

# Thurrock Joint Strategic Needs Assessment for Common Mental Health Disorders in Adults

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**Authors:**

Funmi Worrell  
Strategic Lead – Public Health

Maria Payne  
Senior Programme Manager Health Intelligence

Tim Elwell-Sutton  
Assistant Director and Consultant in Public Health

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# 1 Introduction

## Key Points

- Mental health is the leading cause of disability worldwide.
- One in four people will experience mental ill health in their lifetime
- Improving emotional health is one of the five high level goals set out in the Health and Wellbeing Strategy 2016-21 for Thurrock.
- Improved mental health and wellbeing is associated with a range of better physical and social outcomes for people of all ages and backgrounds.
- The cost of mental ill health to the NHS is £105 billion per year

*“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”*

World Health Organization, 2014

*“[Mental health is] a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community”.*

World Health Organization, 2014

## 1.1 Scope and purpose of the document

This Mental Health Joint Strategic Needs Assessment (MH JSNA) has been written in order to understand the level of need for mental health services, to understand the variation in access and quality of treatment and to identify mental health priorities for Thurrock residents.

It focusses on Common Mental Health Disorders (CMHDs) in adults as well as Serious Mental Illness (SMI). It excludes specific mental health disorders such as Dementia and Learning Disabilities. Details of Mental Health in children will be detailed in a separate product due for publication by the Public Health Team later in 2018.

This document is structured around a series of key questions:

- Who is affected by mental illness?
  - The scale of the problem
  - The trends
  - High risk groups
- What are the causes and consequences of mental illness?
- What services are provided for those with mental illness?
  - Primary care
  - Secondary care
  - Social care
- What do residents think of mental health services in Thurrock?

## 1.2 Definitions of Health and Mental Health

Common Mental Disorders (CMHDs)	Includes: depression, anxiety, panic disorder, obsessive-compulsive disorder (OCD), generalized anxiety disorder (GAD), phobias, post-traumatic stress disorder (PTSD). CMHDs do not generally exist in isolation to each other. Mixed anxiety and depression being the most commonly diagnosed CMHD.
Serious Mental Illnesses (SMIs)	Includes conditions characterised by psychosis (losing touch with reality) or requiring high levels of care. Two of the most common are: schizophrenia and bipolar disorder (manic depression). Also known as <i>Severe Mental Illness</i> .
Improving Access to Psychological Therapies (IAPT)	A national programme to increase the availability of 'talking therapies' on the NHS. IAPT is primarily for people who have mild to moderate mental health difficulties.
Early Intervention in Psychosis (EIP)	Early Intervention in Psychosis (EIP) teams provide specialist treatment and care for people who have signs of psychosis. The teams are made up of a number of different health and social care professionals.

## 1.3 National Context of Mental Health in England

Current figures suggest that 1 in 4 people will experience poor mental health at some point in their lives and that 1 in 6 adults are experiencing mental health difficulties at any one time. Moreover, 1 in 10 children aged between 5-16 years of age will have a mental health condition with many of these individuals continuing to experience poor mental health in adulthood.

Estimates suggest that between a quarter to half of mental health issues experienced in adulthood could be averted with effective early interventions in childhood (COI, 2011). Linking to this is the need to focus on the perinatal mental health of pregnant women, as mental health issues during pregnancy increase the risk of both adverse pregnancy outcomes and also neurodevelopmental problems for the child both before and after birth. This sets a precedent for the importance of early intervention and prevention programmes as well as the crucial need to reduce pressure on the NHS in providing emergency care to those facing crisis.

The cost of mental illness for the NHS in England is £105 billion of which £30 million is allocated to work related sickness. This is due to increase and double over the next 20 years. The costs to Social Care for people with mental health collates to £2 billion annually and is also likely to continue to increase if mental health services are not re-organised and managed more effectively (COI, 2011). This will put ever more pressure on an already overstretched NHS and Social Care system.

## 1.4 Local context of mental health in Thurrock

Thurrock is the fourth most under-doctored Local Authority within England. This affects the number of people being diagnosed with mental health conditions as GPs often do not have the time to explore whether physical symptoms are related to underlying mental health disorders and vice versa (Thurrock Council, 2016). In general, 90% of mental health conditions are managed within Primary Care. However, under-doctoring in Thurrock compared to other areas leads, to increased waiting times for appointments and subsequent referrals to specialist services. Some individuals are likely to experience deterioration in their condition due to wait times for treatment (Mental Health Taskforce, 2016 2016).



## **1.5 Benefits of improving mental health in the population**

Improved mental health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. For the health and social care system these include:

- Improved physical health and life expectancy,
- Increased self-management of mental health and Long Term Conditions (LTCs),
- Increased rates of recovery from ill health and reduction on demand for services,
- Reduced health risk behaviours such as smoking and alcohol misuse,
- Reduced risk of self-harm and suicide,
- Reduced hospital admissions and therefore savings to NHS and Social care.

Benefits for society include:

- Better educational achievement,
- Improved employment rates and productivity,
- Increased employment skills,
- Breaking the intergenerational cycle of mental ill health,
- Reduction in health inequalities within communities,
- Stronger, more socially cohesive communities,
- Reduced anti-social behaviour and criminality

The ability to cope with the normal stresses of life as outlined in the World Health Organisation's definition of mental health reflects upon an individual's psychological resilience. The American Psychological Society (APA) defines resilience as: "The ability to cope with, and adapt in the face of adversity, trauma or stress and the ability to 'bounce back' from such difficult experiences" (2017). Building the resilience of individuals and communities within Thurrock will be one of the key ways in which mental health can be improved in Thurrock.

## **1.6 Thurrock's Health and Wellbeing Strategy 2016-21**

Thurrock's Health and Wellbeing Strategy 2016-21 includes a focus Better Emotional Health and Wellbeing (Goal C). However, improving mental health is a common thread running through the entire strategy as mental health is linked to strong communities and environments (Goal B) wider determinants such as education and employment (Goal A) as well as putting people in control of their own care (Goal D) for example if they have long term conditions, which we know affects mental health.

**Table 1: Thurrock Health and Wellbeing Strategy, 2016- 21.**

GOALS	A. OPPORTUNITY FOR ALL	B. HEALTHIER ENVIRONMENTS	C. BETTER EMOTIONAL HEALTH AND WELLBEING	D. QUALITY CARE CENTRED AROUND THE PERSON	E. HEALTHIER FOR LONGER
OBJECTIVES	A1. All children in Thurrock making good educational progress	B1. Create outdoor places that make it easy to exercise and to be active	C1. Give parents the support they need	D1. Create four integrated healthy living centres	E1. Increase the number of people in Thurrock who are a healthy weight
	A2. More Thurrock residents in employment, education or training.	B2. Develop homes that keep people well and independent	C2. Improve the emotional health and wellbeing of children and young people.	D2. When services are required, they are organised around the individual	E2. Reduce the proportion of people who smoke.
	A3. Fewer teenage pregnancies in Thurrock.	B3. Building strong, well-connected communities	C3. Reduce social isolation and loneliness	D3. Put people in control of their own care	E3. Significantly improve the identification and management of long term conditions
	A4. Fewer children and adults in poverty	B4. Improve air quality in Thurrock.	C4. Improve the identification and treatment of depression, particularly in high risk groups.	D4. Provide high quality GP and hospital care to Thurrock	E4. Prevent and treat cancer better

## 2 Who is affected by mental illness? The Scale of the Problem

### 2.1 Prevalence of CMHDs in England

It is now commonly accepted that 1 in 4 adults and 1 in 10 children will be affected by a mental health condition at any one point in their lifetime. In 2011, the National Institute for Health and Care Excellence (NICE) found that these CMHDs may affect up to 15% of the population at any one time. The table below shows estimates of specific mental health disorders in the population.

**Table 2: Estimated Lifetime Prevalence of mental health disorders, 2011.**

Condition	Estimates Lifetime Prevalence (%)
Specific Phobias	12.5
Social Anxiety Disorder	12.1
Major Depression	4 to 10
Post-Traumatic Stress Disorder (PTSD)	6.8
Generalised Anxiety Disorder (GAD)	5.7
Dysthymia	2.5 to 5
Obsessive Compulsive Disorder (OCD)	1.6
Panic Disorder	1.4

Source: NICE 2011

#### **Prevalence of mental ill health by age and gender**

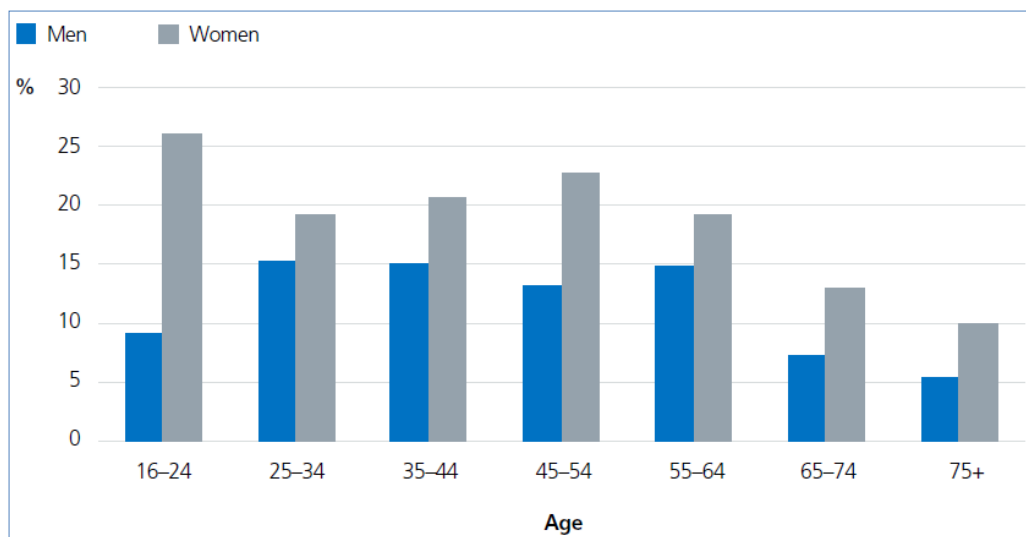
Statistics and research have identified a gap between rates of CMHD between men and women as well as across age groups. According to the Adult Psychiatric Morbidity Survey (APMS) 2014<sup>1</sup>, in England women are more likely to have a CMHD than men with 1 in 5 women with CMHD symptoms compared with 1 in 8 men with CMHD symptoms – which correlated with previous findings (McManus, 2016; Martin-Merino *et al*, 2009)

The pattern of association between age and CMHD symptoms is different for men and women. As shown in Figure 1, rates of CMHD symptoms in women peaked in the youngest group (26% of 16 to 24 year olds) – which was three times the rate for 16 to 24 year old men (9.1%). Overall working-age people were around twice as likely to have symptoms of CMHD as those aged 65 and over.

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<sup>1</sup> Adult Psychiatric Morbidity Survey 2014

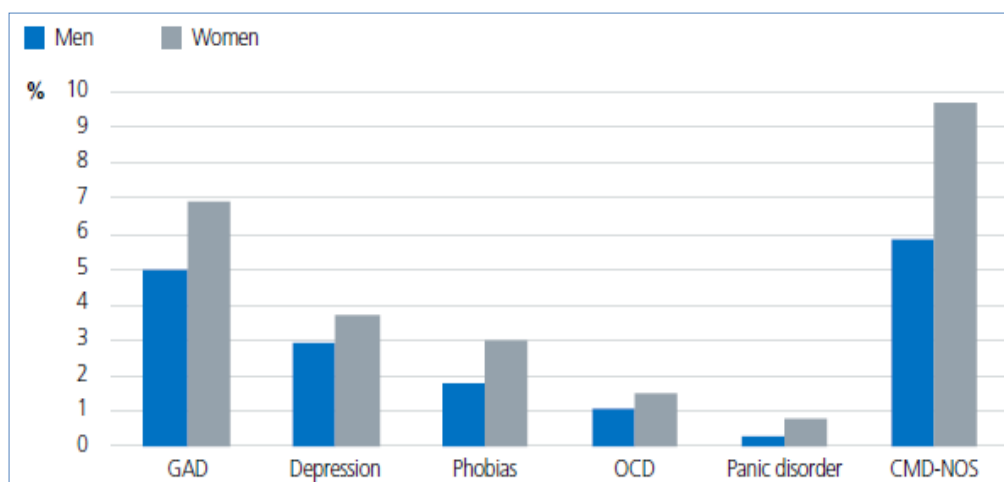
Figure 1. Prevalence of Common Mental Health Disorders by age and gender (age 16+), 2016



Source: APMS, 2016

All types of CMHDs were more prevalent in women than in men, with differences by gender reaching statistical significance for Generalised Anxiety Disorder (GAD), phobias, panic disorder and Common Mental Disorders Not Otherwise Specified (CMD-NOS) (Figure 2).

Figure 2. Prevalence of CMHDs by Gender, 2016



Source: APMS, 2016

The significant difference in prevalence across the CMHDs between women and men could represent an increased likelihood for women to report symptoms compared to men (Kovess-Masfety *et al*, 2014), or an increase in risk factors for CMHDs in women such as exposure to domestic violence (Trevillion *et al*, 2012), increased work and home stressors such as caring (Pinquart & Sorensen, 2006), financial problems, unemployment or social isolation (Clark *et al*, 2012).

## 2.2 Local Context of Mental Health in Thurrock

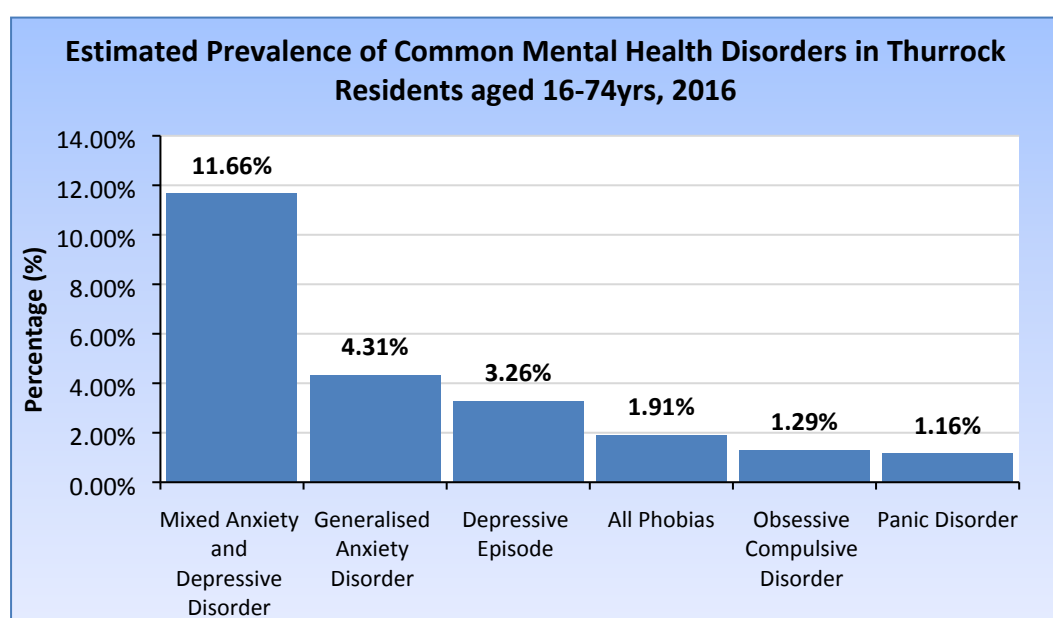
### Population Projections

The population projection for Thurrock suggests that with a significant rise in those aged 50-59 years, we should expect to see more women with mental ill health in the years to come.

Population projection data shows that the numbers of people with mental health disorders are due to increase steadily over the next 15 years, which means that the need and demand for mental health services will increase in coming years.

The prevalence of common mental health disorders in Thurrock varies across condition types and age range. Figure 3 below illustrates the estimated prevalence of some common mental health disorders for residents aged between 16-74 years living in Thurrock in 2016. Some caution needs to be taken when interpreting this data as there are some issues with the quality of the data.

**Figure 3: Estimated prevalence of Common Mental Health Disorders in residents aged 16-74 years living in Thurrock, 2016**

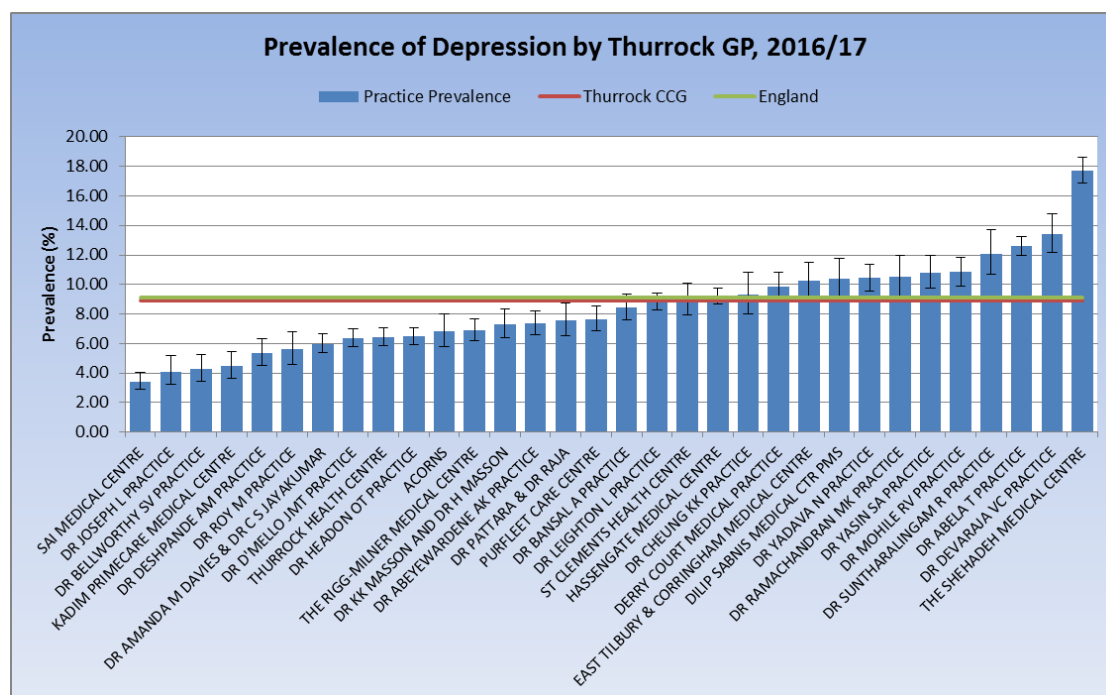


Source: - PHE Fingertips – Common Mental Health Disorders – Prevalence profile (2016)

## 2.3 Quality and Outcome Framework (QOF) Prevalence of Depression in Thurrock by GP Practice

In 2016/17, there were 11,689 patients registered on the Thurrock GPs QOF register for depression. This equates to a prevalence of 8.9%. Variation can be seen in the chart below – diagnosed prevalence ranges from 3.41% (Sai Medical Centre) to 17.71% (Shehadeh Medical Centre).

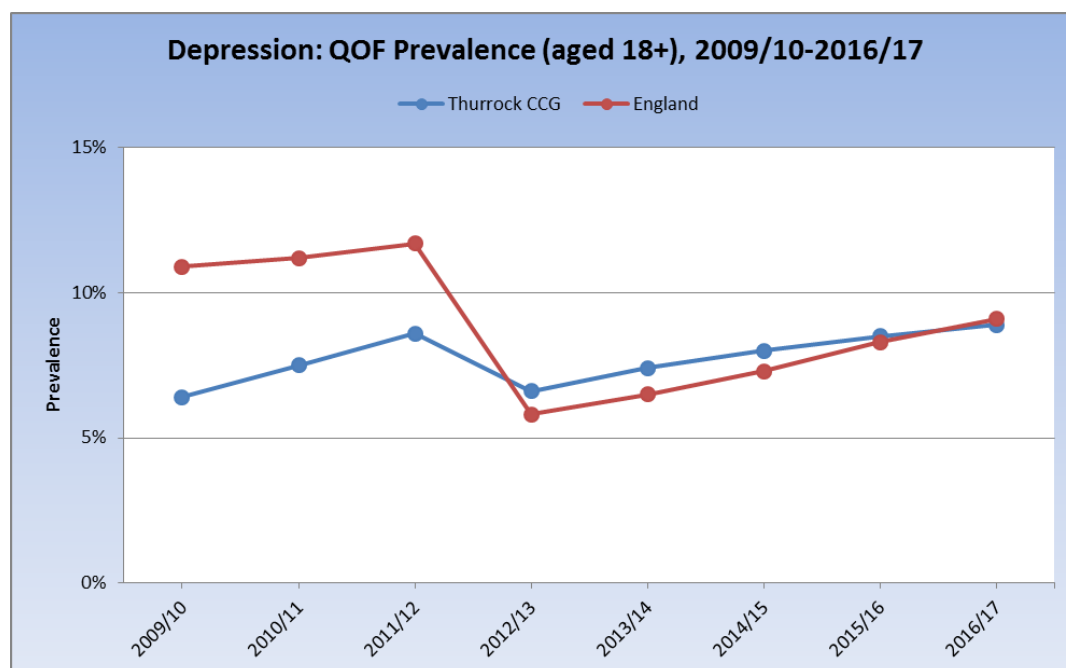
Figure 4: Depression prevalence in Thurrock by GP practice, 2016/17.



Source: QOF 2016/17

In general, prevalence of depression appears to have increased since 2012. Prior to this, Thurrock's prevalence of depression was significantly below the national average but followed a similar pattern to the national trend. This can be seen in Figure 5 below.

Figure 5: Depression: QOF Prevalence (in those aged 18+), 2009/10 – 2016/17

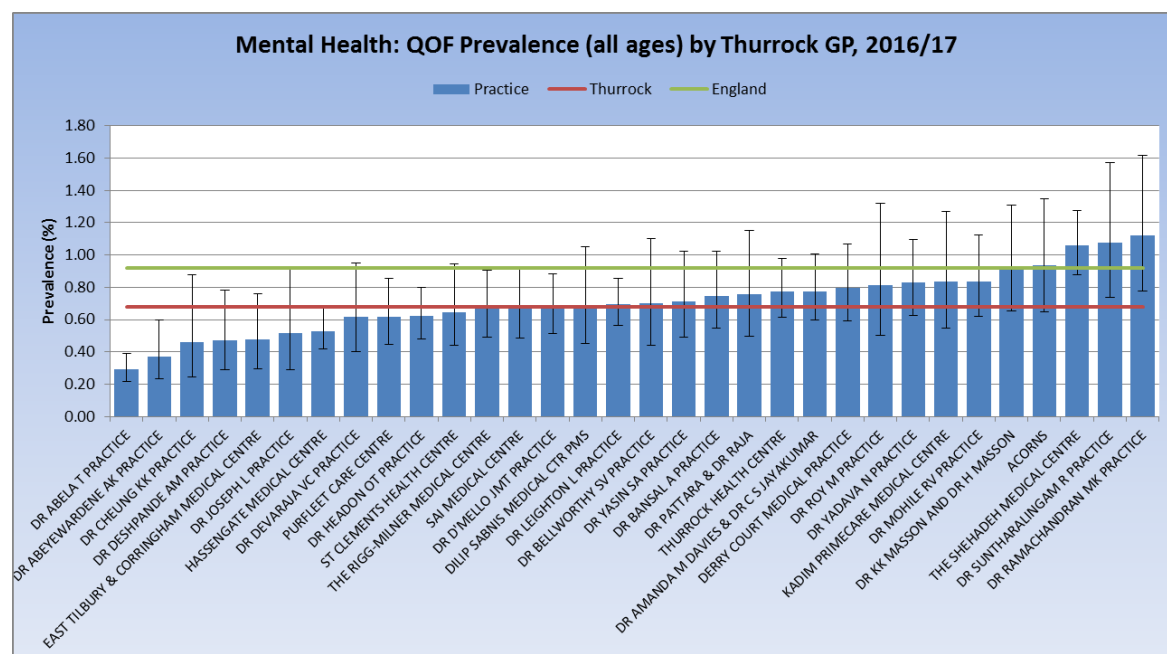


Source: QOF 2009/10 – 2016/17

## 2.4 Serious Mental Illness prevalence

Prevalence of serious mental illness (SMI) is much lower (~0.7%) but this also varies by GP practice as shown in Figure 6 below.

Figure 6: Mental Health: QOF Prevalence (across all ages) By Thurrock GP, 2016-17.

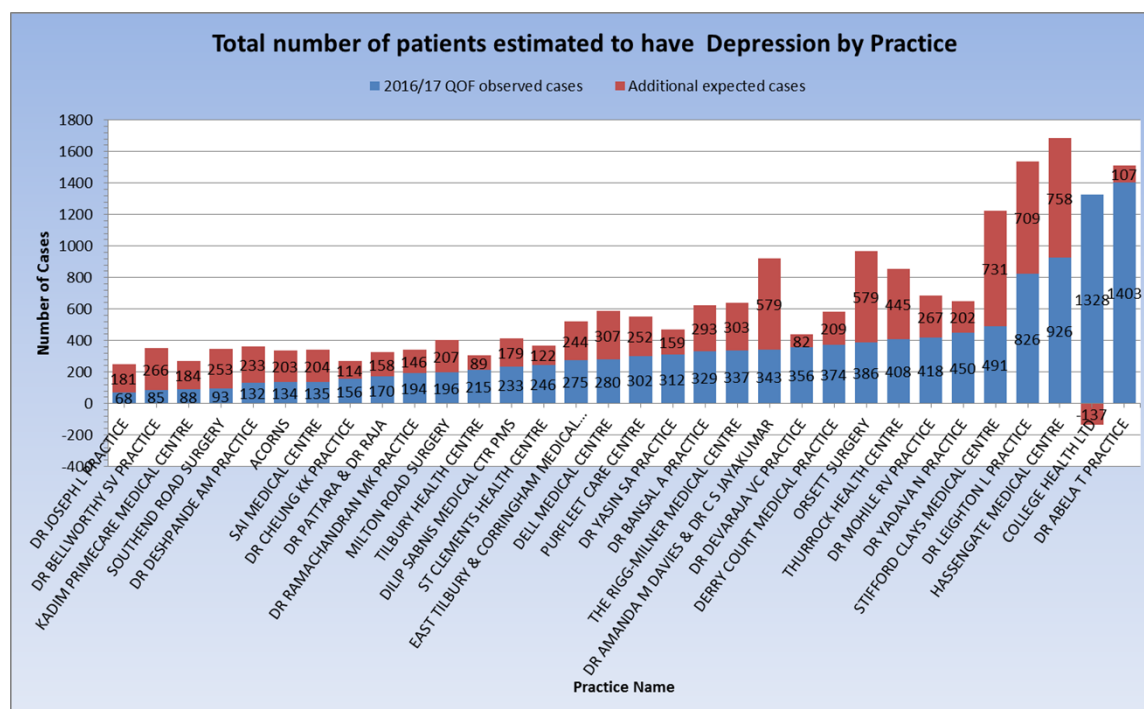


Source: QOF 2016/17

## 2.5 Observed vs estimated prevalence of depression in Thurrock by GP Practice

The latest modelled estimates from Public Health England (2016) found there are likely to be as many as 21,317 patients who have depression in Thurrock - which is a difference of 8,628 from the number diagnosed. These estimates were generated using a range of variables relating to the demographics of the population (e.g. age, sex, ethnicity etc.), known risk factors for depression (e.g. BMI, alcohol consumption etc.) and wider determinants such as employment status. A model was built for every practice population in the country to estimate the true likely prevalence of depression – which would include some already diagnosed.

Figure 7: Observed and estimated number of patients with Depression by Thurrock GP, 2017.

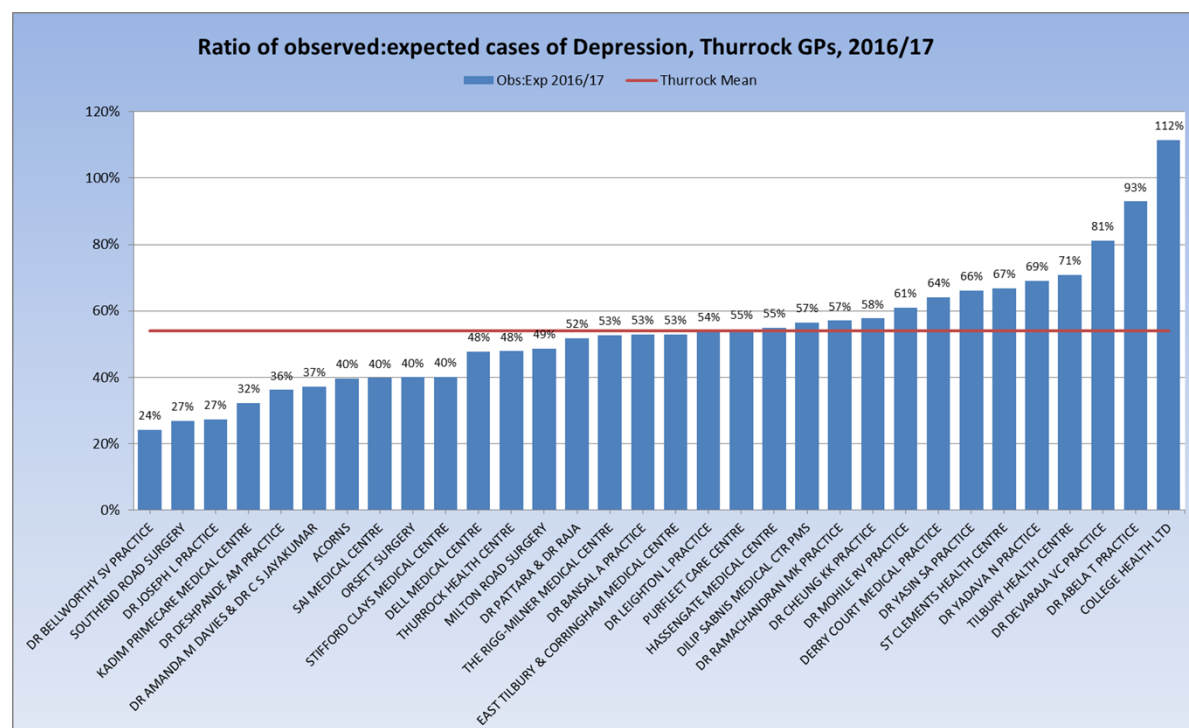


Source: PHE 2016, QOF 2016/17

When comparing the number diagnosed to the number estimated at practice level, there is a large amount of variation within the borough - whilst the Thurrock ratio of those diagnosed: estimated is 54%, practices such as Dr Bellworthy and Southend Road Surgery have extremely low ratios (24% and 27%) whereas College Health Ltd appears to be diagnosing more than estimated (112%). This information indicates there is a large opportunity in terms of case finding and treating undiagnosed patients with depression.



**Figure 8: Ratio of Observed vs Expected Numbers of Patients with Depression by GP Practice in Thurrock, 2016-17.**



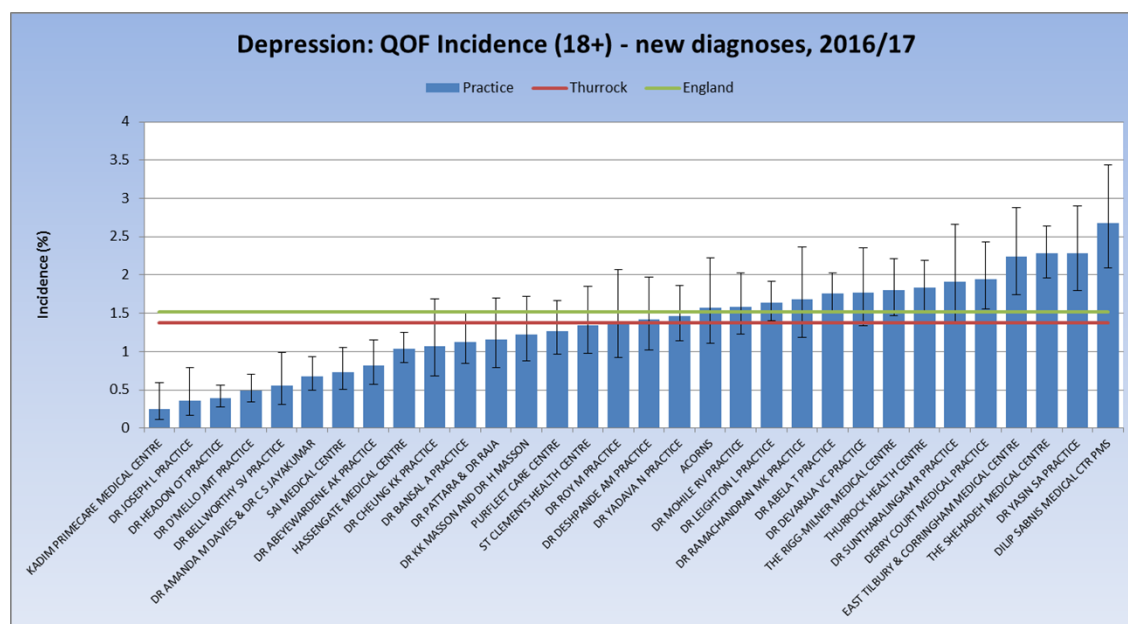
Source: QOF and PHE model data, 2016/17

## 2.6 Incidence of depression in Thurrock

### Incidence of common mental health disorders

Incidence is defined as the number of newly diagnosed people with the condition being measured within a certain time period e.g. a year. Figure 9 below shows incidence of new diagnoses of depression in adults (18+) by GP practice in Thurrock for 2016/17. Although the Thurrock CCG average 1.4% is similar to the national average 1.5%, there is a wide range between the GP practices with the lowest and highest being 0.3% and 2.7% respectively.

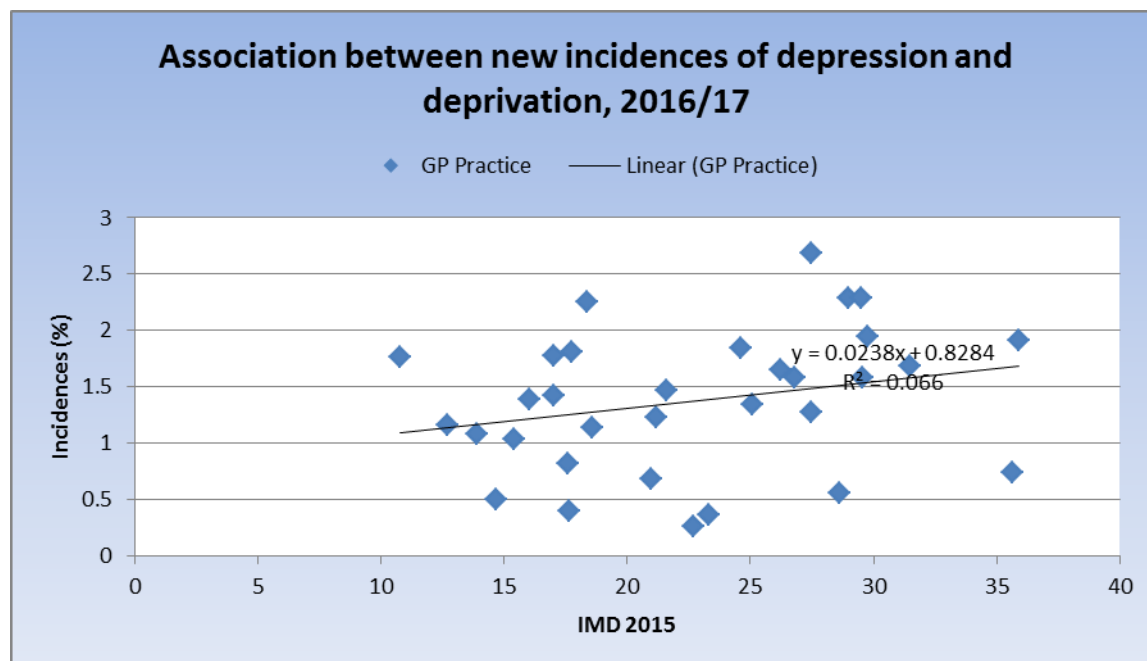
Figure 9: Depression: QOF Incidence of new diagnosis in 18+ year olds, 2016/17



Source: QOF 2016/17

When seeking to understand reasons behind this variation, it was hypothesised that practice-level deprivation may impact upon this. However, it can be seen from the chart below that no association could be seen between new incidences of depression and deprivation at practice level ( $R^2 = 0.07$ ). However, this may be due to diagnosis failures or recording/coding issues.

Figure 10: Association between new incidences of depression and deprivation, 2016/17.



Source: QOF and IMD 2015

## 2.7 The role of Local Area Co-ordinators (LACs)

Local Area Coordinators work with Thurrock residents to prevent them accessing a higher level of support in the future. This could range from signposting to services, or accompanying them to visits until they feel empowered to attend services alone. The local data captured is limited, although work is in process to strengthen the data captured. For 2015/16, the LACs received 1,066 referrals, of which 100 stated mental ill health as the reason for referral.

**Table 3: Age Group of Thurrock Residents accessing LAC support with mental ill health as reason for referral, 2015-16.**

Age group	Number of individuals
18-35 years	20
36-55 years	38
56-75 years	20
76+ years	5
Not known	17
<b>Grand Total</b>	<b>100</b>

Source: Thurrock Council 2015-16.

Of the 100, 29 were referred by Adult Social Care, 27 by Mental Health services and 12 by Housing. The fact that 27% came from Mental Health services indicates that these individuals are already being helped by a service, but that they may need further support than their statutory service can provide.

## 2.8 Recommendations

Modelled data tell us that there is a huge opportunity to identify and diagnose thousands of patients with (CMHDs) in Thurrock. Therefore, Public Health should work in collaboration with primary care and social care colleagues in order to identify those undiagnosed patients with CMHDs. As under-doctoring is a major problem in Thurrock, other healthcare professionals could be useful in assisting with this work.

Working together the public health team, CCG primary care team, CCG medicines management team and GP practices should improve the identification of the many thousands of undiagnosed residents who have common mental health disorders. Strategies to achieve this could include:

- Using community and GP practice pharmacists to support the work to identify undiagnosed depression in the community and in primary care by increasing screening for depression using the PHQ9 depression screening tool.
- Carrying out audits on practice registers to make sure that those prescribed antidepressants for mental health issues i.e. depression, are on the depression register.
- Preparing services/the workforce to increase their capacity in anticipation of an increase in diagnosed mental ill health from population predictions of increases in population sizes. There will also be an increase in diagnosed mental ill health if recommendations are implemented.
- Using modelled data on observed vs estimated prevalence of depression by GP practice to target those practices where more could be done to find and treat patients with undiagnosed depression.

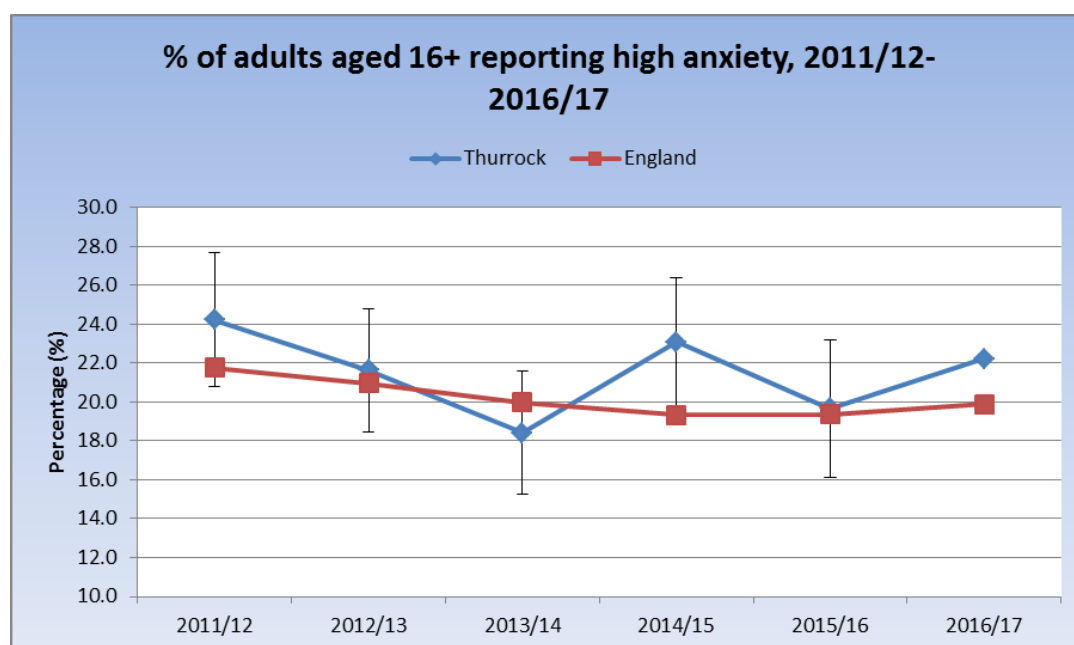
### 3 Who is affected by mental illness? The Trends

#### 3.1 Trends in wellbeing

The Annual Population Survey contains a number of measures relating to personal wellbeing at local authority level. Data from 2016/17 indicates that 22.2% of Thurrock respondents reported themselves as having a high level of anxiety, which is a similar level to the national average of 19.9%.

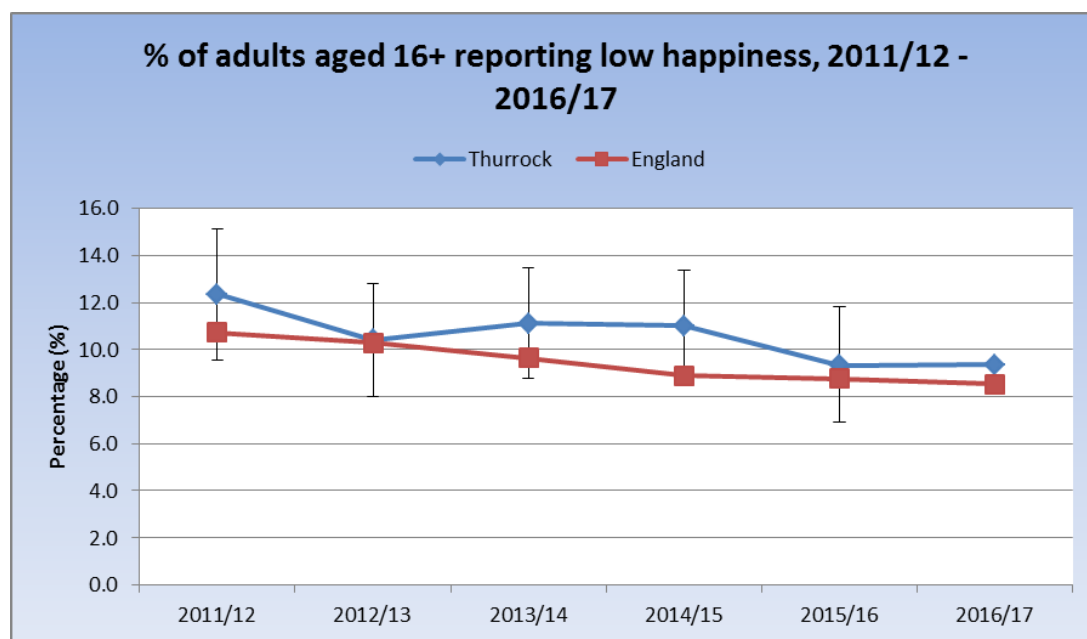
In Thurrock 9.4% of respondents reported having low level of happiness, which was also statistically similar to the national average of 8.5%. Both the measures for anxiety and happiness have remained consistent across surveys since 2011/12, meaning data can be compared to previous years. It can be seen from the figures below (Figure 11 and Figure 12) that, with the exception of anxiety in 2014/15 which was significantly higher in Thurrock than nationally, all values are similar to the national average for all years.

Figure 11: Percentage of adults (aged 16+) reporting high anxiety, 2011/12-2016/17.



Source: ONS

Figure 12: Percentage of adults (aged 16+) reporting low happiness, 2011/12-2015/16.

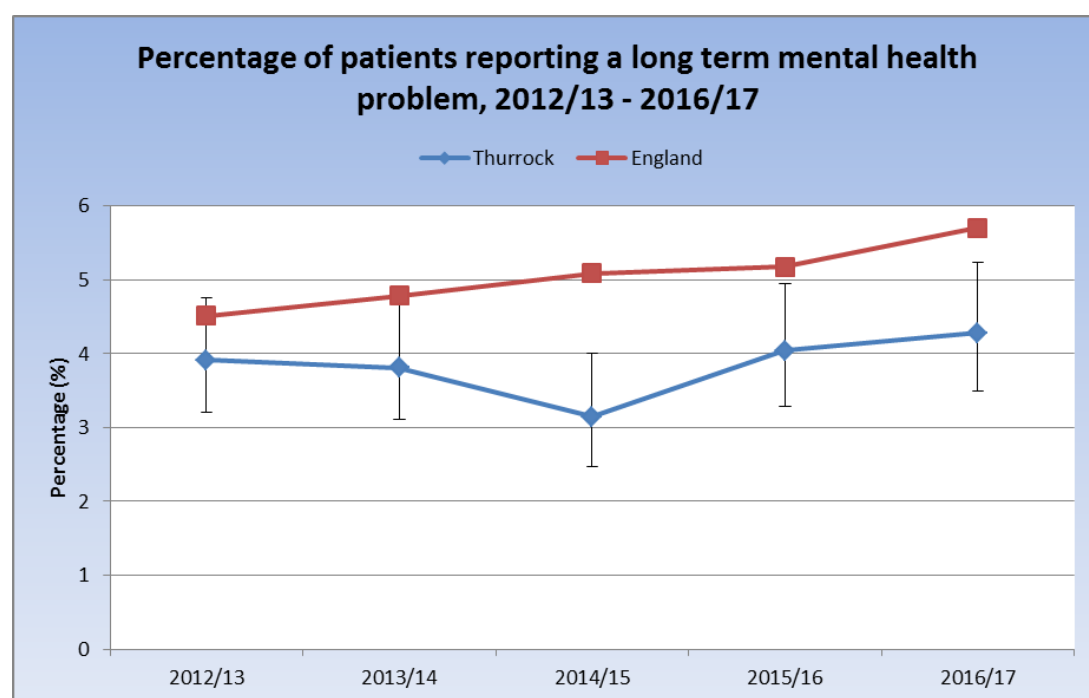


Source: ONS

### 3.2 Self-reported prevalence of mental health conditions

Another possible measure of understanding likely need could come from the GP Patient Survey. Data from 2016/17 found that 4.3% of Thurrock respondents reported to have a long-term mental health problem, which was significantly below the England average was 5.7%. This has been observed for the last few years. The data is also published at GP practice level; however due to the small sample of respondents per practice, the large confidence intervals mean that none were significantly higher or lower than the national average. Association was tested with both IMD and case-finding ratio, but neither were found to be correlated with the variation in mental health problems from the survey. The general trend at national level is upwards and, with some variation, this appears to be the case in Thurrock as well.

**Figure 13: % of patients reporting a long-term mental health problem, Thurrock and England, 2012/13 – 2016/17.**

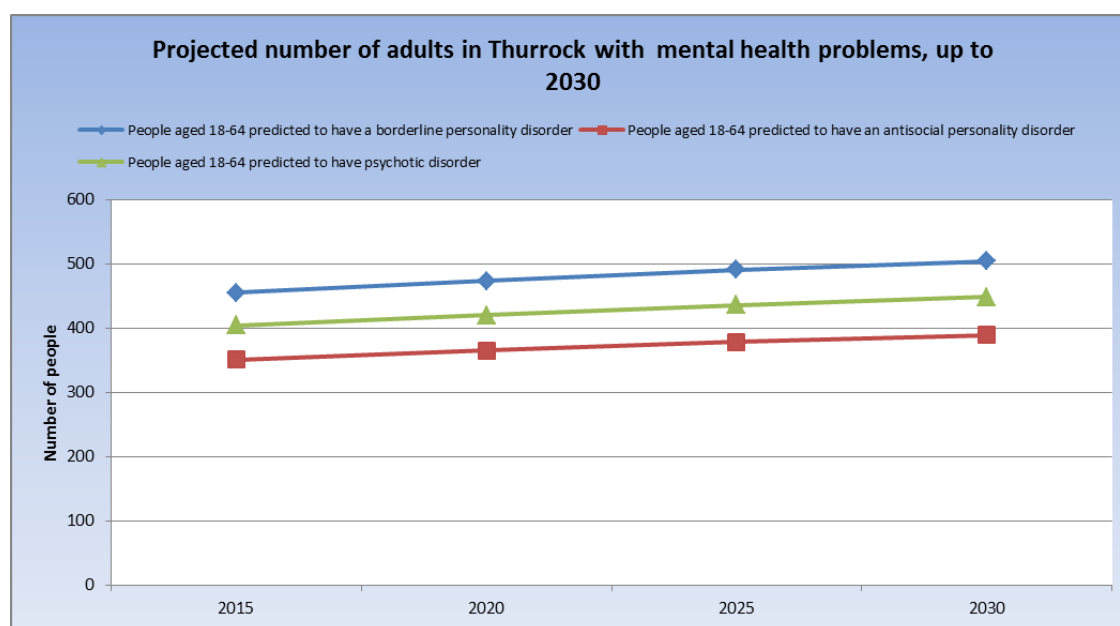


Source: GP Patient Survey

### 3.3 Projections for the number of residents with a mental health condition in future

It is possible to make estimates about future trends in mental health conditions by making assumptions about future population growth and changes in health and wellbeing. Estimates made by the Projecting Adult Needs and Services Information (PANSI) suggest that 16,270 adults aged 18-64 in Thurrock had a common mental health disorder (includes diagnosed and undiagnosed) in 2015. This is projected to increase to 18,029 by 2030 – an increase of 10%. Figure 14 below shows increases for specific conditions – borderline personality disorder, psychotic disorder and anti-social personality disorder. All conditions are projected to increase by around 10% by 2030. All three of these conditions can have serious impacts on wider health and wellbeing also. Someone with borderline personality disorder for example is likely to differ significantly from an average person in terms of their feelings and thoughts towards others, which could result in impulsive behaviour and emotional instability. Someone with psychotic disorder might experience hallucinations or delusions, which again could have a profound impact on their day to day life. And someone with anti-social personality disorder could be at risk of losing control of their temper, potentially leading to dangerous situations for themselves and others.

**Figure 14: Projected number of adults in Thurrock with mental health problems, up to 2030.**



Source: PANSI

In addition, the number of adults with two or more psychiatric disorders is projected to increase from 7,267 in 2015 to 8,052 by 2030 – an increase of 10.8%. [Calculated using prevalence estimates of 6.9% males having two or more conditions, and 7.5% females]

### 3.4 Projections for the number of residents with depression in future

It is known that older adults are a population group with a higher risk of depression (see section above). The estimates below (Table 4) are national prevalence estimates by age and sex for older people, and it can be seen that older females are particularly at risk. This could be associated with them living alone for longer periods (due to extended life expectancy compared to males).

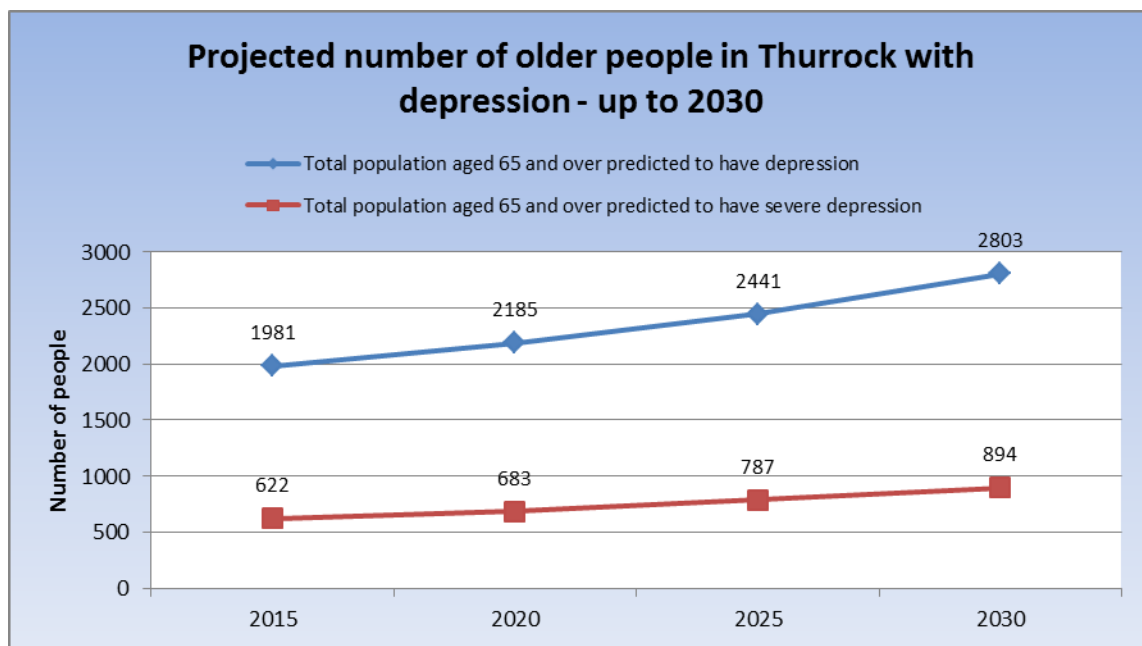
**Table 4: National Depression Prevalence estimates by age and sex for older people, 2014.**

Age range	% males	% females
65-69	5.8	10.9
70-74	6.9	9.5
75-79	5.9	10.7
80-84	9.7	9.2
85+	5.1	11.1

Source: POPPI (Projecting Older People Population)

Applying these estimates to the Thurrock population, it currently appears that we have 1981 older adults with depression – these could include diagnosed and undiagnosed. This is estimated to increase to 2803 older adults by 2030, which is an increase of 41.5%. Whilst the population projections shown earlier in the document predicts a large increase in older people, this is a faster rate of increase than can just be attributed to population growth. In addition, the number of older adults predicted to have severe depression is set to increase from 622 in 2015 to 894 in 2030 – a rise of 43.7%. These can be seen in Figure 15 below.

Figure 15: Projected number of older people in Thurrock with depression, up to 2030.



Source: POPPI



## 4 Who is affected by mental illness? High Risk Groups

### Key Points

- There are several demographic groups that have been identified as being at increased risk of developing mental ill health
- Deprivation is linked to employment, housing and other predictors of ill mental health
- Some people are at risk of multiple disadvantage, further increasing their risk of ill mental health
- Employment is a protective factor for good mental health and unemployment is predictive of mental ill health

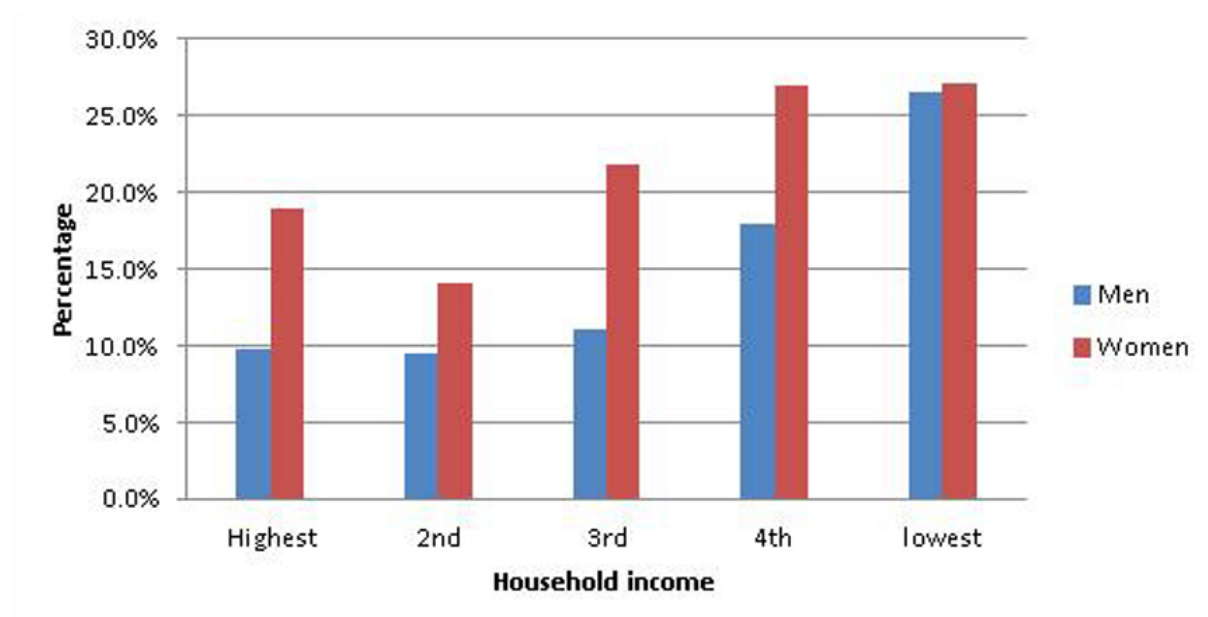
The causes of poor mental health are multifactorial and complex; however there are often specific groups of individuals who may be at an increased risk of experiencing mental health disorders. These include those living in deprivation, individuals who are unemployed, carers, mothers and fathers experiencing perinatal and/or post natal depression, black and minority ethnic groups (BMEs), young men at risk of suicide, those who experience social isolation, LGBT individuals and young women at risk of self-harm, those who misuse substances and those with LTCs and learning disabilities (LDs).

### 4.1 Deprivation

Deprivation can include social exclusion, unemployment (or lack of engagement in meaningful activities), under-employment, low income, homelessness and housing problems.

There is a correlation between household income and the prevalence of common mental health disorders in both men and women. Figure 16 below shows that, as household income rises, the prevalence of common mental health disorders generally falls for both men and women.

Figure 16: Common mental health disorders by household income and gender, 2011.



Source: National Institute for Health and Care Excellence, 2011

Poverty and mental health are considered to interact in an intergenerational cycle (Department for Health, 2011). For example a review conducted in 2010 illustrated a clear relationship between socioeconomic status and mental health difficulties in children and young people. Children living in deprivation are 3 times more likely to experience depression than their more affluent peers (Department for Health, 2011).

In Thurrock in 2014, 13.3% of residents were living in the 20% most deprived wards in England and in 2014 the prevalence of children under 16 living in poverty was 21.2%.

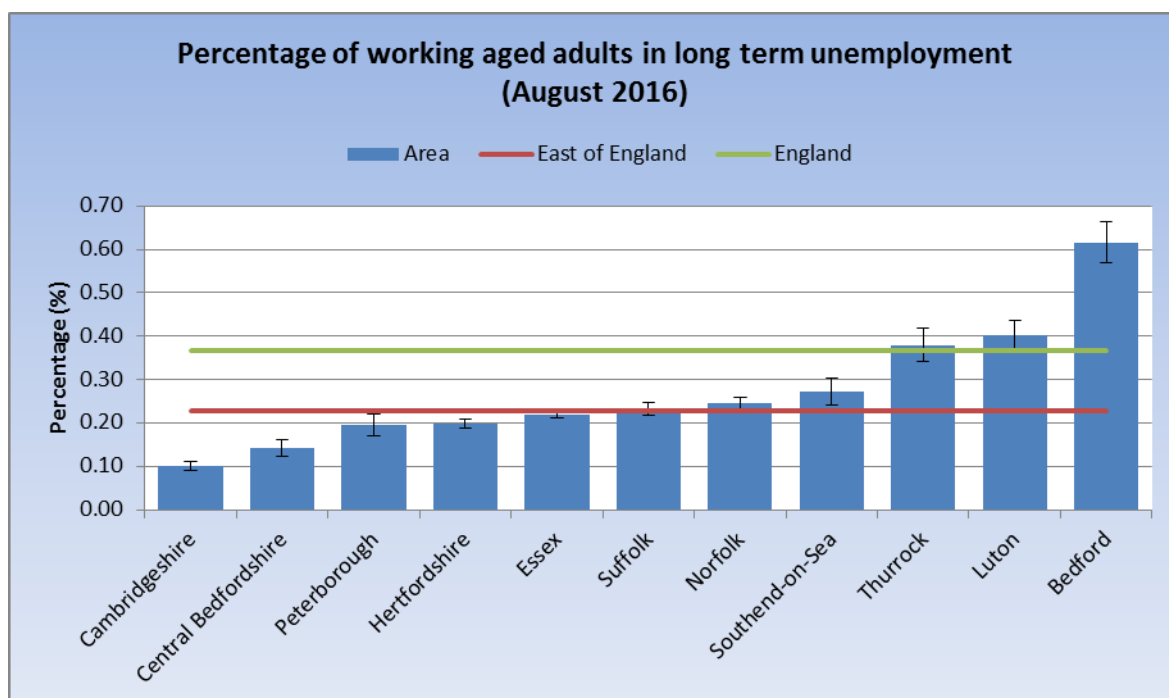
CMHDs are more likely to persist in people in lower socioeconomic groups such as people who are on low incomes, long-term sick or unemployed. The Marmot report, Fair Society, healthy lives (2010) showed that, among other factors, poor housing and unemployment increase the likelihood that people will experience mental health disorders and affect the course of any subsequent recovery. These factors vary across different sections of society, with the result that some groups suffer multiple disadvantages.

## **4.2 Unemployment**

Unemployment is closely linked to deprivation. There is evidence to show that being employed is protective of good mental health and wellbeing. The workplace provides important opportunities for building resilience, self-esteem and development of social networks. Unemployed people may feel a lack of purpose as well a lack of social opportunities for development of self-esteem. This can lead to some experiencing mental health disorders such as depression and anxiety. In accordance with a review commissioned by the Health Work and Wellbeing Programme, people in England who are unemployed are between 4 and 10 times more likely to experience depression and/or anxiety. Based on this evidence, employers can play an important role in supporting the health and wellbeing of their employees by providing healthy workplaces which are supportive of their employees' mental health and that are adaptable to meet individuals' health needs to encourage them to remain in employment, a bidirectional relationship, with the Job Centre Plus teams supporting people on ESA back into work.

In 2015 6.9% of people of working age were unemployed in Thurrock. Long Term unemployment can be defined as those of working age claiming a benefit (formerly Job Seekers Allowance) for 12 months or more. In 2016, Thurrock had 0.38% of its working aged population in this position, which when compared to the other LAs in the East of England, shows Thurrock to have the third highest proportion in the region.

Figure 17: Long-term unemployment: % of working age population, 2016.

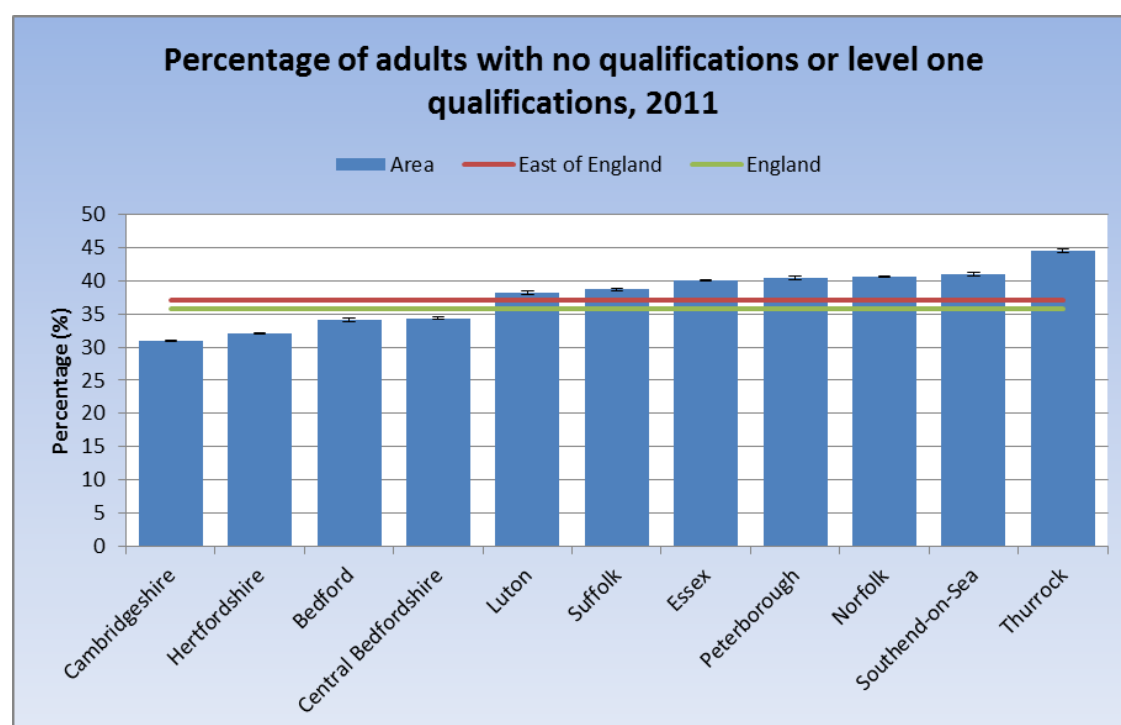


Source: ONS NOMIS/PHE Fingertips

### 4.3 Education

Education is a strong predictor of health; poor education is linked to poorer health outcomes. Almost half of adults in Thurrock have no qualifications or level one qualifications. Thurrock is the worst performer for this indicator in East of England and is also worse than the England average. Educational attainment is strongly linked to income as well as deprivation levels therefore this indicator may be a strong predictor for mental ill health in Thurrock.

**Figure 18: Adults with low education: % of adults that have no qualifications or level one qualifications (2011).**



Source: PHE Fingertips, 2011 data

## 4.4 Carers

Caring for a family member with a health condition can impact on the mental health of the person who is providing care. This can lead to carers suffering from emotional distress or stress in general. This in turn increases the risk of poor physical health. Carers may not be able to find time to undertake healthy behavioural practices such as eating healthily, or exercising regularly due to their felt need to prioritise the care of their loved one. Factors that impact on carer's mental health and wellbeing, based on self-reports within the UK Carers' survey (2015) included inability to get a good night's sleep (74% of those surveyed reported this). Nearly 50% of participants reported that they find it hard to maintain a balanced diet. Additionally, 78% reported experiencing anxiety and 55% reported suffering from depression. (Carers UK, 2015). If carers' are experiencing poor mental health this is likely to impact on their ability to care for their loved ones and could create a cycle of poor mental or physical health outcomes for both individuals. Within Thurrock there is a prevalence of 2.42% of unpaid carers (Public Health England, 2011-16). Therefore, providing appropriate support at the right time is vital to ensuring that the health of carers is not adversely affected by their caring responsibilities.

## 4.5 Perinatal/postnatal depression (affecting mothers and fathers)

Suicide is the second leading cause of maternal death and may be due to women experiencing undiagnosed/untreated perinatal depression (Mental Health Taskforce, 2016 and WHO, 2018).

For mothers who experience perinatal mental health during pregnancy, there is an increased risk of poor pregnancy outcomes as well as neurodevelopmental difficulties for the child both before and after birth. Additionally, mothers who experience postnatal depression may struggle to care for both themselves and their child which increases the risk of the child experiencing adverse outcomes and is linked to a five-fold increased risk of them developing a mental health condition later in life. Conversely, positive relationships between a child and their father are correlated with positive outcomes for the child (COI, 2011).

#### **4.6 Black and Minority and Ethnic (BME) Groups**

BME groups are much less likely to, or may be excluded from accessing services in relation to their mental health and wellbeing. (McManus et al 2016). Thurrock has a diverse range of ethnic groups within its population. This group is of relevance in Thurrock because we know that it has grown in size between the 2001 and 2011 census, as discussed in section 3 of this document.

Based on the growing number of people from BME groups who reside in Thurrock there is a need to examine the underlying reasons why this group are not accessing support around their mental health, with the aim of encouraging such individuals to seek and access treatment. Understanding the barriers will support professionals to develop more effective pathways to access, with the aim of reducing health inequalities and enhancing good mental health and wellbeing for this subgroup of the population.

#### **4.7 Those “At Risk” of Suicide**

The suicide rate for men is higher than the rate for females (HM Government et al, 2012). This is evident in Thurrock with men being three times more likely to commit suicide than women. Between 2013-15 the age standardised suicide rate for males was 15.7 per 100,000 whereas data could not be calculated for females as the number was too low. (Public Health England, 2013-15). This could be related to the fact that fewer men are receiving treatment for CMHDs than their female counterparts. This creates missed opportunities for diagnosis and treatment. Furthermore, men are less likely to report previous suicide attempts than women (McManus, et al 2016). Similarly, in relation to self-harming behaviours in 2014, only 8% of men aged between 16-24 years reported that they had self-harmed at one point in their lives compared to 20% of women of the same age. Data for the prevalence of self-harming behaviours in Thurrock is not clearly known due to miscoding issues in secondary care (see section 8.4). McManus, et al (2016) suggest that for individuals who engage in self-harming behaviours from a young age, there is a greater tendency for this to become embedded as a long term coping strategy. Additionally, for those who exhibit greater levels of self-harming behaviours there is the increased risk that this may lead to suicidal behaviours.

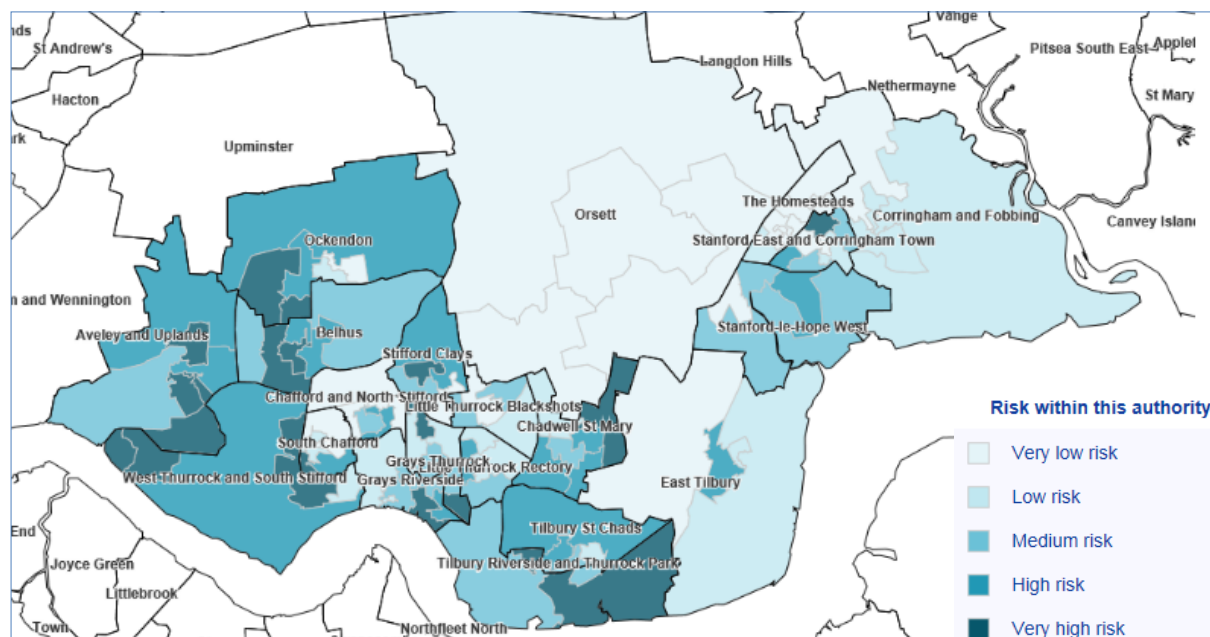
#### **4.8 Those living in Loneliness and Social isolation (especially those aged 65+)**

There are strong links between the older community and depression. It has been stated that about 40% of older people living in nursing/care services suffer depression in comparison to those living in their own homes with contact maintained with their families (Mental Health Taskforce, 2016). Living in a nursing home away from family and in some cases far from home seems to have an impact on older people. It can lead to them experiencing social isolation which in turn can lead to depression. The No Health without Mental Health report (COI, 2011) found that older people's needs are often neglected with older people not seeking treatment. Difficulties may also be related to access issues. As Thurrock has a growing older population, services targeted to this cohort need to be

implemented to support the older residents within the borough to maintain healthier lives for longer in line with Thurrock's Health and Wellbeing Strategy (Thurrock Council, 2016-21). In addition, developing interventions and services aimed at this population group should ensure more effective support for the future and create more cohesive communities.

Within Thurrock, we are aware of parts of the borough where it is more likely that the older residents there will feel lonely. Age UK have produced a map at LSOA level, ranking the risk of loneliness across the country. It can be seen from Map 1 below that parts of Tilbury Riverside, West Thurrock, Belhus, Ockendon, Grays, Chadwell and Corringham all have pockets where residents are deemed to be at high risk of loneliness.

**Map 1: Depiction of parts of Thurrock by relative risk of older people likely to feel loneliness.**

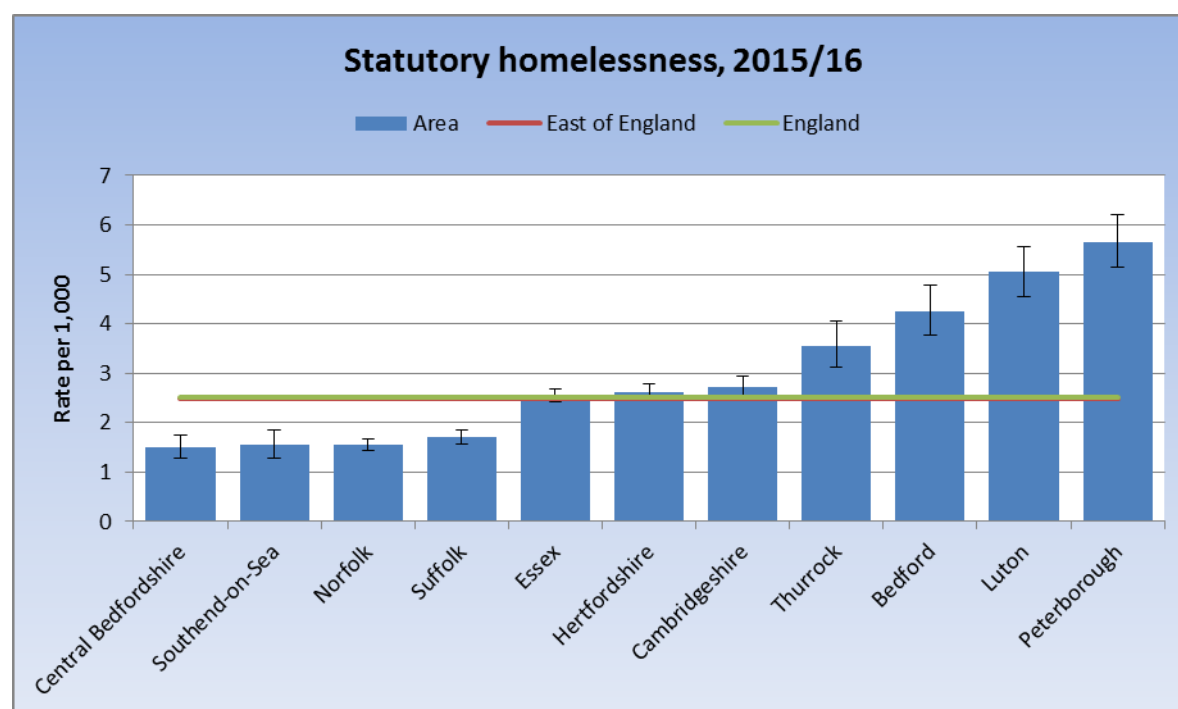


Source: Age UK

#### 4.9 Those who experience housing problems or are homeless

There is evidence to show that mental health disorders are more common among homeless and vulnerably housed people than in the general population. In several cases, mental health disorders play a significant part in the circumstances that cause people to lose their accommodation. The mental health disorder may then be exacerbated by the stresses associated with being homeless, which in turn will make it even harder for the person to achieve stability in their housing (NICE 2011). Studies suggest that although the largest group of homeless people are white men, the proportion of homeless people with a mental health disorder who come from black and minority ethnic groups is disproportionate in relation to their proportion in the general population.

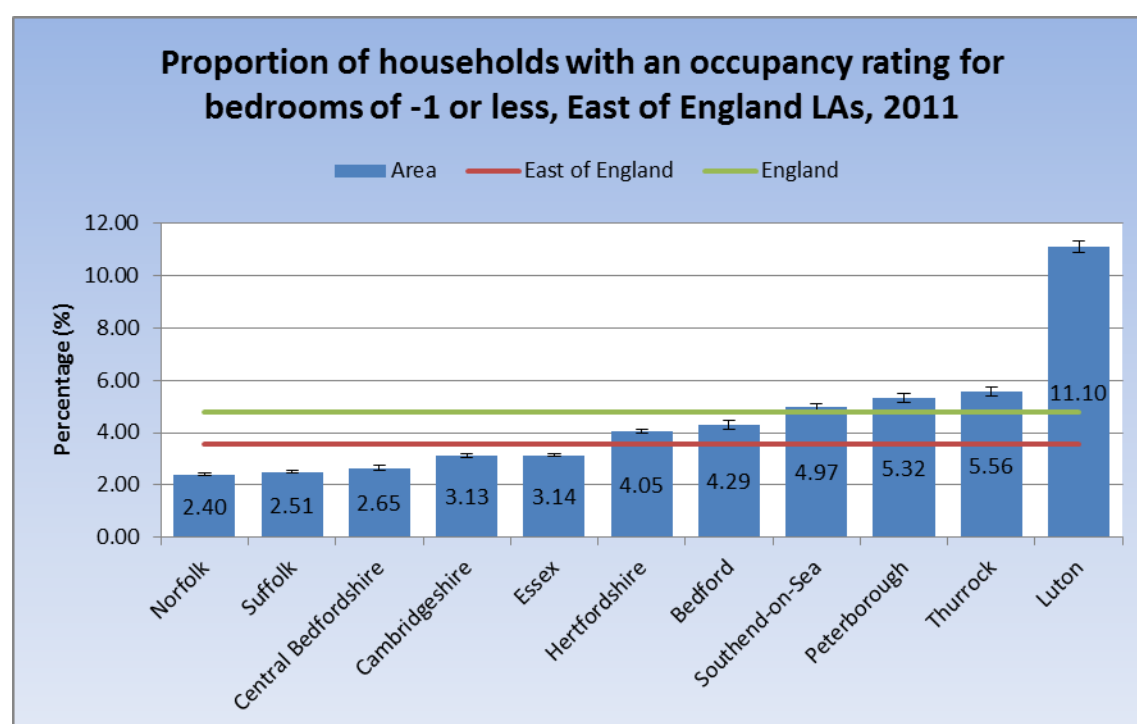
Figure 19: Statutory Homelessness – Rate per 1000 households, 2015/16.



Source: Department for Communities and Local Government

The chart above shows that Thurrock had the fourth-highest rate of statutory homelessness in the East of England region, in 2015/16. Statutory homelessness can be defined in various ways and does not mean that people are sleeping on the street, as this is only one type of homelessness. In 2015/16 the statutory homelessness rate within Thurrock was 3.6 per 1000 households which is higher than both the regional and national averages. People who are homeless are between 40-50 times more likely to experience poor mental health than the general population, as well as 40 times less likely to be registered with a GP which creates issues in relation to access to services and care, including A+E attendance at a cost to the NHS (COI, 2011). Based on this promotion of re-housing services that incorporate a holistic approach such as Housing First need to be prioritised, to reduce health inequalities and promote access to services for this population. In turn this will reduce the number of individuals within this subgroup attending A+E which places a burden on the NHS and will increase access to appropriate community based services. In Thurrock this action is supported by the objectives set out in Thurrock's Health and Wellbeing strategy in relation to goals C, D and E, better health and wellbeing, quality care centred around the person and healthier lives for longer respectively (Thurrock HWB Strategy, 2016-21).

Figure 20: Household overcrowding: % of households with occupancy rating for bedrooms of -1 or less.



Source: Census 2011

The chart above shows the proportion of households with occupancy rating for bedrooms of -1 or less expressed as a percentage of all households. An occupancy rating of -1 implies that a household has one fewer bedrooms than the standard requirement. The chart shows that Thurrock has the 2<sup>nd</sup> highest proportion of such households, compared to other areas in the East of England.

#### 4.10 Those with Long Term Conditions (LTCs)

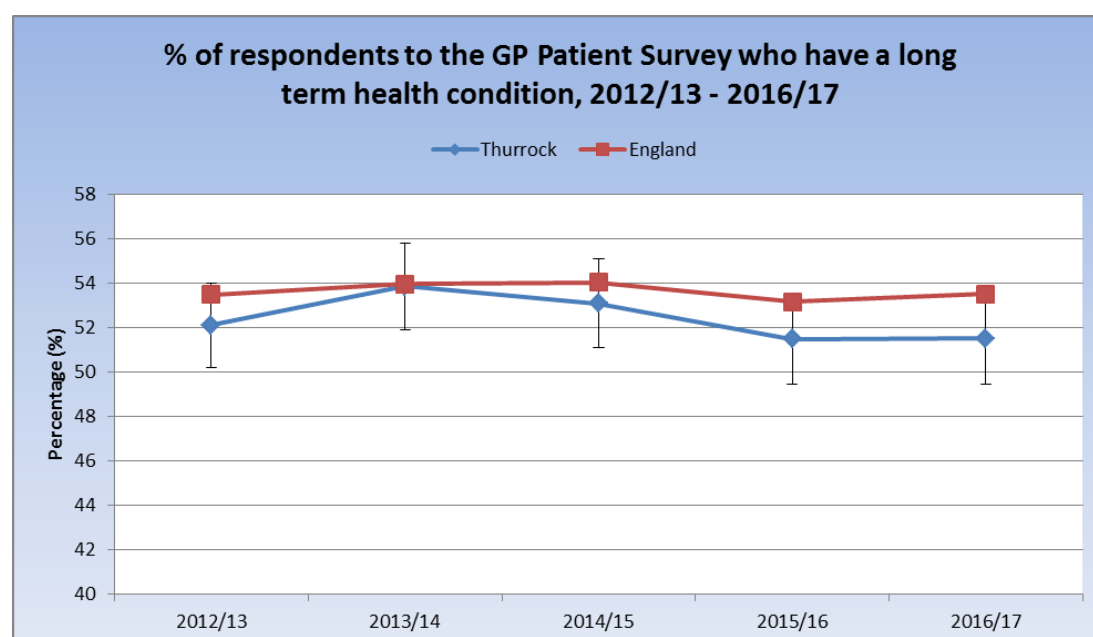
There are clear links between physical and mental health and there are shared risk factors for physical and mental illnesses. People with physical illnesses frequently present with both psychological and physical symptoms. Being physically ill, particularly with Long Term Conditions and disability, often affects mental health negatively.

People with two or more long-term conditions, such as cardiovascular disease or diabetes, are seven times more likely to have comorbid depression than those without long-term conditions. Depression has been associated with a four-fold increase in the risk of heart disease, even when other factors are controlled for.

There is also evidence that people with mental health problems smoke much more than the rest of the population, consuming 42% of all cigarettes smoked in England. This increases their risk of developing chronic physical health problems, such as chronic obstructive pulmonary disease (COPD), which in turn increases their risk of developing depression or anxiety. Studies show that a significant proportion of people with COPD have depression or anxiety.



**Figure 21: Long-term conditions or disability: % of people who report to have a long term health condition, 2012/13 – 2016/17**



Source: GP Patient Survey

The chart above indicates that just over half of the respondents to the GP Patient Survey state that they have a long term health condition, which is similar to the national average. Whilst the survey sample can be viewed as selective (as patients with more regular access to their GP might be more likely to return it), it gives an indication that there are a large number of residents in Thurrock with long term conditions.

More information on the overlap between mental health and LTCs is found below (Section 5.1)

#### 4.11 Recommendations

The social patterning of mental illness creates an opportunity for prevention and treatment to be targeted at those most at risk. Thurrock's strong community development work programme, including Local Area Coordinators, is a good example of preventative work, building on community assets and creating social connections which protect against poor mental health.

There is scope for case-finding and support work to be better targeted through:

- Health professionals in primary care reviewing patients with Long Term Conditions on a regular basis using the NICE approved PHQ9 questionnaire which screens for common mental health disorders (anxiety and depression).
- The roll out of social prescribing across the Borough but focussing on areas of highest deprivation.

## 5 What are the causes and consequences of mental illness?

### Key Points

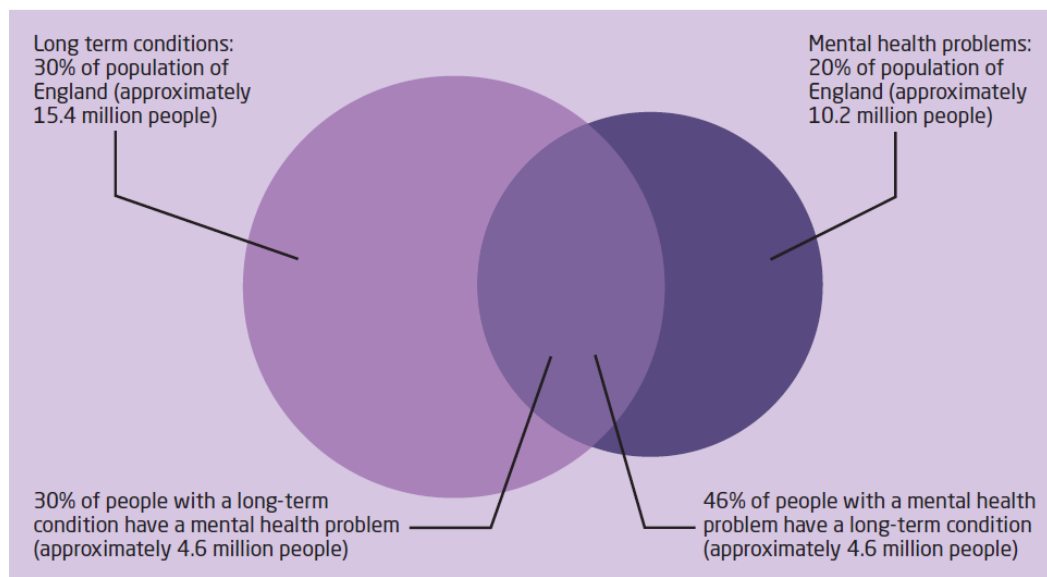
- Mental illness interacts in complex ways with physical health conditions and health-related behaviours.
- CMHDs are strongly linked with obesity, substance misuse and LTCs.
- It is estimated that by 2026 up to a third of those diagnosed with depression will also be obese.
- In Thurrock the smoking prevalence of adults with an SMI is 45.5%.
- 30% of people with a physical LTC also had a CMHD, whilst 40% of those with CMHD had a physical LTC.
- In 2010 the DH estimated that between £8-13billion of NHS spend in England is attributable to comorbid CMHDs with LTCs.

Mental health interacts with physical health and health-related behaviours, such as smoking, in complex ways which may reinforce one another. Poor physical health can increase the risk of mental illness, such as depression, while being depressed may also make physical health worse. This can create a vicious cycle. Conversely, it is possible for a virtuous cycle to be created through interventions and services which address both physical and mental health. Some of the key links to physical health and health-related behaviour are explored below.

### 5.1 Mental Ill Health, Long Term Conditions (LTCs) and Learning Disabilities (LDs)

The Department of Health estimates that long-term conditions account for around 70 per cent of total health spending (Department of Health, 2010). After subtracting expenditure on research and training, this means that between £8 billion and £13 billion of NHS spending in England is attributable to co-morbid mental health problems among people with long-term conditions. Evidence suggests that between 12% and 18% of all NHS expenditure on long-term conditions is linked to poor mental health and wellbeing. The more conservative of these figures equates to around £1 in every £8 spent on long-term conditions. Costs of mental health 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 per cent for each person with a long-term condition and co-morbid mental health problem (Naylor et al, 2012). Putting this in terms of individual patient costs, the presence of poor mental health increases the average cost of NHS service use by each person with a long-term condition from approximately £3,910 to £5,670 a year.

Figure 22: The overlap between LTCs and MH problems in England, 2012.



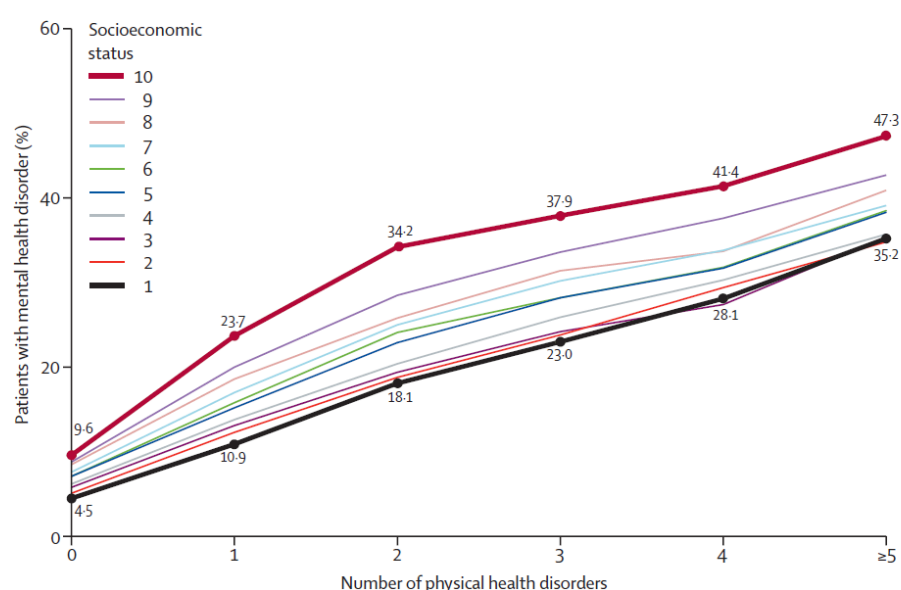
Source: Naylor et al, 2012

Co-morbid mental health problems are particularly common among people with multiple long-term conditions. Data from the World Health Surveys indicate that people with two or more long-term conditions are seven times more likely to have depression than people without a long-term condition (Moussavi *et al* 2007). A 2012 report by The King's Fund found that 30% of people with a long-term physical health problem also had a mental health problem and 46% of people with a mental health problem also had a long-term physical health problem (Naylor et al, 2012).

Co-morbid mental health problems have a number of serious implications for people with long-term conditions, including poorer clinical outcomes, lower quality of life and reduced ability to manage physical symptoms effectively. A significant part of the explanation for poorer clinical outcomes is that co-morbid mental health problems can reduce a person's ability to actively manage their own physical condition and are associated with unhealthy behaviours such as smoking. Self-management is at the core of effective treatment for long-term conditions – but this is impeded significantly by poor mental health, which can reduce the motivation and energy needed for self-management, and lead to poorer adherence to treatment plans (DiMatteo *et al* 2000).

The figure below shows the relationship between mental health and physical health co-morbidity (Barnett et al, 2012). As the number of physical health disorders increases, so does the proportion of patients with MH problems.

**Figure 23: Relationship between mental health and physical co-morbidity, 2012.**



The strong relationship between mental health and LTCs suggests that care for large numbers of people with LTCs could be improved by the better integration of MH support with primary care LTC management programmes. The challenge is to integrate interventions for MH within physical health management protocols rather than merely overlaying MH interventions on top of existing protocols.

An estimate of the number of people affected by both mental health problems and LTCs in Thurrock is given below in Table 5:

**Table 5: Numbers affected by LTCs and MH in Thurrock, 2017.**

Thurrock parameters	Numbers (nearest 100)
Population (all age)	173,400
Long-term condition (30%)	52,000
Mental health problem (20%)	34,700
30% of people with a LTC also have a MH problem	15,600
46% of people with a MH problem also have a LTC	16,000

Population source = registered population 01.01.17 (NHS digital)

### **Depression Screening**

Screening to detect depression in patients with LTC is recommended by NICE. However, depression screening alone is not enough. Screening must be linked to effective treatment services and must ideally be done in conjunction with new approaches to LTC management. For example, Katon et al (2010) found improved outcomes over usual care in the control of LTC and depression in an intervention which involved a nurse who provided guideline-based patient-centred management of depression and the chronic disease(s).

The purpose of depression screening in patients with one or more long-term conditions is to achieve:

- Better management of the LTC(s),
- Earlier identification and management of MH problems,
- Better quality of life (physical and mental health outcomes),
- Increase in life expectancy.

## 5.2 Mental Ill Health and Obesity in England

The connection between obesity and common mental health disorders is an important public health issue. Current research suggests that obesity is more prevalent among adults with serious mental illnesses (SMIs) than those in the general population (Bradshaw et al 2014; Compton et al, 2006). Both these conditions have major implications for the UK health care system and account for a significant proportion of the global burden of disease (World Federation for Mental Health, 2010). Individuals who suffer from both obesity and common mental health disorders may also face particular risks to health and well-being, as people with mental disorders are more vulnerable to the health risks associated with obesity such as type 2 diabetes, heart disease, stroke, high blood pressure, high cholesterol, and premature death (De Hert et al, 2011; Markowitz et al, 2008).

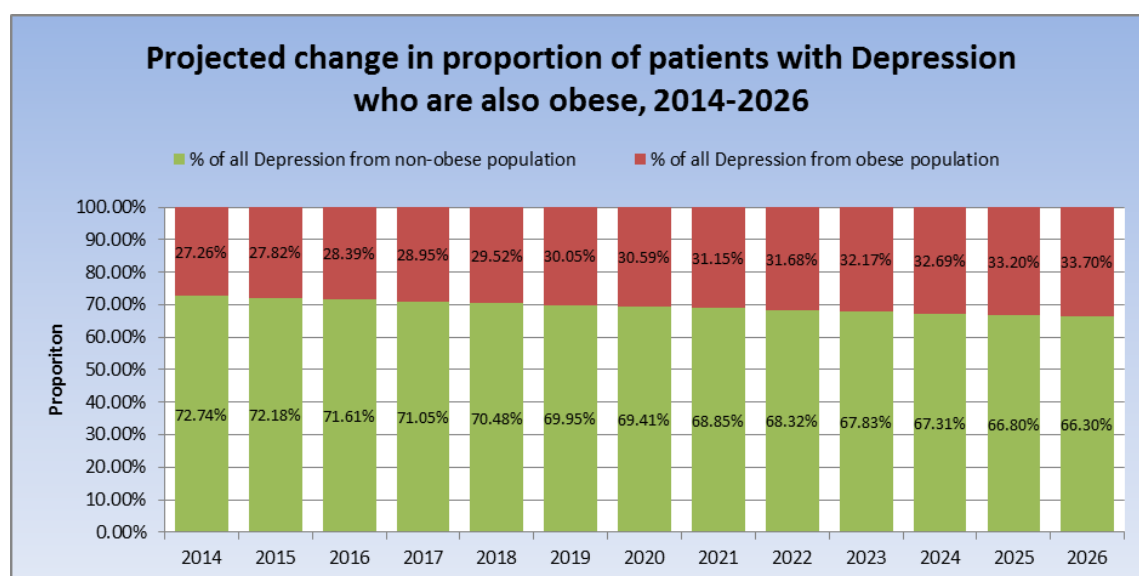
Research studies around the world are providing evidence of the bi-directional associations between depression and obesity. Luppino et al (2010), concluded that 'obese persons had a 55% increased risk of developing depression over time, whereas depressed persons had a 58% increased risk of becoming obese'. It has been suggested that poor mental health can lead to unhealthy lifestyle choices and increased appetite. A combination of the biological effect of increased stress alongside poor adherence to weight loss programmes, binge eating, negative thoughts and reduced social support, may make it difficult for a depressed person to avoid weight gain (Markowitz et al, 2008). There is also evidence that people with chronic or repeated episodes of depression are a particular risk of subsequent obesity (Kivimaki et al, 2009).

The bi-directional association between obesity and common mental health disorders is complex and multi-factorial. Gender, severity of obesity, socioeconomic status and level of education, age and ethnicity have all been suggested as potentially important risk factors that could affect the direction and/or strength of the association between the two conditions. There is also a wide range of behavioural, biological, social and psychological moderating factors that could help explain the relationship (Gatineau et al, 2011).

It has been recommended that the risk for co-morbidity should be considered in the treatment of the obese and depressed, with care providers made aware that in depressive patients, weight should be monitored and in overweight or obese patients, mood should be monitored (al, 2010; Luppino et al, 2010). Also strategies to enhance self-worth and develop self-efficacy can help overweight patients to take control of their well-being (Gatineau et al 2011).

Although there are no published local estimates of those with poor mental health and obesity, some modelled estimates have been produced with the support of Norfolk County Council. This estimates that as of 2016, approximately 28.4% of those on the depression register are also likely to be obese. Projecting this forward, it is likely that, if the current obesity trends continue, the proportion of patients with depression and obesity will increase, with an estimated 33.7% of them by 2026. This can be seen in Figure 24 below.

**Figure 24: Projected change in proportion of patients with Depression who are also obese, 2014-2026.**



Source: ONS, Foresight report, and Norfolk County Council

Estimates are also available for other mental health conditions and obesity. These can be seen in Table 6 below, along with the estimated additional number of mental health patients with obesity over the 10 year period.

**Table 6: Percentage of patients estimated to be obese and experiencing a CMHD in 2016-2026.**

	% patients estimated to be obese in 2016	% patients estimated to be obese in 2026	Additional Number of Obese patients
<b>Neurotic Disorder</b>	28.3%	33.5%	2000
<b>Personality Disorder</b>	28.5%	34.1%	555
<b>Psychotic Disorder</b>	28.5%	33.9%	69
<b>Dementia</b>	28 %	32.7%	211

Source: ONS, Foresight report, and Norfolk County Council

The impact of increased numbers of patients with mental health conditions who are also obese will increase the health and social care costs, with obese patients estimated to have approximately 30% higher medical costs than non-obese patients<sup>i</sup>. Research by Public Health England (2016)<sup>ii</sup> also found that severely obese people are over 3 times more likely to require social care than those of a normal weight, with examples of requirements including housing adaptations, carers or provision of appropriate transport and facilities. The same research also showed that obesity reduces life expectancy by an average of 3 years, and severe obesity could reduce life expectancy by an average of 8-10 years.

Average treatment costs for all of the above mental health conditions were difficult to source in the literature. However, an approximation of the increased cost impact can be made for psychotic disorder. Using the above assumption of a 30% increase in treatment costs for obese psychotic patients, and an average annual treatment cost of £8,250 per patient<sup>iii</sup>, an additional 69 obese psychotic patients could increase costs from £569,250 [standard treatment costs] to £740,025 [treatment costs including the additional impact of obesity].

### 5.3 Poor Mental Health and Substance Misuse

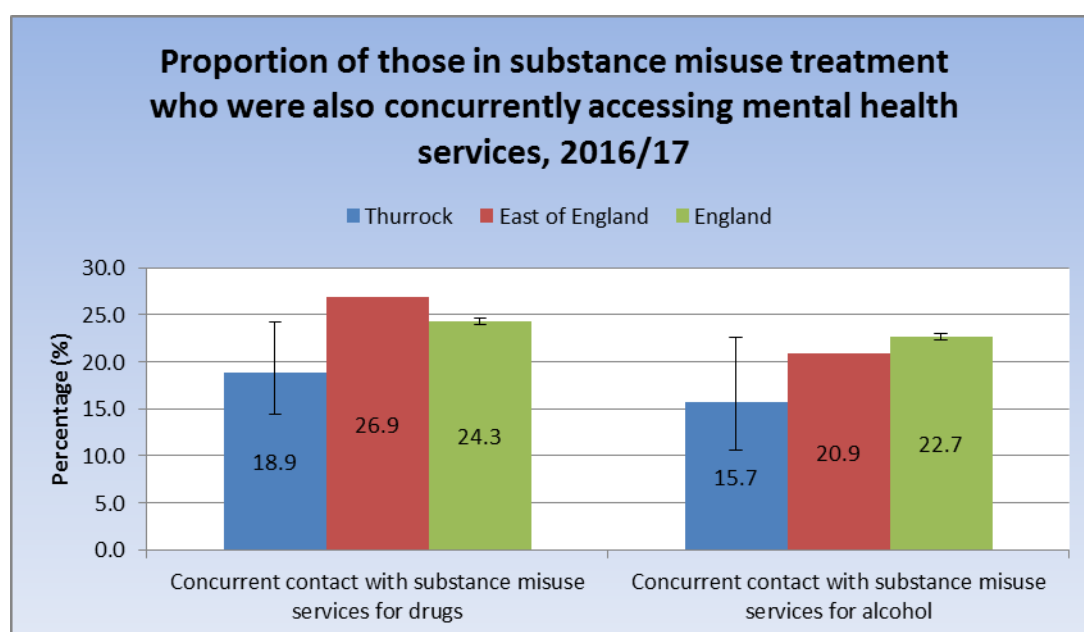
It has been shown in various studies that large proportions of people with substance misuse problems also experience major depression and other common mental health disorders. Heavy use of alcohol or illicit substances can cause symptoms of depression. Conversely, some individuals with depression misuse substances as a coping mechanism.

#### Drugs and Alcohol

Drug misuse and drug dependence are more prevalent in adults with various psychiatric problems, from common mental disorders to personality disorders and severe psychotic illness (Coulthard et al. 2002; CMH et al. 2011) The 2002 Comorbidity of Substance Misuse and Mental Illness Collaborative study concluded that 75% of users of drug services and 85% of users of alcohol services were experiencing mental health problems (Weaver et al 2003)

The number of admissions to NHS hospitals with a primary diagnosis of drug-related mental health or behavioural disorder has risen since 2012/13 but is still lower than ten years ago; in 2013/14 there were 7,104 (HSCIC, 2014). This is an 8.5% (555) increase from 2012/13 when there were 6,549 such admissions. Overall, however, between 2003/04 and 2013/14 admissions have decreased by 11% (Roberts et al, 2016).

**Figure 25: Proportion of those in substance misuse treatment who were also concurrently accessing mental health services, 2016/17.**



Source: Public Health England 2016/17

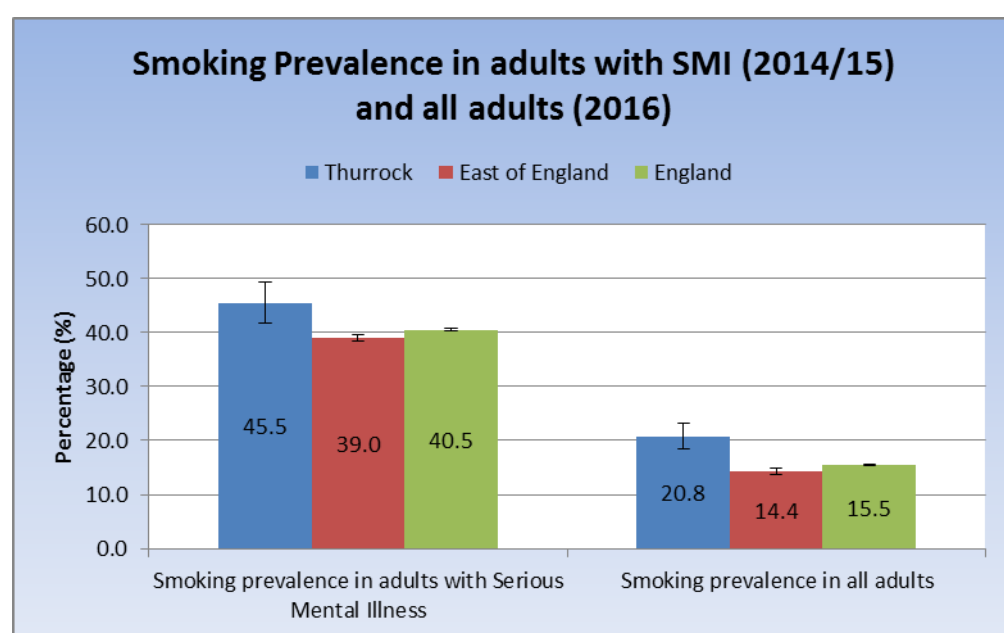
Figure 25 above shows the level of concurrent contact with mental health services and substance misuse services for drug and alcohol misuse respectively. The concurrent contact with mental health services and substance misuse services for drug misuse in Thurrock (18.9%) was below the national average (24.3%), and for alcohol misuse, Thurrock (15.7%) was similar to the national average of 22.7% (significance could not be calculated against regional values). Putting this another way, around one in six of those accessing alcohol treatment, and almost one in five of those accessing drug treatment are also accessing mental health services for support.

The Thurrock Drug and Alcohol Action Team (DAAT), reporting to the Health and Wellbeing Board and the Thurrock Community Safety Partnership Strategic Board, commissions a range of local treatment services in response to the harms caused by drugs and alcohol.

## Smoking

It is known that there is a higher prevalence of smoking in those with a serious mental health condition than the wider population. This can be seen in Figure 26 below for Thurrock, East of England and England, where the prevalence in those with serious mental ill-health is approximately double that of those without - 45.5% of Thurrock residents with a serious mental health condition were smokers, compared to 20.8% of all adults. In addition, smoking prevalence in adults with serious mental illness in Thurrock (45.5%) is significantly higher than the national (40.5%) and regional average (39.0%).

**Figure 26: Smoking Prevalence in adults with SMI and all adults, 2014-15 and 2016.**



Source: Public Health England 2014/15

## E-cigarettes

Abstinence from smoking is always the best option. Inhaling nicotine and water vapour produced by electronic cigarettes, commonly referred to as e-cigs, offer an enormous harm-reduction opportunity for smokers who wish to reduce the amount of combustible tobacco cigarettes they smoke or quit smoking completely. ASH recently stated that there are now 2.9 million e-cig users in the UK and of these just over half, 1.5 million, no longer smoke cigarettes. Public Health England has endorsed the evidence that shows these devices are 95% safer than combustible tobacco cigarettes.

There is considerable debate about the use of e-cigarettes in healthcare settings. Some health and mental health trusts permit vaping on their grounds and in single occupancy rooms whereas others still hold a level of scepticism towards e-cigs and ban them, treating them the same as combustible tobacco cigarettes.

Given the high prevalence of smoking rates across people who suffer from mental ill health these devices offer a real opportunity to significantly improve the health of this population, increasing life expectancy and typically halving the amount of medication patients require, which is better for the



patient and saves money for the health sector (ASH Briefing: Health inequalities and smoking, June 2016 & NCSCT Briefing 10: Stop Smoking Services and Health Inequalities, 2013).

#### 5.4 Recommendation

- Strong connections between long-term conditions and mental illness need to be recognised in the organisation and integration of services. There is a huge opportunity for mutual benefits to be realised by offering integrated physical and mental health care. The new model of care being developed and implemented in Thurrock presents a huge opportunity to create a health and social care system which addresses physical and mental health issues together.

## 6 What services are provided for those with mental illness? Primary Care

### Key Points

- There are a large number of newly diagnosed patients who are not receiving the appropriate review 10-56 days after diagnosis.
- There is widespread variation at GP practice level in care and treatment for serious mental illnesses (SMIs).
- Two thirds of those referred into IAPT services are women
- There appears to be no association between deprivation, depression prevalence and referral into IAPT services.
- The number of antidepressants prescribed has increased over the last four years although the total cost has decreased.
- Both the number and cost of drugs prescribed for serious mental illness have decreased over the last four years, with the largest reductions seen in the cost of antipsychotic drugs.
- The percentage change in items and costs for both antidepressants and SMI drugs over the last four years vary considerably across GP practices.

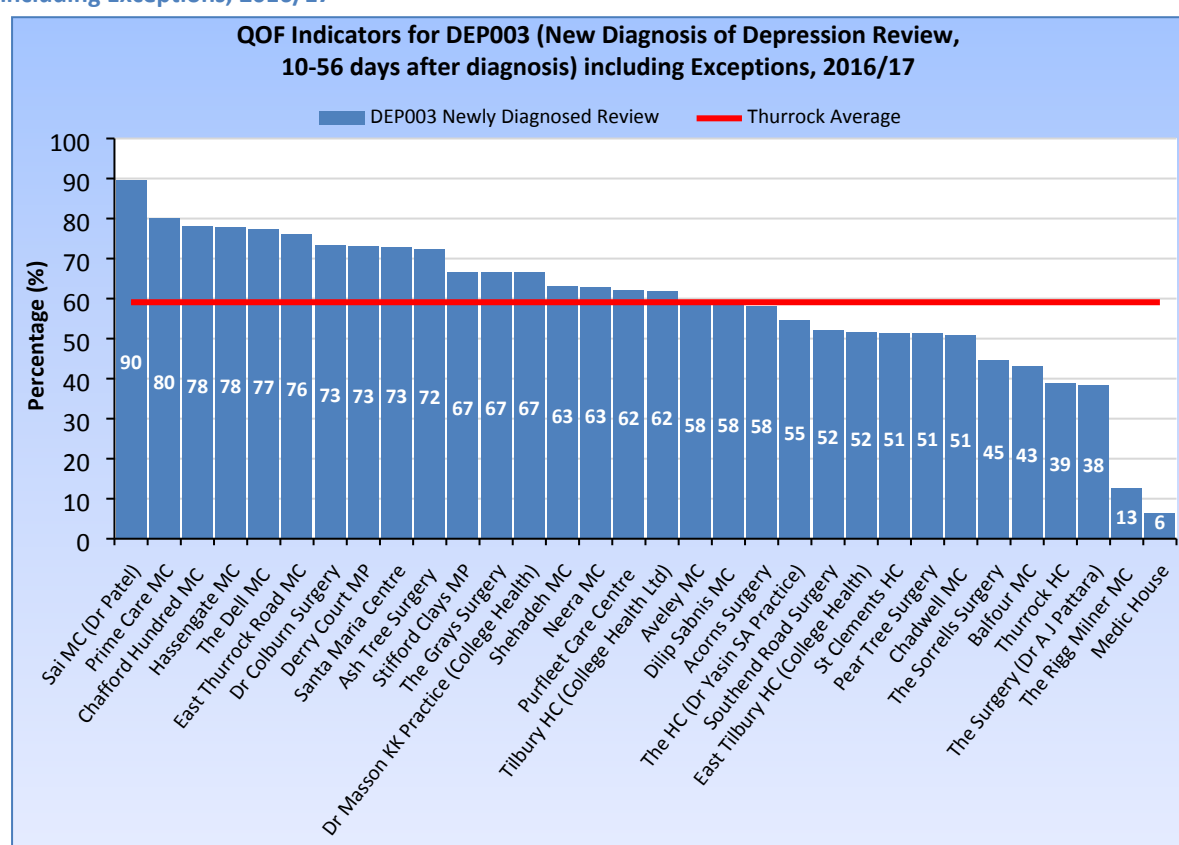
The majority of treatment for mental illness occurs in primary care which, for the purpose of this report, includes GP practices and IAPT (Increasing Access to Psychological Therapies) services, which offer access to talking therapies in the community.

### 6.1 Management of Depression in Primary Care

A number of care standards and targets are set out for GPs as part of the Quality Outcomes Framework (QOF) which forms an essential part of GP payment calculations. As well as recording patients diagnosed with depression and serious mental health conditions on QOF prevalence registers, QOF sets out a number of key care processes for GPs to follow. For example, Figure 27 below shows the variation by GP in achievement of QOF points for patients with a new diagnosis of depression receiving a review 10-56 day after diagnosis. Whilst the Thurrock average is 59%, achievement appears to range from 90% to 6%.

Translating this to numbers, it means that in 2016/17, 742 patients newly diagnosed with depression did not receive their review within 10-56 days post-diagnosis (this includes some who were exception reported). Work is currently in process to explore the possibility for a 'stretched QOF' in order to incentivise GPs to identify and review more of these patients.

**Figure 27: QOF indicators for DEP003 (new diagnosis of depression review 10-56 days after diagnosis) including Exceptions, 2016/17**



Source: QOF 2016/17

## 6.2 Management of Serious Mental Illness (SMI) in Primary Care

The six figures below analyse the performance of all Thurrock GP practices on the six QOF indicators that consider how effectively the practices are diagnosing and managing serious mental ill-health. The GREEN element of the bar shows the number of patients practice level that have received and/or been successfully treated against the indicator and the amount of financial reward received by the practice because of successful treatment under QOF.

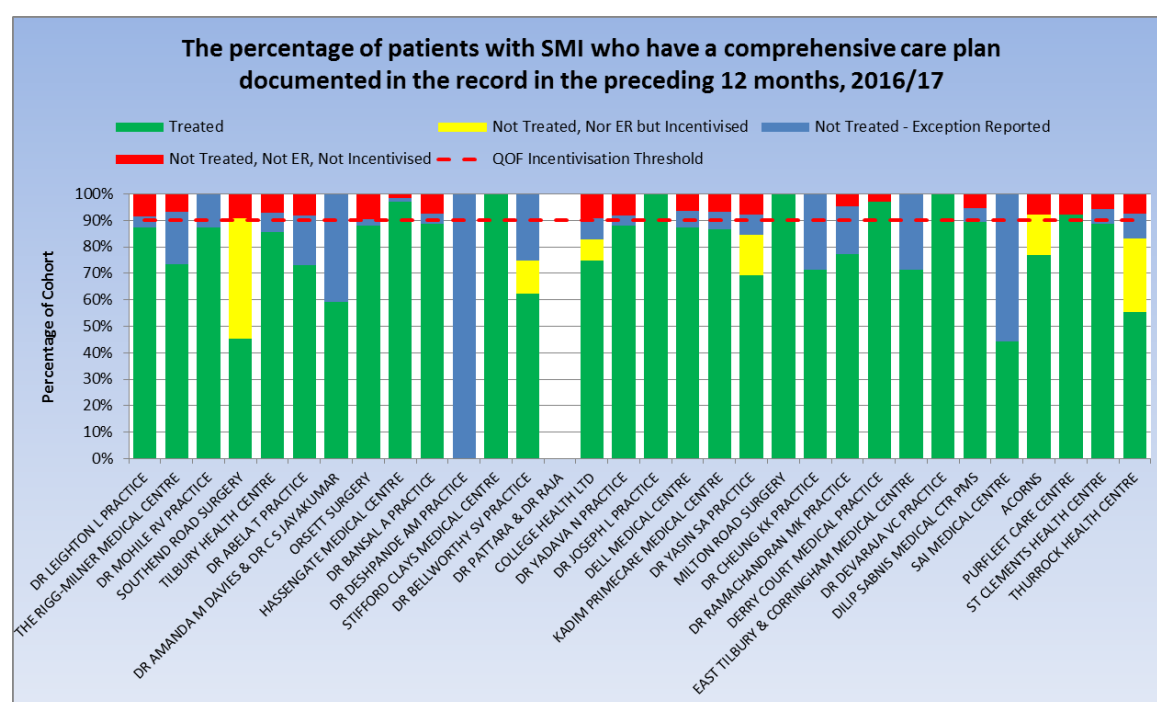
The BLUE element of the bar shows the number of patients that the practice has 'exception reported'. Patients who are 'exception reported' are removed from the cohort of patients relating to the indicator for the purposes of calculating incentive payments against QOF performance. Hence exception reporting patients makes it easier for a GP practice to claim maximum QOF financial rewards.

The YELLOW element of the bar shows patients that were neither treated nor exception reported but for whom the GP practice could have received financial reward for had they done so because the practice has failed to hit the maximum QOF payment threshold. It could be hypothesised that a GP practice with large elements of yellow within their bar has capacity issues or is failing to run its long term conditions management programme as efficiently or effectively as it could, as it is missing out on funding available to treat patients with LTCs.

The RED element of the bar shows the number of patients that were neither exception reported nor treated, but for whom QOF provides no additional financial incentive to treat. QOF provides a maximum payment threshold for each indicator. Once the GP practice hits this % threshold of treated patients, no further funding is provided. The maximum threshold varies between indicators but is never 100%. As such, QOF provides a perverse incentive to stop managing a cohort of patients with LTCs. Practices with a large proportion of their bar shown in red would potentially respond to a "stretched QOF" programme. This would be a local contract commissioned by the CCG that would financially incentivise GP practices to treat the patients that they do not currently get financially rewarded to treat under the current QOF contract.

The 1st figure below (Figure 27/Figure 28) shows practices such as Southend Road Surgery and Thurrock Health Centre to have large proportions of yellow bars, indicating that they are failing to ensure these patients have comprehensive care plans in place despite being financially incentivised to do so. In addition, Dr Deshpande has a completely blue bar, indicating they are exception reporting all of their patients.

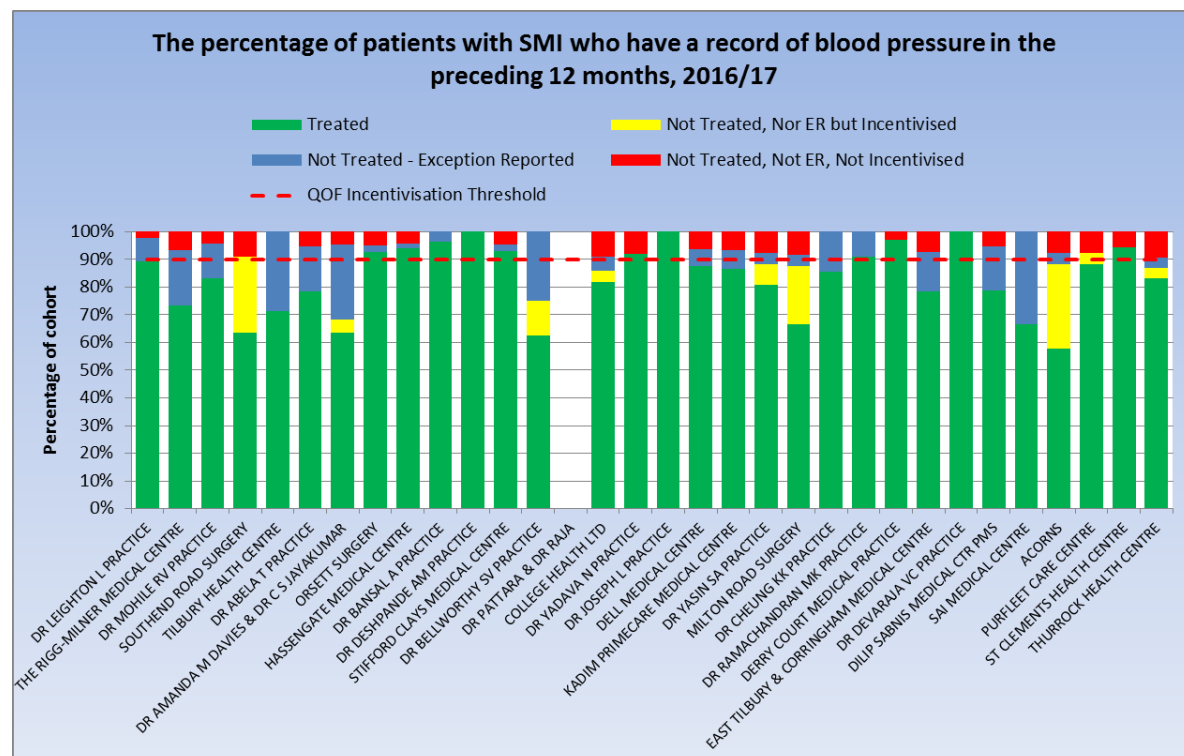
**Figure 28: Percentage of patients with SMI who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate, 2016-17.**



Source: QOF

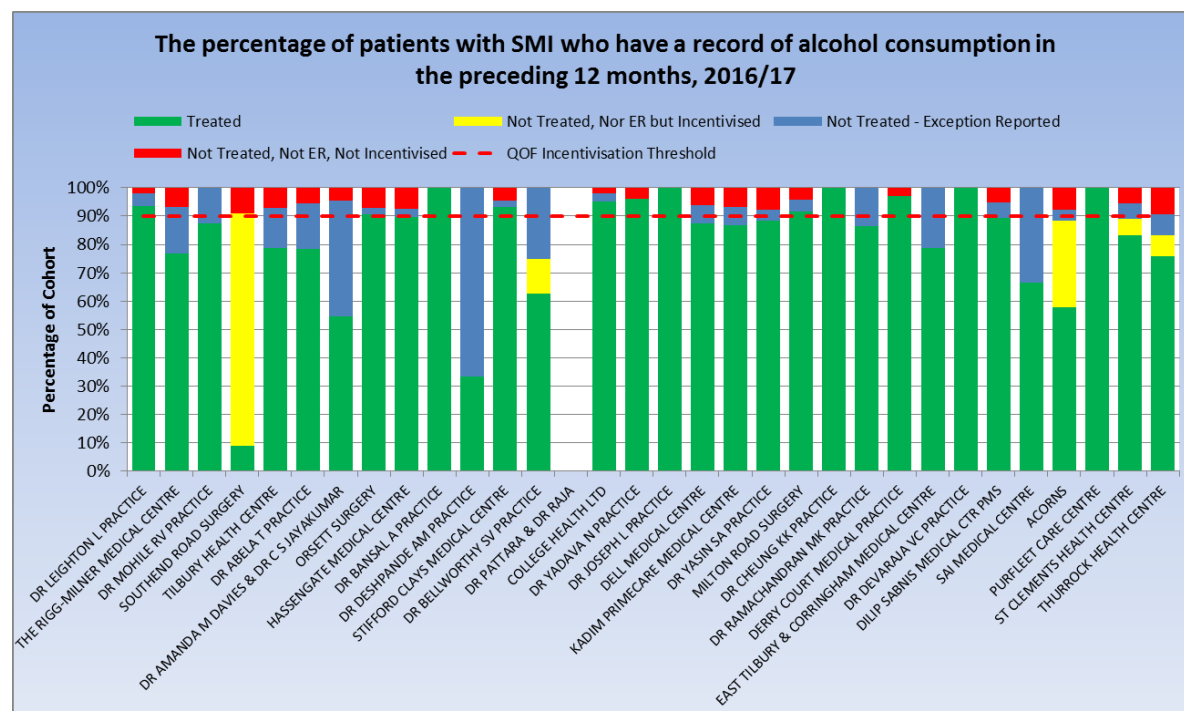
The two charts below show that the majority of practices are treating a lower proportion of patients than the QOF incentivisation threshold of 90%. The large number of practices with red proportions in their bars indicates they may respond favourably to a stretched QOF programme which would incentivise them to treat these patients. The Public Health Team have built a modeller enabling this opportunity to be calculated for all long term conditions, and which also apportions costs per practice. This is being explored further as part of the Tilbury ACP work.

Figure 29: The percentage of patients with SMI who have a record of blood pressure in the preceding 12 months, 2016-17.



Source: QOF

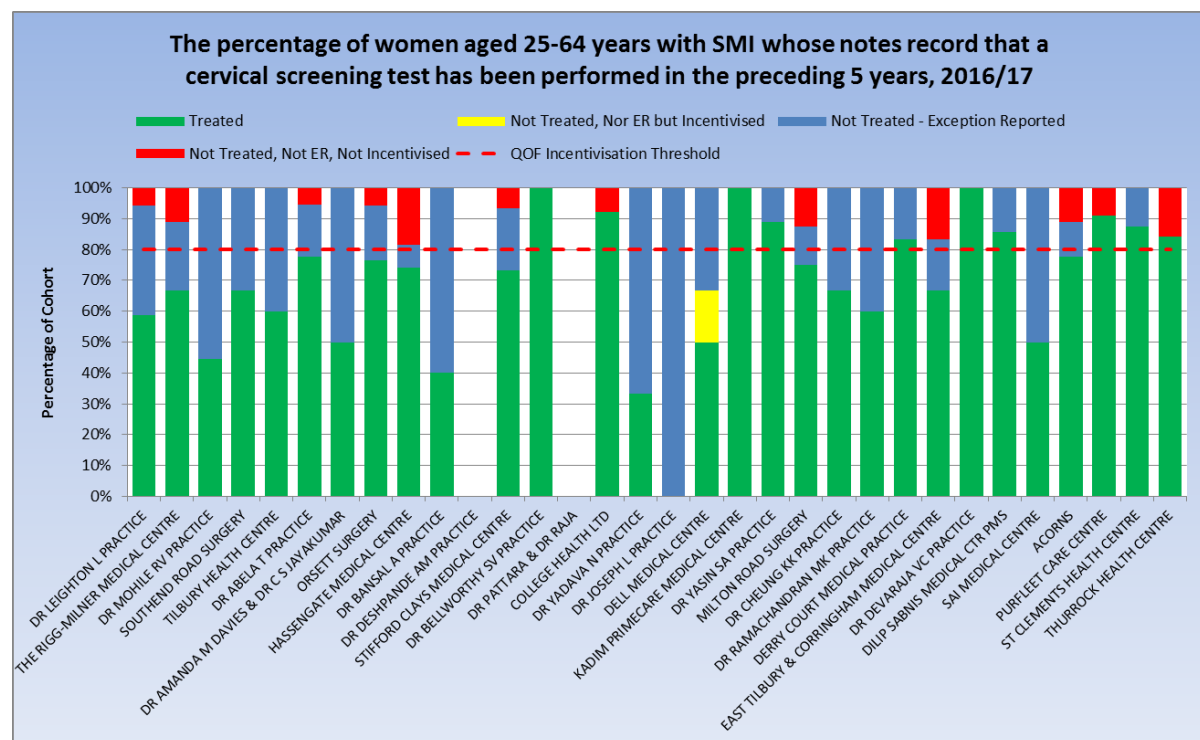
Figure 30: The percentage of patients with SMI who have a record of alcohol consumption in the preceding 12 months, 2016-17.



Source: QOF

As with the two charts above, the chart below shows that the majority of practices are treating a lower proportion of patients than the QOF incentivisation threshold of 80%. In addition, many practices have large proportions of patients being exception reported, and it is not clear why that might be the case.

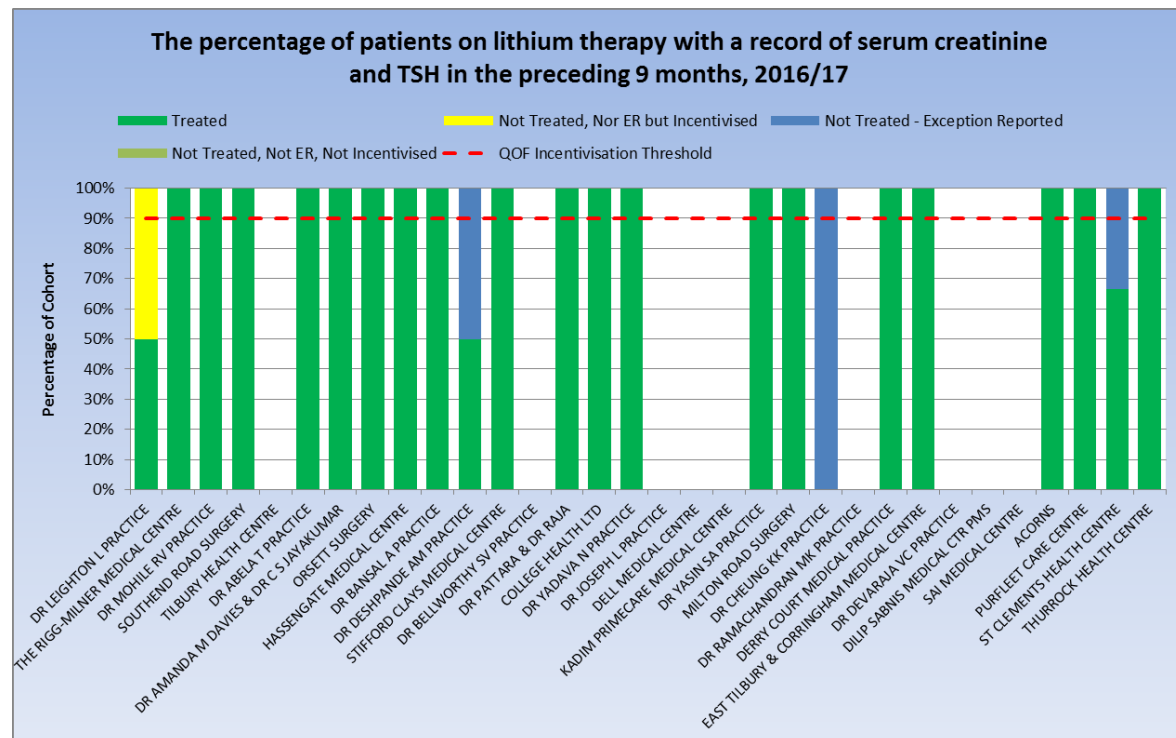
**Figure 31: The percentage of women aged 25 or over and who have not attained the age of the 65 with SMI whose notes record that a cervical screening test has been performed in the preceding 5 years, 2016-17.**



Source: QOF

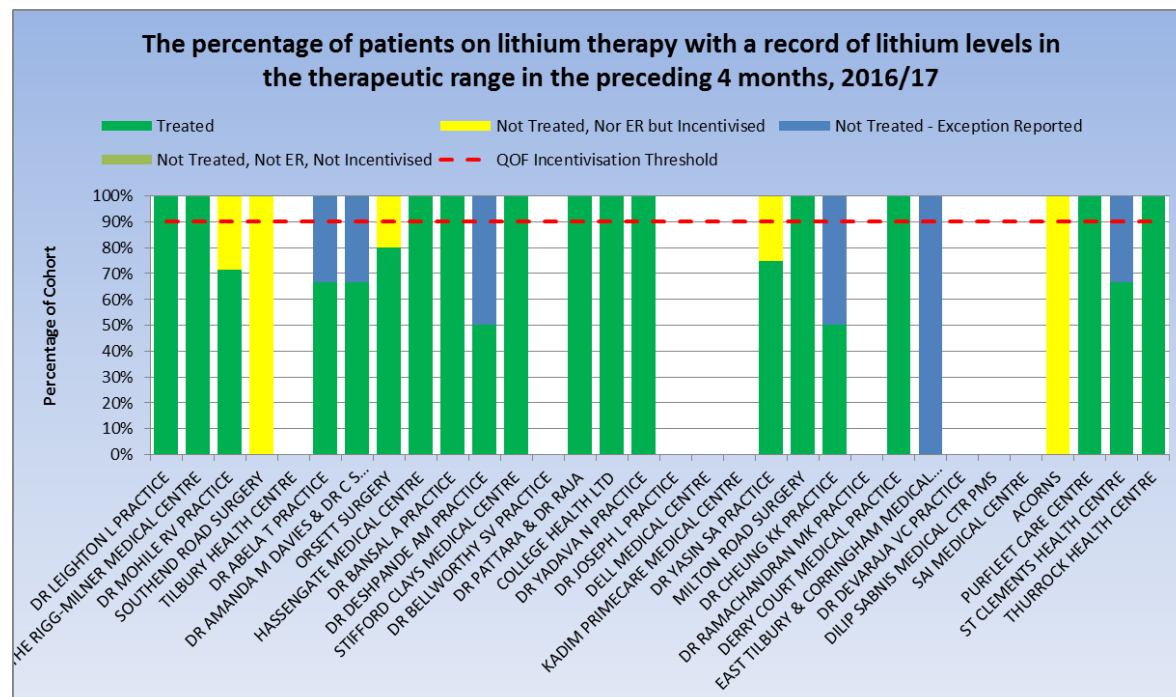
The two charts below have several practices with no eligible patients. Of the ones that do, the majority of them are receiving treatment. These two charts should be viewed with caution in light of the small denominator sizes of the registers.

**Figure 32: The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months, 2016-17.**



Source: QOF

**Figure 33: The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months, 2016-17.**



Source: QOF

### 6.3 Improving Access to Psychological Therapies (IAPT)

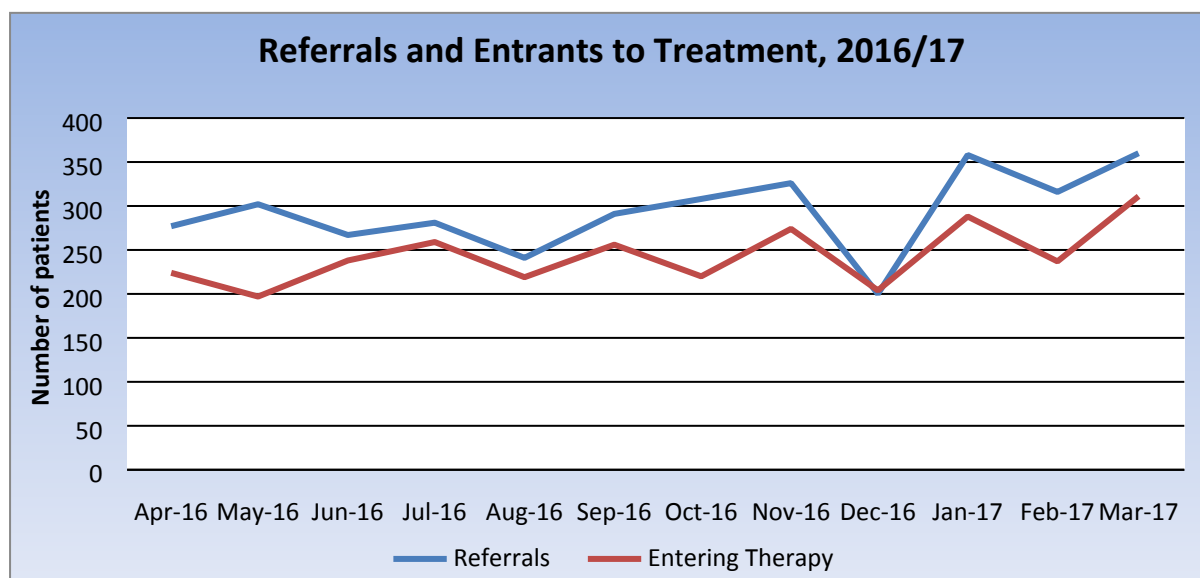
IAPT services are an evidence-based method of treating mental health disorders via talking therapies. The National Institute for Health and Care Excellence (NICE) recommends the use of IAPT for mental ill health and the Five Year Forward View for Mental Health Implementation Plan will see increases to the provision of IAPT services nationally in its 5 year plan. A new IAPT provider was commissioned to provide IAPT services from April 2016.

#### 6.3.1 Who is accessing IAPT services?

In 2016/17 there were 3,527 referrals made to the Thurrock IAPT service. As part of the Five Year Forward View, all IAPT services are being set targets to work towards having 25% of the patients estimated to have anxiety/depression accessing IAPT services by 2020/21. Converting the referrals into a proportion of the estimated patients with anxiety/depression, this would indicate that 17.11% of these patients received a referral to IAPT.

Of those 3,527 referrals, 2,927 went on to enter treatment – equating to 83%. Both the number of referrals and treatment entrants fluctuated by month, which can be seen in the chart below. It should be noted however that due to waiting times between referrals and treatment, it is not the same patient cohorts at each monthly stage.

Figure 34: IAPT referrals and treatment entrants, 2016/17

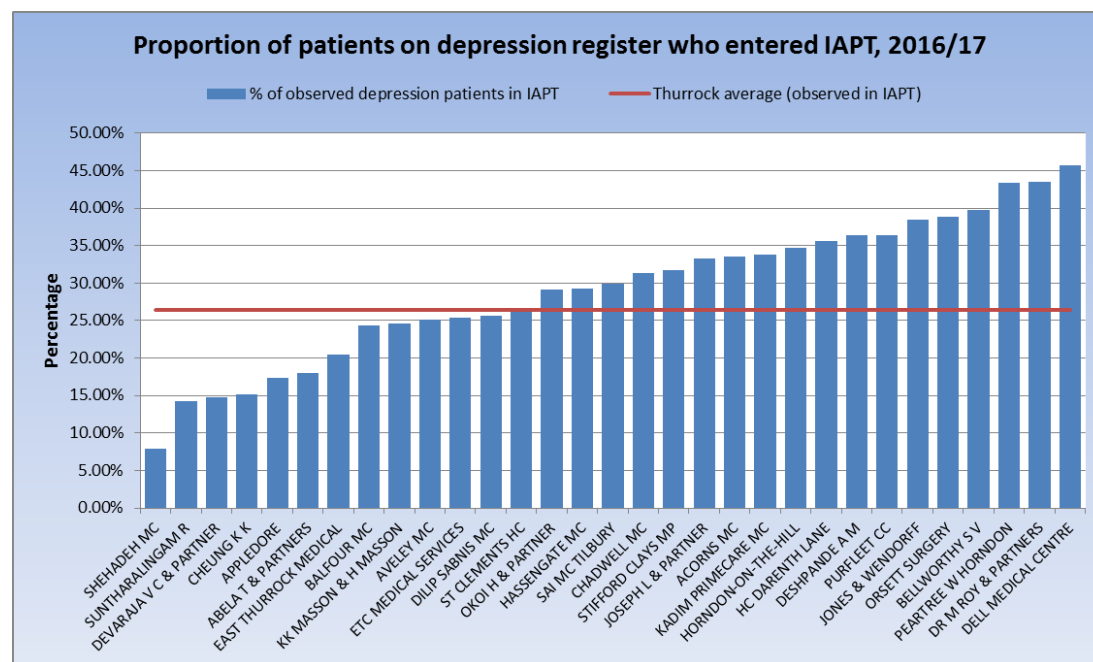


When looking at the age of entrants to treatment, it could be seen that the majority of entrants are aged 17-64 years, with 154 of the 2,927 aged over 65 (7.05%). Evidence suggests that those over 65 are more likely to suffer from depression and common mental health disorders. This age group is also more likely to suffer from isolation and those aged 65+ are more likely to have at least one long term condition; these are strong predictors of mental ill health.



Referrals and entrants into IAPT services varied per GP practice. Below we have considered IAPT entrants in two ways – one as a proportion of all known depression patients (whilst not all IAPT entrants would access the service due to depression, it is an approximate measure of known need), and also as a proportion of the total estimated number of depression patients (using the 2016 PHE estimates referred to earlier in the document). The variation in entrants can be seen in the two charts below. Whilst the Thurrock average for IAPT entrants as a proportion of known depression patients is 26.38%, activity ranges from 7.87% (Shehadeh Medical Centre) to 45.67% in Dell Medical Centre.

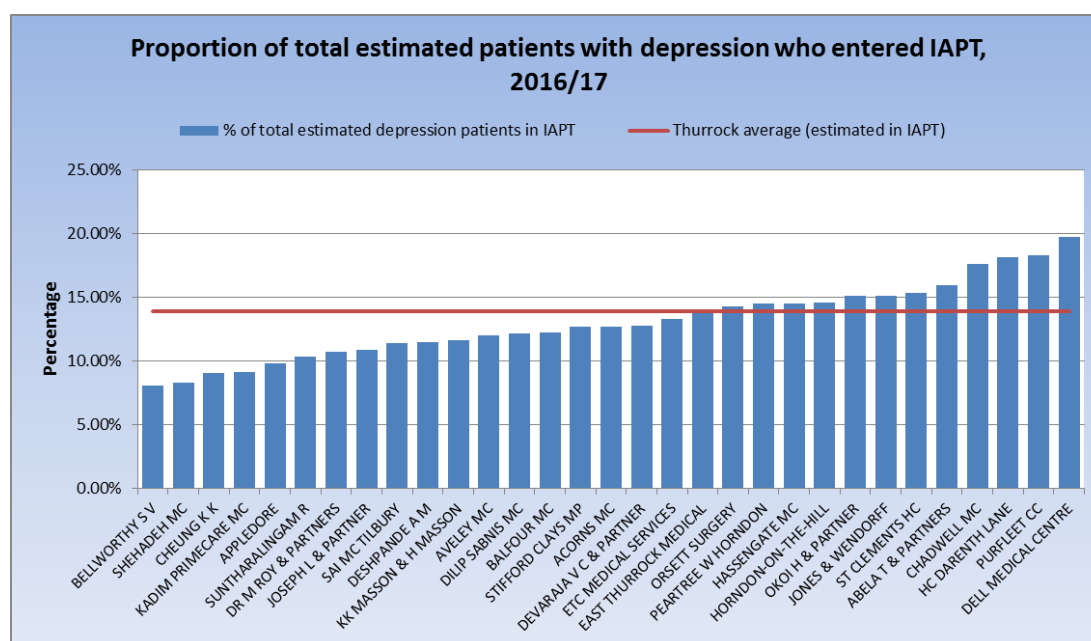
**Figure 35: IAPT entrants as a proportion of those on the QOF depression register, 2016/17.**



Source: IAPT and QOF 2016/17

The national ambition is for 25% of patients estimated to have anxiety or depression to be accessing IAPT by 2020/21. Due to the large estimated number of undiagnosed patients with depression in Thurrock, the latest data indicates that there is a large proportion of patients likely to have depression who are not accessing IAPT. The chart below shows entrants to IAPT as a proportion of the total estimated practice population with depression, and it can be seen that the Thurrock average is now 13.91%, with practices varying from 8.11% (Bellworthy S V) to 19.78% (Dell Medical Centre). It is also of note that it is not always the same practices with the highest proportions of known patients accessing IAPT as the total estimated patients – for example, Dr Bellworthy appears to have a relatively high proportion of known depression patients accessing IAPT (39.73%), but a low proportion of total estimated depression patients accessing IAPT (8.11%) – reflecting the variation in diagnosing behaviour described elsewhere in the document.

Figure 36: IAPT entrants as a proportion of the total estimated population with depression, 2016/17.

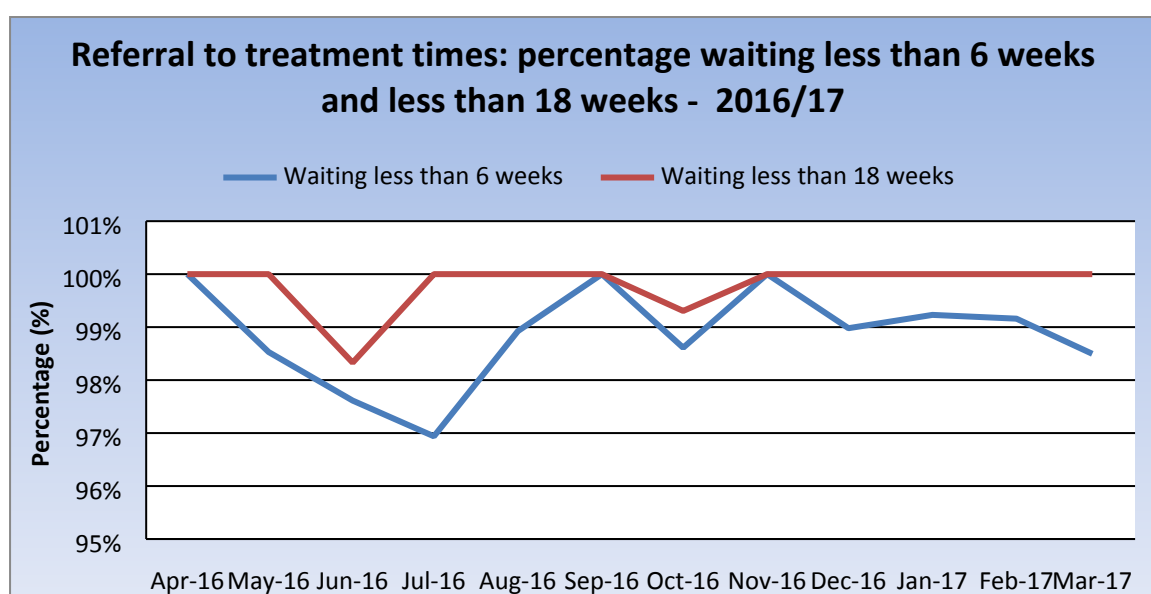


Source: IAPT 2016/17 and PHE 2016

### 6.3.2 Waiting Times

There are two key national targets in place with regard to patients waiting for IAPT treatment. It is expected that 75% of all patients completing IAPT treatment each month should have had a referral-treatment waiting time of less than 6 weeks, and that 95% of completers each month should have had a referral-treatment waiting time of less than 18 weeks. The chart below shows this for Thurrock for 2016/17, and it can be seen that for every month, more than 95% of patients are seen within 6 weeks and almost 100% every month are seen within 18 weeks.

Figure 37: Referral to treatment times, 2016/17

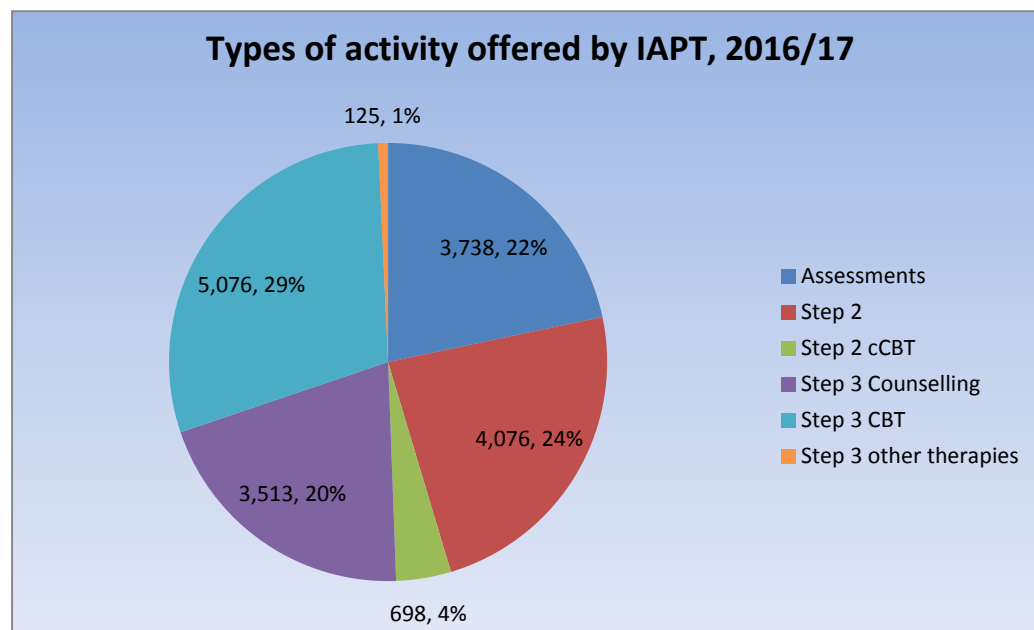


*It should be noted that the current provider (Inclusion) took on the contract from April 2016 with a backlog to work through. Interrogating the waiting time data further showed a large number of patients who had waited more than 18 weeks for their second treatment appointment in April and May 2016; however these figures were not seen for the rest of the year.*

### 6.3.3 Treatment Activity

When considering the type of activity that IAPT offered, it can be seen that 50% of their activity relates to step 3 therapies (Counselling, CBT or other therapies), which gives an indication of the complexity of patients being seen by the service.

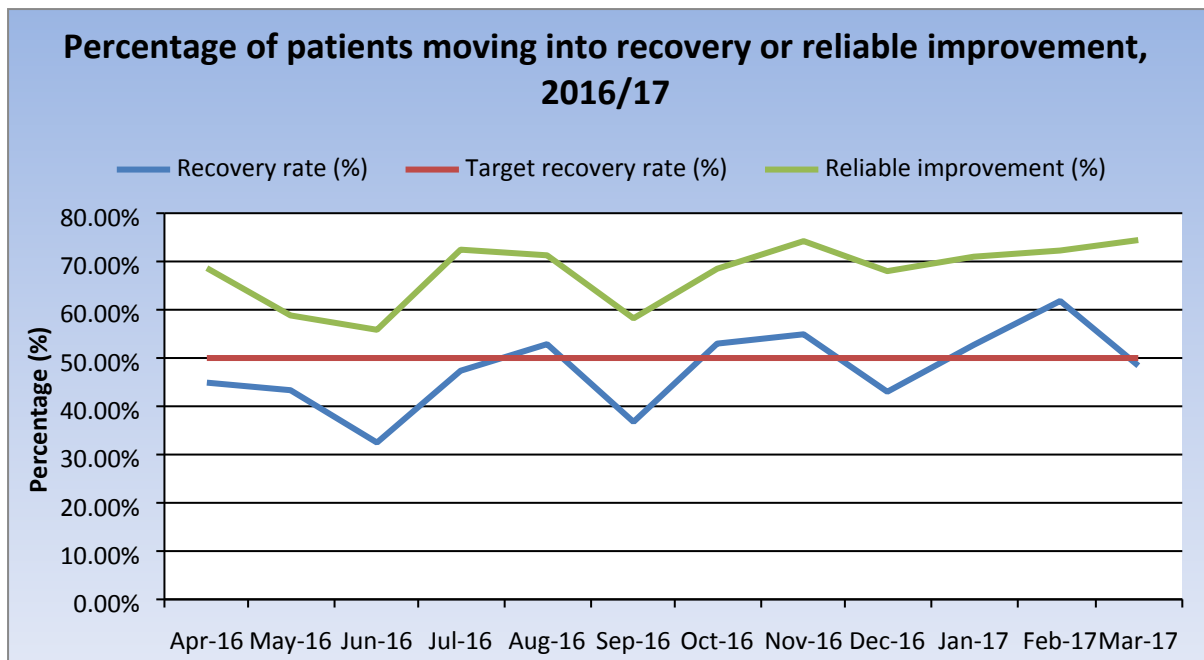
**Figure 38: IAPT Treatment Activity Offered, 2016/17**



### 6.3.4 Outcomes

The aim is for 50% of patients completing treatment each month to be moving into recovery. In 2016/17, this varied on a monthly basis, but for the year was 45.43%. The percentage of patients recorded as seeing a reliable improvement is also recorded as an indication of how effective treatment has been. 65.71% of patients completing treatment in 2016/17 were classified within this category, although this also varied within the year. This can be seen in the figure below.

Figure 39: Percentage of patients moving into recovery or reliable improvement, 2016/17



## 6.4 Prescribing Data

### Key Points

- Antidepressants were the area with largest increase in prescription items in 2016 (NHS Digital)
- Four year data trends tell us that in general the total costs and items of mental health prescribing data have been decreasing (except for antidepressant items and hypnotics costs)
- There was an increase in the total cost of hypnotic drugs between 2015/16 and 2016/17 of £25,000, which may be because GPs are prescribing more expensive types of these drugs, as the number of items have decreased
- There are some limitations to what prescribing data tell us, including the fact that many people with mental health disorders have mixed presentations and therefore use various mental health drugs and also mental health drugs can be used for other indications such as pain

Data on prescribing by GPs and independent or supplementary prescribers for NHS patients (usually on green FP10 prescriptions) is collected by an online system called ePACT. Five years of prescribing data can be analysed in different levels of detail. However, the data cannot be linked directly to individual patients. We have looked at Thurrock CCG's ePACT for the four years including 2013/14 to 2016/17 for mental health prescribing. The broad categories that have been analysed include: antidepressants, hypnotics, benzodiazepines and antipsychotics.

Antidepressants are used for the treatment of moderate to severe depression (and should not be used routinely in mild depression). They can also be used for other indications such as neuropathic pain and migraine. Depression and anxiety do not always occur independently of each other therefore a patient could be prescribed an antidepressant for co-existing conditions such as mixed depression and anxiety or mixed depression and psychotic episodes. There are several types of antidepressants such as Serotonin Selective Re-uptake Inhibitors (SSRIs) e.g. citalopram, fluoxetine and paroxetine. Other types include tricyclic antidepressants e.g. amitriptyline, and monoamine oxidase inhibitors (MAOIs) such as phenelzine.

Hypnotic drugs are often used for insomnia and other sleep disorders. Benzodiazepines are a type of hypnotic drug and are often used for short-term treatment of anxiety. They may be helpful in the initial stages of treatment for behavioural disturbance or agitation; however they should not be used for long periods due to risk of dependence. Examples include lorazepam, temazepam and zopiclone.

Antipsychotic drugs are used for serious mental illness (SMI) such as psychosis, mania and hypomania. Examples include olanzapine, quetiapine or risperidone. If the response to antipsychotic drugs is inadequate, lithium or valproate may be added. NICE recommends that clozapine is started if a patient remains unresponsive to 1<sup>st</sup> and 2<sup>nd</sup> line antipsychotic drugs. In elderly patients with dementia, antipsychotic drugs are associated with a small increased risk of mortality and an increased risk of stroke or transischæmic attack (TIA). Therefore there are lots of

considerations that clinicians must take before prescribing drugs for mental health disorders and it is important that NICE guidance is adhered to, for best clinical practice.

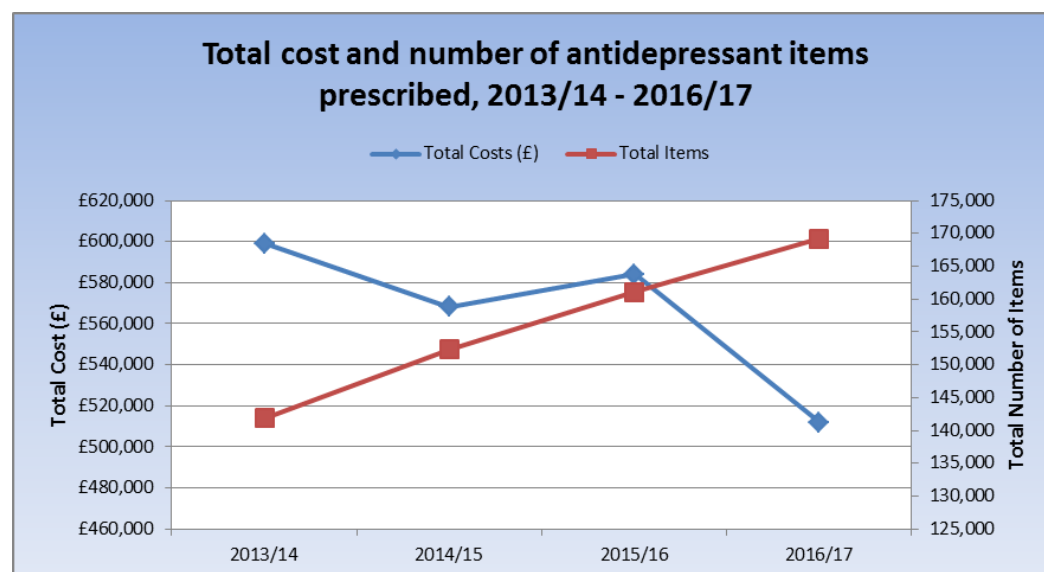
The section below presents analyses of prescribing data for mental health conditions split into two groups – those categorised as antidepressant items (although it should be acknowledged that these can be taken by patients with a range of conditions), those for hypnotics and benzodiazepines and those for more serious mental health conditions (antipsychotics).

### Antidepressants

The total number of items dispensed in 2016 for antidepressants showed the greatest numeric rise since 2015. They increased by 3.7 million items (6% increase) – NHS Digital. The number of antidepressants prescribed in Thurrock has increased from 161,038 items in 2015/16 to 169,202 items in 2016/17 (5% increase) – ePACT. Although the dates are different, NHS Digital being January to December 2016 whilst ePACT is by financial year, it shows that the increase in Thurrock is generally in line with the national increase. Over the last four years, from 141,875 in 2013/14 to 169,202 in 2016/17, there has been a 19% increase in numbers of antidepressant items prescribed.

In reverse to numbers prescribed, the total cost of antidepressants prescribed in Thurrock has decreased over the last four years, with the largest decrease between 2015/16 and 2016/17. In 2016/17 the total cost was £511,934, which was a 15% decrease from the 2013/14 cost. The decrease in cost could be due to wider changes to pricing of medication (e.g. if certain drugs came off patent), changes to prescribing guidance or work by the local CCG Medicines Management team – or a combination of all of these factors. The increase in items could be interpreted as an increase in need (and diagnosis), although also likely influenced by GP prescribing preferences and population growth.

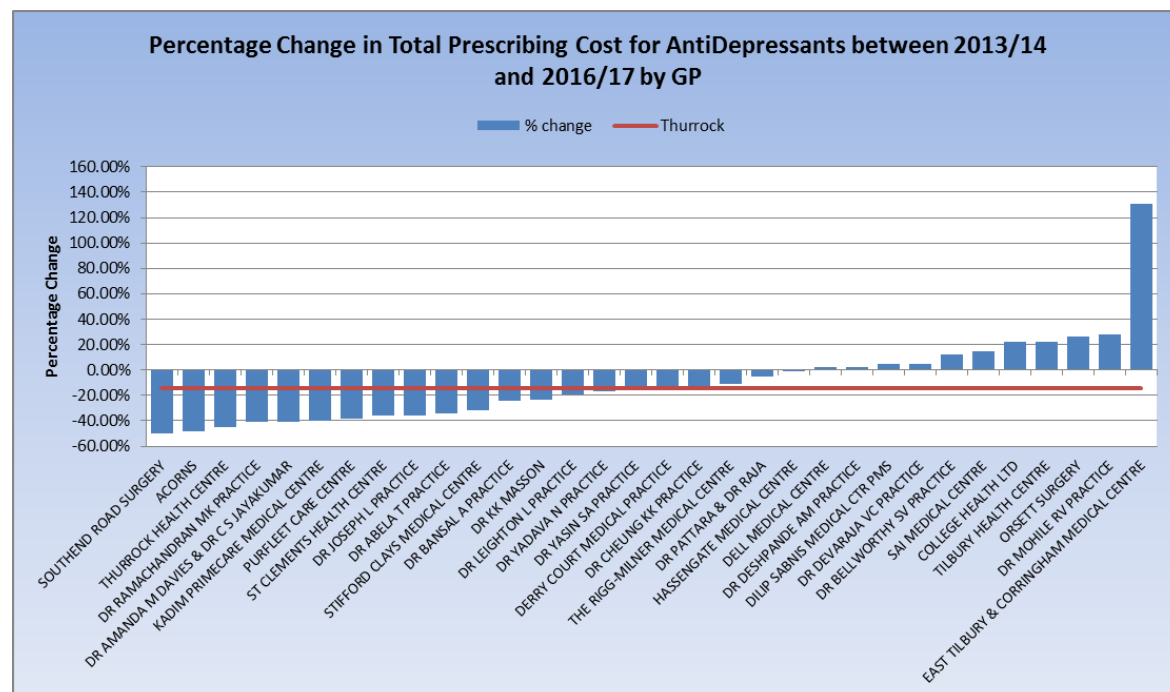
**Figure 40: Cost and Number of Antidepressants prescribed, 2013/14 - 2016/17.**



Source: ePACT

Analyses of the percentage change in total cost between 2013/14 and 2016/17 at practice level shows a large amount of variation of antidepressant prescribing practice, ranging from a 50% decrease (Southend Road Surgery) to a 131% increase (East Tilbury Medical Centre).

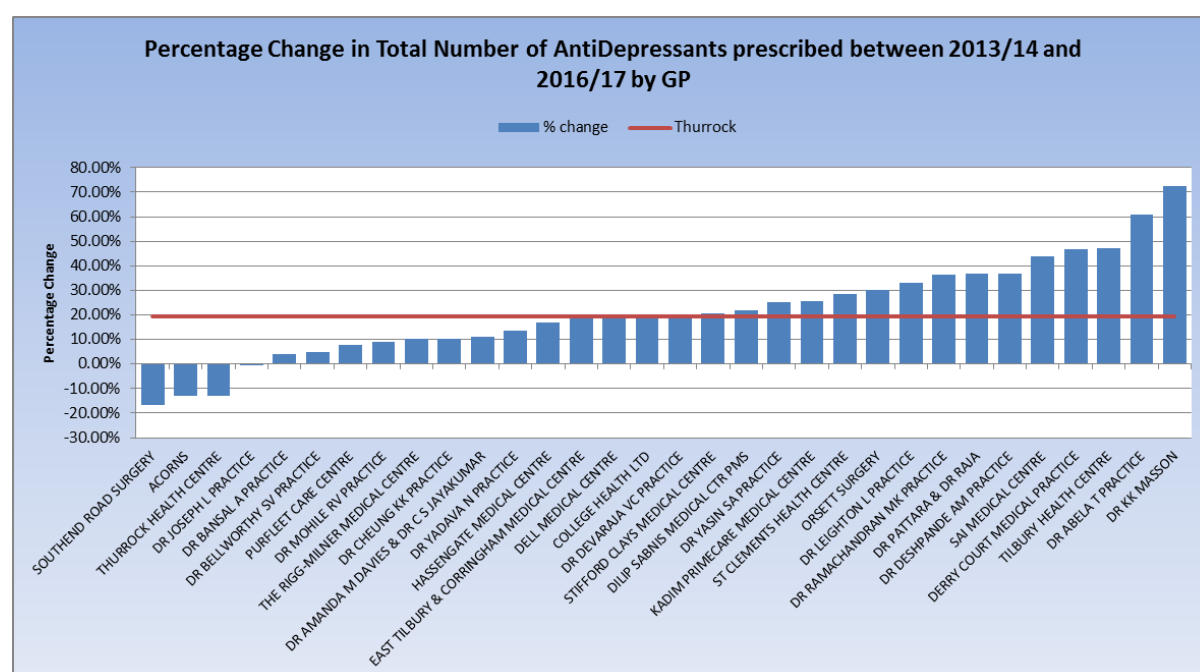
Figure 41: Percentage change in prescribing cost for antidepressants, 2013/14 - 2016/17 by GP.



Source: ePACT

There is also a large amount of variation in the percentage change in items from 2013/14 to 2016/17 at practice level – ranging from a 72% increase (KK Masson) to a 17% decrease (Southend Road Surgery).

Figure 42: Percentage change in prescribing for antidepressant items, 2013/14 - 2016/17 by GP.



Source: ePACT

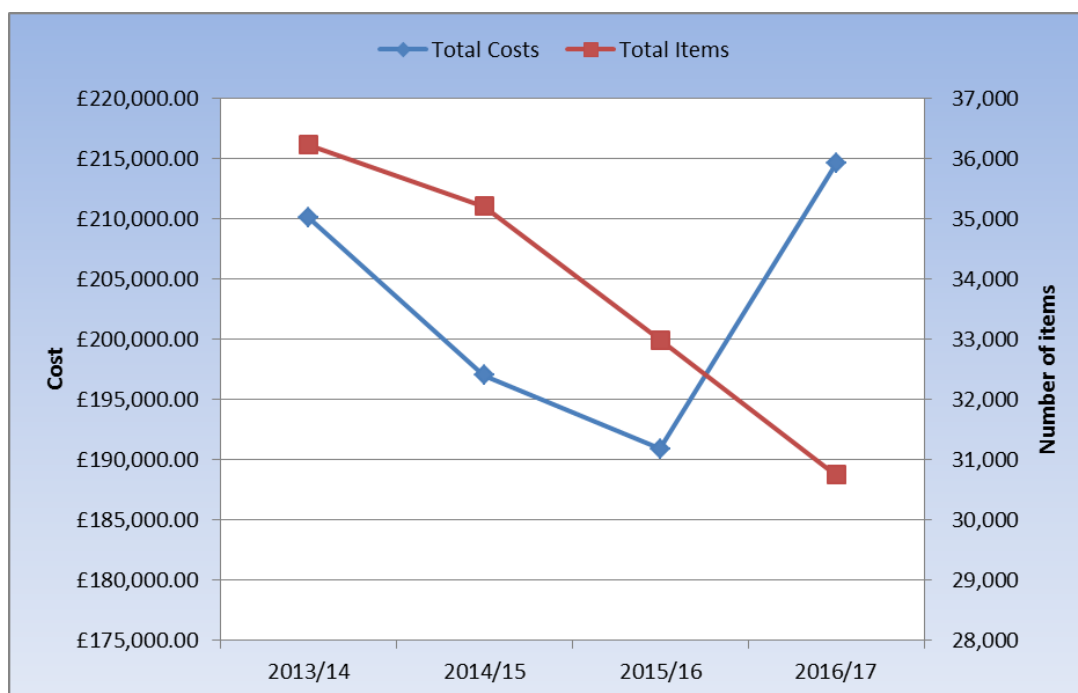
The variation in prescribing patterns could be due to a number of things. As mentioned at the start of this section, antidepressants can be prescribed for a variety of indications, including mixed diagnoses of mental health conditions or other conditions such as pain. There might be differences in the practice depression register size, levels of deprivation per area – we would expect to see larger depression registers in more deprived areas. GPs might also have different prescribing preference or choose to use other services such as IAPT before prescribing antidepressants, depending on whether patients are presenting with mild or moderate to severe depression.

## Hypnotics

Over the last four years, the main trend for the prescribing of hypnotic drugs was a reduction in total costs and total items prescribed. However, between 2015/16 and 2016/17, there was an increase in total costs, which went from just over £190,000 to around £215,000, an increase of £25,000 in a year. However, overall, there has been a decrease in the number of hypnotics by 15% over the last four years. Therefore, the likely explanation is that a smaller number of more expensive hypnotics have been prescribed by GP practices in the last year.



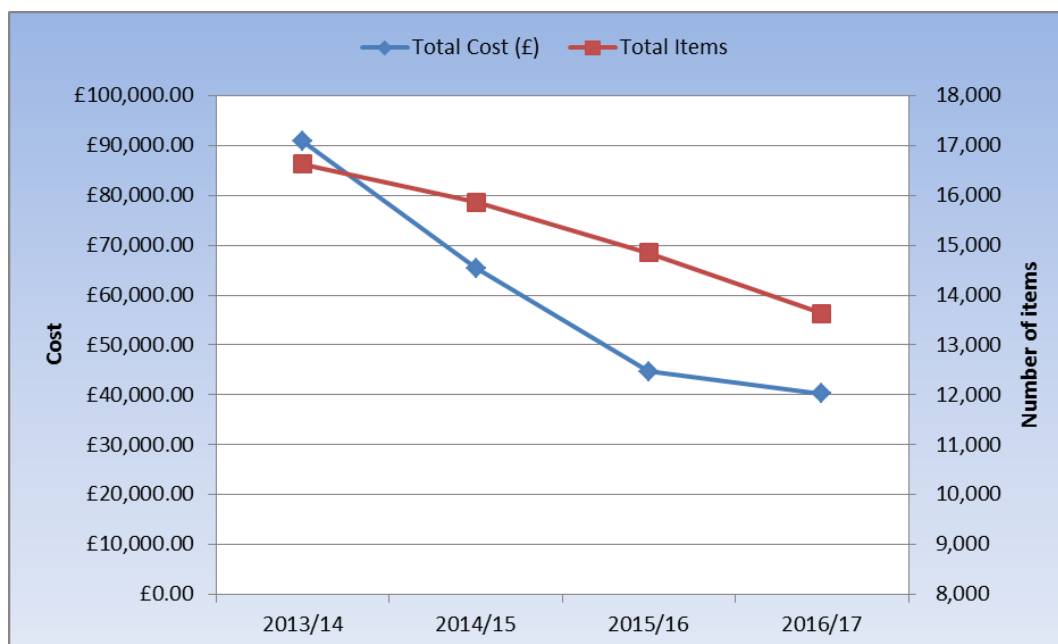
Figure 43: Total Cost and number of items prescribed for hypnotics, 2013/14 - 2016/17.



### Benzodiazepines

The trend seen in the prescribing of benzodiazepines over the four year period is that there has been a reduction in the total costs and items prescribed.

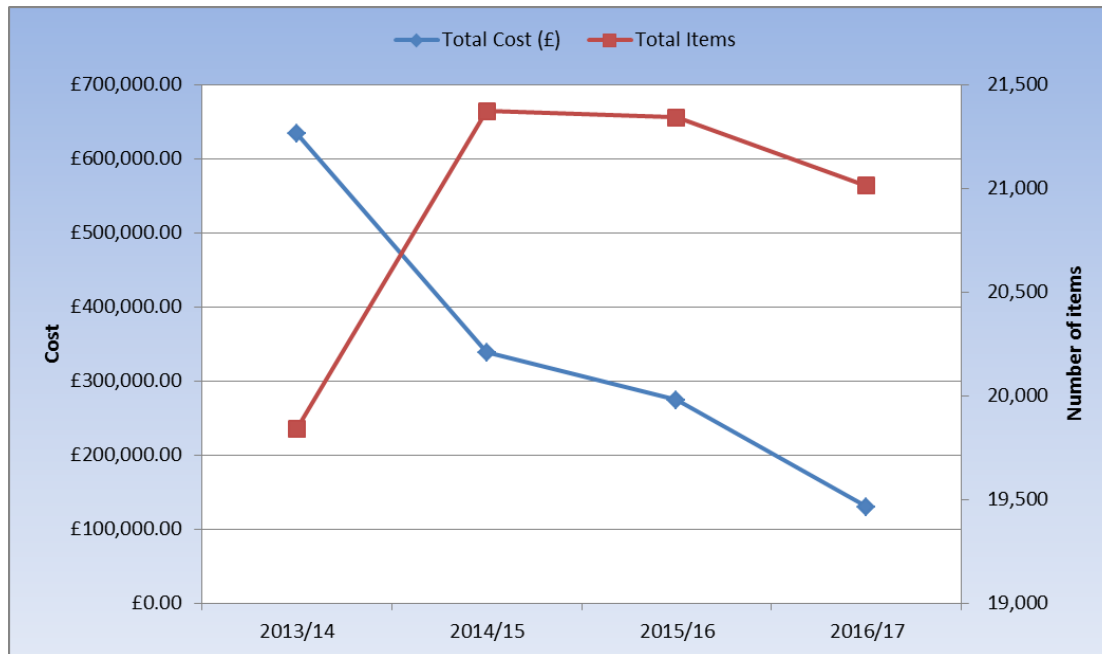
Figure 44: Total Cost and number of items of benzodiazepines prescribed, 2013/14 - 2016/17.



### Drugs for treatment of Serious Mental Illness (SMI) - Antipsychotics

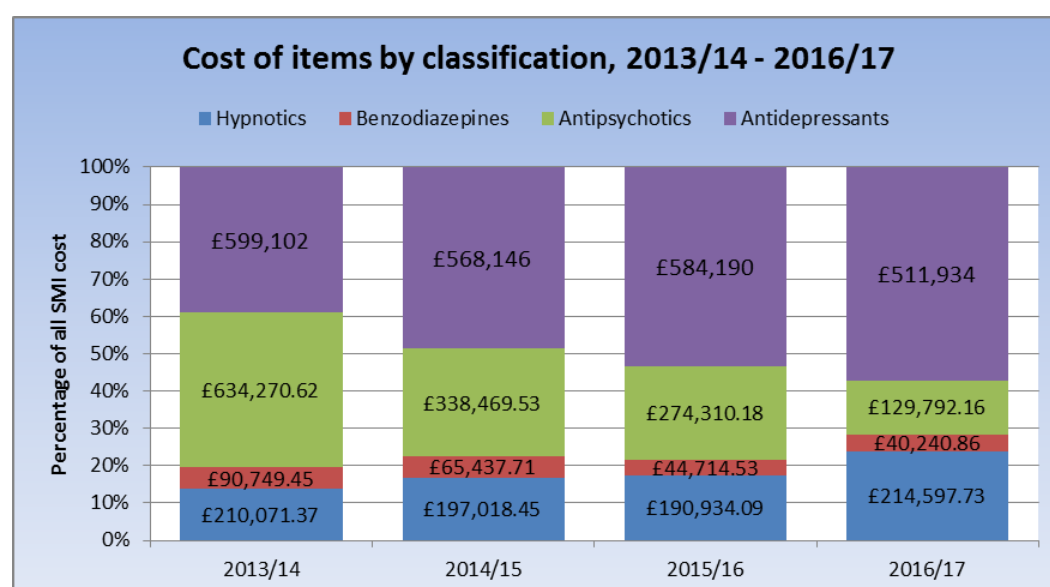
Over the last four years it can be seen that whilst the number of antipsychotic items has increased and then levelled off, the cost of these items has decreased, potentially due to a combination of the reasons described above.

**Figure 45: Total Cost and number of items prescribed for SMI, 2013/14 - 2016/17.**



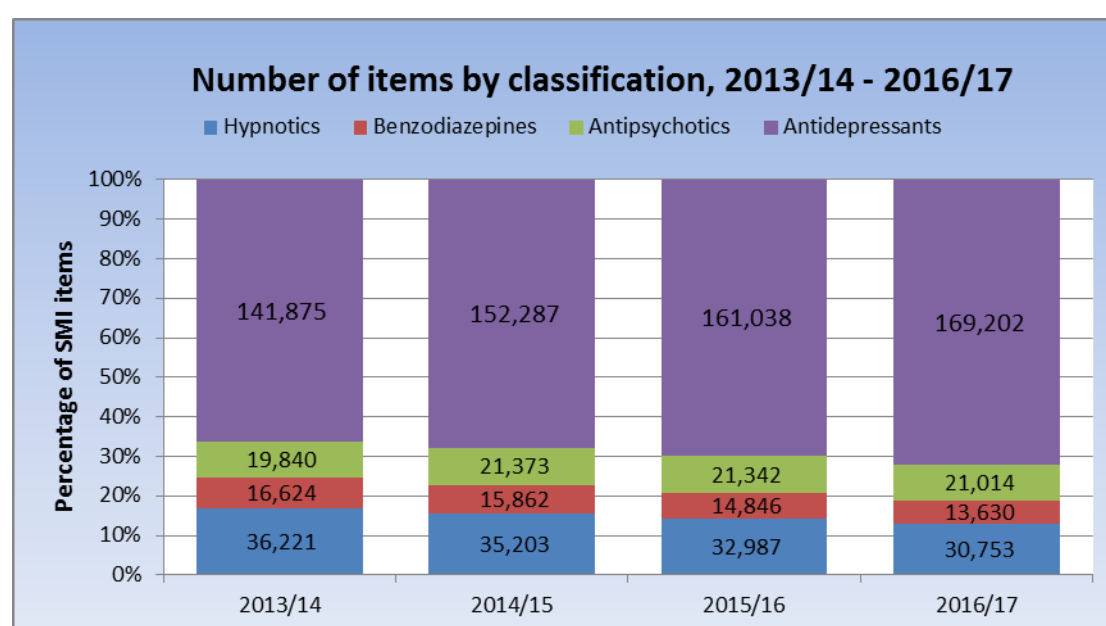
Source: ePACT

Figure 46: Total cost of items prescribed of mental health drugs by category and year 2013/14-2016/17.



Source: ePACT

Figure 47: Total number of items prescribed for SMI by category and year 2013/14-2016/17.



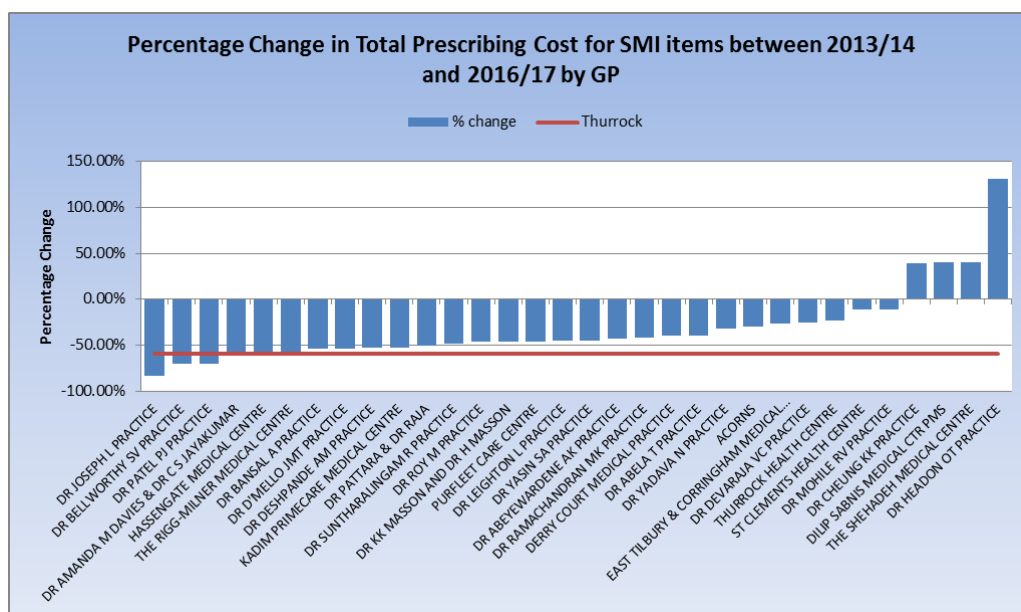
Source: ePACT

Analyses of the percentage change between 2013/14 and 2016/17 for both cost and number of items indicate some variation at GP practice level. In terms of cost, whilst the Thurrock total percentage change was a 59% decrease, the average of the 32 GP practices is actually a 31.64% - the difference is due to a large reduction in costs associated with the Walk In Centre which closed between these two periods but which is not shown on the charts below. It can be seen that the majority of GP practices reduced their prescribing costs, with the exception of four. The practice

with a largest increase was Dr Headon (131.43%), and the practice with the largest percentage decrease was Dr Joseph (83.61%).

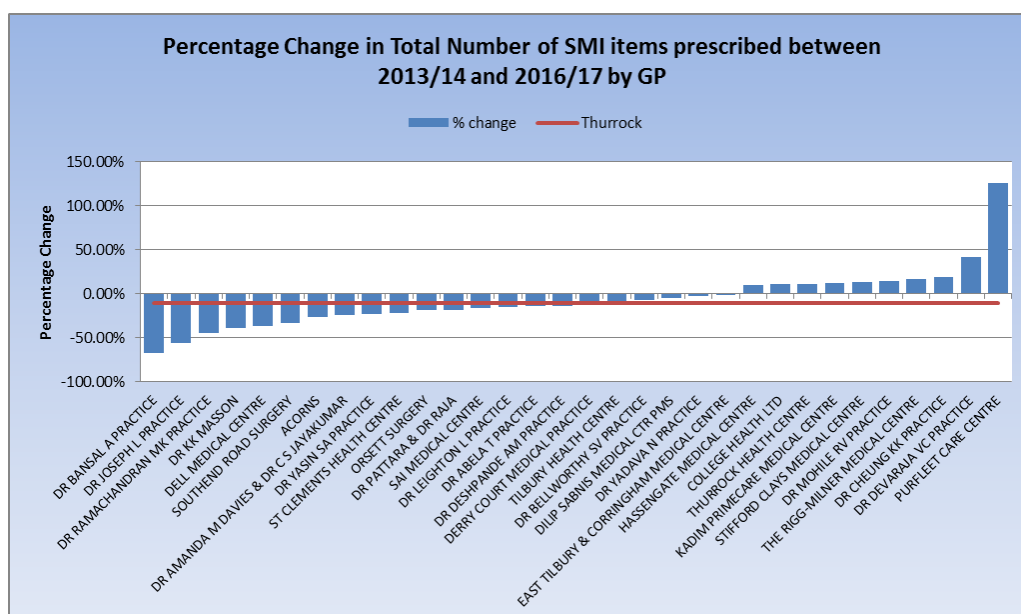
Whilst the total percentage change for Thurrock for items prescribed was 10%, this ranges from a 68% decrease (Dr Bansal) to a 126% increase at Purfleet Care Centre. These are illustrated in the two charts below.

**Figure 48: Percentage change in total prescribing cost for SMI items between 2013/14 and 2016/17 by GP.**



Source: ePACT

**Figure 49: Percentage change in total number of SMI items prescribed between 2013/14 and 2016/17 by GP.**

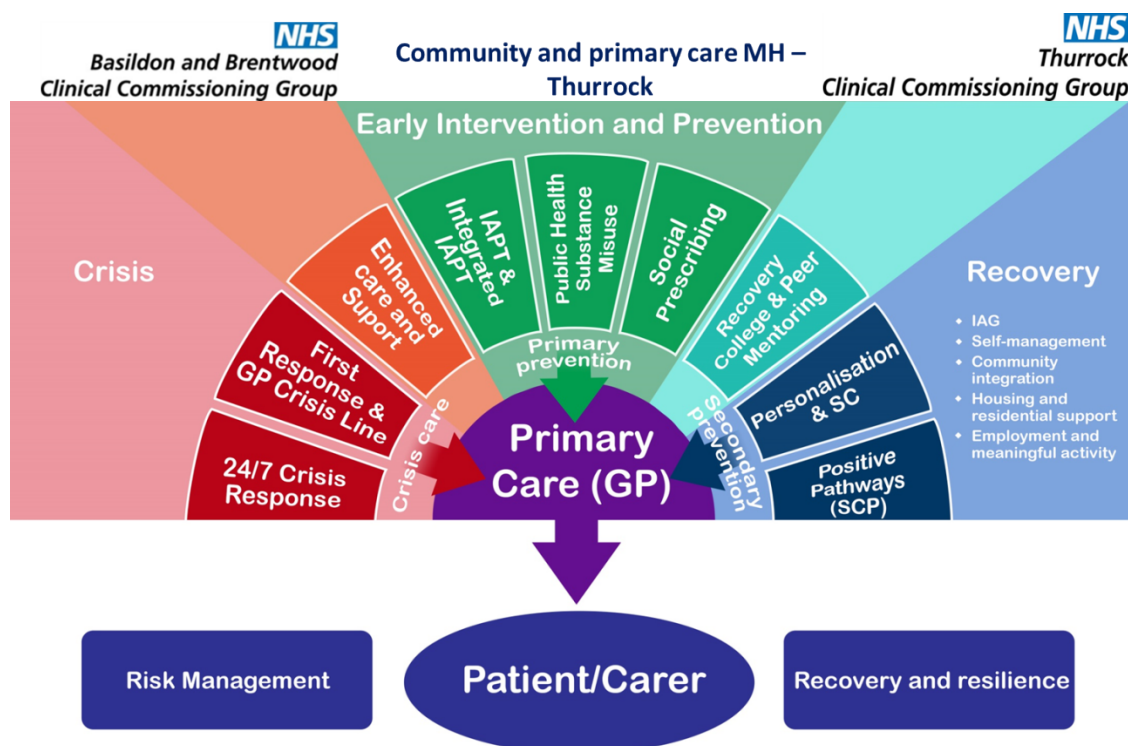


Source: ePACT

## 6.5 Integrating primary and community services

The sections below detail ways in which the current primary care system treats and manages mental illness. It is important to note, however, that work to integrate services is currently underway which means that the service landscape is likely to change rapidly over the next year or two. Working closely with a neighbouring CCG and with Thurrock's public health team, Thurrock CCG have developed a vision for integrating community and primary mental health care in Thurrock. This is set out below in Figure 50.

Figure 50. Thurrock Mental Health Transformation: Integrated Community and Primary Care



A clinical leadership and oversight group has been set up bringing together key clinicians and in primary and community services with commissioners from the CCG and local authority to drive this integration agenda. The aims of the group are to:

- Improve urgent and emergency care
- Integrate social, mental and physical health providing care closer to home
- Promoting good mental health and preventing poor mental health

## 6.6 Recommendations

### General Practice

Significant opportunities to improve the quality of care and management of mental health conditions in General Practice have been identified in this report. Improving these areas will require changes in clinical practice in primary care, supported by the CCG and public health teams.

- There is strong evidence that after starting patients on anti-depressant treatment, GP practices are often not carrying out a patient review within the timeframe set out in the QOF guidelines (10 – 56 days). This is a significant opportunity to improve the management of depression in primary care. This has been included as part of practice profile cards and public health needs to work with practices to audit and review patients in a timely way.
- Review those on the SMI QOF register and ensure that their records are up to date and action taken where necessary e.g. recommending smoking cessation and referring into exercise and other lifestyle services.
- Greater use of depression screening of high risk groups in primary care would to identify some of those who are currently undiagnosed.

### Prescribing

- The CCG medicines management team should continue to ensure that mental health prescribing is appropriate and according to NICE guidance in primary care:
- The CCG medicines management team and practice pharmacist should audit patient databases in GP practices with a view of adding patients to QOF registers appropriately and also auditing medicines use e.g. for antidepressant drugs.
- The increase in the costs and volumes of mental health drugs is likely to continue to increase. These should be monitored against expected levels of SMI and/or other mental ill health so that the prescribing of the right drugs in appropriate volumes continue across primary care in Thurrock.
- The variable prescribing practices between GP practices must be monitored by the medicines management team, where the practice is not due to numbers on the QOF depression register alone.

## 7 What services are provided for those with mental illness?

### Secondary Care

#### 7.1 Accident and Emergency Data - The National Context

There is an increasing gap between needs of mental health patients with complex problems and community resources accessible to these patients. Consequently, these unmet needs result in an increasing number of individuals repeatedly using a considerable number of mental health resources, especially emergency visits (Kalucy et al, 2005).

The demographic profile of patients who use A&E departments has remained relatively stable when compared to previous years. In 2015-16, there were approximately 20.5 million A&E attendances recorded in the UK, with 49.2% (10.1 million) male and 49.9% (10.2 million) female attendances. Attendances from April to December increased by 2.2% from 14.9 million in 2014-15 to 15.2 million in 2015-16. Attendances from January to March increased by 12.2% from 4.6million in 2014-15 to 5.2million in 2015-16 (HSCIC, 2017).

Studies have shown that those who are young, unemployed, males, living in transient accommodations, and having a psychiatric disorder, are more likely to use emergency departments (Vandyk et al, 2013; Meng et al, 2017). Studies have also consistently shown that substance abuse and other mental health problems are significantly associated with emergency room visits (Fahimi et al, 2015; Brenda et al, 2011; Vu et al, 2015).

Deprivation is strongly associated with emergency care use. In 2013/14, the most deprived people with mental ill health visited A&E 1.8 times more than the least deprived and had 1.5 times more emergency inpatient admissions (Dorning et al, 2015).

The HSCIC (2013) reports users of mental health services were twice as likely to have attended A&E more than non-users. They were also likely to attend more frequently. For common inpatient procedures, people with mental ill health were more likely to have an emergency admission rather than a planned one, stay longer in hospital and be admitted overnight (Dorning et al, 2015). Similarly, people with chronic physical conditions and mental illness are more likely to use emergency services and have higher total, outpatient, and pharmaceutical expenditures than those without mental illness (Shen et al, 2008).

**Table 7: Attendance by Mental Health service users (aged 18+), 2012-13.**

Patients who accessed A&E services at least once 2012/13	Average number of A&E attendances per patient	Percentage accessing A&E services (at least once)
All Patients	1.56	21.3%
Non-MH Service users	1.49	20.6%
MH Service users	2.43	43.1%

Source: HSCIC, 2013

People with mental ill health had 3.6 times more potentially preventable emergency admissions than those without mental ill health in 2013/14. Visiting A&E or having an emergency admission

can be distressing for patients and carers, is associated with a greater risk of mortality and longer-term morbidity, and is expensive to the healthcare system (Blunt, 2014). People with mental health problems using more emergency care than people without are particularly troubling given the poor healthcare outcome of people with mental health problems.

Preventing emergency admissions for people with mental health problems could improve the quality of care, reduce the amount of distressing unplanned care for the patient, and provide potential cost savings. Moreover, providing appropriate primary or community care to this group could result in further improvements. (Dorning et al, 2015).

Improving Access to Psychological Therapies (IAPT), principally the provision of brief interventions and access to cognitive behavioural therapy, has been provided by the NHS in England (Clark et al, 2009). Research shows that IAPT may have a role in helping to reduce attendances at A&E departments. Referral of people with long term conditions and common mental health problems to an IAPT service was associated with increased antidepressant medication and less use of the emergency departments (de Lusignan et al, 2011; 2013).

## 7.2 Early Intervention in Psychosis (EIP)

### Key Points:

- From 1 April 2016 more than 50% of people experiencing first episode psychosis (FEP) should be treated with a NICE-approved care package within two weeks of referral
- The current cost of psychosis to society is estimated to be £11.8 billion per year
- EIP services have demonstrated that they can significantly reduce the rate of relapse, risk of suicide and number of hospital admissions. They are cost-effective and improve employment, education and wellbeing outcomes.
- There are 8 NICE Quality Standards that should be followed to measure the quality of for EIP services
- Currently, none of the NICE Quality Standards (which take the holistic view of the patient into consideration using care co-ordination) are being reported from the EIP service provider.

The access and waiting time standard for early intervention in psychosis (EIP) services requires that, from 1 April 2016 more than 50% of people experiencing first episode psychosis (FEP) would be treated with a NICE-approved care package within two weeks of referral. The standard is targeted at people aged 14-65.

There are significant personal, social and health impacts of psychosis when treatment and support is not effective. The cost of not intervening early can often be poor health outcomes and lengthy, costly use of mental health services. The current cost of psychosis to society is estimated to be £11.8 billion per year resulting from direct healthcare costs, lost productivity due to unemployment or death and informal costs to families and carers. EIP services have demonstrated that they can significantly reduce the rate of relapse, risk of suicide and number of hospital admissions. They are cost-effective and improve employment, education and wellbeing outcomes.



Despite this, in recent years, there has been evidence of disinvestment in EIP services including the absorption of some EIP services into generic community mental health services, with consequent impact on the timeliness, quality and effectiveness of treatment. We know that currently far too few individuals experiencing or at high risk of first episode psychosis are receiving the ‘right care’ at the ‘right time’ and there can be very long delays in accessing some of the key effective interventions recommended by NICE. For example, only 10% of those with schizophrenia who could benefit from services receive appropriate psychological treatment<sup>7</sup> and only 33% receive recommended physical health checks. These poor levels of access and long waits are unacceptable both in terms of quality of care and effective use of NHS resources.

NHS England commissioned NICE to oversee delivery of an enabling programme of work to support the development and implementation of evidence-based treatment pathways in mental health, including the introduction of access and waiting time standards. NICE commissioned the National Collaborating Centre for Mental Health (NCCMH) to develop this guide.

**Table 8: NICE Quality Standards for Early Intervention in Psychosis (NICE QS80).**

<b>Quality Statements</b>	<b>Action (in adults)</b>
Maximum waiting time from referral to treatment	Adults with FEP start treatment in EIP services within 2 weeks of referral
Psychological therapy	Adults with psychosis or schizophrenia are offered cognitive behavioural therapy for psychosis (CBTp)
Psychological therapy	Family members of adults with psychosis are offered family intervention
Medicines management	Adults with schizophrenia that has not responded adequately to treatment with at least two antipsychotic drugs are offered clozapine.
Education, Employment and Training	Adults with psychosis or schizophrenia who wish to find or return to work are offered supported employment programmes.
Physical health and healthy lifestyles	Adults with psychosis or schizophrenia have specific comprehensive physical health assessments.
Physical health and healthy lifestyles	Adults with psychosis or schizophrenia are offered combined healthy eating and physical activity programmes, and help to stop smoking.
Support for Carers and families	Carers of adults with psychosis or schizophrenia are offered carer-focused education and support programmes.

Source: NICE Psychosis and Schizophrenia in Adults, Feb 2015

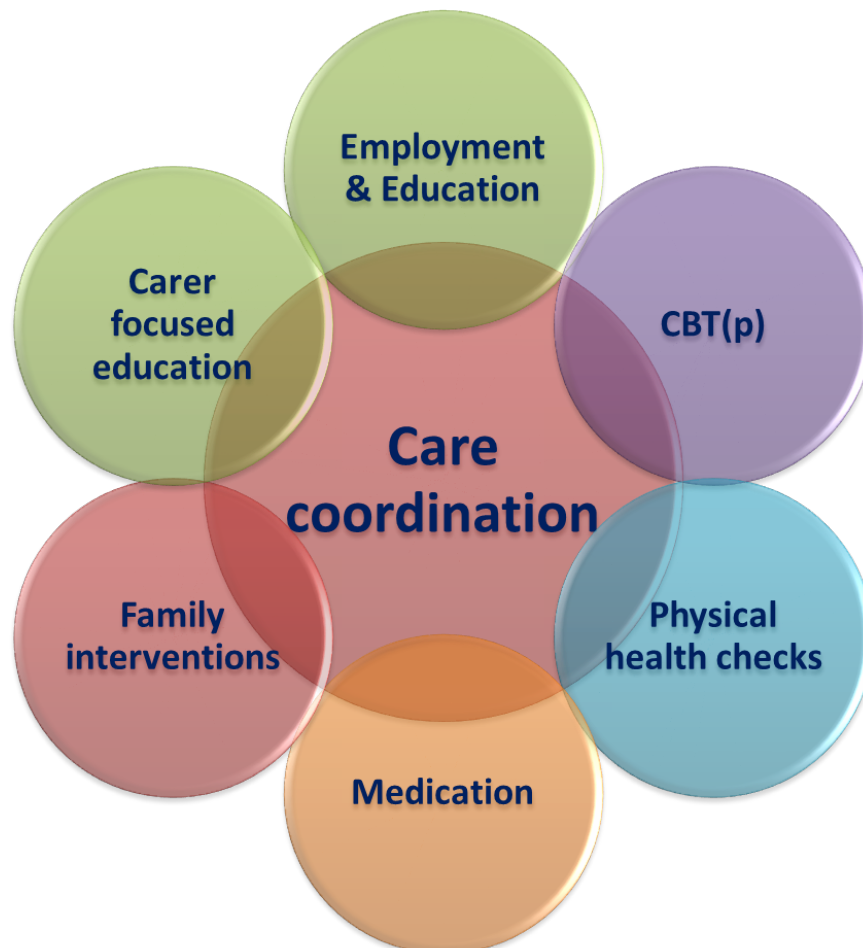
### **Provider Performance against NICE Quality Statements in Thurrock:**

It is recommended that adults with FEP start treatment in EIP services within 2 weeks of referral; the current target is 50% and is due to increase to 60% by 2021. Currently, this is reported in Thurrock

as 0%. The rationale behind this is stated as: the Trust is not commissioned / funded to provide a NICE recommended package (Vocational programmes not funded and carer focused education not funded but covered where possible by Care Coordinators).

For all of the other NICE Quality statements listed above, the provider does not collect the data and therefore there is no evidence that the statements are being adhered to by the Provider in Thurrock.

**Figure 51: Case Management and Care Co-ordination:**



Source: NICE guidance and Thurrock CCG, 2017

Case management is a process of planning, coordinating and reviewing care around the individual. It refers to a package of care which covers a range of activities that can vary widely between different programmes.

**Core Components include:**

**Case finding:** E.g using predictive modelling / Integrated datasets, combined with clinical judgement.

**Assessment:** In terms of current level of ability and physical, mental and social care needs. This must be holistic.

**Care planning:** Addressing an individual's full range of needs, taking into account their health, personal, social, economic, educational, MH and cultural/ethnic circumstances. Recognises needs

are wider than medical and should include housing. Care plan should result that supports the case manager in providing a structure to the individual's care and ensure the goals of all the different services are aligned and monitor progress. It is a live document.

**Care coordination** (usually undertaken by a case manager in the context of a multi-disciplinary team) including but not limited to:

- Medication Management
- Self-care support
- Advocacy and negotiation
- Psycho-social support
- Monitoring and review

**Case closure** (e.g. When recovery is achieved)

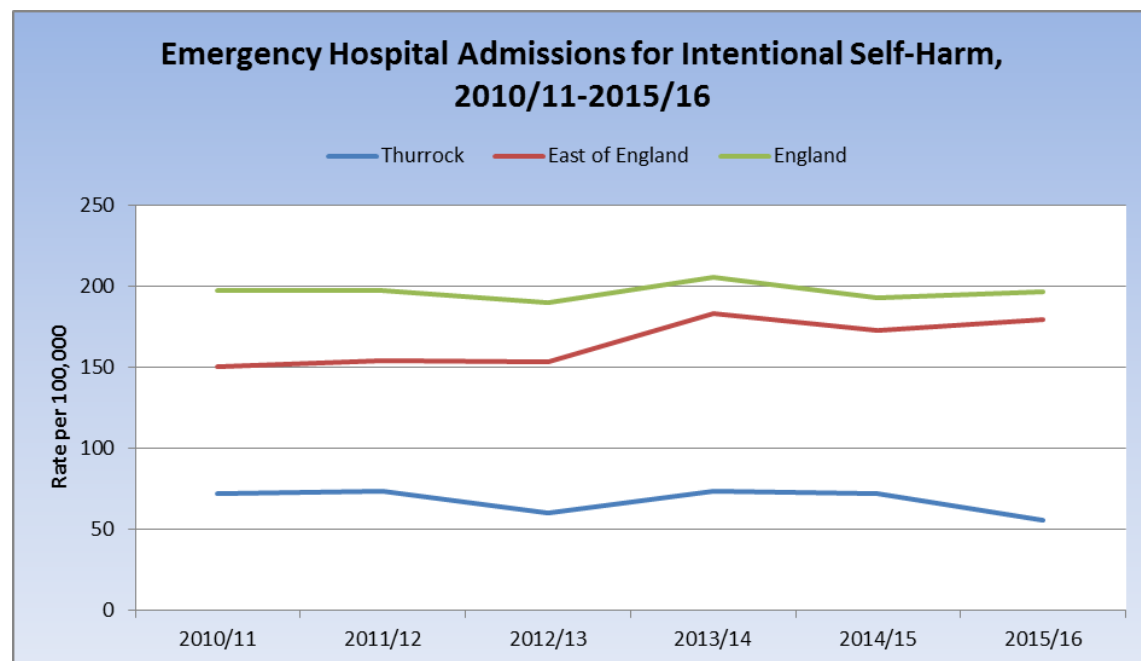
### 7.3 Emergency Hospital Admission and Self-harm

#### Key Points

- Hospital admissions due to self-harm are low in Thurrock
- This is most likely due to poor coding practices
- More needs to be done with secondary care colleagues to make sure that the true picture of self-harm in Thurrock is being accurately captured.
- Hospital A&E attendance data should be gathered and analysed when available

Emergency Admission data show that there is a data coding issue around self-harm and intentional poisoning. Of the almost 12,000 emergency admissions there are none that have a primary diagnosis code of X65-X84 which are the codes for self-harm and intentional poisoning. There are only a few that are recorded with this as a secondary diagnosis (around 15).

Figure 52: Emergency hospital admissions for intentional self-harm, 2010/11-2015/16.



Thurrock is consistently coded as having low rates of admissions for intentional self-harm. Taking the chart above at face value, it would appear that Thurrock does not have an issue, with rates consistently below the regional and national averages. However, this does not mean that we don't have a problem in Thurrock. It is clear that we have a coding issue in Thurrock where self-harm attempts leading to hospitalisation are not well recorded. More work needs to be done with colleagues in secondary care to ensure that coding is done correctly, so that the problem of self-harm can be accurately described and appropriate interventions recommended.

## 7.4 Recommendations

- The Provider must become NICE compliant as soon as possible.
- The Provider must review their workforce to make sure they can address the physical health and healthy lifestyle issues that patients might have.
- The CCG mental health commissioner should work more closely with BTUH to understand the limitations of coding data by following patient journey through A&E and admissions by their coding data.
- The CC mental health commissioner should be working closely with BTUH to look at re-admission rates (frequent flyers) to determine what can be done to reduce these rates.
- The CCG commissioner should be working more closely with patients and their carers to understand why they attend A&E services rather than other available mental health services. This can be done by completing questionnaires and organising focus groups to gather qualitative data.
- More secondary care data should be collected and analysed so we have more information about the epidemiology of those with a CMHD who access secondary care in Thurrock. This might be possible using Mede analytics data.
- More work should be done with secondary care colleagues to identify and code appropriately those who self-harm as this group is very high risk of CMHDs, and especially for self-harm and suicide. This can be done by:
  - Working with Mede analytics to analyse available data on the characteristics of those who attend A&E for mental health disorders.
  - Working with BTUH to improve smoke-free services in the acute trust by removing smoking shelters and replacing with evidence based best practice e.g. e-cigarette stations such as done in the Maudsley Hospital (SLAM) in London.

## 8 What services are provided for those with mental illness? Social Care

Users of social care services are generally at high risk of having poor mental health. As explored above, there are strong links between the social and physical health problems which lead people to need social care support and mental illness.

### 8.1 Depression screening in Adult Social Care via social care workers

Depression screening involves the use of a standardised depression questionnaire to identify those who have (or are likely to have) depression, allowing them to be referred into treatment services. This is approved by the National Institute for Health and Care Excellence (NICE) as an effective, evidence-based intervention. Adult social care clients are known to be at high risk of depression. This can interact with physical health needs (See Section 5) and, therefore, increase their need for social care. There is also evidence that depression frequently goes undiagnosed among social care clients. Depression screening by social care workers, therefore, has the potential therefore, not only to improve the mental health of some of the most vulnerable adults in the community, but also to have a positive effect on their physical health and social care needs. For example, identifying and treating depression more systematically and earlier in social care clients is likely to delay admission to residential care for some clients and result in cost savings.

Depression screening is included as one of the Health and Wellbeing Strategy objectives for Thurrock under Goal C: Better emotional health and wellbeing. The specific objective is: "Identification and treatment depression will be improved, particularly for those at greatest risk." The action associated with the objective is to: "Increase % of ASC clients over 65 screened for depression by frontline Thurrock Council social care staff."

Depression screening of appropriate social care clients began as a pilot in July 2016. A mid-pilot evaluation was carried out in autumn 2016. It identified issues that social care staff were coming across as they undertook depression screening and aimed to resolve these issues. The pilot ended in March 2017 and depression screening continues to be recommended as an evidence based intervention that is effective in improving outcomes for the target population.

At present, however, there is no systematic monitoring of the implementation of this intervention so it is unclear how widespread its use is.

**Recommendation:** That the extent of depression screening in adult social care be systematically monitored with feedback to social care managers. Monitoring could involve collecting data on referrals into IAPT from adult social care and/or data being collected by the adult social care system. It is recommended that the Mental Health Operational Group consider the best way of monitoring this objective.

### 8.2 Adult Social Care Data Analysis

In 2015-16, there were a total of 9,958 packages provided to 2,492 clients aged 18+ in Thurrock. The majority of the clients were in the 78-87yrs (703) and 88-97yrs (687) age bands, which accounted for over 50% of the total client count.

There were 15 service level categories (packages), further broken down by 9 primary support reasons (shown in

Table 9 below). The total cost of packages provided in 2015/16 was £37,097,751. With the exclusion of five ASC packages with £0 cost attribution (equipment, residential short break, carers service,

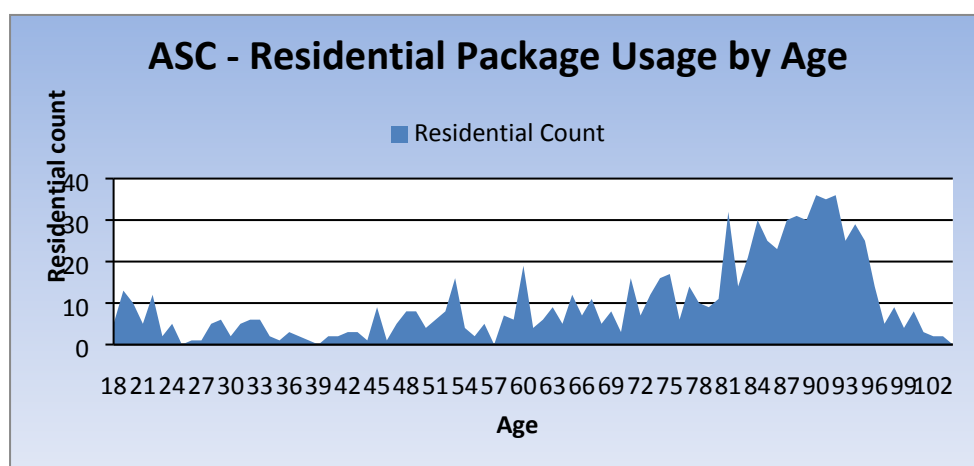
meals on wheels and field work), the top two highest spend was for residential and homecare packages (£21,541,631 and £5, 851,032 respectively).

Looking at spend in terms of primary support reason, the top two highest spend were on personal care support and learning disability support (£11,845,317 and £13,775,107 respectively), followed by mental health support with a total spend of £3,755,206.

**Table 9: Number of ASC Packages (Service Level Category) and Primary Support Reason.**

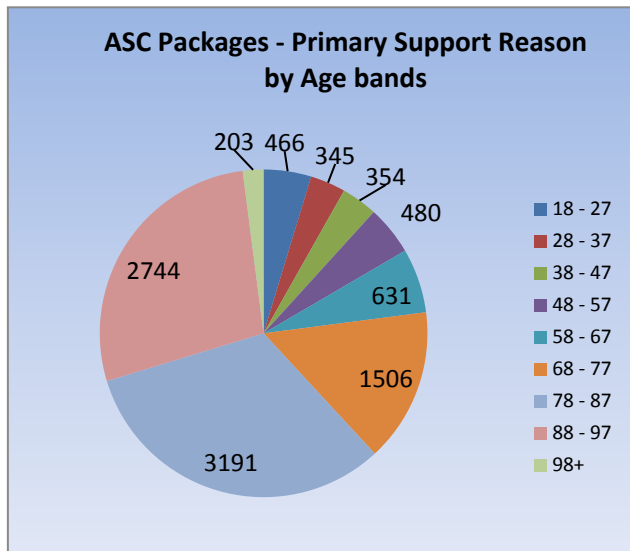
Service Level Category	Number	Primary Support Reason	Number
Homecare	3362	Physical Support - Personal Care Support	4901
Equipment	2688	Physical Support - Access and Mobility Only	1789
Residential	869	Support with Memory and Cognition	1160
Direct Payment	713	Learning Disability Support	1136
Supported Living	508	Mental Health Support	566
Residential Short Break	579	Social Support - Support for Social Isolation /	228
Transport	311	Other	
Day care	320	Sensory Support - Support for Visual	79
Carers service	84	Impairment	
Meals on Wheels	248	Sensory Support - Support for Hearing	41
Intermediate care	177	Impairment	
Nursing	76	Sensory Support - Support for Dual Impairment	15
Fieldwork	6	Social Support - Substance Misuse Support	4
Extracare	9	Social Support - Support to Carer	1
Interpreter	7		
Misc.	1		
TOTAL	9,958		9,920

**Figure 53: ASC Residential Package Usage by Age.**



Of the total ASC package spend in 2015/16; residential packages accounted for 58.1% of the total spend. A breakdown of the residential package usage by age, (Figure 54) showed that clients within the ages of 81-95years had the highest residential package usage.

**Figure 54: ASC Package - Age bands usage by primary support reason.**



As shown in Figure 54, the three highest users of ASC packages by primary support reasons are clients in the 78-87years (3191), 88-97years (2744), and 68-77years (1506) age bands. Further breakdown by Mental Health Support as the primary support reason, also reflects the highest usage by the three age bands identified above.

The chart below shows that 11.2% of those in the 68-77years age bands are accessing ASC packages primarily for Mental Health support whilst less than 10% of those in all other age bands are accessing ASC packages for mental health support.

**Figure 55: ASC Package - Age Bands Usage by Mental Health Support.**

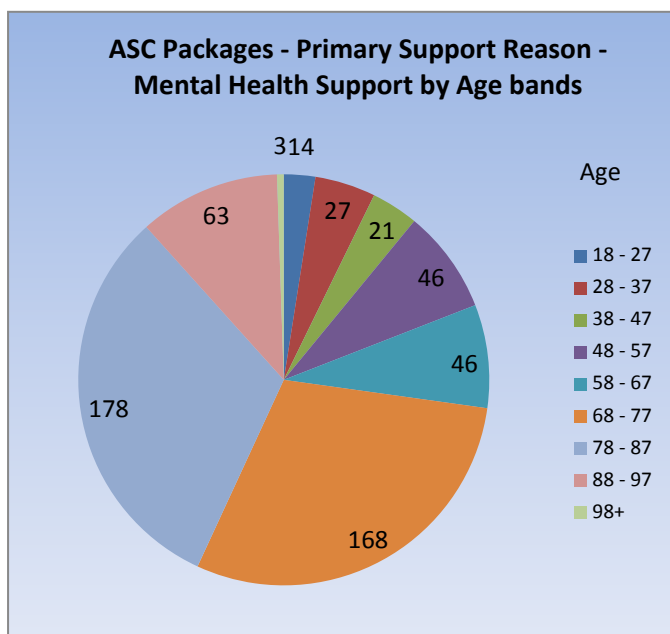
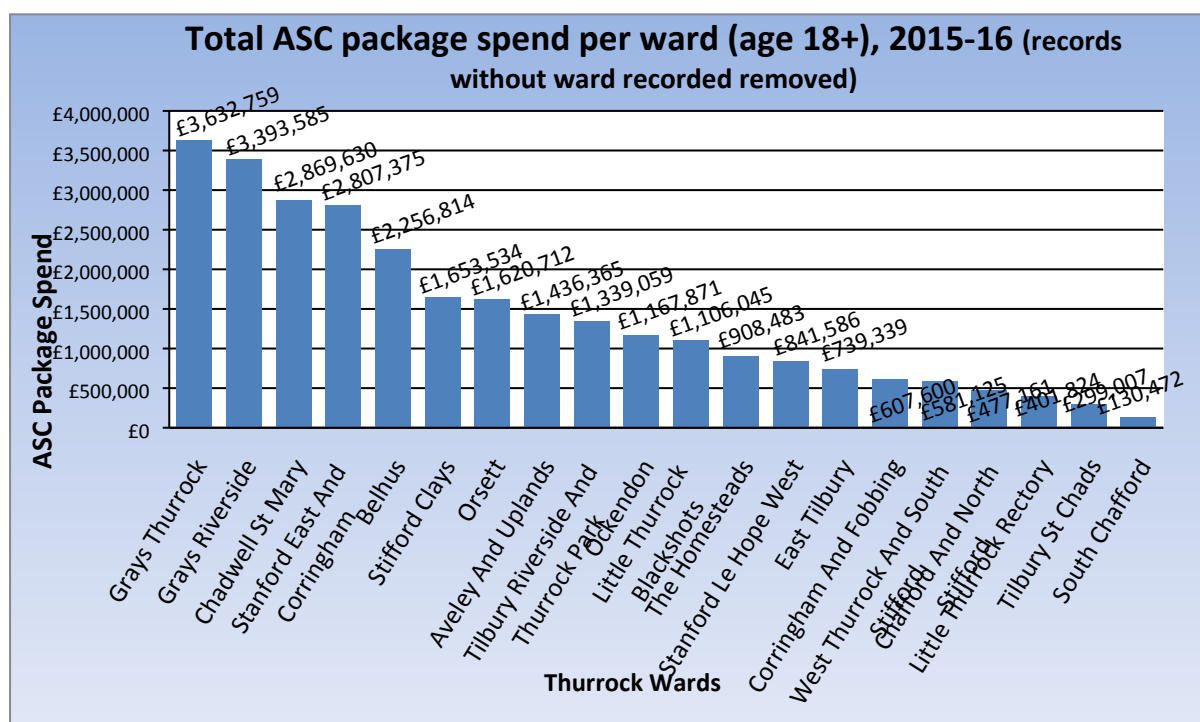
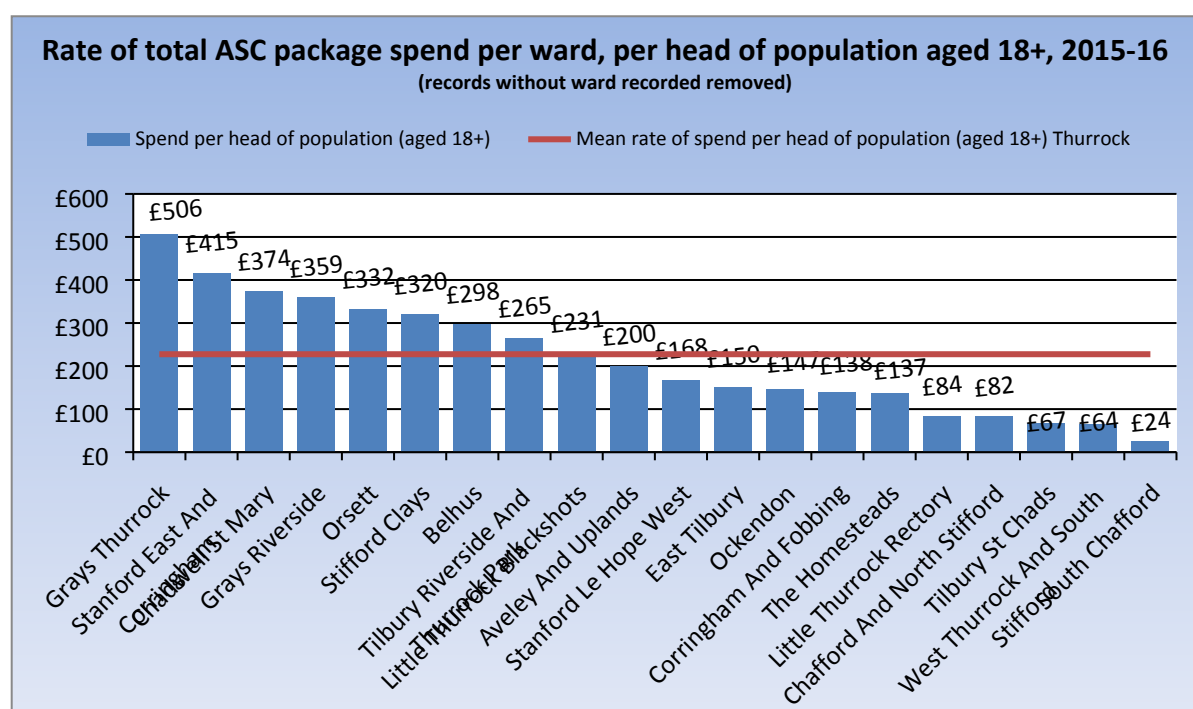


Figure 56: ASC Package spend by Thurrock wards 2015/16.



The figure above (Figure 56) shows ASC package spends by wards in Thurrock. ASC package spend varied widely within the Thurrock Wards, the highest spend was recorded for Grays Thurrock and Grays Riverside (£3,632,759 and £3,393,585 respectively) and the lowest spend for South Chafford and Tilbury St Chads (£130,472 and £299,007 respectively).

Figure 57: Rate of total ASC package spend per ward, per head of population (aged 18+), 2015-16.

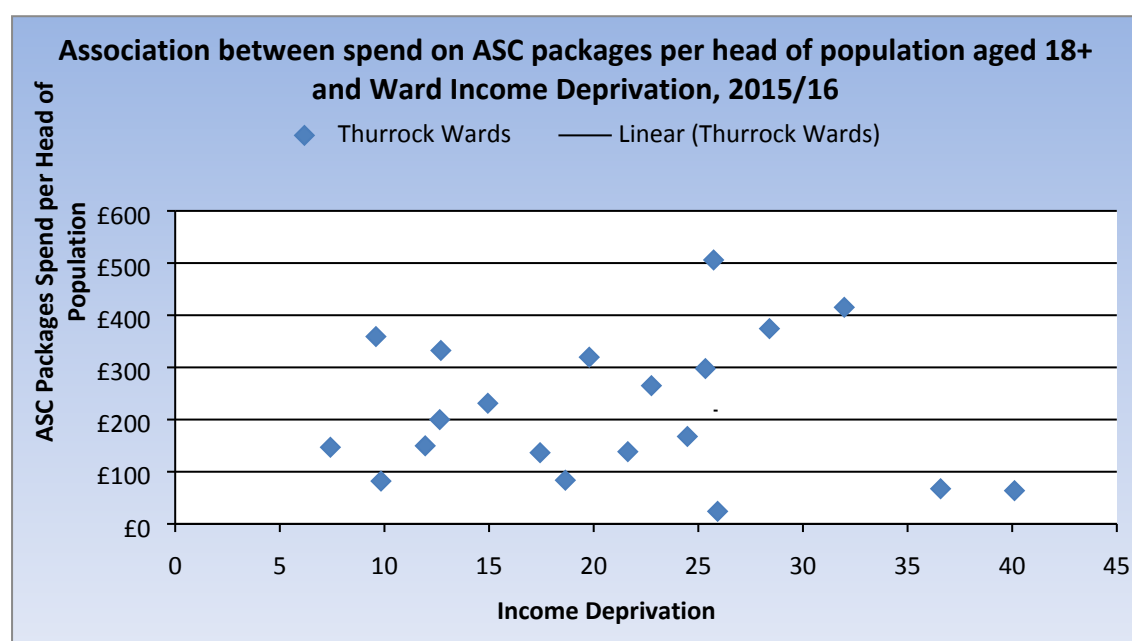




As shown in Figure 57 above, the Thurrock mean rate of ASC spend per head of population aged 18+ was £228, however Grays Thurrock (£506) and Grays Riverside (£425) had the highest rate per head, with the lowest rates recorded for South Chafford (£24) and Tilbury St Chads (£64).

Further analysis to explore an association between ward spend on ASC packages per head of population and ward income deprivation (Figure 58), showed there was no association ( $R^2 = 0.0001$ ).

**Figure 58: Association between spend on ASC packages per head of population (aged 18+) and ward income deprivation, 2015-16.**



### 8.3 Demographics of Social Care Clients

Social care data show that there are currently 4376 clients accessing social care for services and care packages. Of the 4376, there are 280 (6%) individuals whose primary reason for accessing social care services is recorded as being due to mental health issues.

**Table 10: Gender of all clients accessing social care, 2016.**

Gender	Numbers	Proportions
Males	1519	35%
Females	2856	65%
Unknown	1	0%
Total	4376	100%

Source: Social Care Team, TC 2016

The table above shows that there roughly a third of males (35%) and two thirds of females (65%) accessing social care packages.

The range of start dates on these packages range from March 1993 to March 2016.

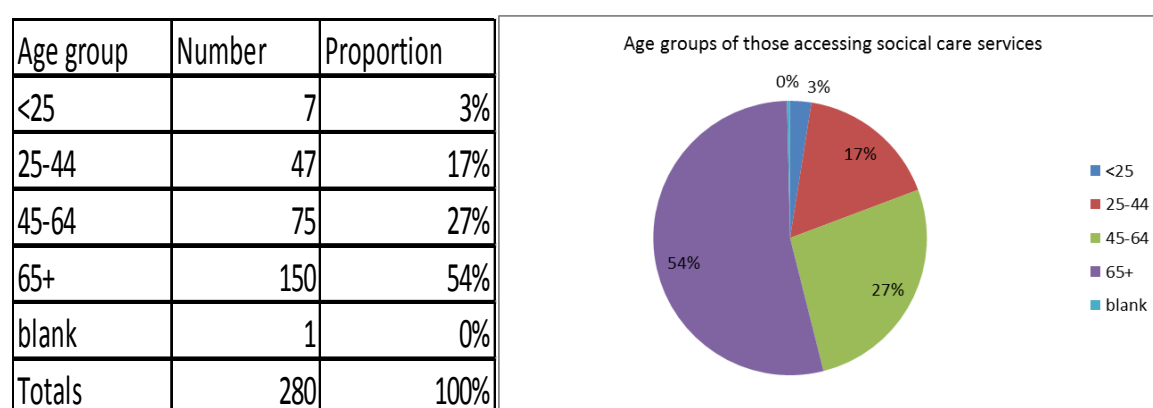
**Table 11: Gender of those clients accessing social care due to mental health reasons, 2016.**

Gender	Numbers	Proportions
Males	126	45%
Females	154	55%
Totals	280	100%

Source: Social Care Team, TC 2016

We can see from Table 11 above that more women (55%) compared to men access social care services due to mental health reasons.

**Figure 59: Age groups of those accessing social care services.**



Over half of those accessing social care services (54%) are aged 65+. This is interesting as it is in direct contrast with those who access mental health services via IAPT; those patients are in the younger age groups. Therefore, we can see that for those with mental health conditions accessing care, older people are more likely to access social care whilst younger people are more likely to access IAPT services. This might also reflect a trend for older people to access social care services but not access health care for diagnosis and treatment of a mental health condition. There could be various explanations for these trends, not purely mental health alone.

### Ethnicity

No ethnicity data is collected with mental health data by social care so it is impossible to comment on whether those accessing the service are reflective of the population make up by ethnicity.

**Table 12: Employment**

Employment status	Numbers	Proportions
Unemployed	30	11%
Blanks	187	67%
Retired	61	22%
Totals	278	100%

Out of the 280 clients reviewed, 278 were accounted for. Two thirds of the clients did not have an employment status filled in so it is unclear whether these people are employed or unemployed. Retired or unemployed clients made up a third of clients.

**Table 13: Costs of packages.**

Cost	Numbers	Proportions
Blank	79	28%
Zero (0)	26	9%
Cost stated	175	63%
Totals	280	100%

The costs of social care packages are enormously varied. They are reported with a weekly cost figure. Over a third (37%) listed with a blank figure or zero, which does not mean that they cost nothing; for these clients, the figure is recorded this way because the actual cost cannot be separated out from the package cost e.g. for occupational therapy packages. This makes accounting for financial spend in social care very difficult to do.

For those clients with weekly costing information supplied, there is a huge range of costs which vary from £3.90 a week to £2440.20 a week. This equates to a range of £203 and £116,500 spend a year for individual clients.

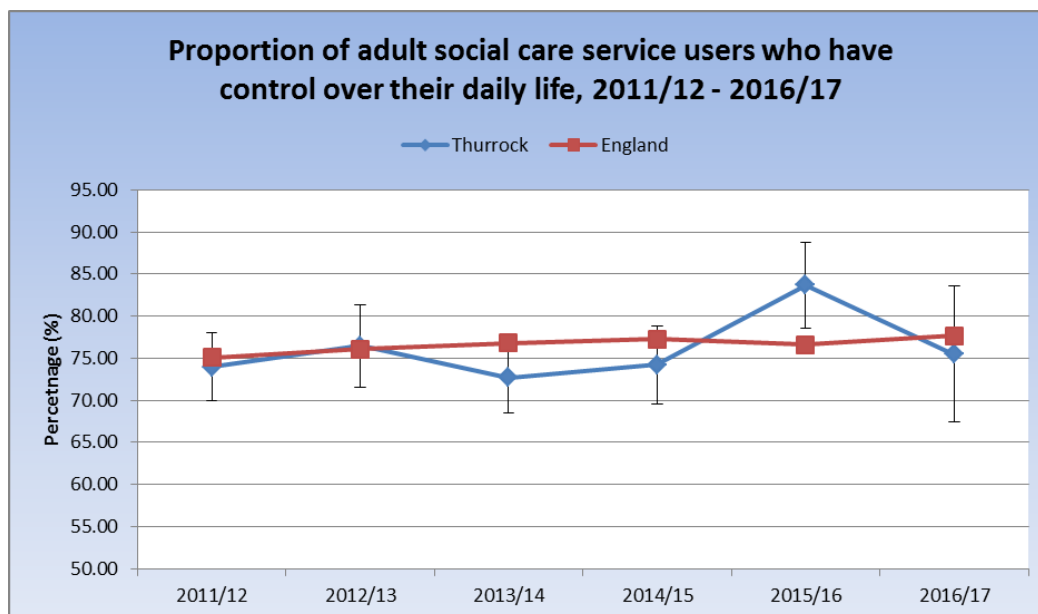
The client with the highest spend (£116,500 a year) is aged under 30 and unemployed with no further details about why their package of care is so expensive.

### **8.3.1 Adult Social Care Outcomes Framework**

The Adult Social Care Outcomes Framework contains a number of measures from the Adult Social Care Service User survey. These are asked to a sample of those accessing all types of social care service aged 18+. The two measures shown below give some insight into the mental health and wellbeing of those accessing social care for support in Thurrock and England. Figure 60 shows the trend in service users feeling they have control over their daily life. In 2016/17, this was 75.5% in Thurrock, which was similar to the national average of 77.7%. With the exception of the previous year, Thurrock has generally been similar to the national average.

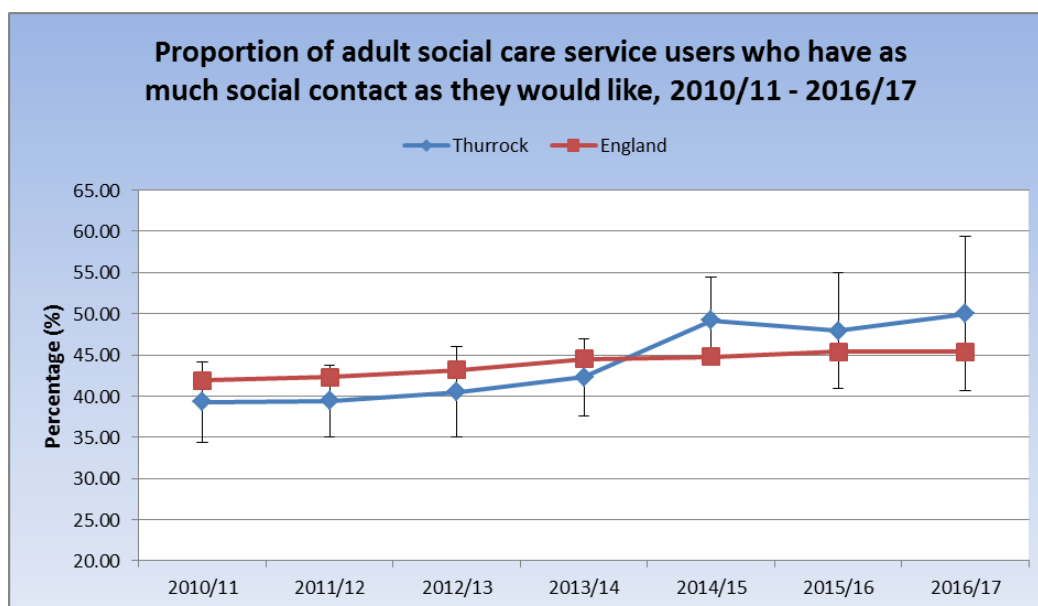
Figure 61 shows the trend in service users who feel they have as much social contact as they would like. In 2016/17, this was 50.0% for Thurrock, which was statistically similar to the national average of 45.4%. This has been statistically similar to the national average for all years since 2010/11. Enabling people to retain a sense of control is vital in helping them to remain independent for longer and maintain good health and wellbeing.

Figure 60: Proportion of adult social care service users who have control over their daily life, 2011/12-2016/17.



Source: Adult Social Care Outcomes Framework

Figure 61: Proportion of adult social care service users who have as much social contact as they would like, 2010/11-2016/17.

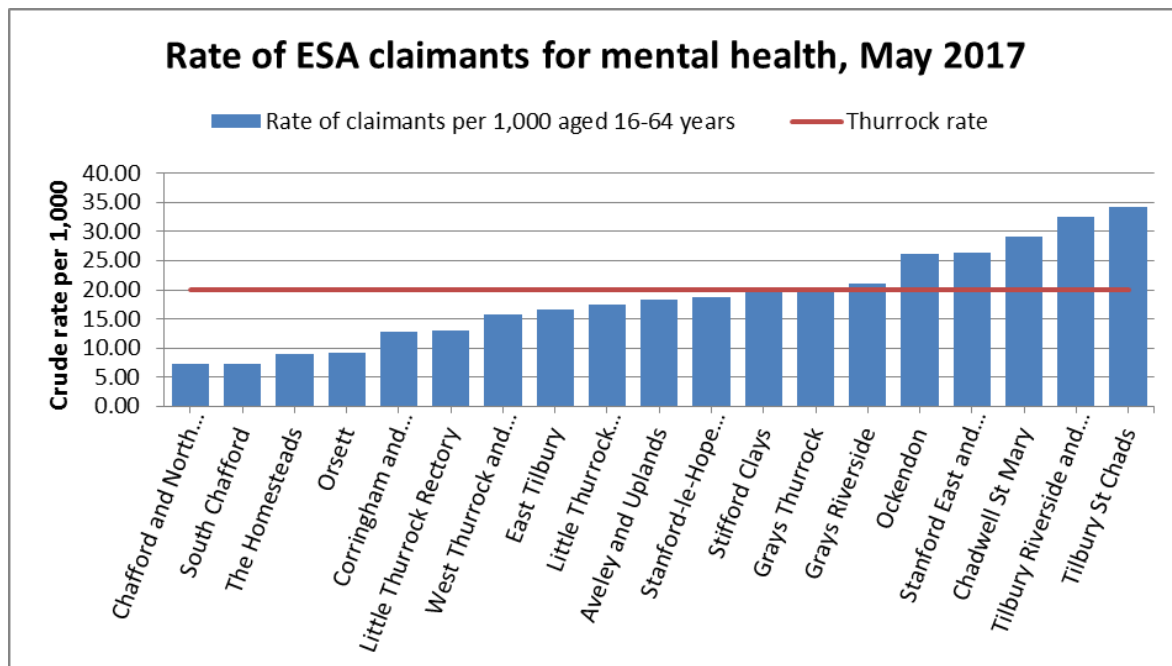


Source: Adult Social Care Outcomes Framework

### Employment and Support Allowance (ESA) Claimants for Mental Health reasons:

The Employment and Support Allowance (ESA) is a benefit for people who are unable to work due to illness or disability. Poor mental health is a common reason nationally for claiming this type of benefit.

Figure 62: Rate of ESA claimants for mental health, May 2017.



Source: NOMIS, 2017

The chart above shows the rate of ESA claimants for mental health by ward category in Thurrock. The rate of ESA claimants varies widely within the Thurrock wards - the highest rate of claimants live in Tilbury St. Chads where 34.19 per 1000 residents aged between 16-64 claim benefits compared to Chafford and North Stifford where 7.23 per 1,000 of the 16-64 age group claim ESA benefits. The 3 highest areas are 62%-81% higher than the Thurrock average of 20 per 1000 residents in the 16-64 age group. It should be noted that this was the most recent data available due to the transition to Universal Credit in 2017.

## Recommendations for social care

- Integrated commissioning: Plans for joint commissioning across health and social care in Thurrock should include integration of mental health commissioning between the local authority and CCG. Joint commissioning should be used as a platform to drive the integration of services around the individual. An appropriate system of governance to oversee joint mental health commissioning needs to be put in place under the Integrated Commissioning Executive.
- Integrated service delivery: The piloting of Wellbeing Teams to deliver social care in 2018 should be used as an opportunity test new ways of delivering mental health support as part of a holistic approach to care. It is important that lessons about mental health are captured when these pilot schemes are evaluated. This should include learning about how the teams can and should interact with mental health specialists and what specialist mental health support they need.
- Data quality: commissioners should work with the providers of social care mental health services to determine the costs of services per package as these are currently unavailable.
- Depression screening: The extent of depression screening in adult social care is currently unknown. It should be systematically monitored with feedback to social care managers. Monitoring could involve using IAPT data to monitor the number of referrals coming in from adult social care and/or data being collected by the adult social care system. It is recommended that the Mental Health Operational Group establish a system for monitoring this objective.
- Addressing the social determinants of mental health: Plans to develop four Integrated Medical Centres and implement a new model of care across Thurrock offer an excellent opportunity to integrate employment and housing services into front-line health and social care settings. A focus on reducing the burden of mental health and targeting groups at high risk of mental health should be included in plans for these projects.

## 9 What do residents think of mental health issues in Thurrock?

Healthwatch Thurrock is an independent Health and Social Care service organisation that represents the people of Thurrock. They gather views on local services in order to paint a picture of health and social care services; where they are doing well and where improvements are required.

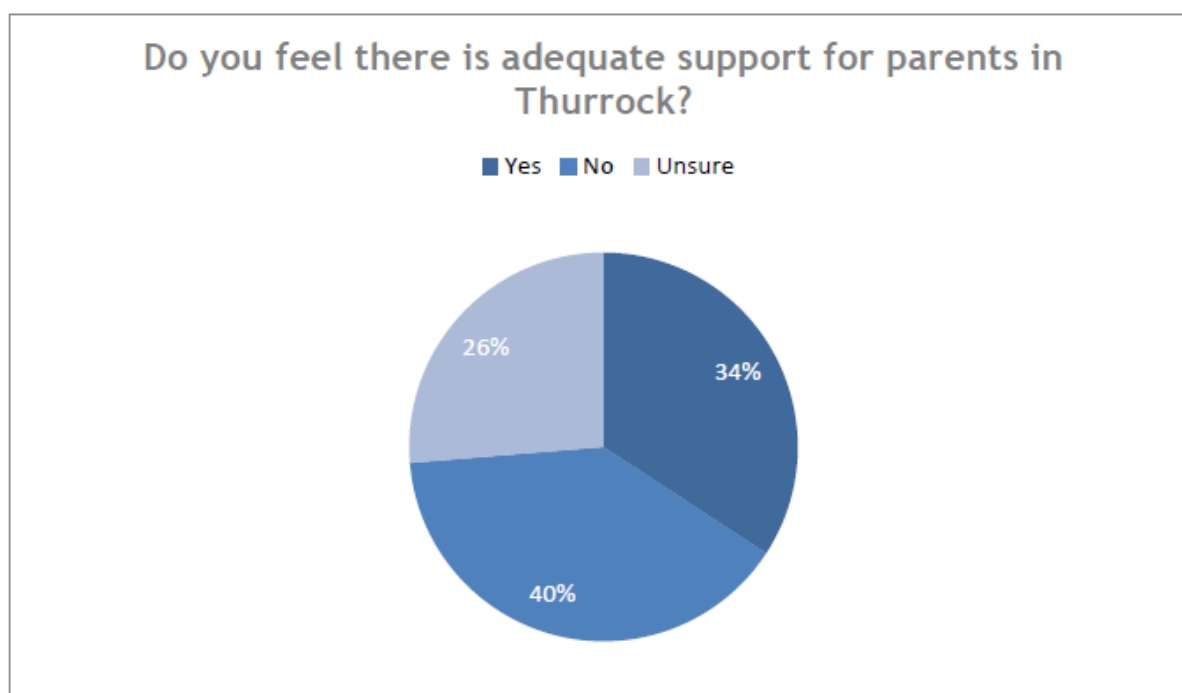
As part of Thurrock Health and Wellbeing Strategy, Healthwatch was asked to engage with the community in Thurrock and ask them questions around emotional health and wellbeing, as related to the Health and Wellbeing Strategy 2016-2021. The views of both young and older people were gathered.

### Goal C: Better Emotional Health and Wellbeing

1. Give parents the support they need
2. Improve children's emotional health and wellbeing
3. Reduce social isolation and loneliness
4. Improve the identification and treatment of depression, particularly in high risk groups

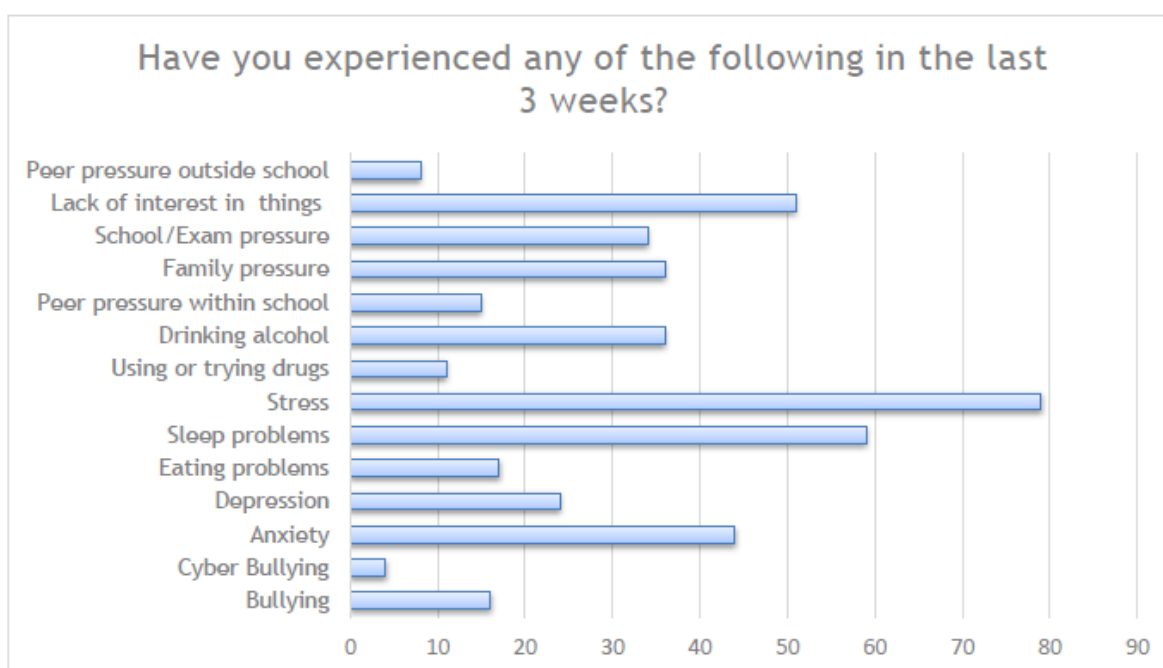
Using on-line and face-to-face methods, a survey was carried out including 126 young people aged 10-18 years and 62 adults aged 19-82 years. Of the adults included in the survey, 77% were female. Areas targeted included educational establishments, community hubs, a children's centre and a Stroke support group.

### Giving parents the support they need:



<ul style="list-style-type: none"> <li>• “I think there is plenty of support for parents and children under 5 years. Once they start school there isn’t as much help available.”</li> </ul>
<ul style="list-style-type: none"> <li>• “If there were more playgroups for new parents as everything seems to be closed.”</li> </ul>
<ul style="list-style-type: none"> <li>• “Referral streams should be made easier. Getting the word out there as to what support parents can access.”</li> </ul>
<ul style="list-style-type: none"> <li>• “If there were Children Centres nearer to where I live as they are only in Tilbury.”</li> </ul>
<ul style="list-style-type: none"> <li>• “I believe my daughter who has downs syndrome received the support she needs but I feel some of the teams need a deeper understanding of Downs Syndrome children and their needs.”</li> </ul>
<ul style="list-style-type: none"> <li>• “I was told my son who has special educational needs couldn’t attend children centre activities - hard to find any groups locally. There seems to be little support here.”</li> </ul>
<ul style="list-style-type: none"> <li>• “There used to be hydrotherapy available for a short term for children with disabilities however once this is over there isn’t much else. I go to a Sunday swimming session at Impulse Leisure Centre with my child which is for disabilities. Would be good if there were more available activities like this.”</li> </ul>

#### Improving Children’s Emotional Health and Wellbeing:

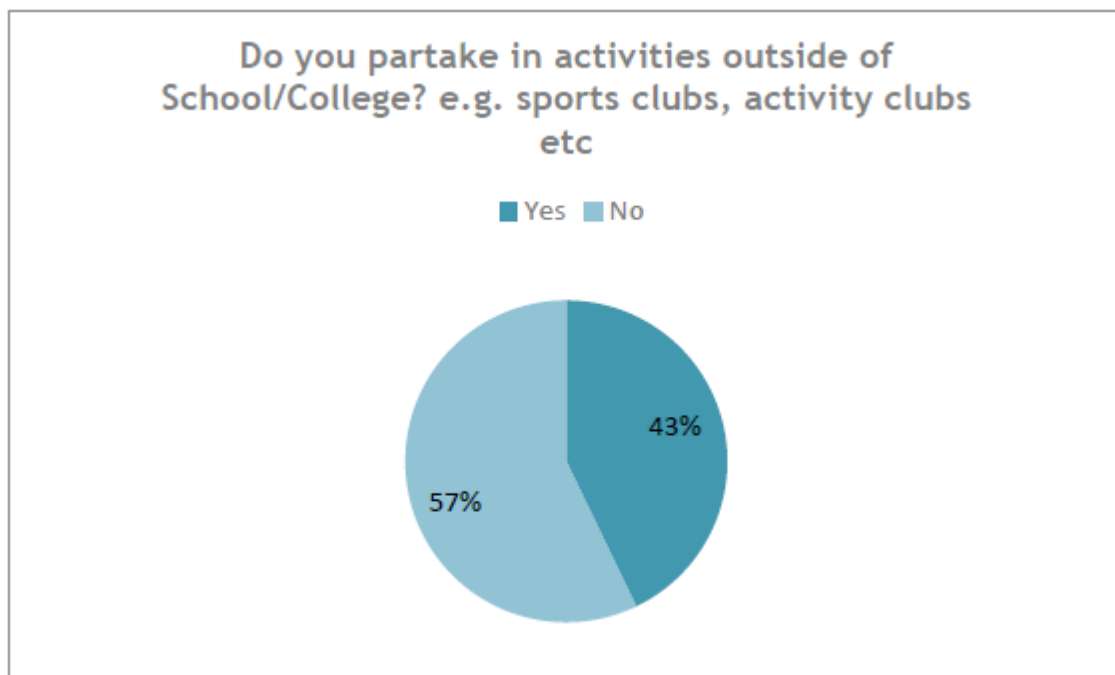




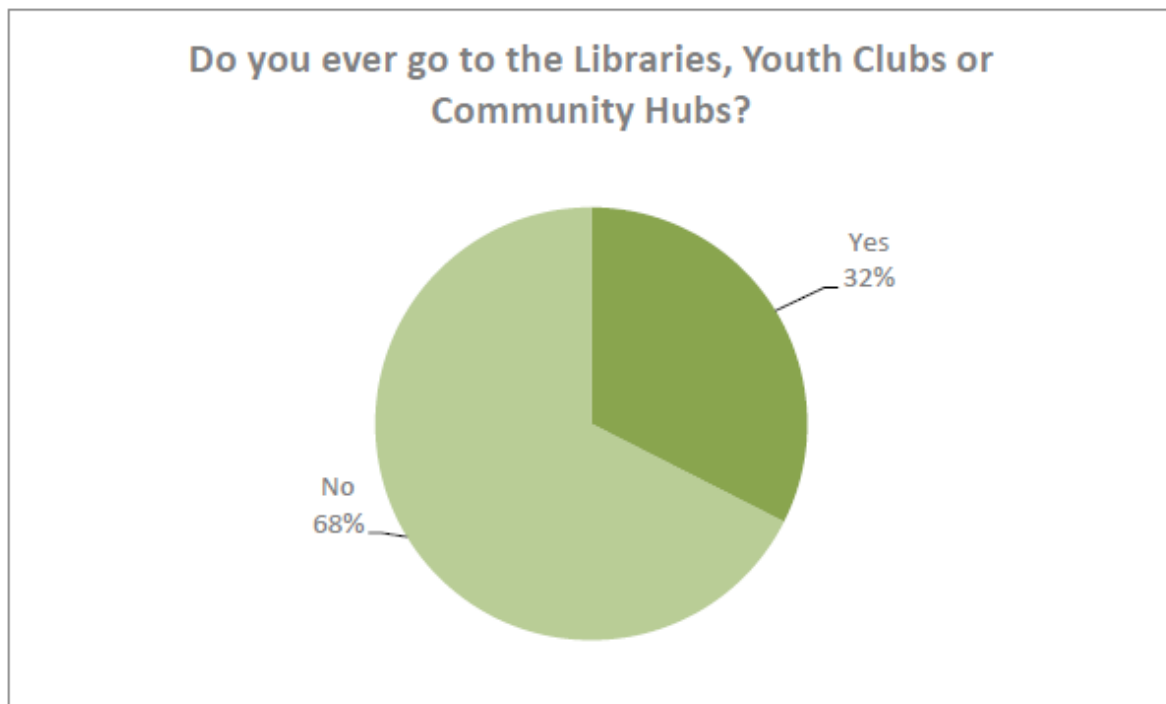
The most common mental health issue identified by young people was stress. This was followed by problems sleeping, a lack of interest in things and then anxiety.



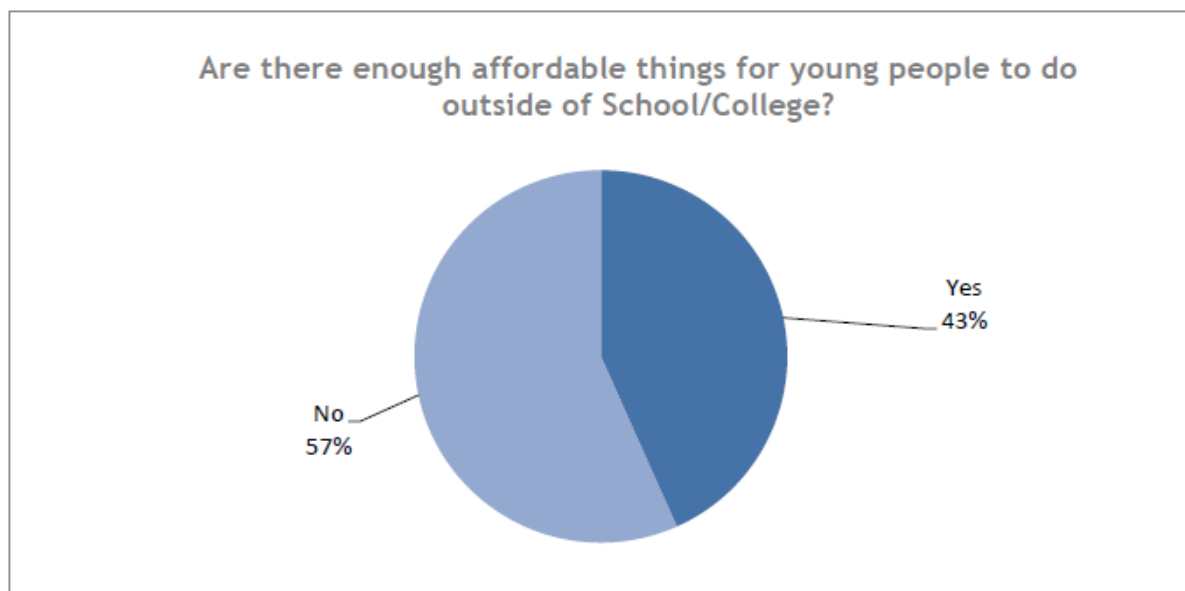
The majority spoke to a friend when feeling anxious, depressed or worried. However, the second most common response was to do nothing.



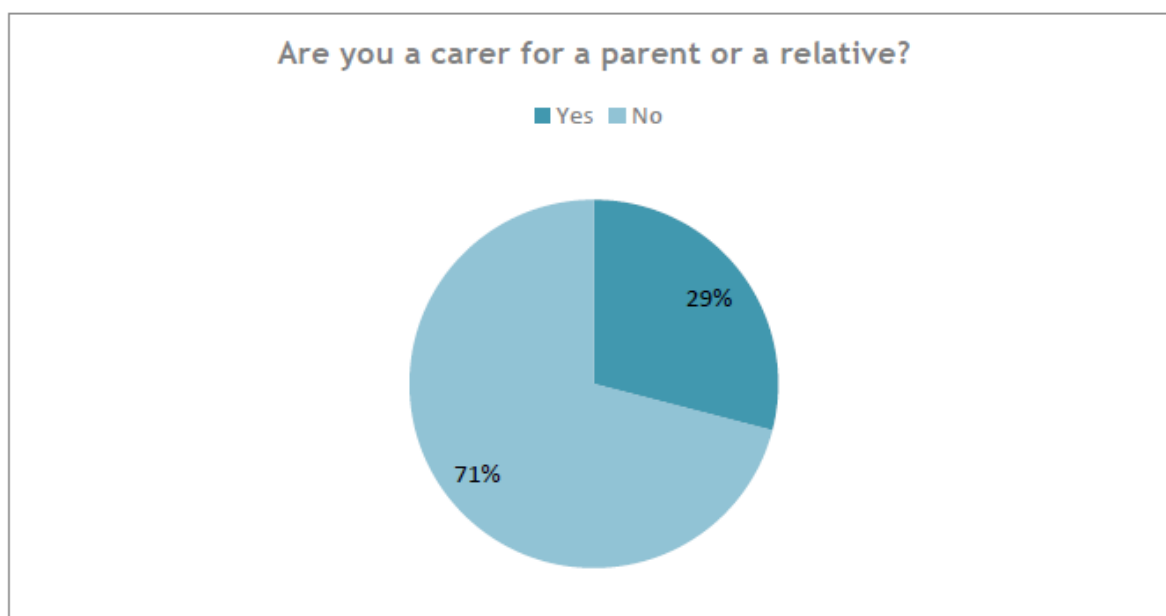
The majority do not take part in activities outside of school or college.



Two thirds of the young people interviewed do not go to libraries, youth clubs or community hubs. However, this might be because some hubs are only open during school hours, which might prevent access to them.



Most do not feel that there are enough affordable things for young people to do outside of school or college. This might be a cause of social isolation and possible antisocial behaviour.

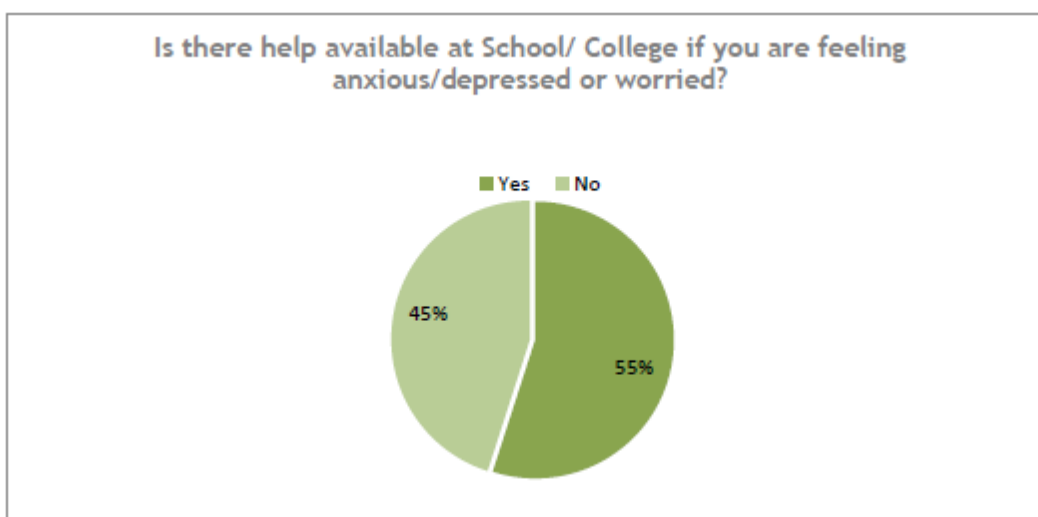


Less than a third are a carer for a parent or relative. Carers have been identified as a group that are at higher risk of having mental (and physical) health disorders.

Comments on mental health services:

• More assistance and people to talk to about mental health.
• More support for those with mental health issues.
• Youth groups, more things for young people what won't cost money
• Mental Health professionals to listen to their patients.
• Health Professionals should listen to their patients more.
• More investment in Mental Health Services.
• Easier access to adult care.
• Moral support.
• More help/support for young depressed people.
• Help create less of a stigma around mental health and using the services.
• Longer opening times (e.g. at the doctors)
• Listen to young people more - be less dismissive etc.
• Counselling on problems we experience in school and outside of school.
• I would like to see better medication and treatment for mental health
• More services available e.g. more confidential online services
• I would like to see a centre that children/teens experiencing neglect can go to.
• Prevent using medication and just pill taking. People need more support than that.

• More youth groups - don't close them!
• Advice and assistance
• Campaign against the stigma of mental health illness.
• More support for the carers of the people with the health issue.
• Better provision of Youth Clubs in Thurrock e.g. Youth Zone with youth facilities ( <a href="http://www.youthzone.com">www.youthzone.com</a> ).



More than half of those surveyed felt there was help available at school or college if they were feeling anxious/depressed or worried.

When asked where they would go for help, responses were as follows:

Category	Number	Proportion (%)
GP	28	28
Family support	22	22
School support	21	21
Healthcare services	11	11
Friend support	8	8
Unsure	3	3
A quiet place eg bedroom	2	2
on-line support	2	2
Outside school/college clubs	2	2
Totals	99	100

Just over a quarter of those surveyed would seek help from their GP (28%), although another 11% would go to healthcare services. Just over a fifth (22%) would rely on family for help and a similar proportion (21%) would access school support services.

## Reducing social isolation and loneliness

Around half (51%) of the adults surveyed were aware of Local Area Co-ordinators.

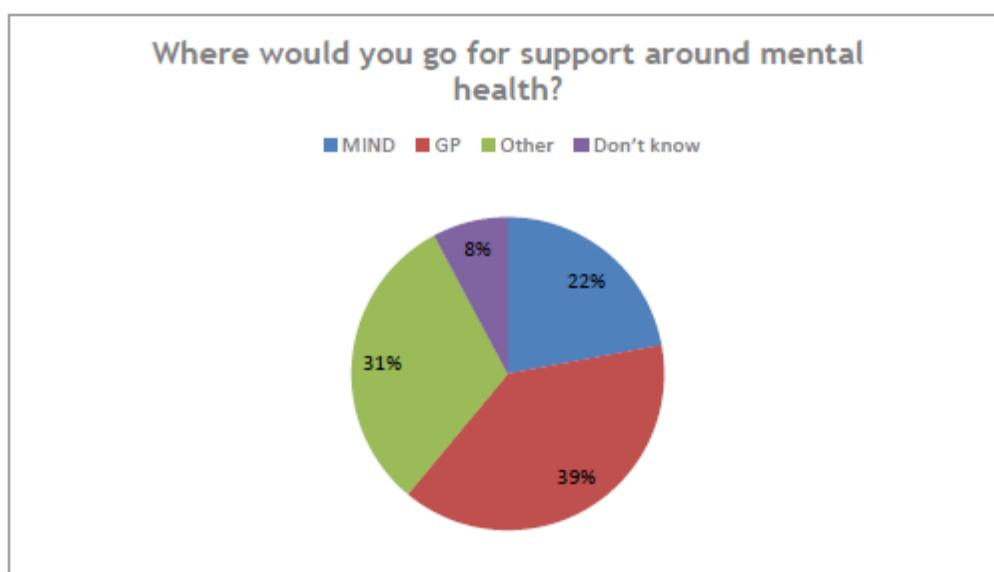
Comments on how to reduce social isolation and loneliness:

<ul style="list-style-type: none"><li>• “More publicity of community hubs and events. Better times for events that do take place. Events and hubs being held in central/clearly accessible areas.”</li></ul>
<ul style="list-style-type: none"><li>• “Information on what’s happening in the area, better advertisement of this.”</li></ul>
<ul style="list-style-type: none"><li>• “I’m elderly now. But I am interested in joining Waterstones book club at Lakeside. It is just the getting there.”</li></ul>
<ul style="list-style-type: none"><li>• “Being able to find out about activities and groups. I work so don’t have much time.”</li></ul>
<ul style="list-style-type: none"><li>• “I am new to area. Accessing the groups etc. Working out of the Borough so it’s hard to find out what is going on locally sometimes.”</li></ul>
<ul style="list-style-type: none"><li>• “Being more aware of community groups and the community hubs in Thurrock and ways to become more involved.”</li></ul>
<ul style="list-style-type: none"><li>• “If information about community groups was put on notice boards - in the flats, in doctors surgeries etc.”</li></ul>
<ul style="list-style-type: none"><li>• “More awareness of what’s going on and volunteering opportunities. If I had more time I would volunteer.”</li></ul>
<ul style="list-style-type: none"><li>• “I would use the community hubs and I have planned to but not got round to it yet.”</li></ul>

<ul style="list-style-type: none"><li>• “I work and the community hubs are not open in the evening, therefore I have not visited my local hub.”</li></ul>
<ul style="list-style-type: none"><li>• “I work 40 hours a week but do my best to be an active member of the community through social media and always help out neighbours.”</li></ul>
<ul style="list-style-type: none"><li>• “Now both my children are in full time education, I could help volunteer.”</li></ul>
<ul style="list-style-type: none"><li>• “I would like to try to get more involved in my neighbourhood groups in my community.”</li></ul>

It seems that increasing awareness of available groups and activities is something that Thurrock residents think is important in reducing social isolation and loneliness.

## Improving the identification and treatment of depression, especially in high risk groups



Although the majority (39%) would go to their GP for support around mental health, almost a quarter (22%) would rather go to MIND. Another 39% would either go elsewhere or don't know where to go. Some of the places listed in other included: Inclusion, SEPT, Healthwatch, Children's centre, Cariads, Samaritans, Health Visitor, Local Area Co-ordinator, hospital, Samaritans and the community and older people's mental health teams.

### Comments on mental health services:

<ul style="list-style-type: none"> <li>I was referred to them by social services. My mentor was Heidi at Open Door she was brilliant. I recommended Heidi to my mum for my brother.</li> </ul>
<ul style="list-style-type: none"> <li>It was awful. We had Family Therapy because of my eldest daughter's behaviour, especially towards her younger sister. After four sessions of enabling my elder daughter to vilify and verbally abuse my younger daughter and the therapists telling me to be quiet every time I objected, the two "professionals" announced rather smugly that it's common for step sisters to clash. They were full siblings. Your "professionals" hadn't even bothered to read the referral and subsequently put my already abused child through utter hell. Disgraceful!</li> </ul>
<ul style="list-style-type: none"> <li>I am trying to get word out in Thurrock that we have a running club and running is an amazing way of overcoming anxiety and depression.</li> </ul>
<ul style="list-style-type: none"> <li>I was supposed to go see someone by now about my emotional wellbeing but never heard back from them.</li> </ul>
<ul style="list-style-type: none"> <li>Counselling in GP service (Pre Therapy For You) was great. Low intensity CBT good. High intensity CBT did more harm than good - partly down to CBT (limited to one type of therapy rather than person centred), partly due to therapist. Too long to wait for the first appointment. Set number of (maximum) sessions is restrictive.</li> </ul>

<ul style="list-style-type: none"> <li>There should be more health centres open. For people with mental health issues, somewhere they can meet and talk out their problems and maybe get advice on any issues troubling them, whether mental health, financial or medical advice. After the closure of our local hospital in Ockendon that dealt with people with mental health issues, it seems the council and government have turned their backs on these people. They have rights and needs just as much as anyone else, but nobody has spoken to them or advised them on what's available in the local area. These sorts of issues need to be addressed and hopefully remedied sooner rather than later.</li> </ul>
<ul style="list-style-type: none"> <li>To be truthful at the time (of having treatment for mental health) I was not too forthcoming with how actually I felt. This was my fault; it is hard to tell with mental health.</li> </ul>
<ul style="list-style-type: none"> <li>I was in a place I didn't want to be on during my early path of recovery from stroke I attend Mind at Bridge Road, Grays. I didn't think it could be helped; I wasn't too forthcoming with the truth of how I actually felt. But on hindsight I think it helped me.</li> </ul>
<ul style="list-style-type: none"> <li>SEPT is incompetent virtually.</li> </ul>
<ul style="list-style-type: none"> <li>IAPT inclusions were friendly helpful people who were willing to help.</li> </ul>
<ul style="list-style-type: none"> <li>Mental health illness is a problem that people often feel they cannot share and they find it hard to talk about. I would love for a breakthrough to be in place to help others get help they need or to encourage family members to get help</li> </ul>
<ul style="list-style-type: none"> <li>There is a lack of information and resource around mental health</li> </ul>
<ul style="list-style-type: none"> <li>Make more info available about them</li> </ul>
<ul style="list-style-type: none"> <li>I had a service I waited for but never got an appointment.</li> </ul>
<ul style="list-style-type: none"> <li>Lack of empathy and proper support</li> </ul>
<ul style="list-style-type: none"> <li>In the past I have paid privately for support regarding Mental Health conditions (depression).</li> </ul>
<ul style="list-style-type: none"> <li>Phoned for counselling, spoke to someone who didn't know what they were on about, (call centres), they offered a group session but that was not what I was looking for.</li> </ul>
<ul style="list-style-type: none"> <li>I think more should be done to help people become more confident in approaching professionals about mental health. To break down barriers of stigma or mental health. There should be more services for mums and families with Post Natal Depression.</li> </ul>
<ul style="list-style-type: none"> <li>My treatment was mostly satisfactory but I could tell the service was understaffed and overworked.</li> </ul>



## Views of those interviewed that have a Long Term Condition (Stroke)

- *Working out personal independent payment (PIP) and other benefits that are continually cut, or requires appealing puts enormous pressure on people. These financial worries can cause anxiety and/or depression.*
- *Not assuming people are depressed because of a LTC and physical issues. But to have the option of an assessment or simply be asked by the relevant health professionals.*
- *People don't always realise they are suffering from depression and may need to be prompted to get help.*
- *Why is nobody picking up depression at the start of any long term illness, when hospitals, doctors, nurses and often adult social care are involved?*
- *Having a LTC can lead to reduced income, loss of money and not being able to work can have a great impact on someone's life, and then can lead to depression.*
- *To overcome feeling low with a LTC it helps to join clubs, get out, mix with people, and recover by going to a gym but most of these things cost.*
- *Men who have LTCs are less likely to discuss depression.*

## Summary of Recommendations made by Healthwatch:

### C1: Give parents the support they need

#### C1 Recommendations

- Increase the awareness of support for parents with children who have disabilities and make it easier for parents to access this support.
- Provide disability support groups and ensure sessions at the Thurrock Children Centres are suitable and accessible to children with a disability.

### C2: Improve children's emotional health and wellbeing

#### C2 Recommendations

- To ensure that activities such as youth clubs, groups and sports for young people are equitable across the Borough. Some areas now do not have a youth club e.g. Aveley. Also, these resources should link in well with each other in order to fulfil the wide range of young people's needs. E.g. academic support, getting into employment, mental health support, promoting healthy lifestyles and fun activities.
- Over half the young people we spoke to (57%) do not feel there are enough affordable activities for young people to do. LA should consider voucher schemes or encourage better promotion of student discounted opportunities such as reduced fees for train fares and bus fares.
- Some of the young people we spoke to (45%) did not know about the offer of help available within their school or college for mental health concerns. This suggests



that more needs to be done within schools/colleges to raise the profile of the help available and to promote a culture of asking for help when needed rather than doing nothing. Make it easy for people to seek help, e.g. through use of social media or an app.

### **C3: Reduce social isolation and loneliness**

#### **C3 Recommendations (as cross referenced with B3 findings and recommendations)**

- Publication/notification of local community activities. Many people in the community are not aware of everything that is going on.
- Continue to strengthen social relationships and opportunities for community connection for individuals and families, especially those in greatest need e.g. the most vulnerable and isolated. For example through use of the local area coordinators.
- Work on how to strengthen relationships between communities and health and social care agencies.

### **C4: Improve the identification and treatment of depression, particularly in high risk groups**

#### **C4 Recommendations**

- Counselling services should be able to recognise and understand the links between LTCs and mental health. It was suggested (by Stroke Group) that often counsellors do not understand that having a LTC can be the main cause of depression. Living with a LTC greatly impacts on a person's quality of life and can lead to mental health conditions.

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## Appendix A

### 11 Demographics of the Thurrock Population

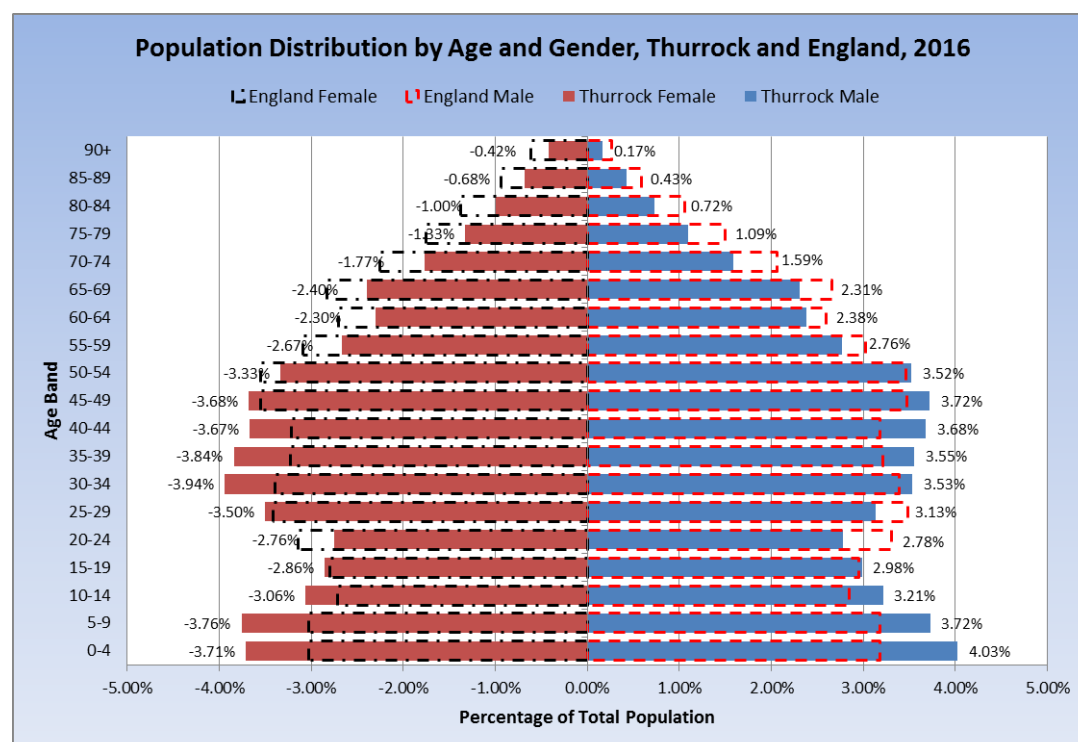
#### Key Points

- The population of Thurrock is set to increase at a faster rate than the national average. By 2039, there will be approximately 27% more residents in Thurrock than in 2014, which is around 44,400 additional residents (compared to the national growth of 17% in the same time frame).
- Thurrock's population is growing rapidly, especially in the very young and very old (0-14 years and 70+)
- The southern and central areas of Thurrock have the highest population density as well as the highest levels of deprivation
- Thurrock is the 4<sup>th</sup> most deprived area in the East of England region
- Thurrock is becoming more ethnically diverse with a White British population of 82% at the 2011 census compared to nearly 90% in 2001.

#### 11.1 Thurrock Population Pyramid

Of the 167,025 people living in Thurrock, 82,374 (49.3%) are males and 84,651 (50.7%) females.

**Figure 2: Thurrock vs England Population Pyramid, 2016.**

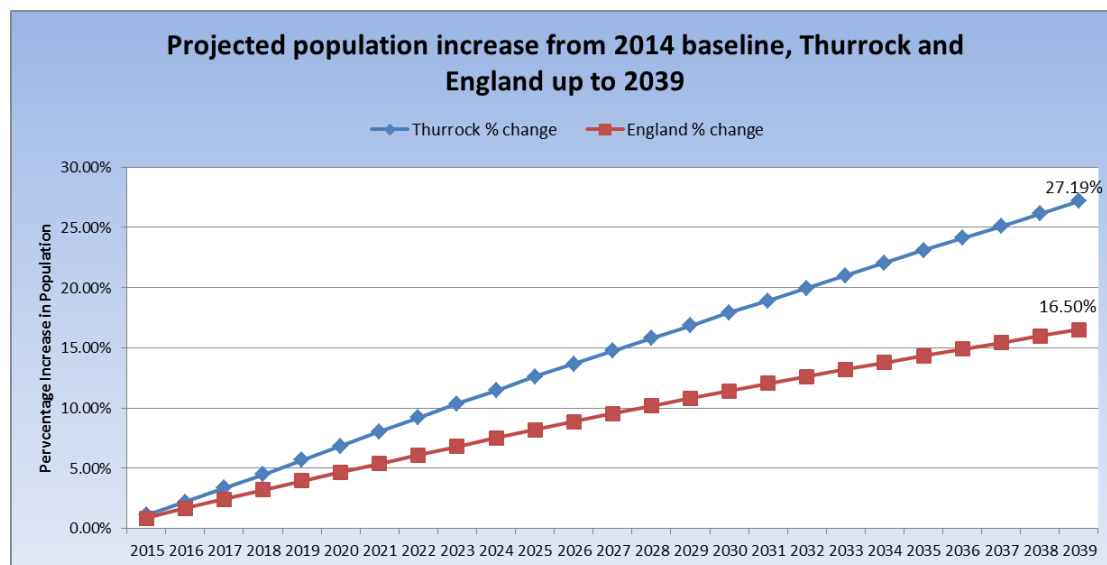


Source: Thurrock Public Health Team, 2017

## 11.2 Thurrock Population Projections

The population of Thurrock is set to increase at a faster rate than the national average. According to the Office for National Statistics, by 2039, there will be approximately 27.19% more residents in Thurrock than in 2014, which is around 44,400 additional residents. To set this in context, the anticipated rate of national growth is around 16.5% over the same 15-year period. It should be noted that the Thurrock growth rate could be even larger than this if the ambitious regeneration plans in growth areas such as Purfleet and Tilbury are realised. Further work is underway to more accurately quantify the impact of the proposed developments on these population projections.

**Figure 63: Projected Population Increase from 2014 to 2039.**

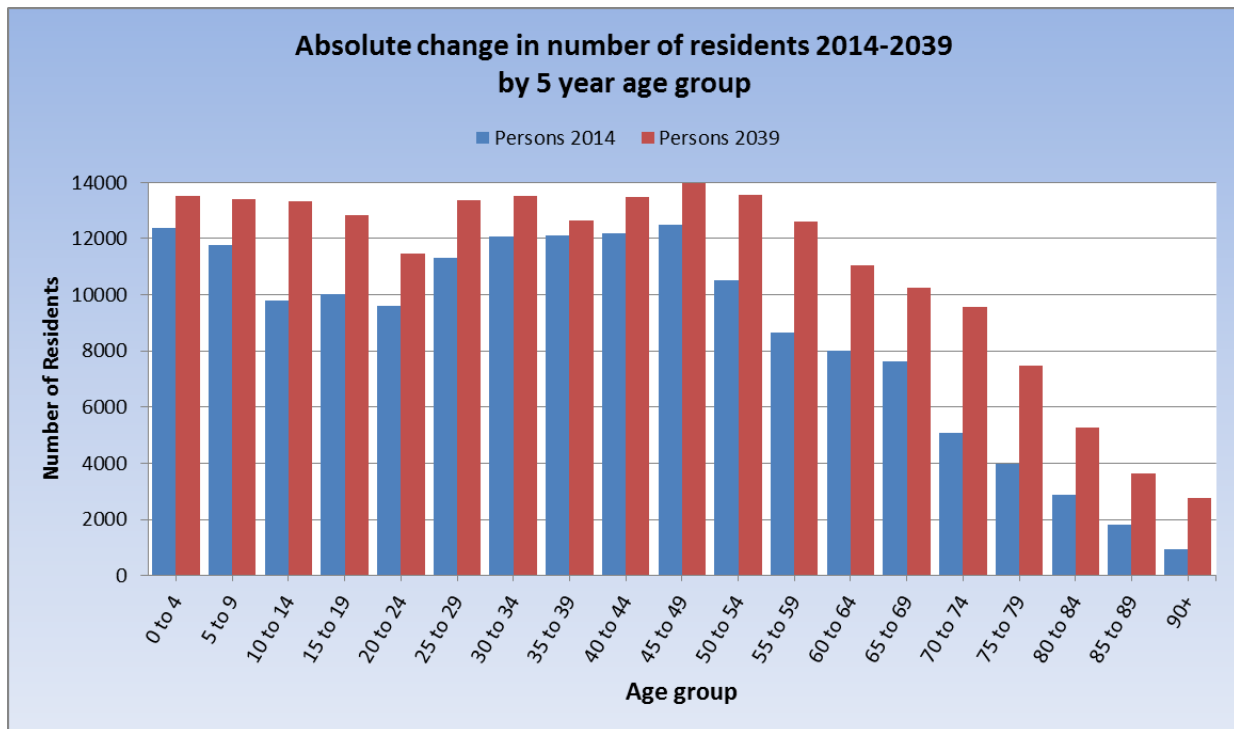


Source: ONS

Figure 64 below depicts the expected change by age group, and it can be seen that, whilst increases are expected in all age groups, the largest differences can be seen in the older age groups. This is likely to have a substantial increase on future health and social care services – further details on this can be found in the Thurrock 2016 Annual Public Health Report.

**Figure 64: Absolute Change in Number of Residents from 2014 to 2039 in Thurrock.**





Source: ONS 2014

### 11.3 Population distribution of Thurrock residents

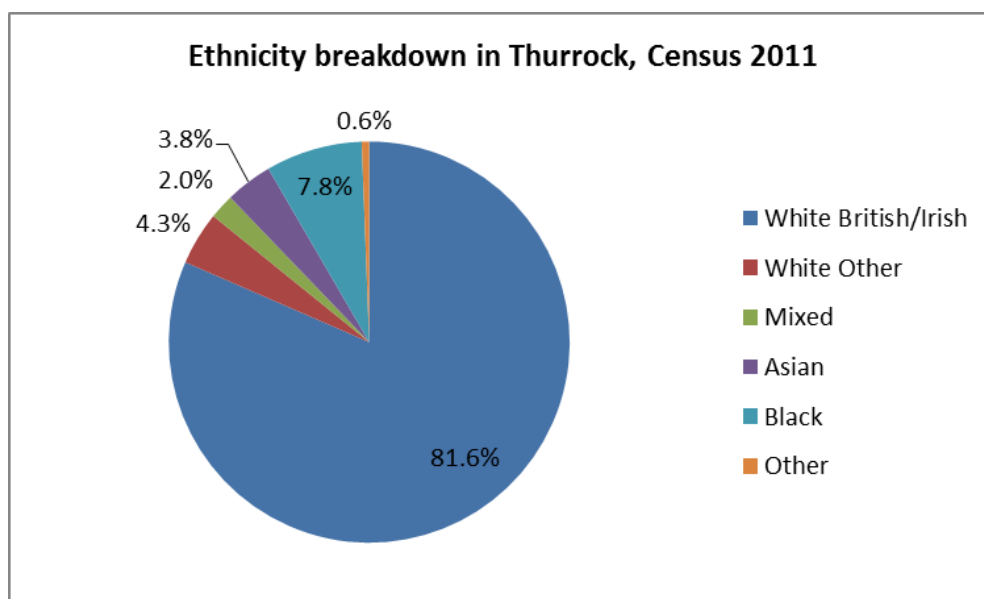
The population density and distribution in Thurrock varies considerably from low density in the more rural areas to high in the urban areas. At the time of the 2001 Census, the average population density in Thurrock was measured at 8.8 persons per hectare compared to 9.7 persons per hectare in the 2011 census, demonstrating the recent increase in population density. Map 2 below highlights that generally the southern and central areas of Thurrock have the wards with the largest numbers of residents, often in quite small, built up areas such as within the Grays Riverside ward. Evidence shows that people are more likely to suffer from mental ill health in inner cities and built up areas with higher population densities, therefore we would expect to a higher prevalence of mental ill health in areas such as Grays Riverside ward.

[illegible]

## 11.4 Ethnicity of Thurrock Residents

98

Figure 65: Ethnicity Breakdown in Thurrock, 2011.

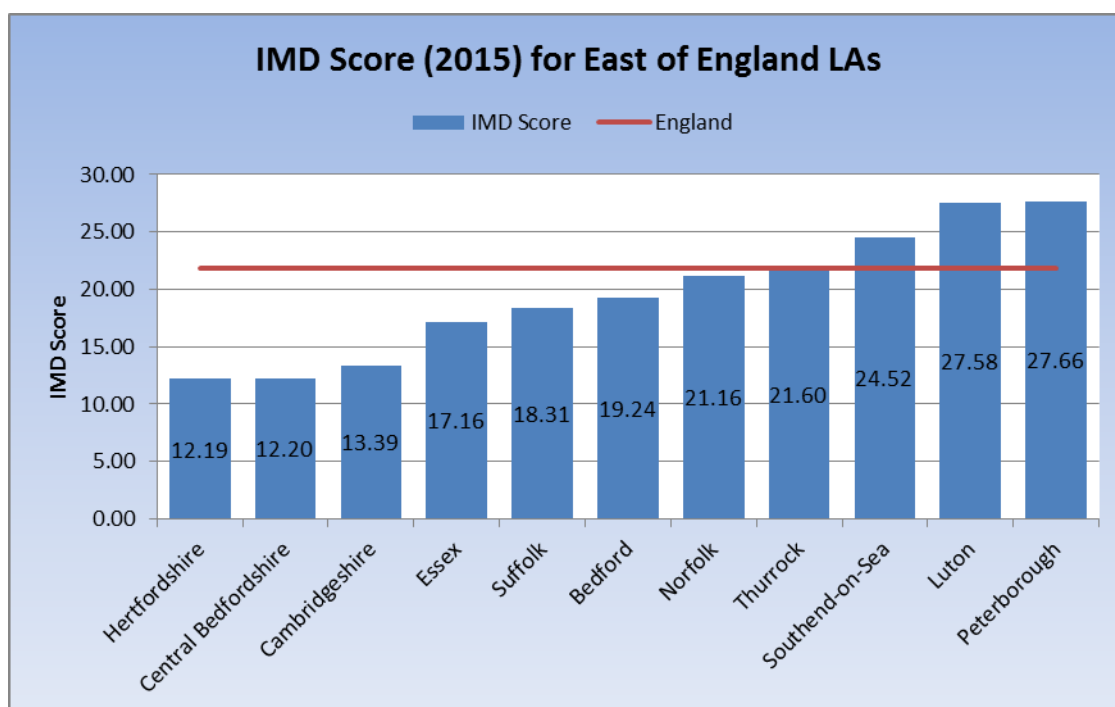


Source: Census data, 2011

### 11.5 Socioeconomic Status

The chart below compares Thurrock with other areas in the region and against the national IMD score. It shows that Thurrock is the 4th most deprived area in the East of England.

Figure 66: Socioeconomic deprivation: overall Index of Multiple Deprivation (IMD) Score, 2015.

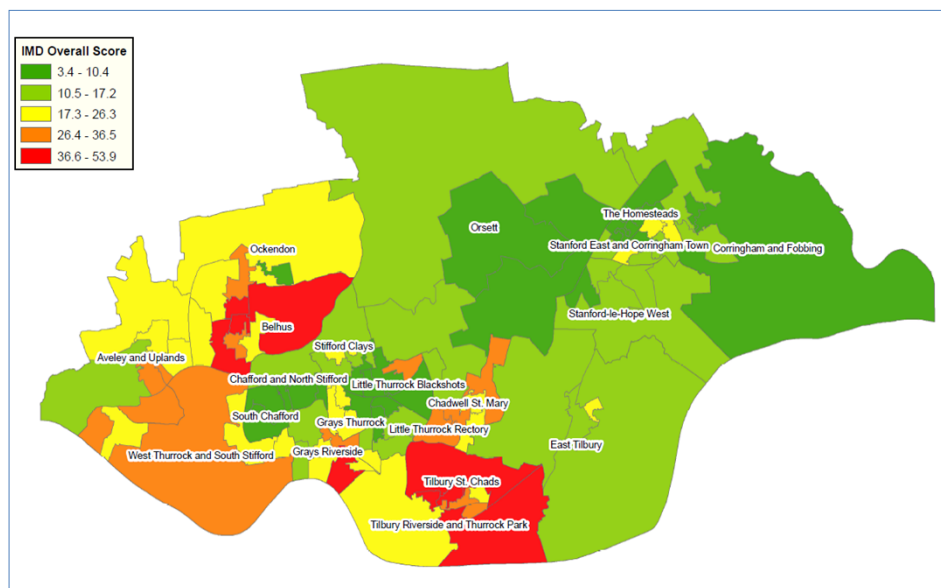


Source: PHE Fingertips

Looking at the whole of Thurrock, it appears that it is not an area that is particularly deprived, as the IMD score is lower than the England average. However, when we take a closer look at the different wards in Thurrock, we can see a more detailed picture.

Deprivation can be measured using the Index of Multiple Deprivation. An overall score is calculated for each Lower Super Output Area [Thurrock has 98] taking into account 7 different domains. Map 3 below depicts the scores within Thurrock – with those areas in red having the highest deprivation scores and falling into the most deprived quintile in England. These are around the areas of Tilbury, Belhus and Grays Riverside. We would therefore expect to see a higher prevalence of mental ill health in these more deprived areas.

**Map 3: Index of Multiple Deprivation (IMD) Overall Score for Thurrock, 2015.**



Source: Public Health Team, 2016

<sup>i</sup>The State of Obesity. *The Healthcare Costs of Obesity*. Available from: <http://stateofobesity.org/healthcare-costs-obesity/>

<sup>ii</sup> Public Health England. Making the Case for Tackling Obesity – why invest. 2015. Available from: [http://www.noo.org.uk/securefiles/161102\\_1758//Making%20the%20case%20for%20tackling%20obesity%20reference%20sheet-0308116.pdf](http://www.noo.org.uk/securefiles/161102_1758//Making%20the%20case%20for%20tackling%20obesity%20reference%20sheet-0308116.pdf) [Accessed August 2016]

<sup>iii</sup> NHS England Investment in Mental Health 2015/16. Available from: <https://www.england.nhs.uk/wp-content/uploads/2014/11/payment-systs-mh-note.pdf> [Accessed June 2017]