Mental Health in Scotland:
Fundamental Facts 2016
Since devolution in 1999, Scottish mental health policy and practice has been more focused on addressing the specific circumstances of its population, with clear divergences in policy and practice direction from the rest of the UK. Scotland has led the way in the UK on mental health prevention and improving policy and practice, recovery and suicide prevention, responding to the comparatively high level of health inequalities in Scotland. As highlighted in a recent report written by Iris Elliott from the Mental Health Foundation on behalf of the Joseph Rowntree Foundation (2016), mental health is shaped by wide-ranging characteristics (including inequalities) of social, economic and physical environments in which people live in. Thus inequalities in these settings can have a considerable impact on an individual’s well-being and mental health.¹

It is difficult to obtain accurate figures presenting the prevalence of mental health conditions in Scotland at any given time; one reason is that many people who have mental health conditions do not seek help from traditional mental health services.² However, large-scale national surveys that estimate the prevalence of mental health conditions at population level through self-report are available to complement service-based data. Where significance is noted in the findings below, this refers to statistical significance, which denotes the finding is unlikely to be due to chance. The Fundamental Facts for Scotland summarises the most up-to-date data on mental health in Scotland and will be revised on a regular basis.
The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS), a scale developed to enable the monitoring of mental wellbeing in the general population, was introduced in 2006 and is now widely used in public and voluntary sectors across the UK. WEMWBS has been part of the Scottish Health Survey since 2008. WEMWBS aims to give a broad picture of the wellbeing of the entire population, rather than highlighting the minority who have mental health problems. Higher scores on the WEMWBS indicates higher levels of wellbeing. WEMWBS scores run from 14 to 70.

- Since 2008, the mean scores on the Scottish Health Survey (2015) have not changed for either men or women, with the mean score across both sexes in 2015 reported as 49.9.
- The Scottish Health Survey (2015) found adults aged between 65-74 years had the highest levels of wellbeing (mean WEMWBS score of 51.0), and those aged between 16-24 years scored the lowest (49.1). The levels of wellbeing significantly varied across age groups for women (see Figure 1). However for men, the variation across age groups was not significant.

![WEMWBS mean score, 2015, by age and sex](image)

**Figure 1: WEMWBS mean scores in 2015, by age and sex.**
• Between 2012-15, the combined WEMWBS mean score for all children aged 13-15 was 51.0. The mean score for boys (52.0) was significantly higher than that for girls (49.9). Wellbeing appeared to decrease as the children got older, with the score for all children aged 13 (52.3) averaging higher than the score for those aged 15 (50.0).6

• Wellbeing scores amongst children did not differ significantly by area deprivation.7

• The mean life satisfaction score for Scottish adults aged 16 and above in 2013 was 7.7, on a scale of zero (extremely dissatisfied) to ten (extremely satisfied). It is worth noting that levels of life satisfaction have not changed significantly since 2002.8

• The Scottish Health Survey (2015) did not include an ethnic breakdown of WEMWBS scores as past surveys have done. Nevertheless, research from the 2012 Survey on equality groups, covering the period 2008-2011, found that White British respondents had the lowest levels of wellbeing of all ethnic groups (mean WEMWBS score of 49.8). This was significantly lower than scores of the other ethnic groups: White Other (51.2); African, Caribbean or Black (53.7); and Asian Other (53.5).9

• With regards to religion, the same 2012 report found that Hindus had the highest levels of positive mental wellbeing (53.2) but this was not significantly different from the Scottish average (49.9). Roman Catholics had significantly lower than average wellbeing (49.4) and Other Christians had slightly, but significantly, higher wellbeing (50.9).10

• This report also found that heterosexual respondents had significantly higher wellbeing (mean WEMWBS score of 50.0), than bisexual respondents (47.9), those with other sexual orientations (47.0) and those that preferred not to disclose their sexual orientation (47.3). The wellbeing of gay men and lesbians (48.8) was not significantly different from the average.11
Common mental health problems

However, beneath these quite positive statistics on wellbeing, there are significant numbers of people who will experience mental health problems;

- Between 2012-15 one in six (15%) adults in Scotland reported symptoms of a mental health condition.\(^\text{12}\)

**Depression**

- In 2014/15, 20% of adults reported one or more symptoms of depression. This is significantly higher than the proportion in 2012/13 (17%) and 2008/09 (14%). Between 2008/09 and 2014/15 the proportion of men with two or more symptoms of depression increased (from 7% to 10%) but the proportion of women remained unchanged (10% for both surveys).\(^\text{13}\)
- Between 2012 and 2015, the age group most likely to report at least one symptom of depression were those aged 35-64 (10-11%); those aged 65 and over were least likely to do so (6-7%). This pattern was found among both men and women.\(^\text{14}\)
- Reported symptoms of depression differed by area deprivation. Individuals in the most deprived areas were 4 times more likely to report two symptoms of depression compared to those in the least deprived areas (16% compared with 4%). This pattern was consistent for both men and women (Figure 2).\(^\text{15}\)

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**Figure 2: Two or more symptoms of depression (age-standardised), 2012-15, by area deprivation quintiles.**

Comparing the pattern of prevalence of two or more symptoms of depression for 2012-15 (see Figure 2) and 2008/09 period (see Figure 3 below), it is evident that between 2012 and 2015 this pattern is more linear than that found in the year 2008/09. In particular, the proportion of men in the most deprived quintile showing 2 or more symptoms of depression has increased dramatically over time, and the gap between men and women in the middle quintile has narrowed considerably.

Anxiety

• In 2014/15, 12% of adults had two or more symptoms of anxiety, an increase from 9% in 2008/09. Between 2008/09 and 2014/15 the increase of individuals with two or more symptoms of anxiety was significant for women (11% to 15%) but not for men (7% to 9%).

• Between 2012 and 2015 the prevalence of two or more symptoms of anxiety was lowest for those aged 75 and over (5%) compared to all other age groups (9-13%). The overall proportion of individuals with at least one symptom of anxiety appeared to decline with age, with levels at 28% for those aged 16-24 decreasing to 13% among those aged 75 and over.

• Prevalence of anxiety differed by area deprivation. Individuals in the most deprived areas were twice as likely to report two symptoms of anxiety compared to those in the least deprived areas (15% compared with 7%).

Figure 3: Proportion with depression symptom score of two or more (age-standardised), 2008-2009, by Scottish Index of Multiple Deprivation quintile.

Mental health across the lifespan

Children and young people

- In Scotland, children and young people (under 19 years old) who are more socioeconomically deprived are significantly more likely to experience many types of mental health problems, except for common mental health problems (only measured for those aged 16-19), and alcohol dependency.\(^{19}\)

- During the quarter ending March 2016, 4,436 children and young people started treatment at Children and Adolescent Mental Health Services (CAMHS) in Scotland, which was similar to the previous quarter (4,483), but higher than the same period the previous year (4,269).\(^{20}\) Over the same period, 84.2% of this group was seen within 18 weeks (an 81% improvement on the previous quarter, and 5.3% on the same period in 2015), and half started their treatment within eight weeks.\(^{21}\) Over 10% (11.6%) of those referred to CAMHS did not attend their first appointment, compared to 13.1% in the previous quarter and 10.7% for the same period in 2015.\(^{22}\)

- A longitudinal study published in 2011 analysing 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.\(^{23}\) Childhood experience of abuse is a major predictor of mental health issues. Between 2011 and 2015, in 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.\(^{24}\) In 2015, there were 2,751 children subject to a child protection act in Scotland, a 4% decrease from 2014, but nevertheless the second highest annual rate on record. 51% of these children were under 5 years old, a 7% decrease from 2014. In comparison to the rest of the UK, the rate of registrations to the child protection register over the last decade remain the lowest in Scotland (Figure 4).\(^{25}\)

**Figure 4: Cross-UK comparison of rate of children on the child protection register per 10,000 under 10s, 2004-2015.**

• The Strength and Difficulties Questionnaire (SDQ) is used to measure five aspects of children’s development: emotional symptoms; conduct problems; hyperactivity/inattention; peer relationship problems; and pro-social behaviour. A score is calculated for each five aspects, ranging between zero and forty, with a higher score indicating greater evidence of difficulties.26

• In 2003, 17% of children aged 4-12 had borderline or abnormal difficulty scores. This decreased to 14% in 2008/09 and remained at 14% in 2015.27

• Since 2003, boys have shown higher scores on the SDQ compared to girls. In 2014/15 the proportion of boys reported to have borderline or abnormal difficulty scores was significantly higher than girls (17% compared to 10%, respectively).28

• SDQ scores varied according to level of area deprivation. Borderline or abnormal difficulty scores were significantly higher for children in the most deprived areas (22%) compared to those in the least deprived areas (6%).29

Perinatal mental health
• Despite increasing figures for those affected by perinatal mental health problems, about 40% of women in Scotland have no specialist perinatal mental health provision.30

• Depression and anxiety affects 10 to 15% of women during pregnancy and first post-natal year, and is the most common mental health issue experienced during pregnancy.31

• 71% of NHS boards have no midwives or health visitors with accredited training in perinatal mental health. Two thirds of perinatal mental health services in Scotland are delivered by generic community mental health teams rather than a specialist perinatal mental health psychiatrist.32

Adult Mental Health

Unemployment and debt
• The employment rate in Scotland over April-June 2016 (the most recent period for which data is available) was 74.1, slightly lower than the UK average of 74.6.33 Unemployment has been shown to increase the risk of mental health problems and suicide.34, 35 A 2008 study in England, Wales, and Scotland found that the more debt people had, the more likely they were to have some form of mental health problem, controlling for income and other socio-demographic variables.36

Substance Misuse
• NHS Scotland recognises substance misuse and parental substance misuse as a determinant of mental health.37 Scotland has the highest rate of alcohol-related deaths of the UK nations, with a rate of 31.2 per 100,000 population for men in 2014 (compared to 18.1 in England, 19.9 in Wales, and 20.3 in Northern Ireland), and 13.3 per 100,000 population for women (compared to 91 in England, 10.4 in Wales, and 8.5 in Northern Ireland).38
Drug taking in the general population is falling - the findings from the 2014/15 Scottish Crime and Justice Survey showed that the number of adults, aged 16-59, who reported drug use in the last year decreased from 6.2% in 2012/13 to 6.0% in 2014/15 (7.6% in the 2008/09 survey). It is estimated that drug misuse costs society £3.5 billion a year whilst the impact of alcohol misuse is estimated to cost £3.6 billion a year - combined, this is around £1,800 for every adult in Scotland. In Scotland in 2006, more than two thirds of the total alcohol-related deaths were in the most deprived two fifths of areas. In 2015/16 there were 97,245 Alcohol Brief Interventions (ABI) carried out in Scotland.

Domestic abuse

- Over 59,000 incidents of domestic abuse were reported in Scotland in 2013/14.
- Increasing severity of domestic violence is related to poorer mental health.
- Domestic violence (DV) is associated with depression, anxiety, posttraumatic stress disorder (PTSD), and substance abuse for survivors of DV.
- The relationship between domestic violence and mental health is bidirectional, with research suggesting that women experiencing abuse are at greater risk of mental health conditions and that having a mental health condition makes one more vulnerable to abuse.

Later Life

- In 2016, approximately 90,000 people are living with dementia in Scotland. Based on relevant population figures, this accounts for 1.8% of the total population. Over 65% of these are women, and 3.5% are under 65 years old.
- Rates of dementia increase with age, with 11% of people in their sixties being affected, compared to 5.4% of people in their seventies, 20.1% of people in their eighties, and 38.7% of people in their nineties.
- In Scotland, between 2004 and 2031 the number of people aged 50+ is projected to rise by 28 per cent and the number aged 75 and over is projected to increase by 75 per cent.
- Among the strongest drivers of the experience of ageing are society’s attitudes to old age and later life. A population-based study involving over 660 individuals aged over 50 found that those with more positive self-perceptions of ageing lived 7.5 years longer than those with less positive perceptions. The Scottish Government launched an initiative “See the person, not the age” to help tackle ageism and provide support for change.
Suicide

- In 2014, the suicide rate in Scotland was 14.5 per 100,000 population, down from 16.6 in 2013. This was lower than Northern Ireland (16.4), but significantly higher than Wales (10.3) and England (9.2). Since 2005, Scotland and Northern Ireland have consistently had higher suicide rates than England and Wales (Figure 5).

- There were 672 suicides registered in Scotland in 2015, compared to 696 in 2014. The suicide rate for males was more than two-and-a-half times that for females.

- Between 2000-02 and 2011-13 the suicide rate in Scotland fell by 19%.

- Suicide rates in Scotland differed between men and women. Of the 794 suicides in Scotland in 2013, 610 were male and 184 were female. Although numbers for males decreased from 2013 to 2014, and increased for females, the number of male suicides (497) vastly outnumbered female suicides (199) in 2014.

- Both individual and area level deprivation increase the risk of suicide. In 2011-15, the suicide rate was more than three times higher in the most deprived tenth of the population (decile) compared to the least deprived decile (22.1 deaths per 100,000 population compared to 7.3). The socio-economic inequality of suicide has decreased between 2001-05 and 2011-15.

Figure 5: Age-standardised registered death by suicide rates by country between 1981-2014.

Suicide attempts and self-harm

It should be noted that results are likely to be an underestimate of the number of suicide attempts and prevalence of self-harm because self-report measures are often reliant on individuals’ willingness to disclose information.

- In 2014/15 the proportion of adults who reported ever having attempted suicide was 6%.57
- The prevalence of suicide attempts differed according to area deprivation. Between 2012 and 2015 the prevalence of attempted suicides was higher in the most deprived areas (10%) than the least deprived areas (3-4%). The same pattern was seen for both men and women.58
- In 2012-15, the percentage of adults who attempted suicide differed across age groups:59
  - 4% of those aged 16-24;
  - 5% of those aged 25-34;
  - 6% of those aged 35-44;
  - 6% of those aged 45-54;
  - 2% of those aged 55-64;
  - 1% of those aged 65-74;
  - 1% of those aged 75 and over.
- The same pattern was seen for both men and women
- In 2012-15, the percentage of adults who reported to have ever self-harmed differed across age groups:60
  - 18% of those aged 16-24;
  - 8% of those aged 25-44;
  - 4% of those aged 45-54;
  - 0-2% of those aged 55 and over.
- The levels of self-harm differed between men and women most significantly in the youngest age group (16-24), with 23% of women reporting to have ever self-harmed compared to 13% of men in this age group (Figure 6).61

Figure 6: Ever self-harmed, 2012-15, by age and sex.
There are stark inequalities in mental health outcomes in Scotland. A report by the Scottish Public Health Observatory in 2012 highlighted that there are clear inequalities in mental health within the Scottish population by socioeconomic status, age and gender.\textsuperscript{62} NHS Scotland and the Scottish Government explicitly recognise the relationship between social inequalities and poor health, with a Ministerial Taskforce on Health Inequalities, whose reports have argued that the solutions to tackling health inequalities lie in targeting the root causes of social inequality.\textsuperscript{65} The following sections provide some insights into the scale and nature of these inequalities in Scotland and how this relates to mental health.

**Deprivation, gender and age**

- Using the General Health Questionnaire (GHQ) (in which a higher score indicates a more severe condition), it was found that the number of people reporting common mental health problems were almost twice as high for people living in deprived areas compared to those living in less deprived areas (Figure 7).

**Figure 7: Mental health problems by Scottish Index of Multiple Deprivation quintile, 2008-2011.**

A lower percentage of men reported common mental health problems than women. This may in part be due to the growing evidence that men are less likely to seek support from services for mental health than women (Figure 8).\(^64\)

The percentage of the adult population reporting common mental health problems varied by age group. The percentage was higher for those aged 20-59 years and 80-89 years, and generally lower among people aged 60-79 years.\(^65\)

**Figure 8: Mental health problems by sex, Scotland 2008-2011.**
To date, little information is available on the prevalence of mental ill health or mental health conditions amongst BAME communities in Scotland.66

**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% have a mental health problem.67
- An analysis of the Mental Health of Children and Adolescents survey (ONS) including 10,438 children between 5-15 years across England, Scotland and Wales found that children and adolescents with intellectual disabilities are at significantly increased risk of certain forms of mental health problems such as conduct disorders, anxiety disorders and attention deficit hyperactivity disorder.68
- In 2014, local authorities knew of 26,786 people with learning disabilities across Scotland (i.e. 6 people per 1000 population), over half of whom lived in the most deprived areas of the country, and 73% of whom lived in urban areas.69

**Lesbian, Gay, Bisexual &/ Transgender (LGB&T)**
- A 2012 survey carried out by LGB&T Youth Scotland of 273 people aged 13-25 found that 40% of LGBT youth consider themselves to have a mental health condition (compared to 25% of the population overall), with higher levels of poor mental health reported by transgender individuals (66.7%) and bisexual women (63%). Homophobic and transphobic bullying was reported as a significant contributing factor to mental health problems.70

**Long-term conditions**
- Just under one in ten adults (9%) had both a long-term physical condition and showed symptoms of a diagnosed mental health problem.71
Service provision and use

- Between 2014 and 2015, there were 20,900 admissions and discharges (i.e. point at which a patient leaves hospital) in psychiatric specialities in Scotland. This number decreased over the period from 1997/98 to 2009/10 due to the shift towards community based care, but has remained relatively stable in recent years (see Figure 9).  

- The more deprived an area, the higher its rate of psychiatric inpatient discharges. In 2013/14, the rate in the most deprived fifth of the population was over three times that of the least deprived (649 compared with 197 per 100,000 population respectively).

- In 2014/15 there were 2006 emergency detentions in Scotland under the Mental Health Act, a 4.9% increase from the previous year. Detentions decreased in the 45-64 age group, and increased by nearly 20% in the 65-84 age group. In the 15 and under age bracket, there were a total of 42 females admitted for short-term detention, a 40% increase from the previous year.

- In 2014/15, 47-55 advance statements (a record made by a person about how they would like to be treated in the future) were overridden in Scotland, although statistics are not available on the number of statements made.

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**Figure 9: Number of mental health inpatient discharges from Scottish Hospitals: Scottish Residents, by age, group on admission, 1997/98 to 2013/14.**

Treatment: Care and cost

- The total cost of mental health in Scotland (including human cost, health and social care costs, and output losses) for 2009/10 is estimated at £10.7 billion.\textsuperscript{77}

- It was found that up to 75\% of people with common mental problems in Scotland do not receive treatment. Around 25\% of those with common mental health problems receive treatment, such as medication or psychological therapies, much of which is provided in primary care.\textsuperscript{78}

- A study carried out by Burton et al. (2012) with 28,027 patients revealed that new courses of anti-depressants accounted for one sixth of the total anti-depressant prescriptions in primary care in Scotland.\textsuperscript{79}

- During 2012 prescribing costs per head of population was £0.41 in Scotland, compared to £0.26 in Wales and £1.71 in Northern Ireland.\textsuperscript{80}

- In 2013, figures of anti-depressant prescribing had decreased to £183.73 per head of population, compared to £192.25 in 2010. This was the second highest of the UK nations with only Northern Ireland having higher prescribing costs (£223.54 per head of population) (Table 1).\textsuperscript{81}

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\textbf{Table 1: Cross-country anti-depressant prescription cost analysis 2007-2013}

• Non-clinical based treatments are also available to aid mental health problems, such as peer support groups. A review by Repper and Carter (2011) identified a number of positive impacts of peer provided support including improved community integration and reduced feelings of stigma of mental health problems.82

• Social prescribing is a non-clinical approach that aims to connect people to non-medical sources of support or resources in the community to aid any mental health problems they are experiencing.83 These can include opportunities for arts, physical activity, volunteering, self-help and peer support and can operate alongside other psychological therapies.84 For example, findings from arts on prescriptions schemes showed that clients who attended experienced improvement in self-esteem, social skills and social inclusion.85

• In Scotland, employers’ costs associated with mental health problems are estimated at £2.15 billion a year. In addition, the burden of unemployment on society is estimated at £1.44 billion for 2009/10.86

• In Scotland, mental health problems at work cost Scottish employers over £2 billion a year due to sickness absence, presenteeism (working while sick) and staff turnover.87
References


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Our mission is to help people understand, protect and sustain their mental health.

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. We inform and influence the development of evidence-based mental health policy at national and local government level. In tandem, we help people to access information about the steps they can take to reduce their mental health risks and increase their resilience. We want to empower people to take action when problems are at an early stage. This work is informed by our long history of working directly with people living with or at risk of developing mental health problems.

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.

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