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Mental health presents one of the greatest challenges that current and future generations will face. In health, economic and social terms, the burden created by mental health problems and mental illness in the UK is immense and growing.

Mental health should be a concern for us all because it affects us all. On an individual level, mental health problems affect our ability to function day to day and our overall quality of life. When you consider such problems collectively, the effect on society is considerable. We need to find out how to turn the tide or future generations will be still further affected by mental ill health.

Mental health and well-being are not nearly as well understood as other areas of health. We are not giving mental health the attention demanded by its impact on society.

As a developed country, we could do better. We need to understand the balance of factors that both promote mental health and support the recovery of people with mental health problems. We need to acknowledge that the way we live and the decisions we make across all areas of policy have a profound impact on our collective mental health.

The Fundamental Facts will help contribute to that understanding.

David Brindle
Public Services Editor, The Guardian
Introduction

If we are to promote mental health and prevent and treat mental illness, better documentation, analysis and comprehension are crucial.

Presenting the facts in a way that is accessible and useful to the many people who have a contribution to make is vital to improving understanding. The Fundamental Facts is designed to do this. It is a quick reference tool, full of thoroughly researched, fully referenced facts and figures. It is for anyone with an interest in mental health – from those who work mainly in the field to those who have an interest in gaining speedy and usable insight or reference material.

A note on terminology and data:
In most of the facts and figures presented, referenced authors’ terms and definitions have been used for accuracy. Very few mental health terms, or the diagnoses they describe, are uncontroversial. Where language has been used which reflects a certain way of seeing mental health, this does not mean that any particular model of mental health is either endorsed or rejected.

The terms ‘mental health problems, mental distress and mental ill health’ are used interchangeably here. The term ‘mental illness’ is used specifically to refer to clinically recognised patterns or symptoms of behaviour that can be diagnosed as mental illnesses.

The Mental Health Foundation has a holistic view of mental health which includes social, psychological and biological factors. Some of the sources quoted here subscribe to other models of mental health.

A lot of studies have been carried out on mental health over recent years, some of them more scientifically robust than others. The Fundamental Facts is a compendium, with no commentary made on the research findings.

The facts and figures are left to speak for themselves.
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1. The extent of mental health problems
Mental health problems are among the most common health conditions, directly affecting about a quarter of the population in any one year. Depression and anxiety are the most widespread conditions, while only a small percentage of people experience more severe mental illnesses. However, estimates of exactly how many people experience which mental health problems vary, and it is not easy to compare different measures.

For example, some calculations are based on how many people have a mental health problem at any point in time, while others measure the likelihood of someone developing mental health problems in their lifetime. Others measure rates per year. Figures may relate to different populations such as the adult population, a regional population or a nation within the UK (eg. the North West or England), or an international population.

Some examples of how many people are affected are:

- The Office for National Statistics Psychiatric Morbidity report found that in any one year 1 in 4 British adults experience at least one mental disorder\(^1\), and 1 in 6 experiences this at any given time.
- Although mental disorders are widespread, severe cases are concentrated among a relatively small proportion of people who often experience more than one mental health problem.\(^2\)
- It is estimated that approximately 450 million people worldwide have a mental health problem.\(^3\)
- 1 in 4 families worldwide is likely to have at least one member with a behavioural or mental disorder.\(^3\)
What are the main types of mental health problem?

Mental health problems are usually defined and classified by medical professionals. But some mental health diagnoses are controversial, and there is much concern in the field that people are too often treated according to, or described by their label. This can have a profound effect on their quality of life. For this reason, diagnostic labels should be used with caution, and do not indicate the severity of illness. Nevertheless, diagnoses remain the most usual way of dividing and classifying symptoms into groups.

Most mental health symptoms have traditionally been divided into groups called either ‘neurotic’ or ‘psychotic’ symptoms.

‘Neurotic’ covers those symptoms which can be regarded as extreme forms of ‘normal’ emotional experiences such as depression, anxiety or panic. Conditions formerly referred to as ‘neuroses’ are now more frequently called ‘common mental health problems’, although this does not always mean they are less severe than conditions with psychotic symptoms.

Less common are ‘psychotic’ symptoms which interfere with a person’s perception of reality and may include hallucinations, delusions or paranoia, with the person seeing, hearing, smelling, feeling or believing things that no one else does. Psychotic symptoms or ‘psychoses’ are often associated with ‘severe mental health problems’.

However, there is no sharp distinction between the symptoms of common and severe mental health problems. It is important to remember that some illnesses feature both neurotic and psychotic symptoms.
Common mental health problems

• In a 2001 survey, 15% of British adults reported experiencing ‘neurotic symptoms’ in the previous week.\(^5\)
• Mixed anxiety and depression is the most common mental disorder in Britain, with almost 9% of people meeting criteria for diagnosis.\(^6\)
• About half of people with common mental health problems are no longer affected after 18 months, but poorer people, long-term sick and unemployed people are more likely to be still affected than the general population.\(^7\)
• Overall, common mental health problems peak in middle age. 20-25% of people in the 45-54 years age group have a ‘neurotic disorder’.\(^8\) As people age, neurotic disorders become less common, with the lowest level recorded in the 70-74 years age group.

Depression

The term ‘depression’ is used to describe a range of moods, ranging from low spirits to more severe mood problems that interfere with everyday life. Symptoms may include a loss of interest and pleasure, excessive feelings of worthlessness and guilt, hopelessness, morbid and suicidal thoughts, and weight loss or weight gain. A depressive episode is diagnosed if at least two out of three core symptoms have been experienced for most of the day, nearly every day, for at least two weeks. These core symptoms are:
• Low mood
• Fatigue or lack of energy
• Lack of interest or enjoyment in life
A depressive episode may be classed as mild, moderate or severe, depending on the number and intensity of associated symptoms, such as sleep disturbance, appetite and weight change, anxiety, poor concentration, irritability and suicidal thoughts.
• Between 8% and 12% of the population experience depression in any year.\(^9\)
• Only 2% of the population are experiencing a depressive episode without ‘co-morbid’ anxiety, meaning ‘occurring at the same time’.

• Depression tends to recur in most people. More than half of people who have one episode of depression will have another, while those who have a second episode have a further relapse risk of 70%. After a third episode, the relapse risk is 90%. For about 1 in 5 people, the condition is chronic.

• Worldwide, 5.8% of men and 9.5% of women will experience a depressive episode in a 12 month period, a total of about 121 million people.

• The World Health Organisation forecasts that by 2020 depression will be the second leading contributor to the global burden of disease.

Suicide

The Government has set a target to reduce the death rate from suicide and undetermined injury by at least a fifth by the year 2010 (from a baseline rate of 9.2 deaths per 100,000 population in 1995/96/97 to 7.3 deaths per 100,000 population in 2009/10/11). Data from the three years 2002/03/04 show a rate of 8.6 deaths per 100,000 population – a reduction of 6.6% from the 1995/06/07 baseline.

• In 2004, more than 5,500 people in the UK died by suicide.

• Scotland has the highest suicide rate in the UK at 20 in 100,000, an increase of 1% over a decade and the only country in the UK to show a rise. In England the suicide rate is 10 per 100,000 people. In both Northern Ireland and Wales the suicide rate is 11 per 100,000.

• The suicide rate in the EU is 17.5 people in 100,000 and 15.1 in 100,000 worldwide.

Suicide and self-harm are not themselves mental illnesses, but they usually result from mental distress.
Although the rate of suicide among young men reduced by 30% in the period from 1998 to 2005, suicide remains the most common cause of death in men under the age of 35.

British men are three times more likely than British women to die by suicide. This is true of younger men in particular – those aged 25-34 are four times as likely to kill themselves as women in this age group.

Since 1979, the gender gap for people dying by suicide has widened. In 1979 the female to male gender ratio for suicides was 2:3. In 2002, it was around 1:3. Nevertheless, women are more likely to attempt suicide than men.

Younger suicides more often had a history of schizophrenia, personality disorder, drug or alcohol misuse, or violence than older suicides.

4% of people who took their lives were the lone carers of children.

Suicide and history of using mental health services

An inquiry into suicides in the five years to 2001 found that approximately a quarter of people who died by suicide in England and Wales, Scotland and Northern Ireland had been in contact with mental health services in the year before death – this amounted to about 1,200 people each year. At the time of their death, 16% of cases in England and Wales, 12% in Scotland and 10% in Northern Ireland were psychiatric in-patients.

The same inquiry reported that 42% of people who took their own lives in England and Wales were diagnosed with either a depressive illness or bi-polar disorder, and 20% had schizophrenia or a related disorder.

In around a quarter of suicide inquiry cases in England, Wales and Scotland and nearly a third in Northern Ireland, the person died within three months of discharge from in-patient care, with a peak in the first one to two weeks after discharge. In England and Wales 40% died before the first follow up appointment. In Scotland this was 35% and in Northern Ireland 66%.
The Fundamental Facts 2007

The Extent of Mental Health Problems

Suicide and ethnicity

- In the five years to 2001, 6% of people who took their own lives in England and Wales were from an ethnic minority group. In Scotland this was 2% and in Northern Ireland 1%. The 2001 Census found that 9% of the population in England were from ethnic minorities. In Wales this was 2%, in Scotland 2% and in Northern Ireland 0.75%.

- The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness in the five years to 2001 found that people from ethnic minorities who died by suicide usually had severe mental illness. Three quarters of Black Caribbean people who took their own lives had a diagnosis of schizophrenia.

Self-harm

Deliberate self-harm ranges from destructive behaviours with no suicidal intent, but which relieve tension or communicate distress, through to attempted suicide.

- The UK has one of the highest rates of self-harm in Europe, at 400 per 100,000 population.

- There is a high correlation between self-harming behaviour and mental health problems. Most of those who attend an emergency department after self-harming would meet the criteria for one or more psychiatric diagnoses. More than two thirds would meet the criteria for depression.

- People with current mental health problems are 20 times more likely than others to report having harmed themselves in the past.

- People who have self-harmed are at significant risk of suicide. A study found that the risk of a person dying by suicide within a year of being treated for self inflicted injury was 66 times the annual risk of suicide in England and Wales, and that there is a significant risk even many years later.
THE EXTENT OF MENTAL HEALTH PROBLEMS

Post-natal depression, also known as post partum depression, is believed to affect between 8 and 15% of women.\textsuperscript{39}

- Self-harming and suicide may be influenced by the depiction of similar behaviour in the media or taking place in peer groups. For example, one study showed a 17% increase in presentations to hospital from self-poisoning in the week after an overdose was depicted in a TV drama.\textsuperscript{37} Similarly, a study of teenagers who self-harmed found that the strongest associated factor was awareness of friends who had also self-harmed.\textsuperscript{38}

- Major public events may lead to amplification of existing distress. In the month following the death of Diana, Princess of Wales, the number of women dying by suicide increased by a third, with a 45% increase in the number of women aged 25-44 years taking their lives. Deliberate self-harm by women increased 65% and was up 44% overall.

Postnatal depression

There are two main types of mental health problem that a woman may experience following the birth of a child: postnatal depression and puerperal psychosis. Puerperal psychosis is classed as a severe mental health problem (see page 18). Post-natal depression, also known as post partum depression, is believed to affect between 8 and 15% of women.\textsuperscript{39} Post-natal depression is not the same as the ‘baby blues’ which are very common, but last only a few days.

Seasonal Affective Disorder

Seasonal Affective Disorder (SAD) is a form of depression that affects approximately 0.8% of the population at some point in their lives. There are two types of SAD: winter and summer depression. Winter depression occurs more frequently and is characterised by recurring episodes of depression that begin in Autumn/Winter as a result of inadequate bright light and go in Spring/Summer.\textsuperscript{40} SAD differs from other forms of depression in that those affected sleep more than normal, whereas people experiencing other forms of depression have difficulty sleeping.
Anxiety

Anxiety is a normal response to threat or danger and part of the usual human experience, but it can become a mental health problem if the response is exaggerated, lasts more than three weeks and interferes with daily life. Anxiety is characterised by worry and agitation, often accompanied by physical symptoms such as rapid breathing and a fast heartbeat or hot and cold sweats. ‘Stress’ is not considered a mental health problem in its own right, but long-term stress may be associated with anxiety or depression.

- Generalised anxiety disorder (GAD) is diagnosed after a person has on most days for at least six months experienced extreme tension (increased fatigue, trembling, restlessness, muscle tension), worry, and feelings of apprehension about everyday problems. The person is anxious in most situations, and there is no particular trigger for anxiety. ⁴¹

- People who experience anxiety usually have symptoms that fit into more than one category of anxiety disorder, and are usually diagnosed with at least one other mental disorder, most commonly depression. ⁴²

- Social phobia, a persistent fear of being seen negatively or humiliated in social or performance situations, is the third most commonly diagnosed mental disorder in adults worldwide, with a lifetime prevalence of at least 5%. ⁴³

Obsessive Compulsive Disorder (OCD)

Obsessive compulsive disorder is a common form of anxiety characterised by obsessive thinking and compulsive behaviour. Obsessions are distressing, repetitive thoughts which may be seen as irrational, but cannot be ignored. Compulsions are ritual actions which people feel compelled to repeat in order to relieve anxiety or to stop obsessive thoughts. For example, someone may believe that their hands are constantly dirty so wash them over and over again.

- 2-3% of people will experience Obsessive Compulsive Disorder during their lifetime. ⁴⁴ It often takes between 10 and 15 years for people to seek professional help.

- 7% of British adults report ‘obsessions’ in any week, with 4% reporting ‘compulsions’. ⁴⁵
Phobias (including panic attacks)

Phobias describe a group of disorders in which anxiety is experienced only, or predominantly, in certain well-defined situations that are not dangerous. As a result, these situations are avoided or endured with dread. The person’s concern may be focused on individual symptoms like palpitations or feeling faint and these are often associated with secondary fears of dying, losing control, or ‘going mad’.

- Phobias are much more common in women than men, affecting about 22 in 1,000 women compared with 13 in 1,000 men in Britain.46

- Agoraphobia is the term for a cluster of phobias that include fears of leaving home, entering shops, crowds and public places, or travelling alone in trains, buses or planes.

- Social phobias are characterised by a fear of scrutiny by other people. Symptoms may include blushing, shaking hands, nausea or the urgent need to go to the toilet.

- There are numerous phobias restricted to highly specific situations such as proximity to particular animals, heights, thunder, darkness, flying, closed spaces, using public toilets, eating certain foods, dentistry, or the sight of blood or injury.

- Panic disorder occurs when there are recurrent, unpredictable panic attacks followed by at least one month of persistent concern about having another attack.

- Panic attacks are usually contained episodes characterised by a sudden and intense sensation of fear and accompanied by physical symptoms, and the person may feel that they are dying.47
Post-traumatic stress disorder

Post-traumatic stress disorder (PTSD) develops following a stressful event or a situation of an exceptionally threatening or catastrophic nature. Intentional acts of violence are more likely than natural events or accidents to result in PTSD. Common symptoms may include re-experiencing the event in nightmares or flashbacks, avoiding things or places associated with the event, panic attacks, sleep disturbance and poor concentration. Depression, emotional numbing, drug or alcohol misuse and anger are also common.

In children, re-experiencing symptoms may take the form of re-enacting the experience, repetitive play or frightening dreams without recognisable content.

- The risk of developing PTSD after a traumatic event is 8.1% for men and 20.4% for women.\(^\text{16}\)
- Symptoms of PTSD usually develop immediately after the traumatic event but for less than 15% of people affected, the onset of symptoms will be delayed.\(^\text{49}\)
- PTSD sufferers may not seek treatment for months or years after the onset of symptoms.
Less than a quarter of people who have distressing psychotic experiences at some time in their lives remain permanently affected by them.\textsuperscript{51}

Severe mental illness

Psychosis

‘Psychosis’ describes a loss of touch with reality, which may include hearing voices, seeing something that no one else sees, holding unusual personally derived beliefs, experiencing changes in perception or assigning personal meanings to everyday objects. Psychosis is associated with schizophrenia, schizoaffective disorder, puerperal psychosis, severe depression and is often experienced during the ‘highs’ of bipolar disorder. Other illnesses such as dementia can also feature psychotic symptoms.

- About 1 in every 200 adults experiences a ‘probable psychotic disorder’ in the course of a year.\textsuperscript{50}
- Less than a quarter of people who have distressing psychotic experiences at some time in their lives remain permanently affected by them.\textsuperscript{51}
- The average age of onset of psychotic symptoms is 22.\textsuperscript{52}
- 4.4% of people in the general population say they have experienced at least one symptom of psychosis such as delusions or hallucinations. Risk factors include smoking, living in the country, little social support, adverse life events, neurosis and excessive drug or alcohol use. Paranoid thoughts are the most commonly reported symptom.\textsuperscript{53}

Bipolar disorder

Bipolar disorder, also known as manic depression, is associated with severe mood changes that fluctuate from elation, overactivity and sometimes psychosis (together known as mania or hypomania) to a lowering of mood and decreased energy and activity (depression). It is diagnosed after at least two episodes in which a person’s mood and activity levels are significantly disturbed, including on some occasions mania or hypomania and, on others, depression. A person usually recovers completely between episodes.

During a phase of ‘mania’, people may exhibit grandiose ideas (an inflated belief in their own power, knowledge or relationship to important people or deities), an inflated sense of self esteem, a reduced need for sleep and impaired concentration and judgment.

Hypomania is a milder mania, in which abnormalities of mood and behaviour are persistent and marked, but are not accompanied by hallucinations or delusions and do not result in severe disruption to work or social rejection.

- Between 0.9% and 2.1% of the adult population experience a bipolar disorder at some point in their lives.\textsuperscript{54} There is very little gender difference.
Approximately 25% of people with schizophrenia make a full recovery and experience no further episodes. Between 10 and 15% will experience severe long-term difficulties.60

Symptoms of bipolar disorder usually begin between the ages of 15 and 24.55 The age of onset of mania is earlier in men than in women, although women have a higher incidence throughout the rest of adult life.56 However the first episode may occur at any age from childhood to old age.

Schizophrenia

The diagnosis of schizophrenia refers to a group of symptoms, typically the presence of hallucinations, delusions, disordered thought, and problems with feelings, behaviour, motivation and speech. When they occur together they represent a severe mental illness.

• Schizophrenia is the most common form of psychotic disorder, affecting between 1.1% and 2.4% of people at any one time.57
• The most frequent age of onset for schizophrenia is between 20 and 30 years.58 On average, men have an earlier age of onset than women by about 5 years.59
• After a first episode, approximately 25% of people with schizophrenia make a full recovery and experience no further episodes. Between 10 and 15% will experience severe long-term difficulties and the remainder will experience recurrent acute episodes with periods of remission or with only residual symptoms in between.60

Schizoaffective disorder

The diagnosis of schizoaffective disorder is given to someone who experiences both symptoms of a mood disorder (ie. depression) and symptoms of the type experienced with schizophrenia at the same time, or within days of each other.

• Symptoms usually begin in early adult life, with men tending to show symptoms earlier than women.
• About 1 in every 200 people is thought to develop the disorder at some point, and it tends to affect more women than men.61

Puerperal psychosis

Puerperal psychosis is rare, following between about 1 and 2 in 1000 births.62 The onset is abrupt, usually within days of the birth. The mother often starts to behave strangely, seeming puzzled and perplexed, sleeping poorly and being restless and erratic in the day. She may have paranoid delusions that often centre around the child, for example a belief that the child is the devil, or that the world is too evil for the child to live in.
Other types of mental illness

Eating disorders
Symptoms of eating disorders include severely reduced eating, intense fear of weight gain, and self perception that is overly influenced by weight or body shape. They also include significant levels of self-induced vomiting, laxative abuse and strenuous exercise for weight control.

- 1.9% of women and 0.2% of men experience anorexia in any year. Anorexia is characterised by a failure to gain weight in relation to age, or excessive loss of weight, through avoiding food. In some cases death can occur because of the physical consequences of persistent starvation. Usually, the condition lasts for about 6 years.

- Between 0.5% and 1% of young women experience bulimia at any one time. The most common age of onset is in teenage years and early 30s. Bulimia also involves a preoccupation with food but is characterised by episodes of intense binge eating, preceded and followed by periods of starvation and/or self-induced vomiting and purging.

- About 40% of people referred to eating disorder clinics are classified ‘Eating Disorder Not Otherwise Specified’, with symptoms that don’t fit neatly into either the anorexia or bulimia classifications.

Attention Deficit Hyperactivity Disorder
Attention Deficit Hyperactivity Disorder (ADHD) is often used to describe children who display overactive (hyperactive) and impulsive behaviour and who have difficulty in paying attention.

- A lack of consensus on the definition of, and criteria for, ADHD has produced widely divergent estimates of prevalence rate, varying between 0.5% and 26% of children. This has been attributed in part to major differences in the way children from different cultures are rated for ADHD.

Personality disorder
This is a controversial diagnosis. Many people believe it is used in cases where symptoms do not obviously fit any other diagnosis. Personality disorder is used to diagnose a person who has difficulty coping with life and whose behaviour persistently causes distress to themselves or others. Personality disorders are characterised by long-lasting rigid patterns of thought and behaviour. The attitudes of people with a disorder usually exaggerate part of their personality and result in behaviour at odds with expectations of what is regarded as normal.
• Between 4 and 5% of people living in Britain meet the criteria for a personality disorder.69

• Obsessive compulsive personality disorder is estimated to be the most common, affecting about 2% of the population (see page 14). Less than 1% fall into each of the other categories, with the highest being 0.8% in avoidant or schizoid personality disorder, followed by paranoid or borderline personality disorder and antisocial personality disorder.70

• Fewer people with a personality disorder make contact with psychiatric services than those with other conditions such as schizophrenia or depression. The probability of people with a personality disorder withdrawing from treatment is higher.71

Alcohol and other substance misuse

Definitions of alcohol and substance misuse vary. However, dependence is usually defined by preoccupation with use of the substance, inability to control use, and failure to cut back despite life-damaging consequences.

• In 2000, a quarter (26%) of adults in Britain, including 38% of men and 15% of women, were assessed as being ‘hazardous drinkers’. Hazardous drinking refers to a pattern of drinking alcohol that brings the risk of physical or psychosocial harm. Prevalence of hazardous drinking decreased with age. For women prevalence was highest in the 16-19 year old group (32%), whereas for men it was highest in the 20-24 age group (62%).72

• Worldwide, 1.7% of adults are thought to have an alcohol-use disorder.73

• 3.7% of adults in Britain are considered to be drug-dependent.74 The number of people who are drug dependent appears to have doubled between 1993 and 2000.75

• 30% of people who are dependent on alcohol and 45% of people dependent on drugs also have another psychiatric disorder.76

• In 2004/05, there were around 35,600 NHS hospital admissions with a primary diagnosis of mental and behavioural disorders due to alcohol. Around two thirds (68%) of those were men.77

• ‘Binge drinking’ is best defined as drinking twice the recommended daily limit of alcohol units. An NHS survey found that, using this measure, 23% of men reported drinking more than 8 units on at least one day in a week. The proportion ranged from 33% of men aged 16-24 to 6% of those aged 65 and over.78
The extent of mental health problems

**Dual diagnosis**

There is considerable overlap between substance misuse problems and other mental health problems. Such overlap affects many people with mental health problems. However, dual diagnosis, when an individual experiences a mental illness and a substance use problem simultaneously, affects far fewer people.

- Between a third and half of people with severe mental health problems consume alcohol or other substances to levels that meet criteria for ‘problematic use’. [79]
- 51% of alcohol-dependent adults say they have a mental health problem. [80]
- 44% of people using services of Community Mental Health Teams in four urban centres reported problematic drug or alcohol use in the preceding year. [81]

**Dementia**

Dementia is a progressive and largely irreversible condition that involves widespread damage to mental functioning. Someone with dementia may experience memory loss, language impairment, disorientation, change in personality, difficulties with daily living, self neglect, and behaviour which is out of character (for example, aggression, sleep disturbance or sexual disinhibition).

- Dementia affects 5% of people over the age of 65 and 20% of those over 80. About 700,000 people in the UK have dementia (1.2% of the population) at any one time. [82]
- Dementia is uncommon before the age of 65, but does affect 1 in 1,000 younger people. [83]
- About 60% of dementia cases are caused by Alzheimer’s disease.
- About a fifth of cases of dementia are related to strokes or insufficient blood flow to the brain, these cases being known as vascular dementia. [84]
- In fronto-temporal dementia, which includes Pick’s disease, damage is usually focused in the front part of the brain. Personality and behaviour are initially more affected than memory.
- People with multiple sclerosis, motor neurone disease, Parkinson’s disease, Huntington’s disease and Down’s syndrome are at increased risk of developing a type of dementia linked to their condition.

Percentage of people affected by dementia by age group [82]


27. Safety First: Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, (2001)


29. Safety First: Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, (2001)


31. Safety First: Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, (2001)


51. Recent advances in understanding mental illness and psychotic experiences, The British Psychological Society Division of Clinical Psychology, (June 2000)


81. Living With Severe Mental Health And Substance Abuse Problems London: Rethink p11, (2004)


2. Differences in the extent of mental health problems
Gender differences

- Women are more likely to have been treated for a mental health problem than men (29% compared with 17%).

- More than half of contacts with the Samaritans are made by men – 53% compared with 43% by women. 4% were unidentifiable.

- Depression is more common in women than men. 1 in 4 women will require treatment for depression at some time, compared with 1 in 10 men. The reasons for this are unclear, but are thought to be due to both social and biological factors.

- Doctors are more likely to treat depression in women than in men, even when they present with identical symptoms.

- Women are twice as likely to experience anxiety as men. Of people with phobias or OCD, about 60% are female.

- Men are more likely than women to have an alcohol or drug problem. 67% of British people who consume alcohol at ‘hazardous’ levels, and 80% of those dependent on alcohol are male. Almost three quarters of people dependent on cannabis and 69% of those dependent on other illegal drugs are male.

- The prevalence of schizophrenia is about the same in men and women, but the average age of onset is 18 in men and 25 in women.

- All personality disorder categories are more prevalent in men, apart from the schizotypal category. Men are five times more likely than women to be diagnosed with anti-social personality disorder.

- About 75% of people to die by suicide are men. This proportion has been about the same for more than a decade.
DIFFERENCES IN THE EXTENT OF MENTAL HEALTH PROBLEMS

Depression in ethnic minority groups has been found to be up to 60% higher than in the white population.\(^95\)

Black and minority ethnic groups

In general, rates of mental health problems are thought to be higher in minority ethnic groups in the UK than in the white population,\(^93\) but they are less likely to have their mental health problems detected by a GP.\(^94\)

- Depression in ethnic minority groups has been found to be up to 60% higher than in the white population.\(^95\)
- Young Asian women are three times as likely to kill themselves as young white women.\(^96\)
- A higher prevalence of diagnosed mental illness, particularly schizophrenia, has been found among Black Caribbean people in the UK.\(^97\) They are twice as likely as white people to be diagnosed as having a psychotic disorder.\(^98\)
- Mental health staff, including psychiatrists, are more likely to perceive black patients as being potentially dangerous, even though there is no evidence that they are any more aggressive than other patient populations.\(^99\)
- Black African and Caribbean people are three times as likely to be admitted to hospital and up to 44% more likely to be detained under the Mental Health Act as white people.\(^100\)
- Black people are more likely than white people to be given physical treatments, such as medication and ECT, and are likely to be prescribed higher doses of medication. They are less likely to be offered psychotherapy, counselling and other non-medical interventions.\(^101\)
- Compared with White British patients, both African–Caribbean and Black African patients are less likely to be referred to mental health services by a GP, and are more commonly referred by a criminal justice agency.\(^102\)

Children and young people

- Estimates vary, but research suggests that 20% of children have a mental health problem in any given year, and about 10% at any one time.\(^103\)
- The British Medical Association estimates that at any point in time up to 45,000 young people under the age of 16 are experiencing a severe mental health disorder, and approximately 1.1 million children under the age of 18 would benefit from specialist mental health services.\(^104\)
Rates of mental health problems among children

- Rates of mental health problems among children increase as they reach adolescence. Disorders affect 10.4% of boys aged 5-10, rising to 12.8% of boys aged 11-15, and 5.9% of girls aged 5-10, rising to 9.65% of girls aged 11-15.\textsuperscript{105}
- In one study, 50-60% of adults with a diagnosed mental disorder had received a mental health diagnosis of some kind before the age of 15.\textsuperscript{106}
- Among teenagers, rates of depression and anxiety have increased by 70% in the past 25 years.\textsuperscript{107}
- Children of single-parent families are twice as likely to have a mental health problem as children of two-parent families (16%, compared with 8%). Also at higher risk are children in large families, children of poor and poorly-educated parents and those living in social sector housing.\textsuperscript{106}
- 41% of British 11-15 year-olds who smoke regularly have a mental disorder, as well as 24% of those who drink alcohol at least once a week, and 49% of those who use cannabis at least once a month.\textsuperscript{109}

Older people

- Older people are less likely to have a neurotic disorder (or common mental health problem), other than depression, than other sections of the British population. 10.2% of those aged 65-69 and 9.4% of those aged 70-74 have a neurotic disorder, compared with 16.4% of the general population.\textsuperscript{110}
- Depression affects 1 in 5 people over the age of 65 living in the community and 2 in 5 living in care homes.\textsuperscript{111} However, it is likely that only a small proportion of older people with depression are in contact with their GP or mental health services.\textsuperscript{112}
- An estimated 70% of new cases of depression in older people are related to poor physical health.\textsuperscript{113,114}
The prison population
Prisoners have particularly high levels of mental illness. Until 2003, prison health care was the responsibility of the Home Office, but it now comes under the auspices of the NHS.

- Prisoners with mental disorders are significantly over-represented in the prison population. As many as 12-15% of all prisoners have four concurrent mental disorders. 30% of all prisoners have a history of self-harm, and the incidence of mental health disorder is higher for women, older people and those from ethnic minority groups.

- Up to 90% of prisoners have a diagnosable mental illness, substance abuse problem or, frequently, both.

- 72% of male and 70% of female sentenced prisoners have at least one mental disorder and 1 in 5 prisoners has four major mental health disorders.

- Male prisoners are 14 times more likely to have two or more disorders than men in general, and female prisoners 35 times more likely than women in general.

- In one UK study, 5.2% of prisoners had displayed symptoms of psychosis in the past year compared with 0.45% of the general population. Psychosis was attributed to toxic or withdrawal effects of drugs and alcohol in a quarter of the prison cases.

- The suicide rate for men in prison is five times that for men in the community. Boys aged 15-17 are 18 times more likely to kill themselves in prison than in the community.

- National research found that 72% of people who died by suicide in prison had a history of mental disorder. 57% had symptoms suggestive of mental disorder at the time they entered prison.

- A fifth of perpetrators of homicide with schizophrenia were sent to prison rather than hospital. Over 90% of perpetrators with personality disorder had no symptoms of mental illness at the time of the offence and received a prison sentence.
• Women make up just 6% of the prison population. In 2003 they accounted for 46% of all reported self-harm incidents with 30% of women reported to have harmed themselves, on average five times each, compared with 6% of men, who on average harmed themselves twice.\textsuperscript{124}

• Behavioural and mental health problems are particularly prevalent amongst children in prison. Of prisoners aged 16-20, around 85% show signs of a personality disorder and 10% exhibit signs of psychotic illness.\textsuperscript{125}

• More than half of all elderly prisoners suffer from a mental disorder, most commonly depression, which often emerges as a result of imprisonment.\textsuperscript{126}

• Homeless people
  
  • In 2005/06 there were 7,340 homeless people experiencing mental illness, more than double the number 15 years earlier.\textsuperscript{127}

  • The percentage of homeless people judged to be homeless and vulnerable due to mental illness or disability rose from 3.25% in 1991 to 7.8% in 2006.\textsuperscript{128}

  • 1 in 4 homeless people will die by suicide.\textsuperscript{129}

  • Less than a third of homeless people with mental health problems receive treatment.\textsuperscript{130}

  • 30-50% of homeless rough sleepers experience mental health problems. About 70% misuse drugs.\textsuperscript{131}

  • Behavioural problems have been found to be higher among homeless children living in temporary accommodation, and mental health problems are significantly higher among homeless mothers and children.\textsuperscript{132}
Other groups

• People who provide substantial amounts of care to relatives are twice as likely to have a mental health problem as the general population.\textsuperscript{133}

• A survey of carers in England found that female carers are 23\% more likely to suffer from anxiety or depression than women in the general population. (Most carers are women.) People who spend 20 or more hours a week caring are twice as likely to suffer from anxiety or depression as those spending less time providing care.\textsuperscript{134}

• Two thirds of refugees have experienced anxiety and depression,\textsuperscript{135} which may often be linked to war, imprisonment, torture or oppression in their home countries, and/or social isolation, language difficulties and discrimination in their new country.

• 30\% of deaf people using British Sign Language have mental health problems, primarily anxiety and depression.\textsuperscript{136}

• 25-40\% of people with learning disabilities are estimated to have a mental health problem.\textsuperscript{137}
References


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128. Answer to Parliamentary Question by Yvette Cooper, (Minister of State (Housing and Planning)), Department for Communities and Local Government), 17th July 2006 London: Hansard available at www.publications.parliament.uk, (accessed October 2006)


3. Factors related to mental health problems
Factors related to mental health problems

Mental health and material deprivation

- Having a low income, being unemployed, living in poor housing, low levels of education and membership of social classes IV (partly skilled people) and V (individuals with no skills) are all associated with a greater risk of experiencing a mental health problem.¹³⁸

- The poorest fifth of adults are at double the risk of experiencing a mental health problem as those on average incomes.¹³⁹

- In a study of British adults taking the GHQ questionnaire (which measures psychological well-being), the prevalence of high scores (indicative of a psychiatric problem) increased as household income decreased.¹⁴⁰

- Financial problems can be both a cause and a consequence of mental health problems. People with mental health problems are three times as likely to be in debt as the general population and more than twice as likely to have problems managing money.¹⁴¹

- Children in poor households are three times as likely to have mental health problems as children in well-off households.¹⁴²

- People without a degree are almost twice as likely to experience depression as those with a degree.¹⁴³
Family-related and social factors

- Social isolation is a factor in mental health problems. 20% of people with common mental health problems live alone, compared with 16% of the overall population.\textsuperscript{144}

- A person with a severe mental health problem is four times more likely than average to have no close friends.\textsuperscript{145}

- 1 in 4 people using mental health services has no contact with their family, and 1 in 3 has no contact with friends.\textsuperscript{146}

- Low levels of social support can reduce the likelihood of recovery – in one study 54% of women and 51% of men with mental health problems and good social support recovered over an 18 month period, compared with 35% of women and 36% of men with a severe lack of social support.\textsuperscript{147}

- People with a common mental health problem are twice as likely to be separated or divorced as their mentally healthy counterparts (14%, compared with 7%).\textsuperscript{148} and are more than twice as likely to be single parents as those without a mental health problem (9%, compared with 4%).\textsuperscript{149}

- Between a third and two thirds of children whose parents have mental health problems will develop problems either in childhood or adult life.\textsuperscript{150} Children of depressed parents have a 50% risk of developing depression themselves before the age of 20.\textsuperscript{151}

- Almost half of children in care have a mental health problem. Children in care are 4 to 5 times as likely to have a mental health problem as other children.\textsuperscript{152}

- Taking part in social activities, sport and exercise is associated with higher levels of life satisfaction. For example, 76% of those who play sport or exercise at least once a week are satisfied, compared with 70% of those who never or rarely play sport or exercise.\textsuperscript{153}

- Other social and economic risk factors for mental health problems include: poor transport, neighbourhood disorganisation and racial discrimination. Social and economic protective factors for mental health include: community empowerment and integration, provision of social services, tolerance, and strong community networks.\textsuperscript{154}
FACTORS RELATED TO MENTAL HEALTH PROBLEMS

Physical health
People with poor physical health are at higher risk of experiencing common mental health problems, and people with mental health problems are more likely to have poor physical health.

- A person with schizophrenia will, on average, live for 10 years less than someone without a mental health problem.\(^ {155} \)

- Depression affects 27% of people with diabetes, 29% of people with hypertension, 31% of people who have had a stroke, 33% of cancer patients and 44% of people with HIV/AIDS.\(^ {156} \)

- People who experience persistent pain are four times as likely to have an anxiety or depressive disorder as the general population.\(^ {157} \)

- 61% of people with schizophrenia presenting at GP surgeries and 46% of those with manic depression smoke, compared with 33% of the remaining population.\(^ {158} \) In one study smoking cessation had been offered to more of those with severe mental illness than to other patients who smoke, and more had been prescribed smoking cessation medication.\(^ {159} \)

Spirituality
Spirituality means different things for different people at different times. Although for centuries spirituality has been expressed through religion, art, nature and the built environment, recent expressions of spirituality have become more varied. Underlying this is an assumption that trying to make sense of the world around us and our place within it is an intrinsic part of what it means to be human.

- Research literature has consistently reported that aspects of religious and spiritual involvement are associated with desirable mental health outcomes.\(^ {160,161} \)

The Royal College of Psychiatrists notes that people who use mental health services identify the benefits of good quality spiritual care as being: improved self-control, self esteem and confidence; speedier and easier recovery; and improved relationships.\(^ {162} \)

- In a study of people with severe mental health problems across a range of diagnoses, 60% reported that religion/spirituality had ‘a great deal’ of helpful impact on their illness through the feelings it fostered of being cared for and of not being alone.\(^ {163} \)
• Studies have found that religious people, those who believe in a transcendent being or higher power, and people who belong to a community with others who share their values and offer support are more likely to recover from depression.\(^{164}\)

**Other factors**

• Overall, people with common mental health problems are more likely to live in an urban area than in the country. However, among rural areas, the most deprived and remote areas have the highest overall levels of mental health problems and suicide.\(^{165}\)

• Workplace stress can frequently contribute to mental health problems. About two thirds of people with mental health problems believe that long hours, unrealistic workloads or bad management at work caused or exacerbated their condition.\(^{166}\)

• Mental health is adversely affected by war, conflict, extreme poverty, displacement and natural disasters. Worldwide, it is estimated that between a third and a half of those affected by such events suffer from diagnosable mental distress, especially post-traumatic stress disorder, depression and anxiety.\(^{167}\)

• Having a sense of control over one's life is linked to good mental health. In one survey, of those who said they had 'complete control' in their lives, only 14% said they had ever been told by a doctor that they had a mental health problem, compared with 56% of those who said they had 'little control'.\(^{168}\)

• Women who have been abused in childhood are four times more likely to develop major depression in adulthood.\(^{169}\)

• People who experienced childhood sexual abuse are almost three and a half times as likely to be treated for psychiatric disorders in adulthood as the general population. They are five times as likely to have a diagnosis of personality disorder.\(^{170}\)


4. Treatment and care
How many people seek help and use services?

- Over an 18 month period, 23% of people in Britain said they received some treatment or service, not necessarily provided by the NHS, for a mental health problem.\(^\text{177}\)
- It is estimated that only about a quarter of people in Britain with a mental health problem receive ongoing treatment, either because they have not gone to the doctor at all, have been misdiagnosed by a GP, or have refused treatment.\(^\text{172}\) In a 12 month period, 3% of all people with mental illness (whether treated or not) saw a psychiatrist and 2% a psychologist.\(^\text{173}\)
- 85% of people with a psychotic disorder receive treatment.\(^\text{174}\)
- Only 2 in every 5 people experiencing anxiety or a substance misuse problem seek help in the year of the onset of the disorder.\(^\text{175}\)
- Almost 40% of drug users with a psychiatric disorder receive no treatment for their mental health problem.\(^\text{176}\)
- Around three quarters of 5-15 year-olds with mental health problems are not in contact with child and adolescent mental health services.\(^\text{177}\)
What treatment and care is available for mental health problems?

Primary care

- Approximately 30% of all GP consultations are related to a mental health problem.\(^{178}\)
- About 90% of people with mental health problems receive all their treatment from primary care services (as opposed to specialist mental health services), as do at least a quarter of those with severe problems.\(^{179}\) On average, a person with severe mental health problems has 13 to 14 consultations per year with their GP.\(^{180}\)

Community care

Community mental health teams now provide most local specialist mental health services.

- Mental health nursing care is provided for 540,000 people living in the community, and there are 2.1 million attendances a year at NHS day care facilities as well as 2 million consultant outpatient attendances.\(^{181}\)
- During 2005/06, crisis and home treatment teams provided 84,000 episodes of home treatment for people who would otherwise have been admitted to hospital.\(^{182}\) This was an increase from 69,000 in 2004/05, although the number of crisis resolution teams reduced to 266 in 2006 from 343 in 2005.\(^{183}\)

- At the end of March 2006, around 19,000 people were receiving care from assertive outreach teams in the community, usually because these people were reluctant to engage with other mental health services. This represents an increase of 7% on the previous year.\(^{184}\)

- 8,000 people received early intervention in psychosis treatment in 2005/06 (up from 4,600 in 2004/05) from 128 early intervention teams (compared with 109 in 2004/05).\(^{185}\)
Hospital provision

- The number of NHS beds for mental health problems in England was 31,667 in 2004/05. In 1999/2000 there were 34,173 beds. In 1983, there were 82,000 beds.

- The NHS spent about £575 million on acute psychiatric in-patient hospital care in 2005/06 about 68% of its budget for clinical mental health services.

- In 2003/04, the average cost of a hospital bed was £225 a day for an acute bed and £440 for intensive care. Costs of secure hospital care were £351 a day in low-secure units and £400 a day in medium-secure units. The weekly cost of local authority residential and nursing care for adults with mental health problems was £496 per person in England in 2004/05.

- While the number of NHS adult mental health admissions fell by about 10% over four years to 122,260 in 2002/03, the average length of stay per admission was stable at roughly 18-19 days.

- Child and adolescent psychiatric units are unevenly distributed across England and Wales, with a concentration in London and the South East. More than a quarter of child and adolescent beds are now provided by the independent sector. In 2002, 124 NHS Trusts were identified as providers of specialised child and adolescent mental health services – between them they had 732 teams and 7,340 staff.
The Mental Health Act (1983)

- There were 46,700 detentions under the Mental Health Act (1983) in 2004/05. On 26,752 occasions the Mental Health Act was used to admit a person to hospital (an increase from 25,642 in 1994/95). On almost 20,000 occasions in 2004/05 the Mental Health Act was used to detain a person already admitted voluntarily to hospital in order to prevent them leaving, down very slightly from a decade earlier.

- A mental health census in 2005 found that 46% of men and 29% of women in mental health units were detained under the Mental Health Act.

- In 2005, 53% of compulsory admissions under the Mental Health Act to NHS hospitals were male, but at a given point in time there were almost twice as many men as women detained. The Office of National Statistics speculates that this could be due to a longer average period of detention for men or to more men being detained to prevent them leaving hospital following a voluntary admission, but notes these data are not collected.

- The highest rate of detentions in 2005 was in London (134 people per 100,000) followed by the North West (93 per 100,000). The East of England had the lowest rate (69 per 100,000).

- Research suggests that use of crisis plans, also known as advance statements or advance directives, drawn up jointly between professionals and patients can reduce the number of compulsory admissions under the Mental Health Act by more than 50%.

- The 2005 mental health ethnicity census found that people from ethnic minorities are more likely to be detained under the Mental Health Act. Inpatients from the Black Caribbean, Black African, and Other Black groups were more likely (by between 33% and 44%) to be detained when compared with the average for all inpatients. The rate of detention for inpatients from the Other White group was also slightly higher than average.
Users’ experience of staff

- Most service users are positive about the way they are treated by mental health staff. In one study three quarters rated their care as good, very good or excellent, compared with 9% who said it was poor or very poor.198
- 15% of people using mental health services say they do not have enough say in decisions about their treatment, while 44% say they only have a say to some extent. 18% say their diagnosis has not been discussed with them.199

Informal care

- In the UK adults with mental health problems receive about 21 million hours a week of informal (unpaid) care from family and friends.200
- Up to 420,000 people in the UK care for someone with a mental health problem,201 including between 6,000 and 17,000 children and young people.202 Including carers of people with dementia, estimates rise to around 1.5 million. 31% of these are involved in caring for more than 50 hours a week.203
- A 2003 survey found that 75% of people who care for a person with a mental health problem are women, and the average age of carers was 62 years. The average age of recipients of care was 39 years, and 68% were male. 44% cared for a person with schizophrenia and 9% for a person with bipolar disorder.204
- 29% of the 175,000 young carers in the UK are looking after people with mental health problems. 82% of young carers provide emotional support to the person they care for.205
- 27% of carers said they had been turned away when trying to access help for the person they care for.206 56% cited an access related issue as the most frustrating aspect of dealing with mental health services.207 A quarter of carers felt they do not have sufficient information available.208
Treatment and coping

- People with mental health problems report a variety of treatments and coping mechanisms as helpful, but one survey found that more than half weren’t given any choice of treatment.\textsuperscript{210}

- According to an online survey by the Mental Health Foundation, of those visiting their GP with depression, 60% were prescribed anti-depressants, 42% were offered counselling and 2% were offered exercise therapy. The same survey found that 82% of people would be prepared to try counselling, 76% would be prepared to try exercise, 60% would be prepared to try alternative therapies, and 52% would be prepared to try anti-depressants.\textsuperscript{210}

- Two surveys\textsuperscript{211,212} of people with mental health problems found that useful techniques and coping strategies include:
  - Support from family and friends
  - Medication
  - Counselling or psychotherapy
  - Something worthwhile to do during the day
  - Peer support
  - Alternative therapies
  - Volunteering and working
  - Hobbies
  - Physical exercise
  - Advice from their GP
  - Spirituality and religion
About half of people with mental health problems pay privately for treatments that are not prescribed, spending on average £61 a month. The most commonly paid for treatments are complementary therapies (63%), followed by counselling or psychotherapy (31%) and exercise (30%). 58% of people with mental health problems feel they miss out on treatment that would be helpful, the majority because they cannot afford it. The treatments most often cited as missed out on are counselling, psychotherapy and complementary therapies.

Medication

A combination of therapies has been shown to be most effective in treating some common mental health problems. Guidance from the National Institute for Health and Clinical Excellence (NICE) states that a variety of psychological therapies, in addition to or instead of medication, can be helpful for managing anxiety and depression, and in some cases bipolar disorder and schizophrenia.

In 2004, GPs wrote a total of 63.9 million drug prescriptions for mental health problems in England, representing 9.3% of the total prescriptions by volume.

Another survey found that 87% of people prescribed medication said they had not received enough information about the drugs they were given, and 86% said they were not warned of possible side effects.

Approximately 2 million people of working age in Britain are currently taking psychiatric drugs, most prescribed by their GPs.
Anti-depressants

- In 2005, doctors wrote 29.4 million prescriptions for anti-depressants, 4 million more than in 2004. The number of prescriptions written for anti-depressants has tripled since the early 1990s, after a newer class of drug called selective serotonin reuptake inhibitors (SSRIs) such as Prozac became available in the late 1980s.
- NICE guidelines state that anti-depressants are not recommended for the initial treatment of mild depression because the risks may outweigh the benefits. Instead it recommends self-guided cognitive therapy or short courses of cognitive therapy with a therapist.
- Although 57% of GPs say that anti-depressants are over-prescribed, 55% use them as their first treatment response to mild or moderate depression. Only 35% believe they are the most effective intervention for mild or moderate depression, with 55% believing counselling and psychotherapy is the most effective intervention. More than three quarters (78%) have prescribed an anti-depressant in the last three years despite believing that an alternative treatment might have been more appropriate, most commonly because the alternative was not available or there was a long waiting list for it.
- Female GPs and those with more years of GP experience are less likely to prescribe anti-depressants.
- Unpleasant symptoms associated with anti-depressants often result in patients not continuing with medication. In one study, only 33% of patients completed an adequate period of treatment.

Anti-psychotics

Anti-psychotics are used to treat symptoms of acute psychosis and to prevent further episodes. Anti-psychotics are generally divided into two classes: the older ‘typical’ agents (neuroleptics) and the newer ‘atypical’ agents, mostly developed since the early 1990s. Atypicals usually have less distressing side effects, and the National Institute for Health and Clinical Excellence recommends they be prescribed for all new cases of schizophrenia.

- 5.7 million prescriptions for anti-psychotic medications were written in 2005 at a cost of £210.9 million. A further 163,600 long-acting anti-psychotic injections were prescribed, costing £5.2 million.
Side effects of typical anti-psychotics may include shuffling and involuntary muscle twitches, jerks and spasms.

The side effects of atypical medication can include sedation, diarrhoea, constipation, muscle spasms, weight gain and heart problems, and these frequently lead to people discontinuing treatment.

An audit study of prescription of anti-psychotic medication found that 20% of patients were prescribed a total dose of anti-psychotic medication above that recommended by the British National Formulary, a biannual manual that provides healthcare providers with information on choosing and prescribing medication.

Sleeping and anxiety medication

Minor tranquillisers and hypnotics, primarily benzodiazepines, are used to treat anxiety and sleep problems. They are usually prescribed on a short-term basis due to their addictive nature. These include benzodiazepines such as diazepam and hypnotics (sleeping pills).

16 million prescriptions for hypnotics and anxiolytics (drugs for anxiety) were written in 2005, costing £38 million.

Mood stabilisers

Mood stabilising medications are used to treat bipolar disorder. They are usually taken long-term, even when a person is not experiencing an episode of mania/hypomania or depression.

- The oldest mood stabiliser is lithium.
- Anti-convulsant drugs developed to treat epilepsy are often used as mood stabilisers. These include sodium valproate, carbamazapine, and lamotrigine.
- Some anti-psychotic medications appear to be effective as mood stabilisers.
- In 2005, 786,300 prescriptions for lithium were written at a cost of £1.6 million.
- The Department of Health does not quantify the overall number of mood stabilisers prescribed, because most individual drugs are also used for other conditions.
Talking Therapies

Talking therapies or psychological therapies are based on the idea that talking to a trained therapist can help people better understand their thoughts and feelings and how they relate to their behaviour, mood and psychological wellbeing. Talking therapies can help people find ways to change their lives by acting and thinking in a more constructive or positive manner.

- Clinical trials show that cognitive behavioural therapy, a form of psychotherapy, is as effective as medication in treating anxiety and depression. The relapse rate is also lower once the treatment has ended.

- When asked, people with mental health problems are most likely to cite access to psychological therapies, such as psychotherapy and counselling, as their highest treatment priority, and the lack of it their biggest complaint.

- The vast majority of those with experience of talking treatments rate them as helpful or helpful at times (88%), compared with 67% of those who had used anti-depressants and 30% of those who had received ECT.

- The National Institute for Health and Clinical Excellence’s guidelines on treatment of depression state that ‘cognitive-behavioural therapy should be offered, as it is of equal effectiveness to anti-depressants’.

- A majority (55%) of GPs believe that counselling and psychotherapy are the most effective strategies for treating depression. However, only 32% refer to them as their first treatment response. This is often because they are not available, despite the government recommending that talking treatments ought to be made available for the treatment of most mental health problems.

- Waiting times for psychological therapies are on average six to nine months, and can be as long as two years. There is no target for reducing waiting times for psychological treatments.

- Early psychological treatment can significantly reduce hospital admissions, GP visits and drug prescriptions.

- Adding family therapy to medication for those with schizophrenia can reduce relapse rates by a half over both one year and two years.
The National Institute for Health and Clinical Excellence recommends that electroconvulsive therapy (ECT) should only be used for the treatment of severe depressive illness or a prolonged or severe episode of mania or catatonia, to gain fast and short-term improvement of severe symptoms after all other treatment options have failed, or when the situation is thought to be life threatening.247

- Around 11,000 people a year receive ECT in England.248
- A 2002 Department of Health survey found that use of ECT had fallen since 1999.249 More than twice as many women as men were given ECT, and that nearly half of people given ECT were aged over 65.250
- Nearly three quarters of people who were given ECT were informal patients (not detained under the Mental Health Act). Of those patients that were detained, 60% did not consent to treatment.251
- A systemic review of patients’ experience of ECT found that at least one third of patients reported persistent memory loss.252

Psychosurgery

- Neurosurgery for mental illness is occasionally carried out in the UK. The Mental Health Act Commission panel authorised seven operations in England and Wales in 1999/2000, and two in 2000/01.253 This compares to 23 operations carried out in England, Scotland and Wales in 1993.254
- Of 74 patients receiving psychosurgery, 12 were experiencing manic depression, 41 depression, 18 obsessions, and 3 anxiety. Of 42 patients on whom data was available, doctors reported significant improvement in 12, some improvement in 22, no change in 6 and deterioration in 2.255
TREATMENT AND CARE

Alternative and complementary therapies

The term ‘alternative therapy’ is used for therapies that offer alternatives to orthodox Western medicine. The term ‘complementary therapy’ is generally used to indicate therapies that differ from orthodox Western medicine, and which may be used to complement, support, or sometimes, to replace it.

• A survey found that of those who had tried alternative treatments, more than a third had to take the initiative and ask for it, and many had to pay for it themselves.

• Herbal medicines, for example St. John’s Wort (hypericum), have been linked to the relief of mild to moderate depression.

• The National Institute for Health and Clinical Excellence recommends that patients of all ages with mild depression should be advised of the benefits of following a structured and supervised exercise programme, typically up to 3 sessions per week of 45 minutes to an hour for between 10 and 12 weeks.

• Only 5% of GPs prescribe exercise therapy as one of their top three treatment responses to mild or moderate depression.

• A Mental Health Foundation survey found that a greater proportion of people who had tried exercise as a treatment for depression found it very or quite effective (81%) than found anti-depressants very or quite effective (70%).

Exercise

• Exercise has been shown to improve both physical and mental health for people with a range of mental health problems, including psychotic disorders, depression and anxiety. It can also help people with alcohol misuse problems and schizophrenia.

• Studies have shown that exercise can be as successful at treating mild or moderate depression as psychotherapy or as medication.

• The National Institute for Health and Clinical Excellence recommends that patients of all ages with mild depression should be advised of the benefits of following a structured and supervised exercise programme, typically up to 3 sessions per week of 45 minutes to an hour for between 10 and 12 weeks.

• Only 5% of GPs prescribe exercise therapy as one of their top three treatment responses to mild or moderate depression.

• A Mental Health Foundation survey found that a greater proportion of people who had tried exercise as a treatment for depression found it very or quite effective (81%) than found anti-depressants very or quite effective (70%).
• Transcendental meditation, hypnotherapy, yoga, exercise, relaxation, massage and aromatherapy have all been shown to have some effect in reducing stress, tension and anxiety and in alleviating mental distress.  

• Massage has been shown to reduce levels of anxiety, stress and depression in some people.  

• Aromatherapy has been successfully used to reduce disturbed behaviour, to promote sleep and to stimulate motivational behaviour of people with dementia.  

• Artistic pursuits can help people with mental health problems feel better about themselves, fostering creativity, self esteem and social networks. One survey found that half of people with mental health problems felt better after becoming involved in the arts.  

• Bright light treatment and dawn simulation is effective in treating Seasonal Affective Disorder, and there are indications that it may be as effective as anti-depressants for treating non-seasonal depression.  

• Bibliotherapy based on cognitive behavioural therapy principles has shown results comparable to medication or psychotherapy for people with depression. In bibliotherapy, a therapist ‘prescribes’ a self-help book for a patient to either read between sessions or as a stand-alone therapy. Some studies show that recovery is faster, and that patients who have used bibliotherapy have a lower relapse rate.  

• Animal-assisted therapy involves the use of trained animals to help patients’ recovery. Also known as pet therapy, it has been shown to reduce short-term anxiety levels of psychiatric inpatients with a range of disorders. The calming influence of dogs has also been useful in psychotherapy, because of the ability to alert the therapist early to clients’ distress and the facilitation of communication and interaction.  

Nutrition

There is growing evidence that diet plays an important role in specific mental health problems including Attention Deficit Hyperactivity Disorder (ADHD), depression, schizophrenia and Alzheimer's disease. A balanced mood and feelings of well-being can be protected by a diet that provides adequate amounts of complex carbohydrates, essential fats, amino acids, vitamins and minerals and water.  

• Research into nutritional and dietary medicine has demonstrated that food sensitivities may cause psychiatric symptoms, whilst a lack of folic acid has been
Unequal intakes of Omega-3 and Omega-6 fats are implicated in a number of mental health problems.273

Food and depression
- A number of studies have linked the intake of certain nutrients with the reported prevalence of different types of depression. For example, correlations between low intakes of fish by country and high levels of depression among its citizens – and the reverse – have been shown for many types of depression.276
- Complex carbohydrates as well as certain food components such as folic acid, omega-3 fatty acids, selenium and tryptophan may help to decrease the symptoms of depression. Those with low intakes of folate, or folic acid, have been found to be significantly more likely to be diagnosed with depression than those with higher intakes.
- Similar conclusions have been drawn from studies looking at the association of depression with low levels of zinc and vitamins B1, B2 and C. In other studies standard treatments have been supplemented with these micronutrients resulting in greater relief of symptoms in people with depression and bi-polar affective disorder, in some cases by as much as 50%.277

Other interventions
- Studies show that there are benefits to involving families in the treatment of people with schizophrenia, depression, alcohol problems and childhood behaviour disorders. Helping to change the nature of family interaction in the home is associated with a reduced risk of relapse.278
- School-based interventions and parent training programmes for parents of children with behavioural problems can improve these children’s conduct and mental well-being.279 Long-term, universal school mental health programmes, involving changes to the school culture, can also be effective, probably more than brief class-based programmes.280
- Home-based social support for pregnant women at high risk of depression improves the mental health of both mothers and children.281

TREATMENT AND CARE
<table>
<thead>
<tr>
<th>Reference</th>
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<tbody>
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5. The costs of mental health problems
Hidden cost

- The ‘hidden’ costs of mental illness have a significant impact on public finances: it has been estimated that the costs of depression through lost working days are 23 times higher than the costs to the health service.\(^{282}\)
- 1 in 4 unemployed people has a common mental health problem.\(^{283}\)
- Childhood mental health problems can have a significant economic effect on society. It is estimated that a child with a conduct disorder will, by the age of 28, have generated costs (such as to the health, education, benefits and criminal justice systems) ten times as high as a child without conduct problems.\(^{284}\)
The economic and social cost of mental health problems is greater than that of crime.\textsuperscript{286}

**Overall cost**

- In 2002/03, the economic and social cost of mental health problems in England was £77 billion.\textsuperscript{285} Updating these figures and incorporating estimates for Scotland, Wales and Northern Ireland, it is calculated that in the UK, the economic and social costs of mental health problems in 2003/04 was £98 billion (£17 billion on health and social care, £28.3 billion in costs to the economy and £53.1 billion in human costs).

- The economic and social cost of mental health problems is therefore greater than that of crime (estimated at £60 billion for England and Wales in 1999/2000),\textsuperscript{286} and larger than the total amount spent on all NHS and social services (£95.2 billion in the UK in 2003/04).\textsuperscript{287}

- The World Health Organisation estimates that the cost of mental health problems in developed countries is between 3 and 4% of Gross National Product.\textsuperscript{288} In the UK this is estimated to be 2% of GDP,\textsuperscript{289} comprising the costs of public spending on health and social care and loss of paid work.
Health and social care costs

- £4.9 billion was spent on mental health services for adults of working age by the NHS and local authorities combined in England in 2005/06. This was the equivalent of £150 per head. After taking account of estimated pay and price inflation, investment in these mental health services increased 3% in 2005/06 compared to 9% in 2004/05.

- The biggest increases in spending for 2005/06 reflect the Department of Health priorities for mental healthcare, and reinforce the trend over the past four years. These are:
  - Assertive outreach – more than £100 million in 2005/06 (less than £50 million in 2001/02)
  - Crisis resolution/home treatment – more than £155 million in 2005/06 (£26 million in 2001/02)
  - Early intervention in psychosis – £42 million in 2005/06 (less than £4 million in 2001/02)

- Mental health priorities have changed over the past five years. While there has been a 25% overall real growth in total investment over the period, actual increases in specific service areas vary widely.

- In 2002/03, spending on mental health accounted for 11.8% of all public expenditure on health and social services in England. Using a comparable ratio for the UK, this implies total public spending on mental health care in 2003/04 of £11.2 billion, equivalent to £190 per head of the population. 82% was spent by the NHS and 18% by local authorities.
The cost of mental health problems

Staff costs
- The cost of a consultant psychiatrist is estimated at £71 per hour, or £216 per hour of direct patient contact. The cost of a community mental health nurse is £26 per hour, or £71 per hour of direct patient contact. Each attendance at NHS day care facilities costs £29. An average GP consultation costs £24.

Private care
- One study estimated that in England in 1996/97 private spending on counselling and related services was £108 million. Spending by mental health charities and voluntary organisations that was financed from private sources amounted to £12 million. This total of £120 million corresponded to 2.1% of public spending on mental health care in the year concerned.

Informal care costs
- If the 21 million hours a week of informal (unpaid) care from family and friends of people with mental health problems was provided as paid work by nursing or care staff, it would cost £4.9 billion a year. This is equivalent to nearly half the cost of all mental health services provided by the NHS and local authorities.

Voluntary sector
- It is estimated that, in total, around 10% of all public spending on mental health services is now in the voluntary sector.
- Residential care and supported housing accounts for about two thirds of this total, but the voluntary sector also supplies a wide range of other services. These include: day care; home and community support services; employment, education and training; services for carers; and information, advice and advocacy.
- The largest purchasers of mental health services from the voluntary sector are social services departments, accounting for almost two thirds of all contracts.
- Independent and voluntary sector agencies also play a major role in the Supporting People programme, introduced in 2003 by the Office of the Deputy Prime Minister to support vulnerable people in their own homes. In 2003/04, around 40,000 people with mental health problems in England received assistance through this programme at a cost of £250 million and, of this total, over 80% was spent on support services provided by private and voluntary organisations.
Drug and talking therapy costs

- The cost of drug prescriptions for mental health problems in England has risen rapidly over recent years, from £159 million in 1992/93,\(^{303}\) to £540 million in 2002,\(^{304}\) and £854 million in 2004. Relative to the drugs bill as a whole, prescriptions for mental health problems represented 10% by cost. Anti-depressants accounted for 47% of total spending on drugs for mental health problems and anti-psychotics for 26%, with other formulations accounting for the remaining 27%.\(^{305}\)

- In 1992, the cost of anti-depressant prescriptions dispensed in the community in England was £18.1 million. By 2003, this had risen to £395.2 million. This rise is linked to the introduction of SSRI (selective serotonin reuptake inhibitor) anti-depressants, such as Prozac, in the 1990s. These drugs were both more expensive and more widely prescribed than other classes of anti-depressants.\(^{306}\) The cost of prescribing SSRIs has fallen in recent years as branded drugs have become available as generic compounds.

- NICE recommends short talking therapies such as cognitive behavioural therapy as an alternative or adjunct to anti-depressants. The cost of this is about £750 for 16 sessions of CBT.\(^{307}\)

- In 2002 in England, expenditure on anti-psychotics was £165.3 million.\(^{308}\) In 2005, it was £223.6 million.\(^{309}\) This increase reflects the impact of guidance from the National Institute for Health and Clinical Excellence on the new atypical anti-psychotic drugs for schizophrenia, which are much more costly than the drugs they replace. However, evidence from cost-effectiveness studies shows that these higher costs are more than offset by reductions in hospital inpatient stays, with savings estimated to average £1,000 per patient year.\(^{310}\)
Economic and social factors

Mental health and employment

- People with a common mental health problem aged between 16 and 74 years are more likely to be economically inactive (39%, compared with 28% of those with no mental health problem), and less likely to be employed (58%, compared with 69%).

- Less than a quarter of people with a long-term mental health problem are employed, the lowest rate for any group of disabled people. However, this group of people form a relatively small proportion of all the people who experience a mental health problem. (About three quarters of the overall working age population are in employment.)

- Unemployment is even more prevalent among people receiving secondary mental health care. About one in ten people in psychiatric care has a job, and, typically, they earn two thirds of the average national hourly rate.

- 35% of adults with long-term mental health conditions say they want to work (compared with 28% of those with other health problems).

- People with mental health problems are at more than twice the risk of losing their jobs compared with the general population.

- Of those people with mental health problems who have lost their jobs, 55% make unsuccessful attempts to return to work, and of those that do return, 68% have less responsibility, work fewer hours and are paid less than before.

- Fewer than 4 in 10 employers would consider hiring a person with a mental health problem, compared with more than 6 in 10 who would hire a person with a physical disability.

- Most employers who have employed people with mental health problems in a supported work placement would do so again, but few other employers would.

- 7 in 10 managers have had experience of managing a staff member with a diagnosed mental health problem (50%) or a suspected mental health problem (20%). Less than a quarter felt they knew enough about managing someone with a mental health problem to handle it and deal with it ‘OK’.

- A survey of people with mental health problems found that 67% had disclosed their condition to close colleagues, 61% had told their manager and 1 in 10 had told everyone. About 1 in 10 of those who had disclosed said colleagues made snide remarks, and 1 in 10 reported that colleagues had avoided them.
The cost of mental health problems at work

- Stress, anxiety and depression accounted for a third of the 168 million working days lost in the UK for health and related reasons in 2004, translating to a cost of sickness absence of about £4.1 billion.\(^{323}\)

- Each case of stress-related ill health leads to an average of 30.9 working days lost.\(^{324}\) In a typical year, about 30 times as many working days are lost through mental ill health as from industrial disputes.\(^{325}\)

- Over 900,000 people in England are in receipt of sickness and disability benefits for mental health problems, more than the total number of unemployed people claiming Jobseekers’ Allowance.\(^{326}\) The number of people claiming Incapacity Benefit because of mental health problems has almost doubled since 1995,\(^{327}\) and makes up more than 40% of the total number of claimants.\(^{328}\) However, almost half the people in contact with community mental health teams do not receive the full amount of welfare benefits to which they are entitled.\(^{329}\)

### Investment in Mental Health Services in England for working age adults by category\(^{322}\)

<table>
<thead>
<tr>
<th>Service categories</th>
<th>2001/02 (£m)</th>
<th>2002/03 (£m)</th>
<th>2003/04 (£m)</th>
<th>2004/05 (£m)</th>
<th>2005/06 (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Mental Health Teams</td>
<td>483</td>
<td>526</td>
<td>530</td>
<td>570</td>
<td>549</td>
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<tr>
<td>Access and crisis services</td>
<td>170</td>
<td>203</td>
<td>254</td>
<td>316</td>
<td>369</td>
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<tr>
<td>Clinical services</td>
<td>764</td>
<td>754</td>
<td>811</td>
<td>878</td>
<td>838</td>
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<tr>
<td>Secure and high dependency</td>
<td>330</td>
<td>376</td>
<td>474</td>
<td>621</td>
<td>661</td>
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<tr>
<td>Continuing care</td>
<td>349</td>
<td>372</td>
<td>380</td>
<td>404</td>
<td>384</td>
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<tr>
<td>Mentally disordered offenders</td>
<td>35</td>
<td>33</td>
<td>53</td>
<td>43</td>
<td>58</td>
</tr>
<tr>
<td>Other community and hospital professionals</td>
<td>52</td>
<td>50</td>
<td>47</td>
<td>67</td>
<td>86</td>
</tr>
<tr>
<td>Psychological therapies</td>
<td>125</td>
<td>142</td>
<td>143</td>
<td>149</td>
<td>142</td>
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<tr>
<td>Home support services</td>
<td>59</td>
<td>63</td>
<td>70</td>
<td>108</td>
<td>91</td>
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<tr>
<td>Day services</td>
<td>178</td>
<td>163</td>
<td>172</td>
<td>156</td>
<td>151</td>
</tr>
<tr>
<td>Support services</td>
<td>37</td>
<td>47</td>
<td>43</td>
<td>43</td>
<td>43</td>
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<tr>
<td>Carer’s services</td>
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<td>11</td>
<td>15</td>
<td>18</td>
<td>19</td>
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<tr>
<td>Accommodation</td>
<td>301</td>
<td>315</td>
<td>369</td>
<td>366</td>
<td>362</td>
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<td>Mental health promotion</td>
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<td>3</td>
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<td>3</td>
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<tr>
<td>Direct payments</td>
<td>6</td>
<td>3</td>
<td>6</td>
<td>3</td>
<td>2</td>
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<tr>
<td>Personality disorder services</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>10</td>
</tr>
</tbody>
</table>
The human costs of mental health problems are estimated to be nearly five times as large as the costs of all mental health services provided by the NHS and local authorities, amounting to around £53 billion in the UK in 2003/04. This includes the adverse effects of mental health problems on health-related quality of life and – as a major risk factor for suicide – on length of life.

About half of people with common mental health problems are limited by their condition, and around a fifth are disabled by it. In total, more than 40% of the World Health Organisation’s ‘years lived with disability’ are caused by mental health problems or alcohol abuse.

Mental health problems and personal and social factors among adults in England, Scotland and Wales

<table>
<thead>
<tr>
<th></th>
<th>Psychotic disorder %</th>
<th>Any psychiatric disorder %</th>
<th>No disorder %</th>
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</thead>
<tbody>
<tr>
<td>Living alone</td>
<td>43</td>
<td>21</td>
<td>15</td>
</tr>
<tr>
<td>In rented accommodation</td>
<td>62</td>
<td>38</td>
<td>24</td>
</tr>
<tr>
<td>With accommodation problems</td>
<td>49</td>
<td>48</td>
<td>33</td>
</tr>
<tr>
<td>No educational qualifications</td>
<td>40</td>
<td>28</td>
<td>27</td>
</tr>
<tr>
<td>Social class IV (partly skilled people) or V (individuals with no skills)</td>
<td>40</td>
<td>25</td>
<td>21</td>
</tr>
<tr>
<td>Economically inactive</td>
<td>70</td>
<td>32</td>
<td>29</td>
</tr>
<tr>
<td>Household income less than £200 a week</td>
<td>25</td>
<td>17</td>
<td>13</td>
</tr>
<tr>
<td>Receiving Income Support</td>
<td>30</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>With debt problems</td>
<td>33</td>
<td>24</td>
<td>9</td>
</tr>
<tr>
<td>Any difficulty with activities of daily living</td>
<td>60</td>
<td>37</td>
<td>16</td>
</tr>
<tr>
<td>Experience of violence within the home</td>
<td>37</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>Experience of sexual abuse</td>
<td>31</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Severe lack of perceived social support</td>
<td>30</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Social isolation (two or fewer friends seen in last week)</td>
<td>55</td>
<td>30</td>
<td>22</td>
</tr>
</tbody>
</table>

Human costs

- Mental health problems are associated with a wide range of adverse personal and social problems. People with mental health problems are more likely than the rest of the population to live alone, have no educational qualifications, be economically inactive, and have a household income of less than £200 a week. They are almost three times as likely to have debt problems, more than twice as likely to be receiving income support, more than four times as likely to have experienced sexual abuse, and twice as likely to report a lack of social support. The differences are even more stark among those with a psychotic disorder (for example, they are almost three times as likely to be living alone, five times as likely to report a lack of social support and more than fifteen times as likely to have experienced sexual abuse).

- One in four tenants with mental health problems is in serious rent arrears and is at risk of losing their home.
Mental health promotion

Mental health promotion involves any action to enhance the mental well-being of individuals, families, organisations and communities, recognising that everyone has mental health needs, whether or not they have a diagnosis of mental illness. Mental health promotion programmes that target the whole community will also include and benefit people with mental health problems. The emotional and cognitive skills and attributes associated with positive mental well-being include feeling satisfied, optimistic, hopeful, confident, understood, relaxed, enthusiastic, interested in other people and in control.

Examples of factors that promote well-being include: eating well, keeping physically active, drinking in moderation, valuing yourself and others, talking about your feelings, keeping in touch with friends and loved ones, caring for others, getting involved and making a contribution, learning new skills, doing something creative, taking a break, and asking for help.

- Evidence shows that mental health promotion can contribute to the prevention of common mental health problems, for example anxiety, depression and substance abuse. It can also contribute to health improvement for people whether or not they are at risk of mental illness, as well as for people living with mental health problems.

- Interventions to reduce stress in the workplace, to tackle bullying in schools, to increase access to green, open spaces and to reduce fear of crime all contribute to health gain through improving mental well-being, in addition to any impact they may have on preventing mental disorders.

- Less than 1% of the £4.9 billion spent by the NHS and local authorities in 2005/06 on mental health for adults of working age was earmarked for mental health promotion.
People with severe mental illness are more likely to be the victims than the perpetrators of violence.\textsuperscript{344}

Violence and mental health

There is widespread public fear that people with mental disorder pose a significant risk of interpersonal violence, but research has shown that the degree of association between violence and mental disorder is small\textsuperscript{343} and is accounted for by a small minority of patients.\textsuperscript{344}

- People with severe mental illness are more likely to be the victims than the perpetrators of violence.\textsuperscript{344} In one study 16\% of people with psychosis living in the community had been violently victimised.\textsuperscript{346}

- A third of people who committed homicide had a lifetime history of mental disorder, but in most cases this was not a severe mental illness. Most had not attended psychiatric services, and only 10\% had symptoms of mental illness at the time of the offence. The most common diagnoses were personality disorder, and alcohol and drug dependence. 90\% of the perpetrators were male.\textsuperscript{343}

- 5\% of all perpetrators of homicide in England and Wales, and 2\% in Scotland, had a diagnosis of schizophrenia. 9\% of people convicted of homicide had a diagnosis of personality disorder.\textsuperscript{348}

- 7\% of people convicted of homicide in England and Wales, and 6\% in Scotland, were committed to a psychiatric hospital.\textsuperscript{349}

- Mentally ill perpetrators were less likely to kill a stranger than those without mental illness.\textsuperscript{350}


300. All figures on the independent sector relate to England only and are taken from Matrix Research And Consultancy with Compass Partnership (2002) Mental Health Services In The Voluntary Sector (unpublished)


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About the Mental Health Foundation

Founded in 1949, the Mental Health Foundation is the leading UK charity working in mental health and learning disabilities.

We are unique in the way we work. We bring together teams that undertake research, develop services, design training, influence policy and raise public awareness within one organisation. We are keen to tackle difficult issues and try different approaches, many of them led by service users themselves. We use our findings to promote survival, recovery and prevention. We do this by working with statutory and voluntary organisations, from GP practices to primary schools. We enable them to provide better help for people with mental health problems or learning disabilities, and promote mental well-being.

We also work to influence policy, including Government at the highest levels. We use our knowledge to raise awareness and to help tackle stigma attached to mental illness and learning disabilities. We reach millions of people every year through our media work, information booklets and online services. We can only continue our work with the support of many individuals, charitable trusts and companies.

To support our work, please visit www.mentalhealth.org.uk

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