Indications of Public Health in the English Regions

7: Mental Health
Authorship and Acknowledgements

This report has been produced jointly by the North East Public Health Observatory (NEPHO) and the National Mental Health Observatory (MHO) on behalf of the Association of Public Health Observatories (APHO) and in collaboration with the National Institute for Mental Health in England (NIMHE), the Healthcare Commission, the Mental Health Foundation and the Prescription Pricing Division of the NHS Business Services Authority.

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Reports in the Series

The reports in the ‘Indications of Public Health in the English Regions’ series address areas covered by the White Paper Choosing Health¹. Previous reports addressed the following topics: general health; lifestyles, ethnicity, child health, sexual health, and can be found at http://www.apho.org.uk/apho/indications.htm. Topics to be addressed in future reports include: older people, alcohol, and substance misuse.

About the APHO and National Mental Health Observatory

Please turn to the inside back cover of this report.
FOREWORD

This report on mental health in the series on Indications of Public Health in the English Regions will provide a useful reference document for the wide range of agencies and individuals involved in public mental health and wellbeing.

It brings together for the first time a variety of sources of data, reminding readers that within our National Service Framework, there is far more to modern mental health services than GP appointments and hospital admissions. Our service users are increasingly benefiting from a spectrum of care, the majority of which is delivered in the community and as close to home as possible. The mental health workforce comprises new types of staff working in new ways to improve the experience of service users and carers.

At the same time, I am glad to see that the report goes beyond service delivery statistics to highlight influences further “upstream” which are known to impact positively or negatively on mental wellbeing, and factors such as employment and social inclusion which are vital to people in recovery.

When I speak at meetings and conferences, I find that there is huge interest in regional comparative data, and with the Government’s recent emphasis on developing regionalisation, I am sure that this new resource will be widely welcomed.

Professor Louis Appleby
National Director for Mental Health

I am delighted to present this seventh report on Indications of Public Health in the English Regions which focuses on adult mental health. As well as the principal authors, a great number of people and organisations have contributed to its successful completion. We have listed these in the report but inevitably will have missed some important contributors, for which we apologise in advance.

The report shows many important differences which we expect will be used to lever change to improve the mental health status of the population of England.

We hope readers will offer constructive comments on the report and let us know if we have missed any important indicators in this report.

Professor John Wilkinson
Director, North East Public Health Observatory

May 2007
EXECUTIVE SUMMARY

This report is the seventh in the series ‘Indications of Public Health in the English Regions’ commissioned by the Chief Medical Officer. It has been produced by the Association of Public Health Observatories, led by the North East Public Health Observatory.

Mental health is identified as one of the six national priorities for action in the White Paper Choosing Health.

In the past, indicators of mental health have been hard to find. Targets for mental health improvement have largely concentrated on suicide rates, which although important, give a limited picture of the mental health of a community.

This report presents a wide range of data on the factors which can give rise to poor mental health, the mental health status of populations, provision of interventions of care for mental illness, service user experience and traditional outcomes such as suicide.

We have had the advantage of access to the Durham Mental Health Service Mapping, which provided a systematic overview of mental health services in England until 2006. We have also been able to make use of the Mental Health Minimum data set (MHMDS) which was developed by one of the authors of this report (Gyles Glover).

The report is structured in a similar way to previous reports and looks at indicators of:

- Risk and protective factors and determinants;
- Population health status;
- Interventions;
- Effectiveness of partnerships;
- Service user experience; and
- Workforce capacity.

Many of the risk factors for mental illness are linked to deprivation, so a general pattern occurs with the three northern regions (North East, North West and Yorkshire and Humber), showing worse measures than the three southern regions (South East, South West and Eastern England) and the two midlands regions (West Midlands, East Midlands) in between. London has a very inconsistent pattern appearing at different places on different indicators.

The service based indicators do not often show this pattern, with the northern regions often doing better.

Our findings fall into three main categories:

- Where there appear to be important differences between the regions, e.g., alcohol consumption.
- Where regional differences appear to be unimportant or insignificant, e.g., expenditure on gambling.
- Issues where there is an absence of data or the data are too poor quality to interpret, e.g., ethnic coding.

There are areas where there is scope for tackling the determinants of poor mental health (e.g., drugs, alcohol, physical activity). The report also identifies important variations in the provision of mental health services between regions in relation to need.
Conclusions and key messages

There is a need to undertake more work at a sub-national level on mental health data. Work needs to be undertaken to develop suitable mental health indicators which can be used as part of the Local Area Agreement (LAA) process. Initially sub-regional analysis needs to be undertaken in order to gain better understanding of the local position.

There is an urgent need to develop new indicators of mental health to enable countries of Europe to be compared, also paying attention to the possibility of comparisons at a sub-national level. At the present time, mortality data provide one of the few ways of making any informed comparisons: suicide is commonly used, but we know that there are very different approaches in European countries which make comparisons difficult.

Within this report there are some important differences which we highlight between regions; however some of the usual patterns which are frequently seen when making health comparisons are very different in mental health.

Readers of this report will be struck by the range and nature of the indicators we have used: this reflects the complexity of the subject and also the wide range of determinants of good mental health.

We hope that Regional Directors of Public Health, Directors of Public Health in PCTs and CSIP (Care Services Improvement Partnership) Directors will find the report a valuable resource in making decisions and in holding to account those responsible for the delivery of mental health care services and improving the mental health of the population.
Indications of Public Health in the English Regions

7: Mental Health

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1 INTRODUCTION

The aim of the ‘Indications’ series of reports is to take a major health policy area and to present information on the relative positions of the English Regions. The focus of this report is Mental Health in adults. Mental health of older people will be dealt with in a report on older people (Indications 8), and we aim to produce a further report on the mental health of children and young people at a later date.

Mental health is one of the most important health topics and is identified as one of the key national priorities for action in the public health White Paper Choosing Health\(^1\). One in six people in the country suffers from a mental health disorder equating to around eight million people being affected in England today.

Pointers

There are over 70 indicators in this report so we offer some starting points for some readers although the index will help to find topics of particular interest for others.

For commissioners

2.2 Mental health needs
3.2 Psychiatric morbidity
3.3 Usage of services
5.1 Expenditure
5.2 Multidisciplinary community teams

For local specialist providers

3.3 Usage of services
5.1 Expenditure
4.2 Assertive outreach
4.4 Early intervention for psychosis
7.1 Staffing

For GPs

3.5 Severe mental illness on a GP register
4.3 Crisis resolution
4.6 Admissions for depression
4.8 GP prescribing
5.2 Multidisciplinary community teams

For users and carers

3.3 Usage of services
4.1 Mental health promotion
4.11 Mental Health Act
6.1 Complaints
6.2 Annual survey of patients
Policy context

The National Service Framework (NSF) for Mental Health\(^2\) together with the National Suicide Prevention Strategy\(^2\) provide the key policy context within which this report considers the mental health of adults of working age. Many of the data for this report are drawn from information sources such as the annual service mapping and financial mapping which were commissioned by the Department of Health so that progress with NSF implementation could be monitored in detail.

In 2004, the National Clinical Director reviewed progress\(^4\). He said:

"We are entering a new phase in which the emphasis will move on from specialist mental health care, crucial though that will remain, to the mental health and wellbeing of the community as a whole."

Choosing Health\(^1\) identified mental health as one of the six overarching public health priorities, and this has recently been reinforced in the Health Challenge England- next steps for Choosing Health.\(^5\)

The government’s consultation preceding the publication of Our Health, Our Care, Our Say\(^6\) found that there was huge public demand for more support for emotional wellbeing. Making It Possible\(^7\) identified positive steps that everyone can take to improve their health and wellbeing, and Our Health, Our Care, Our Say\(^6\) made a commitment to make these more widely known by including mental health in the National Social Marketing Strategy.

That is why we have included in this report indicators relating to healthy lifestyle and some of the key determinants of mental wellbeing, as well as service and workforce information.

At the same time, the Social Exclusion Unit report on Mental Health and Social Exclusion\(^8\) and the more recent Reaching Out: An Action Plan on Social Exclusion\(^9\) have focused attention on programmes to assist people on incapacity benefit as a result of mental health problems who wish to return to work. A joint Department of Work and Pensions/Department of Health programme on Health, Work and Wellbeing\(^10\) is another important policy driver.

As the Department of Health’s regionalisation agenda gathers pace, it will become even more important for regions to be able to access information which enables them to compare themselves with others and with the national picture.

Aims and scope

The report aims to inform the implementation of national and regional priorities. The main audiences include national policy makers, Regional Directors of Public Health, Strategic Health Authority (SHA) and Primary Care Trust (PCT) Chief Executives and Boards, and leads in other health and social care organisations.
**Structure of the report**

There are six sections broadly in line with previous Regional Indications reports:

- Risk and protective factors and determinants;
- Population health status;
- Interventions;
- Effectiveness of partnerships;
- Service user experience; and
- Workforce capacity.

**Choice of indicators**

The choice of indicators has in part been guided by key issues, recommendations and targets identified in a range of policies including the National Service Framework\(^2\) and Choosing Health\(^1\). This provided an opportunity to bring together a number of indicators that have been collated by different projects over the past few years (such as Mental Health Outcomes, Better Metrics\(^{11}\), and the Local Basket of Inequalities Indicators) and to develop indicators utilising new data sources that have recently become available (such as the Mental Health Minimum Data Set and new data from Primary Care) or have been underutilised in this area (such as from the Health Survey for England and employment information).

**Age**

This will be the first report in a sub-series of three reports on mental health; it will concentrate on working age adult mental health (18 – 65 years). The second will concentrate on the mental health of older people (over 65 years) and will closely relate to the eighth report in the series which is to focus on the health of older people. We also intend to produce a third report on the mental health of young people (under 18 years) linked to the fifth report on child health.

Although this report concentrates on “adults of working age” in line with the National Service Framework, for some indicators all adults are included, or the age range is different depending on the data source.

**Geography**

Figure 1 shows the nine Government Office regions in England. Where possible, the data are analysed for these areas.

There are 10 Strategic Health Authorities (SHAs) matching these areas, except in the South East region which has two SHAs. Many agencies work to the Government Office boundaries although some, such as the National Institute for Mental Health in England (NIMHE), recognise eight; combining the North East with Yorkshire and the Humber.

Although mental health trusts do not have fixed catchment areas they can be reasonably easily aggregated to regions. Similarly, the organisational structure for implementing the National Service Framework (NSF) is the Local Implementation Team (LIT). These do not map exactly to Local Authorities (LAs) or Primary Care Trusts (PCTs) but can be effectively aggregated into regions.
Local Area Agreements

This report compares English regions and does not have data for smaller geographic areas such as local authorities. There is great interest in measuring mental health at this level which has been given further impetus by the development of Local Area Agreements (LAA)*. Currently, Health Profiles† have only one mental health indicator for local authorities. In the appendices we have indicated which data are available at local authority level for all councils with social service responsibilities ("top tier authorities"). The availability of data does not mean that they are necessarily suitable for Local Area Agreements as LAAs are relatively short-term (three year) agreements which require indicators that could plausibly change as a result of intervention.

Figure 1: Government Office regions of England

*A Local Area Agreement (LAA) is a three year agreement, based on local Sustainable Community Strategies, that sets out the priorities for a local area. The agreement is made between Central Government, represented by the Government Office (GO), and a local area, represented by the lead local authority and other key partners through Local Strategic Partnerships (LSPs).

[link]

† Local Authority Health Profiles are designed to show the health of people in local authorities across England. These cover all but two of the 388 local authorities, including county councils, district councils, unitary councils and London boroughs. City of London and Isles of Scilly are not covered due to data limitations. These are the first local authority Health Profiles covering the whole of England. They have been produced by Public Health Observatories and will be updated every year.

[link]
Ethnicity

Ethnicity is an important issue in mental health. The recent service user census\textsuperscript{12} found considerable variation in the number of people in hospital from different ethnic groups. There may be variations in underlying morbidity, diagnosis, and management which need further investigation.

There are also good data on ethnic mental health from the EMPIRIC study\textsuperscript{13}. However, for this report which compares English regions we have not broken data down further by ethnicity.

While there is some interest in whether a particular ethnic group has different experiences in different parts of England, the fourth ‘Indications’ report\textsuperscript{14} showed that the data are not robust enough to make these comparisons. Ethnic variations will continue to be best analysed at national level at the moment. We do include a comparison of ethnic coding quality within the Mental Health Minimum Data Set - as this was not possible when the fourth ‘Indications’ report\textsuperscript{14} was published - and an indicator on black and minority ethnic community development workers.

Drugs and Alcohol

We will not cover drug and alcohol issues to any great extent as these will be covered in a later ‘Indications’ report. However, because of the importance of alcohol and drugs as mental health determinants, we have included a small number of indicators on these topics. More detailed alcohol indicators are available from the North West PHO, at: http://www.nwpho.net/alcohol/lape/regions.htm.

Format

Bar charts are used to display regional indicator values and most include 95% confidence intervals to identify whether regional values differ significantly from the national average. This approach is similar to that used in the sixth ‘Indications’ report on sexual health\textsuperscript{15}. The charts are displayed horizontally with regions ranked in standard order, North East to South West. They use one of two colour schemes as follows:

Traffic light colours

| better than average | consistent with average | worse than average |

are used when making a judgement about the performance of a region against the national average based on whether and how the regional value statistically significantly differs from the national average.

Alternative colours

| lower than average | consistent with average | higher than average |

are used when it is felt that a judgement about desirability can’t be made. These indicate whether the regional value is statistically significantly low, consistent, or statistically significantly high compared with the national average.
National target or recommended levels, where these have been clearly stated, are highlighted using a vertical red line.

Stacked bar charts and graphs in different colours are also used to illustrate comparisons.

Each sub-section of the report includes:

- The regional graph(s);
- A brief description of each indicator;
- The rationale for including the indicator(s) and background information - this includes reference to national targets, monitoring requirements and recommendations;
- A summary of the main findings and a regional commentary.

Appendix 1 provides an ‘at a glance’ summary of the regional indicator values, with the traffic light indicators presented first.
2 RISK AND PROTECTIVE FACTORS AND DETERMINANTS

2.1 Deprivation

Figure 2: Percentage of Super Output Areas (SOAs) in each region, by quintile of deprivation

Source: Office for National Statistics

Indicator description

The percentage of Super Output Areas in each region, by quintile of deprivation.

The Index of Multiple Deprivation 2004 (IMD 2004)\textsuperscript{16}, commissioned by the former Office of the Deputy Prime Minister (ODPM) and constructed by the Social Disadvantage Research Centre (SDRC) at the University of Oxford, is a measure of multiple deprivation for small geographical areas. IMD 2004 scores have been calculated for small geographical areas known as Super Output Areas (SOAs) covering the whole of England. These individual small area IMD 2004 scores have been grouped into quintiles representing the most through to the least deprived areas of England. The proportion of each region’s SOAs that belong to each of the five deprivation quintiles produces a useful summary measure of deprivation compared with other regions in England.

Rationale and background

In 2000, the Office for National Statistics (ONS) carried out a survey of psychiatric morbidity among adults\textsuperscript{17}. Those with a neurotic disorder were more likely to belong to socioeconomic class V and least likely to belong to socioeconomic class I. This distribution of prevalence was also observed when psychotic disorders were compared.

In 2004, ONS also carried out a survey to assess the mental health of children and young people in Great Britain\textsuperscript{18}. This survey also showed significantly higher prevalence of mental
health disorders among children of families from the lower socioeconomic groups compared with children from the most affluent families.

Given the evidence that adults and children from disadvantaged backgrounds are more likely to suffer mental health disorders, measures of deprivation can help to identify areas where the need for mental health services is likely to be greatest, thus ensuring that mental health service provision is targeted appropriately.

**Commentary**

There is considerable variation in the proportion of each region belonging to the most and least deprived fifths (quintiles) of all areas in England.

The North East and North West regions have the highest proportion of SOAs in the most deprived fifth of all areas in England (39% and 33% respectively) with the Yorkshire and the Humber, London, and, West Midlands regions following closely behind (29%, 27%, and, 26% respectively). These five regions also have the lowest proportion of areas belonging to the fifth most affluent of all areas in England (range 7% to 13%).

The South East, Eastern, and South West regions have the smallest proportion of the most deprived of all areas in England (5%, 6%, and, 8% respectively).
2.2 Mental Health Needs

Figure 3: Mental Health “Needs” Indices by Region

Source: As described below

Indicator description

i. MINI (The Mental Illness Needs Index)$^{19}$
Index calculated by predicting electoral ward level psychiatric admission prevalences from Census small area statistics, North East Thames region data, 1991.

ii. MINI2000 (The Mental Illness Needs Index)$^{20}$
Index calculated by predicting electoral ward level psychiatric admission rates from index of multiple deprivation component scores and ONS area classification, England data, 1998.

iii. National Psychiatric Morbidity Survey index$^{21}$
Index calculated by predicting postcode sector level prevalence of Revised Clinical Interview Schedule (CIS-R) scores of 12 or more from Census small area statistics, England and Wales data, psychiatric morbidity survey 1993/4 and Census 1991.

iv. AREA mental health services model$^{22}$
Hybrid index calculated from admission statistics and General Health Questionnaire (GHQ) scores, a range of predictor variables, England data 1998.

Rationale and background

The association between rates of mental illness and certain population characteristics, notably poverty, unemployment and social isolation is well established. For planning and evaluation of mental health care it is helpful to have quantitative estimates of the extent to which rates are likely to vary between parts of the country. A number of studies based on statistical modelling have set out to establish indices for the likely rates of mental health problems. Some are designed to predict psychiatric admission rates. These are likely to
reflect patterns of severe mental illnesses, for example schizophrenia and are thus appropriate to planning secondary mental health care. Others are designed to predict prevalence rates observed in population surveys of psychiatric morbidity. These are likely to reflect patterns of common mental health problems such as depression and anxiety and are more appropriate to planning mental health resources in primary care. The 'AREA' index\textsuperscript{22}, designed for health service resource allocation is a hybrid indicator containing elements of both.

Full details of the indicator calculations are set out in the documents as referenced\textsuperscript{19-22}. Available indicators relate only to working age adults. These indicators cannot indicate actual requirements, only relative need levels.

**Commentary**

Four indices were included to indicate two features. First, while the indices show broadly similar patterns, they differ in detail to quite a significant degree. Second, the spread of values in indices based on common mental health problems tends to be smaller than that for indices based on severe mental illness.

Generally London and the North of England are estimated as having higher rates of mental illness while the rest of southern England and the East Midlands have lower rates. The two indices based on more recent (1998) data, MINI 2000\textsuperscript{20} and AREA\textsuperscript{22}, assign lower scores to London.
2.3 Employment

Figure 4: Percentage of people of working age in employment, 2003

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>North East</td>
<td>75%</td>
</tr>
<tr>
<td>North West</td>
<td>76%</td>
</tr>
<tr>
<td>Yorkshire &amp; Humber</td>
<td>73%</td>
</tr>
<tr>
<td>East Midlands</td>
<td>74%</td>
</tr>
<tr>
<td>West Midlands</td>
<td>72%</td>
</tr>
<tr>
<td>East of England</td>
<td>74%</td>
</tr>
<tr>
<td>London</td>
<td>71%</td>
</tr>
<tr>
<td>South East</td>
<td>73%</td>
</tr>
<tr>
<td>South West</td>
<td>73%</td>
</tr>
<tr>
<td>England</td>
<td>74%</td>
</tr>
</tbody>
</table>

Source: NOMIS, Annual Population Survey 2003

Indicator description

The percentage of all working age people who are in employment (either employees, self-employed or on government employment/training programmes). Working age is defined as males aged between 16 and 64 and females aged between 16 and 59.

Rationale and background

Unemployment is associated with social exclusion, which has a number of adverse effects, including reduced psychological wellbeing, and a greater incidence of self harm, depression and anxiety. Two-thirds of men under 35 who commit suicide are unemployed.

There is considerable evidence to support the beneficial effects of employment on an individual’s mental health. Employment can protect a person’s mental health by boosting confidence and self-esteem; unemployment can be both a consequence and cause of mental health problems. People with mental health problems can be particularly sensitive to the negative effects of unemployment.

Commentary

Over three-quarters of people of working age are in employment in England;

The percentage of people in employment varied significantly across the regions. With the exception of London, the more northern regions have lower employment rates than the southern regions.
At regional level, there were nearly 10 percentage points between the lowest working age employment rate (69%), in London, and the highest working age employment rate (79%), in the South East. As well as London, the three northern regions, North East, North West and Yorkshire and the Humber all had employment rates significantly lower than the England average.
2.4 Employment of people with mental health problems

Figure 5: Percentage of adults of working age with a mental health problem in employment, 2003

Source: NOMIS, Annual Population Survey 2003

Indicator description

The percentage of adults of working age with a mental health problem lasting over 1 year who are in employment. Working age is defined as males aged between 16 and 64 and females aged between 16 and 59.

Rationale and background

An individual suffering from the onset of a mental health problem is more than twice as likely to leave employment when compared to other health conditions or impairments\(^23\).

Mental health has the lowest proportion of employment of any disability group at 24%. Over 900,000 people with mental health problems claim sickness and disability benefits, a larger figure than the total number of people claiming Job Seeker’s Allowance in Britain.

Employment is thought to play an important role in rehabilitation. People suffering from mental health problems who are not in employment are thought to be less likely to recover from their illness\(^24\).

People with mental health problems face a number of barriers to entering employment; a recent study found that fewer than 4 in 10 employers indicated that they would consider employing a person with mental health problems, compared with 6 in 10 who would consider employing a person with physical health problems. One third of people with mental health problems felt that they have been discriminated against or forced to leave employment\(^8\).
The National Social Inclusion Programme and the ‘Shift’ campaign to tackle stigma and discrimination against people with a mental illness are seeking to improve the employment prospects of this group (www.socialinclusion.org.uk and www.shift.org.uk).

**Commentary**

Less than a quarter (24%) of people with mental health problems lasting over a year, and only 8% of those with severe mental health problems, are in employment.

Overall, the pattern of people with mental health problems in employment across the regions broadly mirrors that of all people of working age in employment. However, the variation is larger.
2.5 Incapacity Benefits

Figure 6: Mental and behavioural disorders incapacity benefit claimant rate per 100,000 population aged 16 to 59 years, 2004/05

Indicator description

Rate per 100,000 population aged 16 to 59 years claiming incapacity benefit or severe disablement allowance with a diagnosis in the mental and behavioural disorders category (irrespective of whether they receive payments).

Rationale and background

Incapacity benefit is a social security benefit which can be claimed by working age adults unable to work because of illness. Payment of the benefit depends on an adequate history of national insurance contributions, but disabled people who are not eligible for payments on the grounds of national insurance contributions may still claim, thereby gaining national insurance credits. Three levels exist depending on the duration of incapacity. This system replaced the former severe disablement allowance. In all cases, statistics report the medical causes of inability to work by ICD-10 chapter. This indicator shows rates per hundred thousand working age population claiming incapacity benefit or severe disablement allowance, irrespective of whether their contribution history is sufficient for them to receive payments.

The report 'Mental Health and Social Exclusion'\(^6\), published in 2004 by the Office of the Deputy Prime Minister, drew attention to the large numbers of individuals claiming these benefits as a result of mental illness. At the time of publication the most recently available figures related to August 2002.
Commentary

The figures presented relate to August 2005. Numbers claiming Incapacity Benefits are substantially higher than average in the North East and North West regions and lower in the South East, Eastern and London regions. This pattern has remained broadly unchanged although numbers in all regions have risen. The rise has been most striking in London and the South East and Eastern regions, and least in the North East, North West and West Midlands.
2.6 Limiting Long Term Illness

Figure 7: Percentage of adults with a limiting long term illness

Source: Univariate Table UV22, Census 2001

Indicator description

The proportion of people living in a household who consider themselves to have a long term illness, health problem or disability that limits daily activities and work that the individual can undertake.

Rationale and background

Poor quality of life through physical illness is known to be closely related to mental health problems. People with mental health problems are up to twice as likely to report experiencing a long-term illness or disability\(^{25}\); over two-thirds of people with a persistent mental health problem also have a long term physical complaint\(^{24}\).

Limiting long term illnesses impact upon an individual’s ability to work and be economically active, which increases the risk to one’s mental health. The Census demonstrated that people who have never worked or are long term unemployed have the highest rates of limiting long term illness of all socio-economic groups, at 37%.

Serious physical illness is one of a number of stressful events that can be linked to a high prevalence of suicidal thoughts\(^{26}\).

Commentary

In England, 1 in 6 people consider themselves to have a limiting long term illness (17.9%). There is little difference between genders, whilst proportions increase steadily with age.

There is considerable regional variation in the proportion of the population with limiting long term illness.
Only 3 regions fall below the national average; the South East, London and East of England. The northern regions have the highest rates of limiting long term illness. In the North East, over a fifth of the population (22.7%) suffer from a limiting long term illness, compared to the lowest regions (London and the South East) at 15.5%.
2.7 Alcohol

Figure 8: Standardised percentage of alcohol consumption above 'sensible' daily limits, 2005

Source: General Household Survey, 2005

Indicator description

We have used the percentage of survey respondents who consumed more than recommended amounts [4 units (males) or 3 units (females)] on one day during the previous week as the indicator of alcohol consumption. Data are taken from the General Household Survey (GHS) 2005.

Rationale and background

Evidence suggests an association between increased alcohol consumption and mental ill health. Alcohol consumption can be a cause of mental ill health, or a resulting factor. Less than 1% of the general population were classified as being moderately or severely dependent on alcohol, this increased to 2% in people with neurotic disorders, 5% among those with phobias and 6% among those with two or more neurotic disorders. Alcohol dependence is often treated within mental health services.

Commentary

As with many indicators there appears to be a North-South divide with higher levels of consumption in the Northern regions.
2.8 Drugs

Figure 9: People in contact with structured drug treatment, crude rate per 100,000, 2005/06

Source: National Treatment Agency for Substance Misuse

Indicator description

The numbers of individuals in contact with structured drug treatment services recorded on the National Drug Treatment Monitoring System for the National Treatment Agency for Substance Misuse. These are recorded for Drug Action Team (DAT) of residence which are aggregated into regional figures with duplications removed.

Rationale and background

Addiction is seen as a mental health problem in its own right. Drug misuse is linked to mental health through a number of mechanisms. Numbers of people misusing drugs are difficult to get accurate figures for because of its illegality. Rates of people in treatment are increasing.

Services for drug treatment are very heterogeneous. There are statutory sector providers (such as NHS Mental Health Trusts and Primary Care Trusts) and voluntary sector providers (from small charities, to large organisations). The data quality is therefore variable, with a degree of both under and over counting.

The numbers in treatment relate to both the number of problem drug users in an area and the proportion who are in treatment. Current targets are to increase numbers in treatment on the assumption that significant numbers of people are still not on treatment.

Commentary

Highest rates are seen in the North and London. This may reflect higher prevalence of misuse, a greater proportion of misusers in treatment or better (or over) recording of data.
Estimated prevalences of problem drug users have been created but are not currently available nationally.
2.9 Physical activity

Figure 10: Percentage of adults (aged 16 and over) participating in 20 or more days of moderate intensity sport and active recreation (averaging 5 or more times per week) in the last four weeks, 2006

Source: Sport England, Active People Survey 2006

Indicator description

The percentage of adults aged 16 and over participating in 20 or more days of moderate intensity sport and active recreation (averaging 5 or more times per week) in the last four weeks (expressed as a percentage). The data are taken from Sport England’s Active People Survey.

Rationale and background

There is robust evidence for the impact of physical activity on mental health: as a treatment or therapy for existing mental health problems; to improve the quality of life of people with mental health problems; to prevent the onset of mental health problems; and to improve the mental wellbeing of the general population. This has been well summarised by the Mental Health Foundation27.

Commentary

Around 11.6% of adults across England are estimated to participate in moderate intensity sport or active recreation the recommended five or more times a week. One in four adults in England takes no moderate exercise at all.

The South East and South West regions have higher proportions than the England average of adults meeting the physical activity target of participating in moderate intensity sport or active recreation at least 5 times per week. The North West and West Midlands regions have lower proportions than the England average.
2.10 Healthy Eating

Figure 11: Percentage of adults who consume five or more portions of fruit and vegetables per day, 2001 to 2002

Source: Health Survey for England, 2001-2002

Indicator description

Proportion of adults aged 16 and over who consume five or more portions of fruit and vegetables per day. The numerator is an estimate based on the Health Survey for England data 2001 to 2002 and the denominator is based on the 2001 Census. This indicator was used in the APHO Health Profiles 2006.

Rationale and background

While it is too early to state definitively the links between diet and mental health or ill-health, there is sufficient evidence to suggest that nutrition may have an important part to play, and that the essential fatty acids (especially omega-3) may be particularly significant. Anti-oxidants and minerals in fruit and vegetables may also be relevant. The current position has recently been well summarised with full references by the Mental Health Foundation.

Some foods have been linked with specific mental health problems, for example:

1. **Depression**: international comparisons suggest an inverse correlation between the intake of essential fatty acids, as measured by the amount of fish or seafood consumed, and levels of major depression, post-natal depression, seasonal affective disorder and bipolar affective disorder. A study looking at people in the Arctic and sub-Arctic regions found that levels of depression rose at the same time as traditional diets high in essential fatty acids were being abandoned for more processed foods. Controlled trials of the effectiveness of essential fatty acids (omega-3 supplements) in treating various types of depression have shown promising results.
People with low intakes of folate or folic acid are significantly more likely to be diagnosed with depression than those with higher intakes. Foods containing tryptophan, which is a precursor of serotonin, the neurotransmitter associated with feelings of contentment, can enhance the antidepressant effect of selective serotonin reuptake inhibitors. Similar results have been found for supplementing standard treatment with zinc and vitamins B1, B2 and C.

2. **Dementia**: Many studies show a positive association between saturated fat intake and the incidence of dementia, and an inverse relationship with polyunsaturated fatty acid (PUFA) intake. A study of total fat intake of eleven countries found a positive correlation with Alzheimer’s Disease in the over 65s. Other studies suggest that high vegetable consumption may be protective against Alzheimer’s disease.

3. **Attention Deficit Hyperactivity Disorder**: Several trials have found that some essential fatty acids, especially omega-3 fatty acids, were significantly lower in hyperactive children compared with controls and omega-3 supplements have been shown to reduce symptoms of hyperactivity in children with dyspraxia. Similar results have been found with zinc and magnesium levels, and symptoms improved with appropriate dietary supplements.

4. **Schizophrenia**: severe famine in early pregnancy has been shown to result in a two-fold increase in schizophrenia in the children in two very different populations (Holland and China). It has been shown that there is a significant correlation between the amount of fat in the national diet and the rates of schizophrenia, with higher rates where the diet was high in saturated fats and lower rates where the diet was higher in fats from vegetables, fish and seafood. A number of studies have shown reductions in symptoms of schizophrenia with higher intakes of omega-3 fatty acids.

Antioxidant levels are lower in the brains of people with schizophrenia compared with controls, but intervention trials of antioxidants and vitamins have been inconclusive.

5. **Antisocial behaviour**: A randomised double-blind controlled trial of nutritional supplements in a young offender institution found a significant reduction in anti-social behaviour.

Ideally, we would wish to present information on essential fatty acids consumption by region, but the most detailed source of data on the nation’s eating habits, the National Diet and Nutrition Survey does not publish analyses by individual region. Therefore, the most relevant regional indicator available is the percentage of people consuming at least five portions of fruit and vegetables a day, which we present here as a proxy for the percentage of the population likely to heed public health messages about healthy eating.

**Commentary**

This indicator shows striking inequalities between the best and worst regions. The populations of London and the South East show rates of healthy eating significantly above the national average, whilst those of the North East and Yorkshire and the Humber show rates significantly below the national average.

Even in the best region, however, less than a third of the population met the target, suggesting that there is much potential for improving both physical and mental wellbeing by public health interventions related to diet and nutrition.
2.11 Social Capital

Social capital describes the pattern and intensity of networks among people and shared values which arise from these networks.

There are a number of definitions of social capital, but the main aspects that it includes are citizenship, neighbourliness, social networks and participation. The Office for National Statistics uses a definition from the Office for Economic Co-operation and Development (OECD) which is “networks together with shared norms, values and understandings that facilitate co-operation within and among groups”.

Social capital is important as research has shown that higher social capital is associated with better levels of health, better educational attainment, better chances of employment and lower crime rates.

In this section we will consider these different aspects of social capital. There are many potential indicators. We have used a small number of indicators which provide the opportunity to make comparisons at regional level.

We have looked at the data on the following:

- Participation in civic society;
- Religion;
- Social Support;
- Social Networks;
- Neighbourliness.

Whilst it is difficult to imagine interventions which will make an improvement to the social capital in any one area, the context of social capital is very important in the effective delivery of services.
2.11.1 Participation in civic society

Figure 12: Percentage of adults participating in any civic activity in the previous 12 months, 2000

Source: Health Survey for England, 2000

Indicator description

There are many indicators of participation. Here we illustrate one taken from the Health Survey for England, 2000\(^\text{33}\) which asked questions about involvement in civic society in the past 12 months.

Rationale and background

Participation and involvement in the community appears to have an important effect on mental health. Kaplan\(^\text{34}\) showed that the lack of participation in organisations was associated with increased mortality and explained this by suggesting that participation was a buffer against depression which is linked to an increase risk of mortality from CHD\(^\text{35}\).

Commentary

Fifty nine percent of people felt that they were well informed about local affairs and 56% that communities could influence decisions, but a much smaller number (26%) felt that they could personally influence decisions in their area. Only 18% felt civicly engaged.

There are marked differences between the regions in the country, with the Yorkshire and Humber and North East regions having the lowest participation rates and the South West having the highest. The differences are difficult to account for but may be affected by disadvantage or rurality.
2.11.2 Religion

Figure 13: Percentage of population reporting having a religion, 2001

Source: Univariate Table UV15, Census 2001

Indicator description

A number of possible indicators have been considered. Information is collected in the decennial census on religious affiliation, though it is difficult to distinguish between someone who is actively involved in religion from those who just describe a religious affiliation which is not unusual in England. Information on religious affiliation and denomination is also collected in the Household Survey, but has similar problems to the national census. The above indicator shows the proportion of the population reporting having a religion in the 2001 census.

Rationale and Background

There is some evidence which suggests that involvement in religion or ‘spirituality’ may be an important factor for mental wellbeing. Some studies have shown that religious involvement is associated with positive mental health outcomes and religious commitment with better outcomes. More specifically some studies have shown that involvement in religion can lower the incidence and prevalence of depression. More specifically there is a negative correlation between religiosity, spirituality, mental ill health and drug and alcohol abuse. Of course other factors with a direct influence on social capital such as social inclusion, strong social networks, a more positive lifestyle are intimately intertwined with most religious movements and therefore separating out ‘religiosity’ from other determinants of positive social capital is inordinately complex.

Commentary

Overall the population in the regions in the North and Midlands report a significantly higher degree of religious affiliation than people in the south of the country. The highest level of declared Christianity is in the North East of England.
London has a pattern which reflects the diverse multicultural mix of the capital. The South West has few people declaring a religious denomination other than Christian.
2.11.3 Social Support

Figure 14: Percentage of adults who could get a lift somewhere if needed, 2000

Indicator description

Social support is a feature of and derived from a person’s social network which can include family as well as friends and work colleagues. There are a range of possible indicators to demonstrate social support. These include the following:

- Could get a lift somewhere if needed;
- Has at least three sources of informal help for a lift;
- Could get help in bed;
- Has at least three sources of informal help if ill;
- Could borrow £100 if in financial difficulties;
- Has at least three sources of informal help if needed £100;
- Number of people to turn to in a crisis;
- Number of these people living nearby.

These indicators were included in the Social Capital Module of the 2000 General Household Survey.

Rationale and background

There is a clear relationship between social support and risk of morbidity and mortality. Social support is known to be especially important in mental health problems especially if stress is involved. A lack of social support has been shown to be associated with depression and other mental health problems.
Commentary

The graph illustrated shows the reported ability of people to get a lift if needed. Other indicators are shown on the National Statistics website as follows:
http://www.statistics.gov.uk/ssd/surveys/general_household_survey.asp

There is little difference in this indicator between regions of England and the countries of Scotland, Wales and Northern Ireland. There is a noticeable difference in the figures for London and this may be due to the availability of public transport and low car ownership. Similarly in the North East there is low car ownership and higher public transport use, reducing reliance on lifts from other people\(^39\). There is a suggestion that the indicator may be higher in rural areas which could relate to poor public transport, high car ownership or a culture of giving lifts.
2.11.4 Social Networks

Figure 15: Percentage of adults speaking to relatives by phone

Source: General Household Survey, 2000 (Social Capital Module)

Indicator description

Social networks are quantified as the number of contacts, frequency and density, and are to be considered separately from social support which is more a measure of direct help and assistance.

The indicator above shows the variation in frequency with which adults speak to relatives by telephone.

Rationale and background

There is a well described relationship between social networks and mental health. Those with few social contacts are known to be at a greater risk from mental health problems. Social networks can also protect against stress. Research has suggested that social networks can be a factor in the recovery from depression in women.

Commentary

There are some clear differences by regions and by countries. Young people, women and people from certain ethnic groups appear to have better social networks. People from black and other ethnic minority groups tended to have the poorest social networks.

There appears to be a clear North South divide. People living in London and the South East had lower levels of networks than people living in the North East.
2.11.5 Neighbourliness

Figure 16: Percentage of adults speaking to neighbours

Source: General Household Survey, 2000 (Social Capital Module)

Indicator description

There are a number of possible indicators of ‘neighbourliness’. We have chosen to illustrate one which is the percentage of adults speaking to their neighbours. Other indicators which are available include the number known to neighbours, the number of people trusted in the neighbourhood and whether people have received a favour from their neighbours in the past week. Some of these alternative indicators can be found on the National Statistics website as follows: http://www.statistics.gov.uk/ssd/surveys/general_household_survey.asp.

Rationale and background

Neighbourliness is seen as an important component of social capital. Putnam\(^{41}\) states that it measures people’s willingness to ‘co-operate for mutual benefit’.

Commentary

Overall one in four people spoke to their neighbours at least daily. On the other hand, 19% of the population spoke to their neighbours less than once per week.

People in England were less likely than those in Wales or Scotland to speak to, know or trust their neighbours. People living in Wales spoke to their neighbours more regularly than those living in either England or Scotland.

Thirty eight percent of people in Wales spoke to their neighbours daily compared with 27% in England and 29% in Scotland. There were no statistical differences between the countries in the reciprocity measures (i.e., where neighbours look out for and do favours for each other).
One of the most striking differences is that people living in London were the least neighbourly.

The North East, North West and South West were found to be the most neighbourly areas, each being at the upper end of the range for all the indicators of neighbourliness.
2.12 Education

Figure 17: Percentage of pupils aged 15 years in schools maintained by the local authority achieving 5 or more grade A*-C GCSEs or equivalent, 2004/05

![Graph showing percentage of pupils achieving 5 or more grade A*-C GCSEs or equivalent by region]

Source: Department for Education and Skills (DfES), School and College Achievement and Attainment Tables, 2005

Indicator description

Percentage of pupils aged 15 years in schools maintained by the Local Authority achieving five or more grade A*-C GCSEs or equivalent. This indicator includes all level 1 and level 2 qualifications which are approved by the Qualifications and Curriculum Authority (QCA) as appropriate for pupils aged under 16 years and, in addition GCE AS and VCE AS levels (from level 3)\(^2\). The analysis presented is based upon data taken from achievement and attainment tables published by the Department for Education and Skills (DfES). This indicator was used in the APHO Health Profiles 2006.

Rationale and background

The indicator measures the level of GCSE or equivalent achievement in the area. Education has significant bearing upon employment and social inclusion, both of which impact upon mental health. Certain groups of people are at higher risk of common mental health problems; these groups include those with no, or low level, qualifications and the unemployed\(^6\). Psychiatric disorders and suicidal attempts are most likely to occur in people facing socioeconomic disadvantage, such as those in unskilled occupations or unemployed, and who lack formal qualifications. Individuals with a psychotic disorder are most likely to have left school before reaching sixteen years of age, and hold no qualifications\(^25\).

Commentary

The graph illustrates that the four most southern regions have percentages of pupils achieving five or more grade A*-C GCSEs or equivalent that are significantly higher than the national average. The North East, North West, East Midlands and Yorkshire and the Humber...
all achieve a significantly lower percentage of pupils achieving five or more grade A*-C GCSEs or equivalent. The South East has the highest percentage (57.5%), whilst Yorkshire and the Humber has the lowest (51.2%).

The attainment of 5 or more A*-C GCSEs has improved nationally over the last 3 years, from 52.9% to 54.7%, an improvement of 1.8%. Over this period every region has demonstrated an increase, the most significant being the North East, with a 6.7% improvement in attainment, followed by Yorkshire and Humber at 5.6%.
2.13 Learning and Development

Figure 18: Percentage of working age adults in job-related training in the past 13 weeks (working and unemployed), 2004

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage of working age adults</th>
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<tbody>
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<td>North East</td>
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<td>North West</td>
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<td>Yorkshire &amp; Humber</td>
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<td>East Midlands</td>
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<td>West Midlands</td>
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<tr>
<td>East of England</td>
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<td>London</td>
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<tr>
<td>South East</td>
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<tr>
<td>South West</td>
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<tr>
<td>England</td>
<td>20.5%</td>
</tr>
</tbody>
</table>

Source: NOMIS, Annual Population Survey 2004

Figure 19: Percentage of working age adults currently working towards or studying for any qualifications, 2004

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage of working age adults</th>
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</thead>
<tbody>
<tr>
<td>North East</td>
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<td>North West</td>
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<td>South West</td>
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<td>England</td>
<td>15.5%</td>
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</table>

Source: NOMIS, Annual Population Survey 2004
**Indicator description**

The Annual Population Survey 2004 was a new survey of approximately 65,000 household interviews, which was combined with data from the Labour Force Survey and English Local Labour Force Survey to provide enhanced annual data for England. The survey found that more than one in four of all working age adults when interviewed had received some form of job-related training in the previous thirteen weeks.

Two indicators are presented here, as follows:

- Percentage of working-age people who received job-related training in the past 13 weeks, employed and unemployed; and
- Percentage of people of working age currently studying for any qualification.

**Rationale and background**

There is an extensive literature on the mental health benefits of learning, which may include both personal growth and development and the value of participation in learning opportunities. Improved health outcomes may relate to increases in human capital, (knowledge and skills), social capital (trust and dependency) and identity capital (positive self-image, assertiveness and confidence).

People who flourish at school enjoy better health and wellbeing than those who do not, though the effect may not be causal. Adults who participate in adult education in their 30s tend to enjoy positive transformations in their health and wellbeing more than their peers who do not. Adult learning is also associated with positive outcomes in health and wellbeing of adults who did not flourish at school.

Participation in adult learning therefore does not narrow the gap between those who did and did not flourish at school, but if appropriate provision is available at the right time, it may play an important role in promoting healthy lifestyles, wellbeing and mental health.

**Commentary**

Fourteen percent of all working age adults when interviewed were studying for some form of qualification.

With the exception of the South East (significantly higher than England at over 27%), there is no significant difference between the regions with regard to the amount of job-related training received.

There is more variation between the regions when considering the proportion of adults studying for a qualification, with a significantly higher proportion of people in London studying (16%) and significantly less in the North West (13.7%) and the East of England (13.1%). This may be influenced by the proportion of the population who already have qualifications.
### 2.14 Violence and Safety

**Figure 20: Percentage of the population with a “high level of worry about violent crime”, 2004/05**

- North East
- North West
- Yorkshire & Humber
- East Midlands
- West Midlands
- East of England
- London
- South East
- South West
- England

![Bar chart showing percentage of population with high worry about violent crime by region, with England having the highest percentage among the regions listed.](chart)

*Source: British Crime Survey, 2004/05*

**Figure 21: Total incidence of violence per 10,000 adults reported by people in the British Crime Survey, 2004/05**

- North East
- North West
- Yorkshire & Humber
- East Midlands
- West Midlands
- East of England
- London
- South East
- South West
- England

![Bar chart showing total incidence of violence per 10,000 adults by region, with London having the highest incidence among the regions listed.](chart)

*Source: British Crime Survey, 2004/05*
Figure 22: All violent reported crime recorded by the police forces per 10,000 population, 2004/05

Source: Home Office, Police Recorded Crime Statistics

Indicator description

We have used three measures of crime, focusing on violent crime:

- The percentage of the population who had a “high level of worry about violent crime” from the British Crime Survey 2004/5 (‘fear of crime’);
- The total incidence of violence per 10,000 adults reported by people in the British Crime Survey 2004/5 (‘reported crime’); and
- All violent reported crime recorded by police forces per 10,000 total population (‘recorded crime’).

Rationale and background

Crime, particularly violent crime, is linked to mental health in a number of ways. Firstly it may have similar determinants such as drugs, alcohol and deprivation. Secondly, victims of crime are more likely to suffer mental health problems such as depression. Those who suffer from mental illness are more likely to be victims of crime than to commit crime, although violent crimes committed by people with mental illnesses are more frequently reported. We would therefore expect areas with higher levels of violent crime to have higher levels of mental health problems. We have used ‘all violent crime’ to allow comparison between fear, reporting, and recording.

Commentary

Rates of fear of violent crime expressed as a percentage of respondents to the British Crime Survey are significantly higher than the England average in London and the North West and significantly lower in the South East, South West and East of England.
Rates of reported violent crime per 10,000 adults derived from the British Crime Survey show much less regional variation with only the East of England and the North East showing significantly lower rates than the England average.

Rates of violent crime recorded by the police for each region are not easy to compare because there may be different recording procedures in different police force areas and different denominators may be used.

Comparing the regional patterns of these three indicators shows that the ranking for recorded violent crime more closely resembles the ranking for fear of violent crime - where London has a significantly higher rate than other regions – than it does reported violent crime. Comparing figures for reported and recorded violent crime shows that many crimes are not reported to the police and therefore do not appear in the recorded crime figures.

Levels of violent crime appear to be higher in London and the North West and perhaps West Midlands and lower in East of England, South East, South West and perhaps North East. There is a reasonably strong relationship between incidents recorded by the police and fear of crime but the levels of reported violent crime in the British Crime Survey seem to have a different pattern with much less regional variation.

The Health Profiles violent crime indicator uses only violence against the person, rather than all violent crime which gives a slightly different pattern - higher in the North West, much higher in London, low in the North East and South East.
2.15 Gambling

Figure 23: Household expenditure on gambling payments, 2002 to 2005

Source: Office for National Statistics, Expenditure and Food Survey

Indicator description

Household expenditure in pounds per week on gambling payments based upon the Expenditure and Food Survey carried out by the Office for National Statistics (ONS).

Rationale and background

The UK is the largest gambling nation in Europe, accounting for just over 22% of the total European market. Over three quarters of the UK population are estimated to gamble; when excluding the National Lottery this falls to just below half (46%). The Gambling Act 2005 is expected to come fully into force in September 2007, with the introduction of super casinos and 24 hour access. Online gambling already allows for 24 hour access and is a rapidly growing market.

Addiction to gambling is both a problem in its own right and may result in debt, which, in turn, can give rise to other mental health problems. Recent developments in the gambling industry mean that gambling has become more accessible and socially acceptable.

Gambling addiction charity, GamCare, estimate that there are 350,000 people with a gambling addiction in Britain.

Commentary

On average, households spend £3.70 a week on gambling payments in England.

There is considerable variation in gambling payments between regions, Southern regions spending the least.
The South East spends the £2.80 per household per week on gambling. This compares to the North East and Yorkshire and the Humber, where households spend £5.50 a week on gambling payments.
2.16 Ethnic coding

Figure 24: Percentage of records in Mental Health Minimum Dataset (MHMDS) which include a valid and usable ethnic group code, 2004/05

Source: Mental Health Minimum Dataset

Indicator description

The percentage of records in the Mental Health Minimum Dataset (MHMDS) which include a valid and usable ethnic group code.

Rationale and background

The provision of mental health care for people from black and minority ethnic communities raises important and complex issues including linguistic and cultural competence. Variations between ethnic groups in rates of various types of treatment and in particular of the use of compulsion of the Mental Health Act have been the subject of considerable debate over the last two decades. The Department of Health’s action plan for delivering race equality in mental health care identifies better information as one of the three crucial building blocks. The Healthcare and Mental Health Act Commissions, in their recent joint report of a census of mental health care service users in England also stressed the importance of adequate ethnic monitoring.

The MHMDS is the key data source for monitoring the activity of specialist mental health care in England. It is designed to allow, amongst other things, detailed monitoring of ethnic variations in health care provided. However this is dependent on completeness of ethnic group attribution.

Commentary

The figure shows large variations between regions in the extent of satisfactory ethnic coding. This appears relatively unrelated to the size of ethnic minority populations within the regions.
3 POPULATION HEALTH STATUS

3.1 Psychiatric disorder

Figure 25: The percentage of adults with a GHQ12 score of four or more, 2003

Source: Health Survey for England, 2003

Indicator description

The proportion of adults with a score of four or more on the 12-item General Health Questionnaire (GHQ 12). A GHQ score of 4 or more indicates a possible psychiatric disorder.

Rationale and background

The GHQ 12 was developed in the UK and is an epidemiological measure of population mental health, covering a wide range of behavioural and psychological functioning. It asks respondents about their general level of happiness, depression, anxiety, and sleep disturbance over the four weeks preceding the interview.

It is intended to identify cases, as opposed to non-cases of psychiatric disorder, in both clinical and non-clinical populations. It detects a variety of psychiatric disorders at a particular point in time, focusing on breaks in normal functioning, not lifelong traits. It is not intended to identify the severity of an individual’s mental health problem.

A comparative review of key health state measures, funded by the Department of Health, reports that people experiencing a psychiatric disorder of any nature share a common factor. The GHQ 12 comprises the most common factors, designed to identify individuals with a mental health problem as a generic class, not by their particular illness.

The method has been found to be a reliable indicator of both the current state of mental health in the country and the future demand for mental health care services.
Commentary

Rates of a GHQ 12 score of four or more vary little across regions, with the exception of the North East, where the proportion is significantly higher. Applying the findings of the Health Survey for England to the general population of England indicates that 13.2% of England’s population received a point score of 4 or more. The lowest region is the East of England at 11.1%, whilst the highest is the North East at 17.5%, a proportion 4.3% greater than the national average.
3.2 Psychiatric morbidity

Figure 26: Percentage of population scoring 18 or more on the Clinical Interview Schedule, 2000

![Percentage of population scoring 18 or more on the Clinical Interview Schedule, 2000](image)

Source: National Psychiatric Morbidity Survey

NOTE: Uses old NHS regional boundaries

Indicator description

Proportion of the population found to have a score of 18 or more on the Clinical Interview Schedule in the 2000 national psychiatric morbidity survey. It should be noted that this presents data for the eight NHS regions in place in 2000, not the current Government Office regions.

Rationale and background

Many people with mental health problems do not seek help for them. In order to identify the true extent of mental health problems in the community it is necessary to undertake direct population surveys. Two national psychiatric morbidity surveys have been undertaken in mainland Britain, in the years 1993 and 2000. Both have been undertaken by the Office for National Statistics. Members of the public living in private households were approached and asked if they would agree to interview. Those consenting were interviewed by a trained interviewer using a standard questionnaire. A second stage using medically qualified interviewers was used to clarify diagnoses in more detail.

Commentary

Figure 26 above shows the proportions of people in the population scoring 18 or more on the first stage interview schedule applied to all respondents. This roughly corresponds to the level of symptoms likely to require treatment. The calculation of confidence intervals for the survey is complex as a result of statistical approaches taken to allow for the sample design.
While the observed figures show considerable apparent spread, the confidence intervals are fairly wide. There appears to be a difference between the South East and the North West but all confidence intervals overlap.

The use of old NHS regions (for example, “Northern and Yorkshire” approximating to a combination of North East and Yorkshire and the Humber) may well have lost information as North East and Yorkshire and Humber are significantly different on other indicators, e.g., 5.1. Other regions are also not directly comparable, e.g., Trent and East Midlands.
3.3 Usage of specialist mental health services

Figure 27: People aged 18 to 64 years documented as receiving care in the Mental Health Minimum Dataset (MHMDS), rate per 100,000 population, 2004/05

Indicator description

Rate per 100,000 population aged 18 to 64 years documented as receiving care in the Mental Health Minimum Dataset (MHMDS).

Primary care trusts reporting figures below 1,000 or above 5,000 excluded (see below).

Rationale and background

These indicators show the variation in the numbers of individuals per hundred thousand population receiving interventions from the specialist mental health services.

The MHMDS is a new national data return in which mental health provider trusts report the care provided to each individual seen. As with any large-scale data return, some providers’ data suggests errors. Following detailed scrutiny, 39 PCTs (13%) for which the figure reported fell below 1,000 or exceeded 5,000 service users per 100,000 population were excluded on the basis that the data were implausible.

Commentary

London and the West Midlands regions show the highest rates while the East of England, South East and South West regions show the lowest rates. The North East rate is high while that for the North West is relatively low. These patterns are a relatively poor reflection of the likely need levels outlined in the section on needs indicators. However, interpretation of period prevalence findings is complicated by the fact that these are influenced both by the numbers of individuals starting treatment and the length of time for which treatment continued.
3.4 Residential and nursing home care

Figure 28: Council supported residents aged 18 to 64 years with mental health problems, rate per 100,000 population, at 31st March 2005

Indicator description

Council supported residents aged 18 to 64 with mental health problems in local authority and registered staffed care homes, (excluding unstaffed homes and other accommodation) at 31 March 2005. Rate per 100,000 population aged 18 to 64 years.

Rationale and background

Work undertaken in the 1980s on the closure of old mental hospitals indicated a clear requirement for long-term residential care for a small, but severely disabled group of individuals. Failure to make adequate provision initially gave rise to the problems addressed by the homeless mentally ill initiative and the 24-hour nursed-care bed policy of the early 1990s.

The number of placements required within individual PCTs varies considerably and is substantially influenced by the history of re-settlement of former long stay service users. To some extent these should even out between regions. However, in the case of London many of the former Metropolitan Asylums Board hospitals lay outside the current regional boundary and thus many resettled service users would now be in the East of England or South East regions.

Commentary

The figures show striking disparities, with a threefold difference between London and East of England, although most other regions are more closely clustered.
3.5 Severe mental illness on GP register

Figure 29: Percentage of patients registered with a general practitioner who have severe long-term mental health problems, 2004/05

Source: Quality Management and Analysis System (QMAS)

Indicator description

The percentage of registered patients who have severe long-term mental health problems (defined by those who require and have agreed to follow up). Unadjusted “disease prevalence” (see below) per 100 registered patients.

Rationale and background

This indicator measures the proportion of people registered to GPs in the region who have severe mental health problems which are being followed up in primary care. This indicator records only people who are registered with a GP, and who have agreed to treatment or follow up in primary care settings.

The data used for this indicator comes from the first collection year of Quality Management and Analysis System (QMAS) data. QMAS is the system which records GP practice performance on the targets set in their general medical services (GMS) contracts. There is still uncertainty around the quality of information, particularly around consistency of recording. As such, caution should be used when interpreting data as “disease prevalence”. It may be more appropriate initially to consider the indicator a measure of utilisation and quality of service at primary care level for people with severe mental health problems.

Commentary

Just over a half a percent of registered patients in England are being followed up or treated for a severe mental health problem in primary care. It is not possible to interpret this as a measure of prevalence of mental illness, since it may relate to recording issues, or access to
primary care services. It is estimated that severe mental illness affects around 1% of our population\textsuperscript{44}.

Two regions, London and the North West, have a significantly higher proportion of registered patients receiving follow up for severe mental illness (both over 0.6% of their registered population). The other seven regions all have significantly lower proportions of patients recorded, with the lowest percentage of service users in West Midlands at 0.50%.
3.6 Suicide

Figure 30: Directly age standardised mortality rates for suicide and injury undetermined, persons aged 15 years and older, 2003-2005

Source: Compendium of Clinical and Health Indicators, 2006, National Centre for Health Outcomes Development

Figure 31: Directly age standardised mortality rates for suicide and injury undetermined, males 15 years and older, 2003-2005

Source: Compendium of Clinical and Health Indicators, 2006, National Centre for Health Outcomes Development
Figure 32: Directly age standardised mortality rates for suicide and injury undetermined, females 15 years and older, 2003-2005

Source: Compendium of Clinical and Health Indicators, 2006, National Centre for Health Outcomes Development

**Indicator description**

We have used directly age-standardised rates for suicide & injury undetermined, pooled for the 3 years 2003-2005 in persons, males and females aged 15 years and over. Suicide is defined by Coroners in England and has to be proven ‘beyond reasonable doubt’. Since there is some variation in practice it is generally considered that the addition of open verdicts (cause of injury undetermined) provides a more reliable guide to trends in suicide.

**Rationale and background**

Suicide rates have been used as a target since the early 1990s\(^{50}\). While most consider that reducing the death rate from suicide is worthwhile, and there is good evidence of preventability in many cases, it has more controversially been used as an indicator of the quality of mental health services. While useful as an easily quantified measure, the relationship between mental health and suicide is complex with many other societal factors playing an important role. There are effective interventions in mental health services such as reducing in-patient risks and improving the follow-up of recently discharged service users but only about a quarter of people who commit suicide have been in contact with services in the preceding year.

**Commentary**

Rates of suicide are highest in the North East and North West regions. This is statistically significant for men.
3.7 Self Harm Admissions

Figure 33: Directly age standardised self harm hospital admission rate per 100,000 population, 2003

Source: Hospital Episode Statistics

Figure 34: Directly age standardised self harm hospital admission rate per 100,000 population, 2004

Source: Hospital Episode Statistics
Figure 35: Directly age standardised hospital admission rate per 100,000 population, for poisoning, 2003

Source: Hospital Episode Statistics

Figure 36: Directly age standardised hospital admission rate per 100,000 population, for poisoning, 2004

Source: Hospital Episode Statistics
**Indicator description**

Hospital admissions for self harm (primary diagnosis ICD-10 codes X60 - X84) per 100,000 population for the years 2003 and 2004.

Hospital admissions for poisoning by drugs, medicaments and biological substances (primary diagnosis ICD-10 codes T36 - T50) per 100,000 population for the years 2003 and 2004.

**Rationale and background**

Self harm has been defined as "self-poisoning or injury, irrespective of the apparent purpose of the act"51. Previous terms have included: parasuicide, attempted suicide and deliberate self harm (DSH).

In some instances, the person involved may indeed have intended to take their own life, or there may at least have been a degree of recklessness as to whether he or she survived. In other instances it may be clear that the person did not intend to die, but rather to seek relief from intolerable mental distress. However, following an episode of self harm, there is a significant and persistent risk of suicide which varies markedly between genders and age groups. One study of people presenting at Accident & Emergency (A&E) showed a subsequent suicide rate of 0.7% in the first year - 66 times the suicide rate in the general population. After 15 years, 4.8% of males and 1.8% of females had died by suicide52.

A study of self harm in adolescents found that only 12.6% of episodes had resulted in presentation to hospital53 so A&E attendances, even if completely recorded, would represent only the tip of a huge iceberg of mental distress.

In fact, A&E attendances for self harm have not been recorded since 2002/03, and even then the data quality was very poor, with 127 PCTs out of 304 (42%) recording none at all. We have therefore not presented these data.

It is really rather surprising, given that self harm is the most common reason for medical admission of females and given the strong association of self harm with subsequent suicide, that there are no national or regional A&E data available.

A small number of centres have for some years conducted detailed local monitoring, and work at four centres is now being co-ordinated by the Oxford University Centre for Suicide Research into a multi-centre monitoring project funded by the Department of Health (www.psychiatry.ox.ac.uk/csr/resmulticentre.html). This has shown a strong correlation between admission and the likelihood of having a psychosocial assessment.

Hospital admissions are a very small proportion of A&E attendances for self harm but HES data are all that is available. We have also included admissions for poisoning because although they include accidental poisoning it is often difficult to distinguish accidental and deliberate overdose and so (analogous to suicide and open verdicts) this may provide a more stable indicator.
Commentary

There is a similar ranking to suicide across the regions but a much larger difference between regions: threefold between North East and London. This pattern seems stable over time (two years are shown but it is similar for at least five years) which suggests that it is worth exploring further. There are a number of potential explanations for this which include:

- There may be different patterns of behaviour so mental distress and illness may be higher or more likely to be displayed as self harm. There may be differences in contributing factors such as alcohol consumption.
- There could be patterns in clinical behaviour such as the likelihood of admitting someone to hospital who has taken a small overdose. It may be that some areas are better at preventing repeat events.
- There could be differences in recording information. Often the focus is on the type of injury (overdose, laceration) and its treatment rather than the underlying cause which can create large variations in whether the episode is recorded as self harm. The graphs of poisoning, which include accidental overdoses show a similar pattern suggesting that miscoding of poisonings is unlikely to be a major explanation.
4 INTERVENTIONS

4.1 Mental health promotion

Figure 37: Percentage of Local Implementation Teams (LITs) self-assessed as 'GREEN' for having a mental health promotion lead officer, 2004

Source: Adult Mental Health Service Mapping

Figure 38: Percentage of Local Implementation Teams (LITs) self-assessed as 'GREEN' for having a mental health promotion strategy and action plan, 2004

Source: Adult Mental Health Service Mapping
Indicator description

Percentage of national service framework Local Implementation Teams (LITs) declaring their state as ‘GREEN’ for provision of a mental health promotion lead officer.

Percentage of national service framework LITs declaring their state as 'GREEN' for provision of a mental health promotion strategy and action plan.

Rationale and background

Mental health promotion is the first target in the National Service Framework\(^2\) and its importance has recently been re-emphasised both in the five year review\(^4\) of the National Service Framework and in the public health white paper Choosing Health\(^1\). The annual self assessment exercise for National Service Framework Local Implementation Teams (LITs) asks about two markers of the state of local progress, each scored categorically (Red, Amber and Green). The first is whether a mental health promotion lead officer is in place. To score green, there has to be an officer in place who has adequate, dedicated time for the required co-ordination and leadership. The second is whether a mental health promotion strategy is in place. To score green on this, a strategy must be in place with an action plan, joint working arrangements and priorities for working age adults, children and adolescents and older people. There must also be evidence of close collaboration between the adult and older peoples LITs and the child and adolescent mental health services (CAMHS) strategy group. All these requirements have been in place for four years.

Main findings

Figures 37 and 38 above show the proportion of LITs in each region judged green in each category. The numbers are low. In each case the explanation is mainly not that no promotion officer or strategy is in place, but that the qualifications of adequate resourcing, time and collaborative effort are not met.

Regional Commentary

There are wide variations in this indicator. The reasons for this are unclear.
4.2 Assertive outreach

Figure 39: Rate per 100,000 population aged 18 to 64 years reported by primary care organisations to be currently receiving mental health assertive outreach care, 2006

Indicator description
Rate per 100,000 population aged 18 to 64 years reported by primary care organisations to be currently receiving mental health assertive outreach care. Data based upon most recent Local Delivery Plan Return (LDPR) – January to March 2006.

Rationale and background
Assertive outreach teams provide intensive long-term support to a small number of individuals, severely disabled by mental illness, who are disinclined, or unable to engage with conventional programmes of care. Usually these people will have a history of frequent hospital admissions following discontinuation of antipsychotic medication. Commonly their mental illness is complicated by substance misuse and it may have contributed to their committing criminal offences.

Assertive outreach teams form a key component of the service model set out in the National Service Framework\(^2\). The NHS Plan\(^54\), published in July 2000, set a target for 20,000 individuals nationally to receive this type of service each year. The care they provide is long term. Hence the snapshot provided by Local Delivery Plan quarterly returns should closely approximate the target number.

Commentary
All regions have substantial provision. The North East and London have the highest, with the former providing the service to roughly double the number of individuals served in the East of England and South East regions.
4.3 Crisis resolution

**Figure 40: Rate per 100,000 population aged 18 to 64 years reported by primary care organisations to be currently receiving crisis resolution service care, 2006**

Rate per 100,000 population aged 18 to 64 years reported by primary care organisations to be currently receiving crisis resolution service care. Data based upon most recent Local Delivery Plan Return (LDPR) – January to March 2006.

**Indicator description**

Rate per 100,000 population aged 18 to 64 years reported by primary care organisations to be currently receiving crisis resolution service care. Data based upon most recent Local Delivery Plan Return (LDPR) – January to March 2006.

**Rationale and background**

Crisis resolution teams provide intensive, short-term support for people who, formerly, would have been judged in need of psychiatric hospitalisation. While a small number of these teams have been operating in England for 10 years or more, the National Service Framework\(^2\) proposed that this type of care should be available for everybody who could benefit from it.

The NHS Plan\(^54\) indicated a target figure of 100,000 people likely to need this type of service nationally each year. In 2004/05, just under 118,000 admissions were reported in the Adult Mental Illness specialty\(^55\). However, since a substantial proportion of service users are admitted more than once in a year, the number of service users involved is probably less than 100,000. This suggests crisis resolution teams are expected to be slightly more inclusive.

Data are collected each quarter from PCTs about the number of their residents who have used Crisis Resolution Team care in the year to date. The final quarter of the year thus provides a full year figure for the numbers who have received care.
Commentary

The figures indicate that this new type of service is now very widespread and that a very substantial proportion of those likely to have been admitted are using it. This does not mean that admission will have been avoided for all these people. Rates of usage vary considerably between regions. These patterns might be expected to mirror variations in admission rate and to be driven primarily by mental health care need issues outlined above. However, the service is still relatively new in most places, so variations will probably still reflect the recency of implementation.
4.4 Early intervention for psychosis

Figure 41: Rate per 100,000 population aged 15 to 34 years reported by primary care organisations to be receiving psychosis early intervention care, 2006

Source: Local Delivery Plan Return January-March 2006, Department of Health

Indicator description

Rate per 100,000 population aged 15 to 34 years reported by primary care organisations to be currently receiving psychosis early intervention care. Data based upon most recent Local Delivery Plan Return (LDPR) – January to March 2006.

Rationale and background

It is increasingly widely recognised that specialised early intervention teams can benefit individuals experiencing their first episode of psychotic illness. These teams are able to focus on rapid optimisation of medical control of psychotic symptoms, on providing a range of psychological and family interventions and on assisting in the personal adjustments necessarily arising from individuals’ illness.

The National Service Framework\(^2\) indicated that this type of provision should be available throughout England. The NHS Plan\(^54\) indicated that 7,500 new individuals should benefit from this type of service annually. It is anticipated that individuals will be cared for by these teams over a period of around three years. This suggests that the total caseload, once the system has reached a steady state, should be 22,500. However this level would not be expected to appear until all teams have been in place with fully functioning input pathways for three years. It is less clear how this target should be divided between regions. Observed variations in the prevalence of severe mental illness between areas arise partly from differences in incidence and partly from patterns of adult settlement which are a consequence of mental illness.
Commentary

The data show a lot of activity in all regions, though substantially more in the North East. The East and West Midlands and the South West show intermediate activity levels while the East of England, London, and the South East show low levels. The figure for London is particularly notable since admissions statistics indicate it is clearly not a reflection of low need.
4.5 Day care

Figure 42: Percentage of Local Implementation Teams (LITs) with NHS day hospitals, 2005/06

Source: Adult Mental Health Service Mapping

Figure 43: Whole time equivalent care staff in NHS day care facilities, rate per 100,000 population aged 18 to 64 years, 2005/06

Source: Adult Mental Health Service Mapping
Figure 44: Percentage of Local Implementation Teams (LITs) with at least one day centre or resource centre, 2005/06

Source: Adult Mental Health Service Mapping

Figure 45: Rate of drop-in facilities per 100,000 population aged 18 to 64 years of age, 2005/06

Source: Adult Mental Health Service Mapping
**Indicator description**

Four analyses are presented based upon data from adult mental health service mapping:

- Percentage of Local Implementation Teams (LITs) with at least one NHS day care facility.
- Care staff in NHS day care facilities, rate per 100,000 population aged 18 to 64 years.
- Percentage of LITs with at least one day centre or resource centre.
- Rate of drop-in facilities per 100,000 population aged 18 to 64 years of age.

**Rationale and background**

A wide range of day-care facilities are provided for people with mental health problems. Three types are considered here, though these categories are not exhaustive.

Day hospitals run by the NHS provide a range of types of care. Some are designed for the treatment of acutely ill people; some provide a range of social support and rehabilitative work for people with long term mental illnesses. A few offer specialist psychotherapy. Some undertake more than one of these functions. Day centres, run usually either by local authority social service departments or independent (usually voluntary) sector organisations, offer a range of supportive activities including user and carer support groups, assistance with employment, education and leisure activities and sometimes therapy and/or counselling. Drop-in centres are more informal places which people with mental health problems can visit when they like for company and support. About two thirds of the day centres provide drop-in facilities.

This type of service is not easy to quantify. A simple count of the number of facilities conveys no impression of whether they are large or small. In the figures above the proportions of National Service Framework Local Implementation Teams (LITs) with at least one day hospital or day centre are shown. For day hospitals an alternative quantification is the total staff per hundred thousand population. In the presentation shown, administrative and managerial staff have been omitted. This approach was explored for day centres, but dropped for the reasons outlined below. Drop-in facilities are by nature substantially more informal. The presentation shows the number of such facilities per hundred thousand population. Some of these are day centres which offer drop-in, others are separate.

**Commentary**

The figures above show considerable variations. It is surprising that any local implementation teams would have no provision either of day hospitals or of day care centres. Overall staffing in day hospitals broadly follows the proportion of LITs providing this type of care.

A similar analysis of day centre staffing was explored but the data quality was too poor to report. The variation in availability of drop-in facilities reported was very striking.

East Midlands region shows the highest proportion of LITs with NHS day hospitals. However average LIT sizes in this region are substantially higher than elsewhere, so this figure is not really comparable. It is thus particularly surprising that such a low level of drop-in provision is reported for this region. The South East region appears to have the greatest proportion of LITs lacking either a day hospital or a day centre.
4.6 Admissions for depression and anxiety

Figure 46: Directly age standardised hospital admission rates for depression per 100,000 population aged 15 to 74 years, 2001/02

Source: Hospital Episode Statistics

Figure 47: Directly age standardised hospital admission rates for anxiety disorders per 100,000 population aged 15 to 74 years, 2001/02

Source: Hospital Episode Statistics
**Indicator description**

Directly age-standardised hospital admissions for depression (primary diagnosis ICD-10 codes F32 to F33) per 100,000 population aged 15 to 74 years.

Directly age-standardised hospital admissions for anxiety disorders (primary diagnosis ICD-10 codes F40-F48) per 100,000 population aged 15 to 74 years.

**Rationale and background**

Hospital Episode Statistics (HES) are based on consultant episodes (a period of care under one consultant within one provider) and not admissions, hence some over-counting may occur. There may be variation in completeness of hospital records, accuracy of diagnoses, and quality of coding. The data may also reflect variations in symptomatology and diagnostic criteria. Data from the independent sector are not included, although this is unlikely to be significant for these conditions. Another potential artefact to be aware of is NHS Trust Reconfiguration which can artificially create a large number of admissions from one trust to its successor.

Depression and anxiety disorders are two of the greatest contributors to morbidity in the country. However, they are predominantly treated in the community and in primary care so hospital admissions give only limited information about ‘the tip of the iceberg’. Consequently, variation is most likely to represent differences in clinical practice: small differences in threshold for treatment may produce large differences in admission rates. Furthermore a number of different conditions are covered by the term ‘anxiety disorders’ and these cannot be disentangled by the data.

**Commentary**

The North West, North East and South West regions have higher rates of admission for both depression and anxiety. There seems to be very large – two to three fold - variation across the country.

Comparison with the indicator for schizophrenia admissions and total number of available beds suggest that there is not a simple explanation of more beds available reducing admission threshold or a substitution of one type of admission for another.
4.7 Admissions for Schizophrenia

Figure 48: Directly age standardised hospital admission rates for schizophrenia per 100,000 population aged 15 to 74 years, 2001/02

Indicator description

Hospital admissions for schizophrenia (primary diagnosis ICD-10 codes F20, F21, F23.2, F25) per 100,000 population aged 15 to 74 years. Data are taken from the Clinical and Health Outcomes Knowledge Base (http://www.nchod.nhs.uk/).

Rationale and background

Hospital Episode Statistics (HES) are based on consultant episodes (a period of care under one consultant within one provider) and not admissions, hence some over-counting may occur. There may be variation in completeness of hospital records, accuracy of diagnoses, and quality of coding. The data may also reflect variations in symptomatology and diagnostic criteria. Data from the independent sector are not included, which may be significant for this condition. Another artefact to be aware of is NHS Trust Reconfiguration which can artificially create a large number of admissions from one trust to its successor.

Schizophrenia is one of a number of psychotic illnesses and there may be some diagnostic variation across the country. There has probably been less discretion during a severe episode of schizophrenia as to whether a person would be admitted than with conditions such as anxiety disorders. However, the development of a range of new services such as Assertive Outreach, Crisis Resolution, Home Treatment and Early Intervention teams, as well as the quality and quantity of community-based services will have an impact on the admission rate.
Commentary

A North-South divide is less apparent than with anxiety disorders; possibly there are higher rates in more urbanised regions. There still seems to be about a two fold variation across the country.

Comparison with the indicator for anxiety disorders admissions and total number of available beds suggest that there is not a simple explanation of more beds available reducing admission threshold or a substitution of one type of admission for another.
4.8 Prescribing in primary care

Figure 49: Average Daily Quantity (ADQ) of antidepressants prescribed by region, 2005

Source: Prescription Pricing Division, NHS Business Services Authority

Figure 50: Average Daily Quantity (ADQ) of antipsychotics prescribed by region, 2005

Source: Prescription Pricing Division, NHS Business Services Authority
**Figure 51: Average Daily Quantity (ADQ) of hypnotics and anxiolytics prescribed by region, 2005**

Indicator description

Prescriptions of antidepressant drugs (BNF 4.3) in primary care, January to December 2005 by region. Average Daily Quantities (ADQs) per 1,000 antidepressant STAR(01)-PUs (adjusted for the age and sex structure of the population and the number of temporary residents and for the different prescribing profiles of antidepressants).

Prescriptions of antipsychotics total (BNF 4.2.1) in primary care, January to December 2005 by region. Average Daily Quantities (ADQs) per 1,000 service users.

Prescriptions of anxiolytics (BNF 4.1.2) and hypnotics (BNF 4.1.1 including the "z" drugs zaleplon, zopiclone and zolpidem) January – December 2005 by region. Average Daily Quantities (ADQs) per 1,000 Benzodiazepine STAR(01)-PUs (adjusted for the age and sex structure of the population and the number of temporary residents and for the different prescribing profiles of Benzodiazepines).

**Introduction**

In England, all prescriptions written in primary care (by GPs) and dispensed by pharmacists are recorded on a database at the Prescription Pricing Division (PPD) of the NHS Business Services Authority – formerly the Prescription Pricing Authority (PPA). This is a very rich source of data but with a number of particular strengths and weaknesses as follows:

**Strengths:**
- It is a comprehensive system across the country;
- It is a timely data source;
- All drugs in the British National Formulary (BNF) are coded;
Weaknesses:

- There is no link to the service user, diagnosis or service user characteristics;
- Many drugs have numerous indications;
- It does not include hospital prescriptions (although FP10(HP) data are collected and are available to Trusts);
- It can most easily be analysed by 'Cost' or 'Items' but these do not necessarily relate to an equivalent amount of drug (e.g., length of prescription may vary). For individual drugs or groups of drugs estimates of volume can be made using Average Daily Quantities (ADQs) or Defined Daily Doses (DDDs).

Different service user groups such as the elderly have different requirements for medication and 'Prescribing Units' were developed to allow for this. Further refinements have been to allow for a more detailed age, sex structure of the population and the number of temporary residents (ASTRO-PUs) and for the different prescribing profiles of the main BNF chapter areas (STAR-PUs). These have been further refined to sub-chapter areas available from the Toolkit linked to the electronic version of the Prescribing Analysis and Cost Database (ePACT).

Acknowledgments

We are very grateful to the PPD for providing the analyses of these data.

Rationale and background

1. **Depression** is one of the commonest and most important mental illnesses. Prescribing is the mainstay of treatment, although psychological therapies are widely used and promoted by recent NICE guidance. Prescribing rates are very variable at practice level depending on diagnosis, patterns of management, availability of psychological treatments, etc. There are a number of classes of antidepressant: Selective Serotonin Re-Uptake Inhibitors (SSRIs) (BNF 4.3.3); Tricyclic & Related Antidepressant Drugs (BNF 4.3.1); Monoamine-Oxidase Inhibitors (MAOIs) (BNF 4.3.2) and Other Antidepressant Drugs (BNF 4.3.4) and use of these may be variable. There will also be prescribing of antidepressants in secondary care particularly for resistant depression which can significantly influence primary care prescribing in the wider health economy.

2. Antipsychotic drugs are the mainstay of treatment of **psychoses** such as schizophrenia. However, much prescribing takes place in secondary care so caution needs to be exercised in interpreting primary care prescribing as variation will often be due to the local patterns of shared care rather than differing rates of illness. We are currently unable to access data on secondary care prescribing. There are two main groups of drugs used in psychoses: ‘typicals’ and ‘atypicals’ with a ratio about 2-3 atypical to 1 typical with little regional variation.

3. These types of drug are used for the treatment of **anxiety**: most are benzodiazepines. This provides a measure of use of these drugs in the community which may relate to underlying morbidity and diagnostic and treatment practice. The majority of usage is primary care so secondary care use will not be a major problem. There are other indications for these drugs such as for insomnia.
Commentary

There is regional variation in all classes of drug most marked with antidepressants (more than a two fold variation between London and the North East), less for anxiolytics (nearly a two fold variation between London and East Midlands) and least for antipsychotics.

The ranking varies considerably although the North East is always in the highest two. London tends to be on an extreme end: highest for anxiolytics and antipsychotics and lowest for antidepressants.

In interpreting these findings, antipsychotics are particularly difficult because much, if not most, prescribing takes place in secondary care, varying from place to place. Anxiolytics are likely to be mostly prescribed in primary care although differing indications mean some caution should be exercised in interpretation. At a more local level, Primary Care Organisations may host Drug Dependency Units on behalf of a health economy resulting in ‘skewed’ prescribing volumes for that organisation. Antidepressants are probably predominantly prescribed in primary care although there will be some secondary care prescribing and considerable variation in access to alternative treatments such as psychological therapies.
4.9 Suicide audits

Figure 52: Percentage of Primary Care Trusts (PCTs) with completed suicide audit, at 31st March 2004

Indicator description

Percentage of primary care trusts in each region which answered yes to the question: Do you have a local population-based system for suicide audit in place in your organisation, or formal arrangements to participate in suicide audit activity undertaken by another local organisation?

Analysis based upon Local Delivery Plan Return (LDPR) special collection as at March 31st 2004 to support Healthcare Commission star ratings for Primary Care Trusts 2003/04.

Rationale and background

The National Suicide Prevention Strategy for England\(^3\) was launched in 2002 with the aim of supporting the target which first appeared in Saving Lives; Our Healthier Nation\(^57\) to reduce the death rate from suicide and undetermined injury by at least a fifth by the year 2010.

This important national Public Service Agreement target has been retained in current government planning guidance\(^58\). One of the actions recommended in Our Healthier Nation\(^57\) was to “audit suicides in order to learn the lessons for prevention”.

Standard seven of the National Service Framework\(^2\) which deals with suicide prevention, reiterated that local systems should be developed for suicide audit to learn lessons and take any necessary action.

Suicides of people in contact with specialist mental health services are examined in detail through the National Confidential Inquiry based in the University of Manchester. Three national reports have been published based on its findings\(^59-61\). Based on the recommended
twelve steps to a safer service emerging from these reports, the National Institute for Mental Health in England (NIMHE) commissioned and published an audit toolkit for use by in-patient units\(^6\). The Healthcare Commission was assessing mental health trusts on how far their audits had progressed as at March 31\(^{st}\) 2006 via a special data collection; the results will be published later this year.

However, only one in four of those who take their own lives each year are under the care of specialist mental health services, so local suicide audits by PCTs are also needed if lessons are to be learned from the majority of cases. In 2004, the former Commission for Health Inspection (CHI) asked all PCTs whether they conducted local suicide audits and the results were published in the star ratings. This is the basis for the regional data shown in the previous graph.

The Healthcare Commission subsequently dropped this indicator of PCT performance, on the basis that, by comparison with mental health trusts, the criteria for compliance were not specified with sufficient clarity. An audit toolkit for PCTs has been published\(^6\) which may enable the Healthcare Commission to restore local suicide audit as an indicator of PCT performance in future.

**Commentary**

In six regions (North East, Yorkshire and Humber, East Midlands, West Midlands, East of England and South West) 100 per cent of PCTs reported that they had a system in place for local suicide audit. The figures for London and the North West were between 80 and 90 percent, while the South East occupied an intermediate position. However, given the lack of clarity about what precisely a PCT needed to be doing in order to report itself compliant, it would be unwise to draw any firm conclusions; the PCTs in London, the North West and the South East may have been doing less comprehensive suicide audit, but equally they may have set themselves a higher standard. Publication of the Healthcare Commission assessments of mental health trusts for 2005/06 and the availability of a toolkit for PCT suicide audit should enable better information on this issue in the future.
4.10 Administration of Electroconvulsive Therapy (ECT)

Figure 53: Individuals administered ECT, rate per 100,000 population aged 16 to 64 years, January to March 1998 and 1999 compared to January to March 2001 and 2002

Source: Department of Health

NOTE: Uses old NHS regional boundaries

Indicator description

Individuals administered electroconvulsive therapy (ECT), rate per 100,000 population aged 16 to 64 years, January to March 1998 and 1999 compared to January to March 2001 and 2002. Analysis based upon special Department of Health surveys carried out in 1999 and 2002.

Rationale and background

Electroconvulsive therapy is used to treat depression which does not respond to antidepressant drugs. It is a treatment which excites strong controversy; many believe it should be banned, while others, notably psychiatrists, argue that carefully controlled research attests its efficacy. The treatment is administered under general anaesthetic, in most cases to individuals who are currently staying in hospital. Data about its usage are not considered to be reliably available through routine NHS hospital episode statistics – mainly for data quality reasons. In view of the level of public interest the Department of Health has therefore undertaken special surveys of both NHS and independent sector mental health providers on two recent occasions.

Commentary

The figure above sets out population-based rates for individuals aged 16 to 64 receiving ECT in the first three months of the years shown. Generally there has been a fall of about 30% in the use of the treatment over this period. Both the overall level and the reduction show some variation between regions. No overall pattern within the country is obvious.
4.11 Mental Health Act Commission

Figure 54: Service users detained under the Mental Health Act 1983 resident in NHS facilities and independent hospitals, rate per 100,000 population aged 18 years plus, at 31st March 2004

Source: Department of Health

Indicator description

Service users detained under the Mental Health Act 1983\(^7\) resident in NHS facilities and independent hospitals, rate per 100,000 population aged 18 years plus.

Rationale and background

The Mental Health Act 1983\(^7\) makes provision for the compulsory detention and treatment in hospital of those with a mental disorder. People can be formally detained in hospital in the interests of their own health or safety or for the protection of other people.

Commentary

People detained in hospital by the Mental Health Act account for 36 in every 100,000 adults in England. There is considerable regional variation in the proportion of adults being detained in hospital. London has a significantly higher rate of adults detained in hospital by the Mental Health Act than the other regions at nearly 61 persons per 100,000.
5 EFFECTIVENESS OF PARTNERSHIPS

5.1 Mental health expenditure - non statutory

Figure 55: Percentage of total planned investment in adult mental health services by main provider type, 2005/06

Source: National Survey of Investment in Mental Health Services 2005/06

Indicator description

Percentage of total planned investment in adult mental health services by main provider type from the 2005/06 National Survey of Investment in Mental Health Services conducted by Mental Health Strategies for the Department of Health Care Services Improvement Partnership (CSIP). Financial mapping was carried out as part of the Autumn review process.

The investment shown could be commissioned by the NHS or by a Local Authority Social Services Department or by a combination of both. There are four main provider types:

- **NHS** - mental health trusts and PCTs which directly provide specialist mental health services;
- **Non-statutory sector**;
- **Social services**;
- **Non General Medical Services** i.e., services provided by General Medical Services but not funded from GMS including a variety of services such as psychological therapies, counselling and primary care mental health workers.
Rationale and background

The extent to which statutory agencies (NHS and Local Authority Social Services Departments) commission services from a range of providers including the non-statutory sector may give some indication of partnership working.

Commentary

In all regions the vast majority of the mental health investment is in services provided by the NHS, as would be expected. The range is 67% in the North West to 77% in London, and the variation between regions is of doubtful significance. All regions appear to invest similar proportions in the non-statutory sector (range 12% to 23%) and in most regions it exceeds investment in directly provided social services. Only in the North East does Social Services appear to be the major non-NHS provider (14% of all mental health investment). East of England appears to invest relatively little in directly provided social services (3%).
5.2 Multidisciplinary community mental health teams

Figure 56: Percentage of community mental health teams reported as achieving full local integration between NHS and social services partners

![Chart showing percentage of teams reported as fully integrated by region.](chart)

Source: Adult Mental Health Service Mapping

**Indicator description**

Proportion of community mental health teams reported as achieving full local integration between NHS and social services partners.

**Rationale and background**

Specialist mental health care is a multidisciplinary activity with important roles for both health and social services staff. Properly integrated working is easier in situations where all staff operate in a single consolidated team. As part of the annual mental health services mapping, one characteristic of community mental health teams surveyed is the extent to which this integration has been achieved. Full integration is defined as having:

- Interagency multidisciplinary staff (health and social services);
- Single operational management for all staff regardless of their employing agency;
- Integrated assessment, care planning and care co-ordination; and
- Joint recording and IT systems.

**Commentary**

The chart above shows the proportion of teams reported to be fully integrated according to the definition above.
6 SERVICE USER EXPERIENCE

6.1 Complaints

**Figure 57: Percentage of complaints regarding mental health trusts/service that are referred back to trust, July 2004 to April 2006**

![Percentage of complaints regarding mental health trusts/service that are referred back to trust, July 2004 to April 2006](image)

*Source: Healthcare Commission*

**Indicator description**

Percentage of cases made for independent review regarding mental health trusts and services, where the complaint is referred back to the local trust for further resolution. Analysis is based upon data supplied by the Healthcare Commission.

**Rationale and background**

The Healthcare Commission is the second stage of the NHS complaints process. Cases are referred back to local trusts when the Healthcare Commission feels that more could have been done at the first stage to resolve the complaint.

**Main findings**

Nationally, 38% of cases are referred back. There is little regional disparity.

**Regional Commentary**

The percentage of complaints referred back to trusts range from 42% in the South East to 32% in the South West.
6.2 Annual survey of patient experience

Figure 58: Percentage of Healthcare Commission survey respondents that rated the care they had received as either excellent, very good or good, 2005

Source: Healthcare Commission

Figure 59: Percentage of Healthcare Commission survey respondents that had received at least one care review, 2005

Source: Healthcare Commission
**Figure 60: Percentage of Healthcare Commission survey respondents that had an out of hours contact telephone number, 2005**

![Chart showing percentage of respondents with out of hours contact telephone numbers by region.]

**Source: Healthcare Commission**

**Indicator description**

Figures are percentages of respondents to annual Healthcare Commission survey for 2005.

**Rationale and background**

Each year the Healthcare Commission approaches a random sample of 850 working age adults registered on the Care Programme Approach (CPA) programme of each mental health provider trust in England. Sample members are sent a questionnaire about their experience of the mental health care they had received; up to two reminders are sent. The 2005 survey achieved an overall response rate of 41%. The survey covers a wide range of aspects of the experience of mental health care. Three items have been drawn out for attention here. Service users' overall experience of care provides an obvious summary rating. The extent to which users are aware of having had their care reviewed would appear to provide a testing index of the extent to which they are genuinely involved in their care planning process. The provision of a telephone number through which users can obtain help outside normal working hours is an obvious requirement for a service providing for people at risk of finding themselves in emotional crises.

**Commentary**

The overall reported satisfaction rate is reasonably high, although in health service feedback exercises, questions of this nature usually receive positive responses. There are however quite sharp differences with London, East of England and the South East service users notably less satisfied than those in the North of England, the Midlands and the West Country. The striking feature of the other two questions would appear to be the low overall level of satisfactory performance. In each case the overall national satisfaction rate was about half.
7 WORKFORCE CAPACITY

Staff form the core of all mental health services. Many professional groups work in collaboration, each making their distinct contribution. The adequacy of services in an area is dependent not on any one group alone, but on the whole constellation working together. The NHS gathers data about staff through two major types of source.

Annual workforce censuses cover all staff groups. However, for the purposes of this work, they are only really satisfactory for medical staff where reporting is by medical specialty and sub-specialty. For other professional disciplines no similar categorisation is available; hence it is impossible to identify the numbers working in mental health care or providing care to working age adults.

The annual service mapping provides parallel estimates. While less detailed in terms of staff seniority gradation, it identifies numbers working in adult mental health care and provides a detailed profile of the types of service in which they work. As a source documenting simply total whole time equivalent staff in areas, it appears weaker than the workforce census in two ways. First, in some areas there are implausible gaps, probably reflecting missing data. Secondly, in a few other areas it appears that headcount, not whole-time equivalent numbers, have been reported leading to some overestimation; this is probably most important in disciplines such as clinical psychology where individual staff members commonly work in several settings.

In the following pages, major, established staff groups are described first. These are followed by a small number of new staff types which have been introduced as the subject of recent policy initiatives.
7.1 Clinical Psychology staff

Figure 61: Total whole time equivalent clinical psychology staff, rate per 100,000 population aged 18 to 64 years, 2005/06

Source: Adult Mental Health Service Mapping

Figure 62: Clinical psychology staff by grade, 2005/06

Source: Adult Mental Health Service Mapping
**Indicator description**

Analyses are based upon data from adult mental health service mapping for:

- Whole time equivalent clinical psychology staff, rate per 100,000 population aged 18 to 64 years; and
- Clinical psychology staff by grade.

**Rationale and background**

Clinical psychologists are responsible for assessment of psychological aspects of service users’ mental health problems and provision of psychological treatments. Clinical psychology provision has historically been limited by availability of qualified staff.

Usable data in this area are available only from the annual mental health service mapping exercise. This source identifies two grades of qualified clinical psychologists: ordinary and (the more senior) consultant and an additional grade of unqualified assistant psychologists. The latter comprises both aspirant trainees and less qualified staff employed to undertake specific psychological treatments under supervision. Data about clinical psychology staff are also collected through the NHS workforce census. However, this source is unusable for the present purpose as it does not distinguish between those engaged in the care of mentally ill, learning disabled and physically ill people.

**Commentary**

The figures show sharp overall variations between regions both in staff numbers per thousand population and in grade profiles. Interpretations are complex. Higher proportions of consultants within the qualified group may indicate real variations in skill-mix or it may reflect grade drift to encourage recruitment or retention. Higher numbers of assistant psychologists may reflect substitution of less qualified staff as a result of inability to recruit more senior staff, careful tailoring of skill level to jobs, or strategic workforce development.

London has by far the highest overall provision; it also has amongst the lowest proportions of consultants amongst qualified psychologists and assistants amongst all psychologists. North West, West Midlands and Yorkshire and Humber stand out as having particularly high proportions of assistant psychology staff. In the West Midlands, this is in the context of an above average overall provision, suggesting strategic reasons. In the case of Yorkshire and Humber the actual provision of assistant psychologists is only at the national average; the high proportion thus reflects low numbers of qualified staff.
7.2 Medical staff

Figure 63: Total whole time equivalent medical staff, rate per 100,000 population aged 18 to 64 years, 2005/06

Source: National Health Service Medical Workforce Census

Figure 64: Medical staff by grade, 2005/06

Source: National Health Service Medical Workforce Census
Indicator description

Analyses are based upon data from the NHS medical workforce census for:

- Whole time equivalent medical staff, rate per 100,000 population aged 18 to 64 years;
- Medical staff by grade.

Rationale and background

Medical staff in the mental health services are primarily responsible for assessing the nature, severity and prognosis of service users’ problems, and, with others, for defining appropriate care strategies. They have specific expertise in the use of drug and other physical treatments and statutory roles in relation to assessments under the Mental Health Act.

Overall, nationally there are fewer qualified psychiatrists than needed to fill available posts. Historically there has always been a concentration of medical staff around the London teaching hospitals and difficulty in filling posts in some other parts of the country.

The Department of Health's medical workforce census provides reasonably satisfactory data at regional level. Medical staff are classified by their grade and the psychiatric sub-specialty in which they work. Three psychiatric specialties (i.e., general psychiatry, forensic psychiatry and psychotherapy) are predominantly concerned with the care of mentally ill working age adults.

Commentary

Total provision varies relatively little around the country with the exception of London, for which it is better. However this disguises important differences in grade profile. Three regions, the East of England, the North West and Yorkshire and Humber, have 20% fewer consultants in relation to their population. Career grade doctors do not seem to be balancing these shortfalls; if anything they mirror them. Maintaining an adequate ratio of trainees is crucial to long-term workforce maintenance. The national average figure of 1.2 trainees per consultant is noticeably exceeded in four regions while two, particularly the North East, fall substantially below.

The North East has 25% above the national rate of consultant staff but only just over half that for other grades. The East of England and the Yorkshire and Humber regions have the lowest consultant provision, roughly three quarters of the national average.

London has 70% more consultant, 80% more trainee and 45% more staff grade doctors than the national average.
7.3 Psychiatric nurses

Figure 65: Total whole time equivalent psychiatric nursing staff, rate per 100,000 population aged 18 to 64 years, 2005/06

Source: Adult Mental Health Service Mapping

Figure 66: Psychiatric nursing staff by grade, 2005/06

Source: Adult Mental Health Service Mapping
**Indicator description**

Analyses are based upon data from adult mental health service mapping for:

- Whole time equivalent psychiatric nursing staff, rate per 100,000 population aged 18 to 64 years; and
- Psychiatric nursing staff by grade.

**Rationale and background**

Nurses form the largest number of clinical staff in mental health care. Broadly they can be divided into staff nursing groups, comprising qualified nurses and highly experienced nursing assistants, (graded from C to G), senior nurses (graded H to I), and unqualified nursing assistants (graded A and B).

Nurses work in many types of setting. While those working in the various types of community based team caring for ambulatory service users are most prominent, they are in fact the minority, comprising under 30% of the total, though with a relatively senior grade profile. Just over 40% of nurses work in acute in-patient settings with a further 20% in long term residential care and 10% in secure residential care.

**Commentary**

The graph shows numbers of staff per hundred thousand population. Both overall numbers and the grade profiles differ widely.

Overall London and the North East have the highest numbers in total, though with different grade patterns. London has more senior nurses while the North East has more unqualified nursing assistants. The West Midlands, North West and Yorkshire and Humber occupy an intermediate position with other regions reporting substantially fewer nurses in relation to their population. This pattern largely follows the need profiles.
7.4 Occupational, Art, Music and Drama Therapists

Figure 67: Total whole time equivalent occupational and creative therapy staff, rate per 100,000 population aged 18 to 64 years, 2005/06

Source: Adult Mental Health Service Mapping

Figure 68: Occupational and creative therapy staff by therapy staff group, 2005/06

Source: Adult Mental Health Service Mapping
**Indicator description**

Analyses are based upon data from adult mental health service mapping for:

- Whole time equivalent occupational and creative therapy staff, rate per 100,000 population aged 18 to 64 years; and
- Occupational and creative therapy staff by grade.

**Rationale and background**

Occupational Therapists (OTs) have several roles in mental health care. They are involved in the assessment and development of social, occupational and daily living skills in people severely disabled by chronic psychosis or organic mental health problems. They are involved in a range of types of exploratory psychological and social skills programmes, often with service users in groups, and they work alongside nurses providing milieu therapy in in-patient and day-hospital settings. Art, drama and music therapists are present in much smaller numbers and work mainly to assist service users in self exploration and the development of social skills.

**Commentary**

London, the North East, the East and West Midlands and Yorkshire and the Humber have the highest numbers of qualified OTs. The North West stands out as having a low level of provision in view of its high need level. London, the East of England and Yorkshire and the Humber stand out as having the highest number of creative therapists, a pattern clearly not related to need.
7.5 Counsellors and Psychotherapists

Figure 69: Total whole time equivalent counselling and psychotherapy staff, rate per 100,000 population aged 18 to 64 years, 2005/06

Source: Adult Mental Health Service Mapping

Figure 70: Counselling and psychotherapy staff by staff group, 2005/06

Source: Adult Mental Health Service Mapping
Indicator description

Analyses are based upon data from adult mental health service mapping for:

- Whole time equivalent counselling and psychotherapy staff, rate per 100,000 population aged 18 to 64 years; and
- Counselling and psychotherapy staff by grade.

Rationale and background

Service mapping identifies a range of other types of practitioner. These provide a range of interpretative, behavioural and supportive treatments.

Commentary

The North East and London both stand out as having an apparently high level of provision. There is some doubt about the reliability of many of these figures. A high proportion of the professionals concerned work in independent sector settings so completeness of ascertainment and clarity about this distinction between headcount and whole time equivalent (WTE) figures is likely to be less than in other workforce statistics.
### 7.6 Graduate workers

**Figure 71: Percentage of Local Implementation Teams (LITs) with graduate workers, 2005/06**

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>North East</td>
<td>90%</td>
</tr>
<tr>
<td>North West</td>
<td>95%</td>
</tr>
<tr>
<td>Yorkshire &amp; Humber</td>
<td>70%</td>
</tr>
<tr>
<td>East Midlands</td>
<td>80%</td>
</tr>
<tr>
<td>West Midlands</td>
<td>75%</td>
</tr>
<tr>
<td>East of England</td>
<td>85%</td>
</tr>
<tr>
<td>London</td>
<td>90%</td>
</tr>
<tr>
<td>South East</td>
<td>80%</td>
</tr>
<tr>
<td>South West</td>
<td>85%</td>
</tr>
<tr>
<td>England</td>
<td>80%</td>
</tr>
</tbody>
</table>

*Source: Adult Mental Health Service Mapping*

**Indicator description**

Percentage of Local Implementation Teams (LITs) reporting at least one graduate worker. Analysis based upon data from adult mental health service mapping.

**Rationale and background**

The NHS Plan\textsuperscript{54} and the Mental Health Policy Implementation Guidance\textsuperscript{65,66} announced the introduction of a new group of 'Graduate Workers' to supplement the provision of brief, evidence-based psychological therapies for people with common mental health problems in primary care settings. Funding was made available for 1,000 whole-time equivalent graduate workers.

**Commentary**

Service mapping shows that just over 720 WTEs were in post at the end of March 2006. Overall 80% of local implementation teams have introduced some, though this proportion varied considerably between regions.
### 7.7 Gateway workers

**Figure 72: Percentage of Local Implementation Teams (LITs) with gateway workers, 2005/06**

Percentage of Local Implementation Teams (LITs) reporting at least one gateway worker. Analysis based upon data from adult mental health service mapping.

**Source:** Adult Mental Health Service Mapping

#### Indicator description

Percentage of Local Implementation Teams (LITs) reporting at least one gateway worker. Analysis based upon data from adult mental health service mapping.

#### Rationale and background

The concept of 'Gateway workers' was introduced in the NHS Plan\(^{54}\) and described more fully in the Mental Health Policy Implementation Guidance\(^{65,67}\). These staff were intended to facilitate access to secondary mental health services by improving the various 'gateways' that existed, supporting the provision of a 24-hour co-ordinating service for acute care, liaising with mental health teams, and involving service users and carers more. New funding was made available to support the provision of 500 such workers. This initiative was monitored through the annual mental health services mapping.

#### Commentary

Overall, 83% of Local Implementation Teams reported providing at least some Gateway service. The figure shows how this proportion varies by region. The total number of whole-time equivalent staff currently reported is 1,413, nearly 3 times the anticipated number, however clearly by no means are all of these ‘additional’ staff. Unfortunately the interpretation of the initiative seems to have varied widely around the country. Half of all the reported Gateway workers are in just 20 LIT areas, while 29 LITs reported no provision. In a few places, all clinical members of community mental health teams have been described as ‘Gateway staff’, clearly a considerable deviation from the envisaged specialised role.
7.8 Community development workers for Black and Minority Ethnic Communities

Figure 73: Whole time equivalent black and minority ethnic community development workers, rate per million population aged 18 to 64 years, 2005/06

Source: Adult Mental Health Service Mapping

Figure 74: Whole time equivalent black and minority ethnic community development workers, rate per million black and minority ethnic population aged 18 to 64 years, 2005/06

Source: Adult Mental Health Service Mapping
Indicator description

Whole time equivalent numbers of community development workers for black and minority ethnic groups, rate per million population aged 18 to 64 years and rate per million black and minority ethnic population aged 18 to 64 years.

The denominator for the second analysis is an estimate based upon the proportion of regional populations recorded in the 2001 Census as belonging to any ethnic group other than 'White: British'.

Rationale and background

The establishment of a network of Community Development Workers (CDWs) was a key recommendation of Inside Outside NIMHE’s key report on improving mental health services for black and minority ethnic communities in England. The report saw the key problems as the failure of mental health services to orient themselves to the needs and help seeking styles of members of the minority ethnic communities, and the consequent difficulties experienced by individuals in those communities in obtaining help in ways which made sense to them.

Commentary

The graph shows numbers of Community Development Workers reported to have been appointed in the 2005/6 annual mental health services mapping.
7.9 Support time and recovery staff

Figure 75: Whole time equivalent support time and recovery staff, rate per 100,000 population aged 18 to 64 years, 2005/06

Indicator description

Whole time equivalent support time and recovery staff, rate per 100,000 population aged 18 to 64 years. Analysis based upon data from adult mental health service mapping.

Rationale and background

Within its final report, the mental health Workforce Action Team (WAT), discussed a number of areas where it was felt appropriate to establish more 'non-professionally affiliated people' within the mental health workforce. A fuller report on the most prominent of these, Support, Time and Recovery workers, followed from these recommendations in March 2003. These new staff are anticipated to come from a wide range of backgrounds, and to include former service users. The role, indicated by their title, is to have the time to provide practical listening and support to mental health services users.

Commentary

The numbers show a fairly clear north south gradient.
8 REFERENCES


http://www.communities.gov.uk/index.asp?id=1128444


Brugha TS, Bebbington TE, MacCarthy B, Sturt E, Wykes T and Potter J. Gender, Social Support and Recovery from Depressive Disorders: A Prospective Clinical Study. Psychological Medicine 1990; 20(1):147-156.


NHS Health and Social Care Information Centre. HES Online: Main Speciality Table 2004/05 from http://www.hesonline.nhs.uk/


61 The University of Manchester. Avoidable Deaths: Five Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. The University of Manchester. 2006.


63 NIMHE and Peninsula Medical School. Suicide Audit in Primary Care: A Tool to Support Population-based Audit of Suicides and Open Verdicts. 2006.


<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADQ</td>
<td>Average daily quantity</td>
</tr>
<tr>
<td>APS</td>
<td>Annual Population Survey</td>
</tr>
<tr>
<td>APHO</td>
<td>Association of Public Health Observatories</td>
</tr>
<tr>
<td>BCS</td>
<td>British Crime Survey</td>
</tr>
<tr>
<td>BNF</td>
<td>British National Formulary</td>
</tr>
<tr>
<td>CDWs</td>
<td>Community Development Workers</td>
</tr>
<tr>
<td>CHD</td>
<td>Coronary heart disease</td>
</tr>
<tr>
<td>CHI</td>
<td>Commission for Health Inspection</td>
</tr>
<tr>
<td>CSSR</td>
<td>Councils with Social Services Responsibilities</td>
</tr>
<tr>
<td>CSIP</td>
<td>Care Services Improvement Partnership</td>
</tr>
<tr>
<td>DAT</td>
<td>Drug action team</td>
</tr>
<tr>
<td>DDD</td>
<td>Defined daily dose</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DSH</td>
<td>Deliberate self harm</td>
</tr>
<tr>
<td>ECT</td>
<td>Electroconvulsive therapy</td>
</tr>
<tr>
<td>EMPIRIC</td>
<td>Ethnic Minority Psychiatric Illness Rates in the Community</td>
</tr>
<tr>
<td>GHQ</td>
<td>General Health Questionnaire</td>
</tr>
<tr>
<td>GHS</td>
<td>General Household Survey</td>
</tr>
<tr>
<td>GMS</td>
<td>General Medical Services</td>
</tr>
<tr>
<td>HCC</td>
<td>Healthcare Commission</td>
</tr>
<tr>
<td>HES</td>
<td>Hospital Episode Statistic</td>
</tr>
<tr>
<td>IMD 2004</td>
<td>Index of Multiple Deprivation 2004</td>
</tr>
<tr>
<td>LIT</td>
<td>Local implementation team</td>
</tr>
<tr>
<td>MHA</td>
<td>Mental Health Act</td>
</tr>
<tr>
<td>MHMDS</td>
<td>Mental Health Minimum Data Set</td>
</tr>
</tbody>
</table>
MINI  Mental Illness Needs Index
NCI  National confidential inquiry
NEPHO  North East Public Health Observatory
NIMHE  National Institute for Mental Health in England
NSF  National Service Framework
ODPM  Office of the Deputy Prime Minister
OECD  Office for Economic Co-operation and Development
ONS  Office for National Statistics
PCT  Primary Care Trust
PPA  Prescription Pricing Authority
PPD  Prescription Pricing Division
QMAS  Quality Management and Analysis System
SDRC  Social Disadvantage Research Centre
SHA  Strategic Health Authority
SOAs  Super Output Areas
WAT  Workforce Action Team
APPENDIX 1

‘Traffic light’ indicators

KEY: Regional value against the England average based on 95% confidence intervals (CIs) unless otherwise stated:

<table>
<thead>
<tr>
<th>better than average</th>
<th>consistent with average</th>
<th>worse than average</th>
</tr>
</thead>
<tbody>
<tr>
<td>75.1</td>
<td>70.0</td>
<td>73.0</td>
</tr>
<tr>
<td>74.2</td>
<td>76.1</td>
<td>74.3</td>
</tr>
<tr>
<td>78.3</td>
<td>68.9</td>
<td>78.8</td>
</tr>
<tr>
<td>77.6</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

NB: Rates are based on relevant mid-year estimates of resident populations.
Abbreviations used in tables:

LITs = Local Implementation Teams  
WTE = Whole Time Equivalent  
BME = Black and Minority Ethnic

<table>
<thead>
<tr>
<th>Indicator</th>
<th>England</th>
<th>North East</th>
<th>North West</th>
<th>Yorkshire &amp; Humber</th>
<th>East Midlands</th>
<th>West Midlands</th>
<th>East of England</th>
<th>London</th>
<th>South East</th>
<th>South West</th>
<th>Local authority data available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of people of working age in employment, 2003</td>
<td>75.1</td>
<td>70.0</td>
<td>73.0</td>
<td>74.2</td>
<td>76.1</td>
<td>74.3</td>
<td>78.3</td>
<td>68.9</td>
<td>78.8</td>
<td>77.6</td>
<td>Y</td>
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<tr>
<td>Percentage of adults of working age with a mental health problem in employment, 2003</td>
<td>24.7</td>
<td>15.7</td>
<td>20.0</td>
<td>21.6</td>
<td>27.0</td>
<td>22.8</td>
<td>30.1</td>
<td>22.0</td>
<td>33.0</td>
<td>32.3</td>
<td>N</td>
</tr>
<tr>
<td>Mental and behavioural disorders incapacity benefit claimant rate per 100,000 population aged 16 to 59 years, 2004/05</td>
<td>262.6</td>
<td>396.1</td>
<td>386.1</td>
<td>276.8</td>
<td>227.6</td>
<td>270.6</td>
<td>192.8</td>
<td>254.6</td>
<td>186.6</td>
<td>242.0</td>
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<td>Percentage of adults with a limiting long term illness, 2001</td>
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<td>22.7</td>
<td>20.7</td>
<td>19.5</td>
<td>18.4</td>
<td>18.9</td>
<td>16.2</td>
<td>15.5</td>
<td>15.5</td>
<td>18.1</td>
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<td>Percentage of alcohol consumption above ‘sensible’ daily limits (more than 4 units for men, more than 3 units for women), 2005</td>
<td>26.8</td>
<td>32.3</td>
<td>33.1</td>
<td>34.1</td>
<td>27.3</td>
<td>23.5</td>
<td>25.2</td>
<td>19.1</td>
<td>24.2</td>
<td>26.8</td>
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<tr>
<td>Percentage of adults that meet the current recommended level of physical activity, 2006</td>
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<td>11.4</td>
<td>11.1</td>
<td>11.1</td>
<td>11.6</td>
<td>10.5</td>
<td>11.3</td>
<td>12.5</td>
<td>12.6</td>
<td>12.6</td>
<td>Y</td>
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<tr>
<td>Percentage of adults who consume 5 or more portions of fruit and vegetables per day, 2001-02</td>
<td>23.8</td>
<td>16.8</td>
<td>22.2</td>
<td>22.2</td>
<td>22.6</td>
<td>22.8</td>
<td>23.9</td>
<td>27.6</td>
<td>28.9</td>
<td>26.9</td>
<td>N</td>
</tr>
<tr>
<td>Percentage of adults participating in any civic activity in the previous 12 months, 2000</td>
<td>38.6</td>
<td>32.3</td>
<td>36.5</td>
<td>31.4</td>
<td>37.9</td>
<td>38.4</td>
<td>40.6</td>
<td>37.7</td>
<td>41.9</td>
<td>46.0</td>
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<td>Percentage of population reporting having a religion, 2001</td>
<td>77.7</td>
<td>81.9</td>
<td>82.3</td>
<td>78.1</td>
<td>76.6</td>
<td>80.2</td>
<td>75.5</td>
<td>75.6</td>
<td>76.0</td>
<td>75.5</td>
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<tr>
<td>Percentage of adults who could get a lift somewhere if needed, 2000</td>
<td>93.0</td>
<td>94.0</td>
<td>96.0</td>
<td>93.0</td>
<td>94.0</td>
<td>93.0</td>
<td>96.0</td>
<td>84.0</td>
<td>95.0</td>
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</table>
## 'Traffic light' indicators (continued)

### RISK AND PROTECTIVE FACTORS AND DETERMINANTS (continued)

<table>
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<tr>
<th>Indicator</th>
<th>England</th>
<th>North East</th>
<th>North West</th>
<th>Yorkshire &amp; Humber</th>
<th>East Midlands</th>
<th>West Midlands</th>
<th>East of England</th>
<th>London</th>
<th>South East</th>
<th>South West</th>
<th>Local authority data available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of pupils aged 15 years in local authority schools achieving 5 or more grade A*-C GCSEs or equivalent, 2004/05</td>
<td>54.7</td>
<td>53.5</td>
<td>53.8</td>
<td>51.2</td>
<td>52.5</td>
<td>54.2</td>
<td>56.6</td>
<td>55.2</td>
<td>57.5</td>
<td>56.0</td>
<td>Y</td>
</tr>
<tr>
<td>Percentage of working age adults in job-related training in the past 13 weeks (working and unemployed), 2004/05</td>
<td>25.6</td>
<td>26.6</td>
<td>24.5</td>
<td>25.4</td>
<td>26.0</td>
<td>24.3</td>
<td>24.8</td>
<td>25.7</td>
<td>27.4</td>
<td>26.1</td>
<td>Y</td>
</tr>
<tr>
<td>Percentage of working age adults currently working towards or studying for any qualifications, 2004/05</td>
<td>14.6</td>
<td>14.7</td>
<td>13.7</td>
<td>15.2</td>
<td>14.5</td>
<td>14.6</td>
<td>13.1</td>
<td>16.0</td>
<td>14.3</td>
<td>15.1</td>
<td>Y</td>
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<tr>
<td>Percentage of the population with a 'high level of worry about violent crime', 2004/05</td>
<td>16.6</td>
<td>14.6</td>
<td>18.3</td>
<td>16.0</td>
<td>16.0</td>
<td>17.0</td>
<td>14.3</td>
<td>25.5</td>
<td>13.2</td>
<td>10.4</td>
<td>N</td>
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<tr>
<td>Total incidence of violence per 10,000 adults reported by people in the British Crime Survey, 2004/05</td>
<td>563.0</td>
<td>473.8</td>
<td>613.2</td>
<td>507.1</td>
<td>530.6</td>
<td>654.8</td>
<td>470.9</td>
<td>556.5</td>
<td>611.5</td>
<td>559.2</td>
<td>N</td>
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<td>All violent reported crime recorded by the police forces per 10,000 population, 2004/05</td>
<td>225.5</td>
<td>183.1</td>
<td>239.6</td>
<td>225.0</td>
<td>212.4</td>
<td>226.4</td>
<td>176.0</td>
<td>342.3</td>
<td>183.1</td>
<td>190.2</td>
<td>N</td>
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<tr>
<td>Percentage of records in Mental Health Minimum Dataset which include valid and usable ethnic group code, 2004/05</td>
<td>59.3</td>
<td>77.7</td>
<td>78.6</td>
<td>60.2</td>
<td>62.9</td>
<td>66.7</td>
<td>70.8</td>
<td>66.9</td>
<td>36.3</td>
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### POPULATION HEALTH STATUS

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<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Percentage of adults with a GHQ12 score of 4 or more, 2004</td>
<td>13.2</td>
<td>17.5</td>
<td>14.2</td>
<td>12.1</td>
<td>12.9</td>
<td>12.8</td>
<td>11.2</td>
<td>14.8</td>
<td>13.0</td>
<td>11.5</td>
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<tr>
<td>Mortality rates (age-stand) for suicide and injury undetermined (persons aged 15 years and older), 2003-05</td>
<td>10.8</td>
<td>13.1</td>
<td>11.9</td>
<td>11.3</td>
<td>10.7</td>
<td>10.4</td>
<td>10.0</td>
<td>10.4</td>
<td>10.4</td>
<td>11.0</td>
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<tr>
<td>Mortality rates (age-stand) for suicide and injury undetermined (males aged 15 years and older), 2003-05</td>
<td>16.4</td>
<td>20.4</td>
<td>18.5</td>
<td>17.3</td>
<td>16.4</td>
<td>15.8</td>
<td>15.0</td>
<td>15.4</td>
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<td>16.9</td>
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<tr>
<td>Mortality rates (age-stand) for suicide and injury undetermined (females aged 15 years and older), 2003-05</td>
<td>5.4</td>
<td>6.4</td>
<td>5.6</td>
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<td>5.1</td>
<td>5.7</td>
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<tr>
<td>Self harm hospital admission rates (age-stand) per 100,000 population, 2003</td>
<td>142.4</td>
<td>251.2</td>
<td>175.6</td>
<td>206.7</td>
<td>141.5</td>
<td>153.4</td>
<td>112.8</td>
<td>71.1</td>
<td>123.9</td>
<td>151.1</td>
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<tr>
<td>Self harm hospital admission rates (age-stand) per 100,000 population, 2004</td>
<td>158.8</td>
<td>273.6</td>
<td>199.7</td>
<td>212.9</td>
<td>172.5</td>
<td>152.5</td>
<td>124.5</td>
<td>79.5</td>
<td>140.8</td>
<td>189.7</td>
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<tr>
<td>Hospital admission rates (age-stand) for poisoning, rates per 100,000 population, 2003</td>
<td>165.3</td>
<td>283.3</td>
<td>208.9</td>
<td>221.4</td>
<td>160.7</td>
<td>197.9</td>
<td>123.7</td>
<td>95.5</td>
<td>145.3</td>
<td>157.8</td>
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## 'Traffic light' indicators (continued)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>England</th>
<th>North East</th>
<th>North West</th>
<th>Yorkshire &amp; Humber</th>
<th>East Midlands</th>
<th>West Midlands</th>
<th>East of England</th>
<th>London</th>
<th>South East</th>
<th>South West</th>
<th>Local authority data available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admission rates (age-stand) for poisoning, rates per 100,000 population, 2004</td>
<td>183.3</td>
<td>297.3</td>
<td>235.7</td>
<td>224.2</td>
<td>198.9</td>
<td>199.9</td>
<td>135.6</td>
<td>114.6</td>
<td>162.9</td>
<td>198.6</td>
<td>Y</td>
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<tr>
<td>Percentage of LITs self-assessed as 'GREEN' for having a mental health promotion lead officer, 2004</td>
<td>65.9</td>
<td>84.6</td>
<td>69.0</td>
<td>55.6</td>
<td>50.0</td>
<td>77.8</td>
<td>40.0</td>
<td>65.6</td>
<td>81.5</td>
<td>60.0</td>
<td>N</td>
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<tr>
<td>Percentage of LITs self-assessed as 'GREEN' for having a mental health promotion strategy and action plan, 2004</td>
<td>37.0</td>
<td>38.5</td>
<td>41.4</td>
<td>50.0</td>
<td>16.7</td>
<td>27.8</td>
<td>6.7</td>
<td>28.1</td>
<td>63.0</td>
<td>33.3</td>
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<tr>
<td>Hospital admission rates (age-stand) for depression, rates per 100,000 population aged 15 to 74, 2001/02</td>
<td>69.0</td>
<td>78.2</td>
<td>89.2</td>
<td>73.6</td>
<td>61.5</td>
<td>65.0</td>
<td>54.8</td>
<td>46.6</td>
<td>82.2</td>
<td>73.7</td>
<td>Y</td>
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<tr>
<td>Hospital admission rates (age-stand) for anxiety disorders, rates per 100,000 population aged 15 to 74, 2001/02</td>
<td>72.3</td>
<td>86.1</td>
<td>111.8</td>
<td>73.9</td>
<td>82.5</td>
<td>59.1</td>
<td>53.5</td>
<td>46.9</td>
<td>60.6</td>
<td>94.0</td>
<td>Y</td>
</tr>
<tr>
<td>Hospital admission rates (age-stand) for schizophrenia, rates per 100,000 population aged 15 to 74, 2001/02</td>
<td>72.6</td>
<td>70.4</td>
<td>101.1</td>
<td>72.8</td>
<td>58.6</td>
<td>67.0</td>
<td>54.9</td>
<td>99.8</td>
<td>57.9</td>
<td>61.0</td>
<td>Y</td>
</tr>
<tr>
<td>Percentage of primary care trusts with completed suicide audit, at 31st March 2004</td>
<td>96.0</td>
<td>100.0</td>
<td>83.3</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>87.1</td>
<td>98.0</td>
<td>100.0</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Percentage of community mental health teams reported as achieving full integration between NHS and social services partners</td>
<td>93.6</td>
<td>76.9</td>
<td>88.5</td>
<td>96.3</td>
<td>94.1</td>
<td>97.7</td>
<td>82.8</td>
<td>99.3</td>
<td>99.1</td>
<td>97.9</td>
<td>N</td>
</tr>
<tr>
<td>Service User Experience</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Percentage of complaints regarding mental health trusts / service that are referred back to trust, July 2004 to April 2006</td>
<td>37.9</td>
<td>37.3</td>
<td>37.7</td>
<td>37.5</td>
<td>38.1</td>
<td>32.0</td>
<td>39.7</td>
<td>38.8</td>
<td>42.0</td>
<td>31.6</td>
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<tr>
<td>Percentage of Healthcare Commission survey respondents that rated their care as excellent, very good or good, 2005</td>
<td>77.3</td>
<td>82.3</td>
<td>79.8</td>
<td>78.8</td>
<td>79.6</td>
<td>76.3</td>
<td>75.1</td>
<td>73.1</td>
<td>75.1</td>
<td>77.6</td>
<td>N</td>
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<tr>
<td>Percentage of Healthcare Commission survey respondents that had received at least one care review, 2005</td>
<td>51.6</td>
<td>59.3</td>
<td>54.7</td>
<td>52.4</td>
<td>56.1</td>
<td>42.1</td>
<td>55.4</td>
<td>53.3</td>
<td>50.2</td>
<td>51.1</td>
<td>N</td>
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<tr>
<td>Percentage of Healthcare Commission survey respondents that had an out of hours contact telephone number, 2005</td>
<td>49.5</td>
<td>53.5</td>
<td>51.0</td>
<td>49.6</td>
<td>51.6</td>
<td>47.4</td>
<td>51.7</td>
<td>42.1</td>
<td>50.8</td>
<td>52.6</td>
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</tbody>
</table>
Traffic light’ indicators (continued)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>England</th>
<th>North East</th>
<th>North West</th>
<th>Yorkshire &amp; Humber</th>
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<th>East of England</th>
<th>London</th>
<th>South East</th>
<th>South West</th>
<th>Local authority data available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total WTE clinical psychology staff, rate per 100,000 population aged 18 to 64 years, 2005/06</td>
<td>7.9</td>
<td>8.1</td>
<td>6.8</td>
<td>6.3</td>
<td>6.2</td>
<td>9.6</td>
<td>5.4</td>
<td>12.6</td>
<td>6.9</td>
<td>7.6</td>
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<tr>
<td>Total WTE medical staff, rate per 100,000 population aged 18 to 64 years, 2005/06</td>
<td>19.0</td>
<td>15.1</td>
<td>16.9</td>
<td>15.9</td>
<td>17.4</td>
<td>19.0</td>
<td>15.7</td>
<td>31.7</td>
<td>16.1</td>
<td>16.5</td>
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<tr>
<td>Total WTE psychiatric nursing staff, rate per 100,000 population aged 18 to 64 years, 2005/06</td>
<td>120.7</td>
<td>155.7</td>
<td>126.2</td>
<td>120.2</td>
<td>107.2</td>
<td>133.5</td>
<td>101.9</td>
<td>151.7</td>
<td>98.3</td>
<td>100.1</td>
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<tr>
<td>Total WTE occupational and creative therapy staff, rate per 100,000 population aged 18 to 64 years, 2005/06</td>
<td>12.3</td>
<td>13.3</td>
<td>10.4</td>
<td>11.7</td>
<td>11.2</td>
<td>12.1</td>
<td>10.5</td>
<td>15.8</td>
<td>12.2</td>
<td>12.3</td>
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<tr>
<td>Total WTE counselling and psychotherapy staff, rate per 100,000 population aged 18 to 64 years, 2005/06</td>
<td>13.2</td>
<td>27.6</td>
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<td>14.7</td>
<td>5.0</td>
<td>11.6</td>
<td>8.1</td>
<td>22.9</td>
<td>10.2</td>
<td>6.7</td>
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<tr>
<td>Percentage of LITs with graduate workers, 2005/06</td>
<td>78.6</td>
<td>92.3</td>
<td>100.0</td>
<td>72.2</td>
<td>100.0</td>
<td>83.3</td>
<td>60.0</td>
<td>75.0</td>
<td>66.7</td>
<td>66.7</td>
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<tr>
<td>Percentage of LITs with gateway workers, 2005/06</td>
<td>83.2</td>
<td>84.6</td>
<td>86.2</td>
<td>72.2</td>
<td>100.0</td>
<td>77.8</td>
<td>93.3</td>
<td>90.6</td>
<td>74.1</td>
<td>80.0</td>
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<tr>
<td>WTE BME community development workers, rate per million population aged 18 to 64 years, 2005/06</td>
<td>4.7</td>
<td>4.7</td>
<td>5.4</td>
<td>4.0</td>
<td>3.3</td>
<td>5.7</td>
<td>2.9</td>
<td>7.4</td>
<td>2.5</td>
<td>5.3</td>
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<tr>
<td>WTE BME community development workers, rate per million black and minority ethnic population aged 18 to 64 years, 2005/06</td>
<td>35.8</td>
<td>130.8</td>
<td>68.7</td>
<td>47.5</td>
<td>37.8</td>
<td>41.2</td>
<td>33.8</td>
<td>18.5</td>
<td>29.0</td>
<td>116.0</td>
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<tr>
<td>WTE support time and recovery staff, rate per 100,000 population aged 18 to 64 years, 2005/06</td>
<td>6.2</td>
<td>10.2</td>
<td>9.6</td>
<td>7.7</td>
<td>4.5</td>
<td>7.6</td>
<td>3.9</td>
<td>6.3</td>
<td>3.3</td>
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</table>
### Remaining indicators

**KEY:** For selected indicators – regional value against the England average based on 95% confidence intervals (CIs):

<table>
<thead>
<tr>
<th>Indicator</th>
<th>England</th>
<th>North East</th>
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<th>London</th>
<th>South East</th>
<th>South West</th>
<th>Local authority data available</th>
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</thead>
<tbody>
<tr>
<td>People in contact with structured drug treatment, rate per 100,000 population, 2005/06</td>
<td>544.5</td>
<td>642.3</td>
<td>789.5</td>
<td>750.2</td>
<td>479.3</td>
<td>535.0</td>
<td>381.5</td>
<td>619.3</td>
<td>347.5</td>
<td>585.0</td>
<td>N</td>
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<tr>
<td>Council supported residents with mental health problems aged 18 to 64 years, rate per 100,000 population, at 31st March 2005</td>
<td>38.6</td>
<td>41.3</td>
<td>41.8</td>
<td>37.7</td>
<td>42.9</td>
<td>36.1</td>
<td>25.5</td>
<td>55.9</td>
<td>29.3</td>
<td>34.5</td>
<td>N</td>
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<tr>
<td>Percentage of service users registered with a general practitioner who have severe long-term mental health problems, 2004/05</td>
<td>0.6</td>
<td>0.5</td>
<td>0.6</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
<td>0.6</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
<td>N</td>
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<tr>
<td>Rate per 100,000 population aged 18 to 64 years currently receiving mental health assertive outreach care, 2006</td>
<td>59.8</td>
<td>80.7</td>
<td>71.9</td>
<td>57.3</td>
<td>49.5</td>
<td>66.8</td>
<td>41.7</td>
<td>74.9</td>
<td>45.8</td>
<td>54.2</td>
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<tr>
<td>Rate per 100,000 population aged 18 to 64 years currently receiving crisis resolution service care, 2006</td>
<td>267.5</td>
<td>545.9</td>
<td>219.1</td>
<td>241.9</td>
<td>245.2</td>
<td>307.0</td>
<td>237.0</td>
<td>338.0</td>
<td>193.3</td>
<td>233.7</td>
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<tr>
<td>Rate per 100,000 population aged 15 to 34 years receiving psychosis early intervention care, 2006</td>
<td>60.7</td>
<td>138.2</td>
<td>58.8</td>
<td>64.7</td>
<td>78.4</td>
<td>87.0</td>
<td>44.0</td>
<td>49.8</td>
<td>24.3</td>
<td>73.3</td>
<td>N</td>
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<tr>
<td>Percentage of LITs with NHS day hospitals, 2005/06</td>
<td>49.7</td>
<td>53.8</td>
<td>34.5</td>
<td>44.4</td>
<td>100.0</td>
<td>55.6</td>
<td>33.3</td>
<td>59.4</td>
<td>37.0</td>
<td>73.3</td>
<td>N</td>
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<tr>
<td>WTE care staff in NHS day care facilities, rate per 100,000 population aged 18 to 64 years, 2005/06</td>
<td>4.0</td>
<td>5.3</td>
<td>3.3</td>
<td>3.0</td>
<td>5.0</td>
<td>3.9</td>
<td>3.6</td>
<td>4.7</td>
<td>4.1</td>
<td>3.9</td>
<td>N</td>
</tr>
<tr>
<td>Percentage of LITs with at least one day centre or resource centre, 2005/06</td>
<td>93.1</td>
<td>100.0</td>
<td>89.7</td>
<td>88.9</td>
<td>100.0</td>
<td>94.4</td>
<td>100.0</td>
<td>93.8</td>
<td>85.2</td>
<td>100.0</td>
<td>N</td>
</tr>
<tr>
<td>Rate of drop-in facilities per 100,000 population aged 18 to 64 years of age, 2006</td>
<td>0.5</td>
<td>0.8</td>
<td>0.6</td>
<td>0.5</td>
<td>0.2</td>
<td>0.5</td>
<td>0.4</td>
<td>0.6</td>
<td>0.5</td>
<td>0.5</td>
<td>N</td>
</tr>
<tr>
<td>Service users detained under the Mental Health Act 1983, rate per 100,000 population aged 18 years plus, at 31st March 2004</td>
<td>36.1</td>
<td>45.7</td>
<td>40.9</td>
<td>28.0</td>
<td>42.8</td>
<td>27.2</td>
<td>27.4</td>
<td>60.8</td>
<td>28.1</td>
<td>22.6</td>
<td>N</td>
</tr>
</tbody>
</table>

NB: Rates are based on relevant mid-year estimates of resident populations.

Abbreviations used in tables:

- **LITs** = Local Implementation Teams
- **WTE** = Whole Time Equivalent

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**RISK AND PROTECTIVE FACTORS AND DETERMINANTS**

**POPULATION HEALTH STATUS**

**INTERVENTIONS**
About the APHO

The Association of Public Health Observatories (APHO) was established in 2000 and has as a main focus facilitating collaborative working between the Public Health Observatories (PHOs) in the UK and Ireland. APHO was set up with the following aims:

- To be a learning network for members and participants;
- To be a single point of contact for external partners;
- To be an advocate for users of public health information;
- To co-ordinate work across public health observatories.

Joint work is facilitated by:

- Each PHO taking the lead in a defined area to avoid duplication at regional and national levels;
- Acting as a major public health resource, raising the public health profile at regional and national levels;
- Developing collaboration through links at regional, national and international levels.

Further information about APHO, the PHOs and their work can be obtained from www.apho.org.uk.

About the National Mental Health Observatory

The National Mental Health Observatory (MHO) is jointly funded by the National Institute for Mental Health in England (NIMHE) and NHS Research & Development. It is based within the North East PHO, complementing the PHO’s lead role for mental health. Its aim is:

- To develop and extend the use of national mental health data sources, mostly designed originally for routine statistics or performance monitoring, to serve a number of more local purposes including planning, clinical management and research.

The Mental Health Observatory has three main functions as follows:

- To undertake and support research into the availability, distribution and functioning of mental health services in England;
- To support the service development functions of NIMHE e.g., collating and publishing collected statistics, undertaking benchmarking, or supporting needs assessment; and
- To undertake the lead Observatory functions for mental health which the North East PHO currently exercises on behalf of the Association of Public Health Observatories.

Further information about the MHO and its work can be obtained from: http://www.mentalhealthobservatory.org.uk