KENT PUBLIC HEALTH OBSERVATORY

# Draft: Kent Adult Mental Health Needs Assessment

## Chapter 5

## Mental health, Multi-Morbidity and Premature Mortality


**Produced by**

Jessica Mookherjee: Public Health Consultant (Jessica.Mookherjee@kent.gov.uk)
Rachel Kennard: Senior Intelligence Analyst (Rachel.Kennard@kent.gov.uk)
Trudi Godfrey: Information Officer (Trudi.Godfrey@kent.gov.uk)
Correspondence to: Rachel Kennard


Status: Draft

# Contents

# 1. Executive Summary

## 1.1 Introduction

This report presents developmental statistics to explore the relationship between mental health and premature mortality in Kent and Medway.

## 1.2 Key Findings

**Adults with a serious illness in Kent & Medway are around 4 times more likely to die prematurely than their peers**

- The KID study shows that across Kent & Medway, 4.1% of those with a serious mental illness[1] died prematurely over the study period (September 2018) compared with 1.1% of the rest of the 18-74 population. This suggests that adults in Kent & Medway with a serious mental illness are 3.6 times more likely to die prematurely, in line with the England average (of 3.7)[2].
- Age-standardised premature mortality rates suggest an odds ratio of 4.1 (i.e. after adjustment for differences in age profiles).
- Survival analysis (incorporating age and deprivation) yields a hazard ratio for serious mental illness of 4.0 (i.e. after adjustment for age and deprivation).

**Serious mental illness presents a greater risk of dying prematurely than deprivation or multimorbidity**

- Discriminant analysis suggests that when the impact of age, deprivation, multimorbidity and serious mental illness on premature mortality rates is considered, serious mental illness is the next most important driver after age.
- Decision tree (CHAID) analysis based on age, serious mental illness, deprivation and multimorbidity demonstrates that whilst age is the biggest predictor of differences in premature mortality rates, having a serious mental illness is the next most important (of the characteristics considered) for adults aged under 55 and those aged 65-74, i.e. more so than multimorbidity overall and deprivation.

[1] For the purpose of this analysis, membership of the serious illness cohort is defined as individuals aged 18-74 recorded within KID as known to KMPT (i.e. listed within the Mental_Health_Contacts table)
[2] 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)

For those aged 55-64 multimorbidity is the second biggest predictor, followed by having a serious mental illness.

# 2. Introduction & Objectives

## 2.1 Mental Illness, Co-Morbidity and Poverty

### 2.1.1 Thresholds, Diagnosis and Co-Morbidity

In discussing prevalence in this report, the difficulty of mental health diagnosis must be noted. For example, mental health in primary care ranges from sub-syndromal symptoms (i.e. not reaching the definition for disorder), to clear cases of mental disorder which range significantly in the severity and the disability they cause. It is the existence of this spectrum that makes it hard to categorise mental ill health in primary care into simple groupings for service planning. In addition, there is an enormous co-morbidity between both physical and mental health conditions. This is the focus of this report.

### 2.1.2 Thresholds for Services

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

### 2.1.3 Poverty

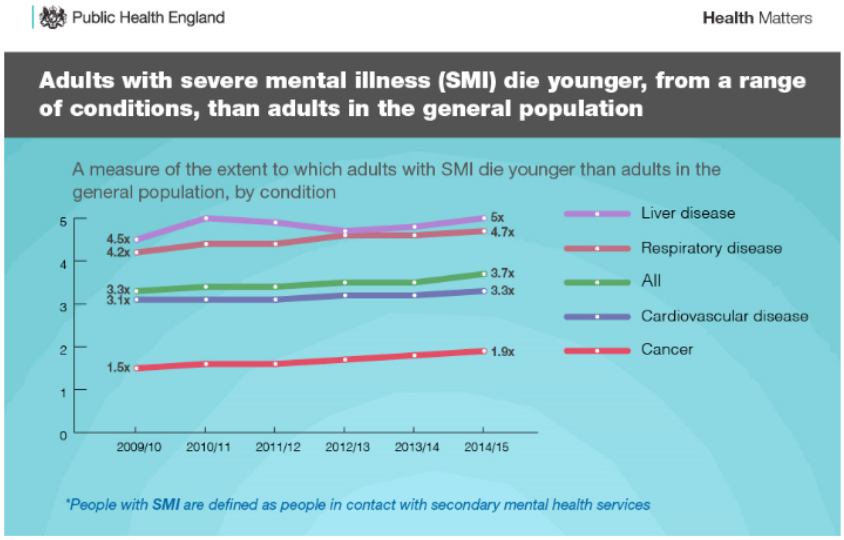
Poverty produces an environment that is extremely harmful to people's mental health. The primary health impacts of economic downturns are on mental health (including the risk of suicide) and people with no previous history of mental health problems may develop them as a consequence of having to cope with the ongoing stress of job insecurity, sudden and unexpected redundancy, and the impact of loss of employment (financial, social and psychological). Keeping people with mental health problems in work and getting people back to work are key policy and service responses to the economic downturn.[3]

### 2.1.4 Premature Mortality

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

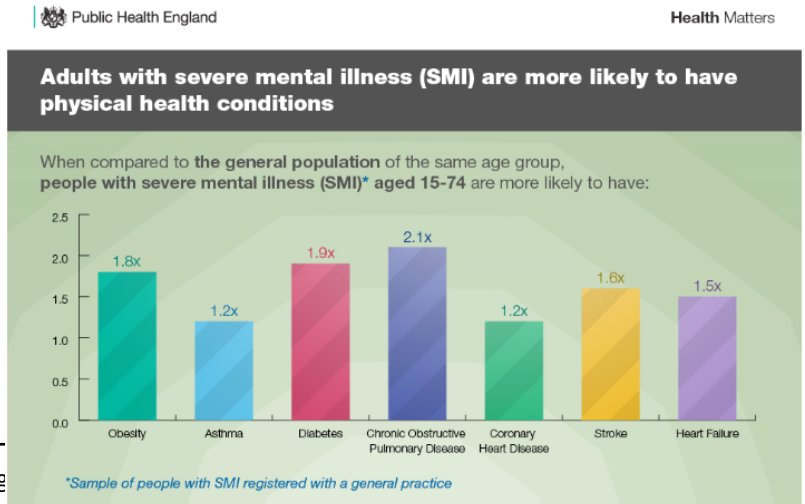
It has been widely documented that people with serious mental illness have worse health outcomes, including reduced life expectancy. Public Health England[4] have stated that excess premature mortality rates are 3.7 times higher amongst people with mental illness in England compared to the general population. 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.

**Figure 1**




The same report also identifies that there are physical health inequalities when comparing people with mental illness to the general population. It states that people with mental illness experience a greater burden of physical health conditions. It is estimated that for people with SMI, two in three deaths are due to physical illnesses such as cardiovascular disease (CVD) and can be prevented.

**Figure 2**




[4] Public Health Eng ntal 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)

## 2.2 Summary of the Findings from the National Mental Health Task Force

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

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

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

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

### 2.2.1 Rising Levels of multi-morbidity:

A King's Fund Report in 2015 indicated that between 12 per cent and 18 per cent of all NHS expenditure on long-term conditions is linked to poor mental health – most commonly in the form of *depression or anxiety disorders*, which if left untreated can significantly exacerbate physical illness and drive up the costs of care (Naylor *et al* 2012).

### 2.2.2 Inequalities in Health Outcomes:

Life expectancy for people with *bipolar disorder or schizophrenia* is 15 to 20 years below that of the general population, largely as a result of raised rates of cardiovascular disease and other physical health conditions (Laursen *et al* 2014; Miller and Bauer 2014).

Other mental illnesses that have significant co-morbidity with physical health are:

*Eating disorders, personality disorders, substance misuse disorders & untreated depression.*

### 2.2.3 Psychological Aspects of Physical Health

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

### 2.2.4 Current Research conclusions on interactions between mental and physical health

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

- cancer
- atrial fibrillation (AF)
- chronic heart disease (CHD)
- cardiovascular disease (CVD)
- heart failure (HF)
- hypertension
- peripheral arterial disease (PAD)
- stroke
- asthma
- chronic kidney disease (CKD)
- chronic obstructive pulmonary disease (COPD)
- diabetes.

- (Kings College London Study) SMI and **Heart Disease**. Those with SMI had 53% higher risk of getting CVD and 83% higher risk of dying then those without SMI.
- (UCL & Edinburgh Study) CMI and **Cancer** Outcomes. Poorer mortality outcomes for those with high levels of common mental distress.
- Many studies have shown the link between **Diabetes** and Depression - this is not fully understood, yet there appears to be elevated risks for CVD where both diabetes and depression are present.
- SMI and Musculoskeletal problems. Bone density is effected by arthritis and osteoporosis. Having SMI more then doubles the risk of developing MSK and low bone density.

### 2.2.5 Summary of Key findings:

Mental health problems represent up to 23% of the total burden of ill health – the largest single cause of disability.

## 2.3 Physical Health of People Severe Mental Illness is worse with people without mental illness (apart from Dementia).

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

Multimorbidity is assessed using the read-coded long-term condition information contained within the GP records held within the KID. The analysis covers 16 QOF conditions (as the

categories serious mental health conditions, dementia and depression are the cohort assessed). Individuals recorded as having two or more of the 16 long-term conditions are classified as multimorbid.

Since data on multimorbidity is captured via GP records, the analysis has been restricted to Kent residents who are also registered at one of GPs flowing data into the KID. At the time of the analysis this represented around 93% of the total GP registered population living in Kent. The analysis covers **21,114** individuals and has been subdivided by mental health cluster groupings. Around 11% of these individuals received support from KMPT under more than one of these cluster groupings during 2017/18, and so appear under more than one category in the analysis.

**This analysis shows age-standardised multimorbidity levels to be higher amongst users of secondary mental health services than for the population as a whole, and particularly for those falling into the organic cluster**. Further analysis of dementia (organic) shows this is a different group to those with mental illness as they are typically far older.

# 3. Methodology

The analysis presented in this report is based on Kent & Medway residents registered with Kent or Medway GPs. It has been conducted using data from the Kent Integrated Dataset (KID). The KID is a whole population, person level, pseudonymised dataset that currently collects information from almost all NHS providers across Kent and Medway.

The majority of the analysis[5] presented in this report covers current Kent & Medway residents aged 18-74 registered with a Kent or Medway GP at September 2018, plus patients within this age group previously registered with a Kent or Medway GP but with a flag indicating that they died (i.e. with a patient deceased flag) between July 2015 and September 2018 (1,338,294 adults).

## 3.1 Serious mental illness

For the purposes of this analysis, membership of the serious mental illness cohort is defined as individuals aged 18-74 recorded within KID as known to KMPT (i.e. listed within the Mental Health Contacts table). KMPT provides mental health, learning disability and substance misuse services as well as other specialist services to 1.8 million people across Kent and Medway.

[5] The exception to this is analysis involving long term condition and multimorbidity prevalence, which is restricted to those registered with a GP flowing data into the KID at the time of the analysis and to deaths occurring between October 2017 and September 2018. Deaths prior to this date have incomplete GP records associated with them, and so identification of long term condition and multimorbidity prevalence is not possible.

## 3.2 Premature mortality

Premature mortality is defined as death in people under 75 years old. For the purposes of this analysis, premature mortality is measured as deaths of individuals aged 18-74.

## 3.3 Multimorbidity

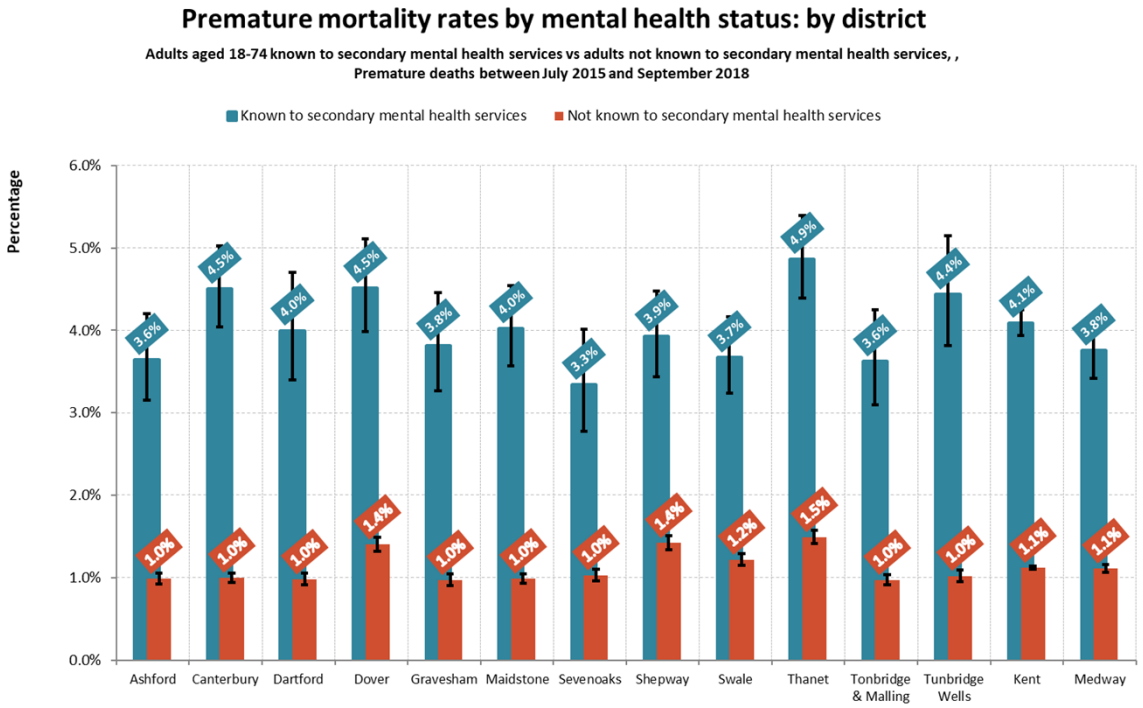
The multimorbidity analysis is restricted to those registered with the GPs flowing data into the KID at the time of the analysis. Individuals were considered multimorbid if they had two or more of the following 16 long-term conditions flagged within the GP records contained within KID: atrial fibrillation (AF), coronary heart disease (CHD), hypertension, heart failure (HF), peripheral artery disease (PAD), stroke, diabetes, asthma, chronic obstructive pulmonary disease (COPD), cancer, chronic kidney disease, (CKD), epilepsy, learning difficulties (LD), osteoporosis, rheumatoid arthritis (RA), or obesity.

# 4. Premature mortality rates

## 4.1 By District & CCG

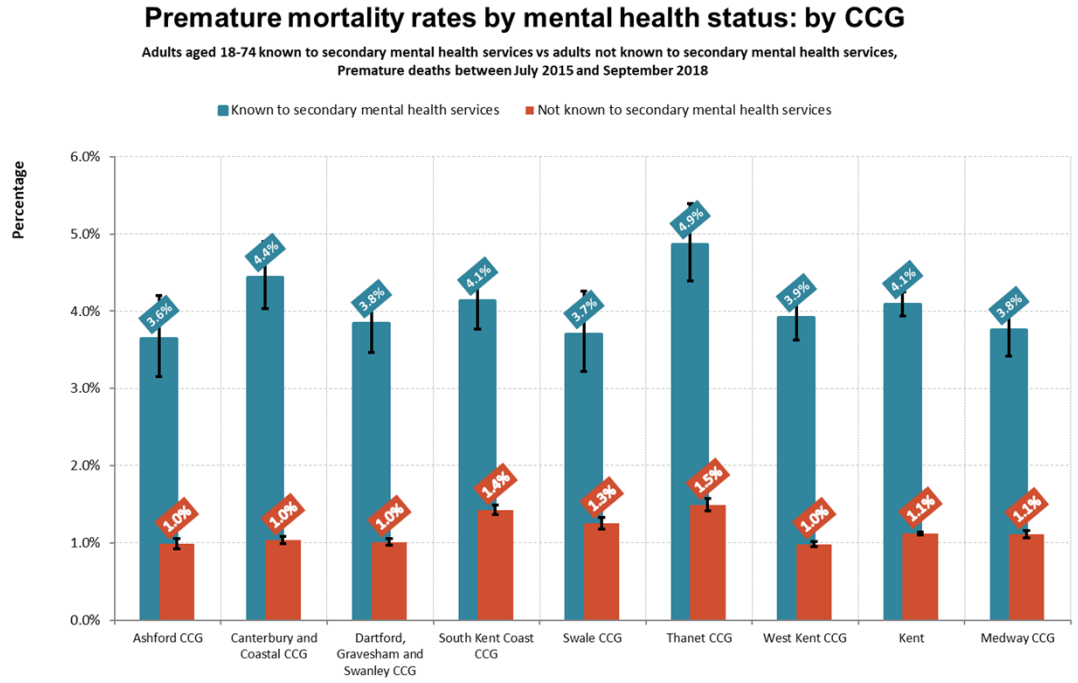
The charts below compare crude premature mortality rates for those with a serious mental illness with other adults aged 18-74, by district and CCG (of residence).

**Figure 3**




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

**Figure 4**




Source: Kent Integrated Dataset (KID), prepared by KPHO (TG), Dec-18

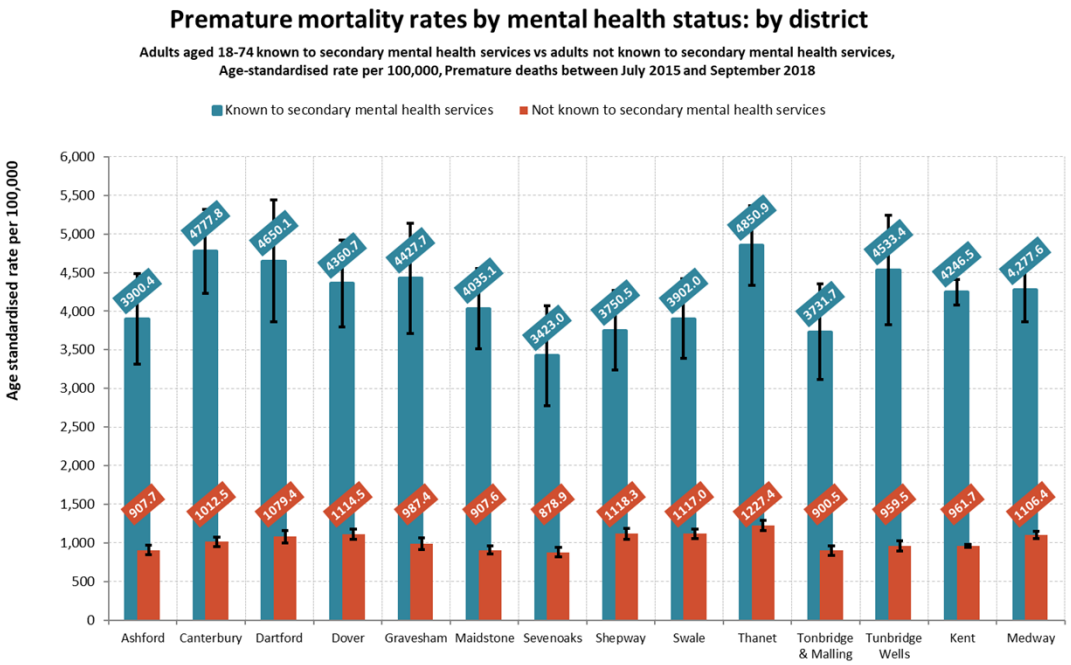
This analysis shows that those with a serious mental illness are much more likely to have died over the study period than the rest of the 18-74 population in every district and CCG.

For Kent & Medway as a whole, 4.1% of those with a serious mental illness died prematurely compared with 1.1% of the rest of the 18-74 population. This suggests that adults in Kent & Medway with a serious mental illness are 3.6 times more likely to die prematurely, in line with the England average (of 3.7)[6].

The chart compares age-standardised premature mortality rates by district and shows an even greater difference between those with a serious mental illness and their peers when adjustments are made for differences in age profile between the two groups. 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.

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

**Figure 5**

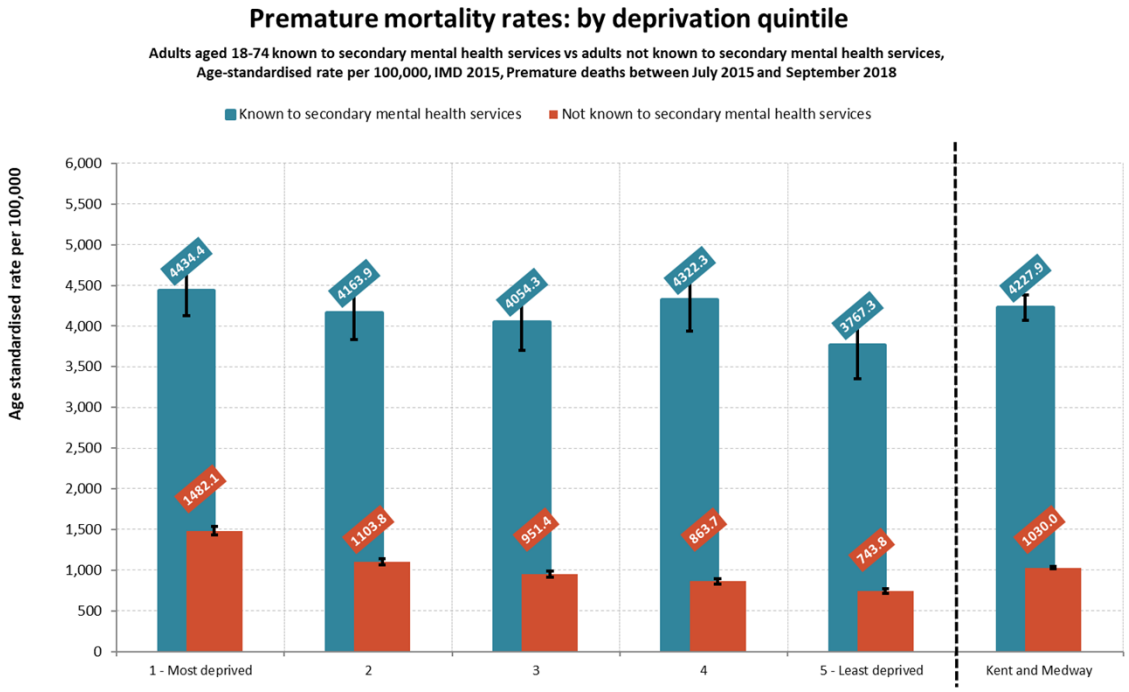



Source: Kent Integrated Dataset (KID), prepared by KPHO (TG), Jan-19

## 4.2 By Deprivation

Whilst it is true to say that premature mortality rates amongst those with a serious mental illness are higher for those living in more deprived areas, the gap is far smaller than is the case for the rest of the 18-74 population. 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.

**Figure 6**




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

# 5. Physical health conditions and multimorbidity

The analysis in this report that draws on long-term conditions and multimorbidity variables (i.e. GP records) is based on a slightly smaller cohort of individuals than the rest of the analysis in this report. These analyses are based on Kent & Medway residents aged 18-74 registered with one of the Kent & Medway *GPs flowing data into the KID* at the time of the analysis who died in the *12-month period* between October 2017 and September 2018[7], or were still alive at the end of the study period (1,233,847 adults).

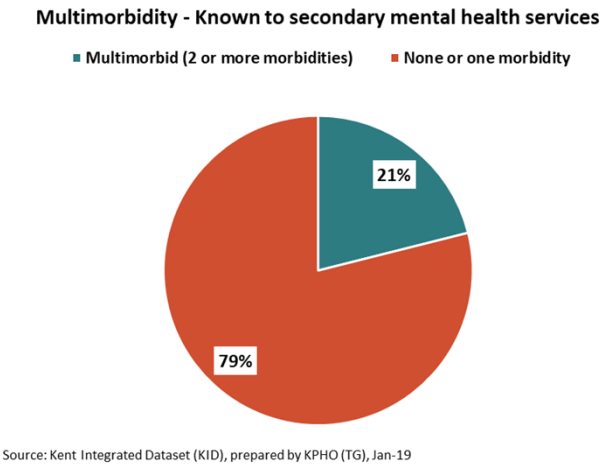
## 5.1 Multimorbidity prevalence

Recorded multimorbidity prevalence in Kent & Medway is around 50% higher amongst those with a serious mental illness than the rest of the population.

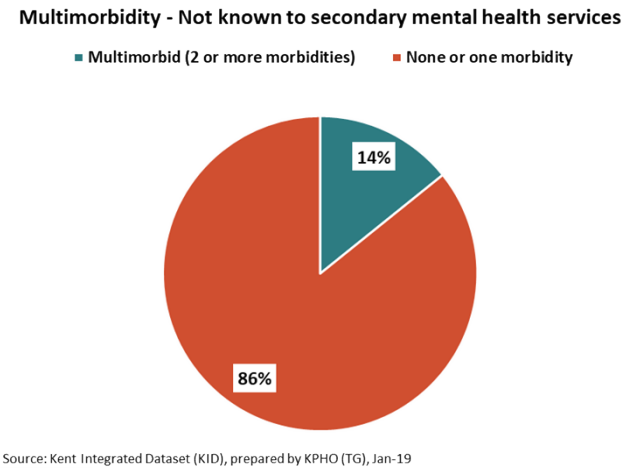
Across Kent and Medway, 21% of adults aged 18-74 with a serious mental illness[8] were recorded as multimorbid[9] by their GP compared to 14% of other adults aged 18-74.

[7] Deaths prior to this date have incomplete GP records associated with them, and so identification of long term condition and multimorbidity prevalence is not possible.
[8] And registered with one of the GPs flowing data into the KID at the time of the analysis.
[9] Patients were considered multimorbid if they had two or more of the following 16 long term conditions: Atrial Fibrillation (AF), Coronary Heart Disease (CHD), Hypertension, Heart Failure (HF), Peripheral Artery

**Figure 7**




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




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

## 5.2 Premature mortality and multimorbidity

Premature mortality rates are higher amongst those with a multimorbidity. Whilst the premature mortality rate was 1.4% for those in the study cohort[10] recorded by their GP as multimorbid, this reduces to 0.2% amongst those without two or more long-term conditions recorded.

Disease (PAD), Stroke, Diabetes, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Cancer, Chronic Kidney Disease, (CKD), Epilepsy, Learning Difficulties (LD), Osteoporosis, Rheumatoid Arthritis (RA), or Obesity.

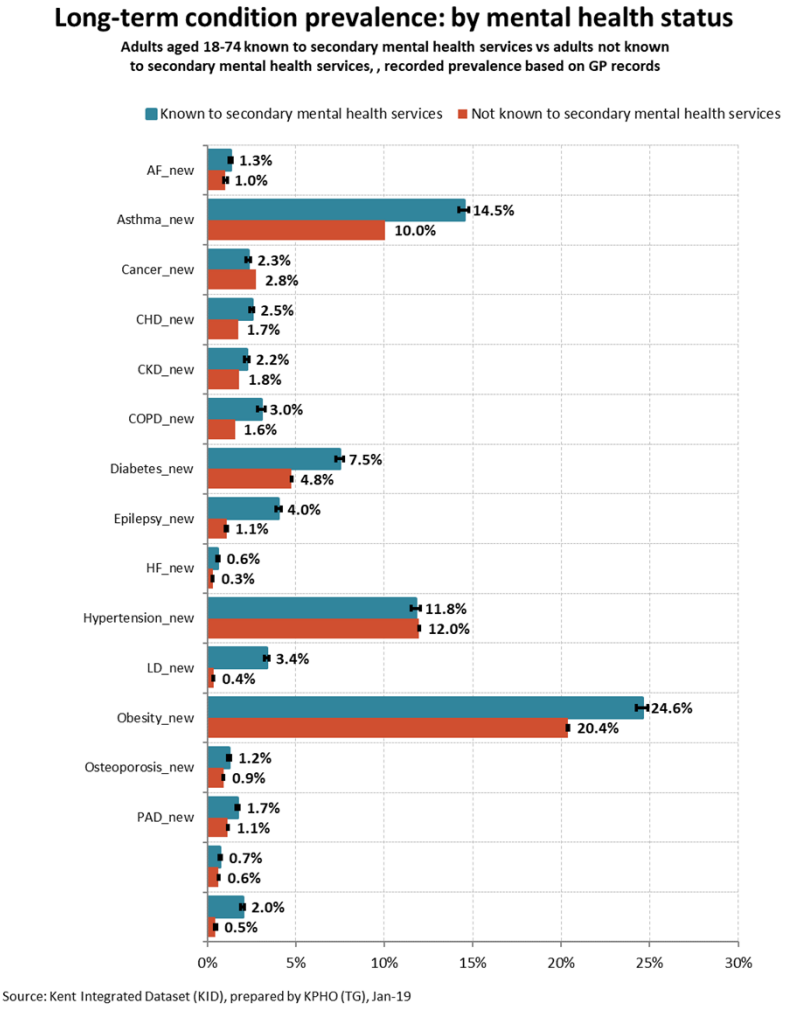
[10] Kent & Medway residents aged 18-74 registered with one of the Kent & Medway *GPs flowing data into the KID* at September 2018 who died in the *12-month period* between October 2017 and September 2018[10], or were still alive at the end of the study period (1,233,847 adults).

## 5.3 Long-term condition prevalence

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

- learning difficulties (odds ratio of 9.5)
- stroke (odds ratio of 4.3)
- epilepsy (odds ratio of 3.7)
- COPD (odds ratio of 2.0)
- HF (odds ratio of 1.9)
- diabetes (odds ratio of 1.6)
- peripheral arterial disease (odds ratio of 1.5)
- coronary heart disease (odds ratio of 1.5)

**Figure 8**




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

# 6. Drivers of inequalities in premature mortality rates

## 6.1 Survival analysis

Survival analysis techniques have been used to explore further the role of serious mental illness in inequalities in premature mortality.

In this analysis the impact of having a serious mental health condition on survival prospects is considered. A Cox regression has been performed with the following covariates:

- Serious mental illness (based on whether or not the individual has had contact with secondary mental health services)
- Age
- Deprivation (measured by Kent & Medway IMD decile)

This yields the following output, which suggests that all three of these covariates are statistically significant (i.e. that all three are associated with survival prospects).

**Table 1**

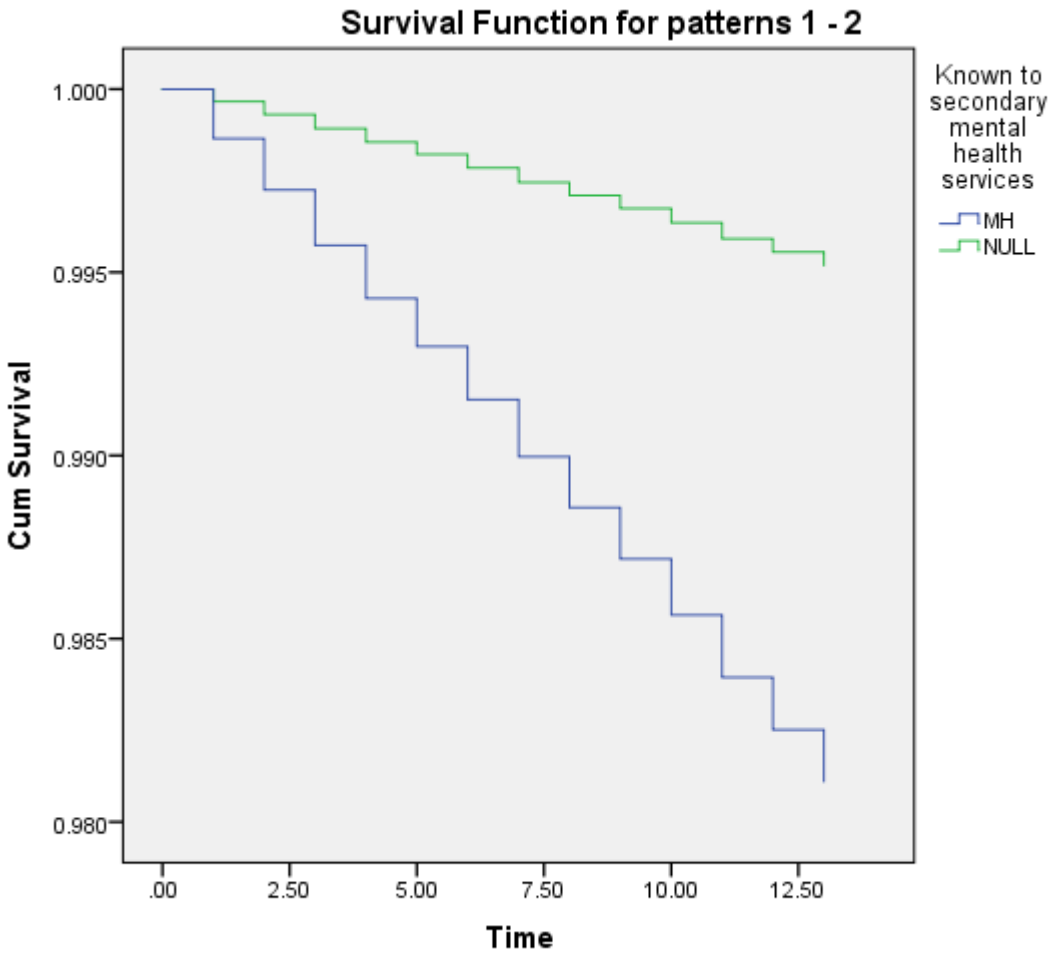
**Variables in the Equation**

| | B | SE | Wald | df | Sig. | Exp(B) | 95.0% CI for Exp(B) | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | Lower | Upper |
| Age | .088 | .001 | 15356.794 | 1 | .000 | 1.092 | 1.090 | 1.093 |
| Deprivation (IMD) | -.144 | .006 | 662.451 | 1 | .000 | .866 | .856 | .875 |
| Known to secondary mental health services | 1.375 | .021 | 4489.875 | 1 | .000 | 3.957 | 3.801 | 4.119 |

The hazard ratio for serious mental illness is 4.0 (95% confidence interval (3.8-4.1)), suggesting that the hazard of premature mortality for adults in Kent & Medway with a serious mental illness (after adjustment for age and deprivation) is four times that of their peers.

The chart below compares survival for those known to secondary mental health services with those who are not *adjusted for age and deprivation*.

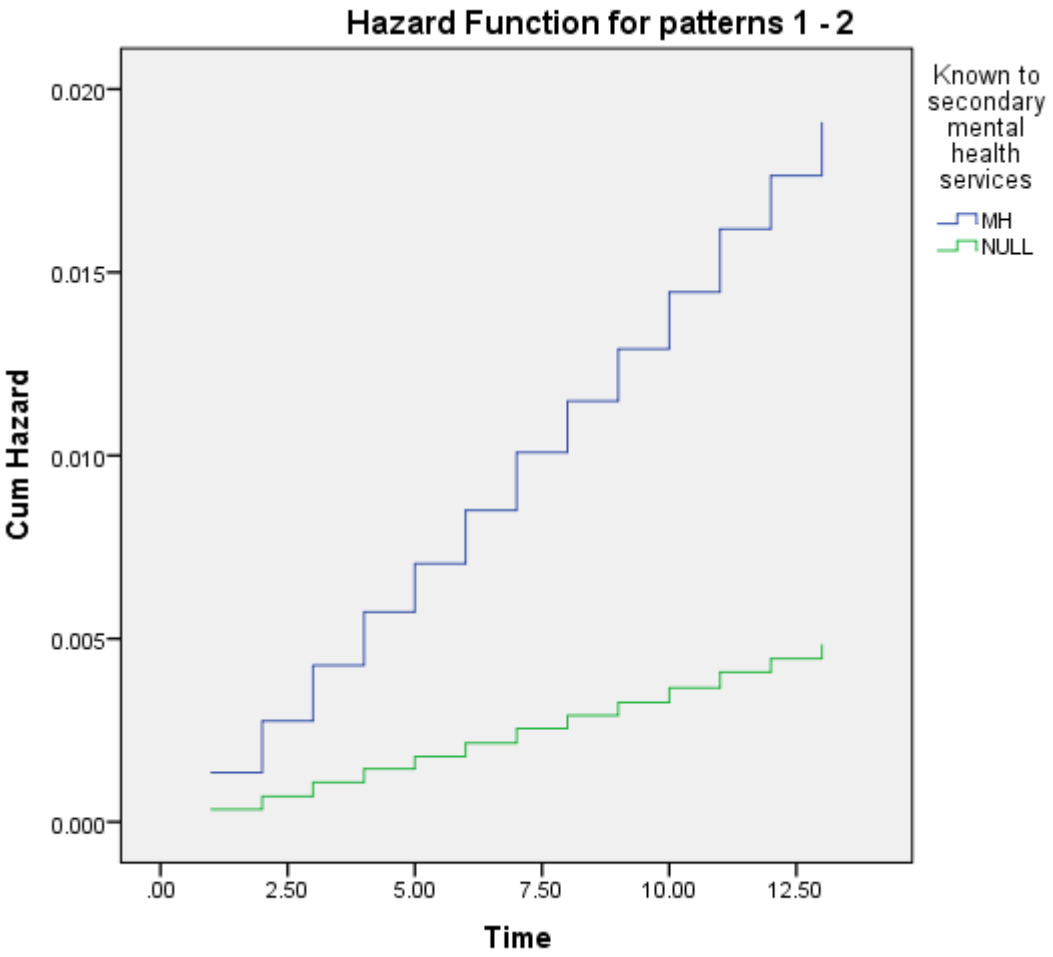
**Figure 9**




This clearly demonstrates inferior survival amongst those known to secondary mental health services (taken here as a proxy for those with serious mental health illness).

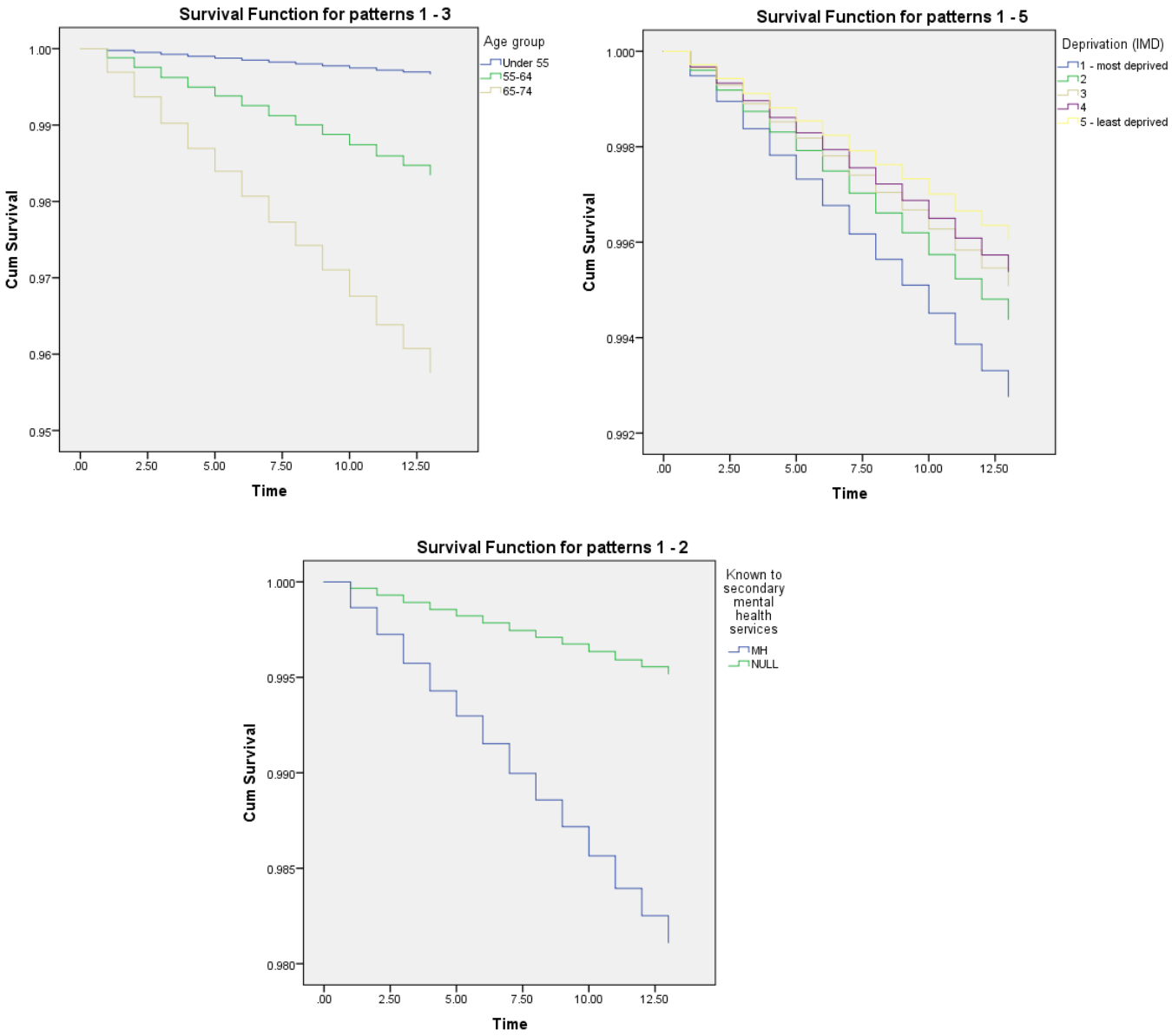
The chart below provides an alternative representation of this analysis, in terms of the hazard function.  Again, this has been adjusted for age and deprivation.

**Figure 10**



The charts below show survival functions for age and deprivation, comparing them with the survival function for serious mental illness.

**Figure 11**




Whilst the greatest differences in the survival functions are seen for age (with older adults less likely to survive than younger adults), this is followed by whether or not they are known to secondary mental health services. Whilst there are differences between the survival functions based on IMD, there is less differentiation suggesting that serious mental illness has a greater impact on survival prospects than deprivation. This hypothesis has been tested further using decision tree analysis (CHAID) and discriminant analysis.

## 6.2 What Predicts Premature Mortality in Kent?: (Decision Tree Analysis).

A decision tree analysis, using CHAID, has been used to explore the relative importance of the characteristics that have been found to be associated with premature mortality rates (i.e. age, deprivation, multimorbidity and serious mental illness)[11]. This type of analysis considers which of a range of potential drivers of premature mortality is the most discriminating in respect of premature mortality rates, and in particular which *combinations* of potential drivers.

### 6.2.1 Age and Mental Illness

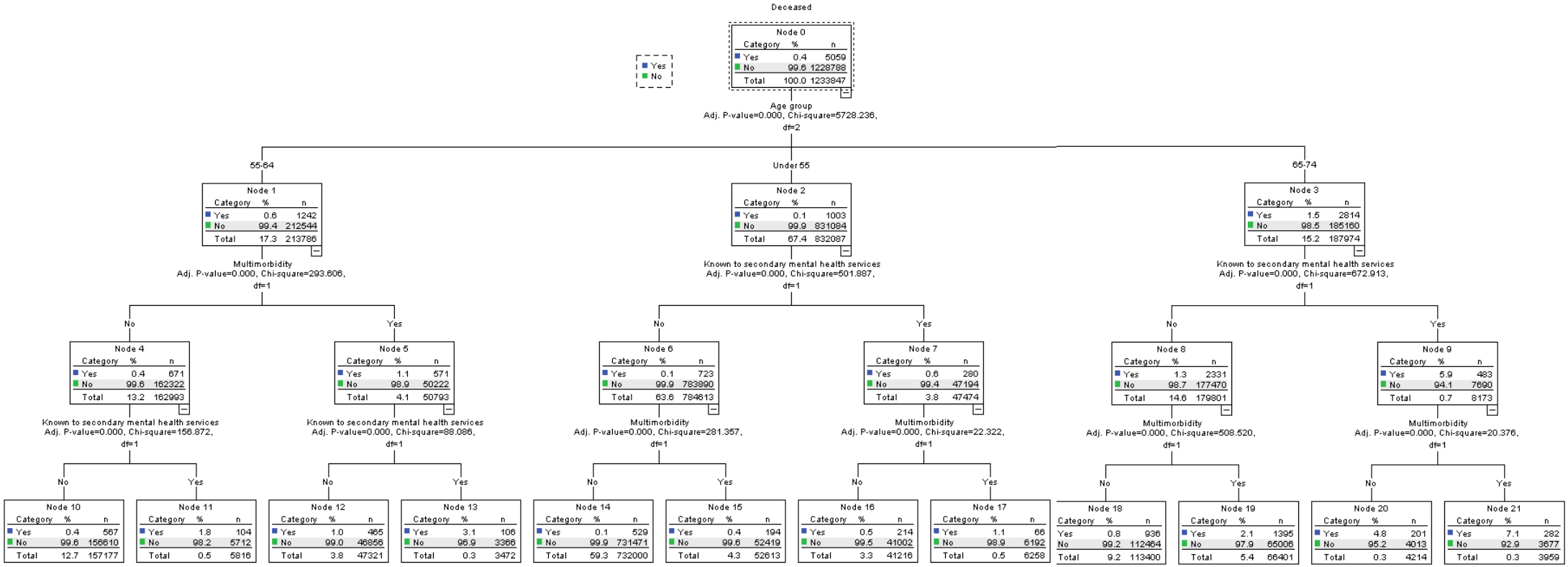
The analysis demonstrates that whilst age is the biggest predictor of differences in premature mortality rates, having a serious mental illness is the next most important (of the characteristics considered) for adults aged under 55 and those aged 65-74, i.e. more so than multimorbidity overall and deprivation.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

### 6.2.2 Cancer, Heart Failure and Mental Illness

If individual long-term conditions are considered (rather than multiple morbidity), cancer is shown to be more important than serious mental illness at predicting premature mortality rates in adults aged 55+. In the case of adults aged under 55, both heart failure *and* cancer are shown to be more important than serious mental illness, but *in both cases serious mental illness is the next most important predictor of premature mortality for those without these conditions.*

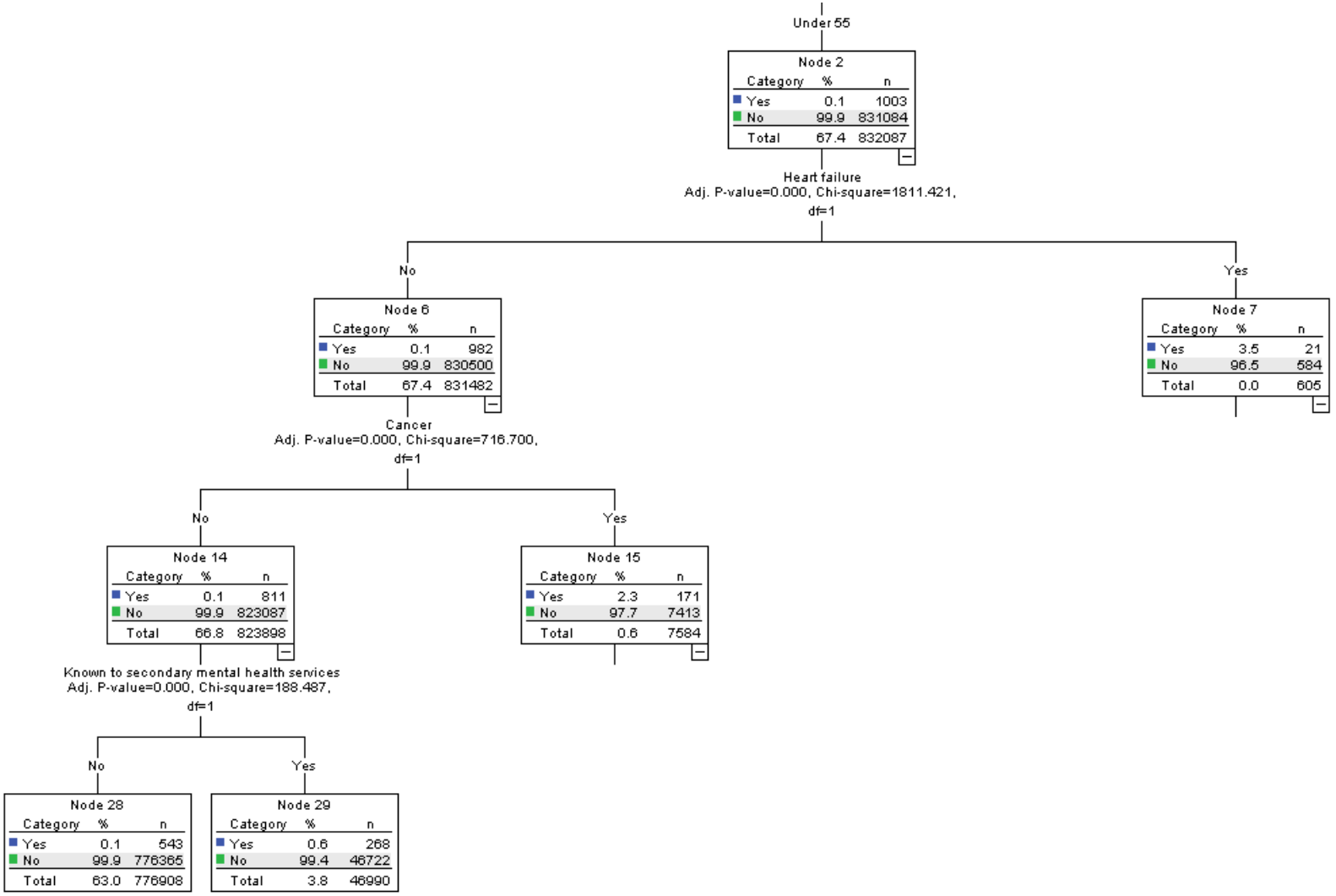
[11] As this analysis includes multimorbidity (i.e. information derived from GP records) it is restricted to Kent & Medway residents aged 18-74 registered with one of the Kent & Medway GPs flowing data into the KID at September 2018 who died in the 12-month period between October 2017 and September 2018 , or were still alive at the end of the study period (1,233,847 adults).

### 6.2.3 Decision tree analysis using age, deprivation, multimorbidity and serious mental illness

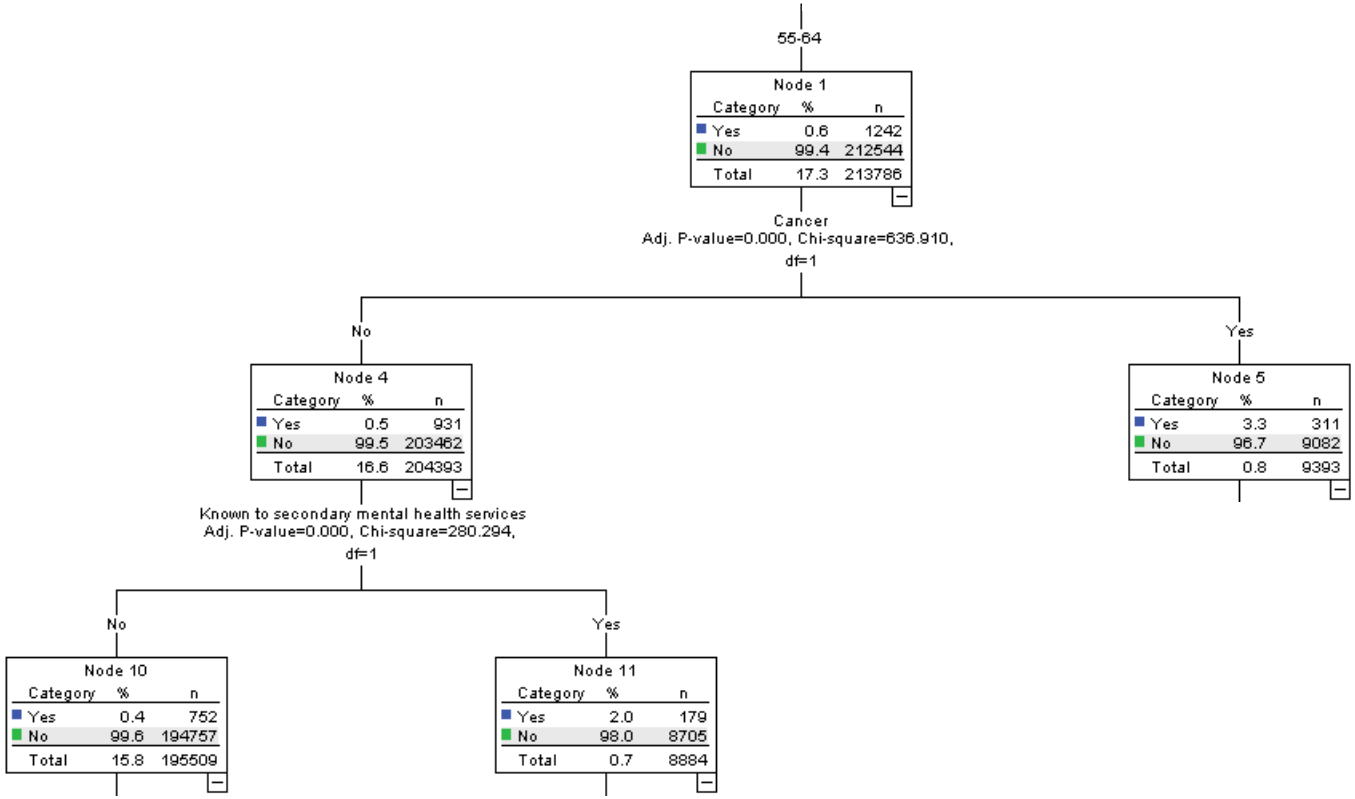


### 6.2.4 Decision tree analysis using age, deprivation, multimorbidity, serious mental illness and individual long-term conditions

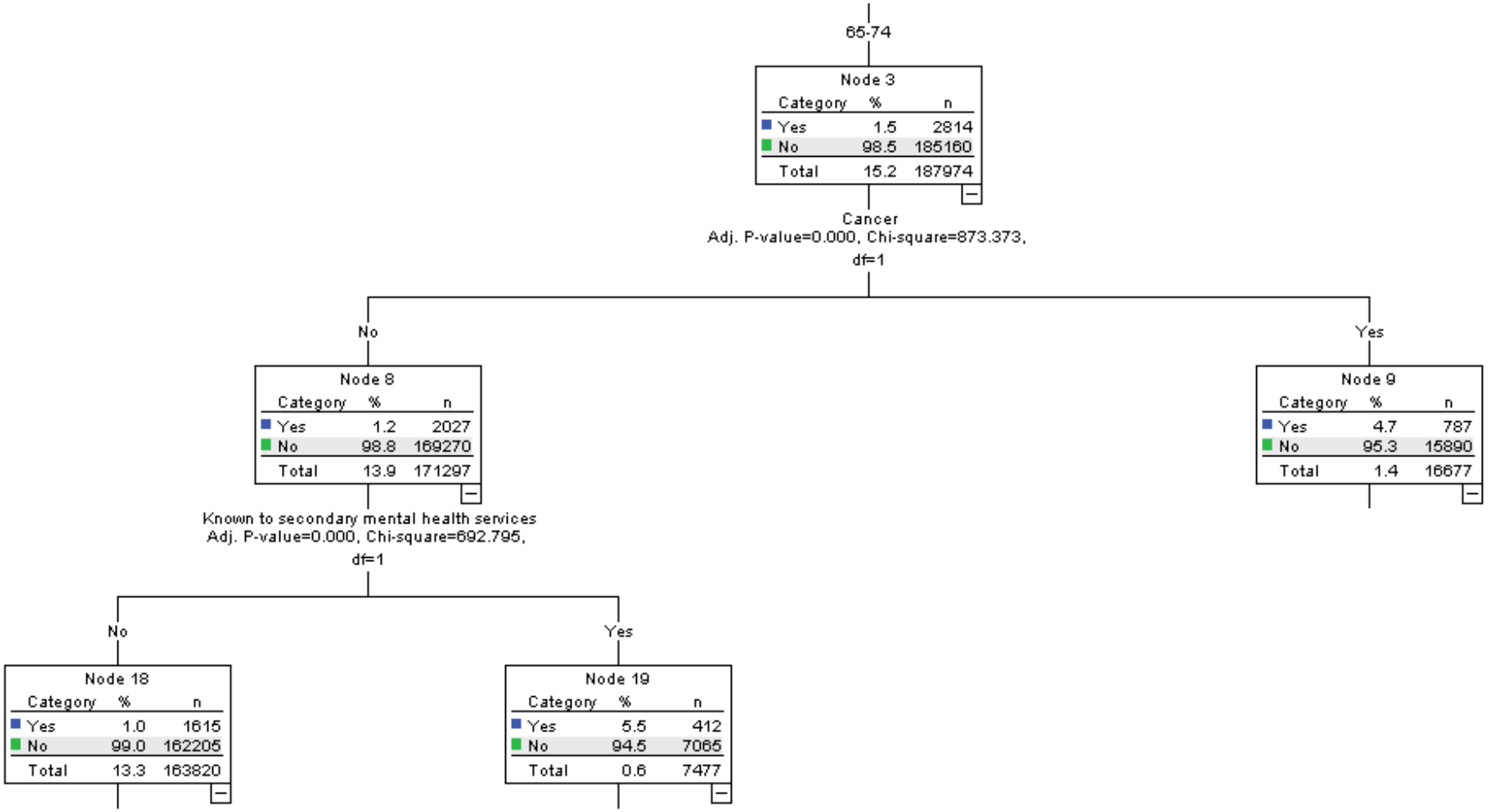
Under 55s



Ages 55-64


55-64
Node 1
Category % n
Yes 0.6 1242
No 99.4 212544
Total 17.3 213786
Cancer
Adj. P-value=0.000, Chi-square=636.910, df=1
No
Yes
Node 4
Category % n
Yes 0.5 931
No 99.5 203462
Total 16.6 204393
Node 5
Category % n
Yes 3.3 311
No 96.7 9082
Total 0.8 9393
Known to secondary mental health services
Adj. P-value=0.000, Chi-square=280.294, df=1
No
Yes
Node 10
Category % n
Yes 0.4 752
No 99.6 194757
Total 15.8 195509
Node 11
Category % n
Yes 2.0 179
No 98.0 8705
Total 0.7 8884

Ages 65-74


65-74
Node 3
Category % n
Yes 1.5 2814
No 98.5 185160
Total 15.2 187974
Cancer
Adj. P-value=0.000, Chi-square=873.373, df=1
No
Yes
Node 8
Category % n
Yes 1.2 2027
No 98.8 169270
Total 13.9 171297
Node 9
Category % n
Yes 4.7 787
No 95.3 15890
Total 1.4 16677
Known to secondary mental health services
Adj. P-value=0.000, Chi-square=692.795, df=1
No
Yes
Node 18
Category % n
Yes 1.0 1615
No 99.0 162205
Total 13.3 163820
Node 19
Category % n
Yes 5.5 412
No 94.5 7065
Total 0.6 7477

## 6.3 Conclusion and Recommendations: Health Inequalities: Health Inequalities will be worse where people age with mental illness: (Discriminant analysis).

Where Health Inequalities and premature mortality exists across Kent, in Kent's most deprived communities, people who are aging (over 50) with a mental illness are likely to be highly vulnerable to premature death.

Discriminant analysis provides an alternative analytical approach to exploring the drivers of premature mortality rates and produces similar overall findings.

With a stepwise approach, age is entered into the model first, followed by serious mental illness (then multimorbidity, then deprivation), and predicts 77% of cases correctly. This suggests that when the impact of age, deprivation, multimorbidity and serious mental illness on premature mortality rates is considered, serious mental illness is the next most important driver after age.

**Recommendation:** The mental health of a person must be as serious a consideration as their physical health in all health and social care treatments with a particular focus on joint management of mental and physical health conditions at primary care, increasing skills for front line clinical and social care staff in managing mental health and understanding medicines interactions. Prioritising areas of deprivation in Kent for integrated health and mental illness case management is also recommended. Ensuing there is increased and targeted support for lifestyle management in areas of deprivation targeted to people with mental health problems is also recommended – particularly alcohol, obesity and smoking for this group.

**Variables Entered/Removed[a,b,c,d]**

| Step | Entered | Wilks' Lambda | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Exact F | | | |
| | | Statistic | df1 | df2 | df3 | Statistic | df1 | df2 | Sig. |
| 1 | Age group | .994 | 1 | 1 | 1233845.000 | 7139.321 | 1 | 1233845.000 | .000 |
| 2 | Known to secondary mental health services | .992 | 2 | 1 | 1233845.000 | 4680.786 | 2 | 1233844.000 | .000 |
| 3 | Multimorbidity | .991 | 3 | 1 | 1233845.000 | 3753.331 | 3 | 1233843.000 | .000 |
| 4 | Deprivation (IMD) | .991 | 4 | 1 | 1233845.000 | 2848.658 | 4 | 1233842.000 | .000 |

At each step, the variable that minimizes the overall Wilks' Lambda is entered.

a. Maximum number of steps is 8.

b. Minimum partial F to enter is 3.84.

c. Maximum partial F to remove is 2.71.

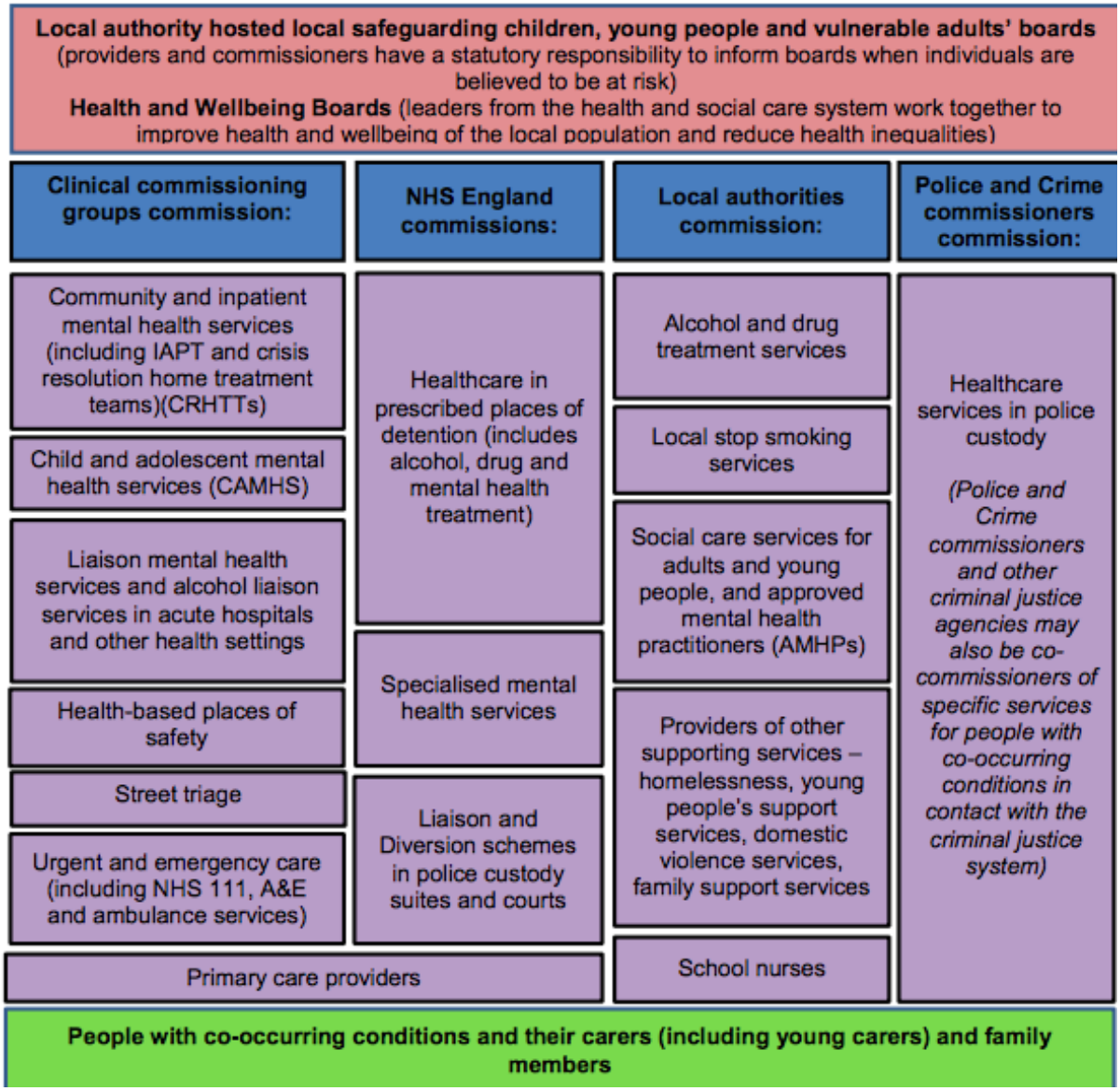
d. F level, tolerance, or VIN insufficient for further computation.

**Classification Results[a]**

| | | Deceased | Predicted Group Membership | | Total |
|---|---|---|---|---|---|
| | | | Yes | No | |
| Original | Count | Yes | 3769 | 1290 | 5059 |
| | | No | 288288 | 940500 | 1228788 |
| | % | Yes | 74.5 | 25.5 | 100.0 |
| | | No | 23.5 | 76.5 | 100.0 |

a. 76.5% of original grouped cases correctly classified.

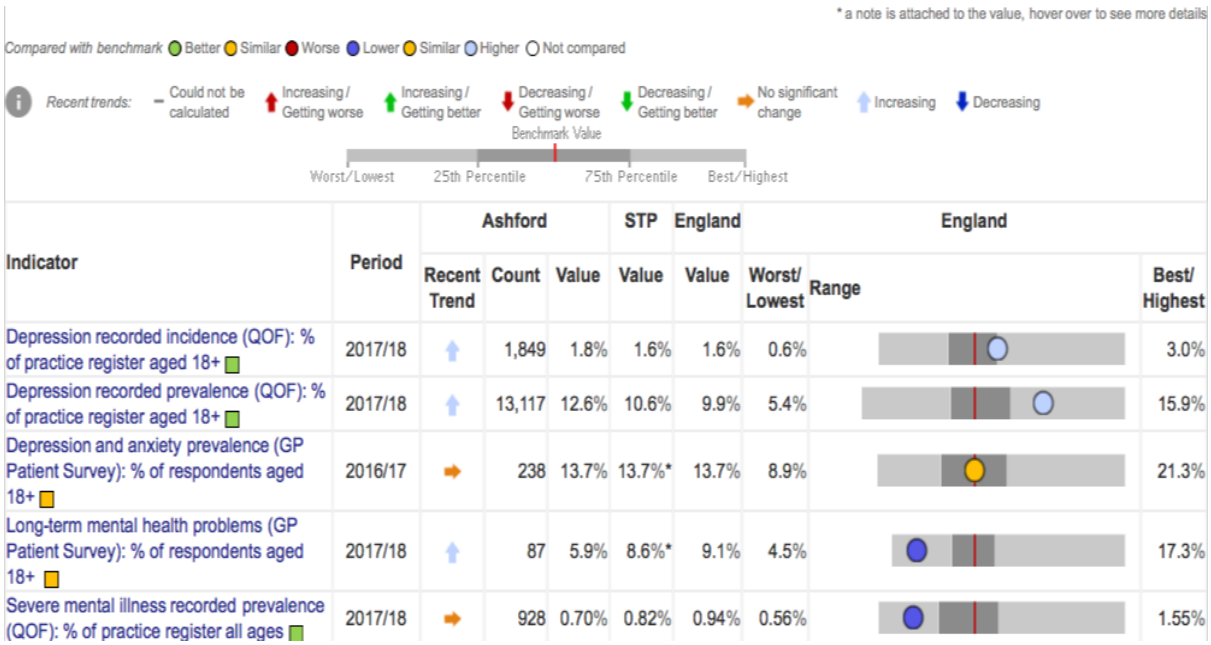
Appendix 1: Who commissions what in Mental Health



Appendix 2 **: Primary Care Data : Prevalence Rates of Mental Illness by Kent CCG**

**East Kent**

**Fig 1**

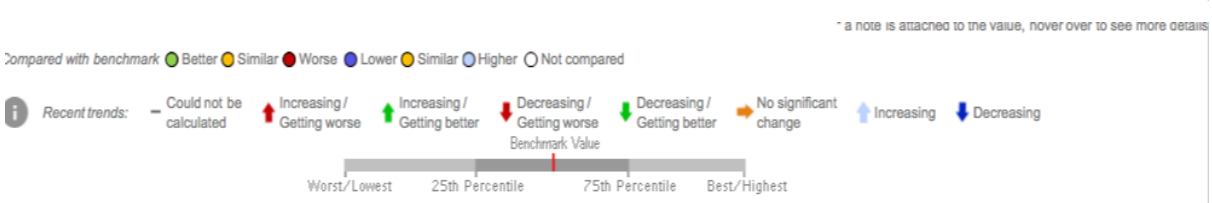



| Indicator | Period | Ashford | | | STP | England | England | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Recent Trend | Count | Value | Value | Value | Worst/ Lowest | Range | | Best/ Highest |
| Depression recorded incidence (QOF): % of practice register aged 18+ | 2017/18 | ↑ | 1,849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

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

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


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




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

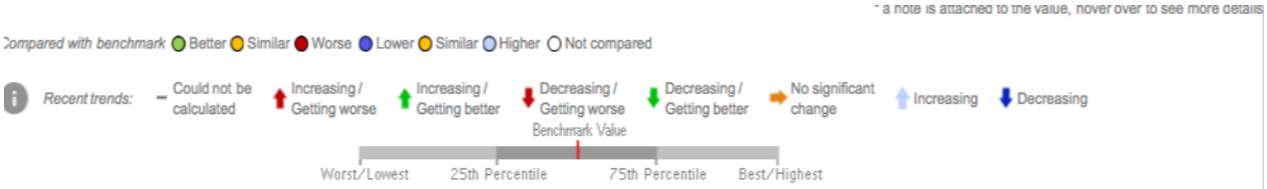
In South Coast Kent the trend for all conditions is increasing. There is below expected prevalence of recorded depression (although it is in line with East Kent CCGs). There appears to be good recording of SMI in South Kent Coast CCG.

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

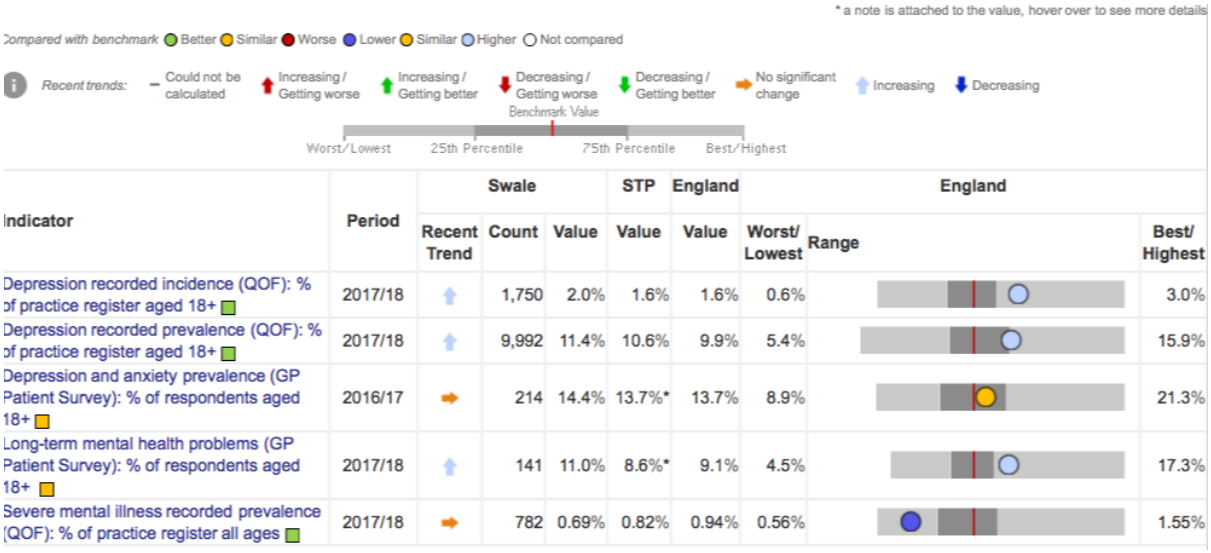

| Indicator | Period | Thanet | | | STP | England | England | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Recent Trend | Count | Value | Value | Value | Worst/ Lowest | Range | | Best/ Highest |
| Depression recorded incidence (QOF): % of practice register aged 18+ | 2017/18 | | 2,523 | 2.2% | 1.6% | 1.6% | 0.6% | | | 3.0% |
| Depression recorded prevalence (QOF): % of practice register aged 18+ | 2017/18 | | 14,650 | 12.7% | 10.6% | 9.9% | 5.4% | | | 15.9% |
| Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+ | 2016/17 | | 347 | 18.3% | 13.7%* | 13.7% | 8.9% | | | 21.3% |
| Long-term mental health problems (GP Patient Survey): % of respondents aged 18+ | 2017/18 | | 147 | 8.9% | 8.6%* | 9.1% | 4.5% | | | 17.3% |
| Severe mental illness recorded prevalence (QOF): % of practice register all ages | 2017/18 | | 1,699 | 1.17% | 0.82% | 0.94% | 0.56% | | | 1.55% |

Overall East Kent is seeing increases in mental illness in primary care.

### North Kent




| Indicator | Period | Dartford, Gravesham And Swanley | | | STP | England | England | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Recent Trend | Count | Value | Value | Value | Worst/ Lowest | Range | | Best/ Highest |
| Depression recorded incidence (QOF): % of practice register aged 18+ | 2017/18 | | 1,700 | 0.8% | 1.6% | 1.6% | 0.6% | | | 3.0% |
| Depression recorded prevalence (QOF): % of practice register aged 18+ | 2017/18 | | 15,045 | 7.2% | 10.6% | 9.9% | 5.4% | | | 15.9% |
| Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+ | 2016/17 | | 426 | 12.1% | 13.7%* | 13.7% | 8.9% | | | 21.3% |
| Long-term mental health problems (GP Patient Survey): % of respondents aged 18+ | 2017/18 | | 230 | 7.5% | 8.6%* | 9.1% | 4.5% | | | 17.3% |
| Severe mental illness recorded prevalence (QOF): % of practice register all ages | 2017/18 | | 1,986 | 0.74% | 0.82% | 0.94% | 0.56% | | | 1.55% |



* a note is attached to the value, hover over to see more details

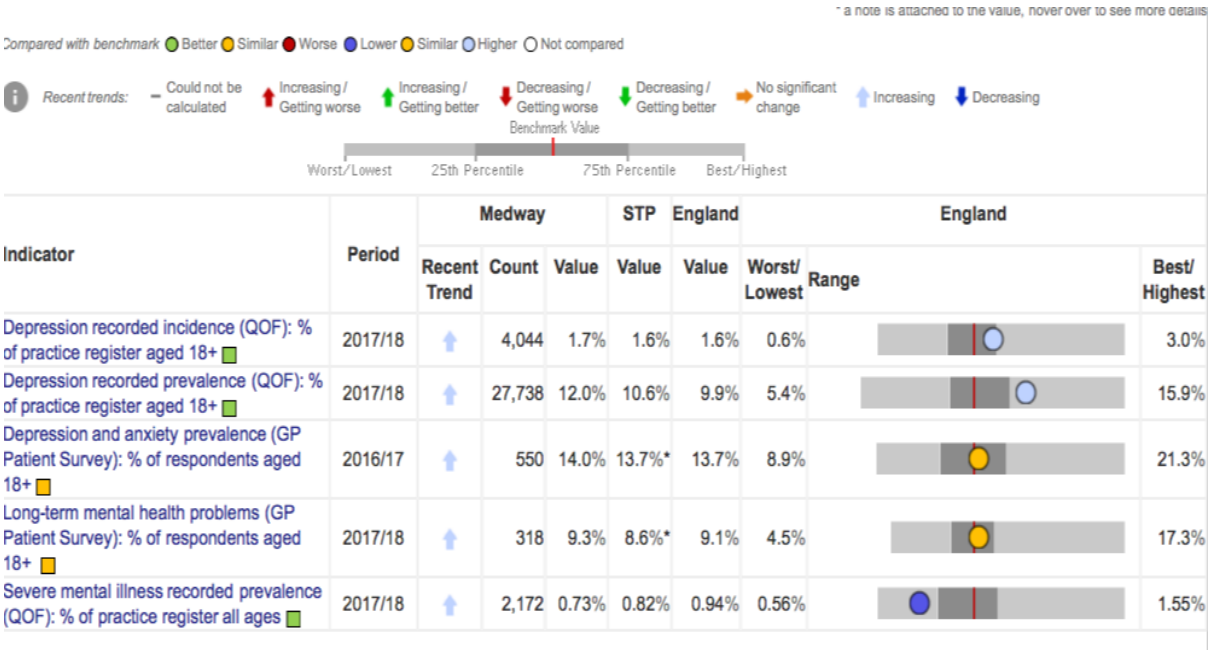
Compared with benchmark: Better, Similar, Worse, Lower, Similar, Higher, Not compared

Recent trends: Could not be calculated; Increasing / Getting worse; Increasing / Getting better; Decreasing / Getting worse; Decreasing / Getting better; No significant change; Increasing; Decreasing

Benchmark Value: Worst/Lowest, 25th Percentile, 75th Percentile, Best/Highest

| Indicator | Period | Swale | | | STP | England | England | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Recent Trend | Count | Value | Value | Value | Worst/ Lowest | Range | | Best/ Highest |
| Depression recorded incidence (QOF): % of practice register aged 18+ | 2017/18 | ↑ | 1,750 | 2.0% | 1.6% | 1.6% | 0.6% | | | 3.0% |
| Depression recorded prevalence (QOF): % of practice register aged 18+ | 2017/18 | ↑ | 9,992 | 11.4% | 10.6% | 9.9% | 5.4% | | | 15.9% |
| Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+ | 2016/17 | → | 214 | 14.4% | 13.7%* | 13.7% | 8.9% | | | 21.3% |
| Long-term mental health problems (GP Patient Survey): % of respondents aged 18+ | 2017/18 | ↑ | 141 | 11.0% | 8.6%* | 9.1% | 4.5% | | | 17.3% |
| Severe mental illness recorded prevalence (QOF): % of practice register all ages | 2017/18 | → | 782 | 0.69% | 0.82% | 0.94% | 0.56% | | | 1.55% |

Swale and Dartford and Gravesham show somewhat differing patterns of mental illness in primary care. With DGS showing lower recording levels then expected and Swale showing higher. It may be important to understand the mental health primary care pathway in DGS given the demand in primary care to understand this better.



* a note is attached to the value, hover over to see more details

Compared with benchmark: Better, Similar, Worse, Lower, Similar, Higher, Not compared

Recent trends: Could not be calculated; Increasing / Getting worse; Increasing / Getting better; Decreasing / Getting worse; Decreasing / Getting better; No significant change; Increasing; Decreasing

Benchmark Value: Worst/Lowest, 25th Percentile, 75th Percentile, Best/Highest

| Indicator | Period | Medway | | | STP | England | England | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Recent Trend | Count | Value | Value | Value | Worst/ Lowest | Range | | Best/ Highest |
| Depression recorded incidence (QOF): % of practice register aged 18+ | 2017/18 | ↑ | 4,044 | 1.7% | 1.6% | 1.6% | 0.6% | | | 3.0% |
| Depression recorded prevalence (QOF): % of practice register aged 18+ | 2017/18 | ↑ | 27,738 | 12.0% | 10.6% | 9.9% | 5.4% | | | 15.9% |
| Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+ | 2016/17 | ↑ | 550 | 14.0% | 13.7%* | 13.7% | 8.9% | | | 21.3% |
| Long-term mental health problems (GP Patient Survey): % of respondents aged 18+ | 2017/18 | ↑ | 318 | 9.3% | 8.6%* | 9.1% | 4.5% | | | 17.3% |
| Severe mental illness recorded prevalence (QOF): % of practice register all ages | 2017/18 | ↑ | 2,172 | 0.73% | 0.82% | 0.94% | 0.56% | | | 1.55% |

**West Kent**

In West Kent it appears that depression is well recorded in primary care as it is above the STP benchmark. However some investigation on the management of SMI may be important as recording is below the STP average.


| Indicator | Period | West Kent | | | STP | England | England | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Recent Trend | Count | Value | Value | Value | Worst/ Lowest | Range | Best/ Highest |
| Depression recorded incidence (QOF): % of practice register aged 18+ | 2017/18 | | 5,967 | 1.6% | 1.6% | 1.6% | 0.6% | | 3.0% |
| Depression recorded prevalence (QOF): % of practice register aged 18+ | 2017/18 | | 38,090 | 9.9% | 10.6% | 9.9% | 5.4% | | 15.9% |
| Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+ | 2016/17 | | 742 | 11.4% | 13.7%* | 13.7% | 8.9% | | 21.3% |
| Long-term mental health problems (GP Patient Survey): % of respondents aged 18+ | 2017/18 | | 430 | 7.7% | 8.6%* | 9.1% | 4.5% | | 17.3% |
| Severe mental illness recorded prevalence (QOF): % of practice register all ages | 2017/18 | | 3,812 | 0.77% | 0.82% | 0.94% | 0.56% | | 1.55% |

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

[ii] Kings Fund