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Foreword



This year's Fundamental Facts follows the recent publication of the 2014 Adult Psychiatric Morbidity Survey (APMS). This highlights that, every week, one in six adults experiences symptoms of a common mental health problem, such as anxiety or depression, and one in five adults has considered taking their own life at some point. Nearly half of adults believe that, in their lifetime, they have had a diagnosable mental health problem, yet only a third have received a diagnosis. The APMS brings to the fore the widening gap between the mental health of young women and young men. Women between the ages of 16 and 24 are almost three times as likely (at 26%) to experience a common mental health problem as their male contemporaries (9%) and have higher rates of self-harm, bipolar disorder and post-traumatic stress disorder. This is clearly an issue that needs a deeper look and a strategy for addressing the factors that are causing it.

Another group at particular risk includes people in mid-life, with a noticeable increase in the prevalence of common mental health problems for both men and women between the ages of 55 and 64.

There are some very worrying levels of poor mental health among people receiving Employment and Support Allowance. Two thirds report common mental health problems and the same percentage report suicidal thoughts, with 43.2% having made a suicide attempt and one third (33.5%) self-harming, indicating that this is a population in great need of targeted support.

Despite an increase in people accessing treatment, around a third of all people with a mental health problem have sought no professional help at all.

At the centre of the Mental Health Foundation's research and programme work is the belief that many mental health problems are preventable. There is far more scope for interventions that reduce the incidence of people developing mental health problems and also support recovery. There are



solutions that we know are not yet being commonly applied, as well as gaps in our knowledge that need to be filled. The Foundation sees its role as being to address both the knowledge gap and the implementation gap.

The demographic inequalities in the prevalence and risks associated with mental health problems are reflected in treatment. People who are white British, female or in mid-life are more likely to receive treatment, while people in black ethnic groups have particularly low treatment rates. People with low incomes are more likely to have requested but not received mental health treatment.

Too often, we approach mental health problems by considering what individuals, families and communities are lacking. It is far more productive to use approaches that build on the knowledge, skills and relationships within communities. We believe that the right information, co-created and communicated through the right channels, can engage people and motivate them to have greater understanding of mental health, to see how we can all take steps to reduce our risks of becoming ill, and to advocate service and policy change to support good mental health. We intend for Fundamental Facts to help us answer the question: What can we do, both individually and collectively, to improve mental health in our society?

Public information is at the heart of what we do. Our online A-Z at www.mentalhealth.org.uk is consulted by hundreds of thousands of people every year and Fundamental Facts is one of our most popular publications.

Fundamental Facts is a resource for everyone interested in good mental health and preventing mental health problems from developing. Please share it and help us to advocate a prevention revolution in thinking about mental health.

A handwritten signature in black ink that reads "Jenny Edwards". The signature is fluid and cursive, with the first name "Jenny" written in a larger, more prominent script than the last name "Edwards".

Jenny Edwards CBE
Chief Executive
Mental Health Foundation

Introduction to the 2016 edition of Fundamental Facts



The Mental Health Foundation has a vision of a world with good mental health for all. To achieve this, we aim to help people understand, protect and sustain their mental health. Central to this is the need for evidence and data that can help us to answer the questions asked about mental health by a wide range of people – not only professionals and service planners, but also people with experience of mental health problems, communities that experience high levels of mental health inequity, politicians and the media. To help people understand mental health, we have committed to creating Fundamental Facts on a regular basis to illustrate that, while we still have a lot to learn about mental health, there is a lot about mental health that we know and can act on now.

The first Fundamental Facts was produced in 2007 to mark the landmark APMS in England.¹ Since 2015, Fundamental Facts has become a regular publication by researchers at the Mental Health Foundation. This 2016 edition of Fundamental Facts has been created to coincide with the release of the newest APMS results from England. The findings of the 2014 APMS show that, for most mental health problems, rates

have either remained unchanged since 2007 or have deteriorated over time. However, the rates of individuals seeking and receiving treatment have risen significantly since the 2007 survey, with over a third of individuals with symptoms of a common mental health problem receiving treatment.

In addition to the full UK report, this edition highlights the publication of a Fundamental Facts for each of the devolved nations in the UK, as we recognise that Northern Ireland, Scotland and Wales have unique health and social care structures and mental health needs. With each publication, we aim to strengthen the range of statistics that we include.

As the UK's leading public mental health charity, we draw together not only illustrative statistics on conditions and services, but also figures relating to the social, political and economic factors that impact on mental health. Fundamental Facts now also provides the statistics that inform readers about mental health equity, with the inclusion of information on protected characteristics and socioeconomic status and mental health.

¹This study is the source of the statistic that '1 in 4' people experience mental health problems in any year. The Foundation's 2016 Fundamental Facts report will present the findings of England's 2014 APMS published in September 2016. (Please note that due to reliability issues with the '1 in 4' statistic, '1 in 6' is recommended with regards to reporting figures of people who have experienced common mental health problems in any week.)



We have structured Fundamental Facts to reflect the many ways in which mental health is understood. We begin with an overview of mental health problems (Chapter 1), and then consider differences in the extent of mental health problems both across the life course (children and adolescents, adults and older adults) and with regard to groups who experience inequalities (Chapter 2). We have drawn together statistics about population groups that are exposed to greater risk, and that have higher rates of mental health problems and lesser access to opportunities to protect their mental health.

A significant body of work now exists that emphasises the need for a life-course approach to understanding and tackling mental and physical health inequalities. Disadvantage starts before birth and accumulates throughout life. This approach takes into account the differential experience and impact of social determinants throughout life (Chapter 3). We know that certain population subgroups are at higher risk of mental health problems because of greater exposure and vulnerability to unfavourable social, economic and environmental circumstances, which intersect with factors including gender, ethnicity and disability. Actions that

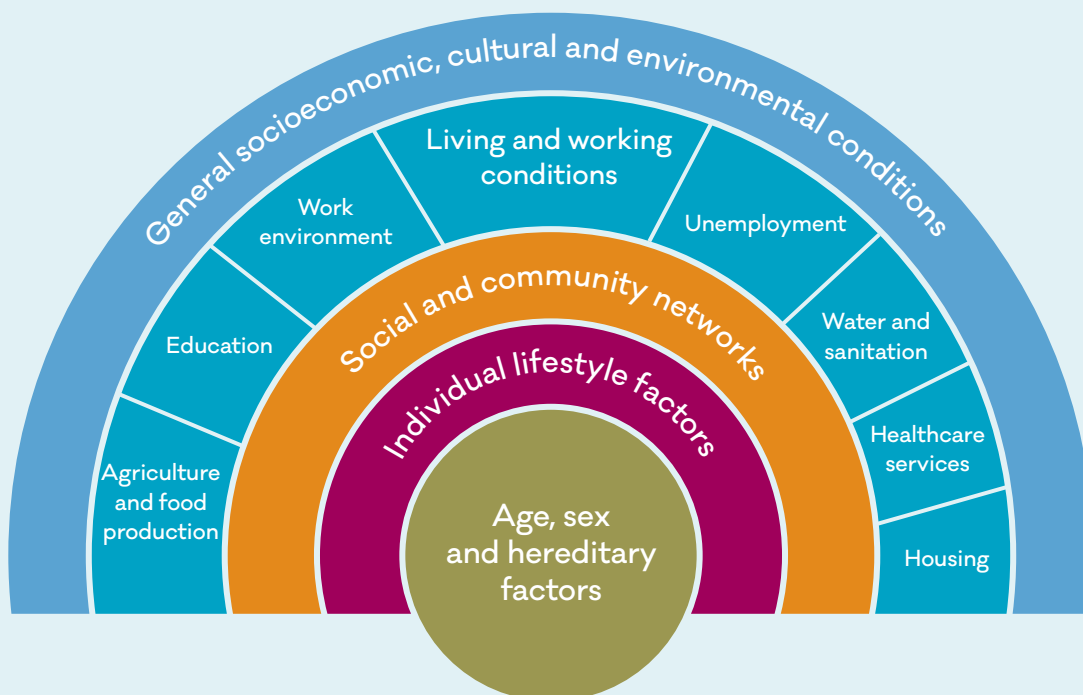


Figure 1: Diagram of the social determinants of mental health adapted from The Determinants of Health

Dahlgren, G., & Whitehead, M. (1993). Tackling inequalities in health: What can we learn from what has been tried? Background paper for *The King's Fund International Seminar on Tackling Health Inequalities*. Ditchley Park, Oxford: The King's Fund.



prevent mental health problems and promote mental health are an essential part of the efforts to improve the health of the UK and to reduce health inequities.¹ Treatment and care data highlights service use and the operation of legislation (Chapter 4). To make the case for investment in mental health, we have described the extent of the cost of mental health problems in society today (Chapter 5).

A note on the data: mental health is a complex field, so we have selected statistics that help to illustrate many of the challenges facing individuals, families, communities and wider society. We have used statistics from reputable sources such as government, research and policy organisations and peer-reviewed publications, and referenced all the statistics so that you can check the source and delve deeper if you wish.

A word of caution: these are illustrative statistics and not the whole picture. They are drawn from many different sources, collected on different dates, and gathered in different places from people with different characteristics (for example, age, sex and ethnicity). They should not be combined into simplistic equations to make comment – or policy or service decisions.

Where available, the Mental Health Foundation has used UK content in the compilation of this report, with comparisons across the devolved nations where possible; however, gaps in the coverage were noted in some areas that we deemed important to include. Where data was limited, we have included European, North American and global

content, noting throughout the text where we have needed to rely on non-UK data. In addition, we have tried our best to find equivalent statistics for all countries in the devolved nations; however, there were a number of areas where very little data was available.

Estimates of the numbers of people who experience mental health problems may vary due to measurements being taken with different sample populations and with different measuring tools. For example, some measurements look at the incidence of a disorder – that is, the rate of new cases in a period of time – and some measurements may look at the prevalence or the proportion of people with a disorder at a specific time. Similarly, some studies may use tools that measure mental health problems using narrow definitions, while other studies may use a broader definition. Indeed, cultural beliefs and differences across regions may also affect how people respond to studies and how data is measured. All of these factors may influence the quality of the data and, therefore, caution should be taken when interpreting and comparing data from one region to another. Unless stated otherwise, data reported in Fundamental Facts should not be compared across countries, and cultural differences should be taken into account when interpreting the data.

While there are a number of studies conducted on mental health, some are more scientifically robust than others and some are more recent. Fundamental Facts is a compilation of current and key statistics in mental health. We have left the data to speak for itself.

Glossary of terms



Absenteeism: The pattern of being absent from work.

Asylum seeker: A person who has left their country of origin and formally applied for asylum (i.e. protection) in another country, but whose application has not yet been concluded.²

Confidential inquiry: The purpose of a confidential inquiry is to detect areas of deficiency in clinical practice and devise recommendations to resolve them. Inquiries can also make suggestions for future research programmes. Confidential inquiries are 'confidential' in that details of the patients/cases remain anonymous, though reports on the overall findings are published.

Deprivation: The damaging lack of material benefits considered to be basic necessities in society.

Devolved nations: 'The devolved nations' makes reference to the other areas of the UK controlled by their own government: Scotland, Wales and Northern Ireland.

Epidemiology: Epidemiology is the study of how often diseases occur in different groups of people and why.³

Global health: The area of study, research and practice that prioritises improving health and achieving equity in health for all people worldwide.

Health inequalities: Health inequalities are preventable and unjust differences in health status experienced by certain population groups. People in lower socioeconomic groups are more likely to experience chronic ill health and die earlier than those who are more advantaged. Health inequalities are not only apparent between people of different socioeconomic groups – they exist between different genders and different ethnic groups.

Hyperkinetic: Hyperkinetic disorder is the generic term used to describe severe attention deficit hyperactivity disorder – an enduring disposition to behave in a restless, inattentive, distractible and disorganised fashion.⁴

Incidence: Incidence measures the rate of new cases of a disease or condition. Incidence is calculated as the number of new cases of a disease or condition in a specified time period (usually a year) divided by the size of the population under consideration who are initially disease-free.⁵

Informal carers: People who look after a relative or friend who needs support because of age, physical or learning disability, or illness, including mental illness. This might be unpaid care.⁶

Literature review: A literature review is a search and evaluation of the available literature/research/evidence in a subject or chosen topic area.



Longitudinal study: This is when a research study observes the outcome across a period of time, usually in years.

Manic/hypomanic symptoms: These are symptoms related to bipolar disorder that include elevated mood, decreased need for sleep, racing thoughts and excessive involvement in pleasurable activities irrespective of the consequences. Diagnostically, mania must last for at least seven days, whereas hypomania has to last for at least four days.

Maternal mental health: The mental health of expectant and new mothers.
Meta-analysis: This is a statistical test for assimilating research findings.

Observational study: This is research in which the researcher observes the outcomes or behaviours of individuals without attempting to change or influence the outcome.

Paternal mental health: The mental health of expectant and new fathers.
Presentism: The lost productivity that occurs when employees come to work ill and perform below par because of their illness.

Presentism: The lost productivity that occurs when employees come to work ill and perform below par because of their illness.⁷

Prevalence: Prevalence measures how much of some disease or condition there is in a population at a particular point in time. The prevalence is calculated by dividing the number of persons with the disease or condition at a particular time point by the number of individuals examined.⁸

Public health: The health of the population as a whole, especially as monitored, regulated, and promoted by the state.

Refugee: A person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such a fear, is unwilling to use the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such a fear, is unwilling to return to it. In the UK, a person is officially a refugee when they have their claim for asylum accepted by the government.⁹

Risk factors: The presence of risk factors means that someone is more vulnerable to or at an increased probability of developing a mental health condition. These can be physical, psychological, social or biological.

Social cohesion: The Organisation for Economic Co-operation and Development (OECD) defines a cohesive society as one that works towards the wellbeing of all of its members, fights exclusion and marginalisation, creates a sense of belonging, promotes trust, and offers its members the opportunity of upward mobility. Its basic components include concerns around social inclusion, social mobility and social capital.¹⁰



Social determinants: The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at the global, national and local levels. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries.¹¹

Social inequality: Social inequality is the existence of unequal opportunities and rewards for different social positions or statuses within a group or society. This may be in relation to race, culture, economic background or class.

Socioeconomic status: Socioeconomic status is commonly known as the social standing or class of an individual or group. It is usually measured as a combination of education, income and occupation.¹²

Systematic review: A systematic review is a type of literature review that collects and critically analyses multiple research studies or papers.

Unsecured debts: An unsecured debt is an obligation or debt that does not have a specific asset, like a house or car, serving as collateral for the payment of the debt.

Wellbeing: This is a measure of social progress and relates to creating the conditions in society for individuals to thrive. The World Health Organization defines wellbeing as a state where everyone is able to realise their potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to their community.¹³

1. The extent of mental health problems



1.1 The prevalence and impact of mental health problems

Mental health problems are a growing public health concern. This chapter provides an overview of the prevalence of mental health problems, both globally and in the UK, and details on the main types of problems and their impact on mortality, disability and suicidal intent. The association between violence and mental health issues is also explored.

Global

- A recent index of 301 diseases found mental health problems to be one of the main causes of the overall disease burden worldwide.¹⁴ (They were shown to account for 21.2% of years lived with disability worldwide.)
 - According to the 2013 Global Burden of Disease study, the predominant mental health problem worldwide is depression, followed by anxiety, schizophrenia and bipolar disorder.¹⁵
 - In 2013, depression was the second leading cause of years lived with disability worldwide, behind lower back pain. In 26 countries, depression was the primary driver of disability.¹⁶
 - Depressive disorders also contribute to the burden of suicide and heart disease on mortality and disability; they have both a direct and an indirect impact on the length and quality of life.¹⁷
- The World Health Organization (WHO) estimates that between 35% and 50% of people with severe mental health problems in developed countries, and 76 – 85% in developing countries, receive no treatment.¹⁸

The UK

Measuring the prevalence of mental health problems is challenging for many reasons: underfunding, the hidden nature of mental health issues, and the variation in diagnostic practices across the country. The devolved nations measure mental health in different ways, which makes it difficult to determine whether areas have more or fewer mental health problems due to differences in the methods used. Therefore, we need to be cautious about directly comparing statistics, as they are not always resulting from similar surveying techniques.

The Adult Psychiatric Morbidity Survey (APMS), which has been carried out every seven years since 1993, offers some of the most reliable data for the trends and prevalence of many different mental health problems and treatments. The survey carried out in 2014 and published in 2016 is the source of many of the prevalence figures cited in this section.

Each of the APMS surveys in the series used the revised Clinical Interview Schedule (CIS-R). The CIS-R is an interviewer-administered structured interview schedule that assesses the



presence of non-psychotic symptoms in the week prior to interview. It is used to provide prevalence estimates for 14 types of common mental health problem symptoms and six types of common mental health problems, which include: depression, generalised anxiety disorder (GAD), panic disorder, phobias, obsessive compulsive disorder (OCD) and common mental disorders not otherwise specified (CMD-NOS). The CIS-R is also used to produce a score that reflects the overall severity of common mental health problem symptoms. A CIS-R score of 12 or more is the threshold applied to indicate that a level of common mental health problem symptoms is present and warrants primary care recognition. A CIS-R score of 18 or more indicates more severe or pervasive symptoms of a level likely to warrant intervention, e.g. medication or psychological therapy.¹⁹

- One in six (17%) of people over the age of 16 had a common mental health problem in the week prior to being interviewed. This is an increase from the 2007 survey, which found that 16.2% had a common mental health problem in the past week.²⁰
- Since 2000, there has been a slight steady increase in the proportion of women with symptoms of common mental health problems (CIS-R score of 12 or more), with this increase in prevalence mostly evident at the severe end of the scale (CIS-R 18 or more). Men overall have remained relatively stable.²¹

- Nearly half (43.4%) of adults think that they have had a diagnosable mental health condition at some point in their life (35.2% of men and 51.2% of women). A fifth of men (19.5%) and a third of women (33.7%) have had diagnoses confirmed by professionals.²²
- A third of people (36.2%) who self-identified as having a mental health problem in the 2014 APMS have never been diagnosed by a professional.²³
- In 2014, 19.7% of people in the UK aged 16 and older showed symptoms of anxiety or depression – a 1.5% increase from 2013. This percentage was higher among females (22.5%) than males (16.8%).²⁴
- The APMS (2014) reports that, in England, the rates of common mental health problems are highest in the South West (20.9%), North West (19%), West Midlands (18.4%) and London (18%). They are lowest in the South East (13.6%) and the East (14.4%).
- In the 2015 Welsh Health Survey, 13% of adults (aged 16 and over) living in Wales were found to be currently receiving treatment for a mental health problem.²⁵
- In the 2014–15 Northern Ireland Health Survey, 19% of respondents showed signs of a possible mental health problem.²⁶
- In the 2014 Scottish Health Survey, it was found that 16% of adults exhibited signs of a possible psychiatric disorder, according to the General Health Questionnaire (GHQ-12) scores.²⁷



Base: all adults

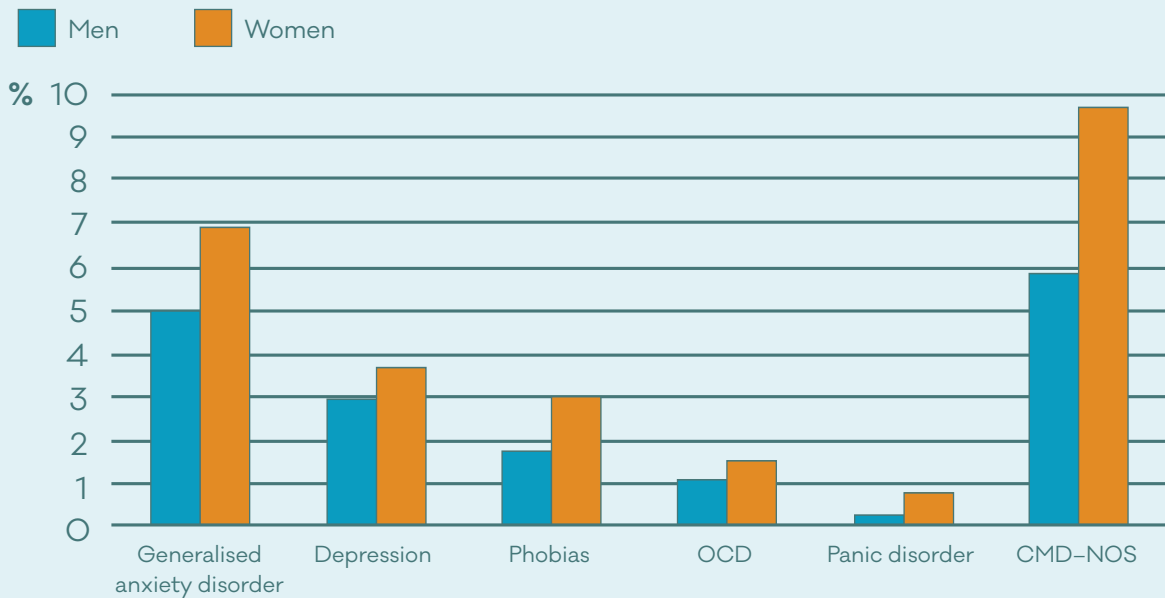


Figure 1a: APMS prevalence of common mental health problems by sex
 Stansfeld, S., Clark, C., Bebbington, P., King, M., Jenkins, R., & Hinchliffe, S. (2016). Chapter 2: Common mental disorders. In S. McManus, P. Bebbington, R. Jenkins, & T. Brugha (Eds.), *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital.

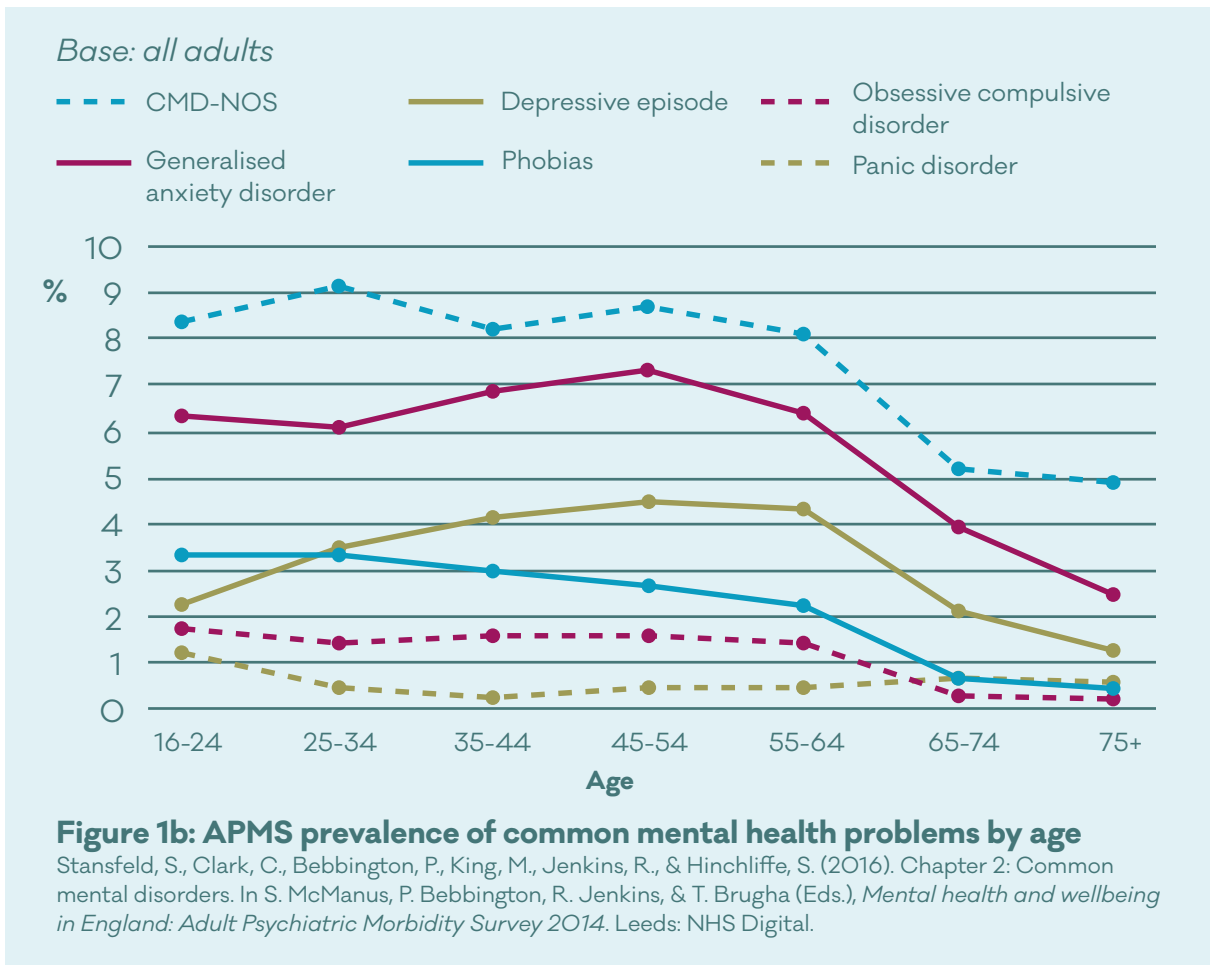
- Findings from the APMS (2014) show that all types of common mental health problems were more prevalent in women than in men, with significance for GAD, phobias, panic disorder and CMD-NOS. See Figure 1a for the prevalence of common mental health problems by sex.²⁸
- The gap in rates of common mental health problems between young men and women (aged 16–24) has been growing. In 1993, young women were twice as likely (19.2%) to have symptoms of a common mental health problem compared to young men (8.4%). In 2014, these symptoms were nearly three times more common in young women

(26.0%) than in men (9.1%). Anxiety was found to be more common in young women than in other age groups.²⁹

- Health surveys across the devolved nations found similar gender patterns in the distribution of common mental health problems.

	Women (%)	Men (%)
Wales³⁰	16	10
Northern Ireland³¹	20	16
Scotland³²	17	14

Table 1a: Gender patterns of common mental health problems in the devolved nations



- Findings from the APMS (2014) show that, with the exception of panic disorder, all types of mental health problems were more prevalent in people of working age (aged 16–64) than those aged 65 and over. See Figure 1b for the prevalence of common mental health problems by age group.³³
- In the survey, common mental health problems were also found to be more prevalent in certain groups of the population, including black women, adults under the age of 60 who are living alone, women who live in large households, unemployed adults, those in receipt of benefits and those who smoke cigarettes.³⁵
- Since the last survey in 2007, the APMS (2014) shows an increase in common mental health problems among late-mid-life men and women (aged 55–64), suggesting that this population group may be particularly vulnerable to the impact of the economic recession.³⁴



1.2 What are the main types of mental health problems?

Common mental health problems

- According to the National Institute for Health and Care Excellence (NICE), common mental health problems include depression, GAD, social anxiety disorder, panic disorder, OCD, and post-traumatic stress disorder (PTSD).³⁶ The APMS (2014) does not include PTSD as a common mental health problem.
- In 2013, there were 8.2 million cases of anxiety disorder, more than 1 million cases of addiction and almost 4 million cases of mood disorders, including bipolar disorder, in the UK.³⁷
- A 2006 meta-analysis of 26 epidemiologic studies of children and adolescents born in Britain between 1965 and 1996 found that the one-year prevalence of depression in mid- to late-adolescence was between 4% and 5%.³⁸
- According to the APMS (2014), in England, one in six (17%) of adults met the diagnostic criteria for at least one common mental health problem in the week prior to being surveyed.³⁹
- The prevalence of mental health problems has increased for each common mental health problem, with the exception of panic disorder, for adults over the age of 16 (see Table 1b).
- In 2014, 17.5% of working-age adults (16–64 years old) had symptoms of common mental health problems. However, for those aged over 65, the rate is much lower (10.2% of 65–74 year olds and 8.1% of those aged 75+).⁴⁰
- For working-age adults, the proportion of common mental health symptoms (CIS-R score of 12+) has remained stable between 2000 and 2014; however, the prevalence of severe mental health symptoms (CIS-R score of 18+) has increased (7.9% in 2000, 8.5% in 2007, and 9.3% in 2014).⁴¹

Mental health condition	2007 (%)	2014 (%)
GAD	4.4	5.9
Depression	2.3	3.3
Phobias	1.4	2.4
OCD	1.1	1.3
Panic disorder	1.1	0.6
CMD-NOS	9.0	7.8

Table 1b: Prevalence of common mental health problems (adults 16+)

Stansfeld, S., Clark, C., Bebbington, P., King, M., Jenkins, R., & Hinchliffe, S. (2016). Chapter 2: Common mental disorders. In S. McManus, P. Bebbington, R. Jenkins, & T. Brugha (Eds.), *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital.



- In the UK, women are almost twice as likely as men to be diagnosed with anxiety disorders.⁴² From the APMS (2014) results it can be deduced that, in England, 6.8% of all women were diagnosed with general anxiety disorder compared to 4.9% of all men.⁴³

Post-traumatic stress disorder

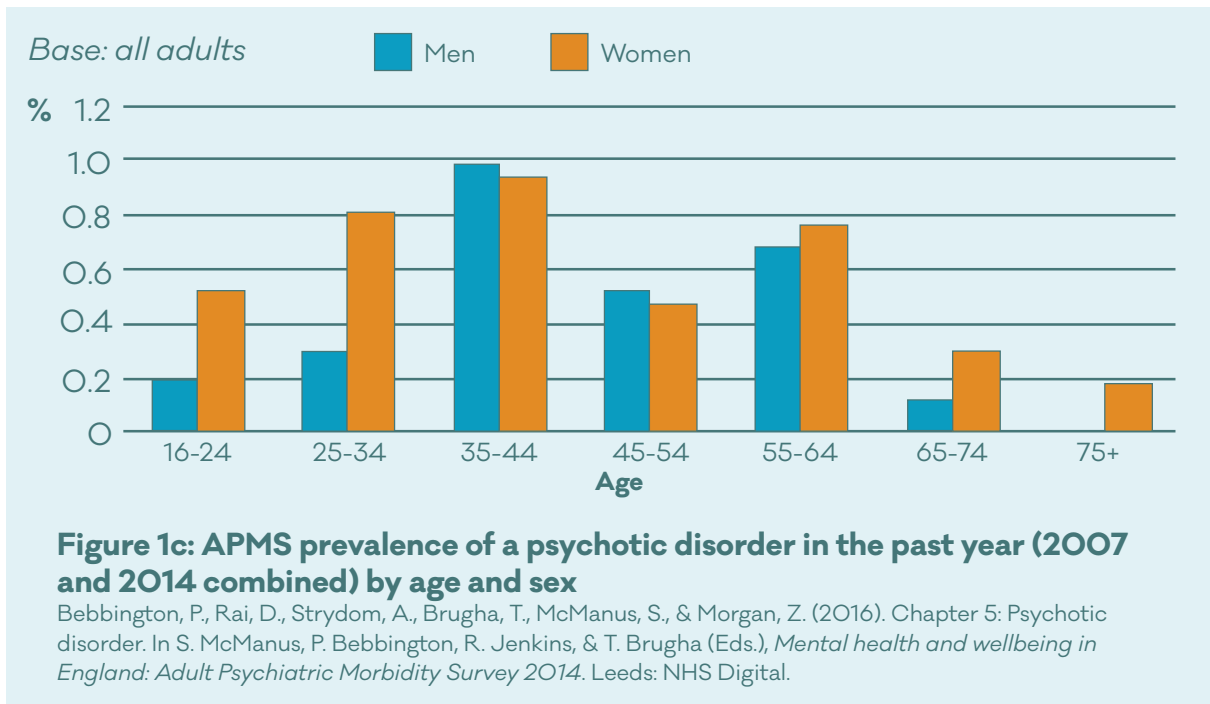
- About one third of adults in England report having experienced at least one traumatic event in their lifetime. Rates were similar for both men (31.5%) and women (31.2%).⁴⁴
- Overall, 4.4% of adults screened positively for PTSD in the last month. This is in contrast to the number of adults who believed they had PTSD, which was lower (3.3%).⁴⁵
- Of those who screened positively for PTSD, only one in eight (12.8%) had been diagnosed by a health professional, while less than half (47.9%) were receiving mental health treatment. Almost 40% of those who had screened positively for PTSD had not spoken to their GP about mental health in the last year.⁴⁶
- Traumatic experiences were found to be associated with lone households, with households containing a lone adult under the age of 60 and households with no children having the highest rates of traumatic experience (39.2%) and PTSD (10.8%).⁴⁷

- Working-age adults who are economically inactive are more likely to have experienced a traumatic event (38.2%) or PTSD (10.5%) compared to those who are in employment (29.7% and 2.7% respectively).⁴⁸
- Those on out-of-work benefits had higher rates of PTSD (25.2% of men and 45.9% of women) than those not receiving out-of-work benefits (3.6% of men and 4.9% of women).⁴⁹

Severe mental health problems

Psychotic mental health conditions

- The prevalence of psychotic conditions in the past year has remained relatively unchanged between the 2007 and 2014 APMS. Less than one adult in a hundred had a psychotic disorder in the past year. In 2007, the estimate was 0.4% and for 2014 it is 0.7%. As the numbers of positive cases were low (23 in 2007 and 26 in 2014), researchers pooled data from the 2007 and 2014 surveys to create a larger sample and found, using the combined dataset, the overall prevalence of a psychotic disorder in the past year to be 0.5% of the adult population.⁵⁰
- The combined data shows no difference in the prevalence rate found for men and women (0.5% and 0.6% respectively). The highest prevalence for both men and women was found among those aged 35–44 (1.0% and 0.9% respectively) (see Figure 1c).⁵¹

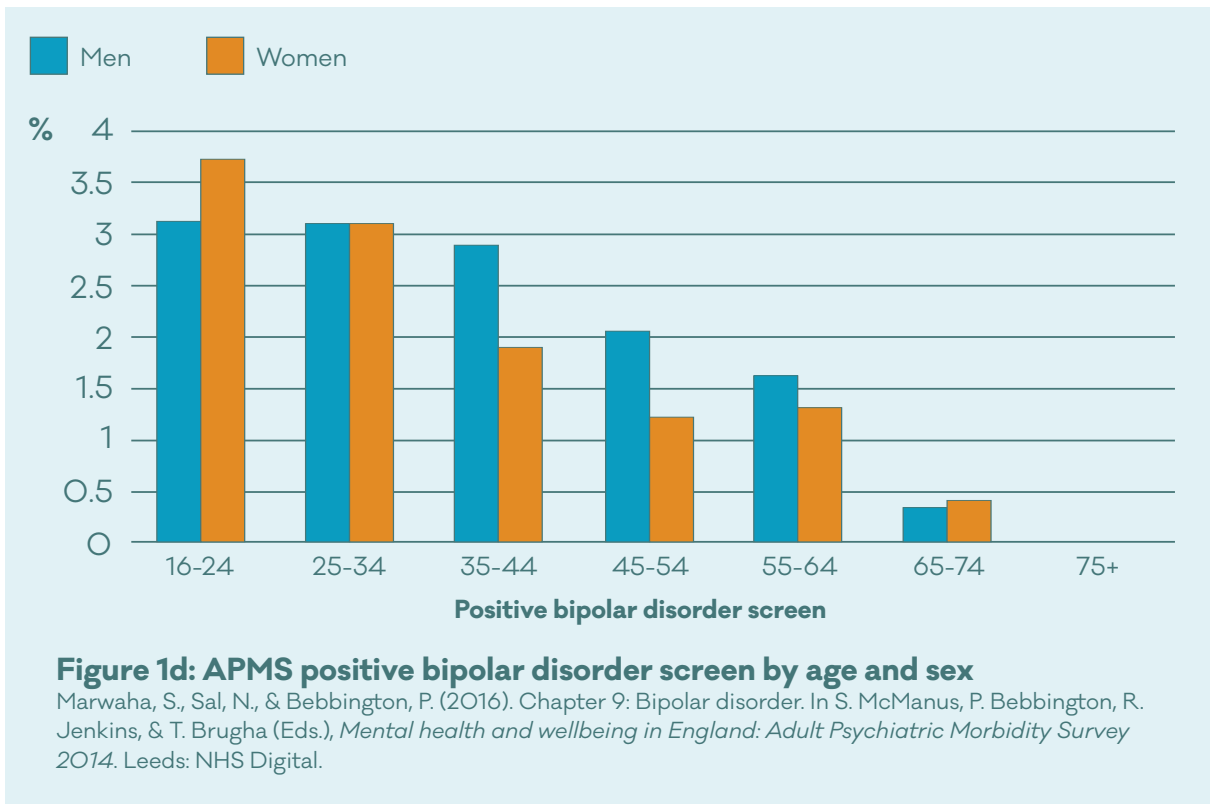


- Psychotic disorder was found to be associated with ethnic group, and prevalence rates in the past year were higher among black men (3.2%) than men from any other ethnic group (0.3% white, 1.3% Asian, and no cases observed in mixed/other ethnic groups (using combined 2007 and 2014 data)). No significant differences were observed for ethnic groups among women.⁵²
- Higher rates of psychotic disorder were observed in those living alone (1.1%) and were lower in people living with others (0.6% with children and 0.4% with other adults (using combined 2007 and 2014 data)).⁵³

Bipolar disorder

Since the APMS series started, this is the first year in which bipolar disorder was measured; therefore, no trend data can be drawn against previous years. The Mood Disorder Questionnaire (MDQ) was used to assess the presence of bipolar disorder. A positive screen required the evidence of at least seven lifetime manic/hypomanic symptoms and moderate or serious functional impairment.⁵⁴

Findings from the APMS (2014) showed that 2.0% of the population screened positive for bipolar disorder. Rates did not differ significantly between men and women,⁵⁵ though they did differ significantly between age groups. Prevalence rates were highest in younger age groups: 3.4% of 16–24 year olds, 0.4% of those aged 65–74 and none of those aged over 75 (see Figure 1d).



Autism spectrum disorder

- Based on data collected from the APMS in 2007 and 2014, it is estimated that 0.8% of adults have autism spectrum disorder (ASD). Men are estimated to have higher rates of ASD (1.5%) than women (0.25%). No clear differences were found in the levels of ASD by ethnicity or age; however, this is considered to be due to the low sample size within the surveys.⁵⁶
- Adults with ASD were found to have lower levels of education, with higher rates of ASD being recorded in those with no qualifications (1.5%) compared to those with degree-level qualifications (0.2%).⁵⁷

Personality disorders

- For those aged 16 and older, over 1 in 10 (13.7%) screened positively for any personality disorder, with similar rates found for both men and women. In adults aged 18–64, 3.3% screened positively for antisocial personality disorder (4.9% in men and 1.8% in women) and 2.4% of 16–64 year olds screened positively for borderline personality disorder (similar rates were found between genders).⁵⁸

Attention deficit hyperactivity disorder

- In the 2014 APMS, 1 in 10 (9.7%) adults screened positively for attention deficit hyperactivity disorder (ADHD). This was similar



for both men (10.0%) and women (9.5%). Rates of ADHD in adults appear to have risen from the 8.2% recorded in the 2007 APMS results.⁵⁹

- The rates of ADHD appear to decrease with age, with the highest rates of ADHD recorded in those aged 16–24 (14.6%).⁶⁰
- Employment status was found to be strongly associated with ADHD levels, with levels of ADHD found to be twice as high in those who were unemployed (14.6% for unemployed men and 14.5% for unemployed women) than those who are employed (7.3% of employed men and 6.7% for employed women). These rates were higher in those who were economically inactive, with one in four men and one in seven women who were economically inactive screening positively for ADHD (see Figure 1e).⁶¹ The term ‘unemployed’ refers to those who have been out of work for the past four weeks, but

are available to return to work within two weeks, while ‘economically inactive’ also includes students, those looking after the home, the long-term sick or disabled, and retirees.

- One in three people receiving Employment and Support Allowance (ESA) screened positively for ADHD compared to one in eleven who did not receive out-of-work benefits.⁶²
- One in three adults (32.2%) who screened positively for ADHD were receiving treatment (medication, counselling or therapy) for a mental health or emotional problem.⁶³
- Almost a quarter of individuals who screened positively for ADHD were receiving treatment for anxiety (23.8%) or depression (22.9%).⁶⁴
- In 2014, 7.8% of adults with a positive screening of ADHD reported that they had requested a particular mental health treatment in the past 12 months but had not received the requested treatment.⁶⁵



Figure 1e: APMS positive ADHD screen by employment status and sex

Brugha, T., Asherson, P., Strydom, A., Morgan, Z., & Christie, S. (2016). Chapter 8: Attention-deficit/hyperactivity disorder. In S. McManus, P. Bebbington, R. Jenkins, & T. Brugha (Eds.), *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital.



1.3 Suicide and self-harm

Suicide and self-harm are not mental health problems themselves, but they are linked with mental distress. Self-harm is not necessarily linked with suicide, but can increase the risk of suicide. In contrast to statistics on the prevalence of mental health problems, suicide statistics are collected systematically across the UK through coroners' reports. We therefore have a much clearer picture of the number of people who die by suicide than of those affected by mental health problems.

- According to the Office for National Statistics (ONS), in 2014, a total of 6,122 suicides were recorded in the UK for people aged 10 and older (10.8 deaths per 100,000 population). This equates to approximately one death every two hours – a 2% decrease from 2013. Of these, 75.6% were male and 24.4% were female.⁶⁶
- People with a diagnosed mental health condition have been shown to be at a higher risk of attempting and completing suicide,⁶⁷ with more than 90% of suicides and suicide attempts having been found to be associated with a psychiatric disorder.⁶⁸
- The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2015) found that, from 2003–13, there were 18,220 suicides by people who had had mental health service contact over the past year in the UK.⁶⁹
- As the previous figures indicate, suicide rates have consistently been lower for women than for men. Between 2007 and 2013, the suicide rate for women in the UK stayed constant, while the rate for men increased significantly. (However, between 2013 and 2014, the suicide rate for women increased in England and Scotland.)⁷⁰
- In 2014, suicide was the leading cause of death for men under 50 years of age in England and Wales, and for women aged 20–34.⁷¹ The demographic with the highest suicide rate (of 23.9 per 100,000 population) was men aged 45–59.⁷²
- Recent statistics show that 72% of people who died by suicide between 2002 and 2012 had not been in contact with their GP or a health professional about these feelings in the year before their suicide.⁷³
- In England, more than 4,882 suicides (among people aged 10 and over) were registered in 2014 – a 3% increase from the previous year. Although males account for nearly three quarters of this figure, the overall increase was driven by a 14% rise in suicide among females.⁷⁴
- There is significant regional variation in suicide rates across England; the highest rate was 13.2 deaths by suicide per 100,000 population in North East England, while the lowest was 7.8 deaths per 100,000 population in London.⁷⁵
- In Northern Ireland, a total of 268 suicides were registered in 2014. Males accounted for over 75% of this figure (207 deaths).⁷⁶



- The number of suicides in Northern Ireland amounts to a rate of 16.4 per 100,000 population. This was the highest of the devolved nations in 2014, compared to 10.3 in England, 9.2 in Wales and 14.5 in Scotland.⁷⁷

Suicide attempts

- The APMS (2014) shows that a fifth of adults (20.6%) reported that they had thought of taking their own life at some point in their lives. Higher rates were reported by women (22.4%) than by men (18.7%).⁷⁸
- The same study found that young people aged 16–24 were more likely to report suicidal thoughts than any other age group, with women in this age group having the highest levels

of suicidal thoughts than any other group (see Figure 1f).⁷⁹

- Rates of suicidal thoughts in the past year have increased from 3.8% in 2000 to 5.4% in 2014. This considerable increase was found for both men and women. Significant increases were found for men aged 55–64, which nearly tripled between 2007 (1.9%) and 2014 (5.3%) (see Figure 1g overleaf).⁸⁰
- One in 15 (6.7%) of adults in England are estimated to have made a suicide attempt at some point in their life. This was found to be higher for women (8.0%) than men (5.4%).⁸¹
- A 2014 UK survey found that one in six people tried to take their own life while on a waiting list for psychological therapy.⁸²

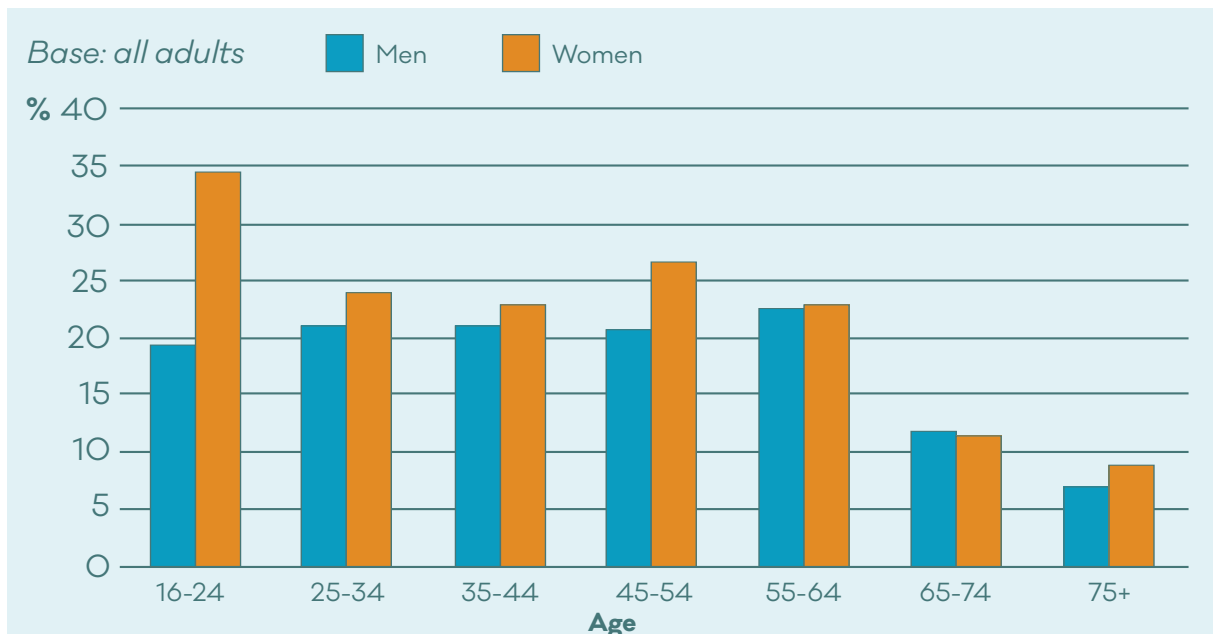


Figure 1f: Suicidal thoughts ever by age and sex

McManus, S., Hassiotis, A., Jenkins, R., Dennis, M., Aznar, C., & Appleby, L. (2016). Chapter 12: Suicidal thoughts, suicide attempts, and self-harm. In S. McManus, P. Bebbington, R. Jenkins, & T. Brugha (Eds.), *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital.



Base: adults aged 16-74 and living in England



Figure 1g: Suicidal thoughts in the past year by sex – 2000, 2007 and 2014

McManus, S., Hassiotis, A., Jenkins, R., Dennis, M., Aznar, C., & Appleby, L. (2016). Chapter 12: Suicidal thoughts, suicide attempts, and self-harm. In S. McManus, P. Bebbington, R. Jenkins, & T. Brugha (Eds.), *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital.

Self-harm

Self-harm is a broad category covering any deliberate self-injury, and can occur with or without suicidal intent. Self-harm is especially common among younger people, and is linked to anxiety and depression, although it also affects adults and those with no diagnosed mental health problem.

Unlike in the case of suicide, it is very difficult to gather reliable statistics about self-harm; most studies focus on hospital admissions (90% of which are for self-poisoning, often with suicidal intent), but many cases of self-harm do not lead to hospital admission.⁸³

The number of hospital admissions due to intentional self-harm has been rising over the last decade, from 91,341 in September 2005–August 2006 to 112,096 in September 2014–August 2015 – a decrease of 1.8% from the previous 12-month period, when there were 114,105 admissions. There were 69,800 female admissions (a 0.6%

decrease from the 70,209 admission episodes recorded in the previous 12 months) and 42,282 male admissions (a 3.6% decrease from the 43,871 admissions the year before). Women and girls comprise the majority (62%) of admissions for intentional self-harm.⁸⁴

- A 2016 observational study of self-harm among people (aged 15 and over) presenting to hospital in England between 2000 and 2012 found that rates of self-harm were 362 per 100,000 population in males and 441 per 100,000 population in females (who accounted for 58.6% of the episodes recorded).⁸⁵
- Self-harm commonly co-occurs with depression, anxiety, borderline personality disorder and eating disorders.⁸⁶
- In 2014, statistics found that 1 in 15 people (7.3%) had self-harmed at some point in their life. This was higher in women (8.9%) than in men (5.7%). The rates did not differ by ethnic group.⁸⁷



- The highest rates of self-harm were reported by women aged 16–24, in which one in four (25.7%) reported having self-harmed, compared to 9.7% of men in this age group.⁸⁸
- The rates of self-harm have increased by 4% over the last 14 years (see Figure 1h).⁸⁹
- The main reason for self-harm behaviour was reported as being to relieve unpleasant feelings or emotions (by 76.7% of adults).⁹⁰
- Half of those who had self-harmed (50.1%) reported seeking help, 26.4% went to their GP, 25.5% had attended the hospital or specialist medical/psychological services, and 21.7% asked family or friends for help or support. This was equal for both men and women; however, young people aged 16–24 were less likely to seek help from medical or psychological services, reporting higher help-seeking rates with family or friends.⁹¹
- Two thirds (66.9%) of 16–34 year olds reported not seeking help for self-harm.⁹²
- A 2015 study in Ireland found that 12.1% of adolescents had self-harmed at some point in their lives. Only 9% of young people had sought professional help prior to self-harming, and 12% after self-harming.⁹³
- Rates of reported deliberate self-harm among British military personnel increased by 36% between 2010–11 and 2014–15. Although some of this increase may be due to improved methods of capturing data and increased awareness, the data clearly shows that some groups are particularly at risk, such as women (4 per 1,000 personnel compared to 2.1 men per 1,000 personnel in 2014–15), and those aged under 20 (5.5 per 1,000 compared to 1.6 per 1,000 aged 30–39). Army personnel were also at greater risk than those in the naval forces or the RAF.⁹⁴



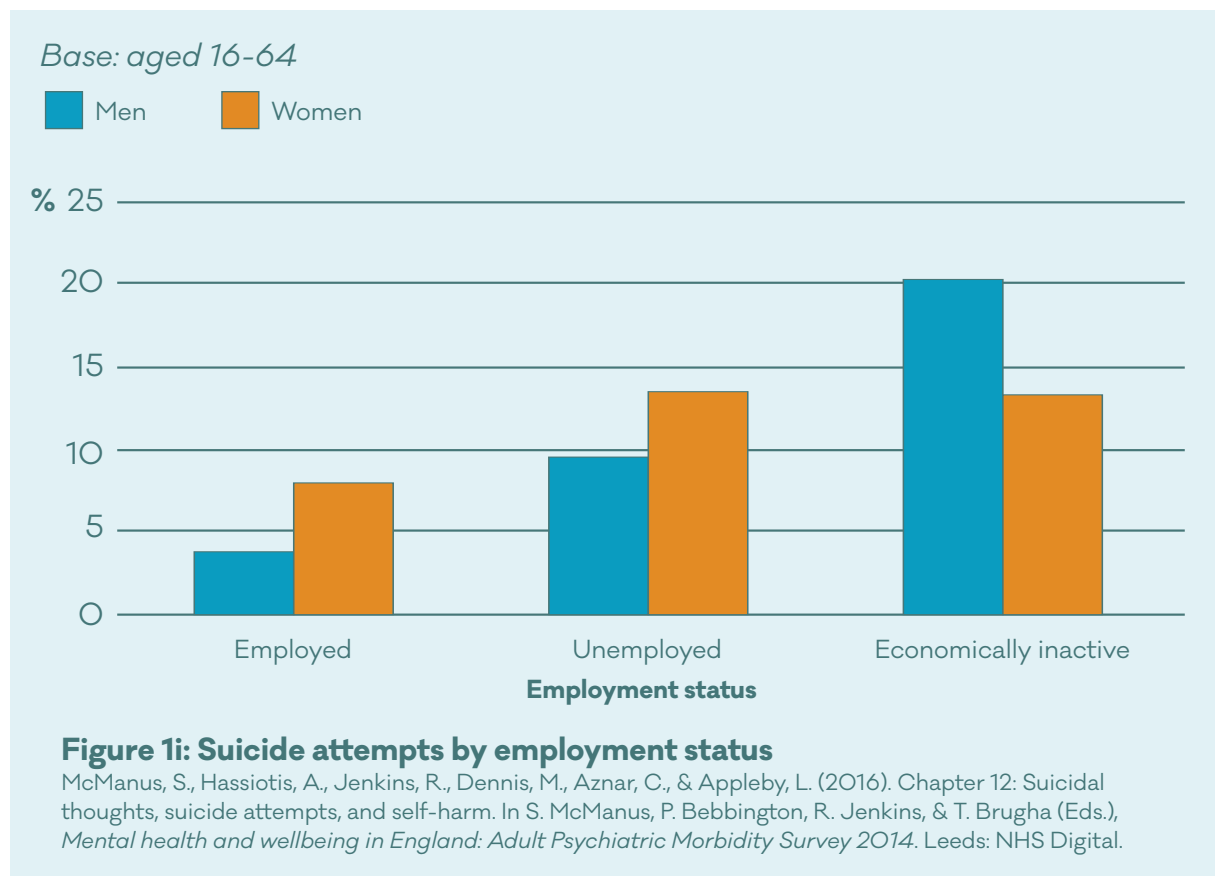
Figure 1h: Percentage of people who have self-harmed

McManus, S., Hassiotis, A., Jenkins, R., Dennis, M., Aznar, C., & Appleby, L. (2016). Chapter 12: Suicidal thoughts, suicide attempts, and self-harm. In S. McManus, P. Bebbington, R. Jenkins, & T. Brugha (Eds.), *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital.



Risk factors

- Non-fatal self-harm is the strongest risk factor for subsequent suicide; a 2014 systematic review found that 1 in 25 patients presenting to hospital for self-harm will die by suicide within five years,⁹⁵ while a 2013 literature review found that up to 16% of survivors try again within a year, with 2% of repeat attempts being fatal.⁹⁶
- Employment status was associated with suicidal thoughts, suicide attempts and self-harm in working-age adults (i.e. 16–64 years). This was strongest for men, with higher rates being reported among those who were economically inactive.⁹⁷
- Two thirds (66.4%) of people in receipt of ESA had thought about taking their life, almost half (43.2%) had made a suicide attempt, and a third (33.5%) reported self-harming, indicating that this is a population in great need of support. People in receipt of other benefits also had higher rates of suicidal thoughts, suicide attempts and self-harm than those not in receipt of these benefits (see Figure 1i).⁹⁸
- Living alone was found to be a predictor of suicidal thoughts, with people under 60 who lived alone being found to be more likely to have suicidal thoughts than those of the same age who were living with others.⁹⁹





1.4 Challenging myths and stereotypes: Violence and mental health

"Most people with mental health problems are not violent and most people who are violent are not mentally ill."¹⁰⁰

Professor Dame Sally Davies
UK Chief Medical Officer

Fundamental Facts can help to challenge myths and stereotypes. One of the most discriminatory stereotypes is the incorrect association between mental health problems and violent behaviour. The media may play a role in portraying people with mental health problems as violent. A 2011 study on discrimination in England reported that 14% of national newspaper articles addressing mental health issues referred to those with mental health problems as being a danger to others.¹⁰¹

- People with severe mental health problems are much more likely to harm themselves than they are to harm others. In 2013, 1,876 suicides were recorded among mental health inpatients in the UK, compared to 51 homicides.¹⁰²
- A recent analysis found that the rate of violence over a four-year period among those with severe mental health problems was 2.88%, compared to 0.83% in the general population. Rather than mental illness causing violence, the two were found to be connected mainly through the accumulation of other risk factors, such as substance abuse and childhood abuse/neglect.¹⁰³
- People with mental health problems are more likely to be victims of violence than those without mental health problems. A 2013 British survey among persons with severe mental health problems found that:
 - 45% had been victims of crime in the previous year
 - One in five had experienced a violent assault
 - People with mental health problems were five times more likely to be a victim of assault and any crime than those without
 - Women with severe mental health problems were 10 times more likely to experience assault than those without
 - People with mental health problems were more likely to report that the police had been unfair compared to the general population¹⁰⁴

2. Differences in the extent of mental health problems



2.1. Mental health across the lifetime

The Mental Health Foundation takes a 'life-course' approach to mental health. A life-course approach calls for interventions and approaches across the lifespan, including before birth, early family-formation years, adolescence, adulthood and working age, and older adulthood. In each area, different challenges present themselves, as well as opportunities to intervene and support mental health. This chapter describes how mental health problems may present over the course of a lifetime, from birth all the way up until later life.

In this chapter, each of these life-course areas will be covered, giving the key statistics of how mental health affects us at each point in our lives.

2.1.1 Family and parenting

Starting a family and parenting can be a milestone in individuals' lives. Many parents with young, dependent children experience short- or long-term mental health problems and many would be affected by a mental health problem as a result of their parenting role. Children can cope well with short-term emotional and behavioural problems experienced by their parents; however, more severe

and long-term parental mental health problems can have a significant negative impact on every aspect of a child's development.¹⁰⁵ It is important to note, however, that this is not to say that all children of parents who experience mental health problems will develop a problem themselves.

Debunking the myth

Although poor maternal and paternal mental health has been associated with poor outcomes in children, not all children of parents who have mental health problems are at risk. A number of biological dispositions, sociocultural contexts and psychological processes are likely to interact and can serve as protective factors or risk factors for both parents' and children's mental health.^{106,107}

Prevalence of maternal and paternal mental health problems

- In 2016, the Royal College of Psychiatrists reported that approximately 68% of women and 57% of men with mental health problems are parents.¹⁰⁸
- According to a report published in 2015, the most common mental health problems experienced during pregnancy and after birth are anxiety, depression and PTSD.¹⁰⁹



- Based on 2012 statistics, the number of women experiencing mental health problems per 1,000 maternities in the UK is:¹¹⁰
 - Postpartum psychosis: 2 per 1,000
 - Serious mental illness: 2 per 1,000
 - Severe depressive illness: 30 per 1,000
 - Mild–moderate depressive illness and anxiety states: 100–150 per 1,000
 - PTSD: 30 per 1,000
 - Adjustment disorders and distress: 150–300 per 1,000
- On average, 39% of those who experienced antenatal depression went on to have postnatal depression.¹¹¹ Similarly, on average, 47% of those with postnatal depression had also experienced antenatal depression. Almost 7% of women who reported severe depressive symptoms in pregnancy also experienced symptoms after childbirth.¹¹²
- A literature review from 2008 revealed that women with a history of serious affective disorders (e.g. depression, bipolar disorder or anxiety) are at increased risk of recurrence, even if they have been well during the pregnancy. Furthermore, between 3% and 10% of women would experience a new episode of affective problems just after birth.¹¹³
- In a 2011 report by the London School of Economics, King's College London and the Centre for Mental Health, it was found that approximately one in eight women experiences moderate to severe postnatal depression, which can severely affect every aspect of the development of her child.¹¹⁴
- Postnatal depression has been linked to both emotional and behavioural problems in children of affected mothers.¹¹⁵
- A recent longitudinal survey carried out by the National Childbirth Trust between 2013 and 2014 found that, among first-time fathers in the UK, more than a third (38%) were concerned about their mental health.¹¹⁶
- In a 2010 meta-analysis that included 43 studies from across the world, it was estimated that 10% of new fathers experience postnatal depression.¹¹⁷
- Mothers with a pre-existing mental health condition may be at a higher risk of developing another mental health problem. Evidence from a global systematic review and meta-analysis in 2016 has shown that a third of women diagnosed with bipolar and/or psychosis prior to birth were experiencing symptoms after giving birth.¹¹⁸
- A 2016 global review of longitudinal studies, which included 35,419 women, found evidence to support that postnatal depression is often a continuation of existing antenatal depression.¹¹⁹

- Perinatal mental health problems carry a total economic and social long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK.¹²⁰
- In 2014, a confidential inquiry investigated the care of 237 women in the UK and the Republic of Ireland who died during or after pregnancy, or who survived and endured severe morbidity. Findings revealed that one in seven women died from suicide between six weeks and one year after giving birth. Almost a quarter of women who died between six weeks and one year after pregnancy died from mental-health-related causes.¹²¹

Access to prenatal and postnatal mental health services

Around 40% of the whole of the UK's services have no specialist perinatal mental health provision.¹²² Regarding access, 40% of women in both Scotland and England have no access to specialist perinatal support, with this figure being much higher for Wales and Northern Ireland, at 70% and 80% respectively.¹²³ (see Figures 2.1a and 2.1b provided by the Maternal Mental Health Alliance).¹²⁴

- There are only 17 specialist mother and baby units in the UK. None of these are located in Northern Ireland or Wales.¹²⁵

Red areas

No specialist team exists.

Pink areas

Some extremely basic level of provision exists but currently falls short of national standards and needs expanding.

Amber areas

Some basic level of provision exists but currently falls short of national standards and needs expanding.

Green areas

Women and families can access treatment that meets nationally agreed standards.

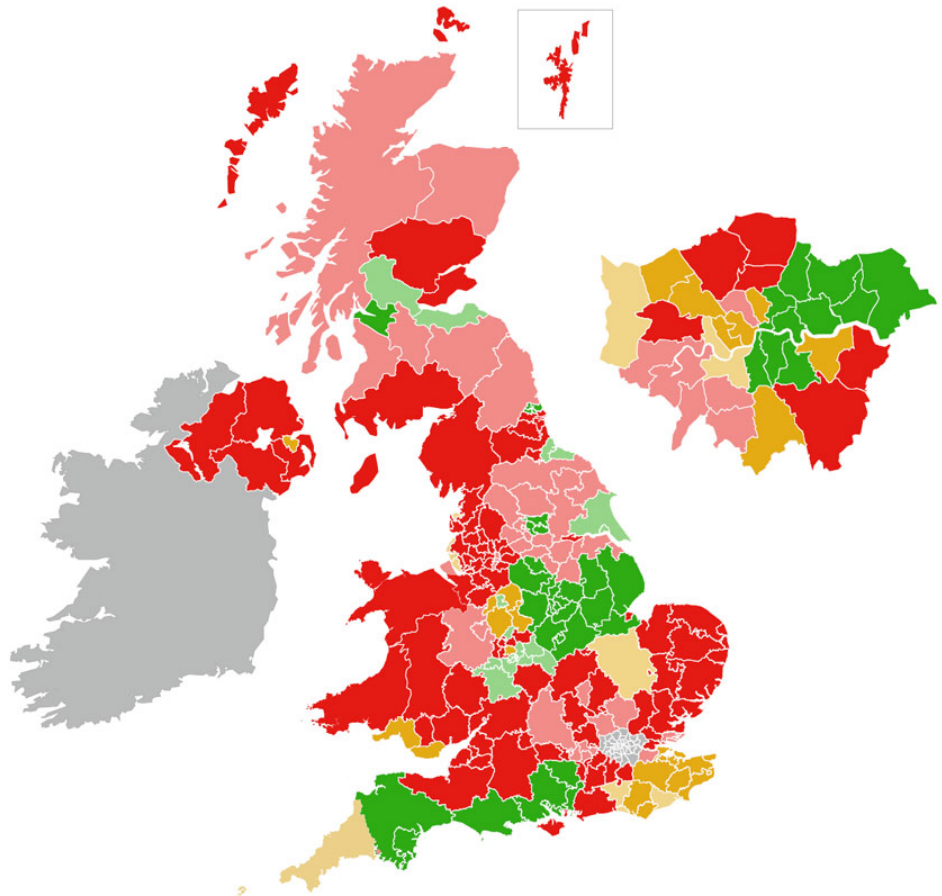


Figure 2.1a: UK specialist community perinatal mental health teams (current provision)

Everyone's Business. (2014). *UK specialist community perinatal mental health terms (current provision)*. Retrieved from everyonesbusiness.org.uk/?page_id=349 [Accessed 19/07/16].

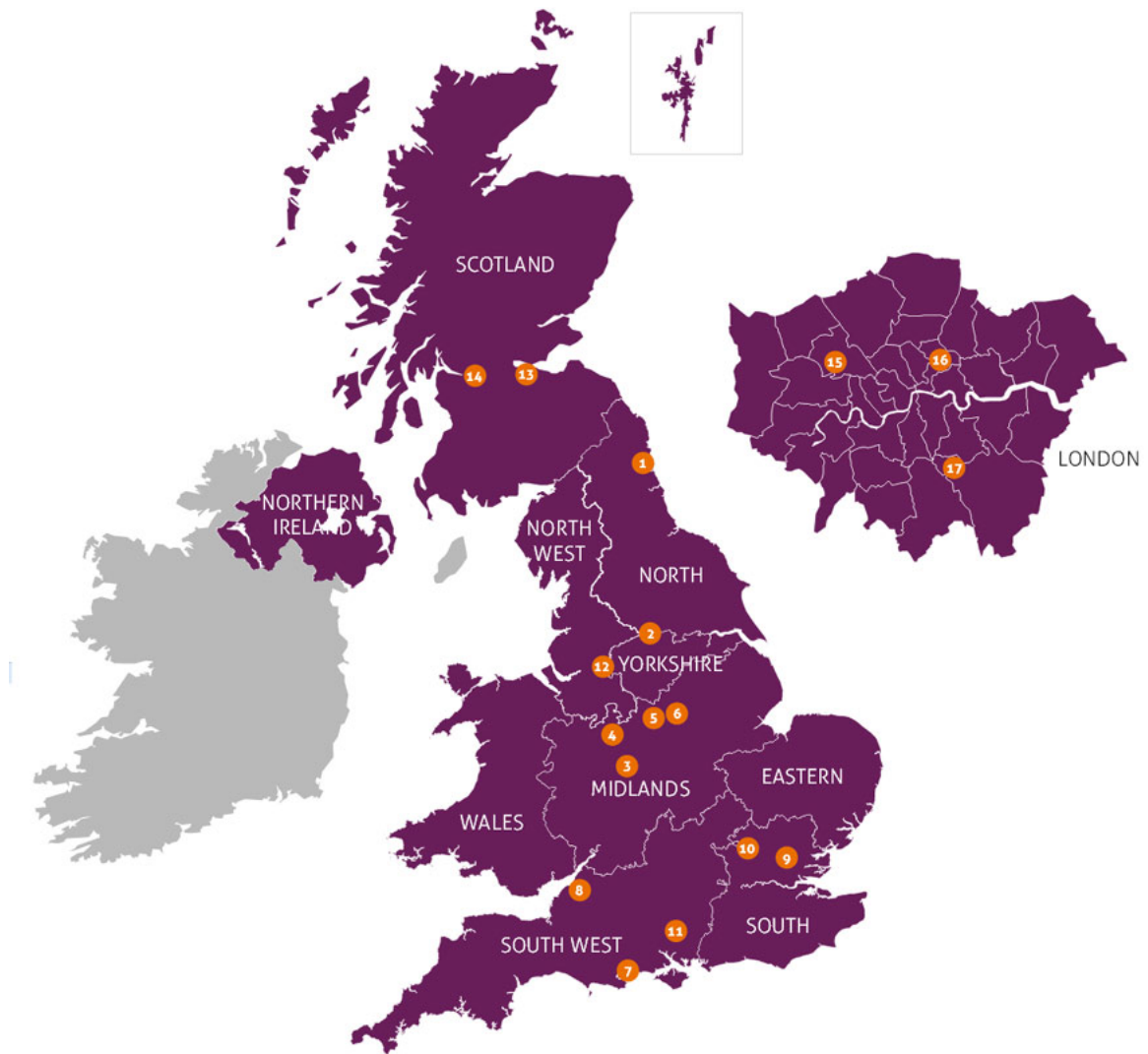


Figure 2.1b: Mother and baby units in the UK

Everyone's Business. (2014). *UK specialist community perinatal mental health terms (current provision)*. Retrieved from everyonesbusiness.org.uk/?page_id=349 [Accessed 19/07/16].



2.1.2 Children's and young people's mental health

The Mental Health Foundation believes that many mental health problems are preventable and that there is considerable scope for increasing interventions that reduce the incidence of people developing mental health problems and increase the potential for sustained recovery after illness. Evidence has shown that most mental health problems start in childhood or adolescence. A key study in the area found that the average age of onset was much earlier for anxiety disorders (age 11) and impulse-control disorders (age 11) than for substance use disorders (age 20) and mood disorders (age 30).¹²⁶ Thus, it is important that research and interventions take account of this crucial time period.

The United Nations Convention on the Rights of the Child defines a child as anyone under the age of 18.¹²⁷ Adolescence is defined as the period in human growth and development that occurs after childhood and before adulthood, typically between the ages of 10 and 19;¹²⁸ this varies within research and in law, where the term 'young person' is widely used to describe anyone aged 15–24, which accounts for the transition into early adulthood.¹²⁹

Childhood and adolescence can be a time of change and transition, which includes:

- Starting school
- Transferring from primary to secondary school
- Changes in friendship groups

- Going through puberty
- Exam pressures
- Family changes, e.g. new siblings, divorce, bereavement, moving house
- Sexual maturation and development, including sexual orientation
- Transition to university or work

The extent of mental health problems in children and adolescents is not well understood, with the lack of regular and up-to-date data on the prevalence of mental health problems during this stage being widely criticised. There is limited data regarding the scale of the problem and a lack of accurate information to understand this issue and its associations.

In 2014, The Child and Maternal (ChiMat) Health Intelligence Network noted that *"the ability to provide robust national data to support local service planning is at best limited and planned improvements to this position have suffered from significant delays."*¹³⁰

The next UK Child and Adolescent Mental Health Survey is due to be published in 2018. Current knowledge on the prevalence of child and adolescent mental health rates is significantly out of date, with the latest national statistics still needing to be drawn from the UK Child and Adolescent Mental Health Survey dating back to 2004.



How common are mental health problems for children and young people?

- Prevalence rates for child and adolescent mental health in the British Isles are out of date. The Child and Adolescent Mental Health Surveys, covering England, Scotland and Wales, were carried out by ONS in 1999 and 2004. In these surveys, it was found that 10% of children and young people (aged 5–16) had a clinically diagnosable mental health problem.¹³¹
- The same ONS surveys (1999, 2004), which comprised 7,977 interviews from parents, children and teachers, found the prevalence of mental health problems among children and young people (aged 5–16) to be:¹³²
 - 4% for emotional problems (depression or anxiety)
 - 6% for conduct problems
 - 2% for hyperkinetic problems
 - 1% for less common problems (including autism, tics disorder, eating disorders and selective mutism)
- A 2005 prevalence study carried out in the USA predicted that 75% of mental health problems are established by the age of 24, with 1 in 10 children and adolescents experiencing a clinically diagnosable mental health problem. This study suggests that lifetime prevalence estimates for the following mental health problems are as follows:¹³³
 - Anxiety disorders: 28.8%
 - Mood disorders: 20.8%
 - Impulse-control disorders: 24.8%
 - Substance use disorders: 14.6%
 - Any mental health problem: 46.4%
- In 2013, the UK ranked 16th out of 29 developed countries in the UNICEF league table of child wellbeing, where rankings are based on child health and safety, education, behaviour, housing conditions and material wellbeing.¹³⁴
- England hospital statistics for 2014 recorded that there were 41,921 hospitalisations for self-harm in young people aged 10–24. Based on these rates, the prevalence for young people under 25 is estimated at 367 per 100,000 population in England – an increase from 330 per 100,000 population estimated in 2007–08.¹³⁵
- Eating disorders in young people under the age of 25 are recorded as double the rate of any other age in the UK – they are estimated to affect 164.5 young people per 100,000 population.¹³⁶
- 2015 UK data from the Higher Education Funding Council for England has shown that the proportion of university students who formally identify themselves as having mental health problems doubled between 2008–09 and 2013–14.¹³⁷ This may reflect, to an extent, different attitudes to the self-reporting of mental health problems.



Gender differences

- According to the ONS surveys (1999, 2004) the rates of mental health problems rise steeply in mid- to late-adolescence. For adolescents aged 11–16, the rate of mental health problems is 13% for boys (an increase from 10% of boys aged 5–10) and 10% for girls (an increase from 5% of girls aged 5–10), and this figure rises to around 23% by age 18–20.¹³⁸
- A 2015 English study of 3,366 adolescents found that, overall, adolescents experienced similar levels of mental health difficulties (i.e. emotional problems, peer problems, or hyperactivity and conduct problems) in 2014 as had been reported in 2009. There were, however, gender differences noted over time, with a significant increase in emotional problems in girls and a decrease in mental health difficulties in boys.¹³⁹
- A survey conducted in 2005 found that, in Great Britain, conduct disorders, hyperkinetic disorder and ASDs were more common in boys, and emotional problems were more common in girls.¹⁴⁰

Youth offending

- A review of joint inspections undertaken by the Healthcare Commission and HM Inspectorate of Probation in 2009 found that 43% of young people aged 18 or younger on community orders have emotional and mental health needs.¹⁴¹

- According to a systematic review of interventions from 2001–08 in the UK, over a third of all children and young people accessing local drug and substance misuse services are referred from the youth justice system.¹⁴²

Bullying

- ONS (2015) reports that being bullied is strongly associated with mental ill health. Between 2011 and 2012, one in eight children (12%) aged 10–15 reported being bullied at school.¹⁴³
- The Ditch the Label cyberbullying survey suggests that new forms of bullying, such as cyberbullying, are increasing, with 6 in 10 young people reporting being victims of cyberbullying.¹⁴⁴
- Based on a 2008 meta-analysis, studies suggest that those who had been bullied had lower wellbeing and life satisfaction than those who had never been bullied.¹⁴⁵
- Over 60% of young people attending Child and Adolescent Mental Health Services (CAMHS) reported bullying as an important reason for their attendance.¹⁴⁶
- Of young people who have reported being bullied within the Ditch the Label 2016 survey:¹⁴⁷
 - 31% reported that they self-harmed
 - 33% had suicidal thoughts
 - 26% skipped class
 - 15% developed an eating disorder



- 15% developed anti-social behaviours
- 12% ran away from home as a result of bullying
- 12% used drugs and/or alcohol
- Research has shown bullying to have long-term adverse effects on individuals' mental health, with these experiences during adolescence found to be a predictor of poor mental health and depression in adulthood,^{148,149} as well as long-term physical health problems such as diabetes and cardiovascular disease¹⁵⁰ – the effects of which can be seen up to 40 years later.¹⁵¹

Effects

- A longitudinal study published in 2011 that analysed the data of 17,634 children from England, Scotland and Wales found associations between childhood psychological problems and the ability to work and earn as adults. Adults who had experiences of childhood psychological problems had a 28% lower net family income than those who did not experience such problems.¹⁵²
- A more recent longitudinal study in 2015 studied 6,719 children in England from the age of 13 who reported being bullied or victimised by their peers, and found that they were twice as likely to develop depression by age 18.¹⁵³

Treatment and care

The effects of mental health problems during childhood and adolescence can be significant and, as shown, can impact on adult mental health and wellbeing. However, with increasingly effective treatment options becoming more widely available and approaches that focus on prevention and early intervention services for young people, most children and young people should be able to recover and experience positive outcomes later on in life.

- A recent report (2015) by the Public Health Department in England cited that around 70% of children and adolescents who experience mental health problems have not had appropriate interventions at a sufficiently early age.¹⁵⁴
- Additional findings by The Children's Society (2015) included that one third of children and teenagers with mental health issues in England failed to access specialist care and were made to wait up to 66 days on average for an initial assessment.¹⁵⁵

Abuse and neglect

- Extensive evidence on the impact of abuse during childhood has shown that it increases the risk of most mental health problems, including PTSD, suicide, depression, anxiety, low self-esteem, OCD, phobias, substance abuse, eating disorders, and personality disorders.¹⁵⁶



- In 2016, for the first time, the Crime Survey for England and Wales included questions relating to experience of abuse in childhood among adults aged 16–59. The findings give a much clearer picture than was previously available of the prevalence of abuse since around the 1960s: 9% of those surveyed had experienced psychological abuse, 7% physical abuse, 7% sexual abuse, and 8% had witnessed domestic violence or abuse in the home. Women were more likely to report that they had suffered abuse than men, particularly in the case of sexual abuse (11% of women compared to 3% of men).¹⁵⁷
- However, contemporary abuse and neglect data is difficult to collect, and many abused and neglected children and young people are under the radar of data systems. A National Society for the Prevention of Cruelty to Children (NSPCC) report in 2013 estimated that there were more children suffering from abuse and/or neglect than are known to social services and that, for every protection plan, another eight children have suffered maltreatment.¹⁵⁸ A 2016 follow-up revealed that this gap continues to exist.¹⁵⁹
- Between 2011 and 2015, across all four nations (England, Scotland, Wales and Northern Ireland), there has been a 50% or more increase in police-recorded child sexual offences against under 18s.¹⁶⁰
- In England and Wales, neglect is the most common reason for being subject to a child protection plan or placed on a child protection register.¹⁶¹
- In 2015, there were 49,700 children subject to a child protection act in England,¹⁶² 2,751 in Scotland,¹⁶³ 2,935 in Wales¹⁶⁴ and 1,969 in Northern Ireland.¹⁶⁵ However, caution must be exercised when comparing across countries, as data collected in the devolved regions may differ due to differences in the measuring tools used and samples selected. It should also be noted that children on the child protection register may include those considered to be at risk of abuse; therefore, this may lead to figures being either an overestimation or an underestimation of the issue.

2.1.3 Adult mental health

Within the Economic and Social Research Council's (ESRC's) 2016 European evidence briefing, it was highlighted that adults and those in mid-life are often ignored and overlooked within mental health policy and research work.¹⁶⁶ This section highlights the key statistics related to adult mental health, including how the workplace can impact on mental wellbeing, and the impact of relationships developing during this time of life.

Employment and mental health

Throughout our adult life, the majority of us will be in work and will experience a range of changing mental health states, from poor to good mental health across our working life.



- 64% of people with common mental health problems are employed; therefore, in the UK, there is an estimated 4.6 million people in work who may have a common mental health problem. That equates to 1 in 6.8 employed people experiencing mental health problems in the workplace.¹⁶⁷
- A 2008 review commissioned for the Health, Work and Wellbeing Programme highlighted that symptoms associated with mental health problems (e.g. sleep problems, fatigue, irritability and worry) affect one sixth of the working-age population of Great Britain at any one time and can impair a person's ability to function at work.¹⁶⁸
- Women in full-time employment were twice as likely to have a common mental health problem as full-time employed men (19.8% vs 10.9% respectively).¹⁶⁹
- Evidence suggests that 12.7% of all sickness absence days in the UK can be attributed to mental health conditions.¹⁷⁰
- Workers with sickness absence due to mental ill health are seven times more likely to have further absence than those with physical health-related sick leave.¹⁷¹
- A 2014 study revealed that one in five of those who disclosed that they had a mental health problem to their employers felt that they had been sacked or forced out of their jobs as a result.¹⁷²

Relationships

- Being happily married or in a stable relationship is linked to both physical and mental health benefits, including lower morbidity and mortality.¹⁷³ People in a stable relationship have greater life satisfaction, lower stress levels, lower blood pressure and better heart health than individuals who are single.¹⁷⁴
- In 2015, more than 9 in 10 adults aged 16 and over in the UK reported that they had one or more close friends whom they could confide in (93%), who supported them (92%) or who they could escape or have fun with (90%).¹⁷⁵
- Overall, social networks tend to decrease during adulthood; adults have been reported to spend as little as 10% of their time with friends.¹⁷⁶
- Findings by Relate in 2014 show that more men report having no friends (11%) compared to women (7%), with men having lower satisfaction in their friends than women (73% of men rated their friendships as good or very good, compared to 81% of women).¹⁷⁷
- Those in full-time work in the UK spend more time with colleagues than with family or friends. The 2014 Relate report highlighted that employees were about as likely to have daily contact with work colleagues (62%) as they were with their own children (64%), and over 4 in 10 (44%) were more likely to have daily contact with their bosses than with their mothers (26%) or friends (16%).¹⁷⁸



2.1.4 Older adults

We have included people aged 50 years and over within this section to take account of the range of research studies in this area. There is no clear definition within research as to what defines an 'older adult'; therefore, age ranges in many studies vary widely.

- An ageing population can have implications on individual, social and economic levels. Life expectancy at birth has seen a significant rise across the world. For instance, the estimated average life expectancy for 2010–15 was 78 years in developed countries, and this figure is expected to rise to 83 years by 2045–50.¹⁷⁹ Such an increase in longevity can put significant pressure on the world economy due to an increase in age-related illnesses and an increased need for healthcare and the associated healthcare costs.
- In a 2015 report published by the United Nations, the number of people aged over 60 made up 12% of the global population, and is expected to almost double, reaching 22% by 2050. The global percentage of people aged 80 years or over was 1.7% and is projected to almost triple to 4.5% by 2050.¹⁸⁰
- In the UK, the proportion of the population that is composed of older adults is increasing. According to ONS (2016), there are more people in the UK aged 60 or over than there are under the age of 18. The proportion of older people aged 65 or over has grown by 21% in the last 10 years, now representing 17.8% of

the total population. The number of people aged 85 or older has increased by 31%, now representing 2.3% of the total UK population.¹⁸¹

2.1.4.1 Older adults and mental health

Depression and anxiety

In a 2010–11 UK survey measuring national wellbeing across people aged 16 and older, the average percentage of all respondents feeling anxious or depressed was 19%. Depression or anxiety was noted to be highest among those aged 50–59 and those of 80 years and older.¹⁸²

Age range	% feeling anxious or depressed
50–54 years	22%
55–59 years	21%
60–64 years	16%
65–69 years	14%
70–74 years	15%
75–79 years	17%
80 and over	20%

- A 2012 systematic review of depression in older adults found that between 4.6% and 9.3% of older adults experience major depression, and an average of 17.1% experience depressive disorders.¹⁸³
- An English health survey with older people in 2005 found that depression affected 22% of men and 28% of women aged 65 or over.¹⁸⁴



- The Royal College of General Practitioners reports that fewer than one in six older people with depression discuss their symptoms with their GP. Furthermore, only half receive suitable treatment.¹⁸⁵
- In 2008–09, 4% of adults accessing the Improving Access to Psychological Therapies (IAPT) programme were aged over 64. This increased to 6.6% of those aged 65 and older completing treatment in 2013–14; however, there is still much to be done to reach the 12% set out in 'Talking Therapies: A four-year plan of action'.¹⁸⁶
- It is estimated that up to 40% of older adults living in a care home experience depression, and it often remains undetected.¹⁸⁷
- It is estimated that up to 60% of older adults who have had a stroke may experience depression, as well as up to 40% of those with coronary heart disease, cancer, Parkinson's, and Alzheimer's disease.¹⁸⁸

Delirium

Delirium is a condition that results in confused thinking and reduced awareness. The changes associated with delirium usually occur rapidly within hours or days and, if responded to quickly, delirium can be fully recovered from.

- A study on the prevalence of mental health problems in hospitalised older adults in England, conducted in Nottingham, found that 27% of older adults aged 70 and over had delirium.¹⁸⁹

- Pre-existing dementia is one of the most prominent risk factors for delirium in elderly patients, with a reported two thirds of all cases of delirium occurring in older people with pre-existing dementia.¹⁹⁰

Dementia

- In 2015, a report from Alzheimer's Disease International (ADI) estimated the number of people living with dementia worldwide to be 46.8 million, and predicted this number to double by 2030.¹⁹¹
- ADI also reports that dementia is primarily prevalent in older people, although 2–8% of all cases of dementia are estimated to be early-onset dementia (dementia diagnosed under the age of 65). In Europe, the peak incidence is among those aged 80–89.¹⁹²
- In 2015, an estimated 850,000 people lived with dementia in the UK. Of these, 84% lived in England, 8% in Scotland, 5% in Wales and 2% in Northern Ireland.¹⁹³
- It has been estimated that the total cost of dementia in the UK is £26.3 billion, with an average cost of £32,250 per person. According to Alzheimer's Society, this is enough to pay energy bills for a year for every household in the UK.¹⁹⁴
- People with learning disabilities, in particular those living with Down's syndrome, have a greater risk of developing dementia. It has been estimated that one in five people with learning disabilities will develop dementia,¹⁹⁵ and that a third of people with Down's syndrome will develop dementia in their 50s.¹⁹⁶



2.1.4.2 Factors contributing to older people's mental health

Participation in meaningful activities

- Meaningful activities can include employment, volunteering, education and learning, personal interests, hobbies and everyday activities. Participation in meaningful activities helps older adults retain their sense of purpose and promotes engagement and stimulation.¹⁹⁷
- An English survey in 2012 found that 29% of people aged 65 and over and 21% of people aged 75 and over participated in volunteering.¹⁹⁸
- An evaluation of peer-support groups for people with dementia living in extra care housing with 21 tenants, carried out by the Mental Health Foundation, found that participants with early-stage dementia showed improvements in wellbeing, social support and practical coping strategies.¹⁹⁹
- Studies have found that high levels of social engagement could benefit the physical health,²⁰⁰ cognition,²⁰¹ and life satisfaction of older adults.²⁰²

Relationships: Social isolation and loneliness

- Social isolation and loneliness can affect many people, but it has been suggested that older adults can be vulnerable, especially given the higher numbers of them living alone.²⁰³
- A 2015 ONS analysis reported that those aged 80 and over are twice as likely (29%) to report feeling lonely than those in the 65–79 age group (14%).²⁰⁴

- A report by Age UK in 2015 states that perceived loneliness increases with age and that there are many factors associated with loneliness in older adults, including living arrangements, marital status, housing, health and income, as well as other changes in circumstances including decreased social participation, retirement and bereavement.²⁰⁵
- A survey in 2014 carried out by Age UK found that 2.9 million people aged 65 and over felt that they had no one to go to for support. 39% of people interviewed said that they felt lonely and one in five said that they felt forgotten.²⁰⁶
- In a systematic review of 70 studies published in 2015, it was found that social isolation, loneliness, and living alone increased the risk of premature death. The increased likelihood of death was 26% for reported loneliness, 29% for social isolation and 32% for living alone.²⁰⁷

Physical health

- Older people can suffer from poor physical health. The International Longevity Centre reported that 50.8% of men and 56.7% of women aged 80 and over report having a long-standing physical health problem.²⁰⁸
- In a 2013 British survey by ONS, the likelihood of someone reporting a long-standing illness was closely associated with age. The survey revealed that 69% of people aged 75 and over reported having a long-standing illness compared with 15% of people aged 16–24.²⁰⁹



- WHO reports that those with physical health conditions, such as heart disease, have higher rates of depression than those who are physically well.²¹⁰ Results of a World Mental Health Survey published in 2007 highlighted that the risk of depression was over seven times more common in those with two or more long-term physical health conditions.²¹¹
- In the UK National Survey carried out between 2009 and 2010, it was found that 69% of adults aged 50–54 agreed or strongly agreed that they belonged to their neighbourhood. This figure rose to 84% for those aged 70 and over. The national average for all respondents was 66%.²¹⁵
- A 2015 survey in the UK with people with dementia found that 29% did not feel a part of their community.²¹⁶

Community and environment

- In a global systematic review conducted in 2009 using 33 studies, it was found that neighbourhood environment was an important factor in the health and functioning of older adults. In particular, neighbourhood socioeconomic disadvantage was found to be associated with poor health, e.g. poorer physical functioning, poorer self-rated health status and poorer cognitive ability.²¹²
- A later study, in 2012, found that neighbourhood social cohesion was significantly associated with the wellbeing of older adults. Single and poorer adults reported lower wellbeing than better-off, married adults; however, these effects were mediated by neighbourhood cohesion.²¹³
- In a 2011 survey in England and Wales, it was found that older adults were more likely to live alone compared to younger people. Of those aged 16 and over in England and Wales who were living alone, less than 4% were aged 16–24, 17% were aged 50–64 and 59% were aged 85 and over.²¹⁴



2.2 Other groups experiencing a higher prevalence of mental health problems

2.2.1. Black, Asian and minority ethnic groups

Limited research has been conducted in this area within the UK, which translates into little being known as to the impact of mental health on black, Asian and minority ethnic (BAME) communities. The lack of adequate and sufficient data on BAME groups contributes to the problems of misdiagnoses, underdiagnoses and fewer treatments accessed.

- BAME communities are generally considered to be at increased risk of poor mental health.²¹⁷ The APMS (2014) found the prevalence of common mental health problems to vary significantly by ethnic group for women, but not for men. Non-British white women were the least likely to have a common mental health problem (15.6%), followed by white British women (20.9%) and black and black British women (29.3%).²¹⁸ Black adults were also found to have the lowest treatment rate of any ethnic group, at 6.2% (compared to 13.3% in the white British group).²¹⁹
- In contrast, a 2015 study by Stewart-Brown and colleagues found that those of African-Caribbean, Indian and Pakistani origin showed higher levels of mental wellbeing than other groups; this was found to be largely attributed to higher levels of wellbeing found among men.²²⁰
- Findings from the 2014 APMS show depression to be more prevalent among black women, while panic disorder appears to be more prevalent among women in black, Asian and mixed or other ethnic groups. However, these findings were not significant because of the small sample sizes, and therefore caution should be taken when interpreting these results.²²¹
- A review published in 2015 exploring the association between ethnicity, mental health problems and socioeconomic status found people from black ethnic minority backgrounds to have a higher prevalence of psychosis compared with the white majority population. This effect was still observed after controlling for socioeconomic status.²²²
- A 2008 study found that women of Pakistani and Bangladeshi origin were at an elevated risk of schizophrenia after adjustment for socioeconomic status.²²³
- Studies show that PTSD is higher in women of black ethnic origin and this association is related to the higher levels of sexual assaults that they experience;²²⁴ however, women of black ethnic origin are less likely to report or seek help for assaults or trauma.²²⁵
- In a report by the National Institute for Mental Health (2003), it was noted that people of black African-Caribbean and South Asian origin are less likely to have mental health problems detected by their GP.²²⁶



- Disproportionate rates of people from BAME populations have been detained under the Mental Health Act 1983. A 2016 UK study examining the Mental Health Act 2007 assessments found this to be disproportionality associated with higher rates of mental health conditions and poorer levels of social support, but not due to ethnicity.²²⁷
- In Northern Ireland, the suicide rate among male Irish Travellers is 6.6 times that of men in the general population. This group also continues to experience discrimination, with 65% of people reporting that they would not accept an Irish Traveller as a close friend.²²⁸
- In the absence of any official data, the Law Centre has provided estimates of numbers of asylum seekers based on information compiled from various organisations, including the Northern Ireland Strategic Migration Partnership, the Home Office Official Immigration Statistics (UK-wide), the Home Office NI Asylum Stakeholders Forum and the Refugee and Asylum Forum. The Centre found that there were almost 200 applications for asylum in Northern Ireland in the year ending August 2015.²³²
- Research suggests that asylum seekers and refugees are more likely to experience poor mental health than the local population,²³³ including higher rates of depression, PTSD and other anxiety disorders.^{234,235}

2.2.2 Refugee, asylum-seeking and stateless people

- A total of 65.3 million people were forcibly displaced worldwide in 2015. By year end 2015, there was a total of 123,000 refugees, pending asylum cases and stateless persons in the UK.²²⁹ In Scotland, there were 1,029 asylum applications made in 2012 according to the data from that year.²³⁰
- There were 1,571 asylum seekers living in Wales in the first quarter of 2013. This number has fallen from a peak of 2,616 in the first quarter of 2007. The number of refugees in Wales is unknown, but is estimated at between 6,000 and 10,000.²³¹
- Increased vulnerability to mental health problems is linked to both pre-migration experiences, in particular exposure to war trauma,²³⁶ and the post-migration conditions that refugees often face, including separation from family, difficulties with asylum procedures or detention, unemployment and inadequate housing.²³⁷



- A 2015 study found that one third of trafficked boys and girls had experienced physical or sexual violence (or both) and, of those, 23% had sustained a serious injury. Mental health issues were common: more than half of young trafficked survivors (56%) screened positive for depression, a third (33%) for an anxiety disorder and a quarter (26%) for PTSD. 12% reported that they had tried to harm or kill themselves in the month before the interview, while 15.8% reported having suicidal thoughts in the past month.²³⁸
- For displaced and refugee children, exposure to violence has been shown to be a key risk factor towards a child developing mental health problems, whereas stable settlement and social support in the host country have a positive effect on the child's psychological functioning.²³⁹
- Research looking at the mental health service usage in Leeds and using qualitative data indicates that asylum seekers are five times more likely to have mental health needs than the general population and more than 61% will experience serious mental distress.²⁴⁰
- Secondary healthcare data indicates that refugees and asylum seekers are less likely to receive mental health support than the general population.²⁴¹
- Preliminary findings from research conducted in Scotland found that this population feels isolated from mental health services, as mental health is a predominantly Western concept, and services are built on models that are often not accessible or meaningful to BAME communities.²⁴²
- In 2011, the Sanctuary Scotland project's evaluation report identified that mental health problems are a major public health issue for asylum-seeking and refugee women.²⁴³
- A 2009 study carried out by the Scottish Refugee Council with 349 refugees found that:²⁴⁴
 - 57% of women were likely to have PTSD
 - 20% of women reported suicidal thoughts in the past seven days
 - 22% of women stated that they had tried to take their own lives
- Research in Northern Ireland found that 47% of refugees stated that they had suffered with stress in the last 12 months; 31% with depression; and 25% with post-traumatic stress. This was attributed to financial worries and unemployment (46% and 49% respectively), as well as missing their family in their home country (58%). Only 5% of those who answered the question indicated that they had availed assistance from medical or mental health services as a result.²⁴⁵



2.2.3 Disability

2.2.3.1 Learning disability

The definition of learning and intellectual disability refers to limited functioning in three areas:²⁴⁶

- Social skills (e.g. communicating with others)
- Conceptual skills (e.g. reading and writing)
- Practical ability (e.g. clothing/bathing oneself)

These terms are often used interchangeably. Mental health problems among people with a learning disability are often overlooked, underdiagnosed and left untreated as a result of poor understanding, awareness, evidence in this area and symptoms mistakenly being attributed as the person's learning disability. The statistics presented in this section highlight that this is an important area to consider, with the prevalence of mental health problems presenting as higher in this group compared to the general population.

- From 2013 census data, it is estimated that there are 900,900 adults (aged 18 and older) with intellectual disabilities in England, with 206,132 (23%) known to social services.²⁴⁷
- In 2014, there were 26,036 adults with intellectual disabilities across Scotland – the equivalent of six people per 1,000 in the general population.²⁴⁸
- As of March 2015, there are 15,010 people registered with intellectual disabilities in Wales, of which 86%

live in community placements and 14% in residential establishments.²⁴⁹

- According to the 2011 census figures, there are 40,177 people in Northern Ireland who reported having a learning difficulty, an intellectual difficulty, or a social or behavioural difficulty – the equivalent of 2.2% of the population.²⁵⁰
- According to the APMS (2014), people with lower intellectual ability had higher rates of symptoms of common mental health problems (25%) compared to those with average (17.2%) or above-average (13.4%) intellectual functioning.²⁵¹
- People with learning disabilities present with a higher prevalence of mental health problems compared to those without. In a 2007 UK population-based study of 1,023 people with learning disabilities, it was found that 54% have a mental health problem.²⁵²
- The prevalence of diagnosed mental health conditions is estimated to be 36% among children with intellectual disabilities compared to 8% among children without. Increased prevalence is particularly marked for ASD, ADHD and conduct disorders.²⁵³
- Increased risk of exposure to social disadvantage has been associated with increased prevalence of mental health problems.²⁵⁴
- Public Health England estimates that, in 2015, up to 35,000 adults with a learning disability were prescribed an antipsychotic, an antidepressant or both without appropriate clinical justification.²⁵⁵



2.2.3.2 Physical disability

More than 15 million people – 30% of the UK population – live with one or more long-term condition(s) and more than 4 million of these will also have a mental health problem.²⁵⁶ The connection between physical and mental health is twofold, with those who have a physical health problem being at an increased risk of developing mental health problems; the same is true for the opposite (mental health problems increase the risk of physical health problems).

- According to the 2014 APMS, people with symptoms of a common mental health problem are more likely than those who do not have symptoms to have a long-term physical condition. This association between physical and mental health was further exemplified by the finding that over a third of people with severe symptoms (37.6%) have a long-term physical condition, compared to a quarter (25.3%) of those with no or few symptoms of a common mental health problem: a pattern that is found in both men and women.²⁵⁷
- Wellbeing scores (calculated using the Warwick-Edinburgh Mental Well-being Scale, e.g. WEMWBS) were lower for people with long-term physical conditions (51.03) compared to those without a long-term physical condition (53.15).²⁵⁸
- People with severe symptoms of a common mental health problem are twice as likely to have asthma as people with no or few symptoms.²⁵⁹
- Rates of CMD-NOS were found to be higher in those with cancer and diabetes. Low wellbeing was found to be higher in those with diabetes (11%) than those without diabetes (5.1%).²⁶⁰
- Both asthma and high blood pressure were associated with a wide range of different mental health problems, including depression, anxiety disorders and PTSD.²⁶¹
- A 2012 report published by The King's Fund and Centre for Mental Health highlighted that individuals with physical health problems are at an increased risk of poor mental health, particularly depression and anxiety.²⁶²
- This report also showed that:²⁶³
 - Long-term conditions account for 80% of GP consultations
 - 30% of people with a long-term physical health condition also have a mental health problem
 - 46% of people with a mental health problem also have a long-term physical health problem
- A meta-analysis of 22 studies shows that, for patients with chronic heart disease, those with depression have higher rates of complications and are more likely to undergo invasive procedures.²⁶⁴



- People with chronic obstructive pulmonary disease (COPD) are 2.5 times more likely to experience depression and anxiety than the general population.²⁶⁵ In a 2008 study, the prevalence of depression for those with COPD ranges between 10% and 42%, while that of anxiety ranges between 10% and 19%.²⁶⁶ Co-morbid depression and COPD are associated with longer hospitalisations and increased symptom burden.²⁶⁷
- The rates of mental health problems are higher in people who develop cancer compared to the general population. Rates of distress vary between 3% and 24%. The prevalence of depression ranges from 3% in patients with lung cancer to 28% in patients with cancer of the brain.²⁶⁸

2.2.3.3. Sensory impairment

Around 350,000 people are registered as blind or partially sighted in the UK:

- 291,100 in England²⁶⁹
- 34,492 in Scotland²⁷⁰
- 16,939 in Wales²⁷¹
- 8,000 in Northern Ireland (RNIB estimate)²⁷²

In 2010, 56,400 people in England were recorded on the deaf register and 156,000 were registered as hard of hearing. 88,500 people in England are registered as deafblind.²⁷³

Individuals experiencing sensory impairments have been found to be at a higher risk of having mental health problems across the life course; however, this can be overlooked when considering the needs of this group.

- A 2011 survey, carried out by the University of Cambridge and Deafblind UK, found that, among 439 deaf and blind people in the UK, 61% reported psychological distress.²⁷⁴
- A 2015 study including 298 people from England, Scotland and Wales found that individuals who are deaf have high levels of depression, with 31% of women and 14% of men self-reporting levels of depression.²⁷⁵
- A 2013 literature review suggests that older people with hearing loss are 2.5 times more likely to develop depression than those without hearing loss.²⁷⁶
- Children who are deaf are also more likely to experience mental health problems. Estimates suggest a 40% prevalence rate of mental health problems in deaf children, compared to a 25% prevalence in children without hearing loss.²⁷⁷
- For older adults who are visually impaired, the prevalence of major depressive disorder (5.4%) and anxiety disorders (7.5%) is significantly higher in visually impaired older adults compared to their normally-sighted peers. The most prevalent anxiety disorders are agoraphobia and social phobia.²⁷⁸



2.2.4 Lesbian, gay, bisexual and/or transgender

- A national English Survey using 2009–10 data found that 27,497 of respondents registered with the NHS who described themselves as gay, lesbian or bisexual were two to three times more likely to report having a psychological or emotional problem compared to their heterosexual counterparts.²⁷⁹ Mental health inequalities such as these have been found across the UK, in England, Scotland and Wales.²⁸⁰
- Evidence suggests that people who identify as lesbian, gay, bisexual and/or transgender (LGB&T) are at a higher risk of experiencing poor mental health.²⁸¹ This includes a higher risk of a range of mental health problems,²⁸² including depression,²⁸³ suicidal thoughts and self-harm,²⁸⁴ and alcohol and substance misuse.²⁸⁵ This higher prevalence can be related to a wide range of factors, including discrimination, isolation and homophobia.²⁸⁶
- In a 2011 British survey with 6,861 respondents, it was found that 1 in 10 gay and bisexual men aged 16–19 attempted to take their own life in the year prior to the survey. Further, 1 in 16 gay and bisexual men aged 16–24 had attempted to take their own life in the previous year. The survey also found that 1 in 7 gay and bisexual men were experiencing moderate to severe levels of mixed depression and anxiety.²⁸⁷
- A UK study found that bisexual women have poorer mental health than lesbian women, with higher rates of marijuana use, eating disorders, self-harming, anxiety and depression.²⁸⁸
- In Scotland, two in five LGB&T young people consider themselves to have a mental health condition, with higher levels of poor mental health reported by transgender individuals (66.7%) and bisexual women (63%).²⁸⁹
- In Northern Ireland, of 571 LGB&T individuals surveyed by The Rainbow Project, 35.3% reported experiences of self-harm, 25.7% had attempted suicide, 46.9% had experiences of suicidal ideation, and 70.9% had experience of depression.²⁹⁰ LGB&T people are substantially more likely than the Northern Ireland population to use drugs and are nearly three times as likely to have taken an illegal drug in their lifetime (62% vs 22%), and 57% of LGB&T respondents to the survey reported drinking to a hazardous level compared to 24% of adults in England.²⁹¹
- High levels of mental health issues appear to start early in LGB&T young people. A 2016 American study looking into the mental health of Lesbian, Gay, Bisexual and Questioning (LGBQ) youth in primary care settings using an online screening tool during routine visits found that:²⁹²
 - Bisexual and questioning females have higher scores of depression, anxiety and traumatic distress than heterosexual females



- Lesbians, bisexual females and questioning females all exhibited significantly higher lifetime suicide scores than heterosexual females
 - Bisexual females exhibited the highest current suicide scores
 - Gay and bisexual males had higher scores on the depression and traumatic distress subscales than did heterosexual males
 - Gay males also exhibited higher scores on the anxiety subscale than heterosexual males, with bisexual males exhibiting higher scores as well, though this was nonsignificant
- In the 2011 census, there was a total of 6.5 million people in the UK who were carers – a rise of 11.5% from 2001 statistics. Just over half of carers in the UK are female (58%) and 42% are male.²⁹⁴

	Number of carers 2001	Number of carers 2011
England	4,877,060	5,430,016
Northern Ireland	185,086	213,980
Scotland	481,579	492,031
Wales	340,745	370,230
UK total	5,884,470	6,506,257

2.2.5 Carers

Carers provide invaluable support and help to their family, friends and loved ones, whether this is for physical or mental health problems. The mental health of carers is often neglected despite many carers having poor mental health. This is also true for young carers, whose long-term outcomes in education, employment and training can be significantly impacted by the caring role that they take on.

- A 2010 literature review found that looking after a family member with a mental health problem can have a significant impact on carers' own mental health. The review found that the mental health problems of carers included emotional stress, depressive symptoms and, in some cases, clinical depression.²⁹³
- The National Carers Strategy in 2008 found that 71% of carers have poor physical or mental health.²⁹⁵
- Carers UK's annual survey (2015) with over 5,000 carers across the UK revealed that 84% of carers feel more stressed, 78% feel more anxious and 55% reported that they suffered from depression as a result of their caring role, which was higher than findings in 2014. In 2014, 82% had increased stress, 73% reported anxiety and 50% were affected by depression as a result of their caring role.²⁹⁶
- According to the 2011 ONS report for England and Wales, there are 5.8 million unpaid carers, representing over a tenth of the population.²⁹⁷



- The Scottish Health Survey estimates that there are 759,000 carers aged 16 and older in Scotland – 17% of the adult population, with 29,000 young carers. 83% of these carers report that they are unpaid.²⁹⁸
- In Northern Ireland, the 2011 census reported that 213,980 people were carers.²⁹⁹ However, in 2016, only 3,286 individuals were offered a carer’s assessment.³⁰⁰
- The diagnosis of the patient was a factor associated with the development of depression among carers. Older carers supporting those with physical health conditions are at the highest risk of developing depression. However, it is important for clinicians to assess the mental health of all carers, regardless of the patient diagnosis.³⁰¹
- According to a report published in 2014 by NHS England, of the 225,000 young carers in England, 68% have had experiences of bullying at school.³⁰³
- One in 20 young carers misses school as a result of their caring responsibilities and is 1.5 times more likely to have a special educational need or a disability. Young carers are 1.5 times more likely to be from a BAME background and to speak English as a second language.³⁰⁴
- Caring responsibilities have been found to have a significant impact on a young carer’s life, with an increased likelihood of disadvantage and health difficulties, as well as a lower likelihood of educational attainment.³⁰⁵

Young carers

The term ‘carer’ can be problematic when applied to children and young people, and is not really appropriate for a five-year-old living with a parent who has mental or physical health problems or addictions. It is used here to reflect the studies drawn upon.

- The 2011 census data shows that there are 177,918 young unpaid carers (between the ages of 5 and 17) in England and Wales – an increase of almost 19% from 2001. Of these, just over half were female (54%) and 46% were male.³⁰²
- Research conducted in England between 2009 and 2010 shows that young carers (aged 16–18) are at an increased risk of not being in education, employment or training³⁰⁶ which has been associated with mental health problems and social isolation in young people.³⁰⁷
- 38% of young carers report having a mental health problem, yet only half report receiving additional support from a member of staff at school.³⁰⁸



2.2.6 Domestic violence

- Levels of domestic violence account for between 15% and 25% of all recorded violent crimes.³⁰⁹ From 2013 to 2014, it is estimated that 1.4 million women in England and Wales were victims of domestic abuse in the last year.³¹⁰
- Over 59,000 incidents of domestic violence were reported in Scotland in 2013–14.³¹¹
- 13,000 domestic abuse crimes in Northern Ireland were recorded in 2014–15.³¹²
- In the UK, a total of 7.1% of women and 4.4% of men reported having experienced any type of domestic abuse in 2012–13; however, these figures only account for official reports of violence.³¹³ This is equivalent to an estimated 1.2 million female victims of domestic abuse and 700,000 male victims.³¹⁴ Therefore, an average of 5.7% of adults aged 16–59 in the UK have experienced intimate-partner violence in the last year.
- Domestic violence has an estimated overall cost to mental healthcare of £176 million.³¹⁵
- The relationship between domestic violence and mental health is bidirectional, with research suggesting that women experiencing abuse are at a greater risk of mental health conditions and that having a mental health condition makes one more vulnerable to abuse.³¹⁶
- In a 2009 UK study, lifetime prevalence of domestic violence among women with mental health problems was found to range between 30% and 60%.³¹⁷
- In a study conducted in England and Wales in 2015, women with experience of domestic violence had high rates of depression, anxiety and PTSD.³¹⁸
- The increasing severity of domestic violence is related to poorer mental health.³¹⁹
- Domestic violence is associated with depression, anxiety, PTSD and substance abuse in the general population.³²⁰
- Exposure to domestic violence has a significant impact on children’s mental health, with poorer educational outcomes and higher levels of mental health problems being found across the literature.³²¹
- A 2016 report found that violence and abuse are associated with poverty: people who are in poverty are more likely to have suffered violence and abuse than those who are not. This is true for both women and men. Among women in poverty, 38% have experienced violence and abuse compared with 27% of women not in poverty.³²²
- The same report found that mental illness is more strongly linked with violence and abuse than it is with poverty. Over half of women who are both in poverty and have experience of extensive violence and abuse meet the diagnostic threshold for a common mental disorder. This rate is three times higher than for women in poverty who have little or no experience of violence. However, women who experience physical violence from a partner (without having suffered other abuse in their lives) are much more vulnerable to anxiety and depression if they are also dealing with poverty than if they are not.³²³



2.2.7 Complex needs and multiple disadvantages

- There is a huge overlap between the offender, substance misusing and homeless populations. For example, in any given year, two thirds of people using homeless services are either in the criminal justice system or in drug treatment services.³²⁴
- The distribution varies widely across the country, and is heavily concentrated in northern cities, and some seaside towns and Central London boroughs.³²⁵
- The combination of structural poverty with family stress appears to be associated with complex needs. 85% of adults within the complex needs group have experienced childhood trauma, including parental violence, addiction, abuse, neglect, starvation or mental health issues.³²⁶
- A study found that the quality of life reported by people experiencing severe mental health problems is worse than that reported by many other low-income and vulnerable groups, particularly with regard to mental health and social isolation.³²⁷
- It is estimated that, in England, there are 58,000 people who experience the multiple disadvantages of offending, substance misuse and homelessness; and 55% of these individuals have a diagnosed mental health problem.³²⁸

2.2.7.1 Homelessness

Homelessness is an increasing issue within the UK. Evidence shows that there is a considerable link between homelessness and mental health problems; however, this link is often overlooked. The following statistics aim to explore this link and describe the impact.

- An ONS report published in 2011 reported that twice as many people in the UK compared to the EU cited mental health problems as a reason for being homeless (26% and 13% respectively).³²⁹
- A census survey on 1,286 participants living in urban homelessness communities in the UK in 2011 found high levels of histories of neglect, abuse and traumatic experiences in childhood continuing into adult life.³³⁰
- In 2014, 80% of homeless people in England reported that they had mental health issues, with 45% having been diagnosed with a mental health condition.³³¹
- Studies have reported a higher prevalence of mental health problems in the homeless population in comparison to the general population, including major depression, schizophrenia and bipolar disorder. Statistics suggest the prevalence of mental health conditions in this population to be at least 25–30% of the street homeless and those in direct access hostels.³³²



- Drawing on the findings from two surveys carried out in 2013–14 by Homeless Link with data from 250 English accommodation providers:
 - 38% of people in accommodation projects needed additional support with at least one other issue
 - 32% of people in projects had a mental health problem
 - 32% of people in projects had drug problems
 - 23% of people had had alcohol problems³³³
- Research from the USA estimates that two thirds of homeless people present with characteristics consistent with personality disorder, many of whom are thought to be undiagnosed.³³⁴
- In a Scottish study dating back to 2002, 70% of homeless people were found to have at least one diagnosable personality disorder and 40% two or more mental health problems.³³⁵
- In 2013–14, in Scotland, of those households accepted as homeless (e.g. hostels, B&Bs, squats, friends'/ family homes), 13% of persons living as 'household homeless' report having mental health problems and 12% report drug- or alcohol-dependency issues.³³⁶
- A 2012 UK study included 452 interviews with people who had experienced homelessness and other domains of deep social exclusion (e.g. institutional care, substance misuse and gang membership). The authors found that the majority of respondents had experienced a range of troubled childhoods influenced by school and/or family problems. Many also reported traumatic experiences such as sexual or physical abuse and neglect.³³⁷
- Women experience some risk factors for both mental illness and homelessness to a greater extent than men. Histories of physical and sexual violence as a child, and prior and subsequent to becoming homeless are common and more likely in women. Women were also more likely than men to give relationship breakdown and violence as a reason for becoming homeless than men.^{338,339}
- According to a 2014 report, homeless women can be further experience sexual and domestic violence, separation from children, bereavement and relationship breakdowns.³⁴⁰
- Homelessness also has a considerable impact on children. Homelessness increases the risk of preterm birth and low birth weight, while homeless infants experience significant development delays between 4 and 30 months,³⁴¹ which can negatively impact on their cognitive, behavioural and academic development.³⁴²



- The most prevalent health problems among homeless individuals are substance misuse (62.5%), mental health problems (53.7%) or a combination of the two (42.6%). In England, given that these problems are causally linked with homelessness, they add significantly more costs to homelessness due to the need for health and social care support. Unfortunately, the exact figure of estimated costs is unavailable at present.³⁴³

2.2.7.2 The prison population

- Prisoners have been shown to have significantly higher rates of mental health problems than the general population (see table below).³⁴⁴
- In a survey for England and Wales published in 2012, it was found that 36% of prisoners are considered to have a disability and/or mental health problem. The survey found that 18% of prisoners report symptoms of anxiety and depression, 11% report a form of

physical disability, and 8% report both (the figures have been rounded and therefore do not add up to 36%).³⁴⁵

- Data from the same survey found that, at the time of measuring, 49% of female prisoners reported experiencing anxiety and depression, compared with 23% of men. It's important to note that there was no differentiation between whether the individuals had these problems before entering prison or as a result of being in prison.³⁴⁶
- In a 2013 survey of 1,435 prisoners, covering both England and Wales, it was found that 29% of prisoners who reported recent drug use also indicated experiencing anxiety and depression, compared with 20% of prisoners who did not report recent drug use.³⁴⁷
- A report on UK prisons by HM Inspectorate of Prisons UK in 2011 found that up to one in three prisoners tested positive in random drug tests, and 13% developed a drug problem while in prison.³⁴⁸

	Prisoners	General population
Schizophrenia and delusional disorder	8%	0.5%
Personality disorder	66%	5.3%
Neurotic disorder (e.g. depression)	45%	13.8%
Drug dependency	45%	5.2%
Alcohol dependency	30%	11.5%



- In a 2016 report from the Prisons & Probation Ombudsman, there were 199 reported self-inflicted deaths. Prisoners who completed suicide had significantly higher rates of mental health problems than other prisoners; at least 17% of self-inflicted deaths had been identified as being due to the individuals having a severe and enduring mental health problem.³⁴⁹
- It is estimated worldwide that suicide rates within prisons are four to five times those of the general population.³⁵⁰
- Many prisoners at risk of suicide and self-harm are battling with multiple complex issues, with 42% of prisoners who died from self-inflicted means identified as having two or more mental health issues.³⁵¹
- Individuals with probable alcohol dependence are twice as likely to be taking psychotropic medication for common mental health conditions, such as anxiety and depression, as those with low levels of drinking.³⁵⁴
- Only a third of adults with probable alcohol dependence recalled having ever been diagnosed by a health professional as having alcohol or drug dependence.
- According to APMS (2014) figures, 35.4% of men and 22.6% of women have taken illegal drugs at least once in their lives. The survey found that 11.3% of men and 6.0% of women had used illegal drugs in the past year.³⁵⁵
- A total of 3.1% of adults showed signs of drug dependence, with cannabis being found to have the highest dependence rate (2.3%). Men were more likely to be dependent on illegal drugs (4.3%) than women (1.9%).³⁵⁶

2.2.7.3 Substance misuse and dependence

- According to the 2014 APMS data, 16.6% of adults in England report drinking to hazardous levels. Using the Alcohol Use Disorders Identification Test (AUDIT), a measure of hazardous drinking, 1.2% of adults scored levels of hazardous drinking that indicated probable dependence.³⁵²
- Men had higher rates of hazardous drinking than women, with between a quarter and a third of men aged 16–64 drinking to dangerous levels.³⁵³
- Comparisons show that drug dependence rates have remained stable across the years (1993–2014).³⁵⁷
- Half of those with drug dependence (50.1%) were receiving mental health treatment in 2014. The results also showed that adults with drug dependence were more likely to be using psychological therapy (5.5% for those dependent on cannabis and 30.7% for those dependent on other drugs) compared to other adults (2.6%).³⁵⁸

3. Social factors associated with mental health problems



There are a number of factors known to be associated with mental health problems, with effects that have the potential to persist and cumulate across generations. Mental health problems can both result from social factors like poverty and unemployment, and increase one's likelihood of experiencing these factors, especially where support is lacking or inadequate. In this section, we highlight some of the more pervasive yet intervenable factors, with particular attention given to the socioeconomic factors that contribute to mental health inequalities.

3.1 Introduction

Certain population subgroups are at a higher risk of mental health problems because of greater exposure and vulnerability to unfavourable social, economic, and environmental circumstances, which intersect with factors including gender, ethnicity and disability; and lesser access to protective resources. Please see Figure 1 in the 'Introduction to the 2016 edition of Fundamental Facts' section to understand how these processes can interact.

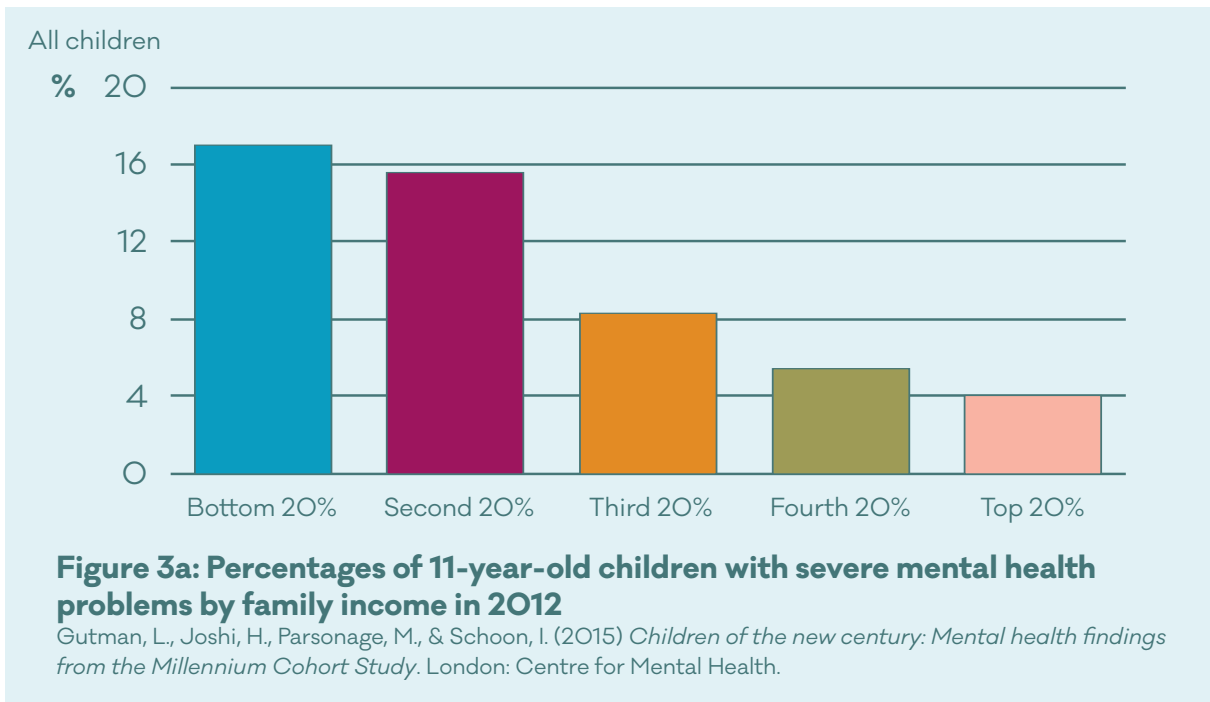
3.2 Social determinants of mental health

- WHO defines social determinants of health as the circumstances in which people are born, grow, live, work and age. These conditions are influenced by the distribution of money, power and resources operating at global, national and local levels.³⁵⁹
- Increasingly, it is recognised that these conditions impact mental (as well as physical) health. Recent research highlights the extent to which life circumstances can determine mental health and create inequalities between societies and communities.^{360,361}
- Although genetic and biological factors are important influences on mental health, this section focuses on social factors, which occur on individual, family, community and societal levels. They include factors such as household income, educational attainment, material circumstances, employment, social support/isolation and gender.³⁶²



3.3 Poverty and disadvantage

- A growing body of evidence, mainly from high-income countries, has shown that there is a strong socioeconomic gradient in mental health, with people of lower socioeconomic status having a higher likelihood of developing and experiencing mental health problems. In other words, social inequalities in society are strongly linked to mental health inequalities.³⁶³ These are defined as socially produced, systematic differences in mental health between social groups that are avoidable and therefore unjust.^{364,365,366}
- A 2006 paper exploring the results from WHO's Mental Health Survey found that socioeconomic disadvantage (e.g. low education, unemployment, poverty or deprivation) was associated with increased mental health problems.³⁶⁷ This gradient does appear to stop at a point – for example, people who earn above a certain average income do not experience more or fewer mental health problems, nor do they report feeling more or less happy.³⁶⁸
- Children and adults living in households in the lowest 20% income bracket in Great Britain are two to three times more likely to develop mental health problems than those in the highest.³⁶⁹
- In 2004, evidence from the Child and Adolescent Mental Health Survey found that the prevalence of severe mental health problems was around three times higher among children in the bottom quintile of family income than among those in the top quintile.³⁷⁰
- Analysis of data from the Millennium Cohort Study in 2012 found children in the lowest income quintile to be 4.5 times more likely to experience severe mental health problems than those in the highest,³⁷¹ suggesting that the income gradient in young people's mental health has worsened considerably over the past decade.
- A 2013 systematic review covering 23 countries found that socioeconomically disadvantaged young people were two to three times more likely to develop mental health problems than their peers from socioeconomically advantaged families. This association was strongest among younger children (i.e. those aged 12 and younger), and improvement in socioeconomic status significantly reduced mental health problems.³⁷²
- Parental educational qualifications and their occupational group are also strong predictors of mental health problems in children. Lower educational qualifications and lower status occupational groups are both correlated with mental health problems in children. Parental income and education have been found to be more strongly correlated with children's mental health than parental occupation.³⁷³



Understanding the relationship between disadvantage and mental health

It is important to note that low income does not necessarily lead to higher rates of mental health problems, but that social factors associated with lower income and socioeconomic status, such as debt, can adversely affect mental health. It is not yet possible to measure the relative importance of such factors; those explored in more detail in this section do not necessarily have a greater impact on mental health, but are intended to provide examples of what the impact of social determinants can look like. It can be difficult to determine the direction of the relationship between socioeconomic adversity and mental health problems, since mental ill health can also increase an individual's vulnerability to adverse circumstances, e.g. unemployment.

- Results from the APMS (2014) found that employment status is linked to mental health outcomes, with those who are unemployed or economically inactive having higher rates of common mental health problems than those who are employed (see Figure 3b).³⁷⁴
- Analysis of data from the WHO Mental Health Surveys in 2012 found that income was not associated with mental health conditions, whereas unemployment and disability were strongly associated with them. Lower educational attainment and living in urban environments increased the risk of mood disorders (e.g. anxiety and depression).³⁷⁵
- In addition to poorer physical health, people with mental health problems are more likely to be homeless, are more likely to live in areas of high social deprivation, have fewer qualifications, and are less able to secure employment.³⁷⁶

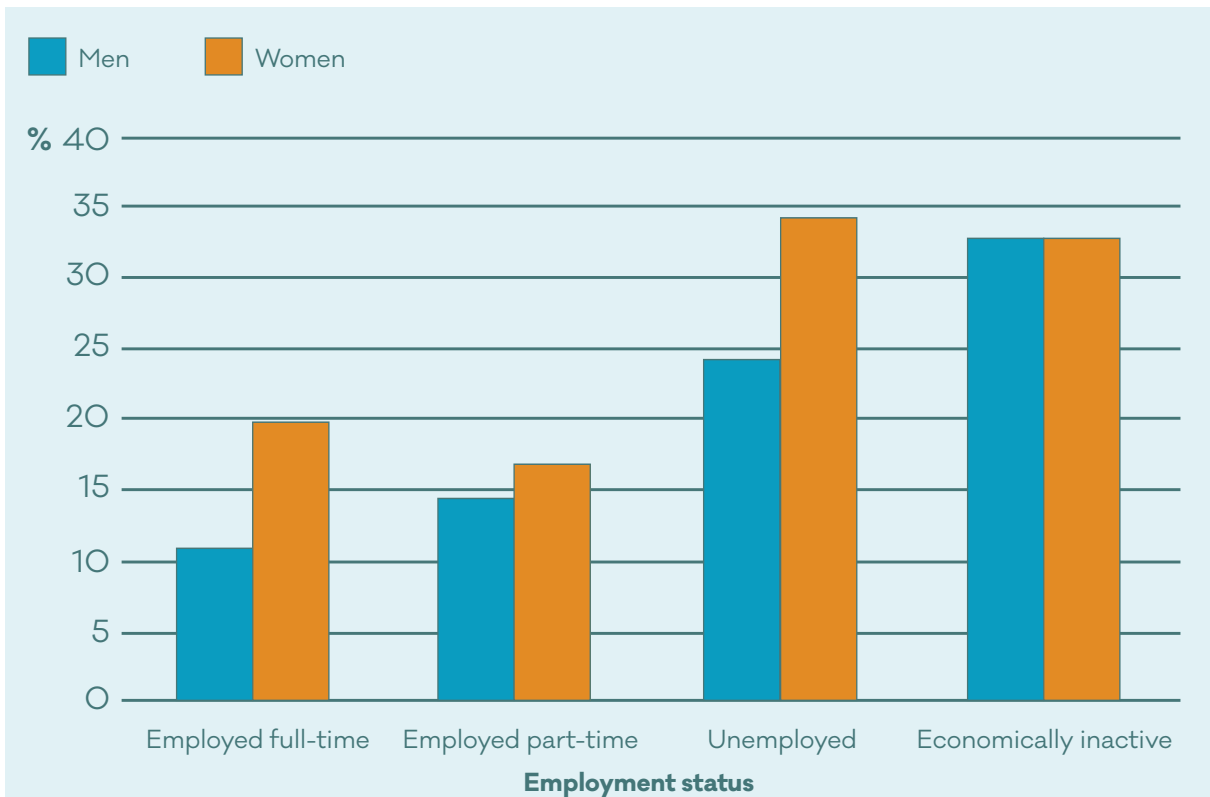


Figure 3b: Prevalence of common mental health problems by employment status

Stansfeld, S., Clark, C., Bebbington, P., King, M., Jenkins, R., & Hinchliffe, S. (2016). Chapter 2: Common mental disorders. In S. McManus, P. Bebbington, R. Jenkins, & T. Brugha (Eds.), *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital.

3.3.1 Debt

- Unsecured debt is strongly associated with depression, suicide and substance abuse.³⁷⁷
- Data from a survey conducted in 2000 by the British National Survey of Psychiatric Morbidity of 8,580 people in England, Wales and Scotland found that the more debts people had, the more likely they were to have some form of mental health problem (controlling for income and other sociodemographic variables).³⁷⁸

3.3.2 Unemployment

- Employment is generally beneficial for mental health. However, the mental health benefits of employment depend on the quality of work; work that is low paid, insecure or poses health risks can be damaging to mental health.³⁷⁹



- Data from both the 2007 APMS and the 2014 APMS shows that employed adults are less likely to have a common mental health problem than those who are economically inactive or unemployed. The rates of common mental health problems in people aged 16–64 were found to be:³⁸⁰
 - 14.1% in those in full-time employment
 - 16.3% in those in part-time employment
 - 28.8% in those who are unemployed and looking for work
 - 33.1% in those who are economically inactive
- Unemployed women were more likely to have a common mental health problem than unemployed men (34.6% vs 24.5% respectively).³⁸¹
- Those who were economically inactive were more likely to have a psychotic disorder (2.3%) than those in employment (0.1%) (using combined data from 2007 and 2014).³⁸²
- According to the APMS (2014), adults aged 16–64 were more likely to screen positive for bipolar disorder if they were unemployed (3.9%) or economically inactive (4.3%) compared to their counterparts who were employed (1.9%).³⁸³

According to the APMS (2014), two thirds of people aged 16–64 on ESA had a common mental health problem compared to 16.9% of adults not on

ESA,³⁸⁴ while 12.4% of people in receipt of out-of-work benefit related to disability screened positive for bipolar disorder compared to 2% of the general population.³⁸⁵

- Among 16–64 year olds in receipt of an out-of-work benefit, such as Jobseeker’s Allowance or ESA, 7.3% were identified as having a psychotic disorder in the past year compared to 0.2% of people not in receipt of these benefits. For those specifically in receipt of ESA, one in seven (13.4%) screened positive for a psychotic disorder in the past year.³⁸⁶
- Unemployment has been associated with an increased likelihood of suicide, with this association being greater for men than for women.³⁸⁷

3.3.3. Housing and environment

- Home ownership, as opposed to renting, has been found to have a positive impact on mental health.³⁸⁸
- Controlling for socioeconomic status, a WHO study of eight European cities found poor-quality housing to adversely affect mental wellbeing, with effects exacerbated by poor physical neighbourhood quality (e.g. public space, private gardens, security and access to amenities).³⁸⁹
- Those on housing benefit are more than twice as likely to have a common mental health problem than those not in receipt of it (35.1% vs 14.9%).³⁹⁰



3.4 Inequality as a determinant of mental health

While an individual's socioeconomic status affects their mental health (those of lower status are more likely to have mental health problems than those of higher status), national levels of income inequality also play an important role in determining the prevalence of mental illness across societies, especially in high-income countries.³⁹¹

- Preliminary analysis of data from WHO's World Mental Health Surveys has found that rates of mental illness increase as countries get richer, in contrast to rates of physical illness and mortality.³⁹²
- A study of nine high-income countries found that higher levels of inequality (i.e. income differences) are associated with increased levels of mental health problems, particularly anxiety disorders, impulse-control disorders and severe mental health problems.³⁹³
- The negative effect of unemployment on mental health has been found to be stronger in countries with more unequal income distributions (controlling for level of economic development).³⁹⁴ It has been suggested that inequality may affect mental health by reducing social capital (i.e. the links between individuals – links that bind and connect people within and between communities),³⁹⁵ or by increasing 'status anxiety' (i.e. concerns about one's position or status in society).³⁹⁶
- A 2014 study in England found that, for mothers of lower socioeconomic status, the negative mental health effects of living in a poorer neighbourhood were greater than any positive mental health effects of socioeconomic congruity in the neighbourhood. That is, any benefits of socioeconomic congruity may have been counteracted by neighbourhood deprivation.³⁹⁷
- Similarly, a 2013 study of neighbourhoods in Wales found that a neighbourhood's level of deprivation compared to the national standard was a more significant determinant of residents' mental health than income differences within a neighbourhood.³⁹⁸



3.5 Social support and relationships

3.5.1 Family and childhood

- Childhood circumstances such as poor attachment, neglect, abuse, lack of quality stimulation, conflict and family breakdown can negatively affect future social behaviour, educational outcomes, employment status and mental and physical health.³⁹⁹ Conversely, children and young people who have good personal and social relationships with family and friends have higher levels of wellbeing.⁴⁰⁰
- A 2015 survey of children attending CAMHS found that family relationship problems were the single biggest presenting problem.⁴⁰¹ Similarly, 'family relationships' were the leading reason why children contacted Childline in 2015.⁴⁰²
- Analysis of findings from the Millennium Cohort Study has found that children's behavioural problems are strongly associated with the quality of their parents' relationship, with a poorer-quality relationship predicting greater behavioural problems, especially among children in lower-income families.⁴⁰³
- Preventative interventions with parents that focus on their relationship as a couple can help to enhance children's wellbeing and reduce emotional and behavioural difficulties.^{404,405}

3.5.2 Couple relationships

- Being happily married or in a stable relationship impacts positively on mental health. A 2008 study found that high marital quality was associated with lower stress and less depression. However, participants who were single had better mental health outcomes than those who were unhappily married.⁴⁰⁶
- Recent studies from Ireland and the USA have found that negative social interactions and relationships, especially with partners/spouses, increase the risk of depression, anxiety and suicidal ideation, while positive interactions reduce the risk of these issues.^{407,408}

3.5.3 Community

- Social cohesion (a measure of how closely knit communities are) has been shown to counteract the adverse effects of deprivation; a longitudinal study published in 2014 found that people in neighbourhoods with higher levels of social cohesion experienced lower rates of mental health problems than those in neighbourhoods with lower cohesion, independent of socioeconomic factors.⁴⁰⁹
- Analysis of data from the English Longitudinal Study of Ageing in 2011 found that neighbourhood social cohesion was associated with a reduction in depressive symptoms in older people.⁴¹⁰

4. Prevention, treatment and care



This section outlines the statistics and facts associated with the number of people accessing support for their mental health problems, as well as information on access and effectiveness. Additionally, this section will provide information on some key approaches in the treatment of mental health; however, the approaches highlighted do not cover the full scope of treatment options available in mental health. Finally, it is important to note that treatment choice is based on individual characteristics and preference.

4.1. Prevention and early intervention

Prevention of mental health problems, as well as the promotion of mental wellbeing, can be undertaken on a universal, selective or an indicated basis. Universal interventions target the entire population, while selective interventions target high-risk groups or communities, and indicated preventions target individuals showing early detectable signs of certain mental health problems.⁴¹¹ Prevention can occur in various settings, including the community, the home, educational settings and workplaces, and throughout the life course.⁴¹² It is important to bear in mind that efforts in relation to the prevention of mental health problems occur across a range of sectors, impacting on social factors, education and the systems that we live in.

Despite the cost-effectiveness of preventing mental health problems in the long term, there are gaps in the research base on prevention of mental ill health. Investment in research typically examines the underlying causes and treatment of mental health problems and, as a result, prevention strategies are not well understood. However, prevention is a growing area of interest in mental health research.

- A 2016 Cochrane review of depression prevention programmes found that prevention programmes are associated with a reduction in depression diagnoses and depressive symptoms at up to 12 months' follow-up when applied on an indicated basis; however, programmes delivered to universal populations were not found to be effective.⁴¹³
- In England, early interventions and home treatment for mental health problems can reduce hospital admissions, shorten hospital stays and require fewer high-cost intensive interventions. This can potentially result in a saving of up to £38 million per year.⁴¹⁴
- Internet-based training for GPs in psychosomatic conditions (where physical symptoms have no known physical cause), and cognitive behavioural therapy (CBT) for 50% of adults presenting with unexplained medical symptoms, can potentially bring a saving of £639 million over three years, mainly due to reductions in sickness and absence from work.⁴¹⁵



- At the universal level, improving mental health literacy can lead to better mental health outcomes, especially in communities where greater stigma is experienced or groups are at high risk of developing problems.⁴¹⁶
- The case for the potential impact of prevention is strong, given that even with optimal care, studies suggest that less than 30% of the burden of mental health problems can be avoided by treatment.⁴¹⁷ On the other hand, prevention programs have shown small but significant reductions in depression, anxiety, antisocial behaviour and substance use, further cementing the case for a prevention approach.⁴¹⁸
- There is a growing evidence base for prevention programmes related to improving outcomes for parental mental health, including the development of universal programmes such as:⁴¹⁹
 - The Beardslee Preventive Intervention Program (PIP) uses a family-based approach that works by promoting resilience in children and increasing positive interactions within the family. Findings from a 2007 randomised trial found that the intervention produced positive effects in parental and child resilience, increased communication and improved family functioning. These outcomes were sustained even 4.5 years after involvement.⁴²⁰
 - The Let's Talk About Children programme, which uses a manual for a two-session discussion with parents with a mental health problem, found that the e-learning resource was effective at enhancing parents' practices – for example, assessing the impact of their mental health problem on their parenting and their child's development. The programme also provides information and resources to families.⁴²¹
 - Parents Under Pressure (PUP) is a promising programme for supporting parenting in families where parents abuse drugs or alcohol. Findings from the PUP trial found that, at the three- and six-month follow-ups, PUP families showed significant reductions in problems across multiple domains of family functioning, including a reduction in potential child abuse, rigid parenting attitudes and child behaviour problems.⁴²²



4.1.1 Interventions during childhood, early years and in school settings

- Families with children at higher risk of conduct disorders cost an estimated £210 million, but £5.2 billion⁴²³ could be saved in the long term or potentially £150,000 per case, if early-intervention approaches are used.⁴²⁴
- The promotion and prevention of conduct disorders through social and emotional learning programmes is estimated to result in an £83.73 return for every £1 invested, while the return on school-based interventions to reduce bullying is £14.35 (based on 2009–10 prices).⁴²⁵
- The Good Behaviour Game (GBG) is a two-year classroom management strategy targeted at six to eight year olds and designed to improve aggressive/disruptive classroom behaviour and prevent later conduct problems/antisocial behaviour. The programme, delivered to all children in this age band, costs around £100 per child. However, the savings over time are estimated to result in more than £50 for each £1 invested in the programme.⁴²⁶
- Prevention of conduct disorders in Wales for a one-year cohort of births is estimated to result in a potential long-term saving of £247.5 million. The estimated cost of prevention approaches is virtually negligible at £9.9 million, compared to the amount of savings produced. Furthermore, promotion of positive mental health through exercise, healthy eating and leisure can bring an additional saving of £1,113.75 million at a cost of £20 million.⁴²⁷
- Mindfulness for different members of the school community (pupils and teachers) is an emerging development within the field of prevention. An evaluation of the Mindfulness in Schools Project has found that mindfulness interventions can improve the mental, emotional, social and physical health and wellbeing of young people who take part. It was shown to reduce stress, anxiety, reactivity and bad behaviour, improve sleep and self-esteem, and bring about greater calmness and relaxation.^{428,429}
- Research into the prevention of eating disorders has found positive outcomes for schools-based prevention programme the Body Project. Results show that the programme has led to reduced levels of eating disorder risk factors, symptomology and onset of eating disorder for high-school-aged girls and young women following participation in the programme. The findings have been replicated by independent research teams and using online approaches. The Body Project is currently the only eating disorder prevention programme that has been warranted by the American Psychological Association as an efficacious intervention.⁴³⁰



4.1.2 Early intervention and psychosis

- The estimated annual savings from early diagnosis of psychoses over 6–10 years is estimated at approximately £14 million to £68 million respectively.⁴³¹
- The total direct cost per patient with psychosis in early intervention services is £10,927, compared to the standard care rate of £16,704. The saving mainly occurs due to a lower need for inpatient care.⁴³²

4.1.3 Prevention and the workplace

- Better mental health support in the workplace can save UK businesses up to £8 billion a year.⁴³³
- Introducing a workplace intervention in the form of an employee screening and care management for those living with (or at risk of) depression was estimated to cost £30.90 per employee for assessment, and a further £240.00 for the use of CBT to manage the problem, in 2009. According to an economic model, in a company of 500 employees where two thirds are offered and accept the treatment, an investment of £20,676 will result in a net profit of approximately £83,278 over a two-year period.⁴³⁴

- Promoting wellbeing at work through personalised information and advice, a risk-assessment questionnaire, seminars, workshops and web-based materials will cost approximately £80 per employee per year. For a company with 500 employees, where all employees undergo the intervention, it is estimated that an initial investment of £40,000 will result in a net return of £347,722 in savings, mainly due to reduced presenteeism (lost productivity that occurs due to an employee working while ill) and absenteeism (missing work due to ill health).⁴³⁵

4.1.4 Suicide prevention

- Installing safety barriers at heights, even if the averted suicide attempts are diverted to other methods of suicide, will result in £40 million in savings over 10 years.⁴³⁶
- Suicide awareness and prevention training, if delivered to all GPs in England, is estimated to cost £8 million. Such training, combined with CBT for individuals at risk of suicide, has an estimated cost of £19 million over 10 years, which is negligible compared to the net savings of £1.27 billion that can result over a 10-year period.⁴³⁷

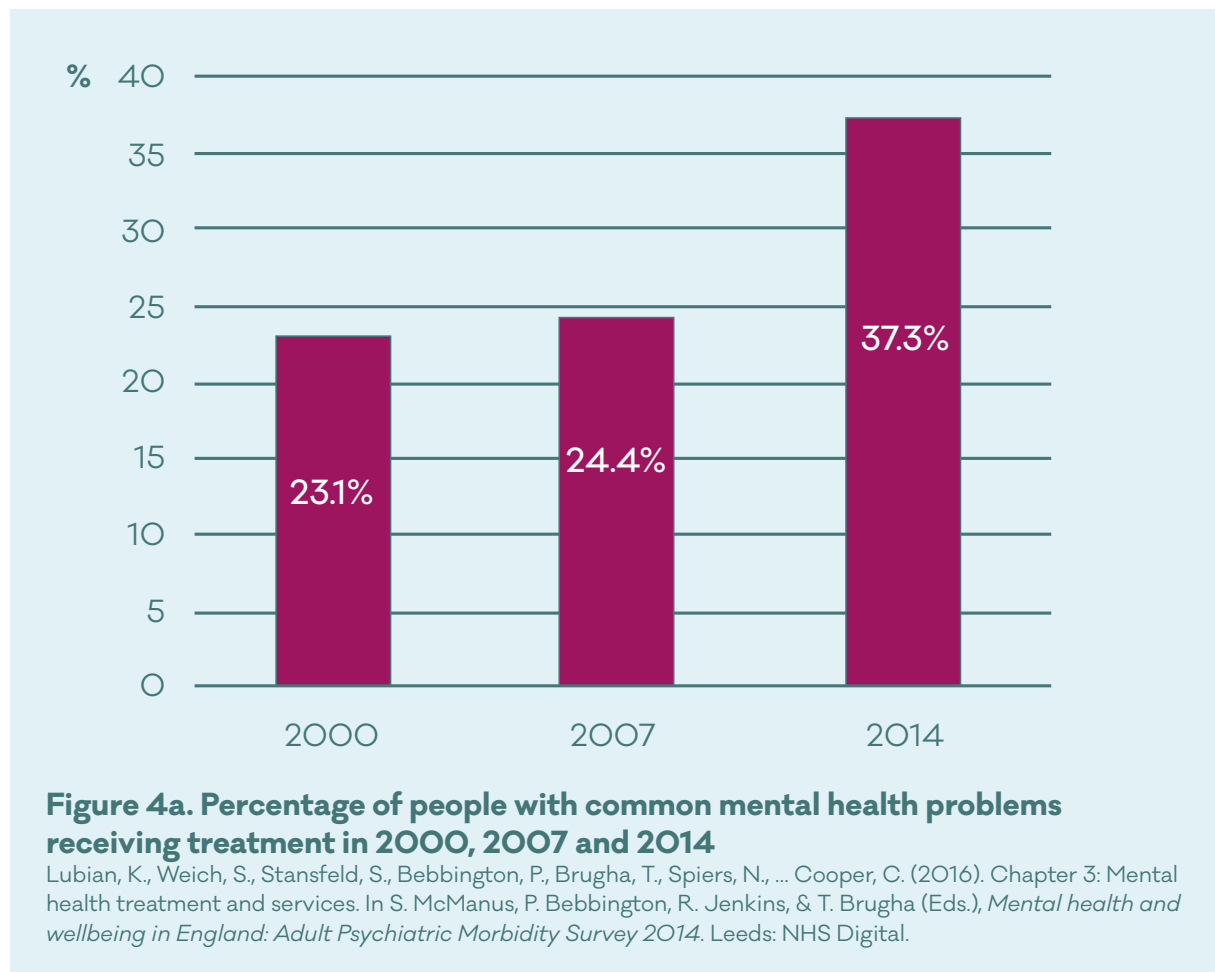


4.2 How many people seek help and use services?

Treatment statistics

- The 2014 APMS found that one adult in eight (12.1%) reported receiving mental health treatment, with 10.4% receiving medication and 3% receiving psychological therapy. The overlap within the statistics is due to 1.3% of those receiving treatment reporting receiving both medication and psychological therapy.⁴³⁸

- For those with common mental health problems, 36.2% reported receiving treatment. The proportion of people with a common mental health problem using mental health treatment has significantly increased. Around one person in four aged 16–74 with symptoms of a common mental health problem was receiving some kind of mental health treatment in 2000 (23.1%) and 2007 (24.4%). By 2014, this has increased to more than one in three (37.3%) (see Figure 4a).⁴³⁹





Type of common mental health condition	Percentage receiving treatment
Depression	59.4%
OCD	52.1%
Phobias	51.6%
GAD	48.2%
CMD-NOS	24.7%
Panic disorder	20.9%

Table 4a: Treatment uptake by type of common mental health condition

Lubian, K., Weich, S., Stansfeld, S., Bebbington, P., Brugha, T., Spiers, N., ... Cooper, C. (2016). Chapter 3: Mental health treatment and services. In S. McManus, P. Bebbington, R. Jenkins, & T. Brugha (Eds.), *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital.

- Treatment rates varied by type of common mental health problem, as outlined in Table 4a above.⁴⁴⁰
- The most used treatment for those with a common mental health problem was medication, with only 11.8% of people reporting receiving psychological therapies. CBT was the most commonly reported psychological therapy, followed by counselling and psychotherapy.⁴⁴¹
- In 2014, 1.7% of people reported asking for treatment but not receiving it; this included 10.3% of those with severe symptoms of a common mental health problem. Analysis found that 16–34 year olds and those from lower-income households were more likely not to receive treatment, even if they asked for it.⁴⁴²
- Between 2014 and 2015, there were a total of 125,710 admissions to a mental health or learning disability hospital in England, reflecting a 3.5% increase from the previous year. During the same time period, there has been an increase in discharges by 1.7% and the average occupied bed days increased by 4.9%.⁴⁴³
- In England, within CAMHS, the number of NHS-funded beds for children and adolescents rose from 1,128 in 2006 to 1,264 in January 2014. Leicestershire and Lincoln had the greatest increase (by 19%) in bed occupancy, followed closely by 15% in East Anglia.⁴⁴⁴ As of April 2016, 46 additional children’s beds have been provided in areas of relative shortage such as Yorkshire and the Humber.⁴⁴⁵



- Across England, there were 3,372 inpatient admissions to child and adolescent psychiatry specialities between 2014 and 2015.⁴⁴⁶
- Between 2014 and 2015, there were 20,900 admissions and discharges in psychiatric specialities in Scotland – similar to the previous year (20,700).⁴⁴⁷
- In 2014 and 2015, there were 9,762 admissions to mental health facilities in Wales (excluding safety detention facilities) – a decrease of 5% from 2013–14.⁴⁴⁸
- Across the UK, a substantial proportion of people don't access any mental health support. For instance, only 65% of people with psychotic mental health conditions, and 25% of adults with depression and anxiety-related conditions, are thought to receive treatment.⁴⁴⁹
- It is estimated that 75% of people with mental health problems in England may not get access to the treatment they need.⁴⁵⁰
- A meta-analysis carried out in Canada by Dagoni et al. (2016) shows that the average length of time between the onset of bipolar disorder and its management and treatment is 5.8 years. These findings highlight the need for more reliable methods of diagnosing bipolar disorder during the early stages of the symptoms to increase the opportunity for early intervention, which might improve symptoms or even prevent the development of bipolar disorder in some cases.⁴⁵¹
- Using combined data from the 2007 APMS and the 2014 APMS, findings showed that four fifths (80.6%) of adults with a psychotic condition in the past year were receiving some form of treatment, compared to 9.3% of those without a psychotic condition. Almost all of those receiving treatment were on medication and about half combined medication with psychological therapy.⁴⁵²
- Data from the APMS (2014) showed that 6 out of 10 people who screen positive for bipolar disorder were not in receipt of psychotropic medication or psychological therapy (59.9%). One in eight of the respondents had unsuccessfully requested a particular mental health treatment in the past 12 months.⁴⁵³
- The type of medication received by people who screened positive for bipolar included:⁴⁵⁴
 - Medication for anxiety (30.0%)
 - Medication for depression (29.6%)
 - Medication to directly treat bipolar disorder (14.5%)



Treatment inequalities

- According to 2014 statistics, women are more likely than men to receive treatment for all mental health conditions, with 15% of women receiving treatment compared to 9% of men.⁴⁵⁵
- Young people aged 16–24 were found to be less likely to receive mental health treatment than any other age group.⁴⁵⁶
- White British people are more likely to receive mental health treatment (13.3%) compared to BAME groups (7%). The lowest percentage of people receiving treatment were those from black ethnic minority groups (6.2%).⁴⁵⁷



4.3 Extent of treatment and care

This section mainly covers England, as there is little information available for the extent of treatment and care in other regions in the UK, which brings about difficulties in comparisons for the extent of treatment and care across the UK.

Primary care

- In 2014, a total of 12.5% of people reported talking to their GP about their mental health, with 44.1% of those with CMD-NOS symptoms reporting contact with their GP.⁴⁵⁸
- Many people with mental health problems will be seen mainly by their GP and will have only limited access to specialist mental health services.⁴⁵⁹ For example, 22% of people in England surveyed in the Community Mental Health Survey in 2015 said that they felt they did not have enough contact with mental health services to meet their needs.⁴⁶⁰ To remedy this, in 2016, NHS England has committed to expanding the primary care workforce, including an investment in providing 3,000 extra mental health therapists to work in primary care by 2020 to better support the mental health of all people.⁴⁶¹
- According to the Care Quality Commission (CQC), on average, one in four patients requires mental health treatment. In England, between 2013 and 2014, there were nearly 3 million adults on local GP registers for depression and approximately 500,000 for serious mental health problems.⁴⁶²

Secondary care

- Data for 2015–16 on secondary care in England will be available from November 2016; consequently, slightly older data is highlighted in this section. The latest data shows that between 2014 and 2015, 1,836,996 people were in contact with mental health and learning disability services. This is the equivalent to 1 in 27 persons (4%) being in contact with secondary mental health services during that year.⁴⁶³
- Individuals in contact with mental health and learning disability services between 2014 and 2015 in England spent a total of 8,523,323 days in hospital in the year. This is an increase of 4.9% compared to last year's figure (8,128,143).⁴⁶⁴
- Regional data on access to treatment and care, as well as on completion rates and IAPT recovery, is available via Public Health England's Fingertips (fingertips.phe.org.uk/profile-group/mental-health).

Community care

- In England, out of the 1,836,996 people that were in contact with mental health services between 2014 and 2015, 94% did not spend any time in mental health hospitals, which indicates that most of the care was provided in the community.⁴⁶⁵



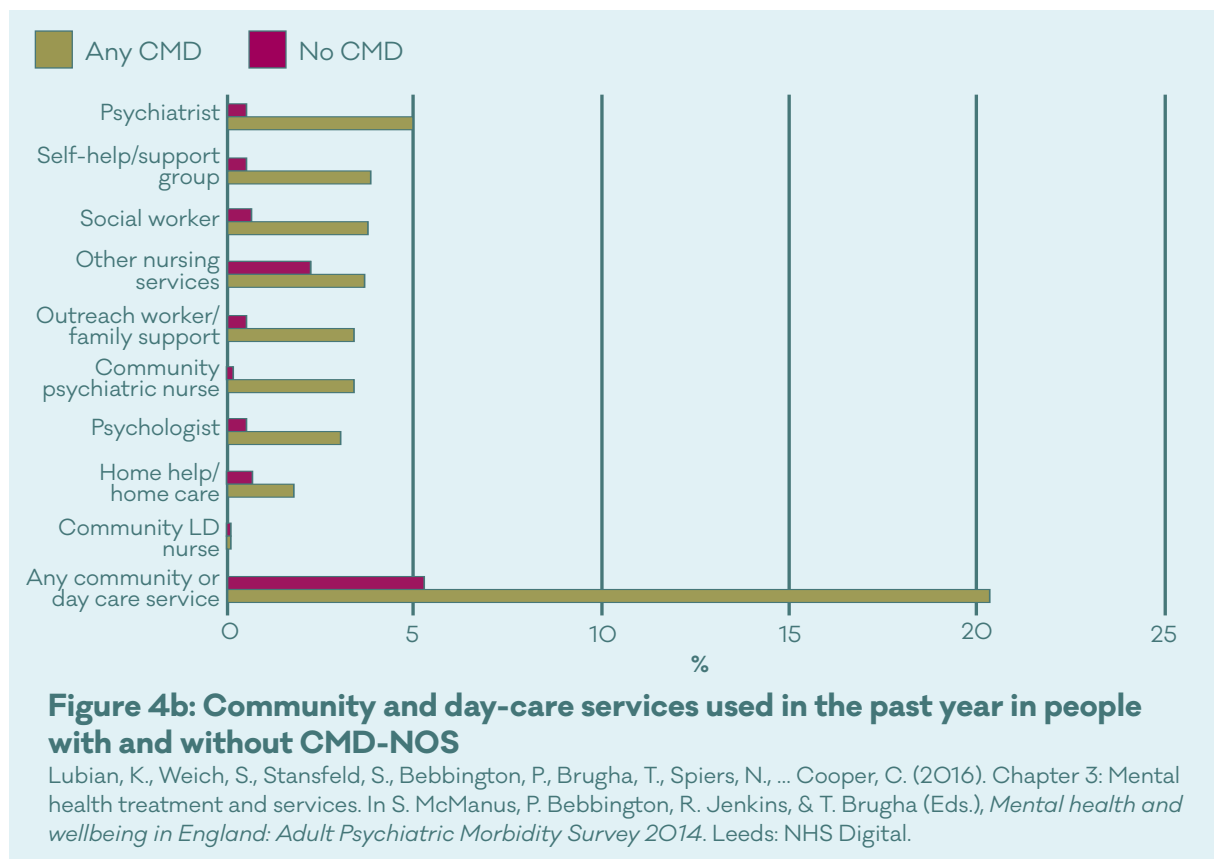
- The most common community and day-care services used by those with common mental health problems were seeing a psychiatrist (6.8%), seeing a community psychiatric nurse (5.4%), seeing an outreach or family support worker (5.4%), seeing a social worker (5.2%) and going to self-help/support groups (4.8%) (see Figure 4b).⁴⁶⁶
- A 2014 survey carried out by the We Need to Talk Coalition in England found that, out of 2,000 people who tried to access talking therapies, only 15% of them were offered the full range of recommended therapies by NICE.⁴⁶⁷
- Between 2014 and 2015, there were 21 million outpatient and community contacts arranged for mental health

service users in England, such as day-care services, criminal justice liaison and division services, and asylum services.⁴⁶⁸

- In Wales, 240 patients engaged in supervised community treatment (SCT) in 2014–15. Of those patients who engaged in SCT, there were 91 recalls to hospital, 78 revocations and 138 discharges in 2014–15.⁴⁶⁹

Informal care

Informal care is also a crucial part in the treatment of mental health difficulties; informal care is described in more detail in section 2 of this document, 'Differences in the extent of mental health problems'. Please refer to section 2 if you wish to know more about informal care in mental health.





4.4 Mental health legislation

The Mental Health Act (1983, amended 2007)

The Mental Health Act is the law in England and Wales that allows people with a mental health problem to be admitted, detained and treated without their consent to protect them or for the protection of others. Different laws operate in Scotland and Northern Ireland: the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Mental Health (Northern Ireland) Order 1986.

The laws provide for safeguards that protect the rights of people subject to the Act. The statistics below outline the number of cases across the UK:

- Between 2014 and 2015, there has been an increase in the total number of people admitted under the Mental Health Act. In England this increased by 10%,⁴⁷⁰ and in Wales, it increased by 14%)⁴⁷¹ while Northern Ireland and Scotland saw a decrease of 0.9⁴⁷² and 5.7%⁴⁷³ respectively. The points below explore these statistics further.
- In England, by March 2015, there was a total of 25,117 people detained under the Mental Health Act. Of these, 19,656 were detained in hospital and 5,461 were being treated in the community. The Act was used 58,399 times to detain patients in hospital for longer than 72 hours, which was a 10% increase from the previous year (53,176).⁴⁷⁴ The 2015–16 data for those detained under the Mental Health Act in England will be published in November 2016.
- In Scotland, in 2014–15, there was a 5.7% decrease in the number of individuals aged 45–64 who were detained in an emergency.⁴⁷⁵
- Between 2014 and 2015, 1,921 inpatients were formally admitted under the Mental Health Act in Wales – an increase of 14% from 2013–14.⁴⁷⁶
- In Northern Ireland, between 2014 and 2015, there were 987 compulsory admissions in hospitals under the Mental Health (Northern Ireland) Order 1986 – a slight decrease from the previous year (996). Of these admissions, the majority were admissions of men (54.5%) compared to admissions of women (45.5%).⁴⁷⁷



The Mental Capacity Act (2005)

The Deprivation of Liberty Safeguards were introduced in 2009 and are a part of the Mental Capacity Act (MCA). These are used to protect the rights of people who have been assessed as lacking the mental capacity to make certain decisions for themselves. The MCA provides a framework for the guidance of people who have to make decisions on behalf of someone else.⁴⁷⁸

- The CQC has stated that, in 2013, approximately 2 million people in England and Wales may lack the capacity to make certain decisions for themselves at some point due to illness, injury or disability.⁴⁷⁹
- From 2009 to 2014, the number of Deprivation of Liberty Safeguards applications had been consistently low. From 2011–14, the CQC had only received notifications for 37% of applications to supervisory bodies.⁴⁸⁰ However, following the Supreme Court ruling in March 2014, which clarified the test for when people are deprived of their liberty, applications increased from 13,715 in March 2014 to 137,540 in March 2015 in England.⁴⁸¹
- Following the Supreme Court ruling in 2014, the number of applications for the Deprivation of Liberty Safeguards in Wales saw an increase from 631 in 2013–14 to 10,679 during April 2014–March 2015.⁴⁸²

4.5 Treatment and care modalities

This section highlights key approaches currently present in mental health service provision, as well as trends in the uptake and delivery of services. For further information on treatment and care, please see the NHS Choices website (<http://www.nhs.uk/pages/home.aspx>) or NICE guidelines (<https://www.nice.org.uk/guidance>).

Improving Access to Psychological Therapies

The IAPT programme was launched in 2008 with the aim of improving the quality and accessibility of mental health services in the UK by focusing on providing improved access to psychological treatments – primarily talking therapies (e.g. CBT, counselling and self-help support). IAPT pathways vary in each of the devolved nations. For instance, Scotland has set Local Delivery Plan Standards for NHS boards to increase access to psychological therapies.⁴⁸³

- In March 2016, 118,989 referrals were received by IAPT in England, of which 53.5% were self-referrals. The average number of attended treatment sessions was 6.4.⁴⁸⁴
- There were 51,000 referrals of 15–19 year olds to psychological therapies between 2013 and 2014 in England.⁴⁸⁵



- In England, CBT was the most common form of talking therapy in the IAPT programme, accounting for 34% of the total appointments attended in 2014–15 (approximately 3.5 million appointments were attended).⁴⁸⁶
- Following recommendations issued by NICE, there has been an increase in funding for psychological therapies through the IAPT programme. From 2011–15, there has been a £60-million investment in Children and Young People’s Improving Access to Psychological Therapies programmes from NHS England and the Children and Young People’s Mental Health and Wellbeing Taskforce,⁴⁸⁷ and a £400-million investment in IAPT.⁴⁸⁸ Additionally, NHS England plans to invest a further £10 million into IAPT in 2015–16, aiming to ensure that 75% of those referred to an IAPT service will be treated within six weeks of referral and 95% within 18 weeks.⁴⁸⁹ Investments are also crucial to providing training to develop qualified therapists, and also to providing top-up training for existing therapists who deliver NICE-approved modalities for treating people with depression and anxiety.⁴⁹⁰
- Between 2014 and 2015, IAPT services received 1.2 million referrals in England, of which 815,665 entered treatments.⁴⁹¹ This is an increase of 43% of referrals since 2012–13, and a 15% increase in the percentage of referrals that enter treatments.⁴⁹²
- In January–March 2016, there were 362,000 referrals to the IAPT service in the UK; 73% of referrals received an assessment within 28 days. Of people who finished treatment, 46% were assessed as making a reliable recovery.⁴⁹³ Reliable recovery is recorded when a person moves from above the clinical threshold to below the threshold following a course of psychological therapy.⁴⁹⁴
- The number of persons moving to recovery through IAPT treatment has been on the increase. Over 285,000 people are reported to have reliably improved after finishing a course of treatment between 2014 and 2015 alone – a reliable improvement rate of 60.8% across England⁴⁹⁵ and a slight increase from the 60% of 2013–14.⁴⁹⁶ Data for IAPT referral rates, recovery rates and waiting times in 2015–16 were released in October 2016.
- One study examining the cost of IAPT in England over the period 2009–10 calculated that the cost per recovered person ranged from £1,043 (low intensity) to £2,895 (high intensity).⁴⁹⁷



Self-management and peer support interventions

- Self-management is used to describe the methods, skills and strategies people use to effectively manage themselves towards achieving certain objectives. For those with long-term mental health problems, this may involve providing training and support that focuses on the development of skills that can help them manage and gain greater control over their life.⁴⁹⁸
- Peer support can be described as the support that people with lived experience of a mental health problem or learning disability give to one another. Support may be social, emotional or practical in nature. A key feature of peer support is that the support is mutually offered and reciprocal.⁴⁹⁹ There are few studies in the UK that have evaluated the effectiveness of these groups for people with mental health problems. The majority of groups that have been studied usually have small numbers of participants and use qualitative methods.
- In Northern Ireland, between 2014 and 2015, 13,069 patients enrolled in a patient education/self-management programme, which was approximately a 6% increase from the previous year (12,385). Of these, 16% attended a programme specifically for dementia.⁵⁰⁰
- In Wales, a study conducted by Cyhlarova et al. (2015) found that a self-management and peer-support intervention delivered by service users to 132 people led to overall significant improvements in wellbeing and health-promoting lifestyle behaviours both at 6 and 12 months after the intervention had finished.⁵⁰¹
- Through the Rain is a Scottish peer-support project that employs peer workers to provide one-to-one support to individuals with mental health difficulties, as well as to groups, to support them in finding their own solutions to challenges they face and to enable them to manage their wellbeing and live satisfying and fulfilling lives. Of the 36 people who took part in the Through the Rain self-management course between 2014 and 2015, 32 reported that they were more confident about managing their wellbeing afterwards.⁵⁰²
- A 2012 survey conducted by Together for Mental Wellbeing with 44 respondents across England revealed that 75% of the respondents said that they offered peer support to others, while 45% revealed that they received and offered peer support through the groups they attended. These groups included informal peer-run services and various other voluntary sector groups.⁵⁰³



Digital technologies

- Technology is a fundamental part of day-to-day life in Britain today; therefore, it is not surprising that people across the UK have embraced it as part of their healthcare. The Aviva Health Check Report conducted in 2015 showed that 63% of those surveyed in the UK use the Internet to read about how to manage a condition or illness, be it physical or mental. Additionally, 39% of people use the Internet to get information on how to improve their health and wellbeing.⁵⁰⁴
- Computerised cognitive behavioural therapy (CCBT) is a form of psychological treatment that appears to be accessible and cost-effective, and suitable for people who prefer using a computer than talking to a therapist about their private feelings. However, they still benefit from occasional meetings or phone calls with a therapist to guide and monitor their progress. There may be different forms of modality some of which use more or less support from a therapist. CCBT is believed to be most effective for treating mild–moderate depression.
- A 2010 systematic review of the evidence from around the globe suggests that CCBT is effective on a comparable level to clinic-delivered CBT at reducing anxiety in children. This finding was reported to be sustained over time.⁵⁰⁵
- In 2015, a study in England with 23 adolescents revealed that CCBT led to improvements in depression and anxiety. This improvement was sustained at 12-month follow-up.⁵⁰⁶
- Gilbody et al. (2015) conducted a study with adults with depressive symptoms who received treatment via CCBT, GP care or neither (controls). This study found that there were no additional improvements in depression from using CCBT compared to usual GP care after four months of treatment.⁵⁰⁷
- Data collected by the Health and Social Care Information Centre (HSCIC) on IAPT found that, in England, CCBT was the second-to-least most common form of psychological therapy, with only 11,168 appointments in 2014–15. However, for referrals with problems of depression or depressive symptoms, CCBT had the highest rate of recovery (58.4%).⁵⁰⁸
- One significant issue to consider with CCBT is adherence to this treatment, as studies highlight that adherence to CCBT is very poor (17%).⁵⁰⁹

Apps and wearables

- Healthcare mobile apps are being used to access information about, and monitor, nutrition. According to Aviva's Health Check Report in 2015, 9% of respondents use a nutrition tracker app and 31% said they are open to the idea of using such apps in the future.⁵¹⁰



Mindfulness

- Mindfulness is an integrative, mind-body-based approach that can help people manage their thoughts and feelings and change the way they relate to experiences. The aim of mindfulness is to pay attention to the present moment without judgement and use techniques that draw on meditation, breathing and yoga.⁵¹¹
- Mindfulness-based cognitive therapy (MBCT) has been recommended by NICE as a preventative practice for people with recurrent depression.⁵¹² A 2016 meta-analysis of randomised control trials found that MBCT was an effective intervention for relapse prevention in recurrent major depressive disorder.⁵¹³
- In 2014, Williams et al. conducted a study in England and Wales with 255 people with major depressive disorder. They found that MBCT provided the most significant protection against relapse for patients with increased vulnerability due to childhood trauma, with a relapse rate of 41% compared to other interventions: cognitive psychological education had a relapse rate of 54%; and treatment as usual, such as medication and attending mental health practitioners and other services, had a relapse rate of 65%.⁵¹⁴
- After conducting a follow-up of an online mindfulness course, Krusche et al. (2013) found that perceived stress, anxiety and depression decreased at course completion and further decreased at one-month follow-up.⁵¹⁵
- A recent systematic review and meta-analysis carried out by Taylor et al. (2016) examining the effectiveness of mindfulness-based interventions for reducing depression, anxiety and stress, and improving mindfulness skills in the perinatal period, failed to find any significant post-intervention benefits for depression, anxiety or stress of mindfulness-based interventions in comparison to control groups.⁵¹⁶
- A meta-analysis of the effectiveness of online mindfulness-based interventions in regards to the improving of mental health and wellbeing showed that online mindfulness-based interventions had a beneficial impact on depression, anxiety, wellbeing, mindfulness and stress.⁵¹⁷



- Online mindfulness has been found to be a positive application of mindfulness, with a research study published by the University of Oxford in November 2013 providing evidence of the effectiveness of the Be Mindful online course. The study examined the effects of the course for 273 people who had completed it, and showed that, on average, after one month, they enjoyed:⁵¹⁸
 - A 58% reduction in anxiety levels
 - A 57% reduction in depression
 - A 40% reduction in stress

A 2016 study by the University of Surrey found that those who completed Be Mindful had lower levels of work-related rumination and fatigue, and improved sleep quality compared with those on a waiting list. The effects were maintained at three- and six-month follow-ups, suggesting that online mindfulness interventions can have positive effects for work-related mental health problems and stress.⁵¹⁹

Medication

Drugs are prescribed for various mental health problems, ranging from depression to bipolar disorder; it is always important to seek medical advice before amending medication.

- In the UK, Aviva's Health of the Nation Report conducted in 2012 with 202 GPs showed that 75% of GPs prescribed medication even though they felt that psychological therapies would be more effective.⁵²⁰ Views have not much changed since 2005, where 78% of NHS GPs prescribed antidepressants despite believing that an alternative treatment might have been more appropriate.⁵²¹
- In 2015, Aviva's Health Check Report showed that, of those surveyed across the UK, treatment by drugs was the most popular method used for those with depression, with 48% being placed on medicine such as antidepressants. Additionally, of those who suffered from stress, the largest proportion (24%) was prescribed drugs such as antidepressants or sleeping pills.⁵²²
- Northern Ireland has consistently had higher antidepressant prescribing costs per capita than other UK regions. The volume of antidepressant prescribing here has been steadily increasing over recent years. The cost of antidepressants fell considerably during 2012, but rose again slightly in 2013. During 2012, prescribing costs per head of population was £1.71 here compared with £0.41 in Scotland and £0.26 in Wales.⁵²³



- In England, 61 million antidepressants were dispensed in 2015 – a 107% increase from 2005. This is a big difference from the 10.9 million antipsychotics that were dispensed in 2015, a 58% increase from 2005 (6.9 million).⁵²⁴
- In England, HSCIC (2015) found that prescriptions of antidepressants decreased in cost by £53.8 million (15.9%) from 2005–15; however, there was an increase in cost from 2014–15 of £19.7 million (7.4%).⁵²⁵
- The Community Mental Health Survey in England surveys people who receive care or treatment for a mental health condition. 84% of respondents of the survey in 2015 had said that they were receiving medication for mental health needs over the past 12 months.⁵²⁶
- 300,000 people in Northern Ireland have been prescribed antidepressant medication from their GP during 2014–15; more than 500 of those people are aged under 15.⁵²⁷
- A cohort study across Western countries between 2005 and 2012 found that the use of antidepressants by children aged 10–19 has increased across Western countries, with the UK showing one of the greatest increases (54.4%).⁵²⁸
- A study carried out in Scotland by Burton et al. (2012) with 28,027 patients revealed that new courses of antidepressants accounted for one sixth of the total antidepressant prescriptions in primary care.⁵²⁹
- A study by Cousins et al. (2016) conducted in England with 465 adolescents with depression found that the 88 individuals (19%) who were prescribed antidepressants before psychological treatment reported lower levels of health-related quality of life than those who were not prescribed medication prior to psychological treatment.⁵³⁰
- A study conducted by Marston et al. (2014) with 47,724 individuals who were prescribed antipsychotics found that less than 50% of the 13,941 people who received first-generation antipsychotics in the UK had any diagnosis of serious mental ill health, which included schizophrenia and bipolar disorder. Only 41% of the 27,966 people who received one of the three most common second-generation antipsychotics had any diagnosis of schizophrenia or bipolar disorder.⁵³¹



Exercise

Exercise has been proven to be effective for various mental health issues – from those more common, such as depression and anxiety, to those less common, such as schizophrenia and dementia.

- In 2016, Carter et al. conducted a study analysing 26 adolescents with depression and found that, of those who engaged in an intervention of their choice, 72% had feelings of improved mood and enjoyment, alongside a reduction in depressive symptoms.⁵³²
- A systematic review conducted by Stanton and Happell (2014) found that aerobic exercise, such as using the treadmill, and walking or cycling performed for 30–40 minutes three times a week for at least a 12-week period, was effective at improving mental health outcomes in people with schizophrenia and schizoaffective disorder.⁵³³
- Browne et al. (2016) evaluated the impact of a walking intervention pilot programme for 16 individuals with schizophrenia spectrum disorder and found improvements in their physical and mental health.⁵³⁴
- Forbes et al. (2013) conducted a systematic review across the globe that found that exercise programmes may have a significant impact on improving cognitive functioning and that these programmes may have a significant impact on the ability of people with dementia to perform daily activities.⁵³⁵

Nutrition

- Evidence has found that good nutrition is important for our mental health. Eating properly can help us to maintain a balanced mood and feelings of wellbeing.⁵³⁶
- A study conducted by Stranges et al. (2014), in England, found that vegetable consumption was associated with high levels of mental wellbeing.⁵³⁷
- A systematic review conducted by O’Neil et al. (2014) showed that unhelpful dietary patterns, which included higher intake of foods with saturated fat, refined carbohydrates and processed food products, can lead to poorer mental health in children and adolescents, with a strong focus on disorders such as depression and anxiety.⁵³⁸
- Healthy eating has been found to be associated with better emotional health compared to unhealthy eating.⁵³⁹ For instance, Beyer and Payne (2016) found that patients with bipolar depression tend to have a poorer-quality diet that is high in sugar, fat and carbohydrates. Additionally, omega-3 – a fatty acid acquired most commonly by eating fish such as tuna, salmon and sardines – was shown to be helpful in the control of bipolar depressive symptoms.⁵⁴⁰



The arts

- Art therapy is a form of psychotherapy that uses a creative medium to aid people to explore and articulate their emotions and feelings.⁵⁴¹ Examples of art that can be used in this way can include the visual arts⁵⁴² and dance.⁵⁴³
- Evidence suggests that music therapy, when combined with standard care, is effective for improving depression symptoms among working-age people.⁵⁴⁴
- A systematic review conducted by Uttley et al. (2015) found that patients receiving art therapy for non-psychotic mental problems (such as depression, anxiety or trauma) had positive improvements in their mental health symptoms compared to the control group.⁵⁴⁵
- A systematic review conducted in 2011 by the Mental Health Foundation revealed that participatory arts have a significant, positive impact on the wellbeing of older people.⁵⁴⁶
- The benefits of music for those with dementia was evidenced in a 2014 study, which found that the effects of music go beyond the reduction of behavioural and psychological symptoms, and individual preference of music was preserved throughout the process of dementia in that individuals at all stages of dementia can access music.⁵⁴⁷

5. The cost of mental health problems



Mental health problems pose emotional and financial costs to individuals, their families and society as a whole. However, there is room to decrease this cost and the distress associated with mental health problems by investing in preventative approaches to tackle these issues. Globally, the financial burden of mental health problems is greatly disproportionate to the expenditure for treatment and prevention. In this section, we present direct and indirect costs associated with mental health problems, as well as the estimated savings that could be made through prevention and early intervention approaches. The statistics presented below mainly apply to England, with fewer references for Northern Ireland, Scotland and Wales due to the limited data available in these areas.

5.1 Overall global and nationwide costs of mental health problems

Global overview

- According to a report published by WHO in 2011, untreated mental health problems account for 13% of the total global burden of disease. It is projected that, by 2030, mental health problems (particularly depression) will be the leading cause of mortality and morbidity globally.⁵⁴⁸ According to WHO's Atlas (2014), globally, governments are the most commonly cited source of funding for mental health services, with non-governmental and not-for-profit organisations coming

second, followed by employers (through social health insurance) and household income (private insurance and out-of-pocket).⁵⁴⁹

The UK

- The 2013 Chief Medical Officer's report estimated that the wider costs of mental health problems to the UK economy are £70–100 billion per year – 4.5% of gross domestic product (GDP).⁵⁵⁰ However, estimating this figure is very complex and an earlier study carried out by Centre for Mental Health found that, taking into account reduced quality of life, the annual costs in England alone were £105.2 billion.⁵⁵¹
- Levels of poor mental health in Northern Ireland continue to be higher than elsewhere in the Republic of Ireland and the UK. The total cost of mental health problems in Northern Ireland is estimated at £3.5 billion, or 12% of Northern Ireland's national income.⁵⁵²
- The overall cost of mental health problems in Wales for 2007–08 was estimated at £7.2 billion a year, which is larger than the amount spent on health and social care costs for all other illnesses in the same year – a total of £6.1 billion.⁵⁵³ The total cost of mental health problems in Scotland (including human cost, health and social care costs, and output losses from missed employment) for 2009–10 is estimated at £10.7 billion.⁵⁵⁴



5.2 Economic and societal costs

Mental health problems are associated with large direct costs for individuals and society, such as the provision of health and social care, and indirect costs including lost employment.

Economic and societal costs due to lost employment

- In 2015, employees in the UK took 138.7 million working days off because they were ill or in pain, according to the ONS's Labour Force Survey. That is approximately 4.4 days per person employed.⁵⁵⁵
- Recent statistics show that the number of days absent from work due to sickness, per person employed in the UK in 2015, is 4.4 days; this is 60% of the number of days taken per person employed in 1993 (7.2 days).⁵⁵⁶
- In 2015, common mental health problems (e.g. anxiety, depression and stress) and more serious mental health problems were the third most important cause of sick leave. In 2015, mental-health-related issues were found to lead to approximately 17.6 million days' sick leave, or 12.7% of the total sick days taken in the UK.⁵⁵⁷
- Research carried out by Oxford Economics suggests that 181,600 people cannot join the labour force because of their mental health problems.⁵⁵⁸
- According to calculations by Oxford Economics, it is estimated that the UK GDP in 2015 could have been over £25 billion higher than what it was if not for the economic consequences of mental health problems to both individuals and businesses. This value is a total of 1.3% higher than what it was.⁵⁵⁹
- About £7.3 billion of this total (87%) is from long-term illness, while £1.1 billion (13%) arises from common mental health problems.⁵⁶⁰
- In Scotland, in 2009–10, employers' costs associated with mental health problems were estimated at £2.15 billion a year. In addition, the burden of unemployment on society was estimated to be £1.44 billion.⁵⁶¹
- In 2015, an estimated 93,100 people were out of the labour force because they were caring for someone with a mental health problem. A further 27,800 people were working reduced hours in order to care for someone with a mental health problem.^{562,563}
- It has been estimated that the cost to UK GDP of workers either leaving the workforce entirely, or going part time in order to care for someone with a mental health problem, was £5.4 billion in 2015, with over 91% of this amount being due to those leaving the labour force entirely.⁵⁶⁴



Spending on the mental health workforce

- The Centre for Workforce Intelligence has reported that, from 2003–13, the number of psychiatrists in England increased by 40%, from 2,920 to 4,084.⁵⁶⁵
- According to the same report, a 33% growth in the employment of clinical psychologists has been observed between 2003 and 2013, while the number of mental health nurses has fallen from 44,916 to 38,590 between 2002 and 2013. Furthermore, despite the increasing demand for mental health professionals, between 2009 and 2013, an almost 10% fall has been observed among the mental health and learning disability nursing workforce, from 47,355 to 42,762.⁵⁶⁶

Health and social care costs

- Based on 2007 data, a report published by The King's Fund estimates that mental-health-related social and informal care costs in England amount to £22.5 billion a year. These costs are projected to increase to £32.6 billion by 2030, which is mainly due to a £9 billion increase in treatment and care for people with dementia.⁵⁶⁷ These figures, however, are based on 2007 costs, and are likely to be an underestimate.
- Over £1.7 billion of costs associated with perinatal mental health problems are borne by the public sector, with the majority (£1.2 billion) falling to the NHS. For example, the average cost to society of perinatal depression is around £74,000, of which £23,000 relates to the mother and £51,000 to the child.⁵⁶⁸

- Perinatal anxiety alone costs about £35,000 per case, while perinatal psychosis costs around £53,000 per case. These figures are likely to be an underestimate of the real burden of costs associated.⁵⁶⁹
- A Centre for Mental Health report (2014) estimates that perinatal depression, anxiety and psychosis carry a total long-term cost of about £8.1 billion for each one-year cohort of births in the UK, or just under £10,000 for every single birth in the country. The figure is likely to be much larger if including other mental health problems, such as eating disorders.⁵⁷⁰
- Between 600,000 and 750,000 people in the UK have an eating disorder at any one time; the estimated direct economic cost of these illnesses is estimated to be between £6.8 and £8 billion per year.⁵⁷¹
- An estimate suggests that the NHS will acquire an additional expenditure of around £280 million per year in England, in order to provide perinatal mental health care up to a national standard.⁵⁷²
- In 2012–13, the total cost of psychoses to the NHS was estimated at £2 billion per year.⁵⁷³
- In 2009–10, substance-misuse-related treatment cost the NHS approximately £3 billion.⁵⁷⁴
- In England, the total cost of alcohol misuse, in 2009–10, was estimated at £23.1 billion.⁵⁷⁵
- In 2009–10, the output loss in England due to substance misuse was estimated to be £7.2 billion.⁵⁷⁶



Missed opportunities

- The average annual cost of lost employment (per employee) in England is estimated at £7,230 due to depression and £6,850 due to anxiety in 2005–06.⁵⁷⁷
- In England, the average cost per completed suicide of those of working age is estimated to be £1.7 million, including loss of life, output, police and funeral costs, based on 2009 prices.⁵⁷⁸
- Based on 2008 data, the total social and economic cost for schizophrenia and bipolar disorder was estimated to be £3.9 billion and £9.2 billion a year respectively.⁵⁷⁹
- Mental ill health and its associated output losses in Wales in 2007–08 were estimated to be £2,681 million per year, of which £1,161.50 million is due to sickness and other in-work costs, £1,409.60 million is due to unemployment, and £110 million is due to premature mortality.⁵⁸⁰ Unfortunately, specific data for Northern Ireland and Scotland is unavailable.



5.3 Mental health research costs

According to an MQ report on mental health research funding in the UK, published in April 2015:⁵⁸¹

- On average, the UK invests approximately £115 million per year in mental health research.
 - The Wellcome Trust, the National Institute for Health Research, and the Medical Research Council provide 85% of the funding for mental health research in the UK.
 - Even though UK institutions are carrying out cutting-edge mental health research, they receive only 5.5% of the UK research budget dedicated to this area. In contrast, investment in cancer research is four times higher, at 19.6%.
 - Funds spent on depression research make up 7.2% of the total mental health research expenditure, followed by psychosis at 4.9%, substance misuse at 4.8% and schizophrenia at 4.4%.
 - In 2011, the amount spent on cancer research was £521 million, resulting in approximately £1,571 per cancer patient, while the average spent on mental health was £115, equating approximately to £9.75 per adult with a mental health problem.
 - Mental health research accounts for just 3.1% of charity-funded research in the UK, compared to over 30% for cancer, 13.5% for infectious diseases and 7.6% for cardiovascular research.
- The return on investment for mental health research to the public is calculated at 37%, meaning that, for every £1 spent, 37p goes back to the public. Despite the rate of return on public investment, general public funding on mental health is virtually non-existent. For example, for every £1 the government spends, the public invests £2.75 for cancer, £1.35 for heart and circulatory problems, and only 0.3p (or one third of a penny) for mental health.
 - According to an MQ report on mental health research funding in the UK published in April 2015 the average yearly spend on mental health research per condition breaks down as follows;
 - The average yearly spend on schizophrenia and bipolar disorder research is £12.6 million, or £61.39 per adult
 - The average yearly spend on autism research is £2 million, or £3.98 per adult
 - The average yearly spend on depression research is £9 million, or £1.55 per adult
 - The average yearly spend on OCD research is £0.5 million, or £0.89 per adult
 - The average yearly spend on anxiety research is £1.7 million, or £0.21 per adult
 - The average yearly spend on eating disorders research is £0.5 million, or £0.15 per adult



5.4 Mental health investments and divestments

- According to a 2013 survey published by the Department of Health, the total investment in adult mental health services for 2011–12 was £6.629 billion, while this was a 1.2% in cash increase compared to 2010–11, it was a real-terms decrease (taking inflation into account) of 1%⁵⁸² from £2.859 billion in 2010–11 to £2.830 billion in 2011–12.⁵⁸³
- According to the same report, priority was given to three areas (i.e. crisis resolution, early intervention and assertive outreach) and, overall, investment fell by £29.3 million. Only early intervention reported an increase.⁵⁸⁴ However, investment in psychological therapies, in real terms, increased by 6% in 2010–11.⁵⁸⁵
- In 2015, Community Care reported that the funding across mental health NHS trusts dropped by 8.25% (or £600 million), in real terms, between 2010–11 and 2014–15.⁵⁸⁶ In addition, according to a BBC Freedom of Information request published in 2016, the funding for mental health in the UK has fallen by only 2% from 2013–14 to 2014–15.⁵⁸⁷
- For 2015, mental health spending in Scotland has increased by just 0.1% and is projected to fall by 0.4% in 2016. In contrast, spending in Wales decreased by 1.1% in 2014–15 and is expected to rise by 1.2% in 2015–16.⁵⁸⁸

- According to the BBC Freedom of Information request, Northern Ireland was the only country that saw an increase in spending on mental health by 1% in 2015, and by 2.6% in 2016.⁵⁸⁹

Conclusions

The financial gap in mental health expenditure is one of the biggest concerns of health professionals and researchers. The number of individuals with mental ill health is expected to rise significantly in the near future.⁵⁹⁰ Given the relationship between mental and physical health, urgent action is needed to overcome barriers to treatment and prevention. Much can be done to avoid the impact of mental health problems and to promote wellbeing; therefore, raising awareness of mental health costs and potential savings through prevention and early intervention is vital.

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London Office:
Mental Health Foundation
Colechurch House
1 London Bridge Walk
London SE1 2SX

Glasgow Office:
Mental Health Foundation
Merchants House
30 George Square
Glasgow G2 1EG

Cardiff Office:
Mental Health Foundation
Castle Court
6 Cathedral Road
Cardiff, CF11 9LJ