Department of Health

NO HEALTH WITHOUT MENTAL HEALTH: A cross-Government mental health outcomes strategy for people of all ages

Analysis of the Impact on Equality (AIE)

Annex B - Evidence Base

Supporting document to: No Health without Mental Health: a cross-Government mental health outcomes strategy for people of all ages

Department of Health

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Contents Page

Introduction 3

- **Age** 3
- **Disability** 15
- **Gender reassignment** 24
- **Marriage and Civil Partnership** 25
- **Pregnancy and maternity** 26
- **Race (including ethnic origin, nationality)** 27
- **Religion or belief (including lack of belief)** 36
- **Sex** 39
- **Sexual orientation** 46

Introduction

This document summarises relevant evidence against the protected characteristics defined in the Equality Act 2010. The nine characteristics are:

- Age
- Disability
- Gender reassignment
- Marriage and Civil Partnership
- Pregnancy and maternity
- Race (including ethnic origin, nationality)
- Religion or belief (including lack of belief)
- Sex
- Sexual orientation

The evidence includes responses to the public consultation carried out in July 2009 to inform the previous Government's mental health strategy *New Horizons: a shared vision for mental health.*

Age

Children and Young People

From the consultation
In particular, respondents wanted to see education on mental health in schools – several called for inclusion in the national curriculum – and in Early Years education, involving parents.

Prevalence of mental illness during childhood and adolescence
One in ten children and adolescents between the ages of one and 15 has a mental disorder[1] which can be divided into the following categories:

- Conduct Disorders: 6% of 5-16 year olds have a conduct disorder[2] although 18% have sub-threshold conduct problems.[3] Conduct disorders are more common in boys than in girls.
- Emotional Disorders: 4% of 5-16 year olds have an emotional disorder.[4] They are more common in girls and include anxieties, depression and phobias.
- Hyperkinetic Disorders: 2% of 5-16 year olds have a hyperkinetic disorder.[5]
- Less Common Disorders: 1% of all 5-16 year olds suffer from less common disorders such as autism, eating disorders, tics and selective mutism.

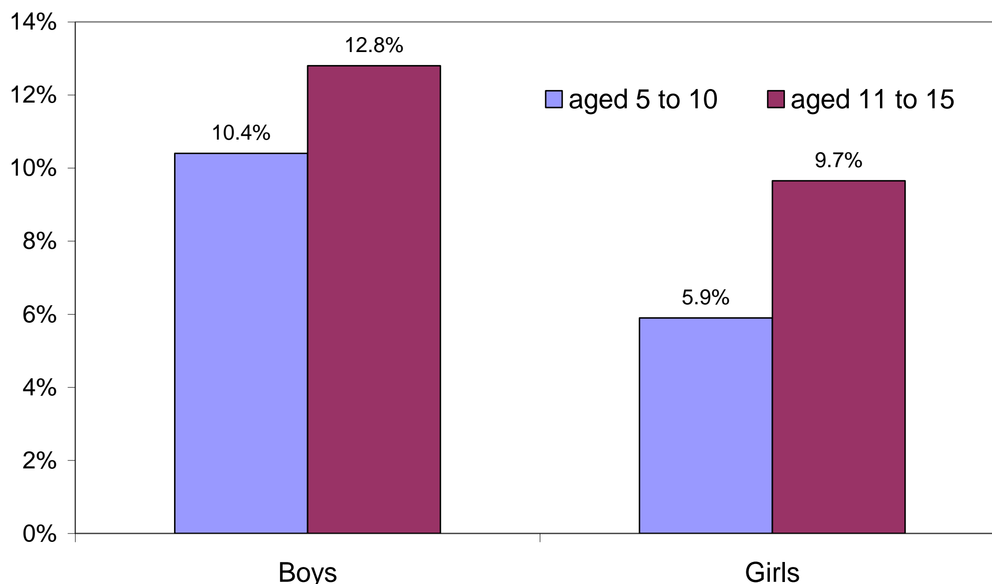
[1] Green H, McGinnity A. Meltzer H et al (2005) Mental health of children and young people in Great Britain, 2004. ONS.
[2] Green H, McGinnity A. Meltzer H et al (2005) Mental health of children and young people in Great Britain, 2004. ONS.
[3] Colman I, Murray J, Abbott RA et al (2009) Outcomes of conduct problems in adolescence: 40 year follow-up of national cohort. *BMJ*, 338, a2981
[4] Green H, McGinnity A. Meltzer H et al (2005) Mental health of children and young people in Great Britain, 2004. ONS.
[5] Green H, McGinnity A. Meltzer H et al (2005) Mental health of children and young people in Great Britain, 2004. ONS.

- Autistic Spectrum Disorders: These are more common in boys. The spectrum ranges from Asperger's Syndrome to more extensive forms of learning disability and difficulties in interacting and communicating with others.
- Eating Disorders: Eating disorders are more common in young women. Up to 1% of women in the UK between the ages of 15 and 30 suffer from anorexia nervosa, and about 2-3% develop bulimia nervosa.

Research also suggests that 20% of children have a mental health problem in any given year, and about 10% at any one time.[6]

The UK also came bottom of the rank for children's wellbeing compared with North America and 18 European countries[7] and 24th out of 29 European countries in more recent survey.[8]

Prevalence of mental disorders in children by age and sex



Risk factors for mental disorder during childhood and adolescence

Risk of mental disorder among children and adolescents is associated with a broad range of factors linked to inequality (see table 1 below) More details will be available in the Public Health review 3.[9]

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[6] Mental Health Foundation (2005), Lifetime Impacts: Childhood and Adolescent Mental Health, Understanding The Lifetime Impacts

[7] UNICEF (2010) The children left behind. Innocenti Research Centre. Report Card 9. http://www.unicef.org.uk/Documents/Publications/rc9.pdf

[8] Bradshaw J, Richardson D (2009) An index of child wellbeing in Europe. Child Indicators Research, 2(3), 319-351

[9] Eight public mental health public mental health reviews are to be published by Department of Health in March 2011.

Table 1: Risk factors for mental disorder in children and young people (from DH Public Mental Health review 3)

Risk factor	Impact on risk of mental disorder	Prevalence in population
Use of alcohol, tobacco or drugs during pregnancy	Increased risk of a wide range of poor outcomes including long-term neurological and cognitive-emotional development problems[10]	
Maternal stress during pregnancy	Increased risk of child behavioural problems[11] Impaired cognitive and language development [12]	
Low birth weight	Associated with increased risk of common mental disorder[13] 4-5 fold increased risk in onset of emotional/conduct disorder in childhood[14]	
Poor maternal mental health		5.7% of mothers experience depression 2 months post-natally, 6.5% at 6 months and 21.9% at 12 months[15]
Unemployed parent	2-3 fold increased risk of emotional/ conduct disorder in childhood[16] [17]	1.9 million children live in a workless household[18]
Poor parenting skills	4-5 fold increased risk of conduct disorder in childhood[19]	
Parents with no qualifications	4.25 fold increased risk of mental health problem in children[20]	
Deprivation – children in families with lower income levels	3 fold increased risk of mental health problems between highest and lowest socioeconomic groups (15% vs 5%)[21]	In 2007/8, four million (30%) children living in relative poverty (less than 60% median income)[22]
Four or more adverse childhood experiences (ACEs)[23]	12.2 fold increased rate in attempted suicide as an adult 10.3 fold increased risk of injecting drug use	15% of females and 9% of males experience four or more ACEs

[10] WHO (2004). Prevention of Mental Disorders. Effective interventions and policy options. Geneva: World Health Organization.

[11] O'Connor TG, Heron J, Golding J et al (2003) Maternal antenatal anxiety and behavioural/emotional problems in children: A test of a programming hypothesis. *J Child Psychol Psychiat,* 44,1025-1036.
O'Connor TG, Heron J, Golding J et al (2002) Maternal antenatal anxiety and behavioural problems in early childhood. British Journal Psychiatry, 180, 502-508.

[12] Bergman K, Sarkar P, O'Connor TG et al (2007) Maternal stress during pregnancy predicts cognitive ability and fearfulness in infancy. J. Am. Acad. Child. Adolesc. Psychiatr, 46, 1454-1463

[13] Colman I, Ploubidis GB, Wadsworth MEJ et al (2007) A longitudinal typology of symptoms of depression and anxiety over the life course. *Biol Psychiatry*, 62, 1265–1271

[14] Meltzer H, Gatward R, Corbin T et al (2003) Persistence, onset, risk factors and outcomes of childhood mental disorders. ONS, London TSO

[15] Gavin NI, Gaynes BN, Lohr KN *et a.* (2005) Perinatal depression: a systematic review of prevalence and incidence. *Obstetrics and Gynecology*, *106*, 1071–1083.

[16] Meltzer H, Gatward R, Corbin T et al (2003) Persistence, onset, risk factors and outcomes of childhood mental disorders. ONS, London TSO

[17] Green H, McGinnity A. Meltzer H et al (2005) Mental health of children and young people in Great Britain, 2004. ONS.

[18] ONS (2009) Labour Force Survey http://www.statistics.gov.uk/cci/nugget.asp?id=409

[19] Meltzer H, Gatward R, Corbin T et al (2003) Persistence, onset, risk factors and outcomes of childhood mental disorders. ONS, London TSO

[20] Green H, McGinnity A. Meltzer H et al (2005) Mental health of children and young people in Great Britain, 2004. ONS.

[21] Green H, McGinnity A. Meltzer H et al (2005) Mental health of children and young people in Great Britain, 2004. ONS.

[22] DWP (2009) Households Below Average Income (HBAI) An analysis of the income distribution 1994/95 – 2007/08. http://research.dwp.gov.uk/asd/hbai_arc.asp

[23] Centres for Disease Control and Prevention (2005) Adverse Childhood Experiences Study http://www.cdc.gov/nccdphp/ace/prevalence.htm; Collishaw S, Pickles A, Messer J et al (2007) Resilience to adult psychopathology following childhood maltreatment: Evidence from a community sample. *Child Abuse & Neglect*, 31, 211–229

Risk factor	Impact on risk of mental disorder	Prevalence in population
	7.4 fold increased risk of alcoholism 4.6 fold increased risk of depression in past year 2.2 fold increased risk of smoking	
Child abuse (physical, emotional and/or sexual abuse and/or neglect) [24]	15.5 fold increased risk of minor depression as a child 8.9 fold increased risk of suicidal ideation 8.1 fold increased risk of anxiety 7.8 fold increased risk of recurrent depression as adult 9.9 fold increased risk of adult PTSD 5.5 fold increased risk of substance misuse/ dependence	16% of children (1 in 6) experience serious maltreatment by parents[25]
Adolescent dating violence (ie. physical or sexual abuse by a dating partner)	8.6 fold increased risk of suicidality[26]	8.9% of women and 1.2% of men aged 16 to 19 sexually assaulted in previous 12 months[27]
High level use of cannabis in adolescence	6.7–6.9 fold increased risk of developing schizophrenia[28]	9% of children aged 11– 15 report cannabis use in last year, 7% of 15-year-olds report frequent drug use[29]

Child and adolescent high risk groups

Inequality disproportionately affects certain groups as highlighted in table 2 below. During childhood and adolescence, these include looked after children (5 fold increased risk of any childhood mental health problems)[30], young offenders (3 fold increased risk of mental health problems)[31], children of prisoners (3 fold increased risk of antisocial behaviour) and homeless young people.

Table 2: Level of increased risk of mental health problems in children and young people from high risk groups (from DH Public Mental Health review 3)

[24] Collishaw S, Pickles A, Messer J et al (2007) Resilience to adult psychopathology following childhood maltreatment: Evidence from a community sample. *Child Abuse & Neglect*, 31, 211–229
[25] Cawson (2002) Child maltreatment in the family: the experience of a national sample of young people. London: NSPCC.
[26] Silverman JG, Raj A, Mucci LA, Hathaway JE. (2001) Dating violence against adolescent girls and associated substance use, unhealthy weight control, sexual risk behavior, pregnancy, and suicidality. JAMA, 286(5), 572-9.
[27] Povey D, Coleman K, Kaiza P, Roe S (2009) Homicides, Firearm Offences and Intimate Violence 2007/08 (Supplementary Volume 2 to Crime in England and Wales 2007/08). Home Office Statistical Bulletin
[28] Zammit S, Allebeck P, Andreasson S et al (2002) Self reported cannabis use as a risk factor for schizophrenia in Swedish conscripts of 1969: historical cohort study. BMJ, 325(7374),1199.
[29] NatCen. (2009) Smoking, drinking and drug use among young people in England in 2008, schools survey. NHS Information Centre for Health and Social Care
[30] Meltzer H, Corbin T, Gatward R, Goodman R, Ford T (2003) The mental health of young people looked after by local authorities in England. ONS
[31] Lader D, Singleton N, Meltzer H, (2000) Psychiatric Morbidity among Young Offenders in England and Wales. ONS

Risk group	Impact on risk of mental disorder	Prevalence in population
Children with learning disability	6.5 fold increased risk of mental health problem[32]	2.6% of pupils have learning disabilities[33]
Children with Special Educational Needs	3 fold increase in conduct disorder[34]	
Children with physical illness	2 fold increased risk of emotional/conduct disorders over a 3 year period[35]	5-6% of children (600,000) report/are reported by parents as being in 'fair or poor' health)[36]
Homeless young people	8 fold increased risk of mental health problems if living in hostels and bed and breakfast accommodation[37]	Between 36,000 to 52,000 homeless young people in England[38]
Young LGBT	7- fold increased risk of suicide attempts in young lesbians 18- fold increased risk of suicide attempts in young gay men[39]	Estimate 6% of population are LGB[40]
Young offenders	18 fold increased risk of suicide for men in custody age 15–17 [41] 40 fold increased risk of suicide in women in custody age < 25 [42] 4 fold increased risk of anxiety/ depression[43] 3 fold increased risk of mental disorders	Over 6,000 children aged under 18 entering custody during a year – the vast majority are boys[44] 10% of 10– 25-year-olds report committing a serious offence in previous year[45]
Looked after children	5 fold increased risk of any childhood mental disorder[46] 6–7 fold increased risk of conduct disorder 4–5 fold increased risk of suicide attempt as an adult[47]	64,400 children (0.5% of under 18 year olds) are 'looked after' in England[48]
Children of prisoners	3 fold increased risk of antisocial-delinquent outcomes[49]	160,000 children and young people per year have a parent in prison [50]

[32] Emerson E, Hatton C (2007) Mental health of children and adolescents with intellectual disabilities in Britain. British Journal of Psychiatry,191, 493-499.
[33] Emerson and Hatton (2008) People with Learning Disabilities in England. Centre for Disability Research
[34] Parry-Langdon N, Clements A, Fletcher (2008) Three years on: Survey of the development and emotional wellbeing of children and young people. ONS.
[35] Parry-Langdon N, Clements A, Fletcher (2008) Three years on: Survey of the development and emotional wellbeing of children and young people. ONS.
[36] Health Survey for England (2009) 2008 trend tables
[37] Mental Health Foundation (2002) The mental health needs of homeless young people. Barnardos.
[38] Pleace N, Fitzpatrick S (2004) Centrepoint Youth Homelessness index. An estimate of youth homelessness for England. Centre for Housing Policy. University of York
[39] Fergusson D, Horwood JL, Ridder EM et al (2005) Sexual orientation and mental health in a birth cohort of young adults. Psychological Medicine, 35, 971-81
[40] DTI (2005) Final Regulatory Impact Assessment: Civil Partnership Act 2004 (page 13) http://www.berr.gov.uk/files/file23829.pdf
[41] Fazel S, Benning R, Danesh J (2005) Suicides in male prisoners in England and Wales, 1978–2003. *Lancet*, 366(9493), 1301-1302
[42] Fazel S (2009) Suicides in female prisoners in England and Wales, 1978–2004 *The British Journal of Psychiatry,* 194, 183-184.
[43] Lader D, Singleton N, Meltzer H (2000) Psychiatric Morbidity among Young Offenders in England and Wales. ONS
[44] HM Government (2009) Healthy Children, Safer Communities – A strategy to promote the health and wellbeing of children and young people in contact with the youth justice system.
[45] Roe S, Ashe J (2008) Young people and crime: findings from the 2006 Offending, Crime and Justice Survey. Home Office statistical bulletin
[46] Meltzer H, Corbin T, Gatward R, Goodman R, Ford T (2003) The mental health of young people looked after by local authorities in England. ONS
[47] Vinnerljung, B (2006) Children in care have a high risk of mental illness as adolescents and young adults. Journal of Child Psychology and Psychiatry, 47,723-33
[48] DfE (2010) Children Looked After by Local Authorities in England (including adoption and care leavers) - year ending 31 March 2010. http://www.education.gov.uk/rsgateway/DB/SFR/s000960/index.shtml

Persistence of mental health problems

Other studies confirm the high level of persistence of mental health problems among children:

- One quarter of the children who had a clinically-rated emotional disorder in 1999 were still assessed as having an emotional disorder three years later
- 43% of the children who were assessed in 1999 as having a conduct disorder were still rated as having a conduct disorder three years later.
- Children who were less positive about their neighbourhood, who felt unsafe and who thought that people were less trustworthy were more likely to develop emotional disorder 3 years later, while low levels of trust of people in their neighbourhood was associated with increased risk of conduct disorder.[51]

Impact of mental health problems on further inequality in childhood and adolescence

The evidence for how inequality increases risk of mental health problems is detailed above. However, once mental health problems have developed, this further exacerbates inequality. The links between mental health problems and poor psycho-social and educational outcomes are summarised in the table below. Particular striking features are that children and young people with conduct disorder are 17 times more likely to be excluded from school and 4 times more likely to be two or more years behind in intellectual development. Those with emotional disorders are almost 5 times more likely to self-harm or commit suicide, and are over four times more likely to be in poorer health or to have long periods of time off school.

Mental health problems, risk taking behaviour and associated inequality

Mental health problems are associated with increased rates of a range of risk-taking behaviour including alcohol, tobacco and drug use as highlighted in table 3. For instance, 5-16 year olds with conduct disorder are six times more likely to smoke.

[49] Niven S, Stewart D (2005) Resettlement outcomes on release from prison in 2003. Home Office research findings, number 248. Home Office, London.

[50] SCIE (2008) Children's and families resource guide 22: Children of prisoners – maintaining family ties. SCIE, London

[51] Parry-Langdon N, Clements A, Fletcher (2008) Three years on: Survey of the development and emotional wellbeing of children and young people. ONS. http://www.statistics.gov.uk/articles/nojournal/child_development_mental_health.pdf

Table 3. Relative risk of health and social skill outcomes, school outcomes and risk taking behaviours in children and young people with and without mental disorders[52] (from DH Public Mental Health review 3)

Health and other outcomes and risk taking behaviours in children and young people with and without mental disorders					
	Age	**Emotional Disorder**	**Conduct disorder**	**Hyperkinetic disorder**	**Whole Survey**
		RR*	RR*	RR*	Prevalence
Health and social skill outcomes					
health is fair or bad (parent report)	5-16	4.6	3.4	2.6	7%
found it harder than average to make friends	5-16	3.9	2.7	3.2	10%
no friends	5-16	6.0	8.0	5.0	2%
School outcomes					
2 or more years behind in intellectual development	5-16	1.4	4.0	4.4	10%
more than 15 days absence in the previous term	5-16	4.3	3.5	2.2	5%
ever been excluded from school	5-16	3.0	16.5	9.7	4%
Self-reported risk taking behaviours					
Regular smoker	11-16	3.8	6.0	2.5	6%
Regular drinker	11-16	1.4	2.1	1.4	9%
Drinks twice a week or more	11-16	1.7	4.0	2.3	3%
Taken drugs mainly cannabis	11-16	2.5	3.5	2.9	9%
Taken drugs excl. cannabis	11-16	4.0	2.5	5.0	2%
Self reported self harm	11-16	4.7	3.5	2.6	7%

*RR = relative risk compares those with to those without disorder

Mental health problems during childhood and adolescence influence adult outcomes and inequality

Mental health problems during childhood and adolescence are associated with a wide range of adverse outcomes in later life, including higher rates of adult mental health problems, poor educational outcomes, unemployment, low earnings, teenage parenthood, marital problems and criminal activity.[53] They also impact on physical health and social functioning, and have serious repercussions on the life of the family and the community.

Outcomes are worse for conduct problems than for emotional difficulties. Adults whose antisocial behaviour began in childhood as opposed to adolescence have higher levels of mental illness, substance dependence, financial problems, work problems, and drug-related and violent crime, including violence against women and

[52] Green H, McGinnity A. Meltzer H et al (2005) Mental health of children and young people in Great Britain, 2004. ONS.

[53] Richards M, Abbott R (2009) Childhood mental health and life chances in post-war Britain. Insights from three national birth cohort studies. http://www.scmh.org.uk/pdfs/life_chances_report.pdf

children.[54] Nearly half of children with early onset conduct problems go on to have persistent, serious life-course problems including crime, violence, drug misuse and unemployment.[55] However, if conduct disorder is limited to childhood, there is no increased risk of poor adult outcomes and conduct disorder beginning in adolescence rarely continues beyond adolescence.

Mental wellbeing and outcomes in children and young people
Mental wellbeing is also associated with a range of outcomes. For instance, poor mental wellbeing among children and young people is associated with higher rates of crime, truancy or poor school attendance, use of alcohol, tobacco or cannabis. Low levels of wellbeing are associated with four-fold increased rates of three or more conduct problems compared with young people with optimal levels of wellbeing.[56]

A large survey of wellbeing in the North West of England found that living in a deprived community is strongly associated with lower levels of mental wellbeing, and confirmed the inverse correlation between poor mental wellbeing and behaviours such as smoking, drinking at harmful levels, cannabis use and low levels of physical activity.[57]

From the consultation
Respondents wanted to see clarity about responsibility for young people's transition between services. There were variations in the transition processes proposed or described, which included transition planning groups, teams and key workers, but they were all geared to ensure that there was planning for transition and a good process implemented.

As regards the content of transition, people wanted to see person-centredness and multi-agency care planning – to ask young people and families what they want and give it to them, to use personalisation tools, and to be flexible about the timing (both transition itself and appointments).

From the consultation
While supporting initiatives to combat stigma, the UK Council for Psychotherapy, Child Psychotherapy and Psychotherapy with Children Committee said
"We particularly see children and young people's fear of stigma as a consequence of the failure of various arms of provision to work together. It is imperative that the statutory, voluntary and private sectors collaborate in sharing their skills and knowledge, and valuing the diversity of options they can offer each other and their clients."

There is considerable evidence that programmes which involve parents, schools and the wider community can be effective in promoting wellbeing in children and young people. Programmes can be both universal or targeted to children at higher risk to

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[54] Moffitt TE, Caspi A, Harrington H, Milne BJ. (2002) Males on the life-course persistent and adolescence-limited antisocial pathways: follow-up at age 26 years. *Dev Psychopathol,*14,179-207.
[55] Fergusson DM, Horwood LJ, Ridder EM. (2005) Show me the child at seven: the consequences of conduct problems in childhood for psychosocial functioning in adulthood. *J Child Psychol*, 46, 837-49.
[56] Keyes CLM (2006) Mental health in adolescence is America's youth flourishing? *American Journal of Orthopsychiatry*, 76, 395-402
[57] Deacon L, Carlin H, Spalding J et al (2009) North West Mental Wellbeing Survey. North West Public Health Observatory. http://www..nwph.net/nwpho/publications/ NorthWestMentalWellbeing%20SurveySummary.pdf

prevent widening of inequality (see DH Public Mental Health review 3 for details of programmes).

Managing mental health problems in children and young people

Early identification and intervention for children and young people who are developing problems is critical as half of lifetime of mental health problems arise by the age of 14 and three fourths by the mid twenties.[58] Timely intervention is critical to both improve outcomes across a range of areas but also prevent progression into adulthood since it has been estimated that 25-50% of mental illness during adulthood could be prevented with effective intervention during childhood and adolescence.[59]

- However, very few children are able to identify their own mental health needs or to self-refer, and most rely on their needs being identified and met by non-professionals such as parents or teachers. Furthermore, there is lack of screening and low levels of treatment: In 2004, it was estimated that around three in four of 5-15 years-olds with mental health problems are not in contact with child and adolescent mental health services (CAMHS).[60]
- ONS survey results show that only 25% of children and adolescents with conduct and emotional disorder are seen by CAMHS and receive less support from other services even though these are the most common mental disorder in this age group.[61]
- More than half of all children with Autism or Asperger's levels of impairment or symptoms remain undetected and do not receive any additional needs support in education or health.[62]

Therefore, most mental disorder in children and adolescents remain undiagnosed and untreated with both short and longer term impacts. These persist across the life course and underlie a range of inequality. Table 2 identifies high risk groups such as looked after children who are particularly vulnerable both to poor mental health as well as to missing out on early identification and treatment.

From the consultation

Personalisation is a key issue across the entire age range – many consultation responses assumed or propose an age-based service and support raising the upper age for young people's services, alternatives for this range from 18 to 30. They do not support a hard and fast cut-off, but a flexible situation according to the individual's need, maturity and choice. *Young Minds* consulted with young people and they stress that services should be flexible, based on need but that no-one should be left without a service.

[58] Kessler RC, Amminger GP, Aguilar-Gaxiola S et al (2007) Age of onset of mental disorders: a review of recent literature. *Curr Opin Psychiatry*, 20(4), 359-64

[59] Kim-Cohen, J. Caspi A, Moffitt TE et al (2003) Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective longitudinal cohort. Archives of General Psychiatry, 60, 709-717

[60] Social Exclusion Unit (2004), Mental Health and Social Exclusion, ODPM

[61] Green H, McGinnity A. Meltzer H et al (2005) Mental health of children and young people in Great Britain, 2004. ONS.

[62] Russell G, Ford T, Steer C, Golding J (2010) Identification of children with the same level of impairment as children on the autistic spectrum, and analysis of their service use. J Child Psychol Psychiatry, 51(6), 643-51

Older People

35% of people with mental health problems are over 65.[63]

Approximately 25% of older people in the community have symptoms of depression that require intervention with 11% having minor depression and 2% having major depression.[64 65] Particular groups of older people are at higher risk; for example, 20-25% of people with dementia also have major depression[66] while a review found that 40% of care home residents had depression, 50-80% had dementia and 30% had anxiety. However, these figures may significantly underestimate the true incidence of depression among older people.[67 68]

Depression is 2-3 times more common in people with a chronic physical health problem than in people who are in good physical health[69] and more than 7 times more common in those with 2 or more chronic physical conditions.[70] Particular conditions affecting older people increase risk of depression with 50% of those with Parkinson's disease affected.[71] Social isolation is another key cause of depression in older people, as highlighted in the consultation response below.

From the consultation
Respondents to the consultation commented on poverty and isolation in old age, discrimination in benefits and housing, ageist notions that mental health problems are a natural and inevitable part of ageing, and unrecognised depression among older people. They highlighted the need for prevention and promotion to address issues linked to poverty, housing, isolation, physical health and bereavement.

From the consultation
"In real communities, age groups mix so reduce the segregated nature of services and promote inter-generational support and mutual self-help." (Individual)

Service provision for older people
The national review and consultation on the Equality Bill (including the reviews by the centre for policy on ageing) provided evidence of:

- Age-based services not being tailored to clinical need, meaning that some people over 65 years old are denied specialist services (even when they have had mental health problems for years).

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[63] Healthcare Commission, Care Services Improvement Partnership, National Institute for Mental Health in England and Mental Health Services Act Commission (2008) *Count me in 2008: results of the 2008 national census of inpatients in mental health and learning disability services in England and Wales*, [London]: Commision for Healthcare Audit and Inspection
[64] Godfrey M, Townsend J, Surr C et al (2005) Prevention and Service Provision: Mental Health Problems in Later Life, Institute of Health Sciences and Public Health Research, Leeds University &Division of Dementia Studies, Bradford University.
[65] Craig R, Mindell J (eds.) (2007) Health Survey for England 2005: Health of older people. Leeds: The Information Centre.
[66] Amore M, Taqariello P, Laterza C, Savioa EM (2007) Subtypes of depression in dementia. Archives of Gerontology and Geriatrics, 44 (1), 23-33.
[67] Godfrey M, Townsend J, Surr C et al (2005) Prevention and Service Provision: Mental Health Problems in Later Life, Institute of Health Sciences and Public Health Research, Leeds University &Division of Dementia Studies, Bradford University.
[68] (Adults In Later Life with Mental Health Problems, Mental Health Foundation quoting Psychiatry in the Elderly (3rd edition) Oxford University Press (2002)
[69] NICE (2009) Depression in adults with a chronic physical health problem: Treatment and management http://www.nice.org.uk/nicemedia/pdf/CG91FullGuideline.pdf
[70] Moussavi S, Chatterji S, Verdes E. et al. (2007) Depression, chronic disease and decrements in health. Results from the world Health Surveys. Lancet, 370, 851–858.
[71] NICE (2009) Depression in adults with a chronic physical health problem: Treatment and management http://www.nice.org.uk/nicemedia/pdf/CG91FullGuideline.pdf

- Greater provision of crisis response and preventative services for younger than older people.
- Much lower rates of specialist referral for older people than younger with depression.
- Discrimination against people suffering from dementia in service provision (for example, intermediate care).

In January 2009 Help the Aged carried out a survey of members of the British Geriatrics Society which found that:

- 47% of doctors ...think that the NHS is institutionally ageist.
- 66% agreed that, in their experience, older people are less likely to have their symptoms fully investigated.
- 72% said that older people were less likely to be referred on for essential treatments.

In 2009, the Royal College of Psychiatrists published a report on age discrimination in mental health services making clear that access to services must be based on needs, not age.[72]

There is a growing evidence base to show that older people benefit from a wide range of psychological therapies. However, obstacles to access and to appropriate assessment, diagnosis and management remain. Although depression in older adults occurs at similar rates to younger adults, it is less often diagnosed or treated promptly in primary care with lower rates of prescription of antidepressants for older compared to younger people. Only 15% of older people with depression discuss their symptoms with their general practitioner and less than half of these will receive adequate treatment.[73] [74]

These may be the result of age discrimination and also a lack of knowledge among older people. Older people visit their GPs more frequently than other age groups, and the health service is a place to which many of them turn for help and support, so that health professionals play a crucial role in identifying mental health problems and the coordination of care. However, the evidence shows that older people are under-represented among those benefiting from Improving access to Psychological Therapies (IAPT) and other new treatments.[75]

Dementia

Another key mental health issue for older people is dementia, which affects 5% of people over the age of 65 and 20% of those aged over 80.[76] The prevalence of dementia in England is predicted to rise from 680,000 in 2007 to 1.01 million people by 2031.[77]

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[72] Age Discrimination in Mental Health Services: Making Equality a Reality, Royal College of Psychiatrists, October 2009
[73] Godfrey M, Townsend J, Surr C et al (2005) Prevention and Service Provision: Mental Health Problems in Later Life, Institute of Health Sciences and Public Health Research, Leeds University &Division of Dementia Studies, Bradford University.
[74] Chew-Graham C, Burns A, Baldwin R, (2004) Treating depression in later life: We need to implement the evidence that exists. British Medical Journal, 329, 181-2.
[75] DH (2010), Commissioning IAPT for the whole community: Improving Access to Psychological Therapies – Older people positive practice guide http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_094203.pdf
[76] Knapp M, Prince M (2007) Dementia UK: A Report into the Prevalence and Cost of Dementia, Alzheimer's Society, London.
[77] Knapp M, Prince M (2007) Dementia UK: A Report into the Prevalence and Cost of Dementia, Alzheimer's Society, London.

However, only a third of cases of dementia are currently ever diagnosed, meaning opportunities to minimise harm and promote good life quality are not taken.[78] [79] [80] It can be difficult to identify and assess the mental health needs of older people from ethnic minorities, especially in the case of dementia.[81] This can be due to a number of factors, including cultural factors. As a result, the true level of need may be under-estimated.

Key issues are:

- Low levels of recognition and diagnosis, due to inappropriate diagnostic tools or difficulties in communicating with service users or their families.
- Stigma, due to the negative perception of dementia in some cultures.
- Impact on carers, who are often elderly spouses or other relatives, who are at high risk themselves of isolation and distress.

Some barriers to establishing a more accurate estimate of need include:

- Difficulty in recruiting participants from ethnic communities because of the small size of many local ethnic communities. In addition, due to the stigma associated with dementia, few people from ethnic minorities come forward for diagnosis.
- Need for different research approaches because focus groups may not be appropriate to discussing stigmatising issues such as dementia. Also, the appropriate qualitative research methods are more resource intensive, and hence harder to find funding for.
- A need for a wider scope of research into risks and prevention - for example, research on vascular dementia in ethnic minorities focuses on people from the West Indian community – this could lead to the misconception that this health issue is unique to this group.

Special areas of provision for ethnic minority elders will include domiciliary care, as many communities regard residential care as inappropriate, and culturally appropriate respite services.

From the consultation
Respondents wanted an end to age discrimination and to see equality of service either side of age 65 with public mental health interventions and service developments that target, or are inclusive of, older people. They said that older people's mental health was neglected and the disparity between funding of older and younger adult services was discriminatory.

From the consultation
Age Concern and Help the Aged emphasised the need to remove age discrimination in the distribution of resources. They recommended that local authorities move towards a single Resource Allocation Scheme (RAS) across all age groups.

From the consultation
Age discrimination and the social isolation and poverty of older people were raised by respondents including Age Concern/ Help the Aged (now Age UK) and the Royal

[78] National Audit Office(NAO) (2007) Improving services and support for people with dementia. London: The Stationery Office.
[79] National Institute For Clinical Excellence (2004)
[80] Knapp M, Prince M (2007) Dementia UK: A Report into the Prevalence and Cost of Dementia, Alzheimer's Society, London.
[81] Mental Health Foundation (2003) Updates Vol 4.17, Dementia, Ethnicity and Culture, May 2003

College of Psychiatrists. In addition to implementing age discrimination law, recommended measures were scrapping the default retirement age, reforming the benefits system to provide automatic payment of entitlements, and building all new homes to Lifetime Home standards. Prevention activity should be resourced in all services (for example podiatry, optician, utilities, lifelong learning) and the "well elderly" be encouraged to plan ahead.

There were also calls for a level playing field in terms of funding for services for older people with investment in specialist Some respondents wanted to see more effort and/or campaigns to meet the needs of older people with undiagnosed depression and for older people to have access to psychological therapies through the IAPT programme.

The Foyer Federation supplied an example of intergenerational activity in which young people provided information technology training for pensioners and pensioners assisted the young people with gardening skills to establish an allotment, resulting in "a dramatic shift in attitudes" in both groups.

The Mental Health Foundation advocates that the commissioning of health and social care services should include mental health promotion and prevention activity amongst the older population, challenging the inherently ageist notion that mental health problems are a natural and inevitable consequence of ageing. They also advocate that the Care Quality Commission should establish appropriate Quality of Life (QOL) outcome measures against which older people's mental health services can be judged, and so ensure that they are receiving an equitable level of care to younger adults, particularly in the light of forthcoming Equality legislation.

Disability

Disability covers a very broad spectrum of physical or sensory impairment, each of which can affect people's mental health as well as their ability to access services.

There are two main issues to be considered where mental health problems and disability are concerned:

- mental health problems such as depression, bipolar disorder, obsessive compulsive disorder, schizophrenia, dementia and self-harm can constitute a disability in themselves;
- the link between mental illness and disability.

Poor mental health increases the risk of physical illness as well as affecting people's ability to seek help for and manage physical conditions such as heart disease and diabetes. Conversely, people with physical impairments are more likely than the general population to experience mental health problems due to a number of possible reasons including higher rates of poverty and unemployment that are themselves associated with poor mental health. People with mental health problems are also more likely to become physically disabled as a result of accidents or attempted suicide.

People with learning disabilities have a particularly high risk of mental illness, linked to poor physical health, social exclusion and other factors. They also have specific needs relating to support for mental wellbeing and treatment for mental health conditions.

Smoking affects mental and physical health and is the largest cause of health inequality. The relationship between smoking, mental and physical illness and premature mortality are considered below.

Impact of mental illness on physical illness

Depression

- Depression is associated with the following effects on physical health (see DH Public Mental Health review 7).
- Increased mortality: A meta-analysis of 15 population-based studies found that a diagnosis of depression in those over 65 increased subsequent mortality by 70%.[82]
- Depression is associated with 50% increased mortality after controlling for confounders.[83] It is associated with increased mortality from cardiovascular disease, cancer, respiratory disease, metabolic disease, nervous system diseases, accidental death, and mental disorders.[84]
- Depression almost doubles risk of later development of coronary heart disease after adjustment for traditional factors.[85] [86]
- Increased psychological distress is associated with 11% increased risk of stroke after adjusting for confounders.[87]
- Depression increases risk of colorectal cancer, back pain, irritable bowel syndrome and multiple sclerosis.[88] [89] [90] [91]
- Depression increases risk of non-compliance with treatment recommendations by three fold compared to non-depressed patients.[92]

Serious mental health problems such as psychosis

- Compared with the general population, people with schizophrenia experience an increased prevalence of obesity, diabetes, dyslipidaemia[93] and smoking.[94]

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[82] Dewey ME, Saz P (2001) Dementia, cognitive impairment and mortality in persons aged 65 and over living in the community: a systematic review of the literature. *International Journal of Geriatric Psychiatry*, 16, 751–761

[83] Mykletun A, Bjerkeset O, Overland S et al (2009) Levels of anxiety and depression as predictors of mortality: the HUNT study. *British Journal of Psychiatry,* 195, 118-125.

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[92] DiMatteo MR, Lepper HS, Croghan TW (2000) Depression is a risk factor for non-compliance with medical treatment: meta-analysis of the effects of anxiety and depression on patient adherence. *Annals of Internal Medicine, 160,* 2101–2107.

[93] De Hert M, Dekker JM, Wood D et al (2009) Cardiovascular disease and diabetes in people with severe mental illness. Position statement from the European Psychiatric Association. European Psychiatry,

- In the UK people, men with schizophrenia die an average 20.5 years earlier while women with schizophrenia die an average 16.4 years earlier although this study did not include those with co-morbid substance misuse or the more severely unwell in long- stay hospital settings.[95] In the USA, people with schizophrenia and bipolar disorder die an average 25 years earlier than the general population, largely due to physical health problems.[96]
- Standardised Mortality Rates for those with Serious Mental Illness are 150 all cause, respiratory disease 250, cardiovascular disease 250 and infectious disease 500.[97]
- A person with schizophrenia is 12.8 times more likely to commit suicide, 3.2 times more likely to die from respiratory disease and 4.3 times more likely to die from infectious disease than someone from the general population.[98]
- They are also less likely to benefit from mainstream screening and public health programmes.

Physical illness increases the risk of mental illness

While mental illness increases risk of physical illness, the converse is also true:

- Physical illness more than doubles the risk of developing depressive disorder. A similarly heightened risk was found for a wide range of physical illnesses including hypertension, asthma, arthritis and rheumatism, back pain, diabetes, heart disease and chronic bronchitis.[99]
- People with physical illness are at six time higher risk of experiencing mental illness as a result of experiencing two or more recent adverse life events than people without physical illness.[100]
- In the first year after a diagnosis of cancer or first hospitalisation for heart attack, people have a 20% increased rate of new onset of depression or anxiety.[101] [102]

Long-term conditions increase risk of depression

- Depression is two to three times more common in people with a chronic physical health problem than in people who are in good physical health
- Rates of depression are doubled in diabetes, hypertension, coronary artery disease and heart failure
- Rates of depression are tripled in end-stage renal failure, chronic obstructive pulmonary disease and cerebrovascular disease.
- Rates of depression are seven times more common among those with two or more chronic physical conditions compared to healthy controls. [103] [104]

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http://www.easd.org/easdwebfiles/statements/EPA.pdf.

[94] McManus S, Meltzer H, Campion J (2010) Cigarette smoking and mental health in England. Data from the Adult Psychiatric Morbidity Survey. National Centre for Social Research. http://www.natcen.ac.uk/study/cigarette-smoking--mental-health.

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People with learning disability

Children, young people and adults with learning disability have higher rates of mental health problems.

- Children with learning disability have psychiatric disorder prevalence rates of 36% compared with 8% in children without learning disability. They comprise 14% of all British children with a diagnosable psychiatric disorder.[105]
- Children with learning disability are 6.5 times more likely to have a psychiatric disorder, 3.6 times more likely to have an emotional disorder 3.9 times more likely to have an anxiety disorder and 8.9 times more likely to have ADHD or a conduct disorder compared to those without learning disability.[106]
- Socio-economic disadvantage may account for a significant proportion of the increased risk for poorer health and mental health of children and adolescents with intellectual disabilities.[107]
- Between 30% and 50% of adults with learning disability in the UK have mental health problems. [108] Mental ill health affects 48% of those in the 20–64 age range and 69% of those aged over 64.[109]
- Adults with learning disability have a three-fold higher risk of schizophrenia and a doubled risk of depression compared with adults in the general population.[110]
- The above factors are compounded by poor physical health and social exclusion
  - people with learning disability have a high level of unrecognised physical illness as well as reduced access to health services, including promotion activities.[111] [112]
  - Learning disability is associated with higher levels of morbidity and mortality; a South London study found a 58-fold higher risk of dying before the age of 50 than the general population.[113]
  - Only 17% of people with learning disability of working age had a paid job, compared with 67% of men and 53% of women without learning disabilities.[114]

People in the care of learning disability services

- More than half of all patients (52%) in learning disability services have at least one other disability. Seventy percent of patients are male and 76% are aged under 50 years.

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[103] NICE (2009) Depression in adults with a chronic physical health problem: treatment and management http://www.nice.org.uk/nicemedia/pdf/ CG91FullGuideline.pdf

[104] Moussavi S, Chatterji S, Verdes E *et al.* (2007) Depression, chronic disease and decrements in health. Results from the world Health Surveys. *Lancet, 370,* 851–858.

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[106] Emerson E, Hatton C (2007) Mental health of children and adolescents with intellectual disabilities in Britain. *British Journal of Psychiatry*,191, 493-499.

[107] Emerson E, Hatton C (2007) Mental health of children and adolescents with intellectual disabilities in Britain. *British Journal of Psychiatry*,191, 493-499.

[108] Smiley E (2005) Epidemiology of mental health problems in adults with learning disability: an update. Advances in Psychiatric Treatment, 11, 214-222

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[113] Hollins S, Attard MT, von Fraunhofer N et al (1998). Mortality in people with learning disability: risks, causes, and death certification findings in London. Dev Med Child Neurol, 40(1), 50-6.

[114] ONS, 2003/4

- Almost one in three (32%) of those in learning disability services had been in hospital for over 5 years. The median length of stay for men was 31 months, while the medial length of stay for women was slightly longer, at 33 months.
- A small proportion of patients aged under 18 were found to be in 'out of age' placements i.e. on wards for working-age adults.
- Almost half of all men (48%) and almost three in four women (73%) were in mixed-sex accommodation. Over one in three men (37%) and more than half of the women (53%) did not have access to common space designated for single-sex use. More than one in five men (22%) and more than one in three women (35%) did not have access to single-sex toilet or bathing facilities.
- Certain ethnic minorities were over-represented relative to their proportion in the general population, especially Mixed White/Black Caribbean (2.4 times), Black Caribbean and Black Other (1.8 times respectively).[115]
- Of all patients in learning disability services in 2009, 45% were detained under the Mental Health Act on admission, including 18% from ethnic minorities. The highest rates of detention relative to general population proportion occurred among Chinese (2.1 times), Other Mixed (1.5 times) and Black Africans (1.5 times).

Smoking and disability

Increased smoking is responsible for the largest proportion of the excess mortality of people with mental illness:

- Smoking is the largest preventable cause of death in the UK and is responsible for an average reduction in life expectancy of 10 years in the general population; 1 in 4 smokers in the general population dies 15 years early and 1 in 2 smokers dies 23 years early.[116]
- Higher smoking rates in lower socioeconomic groups account for half the differences in mortality between socioeconomic class I and V.[117]
- In England, 42% of all tobacco consumed is by those with mental disorder.[118]
- In England, 31% of all tobacco consumed is by those with common mental disorder.[119] Furthermore, the amount of tobacco smoked is related to the number of depressive or anxiety symptoms and after cessation, such symptoms reduce.[120] [121]
- Similar proportion of consumption of tobacco in the USA results in almost half of annual deaths from tobacco being those with mental illness or addictions.[122]

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[115] CQC(2010), Count me in Census http://www.cqc.org.uk/_db/_documents/Count_me_in_2009_(FINAL_tagged).pdf

[116] Doll R, Peto R, Boreham J, Sutherland I (2004). Mortality in relation to smoking: 50 years' observation on male British doctors. British Medical Journal. 328: 745.

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[118] McManus S, Meltzer H, Campion J (2010) Cigarette smoking and mental health in England. Data from the Adult Psychiatric Morbidity Survey. National Centre for Social Research. http://www.natcen.ac.uk/study/cigarette-smoking--mental-health

[119] McManus S, Meltzer H, Campion J (2010) Cigarette smoking and mental health in England. Data from the Adult Psychiatric Morbidity Survey. National Centre for Social Research. http://www.natcen.ac.uk/study/cigarette-smoking--mental-health

[120] Farrell M, Howes S, Bebbington P et al. (2001). Nicotine, alcohol and psychiatric morbidity. Results of a national household survey. British Journal Psychiatry, 179, 432-7.

[121] Campion J, Checinski K, Nurse J, McNeill A (2008). Smoking by people with mental illness and benefits of smoke-free mental health services. Advances in Psychiatric Treatment. 14, 217-228.

[122] Williams JM, Ziedonis S (2004) Addressing tobacco among individuals with a mental illness or an addiction. Addictive Behaviours, 29, 1067-1083

Prevalence of smoking among people with mental illness

- Those with mental illness are far more likely to smoke and at much higher levels than people in the general population, and consequently suffer a much-elevated risk of smoke-related harm.
- Compared to smoking rates of 21% in the general population[123], rates of over 32% are seen among those with common mental disorder, 37% for those screening positive for PTSD, 40% for those with psychosis, 57% for those attempting suicide in the previous year, 69% for those with drug dependence and 46% for those with alcohol dependence (see table 5).[124]
- 70% for psychiatric inpatients[125] and over 80% for those attending methadone maintenance clinics.[126]
- In adolescents, smoking is six times more common in those with conduct disorder and four times more common in those with emotional disorder.[127] 43% of smokers under the age of 17 are from the 10% of children and adolescents with conduct disorder and emotional disorder.[128]
- 76% of people with a first episode of psychosis are already smoking, putting these young people at high risk of future co-morbidity and premature death.[129]
- Most of the excess mortality of people with mental illness has been ascribed to increased smoking.[130]

Impact of smoking on mental health

- A number of studies have shown that smoking is associated with increased risk of depression and anxiety disorder in young people[131], higher suicide rates[132] as well as 56% increased risk of developing mental disorder.[133]
- Smoking during pregnancy is associated with two fold increased risk of conduct disorder in boys and increased antisocial behaviour and ADHD symptoms in children.[134] [135]

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[123] NHS Information centre (2010) Statistics on Smoking: England, 2010 http://www.ic.nhs.uk/webfiles/publications/Health%20and%20Lifestyles/Statistics_on_Smoking_2010.pdf .
[124] McManus S, Meltzer H, Campion J (2010) Cigarette smoking and mental health in England. Data from the Adult Psychiatric Morbidity Survey. National Centre for Social Research. http://www.natcen.ac.uk/study/cigarette-smoking--mental-health
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Table 4: Proportion of population in England with different mental disorder and rates of smoking[136]

	Prevalence of disorder in population	Proportion who are regular smokers
Any mental disorder	23%	33%
Common mental disorder	16%	32%
Depressive episode	3%	37%
Phobias	2%	37%
Generalised anxiety disorder	4%	36%
PTSD screen	3%	37%
ADHD screen	1%	31%
Psychosis	1%	40%
Suicide attempt in past year	1%	57%
Drug dependence	3%	69%
Alcohol dependence	6%	46%
Alcohol problems	24%	30%

Smoking cessation

- Smoking cessation results in improved mental health, reduced depressive symptoms[137], reduced doses of some psychiatric medications[138], reduced financial stress[139], reduced physical illness and improved life expectancy. Therefore cessation not only reduces likelihood of developing physical illness but may also play a role in prevention of mental illness.
- However, although smokers with mental illness are just as motivated to stop as the general population[140], they are less likely to be offered cessation support.
- Smoking cessation interventions for those with mental illness are the same as for the general population but with additional monitoring and in some cases adaptation.
- Effective non-pharmacological interventions include group therapy and exercise.
- Effective pharmacological interventions include NRT which doubles cessation rates for those with depression. For those with schizophrenia, NRT increases cessation particularly in combination while bupropion almost triples cessation at 6 months[141]. Combination NRT and bupropion is also effective.

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[136] McManus S, Meltzer H, Campion J (2010) Cigarette smoking and mental health in England. Data from the Adult Psychiatric Morbidity Survey. National Centre for Social Research. http://www.natcen.ac.uk/study/cigarette-smoking--mental-health

[137] Campion J, Checinski K, Nurse J, McNeill A (2008). Smoking by people with mental illness and benefits of smoke-free mental health services. Advances in Psychiatric Treatment. 14, 217-228.

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Disability - summary of issues

1. Improved access to health promotion and physical health services for people with mental illness

People with mental health problems have higher rates of physical illness and premature death. Early access to a range of health promotion activities including smoking cessation, physical activity and healthy eating can both prevent health risk behaviour leading to physical ill-health and have an important impact on recovery. Early intervention for physical illness is also important.

2. Improved access to mental health services for people with physical illness

People with a physical long-term condition such as diabetes or COPD have a significantly increased risk of depression compared to the rest of the population.[142] Early targeted interventions for such groups can prevent mental illness. Early access to a range of treatment including talking therapies is associated with better outcomes. The new Talking Therapies Strategy will extend Talking Therapies to people with long-term conditions.

3. Improved access to services for people with physical disabilities

Services have not always been quick to recognise that the needs of mental health service users who are also disabled. Inadequate arrangements by service providers and slowness to react to the need for reasonable adjustments, for example in the case of mobility difficulties, or even just a lack of sympathy and understanding, can impede access to treatment and care.[143]

4. Better linkage across physical and mental health service providers

An important issue for people with physical disabilities who access mental health services is the separation of service provision across physical health and mental health. Mental health services and physical disability services must each take account of needs relating to the other and communicate better about these.

Challenging Behaviour Foundation submission to DH consultation
"There needs to be much greater use of the DDA [Disability Discrimination Act] – and a greater emphasis on reasonable adjustments in all mental health support services to meet the needs of all. In particular, the mental health needs of people with a learning disability – all aspects need to be accessible – from diagnosis, information, treatment, person centred approaches, etc."

The Joseph Rowntree Foundation carried out in-depth qualitative research on a small sample of people with physical impairments as well as mental health support needs about their experiences of accessing mental health and physical disability services. They identified a range of problems with both types of service, and their levels of satisfaction seemed to be significantly lower than that found in other surveys of mental health service users and users of physical disability services.[144]

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[142] NICE (2009) Depression in adults with a chronic physical health problem: treatment and management http://www.nice.org.uk/nicemedia/pdf/ CG91FullGuideline.pdf

[143] Morris, J (2004), Services for people with physical impairments and mental health support needs, Joseph Rowntree Foundation

[144] Morris, J (2004), Services for people with physical impairments and mental health support needs, Joseph Rowntree Foundation http://www.jrf.org.uk/publications/services-people-with-physical-impairments-and-mental-health-support-needs

Royal National Institute for the Deaf submission to DH consultation
The mental health workforce should include people who are deaf and that some services be delivered using British Sign Language (BSL). They quoted the example of SignHealth Counselling whose staff are themselves deaf and offer counselling in BSL.

They also recommended extending training beyond traditional professional boundaries, so as to move towards more inclusive services and person-centred approaches. An example is the Certificate in Mental Health & Deafness, which is part-funded by RNID, and developed in association with Birmingham University by a collaborative of hearing and deaf people and organisations. Its first intake was scheduled for March 2010.

Two-thirds of respondents said they had difficulty accessing mental health services because of their physical impairments. Barriers ranged from inaccessible physical environments to unhelpful attitudes amongst staff, in-patient experiences characterised by a lack of physical assistance for simple things, withdrawal of medication on admission. Community mental health workers were often unfamiliar with physical impairments, and the assistance that people with disabilities might need to access services.

From Joseph Rowntree Foundation study
"The psychiatric hospital just wasn't geared up for people with physical impairments at all. The room I had had an incredibly heavy door. The shower was lethal: there was no alarm, no handrails, it was very slippery - it was difficult to get in and out of. The distance down to breakfast was just about the limit of my walking, but …I couldn't serve myself with the meals because …you queued up, picked up your meal and then took it over to your table, put your dishes away and went to somewhere different to get your drink. I couldn't manage that."

5. Improved awareness among primary health care providers about disability and mental health needs

GP services were variable in terms of their ability to cope with the range of issues posed by patients with physical impairments.   The Joseph Rowntree study quoted above found that about half (48%) of respondents rated their GP's response to needs relating to physical impairment as good or better; a third (35%) said it was either poor or very poor. Conversely, 45% rated their GP's response to mental health needs as either poor or very poor while 36% said it was either good or very good.

6. Improved awareness of the needs of people with learning disabilities

Key intervention areas include:

- Early detection of learning disabilities and intervention.
- Support for children with learning difficulties and for their carers including support for training, education and returning to work, and access to respite care.
- Promoting physical activity and good physical health; ensuring access to screening and health education; access to opportunities for meaningful social activity and occupation for both people with learning disability and family carers.[145]

[145] Alborz A, Kalambouka A, McNally R et al (2006) A Literature Review on the Effectiveness of Interventions to Improve the Physical Health of People with Learning Disabiltiies. Disability Rights Commission.

- Improved service provision for people with learning disability e.g. increased access to single-sex provision.[146]
- Reduction of poverty may have the largest impact on mental health of this group.
- Positive behavioural support, CBT, psychoanalytic and psychodynamic psychotherapy offer promise in dealing with emotional problems, including anger, aggression and offending.[147] [148]

From the consultation

RNID said that the mental health workforce should include people who are deaf and that some services be delivered using British Sign Language (BSL). They gave as an example staff of SignHealth Counselling who are deaf themselves and training as counsellors using BSL. They also recommended extending training beyond traditional professional boundaries so as to move towards more inclusive services and person centred approaches. An example is the Certificate in Mental Health & Deafness. Part-funded by RNID, and in association with Birmingham University, by a collaborative of hearing and deaf people and organisations, its first intake of participants is in March 2010.

Gender Reassignment

Transgender/transsexual people seeking access to interventions such as hormone treatments or gender reassignment surgery are required to obtain a diagnosis of gender dysphoria from a consultant psychiatrist as part of current clinical practice. Almost all transgender people who have undergone transition report that the change was a life-enhancing move.[149]

Transgender people need therefore to engage with at least one mental health professional as part of their process of defining their identity, unlike people of any other protected characteristic. Gender dysphoria is classified as a mental health disorder similar to the way that homosexuality used to be. Transgender people may also require support from a mental health professional for emotional support as a component part of transitioning, or may engage in mental health services as a result of e.g. experiencing stigma, harassment, or discrimination as a result of society's attitudes to their transsexual status.

- The average age of presentation for gender identity treatment is 42.[150]
- 21% transgender people's GPs did not want to help with gender reassignment (and 6% refused).[151]
- Transgender people report that general psychiatrists often lack understanding and knowledge about gender dysphoria; this can result in inappropriate treatment

[146] (Foresight, 2008).
[147] Wilner (2005) The effectiveness of psychotherapeutic interventions for people with learning disabilities: a critical overview. Journal of Intellectual Disability Research, 49(1), 73-85
[148] Carr EG, Dunlap G, Horner RH et al (2002) Positive behaviour support. Evolution of an applied science. Journal of Positive Behaviour, 4(1), 4-16
[149] A Change For The Better (Christine Burns) http://www.guardian.co.uk/society/2004/aug/03/socialcare.health
[150] Gender Variance in the UK: Prevalence, Growth, Incidence & Geographic Distribution (GIRES 2009) http://www.gires.org.uk/assets/Medpro-Assets/GenderVarianceUK-report.pdf
[151] Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination (Press For Change 2007) http://www.pfc.org.uk/files/EngenderedPenalties.pdf

and delays in access to assessment and treatment by experienced gender specialists.[152]

- The average waiting time for referral to Gender Identity Clinics is 30 weeks and 23% seek gender reassignment treatments in the private sector.[153] [154]

Transgender people often meet with discrimination and prejudice in their personal, social and professional lives. This can result in social isolation and put them at increased risk of alcohol abuse, depression, suicide, self-harm, violence, substance abuse and HIV.

- A survey of 872 adult transgender people found that 34% had attempted suicide.[155]
- 73% transgender people experience harassment in public spaces.[156]
- 64% young transgender men, 44% young transgender women experience bullying & harassment at school (including from teachers).[157]
- General public attitudes towards transgender people are negative[158]; in particular 50% of people would be unhappy if a relative was in a relationship with a transgender person.[159]

A mental health strategy for both improving general wellbeing of the population as well as improving access to mental health support should reflect this.

From the consultation
The Citizens Advice Service identified transgender groups as a section of the community whose mental health needs need further research:- "*Further research is also required into the mental health needs of other sections of the community, specifically the mental health needs of the LGB community and especially the transgender communities as well as those of asylum-seekers, Gypsies and Travellers, single-parents, ex-service personnel and other specific groups. Given the harassment and victimisation some of these groups face on a daily basis, it is possible that there may be higher incidences of mental health illnesses which require addressing with more targeted interventions.*"

Marriage and Civil Partnership

A major international study across 15 countries and 34,493 people published recently found that getting married is associated with better mental health of both men and women, resulting in reduced risks of most mental disorder. By contrast, ending

[152] SCOTTISH TRANSGENDER ALLIANCE (2008), Transgender Experiences in Scotland –research summary, http://www.scottishtrans.org/Uploads/Resources/staexperiencessummary03082.pdf
[153] Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination (Press For Change 2007) http://www.pfc.org.uk/files/EngenderedPenalties.pdf
[154] Trans Research Review (EHRC 2009) http://www.equalityhumanrights.com/uploaded_files/research/trans_research_review_rep27.pdf
[155] NMHDU
[156] Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination (Press For Change 2007) http://www.pfc.org.uk/files/EngenderedPenalties.pdf
[157] Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination (Press For Change 2007) http://www.pfc.org.uk/files/EngenderedPenalties.pdf
[158] Trans Research Review (EHRC 2009) http://www.equalityhumanrights.com/uploaded_files/research/trans_research_review_rep27.pdf
[159] Trans Research Review (EHRC 2009) http://www.equalityhumanrights.com/uploaded_files/research/trans_research_review_rep27.pdf

marriage through separation, divorce or being widowed, is associated with substantially increased risk of mental disorder in both genders in particular substance abuse for women and depression for men.[160]

There is limited research on the effect of civil partnership, although some of the findings on marriage will be of relevance.

Pregnancy and maternity

Effect of maternal mental illness on pregnancy outcomes

Depression and anxiety during pregnancy increases the risk of low birth weight[161] as well as the risk of giving birth to a preterm baby[162] (see Public Mental Health review 3). More severe depression, schizophrenia and bipolar affective disorder are also associated with poorer obstetric outcomes including low birth weight and increased infant mortality.[163] Mothers of preterm infants have a particularly high risk postnatal depression of up to 40%.[164]

Postnatal depression

During pregnancy, 12.7% of mothers experience depression.[165] Subsequent rates are 5.7% between birth and 2 months post-natally, 6.5% at 6 months and 21.9% at 12 months. Income, marital status, occupational position and number of children are significant predictors of postnatal depression.[166] Risk is increased for low-income urban mothers more than half of whom experienced depression in the 3 months following birth.[167]

Maternal depression increases the risk of mental illness in children to the extent that they are five times more likely to have a mental health problem[168] [169], more than three times more likely to have an emotional problem that persists for at least three years and almost seven times more likely to have conduct problems that persist for at least three years.[170] Children of parents with an affective disorder have a 40% risk of

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[160] Scott KM et al (2009) Gender and the relationship between marital status and the first onset of mood, anxiety and substance use disorders," *Psychological Medicine*, Cambridge University Press

[161] Vigod S, Villegas L, Dennis C-L, Ross L (2010) Prevalence and risk factors for postpartum depression among women with preterm and low-birth-weight infants: a systematic review. BJOG, 117, 540–550.

[162] Smith MV, Shao L, Howell H et al (2010) Perinatal Depression and Birth Outcomes in a Healthy Start Project. Matern Child Health J, Mar 19. [Epub ahead of print]

[163] NICE (2007) Antenatal and postnatal mental health. http://guidance.nice.org.uk/CG45/Guidance/pdf/English

[164] Bergman K, Sarkar P, O'Connor TG et al (2007) Maternal stress during pregnancy predicts cognitive ability and fearfulness in infancy. J. Am. Acad. Child. Adolesc. Psychiatr, 46, 1454-1463.

[165] Gavin NI, Gaynes BN, Lohr KN *et a.* (2005) Perinatal depression: a systematic review of prevalence and incidence. *Obstetrics and Gynecology*, *106*, 1071–1083.

[166] Segre LS, O'Hara M, Arndt S et al (2007) The prevalence of postpartum depression. The relative significance of three social status indices. Social Psychiatry and Psychiatric Epidemiology, 42(4), 316-321

[167] Chaudron LH, Szilagyi P, Tang W et al (2010) Accuracy of depression screening tools for identifying postpartum depression among urban mothers. Pediatrics, 125, e609-e617.

[168] Meltzer H, Gatward R, Corbin T et al (2003) Persistence, onset, risk factors and outcomes of childhood mental disorders. ONS, London TSO

[169] Parry-Langdon N, Clements A, Fletcher (2008) Three years on: Survey of the development and emotional wellbeing of children and young people. ONS. http://www.statistics.gov.uk/articles/nojournal/child_development_mental_health.pdf

[170] Parry-Langdon N, Clements A, Fletcher (2008) Three years on: Survey of the development and emotional wellbeing of children and young people. ONS. http://www.statistics.gov.uk/articles/nojournal/child_development_mental_health.pdf

developing depression by the age of 20.[171] Children of depressed parents are at 2-3 fold increased risk of developing depression.[172]

Postnatal depression has also been shown to impact adversely on children's future GCSE performance. [173]

Race (including ethnic origin, nationality)

The term 'ethnic minority' covers a very wide range of people with a very diverse range of needs. These needs are often driven by cultural factors, practices or assumptions. Ethnic minorities of interest in the mental health context can be White or non-White. In recent years, due to increased migration from Eastern Europe and other parts of continental Europe, the Other White group has also emerged as a group whose experience of mental health services presents concerns.

At the 2001 Census, 7.9% of the UK population self-identified as non-White - 4.0% as Asian/Asian British, 2.0% as Black/Black British and 1.5% as Mixed, and it is likely that the next Census in 2011 will show an increase in the non-White population, especially among Mixed groups. Each of the non-White groups can be further differentiated according to racial or ethnic origin e.g. Black groups include Black African or Black Caribbean communities; Asian groups could be Indian, Pakistani, Bangladeshi or Chinese, to name but a few. Each group has distinct cultural, social and medical characteristics that can affect, or be affected by, the incidence and experience of wellbeing and mental illness within that group.[174]

From the consultation

"…The lack of cultural awareness around mental health issues and how these are perceived within different ethnic minority communities should not be under- estimated when tackling greater public awareness of mental health issues and barriers that impact on access to services and people's experiences of these services."

(Acocks Green Neighbourhood Forum, Birmingham).

Prevalence of mental health problems according to ethnicity

Prevalence of different mental health problems varies by ethnicity. The latest Adult Psychiatric Morbidity Survey highlights that the Black population experiences highest rates of PTSD, suicide attempt, psychotic disorder, any drug use and drug dependence while the White population experiences highest rates for suicidal

[171] Beardslee WR, Versage EM, Gladstone TRG. (1998) Children of affectively ill parents: a review of the past 10 years. J Am Acad Child Adolesc Psychiatry, 37(11), 1134-1141.
[172] Weissman MM, Wickramaratne P, Nomura Y et al (2006) Offspring of depressed parents: 20 years later. *Am J Psychiatry,* 163(6), 1001-1008.
[173] Murray L, Arteche A, Fearon P et al (2010) The effects of maternal postnatal depression and child sex on academic performance at age 16 years: a developmental approach. J Child Psychol Psychiatry. 51(10), 1150-9.
[174] ONS Census site, 2001

thoughts, self harm and alcohol dependence (see table 5).[175] Women from the South Asian group experience highest rates for any common mental disorder.

Table 5. Age standardised rates of different mental disorder according to ethnicity.[176]

	White		Black		South Asian		Other	
	Male	Female	Male	Female	Male	Female	Male	Female
Any CMD	12.0	19.3	12.9	21.0	10.3	34.3	20.2	20.6
PTSD	6.9	10.6	16.3	13.2	11.0	9.1	7.3	5.0
Suicidal thoughts	15.0	20.0	7.1	11.4	6.1	7.7	7.3	12.3
Suicide attempts	4.4	7.1	4.6	7.8	0.6	1.5	4.0	3.3
Self-harm	4.7	5.7	3.3	1.2	2.2	0.9	2.3	6.7
Psychotic disorder	0.2	0.5	3.1			0.6		
Alcohol dependence	9.6	3.7	3.0		1.0		3.5	1.4
Any drug use	12.4	6.8	21.8	5.6	3.5	0.8	9.2	11.5
Drug dependence	4.7	2.2	12.4	4.8	1.5	0.2	2.3	5.0

Common mental disorder

Table 5 above highlights similar rates for any common mental disorder for White, Black and South Asian men while rates are double for White and Black women and triple for South Asian women. Previous studies have also highlighted higher rates of common mental disorder among South Asian and Irish subgroups.[177] Black men are three times more likely than White men to screen positive for PTSD.[178]

Table 6 below highlights how the use of mental health services for common mental disorders varies by ethnicity and gender, with the highest use among Indian and Pakistani women, although none of the differentials are statistically significant.[179]

	White	Irish	Black Caribbean	Bangladeshi	Indian	Pakistani
Men	11.6	18.4	13.8	12.9	12.1	12.6
Women	19.9	18.6	19.8	12.3	23.8	26.0
Total	15.8	18.5	17.3	12.3	18.1	19.6

[175] McManus S, Meltzer H, Brugha T et al (2009) Adult psychiatric morbidity in England, 2007. Results of a household survey. Health and Social Information Centre, Social Care Statistics
[176] McManus S, Meltzer H, Brugha T et al (2009) Adult psychiatric morbidity in England, 2007. Results of a household survey. Health and Social Information Centre, Social Care Statistics
[177] Weich S, McManus S (2002) Common Mental Disorders, in Sproston, K., Nazroo, J., (ed) *Ethnic Minority Psychiatric Illness Rates in the Community* (EMPIRIC), National Centre for Social Research, TSO
[178] McManus S, Meltzer H, Brugha T et al (2009) Adult psychiatric morbidity in England, 2007. Results of a household survey. Health and Social Information Centre, Social Care Statistics
[179] Glover G, Evison F (2009) Use of new mental health services by ethnic minorities in England, NEPHO

Suicidal rates, thoughts, attempts and self harm
Suicide rates are higher among Black African (2.5 times) and Black Caribbean (2.9 times) men aged 13–24, and among Black African (3.2), Black Caribbean (2.7) and South Asian (2.8) women aged 25–39 than among their white British counterparts.[180]

Table 5 contrasts the rates of common mental disorder with more than double the level of suicidal thoughts among the white population compared to other groups. However, suicidal attempts were similar among White and Black groups although significantly lower in the South Asian group. South Asian had lowest rates of suicidal thoughts, attempts and self harm compared to women from other groups despite higher levels of common mental disorder.

Psychosis
Most research on prevalence by ethnicity has focused on psychotic disorders. BME groups are, on average, three times more likely to experience psychosis than white British ones.[181] Risk of psychosis in Black Caribbean groups is nearly seven times higher than in the White population.[182] The 2007 Survey of adult psychiatric morbidity in England also found that age-standardised prevalence of probable psychotic disorder in the previous year was overall 0.4% for the White population, 1.4%% for the Back population and 0.2% for the South Asian population.[183] Rates were significantly higher among black men (3.1%) compared to white men (0.2%). The survey found no significant variation by ethnicity among women.

The question of why some ethnic minority communities appear to suffer higher rates of severe mental health problems is the subject of debate. Some researchers hold that these rates are artefacts arising from discriminatory or culturally insensitive professional practice. More research is needed to resolve this question.

Hazardous and harmful alcohol use
Reported hazardous and harmful use of alcohol varies according to ethnicity. Hazardous drinking occurred in 29.6% of White men, 15.6% of Black men, 9.9% of South Asian men and 13.8% of Other men.[184] For women, hazardous drinking occurred in 14.5% of White women, 4.6% of Black women, 3.1% of South Asian women and 13.9% of Other women.

Reported harmful drinking occurred in 6.2% of White men, 3.0% of Black men, 2.1% of South Asian men and 2.1% of Other men. For women, hazardous drinking occurred in 2.0% of White women and 13.9% of Other women.

Alcohol dependence
As highlighted in table 5, rates are highest for White men (9.6%) followed by White women (3.1%). Lower rates are experienced by Black men (3.0%) and South Asian men (1.0%).

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[180] Bhui K, McKenzie K (2008) Rates and risk factors by ethnic group for suicides within a year of contact with mental health services in England and Wales. Psychiatr Serv, 59(4), 414-20
[181] Kirkbride J, Morgan C, Dazzan P et al (2006). Incidence of schizophrenia and other psychoses in ethnic minority groups: results from the MRC AESOP Study. Psychological Medicine , 36, 1541-1550
[182] Fearon P, Kirkbride JB, Morgan C et al (2006) Incidence of schizophrenia and other psychoses in ethnic minority groups: results from the MRC AESOP Study. Psychological Medicine, 36(11), 1541-1550
[183] McManus S, Meltzer H, Brugha T et al (2009) Adult psychiatric morbidity in England, 2007. Results of a household survey. Health and Social Information Centre, Social Care Statistics
[184] McManus S, Meltzer H, Brugha T et al (2009) Adult psychiatric morbidity in England, 2007. Results of a household survey. Health and Social Information Centre, Social Care Statistics

Any drug use
As highlighted in table 5, rates of any reported drug use are highest for Black men (21.8%) followed by White men (12.4%), Other women (11.5%) and Other men (9.2%).[185] Lowest rates occur among White women (6.8%), Black women (5.6%), South Asian men (3.5%) and South Asian women (0.8%).

Alcohol dependence
As highlighted in table 5, drug dependence is highest in Black men (12.4%) and then much lower in Other women (5%), Black women (4.8%) and White men (4.7%).

Experience of care

The 2010 Delivering Race Equality in Mental Health (DRE) report on community engagement with ethnic minority service users and communities identified key factors contributing to a good experience of care for ethnic minority service users and their carers[186] :

- The need to alleviate service users' and carers' fear of mental health services, and to address related issues of stigma and discrimination.

From Delivering Race Equality in Mental Health Care Race Equality Action Plan: a five-year review

"Those with little or no experience of mental illness reported that their biggest fear of seeking help was not what might happen to them in mental health services, but rather the stigma, shame and the social repercussions. The biggest fear of those who had direct experience of services, particularly as inpatients, was re-engaging with these services. They were particularly afraid of being over-medicated, that services would breach confidentiality, and of developing further symptoms and illnesses after contact with other service users."

- Provision of effective and culturally appropriate therapies or intervention, with medication used only when other treatments have proved ineffective.

From Delivering Race Equality in Mental Health Care Race Equality Action Plan: a five-year review

"Study participants strongly criticised the unbalanced approach to treatment, with its over reliance on medication which had unwanted side-effects. The majority of the mental health service users who had been treated only with medication thought that other and/or additional therapies would have made their treatment more effective. … A choice and combination of therapies were not routinely offered to service users. "

- Opportunities for service users and their communities to be actively involved in designing and delivering services.

[185] McManus S, Meltzer H, Brugha T et al (2009) Adult psychiatric morbidity in England, 2007. Results of a household survey. Health and Social Information Centre, Social Care Statistics
[186] Jane Fountain and Joanna Hicks (2010), Delivering race equality in mental health care: report on the findings and outcomes of the community engagement programme 2005-2008 http://student.uclan.ac.uk/schools/iscri/files/DRE_CE_Summary_Report.pdf

From Delivering Race Equality in Mental Health Care Race Equality Action Plan: a five-year review

"Study participants and community organisations raised a number of practical issues about the cultural competence of services in matters of language, faith and religion, food, gender, the ethnicity of staff and racism."

- Ensuring equity of access to IAPT and to talking therapies for people from ethnic minorities has bene highlighted as an issue for IAPT services and will be taken forward within the Talking Therapies strategy.

Afiya Trust submission to the DH consultation

The Trust was critical of the existing Shift and Time to Change programmes in tackling mental health stigma and discrimination, saying that it involved racist, Islamophobic and culturally ignorant stereotypes. The Trust called for a clear focus in a new strategy to address the multiple stigma and discrimination faced by ethnic minority communities.

Findings of the Delivering Race Equality in mental health care (DRE) community engagement programme 2005-2008

Fear of mental health services

Not all participants who were asked expressed a fear of mental health services. However, fear as a barrier to accessing services was a recurring theme in the majority of the study reports. Those with little or no personal experience of mental illness reported that their biggest fear of seeking help was the stigma, shame and social repercussions. Those who had direct experience of services particularly as inpatients reported that their biggest fear was re-engaging with these services. They were particularly fearful of medication and hospital admission, of being sectioned under the Mental Health Act 1983, of being mistreated by services, that their confidentiality would not be respected, and of their symptoms and illnesses becoming worse through contact with other service users.

Effective therapies and interventions

Study participants and the community organisations strongly criticised what they perceived to be an unbalanced reliance on medication, with its unwanted side effects. The majority of the mental health service users who had been treated only with medication felt that other and/or additional therapies would have made their treatment more effective. However, it was reported that a choice and/or a combination of therapies were not routinely offered to service users. Talking therapies were most often cited as the preferred alternative to, or accompanying treatment with, medication although some concerns were also expressed about confidentiality and the need for cultural competence. A minority of the study participants with mental health problems, across all the ethnic groups, had used complementary therapies and wanted them to be available in mainstream mental health services.

Social interaction and taking part in activities were thought to maximise the benefits of prescribed treatment. Services from voluntary and community organisations were particularly valued for the opportunities they offered for socialising, befriending and

participation in activities such as outings, lunch clubs, exercise and discussion groups.

Culturally appropriate treatment and interventions
Reports from across all the studies and all the participating Black and minority ethnic communities point to a strong need for greatly increased cultural competency in mental health services. Study participants highlighted the need for practical improvements in language (interpreting, translating, literacy support), meeting faith-related and religious needs, culturally appropriate food, gender-specific services and staff, increasing the ethnic diversity of staff, and action to tackle racism.

Ethnic minority service users' experience of IAPT services

The Newham pilot of the Improving Access to Psychological Therapies (IAPT) programme offers an example of how culturally sensitive practice can support good recovery. This pilot was based at the Newham Psychological Treatment Centre, in an area with a large local BME population.

- A variety of access pathways for treatment are essential. Initial issues around disparity of access between ethnic groups were successfully rectified after the pathways for referral into treatment were increased. As a result, the number of BME people accessing IAPT services increased to mirror the ethnic distribution of the area's population. In addition, treatment outcomes for people from BME groups were at least as good as, and achieved similar satisfaction rates, to those for non-BME patients.

- Culturally sensitive service provision is key to good treatment outcomes, as was stressed by the lead Newham clinician Dr Ben Wright: "We telephone all patients to speak to them about any concerns before treatment begins – this is of real importance as BME patients in particular may be wary of treatment procedures. Our access materials are translated into the main languages spoken in the area; we use interpreters in Punjabi, Hindi, Bengali and Urdu. All members of our team have significant experience of trans-cultural work." [187]

Experience of mental health in-patient services

The impact of the higher rates of acute mental illness among Black groups is that people from these groups, particularly boys and men, are more likely than average to encounter mental health services. This may be at least in part explained by the higher rates of psychosis with the UK population. Reported rates are 0.4% for White adults, 1.4%% for Black adults, 3.1% among Black men and 0.2% for South Asian adults.[188] They are also more likely to be admitted via the criminal justice system or be sectioned under the Mental Health Act, to be admitted to secure services or to experience control or seclusion.

[187] Wilson,, Delivering Race Equality Action Plan: a five-year review , DH/NMHDU December 2010 – http://www.nmhdu.org.uk/silo/files/race-equality-action-plan-a-five-year-review.pdf
[188] McManus S, Meltzer H, Brugha T et al (2009) Adult psychiatric morbidity in England, 2007. Results of a household survey. Health and Social Information Centre, Social Care Statistics

- The annual Count Me In Census has recorded information from all mental health inpatients since 2006, with almost complete coverage of respondents' ethnicity. It has found higher than average admission and detention rates for Black Caribbean, Black African and Other Black groups in every year since 2006, as well as higher compared to average detention rates for Other Whites in 2007-2009[189]. Although ethnic minorities comprise 7.9% of the UK population, 22% of all mental health in-patients were from minority ethnic groups, and almost half of these were from Black or White/Black Mixed groups. The proportion of in-patients from with Other Black ethnicity was more than 10 times as high as their proportion in the population, while the proportion of Mixed White/ Black Caribbean Black Caribbean inpatients was almost 6 times as high as their population proportions. The only ethnic minorities who were under-represented among in-patients were Indian and Chinese.

- The data show that admission rates, admissions via the criminal justice system, detention rates and sectioning rates for Black Caribbean, Black African and Black Other patients remain higher than average, while rates of referral from GPs and community mental health teams remain lower than average – although there is no evidence that Black inpatients were more likely than other groups to be subject to physical restraint or seclusion. This suggests a delay in presentation to primary care.

- A recent study suggests that the perceived association between ethnicity and coercion is due to the higher likelihood that BME patients are admitted to treatment in areas (PCTs) where the prevailing institutional practice is for more coercive types of treatment. Within these areas, there is little ethnic differentiation in reports of coercion, either at admission or during the first 4 weeks after admission.[190]

Ethnic disproportionality in access or referral to mental health services

Rates of access to mental health services by different ethnic groups should reflect prevalence of mental disorder as highlighted in table 6.

In 2008-2009, rates of access to mental health services (all services including inpatient care) were highest for the Black and Black British group which had with a rate of access of 3,453 per 100,000 population. This was 17.1% higher than the rate for all ethnic groups, which was 2,949 per 100,000 population.[191]

As with the rate of access to services overall, the rate of access to admitted care was highest for the Black and Black British group at 674 per 100,000 population, which is 2.7 times more often than the rate for all ethnic groups (at 250 per 100,000 population). Whereas 8.4% of all patients spent time as an inpatient, for the Black and Black British group) this figure was a little over twice this rate at 19.3%.[192]

[189] http://www.cqc.org.uk/_db/_documents/Count_me_in_2009_(FINAL_tagged).pdf
[190] Bennewith, O et al (2010), Ethnicity and coercion among involuntarily detained psychiatric in-patients, The British Journal of Psychiatry (2010) 196, 75–76, http://bjp.rcpsych.org/cgi/reprint/196/1/75
[191] Source: http://www.ic.nhs.uk/statistics-and-data-collections/mental-health/nhs-specialist-mental-health-services/mental-health-bulletin--third-report-from-mental-health-minimum-dataset-mhmds-annual-returns-2004-2009
[192] Source: http://www.ic.nhs.uk/statistics-and-data-collections/mental-health/nhs-specialist-mental-health-services/mental-health-bulletin--third-report-from-mental-health-minimum-dataset-mhmds-annual-returns-2004-2009

Ethnic disproportionality in non-voluntary experience of care

The Count Me In Census has found in every year since its inception in 2005 that inpatients from the Black Caribbean, Black African and Other Black groups were more likely to be detained under the Mental Health Act than inpatients from other groups[193]. However, the most recent adult psychiatric morbidity survey in England found that 1.4% of Black adults including 3.1% of Black men experience psychosis in the UK compared to 0.4% of White adults and 0.2% of South Asian adults.[194]

The 2009 Census again shows over-representation of some BME groups in the more coercive forms of care and a comparison with the 2007-2008 data suggests that this situation grew worse between 2007-2008 and 2008-2009. In 2008-2009, 53.9% of the Black and Black British group who were inpatients during the year spent time compulsorily detained in hospital, compared with 31.8% of inpatients overall. 12.3% of the people who spent time detained in hospital were Black or Black British. Whilst the number of people spending time as an inpatient fell by 3.0% there was a 5.3% increase in the number of people in the Black and Black British group spending time as an inpatient.[195]

The number of people in the Black and Black British group who were detained in hospital during the year rose by 9.7% whilst the overall number of people detained in hospital barely changed (approximately 32,600 in both years) and the number of people in the White group who were detained fell by 1.6%. Although this rise may be partly attributed to data quality, because some trusts with high proportions of BME patients did not return information about legal status in 2007-2008, this improvement in data quality applied equally to all people who were inpatients in these trusts. The number of people in the Mixed and Asian or Asian British groups who spent time compulsorily detained in hospital also rose, by approximately 9 per cent for both groups.

Experience of recovery

Studies have shown the primary importance of the pathway in supporting a good outcome or recovery from mental illness. There is a strong association between a good initial experience of care and an eventual positive outcome. However, there is little information about the overall experience of recovery among ethnic minorities.[196]

The Delivering Race Equality in Mental Health Care report[197] found an increase in the proportion of BME service users who felt that they had recovered from their illness, and other research shows there is no disparity between rates of self-assessed recovery among BME and White British groups.

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[193] Count Me In (2005), National Mental Health and Ethnicity Census, Care Quality Commission https://www.countmeinonline.co.uk/

[194] McManus S, Meltzer H, Brugha T et al (2009) Adult psychiatric morbidity in England, 2007. Results of a household survey. Health and Social Information Centre, Social Care Statistics

[195] Mental Health Minimum Dataset (MHMDS) annual returns http://www.ic.nhs.uk/statistics-and-data-collections/supporting-information/mental-health/nhs-specialist-mental-health-services/mental-health-bulletin/mhmds-2006-2009-annual-data-tables

[196] Moffat J, Sass B, McKenzie K, Bhui K (2009), Improving pathways into mental health care for black and ethnic minority groups: a systematic review of the grey literature, Int Rev Psychiatry 21(5), pp 430-8.

[197] Wilson,, Delivering Race Equality Action Plan: a five-year review , DH/NMHDU December 2010 – http://www.nmhdu.org.uk/silo/files/race-equality-action-plan-a-five-year-review.pdf

Healthcare Commission community patient surveys showed no disparity between BME and White British service users when asked about their feelings about their own mental health. Ethnic minority service users were found to have better outcomes than average on symptom improvement scales and scales rating 'satisfaction with life in general and different life domains' one year after admission.[198] [199]

Findings of the Delivering Race Equality in mental health care (DRE) community engagement programme 2005-2008[200]

The journey towards recovery
Factors that facilitate recovery were identified as support from family and friends, 'keeping busy', a positive attitude, faith and religion, and medication. Lack of support from family and friends, the stigma of mental illness, a return to an unchanged environment after treatment, a poor experience of treatment, and disbelief that recovery is possible were seen as obstacles to recovery.

Service user and carer satisfaction with mental health services
Levels of satisfaction with mental health services were highly individual and subjective, but also inextricably linked to service users' fears of mental health services, perceptions of the effectiveness of the treatment received, experiences and perceptions of services' cultural competence, and whether or not they felt their treatment resulted in recovery. There were many accounts and much statistical data showing that services had made a positive impact. Equally, there were some powerful stories of problematic experiences.
As one of the community organisations commented: ' Where someone's illness was explained and understood... and a choice of treatment offered, people, in general, had a much better perception of the mental health services provided.'

A more active role for Black and minority ethnic communities and service users
The NIMHE Community Engagement Project of itself enabled a more active role for Black and minority ethnic communities and Black and minority ethnic service users, in that so many community members and organisations were actively involved in the studies and in identifying barriers and opportunities for improving service accessibility and provision.

From the consultation

The National BME Committee of the Ambulance Service Network supported the delivery of personalised care, but believed this can only be achieved if its workforce reflects the diversity of the population it serves and cultural competence training is provided to the full range of staff. They provided examples of work underway on these issues.

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[198] HCC/CQC surveys of community mental health
[199] Priebe, S. et al (2009) Patients' views and readmissions 1 year after involuntary hospitalisation, BJPsych 194 pp.49-54 http://bjp.rcpsych.org/cgi/reprint/194/1/49?ijkey=ecf07f73388459bf48046a090de21bf21a673d2d
[200] Fountain, J and Hicks, J (2010), Delivering race equality in mental health care: report on the findings and outcomes of the community engagement programme 2005-2008 http://student.uclan.ac.uk/schools/iscri/files/DRE_CE_Summary_Report.pdf

Service design and delivery

Evidence-based interventions for prevention and treatment of mental illness, as well as the promotion of mental health for BME groups, are the same as for the general population. However, interventions need to be targeted, given the elevated risk of mental illness among certain communities, and culturally adapted, to increase their effectiveness particularly for promotion. For example, service provision to BME groups delivered by service providers of similar cultural, ethnic or racial backgrounds, supported by culturally-sensitive service design have been found to be effective in delivering parenting, social and lifestyle support, as well as campaigns against drug misuse.[201] [202]

From the consultation

The Afiya Trust were concerned that he New Horizons consultation did not chart the relationship between the criminal justice system and the pathways into care for people from some BME backgrounds. They also indicate that the complex nature of the stigma and discrimination faced by these communities has not been addressed successfully.

From the consultation

The Race Equality Foundation (African and Caribbean men and mental health, 2007) recognise the need for a multidisciplinary and multi-agency approach that should involve service providers outside the field of mental health.

From the consultation

Pan Birmingham Mental Health Commissioning cited the development of a direct payments leaflet aimed at the Somali community as a good example of engaging communities to raise awareness of the agenda.

Improved recording of data on ethnicity

Many improvements to mental health services resulted from the DRE programme, but the difficulty of measuring these improvements persists. This arises because of poor record-keeping in many areas of data on the ethnicity of service users and also because of service users' unwillingness to disclose information about their ethnicity.

Recording rates vary across different groups. While there is relatively good recording of ethnicity for Black and Asian groups, data on Gypsy and Travellers is almost non-existent. The use of non-standard ethnic classification can also hamper comparison.

Service providers can do much more to improve the recording of ethnicity data, using standardised classifications, and to promote the value of disclosure to both providers and users of services. The Count Me In Census has shown that it is possible to

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[201] Griner D, Smith T (2006) Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training, 43*(4), 531-548.

[202] Kirkbride JB, Jones PB (2008) Putative prevention strategies to reduce serious mental illness in migrant and black and minority ethnic groups. Foresight State-of-Science Review: Government Office for Science.

produce near-perfect compliance in terms of recording ethnicity; this should be seen as the norm across all mental health services.

Religion or Belief (including lack of belief)

Spiritual experience is associated with improved subjective wellbeing particularly positive affect and life satisfaction[203] as well as self-esteem, personal growth, mastery and control.[204] Clear evidence for marked physical and psychological benefits associated with spiritual awareness, practices and beliefs are confirmed by reviews.[205] [206] This appears the same for all religions and for people engaging in spiritual practices who do not follow any particular faith.[207] A study in 18 countries involving 5087 individuals found that spirituality, religion and personal beliefs were highly correlated with all domains particularly psychological and social domains and overall quality of life[208] and could make substantial difference in quality of life particularly for those with poor health.

The value of spiritual belief in supporting people with mental illness towards recovery is well-attested; a review of 101 studies found that 65% reported a significant positive relationship between a measure of religious involvement and lower rates of depression or depressive symptoms, anxiety and hopelessness.[209] A meta-analysis of 147 studies involving almost 100,000 subjects found that religious involvement was also associated with reduced depression particularly for stressed populations.[210] However, certain kinds of spiritual beliefs can also contribute to triggering episodes of mental illness or to worsening existing conditions.[211]

Spiritual interpretations of mental disease can play a crucial part in therapeutic success.[212] An awareness of other religious interpretations of mental illness is important as this is how this often contributes to stigma and attitudes to treatment. [213]

Significant evidence base supports the effects of mindfulness in both clinical and non-clinical populations. [214] [215] [216] Mindfulness Based Cognitive Therapy (MBCT) has been shown to be at least as effective as maintenance antidepressant medication in

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[203] Emmons RA (2003). Personal goals, life meaning, and virtue: Wellsprings of a positive life. In CLM Keyes (Ed.) Flourishing: The positive person and the good life (pp. 105-128). Washington, DC: American Psychological Association.
[204] Koenig HG (2009) Research on religion, spirituality, and mental health: A Review. Can J Psychiatry, 54(5), 283–291.
[205]Koenig HG (2009) Research on religion, spirituality, and mental health: A Review. Can J Psychiatry, 54(5), 283–291.
[206] Plante TG, Thoresen CE Eds. (2007) Spirit, Science and Health: How the spiritual mind fuels physical wellness. Westport, Conn and London: Praeger.
[207] Culliford L (2007) Taking a Spiritual History. Advances in Psychiatric Treatment,13, 212-219.
[208] WHOQOL (2006) A cross-cultural study of spirituality, religion, and personal beliefs as components of quality of life. Soc Sci Med, 62(6), 1486-97
[209] Koenig HG, McCullough ME, Larson DB, editors (2001). Handbook of religion and health. New York (NY): Oxford University Press. Pages 514-554
[210] Smith J, Richardson J, Hoffman C, Pilkington K (2005) Mindfulness-based stress reduction as supportive therapy in cancer care: systematic review. Journal of Advanced Nursing, 52(3), 315-327
[211] Bhugra,D (ed.), Psychiatry and Religion: Context, Consensus and Controversies, Routledge, 1996
[212] DH (2009) Religion or belief: a practical guide for the NHS.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_093133
[213] DH (2009) Religion or belief: a practical guide for the NHS.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_093133
[214] Hofmann SG, Sawyer AT, Witt AA, Oh D (2010) The effect of mindfulness-based therapy on anxiety and depression: a meta-analytic review. J Consult Clin Psychol.78, 169–183.
[215] Grossman P, Niemann L, Schmidt S, Walach H (2004) Mindfulness-based stress reduction and health benefits: A meta-analysis. Journal of Psychosomatic Research, 57, 35-43
[216] Chiesa A, Serretti A (2009) Mindfulness-based stress reduction for stress management in healthy people: a review and meta-analysis. Journal of Alternative and Complementary Medicine, 15(5), 593-600

preventing relapse in recurrent depression and more effective in reducing residual depressive symptoms, psychiatric co-morbidity and quality of life. [217] MBCT is included in NICE (2009) guidelines for the management of recurrent depression.

From the consultation

Respondents asked that mental health services respect spiritual issues. They also mentioned the challenges posed by non-Western belief systems to prevailing models of mental health and the need for cultural sensitivity to religion, whether Christian or non-Christian.

This was illustrated by the submission from the Newham Asian Women's Project: "*Older people felt that majority services often did not meet the needs of culture and beliefs that are important to different minority communities. This might range from basics of food to a lack of knowledge and respect for religious beliefs and practices.*

Different communities often have a different view of health and wellbeing, and find that their own views of complementary medicine or a holistic approach to health needs are not seen as being important or relevant.

There were real frustrations here: older people felt that the Western mindset simply saw communities as "problems" rather than respecting the fact that different communities had real strengths to be valued."

Staff awareness of a patient's religion and/or spirituality as well as their interpretations of mental events is a key component for effective treatment.[218] Diagnosis, treatment and recovery prognosis are all likely to be adversely affected if health professionals and other service providers ignored the beliefs of patients. Key needs identified by the review included

- Training for clinicians and other mental health delivery staff to include aspects of religion and spirituality, to develop their understanding of spiritual concepts in the lives of their clients;
- mental health chaplains to work alongside clinicians to design treatments appropriate to patients who either have a religious component to their mental health condition or who use spiritual beliefs or practices as coping mechanisms;
- audits of standards of care to cover sensitivity to, and respect for, the spiritual and cultural needs of patients.[219]

From the consultation

One respondent called for the elimination of sectioning, or failing that, "*rewriting the Mental Health Act to protect individuality and freedom of religion. I was sectioned for talking to G-d! Perhaps on this basis all religionists could be sectioned*!"

The importance of faith communities and religious organisations in mediating between people with mental health issues and the rest of the community were also emphasised.

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[217] Kuyken W, Byford S, Taylor RS et al (2008) Mindfulness-based cognitive therapy to prevent relapse in recurrent depression. Journal of Consulting and Clinical Psychology, 76(6), 966-978.
[218] DH (2009) Religion or belief: a practical guide for the NHS. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_093133
[219] Chapple, P (2003), Mental Health and Religion: A Guide for Service Providers – from website of Royal College of Psychiatrists *www.rcpsych.ac.uk*

Coventry Council highlighted the importance of *"releasing the potential of social capital within the third sector, faith communities and other groups through supporting local grassroots initiatives with outcome- focussed funding, the outcomes being user determined".*

Sex

Men and women experience mental health problems in different ways. Women are more likely to experience mental illness than men – one in five women (19.7%) had a common mental disorder (CMD) compared to one in eight men (12.5%).[220] However, women are more likely than men to seek help from professional sources or from their social networks, so that treatment rates for women are higher than those for men (29% compared to 17%).[221]

Women

Depression and anxiety

- Common mental disorder occurs in 21.5% of women and 13.6% of men.[222]
- Depressive episodes occur in 3.0% of women compared to 2.2% of men.[223]
- Generalised anxiety disorder occurs in 5.8% of women compared to 3.6% of men. Phobias occurs in 2,4% of women compared to 1.0% of men. Mixed anxiety and depressive disorder occurs in 11.8% of women and 7.6% of men.[224]
- 1 in 4 women will require treatment for depression at some time, compared to 1 in 10 men. The reasons for this are unclear, although it has been suggested that depression in men is under-diagnosed, for example because men present to their GP with physical rather than psychological symptoms.
- Women's increased life expectancy means they are more likely than men to live to an age at which they suffer bereavement, physical illness or dementia, or need to move into residential care. It is estimated that one in five older people living at home shows symptoms of depression and that the incidence of depression doubles for older people living in care homes, most of whom are women.

Self-harm

Girls are more likely to self-harm than boys. Data from the most recent psychiatric morbidity survey found that 7,3% of 16-24 year olds had attempted suicide while 12.4% had self harmed.[225] It is estimated that between 1 in 12 and 1 in 15 young people self-harm in the UK and that rates of self-harm in the UK are the highest in Europe.[226]

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[220] McManus S, Meltzer H, Brugha T et al (2009) Adult psychiatric morbidity in England, 2007. Results of a household survey. Health and Social Information Centre, Social Care Statistics
[221] ONS (2003), Better Or Worse: A Longitudinal Study Of The Mental Health of Adults In GB,
[222] McManus S, Meltzer H, Brugha T et al (2009) Adult psychiatric morbidity in England, 2007. Results of a household survey. Health and Social Information Centre, Social Care Statistics
[223] McManus S, Meltzer H, Brugha T et al (2009) Adult psychiatric morbidity in England, 2007. Results of a household survey. Health and Social Information Centre, Social Care Statistics
[224] McManus S, Meltzer H, Brugha T et al (2009) Adult psychiatric morbidity in England, 2007. Results of a household survey. Health and Social Information Centre, Social Care Statistics
[225] McManus S, Meltzer H, Brugha T et al (2009) Adult psychiatric morbidity in England, 2007. Results of a household survey. Health and Social Information Centre, Social Care Statistics
[226] Truth Hurts - Report of the National Inquiry into Self-harm among Young People http://www.mhf.org.uk/campaigns/self-harm-inquiry/

A four-year cohort study of people who had self-harmed reported a 30-fold higher suicide risk relative to the general population.[227] Suicide risk was highest in the first 6 months after harm and higher in males compared to females, although the suicide mortality rate for women was twice that for men.

Young women aged 25-39 from ethnic minorities are much more likely to commit suicide than White British women – 3.2 times, 2.7 times and 2.8 times higher for young Black African women, young Black Caribbean women and young South Asian women respectively.[228]

Abuse

Women are estimated to be three times more likely to have been abused as men, although precise figures are hard to establish. Between 18% and 30% of women are estimated to have experienced domestic violence during their lifetimes and between 14% and 40% to have experienced sexual violence. Women and girls are also at higher risk of sexual violence. One in five (19.7%) women are estimated to have experienced a sexual assault since the age of 16 compared to 1 in 33 (2.3%) of men.[229]

Post-traumatic stress disorder (PTSD)[230]

International studies have shown that women are more likely to be affected by PTSD than men, largely as a result of being at greater risk of sexual violence. In Britain, however, the last APMS survey found no significant difference by sex in rates of PTSD (2.6% for men and 3.3% for women)

Eating disorders[231]

Eating disorders are most common among young women – 20 women in every thousand women and 2 men in every thousand men experience anorexia in any year. The incidence of bulimia among women is between 5 and 10 per thousand at any one time. Overall, 9.2% of women and 3.5% of men screen positive for an eating disorder at any time.[232]

Dementia[233]

Dementia affects 5% of people over 65 and 20% of people over 80. Just over half of these people have Alzheimer's Disease and about a fifth suffer from vascular dementia as the result of stroke. Two thirds of people with dementia are women because women have a higher life expectancy than men.

[227] Cooper J, Kapur N, Webb R et al (2005) Suicide after deliberate self-harm: A 4-year cohort study, American Journal of Psychiatry, 162, 297-303

[228] Bhui K, McKenzie K (2008) Rates and risk factors by ethnic group for suicides within a year of contact with mental health services in England and Wales. Psychiatr Serv, 59(4), 414-20

[229] Flatley J, Kershaw C, Smith K et al (Eds) (2010) Crime in England and Wales 2009/10. Home office. http://rds.homeoffice.gov.uk/rds/crimeew0910.html

[230] McManus S, Meltzer H, Brugha T et al (2009) Adult psychiatric morbidity in England, 2007. Results of a household survey. Health and Social Information Centre, Social Care Statistics

[231] McManus S, Meltzer H, Brugha T et al (2009) Adult psychiatric morbidity in England, 2007. Results of a household survey. Health and Social Information Centre, Social Care Statistics

[232] McManus S, Meltzer H, Brugha T et al (2009) Adult psychiatric morbidity in England, 2007. Results of a household survey. Health and Social Information Centre, Social Care Statistics

Caring responsibilities[234]

Women were more likely to be carers than men (18% of women and 14% of men). Significant risk factors for poor mental health among carers were looking after someone living in the same household, and spending 20 or more hours per week caring. Women providing care were more likely than men to report mental health problems – 21% of the women in the sample compared with only 12% of the men – and taking account of age, female carers were found to be more likely to have high levels of neurotic symptoms than women in the general population but for men no significant difference was found.

Women in prison [235] [236] [237]

More than 70% of the prison population has two or more mental health disorders. Female prisoners are 35 times more likely to have two or more disorders than women in general. Female prisoners also have a 20-fold increased risk of suicide[238], while males in prisons are at five times higher risk, compared to general population. [239] Ex-prisoners were at greatest risk of suicide in the period immediately following release. Among ex-offenders, women have a 36 -fold increased suicide risk (SMR 35.8) while male ex-offenders have an 8 fold increased risk (SMR 8.3)

From the consultation

The Women's Resource Centre, a charity supporting the effectiveness of women's organisations identified violence against women as a significant equalities issue and asked for this to be made a key priority, and resourced appropriately. They identified a specific need for women-only services, and asked DH to issue explicit guidance on their value and legality along with a clear acknowledgement of the role of the third sector. They also raised some doubts on how well women are currently served by locally based decision-making and that a basic equalities framework was vitally important.

Men

Men are

- more likely than women to have undiagnosed depression;
- More likely to self harm and to commit suicide;
- more likely to have an alcohol problem or to use cannabis and other illegal drugs, as well as more likely to be drug dependent.

Admission to hospital [240] [241]

- Although women are more likely to be diagnosed with a mental illness, men are more likely to be admitted to a mental health inpatient ward Men are also more likely to be admitted formally ('sectioned') under the Mental Health Act. The number of men formally admitted to NHS hospitals in England and Wales under the Mental Health Act rose dramatically during the 1990s, from 8,673 per year in

[234] DH and ONS (2002), Mental Health of Carers, http://www.statistics.gov.uk/pdfdir/cib0602.pdf
[235] Social Exclusion Unit (2004) quoting Psychiatric Morbidity Among Prisoners In England And Wales, (1998)
[236] Fazel S, Benning R (2009) Suicides in female prisoners in England and Wales, 1974-2004. BJPsych, 194, 183-184
[237] Pratt D, Piper M, Appleby L, Webb R (2006) Suicide in recently released prisoners: a population-based cohort study. Lancet 368(9530), 119-123
[238] Fazel S, Benning R (2009) Suicides in female prisoners in England and Wales, 1974-2004. BJPsych, 194, 183-184
[239] Fazel S, Benning R, Danesh J (2005). Suicides in male prisoners in England and Wales, 1978–2003. Lancet, 366, 1301 -2
[240] MIND http://www.mind.org.uk/help/people_groups_and_communities/mens_mental_healthcheck [8] [9]
[241] CQC(2010) http://www.cqc.org.uk/_db/_documents/Count_me_in_2009_(FINAL_tagged).pdf

1990 to 13,400 in 2003-2004, while the number of women admitted increased from 8,908 to 11,400.

- The median duration of stay for inpatients in a mental health ward was five and a half months for men compared to two and a half months for women
- Black men have particularly high admission rates to hospital under section, and are over-represented in secure units.

Suicide

- Reasons that have been put forward to explain the high suicide rate among men include the reluctance of men to talk about their problems or express their feelings, and the fact that men are less likely to consult a GP, especially about a psychological problem. Other reasons cited include social changes in education, employment and family relationships.
- Overall, men are more than three times as likely to die by suicide as women in Britain. In the 30-39 age group, male suicide rates are more than four times as high as female rates and suicide is the most common cause of death in men under the age of 35.[242] [243] After 50 years of age, the ratio gradually reduces, until in the 70+ age group, the male rate is twice that for women.[244]
- Between 1971 and 1998, the suicide rate for men in England and Wales almost doubled, while in the same period the rate for women halved.[245] Since then the National Suicide Prevention Strategy has helped to reverse this trend, so that rates have fallen among young men under the age of 35 as well as among mental health inpatients and offenders. However, men remain far more vulnerable to death by suicide than women, and account for three in four of all suicides in the UK.
- Suicide is 12 times higher in those with severe mental illness than for the general population. Risk of suicide in psychotic illness is high and highest in the early phases, including just before and just after the first episode.[246] [247] [248]
- Young black men aged 13-24 are much more likely to die by suicide than their White British counterparts - suicide rates are 2.5 times higher among black African men and 2.9 times higher among black Caribbean men.[249]
- Gay or bisexual men have a 4 times increased risk.[250]
- Certain occupational groups are at higher risk of suicide. Among men, construction workers and plant & machine operatives had the greatest number of suicides, while the highest rates occurred among health professionals and agricultural workers. For women, administrative and secretarial workers had the

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[242] The National Service Framework For Mental Health – Five Years On, Department Of Health (2005)
[243] Samaritans Information Resource Pack (2004)
[244] Office of National Statistics, (2008). http://www.statistics.gov.uk/downloads/theme_population/NPP-2006/NPP06_NSOnline.pdf
[245] MIND http://www.mind.org.uk/help/people_groups_and_communities/mens_mental_healthcheck [10]
[246] Palmer B, Pankratz S, Bostwick JM (2005) The lifetime risk of suicide in schizophrenia. Archives of General Psychiatry, 62, 247-252
[247] Saha S, Chant D, McGrath J, (2007) A Systematic Review of Mortality in Schizophrenia. Is the Differential Mortality Gap Worsening Over Time? Arch Gen Psychiatry, 64(10), 1123-1131.
[248] Harvey S, Dean K, Morgan C et al (2008) Self-harm in first-episode psychosis. *The British Journal of Psychiatry,* 192, 178-184
[249] Bhui K. McKenzie K (2008) Rates and risk factors by ethnic group for suicides within a year of contact with mental health services in England and Wales. Psychiatr Serv, 59(4), 414-20
[250] King M, Semlyn J, See Tai S et al (2008). Mental disorders, suicide, and deliberate self harm in lesbian, gay and bisexual people: a systematic review of the literature. BMC Psychiatry, 8,70.

greatest number of suicides, while the highest rates were for health, and sport and fitness occupations.[251]

- Unemployed people have a two to three fold increased risk.[252]

Criminal Justice System

Men made up approximately 95% of the prison population in June 2010.[253] Levels of mental distress are far higher in the prison population than in the general population. For example,

- 47% of adults and 46% of young offenders exhibit symptoms of anxiety and depression; 63% of adult prisoners and 53% of young offenders have a personality disorder and young offenders have a 20 times higher risk of psychosis.[254]
- 63% of male remand prisoners have antisocial personality disorder compared to 0.3% in the general population.[255] [256]
- More than 70% of the prison population has two or more mental health disorders. Male prisoners are 14 times more likely to have two or more disorders than men in general, and female prisoners 35 times more likely than women in general
- Suicide - as already discussed, females in prison had 20 fold increased risk of suicide[257], and males in prisons a five-fold risk compared to general population.[258]
- Alcohol and drug dependence: a systematic review of a large sample of prisoners found prevalence for alcohol abuse and dependence ranging between 18% and 30% in male prisoners and between 10% and 24% in female prisoners.[259]. The prevalence estimates of drug abuse and dependence varied from 10% to 48% in male prisoners and 30% to 60% in female prisoners.

Prevention of crime and personality disorder through prevention and treatment of conduct disorder in children

There is robust evidence that 80% of crime is associated with conduct problems and disorder in childhood and adolescence.[260] Therefore, conduct disorder is particularly important to address to prevent crime.

- Up to 40% of children with diagnosed but untreated conduct disorder develop later problem behaviours, including drug misuse and criminal and violent behaviour.[261]
- The cost of crime attributable to people who had conduct problems in childhood is estimated at £60 billion a year in England and Wales.[262]

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[251] Meltzer H, Griffiths C, Brock A et al (2008) Patterns of suicide by occupation in England and Wales: 2001–2005. *British Journal of Psychiatry,* 193, 73-76

[252] Blakely TA, Collings SCD, Atkinson J (2003) Unemployment and suicide. Evidence for a causal association? J Epidemiol Community Health, **57,** 594-600

[253] House of Commons (2010), Prison population statistics http://www.parliament.uk/briefingpapers/commons/lib/research/briefings/snsg-04334.pdf

[254] Stewart, D (2008). The problems and needs of newly sentenced prisoners: results from a national survey, Ministry of Justice Research Series 16/08**.**

[255] NICE (2009) Antisocial personality disorder, treatment, management and prevention. http://guidance.nice.org.uk/CG77

[256] McManus S, Meltzer H, Brugha T et al (2009) Adult psychiatric morbidity in England, 2007. Results of a household survey. Health and Social Information Centre, Social Care Statistics

[257] Fazel S, Benning R (2009) Suicides in female prisoners in England and Wales, 1974-2004. BJPsych, 194, 183-184

[258] Fazel S, Benning R, Danesh J (2005). Suicides in male prisoners in England and Wales, 1978–2003. Lancet, 366, 1301 -2

[259] Fazel S, Bains P, Doll H (2006) Substance abuse and dependence in prisoners: a systematic review. Society for the Study of Addiction, 101, 181-191

[260] Sainsbury Centre for Mental Health (SCMH) (2009) The chance of a lifetime. Preventing early conduct problems and reducing crime. http://www.scmh.org.uk/pdfs/chance_of_a_lifetime.pdf

[261] Fergusson DM, Horwood LJ, Ridder EM. (2005) Show me the child at seven: the consequences of conduct problems in childhood for psychosocial functioning in adulthood. J Child Psychol, 46, 837-49.

- The lifetime costs of a one year cohort of children with conduct disorder (5% of the child population) has been estimated at £5.2 billion with 71% of these costs related to crime Lifetime costs of a one year cohort of children with conduct problems) has been estimated at £23.6 billion with 61% of these costs due to crime.[263]
- Parenting interventions for families with children with conduct disorder and conduct problems are very effective and cost saving mainly due to crime prevention. [264] [265] Good evidence also exists for a range of other cost effective interventions which reduce crime which are highlighted in the annex.
- However, only 10-20% of children and adolescents with conduct disorder receive evidence-based intervention. [266] [267]

Interventions for the general population require a targeted and more intensive approach for this group given the high rates of mental disorder and include:

- Appropriate and timely treatment of mental illness with pharmacological and psychological treatments such as CBT[268] as well as drug and alcohol dependence programmes (Williams & Chang, 2000)
- Family therapy – working with the whole family or parent behaviour training. [269] [270]
- Multi-modal interventions such as multi-systemic therapy[271] [272] and wrap-around-service planning (see Pullmann et al, 2006)
- Violence prevention interventions.[273]
- Educational interventions can promote wellbeing and future success outside prison. Many prisoners are poor school achievers and often excluded from educational programmes

Depression

- As highlighted previously, common mental disorder including depression occurs more often in women than men.[274] 'Hidden' or 'covert' depression can be a factor behind problems that are sometimes thought of as being typically male - such as the misuse of drugs and alcohol, behaviours such as social withdrawal, unexplained physical symptoms, relationship problems - and it has been suggested that for some men 'midlife crisis' is a euphemism for depression.
- Depression and low mood in new fathers is probably under-diagnosed, while diagnosed depression is more common in new fathers than previously believed.

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[262] Sainsbury Centre for Mental Health (SCMH) (2009) The chance of a lifetime. Preventing early conduct problems and reducing crime. http://www.scmh.org.uk/pdfs/chance_of_a_lifetime.pdf

[263] Friedli L, Parsonage M (2007) Mental health promotion: Building an economic case. Northern Ireland Association for Mental Health

[264] NICE (2006) Parent-training/education programmes in the management of children with conduct disorders. Technology Appraisal TA102.http://www.nice.org.uk/nicemedia/live/11584/33426/33426.pdf

[265] Knapp et al, in press

[266] Green H, McGinnity A. Meltzer H et al (2005) Mental health of children and young people in Great Britain, 2004. ONS.

[267] Scott S (2010) National dissemination of effective parenting programmes to improve child outcomes. BJPsych, 196, 1-3

[268] Lipsey MW, Landenberger NA (2006) Cognitive-behavioural interventions. In: B.C. Welsh and D.P. Farrington (Eds.), Preventing Crime: What Works for Children, Offenders, Victims,and Places. Berlin: Springer, pp. 57-71.

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Three per cent of men have depression in the first year after the birth of a new child, and 10% before the child is four.[275]

Schizophrenia

Roughly the same number of men and women receive a diagnosis of schizophrenia although men tend to be diagnosed at a slightly younger age and are less likely to make a full recovery. Men from Black and ethnic minority groups are three times more likely to experience psychosis than white British men.[276] The risk of psychosis in the Black Caribbean population is nearly seven times higher than in the White population.[277]

Personality disorders

- Men are more likely than women to have a personality disorder (5.4% of men and 3.4% of women).[278] Men who meet a diagnosis of a personality disorder are heavily represented in the prison population: 63% of male remand prisoners having antisocial personality disorder compared to 0.3% of the general population.[279] [280]
- Personality disorders arise in adolescence. Between 40-70% of children with conduct disorder or sub-threshold disorder going on to develop antisocial personality disorder (ASPD). ASPD can be prevented through relatively low cost and effective interventions for conduct problems during childhood. Clear evidence-based interventions exist to prevent a large proportion of personality disorder as well as other mental illness during adulthood.[281]
- Early intervention for personality disorder; early intervention for borderline personality disorder result in improved functioning for adolescents, reduced psychopathology and parasuicidal behaviour.[282]

Attention deficit hyperactivity disorder (ADHD)

Boys are more likely to experience conduct and behavioural disorders in childhood, such as ADHD (3.6% in boys and 0.85% in girls aged 13-15 years).[283] The prevalence of ADHD declines with age but remains higher among men (estimated at 2.35% in males aged 18+) than among women (estimated to be 0.55% in females aged 18+). The most recent Adult Psychiatric Morbidity Survey highlighted that overall proportion of adults scoring four or more (threshold at which clinical assessment of ADHD is warranted) was 8.8% of men and 7.7% of women while 0.7% of men and 0.5% of women scored all six characteristics on the AHRS

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screen.[284] Recent research indicates that the demand for adult ADHD services currently outstrips supply, which suggests a neglected area for men's mental health.

Post-traumatic stress disorder (PTSD)

Although international studies have found women to be at greater risk of PTSD than men, the last APMS survey found no significant difference by sex in rates of PTSD (2.6% for men and 3.3% for women).[285] The risk of developing PTSD increases with the severity of a trauma, so that combat veterans, fire fighters and victims of violence, groups that include high proportions of men, are at higher risk.

Substance misuse

British men are more than twice as likely as women to consume alcohol at ‘hazardous’ levels (33.2% of men and 15.7% of women), and to be alcohol-dependent (8.7% of men and 3.3% of women).[286] Younger men in the 25-34 age-group are the most likely to be alcohol dependent.[287]

Men are more likely than women to use illegal drugs and to develop a drug addiction or dependency. Survey data estimate prevalence of drug use and drug dependence in 2008/9 to be much higher among men as among women: usage rates were 12.0% of men and 6.7% of women, while dependence rates were 4.5% of men and 2.3% of women.[288]

From the consultation

The Men’s Health Forum raised the need for research into any gender differences in how stigmatisation is experienced, and in how the public perceive men and women with mental health problems. The Campaign Against Living Miserably (CALM) was concerned that campaign messages should be communicated effectively to young men and not be undermined by inappropriate branding.

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Sexual orientation

From the consultation
There were comments about a lack of attention to LGB (lesbian, gay, bisexual), people in New Horizons, and the high prevalence of mental health problems in this group. Homophobia and bullying in schools was identified as a particular problem. The Lesbian and Gay Foundation called for more specialised services (such as LGB counselling services) to work alongside mainstream services, particularly in areas outside cities and large towns. They pointed to isolation in the LGB community, especially for older people whose needs are often overlooked or assumed to be identical to those of heterosexual older people. Other needs were for more preventive work to tackle homophobia throughout school years, role models at a senior level, early intervention, and staff training to create services where lesbian, gay and bisexual people feel comfortable, safe and accepted

Level of mental disorder among Lesbian, Gay, and Bisexual people
Lesbian gay, and bisexual (LGB) people are more likely to suffer from mental disorder including self-harm compared to the general population.[289] [290] [291] [292] . A systematic review of the international literature and meta-analysis of research found that

- LGB people have 1.5-fold increased risk for depression and anxiety disorders and are at higher risk of alcohol and substance misuse;
- gay and bisexual men have a two-fold increase in the probability of suicide attempt and a four-fold increased lifetime prevalence of suicide attempt;
- lesbian and bisexual women have high risk of substance dependence.[293]

A cohort study of 967 young people found rates of mental health problems were as follows: [294]

		Straight	Bisexual	Gay/ lesbian
Major depression	men	15%	43%	71%
	women	24%	37%	50%
Anxiety disorder	men	10%	29%	86%
	women	21%	34%	40%

A 2004 survey of more than 500 lesbian or bisexual women (about 90% white) found that over 40% met the criteria for a diagnosable mental disorder, over 30% had

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attempted suicide and that there was a significant correlation between experience of discrimination and having a mental disorder or attempting suicide.[295]

Stigma and discrimination against LGB people [296] [297] [298]

- Two in three (65%) lesbian and gay pupils report homophobic bullying, including physical violence (41%) and death threats (17%) and 7 in 10 gay pupils feel that homophobic bullying has affected their schoolwork.
- Bullying is compounded by isolation: Very few gay or lesbian pupils feel able to talk to an adult at home or school about being gay and 4 in 5 young people have no access to LGBT resources to help them.
- Public attitudes towards gay people are contradictory. Although 66% of people believe there is not enough acceptance of LGB people, one in five LGB people has still experienced homophobic hate crime in the past three years.

The higher rate of psychological morbidity has been linked to the significantly greater stresses arising out of homophobic stigma and discrimination, including rejection by family and peers, bullying in school and negative attitudes from employers. [299]

Service issues [300] [301]

Discrimination and homophobia have a significant impact on how LGB people are treated by some health care providers.

- One in 3 gay men, 1 in 4 bisexual men and 2 in 5 lesbians reported negative or mixed reactions from mental health professionals.
- A 2009 survey of mental health workers found that 17% had attempted to 'cure' LGB patients of their sexual orientation.

Stigmatisation by providers of mental health services is a particular issue for the LGB community. Anxiety about potential discrimination can cause reluctance to access healthcare, resulting in delayed treatment.

Gay men face particular challenges in looking after their health and wellbeing. Most research on their health needs focuses on sexual behaviour, and on the prevention and treatment of HIV/AIDS. This can divert attention and resources away from other health needs and, by reducing their self-perception to a sexualised model, affect their wellbeing by reducing the quality of their social and other relationships and increasing the risk of eating disorders and drug and alcohol abuse.

Lack of routine monitoring of sexual orientation is a barrier to monitoring outcomes for LGB people.[302]

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[295] Nada L. Stotland, MD, MPH Warner J et al. Rates and predictors of mental illness in gay men, lesbians and bisexual men and women: Results from a survey based in England and Wales. Br J Psychiatry 2004 Dec; 185:479-85.

[296] Stonewall(2007) The School Report: The Experiences of Young Gay People In Britain's Schools http://www.stonewall.org.uk/documents/school_report.pdf

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[300] (Bartlett et al 2009) The response of mental health professionals to clients seeking help to change or re-direct same-sex sexual attraction http://www.biomedcentral.com/1471-244X/9/11

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From the consultation

There is some agreement among respondents that mainstream services are not working appropriately for this group, and some sense of the impact of this.

"*On the whole, LGB people do not feel comfortable using mainstream statutory mental health services. This is due to a woeful lack of knowledge (and, indeed, much prejudice) about LGB relationships and issues affecting LGB people. There are, of course, notable exceptions to this, but on the whole changing the attitudes of mainstream statutory mental health service providers is a massive task."*

"If you're scared that the mental health specialist will judge you for being bisexual, for having more than one partner, for having different beliefs (or for practicing any religion at all) then you will be less likely to ask for help when needed."

There is also a wider view about the need for general specialist services:

"The Government needs to support the funding and promotion of specialist services within mental health. For example services serving particular groups and communities such as lesbian, gay and bisexual people. Through the support of these services individuals will have a wider choice made available to them and will therefore be able to access services that truly cater for their needs."

[302] EHRC(2008), Sexual Orientation Research Review
http://www.equalityhumanrights.com/uploaded_files/sexual_orientation_research_review.pdf