Kent and Medway Joint Strategic Needs Assessment – Mental Health

Overview and Way Forward

April 2009
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1. INTRODUCTION

1.1 What is Joint Strategic Needs Assessment?

Joint Strategic Needs Assessment (JSNA) according to Department of Health guidance:

- ‘Identifies the big picture in terms of the health and wellbeing needs and inequalities of a local population’ (p7)
- Describes a process that will ‘identify the existing and future needs of the community, map services and the way they are used, and include an analysis that will enable the prioritisation of services and therefore [inform] commissioning requirements’ (‘Guidance on Joint Strategic Needs Assessment’, DH 2008, p17).

Needs assessment is formally defined as ‘a systematic method for reviewing the health and wellbeing needs of a population, leading to agreed commissioning priorities that will improve health and wellbeing outcomes and reduce inequalities’ (p7).

1.2 About Kent and Medway’s Mental Health JSNA

This mental health needs assessment describes the current and future needs of the population in terms of mental wellbeing and mental health services (other than dementia). It covers adults aged 18 and over and describes the needs of Kent and Medway as a whole, with key messages for each PCT area.

The following diagram summarises the questions asked, and the key areas addressed, in order to produce the needs assessment.

**Figure 1: Key questions and issues covered in Kent and Medway Mental Health JSNA**

<table>
<thead>
<tr>
<th>Key question</th>
<th>Key areas to address</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the size, structure and characteristics of the population</td>
<td>The increase in size</td>
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<tr>
<td></td>
<td>The age structure</td>
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<tr>
<td></td>
<td>Deprivation</td>
</tr>
<tr>
<td></td>
<td>Diversity</td>
</tr>
<tr>
<td>What are the main determinants of mental health and wellbeing in Kent and Medway</td>
<td>Poverty and low income</td>
</tr>
<tr>
<td></td>
<td>Housing</td>
</tr>
<tr>
<td></td>
<td>Employment</td>
</tr>
<tr>
<td></td>
<td>Social capital</td>
</tr>
<tr>
<td></td>
<td>Healthy lifestyles</td>
</tr>
</tbody>
</table>
What are the mental disorders in the population for which services should be commissioned

- Services should address
  - Suicide and self harm
  - High risk groups locally
  - Serious mental illness and links with physical health
  - Common mental disorders and links with physical health
  - Potential unmet need

Full demographic and epidemiological information for Kent and Medway as a whole, including key messages for each PCT area, is set out in Part One (November 2008, updated April 2009)

<table>
<thead>
<tr>
<th>How far does the current investment of resources meet these needs</th>
<th>Amount of investment in each area</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Range of services commissioned</td>
</tr>
<tr>
<td></td>
<td>Balanced investment within the service system</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How well are resources being used to meet needs</th>
<th>Geographical distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Access</td>
</tr>
<tr>
<td></td>
<td>Acute pathways</td>
</tr>
<tr>
<td></td>
<td>Recovery services</td>
</tr>
</tbody>
</table>

The detailed facts and figures about current services including key points for each PCT area are set out in the Part Two report (April 2009).

The analysis of the gaps (ie between the mental health needs and the current services commissioned to meet those needs) and the implications for commissioners across Kent and Medway are set out in Part Three. (This analysis is also informed by working papers on national guidance and on service user needs.)

The overview and way forward for Kent and Medway as a whole are set out in this report, including the impact of mental illness and the background to the needs assessment in Kent and Medway.
1.3 Overview of JSNA documents

The relationship of the reports is illustrated in the following diagram.

**Figure 2: Documents comprising the Kent and Medway Mental Health JSNA**

Part One and Part Two each contain a summary of their main points. (Electronic versions with appendices as a separate electronic file are available for Part Two. A separate summary of Part One is also available.)

Parts One, Two and Three are available in a single electronic document with this Overview and Way Forward report. They are each also available as separate documents.
The proposed actions arising from the JSNA for the commissioning strategy are summarised in the table in figure 3.

**Figure 3: Summary of proposed actions for commissioning strategy**

<table>
<thead>
<tr>
<th>No</th>
<th>Key issue</th>
<th>Proposed action for mental health commissioning strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Size structure and characteristics of the population</strong></td>
<td>(Strategic direction) Due to likely pressure on resources, promote wellbeing and prioritise prevention in order to limit demand</td>
</tr>
<tr>
<td></td>
<td>1.1 Increase in size of population</td>
<td>Investment strategy for five years</td>
</tr>
<tr>
<td></td>
<td>1.2 Age structure</td>
<td>Health promotion and prevention for older people and those who care for them</td>
</tr>
<tr>
<td></td>
<td>1.3 Deprivation</td>
<td>Shift resources to areas with greatest deprivation</td>
</tr>
<tr>
<td></td>
<td>1.4 Diversity</td>
<td>Local plans to deliver race equality in mental health</td>
</tr>
<tr>
<td>2</td>
<td><strong>Determinants of mental health and wellbeing</strong></td>
<td>(Strategic direction) Use interagency joint programmes to address determinants of mental health</td>
</tr>
<tr>
<td></td>
<td>2.1 Poverty and low income</td>
<td>Promote access to debt advice for people with mental illness.</td>
</tr>
<tr>
<td></td>
<td>2.2 Housing</td>
<td>Identify local needs and required interventions for mental health of those in inadequate housing and housing needs of those with mental illness</td>
</tr>
<tr>
<td></td>
<td>2.3 Employment</td>
<td>Workplace support for those with mental health problems and carers, social and primary mental health care interventions for those who cannot find work, continued training and vocational projects for those with severe mental illness</td>
</tr>
<tr>
<td></td>
<td>2.4 Social capital</td>
<td>Community, social and primary mental health care interventions for carers, and health promotion, preventative and community cohesion interventions for older people</td>
</tr>
<tr>
<td></td>
<td>2.5 Healthy lifestyles</td>
<td>Health checks for carers, nutrition, exercise, smoking cessation, brief alcohol interventions</td>
</tr>
<tr>
<td>3</td>
<td><strong>Needs for mental health services</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.1 Suicide and self harm</td>
<td>Determine statistical significance of differences between PCT and England rates. Prioritise local initiatives to reduce suicide and self harm</td>
</tr>
<tr>
<td></td>
<td>3.2 High risk groups locally</td>
<td>Produce service specifications, identify outcomes and define required activity in order to commission improved services for prisoners and dual diagnosis, and work with partners to identify specific requirements for people with learning disability and mental illness</td>
</tr>
<tr>
<td></td>
<td>3.3 Serious mental illness and links with physical health</td>
<td>Determine effectiveness of current systems for health checks and health promotion Clarify whether women have equal access to services Implement campaigns against stigma and discrimination (see also 5.4)</td>
</tr>
<tr>
<td></td>
<td>3.4 Common mental disorders and links with physical health</td>
<td>Monitor impact of stepped care services on the requirement for secondary services Review how far current and planned services meet the mental health needs of people with long term physical conditions</td>
</tr>
<tr>
<td>No</td>
<td>Key issue</td>
<td>Proposed action for mental health commissioning strategy</td>
</tr>
<tr>
<td>----</td>
<td>---------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>3.5</td>
<td>Potential unmet need</td>
<td>In general, focus on conditions where interventions which have been demonstrated to be effective in reducing morbidity and mortality. Prioritise specialist outpatient services for eating disorder, borderline and antisocial personality disorder, and ante- and post-natal mental health care.</td>
</tr>
<tr>
<td>4</td>
<td>Current pattern of investment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Amount of investment in each area</td>
<td>Assess how far differences between the three PCTs reflect local needs, and where evidence of effectiveness can be transferred from one to another.</td>
</tr>
<tr>
<td></td>
<td>Range of services commissioned</td>
<td>Address gaps, especially A&amp;E liaison, community forensic and dual diagnosis of mental illness and substance misuse.</td>
</tr>
<tr>
<td></td>
<td>Balanced investment within the service system</td>
<td>Review the balance between community teams, crisis teams and inpatient service in Eastern and Coastal Kent. Undertake capacity planning to determine future requirements of review and redesigned services in Kent and Medway.</td>
</tr>
<tr>
<td>5</td>
<td>How far services are meeting needs</td>
<td></td>
</tr>
<tr>
<td>5.1</td>
<td>Geographical distribution</td>
<td>Review size of older people’s teams for functional illness in relation to the population they serve. Agree with providers ways to monitor numbers of key staff working in each locality.</td>
</tr>
<tr>
<td>5.2</td>
<td>Access</td>
<td>Review systems and pathways for referral in order to reduce routine waits for secondary services and achieve uniformly low waits for primary care psychological therapies. Assess the reasons for local variations in referral rates when they occur.</td>
</tr>
<tr>
<td>5.3</td>
<td>Acute pathways</td>
<td>Review systems and pathways for emergency and crisis referral to mental health services. Draw up service specifications for mental health services to A&amp;E, based on local analysis of activity and an agreed service model.</td>
</tr>
<tr>
<td>5.4</td>
<td>Recovery services</td>
<td>Agree with providers the information required to determine that services are supporting recovery, including employment status, accommodation needs, packages of support available, social networks, carer support and illness progression.</td>
</tr>
</tbody>
</table>

In addition to these actions proposed for the commissioning strategy, this overview recommends that priorities for new work to ascertain service user views should on focus on promoting social capital and wellbeing for older people, and giving more choice and more say to people with a serious mental illness.
2. BACKGROUND

2.1 The impact of mental illness on society

The South East Public Health Observatory report ‘Mental Health and Wellbeing’ (2006) states:

- Mental health problems are estimated to be the commonest cause of premature death and years of life lost with a disability – 23 per cent of the burden of disease in high income countries and 40 per cent of years lived with a disability (quoting World Health Organisation reports)

- The wider cost of mental health problems are estimated to cost the country £77 billion per year, mainly due to people with stress and mental health problems being unable to work. This compares with Treasury spending on the NHS as a whole of £76 billion in 2005/06

- Nearly one third of those going to GPs have mental health problems.

2.2 Project approach

This needs assessment relies principally on nationally and locally available documents and on mapping and activity information about local services. Inevitably some areas are better documented than others and there remain shortcomings in the information available. It should be noted that the needs assessment is not a review of the quality or performance of services.

The project was coordinated by a steering group of stakeholders from PCTs, local authorities, and Kent and Medway Partnership Trust. Three meetings with local stakeholders were held, one in each PCT area.

The project was carried out from September 2008 to April 2009 by an external consultancy, Mental Health Strategies, on behalf of the Adult Mental Health Commissioning Team for all three PCTs in Kent and Medway.

A separate needs assessment was carried out for dementia for each PCT area, and dementia is therefore not covered in this report.
3. **THE SIZE, STRUCTURE AND CHARACTERISTICS OF THE POPULATION**

**Key messages for Kent and Medway as a whole**

Total population will increase in Kent by 10 per cent (138,000 people between 2006 and 2021) and in Medway by just over two per cent (5,600 people), including substantial planned increases in housing in Ashford and Thames Gateway growth areas.

The older adult population (aged 65 and over) will increase by approximately 40 per cent in both Kent and Medway, with a significant impact on demand for services.

Deprivation is strongly correlated with mental ill health and in Kent and Medway is concentrated in coastal towns. Resources should be directed towards the most deprived areas and the services should be accessible to people who live there. Kent and Medway’s mental health services should respond to the specific needs linked to deprivation, such as poverty, unemployment, poor physical health or poor housing.

Kent and Medway’s communities are less ethnically diverse than the rest of England (i.e. all age bands in the adult population (up to age 75) have a higher percentage in the ‘white’ population groups than the England average). PCTs and their partners must address mental health inequalities in their communities.

**Strategic commissioning: population change**

In practice, future available resources are likely to be limited rather than increasing in direct relationship with population. Commissioners should seek to maximise investment in those services likely to be most effective in absorbing the increased demand on services, such as early intervention, crisis services and liaison with acute hospitals. These can provide better outcomes and so avoid subsequent service use. Commissioners should minimise investment in high cost services which intervene late in the care pathway.

The NHS should aim to find joint ways with partners to limit the future demand for mental health services, for example by promoting mental wellbeing where this can reduce the risk of mental illness.

**Proposed actions:** Given the population increases, the commissioning strategy should include an investment plan for the next five years, with targets to shift resources to the most deprived areas. Plans should be drawn up to promote the mental wellbeing of older people and those who care for them, together with local programmes to deliver race equality in mental health.
4. THE MAIN DETERMINANTS OF MENTAL HEALTH AND WELLBEING IN KENT AND MEDWAY

The following are key messages for Kent and Medway as a whole.

4.1 Poverty and low income

The association between deprivation and mental health has been noted. Low income and lack of employment (which are indicators for deprivation) are common amongst people with serious mental illness. It has recently been suggested that debt is an even stronger risk factor for mental disorder than low income. Local government can work with financial organisations and utility companies. Services can promote access to debt advice for people with mental illness.

4.2 Housing

Settled accommodation is a key need for mental health service users, and homelessness a strong risk factor. This report did not specifically investigate information about the gap between needs and services in Kent and Medway, but stakeholders have raised concerns about unmet needs.

4.3 Employment

Employment is a major route to social inclusion for people with mental health problems and for carers. Loss of employment is a major risk factor. Medway and five districts in Kent have higher unemployment than the national rate.

4.4 Social capital

Social capital appears weaker in some parts of Kent, especially where deprivation is greatest. This affects all ages, but two groups in the population may benefit in particular from efforts to improve community cohesion:

- Mental health of carers. The number of older people is increasing, and hence the number requiring informal care. In Kent, older people are themselves undertaking more intensive caring. More support for carers may reduce the risk of mental ill health.
- Older adults, due to their increasing numbers. Isolation and loneliness are risk factors for mental health problems. Preventative interventions, health promotion, engagement with learning and supportive neighbourhoods can improve wellbeing and may reduce the risk of depression and anxiety for older people. Interventions for those approaching retirement are also relevant.
4.5 Healthy lifestyles

People with mental health problems are less likely to lead healthy lifestyles. Exercise and healthy eating can reduce the risks of depression.

Alcohol use is associated with a number of mental health risk factors, including depression, and people with mental health problems are more likely to be dependent on alcohol than the rest of the population, with adverse consequences for health and increased health service usage.

**Strategic commissioning: mental wellbeing**

Local strategic partners should prioritise prevention and promote social capital through their interagency programmes, especially covering housing and homelessness, employment and training, and alcohol misuse.

Priorities to strengthen social capital and community cohesion should focus on older people living alone and on carers. Health promotion and preventative programmes for all ages should cover nutrition, exercise, smoking cessation, brief alcohol interventions and health checks for carers, as these will benefit both physical and mental health. Workplace support is also relevant for those experiencing mental health problems, to reduce absence and assist job retention.

There should be social and primary mental health care interventions for those who cannot find work. (Training and vocational projects for those with severe mental illness have not been identified as a gap locally and should continue in the future.) Commissioners should review the housing needs of people with mental health problems in local areas in order to gather detailed information about what needs to be done locally, on the one hand, for the mental health needs of those in inadequate housing, and on the other hand, to meet the housing needs of those with severe mental illness.

The report on Mental Health and Wellbeing by the South East Public Health Observatory and the needs assessment for mental health promotion by Eastern and Coastal Kent PCT provide detailed recommendations in the context of existing local strategies.
5. NEED FOR MENTAL HEALTH SERVICES

The following are key messages for Kent and Medway as a whole.

5.1 Suicide and self harm

Suicide remains a public health issue in Kent and Medway: all PCTs need to reduce the numbers of people committing suicide, and the suicide rate.

Those who survive a medically serious suicide attempt have a poorer outcome in terms of life expectancy. Nationally the number of women reporting ideas of self harm has increased. These two separate but related issues indicate that self harm strategies should be a focus for local commissioning activity.

Proposed actions: The Kent and Medway Public Health Observatory will do further work to determine if the differences between local and national suicide rates are statistically significant. The effective performance of local initiatives to reduce suicide and follow-up self harm should remain a priority for all health services and interagency partners. (Self harm is also covered in sections 6 and 7 below.)

5.2 Priority groups for commissioning

For the following groups, priority is justified by high risk or vulnerability, gaps in services, and poor outcomes. There is little or no information on mainstream service use by these groups. (NB Some individuals may be in all three groups, reinforcing the argument for priority – this was demonstrated in Kent’s prison mental health needs assessment):

- Dual diagnosis of mental illness and substance misuse
- Prisoners
- People with learning disabilities who have a mental illness (subject to further local work to determine the scope).

Proposed action: early commissioning activity should be undertaken to produce service specifications, specify outcomes and define activity information required from providers. For people with learning disabilities and mental health needs, more work should be undertaken to establish this level of understanding.

5.3 Serious mental illness

Based on national rates, the expected number of people in Kent and Medway with psychotic disorder in the population is 5,400 (from the national psychiatric morbidity survey) but the estimated number with serious mental illness ranges from 12,400 for severe and enduring mental illness to 60,400 with severe mental illness, using estimates derived from the Sainsbury Centre for Mental Health.
Using a prevalence rate of 0.5 per cent for schizophrenia and 1.4 per cent for type 1 and type 2 bipolar disorder, the estimates for Kent and Medway are 6,700 and 18,800 respectively.

The prevalence of serious mental illness in the population has remained stable, and some individuals will require support over many decades. Health and social care interventions for people with serious mental illness should concentrate on early intervention to avoid deterioration, and on improving quality of life.

A difference between the expected prevalence and the numbers using secondary services is usual. However, commissioners have limited systems to tell them about the extent of unmet need.

**Proposed actions**: Whatever the position on unmet need, national guidance would indicate that three issues should be explored as a priority, given their relevance to health equalities:

- Physical health needs: since a diagnosis of schizophrenia reduces average life expectancy by 10 years, the effectiveness of existing systems for health checks and health promotion should be ascertained
- Whether women have equal access to services, including some women only services, should be clarified
- Ways of combating stigma and discrimination in the community, in the use of services and unemployment, should be explored.

National guidance exists on all these issues. The need for better information to determine the success of policies to improve quality of life within the recovery model is covered in section 7.4.

### 5.4 Meeting needs for common mental disorders

The number of people with a common mental disorder is between 163,400 and 190,200. There is a local IAPT programme being implemented to treat common mental disorders. Current plans are to assess and treat 34,800 referrals from this population across Kent and Medway.

The resources to treat common mental disorders should be used to address health inequalities in Kent and Medway. Programmes for should prioritise access in areas of deprivation and meet needs of particular groups (recently unemployed, carers, black and minority ethnic communities, women, pregnant women and new mothers, older adults in the community and in care homes, and people with physical health conditions). There are already strategies in place to achieve this and initial steps taken to action them.
**Proposed actions:** Commissioners should monitor the impact of stepped care services for common mental disorders on need, including the particular groups above, and on the requirement for secondary mental health services. They should review how far current and planned services meet the needs of people with long term physical conditions, since depression in this group is associated with higher health service use and worse outcomes.

### 5.5 Potential unmet need

The most recent NICE guidelines and psychiatric morbidity survey (PMS, based on a national household survey in 2007) highlight other specific mental health needs besides serious mental illness and common mental disorders.

In some cases they indicate mental health needs which affect large numbers in the population. However, people in these groups may not have the severity of need which requires specialist mental health services, and the way information is collected means there is very little information is reported on the diagnostic groups who use either primary care or secondary services.

**Table 1: Number of people with mental health problems (other than psychosis and common mental disorders) according to national prevalence estimates.**

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Kent and Medway</th>
</tr>
</thead>
<tbody>
<tr>
<td>At risk of problem gambling</td>
<td>43,000</td>
</tr>
<tr>
<td>Problem gambling</td>
<td>9,400</td>
</tr>
<tr>
<td>Borderline personality disorder</td>
<td>5,400</td>
</tr>
<tr>
<td>Anti-social personality disorder</td>
<td>4,000</td>
</tr>
<tr>
<td>ADHD screen positive</td>
<td>110,300</td>
</tr>
<tr>
<td>ADHD five of six characteristics</td>
<td>30,900</td>
</tr>
<tr>
<td>Eating disorder</td>
<td>21,500</td>
</tr>
<tr>
<td>Sub-syndromal antenatal depression and anxiety</td>
<td>519</td>
</tr>
<tr>
<td>Postnatal depression</td>
<td>1,998</td>
</tr>
</tbody>
</table>

**Strategic approach to potential unmet need**

In general, commissioners should focus on conditions where specialist outpatient interventions have been demonstrated to be effective in reducing morbidity and mortality. In all cases:

- Commissioners should review how well existing services are meeting these needs.
- PCTs should work with interagency partners, stakeholders and communities to agree local priority for these groups.
Where these disorders are combined with other mental disorders (called ‘co-morbid’), staff in mainstream services should be trained to provide appropriate responses.

NICE guidelines, supplemented by research findings, should be the starting point for discussion of effective interventions for these disorders.

**Proposed actions** for specific disorders:

**Personality disorder:** commissioners should focus on outpatient psychological treatment of demonstrated effectiveness for those who have the most serious needs, which are most likely lead to unplanned and ineffective use of services. Commissioners should also work with partners to ensure services provide an appropriate response to the other needs of people with personality disorder.

The most severe form of *eating disorder*, anorexia nervosa, causes years of morbidity and early mortality. Commissioners should invest in specialist outpatient treatment of proven effectiveness.

**Adult ADHD:** There is likely to be an emergent need for a service especially around young people in transition to adulthood. The PMS indicates a much larger potential unmet need in the population. In order to manage this, commissioners need to develop a strategy which sets out the future health service need and considers the case for future investment.

**Ante- and post-natal mental health care:** There is an established case for focusing on postnatal psychosis, severe postnatal depression, and care plans for women with serious mental illness contemplating motherhood. NICE guidelines recommend interventions for sub-syndromal anxiety and depression for pregnant women and PCTs should consider inclusion in their commissioning intentions and/or roll-out of programmes to improve access to psychological therapies.

**Problem gambling:** Although included in the PMS 2007 (published 2009), there is no known local concern and it does not appear a high priority when resources are limited.

6. **HOW WELL DOES THE CURRENT PATTERN OF INVESTMENT MEET THESE NEEDS?**

6.1 **Investment levels**

The following are key comparative messages affecting Kent and Medway as a whole.

- The information about services for older people with functional mental health problems (eg depression, psychosis) is too limited to base conclusions on.
- Eastern and Coastal Kent and Medway spend less than other areas of the country on adult mental health relative to their population. Investment in older adult services appears to be substantially lower in Medway than the national average.
Medway appears to have fewer services relative to its population than Kent in a number of adult service areas: beds, CMHT resources, staff, and caseload.

The differences in expenditure are at least as likely to be based on historical development of services as on responses to local need.

West Kent has higher investment than other areas in Kent and Medway and higher than the ONS cluster average for adult services, and higher than the national average for older adult services.

Over 90 per cent of dedicated mental health spend (excluding prescribing) is for secondary mental health. However, this fact does not itself make the case for a blanket increase for primary care from secondary care.

6.2 Gaps in service

The following are key comparative messages affecting Kent and Medway as a whole.

The core adult mental health services have been commissioned to meet the needs of the population although some gaps remain compared to a fully comprehensive service (A&E liaison, community forensic and dual diagnosis).

There are variations in services commissioned between PCTs; some specialist services not equally available across Kent and Medway, eg ante- and post-natal and specialist personality disorder services. In some cases the service model is different, as in carer support in Medway, or assertive outreach in West Kent.

6.3 Balance within the service system

The following are key comparative messages affecting Kent and Medway as a whole.

Across Kent and Medway, as with the level of expenditure, the differences in the patterns of investment are at least as likely to be based on historical development of services as on responses to local need.

Acute inpatient beds do not account for a disproportionate share of secondary mental health resources. However, in Eastern and Coastal Kent there is higher bed provision (than the national average) and recent pressure.

Eastern and Coastal Kent services have some markers which may relate to the higher need of its population (increase in forensic placements, higher admission rate for schizophrenia, more Mental Health Act assessments) but also some which raise questions about their responsiveness, such as lower referrals, issues in emergency pathways, and lower investment in access and crisis services. Prior to the current investment programme, there was also more limited primary mental health care than in the rest of Kent and Medway.

West Kent has a higher referral rate than the other areas in Kent and Medway.
The balance between investment in CMHTs and crisis teams is different: in Kent, there is greater investment in CMHTs but less in access and crisis services (than cluster and national averages), whereas the pattern is the other way round in Medway.

Higher expenditure on access and crisis services and lower number of adult acute beds are both found in Medway, but it is not known whether this leads to a better, more effective service.

Demand for primary care psychological therapy services and staff levels do not appear to be correlated with population need in Kent, although they are both relatively high in Medway.

**Proposed actions: investment of resources**

Future commissioning should assess how far the differences between areas in Kent and Medway reflect local needs, and how far they represent effective service models, in line with detailed further work suggested in Part Two of the needs assessment report. Where there is evidence of effective and transferrable service models and service delivery, those models should be put in place across Kent and Medway, eg carer support or assertive outreach.

In Medway, capacity planning should be undertaken in the context of the current project to review and redesign of acute services. This will determine whether the service system is well balanced towards community services, or whether the pattern is the result of lower investment.

In Eastern and Coastal Kent, the balance between community teams, crisis teams and inpatient services should be reviewed.

Sections 3 and 7 of this report contain proposals to shift resources to meet the need in the more deprived areas.

**7. HOW FAR SERVICES ARE CURRENTLY MEETING NEEDS**

**7.1 Geographical distribution of resources within PCT areas**

The key message is that there is inequity between PCT areas in Kent and Medway, rather than within them.

Although there are some specific adjustments which could be made in the geographical distribution of resources, the overall pattern of staff resources and referrals at district level within PCT areas (ie Eastern and Coastal Kent and West Kent) does not appear to be skewed towards the more affluent areas for adult services, and there is inadequate information to assess this for older adults. (Proposals in section 3 above refer.)

**Proposed actions:** the size of older people’s mental health teams relative to population should be reviewed in relation to population served. Commissioners could also consider
agreeing with providers local ways to monitor numbers in particular staff groups in order to provide a proxy for equity of service provision.

7.2 Access

The following are key messages for Kent and Medway as a whole.

- There was a wide variation across Kent and Medway in waiting times for primary care psychological therapies (from one to 20 weeks)
- One third of routine referrals to secondary mental health services wait four weeks or more
- There is a higher referral rate in West Kent than in Medway and Eastern and Coastal Kent

**Proposed actions:** review systems and pathways for referral in order to reduce routine waits for secondary services and achieve uniformly low waits for primary carer psychological therapies. Commissioners should also assess the reasons for variation in referral rates and consider ways of managing demand.

7.3 Acute pathways: crisis accommodation, access to over 65s, A&E

The following are key messages for Kent and Medway as a whole:

- Over a third of inpatient admissions are for people with depression
- Significant numbers of people are admitted through A & E
- The number of people presenting to acute hospitals for self harm (where there is a very limited service) is up to 17 and 28 per cent of the number of referrals to CMHTs in Eastern and Coast Kent and Medway respectively.
- There is relatively low investment in crisis services in Kent
- Access to crisis teams for people over 65 has not been assessed.
- Nationally, the PMS shows a large number of people who have attempted suicide or considered self harm, underlining the importance of these services.
- The stocktake of national guidance highlighted the absence of crisis alternative to admission and stakeholders voiced concerns about the service response to self harm.

**Proposed actions:** Systems and pathways for emergency and crisis referral to mental health services, should be reviewed as part of the commissioning strategy (including consideration of crisis accommodation). Service specifications should be drawn up for mental health services to A&E, based on local analysis of activity and an agreed service model.
7.4 Recovery services

Recovery focused services are a priority for most mental health services nationally, as for Kent and Medway, but there is very little evidence about their activity. Low patient survey satisfaction with care plans and carer support may indicate problems in this area. Stakeholder concerns included the need for a single point of access to integrated services and the need for recovery services for people followed up from forensic mental health care.

**Proposed actions:** commissioners should agree with providers the information they need to tell them if services are supporting recovery. This should include employment status, accommodation needs, packages of support available, social networks, carer support and illness progression. With reference to the latter, some trusts are mapping their caseloads against the clusters identified as part of planning for Payment by Results.

8. SERVICE USER AND CARER VIEWS

The JSNA project steering group agreed that the outcome of the reviews of population need and service use should determine whether additional work should be undertaken to find more information about what service users and carers want, ie their views about mental health needs and about how effectively they are being met. The steering group noted that a considerable amount is already known about service users’ and carers’ views, and that they have already been asked about them in several ways (eg Healthcare Commission surveys and West Kent’s recent listening exercise).

The following emerge as new areas for investigation, which are relevant to Kent and Medway’s specific challenges, which are not already covered by major work programmes such as IAPT, and which local commissioners are likely to want to address in the coming years.

- For older adults, how to promote social capital and positive mental health, and how to combat depression and isolation
- How to give people with serious mental illness more choice and a greater say in their own care, in order to promote recovery.

PCTs should therefore consider these as potential development projects for their future commissioning plans.