

Adult Mental Health in Harrow

April 2020

Public Health briefing

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1. Introduction and aim

The World Health Organisation (WHO) defines mental health as a state of well-being in which every individual realizes 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 community¹. 1 in 4 people in the UK will experience a mental health disorder at some point in their lives².

Mental illness has a healthcare and human cost, in addition to a social and economic one. The wider costs in England amount to £105.2 billion a year which includes the costs of health and social care for people with mental health problems, lost output in the economy (sickness absence, unemployment)³. There are substantial potential gains for improving mental health, including increased self-esteem, productivity, relationships, economic benefits and a reduction in the burden on health services⁴.

This briefing aims to describe the range of mental health conditions as they pertain to the 18-64 year old population cohort in Harrow. The emphasis of the brief is to describe the number of people that are known to health and care services, and assess this against regional and national comparators. A further consideration of the report is the particular cohorts of the population that are known to be at a higher level of risk of developing a mental health condition, and to therefore ensure services are appropriately accessible. The scope of the brief is limited to adults, and does not include people with a Learning Disability except as a vulnerable group.

2. Summary

The health, social and economic consequences of poor mental health are substantial. The extent of mental health problems is difficult to assess in any given population, but it is estimated that one in four adults experience at least one diagnosable mental health problem in any one year.⁵ It is also known that poor mental health can begin in childhood, with 50% of long-term mental health problems emerging by the age of 14 and 75% by the age of 18⁶. The Psychiatric morbidity survey, (Appendix 3) estimates that since 2000, rates of Common Mental Disorder (CMD) in England have steadily increased in women and remained largely stable in men⁷

The estimated extent of CMD in Harrow (2018/19) is approximately 30,000 people, most of which are people under the age of 65. The level of CMD is estimated to be lower than both London and England levels. Depression is more quantifiable as GPs keep a clinical register, and this includes a total of over 13,000 people registered to a Harrow GP in 2018/19, with over 2,000 new cases identified in the same year.

¹ WHO, 2014. Factfile. Mental Health: a state of well being. Available here: http://www.who.int/features/factfiles/mental_health/en/

² McManus, S., Meltzer, H., Brugha, T. S., Bebbington, P. E., & Jenkins, R. (2009). Adult psychiatric morbidity in England, 2007: results of a household survey. The NHS Information Centre for health and social care.

³ Centre for Mental Health (2010) The Economic and Social Costs of Mental Health Problems in 2009/10. Centre for Mental Health. <http://www.centreformentalhealth.org.uk/economic-and-social-costs>

⁴ The King's Fund and Centre for Mental Health. Long-term conditions and mental health: The cost of co-morbidities. Available here: <https://www.kingsfund.org.uk/publications/long-term-conditions-and-mental-health>

⁵ The Five Year Forward View for Mental Health. A report from the independent Mental Health Taskforce to the NHS in England February 2016.

⁶ Jones, P. B. 2013. Adult mental health disorders and their age at onset. Br J Psychiatry Suppl, 54, s5-10.

⁷ NHS Digital. Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014. Available here: <https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014>

Perinatal mental health concerns the presence or development of a mental health condition during pregnancy, it includes over 1000 women with adjustment disorders and distress, and over 100 with a severe depressive episodes. It is a vulnerable period of time for the parent and child.

The known prevalence of Serious Mental Illness (SMI) in Harrow is in line with London, along with the rate of self harm and suicide. However there are signs of unmet need, in 2018/19 there were 2,793 people registered with a Harrow GP as having a SMI (in line with the rates across London), but there are a significantly low number of people registered on the Care Programme Approach compared to overall rates in London.

There are several risk factors that determine mental wellbeing, and the Mental Health Tiered services must ensure appropriate outreach and engagement with each. There is a particular correlation with deprivation, and unemployment, Black and Ethnic Minority groups, and people with other health conditions. The presence of the Covid-19 pandemic will present a significant increase in the number of people becoming vulnerable to poor mental and physical health.

Significant efforts to understand and address the level of mental wellbeing in the community are therefore needed to reduce future levels of acute demand. The Covid-19 pandemic is an opportunity to ensure that all levels of service are appropriate, and integrated with housing, education and welfare services. Finally, the pandemic is an opportunity to reassess community attitudes to mental health and encourage individuals to assess their own personal mental wellbeing.

3. Demography of Harrow

Harrow's resident population in 2018 is estimated by the GLA to be 250,149, and this includes 152,574 people between the ages of 18 and 64. Additionally the size of the population registered with a general practice (GP) in Harrow in 2018 was 276,560 people, and approximately 180,000 of these registrations were people between the ages of 18 and 64. The discrepancy of nearly 30,000 between the 'resident' and 'registered' population is a common feature in London, and reflects the high levels of mobility.

Harrow is a culturally diverse London Borough with 62% of the residents of Harrow coming from a Black And Minority Ethnic (BAME) background, and just over half the population of Harrow were born abroad⁸.

Harrow has a low level of deprivation against national comparators; the Index of Multiple Deprivation (IMD) score for Harrow is 14.3 compared with the England score of 21.8. A significant component of the IMD is income deprivation, which has improved in Harrow since 2015⁹. The level of unemployment has also reduced in Harrow, from 5.6% between 2013-16, to 4.8% between 2016-19.¹⁰ However this improvement masks significant deprivation levels in very distinct areas in the centre and south-west of the borough as illustrated in Figure 1.

Figure 1. Income deprivation in Harrow

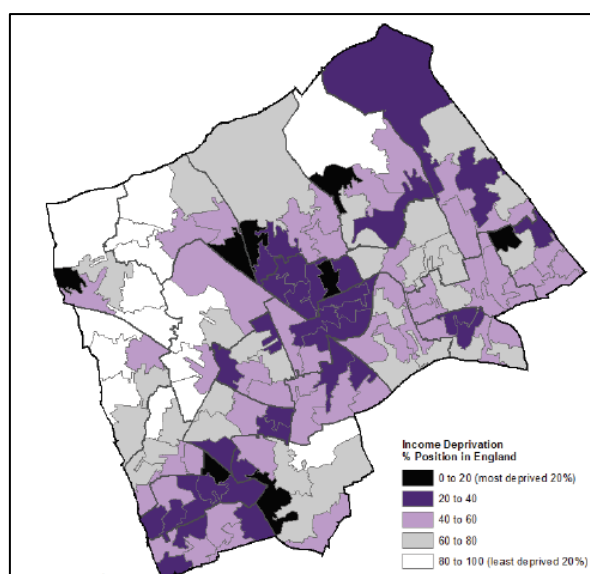
⁸ GLA Datastore, Harrow Report. Available here:

<https://iao.blob.core.windows.net/publications/reports/f11c199d237c4cb79bca5427bfe8511d/E09000015.html>

⁹ Harrow JSNA. Income Deprivation Briefing. Available here:

<https://www.harrow.gov.uk/downloads/file/26518/harrow-index-of-multiple-deprivation-summary-2019>

¹⁰ Trust for London. London's Poverty Profile 2020: Unemployment rate, by London borough. Available here: <https://www.trustforlondon.org.uk/data/unemployment-rate-borough/>



Source: Harrow JSNA, Income Deprivation Briefing

4. Mental Health conditions in Harrow

The spectrum of mental health problems ranges from distress to depression and loss of touch with reality, which may interfere with the ability to cope on a day to day basis. This brief considers Common Mental Disorders, Severe Mental Illness and Perinatal Mental Health.

4.1 Common Mental Disorders (CMD)

Common Mental Disorders are among the most prevalent health conditions in the UK and comprise different types of depression and anxiety. They include depression, generalised anxiety disorder (GAD), panic disorder, phobias, obsessive compulsive disorder (OCD) and CMD not otherwise specified (CMD-NOS).

There are four key indicators available to describe the comparative prevalence of CMHDs by area as illustrated in Table 1, however care must be taken with interpretation as some indicators include the over 65 age population. The figures show that the recorded levels of prevalence in Harrow are generally lower than London and England levels.

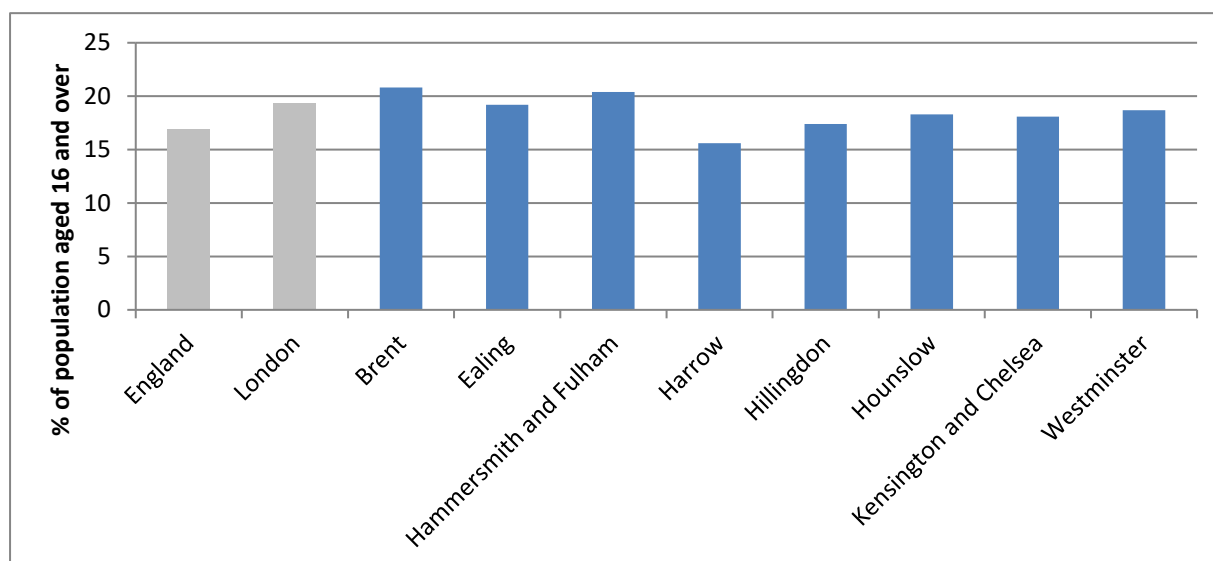
Table 1. Prevalence of common mental health disorders

	Harrow - count	Harrow - rate	London - rate	England - rate
Estimated prevalence of CMHDs % of people aged 16 years and over (2017)	30,724	15.6%	19.3%	16.9%
Estimated prevalence of CMHDs % of people aged 65 and over (2017)	3,679	9.6%	11.3%	10.2%
Estimated prevalence of CMHDs % of people aged 16-65 (2017)	27,045	-	-	-
Depression recorded prevalence (aged 18+) (2018/19)	13,369	6.6%	7.6%	10.7%
Depression QOF incidence (18+) New diagnosis in the financial year (2017/18)	2,320	1.2%	1.2%	1.6%

Source: PHE Fingertips accessed April 2020

In 2017, Harrow had the lowest prevalence of common mental health disorders in North West London, in both the 16 years+ and 65 years+ population as shown in Figure 2.

Figure 2. Estimated prevalence of common mental health disorders in people aged 16 years and over in Harrow, compared to North West London, London and England (2017)



Source: PHE Fingertips accessed April 2020

The prevalence of depression recorded on GP clinical registers in Harrow is lower than the London and England average. In 2018/19 the prevalence of depression in Harrow was 6.6%, compared to 7.6% in London and 10.7% nationally. The recorded level of depression in Harrow has risen significantly over the last five years in line with national and regional trends. (Harrow from 3.5% in 2013/14 to 6.6% in 2018/19 – QoF NHS Digital)

The GP Patient Survey is a postal survey sent to registered patients across England, and is an alternative way to estimate the scale of Common Mental Disorders. In previous surveys, individuals were asked to grade the state of their health today regarding anxiety or depression. The most recent data held on this is from January-March 2017, with responses from 3,434 people in Harrow. In Harrow 25% reported feeling anxious or depressed, compared to 32% in London and 34% in England as shown in Table 2. The percentage of respondents reporting they were not anxious or depressed by practice ranged from 87% to 62%, with a high degree of negative correlation¹¹ with the Severe Mental Illness Mental Health register as discussed below, indicating stability in the evidence base.

Table 2. GP Practice Survey responses on state of health regarding anxiety and depression

	Not anxious or depressed	Slightly anxious or depressed	Moderately anxious or depressed	Severely anxious or depressed	Extremely anxious or depressed
Harrow CCG	75%	16%	6%	2%	1%
London	68.33%	19.23%	8.43%	2.65%	1.36%
England	66%	20%	10%	3%	1%

Source: GP Patient Survey 2017

¹¹ Correlation coefficient of -0.62 expressed by comparing the results from 28 practices from the 2017 GP Survey and the QoF Register for Mental Health 2018/19

Improving Access to Psychological Therapies (IAPT) uptake

IAPT services are approved by NICE for treating people with anxiety or depression. They are delivered by fully trained and accredited practitioners, matched to the mental health problem with an intensity and duration designed to optimize outcomes. From April 2018 all clinical commissioning groups are required to offer IAPT services integrated with physical healthcare pathways.

In the calendar year 2019, 6,430 referrals were received for the Improving Access to Psychological Therapies service. Of these 4,915 entered treatment, and 2,260 finished the course. The most recent comparative data is Q3 2019/20, of the referrals received in Harrow, 51% of clients achieved a reliable recovery, which is in line with the recovery rate for the NW London STP area of 49%. The national target for IAPT services includes an aspiration to reach 25% of all people with anxiety or depression, which is approximately 6,760* people in Harrow, and therefore higher than the current level of 6,430 referrals. (*Based on the estimated 27,045 people in Harrow with a Common Mental Health disorder in 2020).

4.2 Severe Mental Illness (SMI)

Severe mental illness refers to people with psychological problems that are often so debilitating that their ability to engage in functional and occupational activities is severely impaired, examples include schizophrenia and bipolar disorder.

Psychotic illnesses (such as schizophrenia) are relatively uncommon, however have high service and societal costs. There is a high amount of burden and human suffering associated, and people with a psychotic illness have lower rates of employment.¹²

The number of people with schizophrenia, bipolar affective disorder and other psychoses are recorded on practice QoF clinical register for Mental Health. In 2018/19, the prevalence of mental health problems recorded in Harrow GPs was 1.03% (2,793 people), which is similar to the London (1.12%) and national rate (0.96%).¹³ However it is noticeable that the prevalence rate varies by GP, the highest prevalence in a practice is 2.37% and the lowest prevalence is recorded at 0.24%. It is beyond the scope of this brief to understand if this is a difference in clinical management or clinical need in the population.

Demand for mental health services for people with a SMI can be expressed in a number of ways, as shown in Table 3.

- The number of adults with an open admission for specialist MH services is the single largest cohort of patients, and includes the number of admissions to an acute mental health setting in any given period. Compared to London, indicator 1 shows a significantly lower rate of people in contact with MH services, yet indicators 2&3 show similar rates of admissions to hospital.
- Patients in receipt of the Care Programme Approach (CPA). The approach requires specialist health and social services to ensure properly assessed, planned and coordinated care. Indicator 4 shows a significantly lower rate than London, and Figure 3 shows that the % of MH service users on the CPA is also the lowest rate in North West London.

¹² NHS Digital. Adult Psychiatric Morbidity Survey 2014. Available here:

https://files.digital.nhs.uk/pdf/q/3/mental_health_and_wellbeing_in_england_full_report.pdf

¹³ NHS Digital. Quality and Outcomes Framework, Achievement, prevalence and exceptions data 2018-19.

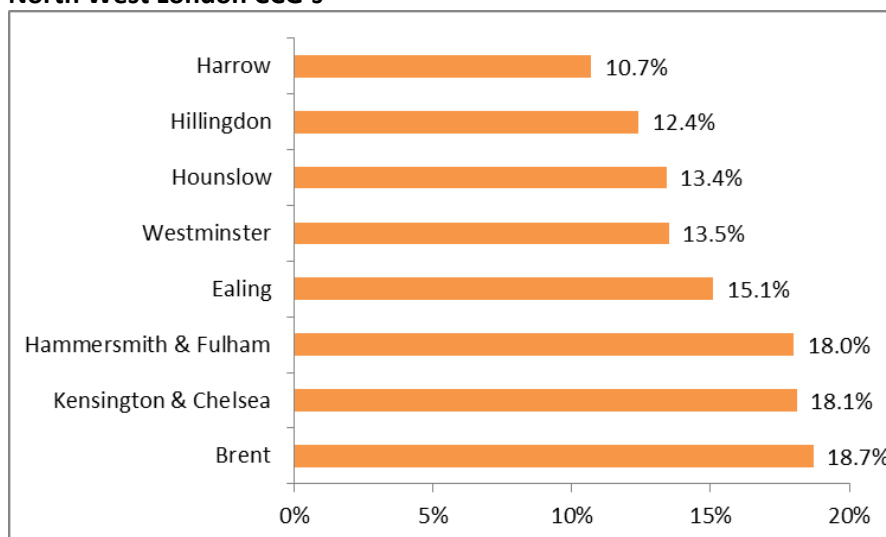
Available here: <https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2018-19-pas>

- The number of people detained under the Mental Health Act. The rate of people detained under the Mental Health Act is similar compared to London – indicator 5 – but the proportion of people detained that are known to MH services is significantly worse than London – indicator 6.
- GP prescriptions for psychoses. There has been a steady increase over the last 4 years of GP prescriptions of drugs for psychoses and related disorders up to the most recently available data for Q1 2017/18 in which there were 9,564 prescription items made – indicator 7. Whilst this rate in Harrow is significantly lower than the rate for England, this result alone is insufficient to prove that the level of psychosis is lower in Harrow, and it may reflect that there is a lower level of known need.

Table 3. Quantified demand for Mental Health Services

Indicator	Period	Harrow count	Harrow rate	Harrow / London	London rate	England
1) People in contact with adult MH service: rate per 100,000 aged 18+	2019/20 Q2	3,725	1,942	Sig. lower	2,201	2,381
2) Mental Health admissions to hospital: rate per 100,000 population	2019/20 Q2	135	281.6	Similar	332.0	276.7
3) Mental Health service users in hospital: percentage	2019/20 Q2	115	3.1%	Similar	2.7%	2.0%
4) People on a Care Programme Approach: rate per 100,000 age 18+	2019/20 Q2	400	209	Sig. lower	424	357
5) Persons detained under MHA: rate per 100,000 population aged 18+	2019/20 Q2	255	532	Similar	486	383
6) Persons detained under MHA: % of people in contact with services	2019/20 Q2	90	1.92%	Sig. worse	1.47%	1.04%
7) GP prescription items for psychoses	2017/18 Q1	9,564	36.3	Sig. lower	-	48.9

Source: PHE Fingertips accessed April 2020

Figure 3. Percentage of mental health service users on care programme approach compared to North West London CCG's

Source: PHE Fingertips-accessed April 2020

4.3 Perinatal Mental Health

Perinatal mental health problems are defined as those that occur during pregnancy or in the first year following child birth. They include mental health problems that arise at this time and those that were present before pregnancy. Women have a substantial risk of developing a mental health condition during pregnancy or postpartum. Up to 20% of women are affected by mental health illness during this period. Serious perinatal mental health disorders are associated with increased risk of suicide, which is a leading cause of maternal mortality. Over the last two decades mental health disorders have contributed to 15% of all maternal mortality during pregnancy and the first 6 months postpartum.¹⁴ The social and emotional wellbeing of a baby or toddler can also be affected by whether the mother has a mental health problem herself.¹⁵

Based on the number of women giving birth in Harrow in 2017, the figures below show how many women that can be expected to develop certain mental health problems in pregnancy and the postnatal period. These estimates are based on national estimates and are not weighted to the Harrow population characteristics. Some women will have more than one of these conditions.

In Harrow, where 3,521 women gave birth in 2017:

- Estimated number of women with postpartum psychosis: 10
- Estimated number of women with chronic SMI: 10
- Estimated number of women with severe depressive illness: 110
- Estimated number of women with PTSD: 110
- Estimated number of women with mild-moderate depressive illness and anxiety: 355
- Estimated number of women with mild-moderate depressive illness and anxiety: 530
- Estimated number of women with adjustment disorders and distress: 530
- Estimated number of women with adjustment disorders and distress: 1,060

Risk factors for some specific perinatal mental health conditions include poverty, poor social support, exposure to violence (domestic, sexual and gender-based), migration, emergency and conflict situations, natural disasters, trauma and history of mental health problems.¹⁶

Parents who have suffered a bereavement including miscarriage, still birth or death of an infant are at increased risk of developing a mental health condition. Women who have a personal or family history of bipolar disorder are also at increased risk of developing postpartum psychosis.¹⁷

¹⁴ Joint Commissioning Panel for Mental Health. Guidance for commissioners of perinatal mental health services. Available here: <https://www.jcpmh.info/wp-content/uploads/jcpmh-perinatal-guide.pdf>.

¹⁵ National Collaborating Centre for Mental Health. Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance. Available here: https://www.ncbi.nlm.nih.gov/books/NBK305023/pdf/Bookshelf_NBK305023.pdf

¹⁶ WHO Maternal Mental Health. Available here: https://www.who.int/mental_health/maternal-child/maternal_mental_health/en/.

¹⁷ PHE. JSNA toolkit: Perinatal mental health. Available here: <https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/4-perinatal-mental-health>

5. The impact of poor mental health and wellbeing

The immediate and quantifiable impact of mental illness can be expressed in terms of the number of suicides and hospital admissions for self-harm. Suicide is defined as deaths given an underlying cause of intentional self-harm or injury/poisoning of undetermined intent¹⁸. The Samaritans Suicide Statistics report¹⁹ shows that three-quarters of deaths are men, and the 45-49 age group are most vulnerable. The World Health Organisation classified suicide risk factors into different groups, Table 4.²⁰

Table 4. WHO Suicide risk factors

<p>Health systems and societal</p> <ul style="list-style-type: none"> • Barriers to accessing health care • Access to means of suicide • Inappropriate media reporting • Stigma associated with help-seeking behaviour <p>Community</p> <ul style="list-style-type: none"> • Disaster, war and conflict • Stresses of acculturation and dislocation • Discrimination against subgroups (e.g. imprisoned/detained, LGBT+, bullying, refugees, asylum-seekers and migrants) • Trauma or abuse (psychosocial stressors include disciplinary or legal crises, financial problems, academic or work-related problems, bullying, childhood and family adversity) 	<p>Relationships</p> <ul style="list-style-type: none"> • Sense of isolation and lack of social support • Relationship conflict, discord or loss (including domestic violence) <p>Individual</p> <ul style="list-style-type: none"> • Previous suicide attempt • Mental disorders (risk increases with more than one mental disorder) • Self-harm • Harmful use of alcohol and other substances • Job or financial loss • Hopelessness (relating to feelings about the future, loss of motivation and expectations) • Chronic pain and illness • Family history of suicide
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There were 11 suicides in Harrow in 2018, representing a drop back to the levels observed in 2013 following a peak of 21 in 2015²¹. Suicide rates in Harrow are also lower than rates in London and England as shown in Table 5.

Table 5. Number and rate of death by suicide (2016-2018)

	Harrow	London	England
Suicides	43	1,809	14,047
Age standardised suicide rate per 100,000	6.4	8.1	9.6

Source: ONS

¹⁸ ONS. Suicide occurrences, England and Wales. Available here:

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicideinenglandandwales>

¹⁹ Samaritans. Suicide Statistics Report 2019. Available here: <https://www.samaritans.org/about-samaritans/research-policy/suicide-facts-and-figures/>

²⁰ WHO. Preventing suicide: A global imperative. Available here: https://www.who.int/mental_health/suicide-prevention/world_report_2014/en/

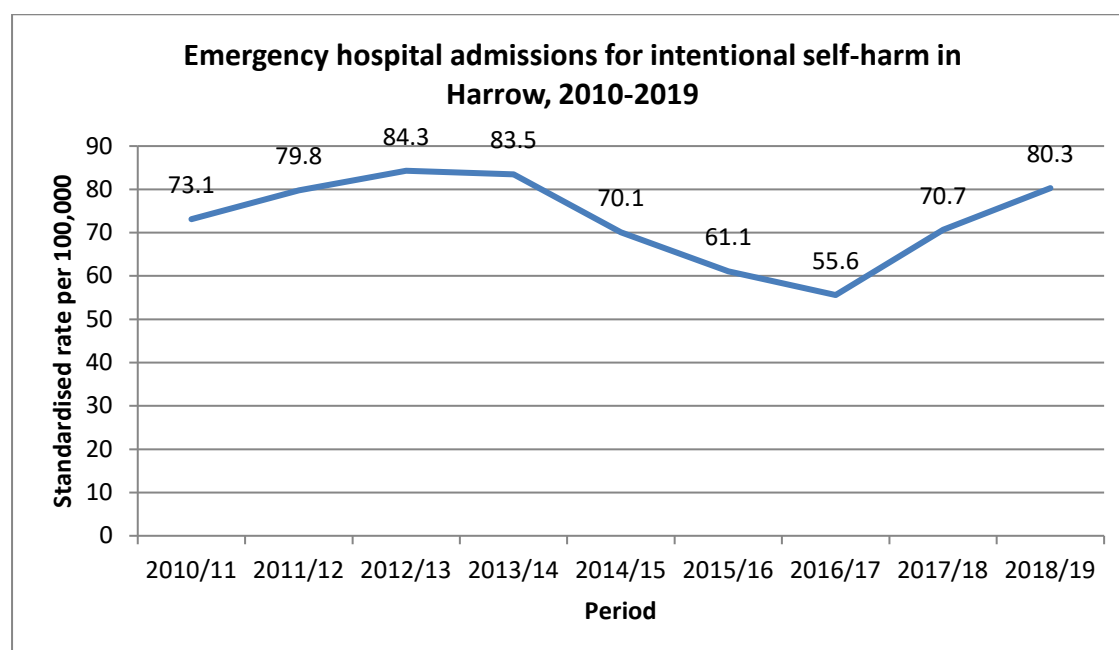
²¹ ONS. Suicides in England and Wales by local authority. Available here:

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidebylocalauthority>

Self-harm is an expression of personal distress with a significant and persistent risk of future suicide following an episode of self-harm. Self-harm is one of the top five causes of acute medical admission and those who self-harm have a 1 in 6 chance of repeat attendance at A&E within the year.²²

Figure 4 shows the rates of emergency hospital admission for intentional self-harm in Harrow, and the increase over the last 3 years. In 2018/19 the rate represented 200 admissions. Table 6 also shows that Harrow has had lower levels than London and England.

Figure 4. Emergency hospital admissions for intentional self-harm in Harrow, 2010-2019



Source: PHE Fingertips accessed April 2020

Table 6. Self-Harm Hospital Admissions per 100,000

	Harrow	London	England
Emergency hospital admissions for intentional self-harm 2018/19 (standardised rate per 100,000)	80.3	83.4	193.4
Hospital admissions as a result of self-harm (20-24yrs) 2017/18 (standardised rate per 100,000)	194.5	188.0	406.0

Source: PHE Fingertips accessed April 2020

²² PHE Fingertips. Emergency Hospital Admissions for Intentional Self-Harm. Available here: https://fingertips.phe.org.uk/search/self%20harm#page/6/gid/1/pat/6/par/E12000007/ati/102/are/E09000004/iid/21001/age/1/sex/4/cid/4/tbm/1/page-options/ovw-tdo-0_car-do-0

6. Vulnerable groups

Mental health problems can affect anyone; however we know that there are certain population subgroups that are at higher risk of mental health problems. This is due to social, economic and environmental factors, which also interrelate with ethnicity, gender and disability.²³ Recent government policies, “No health without mental health”²⁴, “Closing the gap: priorities for essential change in mental health”²⁵ and “Preventing suicide in England”²⁶, have recognised these vulnerable groups as priorities for action.

6.1 Poverty

The relationship between low income and poor mental health is well established. The social gradient is particularly pronounced for severe mental illness, where psychotic disorders are nine times more common in the lowest quintile of household income compared to the highest quintile. Common mental health problems are two times more common in the lowest quintile; and suicide and self-harm are also more common in deprived communities. People on low income may be prevented from participating in social life and may be less able to purchase goods and services that maintain or improve health.^{27 28} A recent survey in 2017 found that the most significant differences in mental health relate to household income and economic activity; 73% of people in the lowest household income bracket reported experiencing a mental health problem compared to 59% in the highest.²⁹

Unemployment is associated with anxiety, depression and suicide, particularly if unemployed long-term. Financial problems from unemployment also have negative consequences.^{27 30} A recent survey in 2017 found a significant difference in mental health between people in employment, and those unemployed. 85% of people currently unemployed reported experiencing a mental health problem, compared to 66% in paid employment.²⁹

²³ Mental Health Foundation. Fundamental Facts About Mental Health 2016. Available here:

<https://www.mentalhealth.org.uk/publications/fundamental-facts-about-mental-health-2016>

²⁴ Department of Health and Social Care. No Health Without Mental Health: A Cross-Governmental Mental Health Outcomes Strategy for People of All Ages. Available here:

<https://www.gov.uk/government/publications/no-health-without-mental-health-a-cross-government-outcomes-strategy>

²⁵ Department of Health and Social Care. Closing the gap: priorities for essential change in mental health.

Available here: <https://www.gov.uk/government/publications/mental-health-priorities-for-change>

²⁶ Department of Health and Social Care. Preventing suicide in England: A cross-government outcomes strategy to save lives. Available here: <https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england>

²⁷ Institute of Health Equity. Fair Society Healthy Lives (The Marmot Review). Available here:

<http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review>

²⁸ Institute of Health Equity. Marmot Review 10 Years On. Available here:

<http://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on>

²⁹ Mental Health Foundation. Surviving or Thriving? The state of the UK's mental health. Available here:

<https://www.mentalhealth.org.uk/publications/surviving-or-thriving-state-uks-mental-health>

³⁰ WHO and the Calouste Gulbenkian Foundation. Social determinants of mental health. Available here:

https://www.who.int/mental_health/publications/gulbenkian_paper_social_determinants_of_mental_health/en/

Income deprived: 30,825. Unemployed: 1,850

The percentage of people (16-64 years old) in Harrow who are income deprived was 12.7% (30,825 people), this was significantly lower than London and England values. (Indices of Deprivation 2015). The unemployment rate in Harrow in 2018 was 3.6% (N=4,700), significantly lower than London average but similar to England. Claimant rate of the working age population who claimed Jobseeker's Allowance plus those who claimed Universal Credit and were required to seek work and be available for work during 2017/18 in Harrow was 1.2% (N=1,850). It was the significantly lower than the levels London and England.

6.2 Black, Asian and Minority Ethnic groups

Black, Asian and minority ethnic groups are generally considered to be at increased risk of poor mental health.²³ The evidence on incidence is complex due to different presentations of problems and different relationships with health services in this group.²⁶ The African-Caribbean and Black-African population in the UK have significantly higher rates of psychosis compared to the White British population. They are also more likely to be compulsorily admitted to hospital and more likely to access services via the police or another criminal justice agency.³¹ People from BME communities are also less likely to use psychological therapies.²⁵

Black and Minority Ethnic Groups: 160,204

The proportion of the Harrow population from a Black or Ethnic Minority background is estimated at 63%, representing 160,204 people.. The proportion of the Harrow population identified as White British was 24% or 61,679 people. (GLA Population estimates 2018.)

6.3 Physical health

People with long term physical health problems are two to three times more likely to experience mental health problems; and overall an estimated 30% have a mental health problem.³² Depression is a common co-morbidity and occurs in approximately 20% of people with a chronic physical health problem.³³ The link between physical and mental health is complex and involves biological, psychosocial, environmental, and behavioural factors. The relationship is also two-way; with mental health problems increasing the risk of physical health problems. People with severe mental illness in England die on average 15 to 20 years earlier than the general population and have 3.7 times higher death rate for ages under 75 than the general population. Also, approximately 2 in 3 deaths in people with a severe mental illness have physical illness that is preventable³⁴.

Obesity can lead to psychological problems, such as depression and low self-esteem. ³⁵ Depression is more common in people with obesity; however the link between the two conditions is not clear. ³⁶

³¹ The AESOP Study Group. First episode psychosis and ethnicity: initial findings from the AESOP study. Available here: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1472260/#B2>

³² The King's Fund and Centre for Mental Health. Long-term conditions and mental health: The cost of co-morbidities. Available here: <https://www.kingsfund.org.uk/publications/long-term-conditions-and-mental-health>

³³ NICE. Depression in adults with a chronic physical health problem: recognition and management. Available here: <https://www.nice.org.uk/guidance/cg91>

³⁴ Public Health England. 2018 Severe mental illness (SMI) and physical health inequalities: briefing. Available here: <https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing>

³⁵ NHS. Obesity. Available here: <https://www.nhs.uk/conditions/obesity/>

People with obesity can also experience weight bias and obesity stigma. Obesity stigma can result in a negative impact on mental health; including increased depression and anxiety, disordered eating, suicidal behaviour and decreased self-esteem. Stigma may also affect the quality of care received.³⁷

NICE clinical guidelines on bipolar disorder recommends that monitoring blood pressure and cholesterol and offering lifestyle management programmes in order to improve the health of both people with severe mental illness and the general population³⁸.

Physical Health: Hypertension 36,289 people, Diabetes 21,143, Coronary Heart Disease 7,471, Physical Inactivity 55,000

The prevalence of specific physical conditions that contribute to co-morbidity in severe mental illness include hypertension, diabetes and obesity.

Physical health condition 2018/19	Harrow	London	England
Hypertension diagnosis (all ages) (%)	13.3	16.5	16.7
Coronary Heart Disease diagnosis (%)	2.7	2.0	3.1
Diabetes diagnosis 17+ years (%)	9.8	6.6	6.9
Overweight prevalence 18+ years (%)	52.9	55.9	62.0
Physical Inactivity	27.8	22.0	22.2

Source: PHE Fingertips accessed April 2020

Harrow performs worse than average when comparing the percentage of patients with severe mental illness who have received the complete list of physical health checks (alcohol, blood glucose, blood lipid, BMI/weight and smoking). In the most recent quarter, 19.5% of patients in Harrow CCG on the GP SMI register have received the complete list of physical health checks in the preceding 12 months; compared to 37% in London and 32.3% in England. The standard for 19/20 is that at least 60% on the GP SMI register should have a comprehensive physical health check once a year.³⁹

Percentage of people with severe mental illness to receive the complete list of physical health checks in the preceding 12 months.

	Harrow	London	England
Q1 2019/20	22.4% (482)	31.5%	29.5%
Q2 2019/20	22.0% (528)	33.5%	30.0%
Q3 2019/20	19.5% (495)	37.0%	32.3%

Source: NHS England. Physical health checks for people with severe mental illness

³⁶ NHS. Genetic links between depression and obesity explored. Available here:

<https://www.nhs.uk/news/obesity/genetic-links-between-depression-and-obesity/>

³⁷ WHO Regional Office for Europe. Weight bias and obesity stigma: considerations for the WHO European Region. Available here: <http://www.euro.who.int/en/health-topics/noncommunicable-diseases/obesity/publications/2017/weight-bias-and-obesity-stigma-considerations-for-the-who-european-region-2017>

³⁸ NICE CG185 (2017). Bipolar disorder: assessment and management - guidance and guidelines. Available here: <https://www.nice.org.uk/guidance/cg185>

³⁹ NHS England. Physical health checks for people with severe mental illness. Available here: <https://www.england.nhs.uk/statistics/statistical-work-areas/serious-mental-illness-smi/>

6.4 Carers

The mental health needs of carers can often be overlooked.²⁵ Carers may be at risk of developing poor mental health due to various factors; such as the pressure of the role, lack of support (practical, financial and emotional), and social isolation. A recent survey in 2015 found that 20% of carers consider themselves to have a mental health condition.⁴⁰

Carers: 4,784

Data from 2011 Census shows 2% of Harrow residents (N=4,784) provided substantial unpaid care, it was significantly higher than the London rate but lower than the national average (2.4%).

The Survey of Adult Carers in England (SACE) 2018- 2019 for Harrow showed 73.1% of carers have been caring for over five years, higher than both London and England (67% and 65.4% respectively). Over a third of carers in Harrow (37.4%) have been caring for 20 years or more, compared to 26.5% in London and 23.5% in England.

SACE 2018- 2019 also shows in Harrow 60.4% of carers reported that caring had caused them feelings of stress, higher than London rate of 56% but similar to the national rate of 60.6%.

6.5 Violence and abuse

Violence and abuse are associated with a higher risk of mental health problems and suicidal behaviour.²⁶ Domestic violence is associated with depression, anxiety, PTSD and substance abuse.²³ Overall, approximately 40% of people accessing a support service for domestic abuse had mental health problems. There is a bidirectional relationship between domestic abuse and mental health; domestic abuse can lead to mental health problems, and having mental health problems can make people more vulnerable to domestic abuse.⁴¹ Similarly sexual assault and abuse are also associated with mental health problems due to the trauma associated with the experience.⁴²

Violence against the person: 4,400

Based on police recorded crime data in 2018/19 there were 4,400 offences of violence against the person in Harrow. The Harrow rate was 17.7 per 1,000 population, significantly lower than the average for London and England, 24.5 and 27.8 per 1000 population respectively.

6.6 Substance misuse

Substance misuse and mental ill health often coexist; this is referred to as dual diagnosis. Mental health problems can provoke the use of substances, and be worsened by substance misuse.⁴³ In 2014, a third of adults with alcohol dependence and half of adults with drug dependence were receiving treatment for mental or emotional problems.⁴⁴

⁴⁰ Tinder Foundation. The Health and Wellbeing of Unpaid Carers. Available here:

<https://www.goodthingsfoundation.org/research-publications/health-and-wellbeing-unpaid-carers>

⁴¹ SafeLives. Safe and Well: Mental health and domestic abuse. Available here:

<https://safelives.org.uk/spotlights/spotlight-7-mental-health-and-domestic-abuse>

⁴² NHS England. Strategic direction for sexual assault and abuse services. Available here:

<https://www.england.nhs.uk/publication/strategic-direction-for-sexual-assault-and-abuse-services/>

⁴³ DrugScope. Mental health and substance misuse. Available here: <https://www.drugwise.org.uk/wp-content/uploads/CoexistingMHandSMfull.pdf>

⁴⁴ NHS Digital. Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014.

Available here: <https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014>

Substance misuse: Opiate and/or crack cocaine use 1,301

The estimated prevalence rate of opiate and / or crack cocaine users (per 1,000 population aged 15 – 64) in Harrow is 8.0, compared to the rate in London of 9.3 and England of 8.9. The estimates are based on data sources from drug treatment, probation, police and prison data.

The number of individuals in Harrow during 2016/17 who entered treatment at a specialist alcohol misuse service and were in receipt of treatment from mental health services for a reason other than substance misuse at the time of assessment was 103, significantly higher than the London and England rate.

6.7 Poor housing and homelessness

Poor housing conditions (including damp, cold, mould and noise) have a negative effect on mental health; and the longer the exposure to these conditions, the greater the impact.²⁸ Improvements in housing conditions have been shown to reduce depression, stress and anxiety.³⁰

People who are homeless have forty to fifty times higher rates of mental health problems.²⁴ 80% of homeless people report some form of mental health problem; and 45% have been diagnosed with a mental health problem. The incidence of depression is substantially higher, as well as increased prevalence of schizophrenia, PTSD and bipolar disorder.⁴⁵ Poor mental health can be a cause and a consequence of homelessness due to the stresses associated.⁴⁶

Households in temporary accommodation: 825**Statutory homeless households: 307**

The number of households in temporary accommodation during 2017/18 (snapshot at 31st March) in Harrow was 825 with a rate of 8.9 per 1,000 estimated total households. The rate in Harrow is higher than the national rate of 3.4 per 1,000 households.

The number of Harrow statutory homeless households in 2017/18 was 307, accounts for a crude rate of 3.3 per 1,000, significantly lower than London rate of 4.2 and higher than England rate of 2.4 per 1,000 populations.

6.8 Learning disability

An estimated 25-40% of people with learning disabilities have mental health problems.²⁴ Factors contributing to the increased prevalence include biological (e.g. genetic causes of learning disabilities), psychological and social factors (e.g. increased exposure to social disadvantages and life events). Specific types of mental health problems that are more common in people with learning disabilities include schizophrenia, bipolar disorder and dementia; many will also have multiple mental health problems. Furthermore, mental health problems are often not recognised in people

⁴⁵ Homeless Link. The unhealthy state of homelessness: Health audit results 2014. Available here: <https://www.homeless.org.uk/facts/our-research/all-research-reports/homelessness-and-health-research>

⁴⁶ Crisis. Mental health. Available here: <https://www.crisis.org.uk/ending-homelessness/health-and-wellbeing/mental-health/>

with learning disabilities; which may in part be due to behaviour and symptoms being attributed to the learning disability.⁴⁷

Learning disability: 1,103

There were 1,103 people registered with a Learning Disability known to a GP in Harrow. The percentage of adults (aged 18 to 64) with learning disability receiving long-term support from their local social services department who are living in unsettled accommodation in Harrow in 2018/19 was 25.7% (140 people), significantly higher than the rates in London (20%) and England (18%).

The rate of working age adults with learning disability in paid employment in Harrow is 18%, which is significantly higher than the rates London (8%) and England (6%).

6.9 Smoking

People with poor mental health die on average 10 to 20 years earlier than the general population, and smoking is the biggest cause of this life expectancy gap. A third of cigarettes smoked in England are smoked by people with a mental health condition, although the gap in smoking prevalence between the general population and people with a mental health condition appears to have narrowed in recent years.⁴⁸

Smoking prevalence is correlated to the severity of a mental health condition, as the severity of mental health conditions increases, smoking prevalence is higher. Data from 2014/15 shows that whilst the prevalence of smoking in all adults was 16%, for people with anxiety or depression the rate was 28%, and for those with a serious mental illness the rate was 41%.⁴⁹

People with poor mental health are also more likely to live in socioeconomic deprivation. This relationship is likely to impact on the prevalence of smoking in people with poor mental health because smoking is strongly associated with socioeconomic deprivation and can itself exacerbate socioeconomic deprivation.

Smoking cessation improves both physical and mental health and reduces the risk of premature death. Research has also shown that smoking cessation is associated with reduced depression, anxiety and stress. Furthermore as tobacco interacts with some psychiatric medicines, stopping smoking may mean that lower doses of medication can be prescribed (and consequently less side effects).

Smoking: 20,774

The 2018 Annual Population Survey estimated the rate of smoking in Harrow as 10.1% of the adult population, this represents a similar rate to London (13.9%) and England (14.4%). There is a significantly lower rate of smoking for people with manual and routine occupations, in Harrow this was 14.3%, London (23.6%) and England (25.4%).

⁴⁷ National Guidance Alliance. Mental Health Problems in People with Learning Disabilities: Prevention, Assessment and Management (NICE Guideline, No. 54.) Available here:

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1472260/#B2>

⁴⁸ PHE. Health matters: smoking and mental health. Available here:

<https://www.gov.uk/government/publications/health-matters-smoking-and-mental-health/health-matters-smoking-and-mental-health>

⁴⁹ PHE. Health matters. NB: Long term mental health condition – similar to severe mental illness, but often including severe anxiety and depression.

6.10 Other vulnerable groups

Several other vulnerable groups exist which service need to appropriately be sensitive to, and engage with. The exact numbers of these groups are more difficult to assess, and they have therefore been grouped here for clarity.

- Refugees and asylum seekers are more likely to experience poor mental health than the local population, due to both pre and post-migration experiences.²³ They may require mental health support for post-traumatic stress disorder and severe depression following experience in their home countries. Post-migration some asylum seekers may experience social isolation, language barriers, racism, homophobia and legal uncertainties about the future.²⁶
- Lesbian, gay, bisexual and transgender people have higher rates of mental health problems.²⁶ LGBT+ people are one and half times more likely to develop depression and anxiety; and are at increased risk of suicidal behaviour and self-harm. The higher prevalence of mental health problems may be attributed to social isolation, discrimination, bullying and risk of attacks/violence.^{50 51}
- People in prison are more likely to suffer from mental health problems, and between 10-90% are estimated to have mental health problems. Rates of suicide and self-harm are also high in this population. Prison environment and culture, understaffing, availability of drugs and lack of continuity (between prison and community) can all contribute to poor mental health. Furthermore social and personal issues such as unemployment, substance misuse and trauma are more common in the prison population.^{52 53}

⁵⁰ Rethink Mental Illness. LGBT+ mental health. Available here: <https://www.rethink.org/advice-and-information/living-with-mental-illness/wellbeing-physical-health/lgbtplus-mental-health/>

⁵¹ Chakraborty, A., McManus, S., Brugha, T. S., Bebbington, P., & King, M. (2011). Mental health of the non-heterosexual population of England. Available here: <https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/mental-health-of-the-nonheterosexual-population-of-england/9EBE3ED4CB8C07BED9EBC1661465D69B>

⁵² National Audit Office. Mental health in prisons. Available here: <https://www.nao.org.uk/report/mental-health-in-prisons/>

⁵³ The Committee of Public Accounts. Mental health in prisons. Available here: <https://publications.parliament.uk/pa/cm201719/cmselect/cmpubacc/400/400.pdf>

7. Forecasted demand for Mental Health Services.

The level of mental health need for the next ten years is dependent on the extent to which mental wellbeing and mental health services are funded, community and individual awareness, and external market forces such as deprivation, in particular the forecast economic downturn after the Covid – 19 pandemic.

The social isolation measures put in place to reduce the spread of the coronavirus have already had, and are likely to continue to have, a major impact on the economy, leading to loss of employment and income for many Baldwin and Weder di Mauro 2020⁵⁴. Early models of the impact on the levels of morbidity in the population are based on observations from the 2008 financial crisis, where a drop in employment of 5% was followed by an increase of chronic conditions. Janke et al⁵⁵ suggest increases in the working-age population of between 7% and 10%, with the full impact being felt within 2.5 years. They go on to state that mental health conditions will be impacted the most, perhaps double the rate of increase in other chronic conditions.

In the context of this briefing, Table 7 applies the population forecast for Harrow in order to demonstrate crude demand increases services should expect, excluding perinatal mental health. The increase of the number of people on a Care Programme Approach could be over 1,300 people. This estimate is dependent on no changes, or increases in referral behaviour to the CPA, or the underlying level of mental well-being in the community. If community wellbeing is impacted by Covid-19, the demonstrated increases of over a thousand for depression, and other common mental health conditions, may not reflect the full extent of the demand. Additional demand of perhaps 10% could be expected for SMI and CMD within 2.5 years, representing a short term increase of 140 people on the CPA and an additional 140 people with a CMD.

Table 7. Population based increases in mental health service demand

Mental health condition	Age	2020	2023	2026	2029	2020 - 2029 increase
Estimated prevalence of CMHDs	19-64	26,700	27,177	27,620	28,098	1,398
Long-term mental health problems (Survey)	18+	11,449	11,780	12,116	12,476	1,027
Depression - registered at GP	18+	12,831	13,202	13,579	13,982	1,151
Depression - new cases registered at GP in a year	18+	2,171	2,234	2,298	2,366	195
Mental health service users on CPA	18+	14,953	15,385	15,824	16,294	1,341
Mental health admissions to hospital	18+	556	572	588	606	50
Adult population forecast		156,600	159,400	162,000	164,800	8,200

Sources: PHE fingertips accessed April 2020 and GLA population (Central Trend-based projection) published July 2017

⁵⁴ Baldwin, R and Weder di Mauro, B (eds) (2020) Mitigating the COVID Economic Crisis: Act Fast and Do what it takes. a VoxEU.org eBook, CEPR Press.

⁵⁵ Janke, K, K Lee, C Propper, K Shields and M Shields (2020), "Macroeconomic conditions and health in Britain: Aggregation, Dynamics and local area heterogeneity", CEPR Discussion Paper 14507

8. Service planning

Commissioning for mental health and wellbeing takes place across four tiers, covering both universal and targeted services across the whole population. The approach is to ensure co-ordination of commissioning activity for the whole population:

Tier 1. At a universal level for people accessing primary care and lower-level advice and support services for a range of issues including depression, anxiety, and medically unexplained symptoms. This level also involves universal and targeted interventions to promote mental health and prevent mental illness.

Tier two. For people recovering from severe mental illness.

Tier three. For people receiving active treatment for severe mental illness, and people using medium/long-term care services.

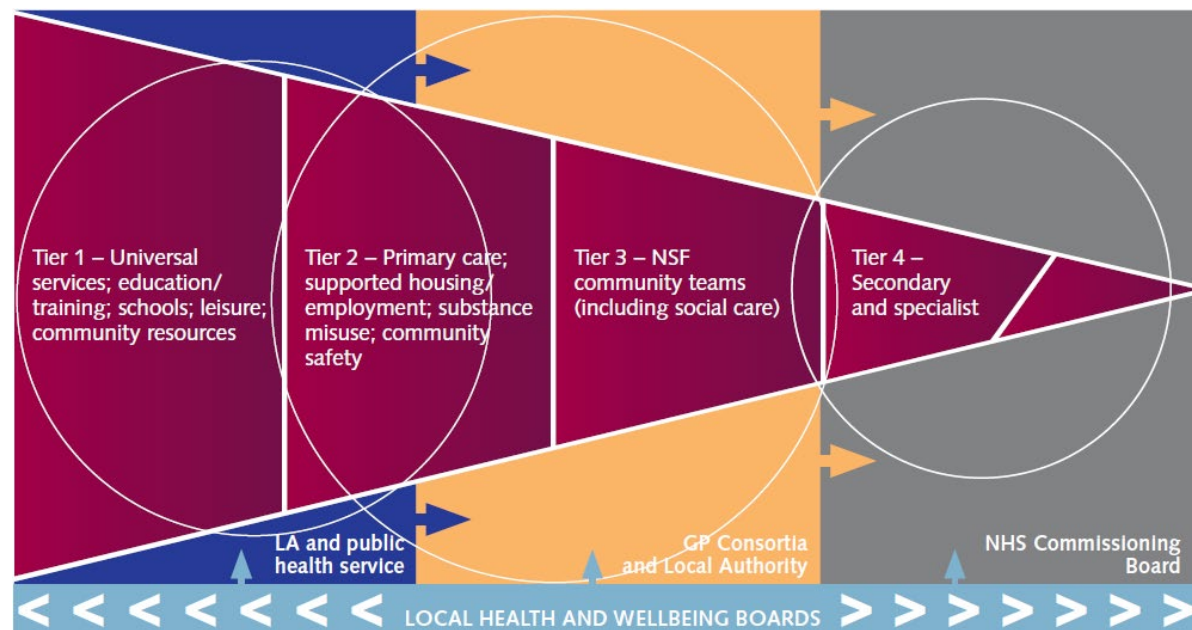
Tier four. For people using specialist, intensive medical or forensic services.

Currently most health resources are focussed at tiers 3 and 4, covering inpatient specialist services. But many of the quality and efficiency actions needed to change the profile of future demand rely on a connected approach at tiers 1 and 2, addressing population and public mental health, prevention, early intervention, personalisation and social care. With the context of mental health problems affecting about 250 per 1000, the majority – about 230 – attend their general practice, placing an emphasis on appropriate engagement at the primary care interface⁵⁶.

In order to address universal mental wellbeing and to manage the future demand for Tier 3 and 4 level services, service planning must appropriately target known at risk groups through integrated services and joint commissioning. The Joint Commissioning Panel for Mental Health published the graphic in Figure 5 which helps identify the settings that are most appropriate for each vulnerable population group. Figure 6 identifies the numbers of each population cohort in Harrow that are at risk but unknown to services, at risk and known to services or are already known to services.

⁵⁶ Shepherd M, Cooper B, Brown A et al (1966). Psychiatric illness in general practice. Oxford: Oxford University Press.

Figure 5. Likely local commissioning responsibilities and overlaps



Source: <https://www.icpmh.info/wp-content/uploads/icpmh-commissioningframework.pdf>

Figure 6. Known vulnerable groups in Harrow

At risk	Known and at risk	Known to service level 1	Known to service level 2
Income deprived: 30,825.	Unemployed: 1,850	Violence against the person: 4,400	People on a Care Programme Approach: 400
Black and Minority Ethnic Groups: 160,204	GP registered Hypertension 36,289	People in contact with adult MH service: 3,725	People detained under the MHA: 255
Smoking (est.): 20,774	GP registered Diabetes 21,143	Substance misuse: Opiate and/or crack cocaine use 1,301	
Carers (est.): 4,784	GP registered Depression: 13,369		
Perinatal mental health (est.): 1060	Households in temporary accommodation: 825	GP registered schizophrenia, bipolar affective disorder and other psychoses: 2,739	
Physical Inactivity (est.): 55,000	Statutory homeless households: 307		
	Learning disability: 1,103		

Appendix 1: Policy context

National Policy

Five Year forward view for Mental Health

In 2011, the Coalition government published a mental health strategy setting six objectives, including improvement in the outcomes, physical health and experience of care of people with mental health problems, and a reduction in avoidable harm and stigma⁵⁷. The strategy placed greater emphasis on outcomes and clarity on delivery. The six key strategic principles were:

1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a good experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination

In addition to this, in 2019, NHS England published the NHS Long Term Plan⁵⁸, setting out its priorities for healthcare over the next ten years and showing how the NHS funding settlement will be used. Within the Plan, the NHS commits to improving care for patients over the next 10 years across the life-course. Some of the actions include a focus on mental health. These are:

- expanding support for perinatal mental health conditions
- increasing funding for children and young people's mental health
- spending at least £2.3bn more a year on mental health care
- helping 380,000 more people get therapy for depression and anxiety by 2023/24
- delivering community-based physical and mental care for 370,000 people with severe mental illness a year by 2023/24.

Local Policy and Context

The Sustainability and Transformation Plan (STP)⁵⁹ sets out the challenges across health inequality, quality and performance, and finance for Harrow. It considers ways in which these challenges can be met across North West London, whilst establishing the parity between mental and physical health. There are eight key priorities for across the wider region:

1. Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves.
2. Improve children's mental and physical health and wellbeing.
3. Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness.
4. Reduce unwarranted variation in the management of long term conditions –diabetes, cardiovascular disease and respiratory disease.
5. Ensure people access the right care in the right place at the right time.
6. Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice.
7. Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population.
8. Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed.

⁵⁷ The Five Year Forward View for Mental Health. A report from the independent Mental Health Taskforce to the NHS in England February 2016.

⁵⁸ The NHS Long Term Plan 2019. Available here: www.longtermplan.nhs.uk/

⁵⁹ Harrow Sustainability and Transformation Plan (STP) Summary. April 2017

The STP is determined to embed parity between mental and physical health care. Thus there is the implicit assumption that all the above initiatives relate equally to mental and physical health and social care.

Central and North West London NHS Foundation Trust (CNWL) provides mental health, learning disability, eating disorder and offender care services in Harrow. The CNWL Five Year Plan 2016/17-2020/21 covers the objectives of the North West London STP and the Five Year Forward View for Mental Health ⁶⁰. There are 7 strategic priorities:

1. The patient at the centre of all we do
2. Partnerships
3. Service improvement, redesign and transformation
4. Workforce
5. Estates
6. ICT
7. Financial delivery

⁶⁰ CNWL. CNWL's Five Year Plan 2016/17-2020/21. Available here: <https://www.cnwl.nhs.uk/about/planning-performance-and-reports>

Appendix 2. Perinatal Mental Health

Mental health conditions commonly associated with pregnancy or post-partum.

Condition	Definition	Prevalence
Postpartum psychosis (puerperal psychosis)	Severe episode of mental illness which begins suddenly in the days or weeks after having a baby. Symptoms vary and can change rapidly. They can include high mood (mania), depression, confusion, hallucinations and delusions ⁶¹ .	2 in 1000
Chronic severe mental illness (SMI)	SMI includes diagnoses which typically involve psychosis, such as schizophrenia and bipolar disorder. A person with psychosis may have hallucinations, delusions and muddled thinking. ^{62 63}	2 in 1000
Post traumatic stress disorder (PTSD) in perinatal period	PTSD is experienced as nightmares, flashbacks, anger, and difficulty concentrating and sleeping. It may be a pre-existing condition or be triggered by a traumatic labour. ⁶⁴	30 in 1000
Mild-moderate depressive illness and anxiety in perinatal period	Symptoms of depression include feeling tearful, irritable or tired, appetite changes, and problems with sleep, concentration and memory. Typically also have negative thoughts and feelings of guilt and worthlessness; some may self-harm or attempt suicide. In mild depression there are a small number of symptoms that have a limited effect on daily life. In moderate depression there are more symptoms that can make daily life much more difficult than usual. Mild anxiety is experienced as feelings of being overwhelmed by responsibilities and unable to cope. People with depression may have feelings of anxiety as well. ^{65 66}	100 in 1000
Adjustment disorders and distress in perinatal period	Adjustment disorders occur in response to a significant life change or stressful life event. It is associated with marked distress not in keeping with what would be expected from the stressor, often affecting social function. Symptoms vary, and can include depression and anxiety. ⁶⁷	150 in 1000

Source: PHE, perinatal mental health

⁶¹ Royal College of Psychiatrists. Postpartum psychosis. Available here: <https://www.rcpsych.ac.uk/mental-health/problems-disorders/postpartum-psychosis>

⁶² Mental Health Wales. What is serious mental illness? Available here: <http://www.mentalhealthwales.net/what-is-serious-mental-illness/>

⁶³ Royal College of Psychiatrists. Psychosis – for young people. Available here: <https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/young-people/psychosis---for-young-people>

⁶⁴ J Affect Disord. 2018 Jan 1;225:18-31. doi: 10.1016/j.jad.2017.07.045. Epub 2017 Jul 27. Maternal posttraumatic stress disorder during the perinatal period and child outcomes: A systematic review. Cook N1, Ayers S2, Horsch A3.

⁶⁵ NICE. Depression in adults: recognition and management. Available here: <https://www.nice.org.uk/guidance/cg90>

⁶⁶ Best beginnings. Antenatal and postnatal mental health. Available here: <https://www.bestbeginnings.org.uk/helping-parents-with-mental-health-issues>

⁶⁷ Clinical Practice and Epidemiology in Mental Health. Adjustment disorder: epidemiology, diagnosis and management. Available here: <https://cpementalhealth.biomedcentral.com/articles/10.1186/1745-0179-5-15>

Appendix 3. Adult Psychiatric Morbidity Survey 2014.

The most recent survey of adult mental health in England was conducted in 2014, *Adult Psychiatric Morbidity Survey 2014*.⁶⁸

- Around one in six adults (15.7%) were identified with symptoms of CMD
- Women are more likely to be affected – one in five women (19.1%) compared to one in eight men (12.2%)
 - The gender gap is greatest in young women, women aged 16-24 are most likely to be affected
- Association with age – working-age people (16-64 years) were around twice as likely to have symptoms compared to those aged 65 and over
- The overall prevalence has remained stable since 2000, but the proportion with severe symptoms has increased (7.9% in 2000, compared to 9.3% in 2014)
- CMD-NOS remains the most common type of CMD (7.8%), followed by GAD (5.9%) then depression (3.3%)
- In men the prevalence of CMD does not vary with ethnicity
- In women CMDs are more common in Black/Black British women (29.3%), and more common in White British women compared to non-British White women (20.9% compared to 15.6%)
- People in receipt of ESA or benefits, a marker for socioeconomic adversity, have higher rates of CMD
- Approximately one-third (38.5%) of those with a CMD were receiving treatment
 - Treatment rates are highest in those with depression (61.3%), phobias (55.2%), OCD (53.6%) and GAD (49.9%)
 - Medication is the most common form of treatment
- Those who were female, white British, or in midlife were more likely to receive treatment
- Black/Black British had particularly low treatment rates

⁶⁸ NHS Digital. Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014. Available here: <https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014>