Mental Health Needs Assessment for Adults in Kent:

Ashford CCG 2014

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Contents

Introduction

Mental Illness is still one of the most complex, hard to define and stigmatised aspects of the health and social care landscape. As such it provides a challenge for epidemiologists and public health specialists to map and chart the range of issues that impact on a person's mental health and wellbeing. It must also be noted that under the banner of 'mental health' there exist almost as many different conditions as the whole spectrum of 'Physical Health'. Indeed there are also areas where the diseases of the mind and body are so interrelated as to make any separation artificial and erroneous.

The severity, duration and impact of mental illness varies hugely, and so prevalence data alone for the various disorders will not provide all of the information required to estimate medical and social care needs, or the extra considerations for education, employment, acceptance, understanding and accommodation by society plus the reasonable adjustments that are required for routine services for people who suffer with mental illness. All services need to be flexible so that they can be tailored to the circumstances of individuals.

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

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

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

This needs assessment will cover the adult 'Working Age' population and will not assess needs of Children and Young People. This will be tackled in an update of the Children & Young People's Mental Health Needs Assessment in 2014. However some elements will be tackled here, such as Self Harm. This report will not assess the needs of dementia sufferers. It will touch briefly on the mental health of older people - but this is an area that demands a needs assessment of its own.

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

Changes brought in to effect from April 2013 through the health and social care act now place the responsibility for local public health with Kent County Council. The close working relationship with the NHS continues through the provision of public health support and advice to seven clinical commissioning groups covering the area, Dartford,Gravesham &Swanley CCG, West Kent CCG, Swale CCG, Ashford CCG, Canterbury and Coastal CCG, South Kent Coast CCG and Thanet CCG.

This report, *Mental Health Needs Assessment of the Population of Kent (MHNA)* has been written for all the commissioning partners of the Kent Health and Wellbeing Board in order to:

- provide a robust evidence base of the links between mental health and illness and the wider determinants of health
- provide information on current and future mental health and wellbeing needs of the people of Kent, in order to improve mental health and wellbeing;
- inform the Commissioners in Kent and others about where services and interventions need to be focused to achieve better mental health and wellbeing outcomes; and
- inform public mental health strategies for each locality and Kent as a whole.

The MHNA is a working document, developing as more information is collected and collated. This is because new data and information become available regularly and will inform an annual refreshed needs assessment. This will include epidemiological information and evidence for current and potential interventions, as it becomes available. Comments and views arising out of public discussion will be incorporated into the MHNA as they are collected. This is planned as a continuing process, to ensure that the assessment remains sensitive to the population's changing needs.

Figure 1.

Boundaries for Clinical Commissioning Groups and Local Authorities across Kent & Medway
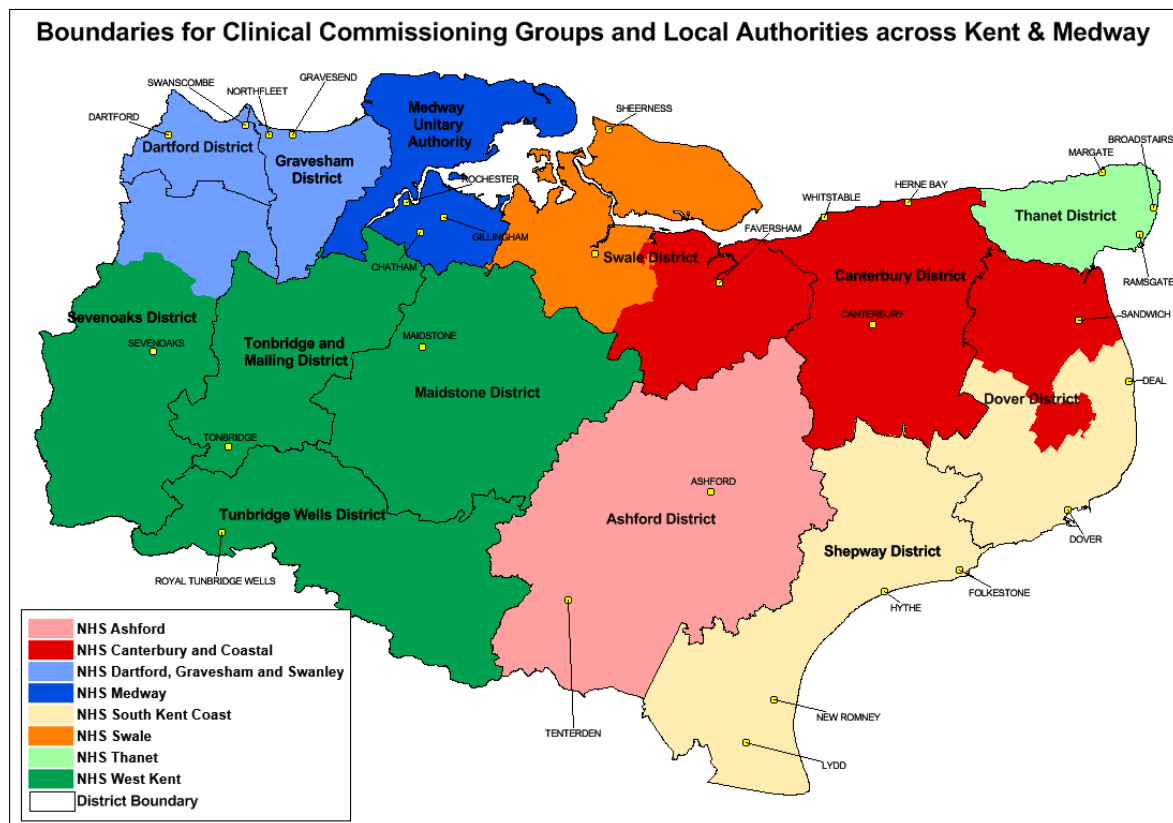
Jess Mookherjee : Consultant in Public Health, February 2014

Aim

The aims of the mental health needs assessment are:

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

Objectives

The objectives of the mental health needs assessment are:

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

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

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

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

Involvement of stakeholders: conducting a mental health needs assessment can stimulate the involvement and ownership of the various stakeholders in the process and ensure that the Kent Live it Well Strategy has active engagement from all those effected by Mental Illness. This will be a priority for 2014.

Key Findings and Recommendations for Ashford CCG

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

It should also be noted that due to the different modelling approaches used within this needs assessment to demonstrate the various needs of the mentally ill population of both Kent and the CCG overall numbers must be viewed with caution and discrepancies may exist.

A key finding from this needs assessment is that whist the rate of people living with any neurotic disorder in Ashford, (124.1 per 1000 people) may be lower than the Kent and Medway district average the projected increase in common mental disorders by 2020 in Ashford is actually the highest amongst all the Kent CCGs. The overall increase from 2013 to 2020 of common mental disorders amongst 18-64 year olds is projected to be 9.87%. This means addressing mental health need within the Ashford CCG community must be a priority.

- **As a matter of urgency improve the evaluation of whether existing services are meeting the existing mental health need within Ashford and evaluate the capacity within the current mental health service for dealing for the large expected increase in common mental health disorders.**

Chapter 1: Mental Health in Context

Mental health is not just the issue of primary care or secondary care services and social services. Mental Health is an issue for all. Stigma and hostility towards people with mental illness is still prevalent and stops people seeking help and makes those suffering more vulnerable. Mental health is associated with deprivation: across all Kent CCGs mental health needs assessments there are associations between areas of high deprivation and high mental health contact rates. Ashford has pockets of high deprivation, and these higher deprivation areas need not just an improvement in mental health services access but also work with partners to tackle the root causes of inequalities: unemployment, poverty, stigma and addictive and violent behaviour.

- **A "Mental Wellbeing Oversight Board" or similar to be set up to report to the Kent and Ashford Health and Wellbeing Boards on the progress towards the National "Closing the Gap" report and it's 25 priorities (many of which are reflected in the other recommendations of this Needs Assessment)**
- **The vulnerable population in Kent is aging. Consider reviewing 'Supporting People" and Housing Services and Policies for vulnerable people in light of the population estimates in this needs assessment and link this with 'integrated care'/Better Care funds.**
- **As this needs assessment covers only adults of working age: Urgently assess need of young adults transitioning from Child to Adult services. Adult services must respond to the differing needs of vulnerable groups: see "Friends and Family Test"**
- **Improve data, pathways and quality of mental health services for people in the criminal justice system and mental health service users who come into contact with police.**

Chapter 2: Definitions

There are as many mental health conditions as there are physical health conditions and no needs assessment for mental health can do them all justice. Many conditions are ill defined and clinicians who are not experts need the help and support of experts. It is important to review pathways periodically – particularly when new guidance emerges.

- **Review the quality of the pathways for the various mental illnesses. Plan pathway reviews against NICE guidance prioritising Dual Diagnosis, Personality Disorder, Psychosis and self-harm. The pathway reviews can form the basis of the next iteration of the Ashford CCG needs assessment.**

Chapter 3: Population

Ashford CCG has a population distribution very similar to Kent and Medway as a whole. Importantly the population of Ashford CCG is expected to increase over the next six years and particularly in the 65-84 age groups. A focus on the mental health needs of this elderly population will be needed in Ashford.

- Ashford Health and Wellbeing Board prioritise local 'asset mapping' and link the results of this to the pathways for both common and severe mental illness.
- Use the progress made with 'the Sherwood Pilot' to understand patterns of service use thereby improving access to psychological therapies and other wellbeing programmes.
- Map the local assets for wellbeing and publicise to the local population.
- Run targeted well –being campaigns using Kent 6 Ways to Wellbeing (Wheel of Wellbeing).

Chapter 4: Risk Factors and Health Inequalities

Whilst Ashford does not have as high a level of deprived areas than other Kent CCGs there are still pockets of high deprivation in the centre of the CCG. Across Kent and Ashford Coast CCG health inequalities exist. As shown by the variation in life expectancy. Health inequalities and short life expectancies are a well known outcome of psycho social stress. In the long-term – this has a corrosive impact on the body and lowers immune systems and leads to physical illness. If untreated and compounded by life events – this can lead to mental illness. Therefore in Ashford CCG people who have the greatest risk of poor outcomes should be proactively sought out by services rather than hoping that people in need will stumble upon the right 'department'. In Ashford CCG as discussed over the next few years there is projected to be a significant increase in mental health need and this will need consideration when commissioning mental health services.

- **Addressing health inequalities in the pockets of high deprivation of Ashford CCG should be a high priority for the Health and Wellbeing Board. Ashford HWBB should ensure that resources are distributed proportionately to need. HWBB's health inequalities plan should contain ways to tackle employment and skills, access to health and wellbeing services, housing and homelessness and community cohesion and support.**
- **Improve access to psychological therapies – particularly for people with a low income, relationship breakdown, offenders, ex-military and substance misuse problems. .**
- **Ensure that health and wellbeing of migrant population is addressed by using 'health trainer' and 'community health champions' to publicise the services that are on offer and monitor and evaluate uptake of commissioned services accordingly.**
- **Proactively provide information and advice on parenting and relationship counselling – targeting young families, via primary care, children's centres, churches and hospitals.**

- **Ensuring community services are non stigmatising and appropriate for all people, not just long-term users of mental health services will be important. Enabling primary care and community services (secondary prevention) to be more proactive and holistic and responsive to the way people want to access services will ensure that the right people get help.**

Chapter 5: Prevalence and Chapter 6: Service Use (Demand)

According to QOF data Ashford of all the Kent CCGs has the highest prevalence of depression (a prevalence rate of 7.5). This rate is also higher than the England average. Whilst variation in QOF prevalence rates can be susceptible to variations in reporting practices this higher rate in Ashford is worthy of deeper investigation. Among different Ashford CCG GP practices there exists variation in mental health prevalence. Due to pressure on resources it will be vital public health and social care services align to NHS services. Amongst the Kent CCGs analysis of rates and ratios between first attendances and follow up for all mental health outpatients found Ashford to have the largest ratio of first attendance to follow up attendance at outpatients: this may be due to variations in clinical behaviour though further information is needed on the patient groups attending outpatient psychiatric services such as forensic and maternal psychiatric services.

- **Ensure there is deeper analysis and investigation of Ashford CCG high prevalence of Depression.**
- **Align public health and social care services with NHS services particularly in areas of greatest deprivation.**
- **Urgently ensure that the available data is cleansed and understood more fully, both through previous national data sifting processes and local commissioning.**
- **Urgently conduct health equity audit on Community/Secondary Mental Health services.**
- **Ensure there is a local 'deep dive' into the APMS survey to ensure that National estimates are accurate. This is underway for the 2015 survey and led by Public Health in Kent**

Chapter 7: Long-term Conditions and Morbidity

People with mental health problems (particularly serious mental health) die on average 20 years earlier than people with no mental health problem. Most People with a mental health condition die of Cardio Vascular Disease. The Risk Stratification project in Kent found that 75% of those in the study with a serious mental health condition had 3 or more long-term conditions. Mental health commissioners need to work closely with the Better Care Programme to improve integrated services.

- **Train Psychiatric staff to be more vigilant and better equipped to notice patient's physical health deterioration.**
- **Train mental health staff in healthy lifestyle awareness**
- **Work Force wellbeing initiatives to be targeted in mental health trusts**
- **Follow NICE Guidance – where physical health of mental health patients is the responsibility of the GP and primary care.**
- **Older people's mental health (non-dementia) should be prioritised for assessment in 2014.**
- **Mental health to form a key work stream in the 'Better Care' Programme.**

Chapter 8: Suicide and Self-harm

In Kent the Suicide rate for men is 8.43 per 100,000 people, for women, 2.24 per 100,000 people and for combined population 5.24 per 100,000 people for 2008-10. Ashford has low rates of suicide compared to other Kent CCGs however this could be due to underreporting of suicides.

Self-harm rates in the UK are higher than Europe. Kent has higher self-harm admission rates then the England average. The highest risk group for self-harm are young women aged 17-25. Self-harm is not well understood and does not always lead to suicide. The main at risk groups are women recovering from drug and alcohol abuse and female offenders. There also appears to be a national increase in reported self-harm in secondary schools.

- **Improve data collection and links with coroners' courts for more responsive data.**
- **Improve data integration with police and paramedics to prevent escalation of risk**
- **Improve training to key front line professionals**
- **Develop bespoke training for police and GPs on mental health awareness and risk assessment/ management techniques**

- **Develop wellbeing programmes in Ashford for men**
- **Work with KIASS and other young people experts to assess what works in addressing self-harm in younger people**

Table 1

[1] **Disease or medical Condition**	**ICD 10 code**
Dementia	F00-F03
Other organic, including symptomatic, mental disorders	F04-F09
Psychoactive substance abuse	F10-F19
Schizophrenia, schizotypal & delusional disorders	F20-F29
Mood disorders	F30-F39
Neurotic, stress-related & somatoform disorders	F40-F48
Behavioural syndromes	F50-F59
Disorders of adult personality & behaviour	F60-F69
Mental retardation	F70-F79
Disorders of psychological development	F80-F89
Behavioural/emotional disorders – usual child/teen onset	F90-F98
Suicide	X60-X84
Undetermined injury (included within boarder definition of suicide)	Y10-Y34 excluding Y33.9
International Classification of Diseases: classification used in Singleton's national adult survey	**ICD 10 code**
Any neurotic disorder	F40-F48
* Mixed anxiety/depression disorder	F41.2
* Generalised anxiety disorder	F41.1
* All phobias	F40
* Obsessive compulsive disorder	F42
* Panic disorder	F41.0
Depressive episode	F32-F33
Personality disorder	F60-F69
Probable psychotic disorder	F20-F29, F30-F31

[1] The International Classification of Diseases (ICD 10) classifies some conditions in the mental and behavioural disorders section. However, suicide and undetermined injury are found within another section dealing with external causes of deaths.

What is Health Needs Assessment?

Health needs assessment is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities. It:

- is a recommended public health tool to provide evidence about a population on which to plan services and address health inequalities
- provides an opportunity to engage with specific populations and enable them to contribute to targeted service planning and resource allocation
- provides an opportunity for cross - sectorial partnership working and developing creative and effective interventions.

Potential benefits subsequent to undertaking Health needs assessment are:

- strengthened community involvement in decision making
- improved team and partnership working
- professional development of skills and experience
- improved communication with other agencies and the public
- better use of resources.

The challenges of undertaking a health needs assessment include:

- working across professional boundaries that prevent information-sharing
- developing a shared language between sectors
- accessing relevant data
- accessing the target population
- maintaining team impetus and commitment
- translating findings into effective action
- it is important to acknowledge these challenges.

Approaches to health needs assessment are:

Epidemiological: which focuses on the quantitative needs of the population in line with the available evidence base.

Comparative: which compares services available locally with those in other areas of the country.

Corporate: which is based on the views of interest groups including health organisations, health professionals, politicians, the media, users and carers.

Participatory appraisal: which seeks to incorporate the values of the wider community in setting priorities.

This report focuses on the epidemiological approach using currently available data.

Note: It should be noted that due to different modelling approaches used within this needs assessment to demonstrate the various needs of the mentally ill population of both Kent and the CCG overall numbers must be

viewed with caution. Due to the high multi morbidities and population assumptions – discrepancies may exist.

1. Mental Health in Context

National Policy

People from different groups of society have different abilities to access support and to engage in communities and this makes some people more susceptible to mental health problems. Recognising the impact of both risk and protective factors relating to the circumstances of people's lives is imperative when designing health improvement interventions.

Mental health has been high on the agenda with both the last and current governments. In February 2011 the Department of Health published the national public health strategy 'No Health without Mental Health: A cross government mental health outcomes strategy for people of all ages.' [2]This document identified six outcomes:

1. More people will have good mental health

2. More people with mental health problems will recover

3. More people with mental health problems will have good physical health

4. More people will have a good experience of care and support

5. Fewer people will suffer avoidable harm

6. Fewer people will experience stigma and discrimination

The current government have committed to ensuring the wellbeing of the whole population. Improving mental and health and wellbeing is associated with a range of better outcomes for all people. These include improved physical health and therefore life-expectancy, better educational achievement, increased skills, reduced risky health behaviours such as smoking and alcohol misuse, reduced risk of mental health problems and suicide, improved employment rates and productivity, reduced anti-social behaviour and criminality, and higher levels of social interaction and participation. Addressing these areas for the whole population will make large steps to reducing inequalities experienced in mental health and also in preventing more serious mental health conditions developing.

After focusing heavily on physical health for many years there is growing recognition of the importance and wide ranging impact of mental health. Mental ill health represents up to 23% of the total burden of ill health in the UK and is the largest single cause of disability[3].

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[2] Department of Health. *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*. 2011

[3] Who (2008) *The Global Burden of Disease: 2004 update*, available at: www.who.int/healthinfo/global_burden_disease

The Royal College of Physicians identified the importance of public mental health, particularly in the early identification and early intervention at the start of the life-course. The document "No Health without Mental Health" also discusses the uses of universal and targeted approaches to prevention and how these need to be applied to the population. It highlights the importance of dual diagnosis, (see section 4), and identifies areas where there are inequalities that need to be addressed. It also emphasises the need for providers to be involved in commissioning of services to ensure need is identified and met, the need for commissioners to consider the effects of mental health and mental illness across the life course and also the wider economic impact of promoting positive mental health and wellbeing.[4]

Economic

In secondary care, 11% of the annual health budget is spent on mental health. Nationally more than £2 billion is spent annually on social care for people with mental health problems.[5] With increases in the population, and particularly in the older age groups with increasing life expectancy, it is estimated that the cost of treating mental health problems could double over the next 20 years.[6]

The impact of mental health on peoples wider lives can affect their educational attainment, employment, housing, family relationships and therefore there are wider costs of mental health problems than just health related costs. Costs to the individuals, their families and their communities in lost potential are essentially incalculable. However detailed estimates suggest the overall calculable cost of mental health problems in England to be around £105 billion and around £30 billion of this estimate is work related.[7] This is largely due to sickness absence and reduced productivity. There are also large costs associated with the impact on the criminal justice system and also the housing system and particularly the homelessness services. One of the largest areas of cost is the benefit system. The most common reason for incapacity benefit claims is mental health, with 43% of the 2.6 million people on long-term health-related benefits have a mental or behavioural disorder as their primary condition.[8]

Life Course

Mental health problems can begin very early in life, often earlier than other causes of disability. There are also connections between mental health problems in childhood and in young adulthood, with one in ten children aged between five and 16 years

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[4] The Royal College of Psychiatrists. *No Health without Public Mental Health: the case for action.* 2010.
http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf

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

[6] 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.

[7] Centre for Mental Health (2010) *The Economic and Social Costs of Mental Health Problems in 2009/10*, available at: www.centreformentalhealth.org.uk/pdfs/Economic_and_social_ costs_2010.pdf

[8] Department for Work and Pensions (2010) statistical summaries, available at: http://campaigns.dwp.gov.uk/asd/index.php?page=statistical_summaries

having a mental health problem.[9] Over half of people with a lifetime mental health disorder at the age of 26 will have met the diagnostic criteria first by the age of 14.[10] Mental wellbeing during pregnancy and the antenatal period can have an impact on the wellbeing of the child, so is an important time within the life course. One in ten new mothers experience postnatal depression.[11] During adulthood mental health can impact upon people's ability to maintain employment, housing and secure family relationships. Depression in older people affects up to 25% of the population and up to 40% of those living in care homes.[12]

In 2008, The Government Office for Science produced a report based on the project Mental Capital and Wellbeing: Making the most of ourselves in the 21st Century. The report looks at how our population is changing and how this will impact on our wellbeing and mental health. The report includes a comprehensive diagram of a synthetic view of the mental capital trajectory and factors that may act upon it. This diagram is shown in figure 2[13]. It is clear that mental health is an issue throughout the life course and in many different areas of people's lives.

Figure 2

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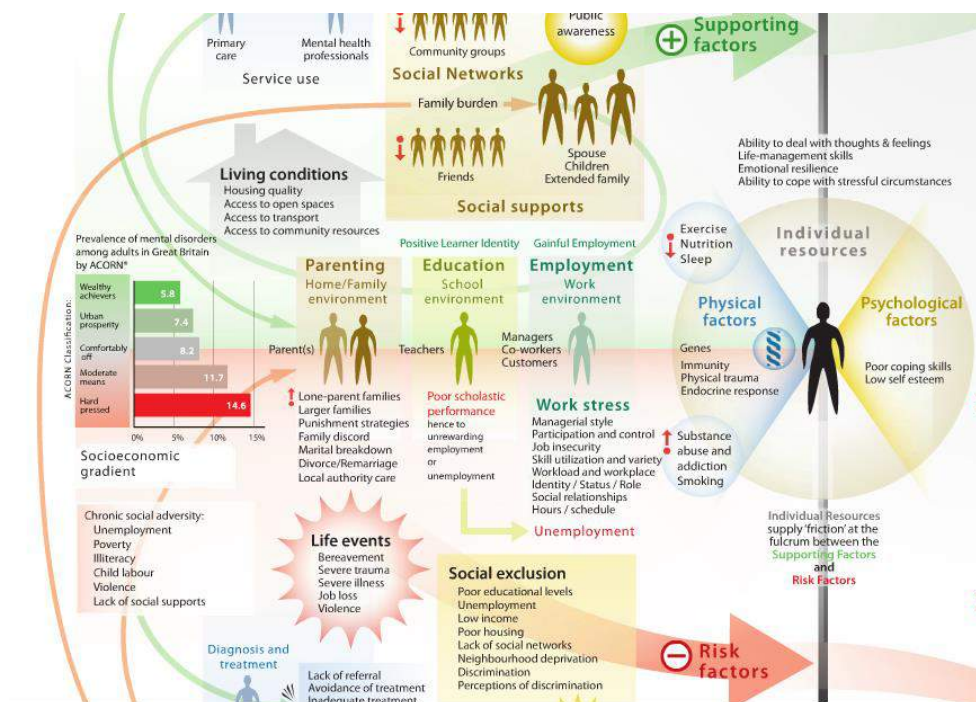
[9] Green h, McGinnity A, Meltzer h et al. (2005) *Mental Health of Children and Young People in Great Britain, 2004.* Basingstoke: Palgrave Macmillan

[10] Kim-Cohen J, Caspi A, Moffitt T , Harrington H, Milne B, Poulton R. *Prior juvenile diagnoses in adults with mental disorder*. Archives of General Psychiatry 2003; 60: 709–717.

[11] Gavin n, Gaynes B, lohr k et al. (2005) *Perinatal depression: a systematic review of prevalence and incidence. Obstetrics and Gynaecology* 106: 1071–1083

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

[13] The Government Office for Science, London (2008) Foresight Mental Capital and Wellbeing Project Final Project report – Executive summary.

Local Policy

Mental health promotion and mental health are priorities for a range of organisations locally. The Kent Live it Well Strategy is supported by all partners. However there have been many changes in commissioning since the Live it Well Strategy was produced and it is hoped this report will help the strategy reflect these changes. All the Health and Wellbeing Boards in Kent recognise the importance of mental health and its impact on quality of life throughout the life course. Consequently the Joint Health and Wellbeing Strategies include mental health, in terms of promoting mental wellbeing and support to people with specific mental health needs, as a priority. Therefore this needs assessment will contribute to the production of local mental health strategies and inform the priorities set out within Clinical Commissioning Group and Local Authority commissioning plans and integrated health and social care plans.

Methodology

Since no single source of information will provide a true picture, this mental needs assessment has identified three distinct areas which, we believe, taken together provide a good body of evidence.

- Analysis of risk factors
- Expected prevalence of mental health conditions
- Service Utilisation vs expected need
- Mortality indicators

2. Mental Health: Some Definitions

Good mental health is a desired and universal quality for everyone, including those with a diagnosed mental health condition. Equally every single one of us, will experienced periods of poor mental health at some time in our lives. In addition mental and physical health are closely linked in terms of cause and effect. Mental health both determines (causes) physical health status and is an outcome (the result) of physical health status.

The term '**flourishing**' has recently been used to describe, positive mental health.

The term '**resilience**' is used to describe the positive protective factors which act as a 'buffer' against poor mental health. This could be thought of as a kind of mental health immune system.

Risk factors are things which pose a threat to positive mental health. An increasing body of evidence tells us what these risk factors are, covering social and environmental factors.

Actions to prevent mental illness and improve the mental health of the whole population requires **a lifelong / life course approach**, enhanced by particular protection for those in high-risk groups and a focus on improving the services and outcomes for those in receipt of treatment.

The key life-stages and actions cover:

Table 2

Laying the foundations	building mental wellbeing and resilience in infancy and childhood (including supporting parents)
Transition from adolescence to adulthood	including the needs of vulnerable groups such as looked-after children, young carers, people with learning disabilities, those with neurodevelopmental disorders and young parents
Better mental health and wellbeing in adulthood	including the importance of employment, housing and access to green spaces in preventing mental illness and risks posed by climate change, alcohol misuse, violence (including sexual and domestic violence and abuse) and discrimination
Support for high risk groups	including people experiencing discrimination and exclusion, those who are socially isolated, experiencing violence or at risk of harm, carers, homeless people, offenders, people with long-term physical illness, armed forces.

Stigma and Discrimination

There are generally believed to be 3 stereotyped beliefs related to mental health needs;

- people with mental health problems cannot make their own decisions
- people with mental problems are dangerous
- people with mental health problems need to be looked after

Each of the above belief sets are damaging to people with mental health problems and remove opportunities for recovery [14] and self-control. The associated stigma can also prevent people approaching services for help. Communities themselves will have different views and beliefs about mental health problems, which will impact on how this is talked about, acknowledged, or hidden.

Experiencing racism has been shown to triple the likelihood of developing depression and psychosis. Experiencing racism from an employer increases the risk of depression by 60%.[15]

Facing discrimination is damaging to self-belief and can prevent people from taking opportunities. Research suggests that correlations between perceived discrimination and mental health problems are as strong as those connected with social status.[16]

One of the objectives of the Government's mental health strategy[17] is that fewer people with experience stigma and discrimination. There is a high-profile national campaign currently, *Time to change*, which aims to end the stigma and discrimination faced by people who experience mental

health problems[18] and has already demonstrated impact on public attitudes with a 15% reduction in reported levels of discrimination.

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[14] National Programme for Improving Mental Health and Wellbeing in Scotland www.wellscotland.info

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

[16] R. C. Kessler, K. D. Mickelson, D. R. Williams. The prevalence, distribution and mental health correlates of perceived discrimination in the united states. Journal of Health and Social Behaviour. 40:208-230.1999

[17] See HM Government, above.

[18] Time to talk, time to change (2011) Annual report http://www.time-to-change.org.uk/sites/default/files/Time%20to%20Change%20Annual%20Report%202010-11.pdf

Table 3

Category	Condition	Link to NICE Guidance
Common Mental Illness	depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and social anxiety disorder	**http://www.nice.org.uk/nicemedia/live/13476/54520/54520.pdf**
Severe Mental Disorder	schizophrenia (psychosis) bi-polar disorder Personality Disorder Serious Eating Disorder	**http://publications.nice.org.uk/schizophrenia-cg82** **http://www.nice.org.uk/cg38** **http://www.personalitydisorder.org.uk/about/pd-resources/nice-guidelines/**

Common MH	Name	Definition & Symptoms	Epidemiology	Treatment
Anxiety	**Generalised Anxiety Disorder**	GAD is a long-term condition which causes you to feel anxious about a wide range of situations and issues, rather than one specific event. People with GAD feel anxious most days and often struggle to remember the last time they felt relaxed. GAD can cause both psychological (mental) and physical symptoms. These vary from person to person, but can include feeling irritable or worried and having	GAD affects about 1 in 20 adults in Britain. Slightly more women are affected than men, and the condition is most common in people in their 20s.	GAD can significantly affect your daily life, making it difficult to carry out everyday tasks. However, several different treatments are available to ease your psychological and physical symptoms. These include psychological therapy and medication.

		trouble concentrating or sleeping		
	Panic Disorder	**Panic disorder is where you have recurring and regular panic attacks, often for no obvious reason.** Everyone experiences feelings of anxiety and panic at certain times during their lifetime. It is a perfectly natural response, particularly when you are in a dangerous or stressful situation. However, for people with panic disorder, feelings of anxiety, stress and panic occur regularly and at any time.	**At least one person in 10 experiences occasional panic attacks, which are usually triggered by a stressful event.** **In the UK, approximately one person in 100 has panic disorder. Most people first develop the disorder when they are in their twenties. The condition is approximately twice as common in women as it is in men.**	The main aim of treatment for panic disorder is to reduce the number of panic attacks that you have and to help ease the severity of your symptoms. The two main types of treatment for panic disorder are psychological therapy and medication
	Post Traumatic Stress Disorder	**Post-traumatic stress disorder (PTSD) is an anxiety disorder caused by very stressful, frightening or distressing events** PTSD can develop immediately after someone experiences a disturbing event or it can occur weeks, months or even years later Someone with PTSD will often relive the traumatic event through nightmares and flashbacks, and may experience feelings of isolation, irritability and guilt. They may also have problems sleeping, such as insomnia, and find concentrating difficult.	PTSD is estimated to affect about 1 in every 3 people who have a traumatic experience, but it's not clear exactly why some people develop the condition and others don't.	These symptoms are often severe and persistent enough to have a significant impact on the person's day-to-day life **watchful waiting -** waiting to see whether the symptoms improve without treatment **psychological treatment -** such as trauma-focused cognitive behavioural therapy (CBT) or eye movement desensitisation and reprocessing (EMDR) **antidepressant medication -** such as paroxetine or mirtazapine

| Depression | Clinical Depression | **Feeling sad persistently for months.**

Persistent feelings of sadness, hopelessness and losing interest in activities and feeling tearful. Often accompanied by symptoms of anxiety.

There can be physical symptoms too, such as feeling constantly tired, sleeping badly, having no appetite or sex drive, and complaining of various aches and pains. There are social symptoms such as neglecting home life and hobbies and poor performance at work.

There are differing intensities – ranging from mild- to moderate to severe.

Unlike Bereavement (which shares many symptoms) – there is no looking forward to the future. | NICE Guidance states worldwide that 4-10% of the population are likely to suffer Major Depression, and 2.5% to 5% for Mild depression.

In UK point prevalence estimate was 2.6% but when linked with Anxiety rose to 11.6%. The rates for women are double that of men. | **There are far more people with depression then seek treatment for it.**
Often people are misdiagnosed or the depression is not picked up (NICE)

Treatments include
- **Antidepressants**
- **Cognitive behaviour therapy**
- **Counselling**
- **ECT**
- **Psychology**
- **Complementary therapies**
- **Lifestyle interventions** |

| Severe | Schizophrenia | Schizophrenia is a long-term mental health condition that causes a range of different psychological symptoms, including:

•hallucinations - hearing or seeing things that do not exist
•delusions - unusual beliefs not based on reality which often contradict the evidence
•muddled thoughts based on the hallucinations or delusions
•changes in behaviour
Doctors often describe schizophrenia as a psychotic illness. This means sometimes a person may not be able to distinguish their own thoughts and ideas from reality. | Schizophrenia is one of the most common serious mental health conditions. About 1 in 100 people will experience schizophrenia in their lifetime, with many continuing to lead normal lives.

Schizophrenia is most often diagnosed between the ages of 15 and 35. Men and women are equally affected. | Schizophrenia is usually treated with a combination of medication and therapy appropriate to each individual. In most cases, this will be antipsychotic medicines and cognitive behavioural therapy (CBT).

People with schizophrenia will usually receive help from a community mental health team (CMHT), which will offer day-to-day support and treatment.

Many people recover from schizophrenia, although they may have periods when symptoms return (relapses). Support and treatment can help reduce the impact of the condition on your life. |
| | Bipolar disorder | Known in the past as manic depression, this is a condition that affects your moods, which can swing from one extreme to another and it is characterised by will have periods or "episodes" of:

•depression - where you feel very low and lethargic
•mania - where you feel very high and overactive (less severe mania is known as hypomania)
The symptoms of bipolar disorder depend on which mood you are experiencing. Unlike simple mood swings, each extreme episode of bipolar disorder can last for several | Patients may initially be diagnosed with clinical depression before having a manic episode later (sometimes years later), after which you may be diagnosed with bipolar disorder.

During a manic phase of bipolar disorder patients may feel very happy and have lots of ambitious plans and ideas e.g spend large amounts of money on things that you cannot afford and would not normally want, Not feeling like eating or sleeping, talking quickly and becoming annoyed easily are a common characteristics of the manic phase of bipolar disorder. During | Treatment can include:

•medication to prevent episodes of mania, hypomania (less severe mania) and depression - these are known as mood stabilisers and are taken every day, on a long-term basis
•medication to treat the main symptoms of depression and mania when they occur
•learning to recognise the triggers and signs of an episode of depression or mania
•psychological treatment - such as talking therapy to help deal with depression and to give you advice about how to improve your relationships |

		weeks or longer, and some people may not experience a "normal" mood very often.	the manic phase, people often feel very creative, viewing mania as a positive experience. However, during the manic phase of bipolar disorder, symptoms of psychosis may be present.	•lifestyle advice - such as doing regular exercise, planning activities that you enjoy and that give you a sense of achievement, and advice on improving your diet and getting more sleep
	Personality Disorder	Personality disorders are conditions in which an individual differs significantly from an average person, in terms of how they think, perceive, feel or relate to others. Changes in how a person feels and distorted beliefs about other people can lead to odd behaviour, which can be distressing and may upset others. There are broadly three categories of personality disorder: **Cluster A**: difficulty relating to others/ distrustful and suspicious **Cluster B**: Difficulty regulating feelings/ unpredictable and disturbing **Cluster C** : overwhelming emotions/ withdrawn and isolated	In England, it is estimated around one in every 20 people has a personality disorder. However, many people have only mild conditions so only need help at times of stress (such as bereavement). Other people with more severe problems may need specialist help for longer periods. The main symptoms are: •being overwhelmed by negative feelings such as distress, anxiety, worthlessness or anger •avoiding other people and feeling empty and emotionally disconnected •difficulty managing negative feelings without self-harming (for example, abusing drugs and alcohol, or taking overdoses) or, in rare cases, threatening other people •odd behaviour •difficulty maintaining stable and close relationships, especially with partners, children and professional carers •sometimes, periods of losing contact with reality Symptoms typically get worse with stress.	This depends on the severity of the disorder and whether there are ongoing problems. Some mild to moderate personality disorders improve with psychotherapy. Different types of psychological therapies have been shown to help people with personality disorders. However, there is no single approach that suits everyone and treatment should be tailored to the individual. Not all talking therapies are effective and it is essential they are delivered by a trained therapist.

			People with personality disorders often have other mental health problems, especially depression and substance misuse.	
	Severe Eating Disorder	Eating disorders are characterised by an abnormal attitude towards food that causes someone to change their eating habits and behaviour. A person with an eating disorder may focus excessively on their weight and shape, leading them to make unhealthy choices about food with damaging results to their health	Around 1 in 250 women and 1 in 2,000 men will experience anorexia nervosa at some point. The condition usually develops around the age of 16 or 17. Bulimia is around five times more common than anorexia nervosa and 90% of people with bulimia are female. It usually develops around the age of 18 or 19. Eating disorders include a range of conditions that can affect someone physically, psychologically and socially. The most common eating disorders are: •anorexia nervosa - when someone tries to keep their weight as low as possible, for example by starving themselves or exercising excessively •bulimia - when someone tries to control their weight by binge eating and then deliberately being sick or using laxatives (medication to help empty their bowels) •binge eating - when someone feels compelled to overeat Some people, particularly young people, may be diagnosed with an eating disorder not otherwise specified (EDNOS). This is means you have	Treatment usually involves monitoring a person's physical health while helping them to deal with the underlying psychological causes. This may involve: •using self-help manuals and books, possibly under guidance from a therapist or other healthcare professional •cognitive behavioural therapy (CBT) - therapy that focuses on changing how someone thinks about a situation, which in turn will affect how they act •interpersonal psychotherapy - a talking therapy that focuses on relationship-based issues •dietary counselling - a talking therapy to help people maintain a healthy diet •psychodynamic therapy - counselling that focuses on how a person's personality and life experiences influence their current thoughts, feelings, relationships and behaviour •family therapy - therapy involving the family discussing how the eating disorder has affected them and their relationships •medication - for example, a type of antidepressant called selective serotonin reuptake inhibitors (SSRIs)

| | | | some, but not all, of the typical signs of eating disorders such as anorexia or bulimia. | may be used to treat bulimia nervosa or binge eating |

Source: NHS Choices (accessed January 2014)

Scale of Mental Health Problems for Adults in Ashford CCG

Adults in Ashford

The most recent population estimates of mental disorders among adults aged 16 - 74 (based on the report of the Adult Psychiatric Morbidity Survey in England, 2007) are:

In the past week

- Common mental disorders: 16.1% of people aged 18-64 years: 11,940 people.
- Post-traumatic stress disorder, 2895 people, aged 18-64 and this number is expected to increase to 3,000 by 2020.

Over the previous year

- Two or more psychiatric disorders: 7.2% of people aged 18-64 years: 5327 people.
- Psychotic disorder: 297 people in Ashford CCG: 0.4%.
- Post-traumatic stress disorder, 2895 people, aged 18-64 and this number is expected to increase to 3000 by 2020.
- Anti-social personality disorder: 256 people ages 18-64 years in Ashford CCG.
- In Ashford CCG: estimated to be 310 adults with psychosis and this has been projected to increase to 325 by 2020.
- In Ashford CCG: estimated to be 35,062 people over 65 years living with depression and 8,136 people aged over 65years with severe depression.
- In Ashford CCG has been estimated that 148 women have postnatal depression and this number if projected to rise to 155 by 2020.
- In Ashford CCG estimated that there are 334 adults with borderline personality disorder.

Suicide

- In Kent the suicide rates are slightly lower compared to England however suicide is responsible for 1% of all deaths in Kent and is the highest cause of death in people aged 25-44 years.
- In Ashford in 2012, 5 people died through committing suicide.

3. Population of Ashford CCG

3.1 Population size: age and sex

Ashford CCG has a slightly higher proportion of adults, both male and female in the 40-49 age brackets compared to Kent and Medway as a whole however as a population it is broadly similar to Kent and Medway in terms of age distribution (figure 3). The population of Ashford CCG is expected to increase over the next 6 years and significantly in the 65-84 years age group.

Figure 3

Registered population for Ashford Clinical Commissioning Group 2013

Source: Kent Primary Care Agency
Produced by: Kent & Medway Public Health Observatory
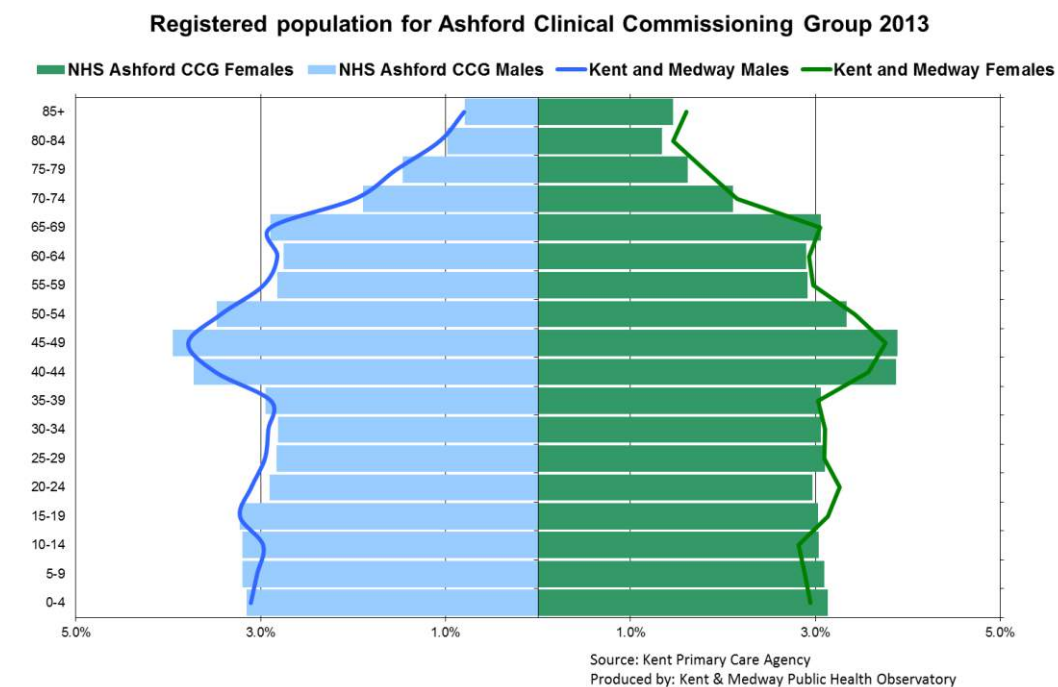
Figure 4 Projected population increase for Ashford CCG

Population projections to 2021 for Ashford Clinical Commissioning Group

	2013	2015	2017	2019	2021
0-4	8211	8704	8963	8942	8897
5-19	23047	23342	23791	24567	25487
65-84	19225	20348	21145	21937	22758
85+	2980	3234	3590	3854	4186

Source: Office for National Statistics
Prepared by: Kent Public Health Observatory
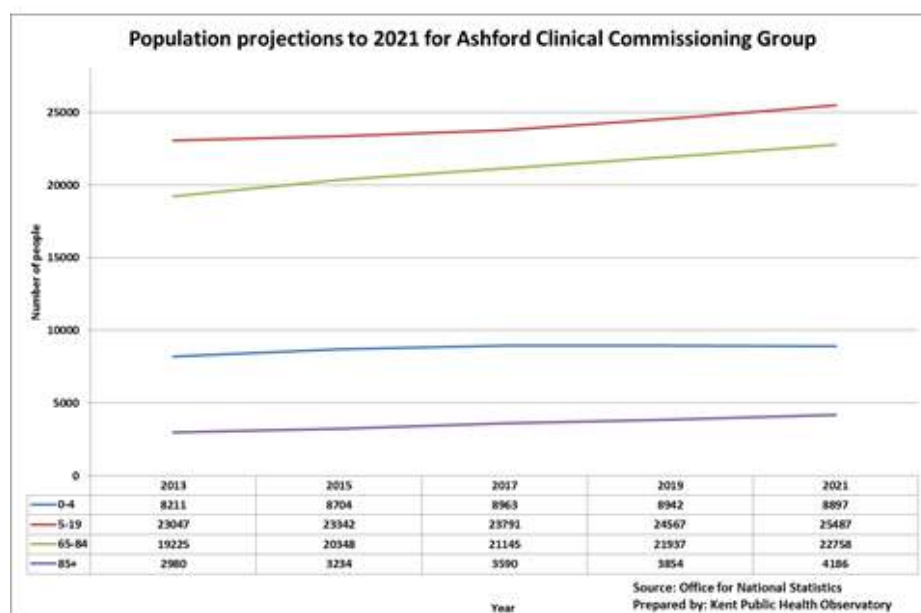
In Kent there are a number of population groups that are transitory and mobile, which will make them vulnerable to mental health problems due to lack of awareness. Many of these vulnerable groups will have their own separate needs assessments – however their mental health needs will be summarised in this report (see Vulnerable Groups).

- Immigrant populations
- Military and ex-military
- Gypsies and travelers
- Children leaving care (see separate report)
- Offenders in the community
- Homeless people.

3.2 Life expectancy

In Kent, males born between 2010 and 2012 have a life expectancy of 79.9 years and females have a life expectancy of 83.4years. Although both of these are higher than the England figure they rank lowest out of all the counties within the South East region. Thanet, Gravesham and Shepway have the lowest life expectancy in Kent.

The higher death rate associated with mental illness has been extensively documented. Of the few studies of life expectancy in people with mental illness, some have reported a gap of 14 years for males and six for females while others a gap of 20 years for males and 15 for females. Little is known on whether life expectancy between people with mental illness and the general population has

changed over time. However a recent report from the BMJ[19] reviews evidence that the Gap in life expectancy between people with mental health problems and those without mental health problems has increased since 1985. (see Health of People with Mental Health Problems)

3.3 Ethnicity

The 2011 Census shows us that the White ethnic group is the largest group both within Kent and nationally. Just under 1.4 million Kent's residents are from the white ethnic group which accounts 93.7% of the total population. This is a higher proportion than the national figure of 85.4% and the South East figure of 90.7%.

Figures from ONS Census 2011 show that the population of Ashford is predominantly white and 6.3% of the population is from a BME group.

No health without mental health noted that the evidence on the incidence of mental health problems in black and minority ethnic groups (BME groups) is complex. This is due to the fact that the term BME covers many different groups with very different cultural backgrounds, socio-economic status and experiences in wider society (see Vulnerable Groups).

Table 4 2011 Census: White and BME population in Kent districts, the South East and England

	All people	N white	% white	N BME	% BME
England	53012456	45281142	*85.4%*	7731314	*14.6%*
South East	8634750	7827820	*90.7%*	806930	*9.3%*
Kent	1463740	1371102	*93.7%*	92638	*6.3%*
Ashford	117956	110520	*93.7%*	7436	*6.3%*
Canterbury	151145	140620	*93.0%*	10525	*7.0%*
Dartford	97365	85070	*87.4%*	12295	*12.6%*
Dover	**111674**	**107966**	***96.7%***	**3708**	***3.3%***
Gravesham	101720	84226	*82.8%*	17494	*17.2%*
Maidstone	155143	145996	*94.1%*	9147	*5.9%*
Sevenoaks	114893	110029	*95.8%*	4864	*4.2%*
Shepway	**107969**	**102215**	***94.7%***	**5754**	***5.3%***
Swale	135835	131155	*96.6%*	4680	*3.4%*
Thanet	134186	128194	*95.5%*	5992	*4.5%*
Tonbridge & Malling	120805	115872	*95.9%*	4933	*4.1%*
Tunbridge Wells	115049	109239	*94.9%*	5810	*5.1%*
Kent & Medway	1727665	1607681	*93.1%*	119984	*6.9%*

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[19] http://www.bmj.com/press-releases/2013/05/21/life-expectancy-gap-widens-between-those-mental-illness-and-general-population (accessed December2013)

3.4 Deprivation

The estimates of households in poverty are based on data from the Family Resources Survey (FRS). The FRS is an annual survey of about 24,000 households in the United Kingdom. The ONS' aim was to publish data on households in poverty at the small area level.

In 2007/08 19.7% of households in Kent were estimated to be in poverty, after housing costs. For the KCC area alone the proportion was 19.5%. The average proportion of households in poverty for the KCC area places the county 102nd out of 152 county and unitary authorities. This is within the lowest third of authorities (1 being the most poor).

13% of Kent MSOAs are within England's highest 20% with regards to the proportion of households in poverty. In contrast, 18% of Kent MSOAs are within England's lowest 20% illustrating the extremes within the county. The lowest proportion of households in a single MSOA that are in poverty was 8.6% (in Sevenoaks). The highest proportion was 37.0% (in Thanet).

There is also a great degree of variation in poverty within each Kent district. Seven of the 12 Kent districts have MSOAs which are in both the national highest and lowest 20% of households in poverty, illustrating that areas with relatively high poverty levels are located close to areas with relatively low levels. This is particularly apparent in Shepway, where 23% of the district's MSOAs are within England's highest 20% in poverty, and yet 15% are within England's lowest 20% in poverty. The highest levels of deprivation are seen by communities living within the district of Thanet, Swale, Medway and Dartford and Gravesham (figure 5). There are areas of high deprivation within Ashford CCG (figure 6).

Figure 5

Index of Multiple Deprivation 2010
Map showing Kent & Medway local deprivation quintiles
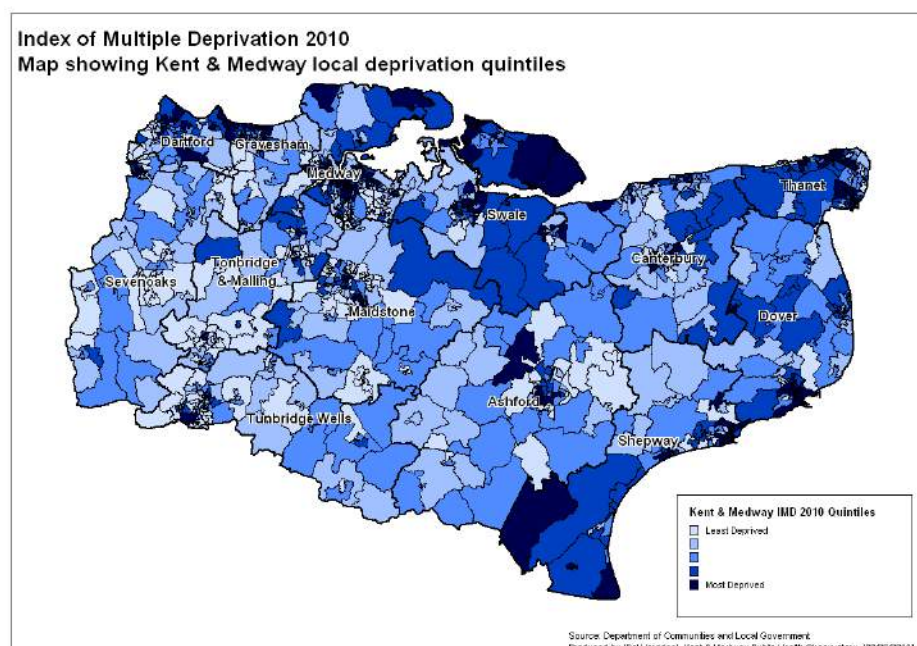
Figure 6
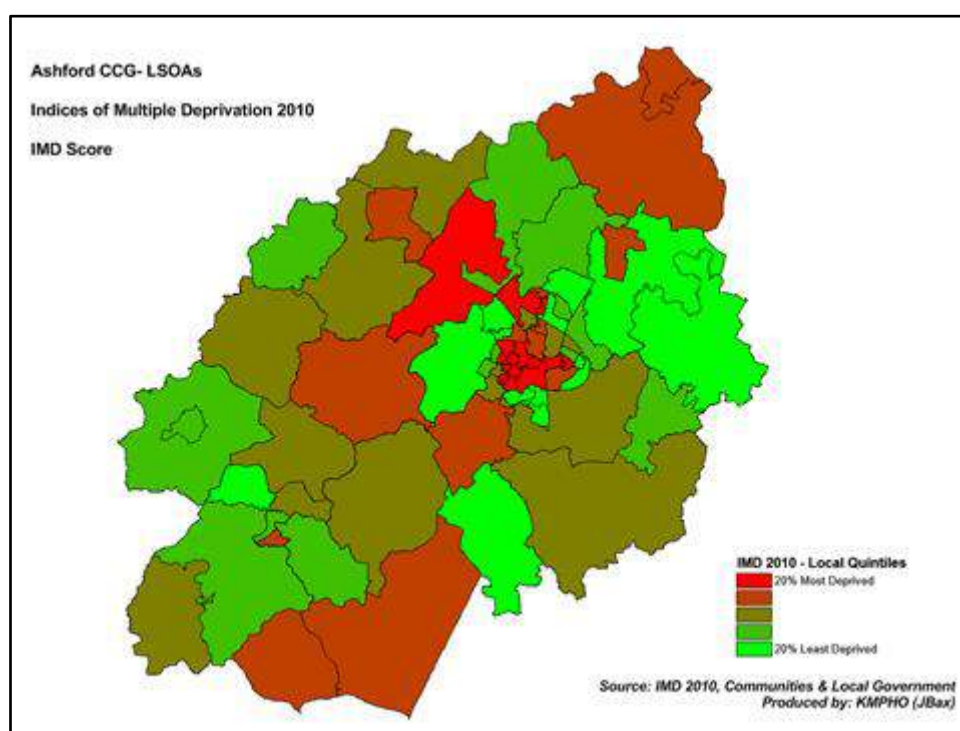
Major risk factors for mental health problems are poverty, poor education, unemployment, social isolation and major life events. Socially excluded and deprived people are at a higher risk of developing mental health problems. A review of large scale studies of mental health problems undertaken by Social Exclusion Unit of the Cabinet Office in 2004[20], reported that such problems are more common among people who are unemployed, have fewer educational qualifications, have been looked after or accommodated, are on a low income or have a low standard of living.

The main reasons for the link between deprivation and mental health risk are[21]:

- Increased risk of major traumatic life events and stressors
- Poorer coping strategies leading to poorer resilience
- Feelings of shame and inferiority and exclusion resulting from social comparison.

_____

[20] Mental Health and Social Exclusion (Cabinet Office2004)
[21] Spirit Level : Why Equality is Better for Everyone (2009: Wilkinson and Pickett)

Kent and Wellbeing

Figure 7

Wellbeing Index Components 2011-2012

Source: ONS Subjective Well-being APS Mar 2011-Apr 2012. © Crown copyright and database right 2011
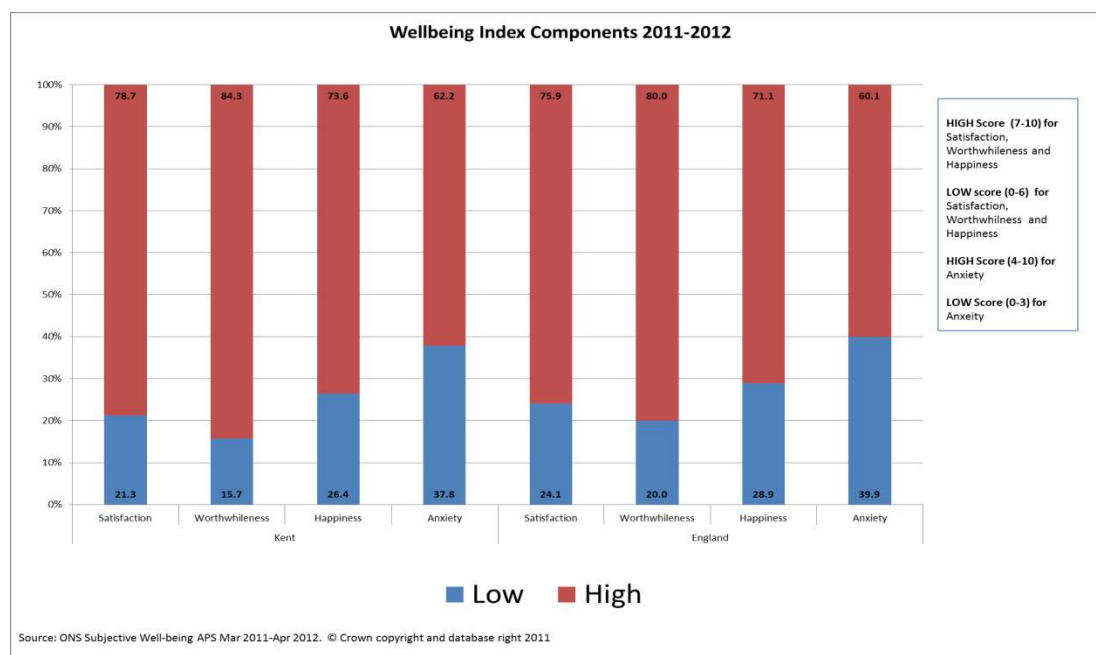
The Office of National Statistics is now measuring population level wellbeing. Unfortunately this is currently only available at County level. Kent scores high on most of the measures compared to England. However Kent did have slightly more people scoring high on anxiety then might be expected given the population demographics of the County. However the County is large and it will be interesting to see what the local scores of wellbeing are. Kent Public Health are embarking on a series of programmes to improve population level wellbeing and starting by mapping local assets, this will compliment work on mental health needs – in this assessment.

Please see the Annual Public Health Report 2013 for more information on this approach.

Annual Public Health Report for Kent 2013:
www.kmpho.org.uk/anualpublichealthreport

4. Risk Factors and Health Inequalities
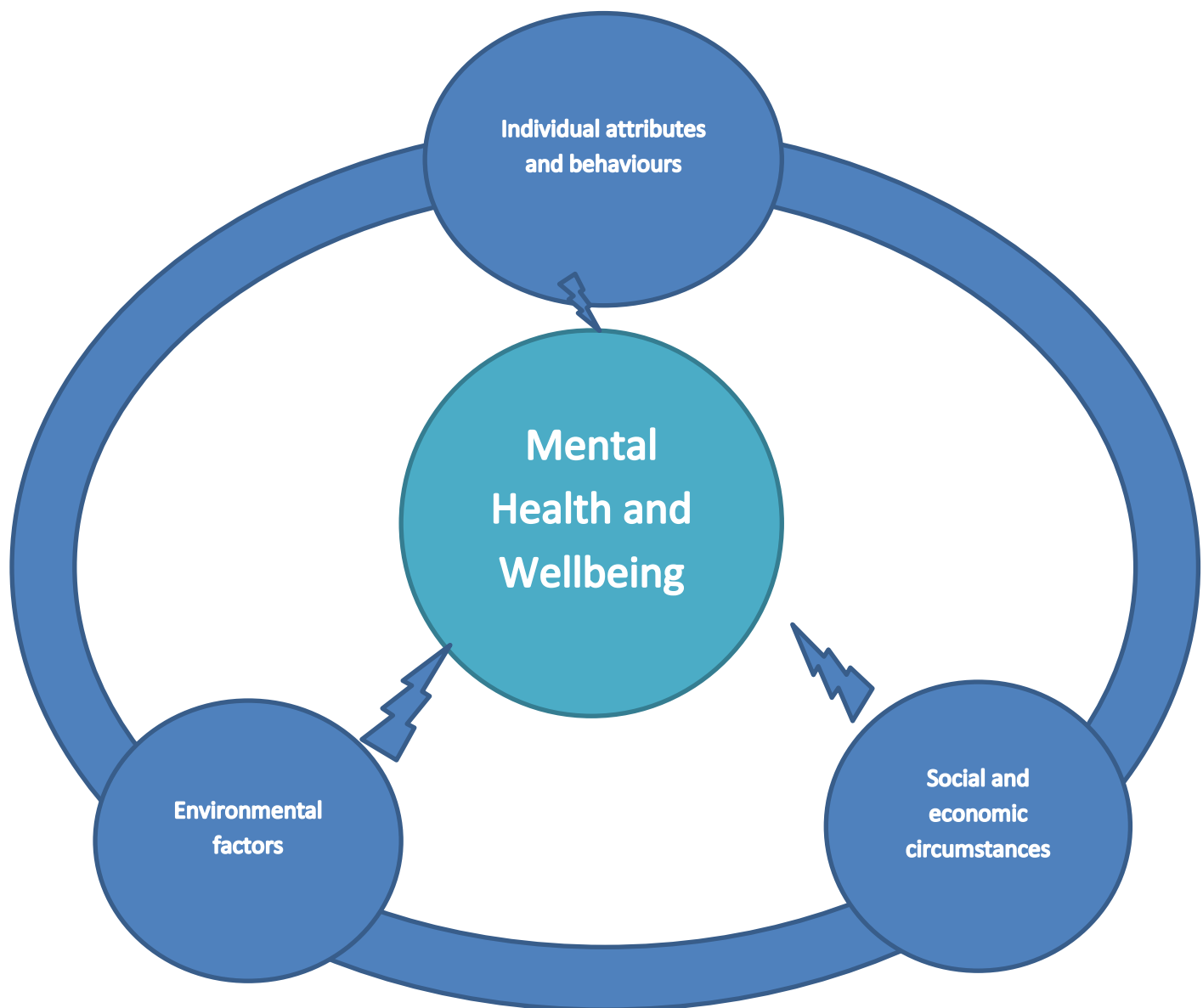
This diagram attempts to show that mental health and wellbeing are 'protected' by good environmental factors, positive social and economic circumstances and a person's own ways to cope with life. All of these factors, when adverse, can impact negatively on a person's mental health.

Risk Factors

This section describes some of the key risks to mental health, and identifies some of the groups of people in Kent who are exposed to these risks. This information needs to be considered alongside the estimate of prevalence (the number and pattern) of mental distress and mental illness which is calculated in section 4 of this report. The prevalence estimates will indicate the number of people, type of condition and the level of co-morbidity (how many people may have more than one condition).

It is important to emphasize that these different determinants interact with each other in a dynamic way, and that they can work for or against a particular individual's mental health state. Table 5 provides an illustrative set of factors that may threaten or protect mental health. For example, an individual's level of self-worth could be enhanced or diminished depending on social support or economic security at the household level, which in turn might be influenced by the extent of political stability, social justice or economic growth in a country.

Table 5

Level	Adverse factors	Protective factors
Individual attributes	Low self-esteem	Self-esteem, confidence
	Cognitive/emotional immaturity	Ability to solve problems and manage stress or adversity
	Difficulties in communicating	Communication skills
	Medical illness, substance use	Physical health, fitness
	Loneliness, bereavement	Social support of family & friends
	Neglect, family conflict	Good parenting / family interaction
Social circumstances	Exposure to violence/abuse	Physical security and safety
	Low income and poverty	Economic security
	Difficulties or failure at school	Scholastic achievement
	Work stress, unemployment	Satisfaction and success at work
	Poor access to basic services	Equality of access to basic services
Environmental factors	Injustice and discrimination	Social justice, tolerance, integration
	Social and gender inequalities Exposure to war or disaster	Social and gender equality Physical security and safety

Individuals who have a secure and supportive period of adolescence and childhood behind them, and who are able to exercise emotional control and social aptitudes, are better equipped to deal with the set of choices and challenges that inevitably present themselves in adulthood.

One of the most critical choices to be made - and a key determinant of an individual's wellbeing - concerns the 'work-life balance'; in economic terms, the allocation of time between production (whether paid for or not) and consumption (including leisure time with family and friends).

Stress and anxiety are a frequent outcome for persons spending too much time working, caring for others or operating in a difficult / insecure work environment, as it

is for those able and willing to work but unable to do so because of adverse socio-economic circumstances.[22]

Unemployment in particular is a well-established risk factor for mental ill-health (while returning to or getting work is a well-recognized protective factor). Unemployment is associated with greater health care use and higher death rates. The association also works in the opposite direction; that is, mental ill-health is a significant predictor of unemployment, and in its wake, of debt or impoverishment. [23]

Estimates of numbers at risk of having mental health conditions amongst some of the vulnerable groups in Kent

The over and under representation of particular groups and communities in mental services reveals a lot about the status of different groups within our society, and provides a useful indicator of social exclusion, and cultural understandings of mental health.

This section describes who these people might be, and what their social and cultural needs might be. It is not possible to do justice to the detail of all of the groups who are known to have particular needs, and further more in depth needs assessments may be required where there are particular gaps in knowledge and understanding.

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 and homeless people. Prisoners have a twenty-fold higher risk of psychosis, with 63% of male remand prisoners having antisocial personality disorder, compared with 0.3% of the general population. 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.

In 2007, NHS Health Scotland and the National Resource Centre for Ethnic Minority Health (NRCEMH) produced a report focused on the six equality and diversity strands of: Gender; Age; Disability; Sexual Orientation – LGBT; Race and Ethnicity; Spirituality. The report made the point that it is not being a woman, or being black or gay, per se that cause mental distress, but the fact that some aspects of social identity can expose people to discrimination, stigma and prejudice.

The experience of discrimination and prejudice can undermine mental health and wellbeing directly through exposure to, for example, harassment, and indirectly through the experience of poverty, deprivation, exclusion and inequality with which they are associated.

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[22] WHO (2004). *Prevention of mental disorders: Effective interventions and policy options*. World Health Organization; Geneva, Switzerland

[23] Lund C, De Silva M, Plagerson S, Cooper S, Chisholm D, Das J, Knapp M, Patel V (2011). Poverty and mental disorders: breaking the cycle in low-income and middle-income countries. *Lancet*, 378: 1502-14

Table 6

	% at risk of mental health problems	Estimated number with mental health problems in Kent
Released prisoners	90%	4387[24]
Adolescents leaving Care to live independently	80%	144
Sufferers of Hate Crime	60%	742[25]
Asylum seekers & refugees	50%	16 [26]
People who are lesbian, gay or bi-sexual	39.4%	9,450[27]
Gypsies and travellers	35%	3,500[28] or 1639[29]
Those with severe or profound hearing impairment	33.3%	3000[30]
Marital status: divorced	27.1%	30,600
Marital status: separated	23.3%	7643
People with a learning disability	25%	1125[31]
Carers	18%	25,000 [32]
Adult survivors of childhood sexual abuse*	12.4%*	13,290[33]
Veteran and ex-military**	1-6%	12000[34]

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

Mental Health and Health Inequalities: Mind the Gap: Building bridges to better health for all in Kent

Inequality in mental health means the unequal distribution of factors that promote and protect positive mental health and factors that are detrimental to mental health. Despite investment to address social disadvantage deep inequalities remain in our

[24] Approximate number from http://www.kentprobation.org/index.php?page=15

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

[26] KCC

[27] University of Kent 2009

[28] University of Kent 2009

[29] Kent Public Health Gypsy & Traveller Needs Assessment 2013 (check this)

[30] KCC We Are The People of Kent 2008

[31] PHE Profiles

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

[33] Baker & Duncun : Child Sex Abuse, A study in Prevalence in Great Britain. 1985 Child Abuse Neglect sited in Centre for Health and Social Research paper "A safe Place to Talk: Needs Assessment of Adult Survivors of Sexual Abuse" 2001

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

society with the gap between the rich and poorest increasing (Howell, 2013[35]; Black and O'Sullivan, 2012[36]). Our unequal society and the costs of this to mental health should be a central concern for us all; it leads to an unequal distribution across population groups of mental health problems and illness and in people's ability to recover and lead fulfilling lives.

If our aim is to create a fairer and more just society and then we need to address the chronic stress and fractures that having less power, status and control brings; and work with people to build strong communities and empowering services. To do this we need to work across all areas of policy to influence the factors that serve as determinants of mental health and enable inequalities and disadvantage to grow.

Both Wilkinson[37] and Marmot[38] show clearly that the chronic stress that occurs as a result of living in economic deprivation and facing the adverse life events that often as a consequence (e.g anti-social behaviour, crime, unemployment and debt) is a mechanism that results in poorer physical and mental health. However it is not only that unhappiness and anxiety caused by these stressors that lead people to 'self-medicate' using drugs, alcohol, poor quality food, tobacco products and other risky behaviours like gambling but the stress hormones themselves can lead to a corrosive action on the organs and systems in the body that result in a host of poor health outcomes (figure 8). This is why there is an inextricable link between mental health and health inequalities.

The Kent wide - Mind the Gap: Building bridges to better health for all in Kent- Health Inequalities Strategy aims to do just this.
www.kmpho.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=326085

There is no need for this report to repeat the details of this important document, much of the actions detailed in it and the local plans that contribute to its delivery will enable mental wellbeing to improve and have an impact, over time, on mental health outcomes. However – as health inequalities are a key risk factor in poor mental health - the following section summarises some of the key facts from the Kent Health Inequalities Strategy.

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[35] Howell (2013) Global Risks 2013 Eight Edition: An initiative of the risk response network. Switzerland. World Economic Forum

[36] Black O and O'Sullivan I (editors) (2012) Wealth in Great Britain Wave 2: Main results from the wealth and assets survey 2008-2010 (part 3). Office for National Statistics www.ons.gov.uk

[37] Wilkinson, R. G. (1996). Unhealthy Societies: The Afflictions of Inequality. New York: Routledge

[38] Marmot & R. G. Wilkinson (Eds.), Social Determinants of Health (2nd ed., pp. 224-237). Oxford, UK: Oxford University Press

Figure 8[39]

Kent's Health Inequalities Action Plan
MIND THE GAP Building bridges to better health for all
2012/15
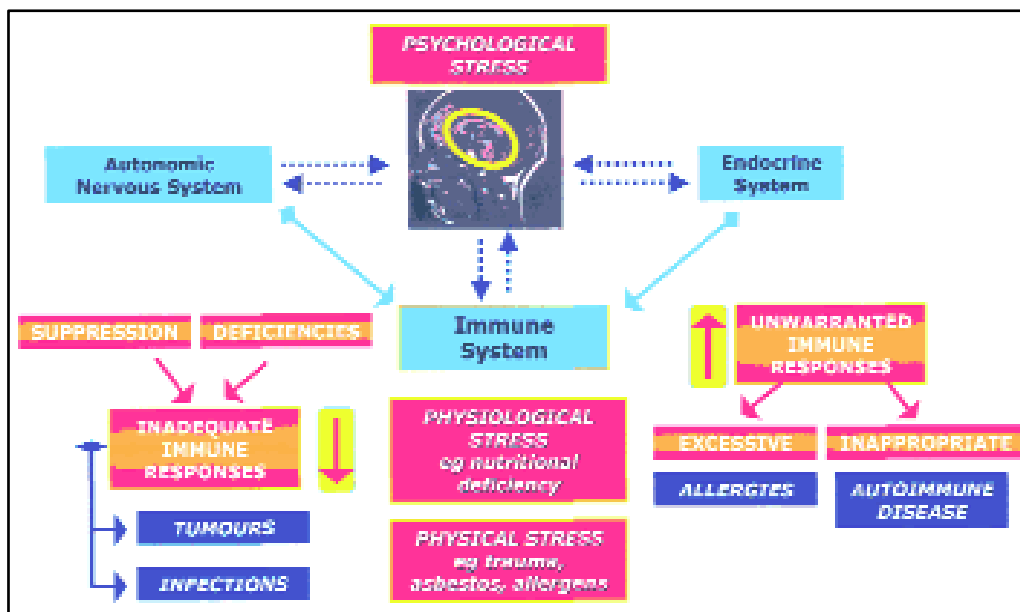
Link between Health Inequalities and Mental Illness in Kent

Adverse mental health outcomes are 2 to 2.5 times higher among those experiencing greatest social disadvantage compared to those experiencing least disadvantage[40]. In addition those living with disability or a mental health problem remain at highest risk of poverty [41]. Socio-economic pressures such as poverty and low levels of education are recognised risks to mental health for individuals and communities. The greater the gap between the rich and the poor, the greater

[39] http://www.positivehealth.com/article/mind-matters/clinical-psychoneuroimmunology-mind-body-integrated-health
[40] Murali V and Oyebode F (2004) Poverty, Social Inequality and Mental Health. Advances in Psychiatric Treatment 10: 216-224 doi: 10.1192/apt.10.3.216
[41] Parckar G (2008) Disability Poverty in the UK, London: Leonard Cheshire

differences are observed in health (table 7). Reducing the impact of poverty and inequality is likely to have a positive impact on mental wellbeing of the population in Kent.

Table 7 Mental Health, Health Inequalities and Economic Deprivation

District	Unemployment rate (%) as at September 2013	ASB (anti social behaviour) rate per 1000 (2013/14)	Long term health problem activities limited a lot	%16-18 year olds not in education or training	% of children living in poverty	Number of households in temporary accommodation	Percent Fuel Poor
Ashford	2.1	19.8	7.1	4.6	16.2%	104	7.6%
Canterbury	2.0	28.8	8.2	3.4	17.1%	64	10.2%
Dartford	2.3	29.4	6.8	4.0	16.7%	38	7.3%
Dover	3.0	33.2	9.7	5.1	20.4%	37	10.0%
Gravesham	3.2	36.2	7.7	4.3	20.1%	44	8.5%
Maidstone	2.0	23.8	6.9	3.8	14.5%	36	8.5%
Sevenoaks	1.3	18.4	6.3	2.2	11.4%	19	8.2%
Shepway	3.3	31.9	10.0	5.5	21.1%	43	9.1%
Swale	3.2	30.7	8.6	6.7	22.5%	72	8.6%
Thanet	5.5	44.0	11.5	7.8	26.4%	27	11.6%
Tonbridge and Malling	1.6	19.6	6.3	3.4	12.5%	16	7.5%
Tunbridge Wells	1.1	21.0	6.1	2.8	11.3%	36	9.4%
England	3.1		8.3		20.1%	55,300	10.9%
Kent CC rate		28.1					

Sources: unemployment rate, MOMIS extracted 20/10/2013
Anti-social behaviour incidents 2013/14 Kent Police, courtesy of KCC Community Safety Partnership analytical team
Long term health problems, ONS 2011 census
16-18 not in education or training, KCC Education learning support (ELS), 2013
Children living in poverty, Department of Work and Pensions, 2012
Temporary housing, Department of Local Government and Communities, 2012/13
Fuel poverty, Department of Energy and Climate Change, 2011

In table 7 the differences in a number of indicators related to economic deprivation are tabled for each district council in Kent. For each indicator the highest and lowest district council is highlighted. There is a noticeable difference between East and West Kent, with the districts in the East having greater number of risk factors.

Thanet, Shepway and Dover and Swale feature as the highest deprivation areas and as such will have far greater number of people suffering from mental distress then the more affluent areas. Figure 9 shows that health inequalities do impact on life expectancy within Ashford CCG as there is variation across the population. However it should be noted that this variation is not as great as in other CCGs. Figure 10 shows the distribution of people claiming out of work benefits across Kent.

Figure 9: Life Expectancy at Birth: Ashford CCG Wards.

Life Expectancy from birth in Ashford CCG, 2008-2012
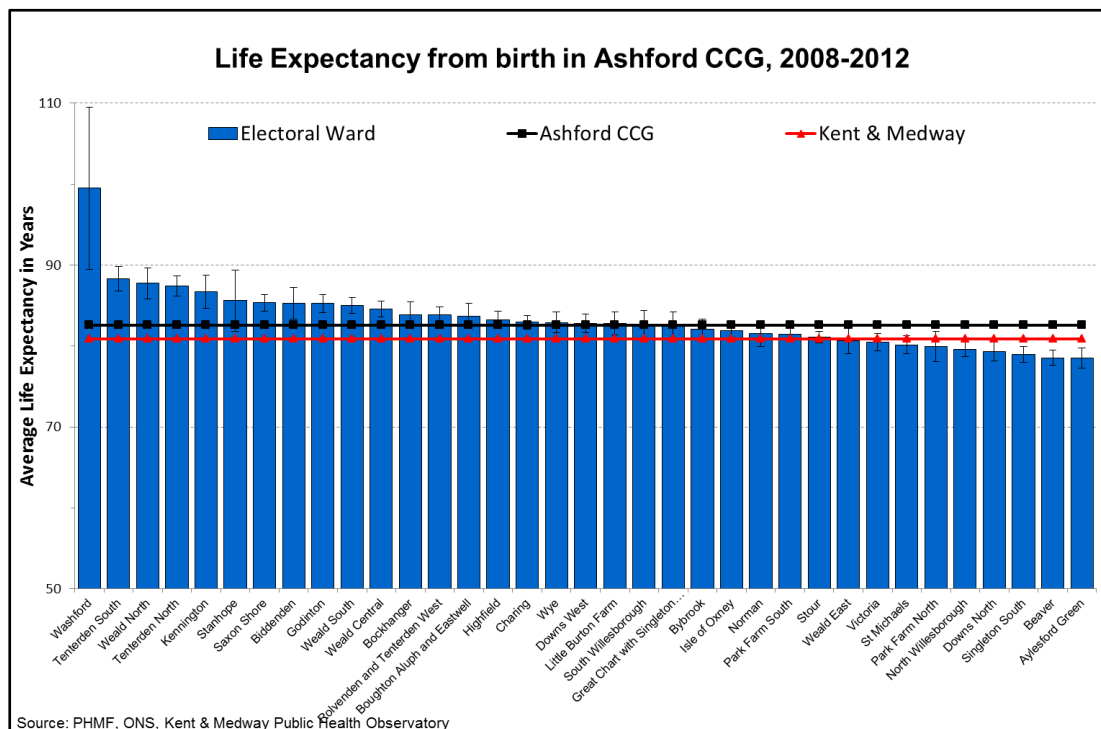
Figure 10
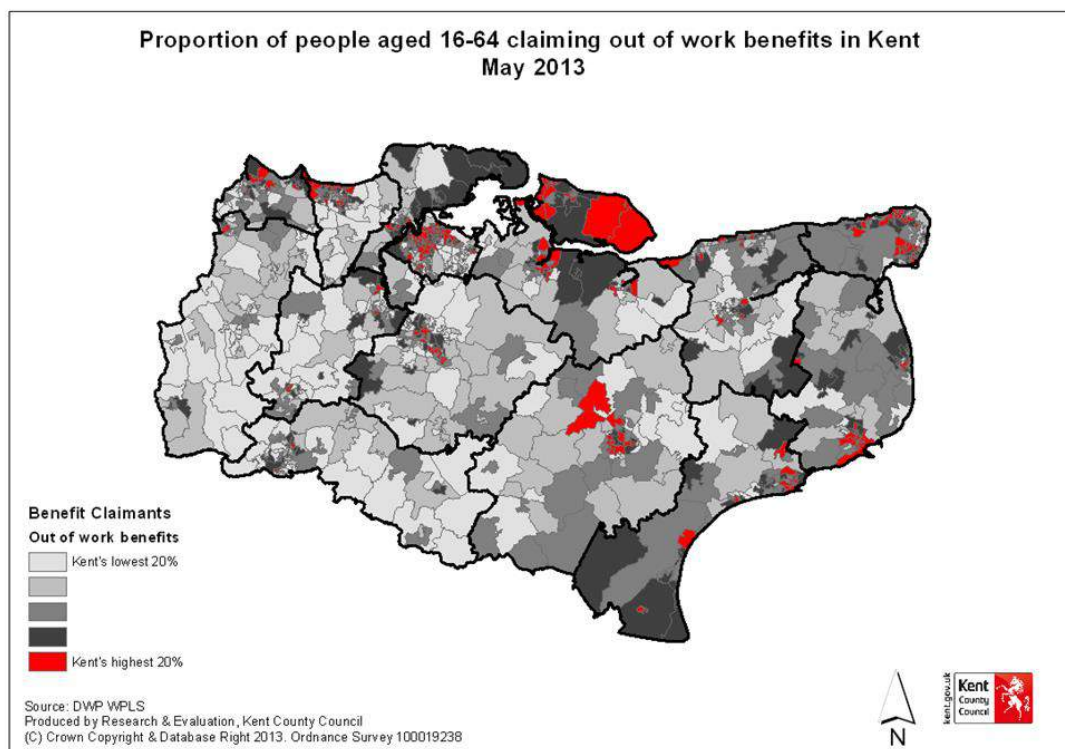
5. Prevalence, Estimates and Projections

The estimates of the number of people with various mental health disorders presented in this document are derived from the findings from the 2007 Adult Psychiatric Morbidity Survey and have been applied to the Kent population (APMS).

The Adult Psychiatric Morbidly Survey (McMannus et al 2007)

The aim of the national survey was to estimate the national prevalence of mental health disorders among adults (aged 16 and over) living in private households. Assessments were made by trained interviewers and additional screening tools were used to check for the presence of characteristics of eating disorders, attention deficit hyperactivity disorder, post-traumatic stress disorder and problem gambling.

There are some limitations to the data obtained in the APMS. Only private households were contacted, this excludes those living in non –settled accommodation, leading to a possible underestimate. There was also a high drop-out rate for follow up interviews among those identified as having symptoms of psychosis.

The Adult Psychiatric Morbidity Survey for England and Wales showed that 'neurotic disorders' were by far the most prevalent mental health conditions as shown in figure 11. When the national proportions are applied to Kent it shows that psychotic disorders account for 1% of the total amount of mental illness in Kent. Caution is needed in interpreting these data however as there is significant amount of overlap between these conditions as well as differences in severity and duration.

Figure 11

Estimated Percentages of people with mental health disorders in Kent

- psychotic disorder 1%
- personality disorder 3%
- Panic disorder 2%
- Obsessive compulsive disorder 2%
- Mixed anxiety depression 25%
- Any neurotic disorder 45%
- Generalised anxiety disorder 12%
- Depressive episode 6%
- All phobias 4%
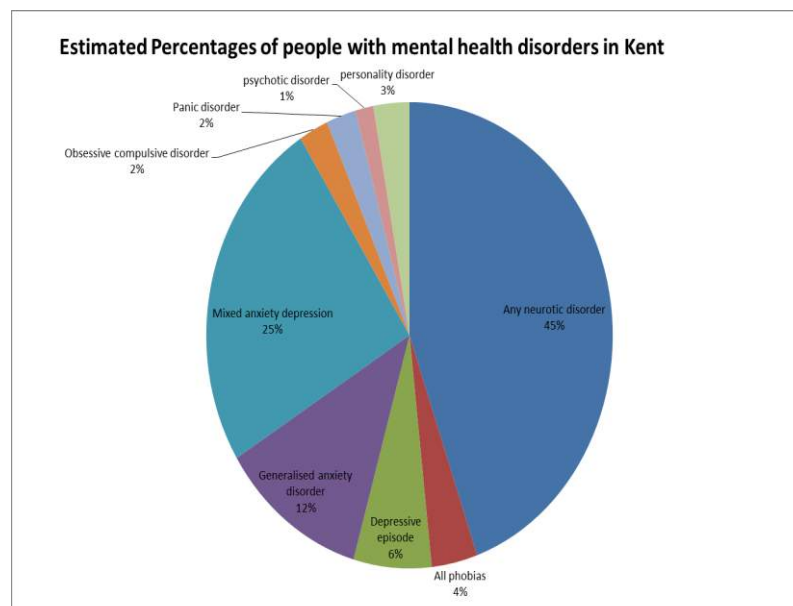
Source: McMannus et al 2007 APMS PHO

When looking further at the issue of duration of illness, McMannus et al (APMS 2007) found that 16% of people reported having common mental illness in the past week and 4% had had suicidal thoughts in the past year. There was considerable co-morbidity found by the survey, where 7% were found to have two or more conditions (See figure 12 & table 8).

Table 8 Prevalence of mental disorders by Condition in England

	%		
	Males	Females	Persons
Common mental disorder (past week)	12.5	19.7	16.2
Current post traumatic stress disorder	2.6	3.3	3
Suicidal thoughts (past year)	3.4	5.2	4.3
Suicide attempts (past year)	0.5	0.9	0.7
Psychotic disorder (past year)	0.3	0.5	0.4
Borderline personality disorder (past year)	0.3	0.6	0.4
Antisocial personality disorder (past year)	0.6	0.1	0.3
Two or more psychiatric disorders	6.9	7.5	7.2

Note: the survey was conducted in 2007 while the results were published in 2009.

(McMannus et al 2007)

Figure 12: Pyramid of Need in Kent

Registered Adult Population of Kent
18-64 is 1,071,767

Severe mental illness

Co morbid SMI 29000

58,000

One condition

25,000

Common mental illness
(50% need treatment in
primary care), 84,000

Co-morbid

58,000

76% of the Kent Registered Population 18-64
with good mental health

814,543
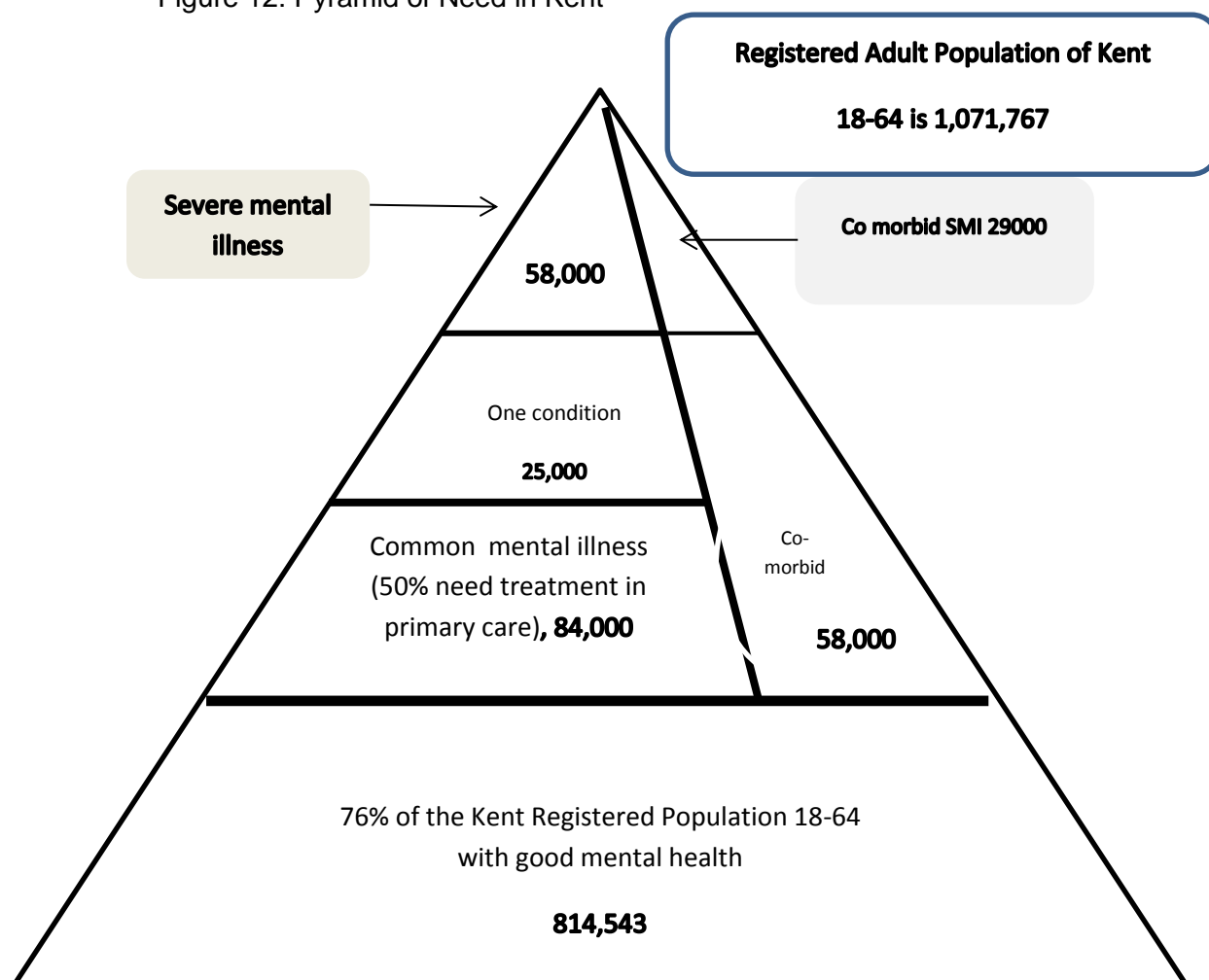
Figure 13: Pyramid of Need: Ashford CCG
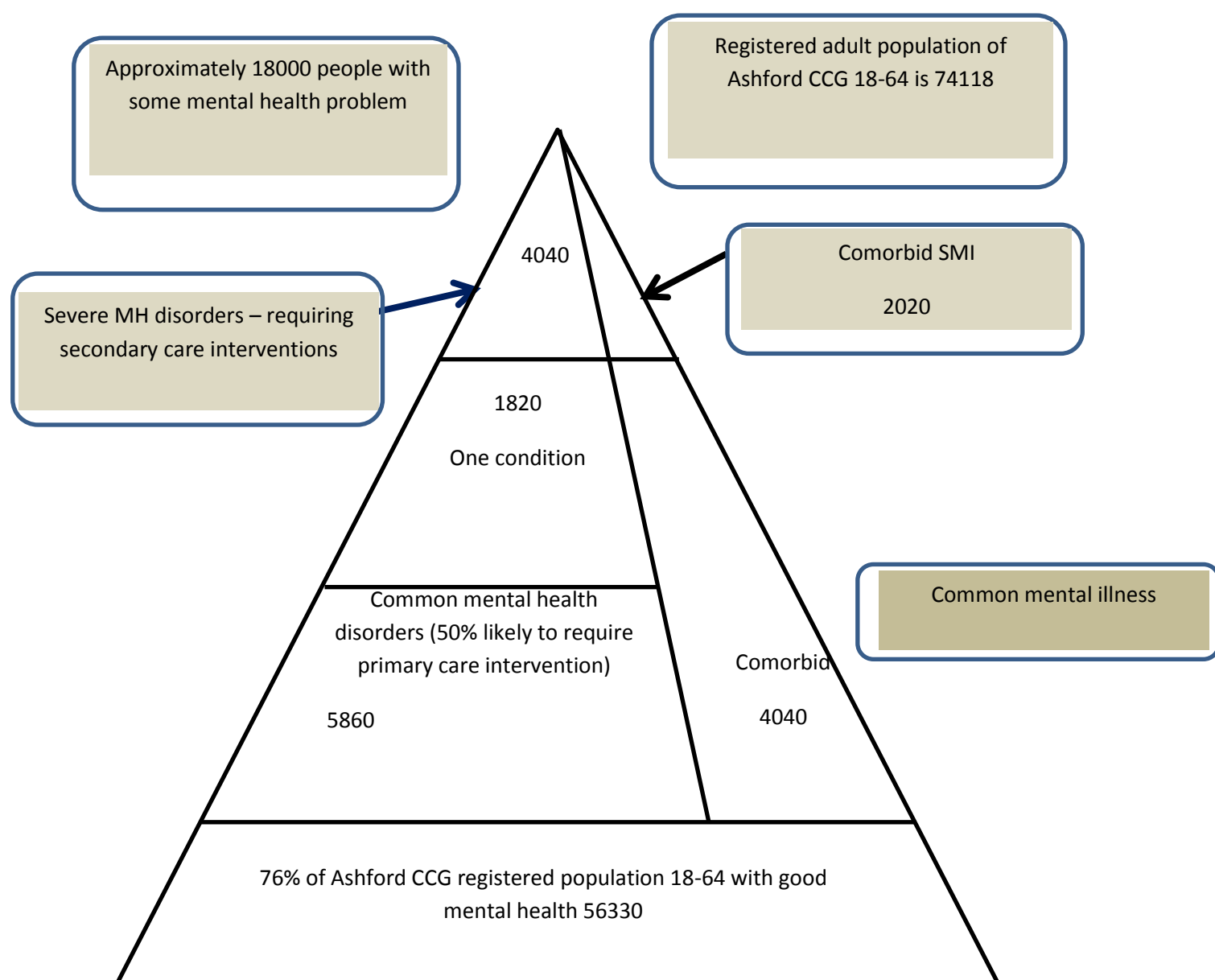
The above diagram (figure 13) shows that by applying national rates to people in Kent, 23% of the adult population will show characteristics of at least one psychiatric disorder and 8.1% of adults (or a third of those who screened positive for a psychiatric disorder) are likely to have characteristics of 2 or more conditions. In Ashford (figure 13) this translates to around 17,788 (24%) adults over 18 years estimated to have symptoms of mental health disorder and around 4040 of these (or 5.5% of all adults) are likely to have comorbid conditions. Within the 17,788 are 5,860 with symptoms of common mental health disorders, of which about half are likely to require treatment.

5.1 Estimates for common mental disorder

The term 'common mental health disorders' (CMDs) refers those conditions that are also referred to as 'neurotic conditions' and covers;

- mixed anxiety and depression,
- generalised anxiety disorder,
- depressive episodes,
- phobias,
- obsessive compulsive disorder and
- panic disorder.

The chart below (figure 14) shows the prevalence of each common mental health disorder, by gender, among adults (16+) in England. Mixed anxiety and depression is predicted to be the most common CMD (affecting around 18% of the adult population), followed by generalised anxiety disorder and depressive episodes.

Figure 14
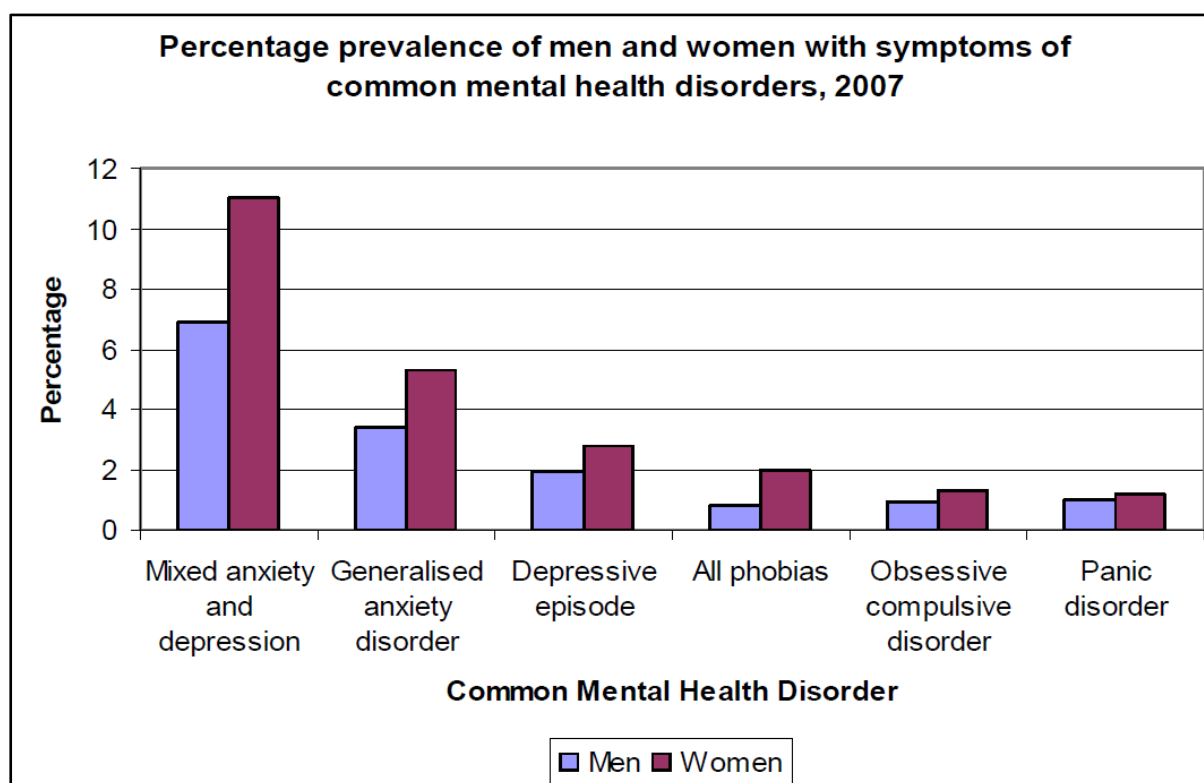
Only around *half* of those suffering from symptoms of CMDs are estimated to be likely to need treatment.

Around 15.1% of adults (11.6% of men and 18.4% of women) are likely to have symptoms of a CMD at any time, but only **7.5%** of adults (5.7% of men and 9.3% of women) are likely to have symptoms severe enough to require treatment.

Table 9 below shows the rates of people in Kent districts with a need for treatment for CMD. The table shows that across Kent there are higher relative higher rates in Thanet for all conditions, followed by Dartford and Gravesham. Canterbury and Shepway also have higher than Kent average rates for anxiety.

The estimated rates from the APMS 2007 have been applied to Kent districts and then the estimated number of people with the disorder shown in table 9. This shows that the larger the population the more people there will be with mental disorders. Across the whole of Kent 133,764 people will have some neurotic disorder and this is 12.5% of the total registered population of Kent (aged 18-64) and around 74,500 people have mixed anxiety and depression (around 7%). The numbers are also described by Kent district in table 9.

Estimated Rates of Mental Illness by Kent District and CCG.

Table 9

LA name	Any neurotic disorder	All phobias	Depressive episode	Generalised anxiety disorder	Mixed anxiety depression	Obsessive compulsive disorder	Panic disorder
Ashford	124.1	10.2	17.4	33.0	68.9	6.5	6.6
Canterbury	139.1	11.3	18.9	33.9	78.6	7.7	7.2
Dartford	158.5	13.1	21.9	41.5	88.6	8.3	8.3
Dover	132.0	10.7	18.4	35.0	73.2	6.9	7.1
Gravesham	157.8	13.0	21.9	41.5	88.0	8.3	8.3
Maidstone	122.7	10.1	17.1	32.6	68.1	6.4	6.6
Sevenoaks	118.5	9.7	16.6	31.9	65.5	6.1	6.4
Shepway	133.3	10.8	18.5	35.3	74.0	7.0	7.1
Swale	131.0	10.7	18.3	34.7	72.8	6.9	7.0
Thanet	171.6	13.9	23.8	45.2	95.5	9.0	9.1
Tonbridge a	118.0	9.7	16.5	31.7	65.4	6.1	6.2
Tunbridge V	126.0	10.4	17.6	34.0	69.8	6.5	6.8
Kent	135.6	11.1	18.8	35.7	75.5	7.1	7.2

Estimate of expected common mental illness based on 2000 APMS
Source: www.nepho.org.uk/mho/briefs/#b4

Estimated Numbers of Mental Illness by Kent District
Table 10

LA name	Any neurotic disorder	All phobias	Depressive episode	Generalised anxiety disorder	Mixed anxiety depression	Obsessive compulsive disorder	Panic disorder
Ashford	9687.6	798.0	1356.2	2577.2	5378.8	507.5	511.6
Canterbury	14752.3	1196.8	2002.4	3593.2	8334.7	816.9	758.6
Dartford	10241.7	849.0	1417.9	2684.0	5727.9	538.8	536.9
Dover	10027.6	814.1	1397.2	2663.3	5559.3	523.7	536.3
Gravesham	11067.2	909.3	1537.3	2909.2	6170.3	582.3	581.4
Maidstone	12730.9	1043.0	1778.8	3386.4	7065.5	668.6	682.8
Sevenoaks	9514.0	779.0	1333.0	2561.3	5256.8	493.5	510.0
Shepway	9479.5	768.7	1315.6	2512.5	5262.5	495.4	505.9
Swale	12087.2	991.1	1687.7	3197.3	6718.8	638.3	641.9
Thanet	15329.0	1237.4	2122.3	4032.3	8524.6	801.2	814.6
Tonbridge a	9557.6	787.0	1337.0	2568.1	5295.3	497.2	505.1
Tunbridge V	9289.7	765.7	1295.2	2504.0	5145.4	479.7	500.0
Kent	133764.4	10939.0	18580.6	35188.7	74439.8	7043.0	7085.1

Figure 15

Comparison of Rates of 'Any Neurotic Disorder' in people living in Kent District

	Ashford	Canterbury	Dartford	Dover	Gravesham	Maidstone	Sevenoaks	Shepway	Swale	Thanet	Tonbridge and Malling	Tunbridge Wells	Kent
Any neurotic disorder	124.1	139.1	158.5	132.0	157.8	122.7	118.5	133.3	131.0	171.6	118.0	126.0	135.6

Figure. 16

Estimated Numbers of Comon Mental Health Disorder for Adults (18-64) in Kent CCGs

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

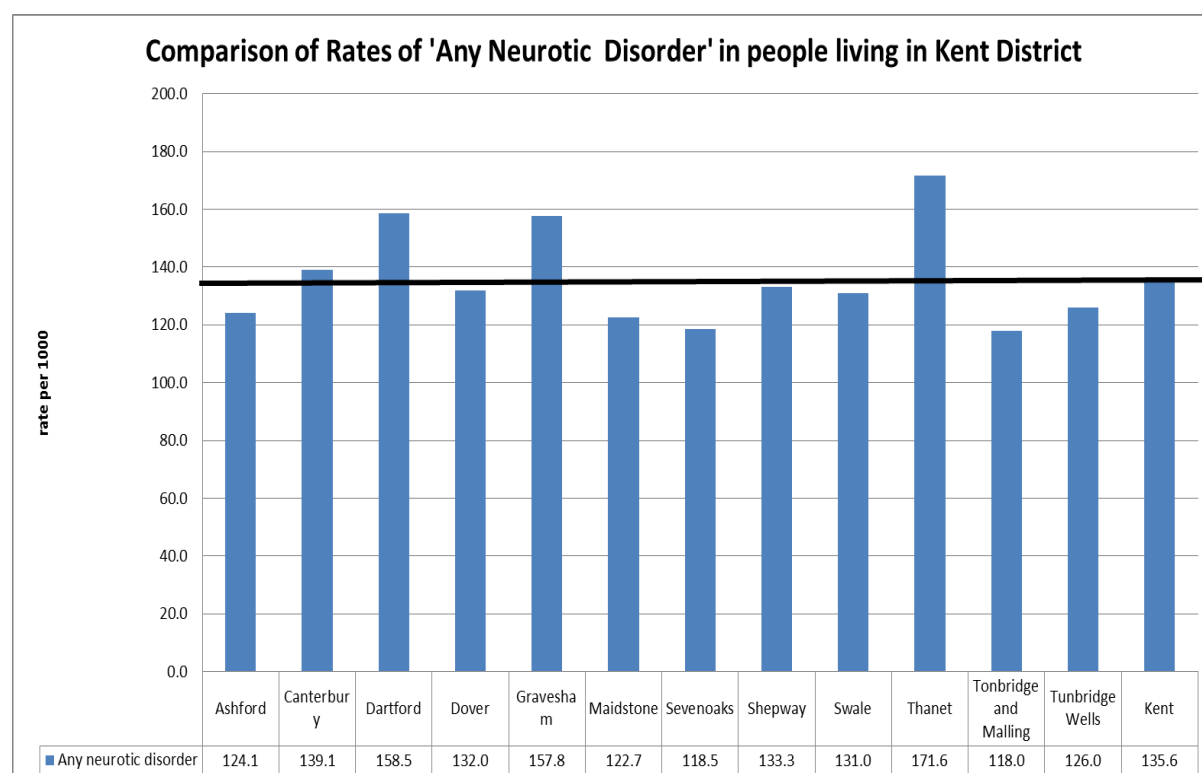**Source** KMPHO 2014

The APMS(2007) wanted to find out whether there was a difference in prevalence of common mental health symptoms across the age spans over one week (period prevalence). They found that it was the age range 16-54 that had the highest reporting of symptoms and women reported more than men. Common mental health symptoms appear to reduce as people age (figure 17).

As expressed previously, important to note that only around half the people expressing symptoms are likely to require treatment, whilst the remaining half may benefit from interventions to improve wellbeing and prevent symptoms becoming more severe. It will be important for clinicians in primary care to get training and be comfortable in detecting who is most likely to benefit from treatment and who can benefit from 'preventative' interventions at primary care and in the community.

When the population increases are factored for the Kent Population, there will be an average 5.8% increase in the numbers of people with CMD. When this is broken down by CCG in Kent, Ashford CCG and Canterbury & Coastal CCG will expect the greater percentage of increase by 2020 (table 11). Ashford is projected to have a projected increase of 9.87% in CMD by 2020: this is the largest of all the CCGs.

Table 11

| Projected Increase of Common mental disorders (ages 18-64) to 2020 by Kent CCG					Overall increase between 2013 and 2020	Average annual increase
	2013	2016	2020			
NHS Ashford CCG	12,005	12,492	13,191		9.87%	1.41%
NHS Canterbury and Coastal CCG	21,059	21,803	22,791		8.22%	1.17%
NHS Dartford, Gravesham and Swanley CCG	24,898	25,510	26,346		5.82%	0.83%
NHS South Kent Coast CCG	19,073	19,256	19,628		2.91%	0.42%
NHS Swale CCG	10,624	10,914	11,335		6.68%	0.95%
NHS Thanet CCG	13,131	13,436	13,801		5.10%	0.73%
NHS West Kent CCG	45,592	45,803	47,785		4.81%	0.69%
Kent	146,383	149,215	154,876		5.80%	0.69%

Source: KMPHO 2014[42]

Figure 17 below shows the estimated overall percentage prevalence of people (aged 16 and over, in England) who have had symptoms of any common mental health disorders in the week prior to interview. Figures 17 and 18 below present the estimated prevalence of each of the CMDs individually, by age and gender.

Figure 17
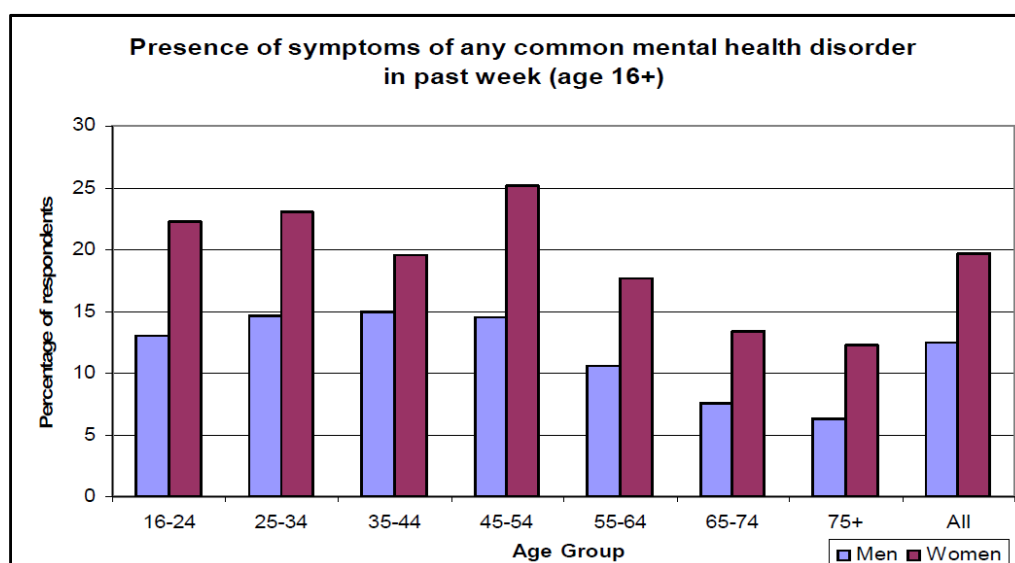
Overall women show higher rates of CMDs than men, however there are a few age groups among certain conditions that buck this trend:

- Men aged 16-24yrs and 65-74yrs have higher predicted rates of panic disorder than women of the same age (men = 1.4% and women = 0.8% in 16-24 age group, men = 1.0% and women = 0.1% in 64-75 age group).

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[42] Notes: A stable rate of 16.2% was applied to the projected CCG population to derive the numbers with CMDs for 2016 and 2020 .CCG population projection is based on average annual growth rate CCG population between 2004 and 2013.

- Depression episodes are more common among men aged 25-34 than women of the same age range (2.7% and 1.7% respectively).
- Obsessive compulsive disorder was found to be slightly more prevalent in men aged 35-44 than women of the same age group (1.2% and 1.0% respectively) and equally Prevalent among men and women aged 25-34 (1.5%).

The chart suggests women are most likely to suffer from mixed anxiety and depression; generalised anxiety disorder or depressive episodes at ages 16-24, 25-34 and 45-54yrs. Men are most likely to suffer from the above CMDs between ages 25 to 54 years.

Figure 18

Source: Adult Psychiatric Morbidity Survey 2007.
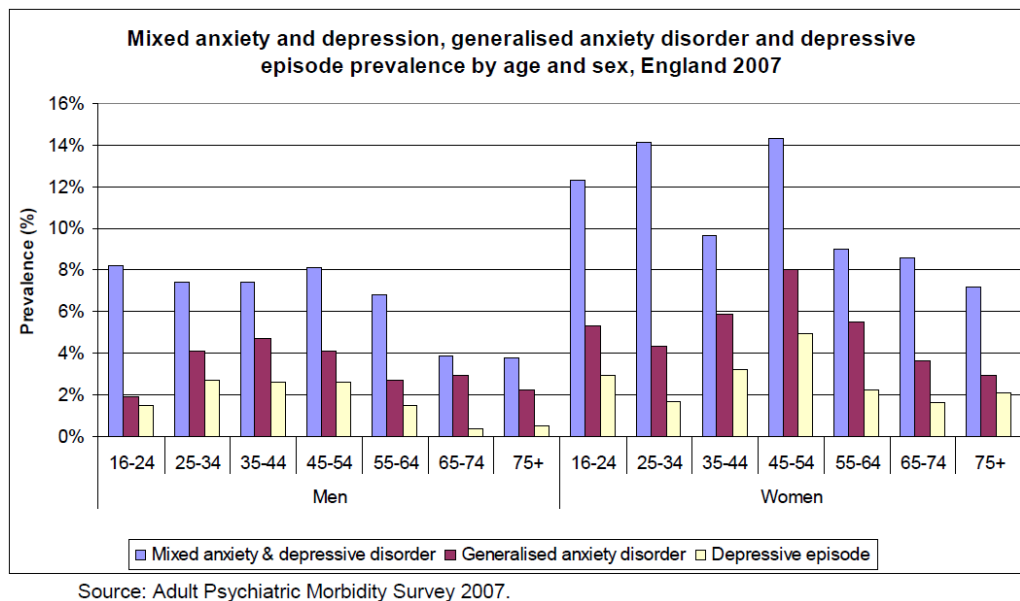
Symptoms of obsessive compulsive disorder are most common among men and women aged 16-24yrs (1.6% and 3% respectively).

Figure 19

Phobias, obsessive compulsive disorder and panic disorder by age and sex, England 2007

Source: Adult Psychiatric Morbidity Survey 2007.

Panic disorder is most common among women aged 25-34 (2.3%) and among men aged 16- 24yrs (1.4%). There is also a small peak among older aged groups; with 1% of men aged 65-74 and 1.4% of wo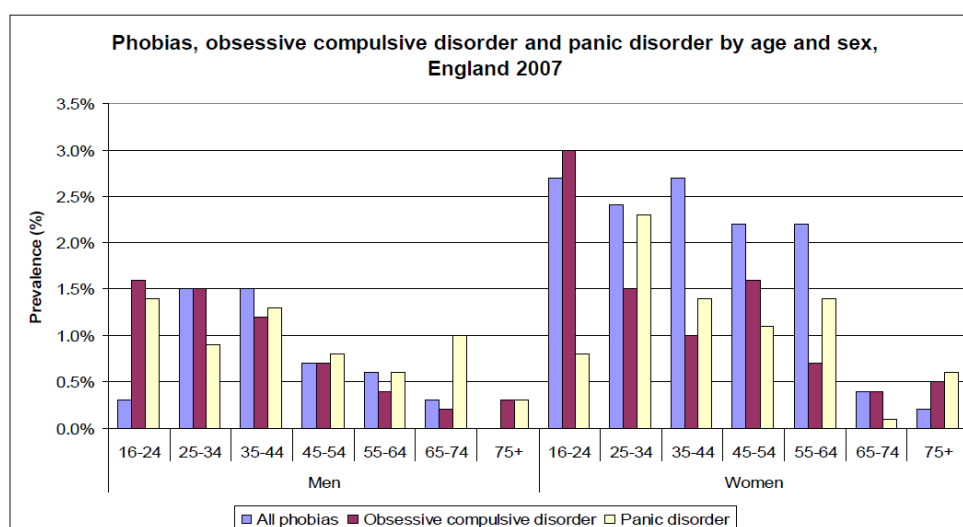men aged 55-64 suffering symptoms of panic disorder. Symptoms of phobias are apparent in over 2% of women from age 16 to 64yrs, while prevalence decreases to less than 0.5% of older women. 1.5% of men aged 25 to 44yrs suffer from symptoms of phobias, with prevalence decreasing in older age groups. Overall, common mental health disorders are most prevalent among black people, followed by 'other' ethnic groups (this category includes Chinese, people of mixed ethnicity and other groups not otherwise specified), South Asians and finally whites (see figures 20 and 21). Mixed anxiety and depression was the most prevalent CMD among all ethnic groups. Broadly speaking the overall prevalence of CMDs by ethnic group again shows them to be more common among women. There are however some differences when disorders are considered separately.

Mixed anxiety and depression was found to be more common among 'Chinese & other' men than women (14.4% and 11.9% respectively). Depressive episodes are more common in black men than women (5.6% and 1.1% respectively).

Figure 20

Prevalence of mixed anxiety and depression, generalised anxiety disorder and depressive episode by ethnicity and sex, England 2007

Source: Adult Psychiatric Morbidity Survey 2007.

Figure 21

Prevalence of phobias, obsessive compulsive disorder and panic disorder by ethnicity and sex, England 2007
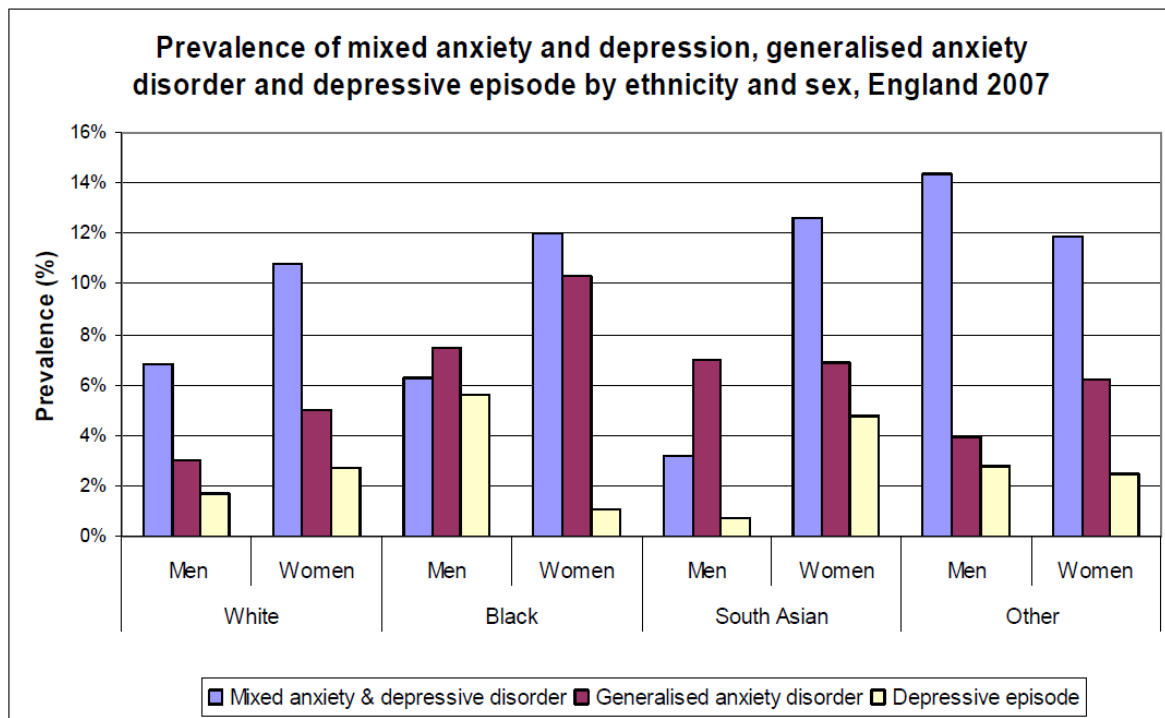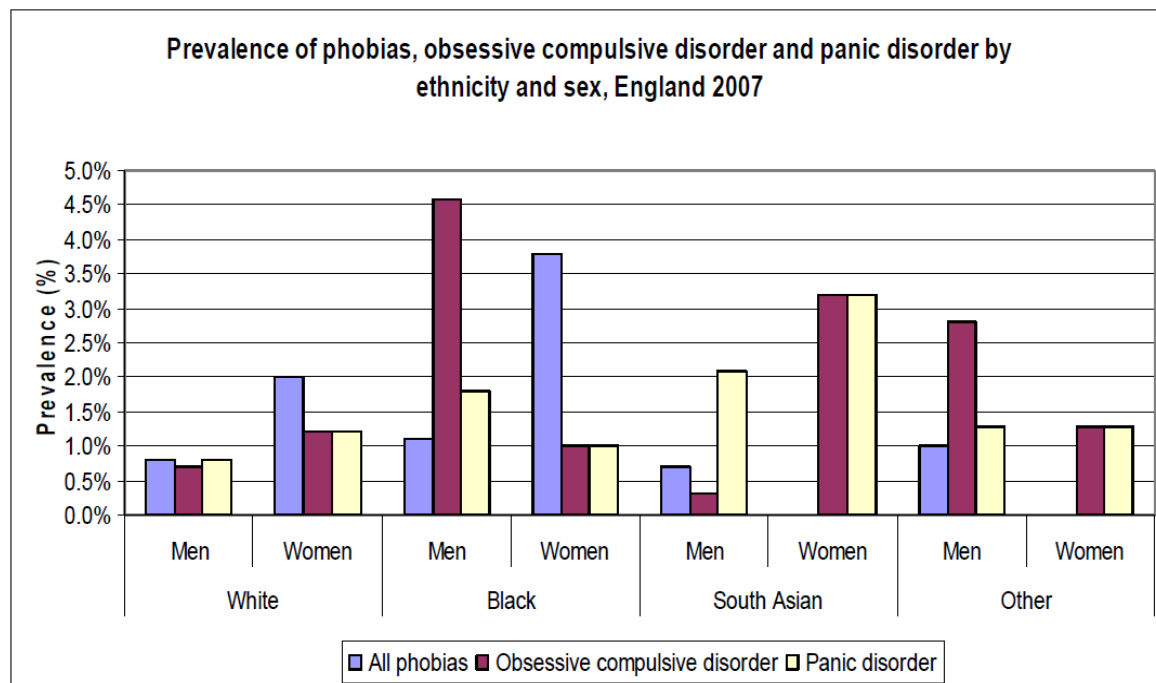
Source: Adult Psychiatric Morbidity Survey 2007.

Analysis of CMD prevalence by marital status shows CMDs to be most prevalent among people who have been divorced or separated and the lowest rates among people who are married or widowed. Whilst a similar percentage of divorced men and women were found to have symptoms of CMDs (27.7% and 26.6% respectively), over three times the proportion of separated women (33%) had symptoms of CMDs compared to separated men (10.5%).

Overall the prevalence of common mental health disorders, such as mixed depression & anxiety, generalised anxiety disorder, tends to increase with decreasing household income (see figure 22), however women in the highest household income quintile have higher prevalence of CMDs than women in the second highest quintile.

Looking at individual CMDs among women by household income the APMS showed the prevalence of mixed anxiety and depression and obsessive compulsive disorder (OCD) to be higher in the highest income quintile compared to the second highest. In fact OCD in women is most prevalent in the most affluent quintile.

As noted at the beginning of this section on common mental health disorders (CMDs) a CIS-R score of over 12 suggests the presence of symptoms of a CMD, a score over 18 suggest symptoms are present at a level likely to require treatment. The 2007 survey found that nationally, 83% of respondents who scored 12-17 were not receiving any treatment for a mental or emotional problem, neither were 68% of people with a score over 18.

Nationally, people suffering from depressive episodes, phobias and obsessive compulsive disorder were found to be most likely to have had contact with their GP or any healthcare service in the past year (see figure 23). GPs appear to be the most common contact point for people wishing to discuss a mental or emotional problem. Around 10% of people with a CMD had had contact with their GP in the last 2 weeks and over a third in the last year.

Figure 22

Prevalence of Common Mental Health disorders by equivalised household income

Source: Adult Psychiatric Morbidity Survey 2007.

Figure 23

Percentage of respondents accessing health services, by presence of common mental health disorders

Source: Adult Psychiatric Morbidity Survey 2007.

Mental Health Needs Assessment for Adults in Kent: Ashford CCG 2014

Figure 24

Percentage of respondents with symptoms of 2 or more psychiatric conditions by equivalised household income, England 2007
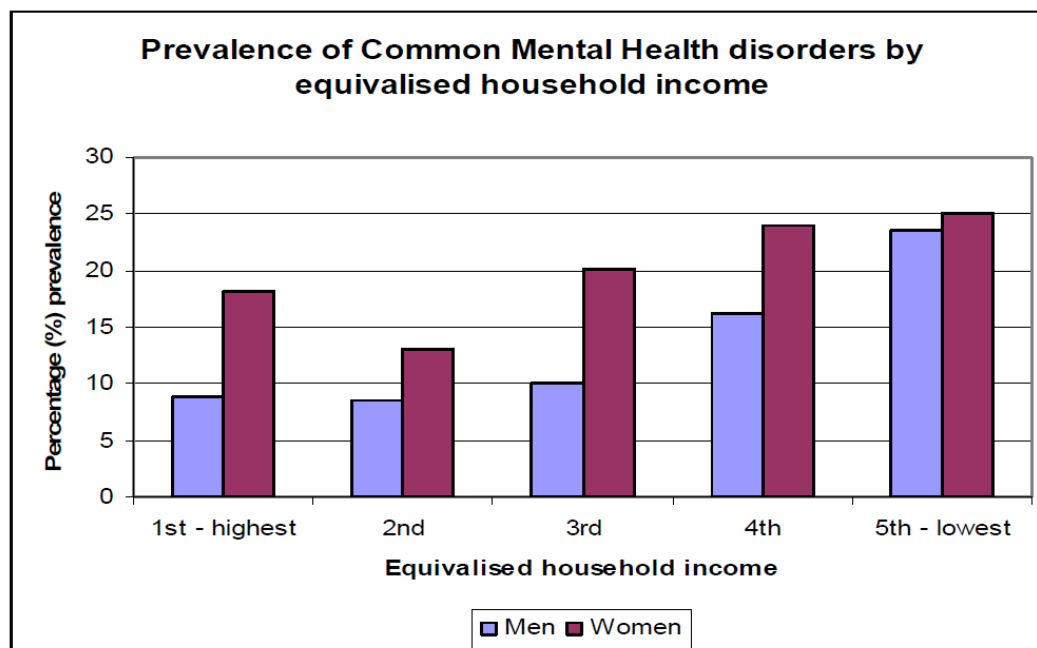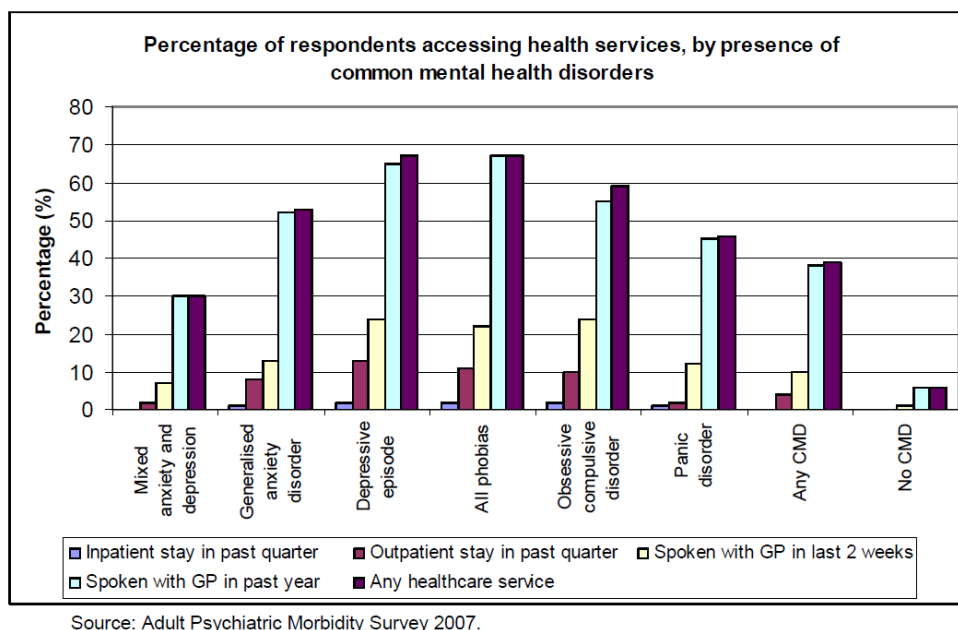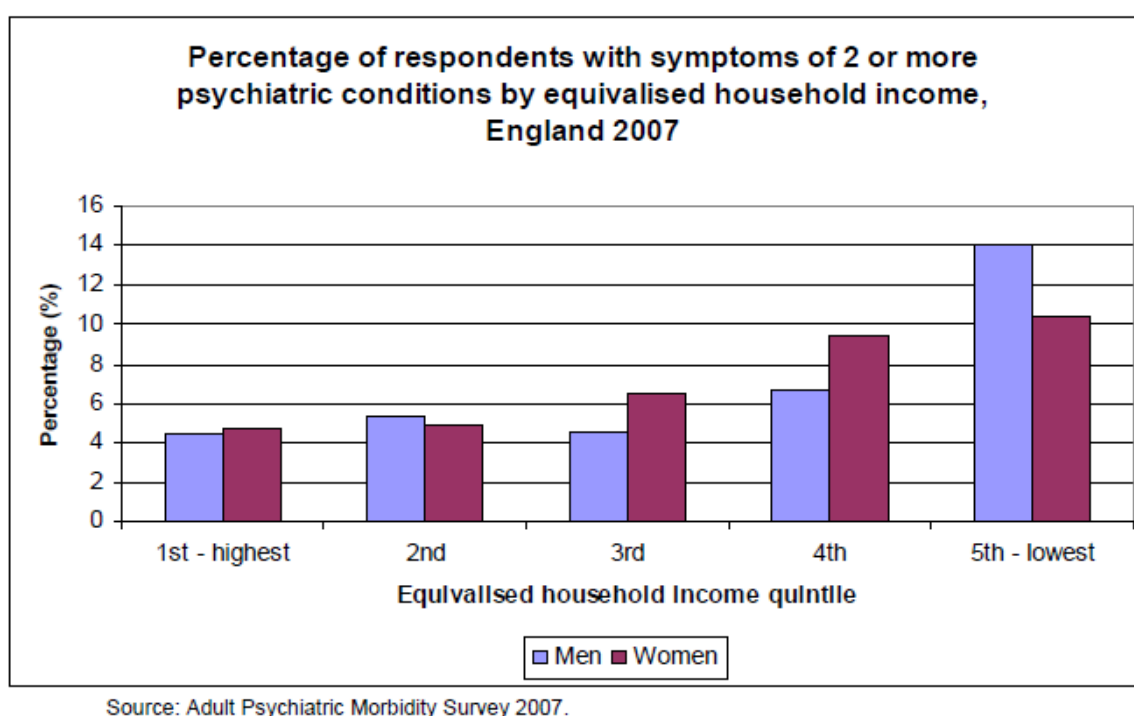
Source: Adult Psychiatric Morbidity Survey 2007.

5.2 Prevalence estimate of psychosis and affective psychoses

Please note organic psychoses, such as Alzhiemers Disease are not covered in this report.

During psychotic episodes a person's senses and sense of reality can be distorted. This may include experiencing hallucinations or delusional thoughts (without being able to identify that the experiences are not real), paranoia and changes of behaviour. Psychosis can occur in schizophrenia, schizoaffective disorder, bipolar disorder, some types of personality disorder, or as a result of substance misuse. Although the proportion of people likely to suffer from psychosis is relatively small the service and societal costs are high and impacts on lives affected by psychosis (the individual and family members) are significant. The APMS used verified interviewers however there were some response rate caveats around the data from the survey (see footnotes). [43]

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[43] **NOTE on Methodology of APMS :**For a diagnosis of psychosis to be confirmed a phase interview was required with a clinically trained interviewer and a SCAN (Schedule for Clinical Assessment in Neuropsychiatry) interview completed. However almost 40% of select respondents from phase one interviewees either refused or could not be contact for the phase two interview. Although a weighting has been applied to phase two interviews to account for non-responses another approach considering "probable psychosis" have also been provided, based on results from the phase one interview. Prevalence of probable psychosis by age and sex has been used to estimate the number of people in Bristol who may be suffering from psychosis; however diagnoses of 'psychotic disorder' are used in discussions around ethnicity, marital status and household income.

Figure 25
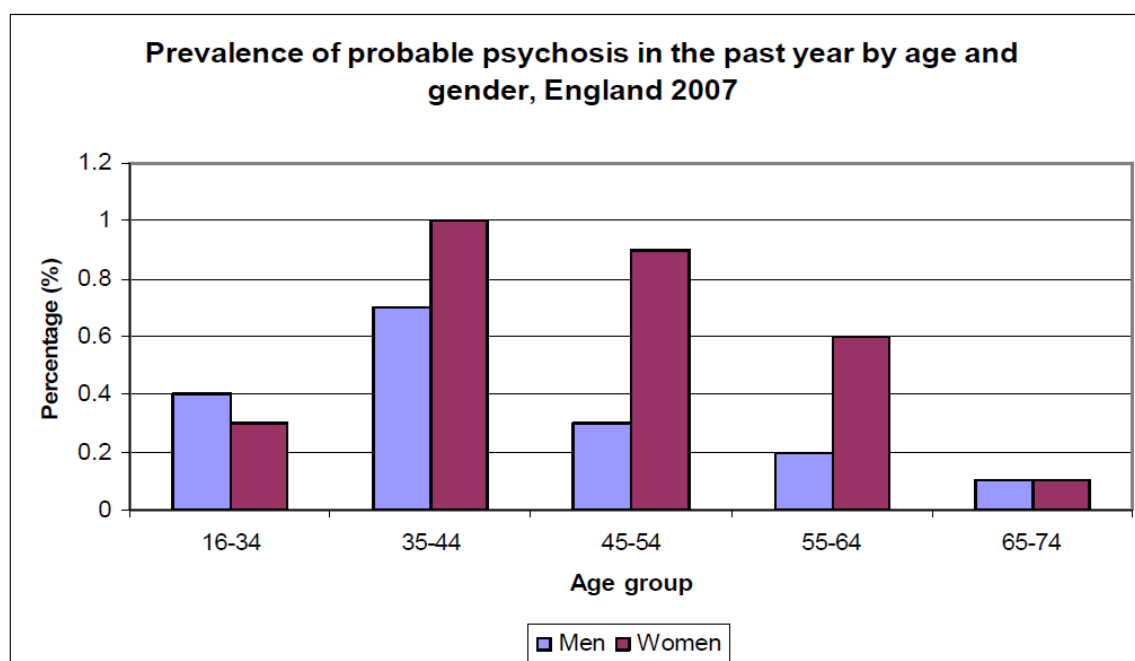
Source: Adult Psychiatric Morbidity Survey 2007.

The 2007 Adult Psychiatric Morbidity Survey found 0.4% (0.3% of men and 0.5% of women) of people to have had signs of a psychotic disorder in the past year (prior to interview - see figure 25). However, the sample size was small (due to a number of refusals or non-contacts for the phase two interview) so a second approach to estimate 'probably psychosis' was used. The prevalence of probably psychosis was found to be 0.5% of adult aged 16-74yrs. 0.4% of men and 0.6% of women were found to have 'probable psychosis'. Probable psychosis rates were slightly higher in men aged 16-34yrs than women in the same age group (0.4% and 0.3% respectively) and overall rates of probable psychosis are highest for both sexes in the 35-44 age group and as with other mental illnesses the prevalence of psychosis tends to decrease with age.

Based on age and sex prevalence rates almost 4,300 Kent people (2010) are estimated to have probable psychosis. Due to population growth this is predicted to rise to by 4509 2016 and 4566 by 2020 (table 12). In Ashford this is estimated to be 310 people rising to 325 by 2020.

Figure 26

Estimated Numbers of Psychotic Disorder (18-64) in Kent CCGs

	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	187.275	336.64	382.84	451.005	291.765	160.13	204.63	698.935
■ Persons	296.748	530.935	605.059	715.776	466.212	256.058	323.436	1106.365

Source: APMS 2007 & KMPHO

Table 12 Projected Increases of People with Psychosis from 2013 to 2020 by Kent CCGs

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

Source: KMPH0 2013

The sample size for psychosis, when split by ethnic group was small in this survey so the data presented below should be handled with caution. However, the figures suggest black people, particularly black men, have an increased risk of experiencing psychosis (3.5 times higher than white people). This increased risk is likely to be linked with discrimination and social circumstances. The prevalence of psychosis increases with decreasing levels of equivalised household income (figure 30) with

overall prevalence rising from 0.1% in the highest income quintile to 0.9% in the lowest income quintile. This trend was stronger among men than women, with

1.2% of men in the lowest income quintile suffering from psychosis.

Nationally, 35% of respondents with a psychotic disorder in the past year were not receiving any treatment for a mental or emotional problem. Among the 65% who were receiving treatment combined counselling and medication was most common (40% of those with a psychotic disorder in the last year).

Almost half of respondents receiving treatment were accessing counselling or therapy, most often psychotherapy or cognitive/behaviour therapy. Over two thirds of respondents with psychosis in the last year had spoken to their GP in the past year, compared to 74% of people with probable psychosis. Almost a quarter with psychosis had an outpatient stay in the last quarter and 3% had an inpatient stay in the last quarter (all in relation to a mental or emotional disorder). Additionally two thirds of people with psychotic disorder had accessed community care, mainly psychiatrists or community psychiatric nurses.

Figure 27
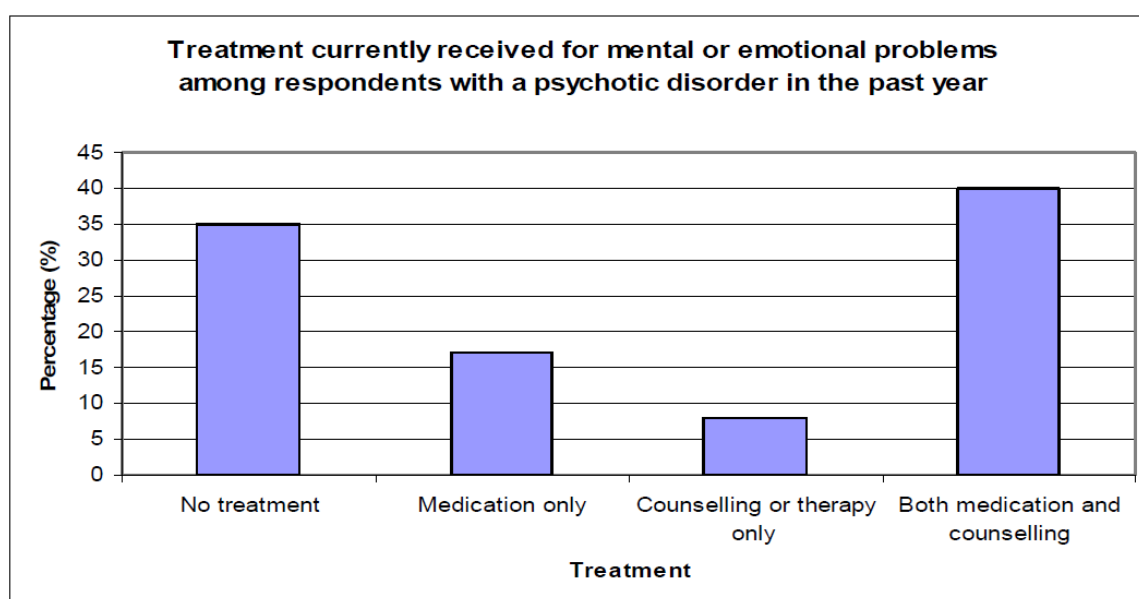
Source: Adult Psychiatric Morbidity Survey 2007.

Estimates for Post-traumatic Stress Disorder

Experiencing or witnessing an external traumatic event that is potentially life-threatening can lead to feelings of anxiety, distress and insomnia. A few people experiencing such trauma may also go on to develop Post Traumatic Stress Disorder (PTSD), generally within three to six months of the event. PTSD is characterised by re-experiencing the traumatic event (through flashbacks or nightmares), avoidance and hyper-vigilance.

The APMS 2007 asked respondents whether they had experienced major trauma[44], both ever or since the age of 16yrs. If major trauma was experienced since the age of 16 a screening questionnaire was delivered to screen for characteristics of PTSD. A positive screening is not in itself does not confirm a diagnosis of PTSD but would warrant a clinical assessment. Overall 3% of respondents screened positive for PTSD, with no significant differences between genders. Positive screening for PTSD generally decreased with age, with the exception of women aged 45-54 who had high rates of positive PTSD screens (5.8%).

Figure 28
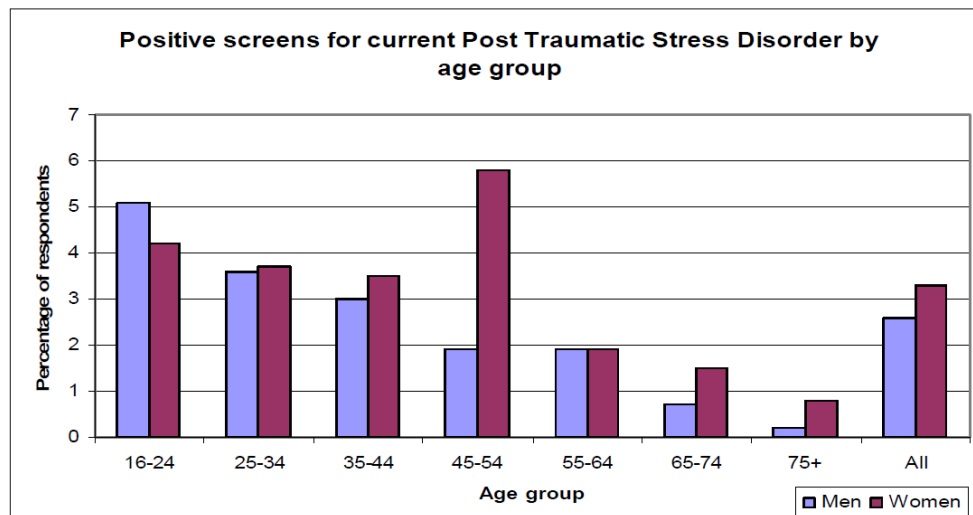
Source: Adult Psychiatric Morbidity Survey 2007.

Figure 29
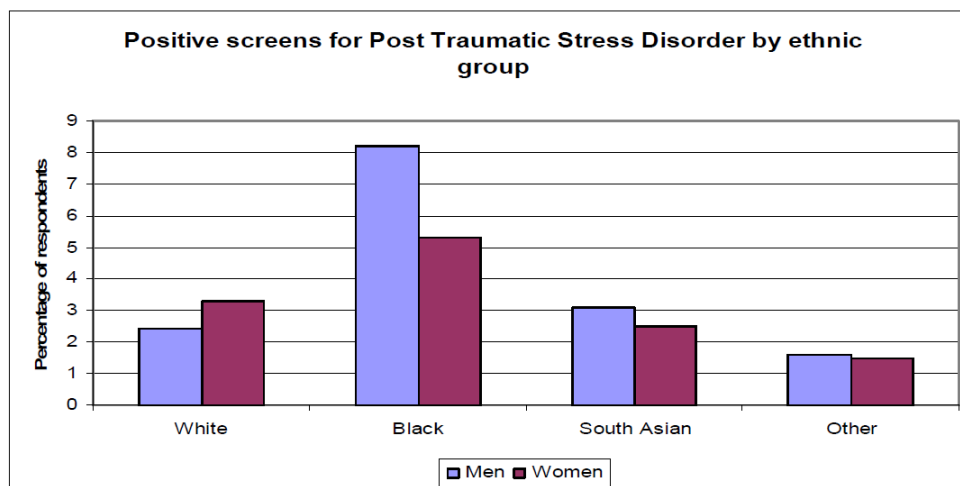
Source: Adult Psychiatric Morbidity Survey 2007.

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[44] Interviewers clarified with respondents which traumatic events were relevant with the following statement: '*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.*'

Younger people tended to have lower rates of experiencing trauma but relatively high rates of positive screening. 23.5% of respondents aged 16-24 had experienced trauma since the age of 16 compared to 33.3% of all respondents, whereas 4.7% aged 16-24 screened positive of PTSD compared to 3% of all respondents. A conditional probability of developing PTSD given a trauma had occurred since age 16 can be applied to groups and this was high for 16-24yr olds at 19.8%, compared to 8.9% of all respondents that had experienced trauma since 16. PTSD screening results by ethnicity suggest rates are highest among black men at 8.2%, compared to 2.4% in white men and 3.1% in south Asian men and 1.6% in men from other ethnic groups. Black women also appear to have higher rates of positive PTSD screens than women form other ethnic groups; however differences between women were removed following age-standardisation of results.

Although there were no significant differences in the proportion of respondents experiencing trauma by equivalised household income there were differences in the proportion with positive screens for PTSD (figure 30). This may be due to different types of trauma being experienced by people with lower incomes, different coping mechanisms or having PTSD may impact on household income.

Figure 30
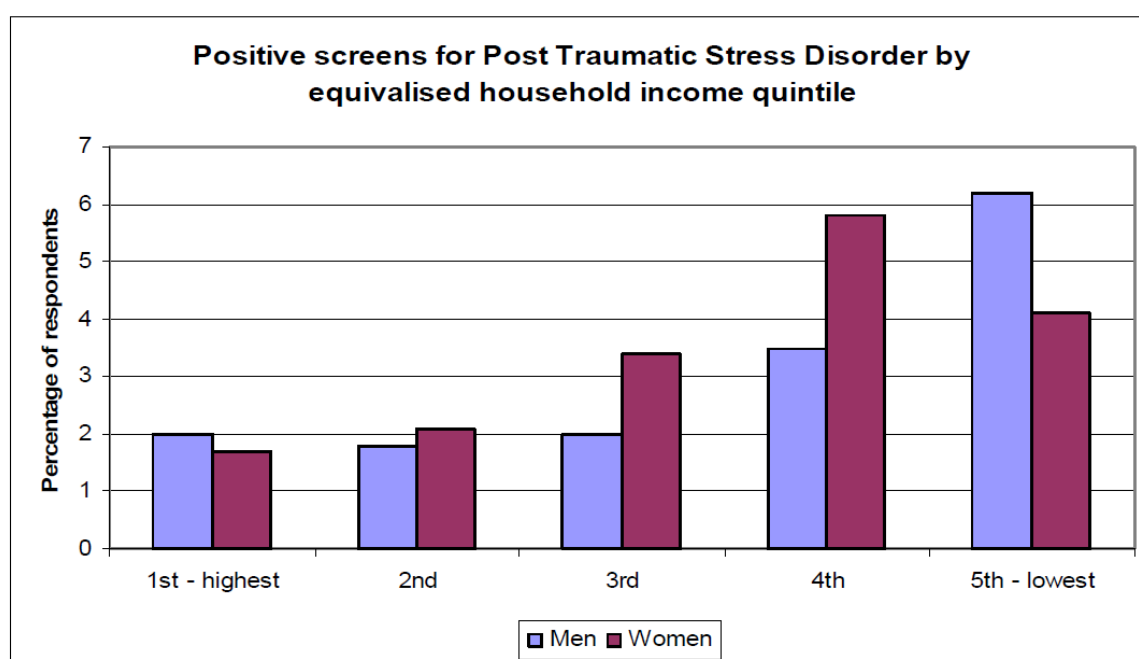
Source: Adult Psychiatric Morbidity Survey 2007.

Table 13

Projected Numbers of people with PTSD in Kent CCGs from 2013 to 2020	2013	2016	2020
NHS Ashford CCG	**2895**	**2945**	**3000**
NHS Canterbury and Coastal CCG	5326	5367	5353
NHS Dartford, Gravesham and Swanley CCG	5915	5882	5593
NHS South Kent Coast CCG	4528	4546	4568
NHS Swale CCG	2484	2510	2502
NHS Thanet CCG	3199	3230	3175
NHS West Kent CCG	10782	10735	10362
Kent	42079	42188	41312

Estimated Numbers of People with Personality Disorders

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

- Irresponsibility
- Deceitfulness
- Indifference to the welfare of others
- Recklessness
- A failure to plan ahead and
- 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 and
- Paranoid thoughts or severe dissociative symptoms (quasi-psychotic).

Nationally only 0.3 of respondents were diagnosed as having antisocial personality disorder and 0.4% as having borderline personality disorder. In Kent there are a predicted 3,713 people with antisocial personality disorder and 4841 people with borderline personality disorder (see figures 31, 32 and 33).

Figure 31

Prevalence of Antisocial and Borderline Personality Disorder, England 2007

Source: Adult Psychiatric Morbidity Survey 2007.

Figure 32

Estimated Numbers of Antisocial Personality Disorder (18-64) in Kent CCGs

	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

Figure 33

Estimated Numbers of Borderline Personality Disorder for Adults (18-64) in Kent CCGs

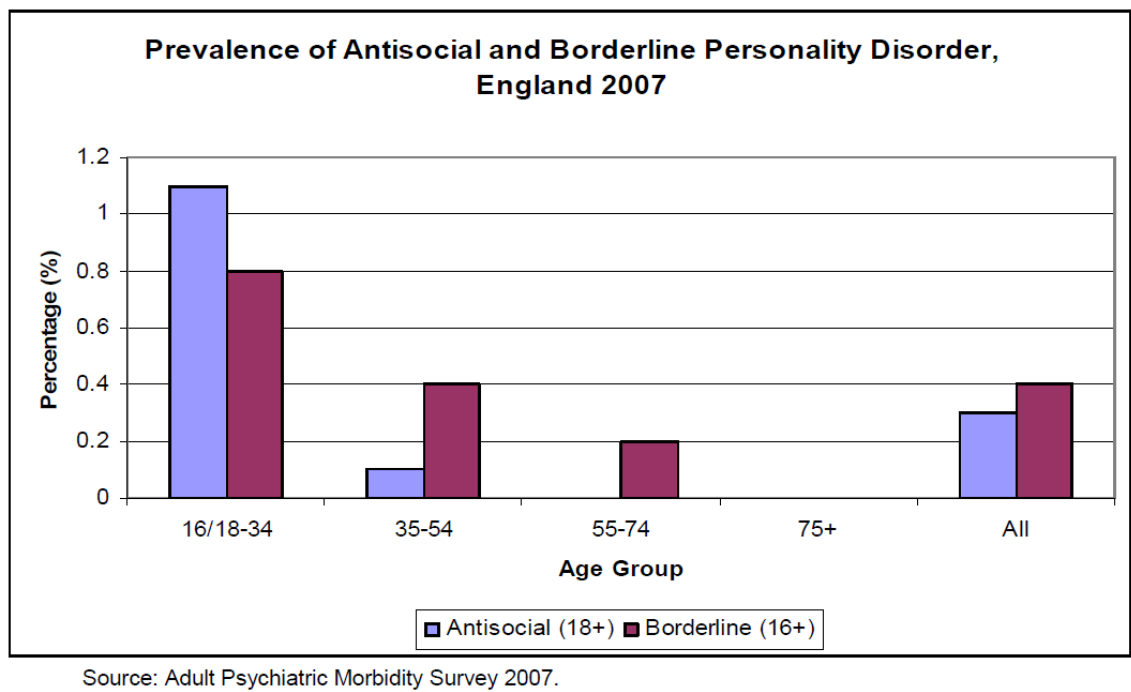|	NHS Ashford CCG	NHS Canterbury and Coastal CCG	NHS Dartford, Gravesham and Swanley CCG	NHS Medway	NHS South Kent Coast	NHS Swale	NHS Thanet	NHS West Kent
■ Males	109.473	194.295	222.219	264.771	174.447	95.928	118.806	407.43
■ Females	224.73	403.968	459.408	541.206	350.118	192.156	245.556	838.722
■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

Adults with Attention Deficit Disorder

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

Identifying the possible presence of ADHD involves a 6 question screen which assesses the presence of six characteristics of ADHD. Presence of four or more characteristics suggests a clinical assessment may be warranted. [i]

The Adult ADHD Self-Report Scale-v1.1 (ASRS-V1.1) does not take in to account differences in behaviour across different situations (work/home life) or the age of onset of characteristics, which are important aspects of a clinical diagnosis of ADHD. Overall 8.2% of adults showed four or more characteristics of ADHD and 0.6% showed all 6 characteristics. The prevalence of ADHD characteristics (four or more) tends to decrease with age, with the highest rates among those aged 16-24yrs.

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

Around 7060 Kent residents in 2012 are estimated to have five - six characteristics of ADHD[ii]. is predicted to rise to almost 2,600 by 2015 (figure 34).

Figure 34

Source: Adult Psychiatric Morbidity Survey 2007.

Figure 35

	Ashford	Canterbury and Coastal	Dartford, Gravesham, and Swanley	South Kent Coast	Swale	Thanet	West Kent
ADHD Screen +	7668	14046	15832	13149	6770	9117	29705
ADHD 5 or 6+ Characteristics	576	1028	1158	962	495	667	2174
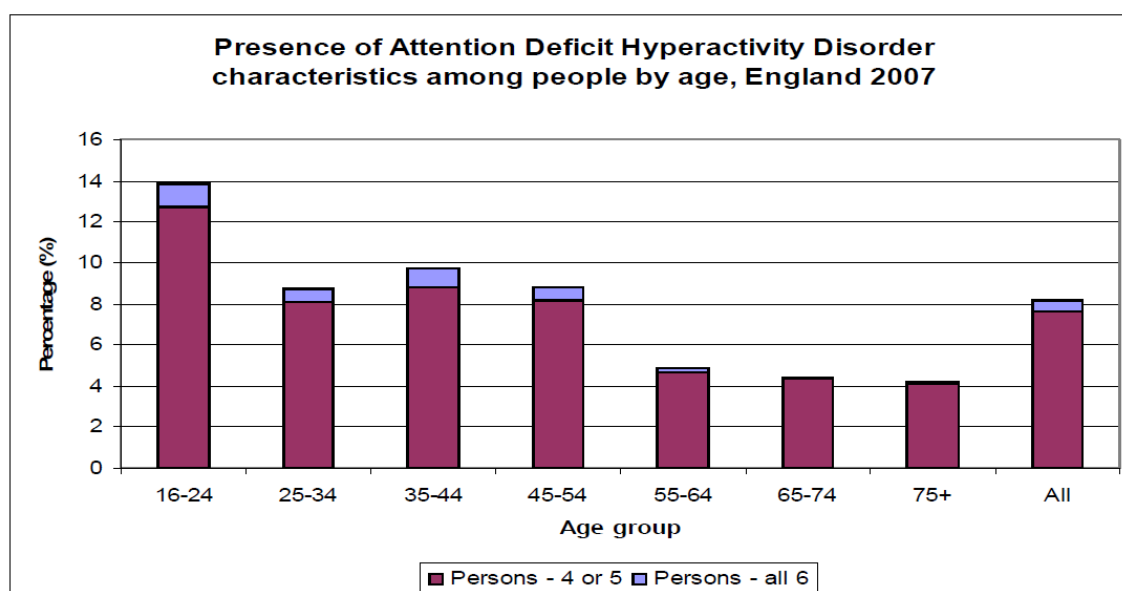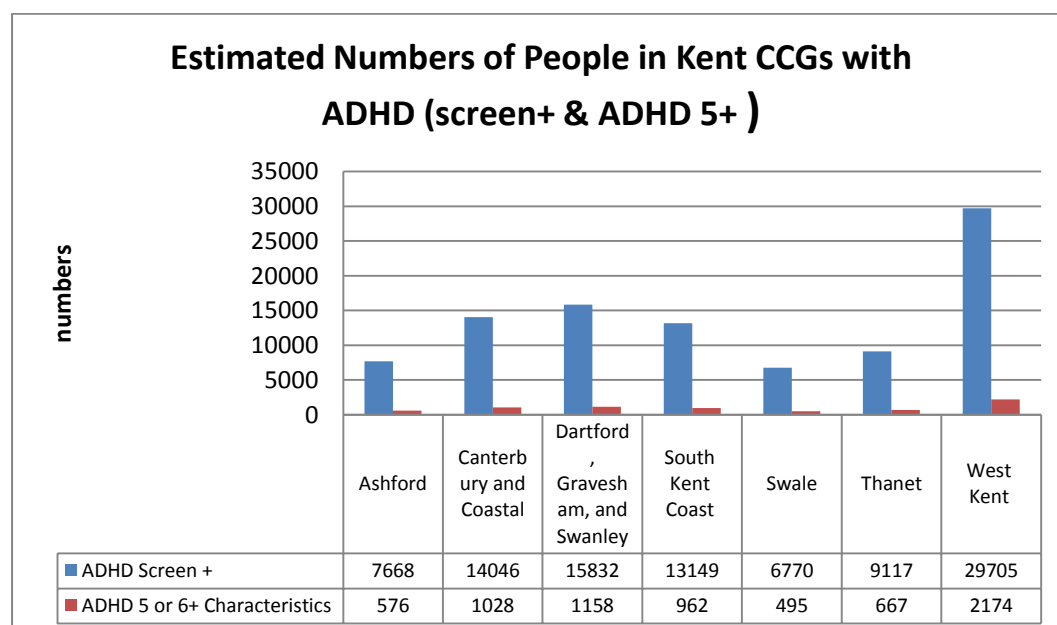
Source: APMS 2007 applied to 2012 Kent population

In relation to employment nationally, men and women who are "economically inactive" (a term which covers students, long-term sick or disabled, retired (early retirement) and those looking after the home) had the highest rates of four or more ADHD characteristics. 21.9% of men and 12.9% of women who were economically inactive showed 4 or more ADHD characteristics. This compares to 8.1% of employed men and 6.8% of employed women.

Older age

Older age is the single most important predictor for cognitive decline and dementia. Older adults are also particularly at risk of social isolation, as they withdraw from the labour market (which may deprive them of a steady income) and become more susceptible to chronic disease (which may deprive them of their mobility, independence and cognitive skills). Feelings of isolation can also come about due to the loss of their partner or friends to illness, or due to inattentive or uncaring family members. The elderly are also vulnerable to physical neglect or abuse, either by formal or informal carers, and this has obvious negative implications for their state of wellbeing. Social and family isolation - and also bereavement - are significant predictors of depression in older age. Since chronic physical illness is also a risk fa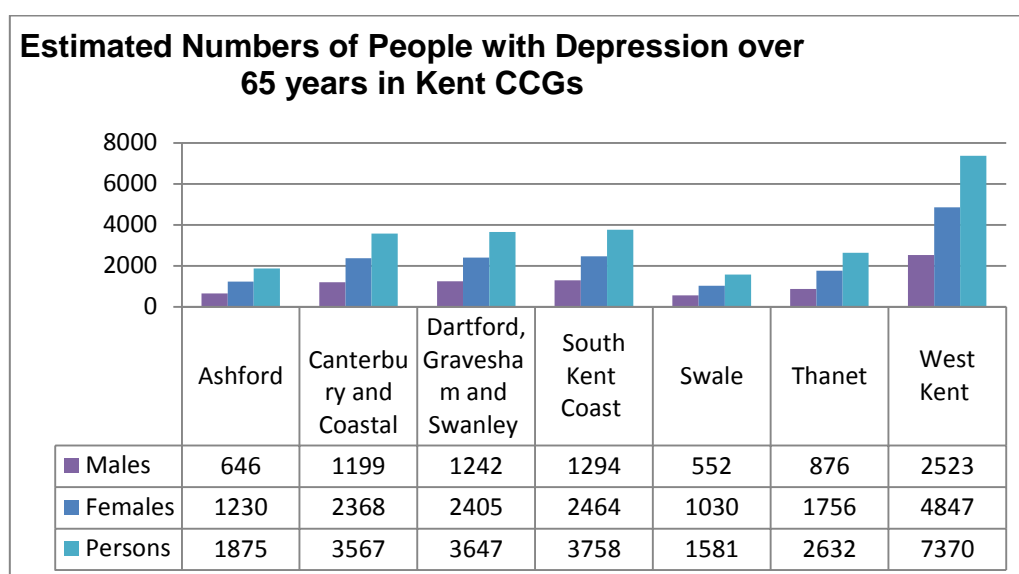ctor for depression, the higher prevalence of physical health conditions in this age group further contributes to elevated rates of depression (see figure 36).

An ageing population will create an increased burden on health services including mental health services. It can be anticipated that there will be higher levels of complexity to respond to due to multiple morbidity, which will require an integrated approach to health.

Alongside this it can be predicted that prevalence of depression amongst older people may increase if family fragmentation as a phenomena continues and growing rates of dementia will bring a whole new spectrum of issues. Not only will this require a new way of approaching health care but health and social care will also need to take a more fundamentally integrated approach. It will also be important to consider how best to support informal carers in the future as demands on them increase.

Figure 36

Estimated Numbers of People with Depression over 65 years in Kent CCGs

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

Source: APMS 2007

Eating Disorder

Please refer to full needs assessment on Eating Disorders (K&MPHO website).

There are two ways to estimate prevalence for eating disorders, firstly to count the numbers of clinical diagnosis made, and secondly to via house hold surveys using an eating disorder screening tool (SCOFF).

Studies looking at the incidence and prevalence of eating disorders in the general population, based on clinical diagnosis, estimate: The incidence of anorexia nervosa to be about 19 per 100,000 per year in females and two per 100,000 per year in males, with rates as high as 50 per 100,000 per year in females aged between 13 to 19 years (Hoek, 1991, Hoek, 2006) The prevalence of bulimia nervosa has been estimated between 0.5 per cent and per cent in young women (Hoek, 1991, Hoek, 2006).

The problem of these studies are that they only count the number of people who present for clinical diagnosis and do not take into account unmet need. The Adult Psychiatric Morbidity Survey (APMS) 2007 provides a prevalence of treated and *untreated* Eating disorders, using the SCOFF screening tool as recommended by NICE thereby giving an indication of unmet need. There are three categories for this a/ screen negative (no disorder) b/screen positive (potential problem) c/screen positive with impact (serious disorder).

The survey found that only 19% of those who screened positive for an eating disorder were receiving treatment for a mental or emotional problem at the time of interview ie 81% of people screening positive were receiving no treatment. The survey shows that the risk of screening positive for eating disorders:

- Was higher among single men and women

- Was not significantly influenced by ethnicity
- Was not significantly influenced by household income

There are more people in the 16-24 age category affected by eating disorders, and most of the predicted cases are for people under 45 years old (table 14). Females are more likely than males to need support for eating disorders and there are a predicted 26,000 serious cases requiring treatment in Kent. Females outnumber males in need by over 400% (table 14). The estimated numbers of cases of people with eating disorders for each Kent CCG is shown in table 15.

Table 14 Kent County Council Estimated Numbers Using APMS SCOFF Tool

Eating Disorder				Eating Disorder with Impact		
age band	male	female		age band	male	female
16-24	5442	17814		16-24	1632	4518
25-34	3915	9504		25-34	626	2851
35-44	3328	10270		35-44	190	2464
45-54	4432	9979		45-54	788	3024
55-64	1752	3720		55-64	87	744
65-74	972	1412		65-74	194	353
75+	305	783		75+	0	98
total	20146	53482		total	3517	14052

Figure 37

Estimated Numbers of People with Eating Disorders in Kent

	males		females	
	screen positive	positive with impact	screen positive	positive with impact
Series1	24496	4199	82460	22408
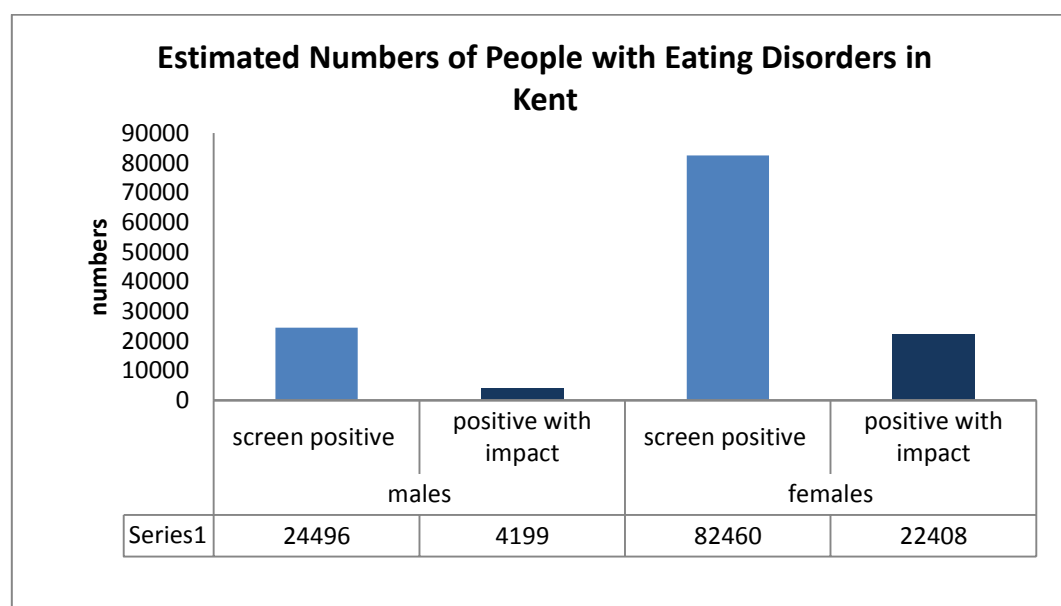
Table 15 Estimated Number of Cases of Anorexia Nervosa 2008 and 2013

	males		females	
	screen positive	positive with impact	screen positive	positive with impact
Ashford CCG	**1684**	**289**	**4686**	**1273**
NHS Canterbury And Coastal CCG	2993	513	8486	2306
NHS Dartford, Gravesham And Swanley CCG	3365	577	9475	2575
NHS South Kent Coast CCG	2823	484	5894	1602
NHS Swale CCG	1467	251	4823	1311
NHS Thanet CCG	1925	330	10574	2873
NHS West Kent CCG	6322	1084	38522	10468

Post Natal Depression

Prevalence of Postnatal depression is estimated at between 10-15% (RCPSych), and applying the lower prevalence to Kent live births 2011 for maternal mothers ages 15-44, the estimates for 2011 are derived. The prevalence is projected to 2015 using average growth rate in birth between years 2007-2011 (see table 16).

Table 16

Estimated numbers of women with postnatal depression		
	2011	**2013**
Ashford CCG	**148**	**155**
Canterbury and Coastal CCG	202	212
Darford, Gravesham and Swanley CCG	322	338
South Kent Coast CCG	208	218
Swale CCG	139	145
Thanet CCG	167	175
West Kent CCG	552	579
Kent	1738	1823
Source: Publc health birth file, and CCG and district population distribution		

Dual Diagnosis (Mental Health and Substance Misuse)

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

Dual diagnosis affects a third of mental health service users, half of substance misuse service users and 70 per cent of prisoners. Service users with a dual

diagnosis typically use NHS services more and cost more.[45]A recent analysis of National Drug Treatment Monitoring Data (July 2013) has revealed that:

- There has been an increase in the proportion of dual diagnosis clients in structured treatment in Kent over the past three years from 11.1% as of July 2011 to 13.7% as of July 2013.
- The proportion of dual diagnosis clients differs across districts with the highest rates of dual diagnosis recorded in Tunbridge Wells (21%), Tonbridge and Malling (20%) and Sevenoaks (20%) and the lowest rates in Ashford (10%) and Dartford (11%).
- Significantly fewer dual diagnosis clients are in regular employment (10%) in Kent compared to non-dual diagnosis substance misuse clients (17%).
- Of the 6,893 dual diagnosis clients, 37.9% were female. This proportion is significantly higher than the proportion of women in structured treatment overall (29.9%).
- Alcohol is the primary substance of misuse for 39.7% of dual diagnosis clients. This is comparatively high with only 27.3 of non-dual diagnosis clients with alcohol as their primary substance.
- Unsuccessful exits have fallen over the past three years for non-dual diagnosis substance misuse clients but have risen slightly for dual diagnosis clients.
- Referral sources have remained stable over the past three years with 42.8% of dual diagnosis clients referring themselves into structured treatment in Kent as of July 2013. GP and psychiatry services however only account for 8.4% of all client referrals. However there has been a recent reduction in referrals from GPs from 12% in 2011/12 to only 7% of all referrals in 2012/13.[46]

A substantial number of adults accessing DAAT services are also receiving mental health care at the same time, and this is increasing. Across Kent, in 2012/13, 19% of adults accessing DAAT services were receiving care from mental health services for reasons other than substance misuse.[47]

There has been a 282% increase in episodes of treatment for Dual Diagnosis in Kent since 2008 (table 17).

The following data is from the 'episodes' of care that are provided in Kent 'Structured Substance Misuse Treatment' services. The term 'episodes' of care means the episode of treatment and one person may have a number of 'episodes' of care. Although this is helpful for payment – this is not a good way to assess need for numbers of patients in treatment and rates were not available for this needs assessment.

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

[46] KDAAT needs assessment 2014 (in press)

[47] ibid

Recommendation: Dual Diagnosis Needs Assessment be carried out in 2014 using analysis from local monitoring data

Table 17

Total Number of Episodes in which the Client has Dual Diagnosis

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

Source: KDAAT 2014

It appears from table 17 that the proportion of episodes of care for dual diagnosis has decreased substantially from 2010-2012. This may be due to changes in commissioning the 'pathway' but without a full understanding of the data and numbers further assessment is not possible.

It appears that episodes of care from most East Coast Kent CCGs have fallen and large increases have been seen in West Kent since 2012 (table 18). It is interesting to note that in Thanet there has been an annual decrease and in Tunbridge Wells – there has been a large increase in 2012. Again: it is important to note that this is 'demand' and not 'need'.

Table 18 Proportion of Dual Diagnosis Episodes per Local Authority

Please note Local Authority is identified via the Client's residential postcode when triaged.

Local Authority	**2008/09 %**	**2009/10 %**	**2010/11 %**	**2011/12 %**	**2012/13 %**
Ashford	5.97%	5.57%	5.75%	6.26%	4.60%
Canterbury	13.52%	16.71%	15.93%	16.22%	14.03%
Dartford	5.66%	3.45%	3.98%	3.32%	2.48%
Dover	7.86%	7.69%	11.36%	9.20%	8.37%
Gravesham	11.64%	9.02%	5.16%	3.19%	6.72%
Maidstone	13.84%	16.45%	11.21%	9.96%	11.08%
Medway	0.31%	0.80%	0.88%	0.26%	0.24%
Sevenoaks	2.52%	1.86%	1.33%	2.94%	4.72%
Shepway	2.20%	4.24%	8.11%	11.24%	9.91%
Swale	4.09%	6.37%	11.95%	12.39%	8.84%
Thanet	19.18%	14.85%	15.93%	17.37%	11.56%
Tonbridge & Malling	4.09%	6.90%	4.13%	3.45%	6.60%
Tunbridge Wells	7.23%	6.10%	4.28%	4.21%	10.85%

A recent joint report from Drugscope and the Centre for Mental Health and the UK Drug Policy Commission called "Dual Diagnosis: A Challenge for the reformed NHS and for Public Health England" urging the following:

- Local Directors of Public Health have the opportunity and potential to transform local services (including those for Dual Diagnosis) – but the report warned that risks due to the broad responsibilities of Public Health Directors may halt progress.
- Joint Commissioning for mental health and substance misuse needs to become the norm. CCG's and local public health structures need to work together with aligned pathways and contracts. It is particularly important that NHS & Public Health England also commission together with local public health in the County Council.
- Concerns exist that the mental health cluster for 'dual diagnosis' is too restrictive and that people with 'dual diagnosis' may be excluded from the Substance Misuse PBR pilot. The two payment systems must work together.
- Health and Wellbeing Boards need to offer a joint forum with Crime and Safety Partnerships to understand the needs of offenders.
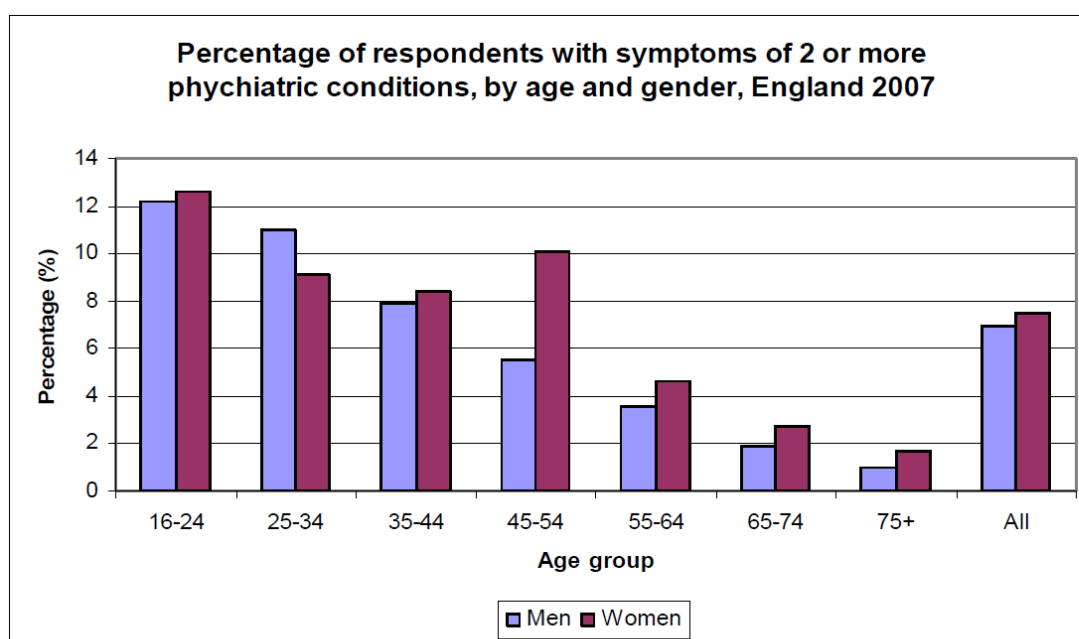- Joined up outcome measures are needed between mental health services and substance misuse services.

Co –Morbidity of Mental Health Disorders in Kent

If a person has more than one mental health disorder they are said to have co-morbid conditions. Co-morbidity of psychiatric disorders is associated with more severe symptoms, greater functional disability, longer duration of symptoms and increased use of health services. 23% of adults screened in the APMS survey screened positive for at least one mental health condition. Of those 19% met the criteria for two conditions and 12% met the criteria for three or more. Application of age-sex prevalence rates to the Kent population shows that around 8% of all adults (aged 16 and over) in Kent are likely to have co-morbid psychiatric conditions.

There were no statistically significant differences in the proportion of males and females with co-morbid conditions. For both genders the prevalence of co-morbidity decreased with age, with 16-24 year olds being most likely to have co-morbid conditions (12.4%) and just 1.5% of people aged 75 and over (figure 38).

There was a small spike in the proportion of women aged 45-54yrs suffering from co-morbid mental health conditions. A spike among women in this age group has also been seen across a number of the mental health conditions considered above (including mixed anxiety and depression, generalised anxiety, depressive episodes and obsessive compulsive disorder, as well as eating disorders).Overall there are 77,203 people registered in Kent who are likely to have a co-morbidity of psychiatric condition (figure 39).

Figure 38

Percentage of respondents with symptoms of 2 or more phychiatric conditions, by age and gender, England 2007

Source: Adult Psychiatric Morbidity Survey 2007.

Figure 39

Estimated Numbers of People (18-64) with Two or More Psychiatric Disorders in Kent CCGs

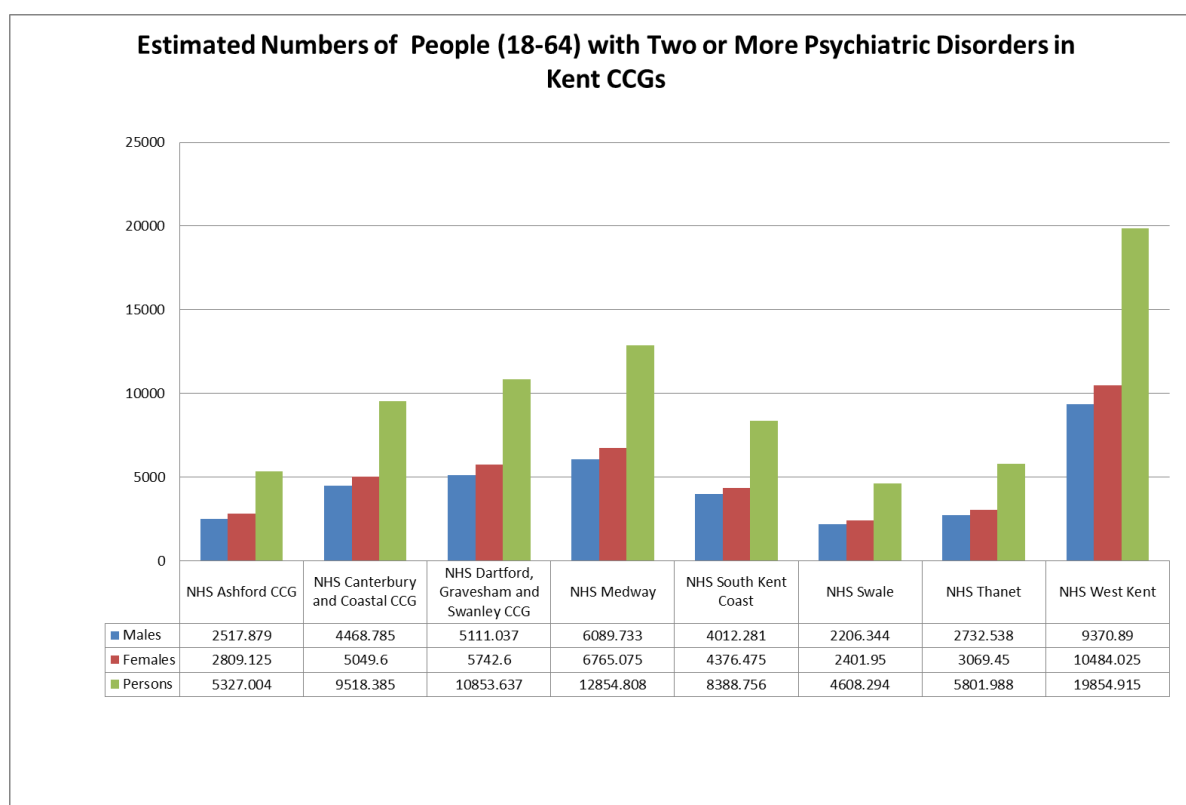|	NHS Ashford CCG	NHS Canterbury and Coastal CCG	NHS Dartford, Gravesham and Swanley CCG	NHS Medway	NHS South Kent Coast	NHS Swale	NHS Thanet	NHS West Kent
Males	2517.879	4468.785	5111.037	6089.733	4012.281	2206.344	2732.538	9370.89
Females	2809.125	5049.6	5742.6	6765.075	4376.475	2401.95	3069.45	10484.025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

Table 19 Co-Morbidities of Mental Health Conditions

Mental health condition	Number of other conditions strongly correlated with	Other conditions strongly correlated with
Psychotic Disorder	10	GAD, OCD, depressive episodes, panic disorder, BPD, ASPD, PTSD, ADHD, eating disorder and suicide attempts
Antisocial personality disorder	10	OCD, depressive episodes, panic disorders/phobia, psychosis, BPD, PTSD, ADHA, alcohol dependence, drug dependence and problem gambling
Panic disorder/phobia	9	GAD, OCD, depressive episodes, psychosis, BPD, ASPD, PTSD, ADHD and suicide attempts
Depressive episode	9	GAD, OCD, panic disorder/phobias, psychosis, BPD, ASPD, PTSD, ADHA and suicide attempts
Borderline personality disorder	9	GAD, OCD, depressive episodes, panic disorders/phobia, psychosis, ASPD, eating disorders, drug dependance and suicide attempts
OCD	8	GAD, depressive episodes, panic disorder/phobia, psychotic disorder, borderline personality disorder, antisocial personality disorder, PTSD and suicide attempts
Suicide attempt	7	GAD, OCD, depressive episodes, panic disorder/phobia, psychosis, BPD and ADHD
PTSD	6	OCD, depressive episodes, panic disorder/phobia, psychosis, ASPD, ADHD
GAD	6	OCD, depressive episodes, panic disorder/phobia, psychotic disorder, borderline personality disorder, suicide attempts
ADHD	6	Depressive espisodes, panic disorder/phobia, psychosis, ASPD, PTSD and suicidal thoughts
Eating disorder	2	Psychosis, BPD
Problem gambling	1	ASPD

Source: APMS 2007

6. Demand: Primary and Secondary

Prevalence (QoF[48]) in Primary Care

Diagnosis and Treatment in Primary Care

As part of the GP contract, which commenced on the 1st April 2004, general practices obtain points for achievements against a range of indicators. The system is known as the Quality and Outcomes Framework (QOF) and is used for calculating financial payment.

One of the achievements is forming registers of patients with specific diseases. For Mental Health (excluding Dementia) – there are two relevant for this report. There is one for people with depression, and one for people with a serious mental illness (schizophrenia, bipolar disorder and other psychosis.

QOF Mental Health

This shows the prevalence of patients within the CCG localities who are recorded on a GP register as suffering from depression and on the GP practice Mental Health register. The Mental Health register includes patients with schizophrenia, bipolar disorder and other psychoses. Although there is variation between areas, these figures are based on practice registers so differences in recording can affect these prevalence figures

QOF Depression in People with Long-term Conditions

These are linked to other sections of the QOF around long-term conditions, to enable case finding of patients suffering from depression alongside long-term conditions. Data is collected around diabetes and coronary heart disease and also looks at the care of people who are identified as suffering from depression by looking at whether an assessment of severity was made and whether further assessments were made in an appropriate time scale. The way the data is collected shows the numbers and proportions of patients offered this intervention and is therefore presented as a percentage

From these registers, the prevalence of these conditions can be estimated bearing in mind that the registers count patients with a *diagnosis*, and there may be a high proportion of patients who have the disease but it is undiagnosed.

Some Issues with using QOF Data (Caveats)

The figures are unadjusted for influencing factors, such as the ages of patients in the practice and deprivation. Practices with a high proportion of elderly patients and practices in deprived areas will tend to have a higher prevalence of disease (and generally a higher prevalence of undiagnosed disease). Patients who have joined the practice within the last three months of any financial year are automatically excluded from this assessment of the register and care indicators. The prevalence is

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[48] Quality and Outcomes Framework (a quality and payment mechanism in primary care)

calculated using the data extracted on 14t[h] February and the list size on 1st January. Any difference between the score for a care indicator and the actual number of patients on the register is the number of exceptions. Patients can be made exceptions from a particular indicator if it is medically inappropriate for that particular person or that particular patient did not attend a particular review. This was introduced so that practices are not penalised, as some of the on-going care indicators depend on achieving a specified percentage of patients receiving the designated level of care.

QOF Prevalence Rates in Kent

The data in figure 40 describes the prevalence rates for serious mental illness across CCGs in Kent. The rate for England is 0.8 and only one CCG, Thanet, has rates higher than the England average. South Kent Coast CCG has the second highest rates in Kent, followed by Canterbury and Coastal CCG.

Figure 40
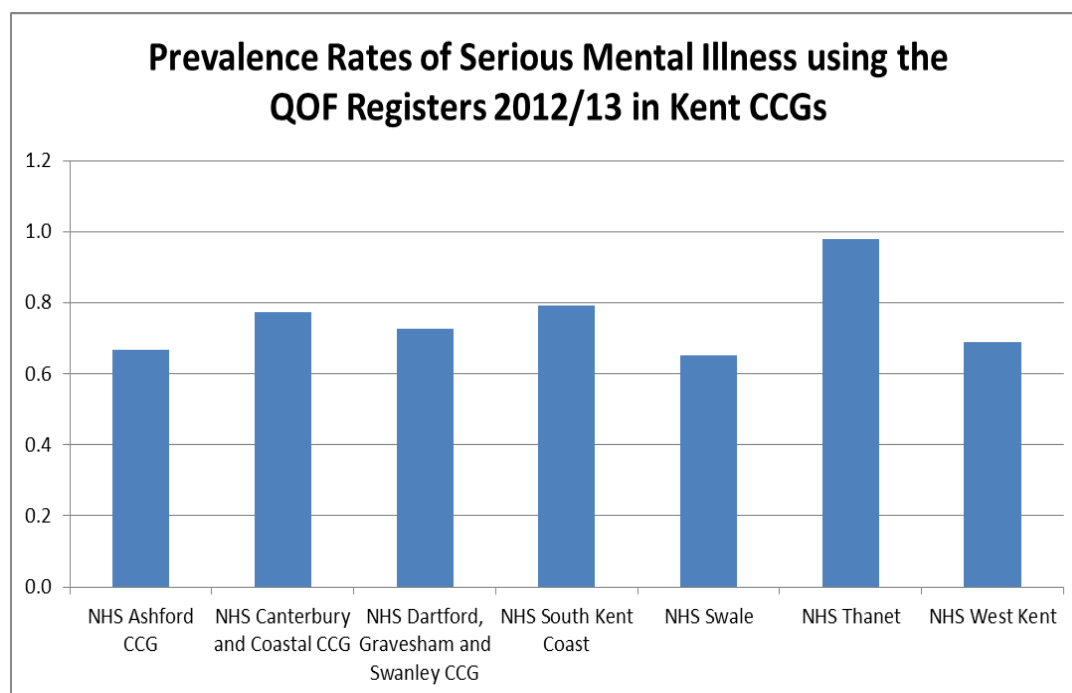
Source QOF 2013

Across the whole of Kent there are 11,215 people on the QoF register for SMI in 2012/13. West Kent has the highest numbers due to their larger population size (figure 41).

For depression QOF Ashford CCG has the highest prevalence rates in Kent and are fairly high compared to the England average. Both Swale and South Kent Coast CCG have slightly higher than the England average for depression (figure 43). There are just over 66,000 people on the QOF depression register in Kent as a whole.

In the north of Kent (DGS & Swale CCGs) there are a high percentage of practices meeting the expected needs of patients in primary care for serious mental illness. This is a general indicator that GPs are managing patients appropriately (figure 45). However there is variable quality in primary care across Kent eg South Kent Coast, Thanet and West Kent (figure 46) have practices performing well, performing below average and a small number where there may some concern that mental health need is not being picked up at all eg 9% of Thanet practices were well below expected SMI prevalence. CCG's will work with their constituent practices to empower primary care to provide at least adequate mental health care and services for their population.

Figure 41

Number of People on the GP QOF Register for Serious Mental Illness 2012/13 by Kent CCG

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

Figure 42

Prevalence Rates of Depression Using the GP QOF Registers 2012/13 in Kent CCGs

	NHS Ashford CCG	NHS Canterbury and Coastal CCG	NHS Dartford, Gravesham and Swanley CCG	NHS South Kent Coast	NHS Swale	NHS Thanet	NHS West Kent	England
Prevalence	7.5	5.1	4.5	6.0	6.2	6.1	5.3	5.8

Figure 43

Number of People on the GP QOF Register for Depression 2012/13 in Kent CCGs

	NHS Ashford CCG	NHS Canterbury and Coastal CCG	NHS Dartford, Gravesham and Swanley CCG	NHS South Kent Coast	NHS Swale	NHS Thanet	NHS West Kent
Number	7103	8771	8877	9733	5220	6842	19543

Figure 44

Table 20

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

Table 20 compares the CCGs 2011/21 QoF performance with the expected prevalence applied to Kent CCGs from the APMS 2007 for both depression and SMI. This shows that overall the CCG with the highest GAP in unmet need was DGS CCG.

Within Ashford however, there is considerable variation in mental health prevalence amongst GP practices with several above the CCG average and many below (figure 45).

Figure 45
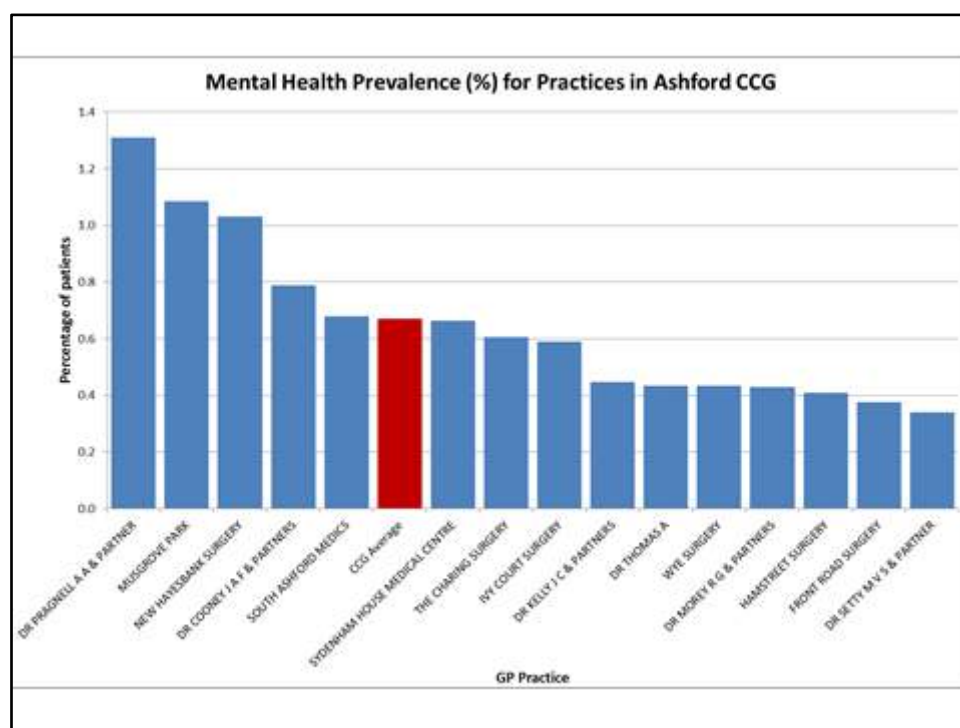
Primary Care Counselling Services

In table 21 the number of referrals from primary care to counselling services was compared to the estimated number of need for the three quarters of 2013 – in that time the CCG with the highest % referred to counselling was South Kent Coast CCG and smallest proportion was West Kent CCG. A forthcoming Equity Audit on IAPT counselling services will capture the full picture in 2014. Across Kent only roughly a quarter of people who need NHS counselling services are referred to IAPT counselling from primary care. However CCGs can help make people be aware that they do not need a referral from primary care to access counselling services.

Table 21 Number of people referred to IAPT services by CCGs in Kent 2013-2014

	Estimated pop at need	IAPT referrals Q1-Q3 2013/14	Estimated 2013/14 IAPT referrals	Gap	% of total in need referred to IAPT services
Ashford	11163	2775	3700	7463	33.1%
Canterbury and Coastal	20296	4552	6069	14227	29.9%
Dartford, Gravesham and Swanley	21852	2568	3424	18428	15.7%
South Kent Coast	17594	4738	6317	11277	35.9%
Swale	9720	2295	3060	6660	31.5%
Thanet	12581	2575	3433	9148	27.3%
West Kent	40509	4953	6604	33905	16.3%

'Secondary' Services and Service Use Models

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

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

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

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

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

Stepped Care

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

The National Institute of Health Research (2010) and the current NICE Guidance advocates for a *'stepped care'* approach to treatment (sometimes known as a

'pathway' approach) (Goldberg and Huxley 1980). The 'stepped care' model illustrates what proportions of people are likely to access which part of the service at any one time.

This is important because it shows that not everyone who seeks help for mental health problems will need to go to hospital, some people can be effectively managed in primary care.

To answer the question about what proportion of patients need to be in which part of the mental health system, the numbers from a model by Huxley et al (1995) have been used here (table 22). The following population estimates of expected numbers are made for Kent based on this hierarchical schema of stepped care and are provided only for guidance for commissioners. This is only a model and *not* meant to be literal predictor of need (due to the wide confidence intervals).

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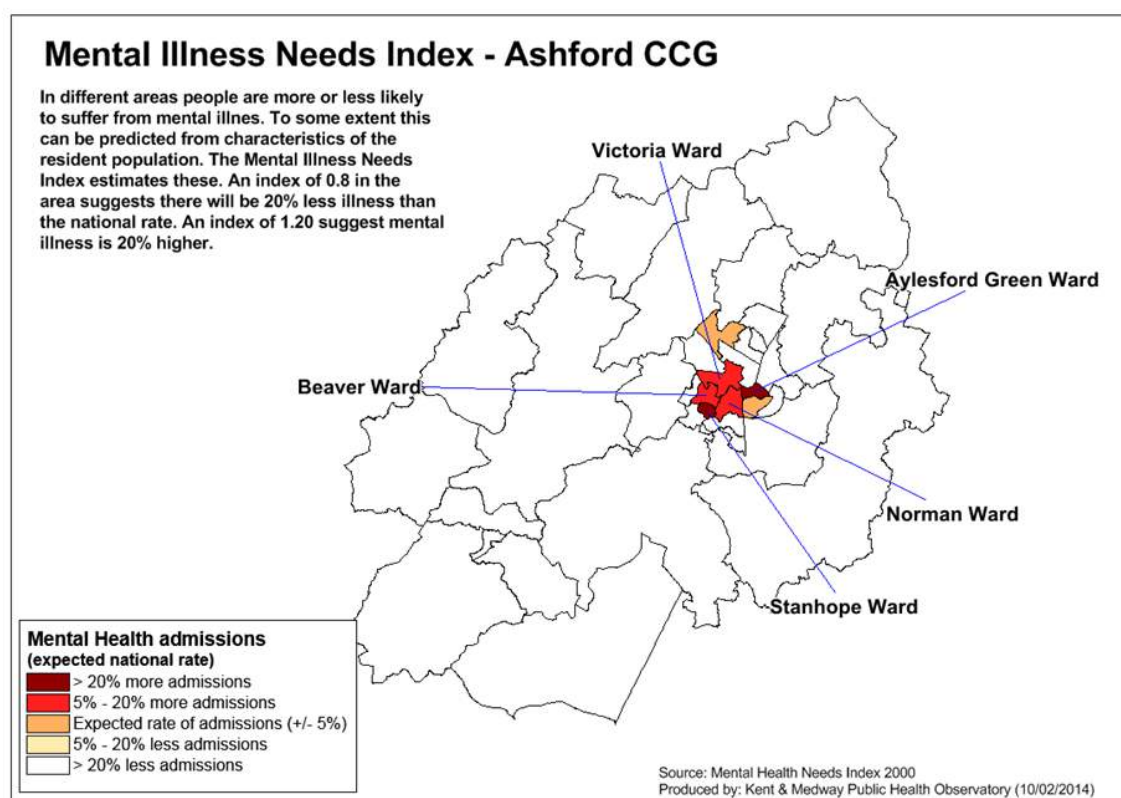
The model below shows that a far smaller proportion of patients will be seen in the community/ inpatients compared to those seen in primary care.

The Mental Health Needs Index 2000 (figure 46) is a national predictor of expected prevalence of *serious* mental illness and assumes that serious mental illness admissions will be greater in areas of deprivation. Therefore it takes into account various local 'poverty' indicators as well as the number of mental health admissions and generates a 'score' based on this assumption. For South Kent the MINI 2K's scores have been mapped for each south Kent district and it shows that there will be higher mental health admissions from those areas such as Snodland, ParkWood, Sherwood and Swanley. When the contact rates are measured and mapped in figures 50 &51 there is a similar pattern for expected and actual rates of serious mental illness, the wards with the highest rates are in the more deprived areas of west Kent.

Table 22

	Number develop symptoms		Attend primary care	GP identifies disorders	GP refers to psychiatric services		Outpatients		Inpatients
	Lower estimate	Upper estimate			Lower estimate	Upper estimate	Lower estimate	Upper estimate	
Ashford	25754	30707	22783	22783	1981	2972	991	1981	495
Canterbury and Coastal	46218	55106	40885	40885	3555	5333	1778	3555	889
Dartford, Gravesham, and Swanley	51774	61731	45800	45800	3983	5974	1991	3983	996
South Kent Coast	**42951**	**51210**	**37995**	**37995**	**3304**	**4956**	**1652**	**3304**	**826**
Swale	22172	26436	19614	19614	1706	2558	853	1706	426
Thanet	29809	35542	26370	26370	2293	3440	1147	2293	573
West Kent	97095	115767	85891	85891	7469	11203	3734	7469	1867
Kent	320616	382273	283622	283622	24663	36994	12331	24663	6166
Source: Goldberg & Huxley, patient flows for adult mental ill-health									
in Stevens A, Raftery J, Mant J, et al. Health care needs assessment (third series) Radcliffe, 2007, p 608.									

Figure 46

Mental Illness Needs Index - Ashford CCG

In different areas people are more or less likely to suffer from mental illnes. To some extent this can be predicted from characteristics of the resident population. The Mental Illness Needs Index estimates these. An index of 0.8 in the area suggests there will be 20% less illness than the national rate. An index of 1.20 suggest mental illness is 20% higher.

Victoria Ward
Aylesford Green Ward
Beaver Ward
Norman Ward
Stanhope Ward

Mental Health admissions (expected national rate)
> 20% more admissions
5% - 20% more admissions
Expected rate of admissions (+/- 5%)
5% - 20% less admissions
> 20% less admissions

Source: Mental Health Needs Index 2000
Produced by: Kent & Medway Public Health Observatory (10/02/2014)

'Clustering' – A Needs Based System Payment System

Traditionally secondary MH services have been commissioned using a block contract model and services are commissioned for capacity (X number of teams with X number of staff). The system is changing to a system which is focused on needs and outcomes. There is a new 'payment mechanism' for providers of mental health services and this is generically known as the Mental Health tariff, where patients are organized in clusters according to their particular need for that service. Patients are assigned to super clusters (A, B or C figure 48) on the basis of assessments (involving diagnosis) using a mental health clustering tool. In this context, cluster can be interpreted as a global description of a group of people with similar characteristics as identified from a holistic assessment and rated using the Mental Health Clustering Tool (MHCT).

The tool has 18 scales. Two things can happen upon referral – a person can be assessed to not need the services on offer or be appropriate for intervention and assigned to a treatment cluster.

Clustering (figure 47), in practice, follows an initial assessment (typically within two contacts) and then the person is allocated to the most appropriate cluster. Each cluster represents a package of care for a defined period of time. At the end of the defined period the individual is reviewed and can be re-assigned to the same cluster (care package) or a new cluster depending on need. A review can also be instigated where there is significant change in planned care and additional services are deemed necessary (eg unplanned reviews, urgent admissions etc.).

Service Data and Clustering: A few problems in assessing population need from payment data

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

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

However – what is available from the mental health providers is the total l numbers of patients in the system (table 23).

There are also three sets of prevalence estimates described in table 23.

- APMS: ALL serious conditions. This is data from the National Survey and picks up considerable 'unmet' need (ie people NOT known to services who could benefit from treatment.

- APMS: psychosis: These are the expected numbers of people with the most severe and enduring psychosis.
- QOF: these are the numbers of people who are on a GP register who have serious mental illness (i.e known to primary care).
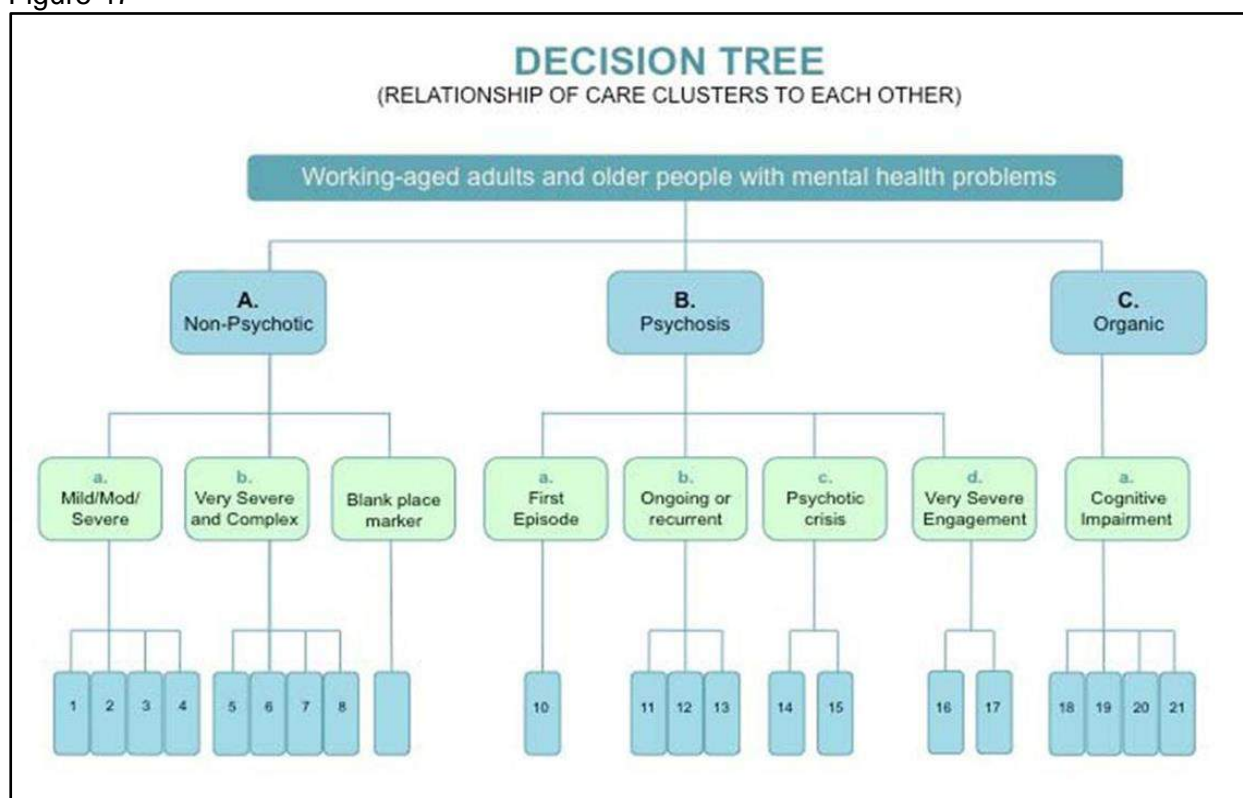
As the data quality is poor, this shows only four things clearly:

- There is unmet need in the community.
- The data from mental health services needs to be understood more fully by commissioners to ensure against double counting and poor coding.
- There are more people on the QOF register then are predicted both by APMS and on secondary care services and this may mean three things.

  a.   that there is considerable double counting
  b.   there are patients being treated in successfully in the community by primary care – not known to secondary services
  c.   there has been movement from secondary to primary using 'recovery' model.
- All three (a, b & c) may be happening.

The over-arching and overwhelming recommendations from this data are:

1. **Urgently ensure that the available data is cleansed and understood more fully, both through previous national data sifting processes and local commissioning.**

2. **Urgently conduct health equity audit on Community/Secondary Mental Health services.**

3. **Ensure there is a local 'deep dive' into the APMS survey to ensure that National estimates are accurate. This is underway for the 2015 survey and led by Public Health in Kent.**

Figure 47

DECISION TREE
(RELATIONSHIP OF CARE CLUSTERS TO EACH OTHER)

Working-aged adults and older people with mental health problems

A. Non-Psychotic | B. Psychosis | C. Organic

a. Mild/Mod/ Severe | b. Very Severe and Complex | Blank place marker | a. First Episode | b. Ongoing or recurrent | c. Psychotic crisis | d. Very Severe Engagement | a. Cognitive Impairment

1 2 3 4 | 5 6 7 8 | | 10 | 11 12 13 | 14 15 | 16 17 | 18 19 20 21

Ethnicity of Patients

Of all people in KMPT services 86% classified themselves as white, 3% of these were self-classified as 'white other'. In Kent the estimated population of people who are BME is 6%. From the data in table xx 6% of the KMPT caseload is BME which is in proportion to local equity. However there are 10% who are not classified.

Learning Disability

Patients were also investigated for learning disability conditions, and about 1.8% of them were identified to have the condition in addition to other mental health conditions (table 12). The distribution of mental health patients diagnosed with or suspected of having learning disability by CCG is shown below. Dartford, Gravesham and Swanley and Swale had the highest rates compared to other CCGs.

Table 23 Numbers of People in 'Secondary' Mental Health Service (i.e people with a serious Mental Health Diagnosis known to services).

	Ashford		Canterbury & Coastal		Dartford, Gravesham & Swanley		South Coast Kent		Swale		Thanet		West Kent	
	Expected (E) APMS	Actual (A)	E	A	E	A	E	A	E	A	E	A	E	A
APMS	4040	655	**7100**	1368	**8200**	1154	**6370**	1191	5250	431	**3500**	1024	**15,100**	1922
Psychosis	300		530		605		292		256		323		1106	
QOF	817		1662		1821		1592		702		1389		3232	

Total : 4594 at December 2013 Source: KMCS

Table 24

Learning disability	LD	Estimated pop with learning disability per 100,000, ages 16+
Ashford	42	42.40
Canterbury & Coastal	53	29.82
Dartford, Gravesham & Swanley	93	46.70
South Kent Coast	72	43.59
Swale	40	46.91
Thanet	34	29.66
West Kent	95	25.44
Kent	429	29.70

Source: KMPT, 2013

## Employment Status of Patients on Continued Care Pathway

Employment is an important social outcome for people on Care Programming Approach (CPA) for serious mental illness as it indicates recovery. The proportion of adults on CPA within employment varies across CCGs in Kent. Thanet (1.69%) and South Kent Coast 4.7% had the lowest rates, while Ashford (11.9%) and Dartford, Gravesham and Swanley (10.7%) had the highest. But, all CCGs show an employment rate that is lower than the National threshold (13%).

Contact Rates for Secondary Mental Health Services in West Kent

The average contact rate (the proportion of individuals in contact with KMPT services) in Kent is 26 per 1,000 people (one year's data December 2012-November 2013). This data is for any contact with any KMPT service. The electoral wards in South Kent Coast CCG (figure 49) demonstrate a wide range of mental
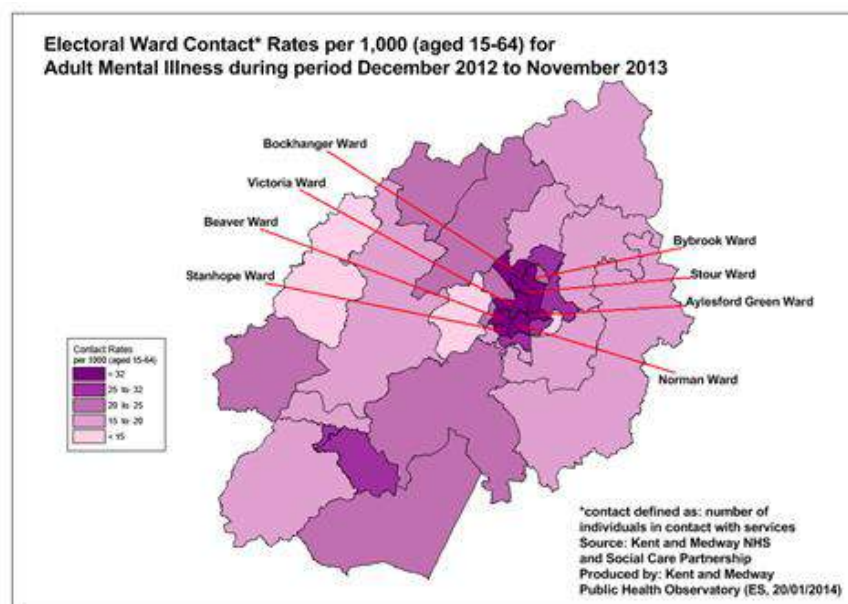
health contact rates with some well below the average rate for the CCG as a whole and Kent and Medway as a whole and some well above

Figure 48: Adult Mental Health Contact rates for electoral wards in Ashford CCG
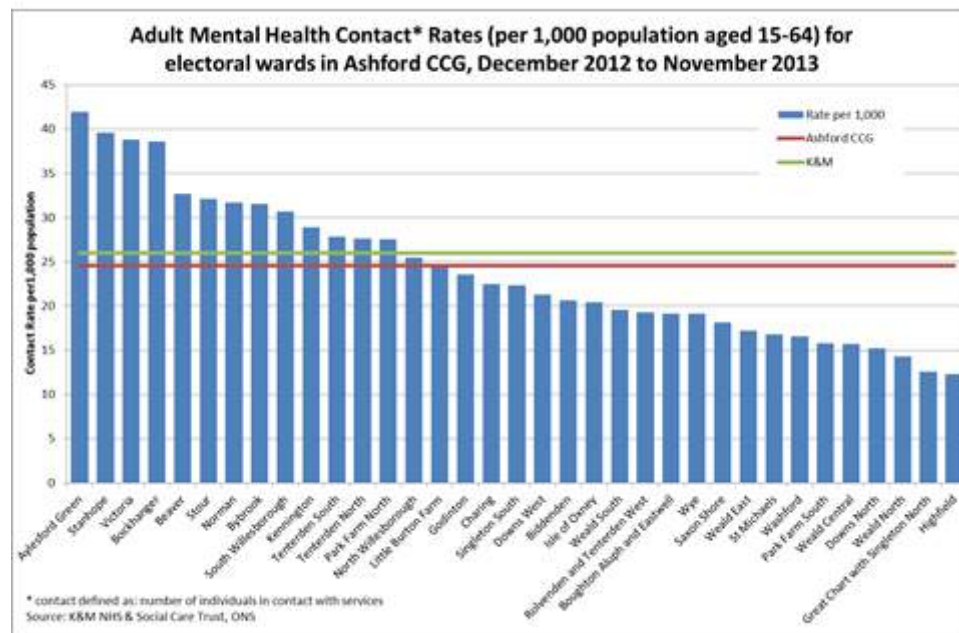
The below figure (49) shows the same data – but presented in map form.

Figure 49

Hospital Admissions

Hospital admission data is collected locally and then 'cleansed' nationally for payment. This data is available routinely. It refers to the entry into the 'acute' services and each entry is coded against a 'reason' for admitting that person. The data in this section refers to both admissions into acute service for a mental illness (primary diagnosis) or a physical health problem for someone with a mental health diagnosis (secondary diagnosis). The data is for 'activity' into hospitals and each data point refers to a single admission. However further analysis is needed to understand the 'numbers' of patients the activity relates to ie one patient may be responsible for three or four admissions.

The data has been pooled for two years and described in table 25. The data shows that each CCG has a proportion of patients entering most of the acute trusts; however the most people with a primary diagnosis are admitted to KMPT (table 25).

Table 25

CCG Patients by hospital providers, mental health as a primary diagnosis 2010-2012 aggregate data								
	Ashford	Canterbury And Coastal	Dartford, Gravesham And Swanley	South Kent Coast	Swale	Thanet	West Kent	Kent
Dartford and Gravesham NHS Trust	2	11	1268	2	4	3	43	1333
East Kent Hospitals University NHS Foundation Trus	418	1431	17	1069	33	770	75	3813
East Sussex Hospitals NHS Trust		5	1	1		1	24	32
Kent and Medway NHS and Social Care Partnership	384	1166	1254	1086	535	1161	1970	7556
Maidstone and Tunbridge Wells NHS trust	3	23	22	13	8	5	1236	1310
Medway NHS Foundation Trust	1	76	19	12	842	15	59	1024
Others in Kent and Sussex	2	16	4	15	6	12	77	132
All providers	810	2728	2585	2198	1428	1967	3484	15200

When hospital admissions for both primary and secondary diagnosis are pooled together (figure 50) and the 2012 data is standardized for age and population size, it is clear that Swale CCG has the highest burden of health need for people with mental illness in Kent. The burden of mental illness in Swale is strategically higher than in other districts. This is followed by Thanet and South Coast Kent CCG's.

Figure 50

Directly age standardised mental health admissions, all diagnoses, primary or secondary, per 100,000 population of ages 18-64, 2012
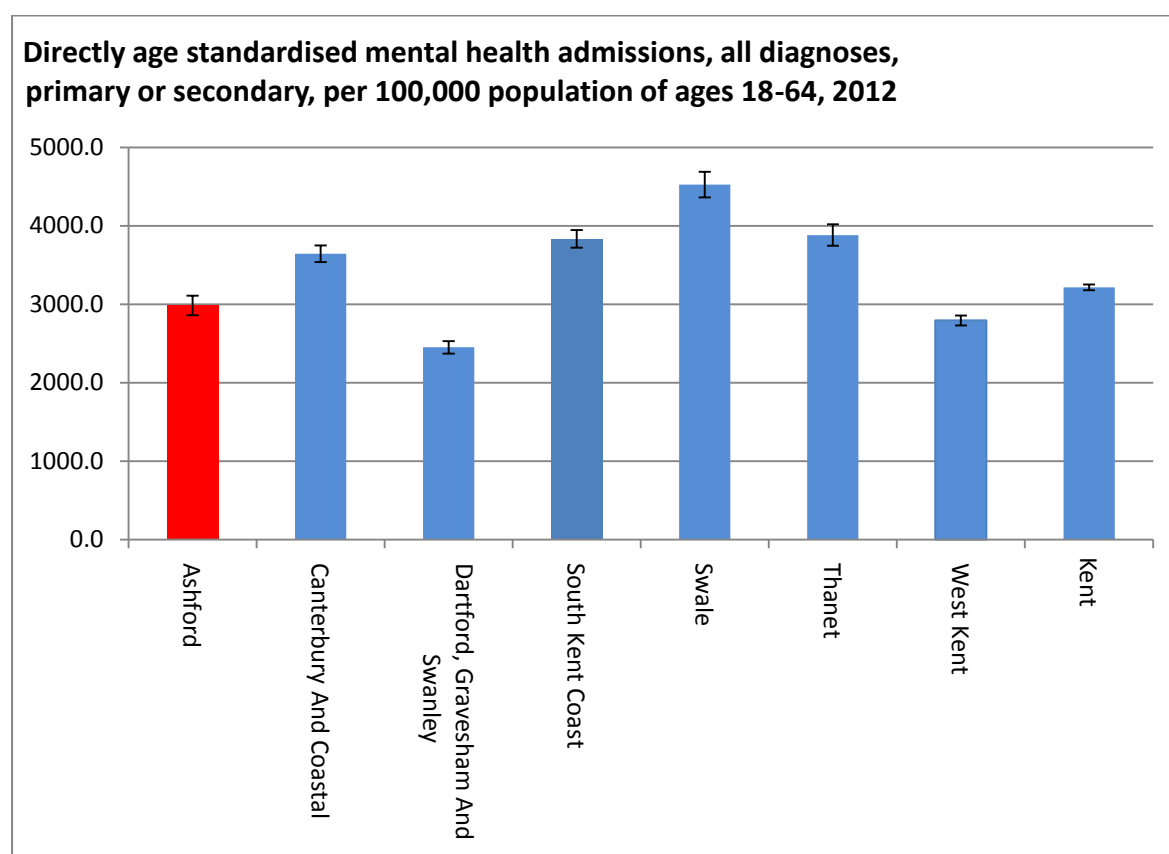
Table 26 shows that young people aged 16-17 make up 2% of the admissions to hospital and the numbers are presented for Kent and each CCG. This shows there is an important minority of patients ending up in a 'transition' to adult services. Pooled data for 2010-12 shows that there were 130 admissions where patients were under 24 years old.

Admission rates for schizophrenia are described in figure 51. This shows Thanet had a statistically significant higher proportion of admissions than any other Kent CCG (in the years 2010-2012). Canterbury and Thanet had highest hospital admissions for psycho-active substance misuse in 2010-12.

Table 26

	Admissions all diagnoses (primary and secondary)				Percentage of all ages admissions (primary and secondary diagnoses)		
	16-17	18-64	16-64		16-17	18-64	16-64
Ashford	**54**	**2222**	**2277**		**2%**	**63%**	**65%**
Canterbury And Coastal	114	4626	4739		1%	59%	60%
Dartford, Gravesham And Swanley	117	3727	3844		2%	55%	57%
South Kent Coast	111	4570	4681		1%	58%	60%
Swale	76	2947	3022		2%	63%	64%
Thanet	86	3177	3262		2%	58%	60%
West Kent	191	7873	8064		1%	58%	59%
Kent	748	29141	29889		2%	59%	60%

Figure 51

Directly age standardised schizophrenia hospital admission rates per 100,000 population, ages 18-64, 2010-2012 pooled data
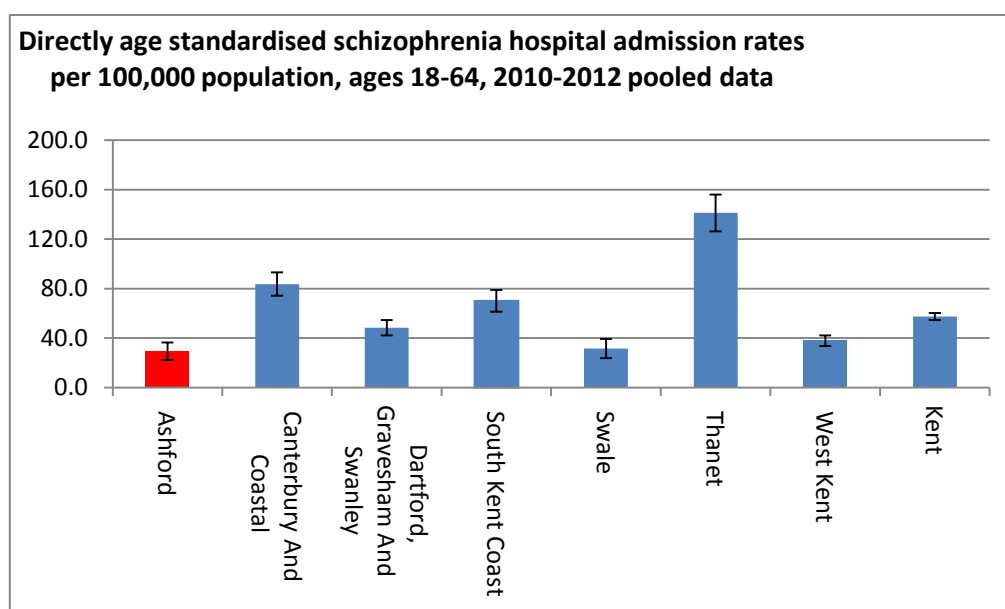
Table 27 2010-2012 pooled data

Hospital Admissions for Psychosis 15-24	
Ashford	5
Canterbury And Coastal	16
Dartford, Gravesham And Swanley	20
South Kent Coast	21
Swale	9
Thanet	26
West Kent	34
Kent	**130**

Figure 52

Directly age standardised psychoactive substance use admission, primary diagnosis, ages 18-64 rate per 100,000 population, 2010-2012 pooled data
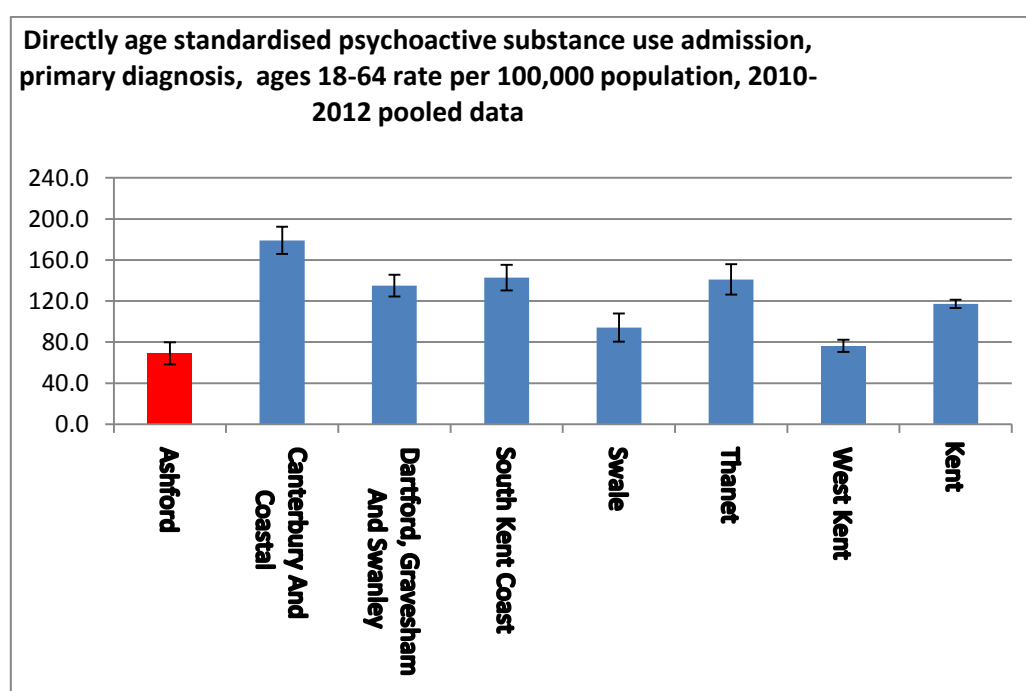
Outpatient and Follow-up Appointments

The main areas where people are seen in outpatients and followed up by hospital services are in either:

- Forensic services
- Liaison psychiatry
- Maternal services

Using pooled data from 2012 and 2013, the public health observatory calculated rates and ratios between first attendance and follow up for all mental health outpatients (see figure 53 and table 28). Ashford and Thanet are the CCGs with the

largest ratio of first attendance to follow up attendance at outpatients. There (figure 53) are variations of care regardless of level of need. This may indicate either:

- A more proactive care offer
- More engaged patients
- Variations in clinical behavior

Figure 53

Kent outpatient attendance, annual average 2012-2013, per 1000 registered population

	Ashford	Canterbury and Coastal	Dartford, Gravesham and Swanley	South Kent Coast	Swale	Thanet	West Kent	Kent
First attendance	4.4	4.7	5.5	3.7	4.0	6.3	6.1	5.2
Follow up attendance	16.0	10.0	9.1	9.1	9.9	12.4	7.6	9.7

Table 28 Selected Main Outpatient Specialties (persons): 2012-13 data.

selected main outpatient specialities individual reported (persons)	Forensic psychiatry		Liaison psychiatry		Perinatal (maternal) psychiatry	
	First attendance	Follow up attendance	First attendance	Follow up attendance	First attendance	Follow up attendance
NHS Ashford CCG	**1**	**4**	**48**	**54**	**2**	**2**
NHS Canterbury and Coastal CCG	2	8	85	90	15	15
NHS Dartford, Gravesham and Swanley CCG	3	10	37	83	1	1
NHS South Kent Coast CCG	1	12	110	145	2	2
NHS Swale CCG	1	8	17	35	0	0
NHS Thanet CCG	4	8	108	72	5	5
NHS West Kent CCG	5	96	58	73	26	26
Kent	17	146	463	553	52	52

7. Long-term Conditions and Morbidity

Mental illness has a huge effect on life expectancy. The statistics are stark:

- People with mental illness die on average 20 years younger[49]
- Nearly a third of all people with long-term physical conditions also have a mental health problem such as depression or anxiety. [50]
- Mental illness has the same effect on life-expectancy as smoking, and more of an effect than obesity. [51]
- Mental illness accounts for nearly as much morbidity as all physical illnesses put together.[52]
- 16.7% of people in England who completed a 2007 household survey that they had thought about committing suicide at some point in their life.[53]
- Every year nearly 800,000 people commit suicide worldwide - 6,000 of them in the UK.[54]

For too long the physical health of people with mental illness has been overlooked. Most people with a severe mental illness do not die of suicide but of cardiovascular disease (CVD). Often clinicians are trained to assess self-harm but appear to miss the risk of CVD.

In 2011 researchers from the University of East Anglia conducted a two year research study[55] on a cohort of 782 patients suffering from severe mental illness in **Kent**. They found:

- Poor lifestyle, inactivity, smoking, hazardous alcohol consumption were the norm
- 66% had a BMI greater then 25
- 34% were suffering from high blood pressure
- 52% had high cholesterol levels

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[49] Brown, et al., (2010) 'Twenty-five year mortality of a community cohort with schizophrenia', British Journal of Psychiatry 196: 116-121; Parks, et al., (2006) Morbidity and Mortality in People with Serious Mental Illness, 13th technical report, Alexandria, Virginia: National Association of state Mental Health Program Directors.

[50] Naylor, C., M. Parsonage, D. McDaid, M. Knapp, M. Fossey and A. Galea (2012), 'Long-term conditions and mental health: The cost of co-morbidities', The King's Fund and Centre for Mental Health.

[51] Mykeltun at al, (2009), 'Levels of anxiety and depression as predictors of mortality: the HUNT study.' The British Journal of Psychiatry 195: 118-125.

[52] Kessler et al., (2005), 'Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication', Archives of General Psychiatry 62: 593-602.

[53] Office for National Statistics, 'Adult Psychiatric Morbidity in England, 2007: A household survey', Chapter 4, p.71

[54] WHO Mental Health factfile; Samaritans, 'Suicide Statistics Report 2011' (2009), p.9

[55] Eldridge, D, Dawber,N., and Gray,R. A wellbeing support programme for patients with severe mental illness: a service evaluation. BMC Psychiatry, 2011; 11:46

- A high proportion of patients were prescribed atypical medication associated with weight gain.

Recommendations from the Kent/ UEA evaluation

- Train psychiatric staff to be more vigilant and better equipped to notice patient's physical health deterioration.
- Train mental health staff in healthy lifestyle awareness
- Work Force wellbeing initiatives to be targeted in mental health trusts
- Follow NICE Guidance – where physical health of mental health patients is the responsibility of the GP and primary care.

Figure 54
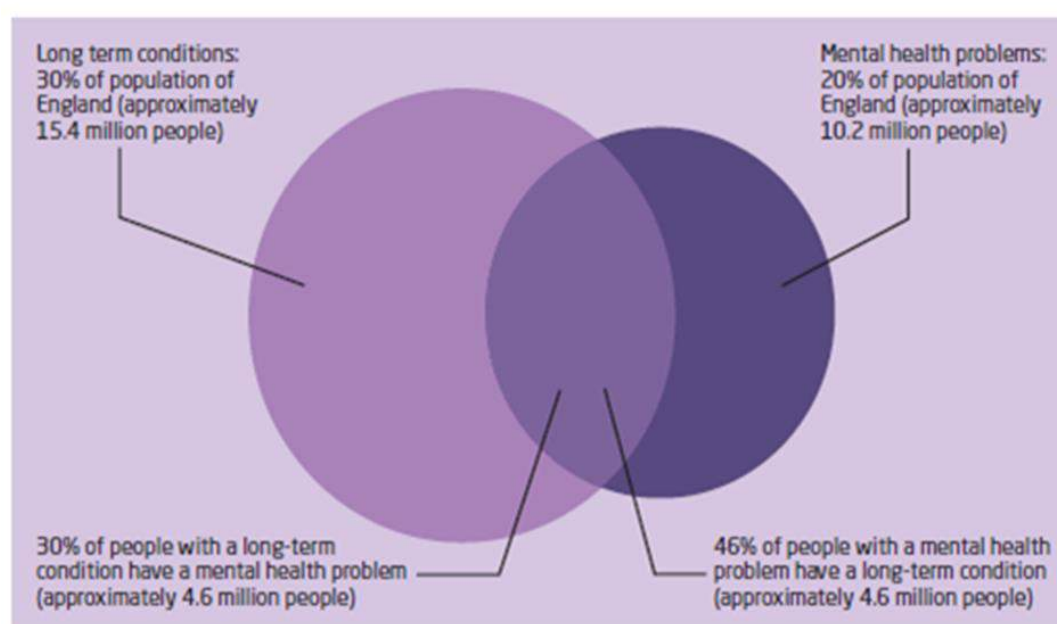
Table 29: Life expectancy gap serious mental illness

	Male		Female	
	Life Expectancy (95% CI)	Difference from male UK population	Life Expectancy (95% CI)	Difference from female UK population
Any serious mental illness	64.5 (63.3–65.6)	−12.9	69.9 (68.7–71.0)	−11.8
Schizophrenia	62.8 (61.6–64.10)	−14.6	71.9 (71.0–72.8)	−9.8
Schizoaffective disorder	69.4 (68.3–70.5)	−8.0	64.1 (60.9–67.2)	−17.5
Bipolar disorder	67.3 (66.1–68.5)	−10.1	70.4 (69.5–71.4)	−11.2
Substance use disorder	63.9 (62.7–65.0)	−13.6	66.9 (65.5–68.3)	−14.8

Source: PLoS; 6(5); 2011.

Table 30 Long-term Conditions and Mental Health

	Population 16-74	Population with mental health problems	Mental health and other LTCs	Estimated long-term conditions
Ashford	**89557**	**17911**	**8239**	**26867**
Canterbury and Coastal	**158790**	**31758**	**14609**	**47637**
Dartford, Gravesham, and Swanley	**179552**	**35910**	**16519**	**53866**
South Kent Coast	**145340**	**29068**	**13371**	**43602**
Swale	**77583**	**15517**	**7138**	**23275**
Thanet	**100385**	**20077**	**9235**	**30116**
West Kent	**334498**	**66900**	**30774**	**100349**
Kent	**1085706**	**217141**	**99885**	**325712**
Source: CCG population, PCIS, March 2013; rates King's Fund, 2012				
20% of people have mental health problems; 30% with LTCs; and 46% with mental health problems have other long-term conditions				

The results , in table x, were compared to 2006-08 UK life expectancy at birth, which was 77.4 years for males and 81.6 years for females. The highest differential for males was recorded for schizophrenia at 14.6 years (ranging between 13.3 and 16.8 years). For females the highest differential in mortality was observed for schizoaffective disorders at 17.5 years (ranges from 14.4 to 20.7 years). Overall, any serious mental illness would reduce life expectancy at birth by about 12.9 years for males (11.8 to 14.1) years for males and 11.8 for females (ranges 10.6 to 12.9).

A similar study conducted in Sweden examined nationwide five-year consecutive cohorts of people admitted to hospital for mental disorders in Denmark, Sweden and Finland in 1987- 2006. The study indicated that men with mental disorders live 20 years less, and women 15 years less. The study also indicated that health promotion actions, improved access to healthcare and prevention of suicides and violence are needed to further reduce the life expectancy gap.

The relationships between mental illness and other long-term conditions are well-documented (for example[56]). It is estimated that at least 30% of all people with a

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[56] King's Fund (2012) Long-term conditions and mental health: the cost of comorbidities, http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf

long-term condition also have a mental health problem[57] and about 46% of people with a mental health problem have a long-term condition.

These 'comorbidities' can lead to significantly poorer health outcomes and reduced quality of life. Costs to the health care system are also significant – by interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45% for each person with a long-term condition and co-morbid mental health problem[58].
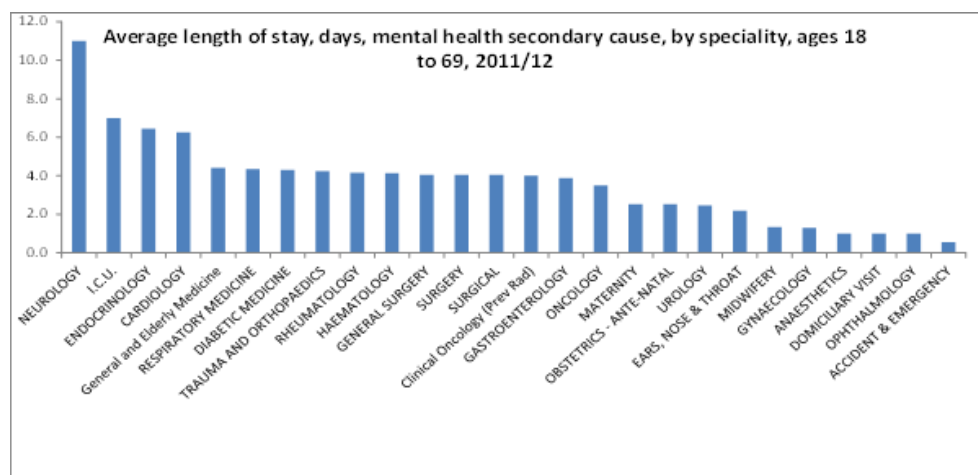
Figure 55
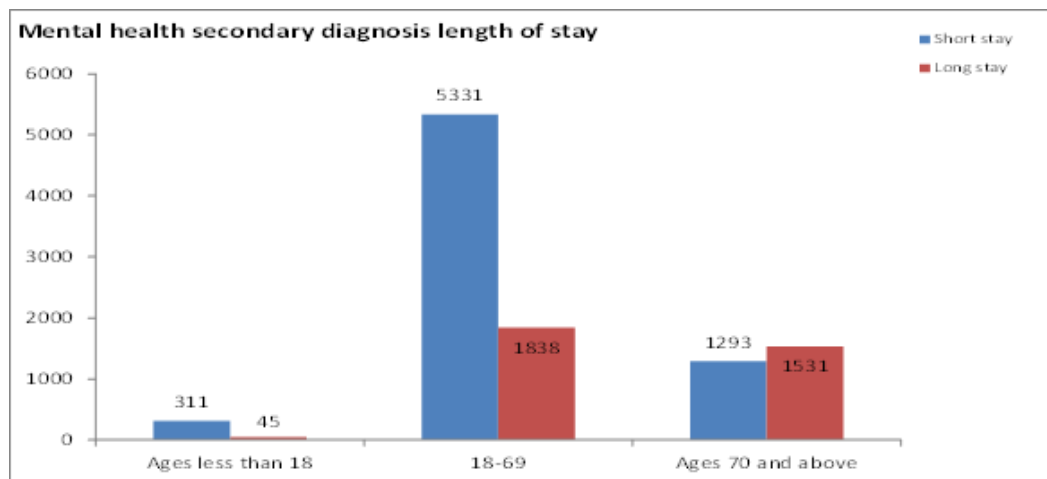
Source: SUS 2013

Data for mental health as secondary diagnosis in Kent shows that surgical, cardiology, ophthalmology, maternity and gastroenterology were the most recurring specialties with length of stay greater than 2.5 days for 2011/12

Figure 56

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[57] Cimpean D, Drake RE (2011) treating co-morbid medical conditions and anxiety/depression, Epidemiology and Psychiatric Sciences, 20;2:141-50
[58] See King's Fund above

Risk Stratification – A population approach for Integrated Commissioning by Kent Public Health

(Full reports and CCG profiles available here www.kmpho.nhs.uk/jsna)

Patients with multiple, long-term conditions, including dementia and other mental health conditions, account for the highest proportion of health and social care resources in the wider population. However current intelligence systems in health and social care are not capable in capturing the prevalence and impact of multi-morbidity because of the current programme or diseased based approach they use to capturing data.

Kent County Public Health has successfully carried out a unique study examining population utilization of health and social care services. The study used a 'baseline' year – where a patient had a hospitalisation (or 'crisis') and then investigated how much health care treatment they had before and after the 'crisis' year. The assumption was that if the highest risk patients could be identified and then given pro-active targeted care- a large number of hospitalisations (or 'crisis') might be either avoided or dealt with better outcomes. An important factor for this Needs Assessment is that a person suffering from mental health problems is also likely to enter hospital with a physical health problem but few studies capture this issue related to risk factors of overall health and illness 'multi-morbidity'. The study showed that over 70% of people with Serious Mental Illness in Kent had over three long-term health conditions and 60% of people who had Anxiety had over three long-term health conditions (figure 57).

Aims of the Risk Stratification for Multiple Morbidities Study

- To raise awareness and importance of multiple morbidities in the population and how it impacts on health and social services.
- To develop a multi-dimensional intelligence system, based on defined population risk cohorts, and understand the overlaps between different programme areas - urgent care, long-term conditions, end of life care, dementia and mental health.
- To understand how resources for integrated care could be targeted and implemented proactively to the patients with multiple morbidities at highest risk of rehospitalisation.

Methodology

A locally developed risk stratification tool (based on the King's Fund model) was applied to a registered practice population list using two years' worth of hospital activity (or SUS) data. Risk scores were generated for each person in the cohort and then that score was risk stratified into four risk groups or bands (based on the Kaiser Permanente Pyramid model of care). The anonymised datasets were linked together and given an anonymous identification code. This linked together people's data from community health, mental health, social care, primary care, continuing health care and death registry in order to assess risks and outcomes

Key Results

The results described the treatment 'activity' the years before, during and after 'crisis':

- The top 0.5% (Band 1) of the population classified as the very high risk, represented 20% of total unscheduled hospital admissions' costs during their year of 'crisis'(Figure 58). The amount of activity and spend in the years before and after were less than half of the above activity. figure 58 shows proportion of patients in Band 1 who represent the highest non elective spend in acute care. It demonstrates mulimorbidity is the norm not the exception across all 17 named long-term conditions, including schizophrenia and depression.
- There was strong evidence of relatively higher morbidity and mortality in Bands 1, 2 and 3 such as higher proportion of elderly population, particularly multiple morbidities in top 5%, higher prevalence of falls related admissions, dementia and death rates.
- Approximately 2% of patients known to community health who were found in Band 1 generated up 11% of activity / contacts. Examination of community beds utilization revealed considerable variation across different CCGs possibly explained by geographical location.
- Analysis of mental health service utilization showed no apparent difference in proportionate activity and bed utilization across the four risk bands.
- Analysis of social care and continuing health care service utilization data revealed average per capita spend in the lowest risk band to be at least three times higher than the very high risk band, possibly explained by higher prevalence of patients with learning, physical and sensory disabilities and impairments requiring long-term residential care.
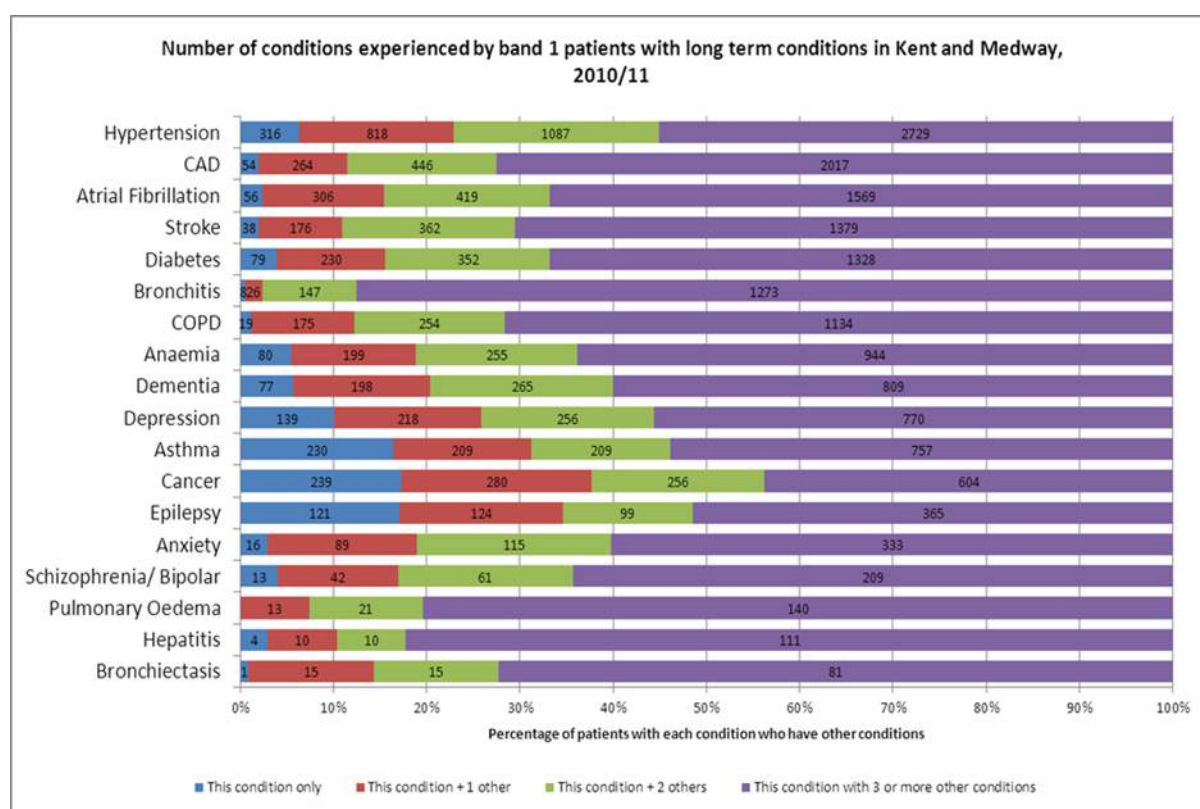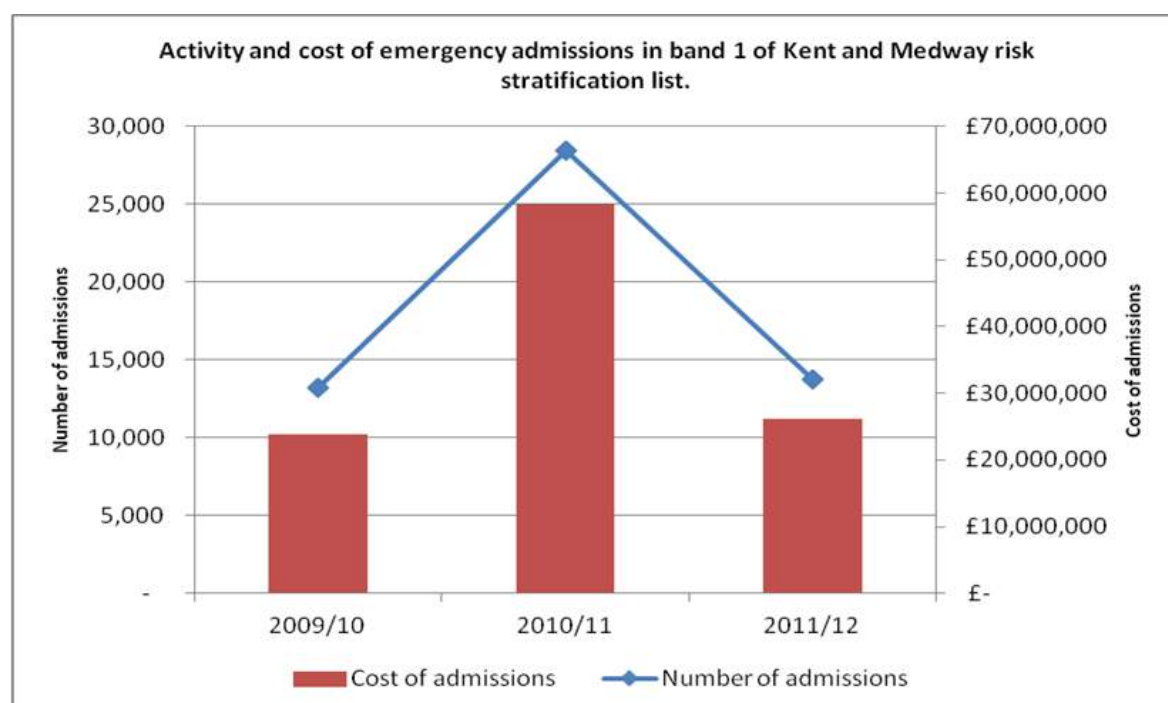
Figure 57

Number of conditions experienced by band 1 patients with long term conditions in Kent and Medway, 2010/11

Figure 58

Activity and cost of emergency admissions in band 1 of Kent and Medway risk stratification list.

Relevance for Mental Health

Mental Health has often been treated as different to other long-term conditions and the physical illnesses of people with a mental illness have often not been mapped locally. This study shows that people with mental health problems in Kent are also likely to suffer a range of other illnesses. As a result commissioning of mental health services and complex care pathways development may not have taken fully into account of patients with multiple morbidities, their impact on hospital services and how integrated model of care improve health and wellbeing and optimise the use of limited resources. National policies such as the Better Care Fund, Integration Pioneer and Year of Care funding model programme have raised the importance of **commissioning of integrated care (figure 60)**, fund and incentivise preventative, proactive and integrated care and move away from the current 'see and treat' model of care.

Figure 59 Three foci of integration
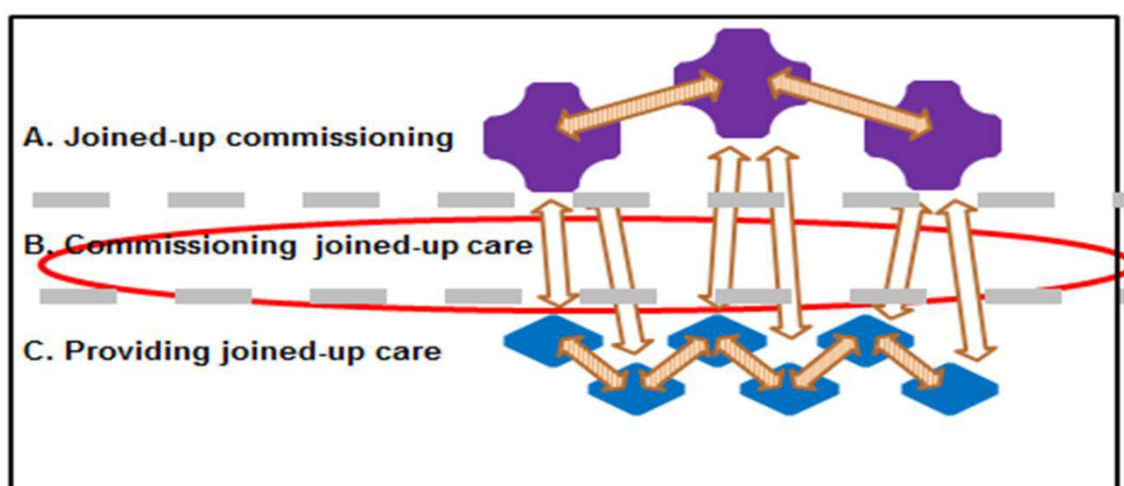
Source NHS England

Mental health teams need to work closely with primary care and other social and health providers to prevent all health crisis, not just mental health ones. This is already happening locally, with the inception of the Kent Health and Social Care Integration Programme set up almost three years ago. Progress in developing care coordination models, and neighbourhood integrated teams, have involved participation from the three main provider organisations: KCHT KMPT and KCC adult social care.

Analysis of mental health utilisation

Data on service utilization was provided by the Kent & Medway Partnership Trust. The linked dataset consisted activity by 70,000 patients over three years, generating more than 1.5 million contacts, 5,433 admission and almost 500,000 bed days (table 31). No costing information was available. While analysis of acute hospital services showed higher use and spend in risk bands 1 and 2, **this was not seen in the case of mental health service use. Headline results indicate no apparent differences or trends in proportion of use of total services, admissions and bed days across all the risk categories.**

However figures 58 and 59 did show variation in higher per capita utilisation of contacts and bed days across the four risk bands, with almost a five fold difference between Band 1 and 4 during the year of 'crisis'.

Table 31

	Contacts			Admissions	
risk band	Clients	no. Contacts	risk band	clients	No. of Bed Days
1	2653 (4%)	89,788 (6%)	1	479 (9%)	39,782 (9%)
2	15,109 (21%)	431,193 (29%)	2	2159 (40%)	187,205 (39%)
3	19,604 (28%)	430,736 (29%)	3	1674 (31%)	144,958 (30%)
4	33,376 (47%)	535,587 (36%)	4	1121 (21%)	106751 (22%)
Kent and Medway	70,742 (100%)	1487304 (100%)		5433 (100%)	478696

The Kent wide picture is shown below in figure 60 and figure 61.

Figure 60

Average number of Mental Health beddays per patient by risk band

Figure 61

Average number of mental health contacts by risk band

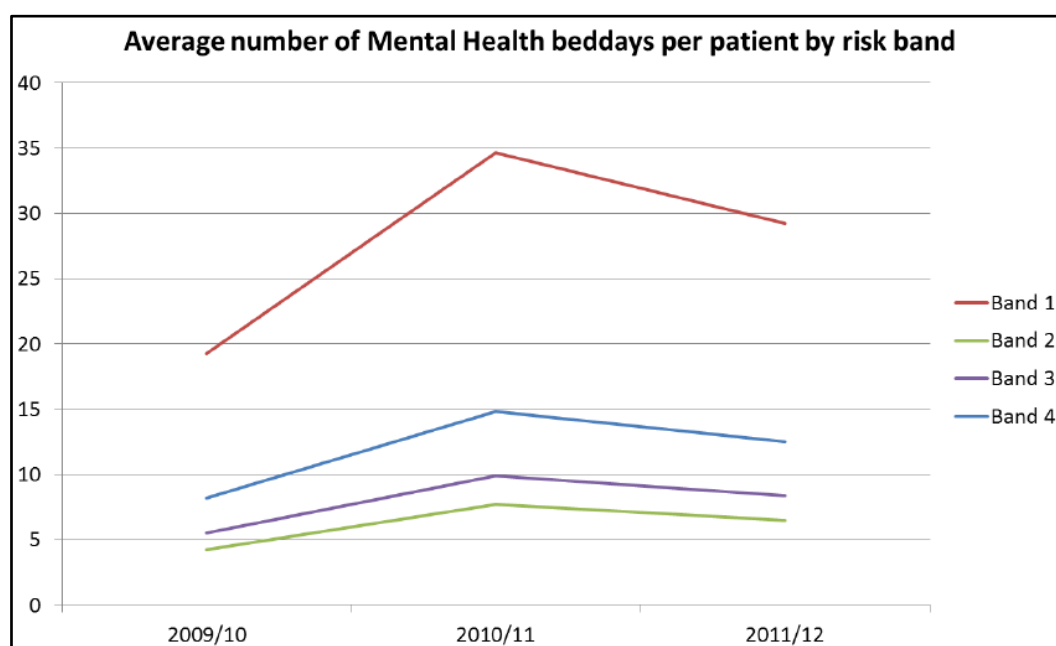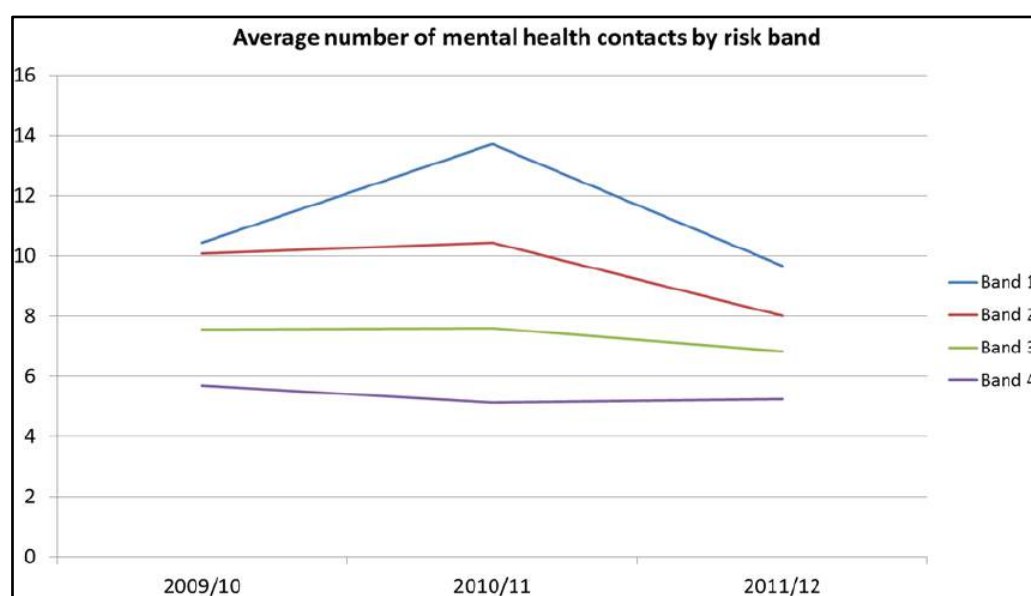**How does this analyses help mental health commissioning?**

Differences in proportions and per capita use of services across risk stratified population gives us a clear baseline understanding of resources required at each level. By understanding the proportionate activity generated In Band 1 by all 'out of hospital' services (community health, mental health, social care, primary care, etc), one can start to develop a systematic approach to improve existing resources

required by investing in proactive, preventative and integrated care and, at the same time, understand how and where benefits may be realised for unnecessary and inefficient care and treatment ie prevention of the 'crisis curve' in the emergency admissions.

CCG profiles have been developed in this regard to estimate the amount of activity generated to enable commissioning of integrated care at their local level.

In Ashford CCG, figure 62 shows how much crisis activity is generated in the Band 1 (top 0.5% of the population with the highest risk scores). If an integrated care model was designed and implemented at pace and scale targeting next year's Band 1 patients, the approximate amount of activity and costs saved as a result of 'crisis' avoidance and prevention would be 838 admissions, nearly £2 million and 5263 bed days (table 32).
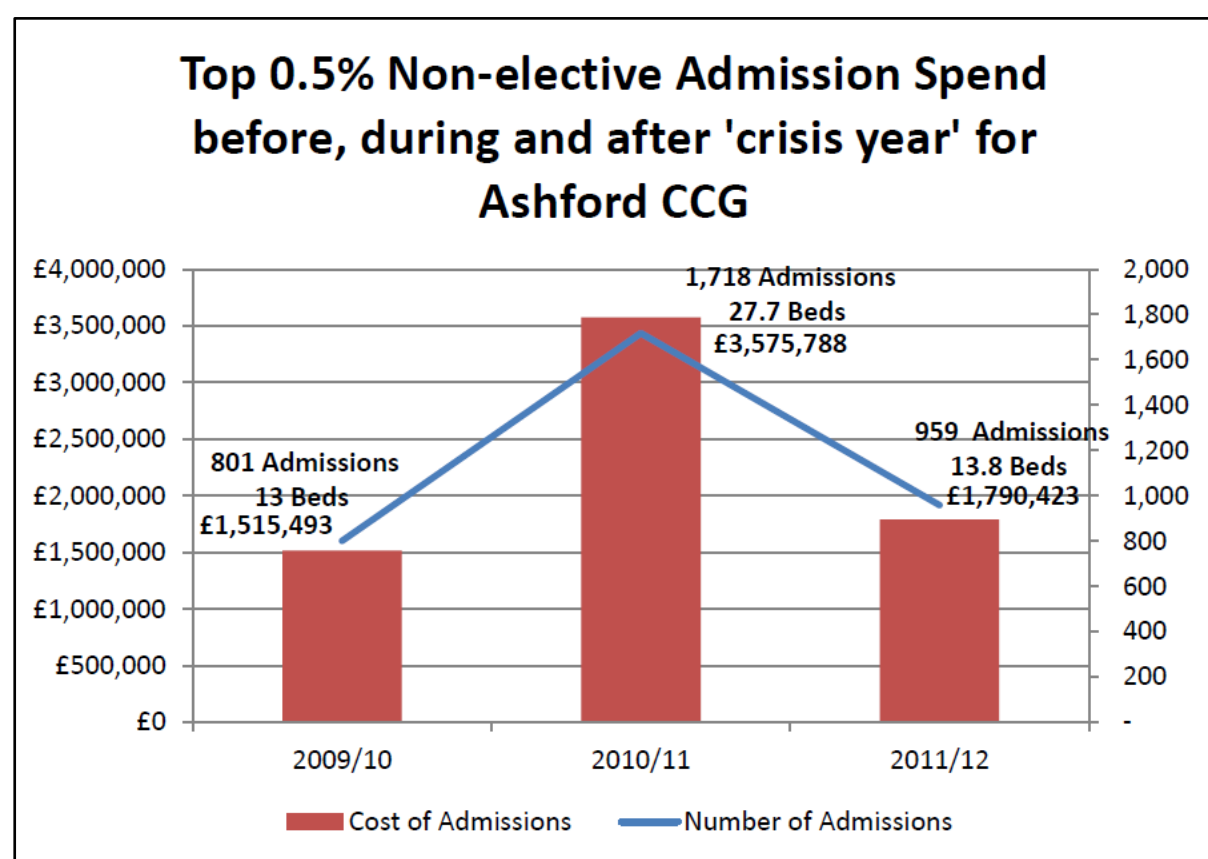
Figure 62

Table 32

Impact of preventing the 'crisis year' on acute provider activity, cost and capacity across Ashford CCG			
	Savings in non-elective admissions	Savings in cost	Savings in Bed days
Year 1 Top 0.5%	838	£1,922,830	5,263
Year 2 Top 1%	1,211	£2,688,334	7,275
Year 3 Top 2%	1,601	£3,561,470	9,843

For more detail on the work of Risk Stratification and Integrated Care please see the reports on the JSNA page of the Kent and Medway Public Health Observatory website.

http://www.kmpho.nhs.uk/jsna/

Recommendation

Stop the silo'd approach to treating mental illness separately to physical health. The physical health of mentally ill patients must be taken seriously:

- Regular health checks at CPA and at primary care
- People with mental health diagnosis and a long-term physical health condition to be part of integrated multidisciplinary teams- where psychiatric support is easy to access- both for patients and supporting clinicians.
- Access to health trainers and public health interventions
- Regular medicine use reviews
- Audit of hospital care outcomes for secondary diagnosis mental health

8. Suicide and Self-harm

Suicide is a major public health issue and is a devastating event for families and communities. Suicide rates in Kent are slightly lower compared to England. In Kent 121 people (aged over 15) committed suicide or died by undetermined causes[iii] in 2012. Suicide is responsible for almost 1% of all deaths in Kent and is the highest cause of death in people aged 25-44 years old and one of the three leading causes of death in young people under 25. The Clinical Commissioning Group (CCG) with the highest suicide rates in Kent is South Coast Kent CCG.

A new national suicide strategy was published in 2012 with a stronger emphasis on public mental health and supporting families than previous strategies. This supports the National strategy for Mental Health "No Health without Mental Health" which outlines a holistic approach to improving population mental wellbeing. Suicide is often used as a 'proxy indicator' for public mental wellbeing and can indicate poor access to mental health services.

In Kent – there is a 'Kent and Medway Suicide Prevention Strategy' and this strategy runs up to 2015 but due to key policy changes is now due for refresh.

This briefing will outline key facts and figures about suicide in Kent and provide an update on what the current strategy has achieved and where to go next.

8.1 Suicide rates in Kent

In Kent the Suicide rate for men is 8.43 per 100,000 people, for women, 2.24 per 100,000 people and for combined population 5.24 per 100,000 people for 2008-10 (Figure 65).

It is commonly acknowledged in the field of suicide research that official statistics underestimate the 'true' number and rate of suicide. The main reason for this is the misclassification of deaths ie the cause of death is coded as something other than suicide. An example of this may be where a coroner cannot establish whether there was intent by the individual to kill his/herself and the cause of death may be recorded as one of 'undetermined intent' or 'accidental'. This may occur in situations where the death involved a road traffic accident or where there is long-term illness. It could also be difficult to determine whether there was intent to die in situations of self-harm leading to suicide. This is why the actual number of suicides is usually higher than the reported numbers.

Figure 63

Directly age standardised suicide rates per 100,000 population, 2008-10 pooled data
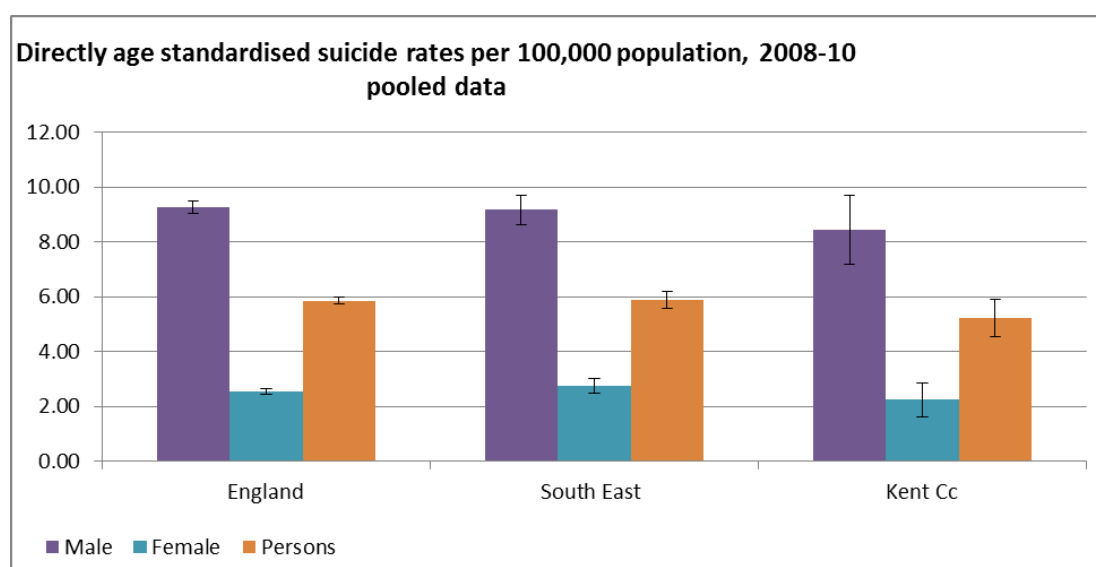
8.2 Who is at risk of suicide in Kent?

Most suicides in Kent are committed by white men aged between 30 and 60 (figure 66). This is similar to the national pattern. Based on national data approximately 30 per cent of people committing suicide have been in contact with mental health services. It is likely that the majority - between 65 and 75 per cent - have *not* been in contact with mental health services. This is why preventing suicide needs to involve people from a wide range of agencies and not just mental health services.

Figure 64
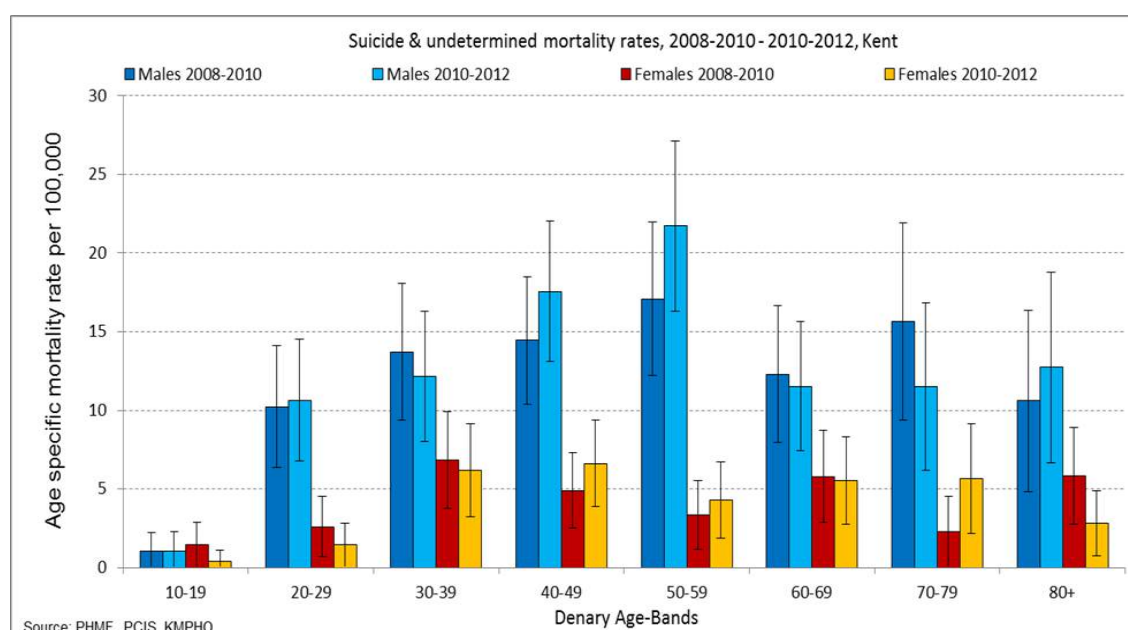
There are five main groups of people who are most at risk from committing suicide.

- young and middle-aged men
- people in the care of mental health services, including inpatients
- people with a history of self-harm
- people in contact with the criminal justice system
- specific occupational groups (doctors, nurses, veterinary workers, farmers and agricultural workers - probably because they have ready access to the means of suicide and know how to use them).

The Kent and Medway Suicide Prevention Action Plan for 2010-13 targets these high risk groups.

There are also nine key groups identified in the National Suicide Prevention Strategy as needing tailored and targeted approaches to public mental wellbeing in order to reduce their suicide risk.

The Nine Key Groups are:

- children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the youth justice system;
- survivors of abuse or violence, including sexual abuse;
- veterans;
- people living with long-term physical health conditions;
- people with untreated depression;
- people who are especially vulnerable due to social and economic circumstances;
- people who misuse drugs or alcohol;
- lesbian, gay, bisexual and transgender people; and
- Black, Asian and minority ethnic groups and asylum seekers.

The Kent Strategy and Action Plan will be reviewing these interventions in the next 12 months.

8.2.1 Self-harm or 'para suicide'

The UK has one of the highest rates of self-harm in Europe, at 400 per 100,000 population. (Self-poisoning and self-injury in adults, Clinical Medicine, 2002)

People with current mental health problems are 20 times more likely than others to report having harmed themselves in the past. (National Collaborating Centre For Mental Health) . People who self-harm repeatedly are at a higher and persistent risk of suicide and even death. (Owens et al, 2002: Hawton et al, 2003).

In contrast to the trends in completed suicides, the incidence of self-harm has risen in the UK over the past 20yrs and is a worrying feature of our society. Recent audits have highlight self-harm is high among young women.

In 2011 Public Health in West Kent conducted an audit of self-harm cases in A&E departments. Applying National Prevalence rates suggested that in 2007 an estimated 30,414 people in West Kent had a history of self-harm. The audit took place from 1st November 2011 to 31st January 2012 and found 126 cases of deliberate self-harm in that period. Of the cases audited, 62% were women and 38% men while 37% of all cases were aged between 16 and 25yrs and 72% of the cases aged 16- 25 yr were young women.

8.3 How do people commit suicide in Kent?

The majority of deaths due to suicide are a result of hanging. Men usually use this method. The next most used method is falling from a high point or throwing self onto rail tracks or traffic. Amongst women the most used method is poisoning (pills or other substances), however more recent reports from national data shows that women are using more aggressive methods of suicide.

8.4 Where are the hot spots in Kent for suicides?

Due to relatively small numbers of people committing suicides in each Kent district the hot spot areas can fluctuate year on year. The highest number of people committing suicide in 2012 were from Dover District, where there were 17 deaths. When converted into rates (so that population size is accounted for) it is Dover and Thanet that are the hot spots for men and Gravesham, Tonbridge & Malling and Tunbridge Wells for women (Figure 67) as their rates are above that of the England average.
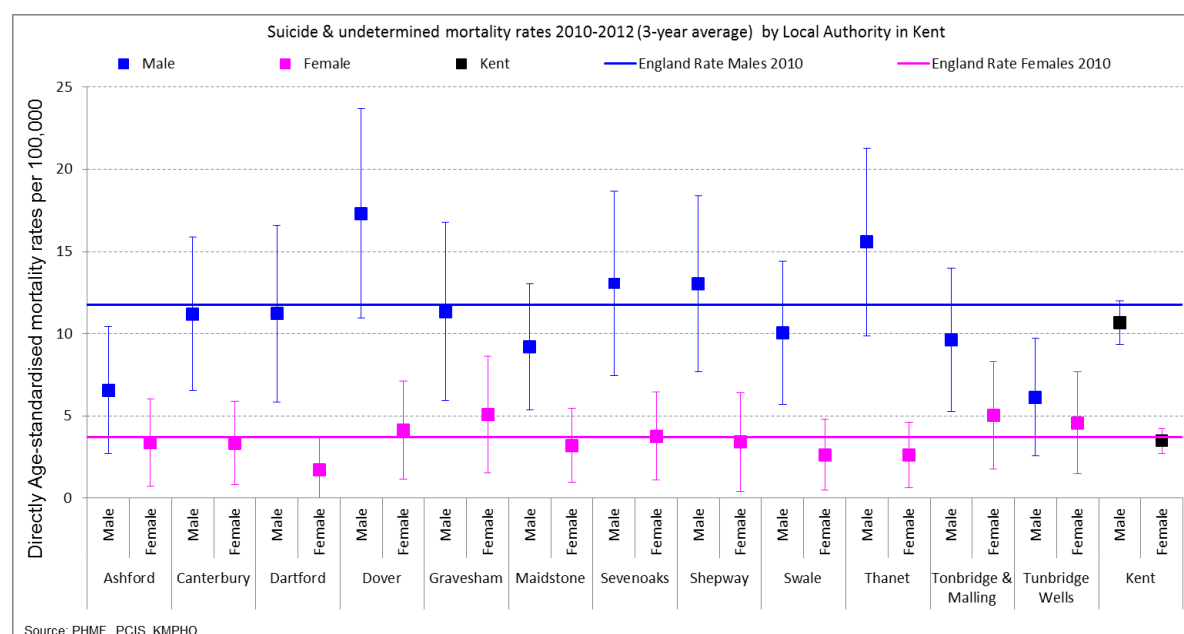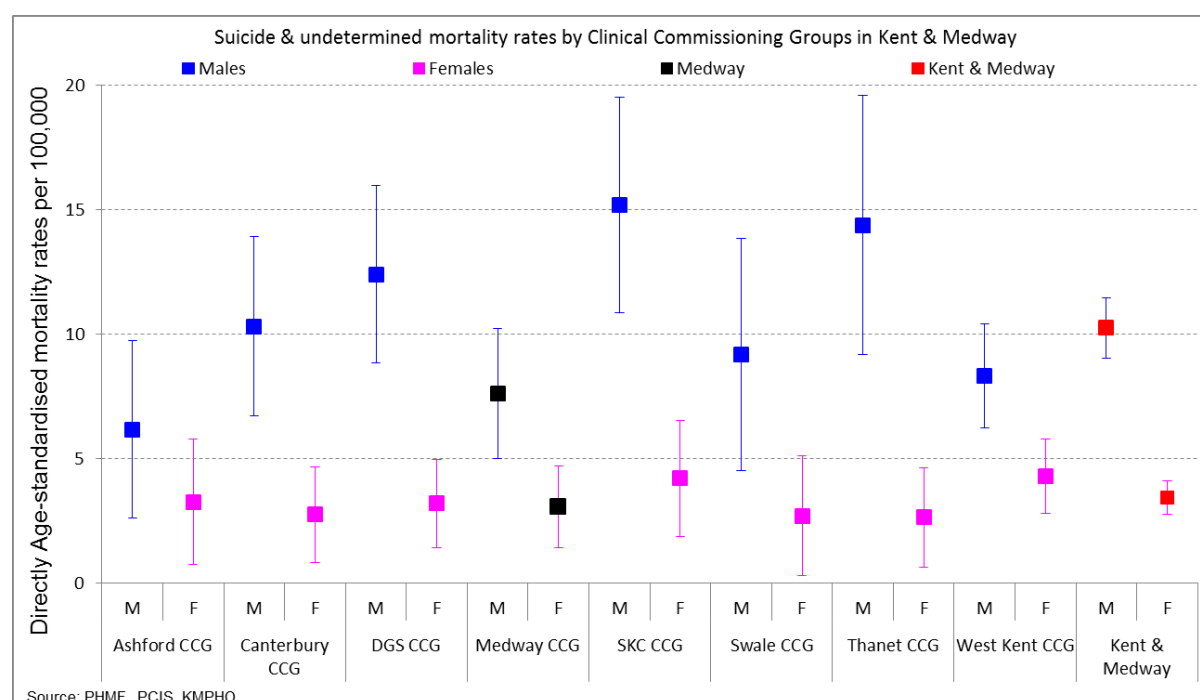
Figure 65

Suicide & undetermined mortality rates 2010-2012 (3-year average) by Local Authority in Kent

Figure 66

Table 33 Number of deaths from suicide and undetermined causes by district

Local Authority	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Ashford	13	9	*	11	7	9	*	6	7	7	*
Canterbury	12	12	14	14	13	10	9	14	10	10	10
Dartford	10	*	9	8	7	7	*	9	*	9	6
Dover	6	11	17	15	6	14	10	12	9	12	17
Gravesham	8	15	12	7	7	12	6	7	8	9	8
Maidstone	14	13	12	14	13	8	11	15	7	9	15
Sevenoaks	9	8	12	*	10	9	*	9	7	9	15
Shepway	11	17	*	13	8	8	*	9	10	12	8
Swale	*	9	17	9	14	10	9	15	11	6	10
Thanet	9	15	14	8	12	17	11	13	8	17	14
Tonbridge & Malling	6	8	6	8	7	11	7	14	11	9	9
Tunbridge Wells	14	14	7	14	10	11	14	9	7	7	7

Mental Health Needs Assessment for Adults in Kent:
Ashford CCG 2014

Table 34 Numbers of deaths by suicide in Kent CCG

Clinical Commissioning Group	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Grand Total
NHS Ashford CCG	13	9	3	11	7	9	4	6	7	7	5	81
NHS Canterbury CCG	12	16	16	16	16	17	10	20	13	13	15	164
NHS DGS CCG	22	28	27	16	18	22	8	21	15	23	22	222
NHS Medway CCG	23	12	20	21	23	22	14	19	14	13	20	201
NHS SKC CCG	17	26	20	27	13	20	12	19	18	24	22	218
NHS Swale CCG	4	7	16	8	12	5	8	11	9	3	8	91
NHS Thanet CCG	9	15	15	8	12	17	11	13	8	17	14	139
NHS West Kent CCG	39	35	31	39	36	36	35	42	30	29	38	390
Grand Total	139	148	148	146	137	148	102	151	114	129	144	1506

Table 35 Method of suicide in Kent women

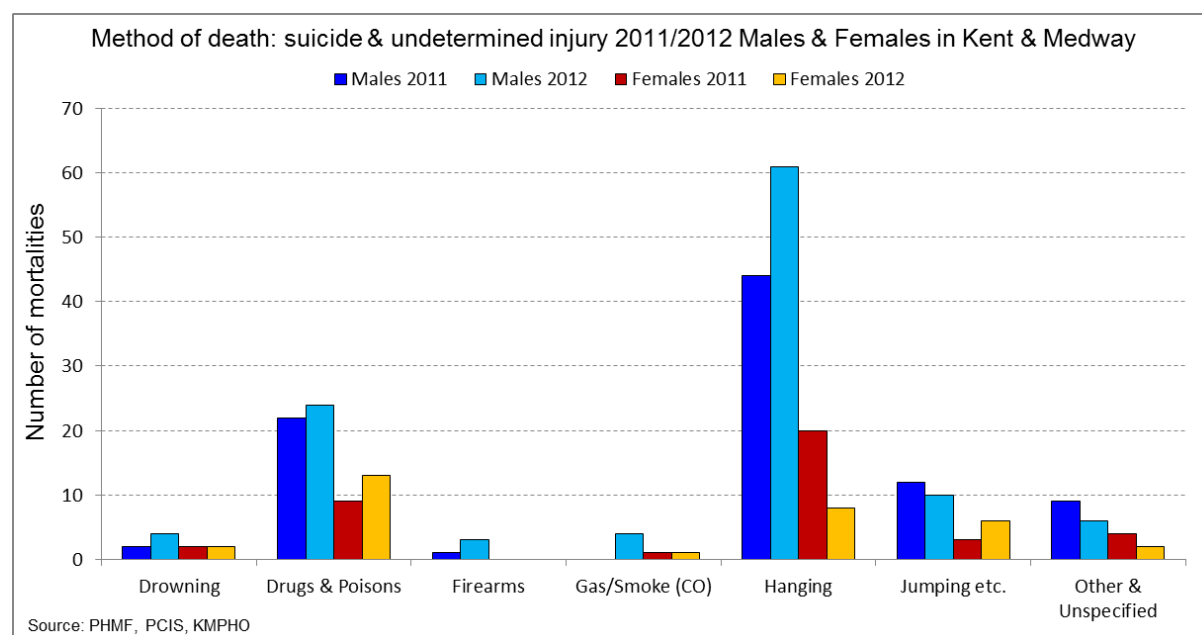| Year	Drowning	Drugs & Poisons	Firearms	Gas/Smoke (CO)	Hanging	Jumping etc.	Other & Unspecified	Grand Total
2002	5	14		1	8	5	2	35
2003	2	9			15	1	3	30
2004	3	15			6	3	4	31
2005	3	20		1	14	3	7	48
2006	2	13		1	10	1	6	33
2007	2	16		1	8	4	3	34
2008	4	10		1	11	1	2	29
2009	6	12			12	3	6	39
2010	1	10		1	13	3	3	31
2011	2	9		1	20	3	4	39
2012	2	13		1	8	6	2	32
Grand Total	32	141		8	125	33	42	381

Source: Coronor's Office/ PCIS

Table 36 Method of suicide in Kent men

Year	Drowning	Drugs & Poisons	Firearms	Gas/Smoke (CO)	Hanging	Jumping etc.	Other & Unspecified	Grand Total
2002	6	30	4	2	40	9	13	**104**
2003	4	22	3	1	66	11	11	**118**
2004	4	27	4	1	57	11	13	**117**
2005	4	25	2		53	7	7	**98**
2006	3	23	6	5	47	15	5	**104**
2007	9	32	1		49	9	14	**114**
2008	3	14	2		44	3	7	**73**
2009	6	25	3	2	54	12	10	**112**
2010	3	15	1		48	8	8	**83**
2011	2	22	1		44	12	9	**90**
2012	4	24	3	4	61	10	6	**112**
Grand Total	**48**	**259**	**30**	**15**	**563**	**107**	**103**	**1125**

Source: Coronor's Office PCIS

Figure 67

Method of death: suicide & undetermined injury 2011/2012 Males & Females in Kent & Medway

Source: PHMF, PCIS, KMPHO

Self-Harm (Para-suicide)

Definition

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

The NICE guidelines use a relatively broad definition:

"Self-poisoning or self-injury, irrespective of the apparent purpose of the act" (1)

Self-poisoning is the intentional use of more than the prescribed or recommended doses of any drug and includes ingestion of non-ingestible substances, overdoses of recreational drugs and severe alcohol intoxication.[59]

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

The most common type of self-injury in the UK is cutting and this is often repetitive. Although it was thought that cutting was more common in females there is some evidence that this may no longer be the case. Incidents of hanging have also increased over the past few decades. [60]

More people attend hospital for self-poisoning than self-injury however studies of the general population indicate that self-injury is more common. [61] An audit of A&E attendances for self-harm in Kent hospitals found that the majority of people (71%) presented following self-poisoning. [62]

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

Epidemiology

It is difficult to collate and accurate analysis of the epidemiology of self-harm in England as it remains a relatively hidden issue with many people never disclosing

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[59] National Collaborating Centre for Mental Health. Self-harm: Longer-term management. NICE Clinical Guideline No. 133. London: The British Psychological Society & The Royal College of Psychiatrists; 2012.

[60] Royal College of Psychiatrists. Slf-Harm, suicide and risk: helping people who self-harm. London: Royal College of Psychiatrists; 2010

[61] Hawton K. Self-harm and suicide in adolescents. Lancet. 2012 June; 379(9834).

[62] Solly K, Johnson B. Retrospective audit of deliberate Self harm cases in Accident & Emergency Departments in West Kent 1st November 2010 - 31 st January 2011 East Kent 1 st January – 31 st March 2010. NHS Kent & Medway & Kent County Council, Public Health Department; 2012

their behaviour, let alone seeking healthcare support. In a recent survey only 42% of men and 53% of women in the UK reported seeking medical or psychological help after self-harming and fewer young people report seeking healthcare support.[63]

The statistics below represent a summary of what is currently known from available data sources:

- It is estimated that the UK has one of the highest self-harm rates in Europe.
- In 2007 the Adult Psychiatric Morbidity Survey found that 4.9% of adults (aged 16 or over) reported having self-harmed at some point in their lifetime. This was an increase since the last survey in 2000 with incidence rising most rapidly in women aged 16-24 (from 6.5% in 2000 to 11.7% in 2007).
- There was no significant difference in the incidence of self-harm between men and women of any age group except in young adults aged 16-24 where rates were considerably higher in young women compared to young men (17.0% compared to 7.9% respectively)
- It is estimated that there are over 200,000 hospital attendances for self-harm in England annually with an estimated attendance rate of approximately 400 per 100,000 people. This is considered one of the highest rates in Europe.
- Applying this rate to the 2012 mid-year population estimate for Kent (1,480,200) suggests that we would expect approximately 5920 hospital attendances for self-harm in Kent hospitals over 12 months.
- In a three month audit of A&E attendances for self-harm in adults (age >16) in Kent hospitals a total of 180 people presented for treatment related to self-harm. In comparison to the expected number of attendances modelled above this appears to be considerably lower than expected. However this figure excludes attendances in children and it is difficult to extrapolate an annual figure from a relatively small sample.
- In contrast to this, data from the latest Health Profile for Kent suggests that <u>admission rates</u> for self-harm in Kent are significantly higher than the England average. [64]

The following table (table 37) illustrates the directly age standardised rate (per 100,000 population) of hospital admissions for self-harm in Kent in 2011/12 in comparison to the national average: [65]

[63] National Centre for Social Research & the Department of Health Sciences, University of Leicester. Adult psychiatric morbidity in England, 2007: The results of a household survey. Leeds: The NHS Information Centre for health and social care; 2009.

[64] Public Health England. Health Profiles. [Online].; 2013 [cited 2013 December 19th. Available from: http://www.apho.org.uk/resource/view.aspx?RID=50215&SEARCH=K*.

[65] ibid

Table 37

No. of admissions for self-harm in Kent	Kent Self-harm admission rate	England average self-harm admission rate	England worst self-harm admission rate	England best self-harm admission rate
3141	227.7	207.9	542.4	51.2

- In general younger people are more likely to self-harm than older people and women are more likely to self-harm than men. Rates of self-harm peak at the ages of 15-19 years in females and 20-24 years in males.
- Data from the Kent Audit of Self-Harm supports these statistics; 37% of attendances at A&E were for people age 16-25 and of these 72% were female.
- It is estimated that at least 1 in 15 young people self-harm at some point in their lifetime. (6) A recent survey of 15-16 year old school pupils in Oxford found that 13.2% of 15-16 year olds reported self-harming at least once in their lifetime (n=6020)with rates higher in girls than in boys (20.2% compared to 8.6% respectively).
- 2/3 of people presenting at hospitals for self-harm are <35 years old and 2/3 of this group are female.

Table 38 The following table illustrates the crude rate of hospital admissions for self-harm in children (per 100,000 population aged 0-17 years) in Kent in 2011/12 in comparison to the national average: [66]

No. of admissions for self-harm in Kent	Kent Self-harm admission rate	England average self-harm admission rate	England worst self-harm admission rate	England best self-harm admission rate
376	116.5	115.5	311.9	26.0

- The self-harm admission rate in Kent is not significantly higher than the England average.
- Rates of self-harm are significantly higher in South Asian women in England compared to white men or women or South Asian men. Rates are highest in South Asian women aged <35. South Asian women are also less likely to attend A&E following a repeated episode of self-harm.
- There is currently conflicting evidence regarding rates of self-harm in other ethnic groups in England.
- People who self-harm repeatedly are at greater risk of suicide than the general population with some studies demonstrating a 30-fold increase in risk of suicide, with greatest risk in the 6 months after the 1st episode of self-harm. Men who self-harm are more than twice as likely as women to die by suicide with the risk for both genders increasing with age.

[66] Child and Maternal Health Observatory. Child Health Profiles. [Online].; 2013 [cited 2013 December 19th. Available from: http://www.chimat.org.uk/profiles

- Certain methods of self-harm are also associated with higher risk of subsequent suicide. These include; hanging, strangulation and suffocation.

Costs

Whilst the mental and physical health impacts of self-harm on the individual and their family and friends have been extensively researched, the economic impacts of self-harm are less well understood.

There has been no overall calculation of the direct and indirect economic costs of self-harm at a national level; however a number of more specific economic studies have revealed the following:

- The direct cost to the NHS of self-poisoning by a single drug (tricyclic antidepressants) has been estimated as £5.1million per year. [67]
- Those who engage in self-harm generally incur a significantly higher health service spend in the 6 months around an episode compared to the general population and that repetitive self-harm has a cumulative effect with costs increasing with each episode. [68]
- A study in 2005 assessing the impact of repetitive self-harm found that total health and social care costs over a 6 month period were £3524 higher for people who self-harmed on 5 or more occasions than for those who only had a single episode of self-harm.
- An RCT study into the lifetime costs of young people who self-poisoned in the UK found that the average annual cost to the public sector was over £1550 in those that self-poisoned compared to an average annual cost of £65 in the control group.
- The indirect cost of self-harm such as lost productivity, sickness absence and the financial impact on families and carers is also considered to be significant.

Motives and Causes

Although self-harm is clearly an indication of emotional distress the motives for this behaviour are extremely varied. Sometimes the intention is suicide but often it is considered an act of self-preservation or a coping mechanism to manage emotional distress. It can also engender a sense of control over an otherwise chaotic situation and it is this that often motivates people to conceal their self-harm. Some people, especially adolescents, believe they will relinquish control of their self-harming behaviour if they disclose it to others. [69]

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[67] Royal College of Psychiatrists. Slf-Harm, suicide and risk: helping people who self-harm. London: Royal College of Psychiatrists; 2010.

[68] Royal College of Psychiatrists. Self-Harm, suicide and risk: helping people who self-harm. London: Royal College of Psychiatrists; 2010.

[69] ibid

A model called; "The 8 Cs of self-injury" [70]has been developed to help clinicians understand the motives behind self-harm:

1. Coping and crisis intervention
2. Calming and comforting
3. Control
4. Cleansing
5. Confirmation of existence
6. Creating comfort and numbness
7. Chastisement
8. Communication

In general the motivations for self-harm vary with age. A recent European study found over 70% of <u>adolescents</u> cited "escape from a terrible state of mind" as their main motivation for self-harm rather than suicide with self-cutting the most common method.

Suicidal intent is a more common motivation for <u>older people</u> and mental illness, particularly depression, is a more common underlying factor in older people who self-harm than in younger age groups. However, in those that repeatedly self-harm, it should be recognised that the behavioural motivations may change over time and assumptions about intent should not be made on the basis of what was known about previous attempts.

Self-harm is can be a habitual behaviour, approximately 20% of those who attend A&E for self-harm will harm themselves again in the following year and 10% of these episodes will occur within 5 days of the index event.

It has also been shown to have a contagious effect particularly in young people. Those living in closed communities such as prisoners and children in residential care can be particularly at risk. However there is also an environmental link as people have attributed the disempowering nature of these settings as the motivation for their self-harm.

Risk Factors

Mental or physical illness

Although self-harm is an indication of emotional distress it may not necessarily infer underlying psychiatric illness. It is important to differentiate the underlying cause as this has implications for treatment and management of the individual.

Most people who present in A&E following an act of self-harm will meet the criteria for one or more psychiatric diagnoses however the psychiatric assessment of patients in A&E may be not be sufficient to detect this.

The presence of mental illness is a key risk factor for self-harm. People with major depression, anxiety, substance misuse, eating disorders, post-traumatic stress

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[70] Sutton J. Healing the heart within Oxford: How To Books; 2005.

disorder, schizophrenia and other personality disorders are all at high risk of self-harm.

In England in 2012/13 over 25,000 people who were previously known to mental health services were admitted to hospital as a consequence of self-harm. [71]

There is limited evidence of the rates of self-harm in people with learning disabilities (PWLD) and current estimates of prevalence range from 1.7 – 24%. It has been acknowledged that some self-harming behaviour may be dismissed as challenging behaviour. The causes of self-harming behaviour in PWLD are considered to be narrower than in the general population with genetic syndromes, other physiological factors, certain medications and autism being common determinants. The experience of PWLD in institutionalised settings, such as bullying and a lack of control over lifestyle, has also been cited as a cause however this should become less of a factor as the closure of NHS Campuses and the review of residential placements in response to the Winterbourne View report is conducted. (Royal College of Psychiatry 2010)

People who have or are recovering from drug and alcohol problems are at greater risk of self-harm than the general population. Approximately 25% of people who self-harm will have a diagnosis of alcohol misuse.

In people who repeatedly self-harm the use of alcohol and drugs can increase their risk of self-harm. This may either occur due to the effects of intoxication or due to the absence of previous forms of self-medication during the withdrawal phase of recovery. Approximately 50% of people presenting to A&E following self-harm will have consumed alcohol immediately preceding or as part of their self-harming behaviour and this is more common in men. (RCP 2010)

Local data reflects this finding; the audit of A&E attendances for self-harm in Kent found that alcohol was associated with 41% of attendances for self-harm. Overall self-harming behaviour linked to alcohol is more common in women and levels of self-harm related to drug misuse is also rising in women. [72]

There is evidence of a link between physical ill health and self-harm however the causal pathway is poorly understood. Self-harm in itself can have long-term health consequences. Self-cutting can result in permanent soft tissue damage and scarring whilst self-poisoning can lead to organ damage.

Wider Determinants

Self-harming is rarely the result of an isolated event or issue and is more frequently a response to the emotional distress caused by a complex range of socio-demographic and personal factors.

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[71] Health & Social Care Information Centre. Mental health bulletin: Annual report from MHMDS returns - England 2012/13. Leeds: Health & Social Care Information Centre; 2013

[72] Solly K, Johnson B. Retrospective audit of deliberate Self harm cases in Accident & Emergency Departments in West Kent 1st November 2010 - 31 st January 2011 East Kent 1 st January – 31 st March 2010. NHS Kent & Medway & Kent County Council, Public Health Department; 2012

The pathways to suicide behaviour were recently mapped in the Scottish suicide prevention strategy: Pathways to suicide behaviour (Adapted from "Choose Life" the suicide prevention strategy for Scotland, 2002). (See figure 68)

Figure 68
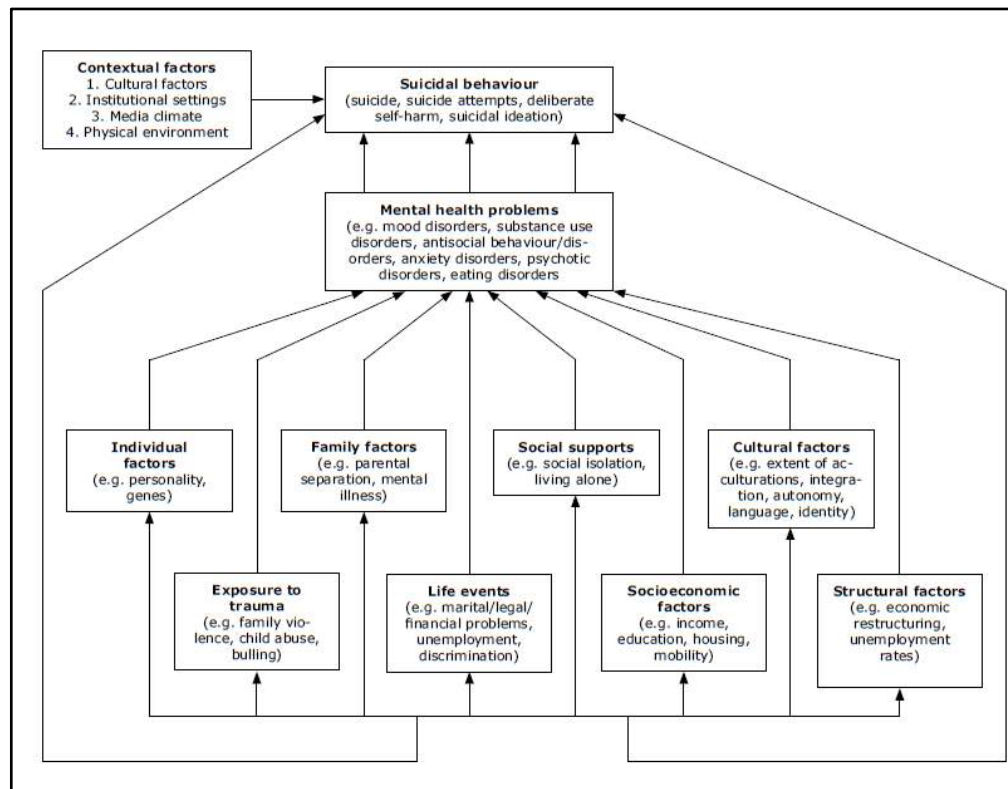
There is evidence that adults in the following groups in the UK are at higher risk of self-harm: (NICE 2012)

- People living in deprived urban areas
- The unemployed and those in debt
- Single people, divorced people and the socially isolated
- People experiencing relationship breakdown
- Single parents
- People who misuse alcohol and drugs
- Those exposed to violence
- Victims of child abuse
- People exposed to multiple adverse life events
- Those with a family history of self-harm

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

The evidence relating to causal factors in adolescents presents a slightly different picture with the following identified as additional underlying causes of self-harming behaviour: [73]

- Difficulties associated with sexuality
- Relationship issues (friends, family, boyfriend/girlfriend)
- Physical or sexual abuse
- Bullying
- Academic pressure
- Personal characteristics such as perfectionism, self-criticism and poor body image

The physical and emotional changes associated with puberty are thought to compound these stressful experiences. The average age of onset of self-harm in children is 12-13, similar to the onset of puberty. [74]

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

- Arranged marriage or the rejection of an arranged marriage
- Disputes with husbands or parents-in-law
- Cultural conflict
- Social isolation.

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

Population Groups at Specific Risk

Prisoners

The rate of self-harm in prisoners of both genders is higher than in the general population and are particularly high in young offenders. Whilst women only comprise approximately 6% of the prison population they account for about 50% of the self-harm incidents in prison.

A number of causal factors have been proposed to explain this inequality:

- Women's offending behaviour is more likely than men to be linked to unmet needs such as education, employment, housing and income.
- Women are more likely to be the primary carer of children and suffer more from the separation caused by incarceration.

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[73] Mental Health Foundation and Camelot Foundation. Truth hurts: Report of the national inquiry into self-harm among young people. London:; 2006.
[74] National Society for the Prevention of Cruelty to Children. Young people who self-harm: Implications for public health practitioners. London: NSPCC; 2009.

It is recognised that particular features of the prison environment can increase individuals' susceptibility to initiating self-harm or exacerbate behaviour in habitual self-harmers.

Looked after children

Looked after children are more likely to suffer from mental health problems putting them at higher risk of self-harm. A study in the 1990s found that, although looked after children only represented 1% of the total child population they accounted for 10% of the A&E attendances for self-harm.

Asylum seekers

In the UK rates of self-harm in asylum seekers are higher than in the prison population. Specific risk factors include; exposure to traumatic events, the experience of the detention process and the uncertainty regarding their legal status.

Veterans

Whilst it is widely recognised that suicide rates in young ex-service personnel are up to three times higher than the general population in the UK, less is known about the rates or underlying determinants of self-harming behaviour in this group and this is an area requiring further research.

Lesbian, gay and bisexual people

The rates of self-harm in this population are known to be higher than the general population. The underlying causes are likely to relate to the specific social and psychological circumstances experienced by this group such as; prejudice, discrimination, social exclusion, violence and shame.

Carers, families and friends of those who self-harm

People who care for those who self-harm are themselves likely to experience a range of emotions including; guilt or shame, isolation, stigmatisation and anger. However the process of caring for someone can also be a rewarding experience with carers having a profound impact on recovery outcome.

What Can Be Done? Public Health Approaches

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

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

- Self-harm should be explicitly included in any strategy to increase mental health, emotional wellbeing and resilience. Promoting emotional wellbeing and resilience from an early age can help children develop alternative coping mechanisms and avoid resorting to self-harm.

- The increasing role of social media in promoting self-harm or providing experiences likely to increase the risk of self-harm (eg exposure to others who self-harm, bullying, peer pressure or social isolation) need to be explored and reflected in any prevention and management strategy, particularly at a national level with the monitoring of harmful internet websites.
- The link between self-harm and substance misuse should also be considered in all drug and alcohol strategies.
- There is an ongoing need for cross-sector training for all frontline staff on identifying and responding to self-harming behaviour. A number of programmes have been evaluated including STORM (Skills-based training On Risk Management) and ASIST (Applied Suicide Intervention Skills) although the high level of participant satisfaction was the only outcome measure quoted.
- Schools were identified as an appropriate setting to provide self-harm prevention interventions with peer support and counselling services identified as approaches worthy of further research.
- There is also need for more accessible information for those who self-harm and their family, carers and friends.

The reports also provided the following recommendations for research

- Research into the epidemiology, motivations and risk factors for self-harm at various ages and the effectiveness of prevention and treatment interventions is urgently needed.
- Research into the relationship between self-harm and drug and alcohol misuse and the effectiveness of interventions for this specific group
- Research into the long-term outcomes for people who self-harm as well as the experience of carers of people who self-harm.

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

Population measures

- School-based psychological wellbeing and skills training programmes
- Gatekeeping programmes
- Screening to identify those who might be at risk
- Restriction of access to means used for self-harm and suicide
- Improved media reporting and portrayal of suicidal behaviour
- Encouragement of help-seeking behaviour
- Public awareness campaigns
- Help-lines
- Internet sources of help
- Reduction of stigma associated with mental health problems and help seeking

Measures for at-risk populations

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

Whilst a number of recent reviews have provided a clearer picture of the epidemiology of self-harm in England, there remains a paucity of evidence regarding the effectiveness of preventative strategies, particularly primary prevention.

More evidence is available regarding secondary prevention measures and this is reflected in a series of NICE guidance on self-harm which have been published over the last nine years.

9 Conclusions

A key finding from this needs assessment is that whist the rate of people living with any neurotic disorder in Ashford, (124.1 per 1000 people) may be lower than the Kent and Medway district average the projected increase in common mental disorders by 2020 in Ashford is actually the highest amongst all the Kent CCGs. The overall increase from 2013 to 2020 of common mental disorders amongst 18-64 year olds is projected to be 9.87%. This means addressing mental health need within the Ashford CCG community must be a priority.

There is no real divide between mental health and physical health and yet services are separate and hard to access for many people. Public Mental Health is now a priority for the UK Coalition government, Public Health England and Public Health in Kent County Council.

In 2008 the report from the UK's Chief Scientist gave the economic case for investment into mental health promotion. The report stated that keeping people healthy and away from mental illness services is better for people and the economy. However – when people do need help and treatment, this needs to happen quickly and efficiently. Also promotion, prevention and treatment are important but currently 97% of the budget for services is spent on treatment.

There is an important message in this report about measurement. Without good measurement we cannot commission the appropriate services. All too often there is a distorted view about what is needed and this can come from many vested interests. Without a rigorous and scientific understanding of the data we are commissioning 'blind' and this cannot serve the taxpayer or the patient. Current mental health data is poor and this urgently needs to be addressed. An audit is being commissioned in 2014 to investigate and make recommendations for change.

There has been a terrible stigma attached to mental illness. Having a mental illness should be no different than having heart disease or cancer, simply regrettable, treatable and with the same high expectations of care. People with mental illness need to be treated with compassion, expertise and optimism for their future recovery. A nurse once told me, when I asked her why there were no stop smoking services on the mental health ward, "having a cigarette is all they have to look forward to". My reply was to question her ambition for her patients, why should people with mental illness not expect the same expectations of recovery and wellbeing as other patients? Surely there must be more to life to look forward to then a cigarette. Health promotion now happens routinely on psychiatric wards yet their patients are still dying of cardiovascular disease. This needs assessment urges all services to work together to bridge the artificial divide between mental and physical health.

The root issue of our mental wellbeing is the ability to cope with life, our resilience and our ability to support ourselves and each other comes from good and healthy parenting. A warm and secure childhood can help us cope with whatever life throws at us. Therefore ensuring parents and families have the support they need and the

ability to know where to go for help with parenting will be money well spent for future generations.

Jess Mookherjee: Consultant Lead for Public Mental Health, Kent. 2014

i Clinical assessments for ADHD were not carried out as part of the APMS and it is noted that the proportion of people with 4 or more characteristics is likely to be an over estimate of the prevalence of ADHA and a score of 6 is likely to be an underestimate.

ii presence of all 6 characteristics may underestimate the number of adults with ADHD and using the percentage of those with 4 or more characteristics is likely to over-estimate the prevalence of ADHD

iii Undetermined causes is a category of coroner verdict that is counted along with Suicide by the ONS and is regarded as 'probable suicide'.