosis. It is important to note the high degree of co-morbidity and co-occurrence of mental health problems.

A third of people (36.2%) who self-identified as having a mental health problem in the 2014 Adult Psychiatric Morbidity Survey (APMS) have never been diagnosed by a professional.[25]

Figure 8: Percentages of mental health disorders in Kent (applied from APMS survey 2014 to 2016 Kent Population aged 16- 74 estimates)



2.2.2 Common Mental Illness

Psychiatry is a complex art and science and conditions are often interacting, fluctuating and dynamic (e.g. they can stabilise over time). Common Mental illness (CMI) is a term used for depression, anxiety, obsessive compulsive disorder and panic disorder. It is called 'common' because it is prevalent (1 in 4 over a lifetime). In many cases of CMI, it can be of short duration. However, there are two forms of depression that are complex and enduring:

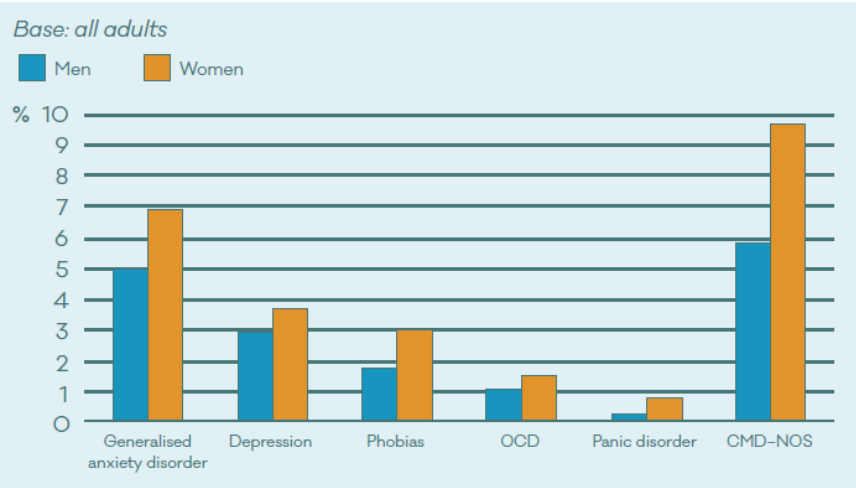
- Major Depressive Disorder (chronic or episodic and recurring severe depression): please note that the prevalence of major depressive disorder is 5 to 15% of the primary care population[37] although it is understood that this is under-diagnosed.
- Dysthymia (chronic moderate depression)

Measuring the prevalence of mental health problems is challenging for many reasons such as the hidden nature of mental health issues, variations in access and stigma and the variation in diagnostic practices across the country. Scotland and England & Wales use

[37] *NICE guidance https://www.nice.org.uk/guidance/ta367/documents/major-depressive-disorder-vortioxetine-id583-final-scope2*

different measures for mental health which makes it difficult to determine whether areas have more or fewer mental health problems. Therefore, we need to be cautious about directly comparing statistics, as they are not always resulting from similar surveying techniques.

Figure 9: Prevalence % of common mental health problems by sex



Data source: APMS (2014)

2.2.2.1 Estimated Common Mental Health Disorders in Kent (APMS)

The 2014 APMS rates have been applied to Kent population data by gender and age band to estimate the *numbers* of people affected by 'Common Mental Health Disorder' in Kent (using 2016 population estimates for the whole population) in figure 9 and (2011 census estimates) for table 2. Overall there has been a slight increase in the numbers of people with CMI in Kent which reflects a real increase in population level needs for depression and anxiety.

The data coloured 'green' in Table 2 show where numbers have *increased* with prevalence. Overall, women in Table 2 below, show higher rates of CMDs than men, however there are a few age groups among certain conditions that buck this trend:

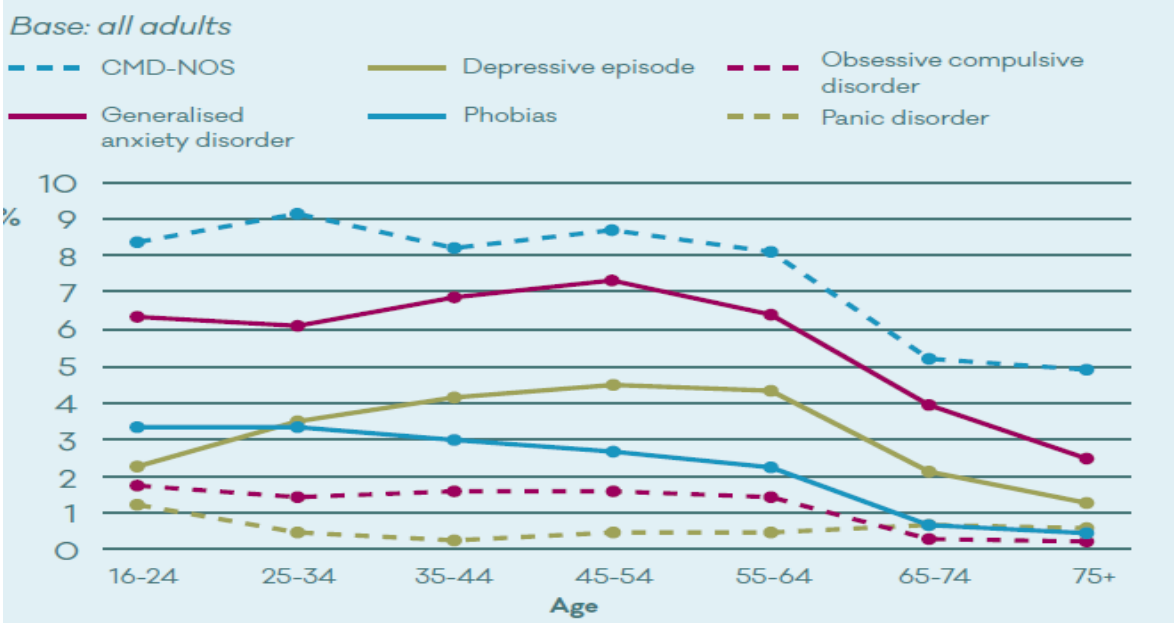
- Men aged 55-64yrs have higher predicted rates of panic disorder than women of the same age (men = 0.7% and women = 0.2%).
- Depression episodes are more common among men aged 25-34 than women of the same age range (4.1% and 2.8% respectively). This is an increase of over 2% for men in this age group and over 1% for women. There is a slight increase in the rates of CMD in people aged over 75 (Table 2).

The APMS (2014) data shows that most of the burden for CMI falls in the 24 to 55 age brackets (Figure 10). However, there is a large proportion of vulnerability in the 16-24 ages, a group that are served by Children and Young People's Mental Health Services (CAMHS).

The estimates of the numbers of people with the most severe depression is calculated from the APMS using the CIS-R measure (Please see appendix 3 for more details about APMS methodology and findings). Those scoring 18+ on this measure are likely to have severe clinical depression and will need a more intensive intervention.

Figure 10: APMS prevalence of common health problems by age (16-75+)[38]

APMS prevalence of common mental health problems by age (16- 75+).



Data source: APMS

[38] *Stansfeld, S., Clark, C., Bebbington, P., King, M., Jenkins, R., & Hinchliffe, S. (2016). Chapter 2: Common mental disorders. In S. McManus, P. Bebbington, R. Jenkins, & T. Brugha (Eds.), Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital.*

Table 2: APMS Estimates of number and rates of Kent residents with Common Mental Disorder (see if we could re-do the table, one issue is labelling score and age, another is improvement and decline (red and green))

Estimates of the number of residents with Common Mental Disorder*- Kent

Clinical Interview Schedule – Revised (CIS-R) score	Estimated number of residents by age band								Percentage change since last APMS in 2007								2014 APMS Prevalence
	16-24	25-34	35-44	45-54	55-64	65-74	75+	All	16-24	25-34	35-44	45-54	55-64	65-74	75+	All	
Men																	
Under 12	70132	65859	87739	79696	74971	54518	43607	378575	2.8%	-2.0%	-1.8%	0.6%	-4.7%	-0.6%	1.0%	-1.0%	86.40%
12 or more	7021	11897	15605	12120	13126	4293	2440	59591	-2.8%	2.0%	1.8%	-0.6%	4.7%	0.6%	-1.0%	1.0%	13.60%
18 or more	3240	6065	8578	6427	8017	2117	507	31986	-2.2%	1.4%	1.8%	-0.4%	4.1%	1.7%	-1.6%	0.9%	7.30%
Women																	
Under 12	56455	65919	85061	72253	74461	55973	65379	354025	-5.0%	2.7%	-2.2%	0.7%	-3.0%	-0.7%	1.6%	-1.3%	78.60%
12 or more	19835	15563	22069	21218	17580	8290	7264	96389	5.0%	-2.7%	2.2%	-0.7%	3.0%	0.7%	-1.6%	1.3%	21.40%
18 or more	11520	7007	11999	11684	8560	3085	3560	50897	3.1%	-1.6%	1.6%	-1.3%	1.3%	0.9%	0.8%	0.6%	11.30%
People																	
Under 12	126587	131778	172800	151949	149432	110491	#####	732601	-0.9%	0.4%	-2.0%	0.7%	-3.9%	-0.6%	1.4%	-1.1%	82.50%
12 or more	26856	27460	37674	33338	30706	12583	9705	155979	0.9%	-0.4%	2.0%	-0.7%	3.9%	0.6%	-1.4%	1.1%	17.50%
18 or more	14760	13072	20576	18111	16577	5202	4066	82883	0.4%	-0.1%	1.7%	-0.9%	2.7%	1.2%	-0.2%	0.8%	9.30%

Source: Adult Psychiatric Morbidity Survey 2014 Represents improvement in prevalence Represents decline in prevalence

* CIS-R score represents severity of overall neurotic symptoms, with a higher score indicating more severe symptoms. A score of 12 or more indicates symptoms of anxiety and depression of a level likely to benefit from acknowledgement and possible intervention; 18+ indicates severe symptoms that would almost certainly benefit from intervention and treatment

The data in Table 2 shows just over 83,000 people in Kent have need for treatment for depression (using the CIS-R scale).

2.2.3 Severe Mental Illness

Severe Mental Illness (SMI) is the *historic* term for conditions that are less prevalent, chronic and highly disabling such as psychosis and bi-polar disorder and affect around 0.5% to 1% of the population. The predicted incidence of severe and enduring mental illness (SEMI) is expected to grow at a faster rate than the population.[39] For example, in East Kent, the annual growth of predicted incidence on SEMI is expected to rise 13.9% over the 10-year period. More details regarding the projections for the ICPs are to be found in appendix 4.

It is estimated that approximately **15% of the CMD** population will be in this severe category. In Tables 3 & 4 the rates of those reporting over 12 (moderate to severe) have been applied to the 2011 census data for men and women in Kent.

[39] *Kent Integrated Care Partnerships. Population Health Analysis for NHS Long-term Planning.*

Table 3: Estimated Numbers and Rates of Men with Severe CMD (Depression/Anxiety) in Kent

CIS-R score (severity)	2000		2014	
Moderate Severe (12-17)	6.7%	**28,948**	6.3%	**27,220**
Severe (18+)	6.7%	**28,948**	7.3%	**31,540**

Data source : APMS 2014 % applied to Kent Census Data 2011- males over 16 years.

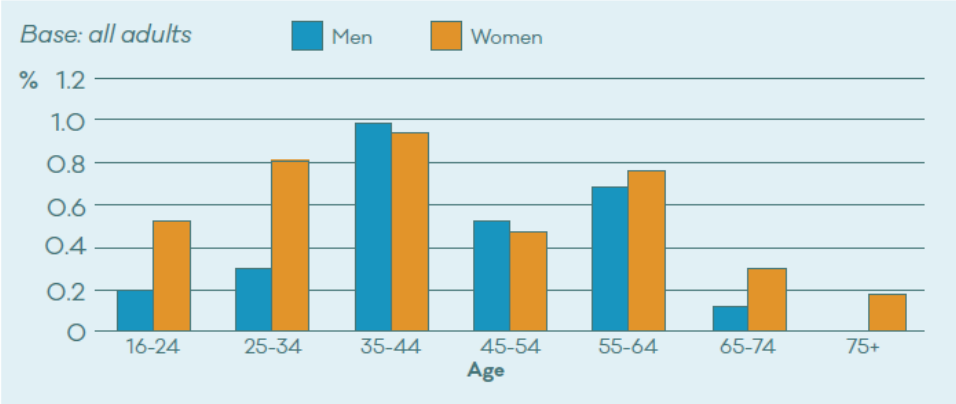
Table 4: Estimated Numbers and Rates of Women with Severe CMD (Depression/Anxiety) in Kent

CIS-R score (severity)	2000		2014	
Moderate Severe (12-17)	10.2%	**47,386**	10.1%	**46,922**
Severe (18+)	9%	**41812**	11.3%	**52,497**

Data source: APMS 2014 % applied to Kent Census Data 2011- females over 16 years.

2.2.3.1 Estimated prevalence and risks of Severe Mental Illness (including Psychosis) in Kent

Figure 11: APMS prevalence of a psychotic disorder in the past year (2007 and 2014 combined) by age and sex.[27]



Data source: APMS

The prevalence of psychotic conditions has remained relatively unchanged between the 2007 and 2014 APMS. Less than one adult in a hundred had a psychotic disorder in the past year. In 2007, the estimate was **0.4%** and for 2014 it is **0.7%.** As the numbers of positive cases were low (23 in 2007 and 26 in 2014), researchers pooled data from the 2007 and 2014 surveys to create a larger sample and found, using the combined dataset, the overall prevalence of a psychotic disorder in the past year to be **0.5% of the adult population**.

Using the 2011 census estimate for Kent population aged 16+, the estimated number of people with psychosis in Kent is **5,900** people.

The combined data shows no difference in the prevalence rate found for men and women (0.5% and 0.6% respectively). The highest prevalence for both men and women was found among those aged 35–44 (Figure 11).

The prevalence of psychotic disorder were higher among black men (3.2%) than men from any other ethnic group (0.3% white, 1.3% Asian, and no cases observed in mixed/other ethnic groups (using combined 2007 and 2014 data). No significant differences were observed for ethnic groups among women.

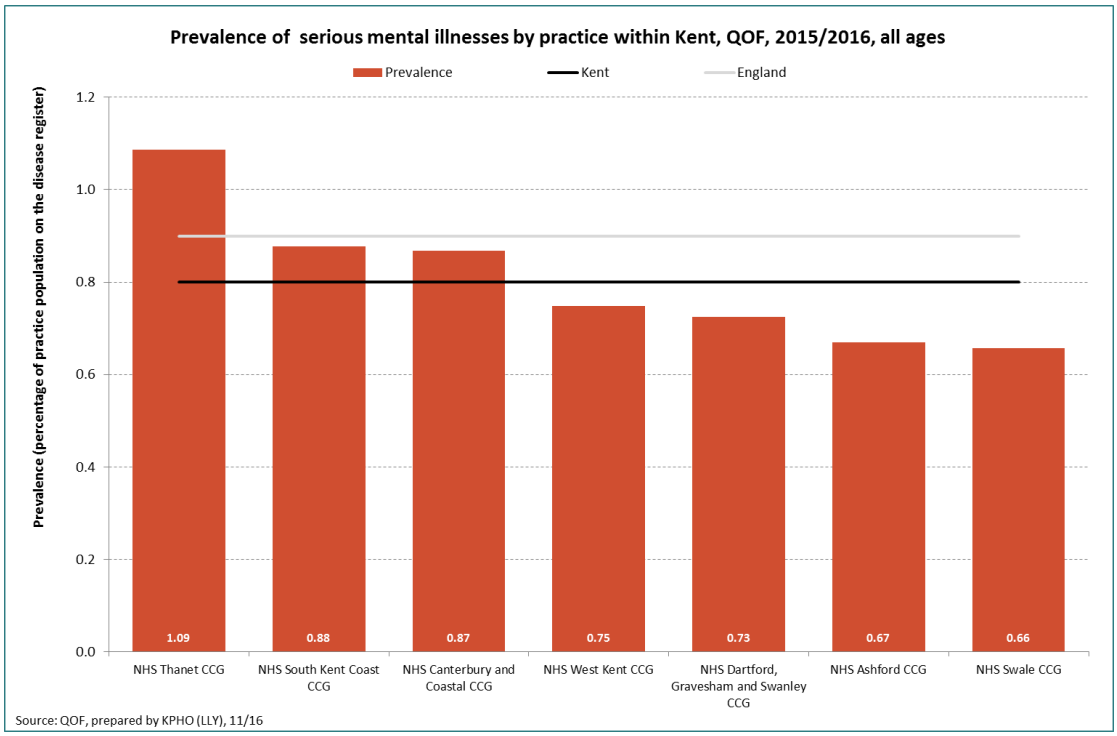
Living alone is a risk factor for psychotic disorder as higher rates of psychotic disorder were observed in those living alone (1.1%) and were lower in people living with others (0.6% with children and 0.4% with other adults (using combined 2007 and 2014 data).

2.2.3.2 SMI (Severe Mental Illness / Psychosis) - QOF

In Figure 12 below the QOF prevalence rate for serious mental illness for NHS Thanet, has rates higher (1.09%) than the QOF England average. NHS South Kent Coast and NHS Canterbury and Coastal have rates higher than the Kent QOF average of 0.8%. The QOF prevalence rate for serious mental illness for England in 2015/16 is 0.85%. Please see Appendix 5 for more details on QOF for mental illness.

Key Finding: Across the whole of Kent there are 12,231 people on the QOF register for serious mental illness in 2012-13. West Kent CCG has the highest numbers of patients suffering from serious mental health illness due to its larger population. Thanet has the highest rates per population.

Figure 12: Prevalence Rates for Serious Mental Illness within Kent (QOF 2015/2016 all ages)



2.2.4 Severity of a Wide Range of Interacting and Co-morbid Mental Illnesses

There are many mental health conditions and both CMI and SMI can differ between mild to moderate and severe and enduring. There has been an increase in the rate and severity of all mental illness – both CMI and psychosis[40]. There is an estimate of **17% of the population who have 'sub-threshold'** (just under the threshold criteria for clinical treatment) depression and anxiety and 6% of the population have sub threshold psychosis. Sub-threshold health status can present an important opportunity for prevention and early intervention.[41]

2.3 Schizophrenia (or psychotic disorder)

Psychotic disorders produce disturbances in thinking and perception that are severe enough to distort perception of reality. The main types are schizophrenia and affective psychosis. Overall, the prevalence of psychotic disorder in the past year has remained broadly stable at less than one adult in a hundred (0.4% in 2007, 0.7% in 2014). Because psychotic disorder

[40] The Centre for Economic Performance's Mental Health Policy G. How mental illness loses out in the NHS? London: The London School of Economics and Polical Science, 2012. http://www.bps.org.uk/news/how-mental-illness-loses-out-nhs.

[41] McManus S, Meltzer H, Brugha T, Bebbington PE, Jenkins R. Adult psychiatric morbidity in England, 2007: results of a household survey. Leeds: NHS Information Centre for Health and Social Care, 2009. HYPERLINK "http://www.ic.nhs.uk/pubs/psychiatricmorbidity07" http://www.ic.nhs.uk/pubs/psychiatricmorbidity07.

has a low prevalence, data from APMS 2007 and 2014 have been combined to increase the number of positive cases for analysis. 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 5 presents the predicted rates of people with psychosis across Kent.

Table 5: 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

Data source: KMPH0

2.3.1 Pattern of development:

Each year 1 in 10,000 adults (12 to 60 years of age) develops schizophrenia. Based on a restrictive and precise definition of the diagnosis and using standardized assessment methods and large, representative populations, the incidence rates appear stable across countries and cultures and over time, at least for the last 50 years.

The uneven distribution of prevalence rates is a result of social selection: an early onset leads to social stagnation, a late onset to descent from a higher social status. The main age range of risk for schizophrenia is 20 to 35 years. In 75% of cases, first admission is preceded by a prodromal (early symptomatic) phase with a mean length of 5 years and a psychotic prophase of one year's duration. On average, women fall ill 3 to 4 years later than men and show a second peak of onset around menopause. Consequently, late-onset schizophrenias are more frequent and more severe in women than in men.[42]

[42] *The Canadian Journal of Psychiatry Vol 42, No 2 Epidemiology of Schizophrenia Heinz Häfner, Wolfram an der Heiden*

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

2.3.2 Ethnicity and Inequality:

Psychotic disorder was associated with ethnic group, with rates found to be higher in black men (3.2%) than men from other ethnic groups. Psychotic disorder did not vary significantly in rate between ethnic groups among women.

2.4 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.

Before APMS 2014, bipolar disorder had not been assessed in the UK general population. APMS 2014 has found that overall, 2% of those surveyed screened positive for bipolar disorder, with similar rates of around 2% for both men and women.

Positive screening for bipolar disorder was more common in younger age-groups. Three per cent of 16 to 24-year-old screened positive compared with less than 1% of those aged 65 to 74 years. None of the participants aged 75 years and over screened positive for bipolar disorder. These were small numbers of individuals and the rates for specific age groups in the overall population may vary from these, but the overall reduction of rate with age was found to be statistically significant.[43]

[43] *http://content.digital.nhs.uk/catalogue/PUB21748*

Table 6: Estimates of the number of residents with bipolar disorder in Kent

Estimates of the number of residents with Bipolar Disorder*- Kent

No. of characteristics	Estimated number of residents by age band								2014 APMS Prevalence
	16-24	25-34	35-44	45-54	55-64	65-74	75+	All	
Men									
0-6	58710	68736	94243	85835	81569	56347	45466	489447	90.1%
7+	18443	9020	9101	5981	6528	2464	581	53577	9.9%
7+ several same time	8654	6478	5611	4099	3390	1225	90	30579	5.6%
Women									
0-6	60033	73330	100330	87698	88571	63157	71666	542386	92.3%
7+	16257	8152	6800	5773	3470	1105	977	44933	7.7%
7+ several same time	7893	6406	4668	2673	2323	457	289	26174	4.5%
People									
0-6	118743	142066	194574	173533	170140	119505	117132	1031834	91.3%
7+	34700	17172	15900	11754	9998	3569	1558	98510	8.7%
7+ several same time	16547	12883	10279	6772	5714	1683	379	56753	5.0%
7+ several same time	6950	5411	4317	2844	2400	707	159	23836	2.1%

Source: Adult Psychiatric Morbidity Survey 2014

*A positive screen requires endorsement of at least 7 lifetime manic/hypomanic symptoms, of which serveral co-occur, and are associated with moderate or serious functional impairment

The APMS 2014 has a higher proportion of people presenting with bipolar disorder from the Black/Black British ethnic groups (Table 7).

Table 7: Percentage breakdown of bipolar disorder by broad ethnicity in Kent

Percentage breakdown of Bipolar Disorder* by broad ethnicity - All Kent

Bipolar Disorder	White British	White other	Black/ Black British	Asian/ Asian British	Mixed/ multiple/ other
Men	2.10%	2.80%	3.80%	1.60%	0.90%
Women	1.70%	1.50%	4.70%	1.20%	2.50%
People	1.90%	2.10%	4.30%	1.40%	1.70%

Source: Adult Psychiatric Morbidity Survey 2014

*A positive screen requires endorsement of at least 7 lifetime manic/hypomanic symptoms, of which serveral co-occur, and are associated with moderate or serious functional impairment

2.5 Personality disorders (PD)

2.5.1 Definitions of PD

A new Needs assessment has been produced on Personality Disorder (PD) in Kent.[44] In summary PD 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

[44] www.kpho.org.uk

criminal behaviour and in milder cases can be linked to behavioural problems or impulsivity. More details about the characteristics of PD can be found in appendix 6.

2.5.2 Prevalence and Treatment of People with PD

Nationally only 0.3% of respondents were diagnosed as having anti-social personality disorder and 0.4% as having borderline personality disorder. In Kent, there are a predicted 3,713 people with antisocial personality disorder (Figure 13).

Research (2000) suggests that among people accessing primary care, the prevalence of PD is 24%.[45] PD will have a greater representation in primary care. The King's Fund research from 2008 argues that we do not know how likely people with PD are to visit their GP and there may be reasons for it being both higher and lower than national norms.[46]

Personal Medical Services data shows that 64.6% of all people have consulted their GP for some reason in the previous year. The Kings Fund has assumed that people with PD have the same rate of use. (In fact, the use of GP services could be more than average, but definitive data were unavailable.) This suggests that, nationally, 1.59 million people with PD are in contact with their GP.[33]

A National study in 2010 found that up to 40% of Community Mental Health Teams' time is spent supporting people with PD.[47]

2.5.3 Prevalence of PD in Hospital Admissions in England

It is important to evaluate the number of hospital admissions relating to PD, to determine the impact this is having on NHS services and to understand the relationship between activity and prevalence. In England, over the last three years, between 2012-13 and 2014-15, there has been a steady increase in hospital admissions in which a diagnosis of PD is recorded.

For each episode a diagnosis is given to record the reason for care as either the primary diagnosis (the main reason for the episode of care) or up to 19 secondary diagnoses, believed to be related comorbidities. The diagnosis of PD is often problematic and subjective. People can show a smaller range of symptoms at a severe end or many symptoms at a milder threshold. The management of PD is often complex and requires a range of talking therapeutic options.

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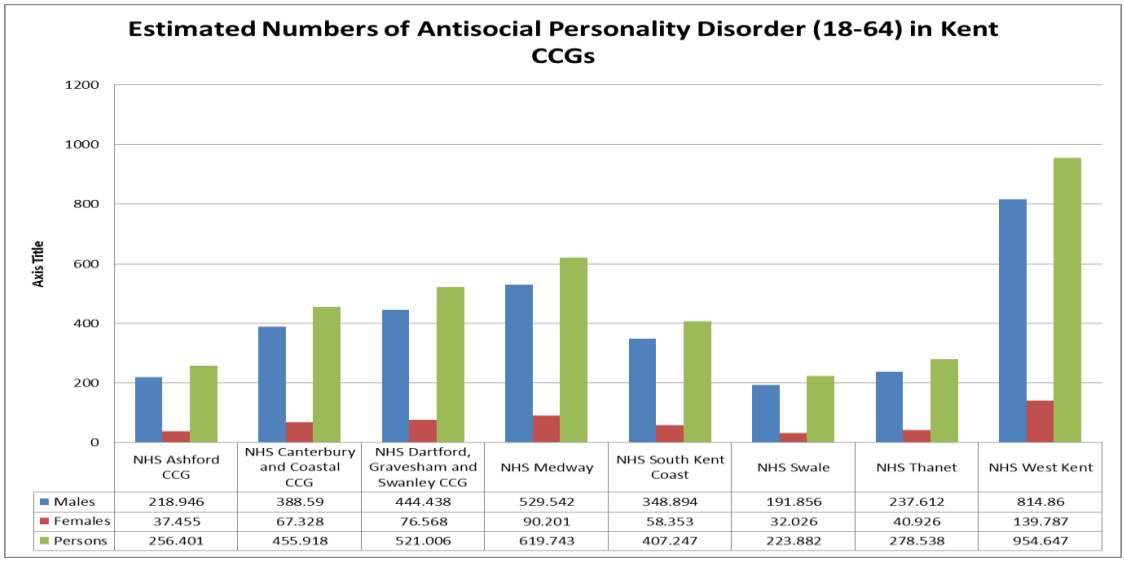
[45] Moran, P., Jenkins, R., Tylee, A. et al. (2000). The prevalence of personality disorder among UK primary care attenders. Acta Psychiatrica Scandinavica, 102, 52–57

[46] P McCrone, S Dhanasiri, A Patel, M Knapp, S Lawton-Smith, 'Paying the price', King's Fund, 2008.

[47] Newton-Howes, G., Tyrer, P., Anagnostakis, K. et al. (2010). The prevalence of personality disorder, its comorbidity with mental state disorders, and its clinical significance in community mental health teams. Social Psychiatry and Psychiatric Epidemiology, 45, 453–460

When looking at all PD diagnoses (primary and secondary), the PD needs assessment describes a rate of 102 Full Consultant Episodes per 100,000 population in 2014-15, **an increase of 28.75% since 2012-2013**.[48]

Figure 13: 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

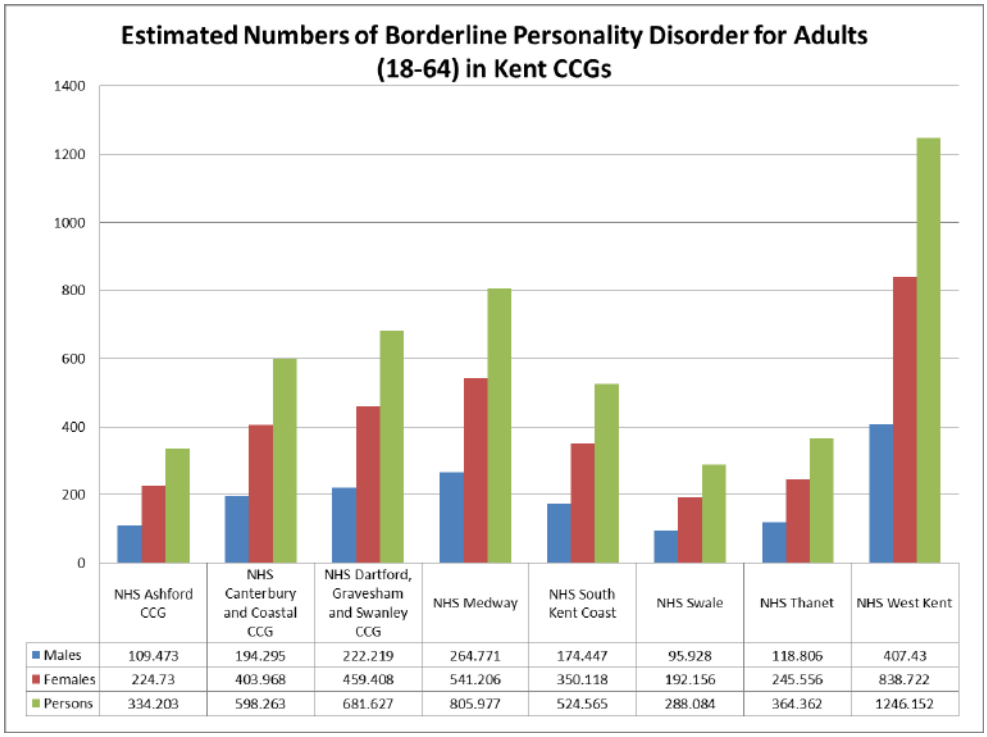
Source KMPHO 2014

Figure 13 demonstrates anti-social behaviour disorder is more prevalent in men.

In Kent, there are a predicted 4,841 people with borderline personality disorder (Figure 14)

[48] *Kent Personality Disorder* www.kpho.org.uk

Figure 14: Estimated numbers of Borderline Personality Disorder for Adults in Kent



	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*

2.6 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)[49] is below 17.5kg/m^2. Eating disorders significantly impact on women and the lifetime prevalence of anorexia nervosa is three times as high among women as men.[50] There is a separate Eating Disorder Needs Assessment 2014 on the Kent and Medway Public Health Observatory website.[51]

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

[50] *Hudson et al., (2007). The prevalence and correlates of eating disorders in the national comorbidity survey replication. Biol Psychiatry: 61(3): 348–358.*

[51] *www.kmpho.nhs.uk*

2.7 Post-Traumatic Stress Disorder (PTSD)

2.7.1 Definition of PTSD

Traumatic events were defined as experiences that either put a person – or someone close to them – at risk of serious harm or death, like a major natural disaster, a serious car accident, being raped, or a loved one dying by murder or suicide. About a third (31.4%) of adults in England reported having experienced at least one traumatic event. Individuals who experienced such trauma may go on to develop PTSD.[52] PTSD is a severe and disabling condition, characterised by flashbacks, nightmares, avoidance, numbing and hyper vigilance.

2.7.2 Prevalence of PTSD

Overall, about one participant in twenty (4.4%) screened positive for PTSD in the past month, with similar rates for men and women. Among women, the likelihood of screening positive for PTSD was particularly high among 16–24-year olds (12.6%) and then declined sharply with age. In men, the rate remained quite stable between the ages of 16 and 64, only declining in much later life.[53]

2.7.3 Treatment of PTSD

While effective treatments exist, many with the condition delay seeking help or are not identified by health services. As part of the APMS 2014 survey, participants completed the 17-item PTSD checklist – Civilian (PCL-C) in the self-completion part of the interview. Those with a score of 50 or more and meeting Diagnostic Statistical Manual (DSM) criteria for PTSD were identified as screening positive for PTSD. A positive screen did not mean that a disorder was necessarily present, only that there were sufficient symptoms to warrant further investigation.

[52] *Stansfeld, S., Clark, C., Bebbington, P., King, M., Jenkins, R., & Hinchliffe, S. (2016). Chapter 2: Common mental disorders. In S. McManus, P. Bebbington, R. Jenkins, & T. Brugha (Eds.), Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital.*

[53] *http://content.digital.nhs.uk/catalogue/PUB21748/apms-2014-ptsd.pdf*

Table 8: Prevalence of PTSD (snapshot data)

Screen positive for probable PTSD in last month and whether experienced trauma, by age and sex - Kent

PTSD Checklist (PCL-C) responses, PTSD screen positive* and trauma**	Estimated number of residents by age band								2014 APMS
	16-24	25-34	35-44	45-54	55-64	65-74	75+	All	
Men									
PTSD screen positive	3,121	3,993	4,056	4,599	4,314	886	246	21,895	3.7%
Trauma experienced	15,380	24,625	30,854	41,797	31,111	26,982	17,001	186,618	31.5%
Women									
PTSD screen positive	10,421	5,487	4,524	5,302	2,279	1,709	604	31,988	5.1%
Trauma experienced	27,255	27,132	28,284	35,281	30,685	24,988	22,335	196,334	31.2%
All adults									
PTSD screen positive	13,542	9,480	8,581	9,901	6,593	2,595	850	51,542	4.4%
Trauma experienced	42,635	51,757	59,138	77,079	61,796	51,970	39,336	383,711	31.4%

Source: Adult Psychiatric Morbidity Survey 2014

*Screening positive for probable PTSD involves both achieving a score of 50 or more on the PTSD checklist (PCL) and meeting the DSM-IV criteria.

** A 'trauma' is an event of such severity that a person fears for their own or a loved one's life or safety. It was defined as: 'The term traumatic event or experience means something like a major natural disaster, a serious automobile accident, being raped, seeing someone killed or seriously injured, having a loved one die by murder or suicide, or any other experience that either put you or someone close to you at risk of serious harm or death'. A participant could screen positive for PTSD without reporting having experienced a trauma.

2.8 Maternal Mental Health

This section describes mental health problems in women during pregnancy (the antenatal period) and the postnatal period, which is defined as up to one year after childbirth. Some fathers have mental health problems during this period but for the purpose of this report we will be referring to women only. Mental health problems occurring during the perinatal period can range from symptoms that do not meet the threshold for clinical diagnosis (sub threshold) to severe mental illness.

The mental health problems that pregnant women or new mothers can experience are the same as those that can affect people at other times, and they are often similar in nature. However, there are a number of reasons why mental health problems in pregnant women and new mothers are different and particularly important to address. These include the effect they can have on the foetus, baby, wider family and mother's physical health and the fact that problems often are not disclosed, recognised or treated during this period.

There are some mental health problems from which women are at increased risk during this period, e.g. women with a history of bipolar disorder are at increased risk of relapse in the postnatal period.

Healthy social and emotional development and attachment in babies and toddlers is important as it is the "building block(s) for healthy behaviour and educational attainment" in the future and helps to prevent behavioural problems and mental illness.

Based on the number of women giving birth in Kent, the figures below show how many women we would expect to have certain mental health problems in pregnancy and the

postnatal period[54].

In Kent, where 16,333 women gave birth in 2016:

- Estimated number of women with postpartum psychosis: 35
- Estimated number of women with chronic SMI: 35
- Estimated number of women with severe depressive illness: 490
- Estimated number of women with mild-moderate depressive illness and anxiety (lower estimate): 1,635
- Estimated number of women with mild-moderate depressive illness and anxiety (upper estimate): 2,450
- Estimated number of women with PTSD: 490
- Estimated number of women with adjustment disorders and distress (lower estimate): 2,450
- Estimated number of women with adjustment disorders and distress (upper estimate): 4,90

Please note that adding all these estimates together will not give you an overall estimate of the number of women with antenatal or postnatal mental health conditions in your area, as some women will have more than one of these conditions. It is believed that overall between 10% and 20% of women are affected by mental health problems at some point during pregnancy or the first year after childbirth.

2.9 Older people with mental illness in Kent

Older age is the single most important predictor for cognitive decline and dementia.

[54] *Source of deliveries: Hospital Episode Statistics, NHS Digital. Source of rates of disorders: Joint Commissioning Panel for Mental Health. Guidance for commissioners of perinatal mental health services. Volume two: practical mental health commissioning. London: Joint Commissioning Panel for Mental Health; 2012. Available from: www.jcpmh.info/resource/guidance-perinatal- mental-health-services/*

Figure 15: Dementia prevalence and service use in Kent

Indicator	Period	Kent		PHE Region	England	England		
		Count	Value	Value	Value	Lowest	Range	Highest
Dementia: Recorded prevalence (all ages)	2015/16	12,726	0.83%	0.84%*	0.76%	0.29%		1.35%
Dementia: Recorded prevalence (aged 65+)	Sep 2016	12,356	4.04%	4.19%*	4.31%	3.42%		5.50%
People receiving an NHS Health Check per year	2015/16	36,685	8.1%	8.3%*	9.0%	3.3%		19.6%
Smoking Prevalence in adults - current smokers (APS)	2015	-	17.0%	-	16.9%	9.5%		26.8%
Hypertension: Recorded prevalence (all ages)	2015/16	226,378	14.7%	14.1%*	13.8%	7.7%		17.9%
Percentage of physically active and inactive adults - inactive adults	2015	-	26.7%	-	28.7%	17.5%		43.7%
Dementia: Ratio of inpatient service use to recorded diagnoses	2015/16	6,302	49.5	-	53.8	38.2		78.1
Dementia: DSR of emergency admissions (aged 65+)	2015/16	8,854	2,910	-	3387	2,055		5,771
Directly Age Standardised Rate of Mortality: People with dementia aged 65+	2015	2,412	794	-	873	476		1,232
Deaths in Usual Place of Residence: People with dementia aged 65+	2015	1,725	72.0%	73.8%*	68.6%	35.5%		86.8%

Data source: PHE dementia fingertip data

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 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. 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.[55]

2.9.1 Schizophrenia and psychosis for older people

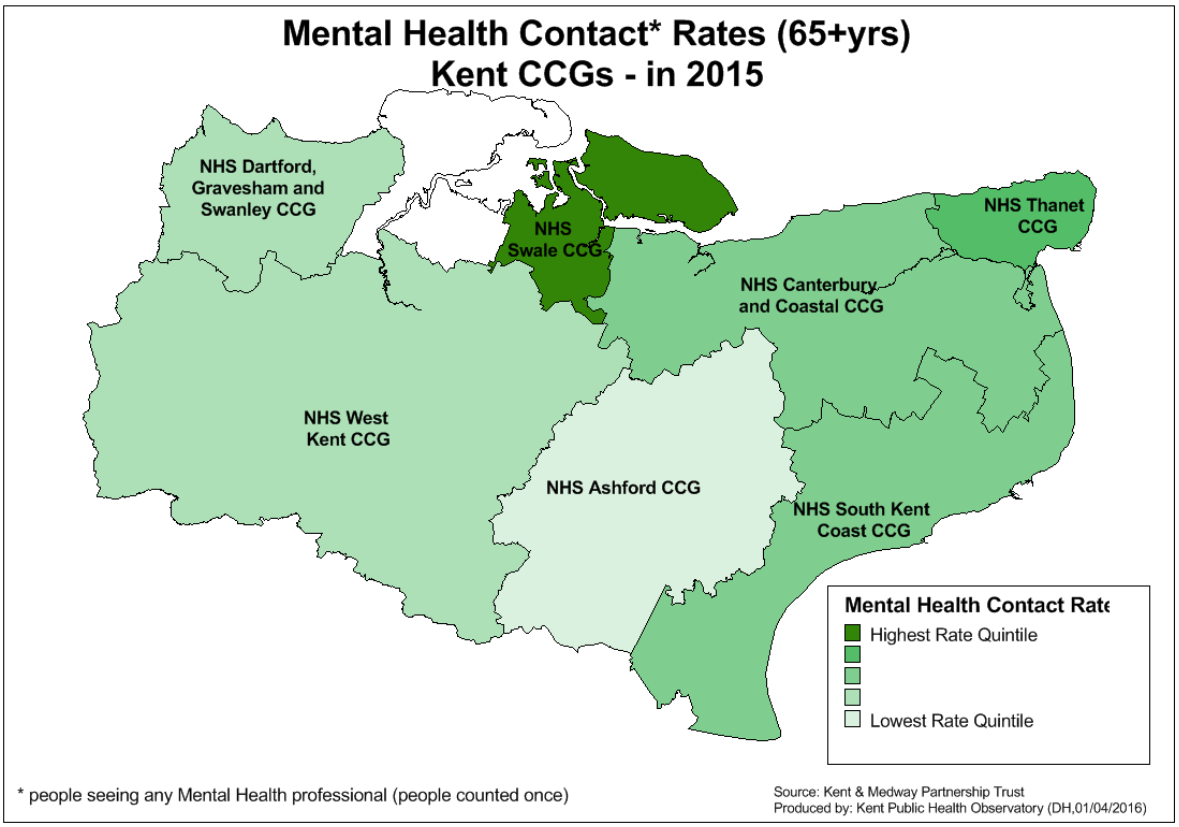
One per cent of people over 65 have psychotic illness and half of these have schizophrenia.[32] The King's Fund report estimated prevalence of 2.6 and 3.6 per 1,000 for schizophrenia in the 64-74 age group (reducing among the older age bands). However, the prevalence of bipolar disorder reduced substantially in the over 65 age group, to approximately 0.2 per 1,000.[56]

NHS Swale CCG has the highest number of older people in contact with a mental health professional (Figure 16) in Kent.

[55] *Age Concern. Improving services and support for older people with mental health problems. London: Age Concern; 2007*

[56] *Paying the Price: Paul McCrone, Sujith Dhanasiri, Anita Patel, Martin Knapp, Simon Lawton-Smith 2008: Kings Fund*

Figure 16: Over 65yrs Mental Health Contact Rates in Kent



Data source: KPHO

In summary, older adults are also particularly at risk of social isolation, as they withdraw from the labour market and become more susceptible to depression.

2.9.2 Mental health disorders amongst carers

The Mental Health of Carers Study[57] 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.[44] Over 91% of carers were not receiving any medication, counselling or therapy for mental, nervous or emotional problems. The proportion 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). Kent is an outlier for Outcome 1.18ii (Social Isolation: percentage of adult carers who have as much social contact as they would like [18+ yrs]). 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.[58]

[57] *Singleton, N, Maung, NA, Cowie, A, Sparks, J, Bumpstead, R, Meltzer, H. (2002) Mental Health of Carers; London: Office of National Statistics, The Stationery Office.*

[58] *PHE Outcomes Framework*

2.10 Health of people with Mental Illness: Parity of Esteem (or Mental Health Investment Standard):

More progress needs to be made across England in carrying out the health checks for people with serious mental health disorders. People with schizophrenia have a mortality of between two and three times that of the general population and most of the excess deaths are from diseases that are the major causes of death in the general population.

A recent prospective record linkage study of the mortality of a community cohort of 370 people with schizophrenia found that the increased mortality risk is probably life-long, and it suggested that the cardiovascular mortality of schizophrenia has increased over the past 25 years relative to the general population.

Figure 17 includes patients with SMI with blood glucose or HbA1c check: % with record in preceding 12 months. This indicator is intended to encourage case finding of diabetes in those with a serious mental illness with random or fasting blood glucose measurements. Patients in whom diabetes has already been diagnosed will be excluded from the denominator of this indicator. They should be managed according to the diabetes indicator set. The relative risk of developing diabetes mellitus is two to three times higher in people with schizophrenia than in the general population. KID data also includes the costs and activity related to long-term conditions and poor mental health.

Figure 17: Percentage of people with Severe Mental Illness who have received the complete list of physical health checks, 2014/15

Indicator	Period	England	Kent and Medway	NHS Ashford CCG	NHS Canterbury And Coastal CCG	NHS Dartford, Gravesham And Swanl...	NHS Medway CCG	NHS South Kent Coast CCG	NHS Swale CCG	NHS Thanet CCG	NHS West Kent CCG
Patients with SMI who have received the complete list of physical health checks: % of patients with SMI	2014/15	34.8	-	34.8	38.0	38.8	42.9	41.2	37.1	30.4	29.6
People with SMI who have received the complete physical health checks: % of people with SMI	2014/15	34.8	35.5*	34.8	38.0	38.8	42.9	41.2	37.1	30.4	29.6

Data source: PHE Public Health Profiles

Swale CCG, Dartford, Gravesham and Swanley CCG, Canterbury and Coastal CCG and South Kent Coast CCG all have a higher percentage of people with SMI who have received the complete list of physical health checks than the England average in 2014/15.

2.11 Ethnicity and Inequality

Figure 18: BME mental health service users: % of mental health service users in 2014/15

Area	Value	Lower CI	Upper CI
England	11.2	11.1	11.2
Kent and Medway	3.8*	3.6	3.9
NHS Ashford CCG	3.5	2.9	4.1
NHS Canterbury And Coas...	2.5	2.1	2.9
NHS Dartford, Gravesham...	8.5	7.7	9.4
NHS Medway CCG	6.1	5.5	6.7
NHS South Kent Coast CC...	2.3	1.9	2.7
NHS Swale CCG	2.3	1.8	2.9
NHS Thanet CCG	3.0	2.5	3.5
NHS West Kent CCG	2.7	2.4	3.1

Source: Mental Health Minimum Data Set (MHMDS)

People in the Black ethnic group had particularly low treatment rates. Access by ethnic group will need auditing in Kent. Socioeconomic inequalities in treatment use were less evident, although people living in lower income households were more likely to have requested but not received a specific mental health treatment.

Summary of Chapter 3

The deeper dive into depression shows that depression is difficult to manage in primary care because people are not always aware of their negative symptoms and unsure as to what to report to their GP. GPs also find it hard to follow up all patients. People with depression are a diverse group and not all interventions will suit all patients. Good patient information is vital at diagnosis. Not all depression needs clinical intervention or management at primary care. However, depression is a serious illness and untreated can get severe and lead to suicide and self-harm and neglect. Therefore, NICE guidance principles of early detection, good patient information on self-help, medication review and flagging self-harm and suicide attempts will be important for keeping more people well. Also, depression is a symptom that many people with illness can have (i.e. it is co-occurring with a vast array of other conditions - notably substance misuse disorder and long-term chronic pain), and therefore, effective treatments and services should be timely and available and provided by high quality trained staff. Short and targeted and opportunistic interventions can be implemented as well as access to high-quality long-term psychotherapy for those with longer term, chronic and severe depression. Overall, access to psychological therapy is good in Kent and Medway, compared to the national average. However, self-harm and suicide rates are higher than the national averages, and it is uncertain whether the right people are targeted for psychological therapy and whether there is the correct range of therapy on offer e.g. DBT (for self-harm). Improvements for treatment of personality disorders (PD) in specialist care should join up with help for depression in primary care to make the best use of resources for patients with depression.

3 Deeper Dive into Depressive Disorder (Depression) in Kent and Medway

The severity of depression varies markedly. At its worst, it can have a profound effect on people's ability to lead normal lives. In terms of disability- adjusted life years, unipolar depression is responsible for more disability and suffering in high-income countries than any other health condition – accounting for 13% of the total 'disease burden' among adults.[59]

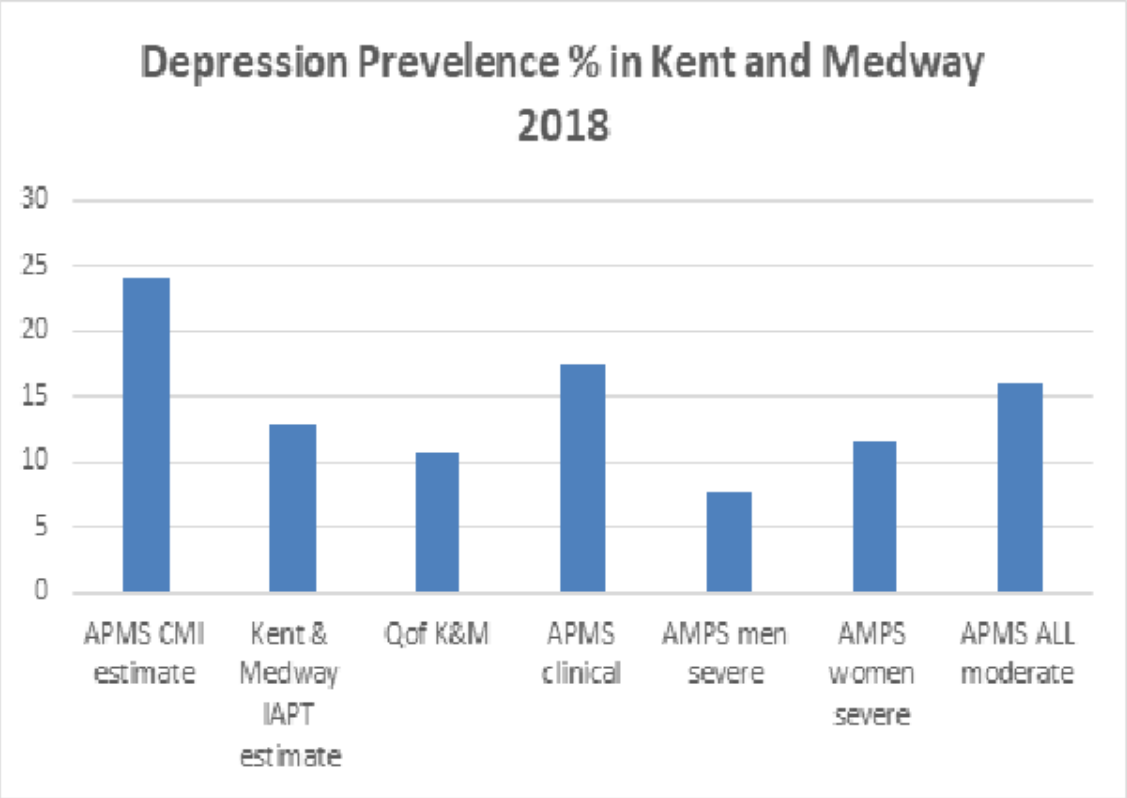
In addition to its effects on individuals' lives, depression imposes a heavy cost at the societal level. In the United Kingdom, depression and anxiety are estimated to cost the economy £17 billion each year through a combination of sickness absence, reduced productivity and

[59] *World Health Organization 2008, The Global Burden of Disease 2004 update. http://www.who.int/healthinfo/global_burden_disease/GBD_ report_2004update_full.pdf Accessed 16.6.2012*

increased staff turnover. The cost to the Exchequer is estimated at £9 billion per year as a result of lost tax receipts and benefits payments.[60]

Depression is not evenly distributed across the population. Consistent positive associations have been found between mental ill health and various markers of social and economic adversity such as lower education, lower income, lower social status, unemployment and poorer material circumstances.[61] There is a two-times variation in the prevalence of depression between the highest and lowest quintiles of household income.[62]

Figure 19: Depression prevalence in Kent and Medway in 2018



Data source: reproduced by Kent Public Health

There are various measures of prevalence of depression. The APMS (2014) is the best reliable large scale survey of prevalence in England and indicates 24% of the adult population have a diagnosable mental illness including depression. The survey measures

[60] *Layard, R., Clark, D., Bell, S., Knapp, M., Meacher, B., Priebe, S., Turnberg, L., Thornicroft, G., & Wright, B. (2006). The depression report; A new deal for depression and anxiety disorders. The Centre for Economic Performance's Mental Health Policy Group*, LSE.

[61] *Meltzer H, Lader D, Corbin T, Goodman R and Ford T (2004) The mental health of young people looked after by local authorities in England, London: TSO.* *http://webarchive.nationalarchives.gov.uk/20130107105354/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4019442*

[62] *McManus S,, Meltzer H,, Brugha, T,, Bebbington, P. and Jenkins, R., (2009) Adult psychiatric morbidity in England, 2007: Results of a household survey. The Health and Social Care Information Centre, Social Care Statistics*

severity and duration and places a 'clinical' threshold of 17% and this is higher than the national estimates calculated for IAPT (NHS counselling). This means that there is a 'real' unmet need of around 7% in the adult population. The APMS estimates for 'severe' depression are 7% for men and 11% for women. The incidence (new cases) of depression is 1.6% of the per year.

3.1 The Management and Recording of Mental Illness in Primary Care

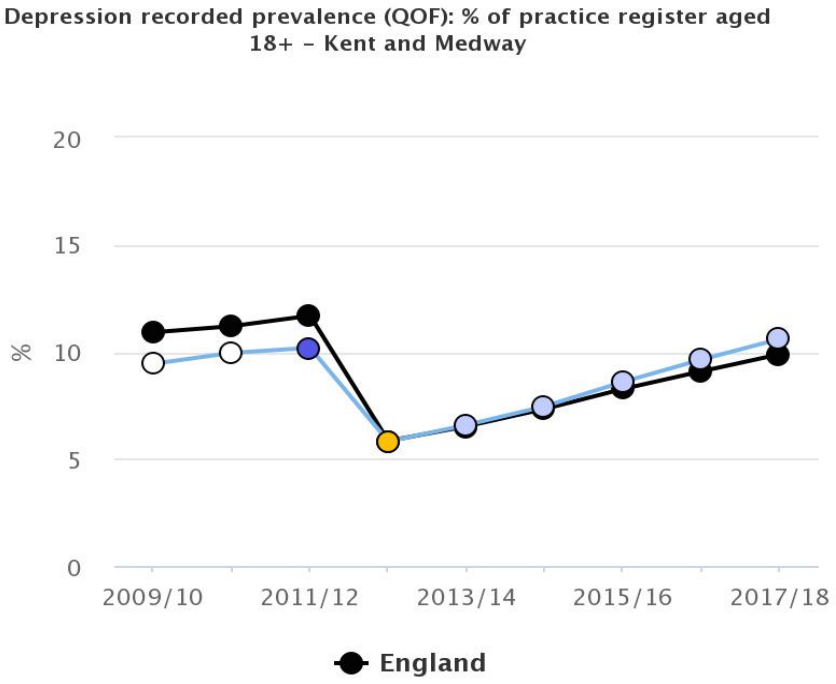
Mental illness needs good monitoring, recording and treatment and often primary care is best placed to provide this important local service. However, across Kent the local systems and pressures on local systems as well as differences in local demographics and vulnerabilities will differ. The below snapshots should be read with caution and are merely indicative of how people are using primary care for mental health needs. As more care is provided within local and primary care it will be important to monitor these variances. Please see more details about prevalence of mental illness by Kent CCG in Appendix 7.

In terms of patient education and support, please see Appendix 8.1 for a list of resources to find support and help for depression in Kent.

There are challenges in implementing NICE guidance, and details are listed in Appendix 8.2.

Patient experience in primary care in Kent was published by Health Watch. More details can be found in Appendix 8.3.

Figure 20: Depression recorded prevalence (QOF): % of practice register aged 18+ - Kent and Medway

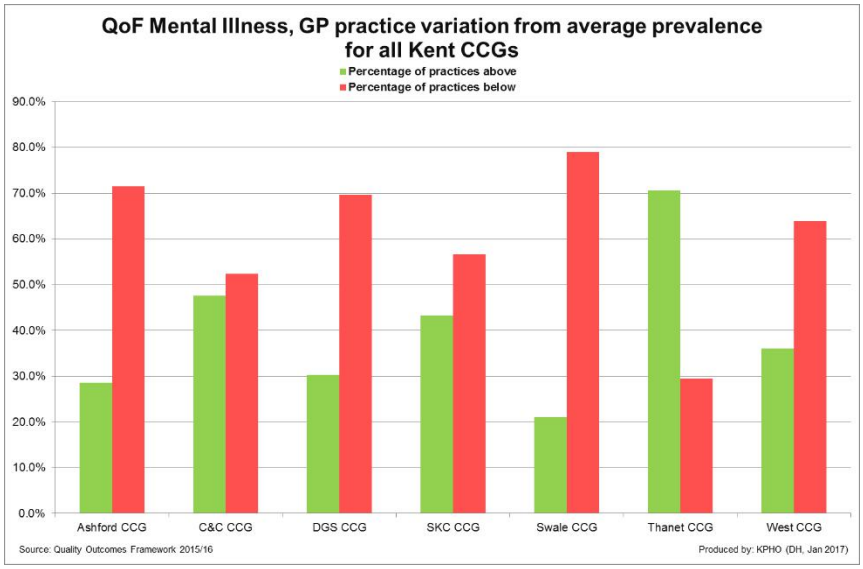


Data source: PHE Fingertips

3.1.1 Expected Prevalence of Mental illness in Primary Care/ Variations in care.

In figure 21, NHS Thanet CCG has a high percentage of practices above the average prevalence which suggests they are the meeting the expected needs of patients in primary care for serious mental illness. This is a general indicator that GPs are managing patients appropriately. The remaining CCG areas may need to review their variation from average prevalence.

Figure 21: Variation in practice level prevalence for serious mental illness

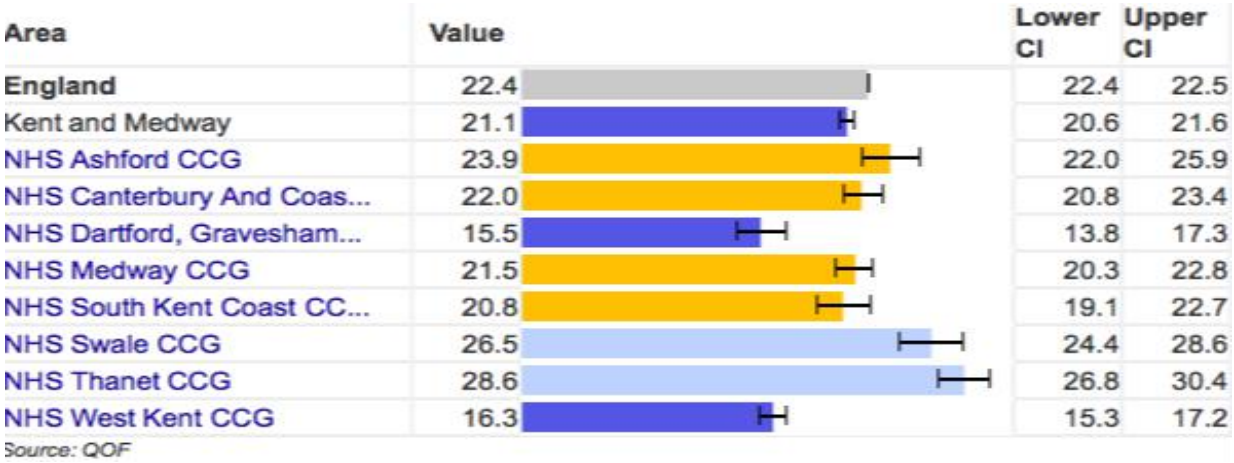


Data source: KPHO

3.1.2 Exception Reporting in QOF for Depression

Some patients with depression are not included in GP Quality and Outcomes Framework (QOF) records. This could be for a number of reasons – such as failure to turn up to appointments, patient's refusal of treatment and being resistant to treatment. Both Swale and Thanet have high exception rates for depression. Swale and Thanet are both deprived areas in Kent with high expected prevalence for mental illness.

Figure 22: Exception rate for depression: % of patients on depression register in 2017/18



Area	Value	Lower CI	Upper CI
England	22.4	22.4	22.5
Kent and Medway	21.1	20.6	21.6
NHS Ashford CCG	23.9	22.0	25.9
NHS Canterbury And Coas...	22.0	20.8	23.4
NHS Dartford, Gravesham...	15.5	13.8	17.3
NHS Medway CCG	21.5	20.3	22.8
NHS South Kent Coast CC...	20.8	19.1	22.7
NHS Swale CCG	26.5	24.4	28.6
NHS Thanet CCG	28.6	26.8	30.4
NHS West Kent CCG	16.3	15.3	17.2

Source: QOF

Figure 23: Snapshot of Kent and Medway STP data on Common Mental Illness pathway compared to the England average

Indicator	Period	Kent and Medway			England			
		Recent Trend	Count	Value	Value	Worst/ Lowest	Range	Best/ Highest
Long-term health problem or disability: % of population	2011	–	300,392	17.4%*	17.6%	12.9%		21.5%
Estimated prevalence of common mental health disorders: % of population aged 16-74	2014/15	–	163,509	12.9%*	15.6%*	11.1%		20.5%
Depression recorded prevalence (QOF): % of practice register aged 18+	2017/18	↑	156,916	10.6%	9.9%	6.4%		12.8%
Depression recorded incidence (QOF): % of practice register aged 18+	2017/18	↑	23,608	1.6%	1.6%	1.1%		2.6%
Antidepressant prescribing: average daily quantities (ADQs) per STAR-PU	2017/18	→	61,390,661	1.5*	1.5	0.8		2.1
Access to IAPT services: people entering IAPT (in month) as % of those estimated to have anxiety/depression	Jun 2018	↓	2,405	17.7%*	17.0%	11.1%		23.7%
Waiting < 6 weeks for IAPT treatment (standard measure): % of referrals that have finished course of treatment waiting <6 weeks for first treatment	Jun 2018	↓	1,375	75.3%*	89.6%	55.9%		100%
Completion of IAPT treatment: rate (quarterly) per 100,000 population aged 18+	2018/19 Q1	↓	5,560	388*	337*	135		569
IAPT paired data completeness: % of completed treatments (in month) with paired PHQ9 and ADSM scores	Jun 2018	↓	1,815	99.5%*	99.0%	92.6%		100%
IAPT reliable improvement: % of people (in quarter) who have completed IAPT treatment who achieved "reliable improvement"	2018/19 Q1	↑	4,205	78.3%*	72.1%*	64.4%		78.3%
IAPT recovery: % of people (in month) who have completed IAPT treatment who are "moving to recovery"	Jun 2018	↑	950	53.4%*	52.3%	39.0%		61.0%
Long-term mental health problems (GP Patient Survey): % of respondents (aged 18+)	2017/18	↑	1,839	8.6%*	9.1%	6.5%		11.4%
Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+	2016/17	↑	3,402	13.7%*	13.7%	10.5%		16.6%
IAPT referrals for BME patients: % of referrals (in quarter)	2018/19 Q1	↓	775	6.6%*	15.6%*	2.4%		51.4%
IAPT ethnic group coding completeness: % of referrals (in quarter) with a valid ethnic group code	2018/19 Q1	↓	8,715	73.8%*	85.5%*	68.9%		97.1%

Data source: PHE Fingertips

The snapshot of Kent & Medway STP (figure 23) for CMI above shows an overall favourable picture compared to the England average. The caveats are that nationally the management of CMI has problems of the type detailed in figure 22 of this report so the snapshot data is interpreted cautiously.

Regarding IAPT, this snapshot highlights that challenges should be noted in managing depression prevalence in primary care, trends in antidepressant prescribing, low referrals and data for BME groups in primary care.

Kent and Medway STP has around the average expected prevalence of long-term conditions as England. In many respects, Kent is an exemplar of the England average. However, prevalence of depression in Kent is predicted to be lower. This 'lower' prevalence estimate arises from the data from NHS estimates of predicted use of psychological therapy (IAPT). It is understood that the data are nationally to be an underestimation.

The expected proportion of people with depression and anxiety from the APMS is in Kent is 24% and for depression that requires treatment for 17% of the adult population. This poses a challenge for health care providers both in the understanding of depression and its management. The graph above (Fig 19) also shows that for severe depression 7.6% of adult males and almost 12% of adult females require specialist help.

3.2 What is Depression?

Depression is a serious mental illness that if untreated can lead to a significant loss of functioning, physical health problems, self-medicating via substance misuse and addictions, self-harm and suicide.

The NICE guidance 2018 described that depression is a broad and heterogeneous diagnosis. Central to it is very low mood, loss of interest and pleasure or loss of energy to be present. Severity of the disorder is determined by both the number and severity of symptoms, as well as the degree of functional impairment. Symptoms should be present for at least two weeks and each symptom should be present at sufficient severity for most of every day.

Increasingly, it is recognised that depressive symptoms below threshold criteria can be distressing and disabling if persistent (Please see Appendix 9 for more details on Symptoms of major depression as barriers to seeking help)

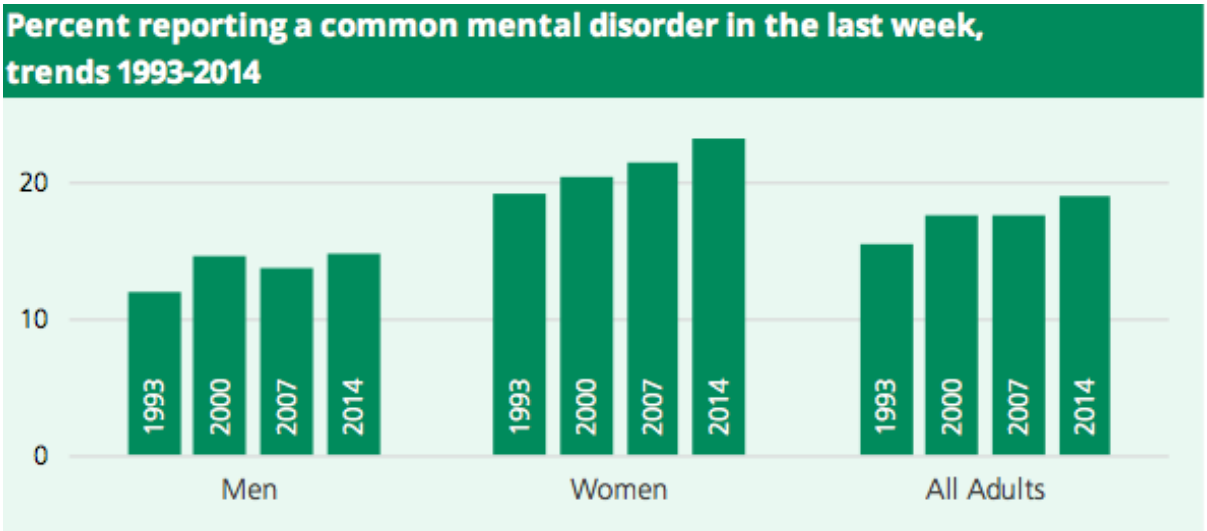
3.2.1 Thresholds

New recommendations are to also treat 'sub threshold depressive symptoms', which fall below the criteria for major depression, and are defined as at least one key symptom of depression but with insufficient other symptoms and/or functional impairment to meet the criteria for full diagnosis. Symptoms are considered persistent if they continue despite active monitoring and/or low-intensity intervention, or have been present for a

considerable time, typically several months. (For a diagnosis of dysthymia, symptoms should be present for at least two years).[63]

Incidence of depression in Kent is increasing. **The incidence of depression in Kent is 1.6%,** this is the crude rate of all new diagnosis at primary care compared to all new diagnosis per year.

Figure 24: % reporting a common mental disorder, 1993 - 2014



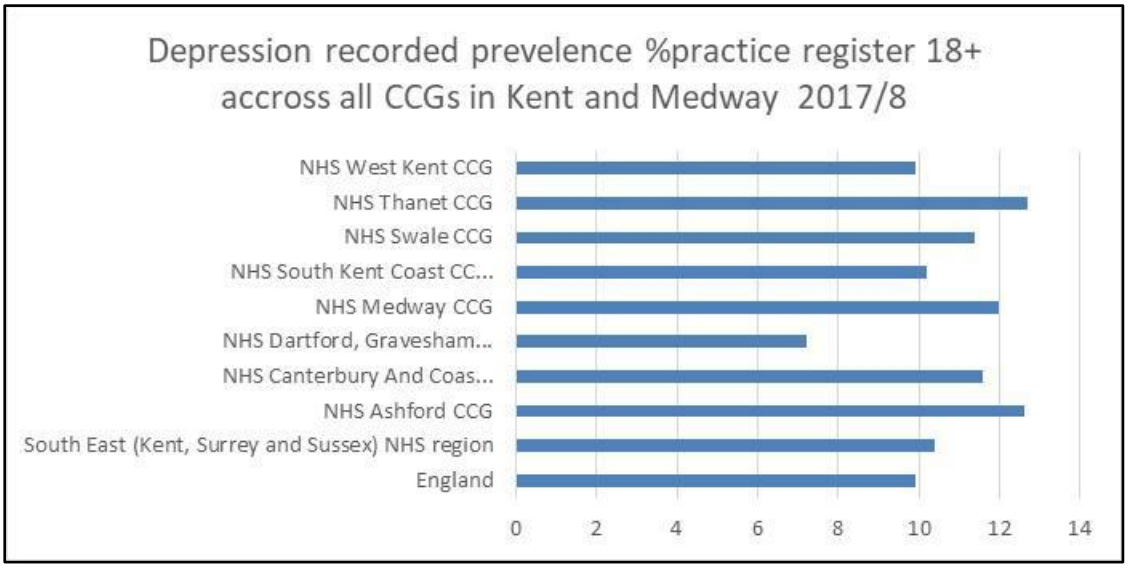
Data source: APMS

There are around 157,000 people in Kent with diagnosed depression. The annual incidence in Kent is 23,608 people (rate 1.6% of new diagnosis in GP practice population).

The below figure 25 is the comparison of all the Kent CCGs recorded prevalence of Depression. All are below the 17.5% predicted APMS clinical threshold.

[63] *NICE guidance on Depression in adults: recognition and management, 2018.*

Figure 25: Depression recorded prevalence % practice register 18+ across all CCGs in Kent and Medway, 2017/18



Data source: PHE Fingertips

3.3 Depression and Co-morbidity

It is now well established that moderate to severe Depression is significantly associated with a wide variety of chronic physical disorders, including arthritis, asthma, cancer, cardiovascular disease, diabetes, hypertension, chronic respiratory disorders, and a variety of chronic pain conditions[64,65].

There is major individual and public health significance for this data. Depression is both a causal risk factor leading to an increased prevalence of these physical disorders, with all their associated financial costs, impairments, and increased mortality risk particularly in first onset of coronary artery disease, stroke, diabetes, heart attacks and certain types of cancer.[66] There are elevated co-morbidities also for depression and alcohol misuse, anxiety and suicide. A major study in the USA among Alcohol treatment dependent people found that 20.5% had co-occurring severe depression (three times more than the general population) and 40% had co-occurring mood disorder.[67]

[64] *The prevalence of comorbid depression in adults with diabetes: a meta-analysis.Anderson RJ, Freedland KE, Clouse RE, Lustman PJDiabetes Care. 2001 Jun; 24(6):1069-78.*

[65] *Depression and cardiac disease.Nemeroff CB, Musselman DL, Evans DL Depress Anxiety. 1998; 8 Suppl 1():71-9.*

[66] *The epidemiology of Depression across Cultures Kessler and Bromit 2014 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4100461/*

[67] *Bridget F. Grant, Ph.D., Ph.D., is chief of, and Deborah A. Dawson, Ph.D., is senior clinician in the Laboratory of Epidemiology and Biometry, Division of Intramural Clinical and Biological Research, at the National Institute on Alcohol Abuse and Alcoholism, Bethesda, Maryland.*

3.4 Treatment for Depression

The figures below point to unmet need in primary care as well as an issue of management of multiple long-term conditions. Many of those in serious need for treatment will not come forward for treatment due to stigma and due to their symptoms and intrusive thoughts. A National survey in the USA (National Epidemiological Survey on Alcohol and Related Conditions (NESARC-III) equivalent to UK's APMS found that there were 30% of people with severe depression never came forward for treatment.[68] Research from the Mayo Institute for Health in 2017 indicates that the symptoms present in major depression were barriers for people seeking help.[69]

In summary below:

- 24% of the adult population of Kent will have some form of CMI
- 17% of the adult population of Kent will have treatable serious depression.
- 10.6% of the adult population are on a treatment register in primary care for depression
- Almost 70% of people with moderate to severe depression will have chronic and relapsing conditions. [70]
- 20.5% will have Severe Depression and Alcohol Dependence.

3.5 Depression Treatment Pathway

NICE guidance is never a replacement for good clinical judgement on a case by case, person centred basis. NICE guidance gives commissioners and providers the best research and evidence to provide the best quality of care in one place.

The current care pathway[71] for depression and depression management can be summarised as follows:

1 Identification and diagnosis [check severity]
2 Patient education and support
3 Medication and monitoring
4 Physical check-up and follow-up
5 Psychological support and psychological therapy
6 Specialist support if needed (e.g. substance misuse or PTSD)

[68] https://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/alcohol-facts-and-statistics

[69] *https://www.mayoclinic.org/diseases-conditions/depression/symptoms-causes/syc-20356007*

[70] *Prevalence and predictors of recurrence of major depressive disorder in the adult population. Hardeveld F, Spijker J, De Graaf R, Nolen WA, Beekman ATActa Psychiatr Scand. 2010 Sep; 122(3):184-91.*

[71] *The NICE guidance for the Treatment of Depression.*
https://www.nice.org.uk/media/default/sharedlearning/624_croydondepressionguidelinefinal1dec11.pdf

7 Social support
8 Self-care (physical and mental).

Given the prevalence and high demand on primary care it is important that services that tackle depression are of the best quality possible.

The Kings Fund Report on Long Term Conditions recommended monitoring the quality of the following in commissioning good pathways for depression:

- the range of interventions provided
- the organisational framework within which these are delivered
- the quality of relationships between the patient and professionals.

The Care Quality Commission Report: The state of Care of Mental Health Services 2014-2017 had the following to say about the continuity of care in mental health services (please see Appendix 10).

3.6 What do we know about the Current Depression Treatment Pathway in Kent?

3.6.1 Identification and diagnosis

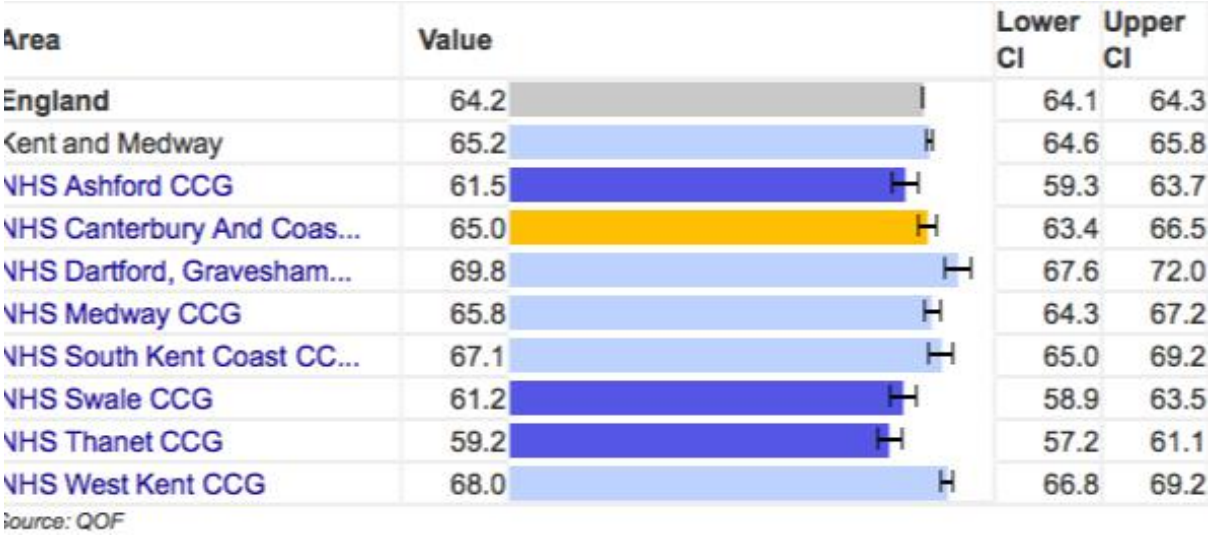
As stated in previous sections of this report, there are a number of problems with the identification and diagnosis of depression.

Depression is underdiagnosed. The APMS estimates 24% of people have a clinical threshold level of depression at any one time. The current estimates and epidemiology indicate that there is an increase in the prevalence of serious depression in Kent.

There are an estimated 17% (see figure 19) of the population of Kent with depression and many of these people are not receiving treatment for depression. There is currently no data on whether duration and severity of depression in primary care or the quality of the management of the illness.

The current QOF indicator for depression in Kent is 10.6% of the primary care population.

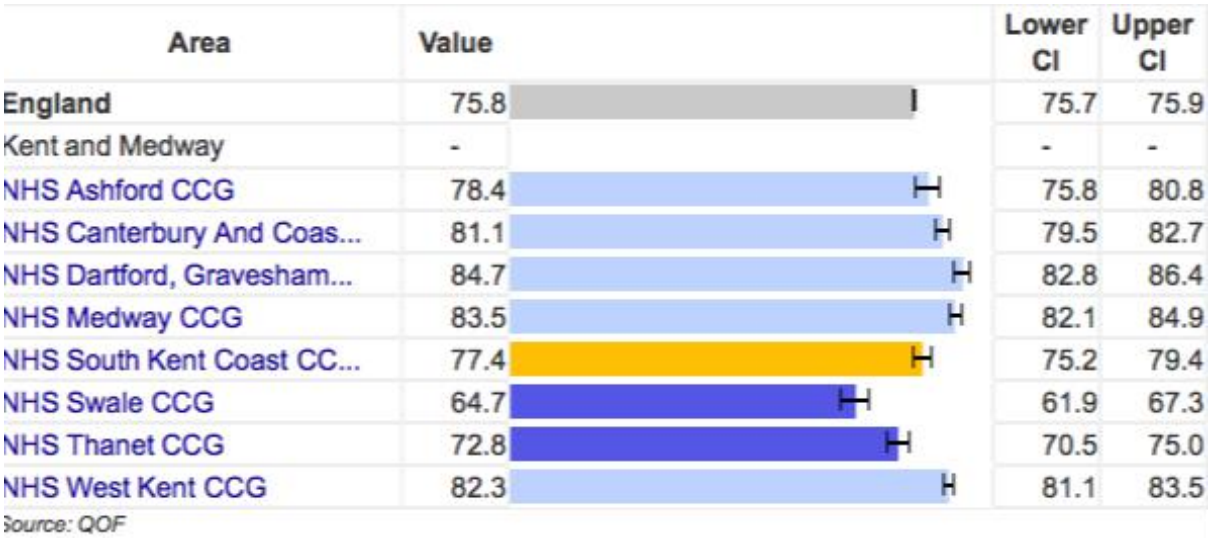
Figure 26: Review of depression: % of newly diagnosed patients with depression who had a review 10-56 days after diagnosis in 2017/18



Area	Value	Lower CI	Upper CI
England	64.2	64.1	64.3
Kent and Medway	65.2	64.6	65.8
NHS Ashford CCG	61.5	59.3	63.7
NHS Canterbury And Coas...	65.0	63.4	66.5
NHS Dartford, Gravesham...	69.8	67.6	72.0
NHS Medway CCG	65.8	64.3	67.2
NHS South Kent Coast CC...	67.1	65.0	69.2
NHS Swale CCG	61.2	58.9	63.5
NHS Thanet CCG	59.2	57.2	61.1
NHS West Kent CCG	68.0	66.8	69.2

Source: QOF

Figure 27: Biopsychosocial assessment at the time of diagnosis of depression: % of newly diagnosed patients (aged 18+) in 2013/14



Area	Value	Lower CI	Upper CI
England	75.8	75.7	75.9
Kent and Medway	-	-	-
NHS Ashford CCG	78.4	75.8	80.8
NHS Canterbury And Coas...	81.1	79.5	82.7
NHS Dartford, Gravesham...	84.7	82.8	86.4
NHS Medway CCG	83.5	82.1	84.9
NHS South Kent Coast CC...	77.4	75.2	79.4
NHS Swale CCG	64.7	61.9	67.3
NHS Thanet CCG	72.8	70.5	75.0
NHS West Kent CCG	82.3	81.1	83.5

Source: QOF

According to the NICE guidance[72], assessment of severity in patients with depression is essential to decide on appropriate interventions to improve the quality of care. An assessment of severity as close as possible to the time of diagnosis enables a discussion with the patient about relevant treatment and options, guided by the stepped care model of depression. The guideline states, for example, that antidepressants are not recommended for the initial treatment of mild depression but should be routinely considered for all patients with moderate or severe depression. The British Association of

[72] *NICE clinical guidance 90. Depression in adults: recognition and management. https://www.nice.org.uk/guidance/cg90*

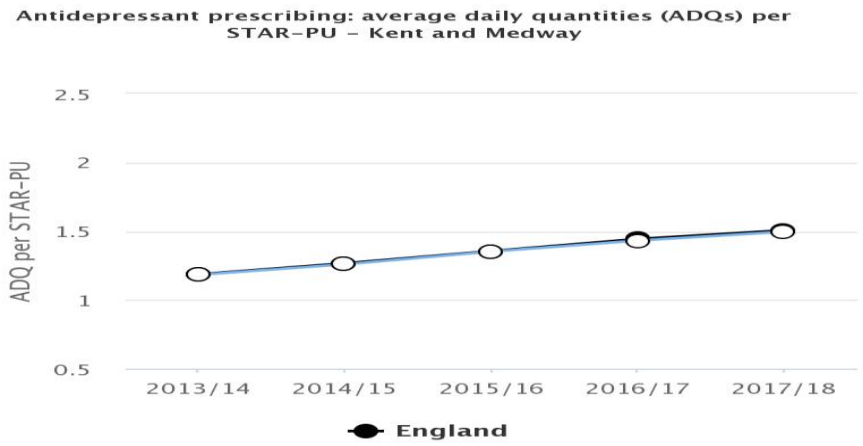
Psychopharmacology guideline[73] on treating depressive disorders with antidepressants state 'that antidepressants are a first-line treatment for moderate to severe major depression irrespective of environmental factors and that antidepressants are not indicated for milder depression unless it has persisted for two years or more' ('dysthymia').

Finding: Swale and Thanet's primary care assessments are below the England average.

3.6.2 Medication and Monitoring

The prescribing of antidepressants has increased in Kent in line with the national average. This means those on medications for depression are taking higher doses then people prescribed medication in 2013.

Figure 28: Antidepressant prescribing: average daily quantities (ADQs) per STAR – PU in Kent and Medway between 2013/14 – 2017/18



Data source: NHS Business Services Authority (NHSBSA)[74]

Prescribing antidepressants for serious and enduring depression is complicated and links to the current fragmentation of services and accountability for people suffering from serious and enduring depression.

This is due to a number of key issues outlined (Appendix 11) alongside evidence and recommendation. In 2020, there will be improvements to the NICE guidance on depression management and key recommendations from the national suicide prevention programme.

[73] https://www.bap.org.uk/pdfs/BAP_Guidelines-Antidepressants.pdf

[74] https://apps.nhsbsa.nhs.uk/infosystems/welcome

3.6.3 Suicidality and Depression: Importance of monitoring patients who have depression, anxiety and alcohol use disorder

In retrospective studies of people completing suicide (both National and Kent) there are high rates of people having contacted primary care about suicidal intent. In one national study[75] there was 91% of cases had requested help one year prior to death.

Those with a previous history of contact with mental health services were most at risk.

People with a primary care diagnosis of depression, anxiety and alcohol dependency are most at risk.[76]

A Kent study of people with suicide attempt and coroner's reports and an analysis of serious case reviews has also found people had sought help from primary care prior to death and attempt[77].

3.6.4 Physical health check for people with severe mental illness

The table below shows summarises the proportions of patients with SMI having received each of the six elements of the comprehensive health check, and the proportion having received all 6 separately, at CCG-level. The data covers **only the 205 Kent practices flowing data into the KID at the time of the analysis**, and GP practice-level data are available upon request.

[75] *https://bjgp.org/content/59/568/825 Anna Pearson, Pooja Saini, Damian Da Cruz, Caroline Miles, David While, Nicola Swinson, Alyson Williams, Jenny Shaw, Louis Appleby and Navneet Kapur Br J Gen Pract 2009; 59 (568): 825 832.* ***DOI:*** *https://doi.org/10.3399/bjgp09X472881*

[76] *Power K, Davies C, Swanson V, et al.(1997) Case-control study of GP attendance rates by suicides with or without a psychiatric history. Br J Gen Pract* ***47****(417):211–215.*

[77] *Darzi report Kent the 70% puzzle Hart et al (forthcoming)*

Table 9: % receiving individual physical health check elements at CCG-level in Kent and Medway in 2017/18

GP practice	List size (KID)	On SMI register	% receiving individual physical health check elements						
			A measurement of weight	A blood pressure and pulse check	A blood lipid (incl cholesterol) test	A blood glucose test	An assessment of alcohol consumption	An assessment of smoking status	Comprehensive physical health check (all six)
Ashford CCG	90103	520	27%	54%	34%	37%	42%	49%	14%
Canterbury & Coastal CCG	208630	1553	35%	70%	41%	47%	59%	61%	17%
DGS CCG	271400	1749	40%	68%	42%	49%	57%	61%	17%
Medway CCG	286365	1666	43%	70%	44%	50%	60%	65%	23%
South Kent Coast CCG	189558	1453	47%	67%	45%	48%	57%	61%	26%
Swale CCG	91202	520	46%	72%	44%	48%	61%	63%	23%
Thanet CCG	146188	1393	44%	71%	38%	48%	59%	65%	19%
West Kent CCG	471438	2883	40%	70%	38%	47%	59%	57%	16%
Kent & Medway	**1754884**	**11737**	**41%**	**69%**	**41%**	**48%**	**58%**	**61%**	**19%**

Regarding NHS Health Check, the challenge is to monitor physical health and mental health together. The NHS Health Check is only one mechanism, as there are a number of exclusions in the NHS Health Check (e.g. people over 40-years-old, every five years and no long-term conditions pathways, therefore, as people with SMI have greater risk of poor self-care behaviour and higher risk of premature mortality, an annual health check, is as important as regular mental health monitoring. Reconnect robust care planning & monitoring.

3.7 Access to Psychological Therapy in Kent

From the GP patient's survey in Kent for the year 2016/17 it showed that almost 14% of the practice population said they had depression. This is higher than the QOF average. NHS Thanet and South Kent Coast had the highest rates of depression. Thanet and South Kent Coast also have the highest suicide rates in Kent.

Figure 29: Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+ 2016/17

Area	Value	Lower CI	Upper CI
England	13.7	13.7	13.8
Kent and Medway	13.7*	-	-
NHS Ashford CCG	13.7	12.2	15.4
NHS Canterbury And Coas...	15.0	13.7	16.3
NHS Dartford, Gravesham...	12.1	11.1	13.3
NHS Medway CCG	14.0	12.9	15.1
NHS South Kent Coast CC...	15.5	14.2	16.8
NHS Swale CCG	14.4	12.7	16.2
NHS Thanet CCG	18.3	16.6	20.1
NHS West Kent CCG	11.4	10.7	12.2

Source: GP patient survey, NHS England. The data used includes that from GP patient surveys undertaken in July - September and January - March, which is equivalent to a financial year's data.

Figure 30: Average wait to enter IAPT treatment: mean wait for first treatment (days) in June 2018

Area	Value	Lower CI	Upper CI
England	18.8	-	-
Kent and Medway	-	-	-
NHS Ashford CCG	23.5	-	-
NHS Canterbury And Coas...	29.0	-	-
NHS Dartford, Gravesham...	37.7	-	-
NHS Medway CCG	12.1	-	-
NHS South Kent Coast CC...	40.9	-	-
NHS Swale CCG	32.1	-	-
NHS Thanet CCG	42.4	-	-
NHS West Kent CCG	52.2	-	-

Source: IAPT

The average waiting time for psychological counselling in England is 18.8 days. Most CCGs in Kent in June 2018 (a snapshot) were higher than the England average. West Kent has the highest waiting times. High waiting times can be dangerous if the patient's depression gets worse in that time. Thanet has the second highest waiting times. This is an issue for both Thanet and South Kent Coast as they also have high emergency admission rates and suicide and self-harm rates.

Figure 31: Access to IAPT services: people entering IAPT (in month) as % of those estimated to have anxiety/depression in June 2018

Area	Value	Lower CI	Upper CI
England	17.0	16.9	17.1
Kent and Medway	17.7*	17.0	18.3
NHS Ashford CCG	19.9*	17.4	22.6
NHS Canterbury And Coas...	20.7*	18.8	22.7
NHS Dartford, Gravesham...	15.9*	14.3	17.7
NHS Medway CCG	20.5*	18.9	22.1
NHS South Kent Coast CC...	22.2*	20.1	24.4
NHS Swale CCG	20.4*	17.7	23.3
NHS Thanet CCG	24.3*	21.8	27.0
NHS West Kent CCG	9.8*	8.8	10.8

Source: Improving Access to Psychological Therapies (IAPT)

The England average rate of people getting treatment for depression via IAPT counselling as a percentage of all people with depression is estimated at 17% (figure 19). This is a significant treatment gap. However, it is also assumed that many people will seek their own

therapy or refuse counselling. It is more important for those people who cannot afford their own counselling to be offered timely support for depression. It is encouraging to see all people living in the most deprived parts of Kent having higher than England average access to NHS counselling. There is some concern in West Kent that those with highest need may not be getting easy access to IAPT.

Figure 32: Completion of IAPT treatment: rate (quarterly) per 100,000 population aged 18+ in 2018/19 Q1

Area	Value	Lower CI	Upper CI
England	337*	335	338
Kent and Medway	388*	378	399
NHS Ashford CCG	382*	344	423
NHS Canterbury And Coas...	576*	541	613
NHS Dartford, Gravesham...	330*	305	356
NHS Medway CCG	407*	381	435
NHS South Kent Coast CC...	469*	437	503
NHS Swale CCG	374*	335	417
NHS Thanet CCG	529*	487	574
NHS West Kent CCG	249*	233	265

Source: IAPT

Overall Kent has good completion rates of treatment compared to the England average. Canterbury and Coastal shows the best completion rates in the first quarter of 2018/19. These rates will fluctuate, and the overall trends are better than national averages. There needs to be some focus on West Kent's activity – when viewed in light of a range of indicators.

For people moving to recovery the snapshot data from June 2018 shows a favourable picture compared to national average rates, with Swale CCG having a particularly good indicator for recovery. Building on this favourable picture, the rates for completed counselling and achieving improvement for all of Kent CCGs are above the national average rates. The overall recovery rates for depression in 2016/17 show that overall just over 50% of Kent persons accessing NHS counselling via IAPT show signs of improvement within a year. Kent's most deprived CCGs had the highest IAPT completions rates in 2016/17.

Figure 33: IAPT recovery: % of people (in month) who have completed IAPT treatment who are "moving to recovery" in June 2018

Area	Value	Lower CI	Upper CI
England	52.3	-	-
Kent and Medway	53.4*	-	-
NHS Canterbury And Coas...	55.0*	-	-
NHS Thanet CCG	51.0*	-	-
NHS South Kent Coast CC...	53.0*	-	-
NHS Medway CCG	54.0*	-	-
NHS Ashford CCG	48.0*	-	-
NHS Swale CCG	62.0*	-	-
NHS Dartford, Gravesham...	54.0*	-	-
NHS West Kent CCG	55.0*	-	-

Source: IAPT

Figure 34: IAPT reliable improvement: % of people (in quarter) who have completed IAPT treatment who achieved "reliable improvement" in 2018/19 Q1

Area	Value	Lower CI	Upper CI
England	72.1*	71.9	72.4
Kent and Medway	78.3*	77.2	79.4
NHS Ashford CCG	74.3*	69.6	78.5
NHS Canterbury And Coas...	78.4*	75.6	80.8
NHS Dartford, Gravesham...	78.6*	75.3	81.6
NHS Medway CCG	77.4*	74.5	80.2
NHS South Kent Coast CC...	79.5*	76.5	82.2
NHS Swale CCG	82.1*	77.6	85.8
NHS Thanet CCG	78.4*	74.9	81.6
NHS West Kent CCG	77.5*	74.6	80.1

Source: IAPT

Figure 35: Recovery rate for depression: % of referrals finishing a course of treatment who are "moving to recovery" (annual)

Area	Value	Lower CI	Upper CI
England	48.5	-	-
Kent and Medway	-	-	-
NHS Ashford CCG	56.0*	-	-
NHS Canterbury And Coas...	56.0*	-	-
NHS Dartford, Gravesham...	57.0*	-	-
NHS Medway CCG	46.0*	-	-
NHS South Kent Coast CC...	47.0*	-	-
NHS Swale CCG	46.0*	-	-
NHS Thanet CCG	47.0*	-	-
NHS West Kent CCG	55.0*	-	-

Source: 2016/17 data: IAPT Annual Report Table 7C https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2016-17-further-analyses

Figure 36: Completing treatment for depression: % of referrals finishing a course of treatment (annual)

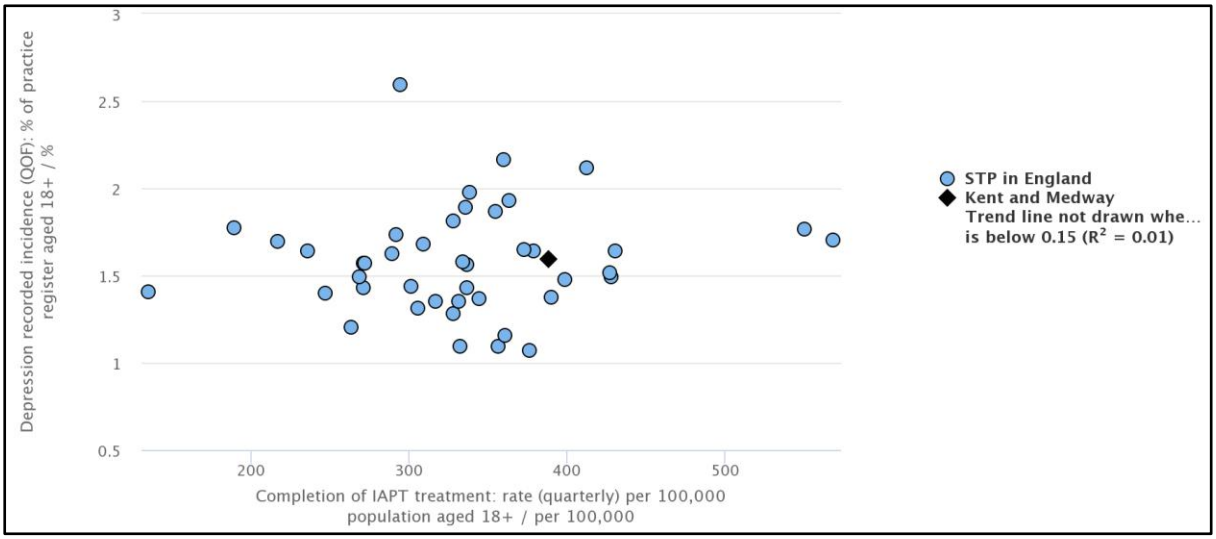
Area	Value	Lower CI	Upper CI
England	53.6	-	-
Kent and Medway	-	-	-
NHS Ashford CCG	66.3*	-	-
NHS Canterbury And Coas...	47.7*	-	-
NHS Dartford, Gravesham...	56.5*	-	-
NHS Medway CCG	60.5*	-	-
NHS South Kent Coast CC...	66.0*	-	-
NHS Swale CCG	62.4*	-	-
NHS Thanet CCG	66.8*	-	-
NHS West Kent CCG	65.3*	-	-

Source: 2016/17 data: IAPT Annual Report Table 1B https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2016-17-further-analyses

Figure 37 (below) shows that of all STPs in England, Kent and Medway's combined performance on IAPT completion rates is clustered in the average range. Kent and Medway's combined incidence of depression in primary care is 1.5% of its practice population and it has comparably good completion of treatment rates. Kent and Medway's variations are a concern. However, if considering IAPT as a population-based approach to tackle depression then there are signs that it is a good approach. A concern that is harder to

answer is how is this outcome of psychological therapy in Kent linking to the patient's long-term management of depression in primary care.

Figure 37: How Kent & Medway STP compares to other STP areas: for Incidence of Depression in Primary Care by IAPT completion of Treatment Rates.



Data source: PHE Fingertips

For more details regarding IAPT and the range of therapies provided in Kent, please see appendix 12.

Summary of Chapters 4 and 5

There is a confusion about the terms SMI (serious mental illness) and Severe Mental illness. The term SMI in primary care - refers to psychosis. However, all people with mental illnesses can become severe and chronic and acute if not treated and helped to recover. A critical step in this process is an adequate care plan and a person who can help the person with the mental health issue to navigate the various stages of their plan and advocate for them if there is crisis. The lack of these plans and help with them is in part a contribution to high relapse rates and hospital admissions and high numbers of people under the mental health act. Another issue is the workforce. A workforce that is adequately trained in suicide prevention, DBT, crisis mitigation, substance misuse and trauma informed care is vital. This same workforce must be supervised clinically and supported to provide care and care planning and safety netting to people who are vulnerable. There are parts of Kent (e.g. Thanet) where there are higher than England average people in primary care getting antipsychotic medication. This group of people need good and safe care planning to avoid relapse and adverse impact of their medications. Therefore, specialist mental health services must work hand in hand with primary care - particularly in areas of most need. Social care is a vital element in good care planning and the most vulnerable people in Kent can benefit from multidisciplinary care provided by local care teams. Thanet and coastal areas are of particular concern. Thanet has high needs for all mental health issues evidenced by its high rates of hospital admissions.

4 Deeper Dive into Treatment and Outcomes of Psychosis in Kent

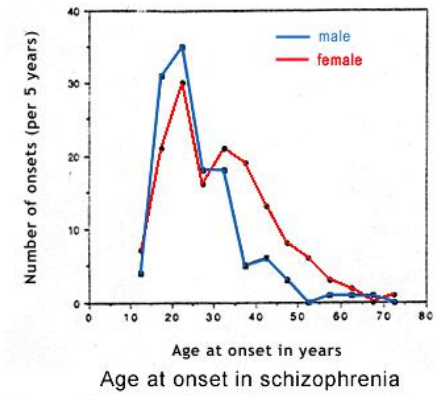
Using APMS estimates, the expected prevalence of the number of people with psychosis in Kent is approximately **4,624** people. Overall Kent and Medway have lower than England average rates (figure 38) with Thanet and South Kent Coast having the highest predicted rates across the STP area.

Figure 38: Estimated prevalence of psychotic disorder: % of population aged 16+, 2012

Area	Value	Lower CI	Upper CI
England	0.40*	-	-
Kent and Medway	0.33*	-	-
NHS Ashford CCG	0.28*	-	-
NHS Canterbury And Coas...	0.35*	-	-
NHS Dartford, Gravesham...	0.31*	-	-
NHS Medway CCG	0.28*	-	-
NHS South Kent Coast CC...	0.39*	-	-
NHS Swale CCG	0.34*	-	-
NHS Thanet CCG	0.48*	-	-
NHS West Kent CCG	0.30*	-	-

Source: Adult Psychiatric Morbidity Survey (APMS) 2007, ONS population estimates and NHS resource allocation formula

Figure 39: The age of onset for psychosis is similar internationally and, in the UK, with earlier onset for males



Age at onset in schizophrenia

Source: A typological model of schizophrenia based on age at onset, sex an familial morbidity. *Acta Psych8atr. Scand.* 89, 135-141 (1994)

For clarity 'Serious Mental Illness' (SMI) is broader than 'psychotic illness'. Psychosis is a subset of SMI. Figure 40 shows another way to predict the population of people with SMI in Kent using QOF ratios. This is a comparison between the percentage of people registered with GPs who are on the mental health Quality and Outcomes Framework (QOF) register for mental health (schizophrenia, bipolar disorder or other psychoses or on lithium therapy) and the estimated prevalence of psychotic disorders (weighted for age, sex, need and service variables). It is expressed as a ratio which divides the QOF prevalence by the estimated prevalence. According to QOF records there were **15,420** people with SMI in Kent and Medway, of these **3,255** had a Care Programme from Secondary Care (CPA). West Kent has the highest QOF SMI ratio indicating primary care is supporting a high proportion of its SMI population, however the ratios are relatively comparable across Kent and Medway. APMS estimates that there may be **209** new cases per year in Kent and Medway.

Figure 40: Ratio of QOF and estimated prevalence of severe mental illness (SMI): QOF register prevalence of SMI as a ratio of estimated prevalence of SMI, 2015/16

Area	Value	Lower CI	Upper CI
England	2.27	-	-
Kent and Medway	-	-	-
NHS Ashford CCG	2.37	-	-
NHS Canterbury And Coas...	2.47	-	-
NHS Dartford, Gravesham...	2.34	-	-
NHS Medway CCG	2.37	-	-
NHS South Kent Coast CC...	2.25	-	-
NHS Swale CCG	1.93	-	-
NHS Thanet CCG	2.28	-	-
NHS West Kent CCG	2.46	-	-

Source: Health & Social Care Information Centre: Quality and Outcomes Framework (for QOF) and APMS and ONS mid-year estimates for estimated prevalence

For GP prescribing of antipsychotic medication all CCGs are under the England average (Figure 41). This indicates that there is less mental health management of psychosis in primary care in Kent than the England average. Only Thanet is different in Kent and Medway, showing a statistically significant higher rate of GP prescribing for anti-psychotic medication.

Figure 41: GP prescribing of drugs for psychoses and related disorders: items (quarterly) per 1,000 population in 2017/18 Q4

Area	Value	Lower CI	Upper CI
England	62.4	62.3	62.4
Kent and Medway	53.7*	53.3	54.1
NHS Ashford CCG	40.9	39.6	42.1
NHS Canterbury And Coas...	43.0	42.0	43.9
NHS Dartford, Gravesham...	54.2	53.2	55.2
NHS Medway CCG	59.9	58.9	60.9
NHS South Kent Coast CC...	52.3	51.2	53.4
NHS Swale CCG	52.4	50.9	53.9
NHS Thanet CCG	69.0	67.5	70.5
NHS West Kent CCG	54.7	53.9	55.4

Source: NHS Digital

5 Mental Health Admissions to Hospital in Kent

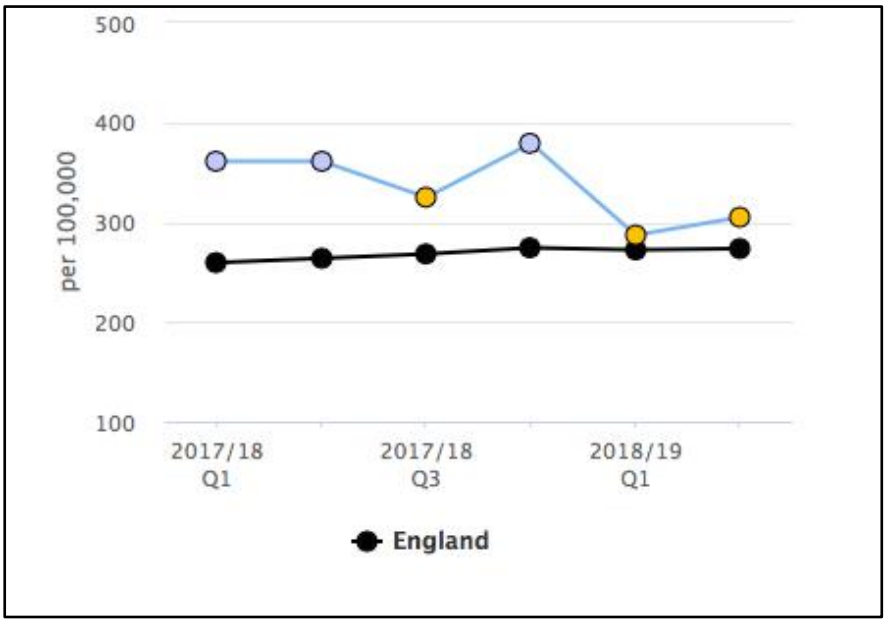
There are some concerns with the hospital admissions data. The data (Fig 42) shows the number and rates of admission to hospital for mental illness (primary diagnosis) per quarter. In 2017/18 there were 3,515 admissions to hospital from Kent and Medway. This roughly the same number of people recoded on CPA. There are higher admission rates in Thanet, but overall, admission is lower than the England average.

Figure 42: Mental health admissions to hospital: rate per 100,000 population in 2018/19 Q2

Area	Value	Lower CI	Upper CI
England	273.5*	270.4	276.6
Kent and Medway	210.9*	196.1	226.5
NHS Ashford CCG	224.2*	168.9	291.8
NHS Canterbury And Coas...	253.6*	208.5	305.7
NHS Dartford, Gravesham...	227.9*	188.2	273.6
NHS Medway CCG	215.3*	177.7	258.4
NHS South Kent Coast CC...	201.7*	161.1	249.4
NHS Swale CCG	178.8*	127.7	243.5
NHS Thanet CCG	304.9*	243.5	377.0
NHS West Kent CCG	159.7*	135.2	187.4

Source: NHS Digital Mental Health Services Data Set monthly reports.

Figure 43: Mental health admissions to hospital: rate per 100,000 population in NHS Thanet CCG



Data source: PHE Fingertips

Thanet's admission rates are higher than the Kent average with the trend over 2017 reducing, although still higher than national average. A hospital admission for mental illness is rarely planned and is mostly a result of crisis. Therefore, high admission rates point to a problem in providing adequate community support, local treatment and care for mental illness. Thanet is the most deprived area in Kent and is predicted to have a more vulnerable population. However, in South Kent Coast and Swale (also deprived communities) the admission rates are lower. This indicates improving mental health community support is a priority in Thanet. Figure 44 shows there are around 90 to 100 admissions a quarter in Thanet. Understanding the needs of these individuals and placing community support around them is likely to be cost-effective.

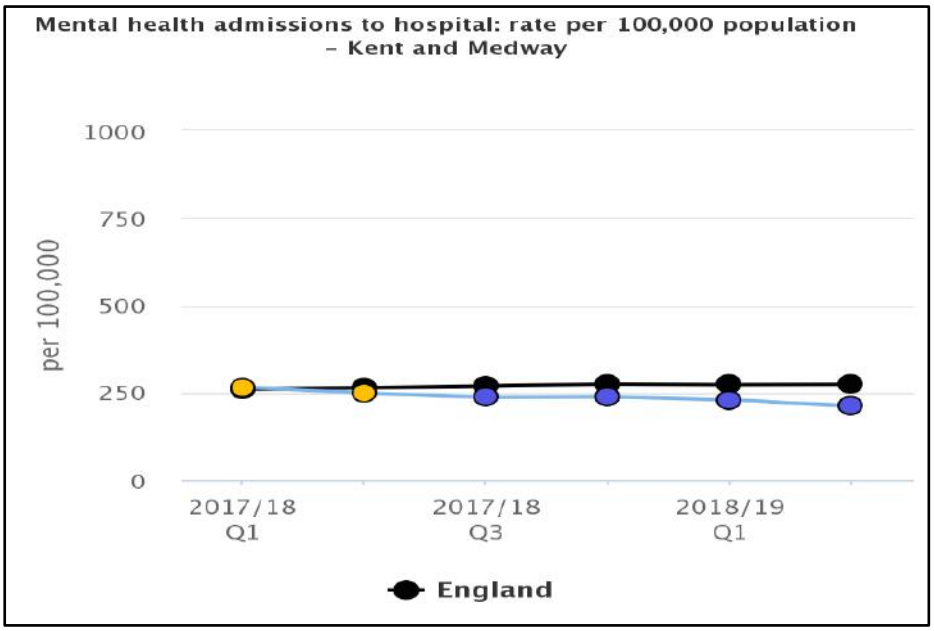
Figure 44: Numbers of mental health admissions to hospital in NHS Thanet CCG

Recent trend: ➡

Period		Count
2017/18 Q1	○	100
2017/18 Q2	○	100
2017/18 Q3	●	90
2017/18 Q4	○	105
2018/19 Q1	●	80
2018/19 Q2	●	85

Data source: PHE Fingertips

Figure 45: Mental health admissions to hospital: rate per 100,000 population in Kent and Medway between 2017/18 and 2018/19



Data source: PHE Fingertips

Overall there is a small reduction in hospital admissions for mental illness in Kent and Medway

Across 2017/18, figure 46 shows the trend continuing into 2019. This appears to be a favourable indication, however it may also indicate 'bed capacity' (meaning people may be re-directed to other places) and therefore needs to be assessed alongside S136 rates, self-harm, A&E attendances and suicide rates to gain a true picture of how the mental health system is functioning in Kent and Medway.

Figure 46: Hospital Admissions to Secondary Care Mental Health Beds: Trends 2017/18/19

Recent trend: ➡

Period		Count	Value	Lower CI	Upper CI	England
2017/18 Q1	●	945	265.5*	248.8	283.0	259.4
2017/18 Q2	●	885	248.6*	232.5	265.6	263.7
2017/18 Q3	●	840	236.0*	220.3	252.5	268.1
2017/18 Q4	●	845	237.4*	221.7	254.0	274.3
2018/19 Q1	●	820	229.0*	213.6	245.2	272.2*
2018/19 Q2	●	755	210.9*	196.1	226.5	273.5*

Source: NHS Digital Mental Health Services Data Set monthly reports.

A recent report[78] by NHS mental health providers states clear concern about the level of demand. Admission levels may be one of the key measures to examine demand in an area.

5.1 A&E attendances for Mental Illness

In 2012/13 there were 4,181 attendances at A&E for people with mental health problems and this is a rate of 239 per 100,000 people aged 18 and over. The breakdown by CCG shows that Thanet is considerably higher than the England average. Focus on A&E rates in Thanet would significantly improve Kent & Medway's average. Please note that **this data is five years old.**

Figure 47: Attendances at A&E for a psychiatric disorder: rate per 100,000 population in 2012/13

Area	Value	Lower CI	Upper CI
England	243.5	242.2	244.9
Kent and Medway	239.1*	231.9	246.5
NHS Ashford CCG	236.4	209.7	265.6
NHS Canterbury And Coas...	195.2	176.3	215.5
NHS Dartford, Gravesham...	225.9	207.6	245.4
NHS Medway CCG	238.6	220.5	257.8
NHS South Kent Coast CC...	250.3	229.0	273.0
NHS Swale CCG	163.6	140.3	189.5
NHS Thanet CCG	448.2	413.3	485.3
NHS West Kent CCG	217.8	204.6	231.7

Source: Health & Social Care Information Centre (HSCIC) and the Office for National Statistics

When viewed next to data on care programme approach (CPA) and mental health hospital admissions the picture is stark for Thanet. However, it is important to have more recent data for A& E attendances.

Thanet reports 37,210 contacts to specialist mental health services in the second quarter of 2018, of these there were 55 people sectioned under the Mental Health Act and 85 people admitted. Over 2017/18 there were approximately 170 new cases to the early intervention for psychosis team in Thanet. These figures are slightly above the national average. Given these numbers it will be interesting to assess the functioning and resourcing of Thanet's mental health services separately to this overall needs assessment alongside the mental health providers.

[78] https://nhsproviders.org/state-of-the-provider-sector-07-17/the-mental-health-provider-challenge

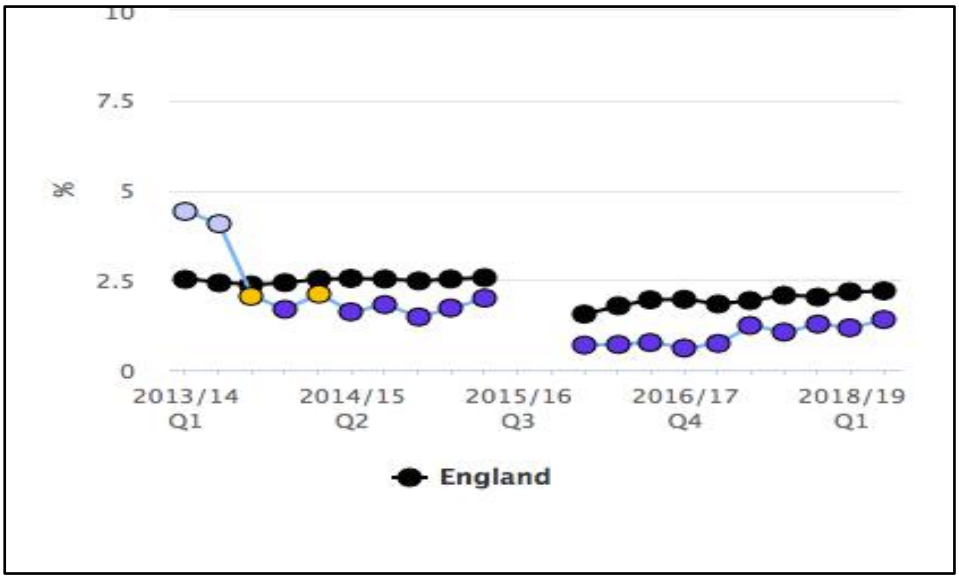
Figure 48: Service users in hospital: % of mental health service users (end of quarter snapshot) in 2018/19 Q2

Area	Value	Lower CI	Upper CI
England	2.2*	2.2	2.2
Kent and Medway	1.2*	1.1	1.4
NHS Ashford CCG	0.5*	0.3	0.8
NHS Canterbury And Coas...	1.1*	0.9	1.4
NHS Dartford, Gravesham...	1.4*	1.0	1.8
NHS Medway CCG	1.4*	1.1	1.7
NHS South Kent Coast CC...	1.0*	0.8	1.3
NHS Swale CCG	1.4*	1.0	2.0
NHS Thanet CCG	1.4*	1.1	1.8
NHS West Kent CCG	1.6*	1.3	1.9

Source: NHS Digital

Figure 48 shows how many of those clients in specialist care are admitted to hospital, showing what proportion of the population with a mental illness require the most intense services. Looking at results across CCGs may reflect variation in needs in different areas but it may also indicate differences in the way mental health trusts provide their services. Thanet, which has the highest proportion of A&E hospital attendances for psychosis (mental illness) shows an increasing trend in the percentage of patients who have had a hospital spell (fig xx). This is however, not in great variance with the rest of Kent and Medway, and there are some issues with the data quality. It is interesting to note the differences in the patients' outcomes within services. If these proportions are indicative of the most vulnerable people in Kent and Medway's mental health system, the numbers in Kent and Medway come to a snapshot count of **460** people in 2018/19 Quarter 2, and **60** of those people are in Thanet. This must indicate differing approaches and thresholds of care across Kent as other indicators for Thanet appear to contradict this data.

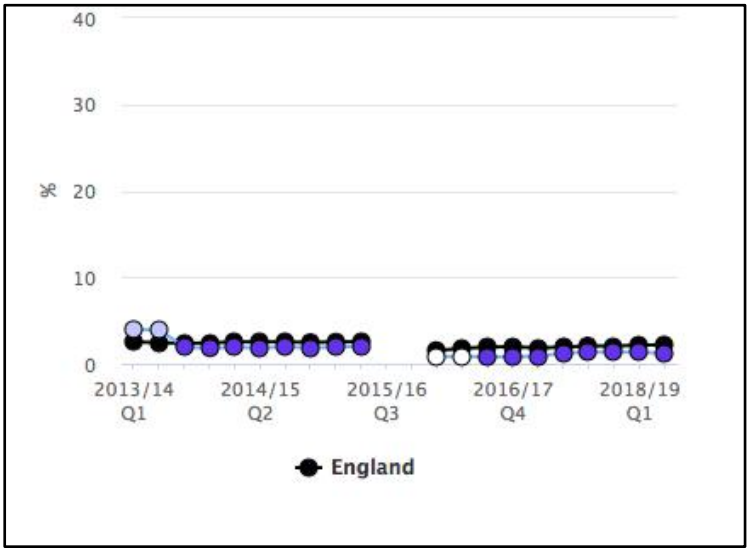
Figure 49: Service users in hospital: % of mental health service users (end of quarter snapshot) in Thanet.



Data source: PHE Fingertips

Figure 49 shows that there is a decrease in service users in Thanet going to hospital for their mental illness. This may also be reflected in a higher proportion of prescribed antipsychotic in primary care in Thanet. However, Thanet is below the Kent and England average (fig 50).

Figure 50: Service users in hospital: % of mental health service users (end of quarter snapshot) in Kent and Medway



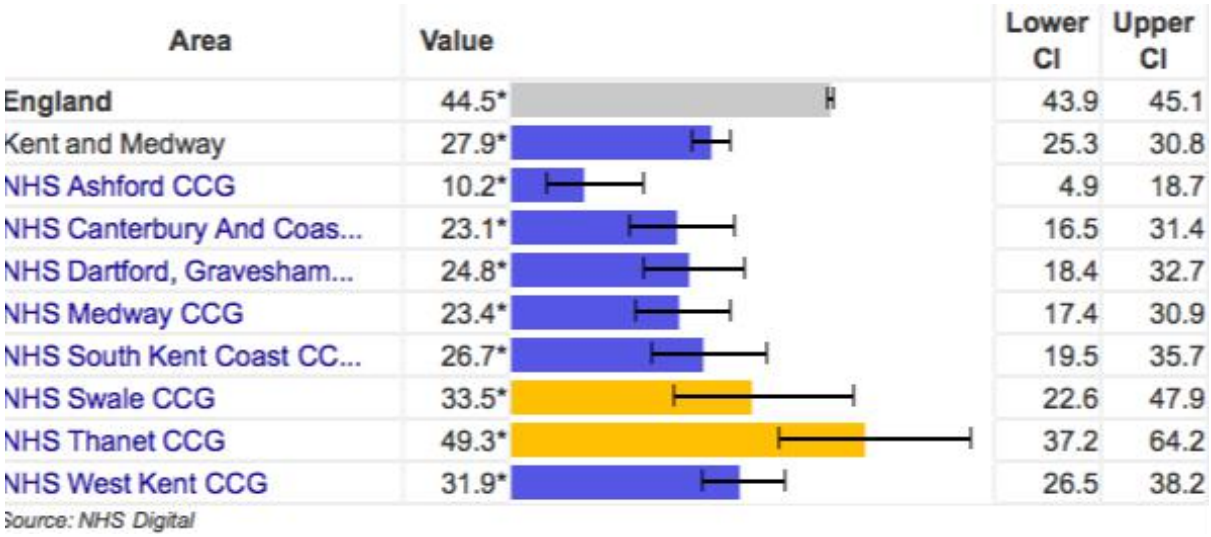
Data source: PHE Fingertips

Figure 51 shows detentions under the mental health act (sectioning). This type of intervention is always to be avoided and if possible, prevented as patients report that the act of sectioning (although put in place to protect the person from harm to their self or

others) is traumatic. Most CCGs in Kent have section rates well below the England average – apart from Swale and notably – Thanet. Thanet also has higher rates of contact with the early intervention for psychosis teams.

Figures 52 and 53 compares Thanet to all CCGs in England in its A&E attendances and rate of new cases to early intervention teams. This data shows Thanet is in the group of CCGs in England with high A&E attendances and relatively low rates (compared with other CCGs in England) of contact with early intervention services.

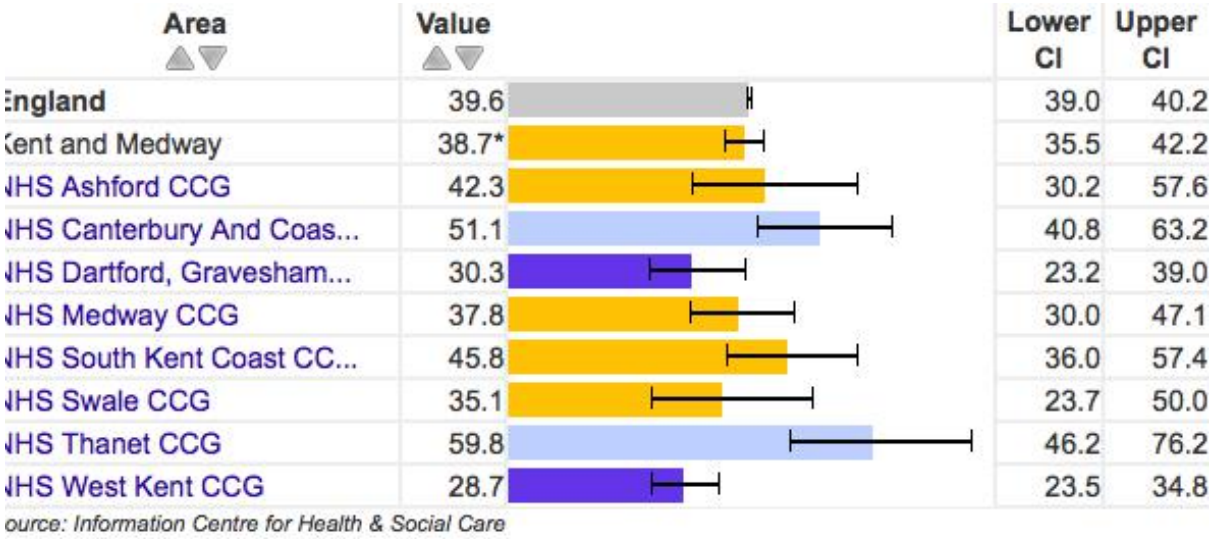
Figure 51: People subject to Mental Health Act: rate per 100,000 population aged 18+ (end of quarter snapshot) in 2018/19 Q2



Area	Value	Lower CI	Upper CI
England	44.5*	43.9	45.1
Kent and Medway	27.9*	25.3	30.8
NHS Ashford CCG	10.2*	4.9	18.7
NHS Canterbury And Coas...	23.1*	16.5	31.4
NHS Dartford, Gravesham...	24.8*	18.4	32.7
NHS Medway CCG	23.4*	17.4	30.9
NHS South Kent Coast CC...	26.7*	19.5	35.7
NHS Swale CCG	33.5*	22.6	47.9
NHS Thanet CCG	49.3*	37.2	64.2
NHS West Kent CCG	31.9*	26.5	38.2

Source: NHS Digital

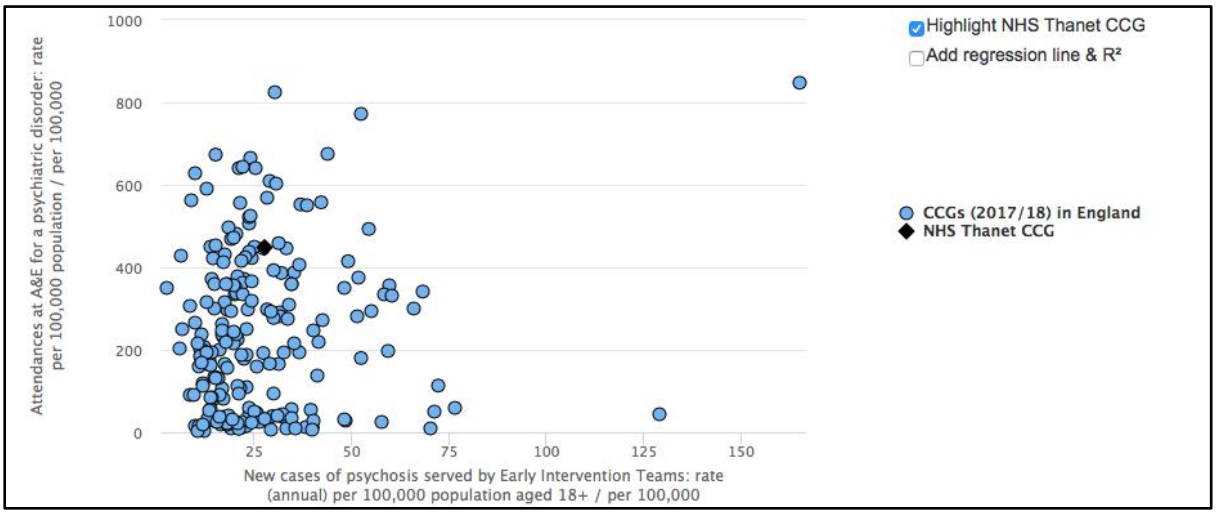
Figure 52: Treatment by Early Intervention Teams: rate per 100,000 population aged 18+ (end of quarter snapshot) in 2015/16 Q2



Area	Value	Lower CI	Upper CI
England	39.6	39.0	40.2
Kent and Medway	38.7*	35.5	42.2
NHS Ashford CCG	42.3	30.2	57.6
NHS Canterbury And Coas...	51.1	40.8	63.2
NHS Dartford, Gravesham...	30.3	23.2	39.0
NHS Medway CCG	37.8	30.0	47.1
NHS South Kent Coast CC...	45.8	36.0	57.4
NHS Swale CCG	35.1	23.7	50.0
NHS Thanet CCG	59.8	46.2	76.2
NHS West Kent CCG	28.7	23.5	34.8

ource: Information Centre for Health & Social Care

Fig 53: New Cases of Psychosis to Early Intervention Compared to Psychosis Prevalence for Thanet



Data source: PHE Fingertips

5.2 Deaths and Serious Incidents (KMPT data)

Deaths and serious incidents are important indicators of the level of need and demand in the mental health system. Across England there were more than 8,000 serious incidents reported by mental health trusts in 2017 - an increase of more than a third over a two-year period. Table 10 shows data taken from KMPT's 2018 Quality Report.

Table 10: Deaths and serious incidents data from KMPT service in 2017-18

Mortality 2017-18

	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Total 2017-18	
	All Deaths	StEIS reported	All Deaths	StEIS reported	All Deaths	StEIS reported	All Deaths	StEIS reported	All Deaths	StEIS reported
Trust total	430	21	327	18	201	22	253	17	1211	78
Acute Care Group	36	3	22	6	20	4	18	1	96	14
Community Recovery	67	14	47	11	40	14	44	12	198	51
Forensic	21	1	16	1	3	1	12	0	52	3
Older Adults	306	3	242	0	138	3	179	4	865	10

Source: Excellent Care, Personal to You: KMPT Quality Report 2018

These are KMPT's own recommendations which mirror recommendations made elsewhere in this needs assessment.

The important themes on lessons learnt following investigation of a mortality report are:

- the need for discharge summaries to be obtained in every case
- full, complete and current care plans improve quality of care
- risk assessments should be formally completed and recorded.
- delays in allocation of care-coordinators can increase risks and must be minimised
- retrospective entries onto patients' records should be avoided to ensure accuracy of data.

Summary of Chapters 6 and 7

Chapter 6 summarises the need for treating a person holistically and wrapping a range of services around a vulnerable person in a coordinated manner. This is because there is high interaction between poverty, mental health, a range of risks and self-neglect and physical health problems. This makes a person's healing from all of the conditions harder and slower. This is particularly evident in substance misuse where there is a very high degree of co-morbidity between the addiction and a person's mental health and suicidal ideation and self-harm (85%). This often leads to barriers to getting care and support when they most need it and outcomes for individuals are poor. Deaths from liver failure is higher and drug deaths are increasing. There are 1,582 people in Kent substance misuse services with a serious mental health. There are far fewer than this number of Kent substance misuse service users in specialist mental health services and currently Kent Substance Misuse services are not commissioned to provide mental health treatment. Health checks and health care needs to prioritised in all people with a long term mental illness. Tackling social isolation will benefit many people as Kent Public Health Observatory Study has shown that people in specialist mental health services have poor physical health and a greater risk of dying early (before the age of 75). In addition, good prevention services and opportunities for people look after their physical health are needed. The current Men's Sheds programme across Kent and Medway is important in enabling men to keep healthy and active in the community.

6 The Triple Threat: Poverty, Mental Health & Co -Occurring Conditions (Multi-morbidity)

This report first outlined the extent of mental illness in Kent, provided summary recommendations from the risks of developing mental illness, it assessed the prevalence estimates for mental illness in Kent from APMS and local QOF estimates and now describes the key long-term conditions associated with mental illness. This chapter gives the numbers and rates of multi morbidity across Kent from various data sources including the Kent Integrated Dataset (KID). It is worth noting that a recent PHE report and audit of Kent substance misuse service users show a concurrence of 68% with high levels of suicidality.

6.1 The Triple Threat: Mental Health Data Problems: Prevalence, Diagnosis & Deprivation

6.1.1 Thresholds, Diagnosis and Co-Morbidity

In discussing prevalence in this report, the difficulty of mental health diagnosis must be noted. For example, mental health in primary care ranges from sub-syndromal symptoms (i.e. not reaching the definition for disorder), to clear cases of mental disorder which range significantly in the severity and the disability they cause. It is the existence of this spectrum

that makes it hard to categorise mental ill health in primary care into simple groupings for service planning. In addition – there is an enormous co-morbidity between both physical and mental health conditions. This is the focus of this report.

6.1.2 Thresholds for Services

The health and social care burden of less severe, sub-syndromal, symptoms are considerable; up to 40-50% of days off work are thought to be stress related problems.[79] The analysis reflects existing evidence that the presence of a long-term condition increases the risk of a mental health problem; 30% of all people with a long-term condition also have a mental health problem.[80] People with long-term conditions and comorbid mental health problems disproportionately live in deprived areas and have access to fewer resources. Common mental illness is more frequent in unemployed people.

6.1.3 Poverty

Poverty is producing an environment that is extremely harmful to people's mental health. The primary health impacts of economic downturns are on mental health (including the risk of suicide) and people with no previous history of mental health problems may develop them as a consequence of having to cope with the ongoing stress of job insecurity, sudden and unexpected redundancy, and the impacts of loss of employment (financial, social and psychological). Keeping people with mental health problems in work and getting people back to work are key policy and service responses to the economic downturn.[81]

6.2 Case for Action on Multi-Morbidity: Background and summary of findings from National Mental Health Taskforce 2016

There is an overwhelming body of evidence that **at least 30%** of all people with a long-term condition also have a mental health problem.[85]

People with long-term conditions and comorbid mental health problems disproportionately live in deprived areas and have access to fewer resources. The interaction between comorbidities and deprivation makes a significant contribution to generating and maintaining health and social inequalities.

There are four key elements that are needed to understand the issue of 'parity of esteem' and the tackling of physical and mental health issues together. The Kings Fund Report 'Bringing it together' highlighted:

- **rising levels** of multi-morbidity

[79] *Cooper C, Cartwright S,. Mental health and stress in the workplace, a guide for employers. London HMSO, 1996*

[80] *https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf*

[81] *Royal College of Psychiatrists, Mental Health Network of NHS Confederation and London School of Economics (2009) in Mental Health Commission (September 2011) The Human Cost. An Overview of the evidence on economic adversity and mental health and recommendations for action. Dublin: Mental Health Commission*

- **inequalities** in life expectancy
- **psychological** aspects of physical health
- **somatic:** medically unexplained symptoms.

6.2.1 Rising Levels of multi-morbidity:

A King's Fund Report in 2015 indicated that between 12% and 18% of all NHS expenditure on long-term conditions is linked to poor mental health – most commonly in the form of *depression or anxiety disorders*, which if left untreated can significantly exacerbate physical illness and drive up the costs of care.[85]

6.2.2 Inequalities in Health Outcomes:

Life expectancy for people with *bipolar disorder or schizophrenia* is 15 to 20 years below that of the general population, largely as a result of raised rates of cardiovascular disease and other physical health conditions.[82, 83]

Other mental illnesses that have significant co-morbidity with physical health are: eating disorders, Personality Disorders, Substance Misuse Disorders & Untreated Depression.

6.2.3 Psychological Aspects of Physical Health

All health conditions have a psychological component and can impact on a person's wellbeing whether or not there is a diagnostic threshold for a mental illness present. The body's stress-response system can be highly corrosive to physical health. Therefore, living with any long-term condition, functional impairment and social isolation can lead to a cycle of restricted physical and mental health. This is also a factor in **Perinatal health** – where the interplay between mental and physical health also has a developmental consequence.

6.2.4 Current Research conclusions on interactions between mental and physical health

People with a long-term physical health condition are two to three times more likely to develop mental conditions, particularly depression and anxiety; conditions include:

- Cancer
- Atrial fibrillation (AF)
- Chronic heart disease (CHD)
- Cardiovascular disease (CVD)
- Heart failure (HF)
- Hypertension
- Peripheral Arterial Disease (PAD)
- Stroke

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[82] *Lauersen et al. (2014). The effectiveness of exercise interventions to prevent sports injuries: a systematic review and meta-analysis of randomised controlled trials. Br J Sports Med. 48: 871-7.*

[83] *Miller and Bauer. (2014). Excess mortality in bipolar disorders. Curr Psychiatry Rep.16: 499.*

- Asthma
- Chronic kidney disease (CKD)
- Chronic obstructive pulmonary disease (COPD)
- Diabetes

7 Substance Misuse and Mental Illness (Co-occurring conditions)

7.1.1 Definitions:

It is not straightforward to set out the policy context in respect of dual diagnosis as no national policy actually exists. The two most relevant dual diagnosis policy drivers are 2002s Department of Health's Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide (May 2002) and Better Care for People with Co-occurring Conditions Mental Health and Substance Misuse': A guide for commissioners (PHE 2018).

Currently Co-occurring mental health problems and substance misuse problems are mostly managed in a way which addresses a person's primary problem, followed by the secondary problem; regardless of equity of condition – generally in Kent co-occurring problems are not effectively managed simultaneously.

Establishing which problem came first is often complicated and current PHE guidance warns that focussing on this issue can result in vulnerable individuals with co-morbidity being excluded from services whilst a decision about ultimate attribution is made.

7.1.2 Ways of presenting with co-occurring conditions

- a primary psychiatric illness precipitating or leading to substance misuse;
- substance misuse worsening or altering the course of a psychiatric illness;
- intoxication and/or substance dependence leading to psychological symptoms;
- substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses.

7.1.3 COSMIC study: Estimated prevalence of mental health problems among substance misuse patients [84]

Table 11: Estimated prevalence of mental health problems among people with substance misuse disorder

Condition	% of drug treatment population	% alcohol treatment population
Psychiatric disorder	75	85
Non-substance induced psychosis disorders	8	19
Personality disorder	37	53
Depression &/or anxiety disorder	68	81
Severe depression	27	34
Mild depression	40	47
Severe anxiety	19	32

[84] *Weaver, T., Charles, V., Madden, P., & Renton, A., 'A study of the Prevalence and Management of Co-Morbidity amongst Adult Substance Misuse & Mental Health Treatment Populations', Drug Misuse Research Initiative/Dept of Health, 2002. Available at http://dmri.lshtm.ac.uk/docs/weaver_es.pdf. Accessed 06/12/2018.*

7.1.4 National Epidemiology and Risks applied to Kent Population.

The 2017 PHE guidance (taken from the large-scale London study COSMIC) states: 74.5% (95%CI: 68.2% to 80.2%) of Drug Users and 85.5% (95%CI: 74.6% to 92.7%) of Alcohol dependent users in treatment have at least one mental health problem.[85]

This is **4,100 (95%CI between 3,650 and 4,450) clients** (2017/8 numbers in treatment) in Kent substance misuse services with a mental health condition.

Kent Substance Misuse Treatment Services report that **44%** of their cohort in treatment in 2017/8 entered treatment with an existing mental health diagnosis, of these **24%** were being treated by CMHT and 58% (n=**258**) were being seen in primary care.[86] This is below the expected number from national research. Research by KPHO finds **fewer** service users with a mental health diagnosis being treated in primary care.

The 2002 COSMIC study Co-Morbidity of Substance Misuse and Mental Illness Collaborative Study found that 44% of all people in secondary and specialist mental health services had a substance misuse problem.

Applying the COSMIC study rates conservatively to the Kent population would estimate that **1000 individuals** in Kent Substance Misuse services are 'complex needs with multi-morbidity'.

Death by suicide is also common, with a history of alcohol or drug use being recorded in 54% of all suicides in people experiencing mental health problems.

In Kent a recent audit of service users in Kent Substance Misuse treatment services showed a suicidal ideation rate of **48% to 68%** between both services.[87]

Research has shown that service users with a dual diagnosis typically use NHS services more and cost more. A study of services in South London found that dual diagnosis patients had significantly higher 'core' psychiatric service costs (a difference of £1,362) and non-accommodation service costs (£1,360) than patients without a dual diagnosis.[88]

Service users with a dual diagnosis are more likely to be non-compliant and fail to respond to treatment than either people with substance misuse issues or a mental illness,

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[85] *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2016: England, Northern Ireland, Scotland and Wales October 2016. University of Manchester.*

[86] *NDTMD Commissioning Pack 2017/18.*

[87] *Suicidality Audit in Substance Misuse Treatment Services in Kent 2018 Kent County Council Commissioning*

[88] *National Mental Health Development Unit, briefing 189, Meeting the challenge of dual diagnosis, September 2009. Available at http://nmhdu.org.uk/silo/files/seeing-double-meeting-the-challenge-of-dual-diagnosis.pdf. Accessed 09/12/2018.*

In the National audit of violence, the Healthcare Commission and the Royal College of Psychiatrists identified drug and alcohol use as a major trigger for violence in mental health services.[89]

The estimated risk of suicide in the presence of current alcohol misuse or dependence is eight times greater than in the absence of such misuse/dependence and as many as 65% of suicides have been linked to excessive drinking. According to np-SAD data, of the 131 cases noted as diagnosed with mental health issues, 51.9% (68/131) were listed as suffering from depression, with 25.0% of these (17/68) deaths being attributed to suicide.

Amongst the general population, alcohol dependence and major depression co-occur at higher levels than would be expected by chance.

Up to 50% of problem drinkers have a personality disorder, up to 80% have neurotic disorders [90]

Individuals with severe and enduring mental illnesses, such as schizophrenia and bipolar disorder, are at least three times as likely to be alcohol dependent as the general population[91]

7.1.5 Local Vulnerability and Local Performance Data

The mental health clients / patients do not just fit neatly into one programme area but actually multiple e.g. risk of suicide vs alcohol substance misuse vs relapsing mental health conditions. These result in significant inter-relationships and interactions between multiple programme areas and so investment in these programme areas has to be carefully thought through taking into multiple assumptions and factors for successful service delivery and outcomes.

There is substantial local evidence available of a substantial local cohort with co-occurring / existing physical and mental health conditions (multiple morbidities). Measurement of the prevalence and incidence of these conditions have largely relied upon standalone single disease registers. However, due to incompatible governance arrangements and adequate contractual levers, the 'linking' of the registers at patient level have not kept up to pace historically with the increased demand for greater understanding of multiple morbidities and their effect on health and care service utilisation within the population.

In 2017/18 there were 27 individuals in Kent who attended residential rehabilitation. NICE guidance recommends this option for the most serious and complex cases, in Kent 2% of the

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[89] *ibid*

[90] *Cited in Dual Diagnosis Needs Assessment: Brighton & Hove, December 2012, p29. See also Preuss, U., Johann, M., Fehr, C., Koller, G., Wodarz, N., Hesselbrock, V., Wong, W., Soyka, M., ' Personality Disorders in Alcohol-Dependent Individuals: Relationship with Alcohol Dependence Severity', European Addiction Research, 2009; 15(4): 188-95.*

[91] *Phillips, P., Johnson, S., 'How does drug and alcohol misuse develop among people with psychotic illness? A literature review,' Soc Psychiatry Epidemiology 2001; 36(6):269-76.*

treatment population. This population is likely to need specialist mental health input alongside the 102 individuals who were given inpatient detox.

Overall Kent's hospital rates of hospital admissions for alcohol related problems are not higher than the UK average (352 per 100,000 population in 2016/7). However, they are still high compared to UK average in Thanet, Dartford and Gravesham and Canterbury and Coastal CCG areas.

7.1.6 Alcohol use disorder – prevalence estimated from APMS and applied to the Kent population

In Kent, there are an estimated 14,000 people with probable dependence and in need of treatment. Since 2007, the estimates of people under 34 years old who are dependent drinkers is decreasing. In Kent, there was a rate of 45.4 per 100,000 people over 18 years old who died of alcohol related conditions and this is 667 people in 2017. The best UK prevalence (2015)[92] estimates for co-occurring conditions (mental illness and alcohol use disorder) state:

- Whole UK population with Alcohol Use Disorder: 16% prevalence
- People with Serious Mental illness with Alcohol Use Disorder: 2-7% prevalence

However, WHO estimates that the prevalence of alcohol use disorders and alcohol dependence in the UK were 8.7% and 1.4%, respectively, in 2016.[93]

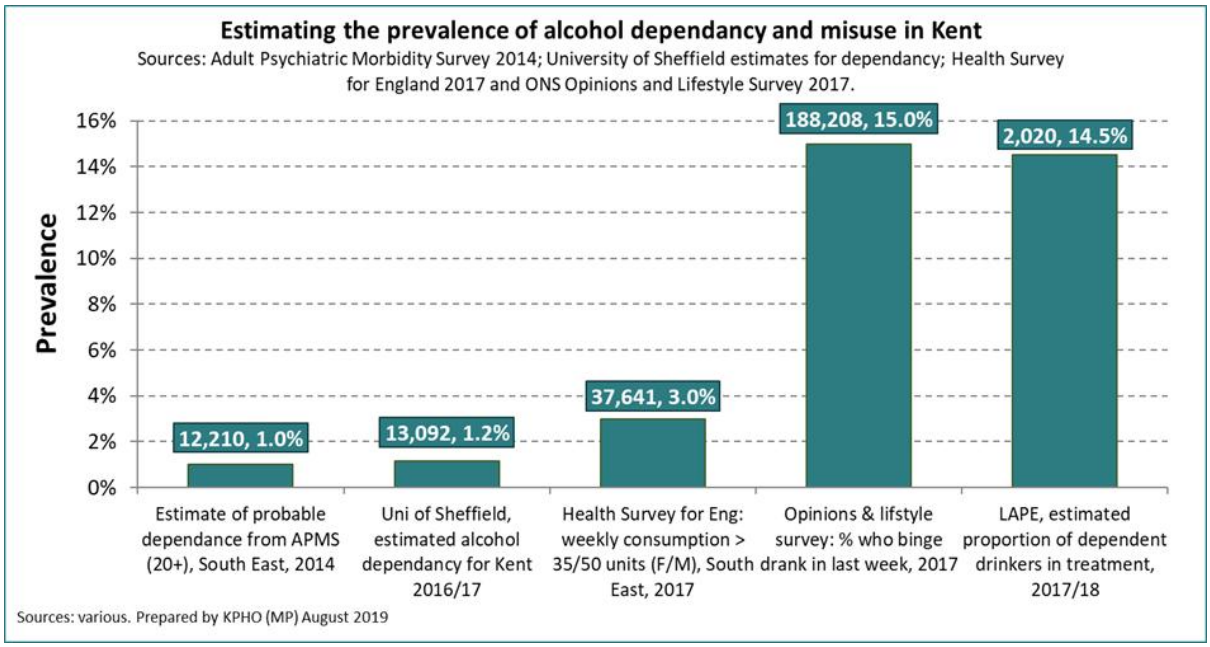
Levels of alcohol misuse are important for mental health as ethanol is a legal psychoactive poison, misuse of can lead to self-harm and depression and complicate the recovery from alcohol use disorder.[94]

[92] *https://www.nice.org.uk/guidance/ng58/documents/evidence-review*

[93] *https://www.who.int/substance_abuse/publications/global_alcohol_report/profiles/gbr.pdf*

[94] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3658562/

Figure 54: Estimating the prevalence of alcohol dependency and misuse in Kent



7.1.7 Local Kent Data on Treatment of Co-occurring conditions[95]

A local study was conducted in 2017/18 by Kent Public Health Observatory's developmental statistics (Kent Integrated Dataset). The aims from this analysis were to describe the recording of mental illness and substance misuse across the following health care settings for Kent in 2017/18, *general practice, admissions to hospital, community mental health teams* and to explore the overlap between mental illness and substance misuse across the different health care settings and by key population subgroups: sex, age group, deprivation and ethnicity. This study was taken from data in the Kent Integrated Data Set and not solely from Kent Substance Misuse Providers. Therefore, is likely to give more accurate and wider population prevalence data than the services 'demand' data.

7.1.8 Key Findings

There are variations in where treatment is provided for people with co-occurring conditions.

Although substance misuse providers report that 58% of service users are being seen in primary care for their mental health needs this report does not support this finding.

Nationally dual diagnosis is estimated to effect 0.05% to 0.16% of the general adult population. But there is evidence for varying prevalence across different healthcare settings, ranging from 45.8% of those in contact with community substance misuse services to **0.02% of those in contact with primary care**.

[95] *Kent Public Health Observatory Deep Dive into treatment of Co-occurring Conditions in Kent: Comparing Primary Care, Hospital Admissions and Community Mental Health Teams.*

Across the health care settings, we can estimate the prevalence of dual diagnosis, as a percentage of the Kent Integrated Dataset sample of **1,221,770** persons aged 14 plus:

- within general practice **0.36%** of persons had evidence of dual diagnosis from recording of harmful and/or dependent drinking **(0.26%)** or drug use and/or opioid substitution treatment (0.10%). [2]
- using hospital admissions **0.14%** of persons had evidence of dual diagnosis from same year admissions for serious mental illness or depression, as well as, alcohol (0.08%) or drug misuse (0.10%).
- **0.02% of Community Mental Health Team contacts were flagged with the cluster for dual diagnosis.** This is far fewer than predicted both by national estimates and the COSMIC study. **COSMIC prediction of problematic substance misuse in CMHT is 44%**

Overall, across all three settings, we identified 6,079 persons equating to 0.5% of the general adult population with evidence of dual diagnosis. We found greater need, from higher prevalence, within those living in the areas of highest deprivation.

Individuals were not known across all health care settings - less than 0.01% were identified concurrently within general practice, hospital admissions and community mental health teams. This finding was consistent when extending the sample to include all those seen by community mental health teams.

Dual diagnosis was consistently highest in the most deprived decile.

More females were identified from general practice and hospital admissions, whereas, Community Mental Health Teams were more likely to see males using tariff cluster 16.

Figure 55: Venn diagram of individuals identified across all settings using tariff cluster 16.

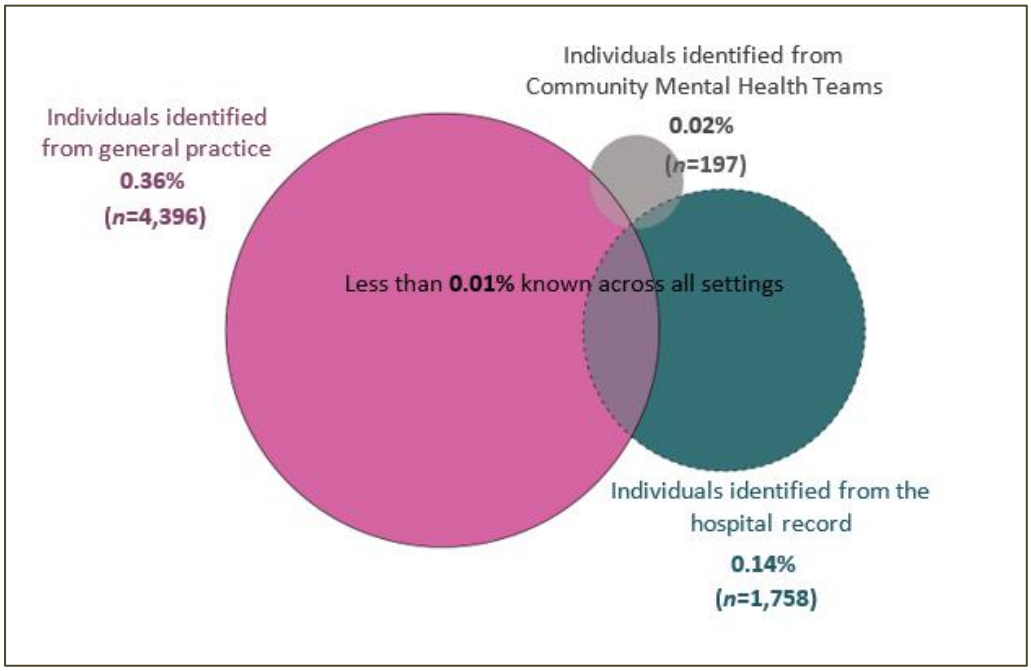
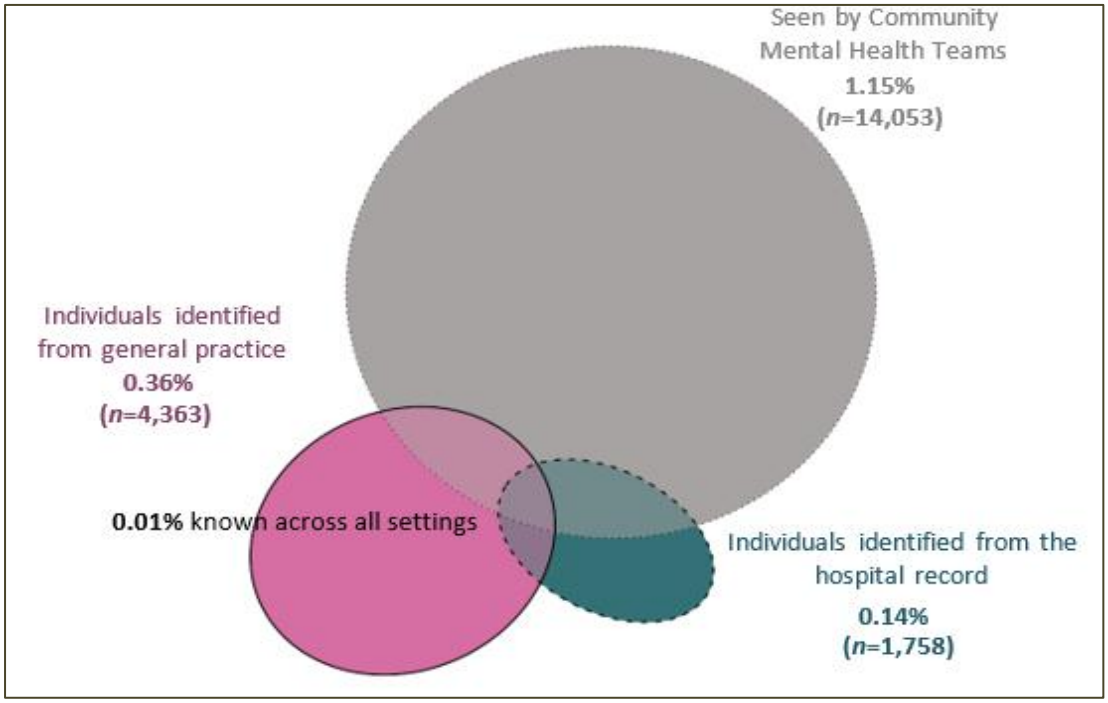


Figure 56: Venn diagram of individuals identified across all settings using all persons seen by community mental health teams.



Our analysis represents a 'snap-shot' of all activity occurring in 2017/18 and further longitudinal analysis is needed. The developmental trajectory of dual diagnosis is complex and varied. For example, psychiatric illness may be pre-existing with recent drug or alcohol use versus drugs and alcohol considered to have a role as contributors to the development of psychiatric illness. This makes secondary data analysis difficult. We also understand that not all individuals would be admitted to hospital. Further, services (primary care, community mental health teams) seek to prevent emergency hospital admission. Despite these limitations, our findings suggest challenge in terms of the connectedness of the whole system – most individuals identified from the community mental health team cluster 16 were not identified within primary care.

7.1.9 Summary of Findings:

National and Local evidence points to previous national recommendations for management and delivery of services for people with co-occurring conditions not having been followed in Kent. Improving quality of services and outcomes for this cohort of people will be important for delivery of 5 Year Forward View, and 10-year NHS plan and the delivery of Crisis Care Concordat.

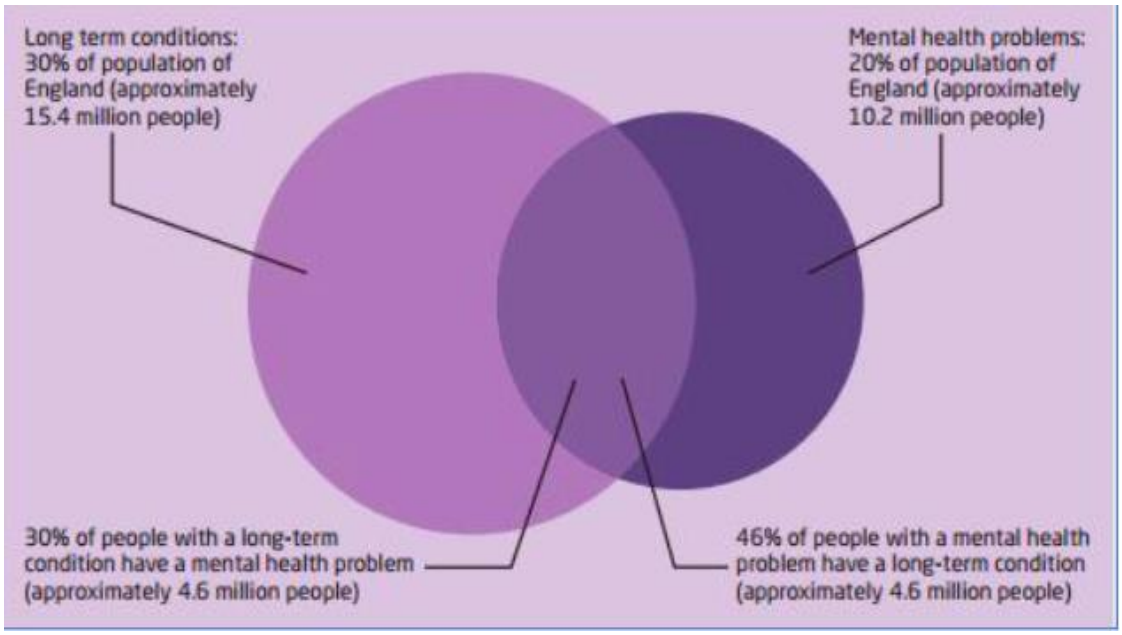
Kent has an expected rate of 0.36% of the population with a harmful drinking and mental illness in primary care. This higher than the NICE national estimate of 0.16%. There are 5,954 people in Kent with a co-occurring mental illness and substance misuse disorder, of which 1% had a hospital admission. Kent population of those with co-occurring conditions

are less likely to be seen in secondary mental health services, their care is likely to be inconsistent across primary care and hospital. There is a 48%-68% estimated prevalence of suicidal intent amongst those in Kent Substance Misuse Treatment Services.

A key finding is that 43.1% (*n*=757) of the dual diagnosis sample identified from hospital admissions were known to community mental health teams. However, only 17.5% (*n*=765) of the dual diagnosis sample identified from the GP record were known to community mental health teams. It is difficult to assess whether this is adequate mental health support for both primary care GPs and for people with co-occurring conditions as current models of care for co-occurring conditions are not routinely in place. Integrated case management at primary care implies the need to understand the various factors that may influence the successful service delivery and meet the desired health outcomes for patient and the population.

7.2 Long-Term Conditions and Mental illness – Data from Kent Integrated Data Sets

Figure 57: Long Term Conditions and Mental illness in Kent



People with depression and anxiety have a greater risk of the same long-term conditions and face greater inequalities in relation to other challenges such as, isolation; unplanned care; and living in areas of deprivation. This Needs Assessment has used the Kent Integrated Dataset (KID) analysis to focus on individuals with mental health problems who also have some of the long-term conditions listed above. It compares them with a matched cohort of adults from the general population who do not have a recorded mental health disorder.

The analysis reflects existing evidence that the presence of a long-term condition increases the risk of a mental health problem.[96]

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

Support Allowance (ESA), a benefit aimed at those unable to work due to poor health or disability, experienced particularly high rates of all the disorders assessed. It is worth noting that Improved Access to Psychological Therapy now has funding identified to increase services with a focus on long-term conditions.

7.2.1 Key Finding: Living alone is associated with serious mental health problems among working age adults.

KID data suggests that it is working age adults with serious mental health problems and long-term conditions that are more likely than their peers (who have similar long-term conditions and demographic profile) to live alone. Living alone is commonplace regardless of mental health problems amongst older people living with long term conditions.

The analysis from the Kent Integrated Data Set shows the following in relation to co - occurring conditions and multi-morbidity.

Adults with serious mental health problems are around twice as likely to live alone than the adult population. (This does not apply to individuals recorded as having anxiety and/or depression.)

Adults with serious mental health problems are also skewed towards our most deprived communities. (Again, this does not apply to individuals recorded as having anxiety and/or depression).

Adults with serious mental health problems tend to have more contact with services, including more hospital and GP visits, higher social care costs and higher secondary mental health costs. Whilst those recorded by their GP as having anxiety and/or depression tend to have more contact with their GP than the adult population, their usage of acute hospital services and social care is like the Kent average.

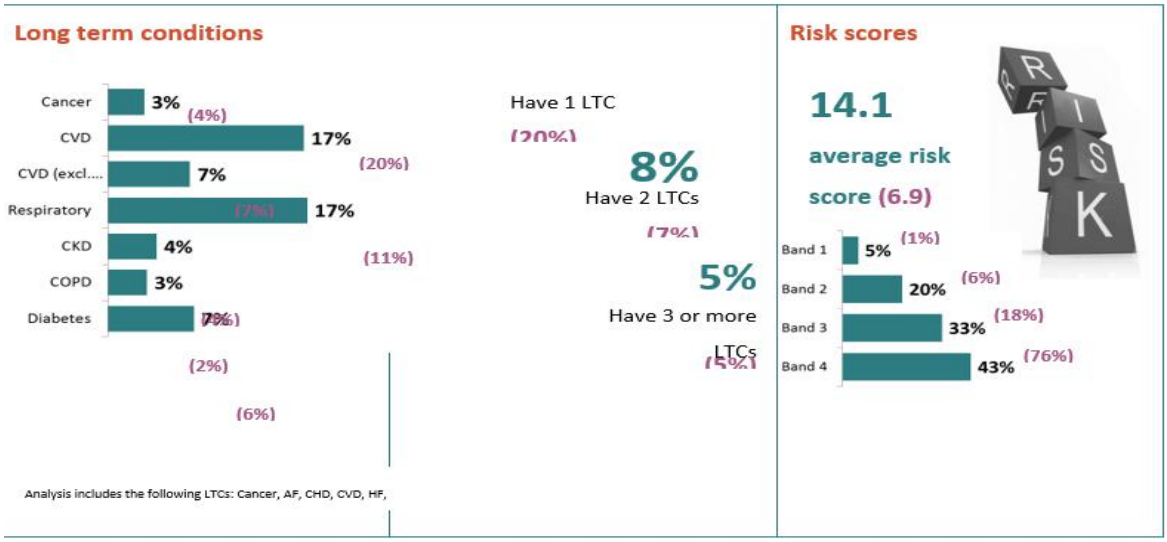
With the exception of secondary mental health service users falling into the organic cluster, adults with serious mental health problems and those recorded as having anxiety and/or depression have an elevated long-term condition profile compared to the Kent adult population as a whole. For example, 24% of those recorded as having anxiety and/or

[96] https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf

depression are also recorded as having CVD, compared with 20% of the adult population. Equivalent figures for respiratory diseases are 17% vs 11%, for COPD 4% vs 2% and for diabetes 8% vs 6%. Of those known to Specialist services (Fig 58), 10% have 2 or more LTC (Fig 59) and have greater risks for respiratory disease and diabetes.

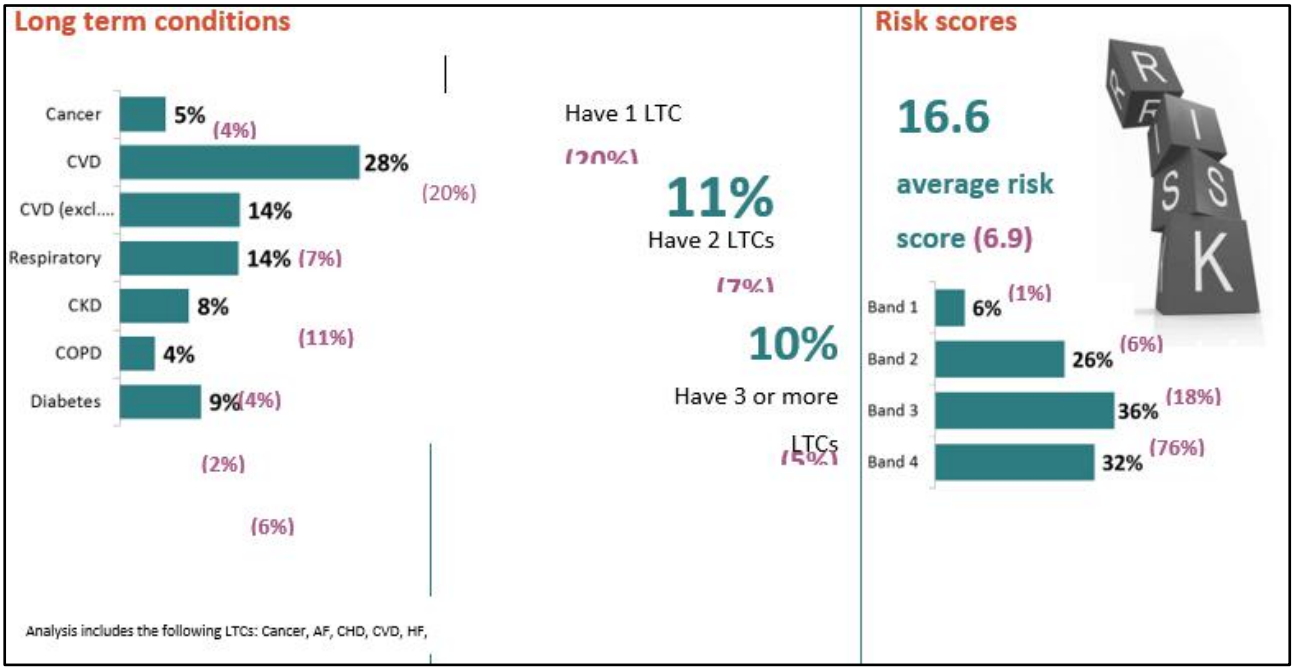
All mental health groups are assessed as higher risk than the population average. Those admitted to hospital as an emergency for a mental health problem have particularly high average risk scores.

Figure 58: Proportion of people known to secondary / specialist mental health services (non-psychosis)



Data source: Kent Integrated Dataset (KID)

Figure 59: Proportion of people with psychosis who are known to primary and secondary (or Specialist) mental health services



Data source: Kent Integrated Dataset (KID)

7.3 Analysis of Data from the Kent Integrated Data Set of Multi Morbidity in users of Specialist Mental Health Services: 1 year.

This analysis explores multimorbidity in users of secondary mental health services, comparing them with multimorbidity rates amongst the Kent population as a whole. For the purposes of this analysis, users of secondary mental health services are those recorded within the Kent Integrated Dataset (KID) in the data provided by KMPT as having received a service during **2017/18 *and* coded into clusters 1-19**.

Multimorbidity is assessed using the read-coded long-term condition information contained within the GP records held within the KID. The analysis covers 16 QOF conditions (as the categories serious mental health conditions, dementia and depression are the cohort assessed). Individuals recorded as having two or more of the 16 long term conditions are classified as multimorbid.

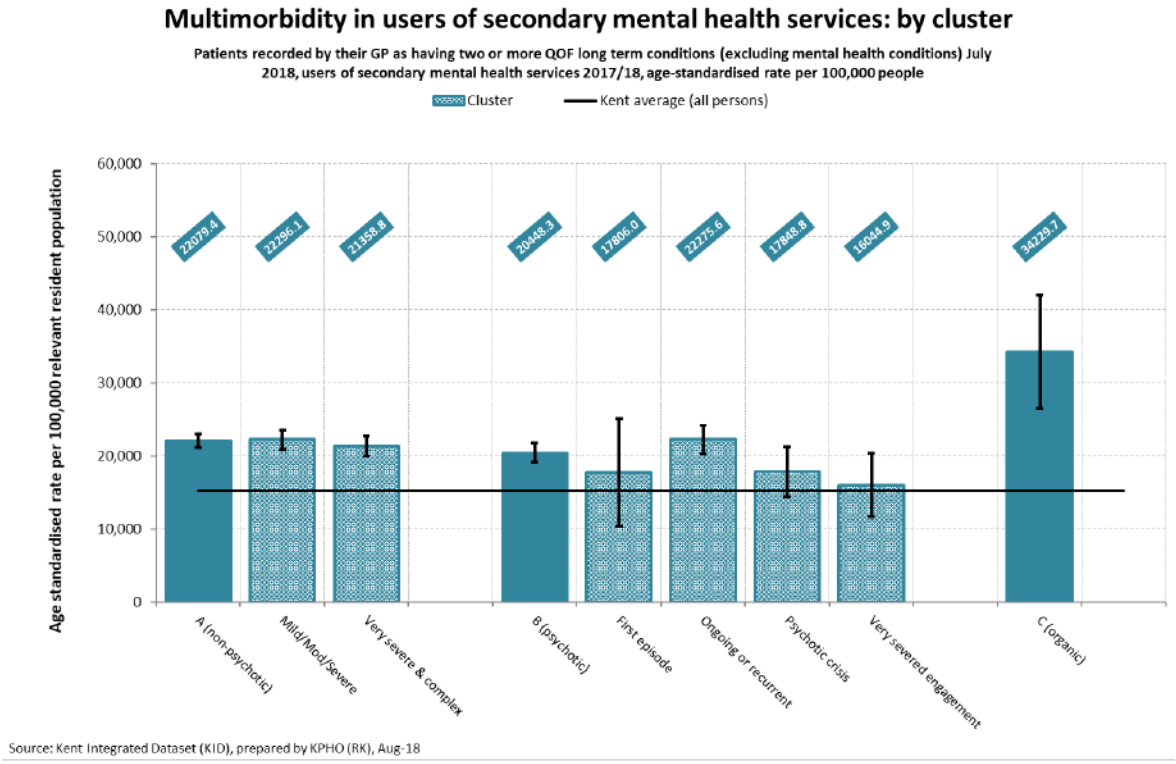
Since data on multimorbidity is captured via GP records, the analysis has been restricted to Kent residents who are also registered at one of GPs flowing data into the KID. At the time of the analysis this represented around 93% of the total GP registered population living in Kent.

The analysis covers **21,114** individuals and has been subdivided by mental health cluster groupings. Around 11% of these individuals received support from KMPT under more than

one of these cluster groupings during 2017/18, and so appear under more than one category in the analysis.

Figure 60 below shows age-standardised multimorbidity rates (at July 2018) for users of secondary mental health services (during 2017/18). These are displayed as a rate per 100,000.

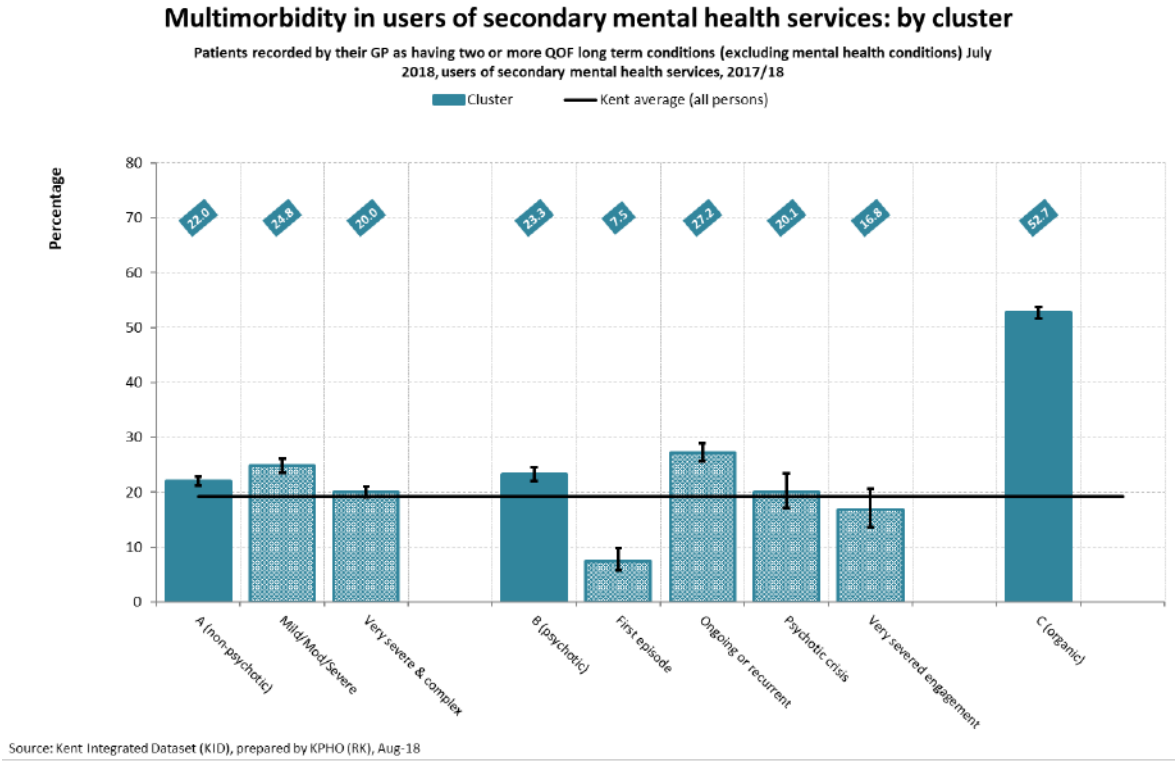
Figure 60: Multimorbidity in users of secondary mental health services: by cluster (age standardised per 100,000 relevant resident population)



This analysis shows age-standardised multimorbidity levels to be higher amongst users of secondary mental health services than for the population as a whole, and particularly for those falling into the organic cluster.

When **dementia** (organic) cluster is not age standardised (see Below graph), the degree of multi morbidity increases substantially as people who are older have more long-term conditions (this is what we would expect in natural aging) and shows that the population of the organic cluster are different to the other mental health clusters (e.g. older).

Figure 61: Multimorbidity in users of secondary mental health services: by cluster (percentage)



7.4 Issues Surrounding Mental Illness Diagnosis & Management of Long-term Conditions: Learning Lessons from Care Quality Commission Reports.

7.4.1 Definitions:

There are a number of key differences between the diagnosis and treatment of mental health and physical health conditions.

There is no physiological test for mental illness and diagnosis is on signs and symptoms alone.

There are many signs and symptoms that overlap in different mental illness (e.g. PD and clinical depression).

There are wide ranges of severity in mental illness that can vary over time.

There is more of a subjective nature of diagnosis between clinicians.

7.4.2 Expectations and limitations of treatment in crisis

There is no magic bullet for mental illness. When a person is in crisis – the main outcome of any crisis intervention is to keep the person safe from harming themselves or someone else. This often entails keeping them physically safe, calming the person down (via social support and or medication) and observing them over time. The CQC report Right Here, Right Now

(2015) reported only 14% of people reported satisfaction with how their crisis care was managed. Many reported that the manner in which people treated them in a crisis was often more important than the timeliness of treatment. The report urged better training for all people to manage a crisis (including police re use of S136 detention powers).[97]

7.4.2.1 Access to treatments

This is often dependent on a diagnosis. A diagnosis is important for good quality care and how a clinician works with the person, e.g. understanding the symptoms of depression and self-care. However, many of the treatments are similar for different conditions, e.g. borderline personality disorder (BPD), suicidality and self-harm may both be treated with Dialectic Behaviour Therapy (DBT) and low doses of anti-psychotics). Mental illness is often a long-term condition and the way it is managed will impact how often a person reaches crisis. The CQC report on Crisis Care[82] points to poor resourcing of home treatment teams but overall good patient satisfaction with GP services.

7.4.2.2 Stigma and help seeking

There are two types of stigma that impact people with mental illness (including substance misuse disorder) which are barriers to seeking help. These are:

- Social stigma: misconceptions of mental illness including media representations
- Self-stigma: feelings of worthlessness and hopelessness experienced as part of the condition and exacerbated by social stigma.

[97] *CQC Report Right Here, Right Now: Mental Health Crisis Care https://www.cqc.org.uk/sites/default/files/20150630_righthere_mhcrisiscare_full.pdf*

Summary of Chapter 8

Kent and Medway have higher rates of suicide then the England average. There is a current Kent and Medway wide strategy that is cross agency and wide reaching to tackle this issue. There has been considerable investment from the NHS STP to the area to enhance various aspects of the mental health system. This fund is focused on the Release the Pressure - campaign to increase people (men in particular) to access a help line in crisis. Other areas the fund is focused is support for families and friends affected by suicide, audits into self-harm, improvements to self-help and understanding of depression, better crisis care, better safety netting and communication in primary care, better access to mental health support for vulnerable groups such as people with drug and alcohol addiction, better trauma informed care providers, better understanding of people with lived experience of suicide attempt and engagement with employers and workforces. Currently the criteria for assessing a suicide has changed and broadened at the Coroner's Courts - making a verdict of suicide more likely where in the past there may have been more caution to give a verdict of suicide. This shows that that suicide reporting and data have most likely been underreported in the past. Time will tell whether the improvements made in the National and Local Suicide Prevention Plans and the NHS Long Term Plan for mental health have a positive impact on suicide rates. Better understanding and awareness of mental health and illness will be an important factor for change.

8 Suicide and self-harm

8.1 Epidemiology and Key Findings

8.1.1 Who is at risk and why?

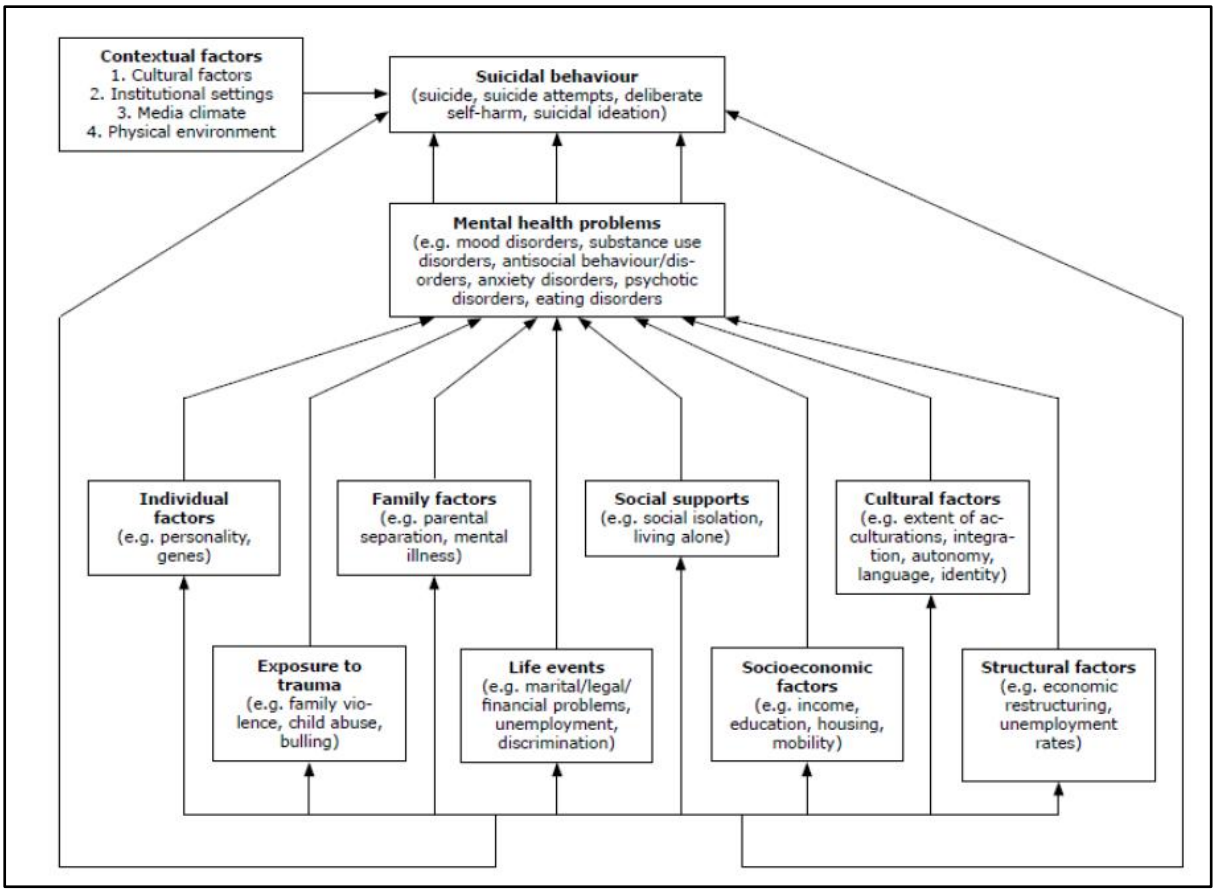
"There is no single reason why people take their own lives. Suicide is a complex and multi-faceted behaviour, resulting from a wide range of psychological, social, economic and cultural risk factors which interact and increase an individual's level of risk"[98]

This quote from a 2017 Samaritans report highlights the complexity of trying to identify who is at risk of suicide. In 2010, the Royal College of Psychiatrists further illustrated this complexity in their diagram of possible pathways to suicide (see Figure 62 below).[99]

[98] Samaritans (2017) *Dying from inequality Socioeconomic disadvantage and suicidal behaviour* Available at http://bjp.rcpsych.org/content/early/2017/03/02/bjp.bp.116.189993

[99] Royal College of Psychiatrists (2010) College report CR158 *Self-harm, suicide and risk: helping people who self-harm* Available at http://www.rcpsych.ac.uk/files/pdfversion/CR158.pdf

Figure 62: Pathways to Suicide Behaviour[103]



National and local research has shown that there are a number of factors which may mean that some individuals or groups are at higher risk of suicide than others. This needs assessment has been developed by analysing local and national data with the intention of identifying increased risk factors within the Kent population. A summary is to be found in Appendix 13.

8.1.2 Suicide statistics and data sources

Coroners are the only officials who can determine whether an individual death was a suicide or not. For a Coroner to reach a conclusion of suicide the intention of the person to end their own life must be beyond reasonable doubt.

However, to aid population level analysis of suicide behaviour, the Office of National Statistics recommend that suicide statistics include both Coroner confirmed suicides and deaths (of self-injury and poisoning) where the intent was undetermined.

To allow for accurate comparisons, suicide rates are reported as a rate per 100,000 (either as an annual or a three-year rolling average).

The statistics which make up this needs assessment come from a variety of sources. Each source will be identified when used, however the most frequent sources are as follows;

- Kent Public Health Observatory (using the Primary Care Mortality Database)
- Public Health England (using the FingerTips online tool)
- National Confidential Inquiry into Suicide and Homicide (based at the University of Manchester).

There is often a time delay (which could be months or even years) between the date of someone dying and the completion of a Coroner's inquest. To allow for the accurate inclusion of the most recent data, most of the statistics in this assessment are based on the date of suicide registration (rather than date of death).

During 2018 the KCC Public Health team is working with KCC's Coroner Service to analyse over 150 recent suicide verdicts. This will enable us to have a deeper understanding of what is happening in the lives of people who die by suicide in Kent in the months before they die. The results of this research will be added to future versions of this needs assessment.

8.1.3 Suicide numbers in Kent in recent years

The number of suicides registered by Coroners in Kent has fallen slightly over recent years. In 2017, the 123 registered suicides accounted for 0.8% of all Kent deaths.

Table 12: Numbers of deaths from suicide and events of undetermined intent, 2010-2017 registrations, aged 15+ Kent residents, by gender

Area resident	Gender	2010	2011	2012	2013	2014	2015	2016	2017
Kent	Male	73	85	97	119	130	116	104	85
	Female	27	34	26	31	35	36	36	38
	Total	100	119	123	150	165	152	140	123

Data source: Primary Care Mortality database, KPHO (JB); Medway Public Health

8.1.4 National comparisons

As figure 63 (below) shows, the suicide rate in Kent is higher than the national average, particularly for men.

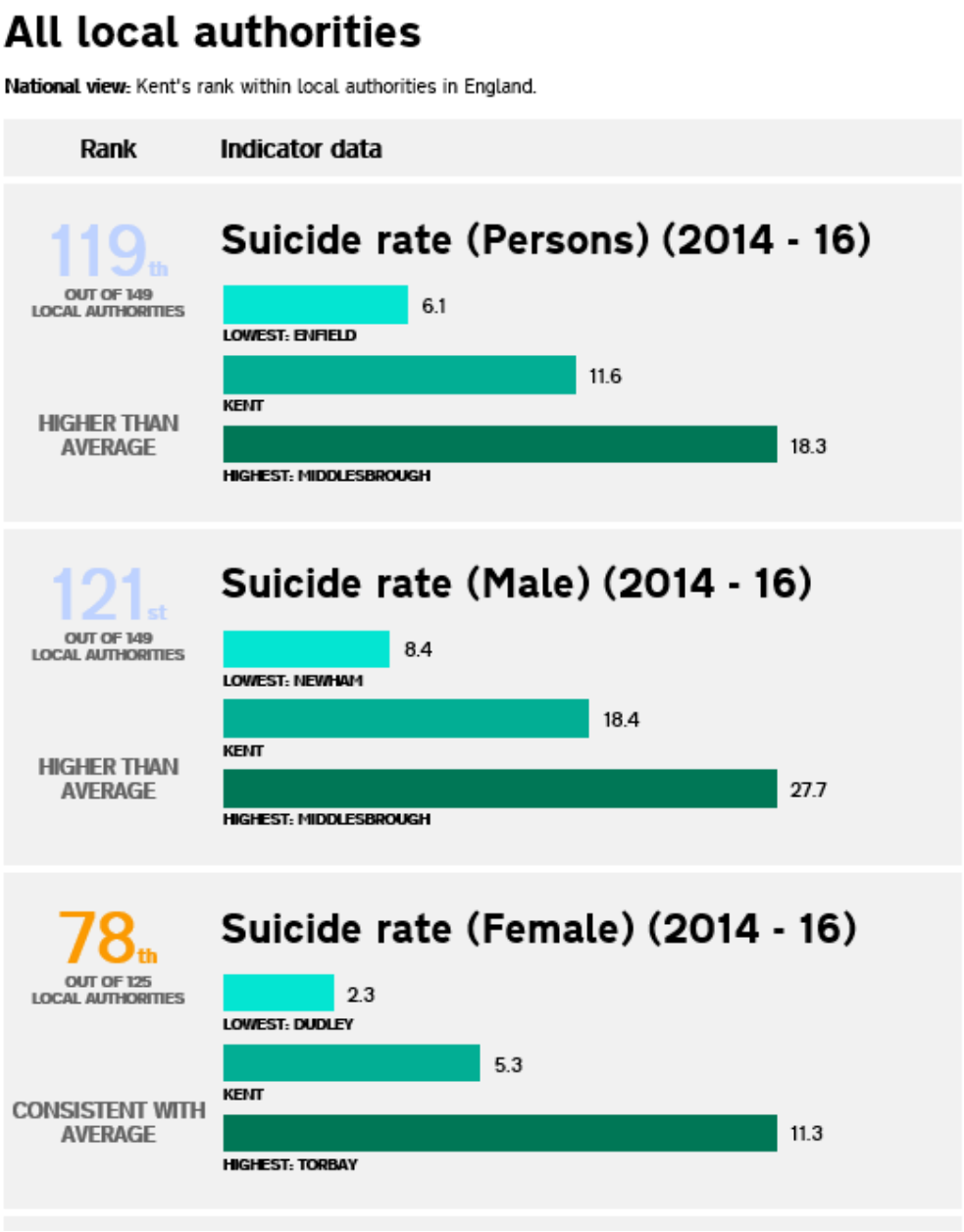
Figure 63: Age Standardised Suicide Rate per 100,000 (3-year average 2014-16) in Kent compared to South East and the England average

Indicator	Period		England	South East region	Kent
Suicide: age-standardised rate per 100,000 population (3 year average) (Persons)	2014 - 16		9.9	9.8	11.6
Suicide: age-standardised rate per 100,000 population (3 year average) (Male)	2014 - 16		15.3	15.1	18.4
Suicide: age-standardised rate per 100,000 population (3 year average) (Female)	2014 - 16		4.8	4.8	5.3

Data source: PHE Fingertips

Figure 64 below shows that Kent's male suicide rate ranks as the 121st highest out of 149 (top-tier and single-tier) local authorities.

Figure 64: Suicide rate, local authority ranking



Data source: Healthy Lives

8.1.5 Variation across Kent CCGs

There is wide variation in suicide rates across Kent (as shown in Table 13 below). Thanet, Swale and South Kent Coast CCG areas have the highest overall suicide rates. However West Kent CCG has the second highest female suicide rate.

Table 13 - Numbers of deaths and rates from suicide and undetermined causes, Kent CCGs, 2014 - 2016 registrations, by gender, - residents aged 15+

	Male		Female		Both sexes	
Clinical commissioning group	**Numbers**	**ASR / 100,000[1]**	**Numbers**	**ASR / 100,000[1]**	**Numbers**	**ASR / 100,000[1]**
NHS Ashford CCG	28	19.7	4	2.7	32	10.9
NHS Canterbury & Coastal CCG	40	16.4	12	4.7	52	10.5
NHS Dartford, Gravesham & Swanley CCG	63	20.7	8	2.4	71	11.4
NHS South Kent Coast CCG	54	21.1	14	5.5	68	13.0
NHS Swale CCG	33	24.0	9	6.7	42	15.5
NHS Thanet CCG	40	25.7	17	9.4	57	16.8
NHS West Kent	92	16.4	43	7.0	135	11.7

Source: PCMD, KPHO (JB)

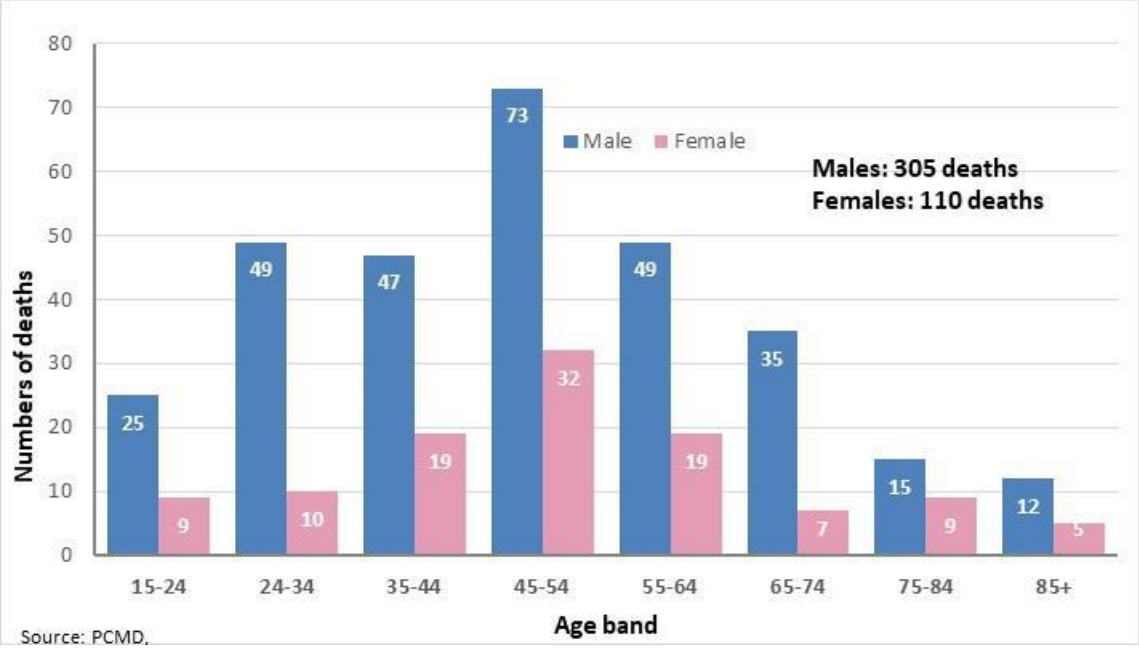
[1] Directly age-standardised mortality rate per 100,000 resident

8.2 High risk groups

8.2.1 Men

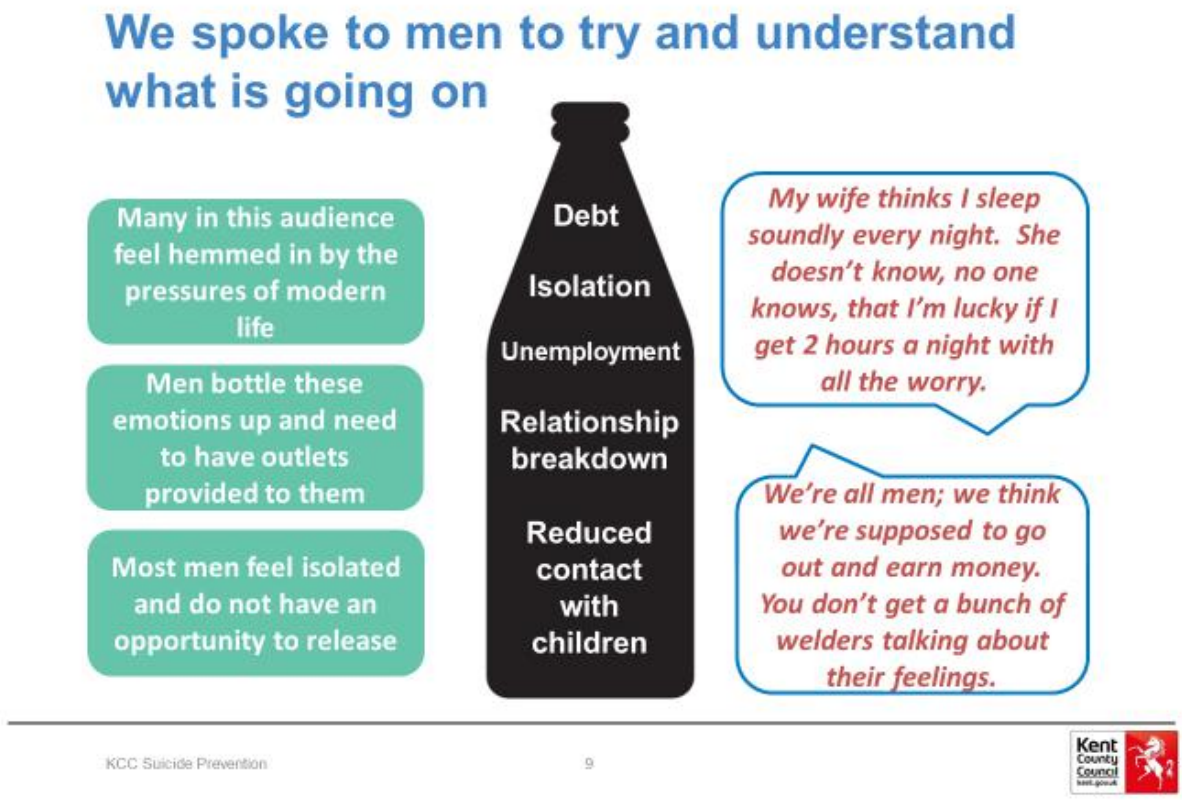
As table 12 shows over two-thirds (69%) of the individuals who died by suicide in Kent in 2017 were male. Figure 65 (below) shows that it is middle aged men who are at most risk.

Figure 65: Numbers of deaths from suicide and events of undetermined intent, 2015-17 by age band and gender



Research below in 2016 (figure 66; in preparation of the Release the Pressure campaign) highlighted that many men felt depressed following life events such as relationship breakdown, money worries, isolation and were unable to express their feelings.

Figure 66: Research with a focus group of men in 2016. KCC Public Health



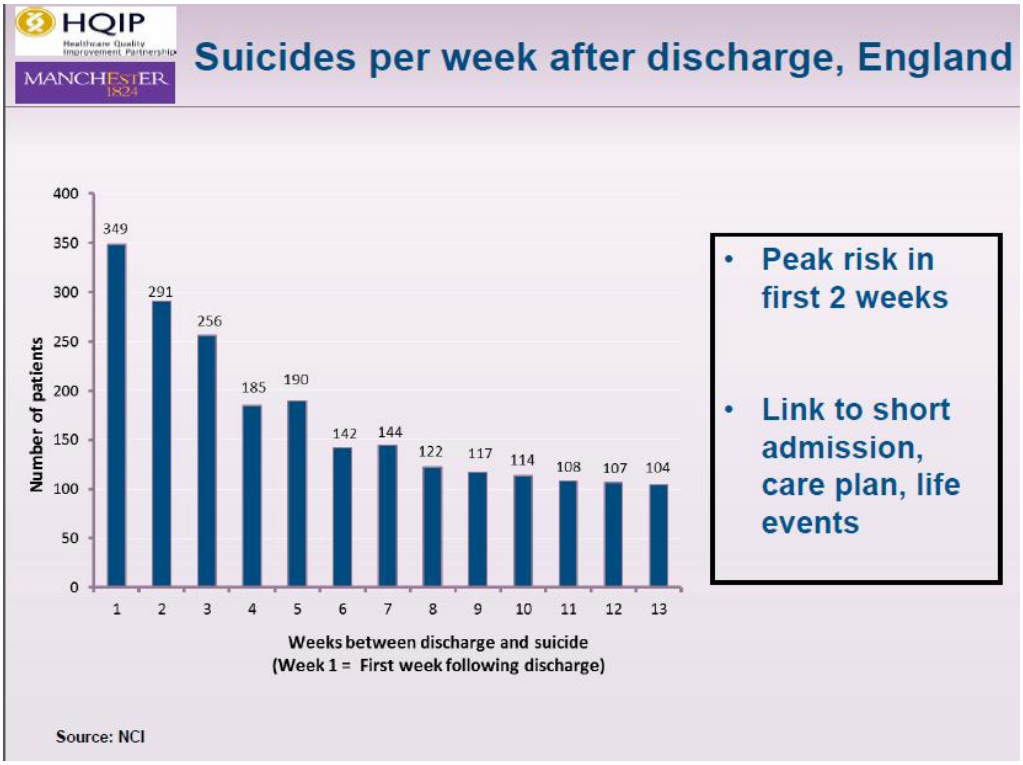
8.2.2 People in contact with mental health services

An analysis of the 2017 Kent suicide registrations has shown that 33% of people who died by suicide were known to KMPT (the local provider of secondary mental health services) in the year before they died. This corresponds well with national estimates (from the National Confidential Inquiry) that in the year before a death by suicide, and in relation to contact with the NHS:

- Around 1/3 have contact with secondary mental health services
- Around 1/3 have contact with primary care only
- Around 1/3 have no contact with the NHS.

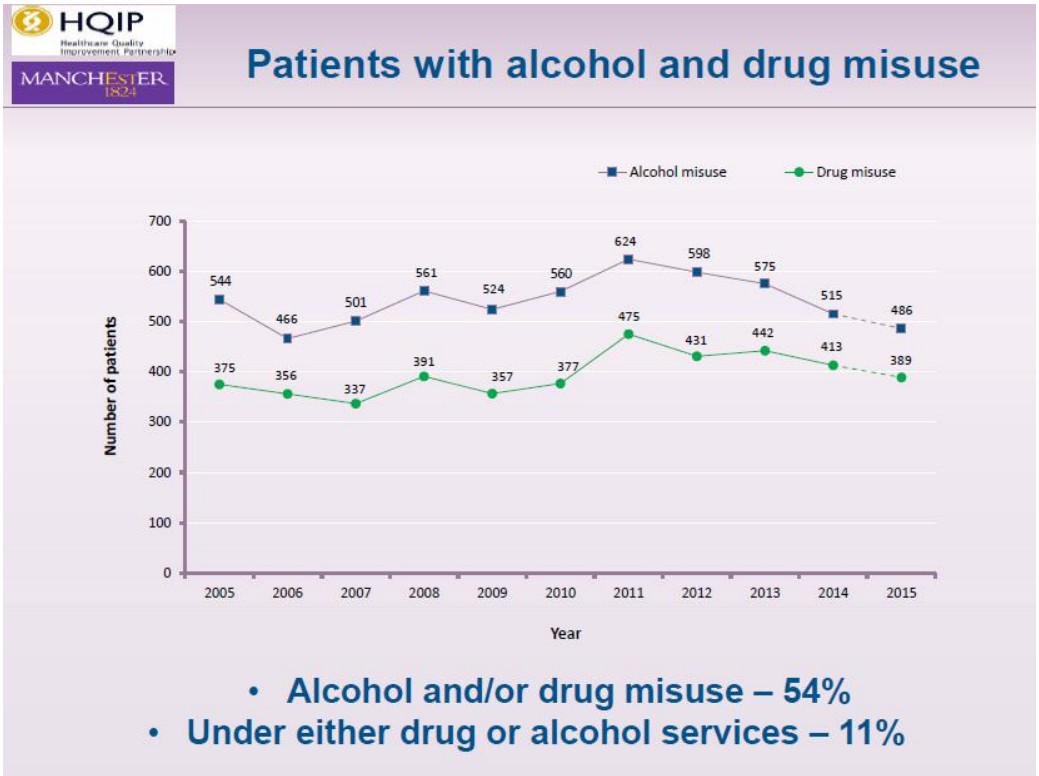
Further analysis from the National Confidential Inquiry has shown that 90% of suicides amongst people known to secondary mental health services are occur in community (rather than inpatient settings). Of these, and as slide 2 shows below, one of the highest risk points is in the first two weeks after discharge from an inpatient setting.

Figure 67: Suicides per week after discharge, patients known to mental health services



The National Confidential Inquiry has also identified that alcohol and drug misuse is also a risk factor for suicide. Amongst people known to secondary mental health services who die by suicide, alcohol and/or drugs were misused by 54% (as shown in Slide 3 below)

Figure 68: Substance misuse in patients known to mental health services who die by suicide

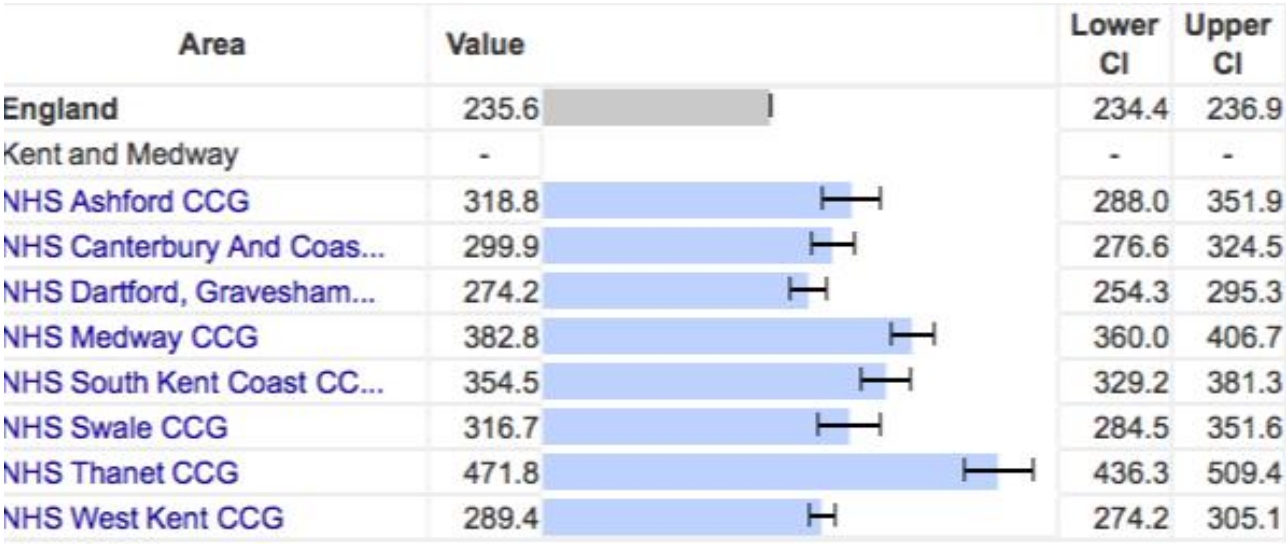


8.2.3 People who have a history of self-harm

Not everyone who dies by suicide will have previously self-harmed, and not everyone who self-harms will go onto end their own lives. However, according to the National Confidential Inquiry into Suicide and Homicide it is the single biggest indicator of risk. As Slide 3 shows, 50% of people who die by suicide have a history.

Figure 69: Self-harm links to suicide from the National Confidential Inquiry

Figure 70: NHS 111 calls regarding mental health - persons: Rate per 100,000 population in 2015



Area	Value	Lower CI	Upper CI
England	235.6	234.4	236.9
Kent and Medway	-	-	-
NHS Ashford CCG	318.8	288.0	351.9
NHS Canterbury And Coas...	299.9	276.6	324.5
NHS Dartford, Gravesham...	274.2	254.3	295.3
NHS Medway CCG	382.8	360.0	406.7
NHS South Kent Coast CC...	354.5	329.2	381.3
NHS Swale CCG	316.7	284.5	351.6
NHS Thanet CCG	471.8	436.3	509.4
NHS West Kent CCG	289.4	274.2	305.1

Source: HSCIC

Figure 70 shows that Thanet and indicates that it is older people calling 111.

Table 14 below shows the numbers of individuals in Kent attending A&E after self-harm incidents. The number of females between the ages of 10-19 attending A&E after self-harm is more than double the number of males aged 10-19. However, the number of males between 20-29 is higher than the number of females in the same age band.

Table 14: Numbers and percentages of A&E self-harm attendance, Kent residents, 2011/12 – 2015/16 (pooled) by gender and age band

	Males		Females		Total	
Age band	**Numbers**	**% of total**	**Numbers**	**% of total**	**Numbers**	**%**
10-19	1,059	7.7	2,158	15.7	3,217	23.4
20-29	1,799	13.1	1,635	11.9	3,434	25.0
30-39	1,235	9.0	1,011	7.4	2,246	16.4
40-49	1,242	9.0	1,296	9.4	2,538	18.5
50-64	1,072	7.8	614	4.5	1,686	12.3
65+	387	2.8	229	1.7	616	4.5
Total	**6,794**	**49.5**	**6,943**	**50.5**	**13,737**	**100**

Source: SUS, KPHO (JB)

Table 15 shows the numbers of individuals in Kent being admitted to hospital after self-harm incidents. The number of females between the ages of 10-19 being admitted to hospital after self-harm is more than four-times the number of males aged 10-19.

Table15: Numbers and percentages of emergency admissions for self-harm, Kent residents, 2011/12 – 2015/16 (pooled) by gender and age band

	Males		Females		
Age band	**Numbers**	**% of total**	**Numbers**	**% of total**	**Numbers**
10-19	618	4.1	2,480	16.4	3,098
20-29	1,584	10.5	2,238	14.8	3,822
30-39	1,127	7.5	1,401	9.3	2,528
40-49	1,199	7.9	1,853	12.3	3,052
50-64	836	5.5	1,057	7.0	1,893
65+	303	2.0	426	2.8	729
Total	**5,667**	**37.5**	**9,455**	**62.5**	**15,122**

Source: SUS, KPHO (JB)

8.2.4 Deprived communities

There is a strong link between suicide rates in Kent and areas of greatest deprivation. Figure 71 and 72 show that the most deprived communities in Kent consistently have the highest suicide rates.

Figure 71: Mortality from suicide and events of undetermined intent, 2015-17 by deprivation decile (D^n), Kent residents

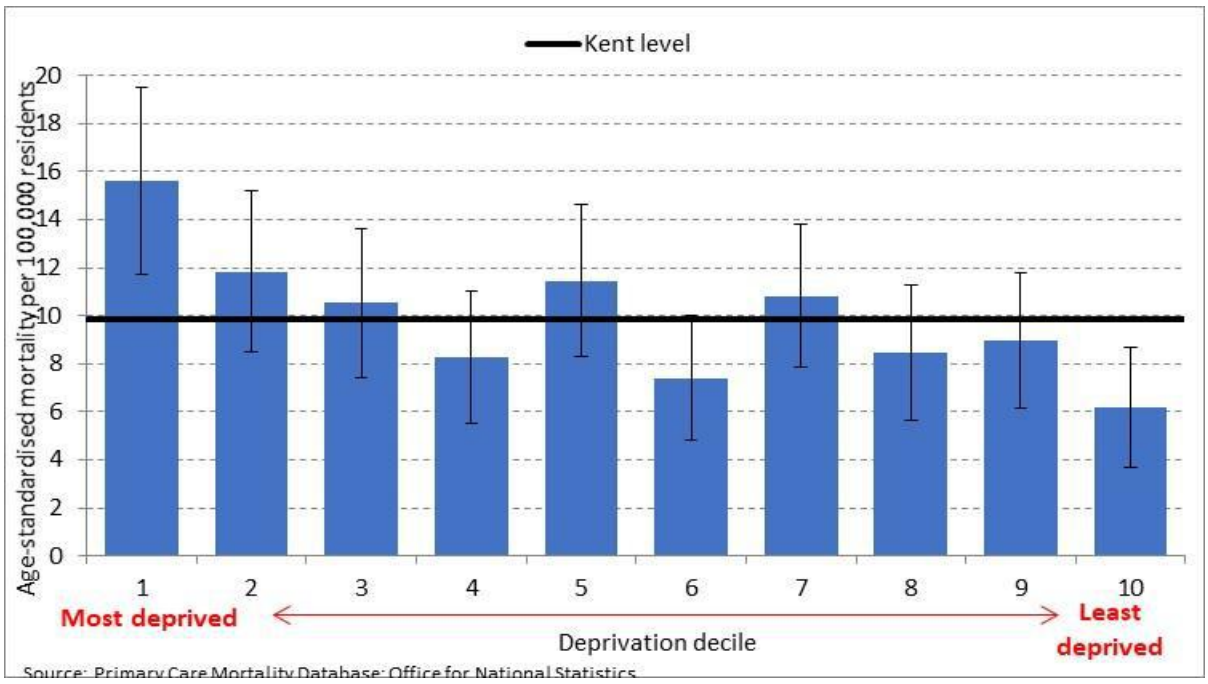
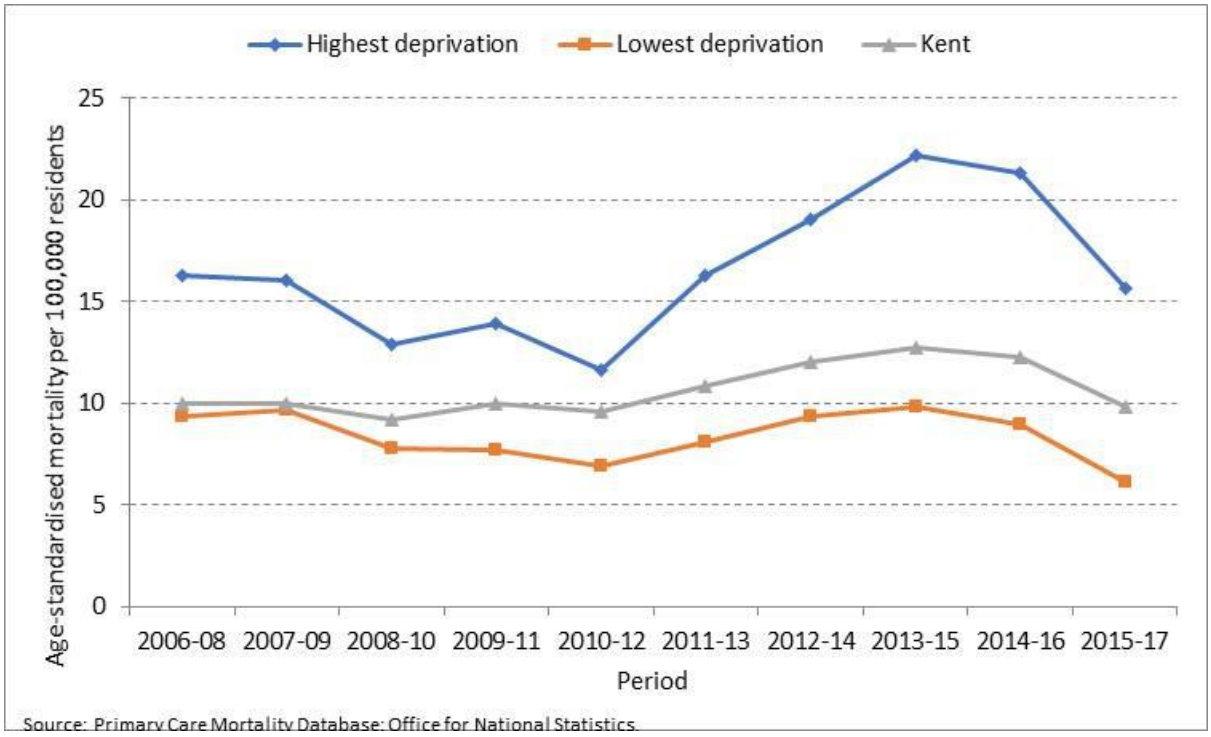


Figure 72: Mortality from suicide and events of undetermined intent, 2006-08 - 2015-17 comparing highest and lowest deprivation deciles, Kent residents



8.2.5 Children and young people

Between 2012 and 2016, 54 people aged 24 and under died due to suicide or undetermined causes in Kent. Of these, 8 (16%) were aged under 18. The number of people under 18 who die from suicide or undetermined causes is low, however the impact on family, friends and communities is so severe that they remain a group to prioritise for support.

The small numbers mean that providing analysis at a lower geographical level than Kent or analysing single year data is not possible.

Between 2012 and 2016, 54 people aged under 25 died due to suicide or undermined causes. Eight people were aged under 18.

8.2.6 Other high-risk groups

National evidence[100] shows that the following groups also have higher rates of suicide that the general population:

- People in contact with the criminal justice system
- People with co-existing substance misuse and mental health conditions
- People who have been bereaved by suicide
- People with long term physical health conditions
- Groups who experience discrimination or abuse (e.g. LGBT or some BME groups)
- Students

The National Confidential Inquiry has identified that individuals that visit their GPs more than 24 times a year have a much higher risk of dying by suicide than individuals who visit their GPs less often. More details please see appendix 14.

As shown in figures 73and 74 below, suspension and poisoning are the two most common methods of suicide for both men and women, however suspension makes up a larger proportion of deaths amongst men than women. Jumping (from a height or in front of a vehicle) makes up the largest part of "All Other Methods".[101]

[100] http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data - page/1/gid/1938132828/pat/6/par/E12000008/ati/102/are/E10000016

[101] http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data - page/1/gid/1938132828/pat/6/par/E12000008/ati/102/are/E10000016

Figure 73: Deaths from suicide and events of undetermined intent, Kent, 2006-2017 by method, Males

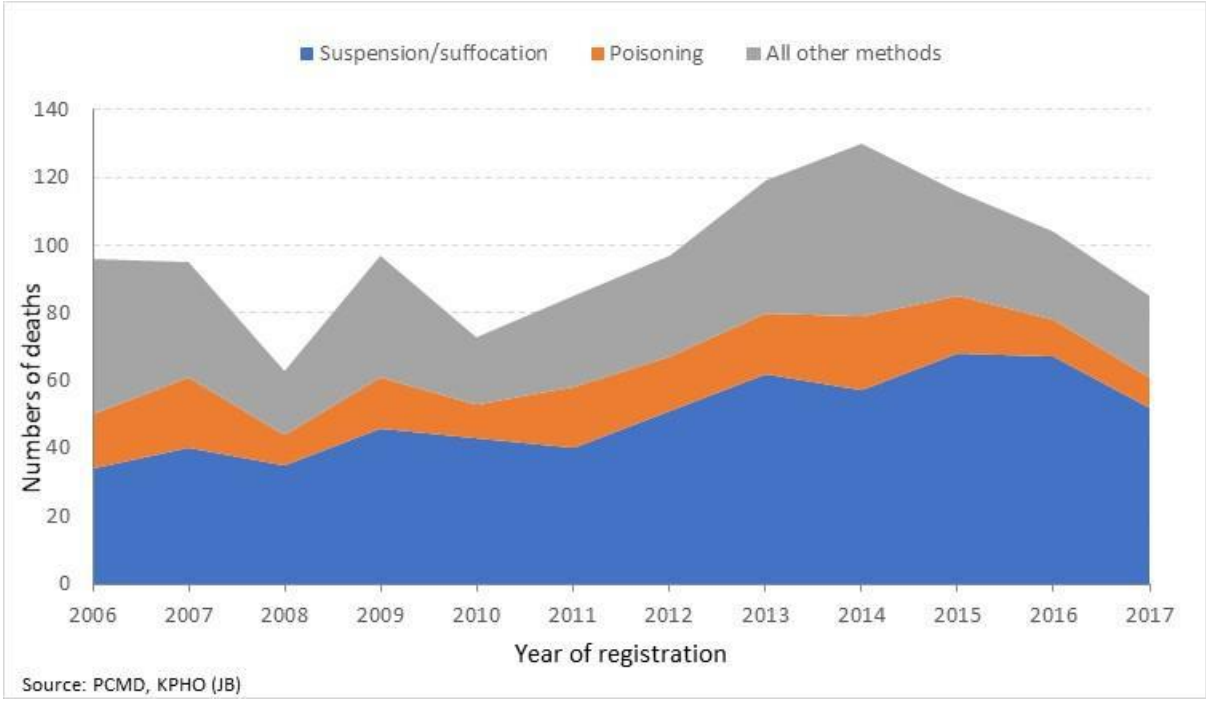
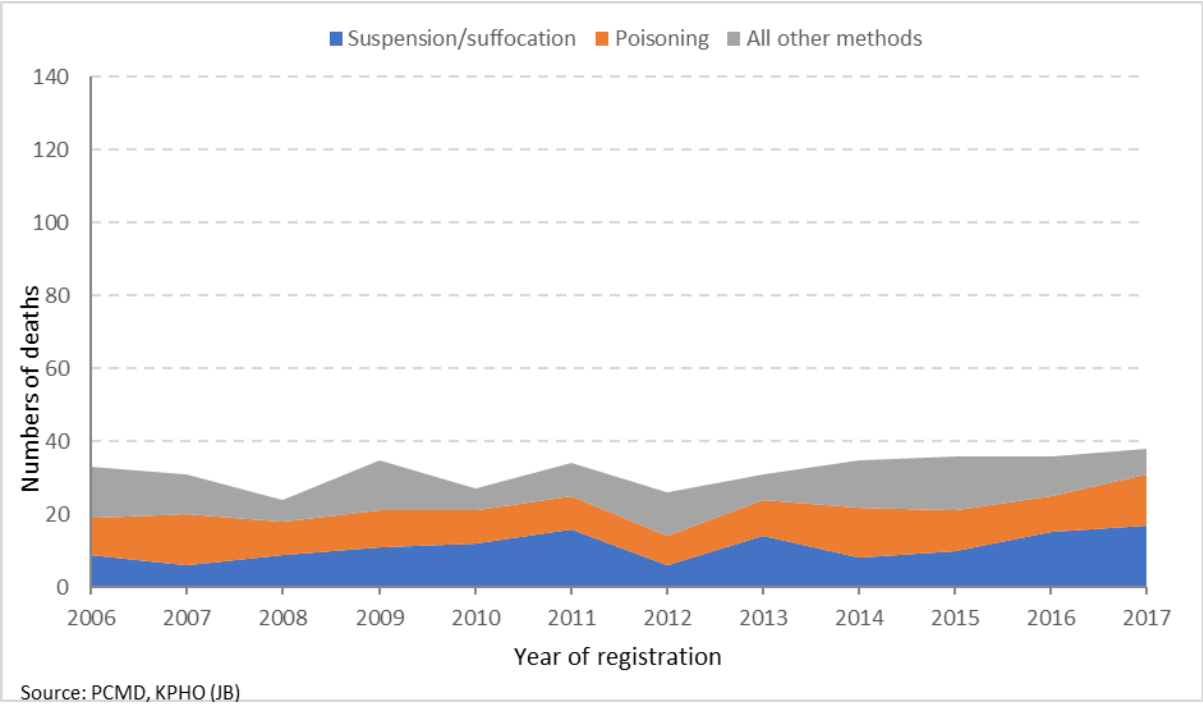


Figure 74: Deaths from suicide and events of undetermined intent, Kent, 2006-2017 by method, females



Summary of Chapter 9

Kent County Council has an important role to play in the mental health system (STP) for Kent and Medway. The links between vulnerable adults, safeguarding, social care and secondary prevention help to mitigate crisis and promote recovery for people with mental health need. Social services and social care providers must play a vital role in the commissioning of a full and safe mental health system. Multidisciplinary care teams must ensure that social care share data and information prevent person's mental health crisis. It is important to note that the high co-occurrence of mental illness alongside learning disability.

9 Mental health and Social Care in Kent

Risk factors disproportionately affect the mental health of people from higher-risk and marginalised groups. Those at higher risk include individuals who have experienced violence or abuse, Black and minority ethnic individuals, those with intellectual disability (neuro atypical) and homeless people offenders/ex-offenders and veterans. People in prison have a twenty times higher risk of psychosis, with 63% of male remand prisoners having antisocial personality disorder, compared with 0.3% of the general population.[102] Such groups are also at a higher risk of stigma and discrimination. Targeted intervention for groups at higher risk of mental illness can prevent a widening of inequalities in comparison with the general population.

Homeless people need good-quality housing to facilitate recovery and independent living.[103] The Kent Public Health team is going to work with wider Kent County Council colleagues including social care, and housing, local CCGs, Public Health England and NHS England, to deliver more appropriate services to the higher-risk and marginalised groups such as rough sleepers, people who left prisons, to help them to make the transition into a settled home, training or employment..[104,105,106]

In August 2018, the Government launched the Rough Sleeping Strategy which contains a commitment to end rough sleeping by 2027 and half numbers by the end of this parliament. The strategy includes some 61 "commitments", although the majority of these are focused on the responsibilities of the housing authorities the following have significance to KCC:

[102] *Royal College of Psychiatrists. No health without mental health: the case for action. October 2010*

[103] *HM Government. No health without mental health: A cross-government mental health outcomes strategy for people of all ages, 2011.*

[104] *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/733421/Rough-Sleeping-Strategy_WEB.pdf*

[105] *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/762854/RSS_delivery_plan.pdf*

[106] *https://www.legislation.gov.uk/ukpga/2017/13/contents*

a. a requirement for local housing authorities to develop homelessness and rough sleeping strategies by winter 2019, local action plans to deliver their strategy (annually refreshed) and, subject to consultation, the development of local homelessness reduction boards[107] (authorities failing to comply will be subject to action from the MHCLG);
b. Adult Safeguarding Reviews to take place when a rough sleeper dies or suffers serious harm;
c. in areas where additional monies have been allocated under the rough sleeping initiative, a requirement for Health and Wellbeing Boards to recognise and respond to the health needs of rough sleepers;
d. more support for people leaving prison and hospital;
e. piloting of specialist personal advisors for care leavers in the 47 housing authority areas where this group are most at risk of rough sleeping;
f. prioritisation of NHS monies for mental health and substance misuse treatment support services for people who are sleeping rough.
g. The Young Future Social Impact Bond aimed at supporting young people who are Not in Education or Training (NEET) and are at risk at homelessness;
h. money to assist non-UK nationals who sleep rough to find work or return to their home country;
i. increased support for those at risk of being trafficked or exploited through modern day slavery:
j. a review of housing related support to be launched autumn 2018 and a review of hostel provision in the Spring of 2019; and
k. ongoing national research to identify gaps and develop solutions and, during the summer of 2019, pilots to establish an outcomes framework.

9.1 The role of Kent county Council under Social Care Act

Social care is the key statutory function that councils have to support those experiencing mental health problems.[108]

Under the **Mental Health Act 1983[109] amended 2007** , councils must employ approved mental health practitioners (AMHPs) to undertake key duties and responsibilities of the Mental Health Act. . Section 117 of the Mental Health Act places a duty on health (Clinical Commissioning Group (CCG) and Social Care to provide aftercare services to individuals in

[107] https://assets.publishing.service.gov.uk/Government/uploads/system/uploads/attachment_data/file/733421/Rough-Sleeping-Strategy_WEB.pdf *See P30*

[108] *Local Government Association. Being mindful of mental health.: the role of local government in mental health and wellbeing. https://www.local.gov.uk/sites/default/files/documents/22.6_Being%20mindful%20of%20mental%20health_08_revised_web.pdf*

[109] https://www.legislation.gov.uk/ukpga/1983/20/contents

relation to the reason for their admission under Section 3, 37, 45A, 47, or 48 of the Mental Health Act 1983. to reduce the risk of readmission.

The Care Act 2014[110] provides the legislative framework for councils to provide social care and support for adults in England. The Care Act provides the national eligibility criteria (the threshold for support) for adult social care and support and for carer support. It covers a range of responsibilities including needs assessment, Care and support planning, provision of personal budgets and support for carers to help meet the outcomes which matter to individuals48.

The Act sets out the legal framework for safeguarding adults and defines how local authorities and other parts of the system such as the NHS should protect adults at risk of abuse or neglect.

In addition to the Care Act duty to provide independent advocacy, councils have the responsibility for commissioning advocacy services under the Mental Health Act (the IMHA service) and the **Mental Capacity Act**[111] (the IMCA service).

Community Treatment Orders[112] **were introduced with the amendments to the Mental Health Act in 2007**[113]**.**

- The Council's Approved Mental Health Professional (AMHP) service has the power to apply to the Local Social Service Authority (LSSA) to accept someone into Guardianship under S7 of the MHA 1983, amended 2007. Guardianship applies to people 16 years old and above who are suffering from a mental disorder of a nature or degree which warrants their reception into Guardianship and it is necessary in the interests of the welfare of the patients or the protection of the other persons. It therefore applies to people with a mental illness including dementia. A diagnosis of learning disability is not sufficient and needs to be associated with "abnormally aggressive or seriously irresponsible conduct". The use of Guardianship enables people to receive care in the community where it cannot be provided without the use of compulsory powers. An application for Guardianship is made by an AMHP based on 2 medical recommendations. The Guardian can require that the person subject to Guardianship:
    - Lives in a certain place
    - Attends for medical treatment, occupation, education or training
    - Allows access to them by a medical practitioner or other professionals

[110] *http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted*

[111] *https://www.legislation.gov.uk/ukpga/2005/9/contents*

[112] *https://www.gov.uk/guidance/community-treatment-orders*

[113] *https://www.legislation.gov.uk/ukpga/2007/12/contents*

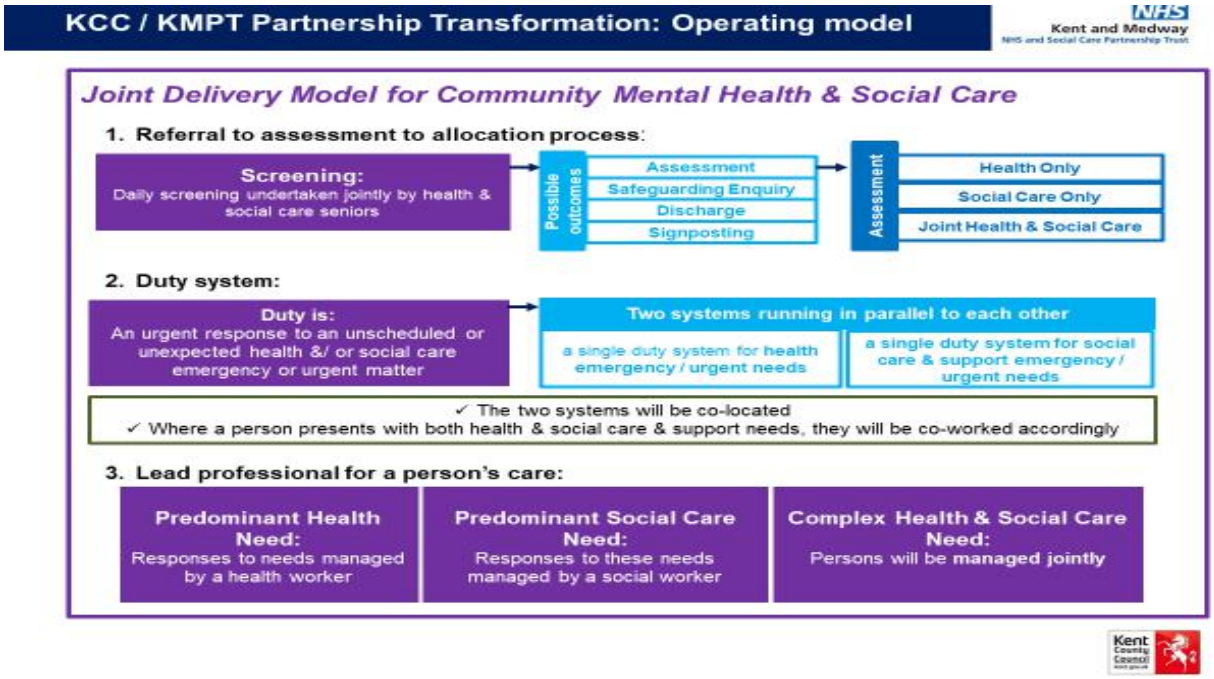
- Usually, the LSSA becomes the Guardian, however the LSSA can appoint someone else to be the Guardian. An application for Guardianship **cannot** proceed when the person identified as the nearest relative exercises their right to object

9.1.1 The Care Programme Approach

The Care Programme Approach (CPA) is the system which coordinates the care of many specialist mental health service patients.[114] CPA requires health and social services to coordinate their assessments to make sure everybody needing CPA receives properly assessed, planned and coordinated care. It should also ensure that patients get regular contact with a care co-ordinator.

Below is the agreed joint operating framework between Kent County Council and Kent and Medway NHS and Social Care Partnership Trust.

Figure 75: KCC/KMPT Partnership Transformation – Operating Model[115]



In Kent, the joint delivery model between KMPT and KCC is to ensure that the person referred to a community mental health team is seen by the right professional at the right time; there is no duplication of process and there is parity for all people referred.

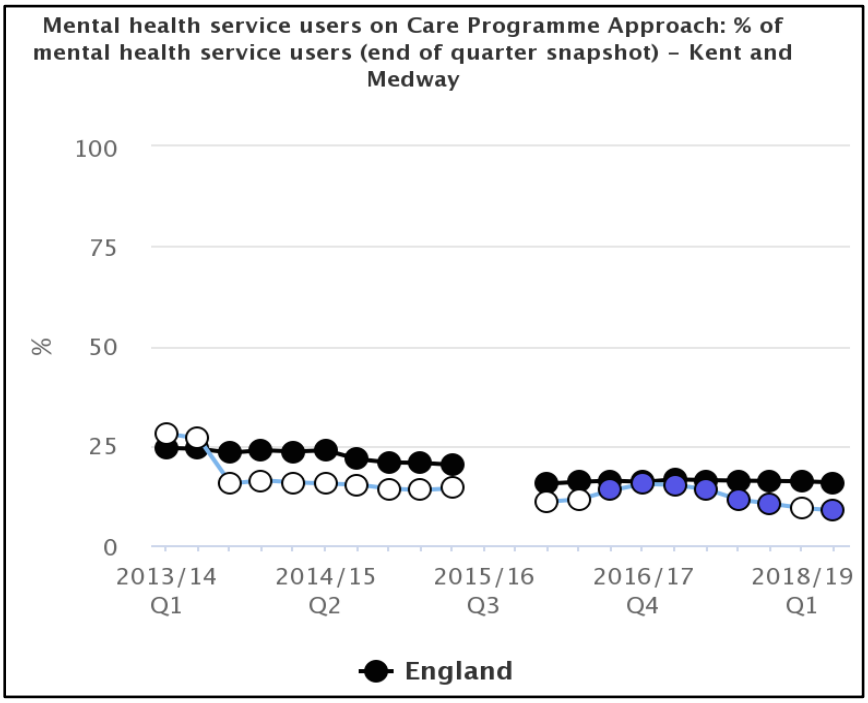
The joint delivery model also needs to ensure that all professional groups are not expected to work outside their professional accountabilities or eligibility criteria and recognises that the social care element will be working with a range of partners.

[114] https://www.rethink.org/advice-information/living-with-mental-illness/treatment-and-support/care-programme-approach-cpa/

[115] *Kent and Medway NHS and Social Care Partnership Trust (KMPT) and Kent County Council. Joint delivery model for community mental health and social care. March 2019.*

Figure 75 shows the number of people who are on the Care Programme Approach per 100,000 population in Kent and Medway. There is a problem with the quality of this data as Kent and Medway NHS and Social Care Partnership Trust (KMPT) are not required to CPA all their patients. However, both commissioners, clinicians and managers may want to understand and evaluate how else they can understand and share their patients care and coordinated care between differing agencies and primary care.

Figure 76: Mental health service users on Care Programme Approach: % of mental health service users (end of quarter snapshot) in Kent and Medway between 2013/14 and 2018/19



Data source: PHE Fingertips

In 2018/19 Quarter 2 there were **3,255** people on CPA in Kent and Medway. This roughly equates to 21% of all the predicted people with psychosis in Kent and Medway. NICE guidance[116] recommends all people with a SMI and complex needs have a care plan and care co-ordinator wherever their care is located.

9.2 Prevention, social support and health improvement of vulnerable adults

The Care Act 2014 provides Kent County Council with the responsibility to prevent and delay the need for care and support. These duties aim to promote health and wellbeing and

[116] *Goodwin N and Lawton-Smith S. Integrating care for people with mental illness: the Care Programme Approach in England and its implications for long-term conditions management. International Journal of Integrated Care: 1-10. https://www.ijic.org/articles/10.5334/ijic.516/galley/1033/download/*

include the provision of universal access to information, supporting safer neighbourhoods, reducing loneliness and isolation and assisting discussion about access to suitable accommodation; thereby helping people to improve and strengthen their ability to self-manage, socialise, be included, be involved and feel valued. Kent County Council leads the community in having the most robust enablement offer in a Local Authority (LA) having enablement offers specifically focussed towards the individual needs of people with a learning disability, mental health, disabled children and their families, autism, older people and physical disability and shortly Sensory.

The vision for Live Well Kent[117] (LWK) is to keep people well and provide a holistic offer of support for individuals living with and without a mental health diagnosis.

The outcome-based contract was designed to engage people in innovative approaches to improving their mental health and wellbeing, based on their individual needs. LWK aims to help prevent entry into formal social care and health systems, reduce suicide and prevent negative health outcomes associated with poor mental health. The approach of delivery is aimed to be community first, values-driven, and outcome focused.

The service is delivered by two Strategic Partners, Porchlight and Shaw Trust, who take on a market stewardship role to build capacity and sustainability within the voluntary sector network, which is funded through the contract. The network has changed over the life of the contract, responding to the needs of users.

Living Well Kent is open to those aged 17 years and over, and offers support on:

- Managing money, including debt and benefits advice
- Employment
- Housing support and guidance
- Improving relationships and social inclusion
- Lifelong learning, employment and accessing volunteering
- Brief advice and signposting to healthy lifestyle support
- Evidence based activities shown to improve health and wellbeing e.g. Arts, yoga, outdoor activities, poetry, reading etc

Below is a table of Live Well Kent Sign-ups between April 2017 and March2019.

[117] https://livewellkent.org.uk/

Table 16: Live Well Kent Sign-ups between April 2017 and March 2019

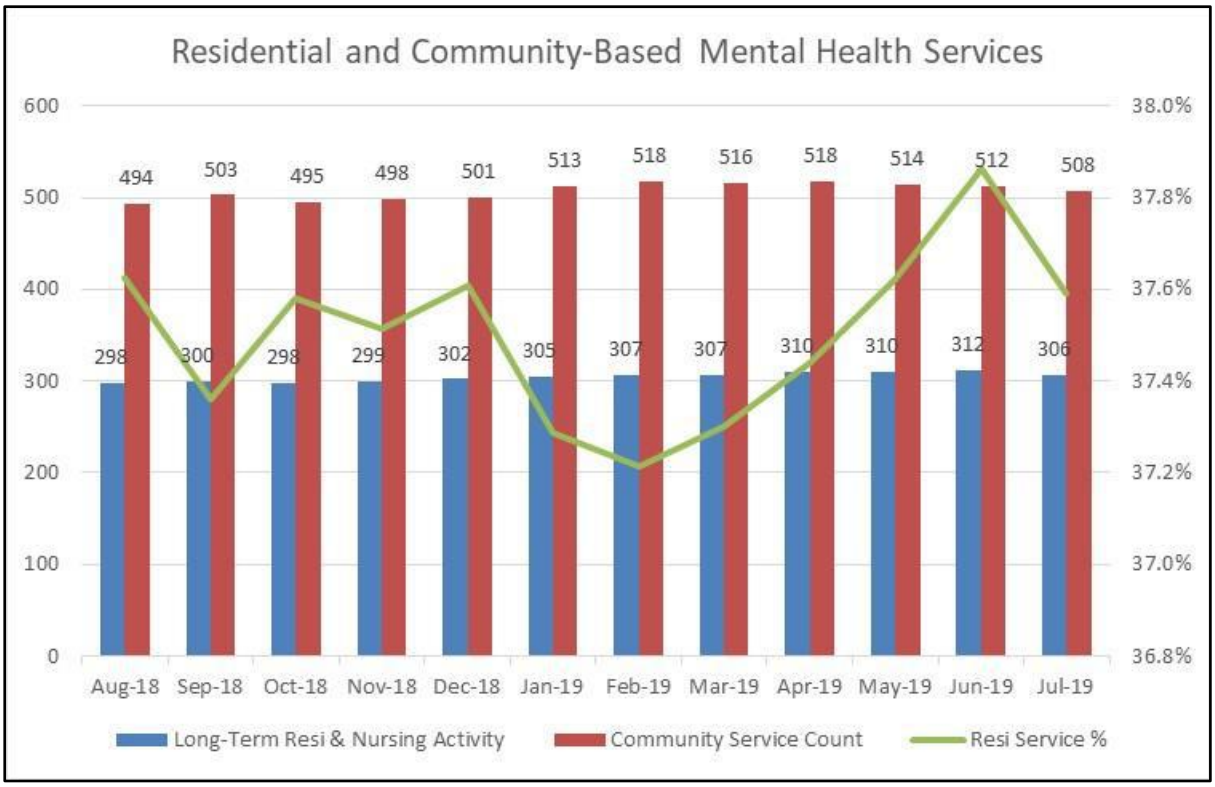
Live Well Kent Sign-Ups (April 2017 - March 2019)		
	Lots (CCGs)	**Total**
Number of people with SMI	Lot 1: Dartford Gravesham and Swanley CCG / Swale CCG	554
	Lot 2: West Kent CCG	522
	Lot 3: Ashford CCG / Canterbury & Coastal CCG	504
	Lot 4: South Kent Coast CCG / Thanet CCG	803
	Total SMI Sign-Ups	**2383**
Number of people with CMI	Lot 1: Dartford Gravesham and Swanley CCG / Swale CCG	1436
	Lot 2: West Kent CCG	690
	Lot 3: Ashford CCG / Canterbury & Coastal CCG	640
	Lot 4: South Kent Coast CCG / Thanet CCG	1845
	Total CMI Sign-Ups	**4611**
Total Sign-Ups		**6994**

9.2.1 Social care mental health in resident care or receiving home care

The following figure depicts the number of people with Mental Health needs who are receiving a residential service (blue) or a community-based service (orange). A community service can include Supported Living services, Direct Payments, or other services such as Homecare.

The grey expresses the number of residential clients as a percentage of all people with mental health needs in receipt of a service. With the residential figure being stable around the 300 mark, this reflects some 37% of people receiving a Community Mental Health service.

Figure 77: Residential and community-based mental health services in Kent



9.3 Supporting adults with care and support needs

The Care Act is needs led and requires a holistic assessment of need based on the 10 domains set out in the National eligibility criteria. Kent County Council delivers its duties through divisions which enable the specific needs of the individual to be supported by staff with knowledge and skills in that area of support. The Kent County Council recognises that there are people whose needs cross more than one of these areas of support and ensures that the staff within divisions work collaboratively to develop care and support plans which are strengths based and which are centred around the individual and their network and provides guidance to staff to underpin this way of working.

Kent has a specialist adults autism team which was designed to meet hidden areas of need identified in the Autism Act 2009; specifically, a Care Act 2014 service for people with autism without a learning disability; a cohort who were not always given a service or the right service in the past. The Kent Adults Autism Team has taken nearly 3000 referrals in seven years.

9.3.1 Depression, Substance Misuse and Self-Neglect

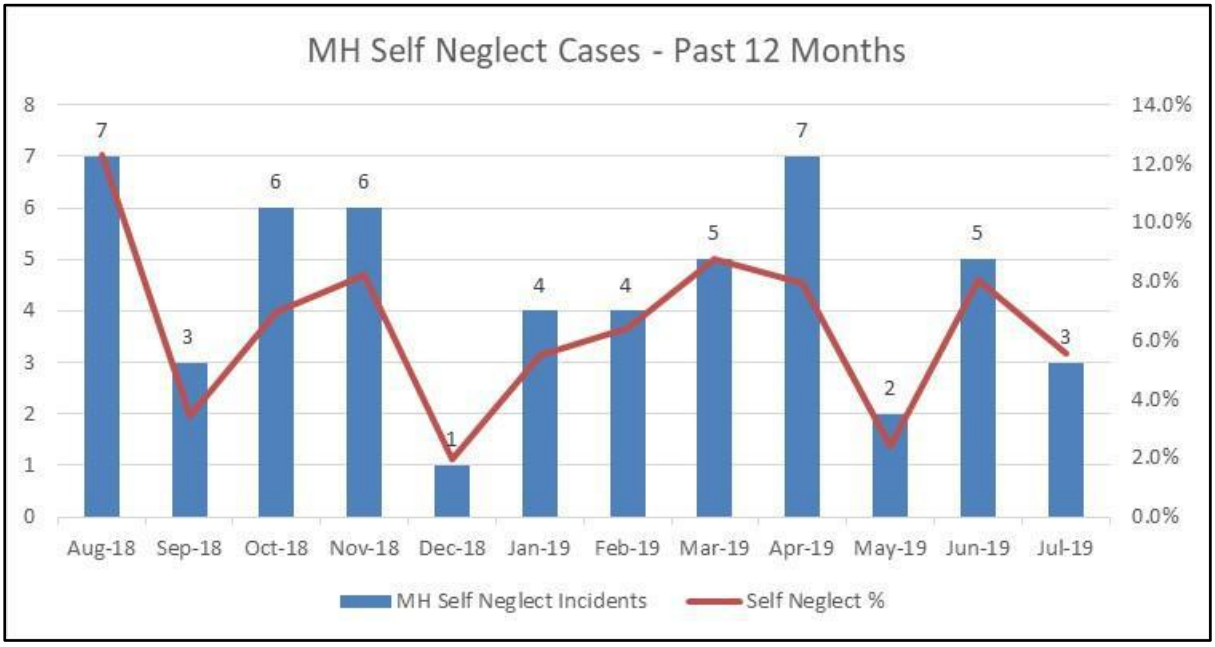
Under the Care Act 2014, safeguarding powers can be used to provide care and support for people who self-neglect (including hoarding). The data on self-neglect cases is developing. The figure below depicts the number of self-neglect incidents relating to mental health clients over the past 12 months.

Each bar represents the number of safeguarding enquiries per month that had a risk category of self-neglect recorded against it. The line on the secondary axis expresses this as a percentage of overall safeguarding enquiries in that month.

Self-neglect enquiries have generally seen increased levels over the past three years following the introduction of the Care Act which places greater emphasis on the management of self-neglect cases, however concerns have been raised that some safeguarding alerts may have been raised inappropriately in response.

In the last 12 months, there were 53 cases of mental health self-neglect in Kent.

Figure 78: MH Self-neglect cases in adult social care between August 2018 and July 2019



The biggest predictors of self-neglect are:

- lack of mental capacity, particularly in older people
- mental illness
- substance misuse
- trauma survivors
- people in pain.

The body of literature[118] on self-neglect cites depression in older people as a key factor in the prevalence of self-neglect. Hansen et al (2016)[119] state that 15-20% of older adults have late life depression and of these roughly 65% are self-neglecting and alcohol consumption is a contributing factor.

[118] *http://sro.sussex.ac.uk/22841/1/Self_neglect_report.pdf*

[119] *Hansen et al (2016) Correlates of Depression in Self-Neglecting Older Adults: A Cross-Sectional Study Examining the Role of Alcohol Abuse and Pain in Increasing Vulnerability https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4845723/*

9.3.2 Learning Disabilities

There is a comprehensive needs assessment available for Adults with Learning Disabilities in Kent and this section will not repeat evidence provided there. It can be accessed at this link: https://www.kpho.org.uk/__data/assets/pdf_file/0017/43550/Learning-Disability-Needs-Assessment-2014.pdf

There was an estimated population of 5,351 people with a learning disability registered in primary care in 2013/14 and predicted to rise to 6000 by 2020. However, there is a predicted 44,000 people with mild to moderate learning disabilities in the community who may need a service from Kent County Council.[120] In 2017/18 Thanet and South Kent Coast had the highest rates of people with Learning disability in Kent.

The prevalence of schizophrenia is likely to be 3-4 times higher in people with learning disabilities and is likely to be harder to diagnose than in the general population. The effects of medication or misdiagnosis of depression and post-traumatic stress may be confounding factors. Recent data from the Kent Integrated Data set (KID) by the Kent Public Health Observatory[121] show that people with a learning disability are 8 times more likely to have a mental health problem and 14% of all adults with a LD in Kent also have depression.

Figure 79: Learning disability QOF prevalence: % of people on GP practice registers in 2017/18

Area	Value	Lower CI	Upper CI
England	0.5	0.5	0.5
Kent and Medway	0.5	0.4	0.5
NHS Ashford CCG	0.4	0.4	0.4
NHS Canterbury And Coas...	0.5	0.5	0.5
NHS Dartford, Gravesham...	0.3	0.3	0.3
NHS Medway CCG	0.4	0.4	0.4
NHS South Kent Coast CC...	0.7	0.7	0.7
NHS Swale CCG	0.5	0.4	0.5
NHS Thanet CCG	0.6	0.6	0.7
NHS West Kent CCG	0.4	0.4	0.4

Source: QOF

[120] https://www.kpho.org.uk/__data/assets/pdf_file/0017/43550/Learning-Disability-Needs-Assessment-2014.pdf

[121] *Cuccu Z, 2019 Kid Data analysis on co-morbidity and Learning disabilities in Kent.*

10. Conclusions

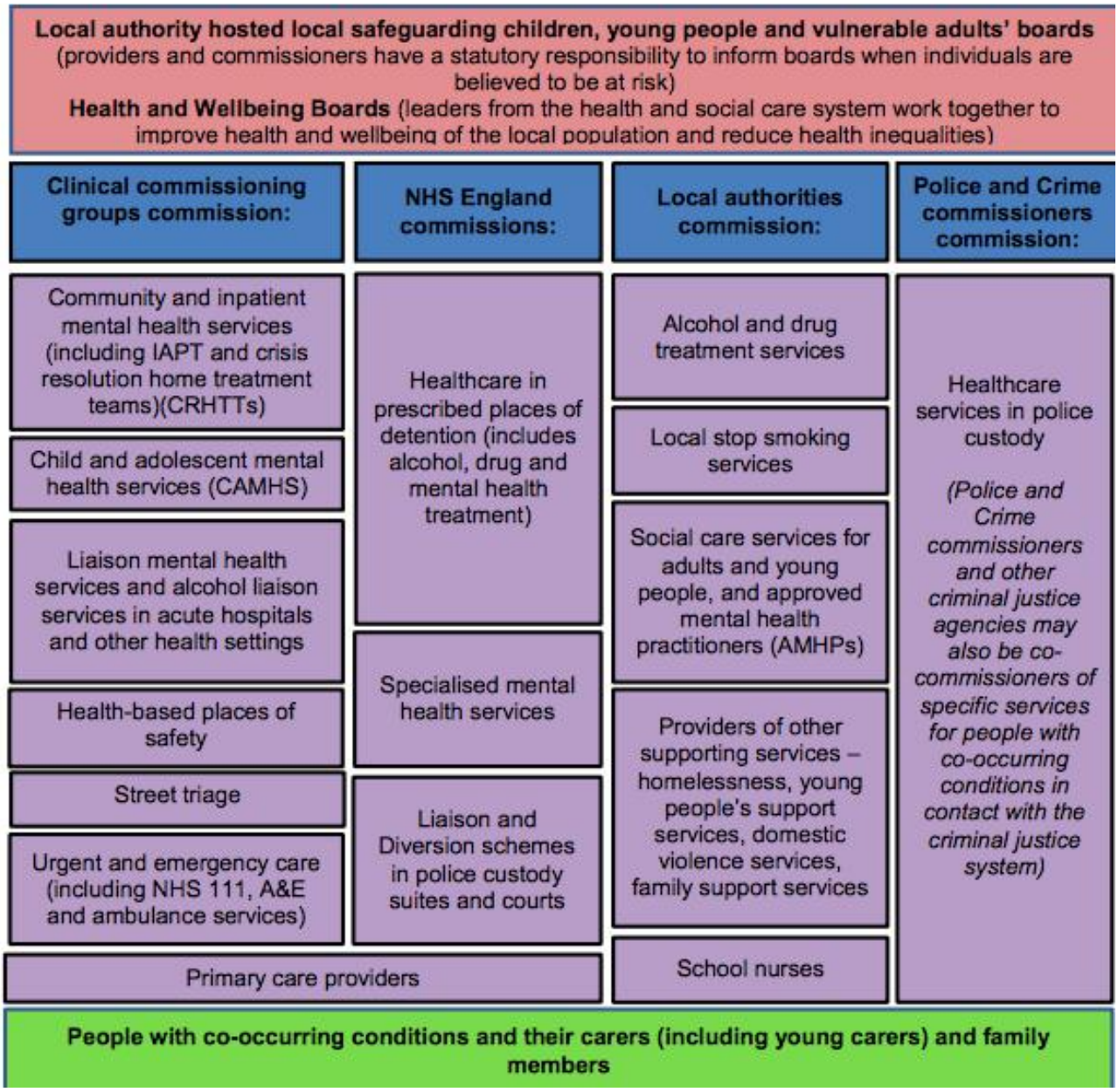
This needs assessment for adult mental health marks an important time in public mental health. It is heartening to see that tackling co-occurring conditions, physical health and putting the person at the heart of care is central to transforming the NHS and social care. Mental health will no longer be marginalised but be an important aspect of health and social care in Kent.

The Call to Action

- Tackle physical health and mental health problems together
- Where a person is vulnerable and at risk, all agencies should work together to plan a person's care and supply
- Create opportunities for people to come together to talk about mental health problems—end stigma and discrimination of mental health.

11. Appendices

Appendix 1: Who Commissions What in Mental Health?



Source: Strategic Transformation Plan and the 10-year Plan for Mental Health

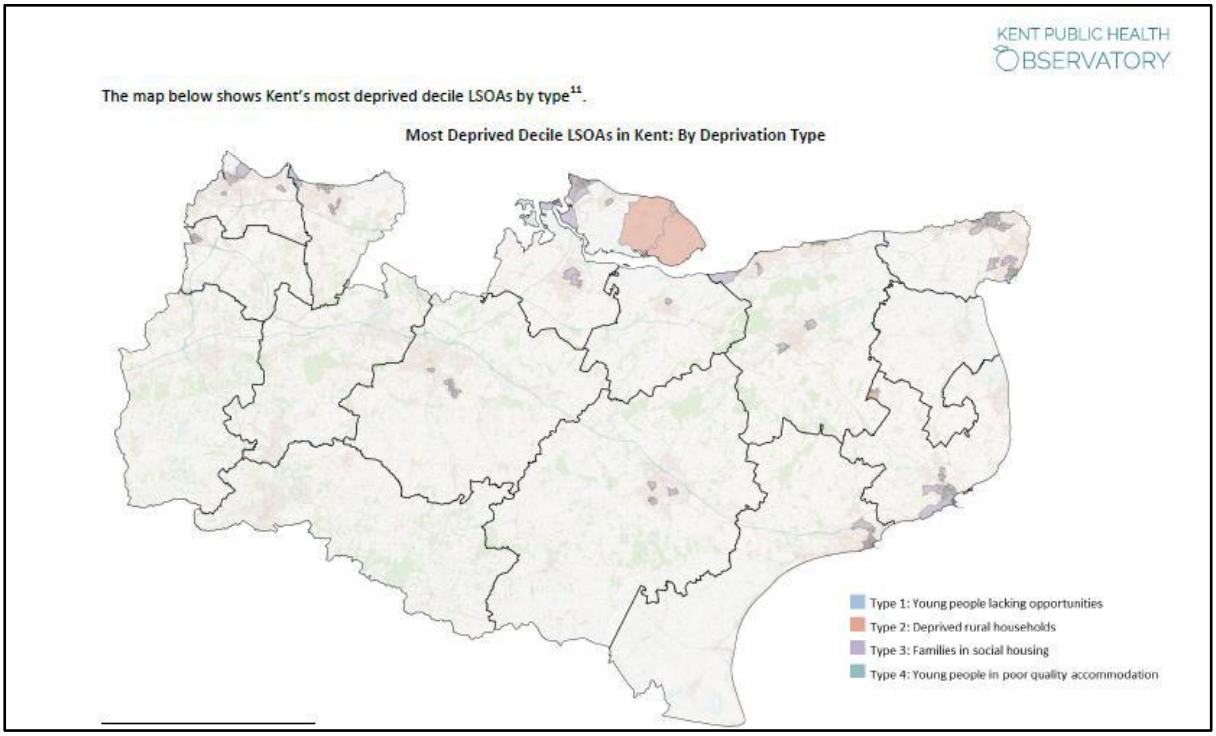
Figure 1: Diagram of the social determinants of mental health adapted from The Determinants of Health

Dahlgren, G., & Whitehead, M. (1993). Tackling inequalities in health: What can we learn from what has been tried? Background paper for *The King's Fund International Seminar on Tackling Health Inequalities*. Ditchley Park, Oxford: The King's Fund.

Appendix 2: The most deprived areas in Kent and four distinct groups:

I. Group 1/ young people lacking opportunities
II. Group 2/ deprived rural households
III. Group 3/ families in social housing
IV. Group 4/ young people in poor quality accommodation.

Figure 1: The map below shows Kent's most deprived decile LSOAs by type

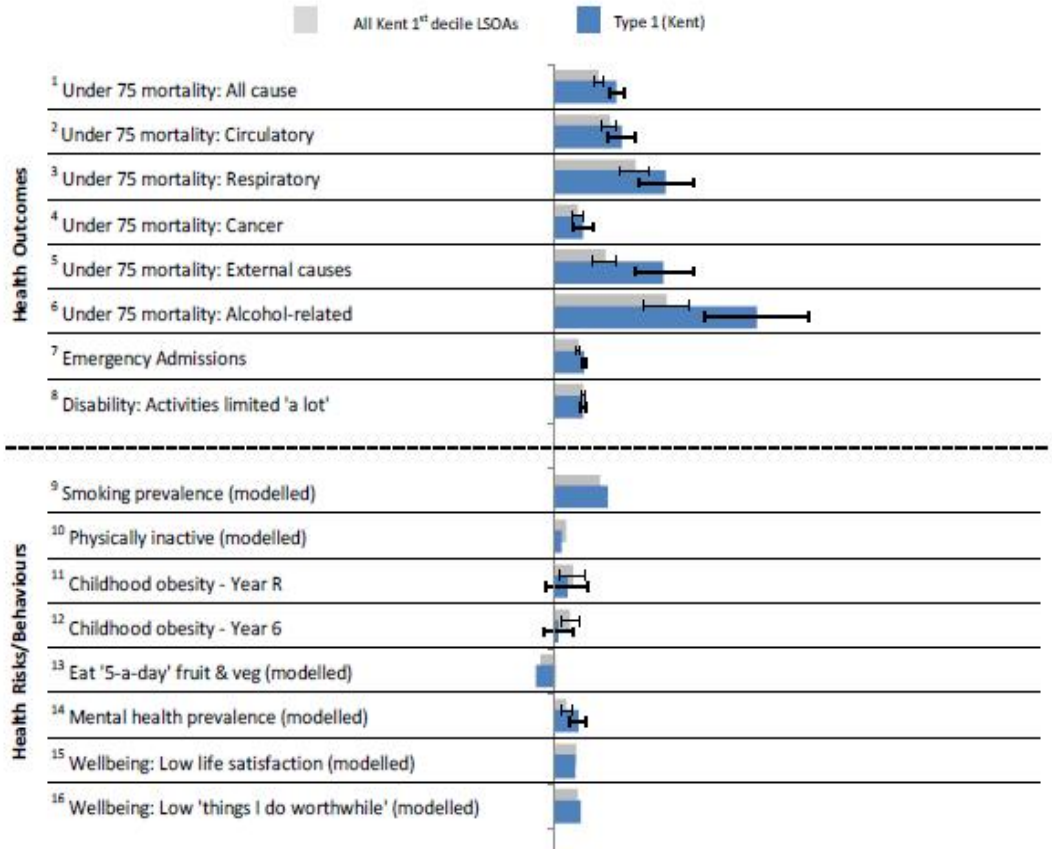


Data source: The Health Inequalities in Kent report

2.1 Group 1/ Young people lacking opportunities

This category is found primarily in Northfleet, Folkestone Harbour, Clarendon, Tower Hamlets, Sheerness, East Margate Central, Cliftonville West and Eastcliffe. This population suffers higher under 75 years deaths from alcohol related and respiratory disease and has higher mental illness prevalence than the most deprived people in Kent. This group also has higher emergency hospital admission rates and higher rates of physical disability.

Figure 2: Comparison between group 1 and all Kent 1st decile LSOAs (the most deprived) in health risks/behaviours and health outcomes



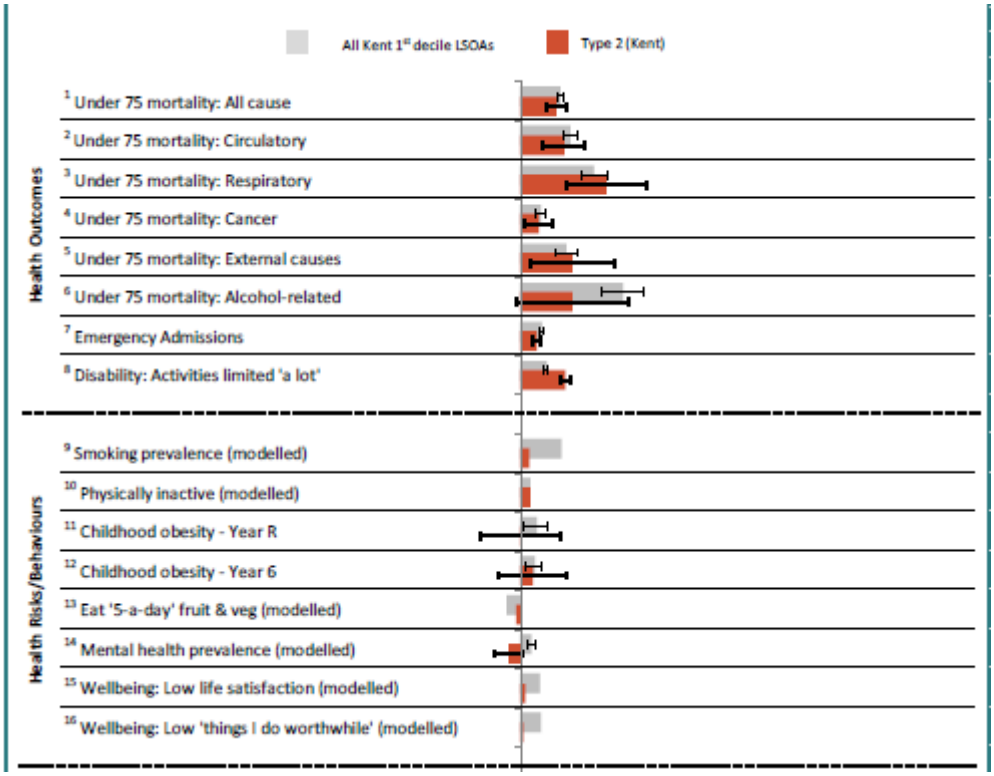
Data source: The Health Inequalities in Kent report

2.2 Group 2/ Deprived rural households

This group is a small population cohort, but they have significant mental and physical health needs.

A total of four of the 88 most deprived decile Lower Super Output Areas (LSOA) in Kent fall into Group 2. These include LSOAs in Aylesham, Leysdown-On-Sea, Warden and Eastchurch. People falling into this group tend to have overall better health and wellbeing than other deprived (or the most deprived?) groups in Kent. However, they suffer in higher rates of disability and have particular issues in accessing services.

Figure 3: Comparison between group 2 and all Kent 1st decile LSOAs (the most deprived) in health risks/behaviours and health outcomes

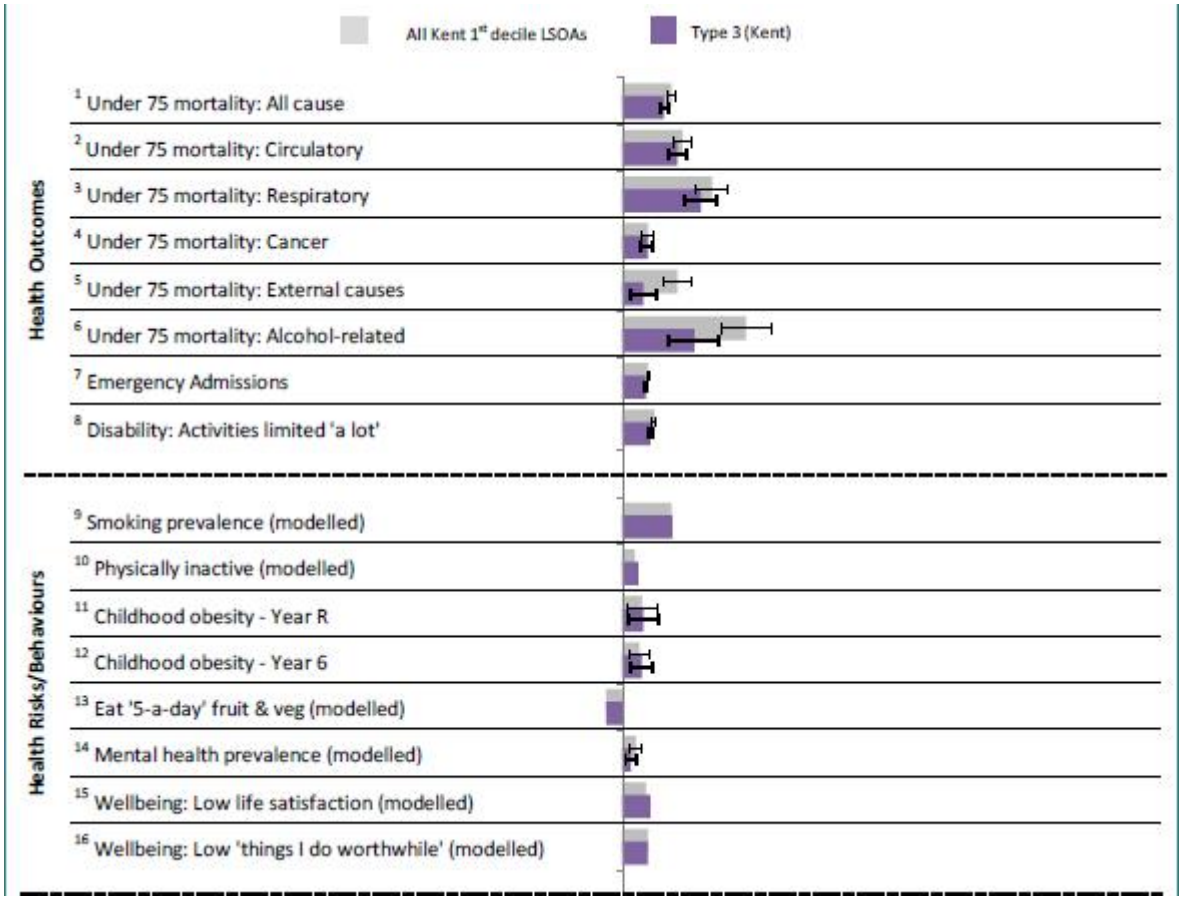


Data source: The Health Inequalities in Kent report

2.3 Group 3/ families in social housing

A total of 51 of the 88 most deprived decile LSOAs in Kent fall into type 3. This is the largest of the four deprivation types. These include LSOAs in Folkestone East, Aycliffe, Buckland Valley, St Radigans, Stanhope, Aylesford Green, Victoria, Davington Priory, Northgate, Gorrell, Seasalter, Wincheap, Swanley St Mary's, Dartford, Swanscombe, Kings Farm, Westcourt, Sheerness, Queenborough, Rushenden, Sittingbourne, Dane Valley, Garlinge, Newington, Parkwood, Shepway and Postley Road.

Figure 4: Comparison between group 3 and all Kent 1st decile LSOAs (the most deprived) in health risks/behaviours and health outcomes



Data source: The Health Inequalities in Kent report

This analysis highlights the following key characteristics of group 3 deprived areas in respect of some of the wider determinants of health, and in comparison with Kent as a whole:

- Low incomes
- poor scores for education
- high numbers of out-of-work benefits claimants
- particularly high number of single parents
- better living environment and lower crime rates than other deprived areas.

In terms of health risks and behaviours, group 3 deprived areas have:

- high smoking prevalence
- low levels of wellbeing.

In terms of health outcomes, group 3 deprived areas have:

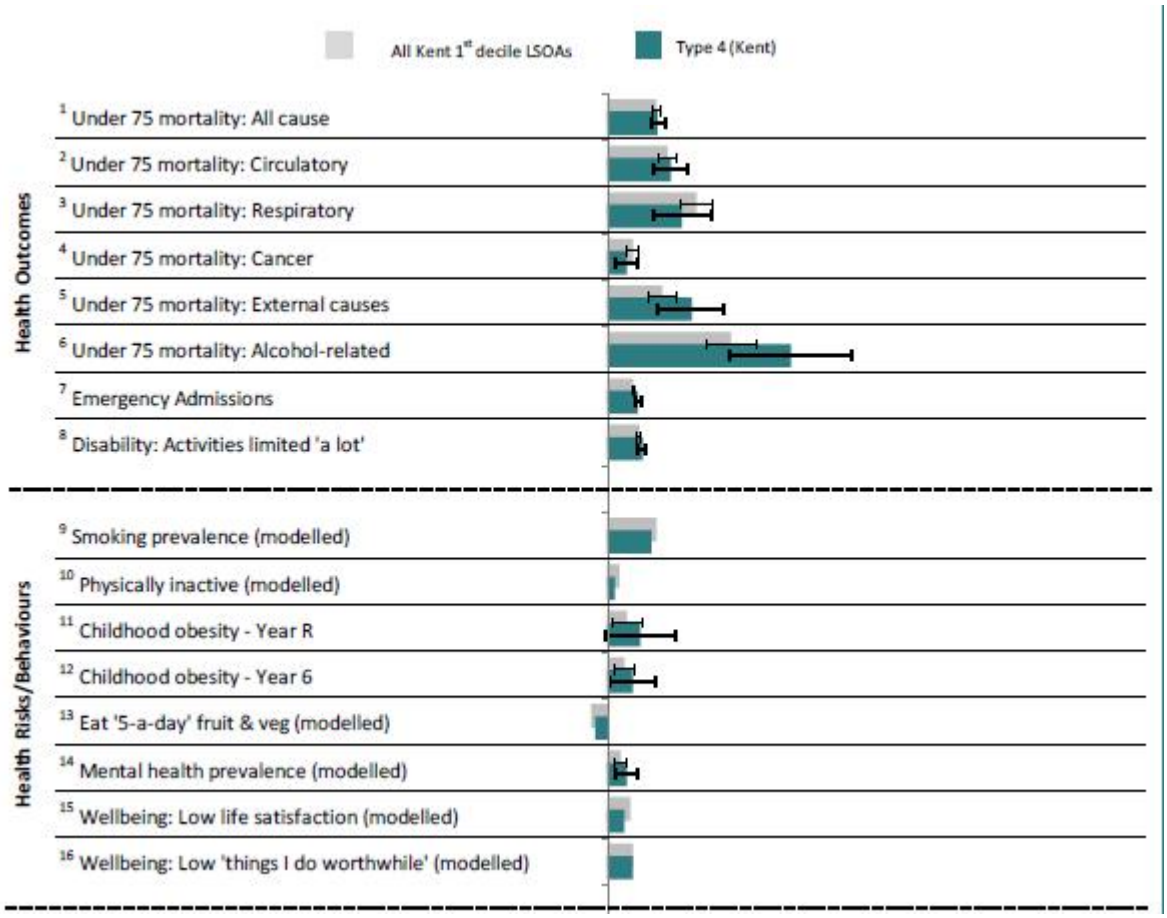
- high premature mortality rates
- high emergency hospital admission rates
- high rates of disability (‘activities limited a lot’).

2.4 Group 4/ young people in poor quality accommodation.

A total of 15 of the 88 most deprived decile LSOAs in Kent fall into group 4. These include LSOAs in Folkestone Harvey Central, Priory, Pencester, Heron, Herne Bay, Central Gravesend, Central Harbour (Ramsgate), and Westbrook.

This group is much like Group 1 but has poorer accommodation and faces risks of homelessness. This group has higher alcohol related death rates, higher hospital admissions, poorer mental wellbeing, higher prevalence of mental illness and higher rates of disability than the most deprived population in Kent.

Figure 5: Comparison between group 4 and all Kent 1st decile LSOAs (the most deprived) in health risks/behaviours and health outcomes



Data source: The Health Inequalities in Kent report

Appendix 3: Methodology and findings of the APMS

3.1 Methodology of the APMS

Each of the APMS surveys in the series used the revised Clinical Interview Schedule (CIS-R). The CIS-R is an interviewer-administered structured interview schedule that assesses the presence of non-psychotic symptoms in the week prior to interview. It is used to provide prevalence estimates for 14 types of common mental health problem symptoms and six types of common mental health problems, which include: depression, generalised anxiety disorder (GAD), panic disorder, phobias, obsessive compulsive disorder (OCD) and common mental disorders not otherwise specified (CMD-NOS). Although NICE guidance includes Post Traumatic Stress Disorder (PTSD) as a CMI, the APMS does not. This needs assessment will tackle PTSD as a SMI.

The CIS-R is also used to produce a score that reflects the overall severity of common mental health problem symptoms. A CIS-R score of 12 or more is the threshold applied to indicate that a level of common mental health problem symptoms is present and warrants primary care recognition. A CIS-R score of 18 or more indicates more severe or pervasive symptoms of a level likely to warrant intervention, e.g. medication or psychological therapy.[122]

3.2 Some findings:

Women have a higher prevalence of CMD then men. Since 2000, overall rates of CMD have steadily increased in women with this increase in prevalence mostly evident at the severe end of the scale (CIS-R 18 or more). Men's overall rates have remained relatively stable.

These APMS 2014 estimates are based on national statistical models which consider local circumstances such as, income, employment, age and rates of physical illness (co-morbidity). Data in the APMS shows that:

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

[122] *Stansfeld, S., Clark, C., Bebbington, P., King, M., Jenkins, R., & Hinchliffe, S. (2016). Chapter 2: Common mental disorders. In S. McManus, P. Bebbington, R. Jenkins, & T. Brugha (Eds.), Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital.*

Appendix 4: Severe and enduring mental illness (SEMI)

4.1 Incidence

The predicted incidence of SEMI is expected to grow at a faster rate than the population.

Table 4.1: predicted incidence of SEMI across Kent ICPs

ICP	Incidence (numbers)			Annual growth %			10-year growth
	2020	2025	2030	2020	2025	2030	
DGS	81	85	90	-	5.6	5.7	11.7
Medway and Swale	116	122	130	-	5.8	6.0	12.1
West Kent	152	162	171	-	6.3	6.0	12.7
East Kent	219	236	249	-	7.9	5.5	13.9

4.2 Prevalence

Table 4.2 – predicted single condition SEMI prevalence across Kent ICPs

ICP	Prevalence single condition			Absolute growth %			10-year growth
	2020	2025	2030	2020	2025	2030	
DGS	1593	1692	1770	-	6.2	4.6	11.1
Medway and Swale	2272	2400	2510	-	5.6	4.6	10.4
West Kent	2831	2996	3148	-	5.8	5.1	11.2
East Kent	4158	4705	5189	-	13.1	10.3	24.8

Table 4.3 – predicted SEMI prevalence across Kent ICPs

ICP	Prevalence (numbers)			Absolute growth %			10-year growth
	2020	2025	2030	2020	2025	2030	
DGS	2024	2161	2277	-	6.7	5.4	12.5
Medway and Swale	3102	3325	3539	-	7.2	6.4	14.1
West Kent	3943	4240	4534	-	7.5	6.9	15.0
East Kent	5911	6686	7404	-	13.1	10.7	25.3

4.3 Demand on services

The following table lists the predicted demand on services and PODs from those with SEMI, as single condition, through to 2030. For comparator the 'Healthy' cohort are displayed in brackets. It also includes key PODs across mental health providers.

Table 4.4 - Predicted service demand across 13 points of delivery, SEMI (healthy), DGS

DGS	Number of contacts			Annual growth %		
Year	***2020***	***2025***	***2030***	***2020***	***2025***	***2030***
A&E	1131 (51357)	1203 (54381)	1262 (56599)	-	6.3 (5.9)	4.9 (4.1)
Non-elective Admission	337 (12804)	361 (13594)	384 (14231)	-	6.9 (6.2)	6.6 (4.7)
Outpatients	3364 (207442)	3578 (221355)	3789 (230471)	-	6.3 (6.7)	5.9 (4.1)
Elective Care	709 (23229)	735 (24908)	738 (26001)	-	3.6 (7.2)	0.4 (4.4)
GP attendances	16446 (623584)	17466 (660632)	18446 (683525)	-	6.2 (5.9)	5.6 (3.5)
Social Care	2810 (17098)	2984 (18114)	3101 (18741)	-	6.2 (5.9)	3.9 (3.5)
Community	4431 (118928)	4706 (125993)	4890 (130359)	-	6.2 (5.9)	3.9 (3.5)
Mental Health	28004	29742	30903	-	6.2	3.9
CRHT	2825	3000	3117	-	6.2	3.9
Early Intervention	1794	1905	1980	-	6.2	3.9
Specialist Mental Health	1120	1190	1236	-	6.2	3.9
CMHT	7493	7958	8269	-	6.2	3.9

Table 4.5:- Predicted service demand across 13 points of delivery, SEMI (healthy)Medway and Swale

Medway & Swale	Number of contacts			Percent growth		
Year	***2020***	***2025***	***2030***	***2020***	***2025***	***2030***
A&E	1801 (74246)	1911 (76831)	2005 (79419)	-	6.1 (3.5)	4.9 (3.4)
Non-elective Admission	539 (18494)	575 (19558)	609 (20534)	-	6.8 (5.8)	5.8 (5)
Outpatients	5367 (304683)	5694 (319125)	5983 (332535)	-	6.1 (4.7)	5.1 (4.2)
Elective Care	393 (34533)	419 (36438)	441 (38046)	-	6.5 (5.5)	5.4 (4.4)
GP attendances	26197 (904000)	27748 (936163)	28829 (967795)	-	5.9 (3.6)	3.9 (3.4)
Social Care	4003 (24786)	4234 (25668)	4396 (26365)	-	5.8 (3.6)	3.8 (2.7)
Community	6313 (172408)	6677 (178542)	6933 (183388)	-	5.8 (3.6)	3.8 (2.7)
Mental Health	45001	47483	49245	-	5.5	3.7
CRHT	5265	5554	5759	-	5.5	3.7
Early Intervention	1445	1517	1569	-	5.0	3.5
Specialist Mental Health	1626	1712	1774	-	5.3	3.6
CMHT	13271	14043	14632	-	5.8	4.2

Table 4.6 - Predicted service demand across 13 points of delivery, SEMI (healthy), West Kent

West Kent	Number of contacts			Percent growth		
Year	***2020***	***2025***	***2030***	***2020***	***2025***	***2030***
A&E	2009 (93636)	2129 (96764)	2242 (100158)	-	5.9 (3.3)	5.3 (3.5)
Non-elective Admission	599 (23356)	638 (24730)	678 (26029)	-	6.4 (5.9)	6.3 (5.3)
Outpatients	5981 (383393)	6337 (401652)	6685 (419425)	-	5.9 (4.8)	5.5 (4.4)
Elective Care	437 (43378)	465 (45867)	492 (48014)	-	6.3 (5.7)	5.9 (4.7)
GP attendances	29225 (1139964)	30925 (1179593)	32526 (1221501)	-	5.8 (3.5)	5.2 (3.6)
Social Care	4993 (31256)	5283 (32343)	5505 (33261)	-	5.8 (3.5)	4.2 (2.8)
Community	217410 (217410)	224968 (224968)	231352 (231352)	-	3.5 (3.5)	2.8 (2.8)
Mental Health	28353	28664	28998	-	1.1	1.2
CRHT	3362	3399	3438	-	1.1	1.2
Early Intervention	1001	1059	1104	-	5.8	4.2
Specialist Mental Health	2183	2310	2407	-	5.8	4.2
CMHT	13271	14043	14632	-	5.8	4.2

East Kent

Table 4.7 - Predicted service demand across 13 points of delivery, SEMI (healthy), East Kent

East Kent	Number of contacts			Percent growth		
Year	2020	2025	2030	2020	2025	2030
A&E	3180 (135123)	3293 (143307)	3350 (150911)	-	3.6 (6.1)	1.7 (5.3)
Non-elective Admission	966 (33081)	1002 (35872)	1014 (38457)	-	3.7 (8.4)	1.2 (7.2)
Outpatients	9576 (550553)	9911 (589951)	10000 (625817)	-	3.5 (7.2)	0.9 (6.1)
Elective Care	709 (61663)	735 (66453)	738 (70549)	-	3.6 (7.8)	0.4 (6.2)
GP attendances	46422 (1641369)	48035 (1740726)	48625 (1832352)	-	3.5 (6.1)	1.2 (5.3)
Social Care	2779 (43478)	3007 (44714)	3221 (46232)	-	8.2 (2.8)	7.1 (3.4)
Community	7971 (302424)	8506 (311021)	8974 (321576)	-	6.7 (2.8)	5.5 (3.4)
Mental Health	19113	20580	21971	-	7.7	6.8
CRHT	1960	2111	2255	-	7.7	6.8
Early Intervention	584	629	671	-	7.7	6.8
Specialist Mental Health	1273	1371	1464	-	7.7	6.8
CMHT	11832	12746	13612	-	7.7	6.8

4.4 Better Health Impacts

The implementation of Better Health Kent can have an impact to reduce the incidence and prevalence of SEMI between 2020, 2025 and 2030 across the ICP. It has an additional impact by reducing the progression from single to multiple and frail cohorts.

Table 4.8 – Impacts of Better Health Kent upon SEMI, DGS

DGS	Cumulative impacts			% reduction		
Year	***2020***	***2025***	***2030***	***2020***	***2025***	***2030***
Incidence	-1	-12	-27	-0.3	-3.0	-2.8
Prevalence	-1	-22	-49	-0.1	-1.0	-2.1
Single condition	0	-15	-37	0.0	-0.9	-2.2
Progression (single to multiple)	0	0	0			
Progression (to frail)	0	0	-1	0.0	-0.4	-0.9

Table 4.9 – Impacts of Better Health Kent upon SEMI, Medway and Swale

Medway & Swale	Cumulative impacts			% reduction		
Year	***2020***	***2025***	***2030***	***2020***	***2025***	***2030***
Incidence	-1	-17	-34	-0.4	-3.4	-3.1
Prevalence	-2	-35	-77	0.0	-0.3	-0.3
Single condition	0	-21	-53	0.0	-0.2	-0.3
Progression (single to multiple)	0	0	0			
Progression (to frail)	0	0	-1	0.0	-0.5	-1.4

Table 4.10 – Impacts of Better Health Kent upon SEMI, West Kent

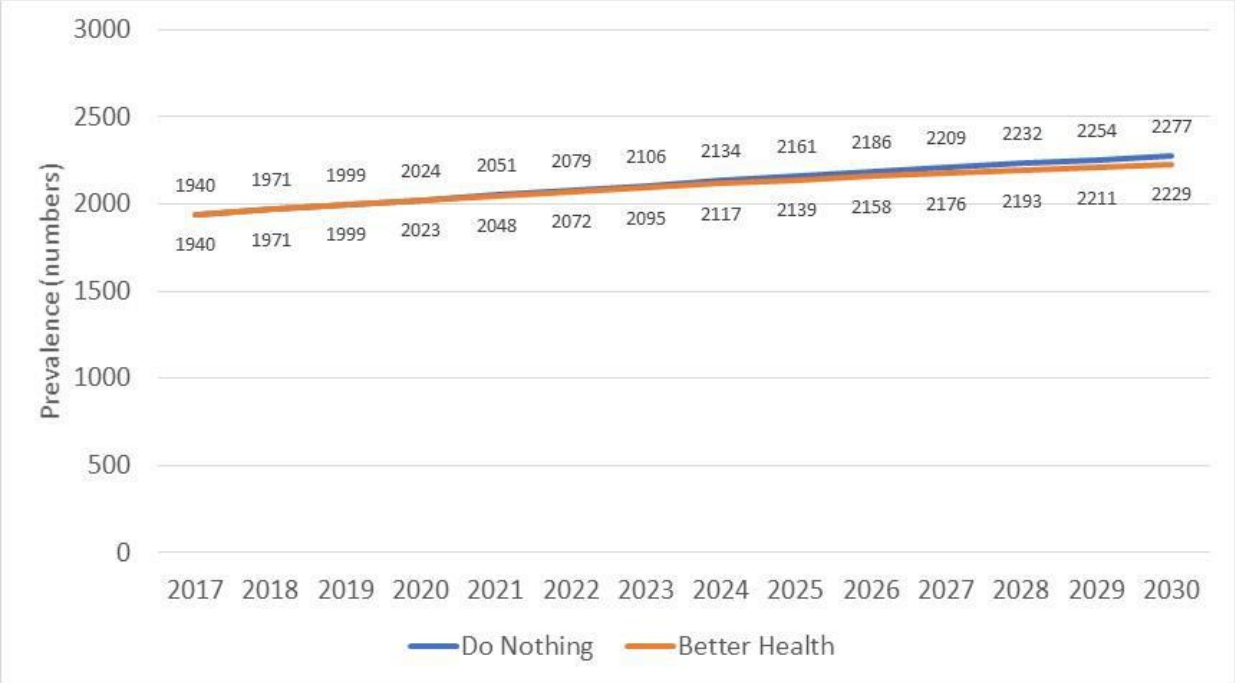
West Kent	Cumulative impacts			% reduction		
Year	***2020***	***2025***	***2030***	***2020***	***2025***	***2030***
Incidence	-1	-20	-40	-0.3	-2.5	-2.3
Prevalence	-2	-43	-96	-0.1	-1.0	-2.1
Single condition	0	-26	-68	0.0	-0.9	-2.2
Progression (single to multiple)	0	0	0			
Progression (to frail)	0	0	-1	0.0	-0.3	-0.9

Table 4.11 – Impacts of Better Health Kent upon SEMI, East Kent

East Kent	Cumulative impacts			% reduction		
Year	*2020*	*2025*	*2030*	*2020*	*2025*	*2030*
Incidence	2	-9	-32	0.4	-0.8	-1.2
Prevalence	0	-45	-157	0.0	-0.7	-2.1
Single condition	0	-27	-118	0.0	-0.6	-2.3
Progression (single to multiple)	0	0	0			
Progression (to frail)	0	-1	-6	0.0	-0.4	-1.1

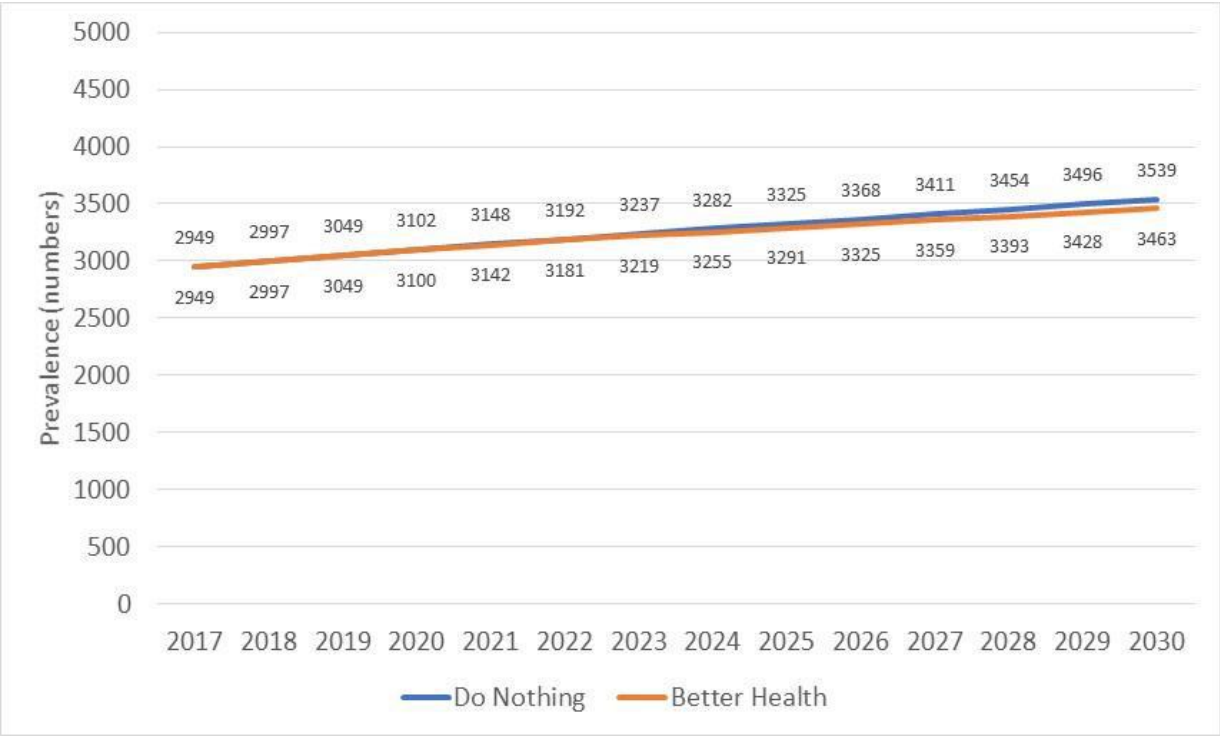
DGS

Figure 4.12: Scenarios with and without better health Kent on future prevalence of severe and enduring mental illness - DGS



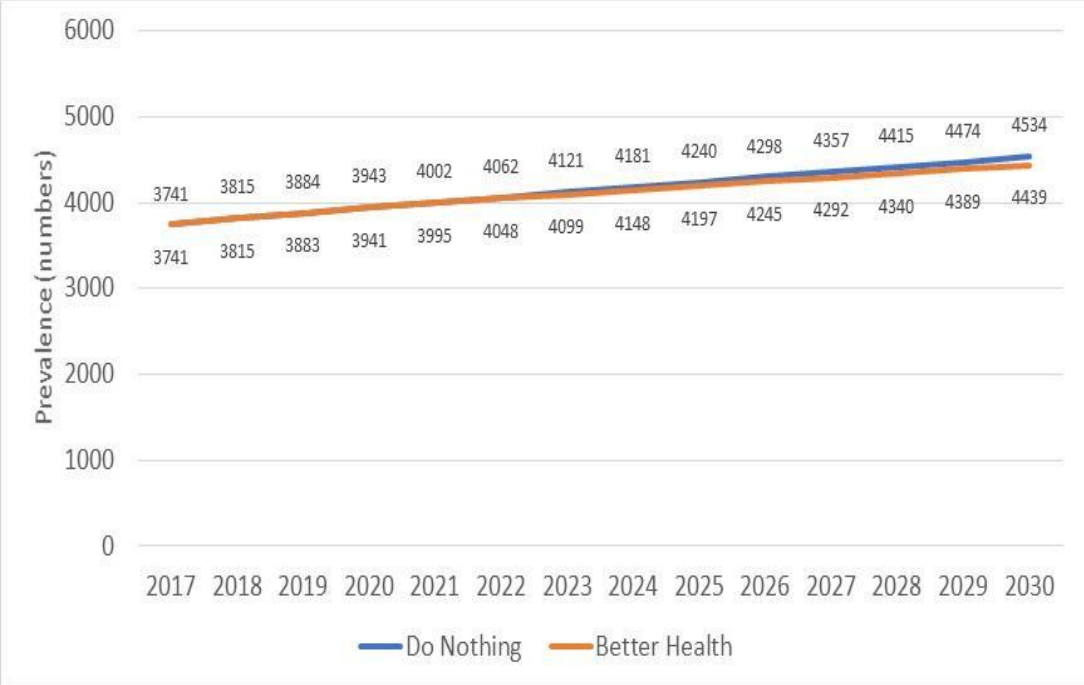
Medway and Swale

Figure 4.13: Scenarios with and without better health Kent on future prevalence of severe and enduring mental illness – Medway and Swale



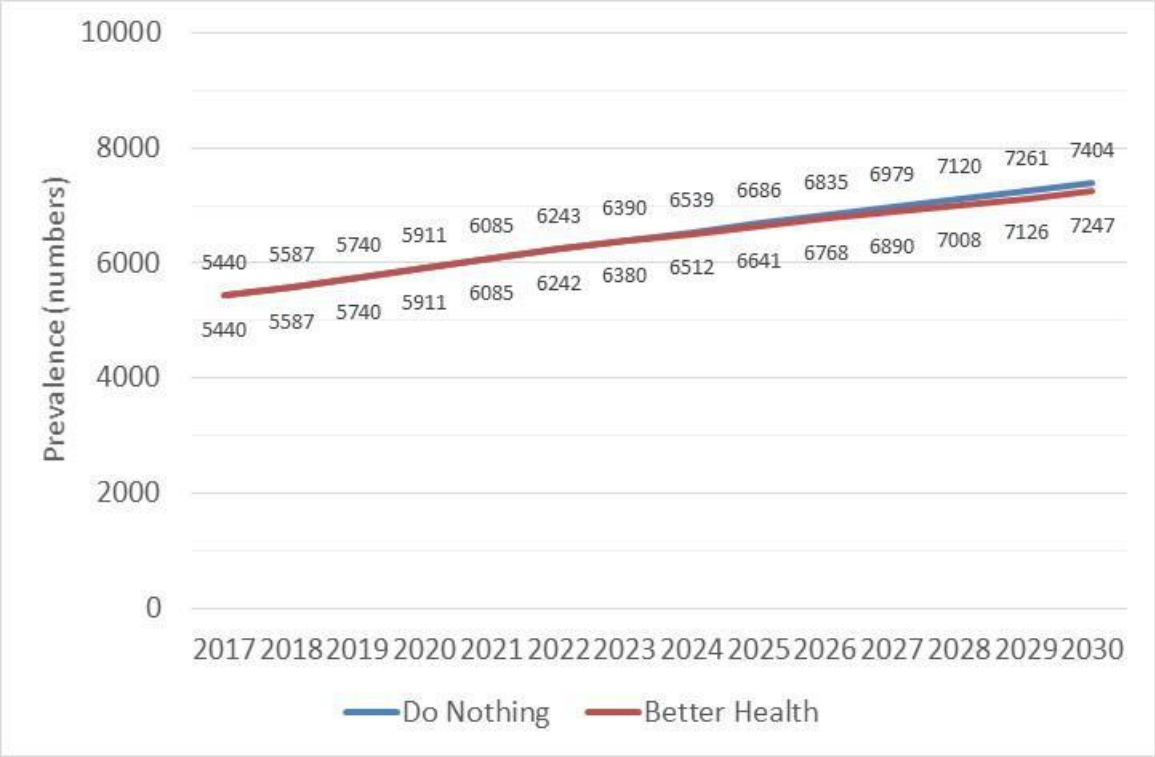
West Kent

Figure 4.14: Scenarios with and without better health Kent on future prevalence of severe and enduring mental illness – West Kent



East Kent

Figure 4.15: Scenarios with and without better health Kent on future prevalence of severe and enduring mental illness – East Kent



Appendix 5: Quality and Outcomes Framework (QOF) for Mental illness

QOF is part of the General Medical Services (GMS) contract for general practices and was introduced on 1 April 2004. The QOF rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care.

The full set of indicators of achievement are outlined in summary of 2017/18 indicators.[123] As there were no changes to QOF for 2017/18, the 2016/17 QOF guidance, published by NHS Employers, still applies.[124] The full set of indicators of achievement are outlined in the latest QOF guidance, published by NHS Employers, which is updated for each year.[125]

[123] https://www.nhsemployers.org/-/media/Employers/Documents/Primary-care-contracts/QOF/2017-18/201718-Quality-and-outcomes-framework-summary-of-changes.pdf?la=en&hash=D08AB4F7CE88F5D76E836E2F57FB6DCF241C8BC6&la=en&hash=D08AB4F7CE88F5D76E836E2F57FB6DCF241C8BC6

[124] *https://www.nhsemployers.org/-/media/Employers/Documents/Primary-care-contracts/QOF/2016-17/2016-17-QOF-guidance-documents.pdf?la=en&hash=2E80C3A7304E39EE61419EDB257F97F8D21FF262&la=en&hash=2E80C3A7304E39EE61419EDB257F97F8D21FF262*

[125] https://www.nhsemployers.org/-/media/Employers/Documents/Primary-care-contracts/QOF/2014-*15/2014-15-General-Medical-Services-contract---Quality-and-Outcomes Framework.pdf?la=en&hash=69CF3870EB19476ECDFF3A5CBAA35F08C34E00DC&la=en&hash=69CF3870EB19476ECDFF3A5CBAA35F08C34E00DC*

Appendix 6: The characteristics of personality disorder (PD)

Only antisocial and borderline personality disorders were assessed in the 2014 Adult Psychiatric Morbidity Survey, there are several 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):

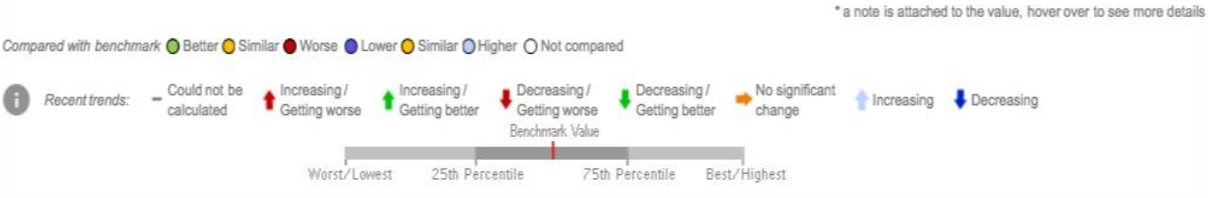
- frantic efforts to avoid real or imagined abandonment
- pattern of unstable and intense personal relationships
- Unstable self-image
- impulsivity in more than one way that is self-damaging
- suicidal or self-harming behaviour
- affective instability
- chronic feelings of emptiness
- anger
- paranoid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

Appendix 7: Snapshot Data - Prevalence Rates of Mental Illness by Kent CCG

7.1 Prevalence Rates of Mental Illness in East Kent

In Ashford: Depression is increasing in primary care which indicates that there is a good coverage however QOF for SMI is lower expected prevalence.

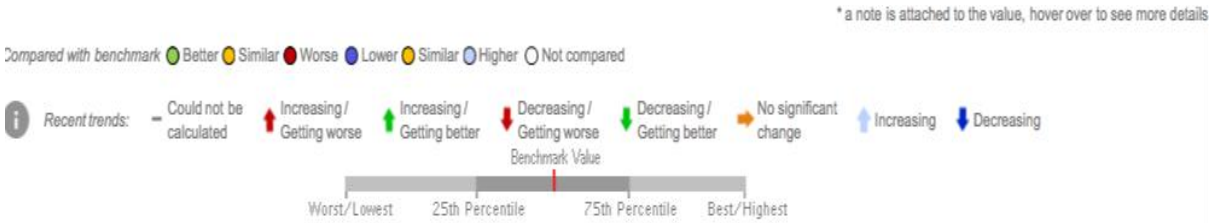
Figure 7.1: Prevalence Rates of Mental Illness in Ashford



Indicator	Period	Ashford			STP	England	England			
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range		Best/ Highest
Depression recorded incidence (QOF): % of practice register aged 18+	2017/18	↑	1,849	1.8%	1.6%	1.6%	0.6%			3.0%
Depression recorded prevalence (QOF): % of practice register aged 18+	2017/18	↑	13,117	12.6%	10.6%	9.9%	5.4%			15.9%
Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+	2016/17	→	238	13.7%	13.7%*	13.7%	8.9%			21.3%
Long-term mental health problems (GP Patient Survey): % of respondents aged 18+	2017/18	↑	87	5.9%	8.6%*	9.1%	4.5%			17.3%
Severe mental illness recorded prevalence (QOF): % of practice register all ages	2017/18	→	928	0.70%	0.82%	0.94%	0.56%			1.55%

Data source: PHE Fingertips

Figure 7.2: Prevalence Rates of Mental Illness in Canterbury



Indicator	Period	Canterbury And Coastal			STP	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Depression recorded incidence (QOF): % of practice register aged 18+	2017/18		3,806	2.0%	1.6%	1.6%	0.6%		3.0%
Depression recorded prevalence (QOF): % of practice register aged 18+	2017/18		21,471	11.6%	10.6%	9.9%	5.4%		15.9%
Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+	2016/17		456	15.0%	13.7%*	13.7%	8.9%		21.3%
Long-term mental health problems (GP Patient Survey): % of respondents aged 18+	2017/18		272	10.9%	8.6%*	9.1%	4.5%		17.3%
Severe mental illness recorded prevalence (QOF): % of practice register all ages	2017/18		2,095	0.93%	0.82%	0.94%	0.56%		1.55%

Data source: PHE Fingertips

In Canterbury the QOF prevalence of both Depression and SMI is as expected.

Figure 7.3: Prevalence Rates of Mental Illness in South Coast Kent

Indicator	Period	South Kent Coast			STP	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Depression recorded incidence (QOF): % of practice register aged 18+	2017/18		1,969	1.2%	1.6%	1.6%	0.6%		3.0%
Depression recorded prevalence (QOF): % of practice register aged 18+	2017/18		16,813	10.2%	10.6%	9.9%	5.4%		15.9%
Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+	2016/17		430	15.5%	13.7%*	13.7%	8.9%		21.3%
Long-term mental health problems (GP Patient Survey): % of respondents aged 18+	2017/18		214	8.9%	8.6%*	9.1%	4.5%		17.3%
Severe mental illness recorded prevalence (QOF): % of practice register all ages	2017/18		1,946	0.95%	0.82%	0.94%	0.56%		1.55%

Data source: PHE Fingertips

In South Coast Kent the trend for all conditions is increasing. There is below expected prevalence of recorded depression (although it is in line with East Kent CCGs). There appears to be good recording of SMI in South Kent Coast CCG.

Figure 7.4: Prevalence Rates of Mental Illness in Thanet

Thanet has higher than average rates for CMI and SMI indicating both high demand and good recording at primary care.

Indicator	Period	Thanet			STP	England	England			
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range		Best/ Highest
Depression recorded incidence (QOF): % of practice register aged 18+	2017/18		2,523	2.2%	1.6%	1.6%	0.6%			3.0%
Depression recorded prevalence (QOF): % of practice register aged 18+	2017/18		14,650	12.7%	10.6%	9.9%	5.4%			15.9%
Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+	2016/17		347	18.3%	13.7%*	13.7%	8.9%			21.3%
Long-term mental health problems (GP Patient Survey): % of respondents aged 18+	2017/18		147	8.9%	8.6%*	9.1%	4.5%			17.3%
Severe mental illness recorded prevalence (QOF): % of practice register all ages	2017/18		1,699	1.17%	0.82%	0.94%	0.56%			1.55%

Data source: PHE Fingertips

Overall East Kent is seeing increases in mental illness in primary care.

7.2 Prevalence Rates of Mental Illness in North Kent

Figure 7.5: Prevalence Rates of Mental Illness in Swale

Indicator	Period	Dartford, Gravesham And Swanley			STP	England	England			
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range		Best/ Highest
Depression recorded incidence (QOF): % of practice register aged 18+	2017/18	↑	1,700	0.8%	1.6%	1.6%	0.6%			3.0%
Depression recorded prevalence (QOF): % of practice register aged 18+	2017/18	↑	15,045	7.2%	10.6%	9.9%	5.4%			15.9%
Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+	2016/17	→	426	12.1%	13.7%*	13.7%	8.9%			21.3%
Long-term mental health problems (GP Patient Survey): % of respondents aged 18+	2017/18	↑	230	7.5%	8.6%*	9.1%	4.5%			17.3%
Severe mental illness recorded prevalence (QOF): % of practice register all ages	2017/18	→	1,986	0.74%	0.82%	0.94%	0.56%			1.55%

Data source: PHE Fingertips

Figure 7.6: Prevalence Rates of Mental Illness in Dartford and Gravesham

Indicator	Period	Swale			STP	England	England			
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range		Best/ Highest
Depression recorded incidence (QOF): % of practice register aged 18+	2017/18	↑	1,750	2.0%	1.6%	1.6%	0.6%			3.0%
Depression recorded prevalence (QOF): % of practice register aged 18+	2017/18	↑	9,992	11.4%	10.6%	9.9%	5.4%			15.9%
Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+	2016/17	→	214	14.4%	13.7%*	13.7%	8.9%			21.3%
Long-term mental health problems (GP Patient Survey): % of respondents aged 18+	2017/18	↑	141	11.0%	8.6%*	9.1%	4.5%			17.3%
Severe mental illness recorded prevalence (QOF): % of practice register all ages	2017/18	→	782	0.69%	0.82%	0.94%	0.56%			1.55%

Data source: PHE Fingertips

Swale and Dartford and Gravesham show somewhat differing patterns of mental illness in primary care. With DGS showing lower recording levels than expected and Swale showing higher. It may be important to understand the mental health primary care pathway in DGS given the demand in primary care to understand this better.

Figure 7.7: Prevalence Rates of Mental Illness in Medway

Indicator	Period	Medway			STP	England	England			
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range		Best/ Highest
Depression recorded incidence (QOF): % of practice register aged 18+	2017/18		4,044	1.7%	1.6%	1.6%	0.6%			3.0%
Depression recorded prevalence (QOF): % of practice register aged 18+	2017/18		27,738	12.0%	10.6%	9.9%	5.4%			15.9%
Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+	2016/17		550	14.0%	13.7%*	13.7%	8.9%			21.3%
Long-term mental health problems (GP Patient Survey): % of respondents aged 18+	2017/18		318	9.3%	8.6%*	9.1%	4.5%			17.3%
Severe mental illness recorded prevalence (QOF): % of practice register all ages	2017/18		2,172	0.73%	0.82%	0.94%	0.56%			1.55%

Data source: PHE Fingertips

7.3 Prevalence Rates of Mental Illness in West Kent

In West Kent it appears that depression is well recorded in primary care as it is above the STP benchmark. However, some investigation on the management of SMI may be important as recording is below the STP average.

Figure 7.8: Prevalence Rates of Mental Illness in West Kent

Indicator	Period	West Kent			STP	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Depression recorded incidence (QOF): % of practice register aged 18+	2017/18		5,967	1.6%	1.6%	1.6%	0.6%		3.0%
Depression recorded prevalence (QOF): % of practice register aged 18+	2017/18		38,090	9.9%	10.6%	9.9%	5.4%		15.9%
Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+	2016/17		742	11.4%	13.7%*	13.7%	8.9%		21.3%
Long-term mental health problems (GP Patient Survey): % of respondents aged 18+	2017/18		430	7.7%	8.6%*	9.1%	4.5%		17.3%
Severe mental illness recorded prevalence (QOF): % of practice register all ages	2017/18		3,812	0.77%	0.82%	0.94%	0.56%		1.55%

Data source: PHE Fingertips

Appendix 8: Patient Education and Support

8.1 List of resource to find support and help for depression in Kent

Kent County Council : Website Page for access to mental health care and support	https://www.kent.gov.uk/social-care-and-health/health/mental-health
Live Well Kent: Access to Social Support Services	https://livewellkent.org.uk
Specialist Mental Health Services in Kent (KMPT)	https://www.kmpt.nhs.uk/need-help/
National support Website for Depression	http://depressionuk.org/index.php/how-we-can-help/find-a-group/

8.2 Challenges in implementing NICE guidance

The NICE Guidance states	**"Provide written & verbal information for patients in an appropriate format"**	**Research says** **GPs are often unsure how to discuss patient's feelings of sadness vs the management of severe depression** **https://bjgp.org/content/57/544/e1** **GP's say** *'The chronic … nature of depression, it's a large workload in general practice and a lot of long-term depressed people come regularly to the surgery. So I see a lady who's been depressed for 20, nearly 20 years, and she comes once a week. That's a huge burden of work. She phones the surgery a lot and we have a system whereby we don't let her talk to me. I mean, a more appropriate person would be someone like the counsellor, but they'll only … see them six times.* (GP16, 46-year-old white male)
An example of a written guide to Depression is available in this link	**https://web.ntw.nhs.uk/selfhelp/leaflets/Depression%20and%20Low%20Mood%20A4%202016%20FINAL.pdf**	

8.3 Patient Experience in Primary Care

A recent report[126] by Health Watch Kent on the experiences of people in primary care - with mental health problems in Kent - was overall favourable regarding the responsiveness of primary care doctors and staff.

Two key issues to highlight from the report are:

- **Communication and Clarity: Not everyone with depression feels able to talk**

"Since mental illness often produces symptoms that are not always visible, many of our respondents underlined the importance of being clear and forthright with your GP. However, we also heard about problems surrounding miscommunication on the part of some practitioners."

- **Continuity of Care: It is difficult for people with severe depression to continue to repeat their case history – particularly if trauma is involved**

"Some patients we spoke to highlighted the difficulties that emerge in not seeing a familiar doctor. The process of establishing a new relationship with a GP could be quite harmful, as they feared having to rake over their mental health history to a person who didn't know them. On a similar theme, some GPs that weren't aware of a patient's past – in particular those who have accessed secondary care – would not look-up their records or care plans stored on the RiO System (the electronic patient record system). This was reported as occurring when a GP was either not willing or denied access to the system."

[126] *http://www.healthwatchkent.co.uk/sites/default/files/healthwatch_kent_report_on_support_for_mental_health_patients_from_gps.pdf*

Appendix 9: Symptoms of major depression as barriers to seeking help

- feeling a loss of hope
- feeling they are a burden
- fixed and logical thoughts about their conditions: everything is hopeless
- withdrawn and isolated: not wanting to talk
- intrusive thoughts and self-criticism: not worthy of help
- wanting to self-harm: seeing this as the only alternative
- rejection: already been rejected and traumatised so not worthy of help
- physical problems and pain: masking depression
- failed attempts at getting help: clinicians unresponsive
- social phobia: not wanting or being able to talk
- self-medicating: drugs and alcohol being a problem getting mental health support
- not knowing how or where to get help as feeling unwell.
- feeling stigmatised and not wishing to appear weak or giving in but not coping.

Depression: Outcomes and Disease Progression and Management, A Chronic Relapsing Condition (Similar to Diabetes)

In a research report from Department for Work and Pensions, it found that around 30% of all GP patients had some co-occurring condition along with depression.[127] The Kings Fund paper 'Managing Long-term Conditions' described depression as 'for many patients it is a long-term condition that follows a chronic or relapsing course'.[128]

Evidence suggests that for up to half of people who experience depression the condition becomes a chronic or relapsing one. In a major international study, 50% of people with depression still had depression one year later.[129]

In a long-term follow-up study, 37% of people with depression and/or anxiety experienced chronic or relapsing illness lasting for at least a decade.[130] Other evidence suggests that at least 50% of people who recover from a first episode of depression go on to experience another episode, and of those who have a second or third episode, 70% and 90% respectively have further relapses.[131]

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[127] *Department for Work and Pensions. Mental health in context: the national study of work-search and wellbeing (RR810). September 2012.*

[128] *https://www.kingsfund.org.uk/sites/default/files/field/field_document/managing-people-long-term-conditions-gp-inquiry-research-paper-mar11.pdf*

[129] *Simon et al. (2002). Understanding cross-national differences in depression prevalence. Psychol Med 32: 585-94.*

[130] *Sim K, et al. (2016). Prevention of Relapse and Recurrence in Adults with Major Depressive Disorder: Systematic Review and Meta-Analyses of Controlled Trials. Int J Neuropsychopharmacol. 19: pyv076.*

[131] *Kupfer. (1991). Long-term treatment of depression. J Clin Psychiatry. 52: 28-34.*

Outcomes are particularly poor for those who experience depression early in life.[132] Such evidence suggests there is a case for managing depression like a chronic disease.[133,134]

A similarly prevalent condition to depression is diabetes. This condition also has a high proportion of under diagnosed people, has a less severe 'pro-dromal' stage and can have severe consequences if untreated. Once a person is diagnosed they can be encouraged to self-care and self-manage their condition. Many of the same principles (with important modifications) can be applied to depression.

[132] *van Weel-Baumgarten. (2005). Is depression a chronic illness? A response from the perspective of general practice. Chronic Illness 1: 113-115.*

[133] *Scott (2006). Depression should be managed like a chronic disease. BMJ 332: 985–986.*

[134] *Tylee and Walters. (2007). Underrecognition of anxiety and mood disorders in primary care: why does the problem exist and what can be done? J Clin Psychiatry 2: 27-30.*

Appendix 10: CQC: Pathways of Care

"Some people with mental health conditions need ongoing care. Also, as their condition worsens and then improves, people often need input over time from a range of different services – both inpatient and community. In these cases, good care coordination and easy transitions from one part of the patient pathway to another are very important. Some providers had effective, detailed handovers between teams with periods of joint working to help patients become settled with a new care team. We also saw innovative practice, such as the use of tracking systems to assist working across different teams or organisations, and a city-wide bed management system." CQC Mental Health Report 2014-17[135]

[135] https://www.cqc.org.uk/sites/default/files/20170720_stateofmh_report.pdf

Appendix 11: Key issues during prescribing antidepressants, alongside evidence and recommendation

Key Issue	Findings from Research	References	Recommendation
non responsiveness to medication	Studies in USA and UK estimate Treatment Resistant Depression rates to be around **50%**	Br J Gen Pract. 2013 Dec; 63(617): e852–e858. Published online 2013 Nov 25. doi: 10.3399/bjgp13X675430	A range of treatment options
poor patient education and support	Patients often report little discussion or understanding of their condition and impact of medication. There is a need to combine medication with psychological support but this system is fragmented.	Prim Care. 2012 Jun; 39(2): 415–431. doi: 10.1016/j.pop.2012.03.010	Better advice and information on self-management of depression
lack of adequate monitoring	Little or no data on monitoring patients with history of chronic depression in primary care A major UK study showed that 30% of patients broke down / did not improve and that it is hard to monitor improvement in primary care.	https://bjgp.org/content/59/559/76 Scott J (2006) Depression should be managed like a chronic disease. BMJ**332**:985–986.	Monitoring for suicidal ideation Monitoring medication responsiveness
poor adherence by patient	Poor data and evidence Patient experience data shows that patients want someone to bring their care together, e.g substance misuse, medication and therapy. This rarely happens even for the the most severe cases.		Understand Patient reported data
side effects and impact on physical health	Depression medication needs to be monitored effectively and the physical symptoms understood and mitigated. Lifestyle support can help.	https://www.nice.org.uk/guidance/cg91/evidence/full-guideline-243876061	Better links to lifestyle support and physical health care
interaction with other medicines	Support from specialists are needed in primary care particular where there are co-morbidities.	See NICE	Improvement of links between psychiatric specialists and primary care

Appendix 12: IAPT and the Range of Therapies Provided in Kent

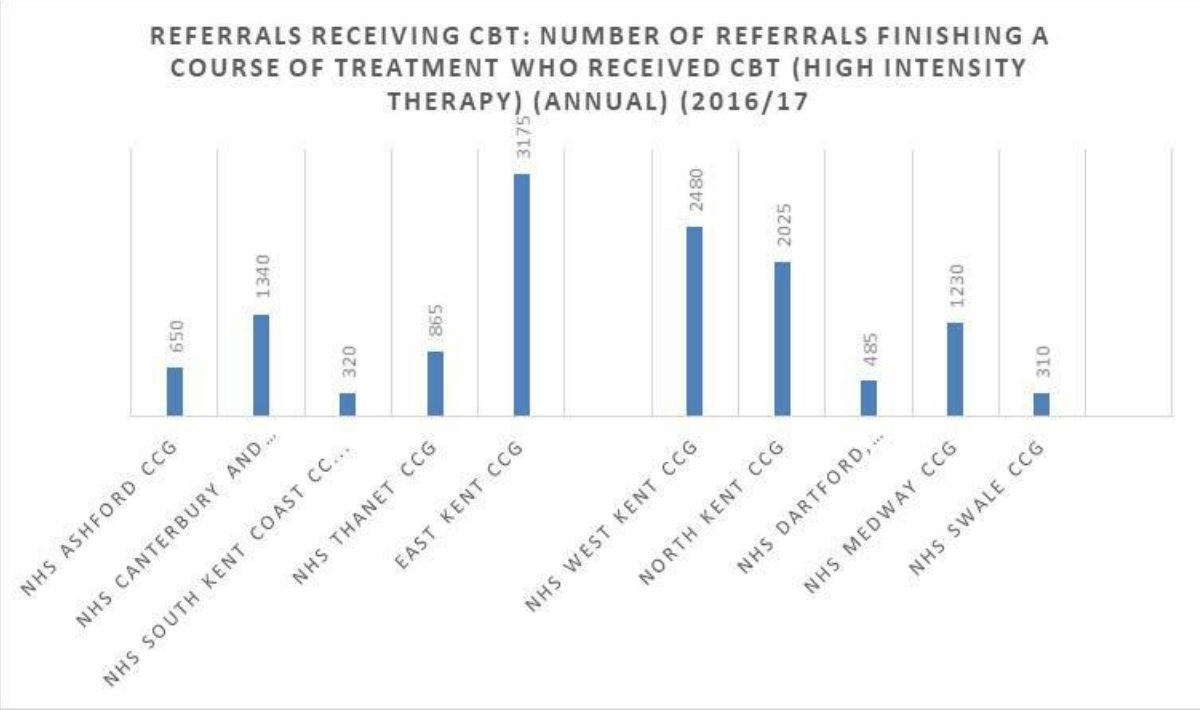
Only in East Kent CCGs are there recorded numbers of referrals and completions of **intensive couples therapy for depression**: In 2016/17 there were 55 couples completed: Thanet (20) South Kent Coast (20) and Canterbury and Coastal CCG (15).

Cognitive Behaviour Therapy (high intensity) was referred to and completed by 7,680 people in Kent and Medway in 2016/17. This is 32.5% of the registered GP population for depression. However, it is impossible to say whether those completing CBT are the same cohort being treated for depression in primary care.

The recorded national data for numbers completing therapy for depression via IAPT is not consistent across Kent CCGs. The best data is for East Kent CCGs, and South Kent Coast CCG records 2,350 people completing treatment for depression compared with 650 in Thanet. This data is of limited value other than highlighting better data recording can help track patients being managed for depression and help with quality across the depression pathway.

Low intensity self-help book support was received by 4,120 people. There is less robust data for computer aided self-help and Canterbury and Coastal CCG is the area in Kent where the most are recorded, with 655 people receiving help this way.

Figure 12.1: Referrals receiving CBT: number of referrals finishing a course of treatment who received CBT (high intensity therapy) in 2016/17



Data source: PHE Fingertips

Figure 12.2: Therapy Type: % of IAPT patients in Kent and Medway receiving high intensity therapy

Area	Value	Lower CI	Upper CI
England	26	-	-
Kent and Medway	-	-	-
NHS Ashford CCG	31*	-	-
NHS Canterbury And Coas...	62*	-	-
NHS Dartford, Gravesham...	43*	-	-
NHS Medway CCG	24*	-	-
NHS South Kent Coast CC...	86*	-	-
NHS Swale CCG	67*	-	-
NHS Thanet CCG	52*	-	-
NHS West Kent CCG	32*	-	-

Source: 2016/17 data: IAPT Annual Report Table 4G https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2016-17-further-analyses

Figure 12.3: Therapy Type: % of IAPT patients in Kent and Medway receiving low intensity therapy

Area	Value	Lower CI	Upper CI
England	35	-	-
Kent and Medway	-	-	-
NHS Ashford CCG	19*	-	-
NHS Canterbury And Coas...	23*	-	-
NHS Dartford, Gravesham...	47*	-	-
NHS Medway CCG	26*	-	-
NHS South Kent Coast CC...	7*	-	-
NHS Swale CCG	10*	-	-
NHS Thanet CCG	11*	-	-
NHS West Kent CCG	24*	-	-

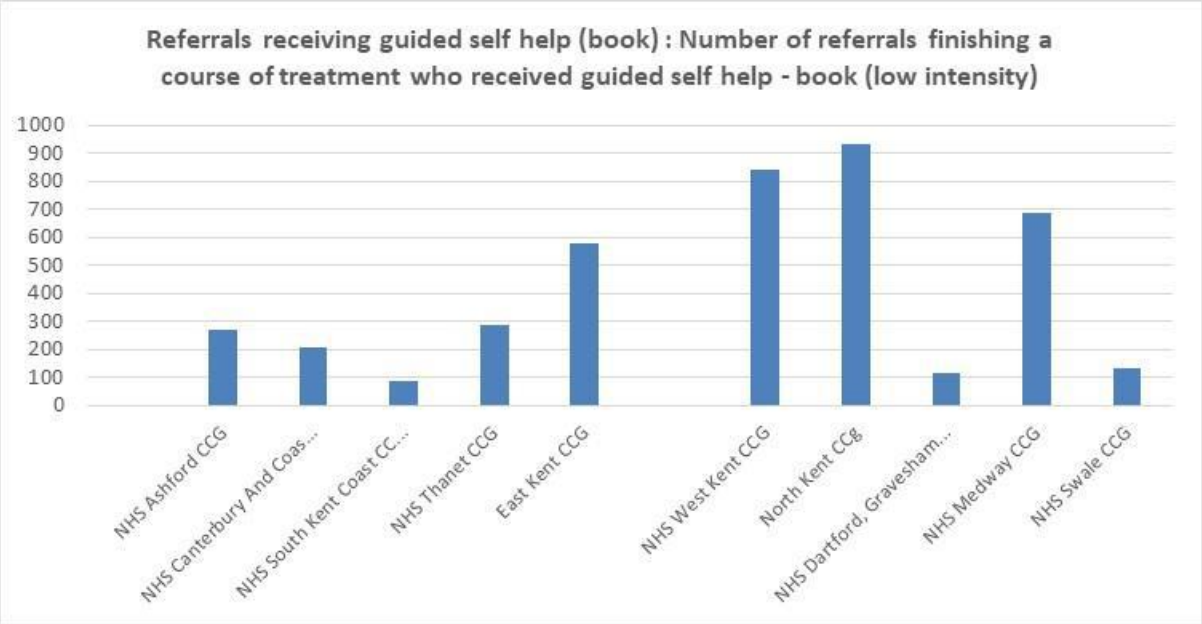
Source: 2016/17 data: IAPT Annual Report Table 4G https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2016-17-further-analyses

Figure 12.4: Therapy Type: % of IAPT patients in Kent and Medway receiving both low & high intensity therapy

Area	Value	Lower CI	Upper CI
England	39	-	-
Kent and Medway	-	-	-
NHS Ashford CCG	50*	-	-
NHS Canterbury And Coas...	15*	-	-
NHS Dartford, Gravesham...	8*	-	-
NHS Medway CCG	50*	-	-
NHS South Kent Coast CC...	7*	-	-
NHS Swale CCG	23*	-	-
NHS Thanet CCG	36*	-	-
NHS West Kent CCG	44*	-	-

Source: Table 4g: Number of referrals finishing a course of treatment in the year by stepped care pathway, 2015-16, counts & percentages, by Clinical Commissioning Groups (CCGs) The IAPT Annual Report data can be found here:http://content.digital.nhs.uk/catalogue/PUB22110

Figure 12.5: Referrals receiving CBT: number of referrals finishing a course of treatment who received CBT (high intensity therapy)



Data source: PHE Fingertips

Figure 12.6: Percentage waiting < 28 days between 1st & 2nd treatment (annual) in 2015/16

Area	Value	Lower CI	Upper CI
England	35.6	35.5	35.7
Kent and Medway	-	-	-
NHS Ashford CCG	65.8	63.7	67.8
NHS Canterbury And Coas...	76.1	74.8	77.3
NHS Dartford, Gravesham...	70.1	68.6	71.6
NHS Medway CCG	49.2	47.7	50.7
NHS South Kent Coast CC...	60.7	59.3	62.2
NHS Swale CCG	57.7	55.3	60.1
NHS Thanet CCG	79.3	77.8	80.6
NHS West Kent CCG	34.3	33.1	35.5

Source: Average waiting time (in days) from first to second treatment appointment table 2b IAPT annual report

Appendix 13: Summary

13.1 Introduction

Every suicide is a tragedy. The impact is devastating for the friends and family of the individual who died, as well as the wider community.

Suicide prevention is a public health priority both nationally and locally, with a role for a wide range of statutory and community organisations.

The current Kent and Medway Suicide Prevention Strategy runs from 2015 to 2020.[136]

The Kent and Medway STP was awarded £667,000 for additional suicide prevention programmes during 2018/19.

13.2 Key Findings

- Kent's suicide rate is higher than the national average, particularly amongst men.
- Men are at greater risk of dying by suicide than women, and middle-aged men are at the highest risk.
- Suicide rates vary across the different CCG areas within Kent and there is a socio-economic gradient to suicide with people in the most deprived communities experiencing higher rates of suicide.
- Other groups at higher risk include;
    - People in contact with secondary mental health services (particularly post discharge from inpatient settings)
    - People in contact with the criminal justice system
    - People experiencing social pressures (such as financial crisis or relationship breakdown)
    - People with co-existing substance misuse and mental health conditions
    - People with long term physical health conditions
    - Groups who experience discrimination or abuse (eg LGBT or some BME groups)
- The biggest single indicator of suicide risk is previous self-harm including previous suicide attempts
- In the year before someone dies by suicide, and in relation to their contact with the NHS;
    - Around 1/3 have contact with secondary mental health services
    - Around 1/3 have contact with primary care only
    - Around 1/3 have no contact with the NHS

[136] https://www.kent.gov.uk/__data/assets/pdf_file/0007/75058/K-M-Suicide-prevention-strategy-2015-20-Final.pdf

13.3 Recommendations

- Continue to implement the Kent and Medway 2015-2020 Suicide Prevention Strategy and Action Plan
- During 2019, develop a new Kent and Medway Suicide Prevention Strategy for 2020-2025
- Ensure that self-harm, suicidality and preventing subsequent suicide attempt are prevented by high quality local and primary care management of depression.
- Ensure that good surveillance and monitoring is in place that highlights good data sharing agreements across coroners, primary care and specialist services.
- Improve access to psychological and trauma informed services to key targeted groups.
- Ensure there is good coverage of mental wellbeing awareness and understanding of where people can seek help. Implement 'Time to Change' to challenge stigma of help seeking.
- Work across agencies and communities to tackle social isolation and loneliness.

13.4 Overview

Every suicide is a tragedy. The impact is devastating for the friends and family of the individual who died, as well as the wider community.

Suicide prevention is a public health priority both nationally and locally, with a role for a wide range of statutory and community organisations. Public Health England guidance suggests that public health teams within local authorities should take the lead bringing together local stakeholders to coordinate local action.

There is a national target to reduce suicide rates by 10% by March 2021. This target has also been adopted by the Kent and Medway STP locally.

13.5 Kent context

Kent County Council's Public Health team co-ordinates and leads the Kent and Medway Suicide Prevention Multi-Agency Steering Group which includes a variety of agencies, charities and individuals affected by suicide including:

- Medway Council
- KMPT
- Kent Police
- Network Rail
- Mind
- Samaritans
- Canterbury Christ Church University
- CCGs
- Survivors of Bereavement by Suicide.

The Steering Group developed the 2015-2020 Kent and Medway Suicide Prevention Strategy and is responsible for implementing the associated Action Plan.

The Strategy includes the following six priorities:

i. Reduce the risk of suicide in key high-risk groups
ii. Tailor approaches to improve mental health and wellbeing in Kent and Medway
iii. Reduce access to the means of suicide
iv. Provide better information and support to those bereaved or affected by suicide
v. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
vi. Support research, data collection and monitoring.

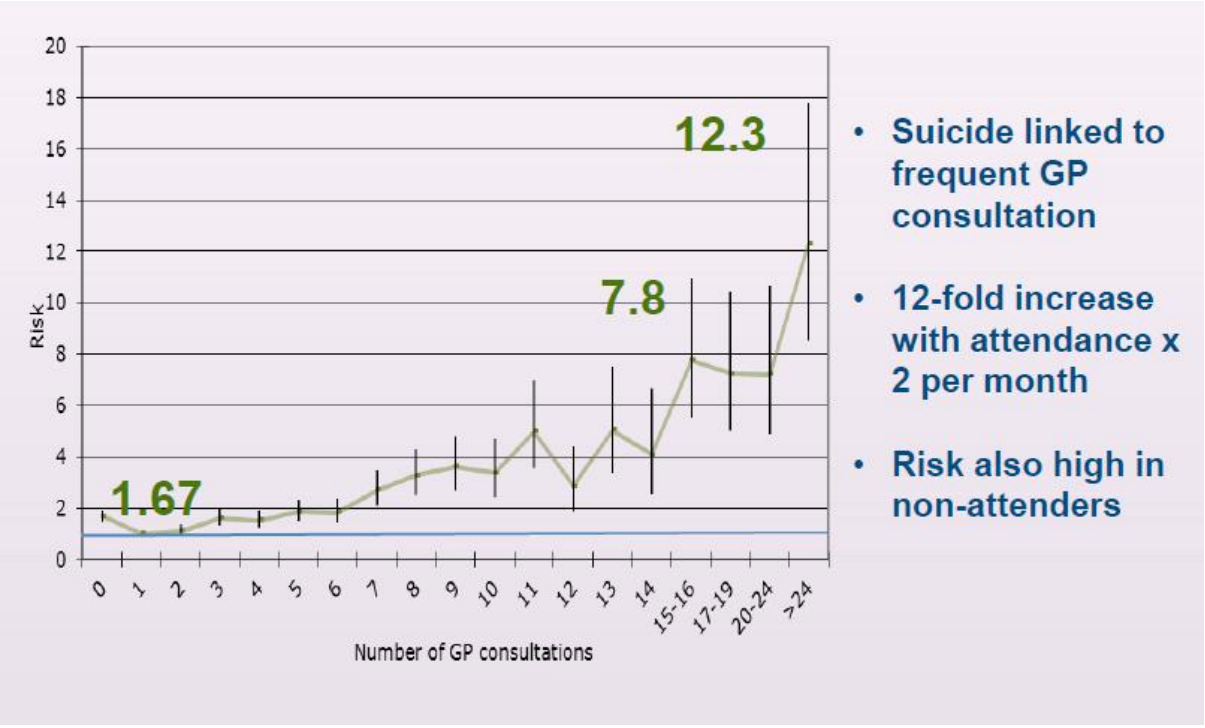
Due to Kent's high rates of suicide and self-harm compared to national average, Kent and Medway was one of 6 STP areas in England to be awarded a national grant to improve the rates.

The funded programme has the following elements:

- Extending the "Release the Pressure" social marketing campaign
- Strengthening high risk points within secondary mental health services
- Better support for those bereaved by suicide
- At least 1000 people trained in suicide awareness and prevention
- Innovation fund for grassroots projects
- Suicide Safer Universities Programme
- Workplace interventions in high risk industries
- Qualitative research
- Better identification and support for people in primary and local care settings.

Appendix 14: The National Confidential Inquiry

Figure 14.1: Suicide risk and GP attendance



Appendix 15: Costs of Mental Health Care

Figure 15.1:

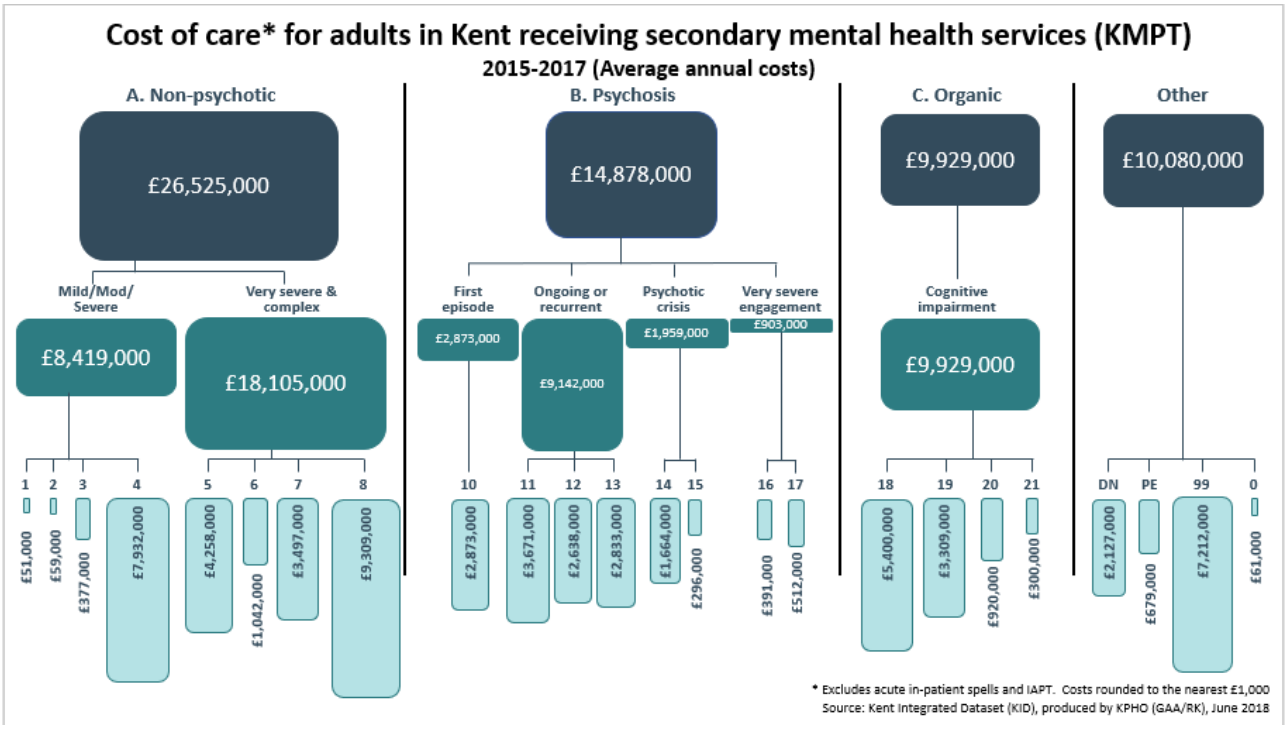


Figure 15.2:

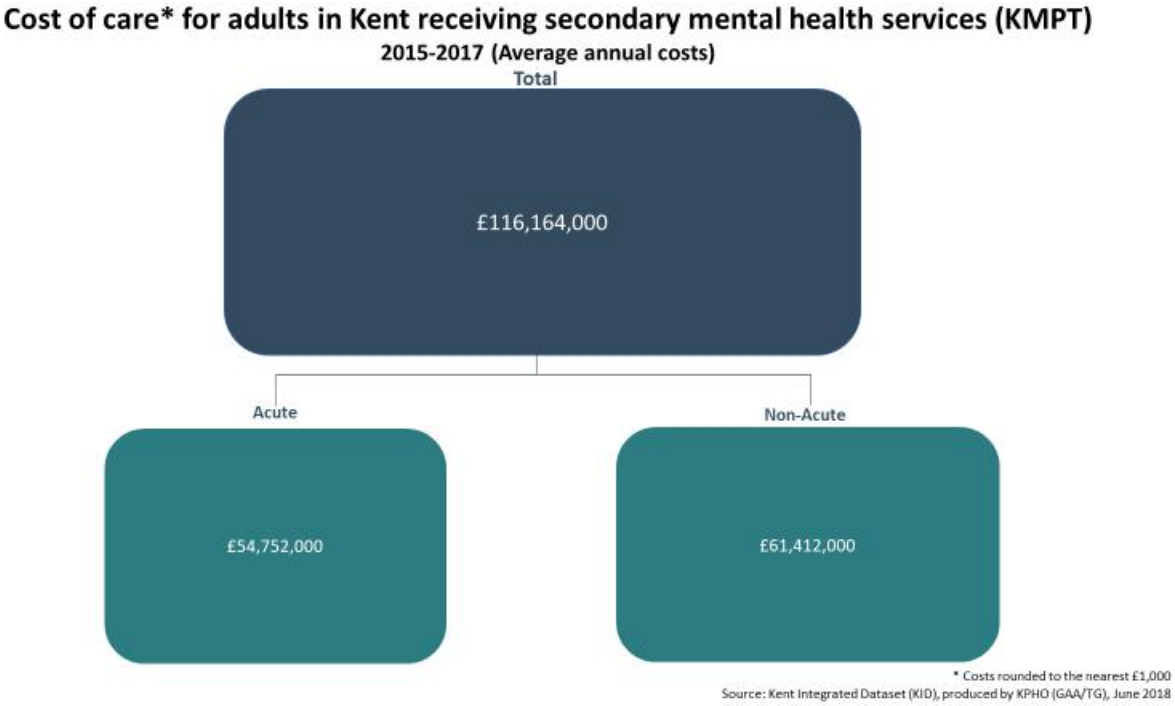
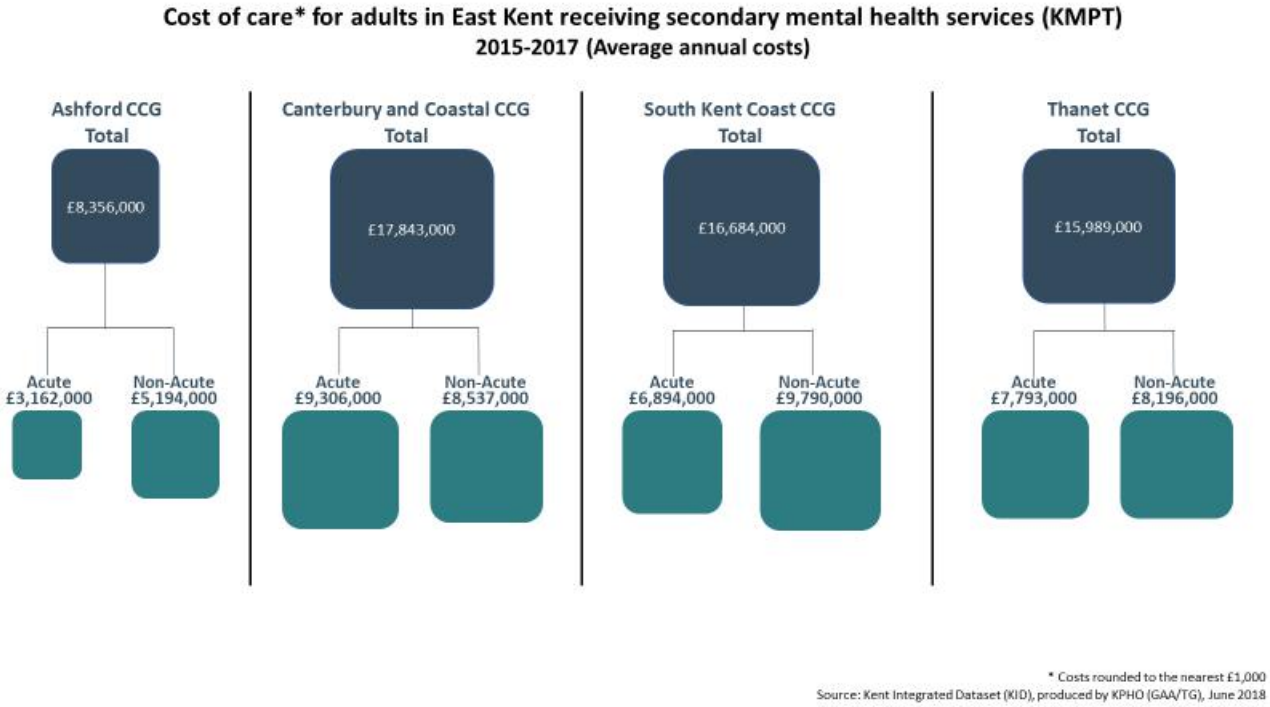
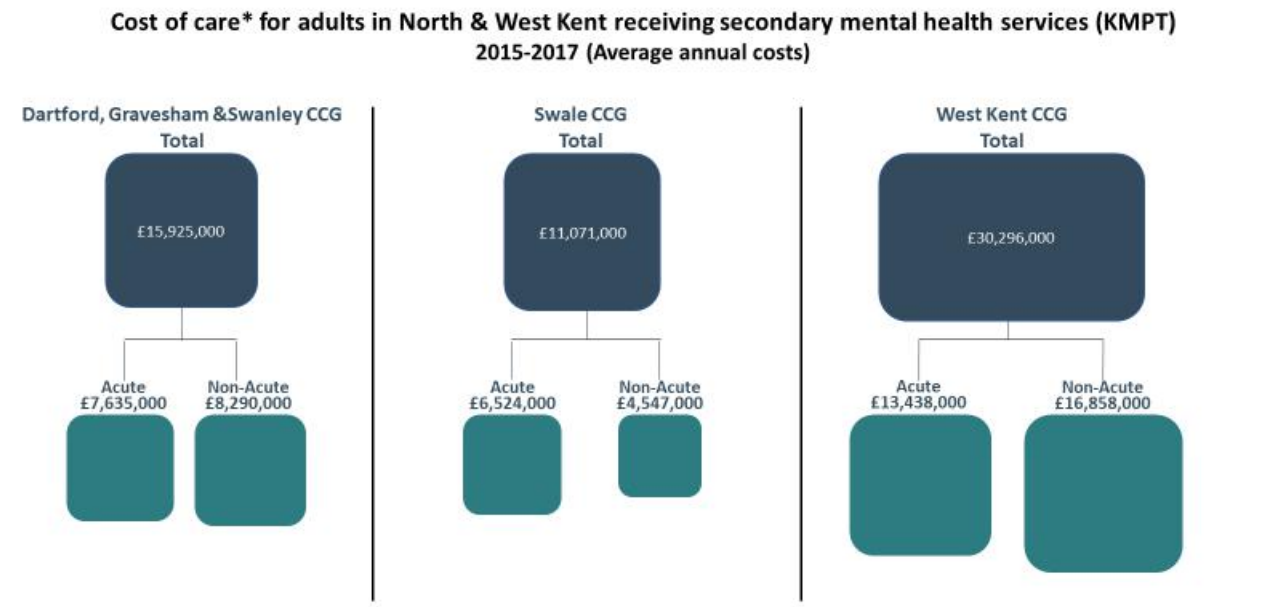


Figure 15.3:



* Costs rounded to the nearest £1,000
Source: Kent Integrated Dataset (KID), produced by KPHO (GAA/TG), June 2018

Figure 15.4:



* Costs rounded to the nearest £1,000
Source: Kent Integrated Dataset (KID), produced by KPHO (GAA/TG June 2018