

Mental health problems

2

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Summary

- This chapter examines prevalence of mental illness in the population, including lifetime experience, recent treatment and experience, and the relationships between mental illness and other aspects of people's lives and health.
- The chapter focuses on people who have ever been diagnosed with a mental illness or condition; this reflects **lifetime experience** of mental illness and not all conditions were current.
- 26% of all adults reported having ever been diagnosed with at least one mental illness. A further 18% of adults reported having experienced a mental illness but not having been diagnosed.
- Women were more likely than men to report ever having been diagnosed with a mental illness (33% compared with 19%).
- The most frequently reported mental illness ever diagnosed was depression, including post-natal depression, with 19% of adults (13% of men, 24% of women) reporting this. The next most frequently reported conditions ever diagnosed were panic attacks, mentioned by 8% of adults, and generalised anxiety disorder, mentioned by 6%. Lifetime prevalence of each other condition was very low, at 3% or less.
- Because the prevalence of most diagnosed mental illnesses was very low, illnesses have been grouped together into common mental disorders, serious mental illnesses, other mental illnesses including complex disorders, and alcohol and drug dependence.
- People may have more than one condition within a type, and may have conditions and disorders in more than one type (for example, a common mental disorder and a serious mental illness). There is considerable overlap between types.
- 24% of all adults reported having ever been diagnosed with a common mental disorder. Smaller proportions reported having been diagnosed with a serious mental illness (4%), other type of condition or disorder including complex disorders (2%) or alcohol or drug dependence (1%).
- Rates of ever being diagnosed with a common mental disorder were higher among women than men (31% and 17% respectively). This pattern was also seen, though with a smaller difference, for diagnoses of serious mental illness (5% and 3%, respectively). There was no difference in the prevalence rates of diagnosis for men and women of alcohol or drug dependence or other types of conditions and disorders.
- Prevalence of ever being diagnosed with a mental illness was highest between the ages of 25-74, peaking in the 55-64 year age group (25% for men and 41% for women). It was lowest among the oldest age groups (10% in 75-84 year group and 12% among those aged 85 and over for men, and 19% in those aged 85 and over for women).
- Men and women living in lower income households were more likely to report ever having been diagnosed with a mental illness than those living in higher income

households (27% of men and 42% of women in the lowest income quintile compared with 15% of men and 25% of women in the highest). There was a similar pattern for area deprivation.

- Half of the men and women who reported ever being diagnosed with a common mental disorder said that they had experienced the condition in the last 12 months. A further 6% of men and 7% of women reported having taken medication or having had therapy for a common mental disorder but not having experienced it in the last 12 months. Overall, 41% of men and 44% of women ever diagnosed with a common mental disorder had received medication or treatment or a combination of the two, with around half of them taking medication only.
- All adults were asked whether they were having counselling or therapy, regardless of any experience of mental illness; 3% reported that they were. People who were currently having counselling or therapy were more likely to report ever having been diagnosed with a mental illness than those not having counselling or therapy (91% of men, 88% of women in therapy, 17% and 31% of those not in therapy).
- People who reported ever being diagnosed with at least one mental illness were more likely to report having a limiting long standing illness (40% of men, 39% of women) than those who had never been diagnosed with a mental illness (16% and 20% respectively).
- Adults were asked about lifetime self-harm and suicide attempts. Overall 3% of men and 5% of women reported self-harm, and 4% and 7% respectively reported suicide attempts.
- 10% of men and 13% of women who reported ever having been diagnosed with at least one mental illness reported having deliberately harmed themselves, and 16% of both sexes reported attempting to take their own life. 5% of men and 7% of women had done both. Among those who had never been diagnosed with a mental illness, only 1-2% of men and women reported either behaviour.

2.1 Introduction

Mental ill health presents a significant and complex public health problem; in the UK, mental ill health is the leading cause of disability, accounts for 28% of the national burden of disease and carries estimated economic costs of between £70-100 billion per year.¹

Mental illness is not experienced equally in the population. Throughout the Adult Psychiatric Morbidity Survey series, inequalities in the prevalence of mental illness across age, gender, ethnicity and income groups have all been highlighted. These inequalities were seen not only in the prevalence of symptoms but also in their diagnosis and treatment.^{2,3}

Mental illness has a profound impact on people's lives. There are clear yet complex links between mental and physical health, particularly long term conditions.⁴ People with long term conditions such as diabetes and cardiovascular diseases are two to three times more likely to experience mental health problems.⁵ Comorbid physical and mental illness poses an increased burden, greater often than the sum of the parts as each condition can magnify the effects of the other.⁴ Premature mortality has also been linked to severe mental disorders including psychosis, bipolar mood disorder and moderate-to-severe depression. The World Health Organisation estimated that people with these disorders die on average 10-25 years earlier than the general population. Much of this premature death is attributed to avoidable causes.⁶

Health lifestyle factors such as smoking, drinking and substance abuse have all been shown to be correlated with mental illness.⁷ Over a third of tobacco use is associated with people with mental health problems.⁸ In addition, poor diet, lower levels of physical activity and increased levels of obesity have also been associated with some mental illnesses.^{4,6}

In addition to the human costs associated with mental ill health, the economic burden it imposes is significant. Mental health is the leading cause of absence from work due to illness; in 2007 alone, poor mental health accounted for 70 million sick days.⁹ There is a higher unemployment rate among those with mental illness¹⁰ and estimates suggest that between £8-13 billion of spending on long term conditions in England was linked to poor mental health.⁵

Mental health has been designated as a priority area for policymakers to tackle for many years. A range of Government publications in recent years have set out the scale of the problem faced and the various plans to tackle it.^{11,12,13,14} In 2013, the Chief Medical Officer's Annual Report¹ focused on public mental health, summarising the public health evidence and making a series of recommendations to improve the mental health of the nation.

This chapter presents findings from the Health Survey for England 2014 and describes the prevalence of mental illness in the population, recent treatment and experience and the relationships between mental illness and other aspects of people's lives and health. Chapter 3 looks at attitudes to mental health, particularly in terms of prejudice and tolerance.

2.2 Methods and definitions

2.2.1 Mental illness diagnosis

In the nurse visit, participants were asked a series of questions about their experience of mental illness. These questions were asked using computer assisted interviewing. The first question showed a list of 17 different mental health conditions and disorders and asked the participant to say which of these they had ever experienced.¹⁵ If participants said they had experienced a condition or disorder they were then asked for each one selected whether they had been told by a doctor, psychiatrist or other professional that they had it. Participants who reported that they had been told by a doctor, psychiatrist or other health professional that they had that condition or disorder are defined in this chapter as having been diagnosed. This relates to a diagnosis for a condition at any point in their life. Self-

reported diagnosis was not checked objectively against administrative records. Therefore, in this chapter the term diagnosed mental illness refers to self-reported diagnosis.

2.2.2 Mental illness categories

The prevalence of most diagnosed mental illnesses is very low, and illnesses have therefore been grouped together into summary types, for the purpose of analysis. Table 2A shows the summary types and the individual conditions and disorders included within each one. There are too few in the ‘alcohol and drug dependence’ group for separate analysis.

Table 2A	
Mental illness types	
Common mental disorder	
Phobia	
Panic attacks	
Post-traumatic stress	
Generalised anxiety disorder	
Depression	
Post-natal depression	
Obsessive compulsive disorder	
Serious mental illness	
Bipolar disorder	
Eating disorder	
Nervous breakdown	
Personality disorder	
Psychosis or schizophrenia	
Other including complex disorders	
Attention deficit hyperactivity disorder (ADHD)	
Attention deficit disorder (ADD)	
Dementia	
Seasonal affective disorder	
Any other mental, emotional or neurological problem or condition	
Alcohol or drug dependence	

Participants may have more than one condition within a type (for example, generalised anxiety disorder and depression) and may have conditions and disorders in more than one type (for example, a common mental disorder and a serious mental illness). Table 2B shows a cross tabulation of the proportion of participants who reported diagnoses of disorders in the different types. As shown, there is considerable overlap between types.

Table 2B				
Cross-tabulation of participants who reported diagnoses in each type of mental illness				
	Common mental disorder	Serious mental illness	Other including complex disorders	Alcohol or drug dependence
	%	%	%	%
Common mental disorder		77	66	72
Serious mental illness	14		26	27
Other including complex disorders	6	14		13
Alcohol or drug dependence	4	8	7	
<i>Only that type of illness or condition</i>	80	23	34	28
Unweighted base	1430	241	129	67

2.2.3 Experience and treatment in the last 12 months

All participants who reported that they had been diagnosed with a condition or disorder were asked about whether they had had that condition or disorder within the last 12

months, whether they had taken medication for it in the last 12 months and whether they had received any therapy or other treatment for it in the last 12 months. These three questions were asked for each diagnosed condition or disorder separately.

This allows the identification of various different categories of experience. Four mutually exclusive groups have been used to classify those with diagnosed illness:

- Experienced the condition in the last 12 months, did not take any medication or receive treatment
- Experienced the condition in the last 12 months, also took medication and/or received treatment
- Took medication and/or received treatment, and did not experience the condition – i.e. their condition was current, but well controlled, or they were receiving medication and/or treatment but not to control current symptoms
- No medication or therapy, and did not experience the condition in the last 12 months – i.e. they did not currently have the condition.

The first two of these can be regarded as ‘current’ conditions. The third group may represent well controlled current conditions but may also reflect people using services or receiving treatment they do not currently need. The fourth group represents previous conditions not currently experienced.

Some people had been diagnosed with more than one condition, and it was therefore possible that some had both current and previous conditions, or different patterns of experience and treatment for current conditions. In such an instance, the participant would be classified according to their most recent experience or treatment; for instance someone with a previous condition, but also experiencing a current condition for which they were taking medication, would be classified in the second category above.

2.2.4 Self-harm and suicide attempts

In the nurse visit, all participants were asked about lifetime self-harm and suicide attempts. A participant was defined as having made a suicide attempt in this chapter if he/she reported that he/she had ever made an attempt to take their life, by taking an overdose of tablets or in some other way. Self-harm was identified by asking participants if they had ever deliberately harmed themselves in any way but not with the intention of killing themselves.

2.2.5 Longstanding illness

During the face to face interview, participants were asked to report whether they had any longstanding illnesses. Longstanding illness is defined as any physical or mental health condition or illness lasting or expected to last 12 months or more. If a longstanding illness reduces participants’ ability to carry out day-to-day activities, either a little or a lot, it is considered a limiting longstanding illness. In this chapter the relationship between mental illness and longstanding illness is examined, and it should be noted that participants may have mentioned their mental illness as a longstanding illness. However, even when excluding any participants who did mention mental illness as a longstanding illness (analysis not shown), the relationships remained between mental illness and longstanding illness, as described in Section 2.7.

2.2.6 Well-being

This chapter looks at the association between mental well-being and mental illness. The Warwick-Edinburgh Mental Well-being Scale (WEMWBS)¹⁶ was developed to capture a broad concept of positive mental well-being and incorporates both eudaimonic and hedonic perspectives on well-being.¹⁷ A eudaimonic perspective relates to people’s functioning, social relationships, and perceptions of whether the things they do in life are meaningful or worthwhile. A hedonic perspective focuses on affect, and relates to experience of pleasure, happiness and the avoidance of pain.

WEMWBS has 14 statements which cover psychological functioning, cognitive-evaluative

dimensions and affective-emotional aspects of well-being. For each statement participants are asked to tick the box that best describes their experience over the previous two weeks. They can answer on a 5-point scale: 'None of the time', 'Rarely', 'Some of the time', 'Often', or 'All of the time'. The statements are all expressed positively – for example, 'I've been feeling optimistic about the future'. The responses, numbered 1 to 5, are aggregated to form the Well-being Index, which can range from 14 (those who answer 'rarely' on every statement) to 70 (those who answer 'All of the time' to all statements).

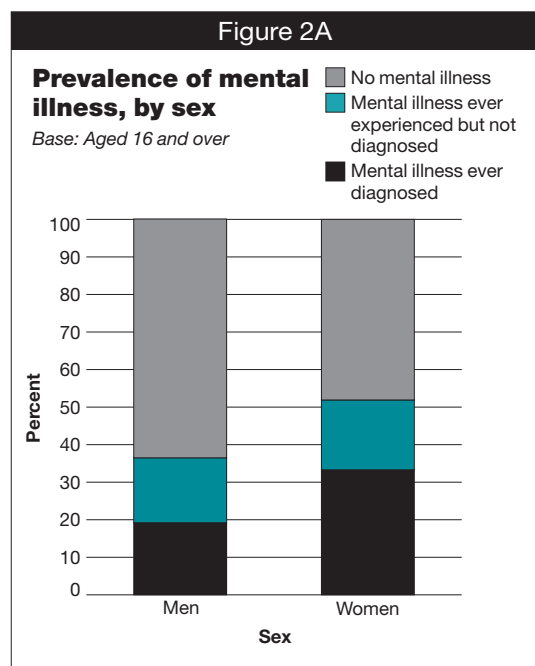
In the survey, the WEMWBS was administered by self-completion questionnaire during the interview.

2.3 Lifetime prevalence of mental illness

2.3.1 Prevalence of ever being diagnosed with a mental illness, by age and sex

26% of all adults reported having ever been diagnosed with at least one mental illness. A further 18% of adults reported having experienced a mental illness but not having been diagnosed. In the majority of cases these were common mental disorders. The remaining 56% of adults reported never having experienced a mental illness.

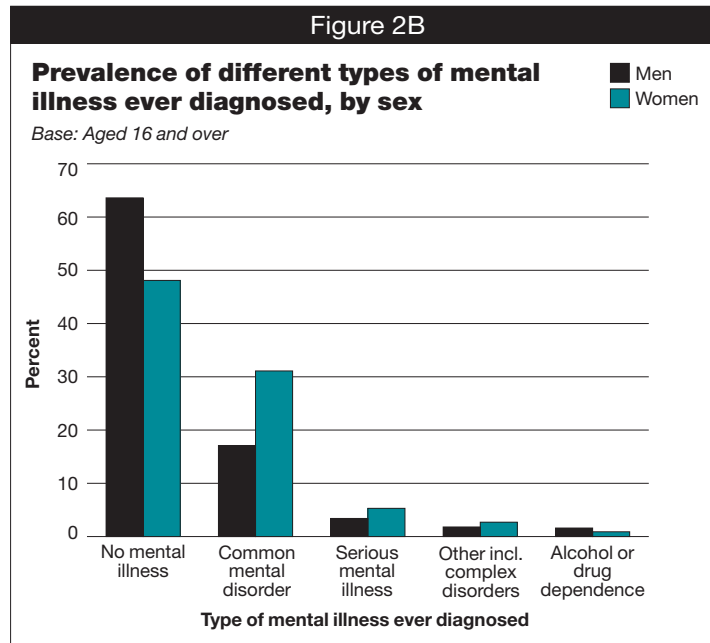
24% of all adults reported having ever been diagnosed with a common mental disorder. Smaller proportions reported having been diagnosed with a serious mental illness (4%), other type of condition or disorder including complex disorders (2%) or alcohol or drug dependence (1%).



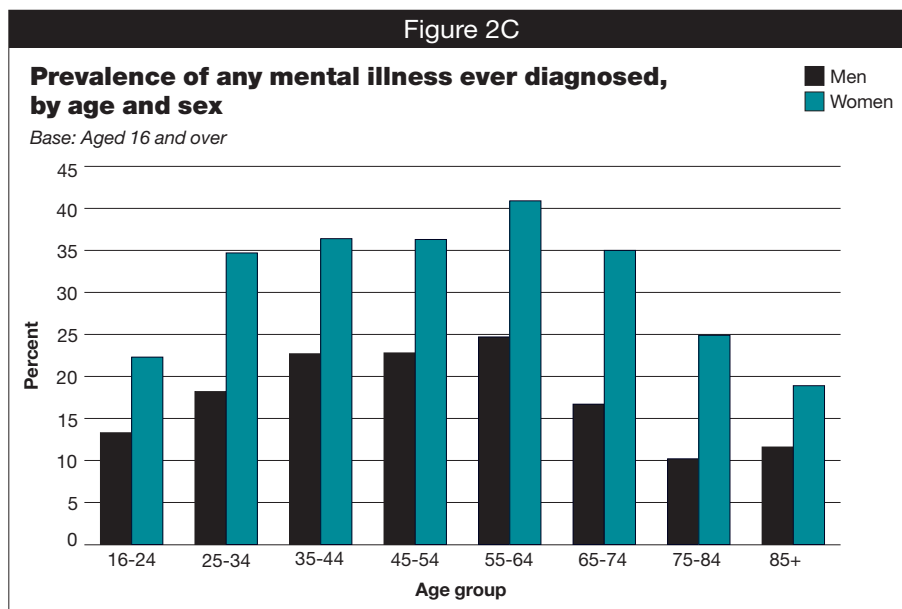
Women were more likely than men to report ever having been diagnosed with a mental illness (33% compared with 19%). Similar proportions of each sex reported having experienced a mental illness but it not being diagnosed (19% and 17% respectively). Therefore a smaller proportion of women than men reported no mental illness (48% and 64% respectively).

Table 2.1 shows the proportions who reported ever having a diagnosis of each of the individual mental illnesses and conditions included in the survey. The most frequently reported diagnosed mental illness was depression including post-natal depression; 19% of participants (13% of men, 24% of women) reported this. The next most frequently self-reported diagnosed conditions were panic attacks, reported by 8% of adults, and generalised anxiety disorder, reported by 6%. Prevalence of ever being diagnosed with each other condition was very low, at 3% or less. The illnesses and conditions have therefore been grouped for the remaining analyses in the chapter, as described in Section 2.2.

Rates of common mental disorder diagnoses were higher among women than men (31% and 17% respectively). This pattern was also seen, although with a smaller difference, for diagnoses of serious mental illness (5% and 3%, respectively). There was no difference in the prevalence rates of diagnosis for men and women of alcohol or drug dependence or other types of conditions and disorders.



There was a statistically significant relationship between ever having been diagnosed with a mental illness and age. As Figure 2C shows, prevalence was highest between the ages of 25-74, peaking in the 55-64 year age group (25% for men and 41% for women). It was lowest among the oldest age groups (10% in 75-84 year group and 12% among those aged 85 and over for men, and 19% in those aged 85 and over for women).



A similar pattern by age was seen for ever having being diagnosed with a common mental disorder. Diagnosis of a serious mental illness was not related to age; there was statistically significant variation by age in ever having being diagnosed with another type of condition or disorder, though the pattern was not clear.

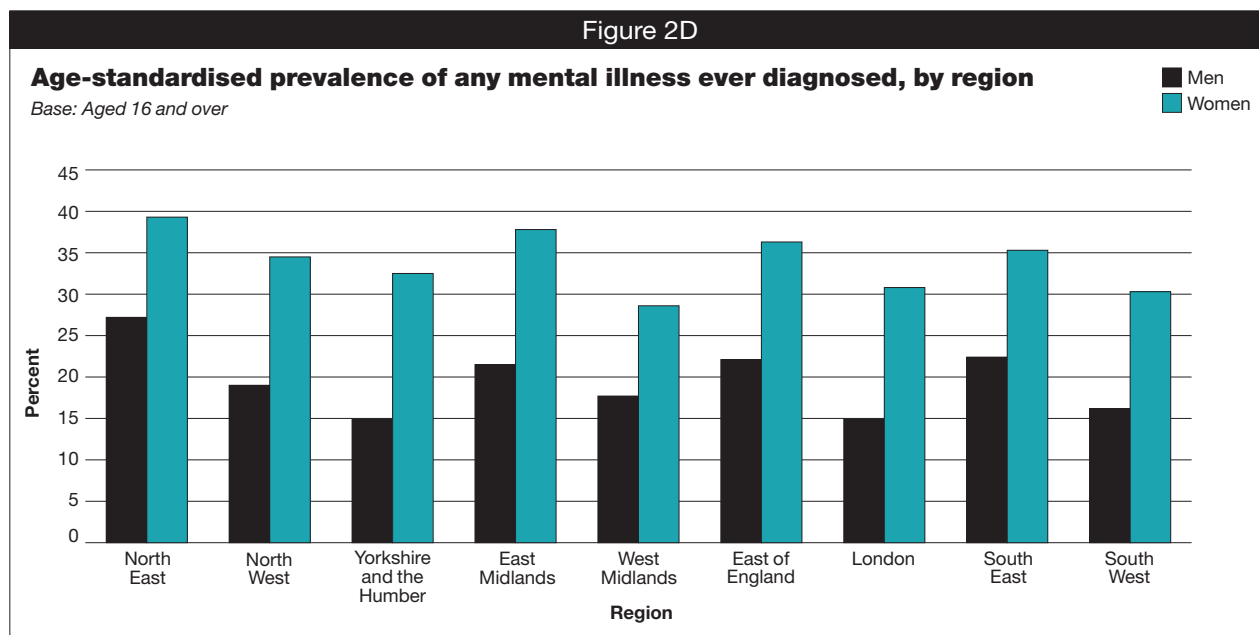
Table 2.1, Figures 2A, 2B, 2C

2.3.2 Prevalence of ever being diagnosed with a mental illness, by region

The age-standardised¹⁸ prevalence of diagnosed mental illness varied by region, as shown in Figure 2D, with broadly similar patterns for men and women. Prevalence was higher in the

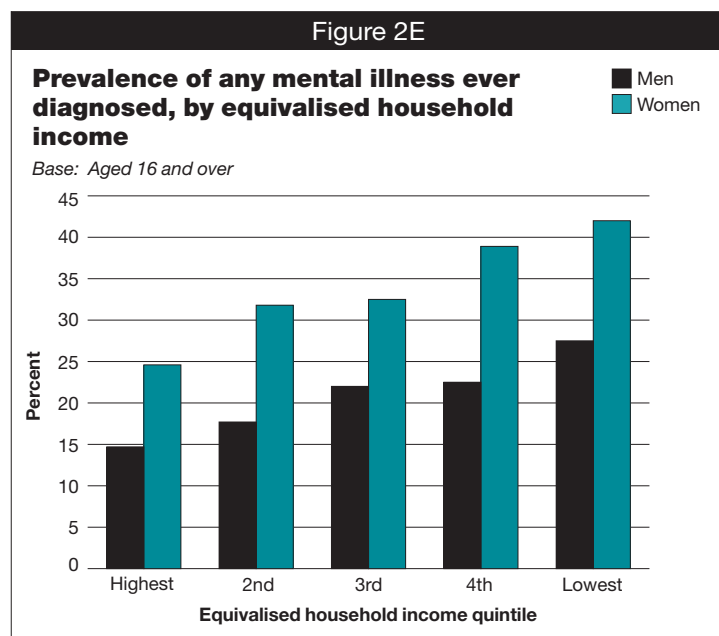
North East, East Midlands, East of England and the South East, while rates were generally lower in the West Midlands, Yorkshire and the Humber, South West and London.

Table 2.2, Figure 2D



2.3.3 Prevalence of ever being diagnosed with a mental illness, by equivalised household income and area deprivation

Men and women living in lower income households were more likely to report ever having been diagnosed with a mental illness than those living in higher income households (27% of men and 42% of women in the lowest income quintile compared with 15% of men and 25% of women in the highest). This pattern of difference by income was also seen for common mental disorders, serious mental illness and alcohol and drug dependence for both men and women. There was no such pattern by income among those ever diagnosed with another type of condition.



A similar pattern was seen by area deprivation, with men and women living in the most deprived areas being more likely to report ever having been diagnosed with a mental illness than those living in less deprived areas (24% of men and 37% of women in the most deprived areas compared with 16% of men and 33% of women in the least). As with income, the pattern of difference by area deprivation was seen for common mental

disorders, serious mental illness and alcohol and drug dependence , and similarly there was no such pattern among those ever diagnosed with another type of condition.

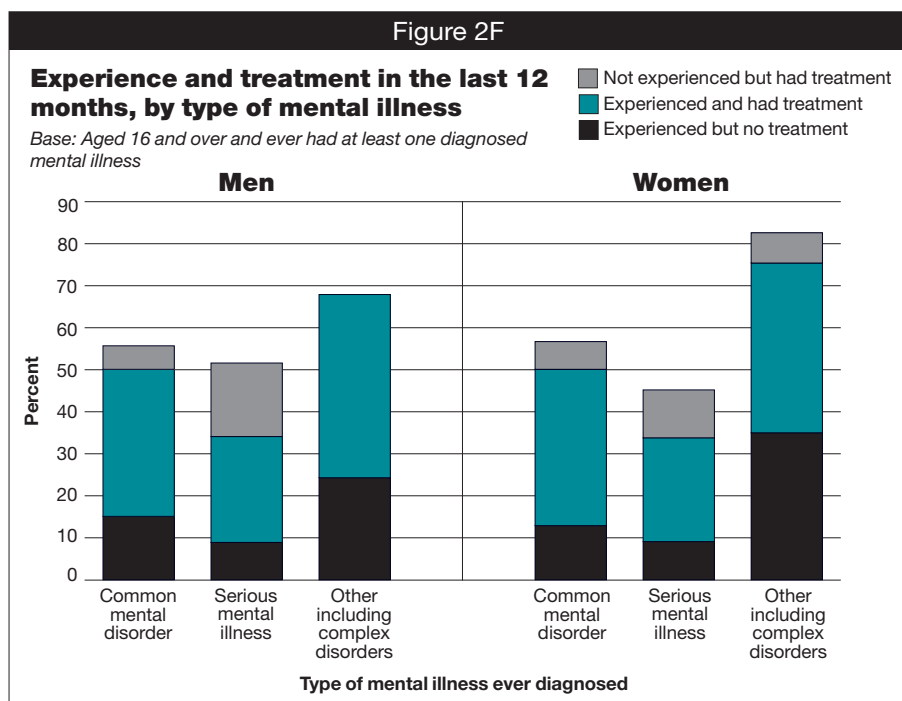
Tables 2.3, 2.4 Figure 2E

2.4 Experience and treatment in the last 12 months

2.4.1 Introduction

This section examines recent experience and treatment of mental illness, looking at three broad categories of illness. Figure 2F shows, for each of those who reported ever having had a common mental disorder, a serious mental illness or another condition (including complex conditions), whether symptoms had been experienced and/or any treatment had been received in the last 12 months.

Figure 2G shows the proportions with each type of mental illness who had received different types of treatment: medication only, therapy or other treatment only, or a combination of both.



2.4.2 Common mental disorders

Half of the men and women who reported ever being diagnosed with a common mental disorder said that they had experienced the condition in the last 12 months. A further 6% of men and 7% of women reported having taken medication or having had therapy for a common mental disorder but not having experienced it in the last 12 months.

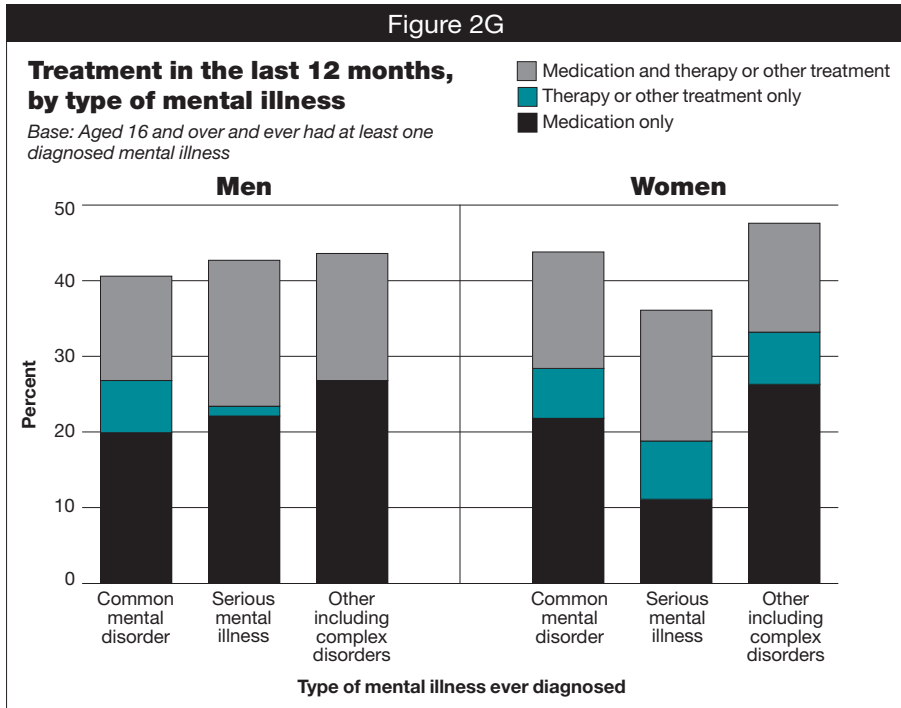
15% of men and 13% of women with a common mental disorder reported having the condition in the last 12 months but not having taken medication or had therapy over that period. Overall, 41% of men and 44% of women had received medication or treatment or a combination of the two, with around half of them taking medication only (see Figure 2G).

Table 2.5, Figures 2F, 2G

2.4.3 Serious mental illnesses

Just over a third of the men and women who reported ever being diagnosed with a serious mental illness said that they had experienced the condition in the last 12 months (34%). In addition, 17% of men and 11% of women with such a condition had had medication or treatment but not experienced the condition.

Figure 2G



Among those who had experienced a serious mental illness in the last 12 months:

- 9% of both men and women had not taken medication or had therapy for it, while 43% and 36% respectively had had some form of treatment.
- Interestingly, twice as many men as women had taken medication only for their serious mental illness (22% and 11%, respectively).
- Women were more likely than men to have received therapy only (8% and 1%, respectively). However, this may be a reflection of the most appropriate treatment option for the particular type of serious mental illness experienced rather than a difference in treatment approach by sex.
- Men were more likely than women to report having been diagnosed with psychosis and women were more likely than men to report having been diagnosed with a nervous breakdown or an eating disorder.

Table 2.5, Figures 2F, 2G

2.4.4 Other mental illnesses including complex conditions

The majority of those who reported ever being diagnosed with a complex or other type of condition or disorder said that they had experienced the condition in the last 12 months (68% of men and 75% of women; the difference is not statistically significant).

24% of men and 35% of women reported having experienced their condition in the last 12 months but not having had any medication or treatment. Looking at types of treatment, similarly as for serious mental illnesses, women were more likely than men to have received therapy only for these other/complex mental illnesses in the last 12 months (7% of women and none of the men interviewed). Again, this may reflect the most appropriate treatments for the particular condition experienced.

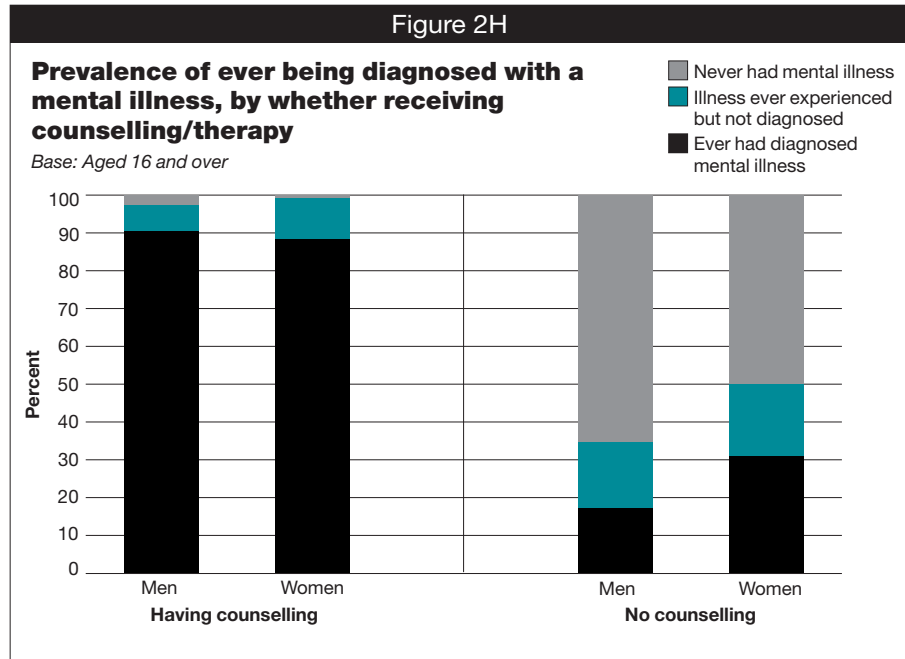
Table 2.5, Figures 2F, 2G

2.5 Counselling and therapy

All participants were asked whether they were currently receiving any counselling or therapy, regardless of whether or not they had reported experience of any current or previous mental illness. Overall, 3% of adults reported some sort of ‘talking therapy’, with the same proportion among both men and women.

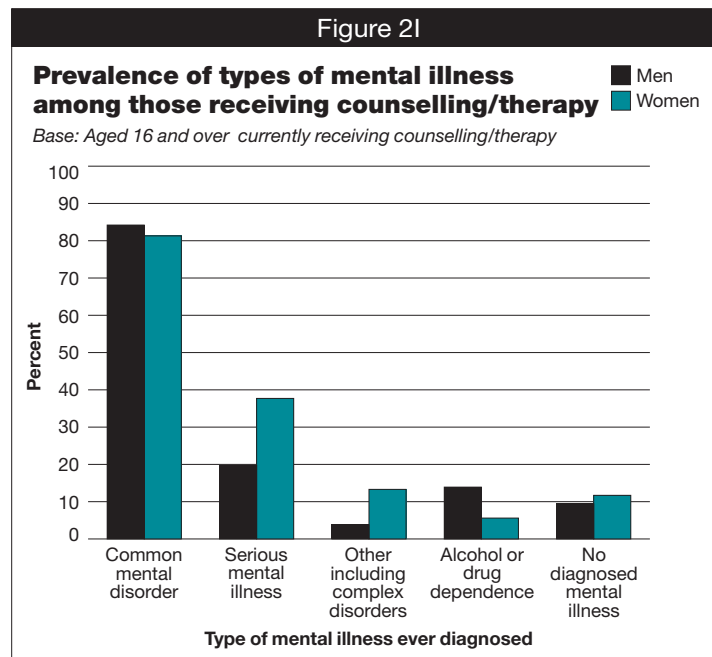
As would be expected, people who said they were currently having counselling or therapy were more likely to have experience of mental illness than those not having counselling or therapy, as shown in Figure 2H. A very large majority of men and women who reported they were currently having counselling or another type of therapy said they had ever been

diagnosed with a mental illness, a few had experienced an undiagnosed condition, while only 2% of men and 1% of women reported never having experienced any type of mental illness.



In contrast, among those who were not having any counselling or therapy, two thirds of men and half of women had never experienced any mental illness, while under a fifth of men and a third of women reported ever having been diagnosed with at least one mental illness (17% and 31% respectively).

Figure 2I shows, among those currently receiving counselling or therapy, the proportions with the different types of mental illness. These broadly reflect the prevalence of the different types of condition. Similar proportions of men and women in therapy had been diagnosed with a common mental disorder (84% and 81%, respectively), despite the greater proportion of women than men who had ever experienced common mental disorders (see Section 2.3.1).

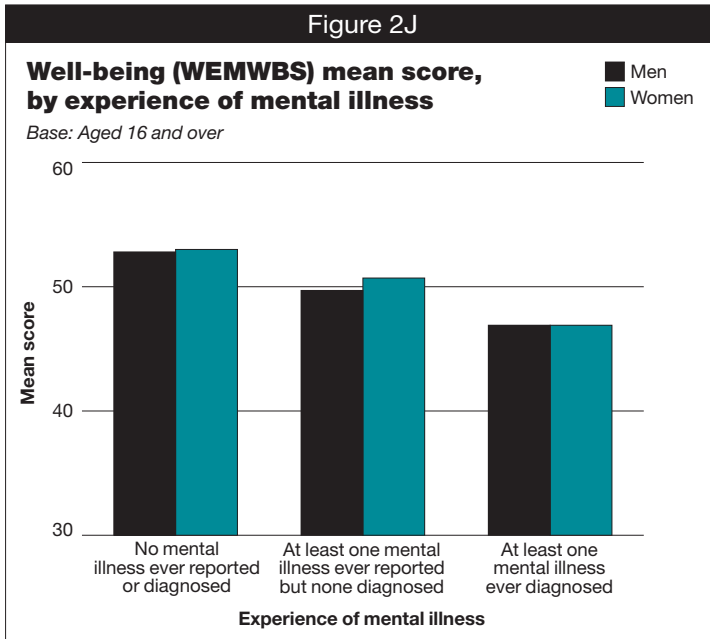


The most common types of counselling or therapy women reported having were counselling (including bereavement counselling) (48%), psychotherapy or psychoanalysis (21%) and cognitive behavioural therapy (19%). For men the most common types were counselling (including bereavement counselling) (31%), cognitive behavioural therapy (20%) and alcohol or drug counselling (18%). The majority of men and women reported that they were finding the counselling or therapy helpful (94% and 91%, respectively).

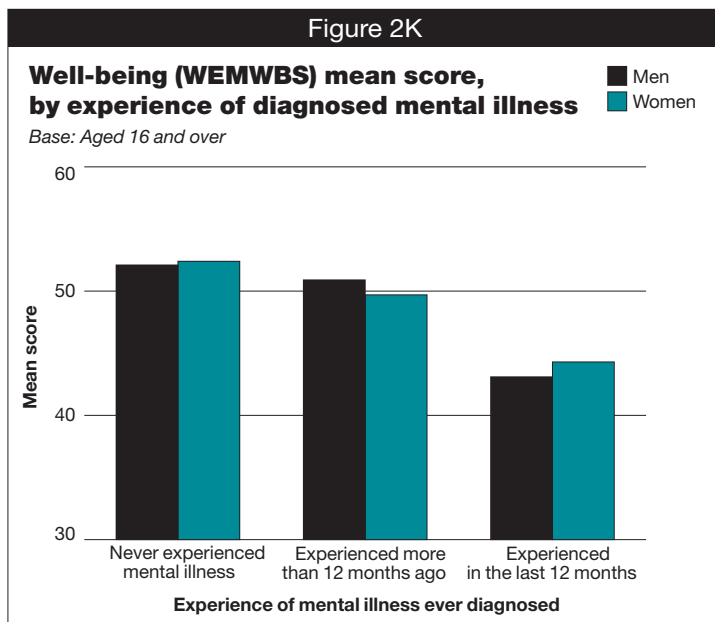
Tables 2.6-2.9, Figures 2H, 2I

2.6 Well-being and mental health

Mental well-being, measured by WEMWBS,¹⁶ varied by mental illness, as shown in Figure 2J. Well-being scores were highest among participants who reported never having had a mental illness (52.8 for men and 53.0 for women) and lowest for those who had ever been diagnosed with at least one mental illness (46.9 for men and 46.9 for women). Those who reported having had at least one mental illness but not having been diagnosed with any had a well-being score between the two (49.7 for men and 50.7 for women).



Recency of experience was also related to well-being, with those who had experienced their diagnosed mental illness in the last 12 months having the lowest wellbeing scores (43.1 for men and 44.3 for women). Men and women who had experienced a diagnosed mental illness but not in the last 12 months had higher mean scores (50.9 and 49.7, respectively), but these were still lower than those who had never experienced a diagnosed mental illness (52.1 and 52.4, respectively).



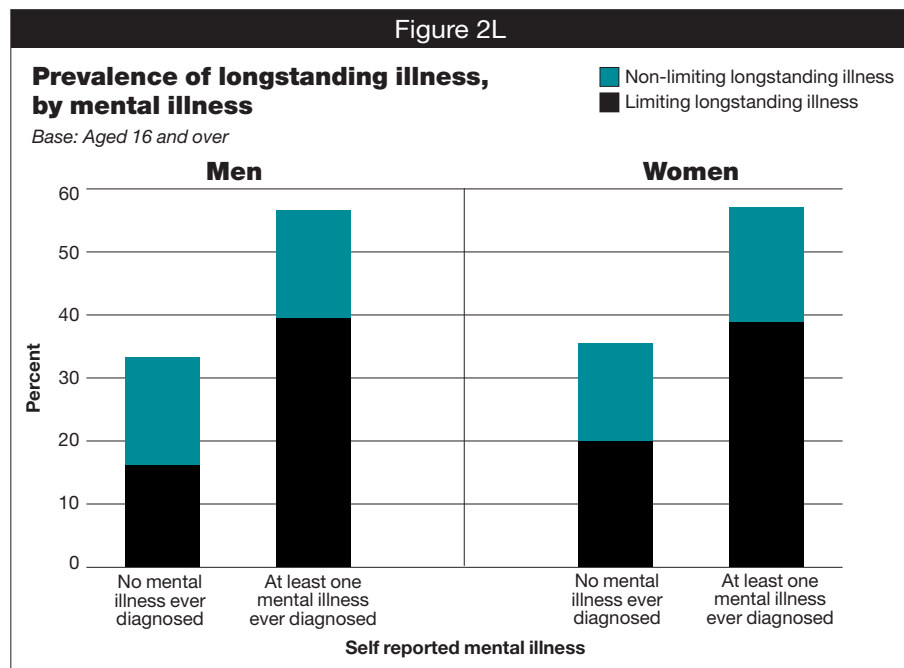
Mean well-being scores for those who had ever been diagnosed with a common mental disorder, serious mental illness or other type including complex disorders were each at a similar level.

Tables 2.10-2.12, Figures 2J, 2K

2.7 Longstanding illness and mental illness

Figure 2L shows the proportions with long standing illness, distinguishing between limiting and non-limiting illness, for those who had ever been diagnosed with at least one mental illness and those who had not. People who reported ever being diagnosed with a mental illness were more likely to report having a limiting long standing illness (40% of men, 39% of women) than those who had never been diagnosed with a mental illness (16% and 20% respectively). The same difference was not apparent in the proportions reporting a non-limiting illness.

Table 2.13, Figure 2L



2.8 Smoking and drinking

There is evidence to show that mental illness is related to a number of lifestyle behaviours, as well as well-being and physical health.⁷ This section looks briefly at the association between mental illness and smoking and drinking.

Almost a third of men and a quarter of women who had ever been diagnosed with a mental illness were current smokers (31% and 23%, respectively). This was very much higher than the population average of 21% of men and 17% of women.¹⁹ Conversely, those men and women who had never been diagnosed with a mental illness were less likely to be current smokers (19% and 13%, respectively).

Among all adults, 22% of men and 16% of women drank above 'lower risk' levels, i.e. more than 21 units per week for men and more than 14 units per week for women. These proportions include 5% of men and 4% of women drinking at higher risk (more than 50 and 35 units per week respectively).² The proportions drinking at these levels of risk were very similar between those who had ever been diagnosed with a mental illness and those who had not.

Tables 2.14, 2.15

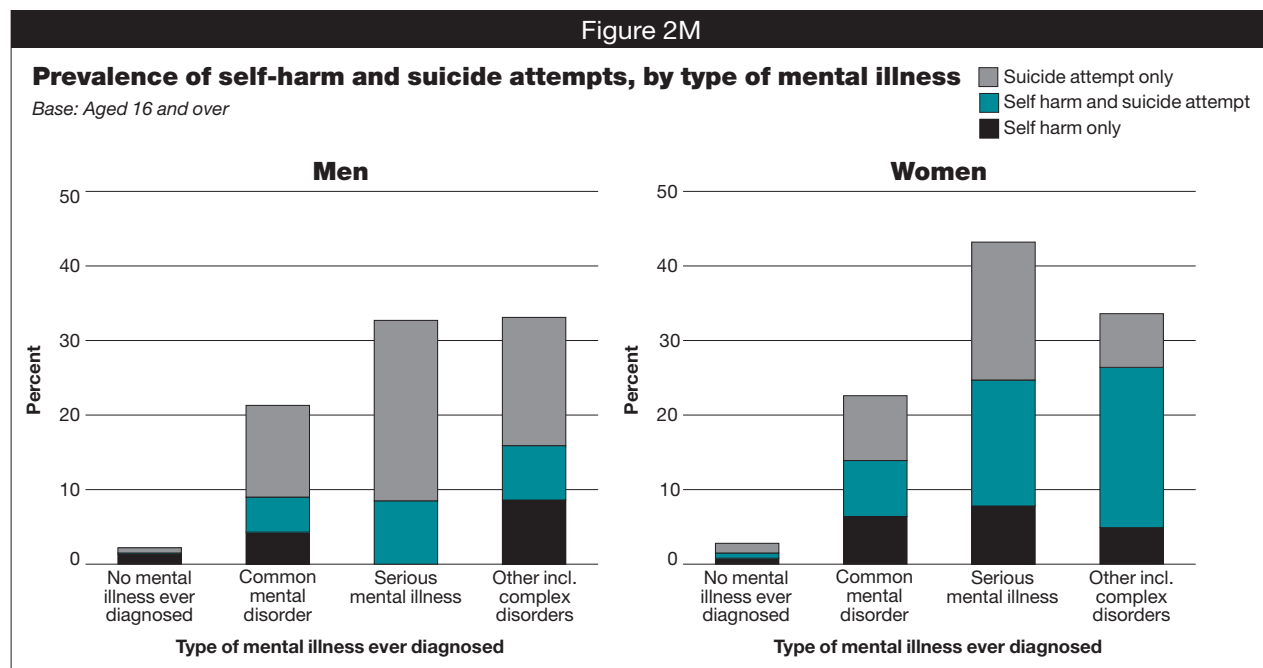
2.9 Self-harm and suicide attempts

Adults were asked about lifetime self-harm and suicide attempts (see Section 2.2.4). Overall 3% of men and 5% of women reported self-harm, and 4% and 7% respectively reported suicide attempts. This included 1% and 3% respectively who reported both.

10% of men and 13% of women who reported having been diagnosed with at least one mental illness reported having deliberately harmed themselves, and 16% of both sexes reported attempting to take their own life. 5% of men and 7% of women had done both. Among those who had never been diagnosed with a mental illness, only 1-2% of men and women reported either behaviour.

Figure 2M shows the pattern of self-harm and suicide attempts reported within the different types of mental illness, comparing these with people who had never been diagnosed with a mental illness. Women were more likely than men to report self-harm for serious mental illnesses. Both men and women with serious mental illnesses were more likely than those with common mental disorders to have made a suicide attempt.

Table 2.16, Figure 2M



2.10 Discussion

It is clear from the findings in this chapter that mental illness is a wide-reaching problem affecting a large sector of the population. More than half of women and more than a third of men reported ever having had a mental illness, and a third of women and almost a fifth of men reported ever having a diagnosed mental illness. In line with other research,² mental illness was more prevalent in those from lower income backgrounds and deprived areas, highlighting the significant mental health inequalities that exist in society.

There was an interesting pattern of variation of diagnosed mental illness by age, with peaks in lifetime prevalence in the middle age groups. While it is expected that ever having had a mental illness would increase with age as people have lived longer and experienced more, it is interesting to note the lower prevalence seen in the oldest age groups. There are a range of possible explanations for this. Mental health has become a much more commonly discussed area of life in recent decades and this has led to a cultural shift in understanding and recognition of mental illness. Campaigns such as Time To Change²¹ have aimed to prevent discrimination, reduce stigma and encourage conversation about mental health.²² In decades gone by, mental illness was more stigmatised and so this may have an impact on the level of recognition, help-seeking and reporting of mental illness in older groups. In addition, as is known from previous research, premature mortality is more common among people who experience mental ill health,⁶ and so they be under-represented among the oldest age groups in the population. It may also be the case that many older people have better mental health. This would correlate with the U-shaped age curve often seen in well-being research.²³

In line with findings from previous research, those with mental ill health were more likely to have longstanding illnesses. Moreover these were more likely to be limiting illnesses that reduced participants' ability to carry out day-to-day activities. While some of these were mental illnesses, a statistically significant relationship remained after accounting for these. Long term health conditions contribute to the excess premature mortality observed among those with mental illness; it is important that policymakers ensure that the links between physical and mental health are fully recognised and explored so that people with multiple conditions receive the interdisciplinary treatment they need to lead full and healthy lives. Integrating mental health services and interventions with services offered to those with long term physical conditions may help to tackle some of the comorbidity observed in the population.

The findings discussed in this chapter focus on the relationships between some current health, well-being and lifestyle factors and having ever been diagnosed with mental illness (there is scope for much further exploration of such relationships than can be covered in this chapter). Only half of participants who reported ever having been diagnosed with a common mental disorder had experienced their mental illness in the last 12 months; a third with serious mental illness and more than two thirds with other including complex conditions had done so. This suggests that the correlations between mental health and health and lifestyle factors are enduring and continue to have an impact long after the mental illness has been experienced. This has implications for the ongoing support needed by those with poor mental health at any stage of their lives. This pattern of enduring impact was also seen for well-being, which was negatively correlated with any experience of poor mental health, and poorest in those who had experienced mental illness in the last 12 months.

There were differences observed in the treatment rates of men and women with different types of conditions. This may be a function of the types of conditions they experienced. Further research and analysis of the data could help to understand more about this issue and clarify whether there is any bias in the treatment rates and options offered to men and women. There were also treatment gaps identified for men and women, where illness was experienced but no medication or other treatment was being received, and these gaps varied by the type of mental illness experienced. Even for common mental disorders, the group least likely to have a treatment gap, almost one in ten people reported having experienced symptoms in the last 12 months but having received no medication or treatment. The HSE 2014 did not establish whether this one in ten sought treatment and did not receive it, whether they managed their condition another way or whether they were not looking for help and treatment at all.

Current estimates suggest that the economic cost relating to mental illness is increasing, and that it is set to rise to more than £60 billion in England by 2026.²⁴ Since 2009 the number of working days lost to stress, anxiety and depression has increased by 24% and those lost to serious mental illness has doubled.²⁵ Over a similar time period, the real terms investment in mental health expenditure has reduced since 2011.²⁶ The Chief Medical Officer indicated in her 2013 annual report that investment in mental health services and research is needed to strengthen the evidence base and services offered to improve the nation's mental health.¹

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- 16 The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) was funded by the Scottish Government National Programme for Improving Mental Health and Well-being, commissioned by NHS Health Scotland, developed by the University of Warwick and the University of Edinburgh, and is jointly owned by NHS Health Scotland, the University of Warwick and the University of Edinburgh.
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