From: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

Andrew Scott-Clark, Director of Public Health

To: Health Reform and Public Health Cabinet Committee – 13 March 2019

Subject: **Summary of the Data, Key Findings and Recommendations of the Kent Adult Mental Health Needs Assessment 2019: Focus on Chapter on Mental Health & Multi-Morbidity.**

Classification: Unrestricted

Previous Pathway: This is the first committee to consider this report

Future Pathway: None

Electoral Division: All

Summary:

Kent public health supports the NHS to commission effective mental health services. The current Adult Mental Health Needs Assessment for Kent updates the 2013/14 version by focusing on two main issues: Depression and Premature Mortality and Co-Morbidity.

It supports the Kent and Medway Strategic Transformation Plan (STP) and its partners to deliver the NHS Long Term Plan. The Kent and Medway STP's approach to improving mental health in Kent focuses on ensuring services are accessible, timely and of high quality, that physical and mental health of people are tackled together, and that suicide and self-harm are significantly reduced and prevented. It also aims to ensure that the Kent population is supported to have improved wellbeing and resilience.

The main findings of this report highlight the increase in severe depression and the importance of a high-quality treatment pathway for depression. The report also highlights the significant impact of co-morbidities that impact on people with mental illness and lead to premature death and health inequalities. This requires care to be co-ordinated across physical and mental health services and where possible the care and support to be integrated, linking up third sector, primary and specialist treatment with an aim to reducing social isolation and in so doing supporting the reduction in health inequalities.

Recommendation: The Health Reform and Public Health Cabinet Committee is asked to **COMMENT** on the report and **SUGGEST** areas of further investigation and focus.

1. Background.

1.1 The mental health strategy “No Health Without Mental Health‟ was introduced by the coalition government in 2012. The adoption of some of the core principles in the strategy has been slow due in part to the major structural changes within the NHS in the past few years. The strategy acknowledges that poor mental health is both a determinant and a consequence of social and health inequalities. Deprivation is associated with increased risk of mental illness and poor mental health is associated with unemployment, lower educational attainment, and risky behaviour Mental illnesses account for the largest burden (23%) of diseases in England. The annual cost of mental disorder in England is estimated at £105 billion. The promotion of mental health has a positive effect on employment, education, relationships, and other important determinants of health and wellbeing. Given the above, one of the aims of commissioning mental health services is to ensure promotion, prevention and recovery all receive appropriate levels of investment to maximise the mental wellness within the population.

2.0 Introduction

2.1 Kent Public Health produces at least one needs assessment for a key mental health condition annually and every three years refreshes a full mental health needs assessment. In 2015/6 a needs assessment for perinatal mental health was produced, 2016/7 a needs assessment for Personality Disorder and in 2018 a needs assessment for suicide prevention.

2.2 In 2019 the focus is a generic refresh of mental health data and a deeper look at data for depression and for co-morbidity & co-occurring conditions. For many years data on mental health has been difficult to understand because one individual can have multiple mental health diagnoses, including untreated physical and mental health needs. Therefore, it is important to understand the whole person’s health needs and not just numbers of people with a specific condition e.g. anxiety. Data on mental illness is becoming more accurate and sophisticated, although there are still many challenges. This report highlights the findings on revised prevalence estimates and the analysis and recommendations on multi-morbidity and mental illness that will appear in the full report.

2.3 There are three main sources of data that are used in this needs assessment:

- The Adult Psychiatric Morbidity Survey (APMS) for England 2007 and 2014. These are conducted by the Office of National Statistics. This is a large scale national survey that covers both treated and untreated mental illness. The 2014 survey updates the data for individual diseases, the 2007 survey is used because it has ‘cluster data analysis’ on complex co-morbid conditions. This data is then applied to the Kent population
- The Quality and Outcomes Framework (QoF) data that comes from primary care. The limitation of this data is that it only covers those people that come forward for diagnosis and treatment.
- The Kent Integrated Dataset (KID); this is pooled data from a number of separate sources (e.g. hospitals) and linked to primary care data.

2.4 The Kent Adult Mental Health Needs Assessment 2019 has six main parts:

- It describes the policy and social context of mental illness in England including risk factors such as health inequalities and social isolation.
- It focuses on the prevalence (how much) of the various main mental illnesses there are in Kent.
- It focuses on the treatment of depression in Kent and assesses this against National Quality guidelines (NICE).
- It assesses co-morbidity between mental and physical illness because people with a mental illness die on average 20 years earlier than those without.
- It covers suicide and self-harm (not covered in this report as the needs assessment came to the September 2018 cabinet committee)
- A summary of recommendations and suggests a call to action. The full needs assessment when completed (April 2019) will be shared with all mental health commissioners and available on the Kent JSNA website.

The full needs assessment when completed (envisaged April 2019) will be shared with all mental health commissioners and providers via the mental health STP Workstream and available on the Kent Observatory Website.

2.5 The purpose of this needs assessment is to support commissioning planning and decisions for mental health services. Mental ill health currently represents 23% of the total burden of ill health in the UK and is the largest single cause of disability[1]. Nearly 11% of England's annual secondary health budget is spent on mental health[2] and estimates suggest that the cost of treating mental health problems could double over the next 20 years[3]. This report focuses on the mental health of adults and has a focus on mental health issues that may be dealt with in primary or secondary care mental health services. This report addresses the broader public mental health and well-being agenda in part as a context and risk factor. This report does not address the mental health of children and young people, specific vulnerable groups e.g. homeless people or older adults with dementia and excludes issues of substance misuse (other than dual diagnoses with mental health). These topics will have their separate needs assessments.

3.0 Policy and Social Context of Mental Health and Illness

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

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

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

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

3.2 The 2016 Task Force that wrote the “Mental Health 5 Year Forward View” underlined that access to mental health services should be as good as access to physical health services. Mental health conditions often bring an enormous degree of co-morbidity which must be tackled together in a systematic way. People who suffer mental illness are often poorly equipped to manage the confusing array of fragmented services and their health outcomes show a 20-year mortality gap compared with those who don’t have mental illness.

3.3 The new NHS Long Term Plan for NHS Mental Health Services launched in January 2019 is ambitious and challenging and acknowledges that mental illness is often a chronic and relapsing condition demanding better continuity and co-ordination of care. The key ambitions are:

- A renewed commitment to grow investment in mental health services faster than the NHS budget overall for the next 5 years, worth in real terms at least a further 2.3 billion a year by 2023/24
- Continue to expand access to psychological therapies (IAPT) services for adults and older adults with common mental health problems.
- Set clear standards for patients requiring access to community mental health treatment and role them out to patients over the next decade.
- Develop new and integrated models of primary and community mental health care to support adults and older adults with severe mental illnesses.
- Expand services for people experiencing a mental health crisis and ensure a 24/7 community based mental health crisis response for adults and older adults is available across England by 2020/21.
- Ensure a single point of access in timely universal mental health crisis care for everyone and will increase alternative forms of provision for those in crisis for example, sanctuaries and safe havens.
- Specific waiting times targets for emergency mental health services which will take affect from 2020 and ambulance staff will be trained and equipped to respond effectively to people in a mental health crisis.
- Upgrade the physical environment for impatient psychiatric care.
- Continue with the focus in reducing suicides over the next decade including a reduction in mental health inpatients and bereavement support.

3.4 The Adult Mental Health Needs Assessment highlights the importance of reading this report alongside the Children and Adolescent Mental Health needs assessment. This is due to the impact of childhood trauma on adult mental health. The current research in to ‘Adverse Childhood Events’ such as bullying, neglect, sexual abuse, exposure to violence and parents with a mental health and or substance misuse problem can lead to a lifetime of mental illness. Exposure to 4+ Adverse Childhood Events gives an 80% likelihood of mental illness in adulthood[4].

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

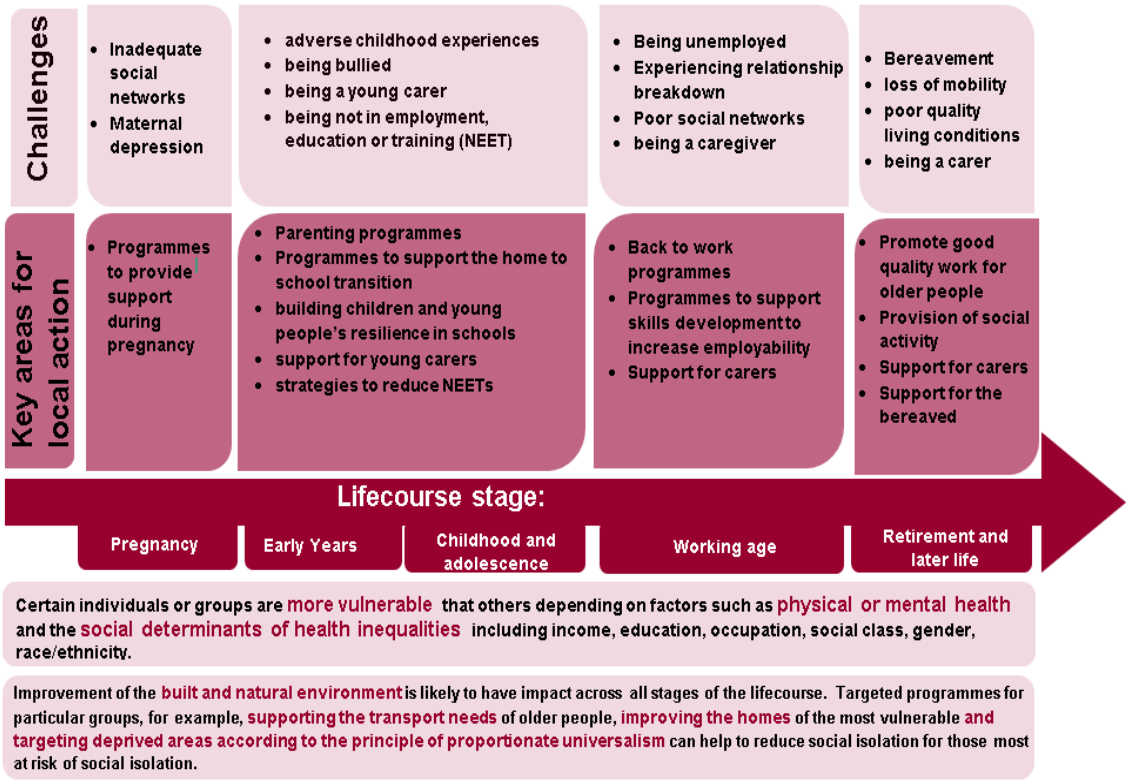
Table 1

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

Source: PHE 2017

3.5 The Adult Mental Health Needs Assessment shows that the group which has the highest levels of multi morbidity, depression the highest use of acute care and social care also have the highest risk of social isolation. The Mental Health Needs Assessment recommends using the PHE Schema (Fig 1) to develop a plan to tackle social isolation in Kent.

Fig 1 **Public Health England's Schema on Tacking Social Isolation**



4.0 The Extent of Adult Mental Illness in Kent

4.1 There are some important factors when considering needs in terms of prevalence in the report. There are overlaps and influences of need and supply;

- The definition of 'need' in a 'needs assessment' indicates where people can benefit from an intervention or service
- supply is what is actually provided. Supply may be influenced by historical patterns of provision and political priorities.

This needs assessment is to identify how closely these two factors are aligned, and therefore, how well needs are being addressed by the commissioners and

providers of mental health services.

4.2 **Limitations of Data in Mental Health Needs Assessments:** The severity, duration and impact of mental illness varies hugely, and so prevalence data alone for the various single 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.

4.3 There are two key terms in defining the prevalence of mental illness: Common Mental Illness (CMI) and Severe Mental Illness (SMI). These terms can be confusing as they do not relate to the severity and duration of the illness. CMI refers mainly to depression and anxiety, called 'common' due to high prevalence rates (24% lifetime prevalence). SMI refers to psychosis (0.7% lifetime prevalence). The Adult Psychiatric Morbidity Survey 2014 does attempt to calculate estimates of severity for all conditions. The Cluster analysis of co-morbidity is used as people can have one or two severe conditions and a number of illnesses of a lesser severity that add to complications in treatment.

4.4 The APMS 2007 and 2014 looked at prevalence of single conditions and co morbidity across the surveyed population. The prevalence of the single conditions can be found in Fig 2. and are presented with estimated numbers in Table 2.

Table 2: APMS 2014 Estimated numbers of Adults (16+) with Mental Health Conditions in Kent.

Condition	Numbers of People (16+) in Kent
Generalised Anxiety Disorder (GAD)	40,254 (3.1%)
Mixed anxiety and depressive disorder	27,269 (2.1%)
Obsessive and Compulsive Disorder (OCD)	10,388 (0.8%)
Depressive episode, Panic disorder or any phobia (combined)	285,676 (22%)
Alcohol dependence	16,881 (1.3%)
Alcohol Hazardous Drinking	276,586 (21.3%)
Psychotic disorder	9,090 (0.7%)
Bi polar disorder	112,972 (8.7%)
Borderline Personality Disorder (BPD)	31,164 (2.4%)
Antisocial personality disorder, (ASPD)	42,851 (3.3%)
Post-Traumatic Stress Disorder (PTSD)	57,135 (4.4%)
Attention Deficit Hyperactivity	135,047 (10.4%)

Disorder (ADHD)	
Eating disorder	20,776 (1.6) (APMS 2007)
Adult Autism	9,090 (0.7%)

Source: APMS 2007/2014 applied to Kent GP registered population 2017.

4.5 One of the problems of trying to identify the prevalence of particular mental health conditions and applying them to Kent populations is that of co-morbidity. This is because a high level of people have more than one condition. The APMS (2007) used a method to explore levels of complex comorbidity called 'latent cluster analysis'. This is useful because it is a better predictor of the number of people who are in need of treatment and support.

4.6 Psychiatric comorbidity is known to be associated with increased severity of symptoms, longer duration, greater functional disability and increased use of health services and poorer resilience. The APMS 2007 grouped people together in 6 clusters in severity and complexity and this is useful to determine how many people will need support in Kent. The descriptions of the clusters are:

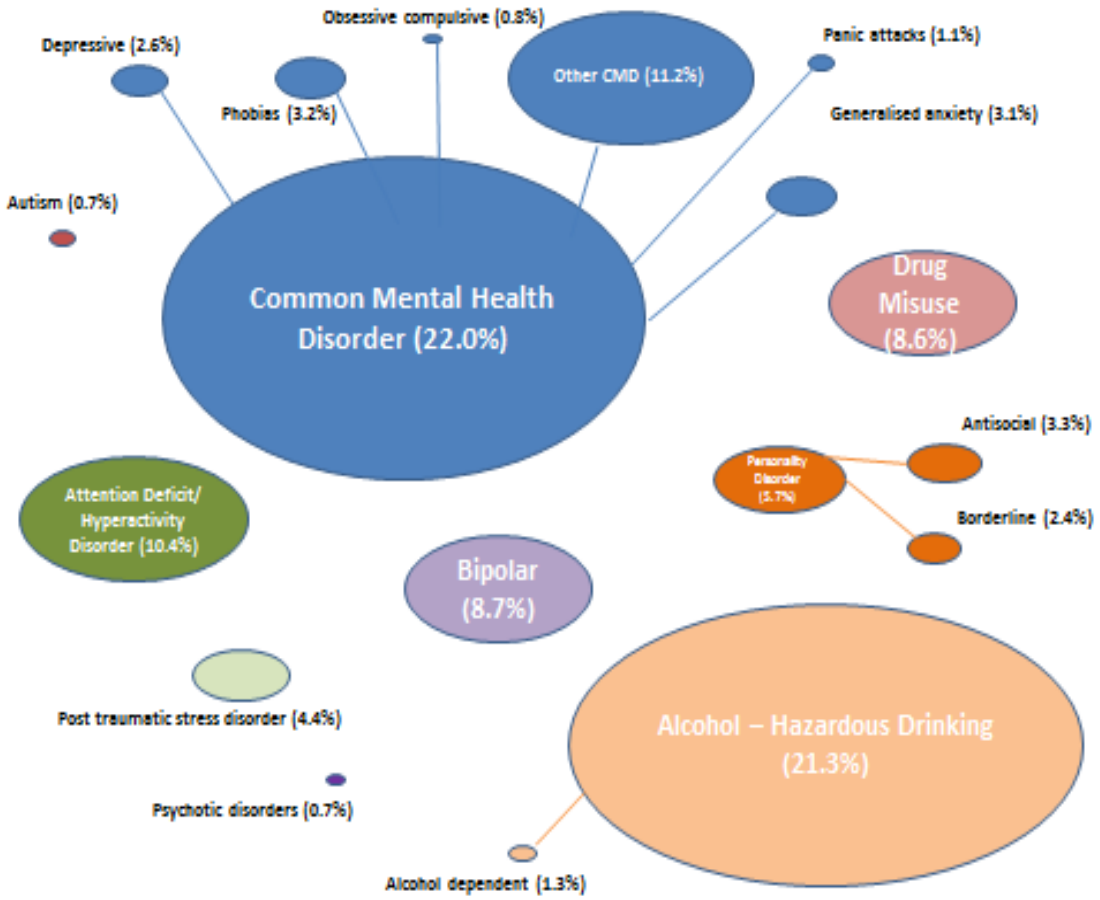
- Cluster 1: **Unaffected** (People with either 1 CMI condition – moderate or none) Usually depression/ anxiety or Moderate Substance Misuse
- Cluster 2: **Moderate Internalising** (people whose thoughts cause distress – Mainly Anxiety, Depression and PTSD)
- Cluster 3: **Cothymia** (Mixed Severe anxiety and depression)
- Cluster 4: **Co-morbid Internalising** (Anxiety, Mood, Phobias, PTSD, Depression, more severe and enduring – including substance misuse)
- Cluster 5: **Externalising** (Acting out behaviours of distress- Personality Disorders, Eating Disorders, Psychosis, Serious Substance Misuse)
- Cluster 6: **Complex and highly co-morbid problems** such as alcohol misuse disorder, psychosis, depression and PD.

Table 3**: Extent of Co-Morbidity and Severity of Mental Illness in Kent.**

Cluster	**% of Adult Population estimated to be in each cluster**	**Estimated numbers in Kent**	**Target Group**	**Expected Levels of service use.**
1.Unaffected	89%	**1,155,689** (of which 151, 395 people will have 1 MH issue) 4% 51,941 will have substance misuse dependency.	Broader Well Being and Prevention	Low
2. Moderate	5.8%	**75,314**	Mental health	Medium

Internalising			issues that may be dealt with in primary care or through psychological therapies	
3. Cothymia	2.1%	**27,269** This group has high rates 40% of serious substance misuse;10,907 14% will have eating disorder; 3,817	Mental health issues that may be dealt with in primary care or through psychological therapies	Medium
4. Co-Morbid Internalising	2.5%	**32,463** Depression, Suicidality and Substance Misuse were high in this group. **High Risk of Suicide.**	Severe mental illness dealt with in secondary mental health services	High
5. Externalising	0.5%	**6,492** 80% Substance Dependency 12% of this group had Gambling Addictions 3,817	Predominantly Co-occuring conditions with serious substance misuse	High
6. Highly Co-morbid and Severe	0.1%	**1,299** Depression was key factor in this group. **Highest Risk of Suicide.**	Severe mental illness dealt with in specialist mental health services	Very High

Source: APMS 2007 Cluster Analysis applied to Kent 16+ GP registered Population.



Prevalence of Psychiatric Conditions in Kent Population from APMS 2014.

4.7 The APMS Cluster Analysis (Table 3) gives strong insight into the complexity of treating mental illness in Kent. It shows that predictive models for single illnesses are less helpful than when the person is seen as a whole, and mental health services are planned to take co-morbidy into account. This is particularly relevant for suicide prevention, substance misuse services, eating disorders and depression. It will also enable whole population interventions e.g. Public Health One You services to align with primary care and community based mental health services for a significant section of the population.

4.8 The Adult Mental Health Needs Assessment for Kent highlights the gap in mental health treatment needs of people aged 65+ and carers. People over 65 are more likely to have a long term physical health condition and either be a carer or needing a carer. There are predicted 25% to 40% prevalence of depression in care homes[5] and 1% of people over 65 have psychosis. Carers were found to be at risk as they had higher rates of depression (24% higher) then those who had no caring role and 91% of carers were not receiving treatment (Singleton 2002).[6]

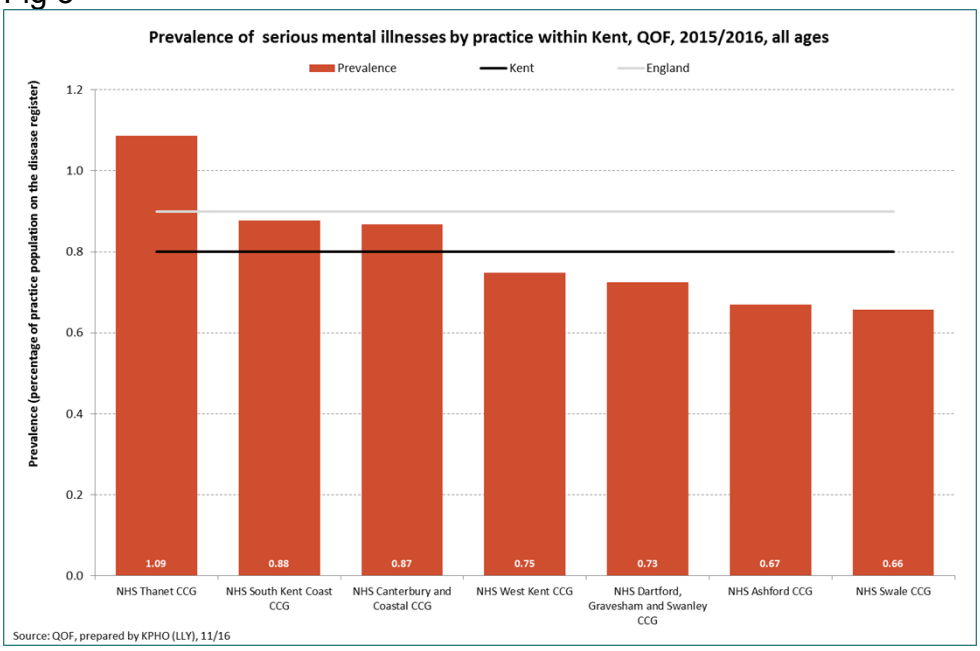
4.9 Tables 2 and 3 show the extent of the mental health need in Kent by applying the APMS 2014 to the Kent GP adult registered population (2017). Another way

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

[6] Mental Health of Carers, Singleton, N. et al, , (ONS 2002)

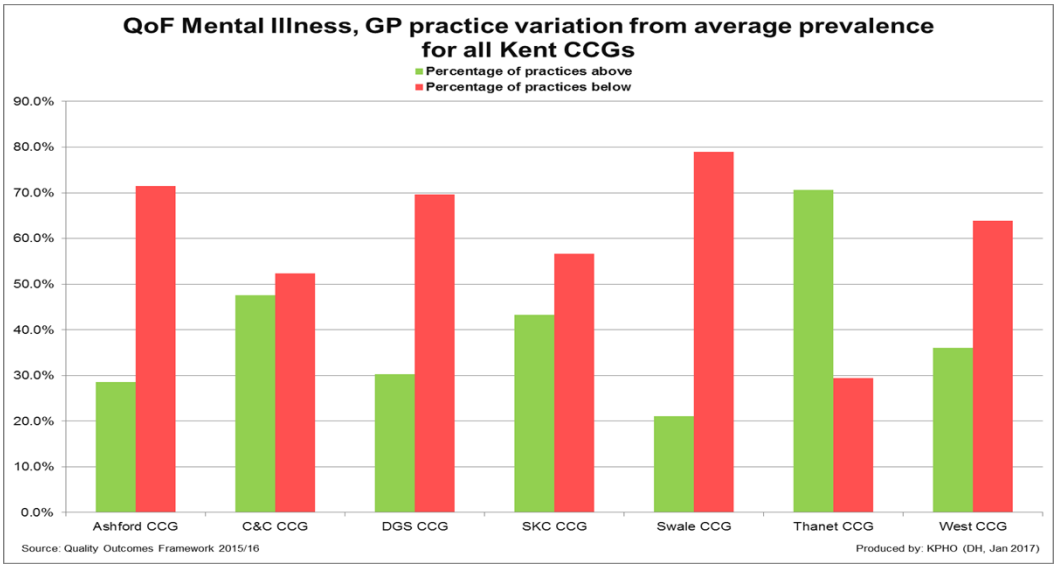
to assess mental health need and treatment is using the QoF data that is collected by GPs in primary care. For psychosis (SMI) the data in Table 2 show that this group will have very high health care needs. The data from the Public Health Kent Health Inequalities report and report on Social Isolation predict there will be highest mental health need in the most deprived communities in Kent. The Data from the QoF from 2015/6 shows that the highest prevalence rates for psychosis are in Thanet, South Kent Coast and Canterbury and Coastal CCGs. Thanet CCG has higher rates of psychosis in primary care then the England Average (Fig 3).

Fig 3



4.10 Overall the QoF data in Kent shows that psychosis recorded in primary care is at the predicted levels from the APMS survey. However, the recording of depression has marked variations. There is also considerable variation between primary care practices in the treatment and support of people with mental illness. In East Kent QoF data shows that the trend for all mental illness presenting in primary care is increasing. In West Kent there is considerable variation in depression prevalence and in North Kent there are fewer than expected people at primary care for depression. (Appendix 1). In 2017 the data for all QoF mental illness data in primary care was assessed relative to the Kent average QoF illness prevalence. This highlights the variation of outcomes in primary care in each CCG (Fig 4). Thanet CCG appears to have 70% of its primary care practices with more than Kent average mental illness QoF rates. This means that 70% of practices in Thanet are seeing more than the expected number of patients with mental illness. In Swale CCG only 20% of practices are seeing the expected rates of people with mental illness suggesting unmet needs. The data is from 2015/6 and there have been recent changes, however it shows the variations in practice that are challenges for the NHS CCGs.

Fig 4



5.0 Understanding the Nature and Extent of Depression in Kent

5.1 The NICE guidance 2018 says Depression is a broad and heterogeneous diagnosis. Central to it is very low mood, loss of interest and pleasure or loss of energy to be present. Severity of the disorder is determined by both the number and severity of symptoms, as well as the degree of functional impairment. Symptoms should be present for at least 2 weeks and each symptom should be present at sufficient severity for most of every day. Increasingly, it is recognised that depressive symptoms below threshold criteria can be distressing and disabling if persistent.

5.2 The severity of depression varies markedly. At its worst, it can have a profound effect on people's ability to lead normal lives. In terms of disability-adjusted life years, unipolar depression is responsible for more disability and suffering in high-income countries than any other health condition – accounting for 13 per cent of the total 'disease burden' among adults (WHO 2008). **Table 2**

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

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

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

Table 5 Estimated Numbers and Rates of Women with Severe CMD (Depression/Anxiety) in Kent

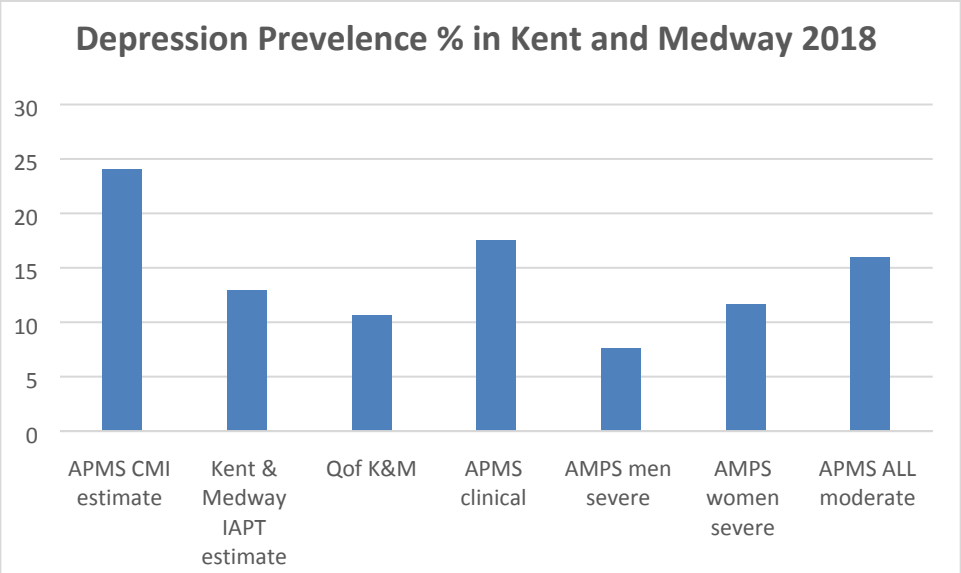
CIS-R score (severity)	2000		2014	
Moderate Severe (12-17)	10.2%	**47,386**	10.1%	**46,922**
Severe (18+)	9%	**41812**	11.3%	**52,497**

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

5.3 Depression is not evenly distributed across the population. Consistent positive associations have been found between mental ill health and various markers of social and economic adversity such as low education, low income, low social status, unemployment and poorer material circumstances (Melzer *et al* 2004). There is a two-fold variation in the prevalence of depression between the highest and lowest quintiles of household income (McManus *et al* 2009).

5.4 There are various measures of prevalence of depression. The APMS (2014) is the best reliable large-scale survey of prevalence in England and indicates 24% of the adult population have a diagnosable depressive illness. The survey measures severity and duration and places a 'clinical' threshold of 17% and this is higher than the national estimates calculated for IAPT (NHS counselling). This means that there is a 'real' unmet need for psychological therapy of around 7% in the adult population. The rates of depression are not spread evenly across all groups. The APMS estimates for 'severe' depression are 7% for men and 11% for women (Fig 5). The incidence (new cases) of depression is 1.6% of the per year. There has been a slight fall in moderate depression across Kent but an increase in severe depression (Table 3 & 4) and this is more marked in women with an increase from 9% in 2000 to 11.3% in 2014. This highlights a critical issue for the commissioning of counselling services and primary care mental health for Kent CCGs.

Fig 5



Sources: APMS 2014, NHS Digital & PHE Fingertips 2017

5.5 Across all CCGs there are around 157,000 people in Kent with diagnosed depression (Fig 6). Ashford, Thanet and Swale have the highest CCG QoF recorded prevalence of depression in Kent. Incidence of depression in Kent is increasing. The annual incidence in Kent is 23,608 people (rate 1.6% of new diagnosis).

5.6 It is now well established that Moderate to Severe Depression is significantly associated with a wide variety of chronic physical disorders, including arthritis, asthma, cancer, cardiovascular disease, diabetes, hypertension, chronic

respiratory disorders, and a variety of chronic pain conditions[7]. Depression is also a causal risk factor leading to an increased prevalence of these physical disorders, with all their associated financial costs, impairments, and increased mortality risk particularly in first onset of coronary artery disease, stroke, diabetes, heart attacks and certain types of cancer (Kessler and Bormit 2014). [8]

5.7 There are elevated co-morbidities for depression and alcohol misuse, anxiety and suicide. A major study in the USA among Alcohol treatment dependent people found that 20.5% had co-occurring severe depression (three times more than the general population) and 40% had co-occurring mood disorder.[9] A recent audit of Kent substance misuse service users (2018) found the approximately 30% had suicidal ideation and 48% had a co-occurring mental illness.

5.8 Summary of Depression Data in Kent

- 24% of the adult population of Kent will have some form of CMI
- 17% of the adult population of Kent will have treatable serious depression.
- 10.6% of the adult population are on a treatment register in primary care for depression
- Almost 70% of people with moderate to severe depression will have chronic and relapsing conditions. [10]
- 20.5% will have Severe Depression and Alcohol Dependence.
- There has been a rise in the prevalence of severe depression in Kent (particularly for women: from 9% in 2000 to 11% in 2014).

5.9 **Treatment of Depression in primary care in Kent**.

The GP patient survey 2016/17 for Kent shows that more people are self-reporting depression then are being treated for depression (Fig 7) e.g in Thanet there are 13% of primary care patients on a register for depression and 18.3% report they have depression. NICE (2009) guidelines state that there are 5 main steps to treating depression in primary care:

- Be alert: Screen and case history of previous depression and self-harm and or suicide attempts.
- For Mild / Moderate consider self-help / physical activity and consider use of medication carefully – consider range of community and primary care services available.
- For Moderate / Severe : combination of medication and psychological therapy. Manage the condition via relapse prevention and monitoring.

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

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

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

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

- Provide easy to understand information and support for self-care.
- Conduct Health checks and management of co-morbidity.

5.10 **Follow Up**

In 2017/8 65% of Kent GP patients (QoF data) received a follow up review 10-56 days after diagnosis. This is higher than the national average. Thanet CCG had the lowest rate of follow up in Kent (59.2%).

5.11 **Bio-psychosocial assessment**

In Kent in 2017/8 an in-depth assessment was conducted at primary care at or above the England average rate (76%) with only Swale and Thanet falling below (65% and 73%), indicating those localities may need extra primary care support.

5.12 **Medication**

Kent has increased its antidepressant medication prescribing in line with the national year on year increases. People in 2018 are taking higher doses of medication then in 2013. (see Appendix report).

5.13 **Suicidality and Depression**

In retrospective studies of people completing suicide (both National and Kent) there are high rates of people having contacted primary care about suicidal intent. In one national study[11] in 91% of cases the person had contacted primary care a year before completing suicide. People with a primary care diagnosis of depression, anxiety and alcohol dependency are most at risk.[12] This is backed up by current research on coroner verdicts being conducted via NHS Darzi Fellowship linked to Kent Suicide Prevention Strategy (report will be available in 2019).

5.14 **Psychological Therapies**

Kent as a whole has higher improvement rates (78.3%) for NHS counselling services then the national average (72.1%). There were 7680 people were referred and completed Cognitive Behaviour Therapy (High Intensity) in Kent and Medway in 2016/7. This is 32.5% of the registered GP population for depression (Data from NHS Digital). However, it is impossible to say whether those completing counselling/ therapy are the same cohort being treated for depression in primary care.

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[11] https://bjgp.org/content/59/568/825 Anna Pearson, Pooja Saini, Damian Da Cruz, Caroline Miles, David While, Nicola Swinson, Alyson Williams, Jenny Shaw, Louis Appleby and Navneet KapurBrGenPract 2009; 59 (568): 825832. **DOI:** https://doi.org/10.3399/bjgp09X472881

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

Fig 6

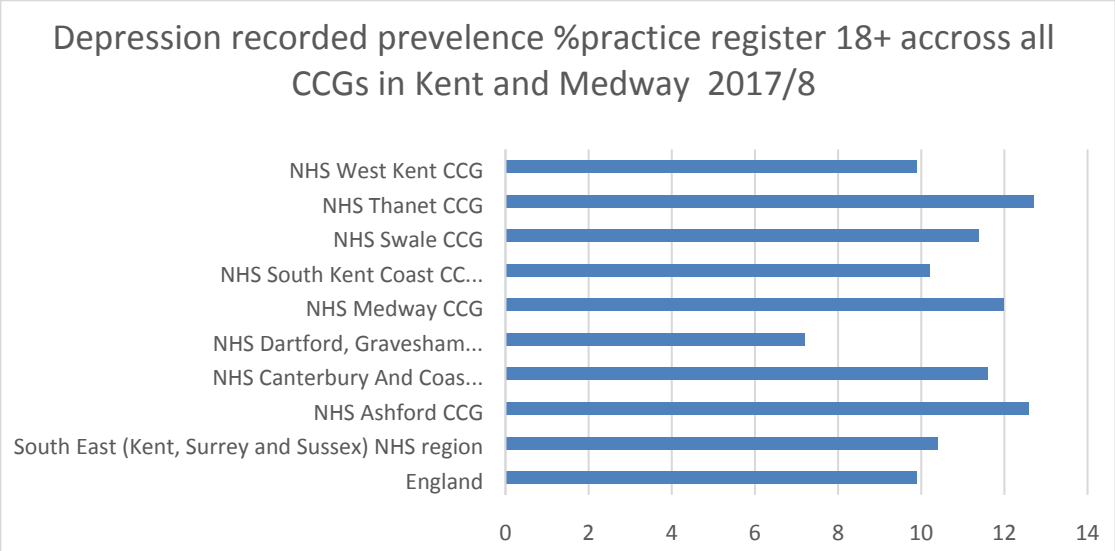


Fig 7

Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+ 2016/7

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

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

6.0 Mental Illness Outcomes in Kent

6.1 The data in Fig 8 shows the number and rates of admission to hospital for mental illness (primary diagnosis) per quarter year in Kent and Medway. In 2017/8 there were 3,515 admissions to hospital from Kent and Medway. This roughly the same number of people recoded on Care Programme Approach (Case Management) in Kent. There are higher hospital admission rates in Thanet. Overall admission rates in Kent are lower than the England average and Fig 9 shows that the trend has continued to reduce compared to the national average from 2017 to 2019. For GP prescribing of antipsychotic medication all CCGs are under the England average (Fig 10). This indicates that there is less mental health management of psychosis in primary care in Kent then the England average. Only Thanet is different in Kent and Medway, showing a statistically significant higher rate of GP prescribing for anti-psychotic medication.

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

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

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

Fig 9: Hospital Admissions to Secondary Care Mental Health Beds: Trends 2017/18/19

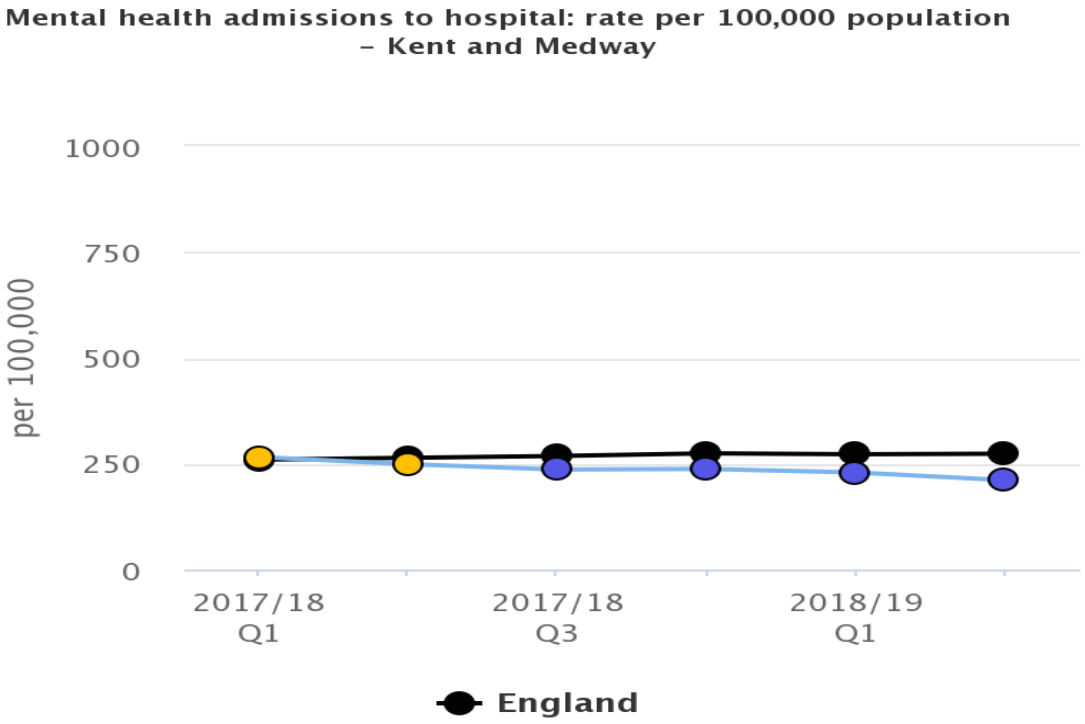


Fig 10 GP prescribing of drugs for psychoses and related disorders: items (quarterly) per 1,000 population 2017/18 Q4

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

Source: NHS Digital

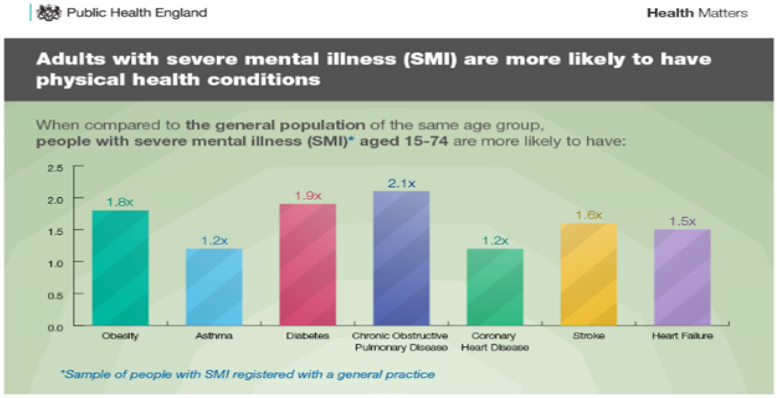
Fig 11 People subject to Mental Health Act: rate per 100,000 population aged 18+ (end of quarter snapshot) 2018/19 Q2

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

Source: NHS Digital

7.0 Mental Health and Physical Health Co- Morbidity and Premature Death.

Fig 12



7.1 People with serious mental illness have worse health outcomes, including

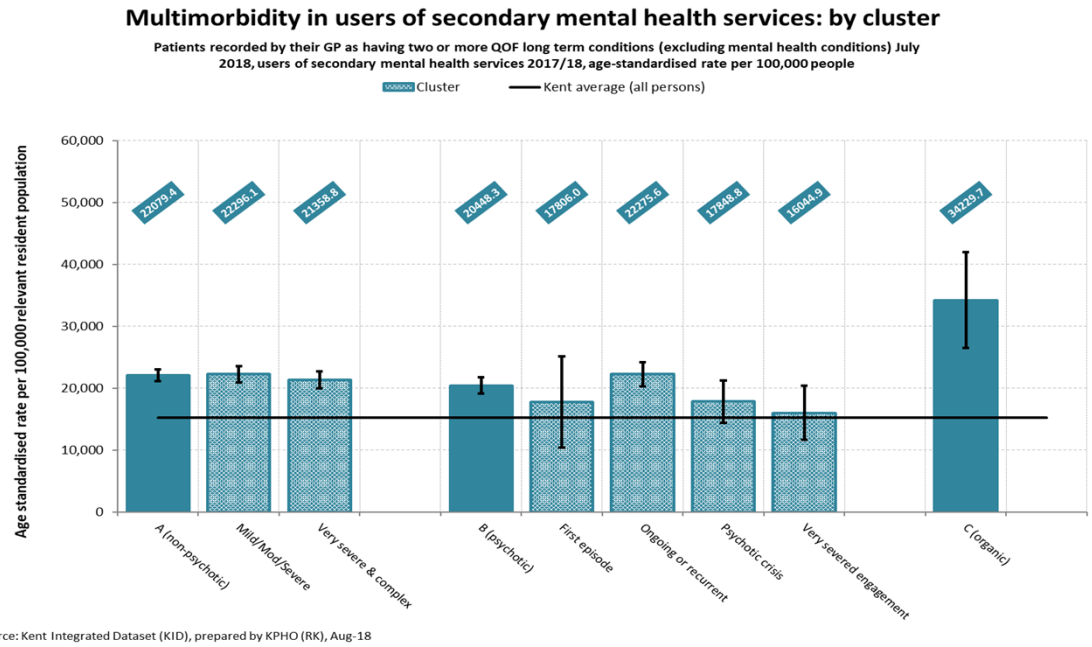
reduced life expectancy. Public Health England[13] have stated that excess premature mortality rates are 3.7 times higher amongst people with mental illness in England compared to the general population (Fig 12). It also states that adults with severe mental illness (SMI) die younger, from a range of conditions, than adults in the general population, with health disparities greatest for liver disease and respiratory disease.

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

7.3 Public Health in Kent conducted a study on the KID data comparing people who had 2+ long term conditions and people who had mental illness and other physical health illness (multi-morbidity). It found that people with a mental illness suffered greater multi-morbidity then those without mental illness and this impacted people with depression/ anxiety and psychosis equally (Fig 13).

7.4 The chart below (Fig 14) compares age standardised premature mortality rates for those with a serious mental illness with other adults aged 18-74, by Kent district and shows a great difference between those with a serious mental illness and their peers. Based on the age-standardised rates (i.e. adjusting for differences in the age profiles of those with a serious mental illness and the rest of the population), we see an odds ratio of 4.1 for Kent & Medway.

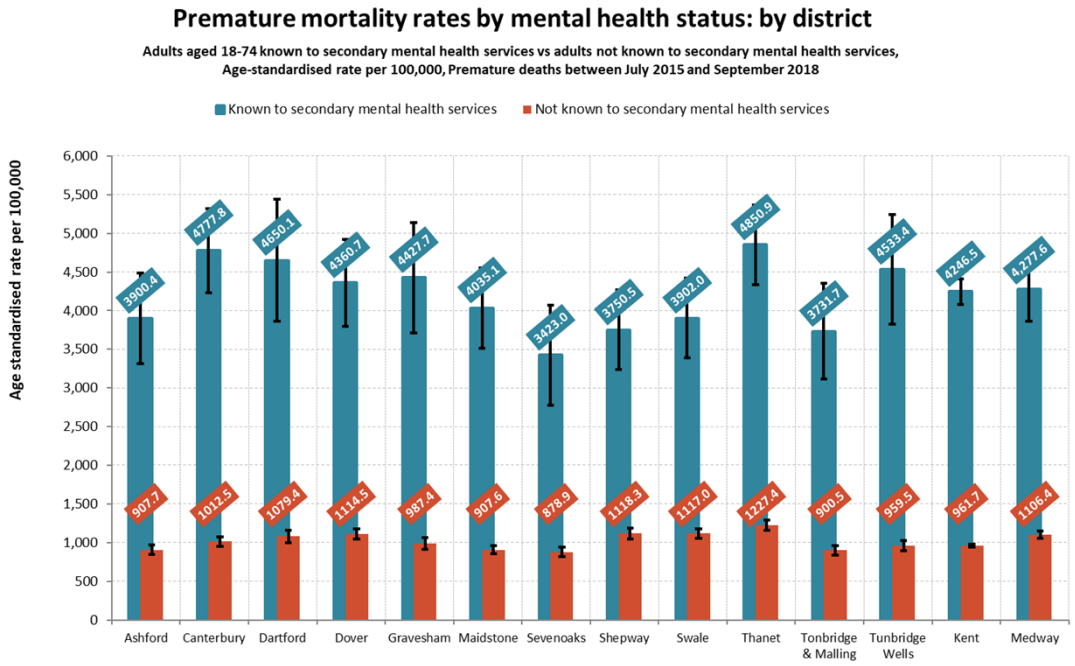
Fig 13.



Source: Kent Integrated Dataset (KID), prepared by KPHO (RK), Aug-18

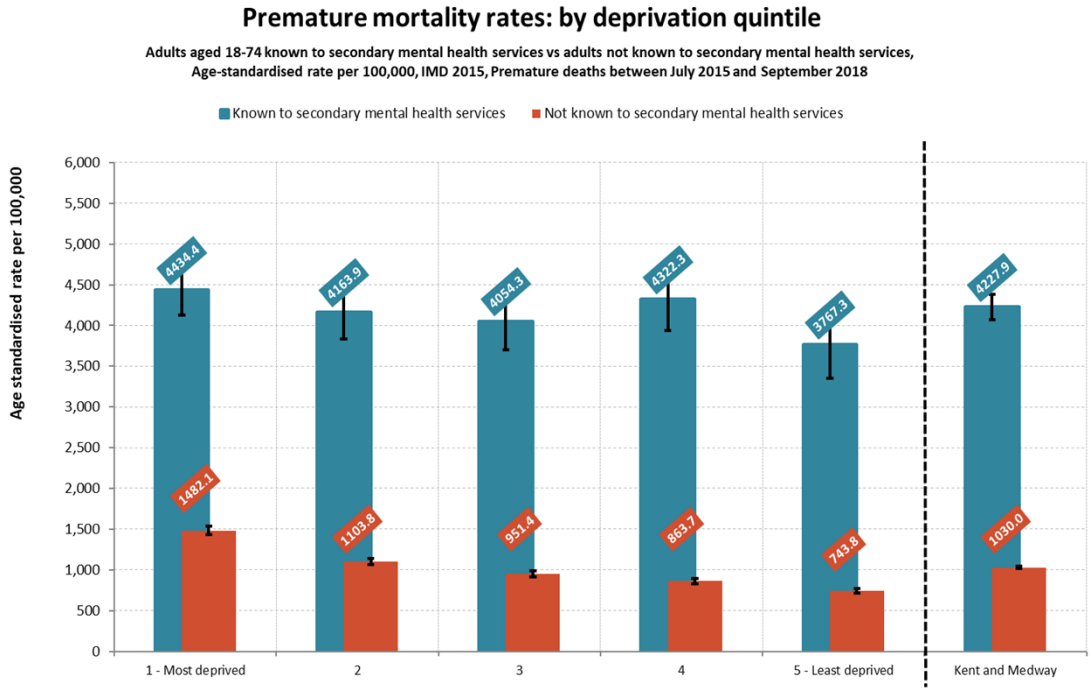
[13] Public Health England, December 2018, Health Matters: reducing health inequalities in mental illness. https://www.gov.uk/government/publications/health-matters-reducing-health-inequalities-in-mental-illness/health-matters-reducing-health-inequalities-in-mental-illness (Accessed 31st December 2018)

Fig 14.



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

Fig 15.



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

7.5 Mental Illness and Health Inequalities: The health and mortality rates for people with mental illness interact with their health status and to living in areas of greater deprivation. The data in Fig 15 shows that premature mortality rates amongst those with a serious mental illness are higher for those living in more deprived areas, the gap is far smaller than is the case for the rest of the 18-74 population. Whilst age-standardised premature mortality rates amongst those

not known to secondary mental health services are 99% higher (i.e. around double) in the most deprived areas compared with the least deprived, this gap reduces to 18% for those with a serious mental illness. This indicates that mental illness in itself is a cause of health inequality.

8. Suicide in Kent

8.1 Whilst suicide is an important element of mental health the updated suicide needs assessment was reported to this cabinet committee in September 2018

9 Next Steps

9.1 A series of recommendations from this data will be developed and shared with relevant commissioners and providers as part of the strategic transformation programme for mental health.

9.2 This data will be shared with NHS STP Local Care in order to improve the health outcomes for people with mental health problems.

9.3 This data will be shared with NHS and Social Care commissioners to improve the pathway for depression and suicide prevention.

9.4 An action plan from the recommendations will be developed by the STP mental health programme.

10 Recommendation

The Health Reform and Public Health Cabinet Committee is asked to **COMMENT** on the report and **SUGGEST** areas of further investigation and focus.

11 Background Documents:

Chapter 5 of Adult Mental Health Needs Assessment 2019: Multi Morbidity and Premature Mortality.

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