Department of Health

No health without mental health

Mental health dashboard – technical appendix

December 2013

DH – Leading the nation's health and care

Technical appendix

Contents

Introduction to the mental health dashboard technical appendix

The main purpose of the dashboard is to bring the best information we have about mental health outcomes together in one place, as a resource for everyone with an interest in improving these outcomes.

For anyone who wishes to investigate the information further, or explore the measures in the dashboard in more detail, links to original data sources are included in this technical appendix. This supporting analysis presents more detailed information on the data sources used. Each dashboard measure includes analysis of a small number of the most relevant Equality Act protected characteristics, based on the data which is currently available. Links to data which will allow additional analysis are included in this appendix.

Objective 1: More people will have better mental health

Self-reported wellbeing	
Source	Office for National Statistics (ONS) Annual Population Survey.
Outcomes framework link	Public Health Outcomes Framework (2.23).
Rationale for inclusion – summary	Improving the mental wellbeing of the population as a whole is a key aspect of the *No health without mental health* strategy. People with higher self-reported wellbeing have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health.
Derivation – summary	ONS measure individual/subjective wellbeing for adults (aged 16+) based on four questions included on the Annual Population Survey: **1.** *Overall, how satisfied are you with your life nowadays?* **2.** *Overall, how happy did you feel yesterday?* **3.** *Overall, how anxious did you feel yesterday?* **4.** *Overall, to what extent do you feel the things you do in your life are worthwhile?* Responses are given on a scale of 0–10 (where 0 is 'not at all satisfied/happy/anxious/worthwhile' and 10 is 'completely satisfied/happy/anxious/worthwhile'). Indicators are presented as the proportion of people who responded 'high' or 'medium' in the questions on 'life satisfaction', 'feeling worthwhile' and 'feeling happy yesterday' and 'medium' or 'low' in the question on 'feeling anxious yesterday'. For the questions on 'feeling satisfied', 'feeling worthwhile' and 'feeling happy', 'high' or 'medium' represents a score above 7 (inclusive). For the question on 'feeling anxious', 'medium' or 'low' represents a score less than 3 (inclusive).
Return format	Percentage.
Collection frequency	Annual.

Past data/trends available	ONS published the first full year of data from the four questions included on the Integrated Household Survey in July 2012 (note these are being treated as experimental statistics).
Data quality	The first full year of data (July 2012) are being treated as experimental statistics. Therefore, some minor changes to the wording of the four questions may arise.
Mental health dis-aggregation required	No. The indicators provide information on the wellbeing of the whole population.
Age range	16+.
Dis-aggregations available	Gender, age, economic activity, ethnicity, disability, religion or belief, sexual orientation.
Self-reported wellbeing: Warwick–Edinburgh Mental Wellbeing Scale (WEMWBS)	
Source	Health Survey for England (HSE).
Outcomes framework link	Public Health Outcomes Framework (2.23).
Rationale for inclusion – summary	Improving the mental wellbeing of the population as a whole is a key aspect of the *No health without mental health* strategy. People with higher self-reported wellbeing have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health.

Derivation – summary	WEMWBS measures social, emotional and psychological wellbeing using responses to 14 positively worded items. **1.** I've been feeling optimistic about the future. **2.** I've been feeling useful. **3.** I've been feeling relaxed. **4.** I've been feeling interested in other people. **5.** I've had energy to spare. **6.** I've been dealing with problems well. **7.** I've been thinking clearly. **8.** I've been feeling good about myself. **9.** I've been feeling close to other people. **10.** I've been feeling confident. **11.** I've been able to make up my own mind about things. **12.** I've been feeling loved. **13.** I've been interested in new things. **14.** I've been feeling cheerful. Responses are given on a scale of 1–5 (where 1 is 'none of the time' and 5 is 'all of the time') and then summed to give a score in the range 14 to 70, where a higher score corresponds to a higher level of wellbeing.
Return format	Numerical.
Collection frequency	Annual.

Past data/trends available	National level WEMWBS data from the Health Survey for England (HSE) was published for the first time in December 2011.
Data quality	No known issues.
Mental health dis-aggregation required	No. The indicators provide information on the wellbeing of the whole population.
Age range	16+.
Dis-aggregations available	Gender, age, equivalised household income, ethnicity, disability, religion or belief, sexual orientation.
Prevalence of mental health problems	
Source	HSE.
Outcomes framework link	None.
Rationale for inclusion – summary	*No health without mental health* sets the objectives that more people will have better mental health and that more people with mental health problems will recover. This measure provides an estimate of the proportion of people with mental health problems.

Derivation – summary	Two sub-indicators on self-defined prevalence of mental health problems. People with long term mental health disorders: *Numerator of the indicator:* • number of people with long term mental health disorders. *Denominator of the indicator:* • general population. People with long term mental health disorders can be identified in the sub-category 'Long-standing illnesses' of the survey by answering 'yes' to the question 'Do you have any long-standing illness, disability or infirmity? By long-standing I mean anything that has troubled you over a period of time, or that is likely to affect you over a period of time?' and subsequently reporting 'Long term mental health disorders'. People with possible mental health problems: People with a score 4 or greater in the General Health Questionnaire 12 (GHQ12). This is a part of the HSE and works as a screening device for identifying people with possible mental health problems. Scores 0–3 are associated with no/few signs of possible mental health problems ('low GHQ12 score') and scores of 4+ indicate possible mental health problems ('high GHQ12 score'). *Numerator of the indicator:* • number of people with a score 4 or greater in the GHQ12. *Denominator of the indicator:* • general population.
Return format	Percentage.
Collection frequency	Annually.

Past data/trends available	The General Health Questionnaire (GHQ12) is included in the survey every year since 1993 – except for the years 1996 and 2007. The question regarding long term mental health conditions is continuously included in the previous years of the survey.
Data quality	No known issues.
Mental health dis-aggregation required	Yes. All data are available from HSE, but require further analysis to create the indicator.
Age range	16+.
Dis-aggregations available	Age, gender, income group, ethnicity, religion.
Sickness absence	
Source	ONS Labour Force Survey.
Outcomes framework link	None.
Rationale for inclusion – summary	Mental health problems have serious consequences for the affected persons and for society as a whole. A large proportion of sickness absence is caused by mental health problems such as depression, anxiety and somatoform disorders.
Derivation – summary	Number of days lost due to sickness absence because of common mental health issues (namely stress, depression, anxiety). Total days lost are estimated as: (total hours lost due to sickness absence*100)/7.5 The methodology used to calculate sickness absence indicators is available on the ONS website.
Return format	Numerical.
Collection frequency	Quarterly indicator is calculated using four rolling quarters.
Past data/trends available	Data are available since Q1 2011.
Data quality	Because the data is only collected about sickness or injury in the reference week, the sample sizes are relatively small.

Mental health dis-aggregation required	Days lost due to common mental health issues (stress, depression, anxiety).
Age range	16+.
Dis-aggregations available	Gender, age.
Homelessness	
Source	Homelessness Statistics https://www.gov.uk/government/organisations/department-for-communities-and-local-government/series/homelessness-statistics.
Outcomes framework link	Public Health Outcomes Framework (1.15).
Rationale for inclusion – summary	A safe and secure place to live is essential for everybody's health and wellbeing. For many people, however, poor mental health is linked to insecure, poor quality and overcrowded housing and homelessness. Homeless households, or households in temporary accommodation, can have greater public health needs than the population as a whole, including mental health needs.
Derivation – summary	There are two sub-indicators for statutory homelessness: *1. Homelessness acceptances* This demonstrates the number of households that are accepted as being owed a duty by their local authority under homelessness legislation as a result of being eligible for assistance, unintentionally homeless and in priority need. *2. Number of households in temporary accommodation* This presents the number of homeless households in temporary accommodation awaiting a settled home. Please note that the number of households in temporary accommodation is a snapshot at the end of the quarter (rather than the number of households that have been in temporary accommodation at any point in the quarter).
Return format	Numerical.
Collection frequency	Quarterly.

Past data/trends available	Since 1998.
Data quality	No known quality issues.
Mental health dis-aggregation required	No.
Age range	16+.
Dis-aggregations available	Ethnicity, household type, age, gender.
Absolute low income	
Source	Households Below Average Income (HBAI) dataset.
Outcomes framework link	None.
Rationale for inclusion – summary	Social and economic inequalities influence health and wellbeing and risk of mental disorder; those from the lowest income levels are at increased risk of mental disorders compared with those from the highest income levels.
Derivation – summary	The indicator is presented as the proportion of people in households in the UK with incomes below 60% of 1998/99 median net disposable household income held constant in real terms a) Before Housing Costs (BHC) and b) After Housing Costs (AHC). Income in HBAI refers to disposable household income; that is income (from earnings, self-employment, benefits, occupational pensions, investments and other flows) after the deduction of income tax, NI contributions, local government taxes and certain other deductions. 'Low Income' is defined using thresholds derived from percentages of median income for the whole population. Households reporting the lowest incomes may not have the lowest living standards. HBAI uses household disposable incomes, after adjusting for the household size and composition, as a proxy for material living standards. All time trends are based on thresholds of median income and are presented and based on the modified OECD equalisation scales.
Return format	Percentage.
Collection frequency	Annually.

Past data/trends available	Since 1998/99.
Data quality	No known issues.
Mental health dis-aggregation required	No. Headline measure is presented as a wider determinant of possible mental health problems.
Age range	All ages.
Dis-aggregations available	Employment status, family type, age, gender, ethnicity, disability, economic situation of household, marital status.
Illicit drug use	
Source	Crime Survey for England and Wales, Home Office National and Regional Estimates of the Prevalence of Opiate and/or Crack Cocaine use, National Treatment Agency for Substance Misuse.
Outcomes framework link	None.
Rationale for inclusion – summary	Although there is still debate as to whether there is a causal link between illicit drug use and the development of long term psychosis, it is well established that the course of psychosis is adversely affected by substance misuse, resulting in a more prolonged and serious condition.
Derivation – summary	The indicators refer to the proportion of 16–24 year-olds recorded to be 'frequent' drug users and the proportion of 15–64 year-olds using opiates or crack cocaine. Frequent use is defined as the use of 'any drug' more than once a month in the last year. The chart focuses on 16–24 year olds as the Crime Survey for England and Wales has consistently shown that drug usage is higher among young people than for the adult population as a whole. *'Any drug'* comprises powder cocaine, crack cocaine, ecstasy, LSD, magic mushrooms, ketamine, heroin, methadone, amphetamines, methamphetamine, cannabis, tranquillisers, anabolic steroids, amyl nitrite and any other pills/powders/drugs smoked.
Return format	Percentage.
Collection frequency	Annually (except for 2007/08 for opiates and crack cocaine use in which year there was no data collection).

Past data/trends available	Since 2002/03 for 16–24 year-olds frequent drug use and since 2005/06 regarding opiates and crack cocaine use.
Data quality	The Crime Survey for England and Wales includes self-reported drug use information from a large, representative sample. Respondents report their drug use completely anonymously, using a laptop. However, issues might still exist around willingness to report illicit drug use, even in a confidential manner. An unknown proportion of respondents may not report their behaviour honestly; hence estimates of prevalence may be considered lower estimates of the true level of illicit drug use within the general population, even for more commonly used drugs. Information regarding opiates and crack cocaine use has been estimated using drug offences data refined with a capture-recapture methodology (the method registers individuals arrested for drugs offences over one period of time and checks their proportion among individuals arrested at a different period, which provides an estimate of the prevalence in the overall population). The method has been shown to be reliable in estimating population prevalence from sample data.
Mental health dis-aggregation required	No. Headline measure is presented as a wider determinant of possible mental health problems.
Age range	15–64.
Dis-aggregations available	Age, gender, ethnicity, indices of deprivation, output area classification, physical disorder, regions, rural and urban areas, households (accommodation type, reference person, structure, income, tenure, employment status, experience of crime, marital status, nightclub visits), personal (alcohol consumption, BME, occupation, pub or bar visits).

Objective 2: More people with mental health problems will recover

IAPT Increasing Access to Psychological Therapies	
Source	Improving Access to Psychological Therapies (IAPT) dataset.
Outcomes framework link	NHS Outcomes Framework (the measure definition for inclusion in the Outcomes Framework is in development).
Rationale for inclusion – summary	IAPT is a major national programme for people with depression and/or anxiety disorders. Government is investing £400 million to ensure that adults in all parts of England have access to a choice of National Institute of Clinical Evidence (NICE)-approved psychological therapies. By 2015, services should have a recovery rate of at least 50% in fully established services.
Derivation – summary	There are two sub-indicators that are both subject to changes. *a) Access rate*: *Numerator:* Number of people entered (i.e. received) treatment *Denominator:* Number of people with anxiety or depression in England as defined by the Psychiatric Morbidity Survey 2000. *b) Recovery rate:* This refers to the proportion of people who complete treatment who are moving to recovery. *Numerator:* Number of people moving to recovery. *Denominator:* Number of people who have completed treatment minus the number of people who have completed treatment that were not at caseness at the initial assessment. A patient is deemed to be at caseness when suffering from depression and/or anxiety disorders, as determined by scores on the Patient Health Questionnaire (PHQ9) for depression and/or the Generalised Anxiety Disorder (GAD7) for anxiety disorders, or other anxiety disorder specific measure as appropriate for the patient's diagnosis.
Return format	Percentage.
Collection frequency	Quarterly.

Past data/trends available	Data available from 2010/11.
Data quality	The IAPT data set is a new data set implemented in April 2012. The Health and Social Care Information Centre (HSCIC) will closely monitor data quality and report data quality issues in on-going publications.
Mental health dis-aggregation required	No. Headline measure relates to mental health.
Age range	Adults aged 18 or over, but can also include children and adolescents aged 16–18 where they are in receipt of care from an IAPT service provider.
Dis-aggregations available	None.
Employment of people with mental health problems	
Source	Labour Force Survey.
Outcomes framework link	NHS Outcomes Framework (indicator 2.5).
Rationale for inclusion – summary	This indicator is to ensure that mental illness is not excluded due to an overriding focus on physical health. Employment of people with mental illness provides an insight into how individuals are able to manage their condition.

Derivation – summary	*Employment rate of population:* *Numerator:* • number of people who are in employment and of working age. *Denominator:* • number of people who are of working age. *Employment rate of people with mental illness/mental health problems:* *Numerator:* • number of people with mental illness in employment and of working age. *Denominator:* • number of people with mental illness of working age. Being in employment is defined as being an employee, self-employed, in Government employment and training programmes or an unpaid family worker. This is the International Labour Organisation (ILO) definition of basic economic activity. Mental illness is defined as the respondent has depression, bad nerves or anxiety, severe or specific learning difficulties (mental handicap) or mental illness, or suffers from phobia, panics or other nervous disorders and he/she expects this to last for more than a year. More detail on derivation is available from HSCIC.
Return format	Percentage.
Collection frequency	Quarterly.
Past data/trends available	Since 2006.
Data quality	No known issues.

Mental health dis-aggregation required	No. The headline measure relates to people with mental health problems.
Age range	16–64.
Dis-aggregations available	Age, gender, ethnicity.
Employment of people with serious mental illness	
Source	Mental Health Minimum Data Set (MHMDS).
Outcomes framework link	Adult Social Care Outcomes Framework (iF) and complementary indicators in the Public Health Outcomes Framework (1.8iii) and the NHS Outcomes Framework (2.5).
Rationale for inclusion – summary	Supporting someone with their employment aspirations is a key part of the recovery process[1]. Employment outcomes demonstrate quality of life and are indicative that social care support is personalised. Employment is a wider determinant of health and social inequalities.
Derivation – summary	The measure shows the percentage of adults receiving secondary mental health services in paid employment at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting. *Adults 'in contact with secondary mental health services' is defined as those aged 18 to 69 who are receiving secondary mental health services and who are on the Care Programme Approach (CPA).* *Numerator:* The number of adults (aged 18–69) in the denominator in paid employment (i.e. those recorded as 'employed') at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting, in a financial year. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported quarter. *Denominator:* Adults 'in contact with secondary mental health services' is defined as those aged 18 to 69 who are receiving secondary mental health services and who are on the Care Programme Approach (CPA). Voluntary work is excluded for the purposes of this measure.
Return format	Percentage.
Collection frequency	Annual (from quarterly returns).

1 Waddell, G. & Burton, A. (2006). *Is Work Good for your Health and Well-being?* London: TSO

Past data/trends available	2008/09.
Data quality	No known issues.
Mental health dis-aggregation required	No.
Age range	18–69.
Dis-aggregations available	Age, gender, ethnicity.
Living in stable and appropriate accommodation	
Source	Mental Health Minimum Data Set (MHMDS).
Outcomes framework link	Adult Social Care Outcomes Framework (1H). and Public Health Outcomes Framework (1.6ii).
Rationale for inclusion – summary	The measure is intended to improve outcomes for adults with mental health problems by demonstrating the proportion in stable and appropriate accommodation. This is closely linked to improving their safety and reducing their risk of social exclusion.

Derivation – summary	The measure shows the percentage of adults receiving secondary mental health services living independently at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting. *Adults 'in contact with secondary mental health services' is defined as those aged 18 to 69 who are receiving secondary mental health services and who are on the Care Programme Approach (CPA).* '*Living independently, with or without support'* refers to accommodation where the occupier has security of tenure or appropriate stability of residence in their *usual* accommodation in the medium to long term, or is part of a household whose head holds such security of tenure/residence. Arrangements that are precarious, or where the person has no or low security of tenure/residence in their usual accommodation and so may be required to leave at very short notice, are excluded from the definition. These are recorded as 'non-settled accommodation' in the MHMDS. *Numerator:* Number of adults aged 18–69 who are receiving secondary mental health services on the CPA recorded as living independently (with or without support). The most recent record of whether the person is in settled accommodation during the financial year is used. *Denominator:* Number of adults aged 18–69 who have received secondary mental health services and who were on the CPA at any point during the financial year.
Return format	Percentage.
Collection frequency	Annual.
Past data/trends available	Since 2008/09.
Data quality	No known issues
Mental health dis-aggregation required	No.
Age range	18–69.
Dis-aggregations available	Age, gender, ethnicity.

Social care related quality of life for people with mental health related social care needs	
Source	Adult Social Care Survey (ASCS).
Outcomes framework link	Adult Social Care Outcomes Framework (1A).
Rationale for inclusion – summary	This indicator gives an overarching view of the quality of life of users of social care. It is based on the outcome domains of social care related quality of life identified in the adult social care outcomes toolkit (ASCOT), developed by the Personal Social Services Research Unit (www.pssru.ac.uk/ascot). An improved quality of life will have an impact on the mental health of people.

Derivation – summary	This measure is an average quality of life score based on responses to the ASCS. It is a composite measure using responses to survey questions covering the eight domains identified in the ASCOT (control, dignity, personal care, food and nutrition, safety, occupation, social participation and accommodation). • *Control* – Q3a: Which of the following statements best describes how much control you have over your daily life? • *Personal care* – Q4a: Thinking about keeping clean and presentable in appearance, which of the following statements best describes your situation? • *Food and nutrition* – Q5a: Thinking about the food and drink you get, which of the following statements best describes your situation? • *Accommodation* – Q6a: Which of the following statements best describes how clean and comfortable your home/care home is? • *Safety* – Q7a: Which of the following statements best describes how safe you feel? • *Social participation* – Q8a: Thinking about how much contact you've had with people you like, which of the following statements best describes your social situation? • *Occupation* – Q9a: Which of the following statements best describes how you spend your time? • *Dignity* – Q11: Which of these statements best describes how the way you are helped and treated makes you think and feel about yourself? Each of the questions has four possible answers, which are equated with having: • no unmet needs in a specific life area or domain; • needs adequately met; • some needs met; and • no needs met.

	Responses to the questions indicate whether the individual has unmet needs in any of the eight areas. The measure gives an overall score based on respondents' self-reported quality of life across the eight questions. All eight questions are given equal weight. Each respondent is assigned a score based on their answers to questions 3a to 9a and 11. Scores are assigned as follows: • no needs met (the last answer option for each question) = 0 • some needs met (3rd answer option) = 1 • needs adequately met (2nd answer option) = 2 • no unmet needs (1st answer option) = 3 *Numerator:* The sum of the scores for all respondents with mental health problems who have answered questions 3a to 9a and 11. *Denominator:* The number of respondents with mental health problems who answered questions 3a to 9a and 11. This indicator focuses on people with mental health related social care needs and compares the results with the other two main groups (people with physical disabilities and learning disabilities). *Exclusions*: Any respondents who failed to answer all of the questions from 3a to 9a and question 11, are excluded from the calculation of the indicator.
Return format	Numeric.
Collection frequency	Annual.
Past data/trends available	2010/11 is the first year.
Data quality	No known issues.
Mental health dis-aggregation required	Yes. Dis-aggregation from headline measure to identify people whose social care needs relate to mental health problems.

Age range	18–64.
Dis-aggregations available	Age, gender, ethnicity.

Objective 3: More people with mental health problems will have better physical health

Excess mortality in people with severe mental illness	
Source	Mental Health Minimum Dataset (MHMDS) data linked to mortality data in the Primary Care Mortality Database (PCMD), Health and Social Care Information Centre. Office for National Statistics (ONS) death registrations and mid -year population estimates.
Outcomes framework link	NHS Outcomes Framework (1.5) and Public Health Outcomes Framework (4.9).
Rationale for inclusion – summary	Excess mortality is an indicator of the difference in physical health between people with serious mental illness (SMI) and the general population. It therefore also provides an indicator of progress towards parity of esteem between physical and mental health.
Derivation – summary	Excess mortality rate in adults with SMI, aged under 75, per 100,000 population. Premature mortality in adults with SMI is compared to premature mortality in adults in the general population. *'Adults with serious mental illness'* are defined as anyone aged 18 or over who has been in contact with the secondary mental care services in the current financial year or either of the two previous financial years and is alive at the beginning of the current financial year. Those aged 75 and over are excluded to align this indicator with the other premature mortality indicators and those aged under 18 are excluded because children under 18 are not covered by the main data source (MHMDS). There is no evidence that children with SMI are at particularly high risk of death by disease. The mortality rate for adults with SMI is directly standardised by age and sex to the general population of the relevant geographical area. The general population mortality rate is the crude rate for people aged 18 to 74.
Return format	Rate (per 100,000 population).
Collection frequency	Annual: MHMDS (financial year), mortality and population data (calendar years).

Past data/trends available	2008/09. Data are not available before 2006/07 on MHMDS.
Data quality	No known issues.
Mental health dis-aggregation required	No. The headline measure relates to people with mental health problems.
Age range	18–74.
Dis-aggregations available	Age, gender.
Comorbid long term physical health conditions among people with long term mental health problems	
Source	GP patient survey http://www.gp-patient.co.uk/
Outcomes framework link	None.
Rationale for inclusion – summary	This measure shows the extent of poor physical health amongst people with mental health problems. It therefore provides a clear guide to progress against the 'No health without mental health' strategy objective that more people with mental health problems will have good physical health. This is mirrored by the indicator showing the extent to which people with physical health problems also have poor mental health.

Derivation – summary	This measure is comprised of a combination of responses in the GP patient survey. *Numerator:* The total number of people with long term mental health problems who also have long term physical conditions. *Denominator:* The total number of people with long term mental health problems. People with long term mental health problems are identified by answering ' Long term mental health problems' to the question Q31: 'Which, if any, of the following medical conditions do you have?' Other long term health conditions are identified from the answers in question Q31: 'Which, if any, of the following medical conditions do you have?' If people answer mental health problems and yes to any of the following list, then they would be in the numerator: • angina • arthritis • asthma • cancer • diabetes • epilepsy • high blood pressure • kidney or liver disease • long term back problem • long term neurological problem
Return format	Percentage.
Collection frequency	Annually. Results are aggregated from two waves of patient responses collected in January to March (Wave 1) and July to September (Wave 2) in each year.
Past data/trends available	2011/12 (Wave 1 and 2).

Data quality	No known issues. The GP patient survey methodology and reporting method are designed to produce results which are representative of the population.
Mental health dis-aggregation required	Yes. The indicator is derived by combining a number of data items.
Age range	18+.
Dis-aggregations available	Age, gender, area of deprivation, ethnicity.
Comorbid long term mental health problems among people with long term physical health conditions	
Source	GP patient survey.
Outcomes framework link	None.
Rationale for inclusion – summary	This measure shows the extent of poor mental health amongst people with physical health problems. It therefore provides a clear guide to progress against the strategy objective that more people with mental health problems will have good physical health. This is mirrored by the indicator showing the extent to which people with mental health problems also have poor physical health.

Derivation – summary	This measure is comprised of a combination of responses in the GP patient survey. *Numerator:* The total number of people with long term physical conditions who also have long term mental health problems. *Denominator:* The total number of people with long term physical conditions. People with long term mental health problems are identified by answering 'long term mental health problems' to the question Q31: 'Which, if any, of the following medical conditions do you have?' Long term physical conditions are identified from the answers in question Q31: 'Which, if any, of the following medical conditions do you have?' If people answer mental health problems and yes to any of the following list, then they would be in the numerator: • angina • arthritis • asthma • cancer • diabetes • epilepsy • high blood pressure • kidney or liver disease • long term back problem • long term neurological problem
Return format	Percentage.
Collection frequency	Annually. Results are aggregated from two waves of patient responses collected in January to March (Wave 1) and July to September (Wave 2) in each year.
Past data/trends available	2011/12 (Wave 1 and 2).

Data quality	No known issues. The GP patient survey methodology and reporting method are designed to produce results which are representative of the population.
Mental health dis-aggregation required	Yes. The indicator is derived by combining a number of data items.
Age range	18+.
Dis-aggregations available	Age, gender, area of deprivation, ethnicity.
Mental health and alcohol misuse	
Source	Health Survey for England (HSE).
Outcomes framework link	Related indicator in the Public Health Outcomes Framework (2.18 alcohol-related admissions to hospital).
Rationale for inclusion – summary	Alcohol is one of the three biggest lifestyle risk factors for disease and death in the United Kingdom after smoking and obesity. Promoting good mental health in children and adults can help prevent alcohol misuse.
Derivation – summary	Prevalence of alcohol misuse is identified by reporting consumption of 8 alcohol units for males and 6 units for females on the heaviest day in the last week. *Numerator:* Number of people that have a possible mental health problem and drink more than 8 units of alcohol for men, and 6 units for women, on the heaviest day in the last week. *Denominator:* Total number of people that have a possible mental health problem People with possible mental health problems are identified by a score 4 or greater in the General Health Questionnaire 12 (GHQ12). This is a part of the HSE and works as a screening device for identifying people with possible mental health problems. Scores 0–3 are associated with no/few signs of possible mental health problems ('low GHQ12 score') and scores of 4+ indicate possible mental health problems ('high GHQ12 score'). Alcohol misuse can be identified from the sub-category of the survey 'alcohol' by reporting more than 8 units of alcohol for men and 6 units of alcohol for women, to the question '*New units drunk on heaviest day in last 7 (16+yrs, ONS wineglass grouped*)'.

Return format	Percentage.
Collection frequency	Annually.
Past data/trends available	Since 1993.
Data quality	No known issues.
Mental health dis-aggregation required	Yes. Two data items are combined to highlight specific results for people with mental health problems.
Age range	16+.
Dis-aggregations available	Age, gender, income group, ethnicity.

Mental health and obesity	
Source	Health Survey for England (HSE).
Outcomes framework link	Related indicator for all adults in the Public Health Outcomes Framework (2.12: Excess weight in adults).
Rationale for inclusion – summary	Having a mental health problem increases the risk of physical ill health and health risk behaviour. People with mental health problems are also less likely to benefit from mainstream screening and public health programmes. In adults, overweight and obesity are linked to increased risk of heart disease, certain cancers and other chronic conditions. Therefore, obesity is a good indicator of people's physical health.
Derivation – summary	This measure is comprised of a combination of questions in the HSE. *Numerator:* Number of people with possible mental health problems that are obese (valid BMI>30 kg/m2). *Denominator:* Number of people with possible mental health problems. People with possible mental health problems are identified by a score 4 or greater in the General Health Questionnaire 12 (GHQ12). This is a part of the HSE and works as a screening device for identifying people with possible mental health problems. Scores 0–3 are associated with no/few signs of possible mental health problems ('low GHQ12 score') and scores of 4+ indicate possible mental health problems ('high GHQ12 score'). People with a valid BMI grouped in the categories: 30–40 and 40+ are considered as obese. The BMI measurements can be found in the sub-category 'measurements' of the survey (BMIVG5).
Return format	Percentage.
Collection frequency	Annually.
Past data/trends available	Since 1993.
Data quality	No known issues.
Mental health dis-aggregation required	Yes. Two data items are combined to create the indicator.

Age range	16+.
Dis-aggregations available	Age, gender, income group, ethnicity.
Mental health and smoking	
Source	Health Survey for England (HSE).
Outcomes framework link	Related indicator for all adults in the Public Health Outcomes Framework (2.14: Smoking prevalence – adults (over 18s)).
Rationale for inclusion – summary	Smoking is considered one of the main causes of mortality. It is a good indicator of people's physical health. Increased smoking is responsible for most of the excess mortality of people with serious mental illness.
Derivation – summary	This measure is comprised of a combination of questions in the HSE. *Numerator:* Number of people with possible mental health problems that are current smokers. *Denominator:* The total number of people with possible mental health problems. Prevalence of smoking is identified by value 4 (= current smoker) in the derived variable cigarette *'Cigarette Smoking Status –Never/Ex-reg/Ex-occ/Current'* in the smoking section of the survey (CIGST1). People with possible mental health problems are identified by a score 4 or greater in the General Health Questionnaire 12 (GHQ12). This is a part of the HSE and works as a screening device for identifying people with possible mental health problems. Scores 0–3 are associated with no/few signs of possible mental health problems (low GHQ12), and scores of 4+ indicate possible mental health problems ('high GHQ12 score').
Return format	Percentage.
Collection frequency	Annually.
Past data/trends available	The GHQ12 has been included in the survey every year since 1993, except 1996 and 2007. The smoking section of the survey has been included every year since 2003.

Data quality	No known issues. The HSE methodology and reporting method are designed to produce results which are representative of the population.
Mental health dis-aggregation required	Yes. Data items are combined to focus on people with GHQ12 score 4 or greater.
Age range	16+.
Dis-aggregations available	Age, gender, income group, ethnicity.

Objective 4: More people will have a positive experience of care and support

Detention and compulsory treatment	
Source	Mental Health Minimum Dataset (MHMDS).
Outcomes framework link	None.
Rationale for inclusion – summary	Admission as a detained patient indicates a comparatively higher level of need, as well as a disruptive route to accessing services. The proportion of inpatients who are formally detained is therefore an indicator of overall service design and patient experience.
Derivation – summary	This indicator includes two measures: • *number of people that are formally detained subject to the Mental Health Act.* People subject to the Mental Health Act who did not spend time in hospital during the year are excluded. • *number of people subject to Community Treatment Orders (CTOs) at 31st of March in each year.*
Return format	Numerical.
Collection frequency	Annual.
Past data/trends available	2009/10.

Data quality	The main areas of concern regarding data quality have been: • issues with the processing of the data which have an impact on the accuracy of person and record counts and data derivations • coverage and completeness – although there is evidence of improving coverage over the years, the lack of feedback to trusts through regular national reporting has had an impact on data quality • the definition of the dataset is not properly representative of all mental health care activities.
Mental health dis-aggregation required	No.
Age range	18–64
Dis-aggregations available	Ethnicity.
Patient experience of community mental health services	
Source	Care Quality Commission Community Mental Health Services Survey (CQC).
Outcomes framework link	NHS Outcomes Framework 4.7.
Rationale for inclusion – summary	Indicator measures people's experience of the care they receive from community health services. Improving scores indicate that more people are having a positive experience of care.

Derivation – summary	The indicator is a composite measure, calculated as the average score of four survey questions from CQC's Community Mental Health Survey below. The questions relate to a patient's experience of contact with a health and social care worker. Thinking about the last time you saw this NHS health worker or social care worker for your mental health condition… …Did this person listen carefully to you? …Did this person take your views into account? …Did you have trust and confidence in this person? …Did this person treat you with respect and dignity? Individual questions are scored according to a pre-defined scoring regime that awards scores between 0–100. Therefore, this indicator will also take values between 0–100, where 0 is the worst score and 100 is the best score. The mean of the scores for each question is calculated for each trust to give the trust indicator score. The mean of the trust scores is calculated to give the national indicator score.
Return format	Percentage.
Collection frequency	Annual.
Past data/trends available	2003/04 onwards.
Data quality	No known issues.
Mental health dis-aggregation required	No.
Age range	18+.
Dis-aggregations available	Provider.

Satisfaction with services for people with mental health related social care needs	
Source	Adult Social Care Survey (ASCS).
Outcomes framework link	Adult Social Care Outcomes Framework 3.A.
Rationale for inclusion – summary	This indicator measures the satisfaction with services of people using adult social care, which is directly linked to a positive experience of care and support. Analysis of surveys suggests that reported satisfaction with services is a good predictor of the overall experience of services and quality.
Derivation – summary	The relevant question drawn from the ASCS is Question 1: '*Overall, how satisfied or dissatisfied are you with the care and support services you receive?*', to which the following answers are possible: • I am extremely satisfied • I am very satisfied • I am quite satisfied • I am neither satisfied nor dissatisfied • I am quite dissatisfied • I am very dissatisfied • I am extremely dissatisfied The measure is defined by determining the percentage of all those responding who identify strong satisfaction – i.e. by choosing the answer 'I am extremely satisfied' or the answer 'I am very satisfied'. This indicator focuses on people with mental health related social care needs and compares the results with the other two main groups (people with physical disabilities and learning disabilities).
Return format	Percentage.
Collection frequency	Annual.
Past data/trends available	2010/11.

Data quality	Sample size issues.
Mental health dis-aggregation required	Yes. Dis-aggregation to identify people whose social care needs relate to mental health problems.
Age range	18+.
Dis-aggregations available	Age, gender, ethnicity.
Proportion of people feeling supported to manage their condition	
Source	GP Patient Survey.
Outcomes framework link	NHS Outcomes Framework 2.1.
Rationale for inclusion – summary	Feeling sufficiently supported to manage a mental health problem is an important element of a positive experience of care and will also contribute towards recovery.
Derivation – summary	The indicator is based on responses to questions in the GP Patient Survey. *Numerator:* total number of 'Yes, definitely' or 'Yes, to some extent' answers to GPPS Question 32: *'In the last 6 months, have you had enough support from local services or organisations to help you manage your long term condition(s)?'* Please think about all services and organisations, not just health services. • Yes, definitely • Yes, to some extent • No • I have not needed such support • Don't know/can't say *Denominator:* number of 'Yes, definitely', 'Yes, to some extent' and 'No' answers to question 32. Responses are presented for: *People with long term mental health problems*. People with long term mental health problems are identified by answering 'yes' to the Q30 'Do you have a long-standing health condition' and then 'long term mental health problem' to the question Q31 'Which, if any of the following medical conditions do you have?'

	People with a long term condition (except from long term mental health problems). People with a long term condition (except from long term mental health problems) are identified by answering 'yes' to the Q30 'Do you have a long-standing health condition' and then one of the below conditions to the question Q31 'Which of the following medical conditions do you have': • alzheimer • angina • arthritis • asthma • blindness • cancer • deafness • diabetes • epilepsy • high blood pressure • kidney or liver disease • learning difficulty • long term back problem • long term neurological problem
Return format	Percentage.
Collection frequency	Bi-annual in future.
Past data/trends available	Series from GPPS available from Q3 2009/10. Summaries of quarterly data are available from: http://www.gppatient.co.uk/results/results/annualsummary.
Data quality	Sample size issues.
Mental health dis-aggregation required	Yes. Dis-aggregation to identify results for people with long term mental health problems.

Age range	18+.
Dis-aggregations available	Age groups, ethnicity, sexual orientation.

Objective 5: Fewer people will suffer avoidable harm

Safety incidents in mental health settings	
Source	National Reporting and Learning Service (NRLS) (National Patient Safety Agency; Population statistics (Office for National Statistics).
Outcomes framework link	NHS Outcomes Framework 5a/5b.
Rationale for inclusion – summary	Reported safety incidents provide a record of avoidable harm. However, increased reporting of incidents is also an indicator of a culture of safety in services, which should lead to reduced overall harm. Safety incidents involving severe harm or death are incidents of avoidable harm.
Derivation – summary	Two indicators: *Patient safety incidents reported to the National Reporting and Learning Service (NRLS)* by provider organisations in England, per 100,000 of the population. *Patient safety incidents reported to the National Reporting and Learning Service (NRLS), where degree of harm is recorded as 'severe harm' or 'death'* by provider organisations in England, per 100,000 of the population.
Return format	Rate per 100,000 population.
Collection frequency	Quarterly for NRLS data, annual for population data.
Past data/trends available	2003 onwards.
Data quality	No known issues.
Mental health dis-aggregation required	Yes. Headline measure applies to all receivers of the NHS funded healthcare that have had unintended or unexpected incident(s) that have led to harm. Dis-aggregation is required to identify reporting from mental health services.
Age range	All ages.
Dis-aggregations available	Provider.

Suicide	
Source	Indicator calculated by Public Health Observatories using Office for National Statistics (ONS) annual death extracts and mid-year estimates of population.
Outcomes framework link	Public Health Outcomes Framework.
Rationale for inclusion – summary	Suicides are incidents of avoidable harm.
Derivation – summary	*Numerator:* Number of deaths from suicide and injury of undetermined intent classified by underlying cause of death recorded as ICD10 codes X60–X84, Y10–Y34 (excluding Y33.9) registered in the respective calendar years. *Denominator:* Population-years (ONS mid-year population estimates aggregated across three years).
Return format	Rate per 100,000 (age standardised and presented as three-year rolling average).
Collection frequency	Annual.
Past data/trends available	Yes. Baseline will be set as 2009–2011 (available in April 2013), but past data exist.
Data quality	There have been concerns about the impact of the increasing use by coroners of narrative verdicts on the reliability of the suicide statistics. ONS has worked with coroners to reduce the number of hard-to-code narrative verdicts, with a significant fall in the number in 2011, thus improving the reliability of the ONS statistics See http://www.ons.gov.uk/ons/dcp171778_295718.pdf.
Mental health dis-aggregation required	No.
Age range	Suicides (X60–X84) refer to all ages and undetermined intent (Y10–Y33.9) to 15+.
Dis-aggregations available	Age, gender.

Objective 6: Fewer people will experience stigma and discrimination

Mental health-related knowledge amongst the general public	
Source	National Attitudes to Mental Illness Survey. Additional analysis conducted by the Institute of Psychiatry (IOP).
Outcomes framework link	None.
Rationale for inclusion – summary	Improvements in mental health related knowledge amongst the general public should result in a reduction in mental health stigma and discrimination.
Derivation – summary	Mental health-related knowledge is measured by the Mental Health Knowledge Schedule (MAKS). The MAKS comprises six statements covering stigma-related mental health knowledge areas: help seeking recognition, support, employment, treatment, and recovery. Respondents specify agreement with each statement on a 5-point scale from strongly agree to strongly disagree, with 'don't know' as an additional response option. The total score is calculated so that higher MAKS scores indicate greater knowledge. Scores are then averaged across the population. The average item score is calculated each year with one representing the most stigmatising response and five representing the least stigmatising response. For additional detail on the instrument development and psychometric properties please refer to: Evans-Lacko, S; Little K; Meltzer H; Rose D; Rhydderch D; Henderson C; Thornicroft G. Development and Psychometric Properties of the Mental Health Knowledge Schedule (MAKS) (Canadian Journal of Psychiatry 2010 Jul; 55, 440–448).
Return format	Numerical.
Collection frequency	Annually.
Past data/trends available	Since 2009.
Data quality	The 2012 sample surveyed had slightly higher representation of individuals in lower socioeconomic classes compared to individuals from middle and upper socioeconomic classes and this has been corrected through sample weighting. The sample included roughly equal numbers of men (47%) and women (53%).

Mental health dis-aggregation required	No. Headline indicator relates to mental health.
Age range	16+.
Dis-aggregations available	Socioeconomic status, gender, and being familiar with someone with a mental health problem.
Attitudes towards mental health amongst the general public	
Source	National Attitudes to Mental Illness Survey.
Outcomes framework link	None.
Rationale for inclusion – summary	Improvements in attitudes towards mental health amongst the general public should result in a reduction in stigma and discrimination experiences by people with mental health problems.
Derivation – summary	The questionnaire includes 26 items from the 40–item Community Attitudes towards the Mentally Ill scale (CAMI) and an added item on employment-related attitudes. Items refer to attitudes about social exclusion, benevolence, tolerance and support for community mental health care and were rated from 1 (strong disagreement) to 5 (strong agreement). The total score is calculated so that higher CAMI scores indicate less stigmatising attitudes. The average item score is calculated each year with one representing the most stigmatising response and five representing the least stigmatising response. For additional detail on the original CAMI instrument and the revised instrument please refer to: Taylor SM, Dear MJ. Scaling community attitudes toward the mentally ill. Schizophr Bull 1981; 7(2):225–240. Rusch N, Evans-Lacko SE, Henderson C, Flach C, Thornicroft G. Knowledge and attitudes as predictors of intentions to seek help for and disclose a mental illness. Psychiatr Serv 2011; 62(6):675–678.
Return format	Numerical.
Collection frequency	Annually.

Past data/trends available	2003 and 2007 onwards.
Data quality	The 2012 sample surveyed, had slightly higher representation of individuals in lower socioeconomic classes compared to individuals from middle and upper socioeconomic classes and this has been corrected through sample weighting. The sample included roughly equal numbers of men (47%) and women (53%).
Mental health dis-aggregation required	No. Headline indicator relates to mental health.
Age range	16+.
Dis-aggregations available	Socioeconomic status, gender, and being familiar with someone with a mental health problem.
Reported and intended behaviour in relation to people with mental illness	
Source	National Attitudes to Mental Illness Survey. Additional analysis conducted by the IOP.
Outcomes framework link	None.
Rationale for inclusion – summary	Improvements in reported and intended behaviour towards people with mental health problems should result in a reduction in stigma and discrimination experiences by people with mental health problems.

Derivation – summary	Behaviour is measured by the Reported and Intended Behaviour Scale (RIBS). Changes in reported and intended behaviour are assessed among four different contexts (domains comprised: living with, working with, living nearby and continuing a relationship with someone with a mental health problem). Four intended behaviour items assess the level of intended future contact with people with mental health problems and an additional four reported behaviour items assess past or current contacts. For reported behaviour items, respondents answer with yes, no or don't know. For intended behaviour items, respondents specify agreement with each statement on a 5–point scale from strongly agree to strongly disagree, with 'don't know' as an additional response option. The total intended behaviour score is calculated so that higher scores indicate more favourable intended behaviour. For reported behaviour, prevalence estimates of any reported behaviour are calculated. The average item score is calculated each year with one representing the most stigmatising response and five representing the least stigmatising response. For additional detail on the instrument development and psychometric properties please refer to: Evans-Lacko S, Rose D, Little K, Rhydderch D, Henderson C, Thornicroft G: Development and Psychometric Properties of the Reported and Intended Behaviour Scale (RIBS), in press, Epidemiology and Psychiatric Sciences
Return format	Numerical.
Collection frequency	Annually.
Past data/trends available	Since 2009.
Data quality	The 2012 sample surveyed had slightly higher representation of individuals in lower socioeconomic classes compared to individuals from middle and upper socioeconomic classes and this has been corrected through sample weighting. The sample included roughly equal numbers of men (47%) and women (53%).
Mental health dis-aggregation required	No. Headline indicator relates to mental health.
Age range	16+.

Dis-aggregations available	Socioeconomic status, gender and being familiar with someone with a mental health problem.
Proportion of people who use secondary mental health services experiencing no discrimination	
Source	Viewpoint survey. Analysis conducted by the IOP.
Outcomes framework link	None.
Rationale for inclusion – summary	This indicator measures directly the level of discrimination experienced by a sample of people with mental health problems.
Derivation – summary	*Numerator:* Number of people who use secondary mental health services who have no experience of discrimination. *Denominator:* Number of people who use secondary mental health services (total sample of the survey). No experience of discrimination is defined as people who answer no to all twenty-two items of the Discrimination and Stigma Scale (DISC). This is a twenty-eight item questionnaire asking about participants' experiences over the twelve months prior to the interview. The main section of the survey is composed of twenty-two questions about experiencing negative discrimination as a result of having a diagnosis of mental illness. Participants are asked if they had been treated unfairly because of their mental health problems in areas related to their daily lives, including work, marriage, parenting, housing, leisure and religious activities. For all items, possible responses are: • not at all • a little • moderately • a lot
Return format	Percentage.
Collection frequency	Annually.

Past data/trends available	Since 2008.
Data quality	The Viewpoint Survey is based on a sample of users of secondary mental health services from four diverse mental health trusts which change every year. The response rate is between 10–15%. In previous years, participation among BME groups has been low. Site selection aims to correct this.
Mental health dis-aggregation required	No. Headline measure relates to mental health.
Age range	18–65.
Dis-aggregations available	None.
Proportion of people who use secondary mental health services who feel confident in tackling stigma and discrimination	
Source	Viewpoint survey. Analysis conducted by the IOP.
Outcomes framework link	None.
Rationale for inclusion – summary	Increasing service users' confidence to tackle or challenge stigma and discrimination should lead to a reduction in stigma and discrimination over time.
Derivation – summary	*Numerator:* Number of people who use secondary mental health services who feel confident in tackling stigma and discrimination. A question is asked to find out about participants' increased confidence in tackling stigma and discrimination compared to the previous year: 'Compared to a year ago, I feel I have more confidence to challenge mental health stigma and discrimination when I see it.' Response options include: not at all/a little/moderately/a lot/don't know/unsure. *Denominator:* Number of people who use secondary mental health services (total sample of the survey).
Return format	Percentage.
Collection frequency	Annually.
Past data/trends available	Since 2011.

Data quality	The Viewpoint Survey is based on a sample of users of secondary mental health services from four diverse mental health trusts which change every year. The response rate is between 10–15%.
Mental health dis-aggregation required	No. Headline measure relates to mental health.
Age range	18–65.
Dis-aggregations available	None.