THE NHS CONFEDERATION

fact sheet

NOVEMBER 2009

Key facts and trends in mental health

This fact sheet outlines some of the key available data relating to mental health, including:

- key trends in morbidity and behaviour
- wider societal changes and challenges
- NHS budget and spending trends
- service activity
- quality, safety and user experience
- staffing levels and staff satisfaction.

Key trends in morbidity and behaviour

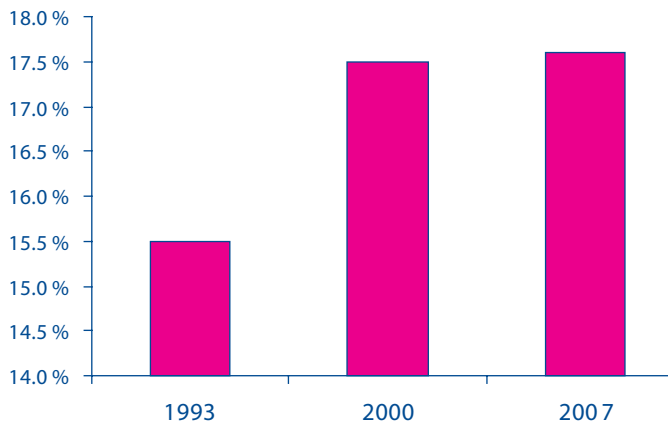
Increasing levels of common mental disorders, such as anxiety and depression

The proportion of the English population meeting the criteria for one common mental disorder has increased from 15.5 per cent in 1993, to 17.6 per cent in 2007.

Other key headlines from the P*sychiatric morbidity in England, 2007* study[1] are listed below.

- More than half of those with a common mental disorder presented with mixed anxiety and depressive disorder (9.0 per cent).
- Women were more likely than men to have a common mental disorder (19.7 per cent and 12.5 per cent respectively).
- The largest increase in the rate of common mental disorders between 1993 and 2007 was observed in women aged 45–64, among whom rates rose by about a fifth.
- Rates of common mental disorders varied by age. Those aged 75 and over were the least likely to have a disorder (6.3 per cent of men; 12.2 per cent of women)
- A quarter (24 per cent) of people with a common mental disorder were receiving treatment for an emotional or mental problem, mostly in the form of medication. The level and nature of treatment varied by type of disorder. Over half (57 per cent) of adults with a phobia were in receipt of treatment, but only 15 per cent of those with mixed anxiety and depressive disorder. Half of the people (48 per cent) with two or more disorders were receiving treatment for a mental or emotional problem.

Figure 1: Proportion of people aged 16–64 meeting criteria for at least one common mental disorder



Source: *Psychiatric Morbidity in England, 2007*, NHS Information Centre, 2008

Stable rates of psychotic disorders[1]

The overall prevalence of psychotic disorder is at 0.4 per cent (0.3 per cent of men, 0.5 per cent of women). In both men and women the highest prevalence was observed in those aged 35–44 years (0.7 per cent and 1.1 per cent respectively).

There was no change in the overall prevalence of probable psychosis between the 2000 and 2007 Psychiatric morbidity surveys. The rate was 0.5 per cent of 16–74-year-olds in both years.

Prevalence of psychotic disorder was significantly higher among black men (3.1 per cent) than men from other ethnic groups (0.2 per cent of white men; no cases observed among men in the South Asian or 'other' ethnic group). There was no significant variation by ethnicity among women.

Prevalence also varies according to income, increasing from 0.1 per cent of adults in the highest income quintile to 0.9 per cent of adults in the lowest income quintile.

No marked change in rates of anti-social and borderline personality disorders[1]

Anti-social personality disorder was observed in 0.3 per cent of adults aged 18 or over (0.6 per cent of men and 0.1 per cent of women) in 2007. 1.7 per cent of men aged between18–34 had the disorder. 0.4 per cent of women aged 16–34 had the same condition, while no cases were identified in women aged over 35 of those sampled. The prevalence in adults aged 16–74 and living in England was similar in 2000 (0.6 per cent) and 2007 (0.4 per cent).

Prevalence of borderline personality disorder was similar to that of anti-social personality disorder, at 0.4 per cent of adults aged 16 or over. While the association with sex was not significant, the observed pattern fits with the expected profile (0.3 per cent of men; 0.6 per cent of women). Rates of borderline personality disorder in those aged 16–74 and living in England did not change significantly between the 2000 (0.8 per cent) and 2007 (0.5 per cent) *Psychiatric morbidity* surveys.

Suicide rates falling, self harm increasing

Suicide rates have fallen most dramatically amongst men (from 21 per 100,000 in 1991, to 16.8 per 100,000 in 2007) and have also fallen for women (from 6.7 per 100,000 in 1991, to 5.0 per 100,000 in 1991).[2]

There is evidence of increasing levels of reporting suicidal thoughts, from 3.8 per cent of adults aged 16–74 in 2000 to 4.5 per cent in 2007.[1]

The reporting of self-harm (ever in lifetime) has increased between 2000 and 2007 (2.4 per cent in 2000, 3.8 per cent in 2007). Among women, this increase was concentrated in the youngest age group, with 6.5 per cent of women aged 16–24 reporting self-harm in 2000 compared with 11.7 per cent in 2007.[1]

Trends in homicides

While the rate of homicides in the general population is increasing, the risk of being a victim remains relatively low, at around 1 in 100,000. In 1997 there were 563 homicides in England and Wales. In 2005 there were 662. Between 1997 and 2005 there were a total of 5,189 homicides in England and Wales.[3]

There continues to be a great deal of interest from the media and public on the risk posed by inpatients who escape or abscond from mental health hospital settings. Homicide involving inpatients is extremely rare. In the years 1997–2005 there were 21 homicides by inpatients, with 17 of those occurring off the ward. Seven of those cases involved absconding.[3] Of those seven, one (14 per cent) had informal/voluntary status, while six were detained. Six (86 per cent) were on a general psychiatric ward, one (14 per cent) was on a psychiatric intensive care ward. None were on a secure unit.[3]

During 1997–2005, 510 people convicted of homicide (10 per cent of all those convicted) had been in contact with mental health services in the 12 months prior to the offence – these are termed 'patient homicides'. Although there is public concern about the risk of random attacks, it is important to note that patient homicide involving strangers is very rare – there were ten such cases in 2005.[3] Of those 510 patient homicides between 1997 and 2005, 42 per cent of patients missed their final service contact. However, in 74 per cent of those cases (where data was available) assertive action was taken by services to re-engage with the patient, such as by telephone call, home visits, contact with other agencies, contact with the patient's family or contact with individuals at risk.[3]

Alcohol dependency declines, mixed trend on drug use

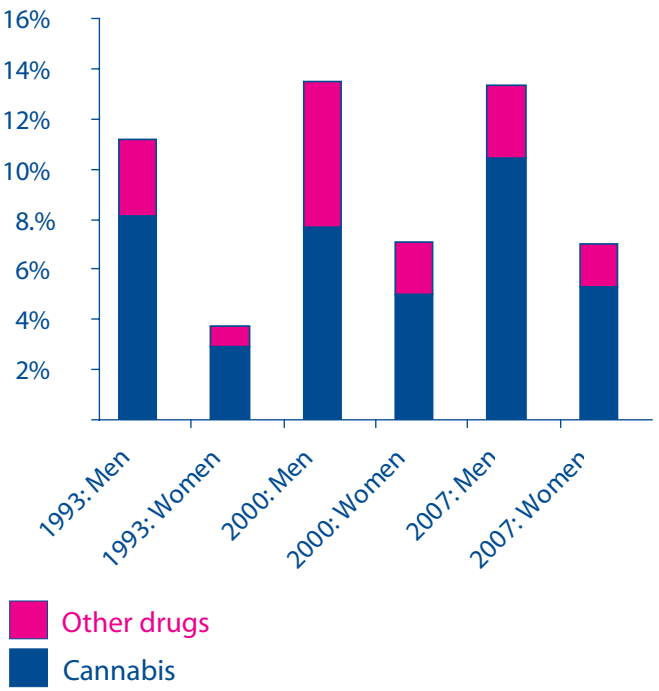
Hazardous alcohol use is defined as an established pattern of drinking which brings the risk of physical and psychological harm. 35.8 per cent of white men in 2007 were classified as hazardous drinkers, compared with 18.6 per cent of black men and 12 per cent of South Asian men. Black and South Asian women were also less likely to be hazardous drinkers than white women (4.6 per cent and 3.1 per cent, compared with 16.6 per cent).[1] The prevalence of alcohol dependence declined slightly

between 2000 and 2007; this decline was seen in men, but not in women. 11.5 per cent of men in England aged 16–74 in 2000 were dependent on alcohol; in 2007, the corresponding figure was 9.3 per cent. The proportion of women dependent on alcohol stayed at a similar level over this period; 2.8 per cent in 2000 and 3.6 per cent in 2007.[1]

Overall, 3.4 per cent of adults showed signs of dependence on drugs in the past year, including 2.5 per cent who were dependent on cannabis only and 0.9 per cent who were dependent on other drugs. Rates of dependence varied with age and sex, and were greatest in men and in the youngest age group. 4.5 per cent of all men showed signs of dependence on drugs (compared with 2.3 per cent of women), including 13.3 per cent aged16–24 and 9.0 per cent of men aged 25–34. For men in other age groups, rates of dependence were markedly lower, and no cases of dependence of those sampled were recorded in men aged 65–74.[1]

Overall rates are largely unchanged from 2000 levels, though compared with 1993 figures there has been a marked increase in overall levels of drug dependency (from 2.2 per cent to 4.1 per cent of the population). What is evident is a general upwards trend in numbers of young people dependent on cannabis, from 8.1 per cent in 1993, to 7.7 per cent in 2000 to 10.4 per cent in 2007.[1]

Figure 2: Drug dependency amongst 16–24-year-olds



Source: *Psychiatric Morbidity in England, 2007*, NHS Information Centre, 2008

14 per cent of adults who were dependent on cannabis and 36 per cent of those dependent on other drugs were receiving counselling or medication, compared with 7 per cent of those reporting no signs of drug dependence.[1]

Wider societal changes and challenges

The recession and associated unemployment

The unemployment rate was 7.8 per cent for the three months to June 2009, up 0.7 per cent over the previous quarter and up 2.4 per cent over the year. The number of unemployed people increased by 220,000 over the quarter and by 750,000 over the year, to reach 2.43 million.[4]

Numerous studies have linked unemployment with poor mental health,[5] and as more people find themselves out of work there is likely to be an associated correlation with more demand for mental health services.

Demographic change

Changing demography – both in terms of an ageing population and changing ethnic make-up – will affect future demand for mental health services.[6] In 2006 there were 9,688,000 people over the age of 65. By 2051 there will be 18,745,000.[7] Changing demography means in the next 30 years the number of people with dementia could double to 1.4 million and costs to the economy could treble from £17 to 50 billion.[8]

Stigma and discrimination

The stigma of mental illness is a burden on service users and their families, and also prevents people from seeking help in the first instance. The Stigma Shout survey, carried out as part of the Time to Change anti-discrimination campaign, found almost nine out of ten people with mental health problems (87 per cent) reported the negative impact of stigma and discrimination on their lives.[9]

69 per cent of service users said they had been treated differently (in a negative way) because of their mental health problem. 71 per cent said stigma and discrimination had stopped them doing the things they want to do.

The Department of Health's *Attitudes to mental illness* research benchmarks public attitudes since 1993 to mental illness. The picture over time is mixed, though not evidence of any significant shifts in public attitude.

The 2008 survey found one in eight people would not want to live next door to someone who has had a mental health problem. Nearly six out of ten people describe a person with a mental health problem as "someone who has to be kept in a psychiatric or mental hospital". One third of people think people with mental health problems should not have the same rights to a job as everyone else.[10]

Vulnerable groups

In respect of children, the case for early intervention is clear. The estimated lifetime costs for a single case of undiagnosed childhood conduct disorder is £150,000.[11] 45 per cent of looked after children have a mental health disorder.[8]

Prisoners constitute another vulnerable group. 72 per cent of male and 70 per cent of female prisoners suffer from two or more mental disorders. 7 per cent of male and 14 per cent of female sentenced prisoners suffer from psychosis. Of women sent to prison, almost 40 per cent say they have attempted suicide at some time.[12]

Black and minority ethnic groups (BME) are over-represented in mental health services and are also more likely to be detained under the Mental Health Act. 23 per cent of inpatients in 2008 were from a BME group.[13]

NHS budget and spending projections

International comparisons

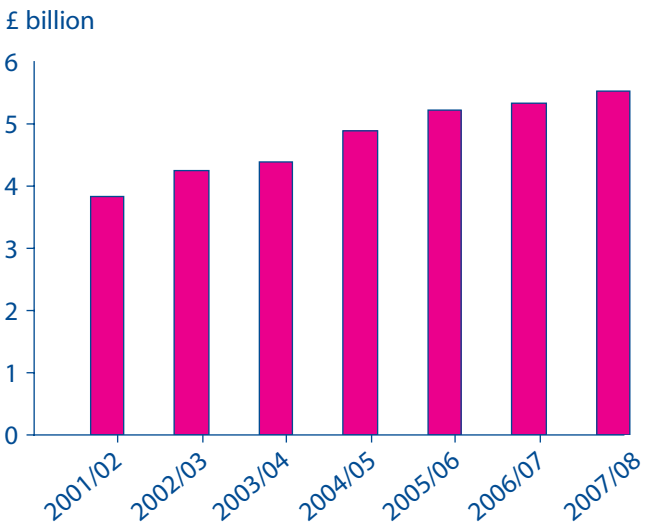
According to the World Health Organization (WHO), English mental health services rank among the best resourced in Europe. Mental health services are provided with 13.8 per cent of England's health budget, the highest percentage among those countries that provided figures. In comparison France spends 11.5 per cent, Germany 10.3 per cent, the Netherlands 8.0 per cent, Sweden 10 per cent and Italy 5 per cent.[14]

Rising spending over recent years[15]

Spending on adult mental health services in 2007/08 totalled £5.530 billion, a 7.1 per cent increase and 3.7 per cent in real terms. That compares with a total investment in 2002/03 of £4.235 billion. In real terms, during the period between 2002/03 to 2007/08 investment in mental health services has increased by 30 per cent.

Across strategic health authority regions, spend per head on adult mental health services varied in 2007/08 – from £152 to £185 per head, with an average of £169 per head.

Figure 3: Real investment in mental health services



Source: ***The 2007/08 national survey of investment in adult mental health services*****, Mental Health Strategies for Department of Health**

Investment into new services

In terms of investment in direct services for adults, the biggest areas of investment have consistently been in clinical services (£881 million in 2007/08), secure and high dependency provision (£859 million in 2007/08) and in community mental health teams (£667 million).[15] Real terms investment in the three priority areas identified by the National Service Framework has also increased:

- assertive outreach – from £71.3 million in 2002/03 to £124.9 million in 2007/08
- crisis resolution/home treatment – from £35.2 million in 2002/03 to £213.7 million in 2007/08
- early intervention in psychosis – from £7.3 million in 2002/03 to £69.2 million in 2007/08.[15]

According to the WHO, England is the only European country to provide a comprehensive network of specialist early intervention teams and one of only three nations to have comprehensive access to assertive outreach teams.[14]

Conversely, some areas have not seen big increases in spend over the same period. Notably, given the growing emphasis on promoting well-being and wider public mental health, spending on mental health promotion has remained largely static, with £4 million spent in 2007/08.

In the Healthcare Commission's *Annual health check 2007/08* 34 per cent of trusts were deemed 'excellent' for use of resources (7 per cent last year) and 50 per cent were deemed 'good' (48 per cent in 2006/07).[16]

Changing population will challenge spending levels

In terms of future spend, it is estimated that because of changing patterns of morbidity (e.g. rise in depression and anxiety-related conditions), projected spending overall for services will rise massively. The King's Fund's calculations (below) do not just take into account NHS service costs, but costs across the public sector and social care, and include costs of informal care from family and friends.

Current service costs, estimated to be £22.5 billion, are projected to increase by 45 per cent to £32.6 billion in 2026 (at 2007 prices). This is primarily due to an estimated increase in service costs for people with dementia of £9 billion. Costs will increase by 111 per cent to £47.5 billion if the real pay and price effect (a 2 per cent annual increase in health prices over and above the GDP deflator) is taken into account – again, primarily due to the impact of dementia.[6]

Service activity

Mental health services in England are provided as part of primary and secondary care, with responsibility split between the NHS, social care and the independent and voluntary sectors. Primary care trusts (PCTs) are responsible for commissioning all mental health services, sometimes jointly – as with drugs and alcohol services – with local authorities. Mental health trusts provide inpatient care, community and rehabilitation services, residential care centres, day clinics and drop-in centres. They also run regional secure units and secure hospitals.

NHS Choices currently list 73 NHS providers of mental health services. These comprise 59 specialist mental health trusts (including 36 foundation trusts) and 14 PCT providers.[17]

Falling bed numbers, declining inpatient cases, decreasing lengths of stay

In line with policy to focus on keeping people out of hospital wherever appropriate, the number of beds in NHS mental health settings has fallen. In 2006/07 there were 27,914 beds, a drop of 23.7 per cent from 1997–1998, compared with an average across NHS settings of 13.7 per cent.[18]

Hospital episode statistics show that in 2007/08 (2006/07 figures in parenthesis):[19]

- learning disability specialties accounted for 18,521 (*21,925*) finished consultant episodes, 428,134 (*433,158*) bed days, with a median length of stay of 3 (*3*) days
- adult mental illness specialities accounted for 113,305 (*115,199*) finished consultant episodes, 4,342,527 (*4,856,678*) bed days, with a median length of stay of 16 (18) days
- child and adolescent psychiatry specialties accounted for 2,411(*2,135*) finished consultant episodes, 126,530 (*126,820*) bed days and a median length of stay of 37 (*39*) days
- forensic psychiatry specialities accounted for 1,968 (*1,988*) finished consultant episodes, 388,667 (*365,819*) bed days and a median length of stay of 302 (*244*) days
- psychotherapy specialities accounted for 89 (*187*) finished consultant episodes, 11,695 (*21,152*) bed days and a median length of stay of 132 (*91*) days
- old age psychiatry specialities accounted for 32,679 (*36,733*) finished consultant episodes, 2,169,902 (*2,389,031*) bed days and a median length of stay of 41 (*39*) days.

Increasing community service provision and keeping people out of hospital

In the ten years since the National Service Framework for Mental Health there have been 700 new community teams established.[20]

Admissions and detentions under the Mental Health Act (1983) show upwards trend

The number of detentions under the Act rose to 47,600 in 2007/08 from 46,500 in 2006/07. Formal admissions rose to 28,100 in 2007/08 from 27,700 in 2006/07, the highest ever level. 93 per cent of all formal admissions were to NHS hospitals. On 31 March 2008, there were 15,200 patients detained in hospital, of which 12,300 were in NHS facilities and 2,900 in independent hospitals.[21]

Quality, safety and user experience

Improvements in quality

The *Annual health check 2008/09* evidences a further positive trend in improving quality in mental health trusts. 66 per cent achieved an excellent rating for quality of services (52 per cent last year) and 25 per cent a good rating (same as 2006/07).[16]

The 2008/09 Care Quality Commission self-assessments against core quality and safety standards saw 41 of the 60 mental health trusts (including learning disabilities) declaring full compliance. At 68 per cent, this was the highest proportion of any sector. 88 per cent of mental health trusts (again including learning disabilities) declared compliance with 90 per cent or more of the standards.[22]

Developing the safety agenda

Overall the pattern of reporting incidents to the National Patient Safety Agency has been largely static, with 26,108 incidents reported in 2008.[23] The top three categories of incidents are consistently around patient accidents, disruptive/aggressive behaviour and self harming behaviour.

User experience

78 per cent of respondents to the survey on community mental health services responded positively, with 27 per cent rating them as excellent, 29 per cent as very good and 22 per cent as good. 43 per cent felt that they 'definitely' had enough say in decisions about care and treatment, with a further 43 per cent feeling that they did 'to some extent'. 46 per cent stated that their diagnosis had 'definitely' been discussed with them, with a further 37 per cent saying that this had been done 'to some extent'. 59 per cent were either given or offered a written or printed copy of their care plan.[24]

Ward accommodation

Currently 70 per cent of sleeping accommodation in mental health settings is in single rooms.[25] The number of children under 16 being treated on NHS adult psychiatric wards has almost come down to zero – from 75 in the first quarter of 2006/07, to 3 in the fourth quarter of 2008/09. The number of 16–17-year-olds being accommodated in adult environments has declined from 4,697 (first quarter, 2006/07) to 3,101 (fourth quarter, 2008/09).[26]

Staffing levels and staff satisfaction

Increased numbers of clinical and medical staff

In the ten years since the National Service Framework for mental health was introduced substantial investment in mental health services has brought about tangible improvements in services. There have been 10,000 more nurses, 55 per cent more consultants and 69 per cent more psychologists.[20]

There are 12.7 psychiatrists per 100,000 of the population, 24 in Sweden, 22 in France, 14.5 in the Netherlands, 9.8 in Italy, 8.7 in Germany and 6.1 in Spain. The European average is 8.9.[14]

Nurse staffing levels in English mental health settings are also higher than average, with 51.9 nurses per 100,000 people, as opposed to the European average of 18.7. Germany has 58, the Netherlands 122, Sweden 73, Spain 9 and Italy 32.9.[14]

In 2008, the NHS in England directly employed 9,739 medical staff in the psychiatry group, with 4,021 consultants. That compares with 2,447 consultants in 1998. There were 17,817 (15,626 FTE) qualified nursing, midwifery and health visiting staff employed in community psychiatry, 31,296 (27,673 FTE) in other psychiatry, 3,187 (2,748 FTE) in community learning disabilities, and 4,010 (3,484 FTE) in other learning disability services.[27]

Staff satisfaction ratings

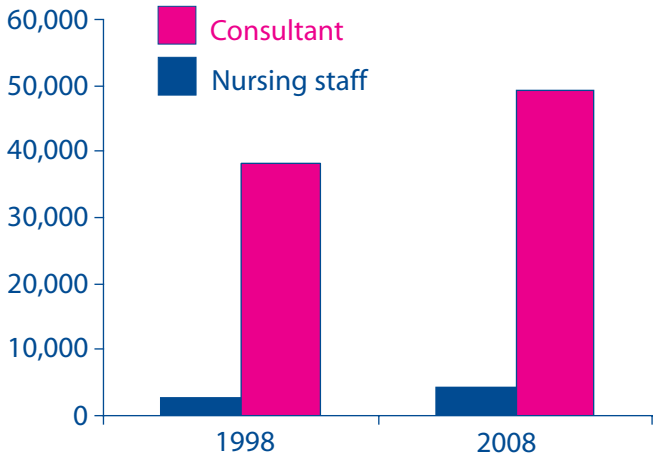
The Healthcare Commission's annual staff survey of 2008 (2007 figures in brackets where available) highlighted the following positive messages:[28]

- 90 per cent of respondents agreed that their role makes a difference to patients
- 81 per cent agreed that they have an interesting job
- 41 per cent felt they worked in a well-structured team environment
- 77 per cent of staff felt valued by their work colleagues
- 73 per cent were generally satisfied with their job (same as 2007)
- 97 per cent of staff were reporting errors, near misses or incidents (94 per cent in 2007).

Though there were some areas for improvement:

- 64 per cent were working extra hours (68 per cent in 2007).
- 8 per cent had suffered a work-related injury in the last 12 months (10 per cent in 2007)
- 30 per cent had suffered work-related stress in the last 12 months (34 per cent in 2007)
- 31 per cent had witnessed potentially harmful errors, near misses or incidents in last month (same as 2007)
- 19 per cent had experienced violence at work from patients/relatives (22 per cent in 2007).

Figure 4: Headcount of consultants and nursing staff employed in NHS psychiatry services



Source: *NHS Staff 1998 – 2008 Overview.* NHS Information Centre, 2009

References

1. *Psychiatric morbidity in England, 2007,* NHS Information Centre, 2008.
2. *Suicide rates in the UK 1991–2007,* Office of National Statistics, 2009, available at **www.statistics.gov.uk/downloads/theme_health/Suicide-rates-in-the-UK.xls**
3. *National confidential inquiry into suicide and homicide by people with mental illness – annual report: England and Wales,* University of Manchester, 2009.
4. *Labour market statistics,* Office of National Statistics, 2009, available at **www.statistics.gov.uk/cci/nugget.asp?ID=12**
5. Murphy, G.C. and Athanasou, J.A.: 'The effect of unemployment on mental health', *Journal of Occupational and Organizational Psychology*, Vol: 72, No. 1, pp. 83–99, 1999.
6. *Paying the price: the cost of mental health care to 2026,* The King's Fund, 2008.
7. *National population projections: 2006-based*, Office of National Statistics, 2008, available at **www.statistics.gov.uk/downloads/theme_population/pp2no26.pdf**
8. *Foresight Mental Capital and Well-being project report*, Government Office for Science, 2008.
9. *Stigma Shout survey,* Time to Change, 2008, available at **www.time-to-change.org.uk/challenging-discrimination/what-discrimination/research**
10. *Attitudes to mental illness 2008 research report,* Department of Health, 2008, available at **www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_084478**
11. *Mental health promotion: building an economic case,* Northern Ireland Association for Mental Health, 2007.
12. *Bromley briefings: prison factfile,* Prison Reform Trust, June 2009.
13. *Count me in 2008: Results of the 2008 national census of inpatients in mental health and learning disability services in England and Wales,* Healthcare Commission, National Institute for Mental Health in England and Care Services Improvement Partnership, 2008.
14. *Policies and practices for mental health in Europe: meeting the challenges*, World Health Organization, 2008, available at: **www.euro.who.int/Document/e91732.pdf**
15. *The 2007/08 national survey of investment in adult mental health services*, Mental Health Strategies, Department of Health, 2008.
16. *Annual health check 2007/08*, Healthcare Commission, 2008.
17. *Mental health trust listings*, NHS Choices, 2009, available at **www.nhs.uk/ServiceDirectories/Pages/MentalHealthTrustListing.aspx**
18. *Memorandum received from the Department of Health containing replies to a written questionnaire from the Committee*, Health Select Committee, House of Commons, 13 November, 2008.
19. *Main speciality*, HES online: hospital episode statistics, NHS Information Centre, 2009.
20. *Mental health ten years on: progress on mental health care reform*, Department of Health, 2007.
21. *Inpatients formally detained in hospitals under the Mental Health Act 1983 and other legislation: 1997/98 to 2007/08*, NHS Information Centre, 2008.
22. 'Briefing note – NHS trust declarations on standards 2008/09', Care Quality Commission, 2009, available at **www.cqc.org.uk/_db/_documents/Declaration_overview_Briefing_note_2008-9_FINAL_FTchange.pdf**

23. *Reporting and learning system (RLS) quarterly data summary*, National Patient Safety Agency, 2006–2008.

24. *Community mental health services survey 2008*, Healthcare Commission, 2008.

25. HC Deb, *Hansard*, Vol. 493, Col. 740, written answers, 8 June 2009, available at **www.publications.parliament.uk/pa/cm200809/cmhansrd/cm090608/text/90608w0013.htm#09060829000465**

26. HC Deb, *Hansard*, Vol. 496, Col. 26, written statement, 15 July 2009, available at **www.publications.parliament.uk/pa/cm200809/cmhansrd/cm090715/wmstext/90715m0003.htm#09071557000024**

27. 'NHS hospital and community health services: non-medical workforce census, England as at 30 September 2008' , NHS Information Centre, 2009.

28. *National survey of NHS staff 2007* and *National survey of NHS staff 2008*, Healthcare Commission, 2007/2008.

Further information

For further information on the issues covered in this fact sheet please contact Rebecca Cotton, **rebecca.cotton@nhsconfed.org**

The Mental Health Network

The Mental Health Network was established as part of the NHS Confederation to provide a distinct voice for mental health and learning disability service providers.

We aim to improve the system for the public, patients and staff by raising the profile of mental health issues and increasing the influence of mental health and disability providers.

The NHS Confederation is the only independent membership body for the full range of organisations that make up today's NHS. Its ambition is a health system that delivers first-class services and improved health for all. As the national voice for NHS leadership, the NHS Confederation meets the collective needs of the whole NHS as well as the distinct needs of all of its parts through its family of networks and forums. The Mental Health Network is one of these.

For further details about the work of the Mental Health Network, please visit **www.nhsconfed.org/mhn** or email **mentalhealthnetwork@nhsconfed.org**

Alternative formats can be requested from:
Tel 0870 444 5841 Email publications@nhsconfed.org
or visit www.nhsconfed.org/publications

Registered Charity no: 1090329

Stock code: INFI9501

THE NHS CONFEDERATION

The NHS Confederation
29 Bressenden Place
London SW1E 5DD

Tel 020 7074 3200 Fax 0870 487 1555
Email enquiries@nhsconfed.org

www.nhsconfed.org