

Fundamental Facts About Mental Health

2015



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Changing minds, changing lives

The Mental Health Foundation is a UK charity that relies on public donations and grant funding to deliver and campaign for good mental health for all.

Our work helps people across the UK to understand, protect and sustain their mental wellbeing, no matter what life throws at them. We work with other charities to move the issue up the national agenda, pressing for mental health to be given the same priority as physical health, and to deliver the necessary changes for improved access to mental health services. We make our research and information available online to inform and engage the public, businesses and campaigners across the health, education and community sectors in advocacy to strengthen our call for change.

Prevention is at the heart of what we do, because the best way to deal with a crisis is to prevent it from happening in the first place. For example, by providing the right information, guidance and support in childhood and adolescence, the chances of developing mental health problems can be reduced for millions of people over a lifetime, with enormous benefits to the individuals directly affected, along with their families, friends and the communities they live in. In particular, we help people to access information about steps they can take to reduce their mental health risks, increase their resilience, and feel empowered to take action when problems are at an early stage. We have a long history of working directly with people across the life course, including families, children and young people, those in later life, and those who are at high risk of developing mental health problems, such as people with learning disabilities.

The bare facts speak for themselves: one in four adults and one in ten children are likely to have a mental health problem in any year.ⁱ This can have a profound impact on the lives of tens of millions of people in the UK, and can affect their ability to sustain relationships, work, or just get through the day. The economic cost to the UK is £70 to £100 billion a year.ⁱⁱ Equally challenging is the estimate that only about a quarter of people with a mental health problem receive ongoing treatment,ⁱⁱⁱ leaving the majority of people grappling with mental health issues on their own, seeking help or information, and dependent on the informal support of family, friends or colleagues.

i. The Health & Social Care Information Centre, 2009, Adult psychiatric morbidity in England, [Results of a household survey](#)

ii. OECD 2014: <http://www.oecd.org/els/emp/MentalHealthWork-UnitedKingdom-AssessmentRecommendations.pdf>

iii. The Health & Social Care Information Centre, 2009, Adult psychiatric morbidity in England, [Results of a household survey](#)

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Foreword by Jenny Edwards



In any year one in four of us experiences a mental health problem. Yet three quarters of the people with mental health problems receive no treatment. These fundamental facts are the foundation for all our work.

We can all understand that mental health problems may destroy lives, often starting at an early age and they have an impact on families, colleagues, communities and indeed on the economy. At the Mental Health Foundation we also work to increase public understanding that we have opportunities to do far more to prevent problems occurring, to step in early or to sustain recovery. These opportunities too often are not taken but we believe that, with the right understanding, they will be and that the result will be transformative.

Well evidenced information is vital to motivate people to advocate for the changes that can make a difference. These need to happen at many levels – national, local, neighbourhood, workplace or school. Understanding also helps to undermine stigma and prejudice, making it easier for people to reach out to help or to seek help before problems develop to a crisis point.

Public information on mental health and how that can be used to change lives is at the heart of the Mental Health Foundation's mission work and mission. Our online A-Z at www.mentalhealth.org.uk is used by hundreds of thousands of people every year and the media source much of their data on mental health from our research and publications. Fundamental Facts has always been popular and we are pleased to bring it in a completely updated and renewed form to a new audience through social media in celebration of World Mental Health Day.



We will publish an updated Fundamental Facts every year. New and updated data will mean that users of Fundamental Facts can be confident that the content is current. To make this a living and evolving document we encourage our readers to send us feedback. Help us to develop the topics covered and the range of sources that we use.

As the mental health charity that covers the UK, we aim to grow Fundamental Facts to give more national data for England, Scotland, Wales and Northern Ireland and to draw the headlines from data available by locality.

We are actively lobbying for more mental health data to be made available and for greatly increased transparency so that people can have information on the prevalence of different mental health issues in their area and the services available to help people manage their mental health problems and to prevent them occurring.

Fundamental Facts is a resource for everyone interested in mental health and prevention. Please help us use it to inform and influence public debate, to build public attention and understanding and to change lives for the better.

A handwritten signature in black ink, reading "Jenny Edwards". The signature is fluid and cursive, with "Jenny" on the left and "Edwards" on the right.

Jenny Edwards C.B.E.
Chief Executive

Executive summary

A selection of our topline facts in each chapter are presented below:

- Mental health problems are one of the main causes of the burden of disease worldwide.¹ In the UK, they are responsible for the largest burden of disease— 28% of the total burden, compared to 16% each for cancer and heart disease.²
- One in four people in the UK will experience a mental health problem in any given year.³
- Mental health services in the UK are overstretched, have long waiting times and in some regions lack specialist services. Despite this, public spending is focused almost entirely on coping with crisis, with only an insignificant investment in prevention.⁴ Mental health research receives only 5.5% (£115 million) of total UK health research spending.⁵
- Around 50% of women with perinatal mental health problems are not identified or treated. The costs to the UK economy for untreated perinatal mental health problems is estimated to be around £8.1 billion for each one-year cohort of births; this is the equivalent to around £10,000 per year for every single birth in the UK. These costs are generally the result of not identifying mothers' mental health needs or treating them effectively.⁶ However, when mothers are referred, there are known treatments that work well for most cases.⁷
- Paternal mental health is also of crucial importance. Postnatal depression in fathers has been associated with emotional and behavioural problems in their child.⁸



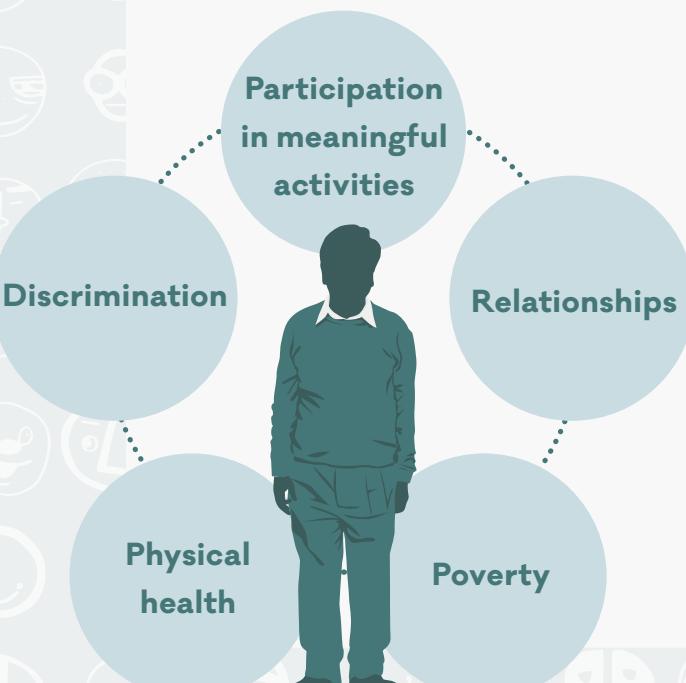
10%



70%



- Ten per cent of children and young people (aged 5-16 years) have a clinically diagnosable mental problem⁹ yet 70% of children and adolescents who experience mental health problems have not had appropriate interventions at a sufficiently early age.¹⁰
- In England, women are more likely than men to have a common mental health problem¹¹ and are almost twice as likely to be diagnosed with anxiety disorders.¹²
- In Scotland, it was found that in 2012-2013 nearly one in ten (9%) adults had two or more symptoms of depression or anxiety.¹³
- The Office for National Statistics (ONS) found that, in 2013, 6,233 suicides were recorded in the UK for people aged 15 and older. Of these, 78% were male and 22% were female.¹⁴
- A 2006 UK Inquiry identified 5 key factors that affect mental health and wellbeing of older people, these were: discrimination, participation in meaningful activities, relationships, physical health and poverty.¹⁵



- Common mental health problems such as depression and anxiety are distributed according to a gradient of economic disadvantage across society¹⁶ with the poorer and more disadvantaged disproportionately affected from common mental health problems and their adverse consequences.^{17, 18, 19}
- Mental health problems constitute the largest single source of world economic burden, with an estimated global cost of £1.6 trillion (or US\$2.5 trillion) – greater than cardiovascular disease, chronic respiratory disease, cancer, and diabetes on their own.²⁰ In the UK, the estimated costs of mental health problems are between £70-£100 billion each year and account for 4.5% of GDP.²¹
- In the UK, 70 million days are lost from work each year due to mental ill health (i.e. anxiety, depression and stress related conditions), making it the leading cause of sickness absence.²²
- There are strong links between physical and mental health problems. A 2012 report by The King's Fund found that 30% of people with a long-term physical health problem also had a mental health problem and 46% of people with a mental health problem also had a long-term physical health problem.²³



Executive summary

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Introduction: Fundamental Facts 2015



The Mental Health Foundation advocates data that helps us to answer the questions asked by a wide range of people about mental health – not only professionals and service planners, but also people who have mental health problems, communities that experience high levels of mental health inequity, politicians and the media.

To do this, we need to continue to build the evidence base for mental health. There has been a long history of under-investment in mental health research and data. Nowhere is this more evident than for child and adolescent mental health. Grossly outdated, the most recent British Child and Adolescent Mental Health surveys by the Office for National Statistics were conducted in 1999 and 2004. Often, it is difficult to access good-quality data on mental health or the known determinants of mental health, such as income, housing, relationships, employment and the environment. It can be hard to find information that 'speaks to' other data; for example, data about mental health problems that can be analysed alongside data about physical health problems. It would be valuable to compare data across the UK and to be able to 'drill down' to local levels so that we can understand and compare patterns of mental health at local authority and community levels.

However, The Fundamental Facts illustrates that there is a lot that we do know. The challenge can be drawing this knowledge together and making people aware of it; and then progressively improving what mental health data is available, by using it intelligently and disseminating it effectively.



We have structured The Fundamental Facts to reflect the ways in which mental health is understood. We begin with an overview of mental health problems (Chapter 1), and then consider the differences in the extent of mental health problems both across the life course (family formation, children and adolescents, adults, and later life) and with regard to groups that 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 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.²⁴

Treatment and care data highlight service use and the operation of legislation (Chapter 4). To make the case for investment in mental health, we have expanded Costings data (Chapter 5). We hope that this will be persuasive.

24. World Health Organisation (2014) Social determinants of mental health. Available at http://apps.who.int/iris/bitstream/10665/112828/1/9789241506809_eng.pdf?ua=1 [Accessed September 2015].



Finally, a note on the data:

This is the first update of the Fundamental Facts since 2007. Mental health is a big, complex field, so we have selected statistics that illustrate many of the challenges facing individuals, families, communities and the wider society. We have used statistics from reputable sources, such as government, research and policy organisations, and peer reviewed publications, and we have 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 do not make up the whole picture. They are drawn from many different sources, and have been collected at different dates, 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 into policy or service decisions.

Broad Themes

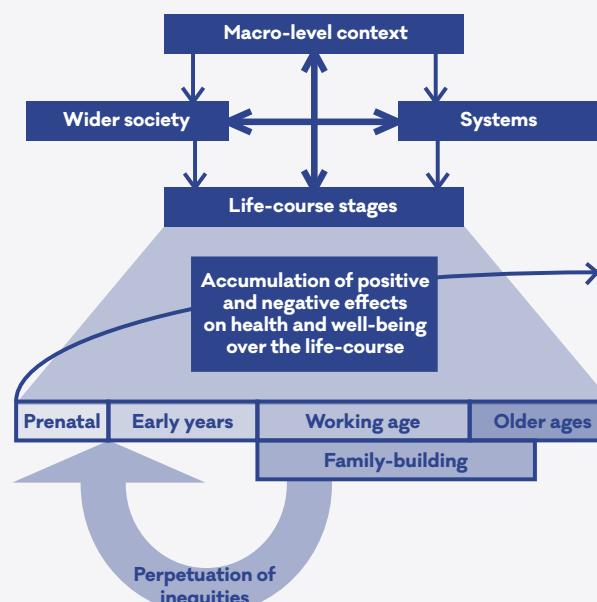


Figure 1: Diagram on social determinants of mental health adapted from the WHO European Review of Social Determinants of Health and the Health Divide in the European Region.²⁵

²⁵. Marmot, M., & World Health Organisation. (2014). Review of social determinants and the health divide in the WHO European Region: final updated report.

Where available, the Mental Health Foundation has used UK content in the compilation of this report; 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, and have reported throughout the text when 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 (i.e. that is the rate of new cases in a period of time), and some measurements may look at prevalence or the proportion of people with a disorder in 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 data and therefore caution should be taken when interpreting and comparing data from one region to another. Unless stated otherwise, data reported in *The 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. *The Fundamental Facts* is a compilation of current and key statistics in mental health. We have let the data speak for itself.

Meta-analysis

A meta-analysis is a formal study design used to systematically combine and assess previous studies in order to come to conclusions about a particular topic or area of research.

Literature review

A literature review is a description and review of the literature in a particular area or topic of research.

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1. The extent of mental health problems

1.1 How many people experience mental health problems?

Mental health problems are a growing public health concern. In this chapter, an overview is provided on how widespread mental health problems are, both globally and in the UK. The overview provides details on the main types of problems and factors commonly associated with mental health problems.

Global

- A recent index of 301 diseases found mental health problems to be one of the main causes of the overall disease burden worldwide.²⁶
- In 2010, mental health and behavioural problems (e.g. depression, anxiety and drug use) were reported to be the primary drivers of disability worldwide, causing over 40 million years of disability in 20 to 29-year-olds.²⁷
- According to the 2010 Global Burden of Disease Study, the most predominant mental health problems worldwide are depression and anxiety.²⁸
- The 2010 Global Burden of Disease Study found major depression to be the second leading cause of disability worldwide and a major contributor to the burden of suicide and ischemic heart disease.²⁹
- Globally, up to 90% of people diagnosed with anxiety and depression are treated in primary care. However, there are many individuals who are undiagnosed and therefore do not seek treatment.³⁰

UK

- The Adult Psychiatric Morbidity Survey (APMS 2007) surveyed 2000 adults living in private households in England. The authors found that 1 in 4 people in England will experience a mental health problem in any given year.³¹ An updated estimate will be made available in the next issue of The Fundamental Facts following the publication of the 2016 survey on the state of mental health in England.
- In the 2013 UK Wellbeing Survey, nearly 1 in 5 people in the UK aged 16 and older showed symptoms of anxiety or depression. This percentage was higher for females (21.5%) than for males (14.8%).³²
- In the 2014 Welsh Health Survey, 12% of adults (aged 16 and over) living in Wales were reported to have received treatment for a mental health problem.³³
- In the 2013-2014 Northern Ireland Health Survey, 19% of respondents showed signs of mental ill health. Of these, 45% of females and 29% of males were taking medication for stress, anxiety or depression.³⁴
- In the 2012-2013 Scottish Health Survey, it was found that nearly one in ten (9%) adults had two or more symptoms of depression or anxiety.³⁵



"1 in 4 people in England will experience a mental health problem in any given year."³¹

1.2 What are the main types of mental health problems?

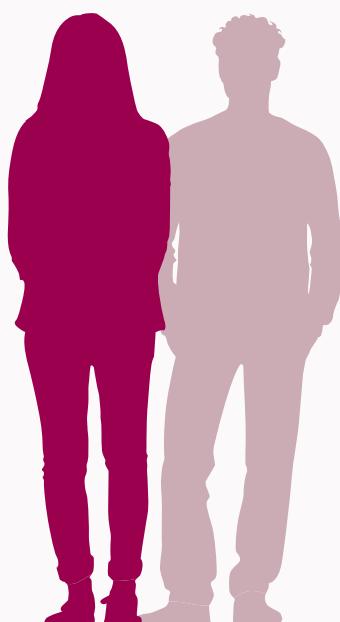
- According to the National Institute for Health and Care Excellence (NICE), common mental health problems include depression, generalised anxiety disorder, social anxiety disorder, panic disorder, obsessive-compulsive disorder (OCD), and post-traumatic stress disorder (PTSD).³⁶
- According to the APMS (2007), in England, 16.2% of adults met the diagnostic criteria for at least one common mental health problem in the week prior to being surveyed. From this figure, more than half of the adults presented mixed anxiety and depression (9%), 4.4% met the criteria for general anxiety, and 2.3% met the criteria for depression.³⁷
- In 2013, there were 8.2 million cases of anxiety disorder, more than one million cases of addiction, and almost 4 million cases of mood disorders, including bipolar mood disorder, in the UK.³⁸
- In England, women are more likely than men to have a common mental health problem (19.7% and 12.5% respectively). This is higher across all categories of common mental health problems, apart from panic and obsessive compulsive disorder.³⁹

Depression

- The APMS (2007) estimates that the proportion of people in England who are likely to experience major depression in their lifetime ranges from 4% to 10%.⁴⁰
- A 2006 meta-analysis of 26 epidemiologic studies of children and adolescents born in Britain between 1965 and 1996 found that the 1-year prevalence of depression in mid to late adolescence was between 4–5%.⁴¹

Anxiety and Trauma

- The APMS (2007) found that the 1-week prevalence of generalised anxiety in England was 4.4%.⁴²
- In the UK, women are almost twice as likely as men to be diagnosed with anxiety disorders.⁴³
- Around 25–30% of people in England experiencing a traumatic event may develop PTSD.⁴⁴
- The APMS (2007) found that 3% of adults in England screened positive for current PTSD. It was also found that nearly a third (28%) of people with PTSD were receiving treatment for a mental or emotional problem, compared with 7% of those who did not have PTSD.⁴⁵



"In the UK, women are almost twice as likely as men to be diagnosed with anxiety disorders."⁴³



1.3 Suicide

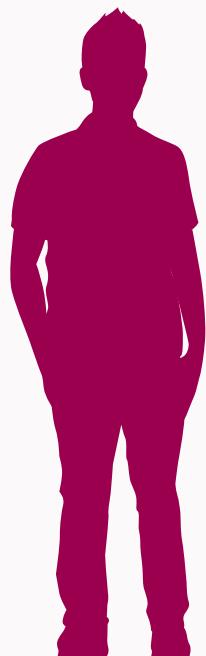
Suicide and self-harm are not mental health problems themselves, but they are linked with mental distress. There are also certain factors that can make individuals more vulnerable to risk of suicide. These include:⁴⁶

- Drug and alcohol misuse
- History of trauma or abuse
- Unemployment
- Social isolation
- Poverty
- Poor social conditions
- Imprisonment
- Violence
- Family breakdown

Caution should be exercised when trying to compare suicide rates between countries. National differences in recording, registration and reporting of deaths present as challenges when interpreting the data.

- The National Inquiry into Suicide and Homicide by People with Mental Illness (2015) found that, from 2003-2013, 18,220 people with mental health problems took their own life in the UK.⁴⁷
- The APMS (2007) found that nearly 6% of adults (aged 16 and over) reported having made a suicide attempt at some point in their life.⁴⁸
- According to the Office for National Statistics (ONS), in 2013, 6,233 suicides were recorded in the UK for people aged 15 and older. Of these, 78% were male and 22% were female.⁴⁹
- In England, more than 4,000 suicides (among people aged 15 and over) were registered in 2013. Of this figure, two thirds were male and one third were female.⁵⁰

- The ONS' most recent report on suicide (2013) details that the highest rate among the English regions was in North East England, with 13.8 deaths per 100,000 people. London had the lowest rate at 7.9 deaths per 100,000 people. In the North East of England, of the 295 individuals who took their own life by suicide, 77.6% were men and 22.4% were women.⁵¹
- In Northern Ireland, a total of 268 suicides were registered in 2014. From this figure, over 75% (207) of suicides were male.⁵²
- Suicide is the largest cause of death for men aged 20-49 years in England and Wales. In 2012, more than three quarters of deaths by suicide were by men.⁵³
- As the previous figures indicate, the rates of suicide have been lower for women than for men, and this has remained consistent over time. Between 1981 and 2007, suicide rates in the UK fell significantly for both sexes. However, since 2007, the suicide rate for women has stayed constant while the rate for men has increased significantly.⁵⁴



"In 2012, more than three quarters of deaths by suicide were by men."⁵³

1.4 Challenging myths and stereotypes: violence and mental health

The Fundamental Facts can help to challenge myths and stereotypes. One of the most discriminatory stereotypes that persists is the incorrect association between mental health problems and violent behaviour. The media may play a role in portraying that people with mental health problems are 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.⁵⁵ "Most people with mental health problems are not violent and most people who are violent are not mentally ill."⁵⁶

- Studies have shown that the estimated risk of violence by people with mental health problems ranges from 3% to 5%.⁵⁷
- People with mental health problems are more likely to be victims of violence compared to those without mental health problems. In a 2013 British survey among persons with severe mental health problems, it was found that⁵⁸:
 - 45% had been victims of crime in the previous year
 - 1 in 5 had experienced a violent assault
 - people with mental health problems were 3 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 to them compared to the general population.

1.5 References

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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 later life. In each area, different challenges present themselves, as well as opportunities to intervene and support good mental health. This chapter describes how mental health problems may present over the course of a lifetime, from before birth all the way up until later life.

2.1.1 Family formation

Forming a family and parenting is an important part of life, with many changes taking place. Both mothers' and fathers' mental health may be affected during this transition, which may influence their child's mental health. The Mental Health Foundation holds a holistic view of mental health, which recognises that social, psychological, biological and environmental factors interact with and impact on an individual's mental health.⁵⁹ 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.

- A 2008 systematic review of 31 studies estimated that in the UK, among parents, around 10% of women and 6% of men had mental health problems at any given time.⁶⁰

- A longitudinal Scottish survey, carried out in 2010 with over 3000 mothers, found that children whose mothers were emotionally well throughout the survey had better social, behavioural and emotional development at age 4 compared with mothers who had briefly had mental health problems. This finding remained significant even after taking into account maternal family characteristics (e.g. age, number of siblings, father involvement, etc.) and socio-economic factors.⁶¹
- A recent survey carried out by the National Childbirth Trust between 2013-2014 found that among the 296 new fathers who were surveyed, more than a third (38%) are concerned about their mental health.⁶²
- Paternal mental health has been associated with a number of outcomes. In a 2008 English longitudinal study with 13,228 fathers, it was found that severe postnatal depression in fathers was associated with emotional and behavioural problems in their children.⁶³
- According to a UK report published in 2015, the most common mental health problems that arise during pregnancy and after birth are anxiety, depression and PTSD.⁶⁴
- In a meta-analysis carried out in 2010 that included 29 studies, it was found that mental health problems during pregnancy have been associated with increased risk for pre-term birth and low birth weight.⁶⁵
- A 2014 English longitudinal study with 7,448 participants found that maternal anxiety during pregnancy predicted behavioural and emotional problems for the child at age 4. These associations were still present after controlling for possible environmental influences such as obstetric and socio-economic risks.⁶⁶



- In a literature review carried out in 2008, it was noted that women with a previous episode of serious affective problems, such as depression, bipolar, or anxiety, were at increased risk of recurrence, even if they had been well during pregnancy and for many years. This highlights the importance of good monitoring, early detection and early treatment.⁶⁷
- This same review also noted that between 3% and 10% of women who have just delivered a child will suffer from a new episode of affective problems.⁶⁸
- 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. The enquiry found that severe postnatal mental health problems were not very common, but were counted as one of the leading indirect causes of maternal deaths.⁶⁹
- In a 2010 meta-analysis that included 43 studies, it was estimated that 10% of new fathers around the world suffer from postnatal depression.⁷⁰



"10% of new fathers around the world suffer from postnatal depression."⁷⁰

Access to services and costs of prenatal and postnatal mental health problems

- According to a 2014 report by the London School of Economics and the Centre for Mental Health, perinatal mental health problems (includes a prenatal and postnatal period of up to 1 year) cost the UK economy about £8.1 billion for each one-year cohort of births. This figure is equivalent to around £10,000 per year for every single birth in the UK. These costs are generally the result of not identifying mothers' mental health needs or not treating them effectively. Around 50% of women with perinatal mental health problems are not identified or treated.⁷¹ However, when referred, there are treatments that are known to work well in most cases.⁷²
- Despite these figures, around 40% of the UK have no specialist perinatal mental health provision.⁷³ Regarding access, 40% of people 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.⁷⁴

"Perinatal mental health problems cost the UK economy about £8.1 billion for each one-year cohort of births."⁷¹



Changes in prevalence

- 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 years, the rate of mental health problems is 13% for boys and 10% for girls, and this figure approaches adult rates of around 23% by age 18–20 years.⁸⁰
- A 2015 English study of 3,366 adolescents found that, from 2009 to 2014, overall, adolescents experienced similar levels of mental health difficulties (i.e. emotional problems, peer problems, hyperactivity and conduct problems). There was, however, a significant increase in emotional problems in girls over time, and a decrease in mental health difficulties in boys.⁸¹

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 of affected children to work and earn as adults.⁸²

Gender differences

- The ONS survey (2004) found that among 5–10 year olds, 10% of boys and 5% of girls had mental health problems, while among 11–16 year olds, the prevalence of mental health problems was 13% for boys and 10% for girls.⁸³
- The survey also found that conduct disorders, hyperkinetic disorder and autism spectrum disorders were more common in boys, and emotional problems were more common in girls.⁸⁴

Treatment and care

- A recent report by The Children's Society (2008) found that around 70% of children and adolescents who experience mental health problems have not had appropriate interventions at a sufficiently early age.⁸⁵

2.1.3 Adult mental health

Targeting adult mental health is critical; key statistics pertaining to this group can be found in Chapter 1 of The Fundamental Facts.

2.1.3.1 Employment and mental health

- There is a lack of information on the mental health of Small and Medium Enterprise business owners.
- According to a 2008 review commissioned by the Health Work and Wellbeing Programme, people in Great Britain who are unemployed are between 4 and 10 times more likely to develop anxiety and depression.⁹³
- According to the Sainsbury Centre for Mental Health – now known as the Centre for Mental Health – (2007), mental health problems are a major cause of presenteeism, which can be described as the practice of remaining in work, even when an employee is unwell, resulting in decreased productivity.⁹⁴
- A 2008 review commissioned by 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.⁹⁵
- A 2006 meta-analysis exploring the associations between psychosocial work stressors and common mental health problems found that; 1. high demands at work, 2. reduced autonomy in decision making, 3. high efforts and 4. low rewards often resulted in stress, and were associated with common mental health problems.⁹⁶

2.1.4 Later life

The Mental Health Foundation broadly defines later life as starting at 50 years old. While we recognise that many people do not self-define as 'older people' at this age, we have included 50 year olds as part of later life due to several critical factors. Many people will begin to experience physical decline or deterioration in their 50s, and many begin to seriously plan for their retirement (or take early retirement), or find it difficult to secure employment.

- An ageing population can have implications at an individual, social and economic level. It may also have important opportunities and consequences for the development of a country.⁹⁷
- In a 2012 report carried out by the United Nations Population Fund (UNFPA) and Help-Age International, the number of people aged 60 years and older made up 11% of the global population, and it was expected to double to 22 % by 2050. The percentage of people aged 80 years and older was 1.6%, and this was estimated to rise to 4.3% by 2050.⁹⁸
- In the UK, the number of ageing people is also increasing. According to the ONS (2015), since 1974, the number and proportion of older people in the UK population (aged 65 and older) has grown by 47%, making up nearly 18% of the total population in 2014. The number of people aged 75 and over has increased by 89% over this period and now makes up 8% of the population.⁹⁹
- According to the ONS (2014), the number of people aged 65-74 represented 9.8% of the total population, people aged 75-84 represented 5.7% of the total population, and people aged 85 and over represented 2.3% of the total population.¹⁰⁰



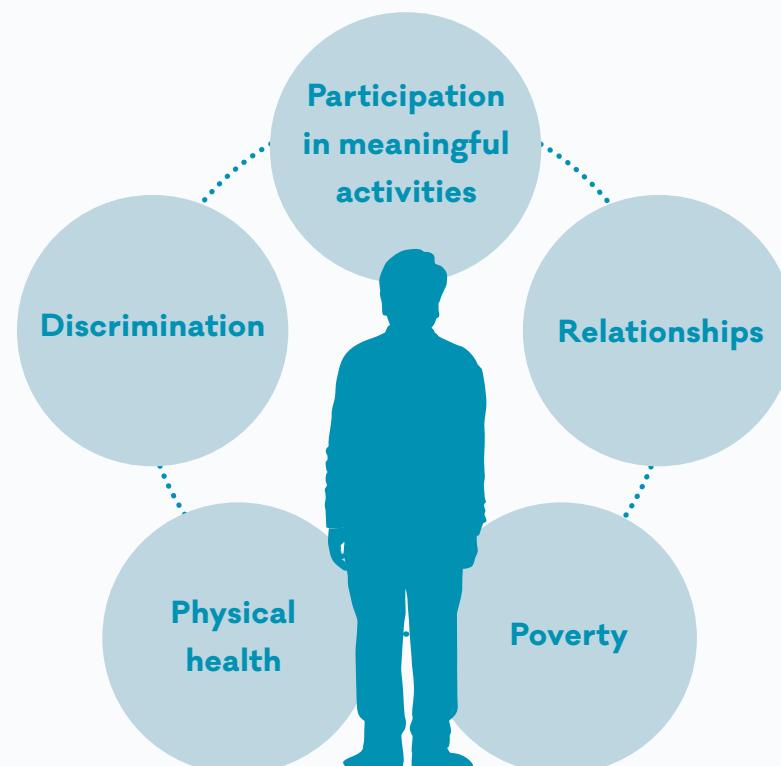
Dementia

- According to a 2014 report from Alzheimer's Disease International, dementia affects mainly older people, but around 2-10% of all cases of dementia are estimated to start before the age of 65 years. After 65 years of age, the prevalence doubles every five years.¹⁰⁷
- In 2014, a report from Alzheimer's Disease International estimated that the number of people living with dementia worldwide was 44 million, and this was predicted to double by 2030.¹⁰⁸
- In 2013, there were 815,827 people living with dementia in the UK. This means that 1 in every 79 people of the total UK population, and 1 in 14 people aged 65 years and over, had dementia. Of the total amount of people living with dementia, 84% lived in England, 8% in Scotland, 5% in Wales and 2% in Northern Ireland.¹⁰⁹
- 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.¹¹⁰
- People with learning disabilities have a greater risk of developing dementia both at a younger age and at a faster rate. It has been estimated that 1 in 5 people with learning disabilities will develop dementia.¹¹¹
- People with Down's syndrome are also at a greater risk. It is estimated that 1 in 50 people with Down's syndrome will develop dementia in their 30s.¹¹²

2.1.4.2 Factors contributing to older people's mental health

Becoming mentally unwell is not exclusively related to older age; however, there are a number of factors that can compromise older people's mental health.¹¹³

- According to a UK Inquiry into Mental Health and Wellbeing in Later Life carried out in 2006,¹¹⁴ the five identified key factors that affect the mental health and wellbeing of older people were:
 - discrimination
 - participation in meaningful activities
 - relationships
 - physical health
 - poverty.



Discrimination

- In the 2013 English Longitudinal Study of Ageing (ELSA), 33% of older people surveyed reported to have experienced age discrimination.¹¹⁵

Participation in meaningful activities

- Meaningful activities can include employment, volunteering, education and learning, personal interests, hobbies, and everyday activities. Participating in meaningful activities can help older people maintain a sense of purpose and can help people feel engaged and stimulated.¹¹⁶
- In an English survey in 2012 it was found that 29% of people aged 65 and over and 17.5% of people aged 75 and over participated in volunteering.¹¹⁷
- In an evaluation carried out by the Mental Health Foundation on peer support groups for people with dementia living in extra care housing with 21 tenants, it was found that people with early stage dementia who participated in the groups showed improvements in wellbeing, social support and practical coping strategies.¹¹⁸
- In a 2002 British study it was found that low levels of social engagement could act as a marker for later ill health.¹¹⁹

Relationships: social isolation and loneliness

- Social isolation and loneliness can affect many people, but it has been suggested that older people are particularly vulnerable.¹²⁰
- In the 2013 ELSA, 46% of people aged 80 and over reported being lonely compared to 34% of people aged 52 and over.¹²¹

- This same study also found that, as age increased, limitations in daily activities together with other changes in circumstances (e.g. loss of partner, losing touch with friends) were likely to contribute to increased feelings of loneliness among older age groups.¹²²
- A survey in 2014 carried out by Age UK found that 2.9 million people aged 65 and over felt they had no one to go to for support. Thirty-nine per cent of people interviewed said they felt lonely, and 1 in 5 said they felt forgotten.¹²³
- 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.¹²⁴

Physical health

- Older people are likely to suffer from ill 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.¹²⁵
- In a 2013 British survey by the ONS, the likelihood of someone reporting to have a long-standing illness was closely associated with age. In 2013, 69% of people aged 75 and over reported having a long standing illness compared with 15% of people aged 16-24.¹²⁶
- Mental health problems are higher for those who suffer from chronic physical conditions. 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 chronic physical health problems.¹²⁷

Community and environment

- In a 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 socio-economic status was a very strong predictor of a variety of health outcomes, suggesting that the impact of deprivation can continue all the way through to older ages.¹²⁸
- In a 2011 survey in England and Wales, it was found that older people 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.¹²⁹
- In the UK National Survey carried out between 2009 and 2010, it was found that 69% of people 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%.¹³⁰
- In contrast, a 2014 survey in the UK on people with dementia found that less than half felt part of their community, and nearly 10% had left the house only once a month.¹³¹

2.2 Other groups and mental health

2.2.1 Black and minority ethnic groups (BME)

- In a report by National Institute for Mental Health (2003) it was noted that people of Black African Caribbean and South Asian origin are less likely to have their mental health problems detected by their GP and more likely to have other problems incorrectly described as mental health problems.¹³²
- A study published in 2008 which explored the association between ethnicity, mental problems and socio-economic status, found that among adults aged 16- 64, Black Caribbean and Black African groups were generally twice as likely to experience psychotic disorders compared with their White British counterparts. This effect was still observed after controlling for socio-economic status.¹³³
- The same study also found that women of Pakistani and Bangladeshi origin were at elevated risk of schizophrenia after adjustment for socio-economic status.¹³⁴
- A study published in 2014, exploring the role of ethnicity as a predictor to being detained under the Mental Health Act (MHA), found that ethnicity did not have an independent effect on the likelihood of being detained. However, a diagnosis of psychosis, the presence of risk, female gender, level of social support and London being the site of assessment did affect the likelihood of being detained.¹³⁵

2.2.2 Physical disability

- A 2012 report published by The King's Fund and Centre for Mental Health highlighted that individuals with physical health problems are at increased risk of poor mental health, particularly depression and anxiety.¹³⁶
- This report also highlighted:
 - long-term conditions account for 80% of GP consultations,
 - 30% of people with a long-term physical health condition also have a mental health problem¹³⁷, and
 - 46% of people with a mental health problem have a long-term physical health problem.¹³⁸

2.2.3 Learning disability

- 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 1023 people with learning disabilities, it was found that 54% had a mental health problem.¹³⁹

2.2.4 The prison population

- In a survey for England and Wales published in 2012, it was found that 36% of the surveyed prisoners were considered to have a disability and/or mental health problem. The survey found that 18% of prisoners reported symptoms of anxiety and depression, 11% reported a form of physical disability, and 8% reported both (figures have been rounded and therefore do not add up to 36%).¹⁴⁰
- Data from the same survey found that 49% of female prisoners reported having experienced anxiety and depression, compared with 23% of men.¹⁴¹

- In a 2013 survey on 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.¹⁴²
- In the same survey, it was found that 26% of women and 16% of men said they had received treatment for a mental health problem in the year before custody.¹⁴³

2.2.5 LGBT

- In a national English survey it was found that 27,497 respondents registered with the National Health Service who described themselves as gay, lesbian, or bisexual, were 2 to 3 times more likely to report having a psychological or emotional problem compared to their heterosexual counterparts.¹⁴⁴
- In a 2011 British survey, conducted by Stonewall, 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 currently experiencing moderate to severe levels of mixed depression and anxiety.¹⁴⁵
- In a 2008 British survey on 6000 women, it was found that 4 in 5 lesbian and bisexual women reported having had a spell of sadness, feeling miserable or depressed. Further, 1 in 5 lesbian and bisexual women have deliberately harmed themselves in some way.¹⁴⁶

2.2.6 Carers

- According to a report published in 2014 by NHS England, there are 225,000 young carers in England and 68% of them have been bullied at school.¹⁴⁷
- According to an ONS report in 2011 in England and Wales, there were 5.8 million unpaid carers, representing over a tenth of the population. From this figure, there were 177,918 young unpaid carers (5-17 years old).¹⁴⁸
- A 2010 literature review found that looking after a family member with a mental health problem can lead to 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.¹⁴⁹
- A 2008 literature review also highlighted that caring for a family member often resulted in carer stress that impacted on physical and psychological health. However, it was also noted that the role of caring could also have beneficial effects, including improvements in their relationship with the family member, and learning more skills.¹⁵⁰ The impact on the mental health of carers seemed to be moderated by a number of factors, including the intensity of caregiving, perceived patient's suffering, patient's illness, caregiver's age, relationship of the caregiver, and gender.¹⁵¹
- Research carried out in 2010 by the Audit Commission found that young adult carers (aged 16-18) had a much greater chance of not being in education, employment and training.¹⁵² This may impact young people's mental health, as not being in education, employment and training (NEET) has been associated with mental health problems and social isolation in young people.¹⁵³

- The Carers UK annual survey (2015) on over 5,000 carers across the UK revealed that 84% of carers feel more stressed, 78% feel more anxious and 55% reported they suffered from depression as a result of their caring role, which was significantly more compared with findings in 2014.¹⁵⁴

2.2.7 Sensory impairment

- 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.¹⁵⁵
- A 2010 meta-analysis showed associations between poor hearing and depression. Overall, poor hearing was potentially found to be an important risk factor for depression in people over 60 years of age.¹⁵⁶
- A 2007 British study of 13,900 people aged 75 years and older showed that rates of depression were estimated to be 2-5 times greater in adults with low vision than in sighted individuals of similar age.¹⁵⁷

2.2.8 Homelessness

- 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).¹⁵⁸
- A 2009 literature review found higher prevalence of mental health problems in the homeless population compared to the general population. The review noted that the prevalence of serious mental health problems was present in around 25-30% of street homeless and in those in direct access hostels.¹⁵⁹



- Drawing on the findings from two surveys carried out 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 problems.¹⁶⁰
- 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, gangs etc.) 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.¹⁶¹ These experiences were most commonly reported by respondents under 25 years of age, and least reported by people aged 50 years and older. Female respondents were more likely to report bad relationships with parents or carers, to have had parents with a mental health problem, and to have experienced childhood sexual abuse.¹⁶²

2.2.9 Refugee, asylum seekers and stateless persons

- In the UK, by year end 2014, the population of refugees, pending asylum cases, and stateless persons made up 0.24% of the population. That percentage is equivalent to 117,161 refugees, 36,383 pending asylum cases, and 16 stateless persons.¹⁶³
- In 2011, the Scottish Sanctuary Project evaluation report identified that mental health problems are a major public health issue for asylum seeking and refugee women.¹⁶⁴

- The project also found that mental health was a predominantly Western concept, and services were built on models that were often not accessible or meaningful to minority ethnic communities.¹⁶⁵
- A 2009 study carried out by the Scottish Refugee Council with 349 refugees found that:¹⁶⁶
 - 57% of women were likely to have Post Traumatic Stress Disorder
 - 20% of women reported suicidal thoughts in the past 7 days
 - 22% of women stated that they had tried to take their own lives.

2.3 References

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3. Factors related to 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. In this section, we highlight some of the more pervasive yet intervenable factors, with particular attention given to the socio-economic determining factors that contribute to the disparity in the population distribution of mental health problems. The section closes by identifying key elements to be considered when taking mitigating or preventative action in this regard.

3.1 Introduction

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; and lesser access to protective resources. Please refer to Figure 1 in the Introduction to the 2015 Fundamental Facts to understand how these processes can interact.

3.2 Social determinants of mental health

- According to the WHO, social determinants of health, including mental health, are 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.¹⁶⁷
- Increasingly, there is also the recognition that there may be broader social determinants of mental health operating, where the application of a social model of health framework would be more applicable within the mental health sphere.^{168,169}

3.3 The impact of socio-economic inequity on mental health

- In a 2006 paper exploring the results from the WHO's Mental Health Survey, a positive correlation was reported between socio-economic inequality and mental health problems across 8 developed countries. More specifically, socioeconomic disadvantage (i.e. low education, unemployment, poverty, deprivation) was associated with increased mental health problems.¹⁷¹
- A 2013 systematic review of 55 studies from 23 countries examining the impact of socio-economic inequalities among children and adolescents found that the socioeconomically disadvantaged were 2-3 times more likely to develop mental health problems. There was a stronger association among younger children (i.e. under 12 years old) than older children. Of significance is that longitudinal studies not only confirmed this association, but also found that an improvement in socioeconomic status resulted in a significant reduction in and remission of mental health problems.¹⁷²

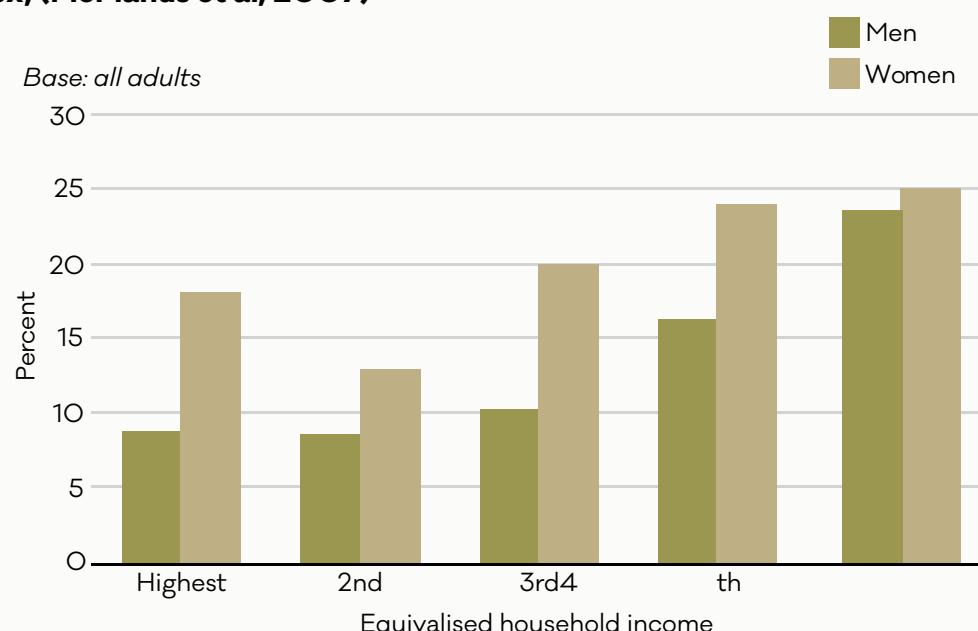
Table 1: Examples of determinants of Mental Health

Society	Community	Family	Individual
Equality vs discrimination	Personal safety	Family structure	Lifestyle factors
Unemployment levels	Housing and access to open space	Family dynamics (e.g. High/low expressed emotion)	Attributional style (i.e. How events are understood)
Social coherence	Economic status of the community	Genetic makeup	Debt vs financial security
Education	Isolation	Intergenerational contact	Physical health
Health care provision	Neighbourliness	Parenting	Individual relationships and responses to those

(McCulloch and Goldie, 2010)¹⁷⁰

- In a 2003 longitudinal English Study with 5,539 civil servants, it was found that both individual and neighbourhood deprivation increased the risk of poor general and mental health.¹⁷³
- In a 2008 study in England, Wales, and Scotland, it was found that, as debt increased, people were more likely to suffer from mental health problems. These associations were still present after adjustment for income and other socio-demographic variables.¹⁷⁴
- Being born into poverty or experiencing discrimination places people at greater risk of developing mental health problems.¹⁷⁵
- Children and adults living in households in the lowest 20% income bracket in Great Britain are 2-3 times more likely to develop mental health problems than those in the highest income bracket.¹⁷⁶
- In a 2000 UK study, it was found that the effects of poverty, dependence, and lack of cohesive social support were thought to be factors that undermined both the physical and mental health of asylum seekers and refugees.¹⁷⁷

Figure 2: Prevalence of any common mental health problem by household income and sex, (McManus et al, 2007)¹⁸⁵



3.3.1 Social environment and social grading

- Social environments refer to the immediate physical surroundings, social relationships and cultural settings within which people live and interact.¹⁷⁸ Within an individual's social environment there may be many inequalities operating, such as lack of stable housing, poor access to open areas and/or space, and family dynamics, including domestic violence.
- Social grading and health outcomes refer to the links observed between socio-economic status and health outcomes. Health inequalities or inequities are systematic differences and are socially produced in health between social groups that are avoidable and therefore unjust.¹⁷⁹
- The more disadvantaged in society have poorer mental health outcomes than those in the middle and those best-off; those in the middle or of average socio-economic status will experience poorer outcomes than those best-off; however, they are still better off than the worst-off in society. This phenomenon can be described as a social gradient of inequality.¹⁸⁰

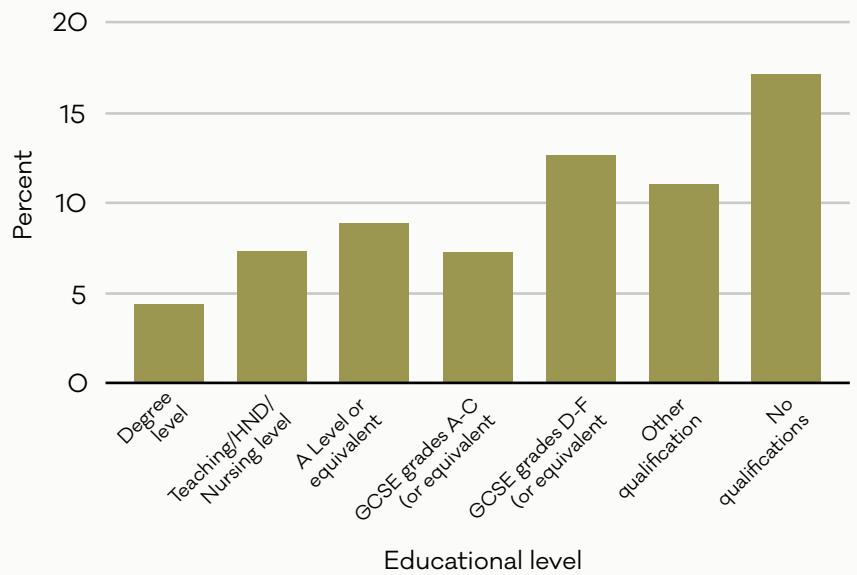
Figure 3: Prevalence of mental health problems in children by gross weekly household income, (Green et al, 2005)



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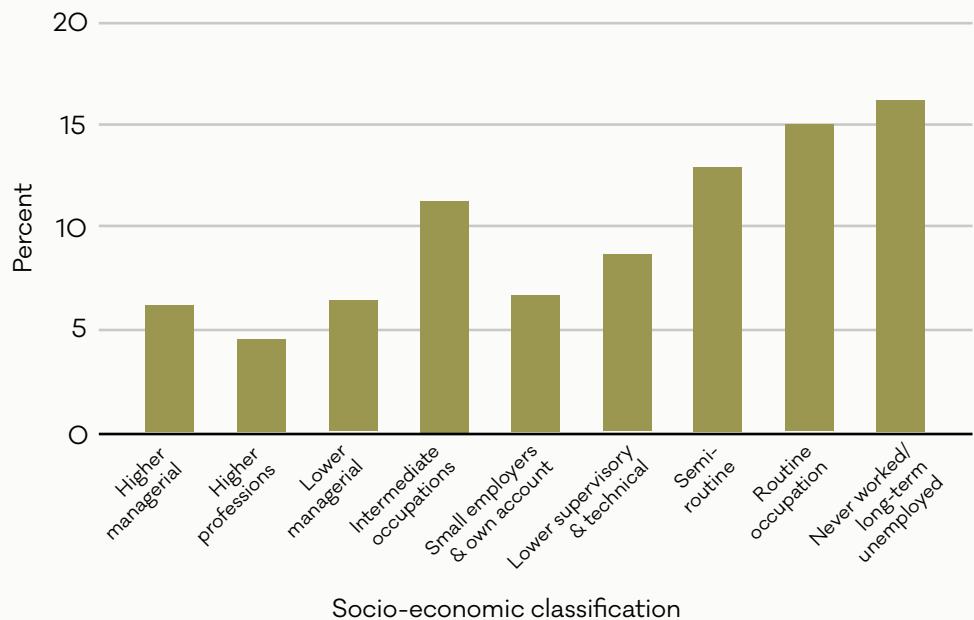
- Common mental health problems, such as depression and anxiety, are distributed according to a gradient of economic disadvantage across society,¹⁸¹ with the poorer and more disadvantaged suffering disproportionately from common mental health problems and their adverse consequences.^{182, 183, 184}
- This pattern of social distribution is also influenced by demographic factors, such as age, gender and ethnicity. Figure 2 illustrates the relationship between household income, gender and prevalence of common mental health problems. Women are disproportionately impacted by lower household income compared to men.
- The impact of living in poverty impacts across generations. For example, Figure 3 illustrates that, among British households in 2004 with a lower weekly household income, there was a greater prevalence of mental health problems in children. The prevalence of mental health problems in children was greater in families with a gross weekly household income of less than £100 (16%) compared with those with an income of £600 or more (5%).¹⁸⁵
- Figures 4 and 5 show the relationship between a parent's level of educational achievement or socio-economic classification and prevalence of mental health problems in their children. As can be seen, there is greater prevalence of mental health problems in children whose parent had no educational qualification (17%) compared to those with degree level qualification (4%) and in families where the household reference person was in a routine occupational group (15%) compared with households whose reference person was in the higher professional group (4%).¹⁸⁷

Figure 4: Prevalence of mental health problems by educational qualifications of parent in Great Britain, (Green et al, 2005)



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Figure 5: Prevalence of mental health problems by socio-economic classification in Great Britain, (Green et al, 2005)



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3.3.2 Poverty and socioeconomic inequity

- A review conducted in 2013 found that socioeconomic deprivation had a clear relationship with mental health problems in childhood and adolescence. Children from socio-economically disadvantaged families were three times more likely to develop mental health problems.¹⁸⁸
- Unsecured debt has been found to be strongly associated with depression.¹⁸⁹
- In addition to poorer physical health, people with mental health problems are more likely to be homeless, more likely to live in areas of high social deprivation, more likely to have fewer qualifications, and are less able to secure employment.¹⁹⁰
- A population study in England, Wales, and Scotland found that the more debt people had, the more likely they were to have some form of mental disorder, even after adjustment for income and other socio-demographic variables.¹⁹¹
- A review of population surveys in European countries found that higher numbers of common mental health problems (e.g. depression and anxiety) are associated with low educational attainment, material disadvantage and unemployment, and for older people, social isolation.¹⁹²

3.3.3 Social determinants in association with lifecourse

The effect of adverse conditions in early life on mental health and how this can influence outcomes through to adult and later life are described in this section.

- Adverse conditions in early life are associated with higher risk of mental health problems.^{193, 194}
- Environmental conditions and lifestyle factors are associated with negative physiological and psychological development in children, which can endure throughout later life.^{195, 196}
- There is evidence that the costs of mental health problems impact across generations, in relation to both the mental health of offspring and their socio-economic status. A significant correlation has been found between maternal mental health and children's income, where one standard deviation reduction in mental health leads to a 2% reduction in income.¹⁹⁷
- In childhood, poor attachment, neglect, lack of quality stimulation, and conflict all negatively affect future social behaviour, educational outcomes, employment status and mental and physical health.¹⁹⁸ Family breakdown, including parental separation and single parent homes, is strongly associated with poor mental health in adults and children.¹⁹⁹
- Protective parenting activities may offset social gradients in social and emotional difficulties among children as young as three years.²⁰⁰

3.3.4 Taking action

- There are various levels on which prevention can occur. A recent report examining the social determinants of mental health, published by the WHO and the Calouste Gulbenkian Foundation (2014), stated that action needs to be universal but also proportionate to the level of disadvantage of particular groups in society, and also encompassing a wide variety of sectors, including health, education, criminal justice, employment, welfare, housing, and transport.²⁰¹
- Action should be taken to ensure universal access to high-quality health services, but also to recognise that, in the case of health status, this will also be dependent on policies in other sectors, such as education and housing, etc.²⁰²
- Education, particularly targeting women and new mothers, can help manage problems such as infant mortality, poor cognitive and physical development, malnutrition, conduct problems, and emotional and mental health problems.^{203, 204, 205, 206}
- Universal promotion and prevention interventions for high-school students have been found to be effective on a range of outcomes. Interventions, such as skills-orientated interventions, are effective in improving social and emotional skills, enhancing self-perceptions, and reducing emotional distress (including depression, anxiety and stress).²⁰⁷

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4. 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. Finally, this section will highlight the different treatment options available.

4.1 How many people seek help and use services?

- Across the UK, few people access mental health services and present to primary care for mental health problems.²⁰⁸ For example, between 2013 and 2014, while NHS England handled 1 million patients every 36 hours, approximately 1.7 million per year were for specialist (i.e. secondary care) mental health services.²⁰⁹
- Across the UK, a substantial proportion of people don't access any mental health support. For instance, only 65% of people with psychotic disorders are thought to receive treatment.²¹⁰
- Between 2013 and 2014, there were a total of 121,499 admissions to a mental health hospital in the UK, which reflected a 5.8% increase from the previous year. During the same time period, there was an increase in discharges (116,988), and the average occupied bed days fell by 15.²¹¹
- In England, within Child and Adolescent Mental Health Services (CAMHS), the number of NHS-funded beds for children and adolescents rose from 1,128 in 2006 to 1,264 in January 2014. In Leicestershire and Lincoln, there was the greatest increase, by 19%, in bed occupancy, followed closely by 15% in East Anglia.²¹²
- Between 2013 and 2014, around 1 in 370 (0.3%) of the Scottish population was discharged from a psychiatric hospital in Scotland at least once.²¹³

4.2 Extent of treatment and care

Primary care

- In 2012, a total of 202 GPs in the UK reported that 84% of their consultations were attributed to issues with stress and anxiety, and 55% reported mental health issues.²¹⁴
- In England, between 2013 and 2014, there were nearly 3 million adults on local GP registers, registered for depression, and approximately 500,000 for a severe and enduring mental health problem.²¹⁵

Secondary care

- In England, between 2013 and 2014, 1,746,698 people were in contact with mental health services. This is the equivalent to 1 in 28 persons (4%) being in contact with secondary mental health services during that year.²¹⁶

Community care

- 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 National Institute for Health and Care Excellence (NICE).²¹⁷
- In the UK, out of the 1,746,698 people that were in contact with mental health services between 2013 and 2014, 90% did not spend time in mental health hospitals, which indicates that most of the care was provided in the community.²¹⁸

Informal care

- In Wales, in 2015, about 1 in 20 women provide 50 or more hours of unpaid care a week to an adult relative, friend or neighbour that has a long-term physical or mental health problem.²¹⁹
- A health survey conducted in Northern Ireland between April 2013 and March 2014 with over 4,500 responses, revealed that 52% of carers spent 20 hours or more per week caring for someone.²²⁰

4.3 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 in order to be protected or for the protection of others.
- In England, by March 2014, there were a total of 23,531 detained under The Mental Health Act. Of these, 18,166 were detained in the hospital and 5,365 were being treated in the community. The Act was used 53,176 times to detain patients in hospital for longer than 72 hours, which was a 5% increase from the previous year.²²¹
- In Scotland, in 2013/2014, in young people (aged 15 and under), there were 18 females detained under the act, which was an 125% increase (compared to 8 females being detained) in the previous year. In contrast, the number of males detained has remained relatively stable.²²²
- In Scotland, in 2013/2014 there was an 13.5% increase in the number of individuals over the age of 85 who were detained in an emergency, with women representing the bulk (65%) of those detained in this age group.²²³

- Between 31st March 2012 and 31st March 2013, 1,423 inpatients were admitted under the Mental Health Act in Wales.²²⁴
- In Northern Ireland, between 2013 and 2014, there were 996 compulsory admissions into hospitals under the Northern Ireland Mental Health Order (1986). Of these admissions:²²⁵
 - 54.7% were males,
 - 45.3 % were females,
 - 47.1% were aged 18-44,
 - 28.2% were aged 45–64,
 - 15.2% were aged 75 and over,
 - 7.1% were aged 65-74, and
 - 2.4% were aged under 18.

The Mental Capacity Act (2005)

- The Deprivation of Liberty Safeguards were introduced in 2009 and are part of the Mental Capacity Act (MCA). These are used to protect the rights of people who lack 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.²²⁶
- The Care Quality Commission (CQC) has stated that 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.²²⁷
- From 2009 to 2014, there has consistently been a low number of Deprivation of Liberty Safeguards applications. Since 2011, the Care Quality Commission has only received notifications for 37% of applications to supervisory bodies.²²⁸ However, a recent Supreme Court decision may impact the numbers of Deprivation of Liberty Safeguards applications.²²⁹

4.4 Approaches for treatment and care

This section highlights key approaches currently present in mental health service provision. For further information on treatment and care, please see the NHS choices website or NICE guidelines.

Improving access to psychological therapies

- The Improving Access to Psychological Therapies programme was launched in 2008 with the aim of improving the quality and accessibility of mental health services in England by focusing primarily on talking therapies (i.e. cognitive-behavioural therapy (CBT), counselling, and self-help support).²³⁰
- New NHS IAPT data will be released from January 2016; this will provide further information on Children's and Young Peoples' mental health care.
- In the UK, CBT was the most common form of talking therapy in the IAPT programme accounting for 38% of the total appointments attended in 2013-2014 (approximately 3 billion appointments were attended).²³¹
- Following recommendations issued by the National Institute for Health and Clinical Excellence (NICE), there has been an increase in funding for psychological therapies through the IAPT programme. Between 2011 and 2012, investment in psychological therapies increased significantly in real terms by 6% over the previous year, forming 7% of direct services investment in England.²³²
- In January and February 2015, there were 224,000 referrals to the IAPT service: 74% of referrals received an assessment within 28 days, and approximately 3% were on a waiting list for more than 90 days.²³³ Of people who finished treatment, 44% were assessed as making a reliable recovery. Reliable recovery is recorded when a person moves from above the clinical threshold to below the threshold following a course of psychological therapy.²³⁴

- The number of persons moving to recovery through IAPT treatment has been on the increase. Over 197,000 people are reported to have recovered between September 2013 and August 2014 alone: a recovery rate of 44% across England.²³⁵
- One study examining the cost of IAPT in England over the period 2009-2010 calculated that the cost per recovered person ranged from £1,043 (low intensity) to £2,895 (high intensity).²³⁶
- In April 2015, 103,897 referrals were received by IAPT, of which 42.4% were self-referrals. The average number of attended treatment sessions was 6.3.²³⁷

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 focusing on interventions, and training and skills that help them manage and gain greater control over their life.²³⁸
- Peer support can be described as the support that people with lived experience of a mental health problem or learning disability are able to give to one another. Support may be social, emotional or practical in nature. A key feature is that it is mutually offered and reciprocal.²³⁹ There are very few studies in the UK that have evaluated the effectiveness of these groups for people with mental health problems. The majority that have been studied are usually with small numbers of participants and qualitatively studied.
- In Northern Ireland, between 2013 and 2014, 12,741 patients enrolled in a patient education/self-management programme, which was a 10% increase from the previous year. Of these, 18% attended a programme specifically for dementia.²⁴⁰

- 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.²⁴¹
- 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 they received and offered peer support through the groups they attended. These groups included informal peer-run services and various other voluntary sector groups.²⁴²

Medication

- In the UK, Aviva's Health of the Nation Report conducted in 2012 with 202 GPs, showed that 75% of GPs have prescribed medication even though they felt psychological therapies would be more effective.²⁴³
- In England, the Health and Social Care Information Centre (HSCIC 2011) found that prescriptions of anti-depressants had the largest increase in cost, at £49.8m (22.6%), and were the most common item dispensed.²⁴⁴
- 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 anti-depressant prescriptions in primary care.²⁴⁵
- 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 (FGA) in the UK had any diagnosis of serious mental ill health, which included schizophrenia or bipolar disorder.²⁴⁶

Computerised cognitive-behavioural therapy (CCBT)

- Computerised CBT is a form of self-help treatment that appears to be accessible and cost-effective, and suitable for people who prefer to avoid disclosure of sensitive information to a therapist. It is believed to be most effective with mild to moderate depression.
- A 2010 systematic review of the evidence from around the globe suggests that CCBT is effective at a comparable level to clinic-delivered CBT in reducing anxiety in children. This finding was reported to be sustained over time.²⁴⁷
- In 2015, a study in England with 23 adolescents revealed that CCBT led to improvements in depression and anxiety. This improvement was sustained at the 12 month follow-up.²⁴⁸

Mindfulness

- Mindfulness is an integrative, mind–body-based approach that can help you manage your thoughts and feelings, and change the way you relate to experiences. The aim of mindfulness is to pay attention to the present moment without judgement, and uses techniques, which draws on meditation, breathing and yoga.²⁴⁹ It has been recommended by NICE as a preventative practice for people with recurrent depression.²⁵⁰
- In 2011, a systematic review found that MBCT was an effective intervention for relapse prevention in recurrent major depressive disorder which was in remission.²⁵¹
- Be Mindful (bemindful.co.uk) is an online mindfulness course offered by the Mental Health Foundation. Research on the online course in 2013 found that for the 273 people that completed the course, on average there was a 58% reduction in anxiety levels, a 57% reduction in depression levels, and a 40% reduction in stress levels.²⁵²
- The imminent Mindful Nation UK report by the Mindfulness All-Party Parliamentary Group will provide an up to date overview of the latest evidence on the practice of mindfulness.

Exercise

- Older people living with a mental health problem can benefit from taking part in regular exercise, which helps increase their fitness and confidence, reduces the risk of falling, encourages social inclusion, and maintains independence.²⁵³
- In Scotland, research found that between August 2010 and June 2014, of the 90 older people referred to the Fit for Life Programme, 83% completed a community-based exercise group: 68% of those people appeared to show an improvement in balance, 54% felt more confident in their balance, and 89% of participants were motivated to access follow-on main stream exercise groups.²⁵⁴
- A systematic review conducted by Stanton and Happell (2014) found that aerobic exercise, such as using the treadmill, 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.²⁵⁵
- 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.²⁵⁶
- A Dutch study conducted with approximately 7,000 people found that doing exercise reduced the risk of developing a mood or anxiety disorder over the following three years.²⁵⁷
- A review by Barnes (2015) revealed that exercise has been shown to improve cognitive function. It also highlights that there is emerging evidence of the impact of exercise on cognition for people with mild cognitive impairment.²⁵⁸

Nutrition

- Evidence has found that good nutrition is important for our mental health. Eating properly can help maintain a balanced mood and feelings of wellbeing.²⁵⁹
- A study conducted by Stranges et al. (2014), in England, found that vegetable consumption was associated with high levels of mental well-being.²⁶⁰
- A systematic review conducted by O'Neil et al. (2014) showed that unhelpful dietary patterns, including a higher intake of foods with saturated fat, refined carbohydrates, and processed food products, can lead to worse mental health in children or adolescents, with a strong focus on disorders such as depression and anxiety.²⁶¹
- Healthy eating has been found to be associated with better emotional health compared to unhealthy eating.²⁶²

The arts

- Art therapy is a form of psychotherapy that uses a creative medium to aid people in exploring and articulating their emotions and feelings.²⁶³ Examples of art that can be used in this way can include the visual arts²⁶⁴ and dance.²⁶⁵
- Evidence suggests that music therapy, when combined with standard care, is effective for depression among working-age people with depression.²⁶⁶
- A systematic review conducted in 2011 by the Mental Health Foundation revealed that participatory art has a significant positive impact on the wellbeing of older people.²⁶⁷

4.5 References

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5. The cost of mental health problems

The costs associated with mental health problems are less well known than the costs associated with physical health problems such as cancer and diabetes. While we recognise that the value of human health is not merely a financial issue, calculating the costs of mental health problems for the national, regional and local economy can be persuasive when making the case for investment in mental health prevention and mental health services. In this section, we present evidence of the direct and indirect costs associated with mental health problems, as well as projected savings through early intervention and prevention. The statistics presented here speak primarily to England and the UK in general, with fewer references to Northern Ireland, Scotland and Wales due to limited data available in these regions.

Overall cost

- Mental health problems constitute the largest single source of world economic burden, with an estimated global cost of £1.6 trillion (or US \$2.5 trillion) – greater than cardiovascular disease, chronic respiratory disease, cancer, or diabetes individually.²⁶⁸
- According to the 2013 Annual Report of the Chief Medical Officer, mental health problems cost the UK economy an estimated £70-£100 billion each year, and account for 4.5% of GDP.²⁶⁹ It is estimated that 20% of this cost is attributed to health and social care costs, 30% to lost productivity, and the remaining 50% to human suffering.²⁷⁰
- In 2009-2010, regional costs were estimated at £105 billion in England,²⁷¹ £10.7 billion in Scotland²⁷² and the most recent figures from Wales (2007-2008) place the cost at £7.2 billion.²⁷³ In 2007, Northern Ireland was reported as having a 20-25% higher prevalence rate of mental health problems than the rest of the UK, with associated costs running at £3.5 billion.²⁷⁴

5.1 Cost of lost employment

- Mental health problems are common in the workplace with 1 in 6 experiencing mental distress, depression or stress-related problems at any one time.²⁷⁵ In 2007, economic inactivity among 72% of men and 68% of women in England was as a result of mental health problems.²⁷⁶
- In the UK, 70 million days are lost from work each year because of mental ill health, making it the leading cause of sickness absence.²⁷⁷
- In 2013-2014, work-related stress, depression and anxiety accounted for 39% (487,000) of all work-related illnesses, with rates consistently remaining higher among females than males, particularly in the 45-54 age group. Each case resulted in an average per person workday loss of 23 days, accumulating to 11.3 million days in total.²⁷⁸
- In Scotland, mental health problems at work cost Scottish employers over £2 billion a year due to sickness absence, presenteeism and staff turnover.²⁷⁹
- According to 2011 figures, it costs UK employers approximately £2.4 billion per year to replace staff lost as a result of mental health problem.²⁸⁰



***"In the UK, 70 million days are lost from work each year because of mental ill health, making it the leading cause of sickness absence."*²⁷⁷**

- Among adults on long-term benefits as a result of ill-health, 43% suffer primarily from a mental health problems.²⁸¹
- In 2007, around 45% of costs associated with mental health problems in England were attributed to its negative impact on employment. The average per person cost of lost employment (including service costs) due to schizophrenia and related conditions for those aged 45-64 was estimated at £19,078, while costs for those aged 15-44 were just under £30,000. Total costs were therefore estimated to run in the region of £4 billion.²⁸²
- Stigmatisation is considered to be one of the greatest challenges faced by individuals with mental health problems, affecting all aspects of the employment process, including job selection, training, promotion and transfer opportunities, as well as interpersonal relationships.²⁸³ People who experience mental health problems face more stigma and discrimination than those with physical health conditions, with the exception of those with HIV/AIDS. The results of a poll reported by the Chartered Institute of Personnel and Development (2011) indicate that 4 in 10 employees are afraid of disclosing their mental health problems to their employers due to the perceived risk of jeopardising their career.²⁸⁴ Interestingly, a survey of 2,082 UK adults found that 56% would not hire someone with depression, even if he/she was the best candidate for the job.²⁸⁵
- Employees returning from a period of 'psychiatric' sick leave are more likely to be closely monitored, demoted or questioned more severely compared to those suffering from a physical ailment. A 2006 US study among 1,139 workers with a mental health problem found that 6.3% reported they had been fired, laid off, or asked to resign because of their condition.²⁸⁶

5.2 Health and social care costs

Overall

- Mental health problems are responsible for the largest burden of 'disease' in the UK – 28% of the total burden, compared to 16% for cancer and 16% for heart disease.^{287,288}
- Mental health problems constitute the largest category of NHS 'disease' expenditure in the UK. Despite this, there is a very significant overall treatment gap in mental healthcare, with about 75% of people with mental health problems receiving no treatment at all.^{289,290} Only 13% of the NHS healthcare budget is spent on mental health problems.²⁹¹ In Wales, mental health problems accounted for 12.2% of public spending in 2007-2008.²⁹² In Scotland, 9.7% of spending by the NHS and local authorities in 2009-2010 was on health and social care in the area of mental health.²⁹³ Figures for Northern Ireland for the period 2006-2007 placed spending at 9.3% of public expenditure, despite the overall cost in that region being greater than all conditions combined.²⁹⁴
- According to the Chief Medical Officer (2013), mental health services are overstretched, waiting times are too long and some areas lack specialist services. Yet, public spending is focused almost entirely on coping with crisis, with only an insignificant investment in prevention.²⁹⁵ Mental health research, for example, receives only 5.5% (£115 million) of total UK health research spending.²⁹⁶
- In 2011-2012, Secure Services and Psychiatric Intensive Care Unit (PICU) services was the largest single area of expenditure in adult mental health services in England, accounting for 19% of spend on direct services.²⁹⁷

Cuts and disinvestment

- The total investment in adult (18-64 years) mental health care across England alone in 2011-2012 (official reported and unreported) was £6.629 billion or £198.30 per person, a 1% decrease compared to the previous year. For older person's' mental health services, overall cash investment also fell by 1% from £2.859 billion in 2010-2011 to £2.830 billion in 2011-2012, averaging £341.20 per person.²⁹⁸ Unreported investments account for 13.9% of total investment in adult mental health care.
- Overall, the reported investment in the three traditional priority areas in England (Crisis Resolution, Early Intervention and Assertive Outreach) overall fell by £29.3 million over the 2011-2012 period. Only Early Intervention reported increased investment. Spending in these priority areas for 2011-2012 was as follows:²⁹⁹
 - Assertive outreach - £126.8million (£11.8 million less than 2010-2011)
 - Crisis resolution/Home treatment - £254.6 million (£11.5 million less than 2010-2011)
 - Early intervention in Psychosis - £109.3 million (£5.2 million more than 2010-2011)
- Over the period 2011-2012, the London Strategic Health Authority (SHA) was overtaken by the South West as having the highest weighted investment per head. Weighted investment in adult mental health services in the South West was £207.0 per head compared to the national average of £198.30 per head. Without sufficient detail, authors of the National Survey of Investment report speculate that this may be due to NHS "efficiency savings" targets.
- In England, extensive disinvestments in Child and Adolescent Mental Health Services have been observed. The latest data suggests that, in the last year, £35 million has been cut from Children and Adolescent services, and £80 million has been cut in the past four years.³⁰⁰

- Research undertaken by Young Minds revealed that there has been a significant amount cut in Child and Adolescents Mental Health Services (CAMHS) budgets in the last year. The research revealed that:³⁰¹
 - 75% of Mental Health Trusts have frozen or cut their budgets between 2013-2014 and 2014-2015.
 - 67% of Clinical Commissioning Groups (CCGs) have frozen or cut their budgets between 2013-2014 and 2014-2015.
 - 65% of Local Authorities have frozen or cut their budgets between 2013-2014 and 2014-2015.
 - 1 in 5 Local Authorities have either frozen or cut their CAMHS budgets every year since 2010.
 - It has been estimated that the tens of millions of pounds in cuts equates to almost 2,000 staff that could otherwise be supporting mental health problems across the UK.

Staff costs

- Standard behavioural treatment for depression by a non-specialist (e.g. mental health nurse) in a group setting is estimated to cost £12 per session or £125 per 12 sessions. Counselling and psychotherapy delivered by trained practitioners, on the other hand, costs approximately £50 per hour. Group-based mindfulness-based cognitive therapy costs £14 per person or £172 per session.³⁰²

Private care

- In 2011-2012, non-governmental spending across all mental health service groups in England amounted to £1.7 million, representing 30% of total spend on adult mental health services.³⁰³

- Voluntary, private and independent sector residential care facilities for those with mental health problems do so at a median cost of £734 per resident per week, compared to £1,062 in local care homes. This expenditure includes social services management and support services, resident Department of Work and Pensions (DWP) allowance, and building maintenance. Private sector community day care runs at an average of £97 per client week, compared to £105 in local authority community day care.³⁰⁴

Informal care

- A substantial portion of care costs for those with schizophrenia, bipolar disorder and other related mental problems are accounted for by informal (unpaid) care. The contributions of informal care providers in England alone were valued at 25% of total service costs, second only to psychiatric inpatient costs.³⁰⁵
- According to 2006 figures, if the care from family and friends were to be paid for, the financial impact would be between £2,500 and £3,000 per person.³⁰⁶ For example, in London, if each carer spends an average of 32 hours per week providing care valued at the median care assistant wage, the value of service would be £14,000 per carer, or £1.21 billion for all carers over a one-year period.³⁰⁷

Drugs and talking therapies

- Evidence suggests that increasing drug prescriptions for mental health in England is on par with trends in other parts of the world. Between 1998 and 2010, prescriptions increased by an average of 6.8% per year, making up an increasing proportion of all prescription drug costs.³⁰⁸ The largest number of prescriptions were for drugs used in substance dependence (e.g. methadone). The total cost of drugs dispensed in England for mental health problems (including antipsychotics, anxiolytics, hypnotics, antidepressants, and mood stabilisers) was £8.8 billion. Although not fully investigated, potential causes for the increase in all but anxiolytics and hypnotics include a growing population and longer-term treatment.

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