Mental health statistics for England: prevalence, services and funding

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Finding data on mental health in England

- NHS England's Mental Health Five Year Forward View Dashboard covers information on funding and service activity, both nationally and locally.

- NHS Digital's Mental Health Services Monthly Dataset provides information on referrals to services, ward stays, and other activity data. An annual Mental Health Bulletin provides a useful overview.

- NHS Digital publishes detailed figures on the Improving Access to Psychological Therapies programme. Monthly and quarterly reports are also available.

- NHS England publishes information on Early Intervention in Psychosis.

- Data on Out of Area Placements is available from NHS Digital.

- NHS Digital also publishes figures on uses of the Mental Health Act.

- Prevalence of conditions among adults is available from the Adult Psychiatric Morbidity Survey, while a further study is available on the Mental Health of Children and Young People.

- Public Health England's data dashboards draw together a range of local and national data on mental health, dementia and neurology, including perinatal mental health, crisis care, and suicide prevention.

- Policy information is available in the Commons Library briefing paper Mental Health Policy in England.

Mental health is a devolved policy area and the devolved nations maintain separate datasets.

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Mental health in England
Key facts

An estimated **1 in 6 adults** have experienced a 'common mental disorder' like **depression or anxiety** in the past week.

Around **1 in 8 children aged 5 to 19** are estimated to have at least one mental health problem.

2.1 million adults and 0.6 million children accessed NHS mental health, learning disability and autism services in 2018/19.

Patients experiencing improvment after NHS psychological therapies (IAPT) in 2018/19

- 53% to 62%
- 62% to 66%
- 66% to 69%
- 69% to 73%
- 73% to 81%

Waiting times for NHS psychological therapy (IAPT) vary from 4 days to 61 days in different parts of England.
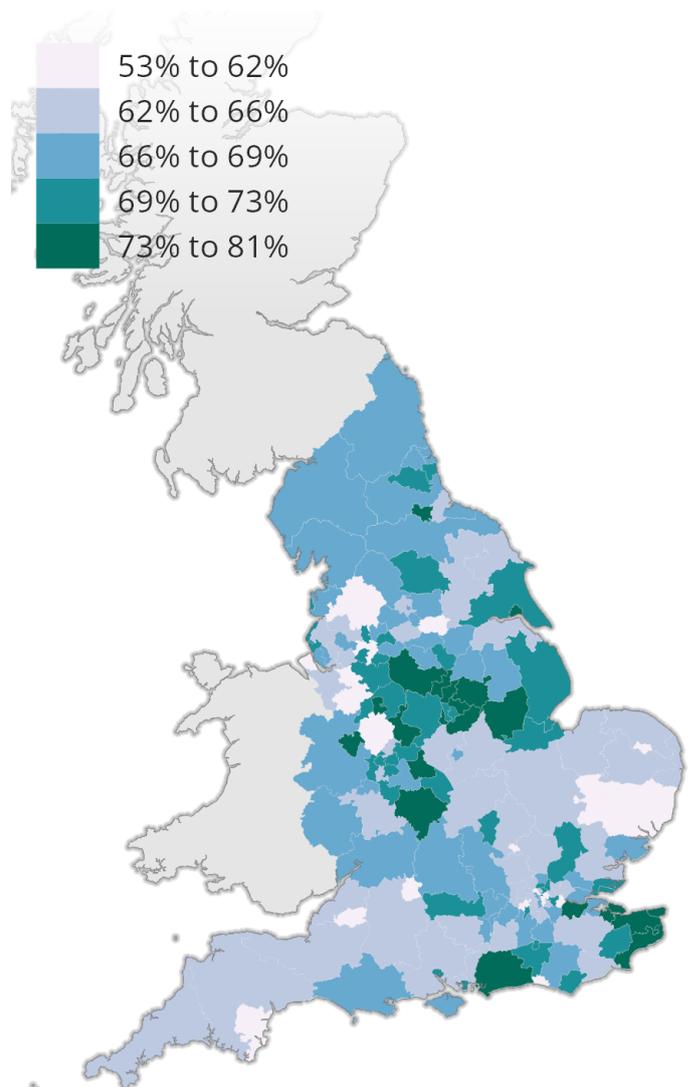
Two-thirds of people experience improvement after IAPT, but this varies in different parts of England and between social groups.

The NHS in England plans to spend **£13 billion** on mental health services in 2019/20 - 14% of local NHS funding allocations.

See the full briefing paper for more information and data sources

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1. How widespread are mental health problems?

A survey of adult mental health in England has been carried out every seven years. The most recent Adult Psychiatric Morbidity Survey was carried out in 2014. In addition, a survey of Children and Young People's Mental Health was carried out in 2017. The results give a national and regional picture of the nation's mental health, but don't contain information for local areas such as constituencies or local authority areas. However, some local estimates of adult depression and anxiety prevalence from the GP Patient Survey are also explored below.

1.1 Depression, anxiety and other common mental disorders

'Common mental disorders' (CMD) include different types of depression and anxiety, panic disorder, phobias, and obsessive-compulsive disorder. **One in six people aged 16+ reported having symptoms of a common mental disorder in the week before being surveyed**.[1]

The following chart shows an age and gender breakdown of CMD symptoms. CMDs are more common among women than men in every age category. This difference is most pronounced among those aged between 16 and 24.

Common mental disorder in the last week
Prevalence (%) by age and gender; England, 2014
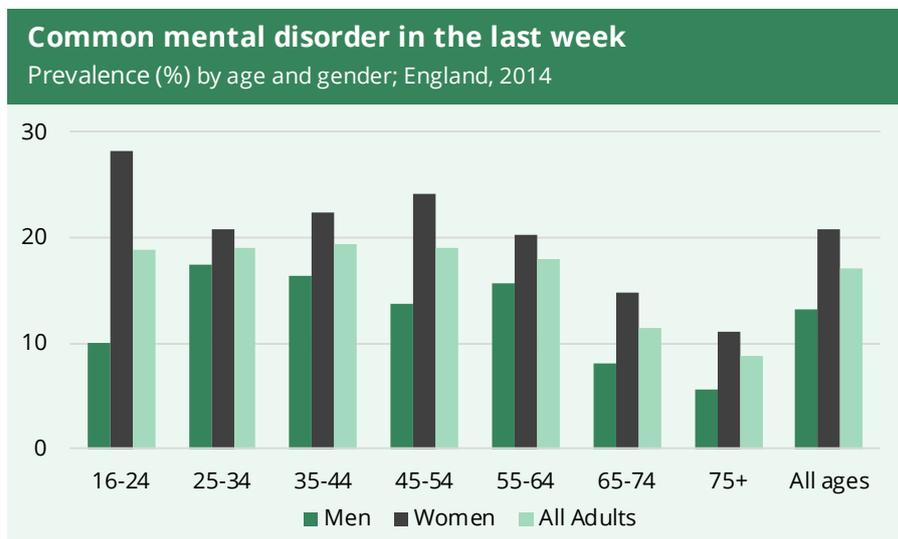
Trends in common mental disorders
CMDs have become more widespread since 1993, as the chart on the following page shows. Prevalence has risen by around one-fifth in both

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[1] NHS Digital, APMS, Common Mental Disorders

men and women. The gender gap has not changed substantially since 1993.

Common mental disorder in the last week
Trends 1993-2014
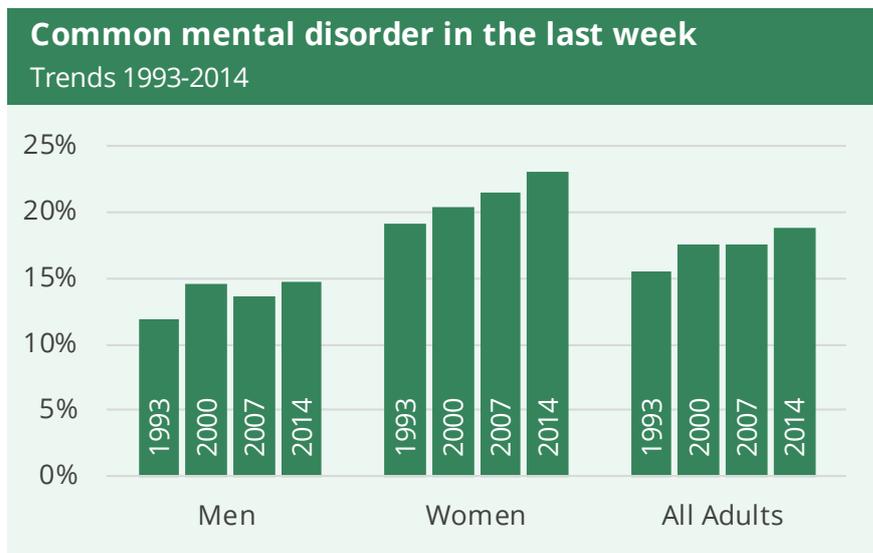
Types of common mental disorder

Generalised anxiety disorder was the most commonly identified CMD in 2014, followed by depressive episodes. Note that a large portion of CMD symptoms were not attributed to a specific disorder – these are captured under 'Other or not specified' below. Since a person can have more than one CMD, these figures sum to more than the total prevalence (17%) of CMDs.

People reporting common mental disorders in the last week
England, 2014

Generalised anxiety disorder	5.9%
Depressive episode	3.3%
Phobias	2.4%
Obsessive compulsive disorder	1.3%
Panic disorder	0.6%
Other or not specified	7.8%
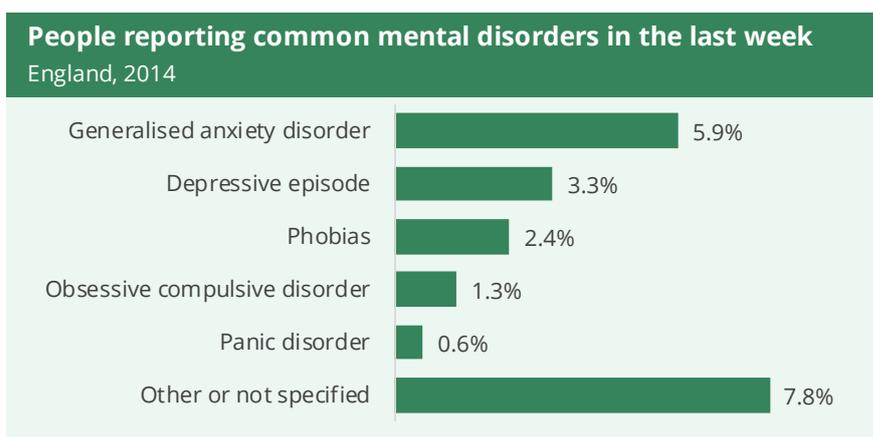
Common mental disorders by ethnicity

Prevalence of CMDs varied by ethnicity, as the chart below shows. Those identifying as Black were more likely than average to have experienced a CMD in the last week, with non-British people identifying as White people less likely. This data is adjusted to account for the different age structures of populations in different ethnic groups.

People reporting a CMD in the last week by ethnicity
England 2014, age-standardised

White British	17%
White Other	14%
Black & Black British	23%
Asian & Asian British	18%
Mixed & other	20%
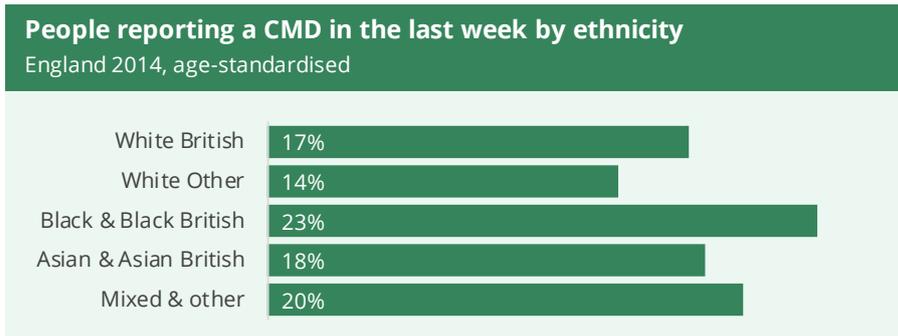
Common mental disorders by employment status

Economically inactive and unemployed people were substantially more likely to have experienced a CMD in the last week than those who are in work. Those who work part-time were slightly more likely than those who work full-time to have experienced a CMD recently.

**People reporting a CMD in the last week by employment status**
England 2014, age-standardised

Economically inactive	33%
Unemployed	29%
Employed part-time	16%
Employed full-time	14%
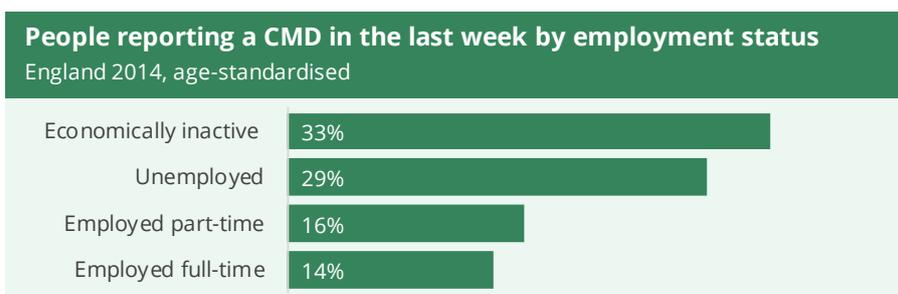
Common mental disorders by region

Those in the South West of England were the most likely to have experienced a CMD in the last week, after accounting for age differences between regions. CMDs were least common in the South East and East of England.

People reporting a CMD in the last week by English region
2014, age-standardised

South West	21%
North West	19%
West Midlands	18%
London	18%
East Midlands	17%
Yorkshire & the Humber	17%
North East	16%
East of England	14%
South East	14%
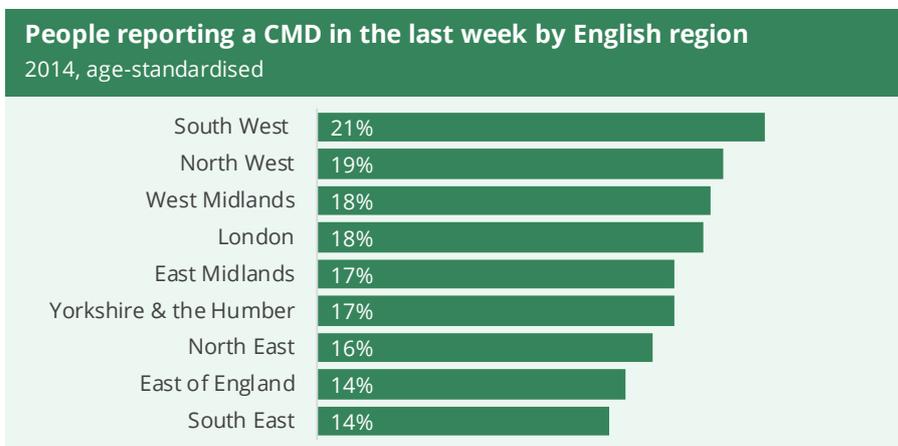
Local prevalence estimates from the GP patient survey

As part of the GP patient survey, patients are asked about the state of their health. This includes a question asking patients to say which of a list of long-term conditions they have. The table and map below shows the percentage of respondents who said that they had a mental health problem.

This is not the only estimate of mental health prevalence made through GP data. The Quality and Outcomes Framework includes data on the proportion of patients diagnosed with depression by their GP. However, as Public Health England note, it's estimated that 50% of patients attending GPs with depressive disorders do not have their symptoms recognised.

Note that this is a measure of self-reported mental ill health and not diagnosis of clinical cases, and that it is not age-standardised.

People saying they have a mental health problem	
GP patient survey, age 18+	
HIGHEST RATES	
Norwich	15.2%
Blackpool	14.6%
Scarborough and Ryedale	13.8%
North East Lincolnshire	13.8%
Brighton And Hove	13.8%
Knowsley	13.6%
Liverpool	13.6%
Southampton	13.5%
Wirral	13.4%
Newcastle Gateshead	13.4%
LOWEST RATES	
Newham	5.6%
Harrow	5.8%
Merton	5.9%
Redbridge	6.0%
Brent	6.2%
Hounslow	6.2%
Barnet	6.3%
Luton	6.3%
Ealing	6.4%
Hillingdon	6.6%

Percentage of adults who say they have a mental health problem

England, GP Patient Survey, 2019

Under 7.7%
7.7% to 9.5%
9.5% to 10.8%
10.8% to 12.3%
Above 12.3%
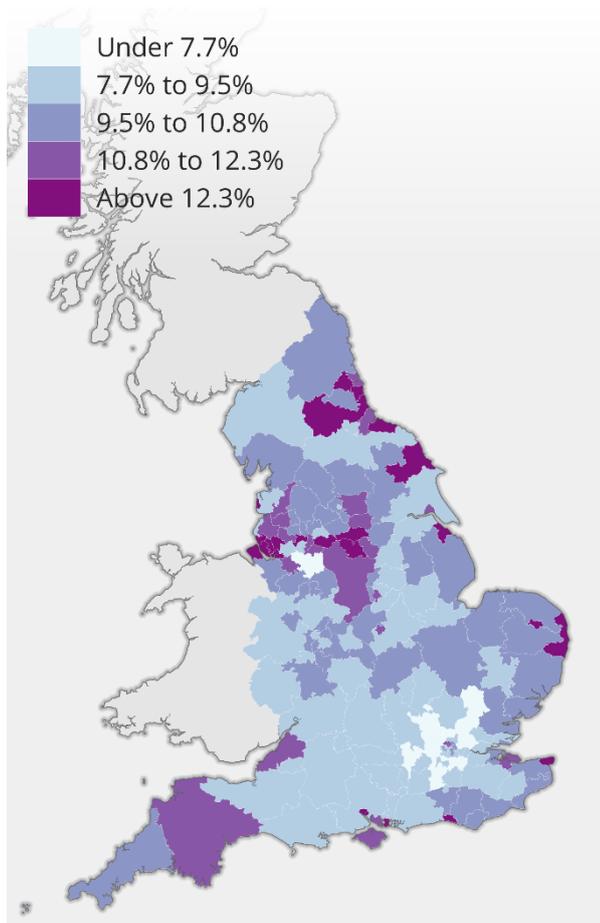
1.2 Post-traumatic stress disorder

After a traumatic event, some people develop post-traumatic stress disorder (PTSD), which often involves "flashbacks, nightmares, avoidance, numbing and hypervigilance".[2]

In the 2014 Adult Psychiatric Morbidity Survey, 3.7% of men and 5.1% of women screened positive for PTSD. Women aged 16-24 were most likely to screen positive (12.6%). Ages 55-64 was the only category where men were more likely to screen positive than women.

1.3 Bipolar disorder

Bipolar disorder, also known as 'manic depression', involves swings between problematic depression and mania. In the survey, screening positive for bipolar disorder involved reporting at least seven characteristics of the disorder, having experienced several at the same time, and reporting that this caused moderate to serious problems.[3]

Around 2% of adults screened positive for bipolar disorder. There was only a small gender difference, with rates among men being slightly higher. The highest rates among women were found in ages 16-24. For men, rates were around 3% for age groups between 16 and 44.

The survey found that bipolar disorder was most common in the East Midlands and the East of England, and lowest in Yorkshire & the Humber and the West Midlands. These figures take account of age differences between regions.

Screened positive for bipolar disorder, by age and gender
England, 2014
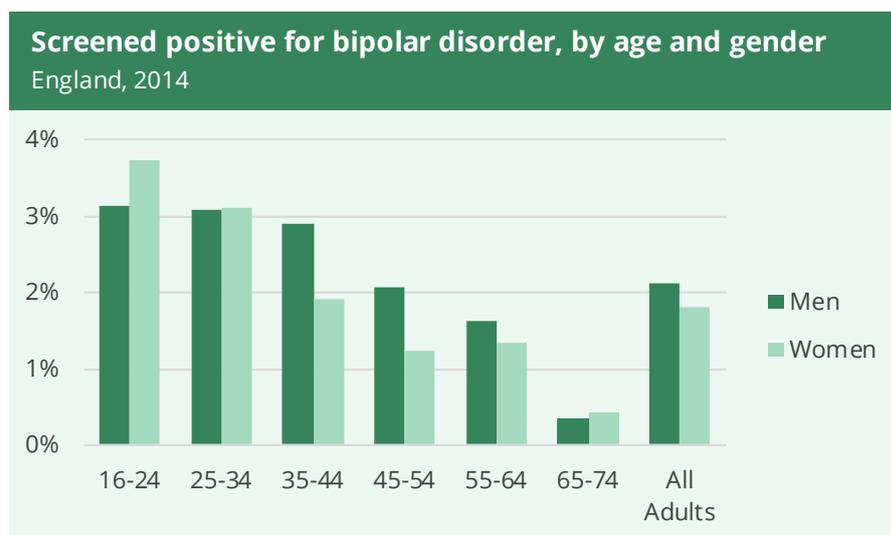
[2] NHS Digital, APMS, Post-Traumatic Stress Disorder
[3] NHS Digital, APMS, Bipolar disorder

Screened positive for bipolar disorder, by region
England, age-standardised, 2014

East Midlands	2.8%
East of England	2.7%
London	2.3%
South West	2.3%
North East	1.9%
South East	1.6%
North West	1.6%
West Midlands	1.4%
Yorkshire & the Humber	1.1%
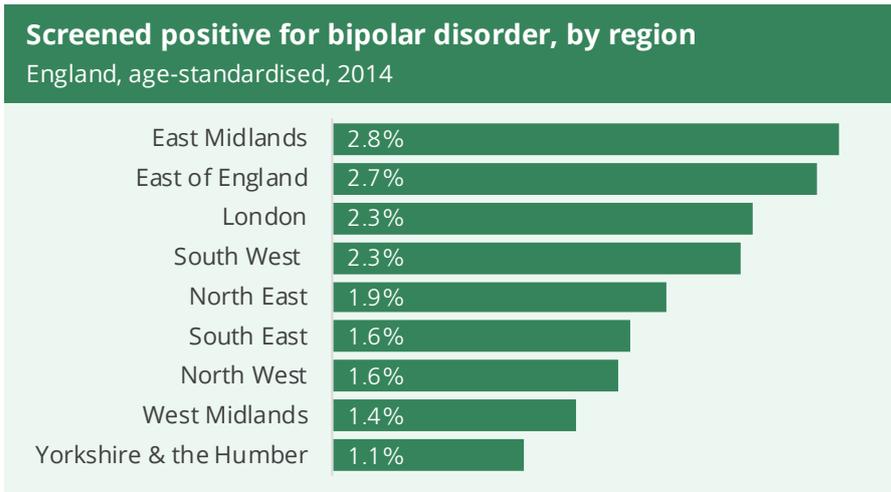
1.4 Psychotic disorder

The main types of psychotic disorder are schizophrenia and affective psychosis.

In the survey, 0.7% of people were assessed as having experienced psychotic disorder in the past year. This is an increase from 0.4% in 2007. The survey report notes that while this appears to be a significant increase, it is nevertheless "consistent with a continued trend of broad stability".[4]

There was no significant difference between rates in men and women.

Psychotic disorder in the last year, by gender
England, 2007-2014

	Men	Women	All adults
2007	0.3%	0.5%	0.4%
2014	0.7%	0.7%	0.7%
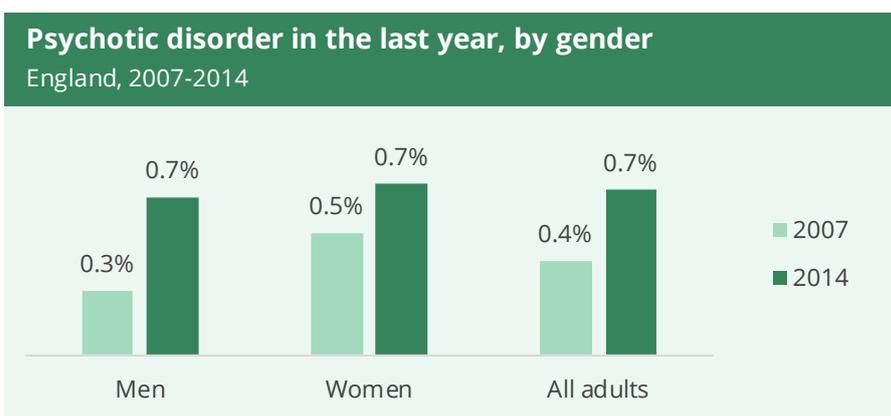
1.5 Suicidal thoughts and self-harm

The survey included questions on suicidal thoughts, self-harm and suicide attempts. As the report notes, these are "strongly associated with mental health problems".[5]

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[4] NHS Digital, APMS, Psychotic disorder
[5] NHS Digital, APMS, Suicidal Thoughts

- 5.4% of people surveyed reported having suicidal thoughts in the past year. This is an increase from 3.8% in 2000.

- 6.4% reported having ever self-harmed, up from 2.4% in 2000.

- 0.7% reported having attempted suicide in the past year. This rate has increased slightly since 2000.

Prevalence of suicidal thoughts, attempts and self-harm
England, 2000-2014
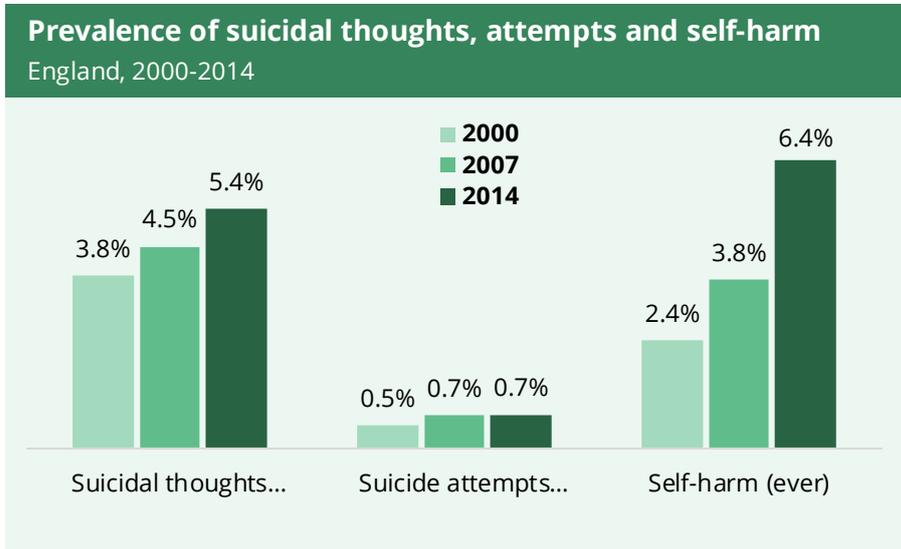
Some groups saw larger increases in suicidal thoughts and suicide attempts over the period – e.g. people aged 55-64. Among women, suicidal thoughts in the past year were most common among those aged 16-24 (10%). Among men, rates were similar in 16-24s and 25-34s (6-7%).

Suicidal thoughts in the last year, by gender and age
England, 2014
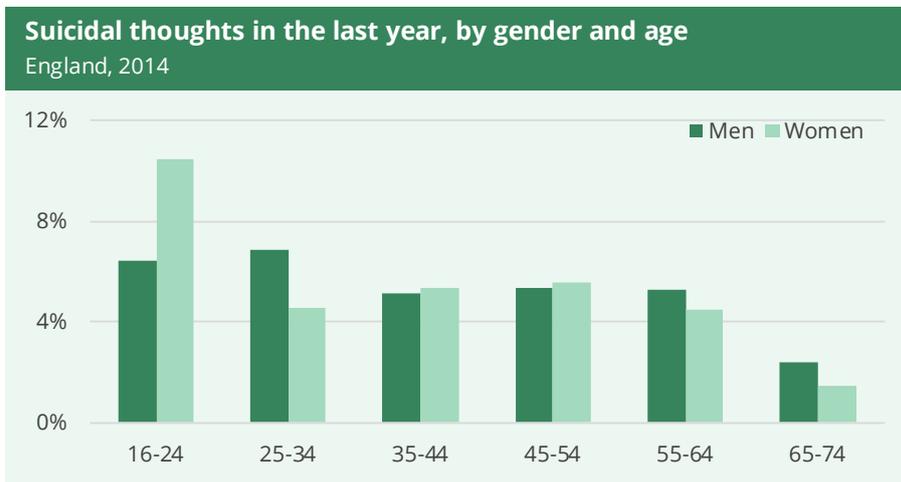
Women aged 16-24 were much more likely to report having ever self-harmed than any other age group, with almost 20% reporting self-harm. Among men, those aged 25-34 were most likely to report self-harm (10%). According to NHS data, there were just over 100,000 hospital admissions due to intentional self-harm in 2017/18.

Self-harm ever, by gender and age
England, 2014

Chart: bar chart showing percentage who have ever self-harmed, by gender and age group (England, 2014), with Men and Women series across age groups 16-24, 25-34, 35-44, 45-54, 55-64, 65-74.
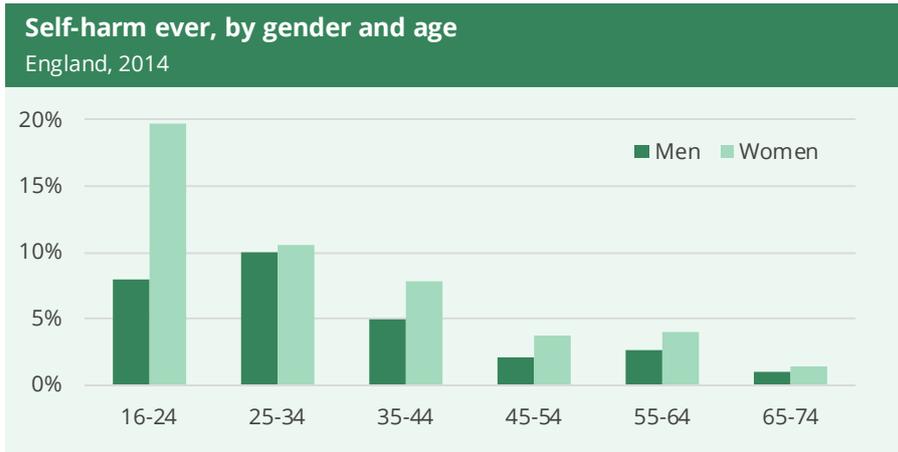
More data on suicide is available from the Office for National Statistics.

1.6 Mental health and physical health

People with mental health problems often also have physical health problems. The presence of multiple health problems in a single individual is known as 'comorbidity'.

The survey found an association between mental health and physical health. 37.6% of people with severe symptoms of common mental disorders reported having also having one of high blood pressure, asthma, cancer, epilepsy or asthma. By contrast, 25.3% of those with no or few symptoms of CMDs reported one of these health conditions.

People with severe symptoms of a CMD were twice as likely to have asthma than those with no or few symptoms.

1.7 Children and young people's mental health

The 2017 survey on children and young people's mental health found that 12.8% of those between ages 5 and 19 had at least one mental disorder. Among ages 5-10, disorders were more common among boys (12.2%) than girls (6.6%). Among ages 17-19, girls had higher prevalence (23.9%) than boys (10.3%). Among ages 11-16 there was little gender gap.

Boys were found to be more likely to have behavioural and hyperactivity disorders than girls, while girls were more likely to have emotional disorders (e.g. anxiety and depression) than boys.

Children whose households were receiving low income benefits were almost twice as likely to have a mental disorder (18.2%) as those who were not (9.8%). Children in a household where an adult with parental responsibility was receiving disability benefits were three times as likely to have a mental disorder (31.8%) as those who were not (9.8%).

Trends over time can be measured among the 5-15 age group which was also surveyed in 1999 and 2004. Between 1999 and 2017, prevalence of mental disorders has risen from 13.1% to 14.2% among boys, and 9.6% to 13.0% in girls.

2. People in contact with NHS mental health services

NHS Digital publishes statistics on NHS-funded mental health and learning disability services, showing the number of people in contact with services and many other details. These figures do not include people who are only in contact with Improving Access to Psychological Therapies (IAPT) services – see section 3 below for details on IAPT.

It's estimated that 2.73 million people were in contact with NHS-funded secondary mental health, learning disability and autism services at some point during 2018/19.[6] This includes 2.09 million adults and 632,000 children. This means that around 1 in 21 people in England were in contact with these services at some point during the year.

2.1 Age and gender

The age groups most likely to be in contact with NHS-funded mental health, learning disability and autism services are 11-19 and 80+. While rates are lowest among those aged 30-69, people in this age group who *are* in contact with services are more likely to be admitted as an inpatient.

Contact with mental health and learning disability services By age group, 2018/19

Age group	Total in contact with services		Admitted only	
	% of population	Number	% of all in contact	Number
Total	**5%**	**2,723,501**	**4%**	**103,968**
0 to 5	1%	37,159	0%	79
6 to 10	5%	163,391	0%	137
11 to 15	9%	293,434	0%	1,401
16 to 19	9%	234,363	2%	4,922
20 to 29	5%	398,649	5%	20,292
30 to 39	4%	336,322	6%	21,264
40 to 49	4%	283,645	6%	16,983
50 to 59	4%	262,833	6%	14,825
60 to 69	3%	166,010	5%	9,092
70 to 79	4%	205,655	4%	8,536
80 to 89	11%	256,930	2%	5,421
90 or over	17%	85,110	1%	1,016

[6] NHS Digital, Mental Health Services Bulletin, 2018/19

Women are slightly more likely to be in contact with mental health and learning disability services than men (5.0% of women and 4.7% of men). The gender gap peaks among older teenagers. Boys aged 10 or under are more likely than girls to be in contact with services. There is little gender gap among those aged over 30.

2.2 Ethnicity

Those identifying as Asian or Asian British are 14% less likely than average to be in contact with mental health and learning disability services. Those identifying as Black or Black British are 20% more likely than average to have accessed services in 2018/19.[7]

2.3 Variation between local authority areas

10.8% of the adult population of Preston were in contact with mental health, learning disability and autism services at some point during 2018/19 – the highest rate in the country. The lowest recorded figure was 2.5% of the population, in Mid Suffolk. Among children, the percentage varied from 10.4% in South Tyneside to 1.8% in Leeds.

Population in contact with mental health, learning disability and autism services
% in contact with services during 2018/19 compared with mid-2018 population estimates

| HIGHEST - Adults		HIGHEST - Children	
Preston	10.8%	South Tyneside	10.4%
Manchester	10.2%	Hartlepool	10.0%
Kingston upon Hull	9.6%	Thanet	10.0%
Blackpool	8.2%	Sunderland	9.7%
Hyndburn	7.8%	Redcar and Cleveland	9.5%
Lancaster	7.7%	Blackpool	9.1%
Burnley	7.6%	Folkestone and Hythe	9.0%
Chorley	7.3%	County Durham	8.9%
Blackburn with Darwen	7.2%	Dover	8.7%
Rossendale	7.1%	Telford and Wrekin	8.5%
LOWEST - Adults		**LOWEST - Children**	
Mid Suffolk	2.5%	Leeds	1.8%
Suffolk Coastal	2.6%	North Somerset	2.4%
Hart	2.8%	Hillingdon	2.6%
South Gloucestershire	2.9%	Forest Heath	2.7%
Vale of White Horse	2.9%	Harrow	2.7%
Lambeth	2.9%	Leicester	2.9%
South Cambridgeshire	3.0%	Redbridge	2.9%
Uttlesford	3.0%	Barking and Dagenham	3.0%
East Cambridgeshire	3.0%	Croydon	3.1%
Tewkesbury	3.0%	Westminster	3.1%

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[7] These figures are age-standardised, which means that they take into account the varying age structures of different ethnicity groups.

Note that differing rates here do not necessarily just reflect variation in need for services or in the prevalence of mental health problems – they are likely to also reflect the nature and extent of mental health service provision in different areas.

Proportion of the population in contact with mental health, learning disability and autism services during 2018/19

Adults

England, NHS Digital

Under 3.8%
3.8% to 4.8%
4.8% to 5.8%
5.8% to 8.2%
Over 8.2%
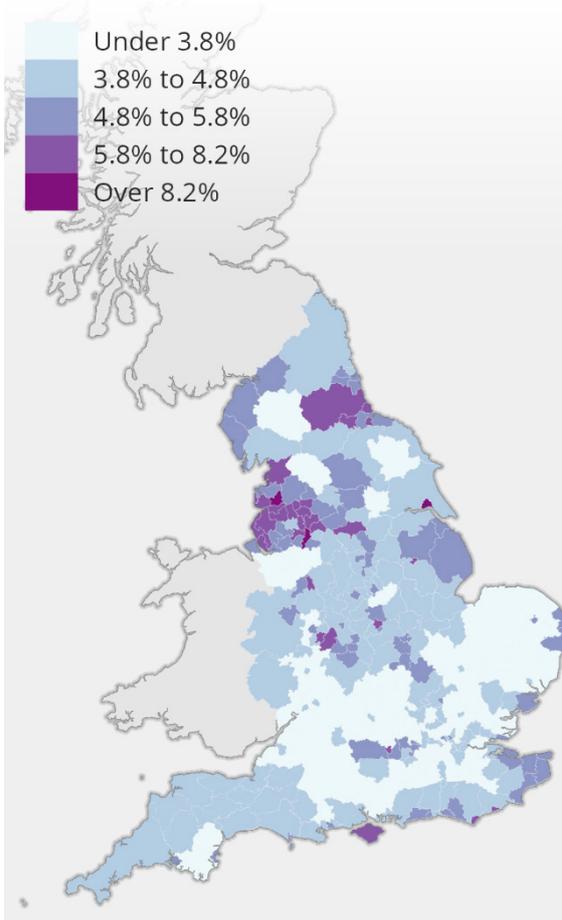
Children

England, NHS Digital

Under 3.8%
3.8% to 4.8%
4.8% to 6.0%
6.0% to 7.6%
Over 7.6%
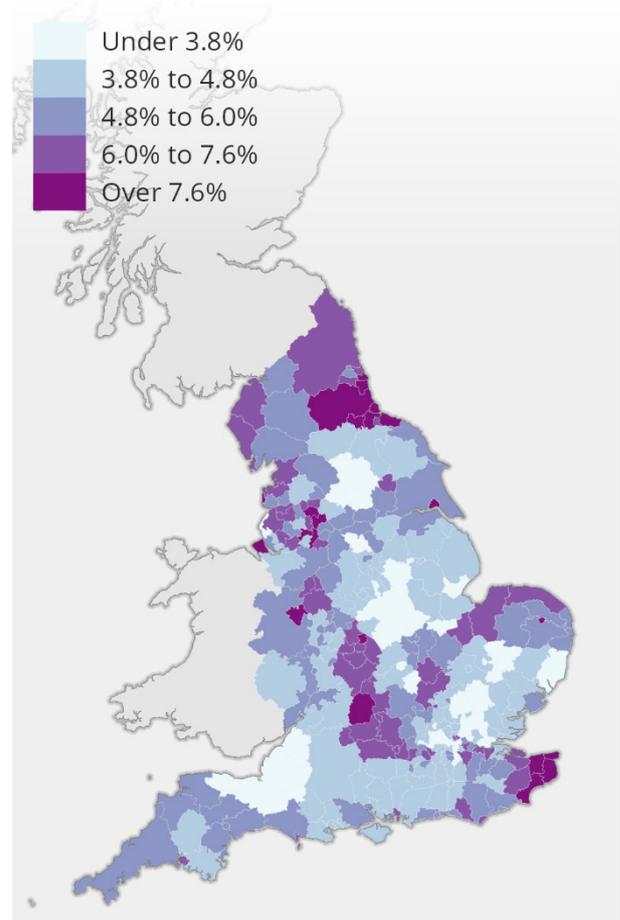
Data: NHS Digital, Mental Health Bulletin 2018/19; ONS Mid-Year Population Estimates 2018

Waiting times

Waiting times aren't routinely collected or published for NHS secondary mental health, learning disability and autism services. Some specific services, like IAPT and Early Intervention in Psychosis, have waiting time targets and associated data publications. These are outlined below. However, for many service contacts, no official data is available on how long patients wait between referral and treatment.

3. IAPT: talking therapies for depression and anxiety

The [Improving Access to Psychological Therapies](#) (IAPT) programme was launched in 2008 to improve the quality and accessibility of mental health services in England. Its focus is on therapies like [cognitive behavioural therapy](#), counselling and self help support – collectively known as 'talking therapies' – for working-age people experiencing common mental health problems such as anxiety and depression. People can be referred to IAPT by their GP, or they can self-refer.

The recent [Five Year Forward View for Mental Health](#) set out the ambition that access to psychological therapies should be expanded to 350,000 more adults each year by 2020/21. IAPT currently aims to reach 15% of those with common mental health problems every year – the aim is to increase this to 25%.

3.1 National data on talking therapies

Referrals and treatments

In 2018/19 there were **1.6 million** referrals to talking therapy through the Improving Access to Psychological Therapies (IAPT) programme in England.[8] This amounts to 3.5 referrals for every 100 people in England aged 16 or over - around 11% higher than the previous year.

1.09 million referrals entered treatment in 2018/19 – 8% higher than in 2017/18. 1.5 million referrals ended, of which 582,000 had finished a course of treatment.[9] 473,000 referrals ended before treatment.

Waiting times

Of those finishing a course of treatment, **89.4% waited less than 6 weeks to enter treatment - above the target of 75%**. 99% waited less than 18 weeks - above the target of 95%. The average waiting time to enter treatment was 20 days, and the average time between first and second treatment was 49 days. However, this this varied substantially across the country. For first treatment, waiting times varied from a low of 4 days in Basildon & Brentwood to 61 days in Manchester. Further information on waiting times for local areas is given below in section 3.3.

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[8] [NHS Digital, Psychological Therapies, Annual report on the use of IAPT services 2018-19](#)

[9] In order to count as finishing a course of treatment, a referral must involve more than two treatment appointments. So those who had only one treatment appointment would count as having entered treatment, but not as having finished a course of treatment.

Outcomes: Recovery and Improvement

Around two-thirds of people see an improvement in their condition after finishing IAPT therapy. NHS England has a target that 50% of those finishing a course of treatment should 'move to recovery', meaning that the patient has moved from having a clinical case of depression or anxiety to not having a clinical case. In 2018/19, 52.1% of those finishing a course of treatment moved to recovery, up from 50.8% in 2017/18.

Recovery rates were higher for anxiety related disorders (54.2%) than depression (50.3%). The conditions with the lowest recovery rates were agoraphobia (39.8%), post-traumatic stress disorder (41.8%), and social phobias (43.5%). This may reflect varying average severities of clinical cases between different conditions – if a person has a more severe clinical condition, then even an improvement after therapy may not result in them crossing the threshold to not being a clinical case.

## 3.2 Age, gender, ethnicity and other characteristics

Age and Gender

65% of those referred to IAPT are women. Women outnumbered men among IAPT referrals in every local CCG area in England in 2018/19. The areas with the highest gender imbalance in referrals were all in the south of England, while those closer to a balanced gender profile were generally in the north of England. Bradford City CCG had the highest proportion of men, at 40.8%.

Referral rates to IAPT are highest among those aged 18-35, with 60 referrals per 1,000 population. Among those aged 36-64, 32 per 1,000 were referred to IAPT in 2018/19, along with 10 per 1,000 of those aged 65 and over. The 18-35 age group has also seen the largest increase in referrals over the past 3 years.

IAPT referrals and treatments by age and gender, 2018/19

Age group	Number of Referrals	Referrals per 1,000 population	Entering Treatment			Finishing Treatment		
			Total	Female	Male	**Total**	Female	Male
16 to 17	31,444	26	**63%**	62%	63%	**20%**	22%	18%
18 to 35	795,315	60	**64%**	65%	63%	**33%**	34%	31%
36 to 64	669,941	32	**72%**	73%	72%	**40%**	41%	40%
65 and over	104,347	10	**75%**	75%	75%	**40%**	40%	40%

Those aged 18-35 are less likely to start treatment after referral and less likely to finish a course of treatment than older age groups. 64% of those referred aged 18-35 entered treatment, and 33% finished
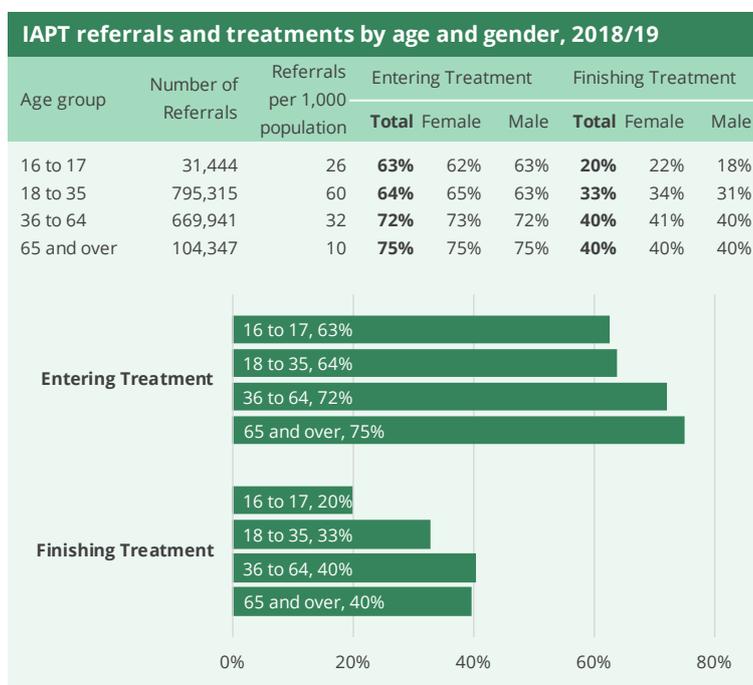
treatment, compared to 72% and 40% respectively for those aged 36 to 64.[10]

In most age groups, women are slightly more likely than men to enter treatment after referral and to finish a course of treatment.

Those in older age groups are more likely to recover after therapy and more likely to see improvement in their condition after therapy. As the table below shows, those aged 65+ were most likely to move to recovery (66%) and have their condition reliably improve (70%), while those aged 16 to 17 were least likely (46% and 60% respectively).

Men were slightly less likely to see improvement in their condition after therapy than women, but slightly more likely to move to recovery. This likely indicates that men's conditions were on average less severe than women's.

Improvement and recovery after IAPT by gender and age						
Age group	Moved to Recovery			Reliably Improved		
	Total	Female	Male	Total	Female	Male
16 to 17	46%	44%	51%	60%	60%	61%
18 to 35	49%	49%	50%	66%	67%	66%
36 to 64	53%	53%	54%	68%	69%	68%
65 and over	66%	65%	67%	70%	71%	69%

IAPT referrals and outcomes by deprivation decile, 2018/19					
Deprivation decile	Referrals per 1,000 16+ population	Entering treatment	Finishing treatment	Reliably improved	Moved to recovery
1: MOST DEPRIVED	51.3	62%	47%	63%	43%
2	44.4	65%	49%	65%	47%
3	40.1	66%	51%	67%	50%
4	37.5	67%	54%	67%	51%
5	34.1	69%	55%	68%	53%
6	32.2	70%	56%	69%	54%
7	30.3	71%	57%	69%	55%
8	29.4	72%	56%	69%	56%
9	27.8	73%	57%	70%	58%
10: LEAST DEPRIVED	25.5	74%	59%	70%	58%

Deprivation

Demand for IAPT services is higher in deprived areas. People living in the most deprived areas of England were twice as likely to be referred to IAPT as those living in the least deprived areas in 2017/18. However, a

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[10] Note that some of those entering or finishing a course of treatment may have been referred in 2017/18 rather than 2018/19, so the percentage comparisons are not exact. However, they do give an impression of variation between different groups.

lower percentage of those referred from the most deprived area entered treatment and finished treatment compared with the least deprived areas.

People in the least deprived areas were more likely to experience improvement in their condition and more likely to move to recovery after treatment. 70% of those living in the least deprived areas saw improvement after therapy, compared with 63% of those in the most deprived areas. 58% of those living in the least deprived areas moved to recovery, compared with 43% of those in the most deprived areas. The deprivation gap is larger for recovery than for improvement, perhaps indicating that people in more deprived areas have more severe conditions on average than those in less deprived areas.

People in more deprived areas are less likely to experience improvement or recovery after IAPT

Least deprived areas	Improved, 70%
	Moved to Recovery, 58%
Most deprived areas	Improved, 63%
	Moved to Recovery, 43%
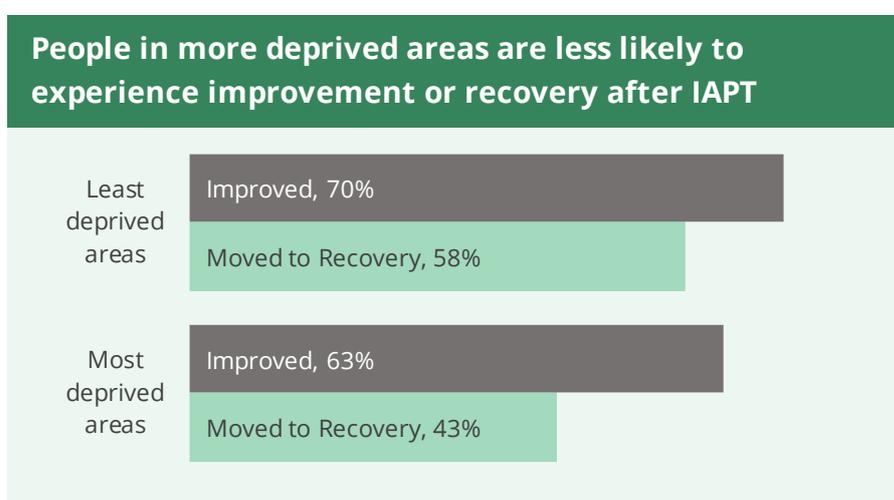
Ethnicity

Information on self-declared ethnicity was collected for around 87% of those referred to IAPT in 2018/19. Around 86% of those with a known ethnicity identified as White.

IAPT: referrals and outcomes by ethnicity, 2018/19

Ethnicity	Referrals	Entering Treatment	Finishing Treatment	Improved	Moved to recovery
Asian or Asian British	77,697	75%	36%	64%	47%
Black or Black British	47,254	73%	34%	66%	49%
Mixed	38,296	70%	34%	65%	47%
Other Ethnic Groups	24,207	73%	35%	64%	46%
White	1,198,827	73%	41%	68%	53%

Those identifying as White were more likely (41%) to complete a course of treatment after referral than those of other ethnicities (34%-46%).

Of people finishing a course of treatment, those identifying as White were more likely to move to recovery and to see an improvement in their conditions than those of other ethnicities. 53% of those identifying as White moved to recovery, compared with 47% of those

identifying as Asian or Asian British. Meanwhile 68% of those identifying as White reliably improved, compared with 64-65% in the other ethnic groups.

Disability

Around 11% of those referred to IAPT in 2018/19 reported a disability. They were less likely to improve or recover after IAPT therapy than those without a disability. 61% of those with a disability improved after treatment compared with 68% without a disability, while 42% of those with a disability moved to recovery compared to 55% without a disability.

Those with a hearing disability had recovery and improvement rates similar to people with no disability. The lowest outcomes were for people with perception of physical danger disabilities – 53% of these reliably improved and 31% moved to recovery.

People with a disability are less likely to experience improvement or recovery after psychological therapy			
Disability	Number of referrals	Reliably improved	Moved to recovery
Any recorded disability	**176,422**	**61%**	**42%**
Behaviour and Emotional	22,327	61%	40%
Hearing	14,453	66%	52%
Manual Dexterity	3,600	62%	41%
Memory or ability to concentrate, learn or understand[a]	21,376	61%	42%
Mobility and Gross Motor	54,218	61%	39%
Perception of Physical Danger	844	53%	31%
Personal, Self Care and Continence	2,802	55%	34%
Progressive Conditions and Physical Health[b]	10,606	63%	43%
Sight	7,660	64%	47%
Speech	2,326	62%	45%
Other	36,210	61%	42%
No Disability	**29,253**	**68%**	**55%**
No data	*1,425,944*	*68%*	*53%*

a Learning disability
b Such as HIV, cancer, multiple sclerosis, fits etc

Note that there were relatively few referrals where "no disability" was specifically recorded. The much larger group is "no code recorded", which makes up most of the 'no data' row above. This has similar improvement and recovery rates to the 'no disability' category, suggesting many people without a disability had no code recorded.

Religion

Information on religion was collected for around two-thirds of referrals. Those identifying as Jewish and Christian were more likely to recover after IAPT treatment than other religious groups. Those identifying as Muslims were least likely to experience improvement after IAPT therapy.

IAPT referrals and outcomes by religion, 2018/19			
Religion	Number of referrals	Reliably improved	Moved to recovery
Christian	311,858	70%	56%
Muslim	44,740	61%	43%
Other	33,920	67%	52%
Hindu	8,473	67%	52%
Sikh	7,087	68%	52%
Buddhist	4,319	67%	51%
Jewish	3,743	66%	57%
Pagan	2,159	66%	46%
No religion	*620,811*	*68%*	*52%*
Unknown	*566,075*	*65%*	*51%*

Sexual Identity

Information on sexual identity was collected for just under two-thirds of those referred to IAPT. Around 3% of those referred to IAPT in 2016/17 identified as gay or lesbian, with a further 3% identifying as bisexual.

Those identifying as heterosexual were more likely to recover after IAPT therapy than any other group. Those identifying as bisexual were less likely to show improvement after IAPT than other groups. There was little difference on this measure between those identifying as heterosexual and those identifying as gay or lesbian.

IAPT referrals and outcomes by sexual identity			
Sexuality	Number of referrals	Reliably improved	Moved to recovery
Heterosexual	1,016,396	68%	53%
Gay/Lesbian	32,518	67%	49%
Bi-sexual	32,121	64%	43%
Unknown	522,608	66%	51%

3.3 Waiting times: local data

The average waiting time between referral and first IAPT treatment in 2018/19 was 20 days (3 weeks), down from 23 in 2016/17.[11] The

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[11] The figures in this section all refer to waiting times for patients who finished a course of treatment in 2018/19. NHS also publishes data on waits for patients who started a course of treatment in 2018/19.

average waiting time between first treatment and second treatment was 49 days (7 weeks), up from 41 in 2016/17. This gives a total average of 69 days (10 weeks) from referral to second treatment.

The waiting time for first treatment ranged from 4 days in Basildon & Brentwood to 61 days in Manchester, while the total wait from referral to second treatment varied from 22 days in Wakefield to 162 in Heywood, Middleton and Rochdale.

In 90% of CCGs, the average waiting time between a patient's first and second treatments was longer than the average initial wait for treatment. In two-thirds of CCGs, the wait for second treatment was more than twice as long. An extreme example was Bromley, where patients waited 2 weeks on average for their first treatment, and then a further 16 weeks on average between their first and second treatment.

The table below shows the CCG areas with the highest and lowest waiting times in 2018/19, measured as an average number of days waiting. The table shows waits from referral to first treatment, from first treatment to second treatment, and the total wait from referral to second treatment.

Highest and lowest IAPT waiting times, 2018/19
Average number of days waiting

HIGHEST From referral to 1st treatment		HIGHEST Between 1st and 2nd treatment		HIGHEST Total from referral to 2nd treatment	
Manchester	61	Heywood, Middleton & Rochdale	130	Heywood, Middleton & Rochdale	162
Barnet	59	Eastern Cheshire	124	Eastern Cheshire	150
Salford	57	Milton Keynes	118	Milton Keynes	150
East & North Hertfordshire	53	Tower Hamlets	118	Barnet	146
Trafford	48	Bromley	113	Wirral	139
West Leicestershire	46	Wirral	107	Tower Hamlets	136
West Kent	42	Barnsley	105	Barnsley	134
Oldham	41	South Cheshire	99	Bromley	128
Brighton & Hove	41	Redditch & Bromsgrove	99	South Cheshire	126
East Leicestershire & Rutland	39	West Essex	92	Redditch & Bromsgrove	120
LOWEST **From referral to 1st treatment**		**LOWEST** **Between 1st and 2nd treatment**		**LOWEST** **Total from referral to 2nd treatment**	
Basildon & Brentwood	4	East Riding Of Yorkshire	14	Wakefield	22
Southend	4	Hartlepool & Stockton-On-Tees	14	Warrington	23
Castle Point & Rochford	4	Hull	14	Wigan Borough	31
Wakefield	5	South Kent Coast	15	East Berkshire	31
Stoke On Trent	5	Warrington	16	Hartlepool & Stockton-On-Tees	32
Southampton	5	Stafford & Surrounds	17	Bassetlaw	33
Knowsley	5	Cannock Chase	17	Swindon	36
Thurrock	6	Wakefield	18	Brent	36
Wigan Borough	6	Canterbury & Coastal	19	Berkshire West	36
South East Staffordshire	7	South Tees	20	East Riding Of Yorkshire	36

IAPT waits: average wait between referral and first treatment

England, NHS Digital, 2018/19

Under 12 days
12-18 days
18-28 days
28-38 days
Over 38 days
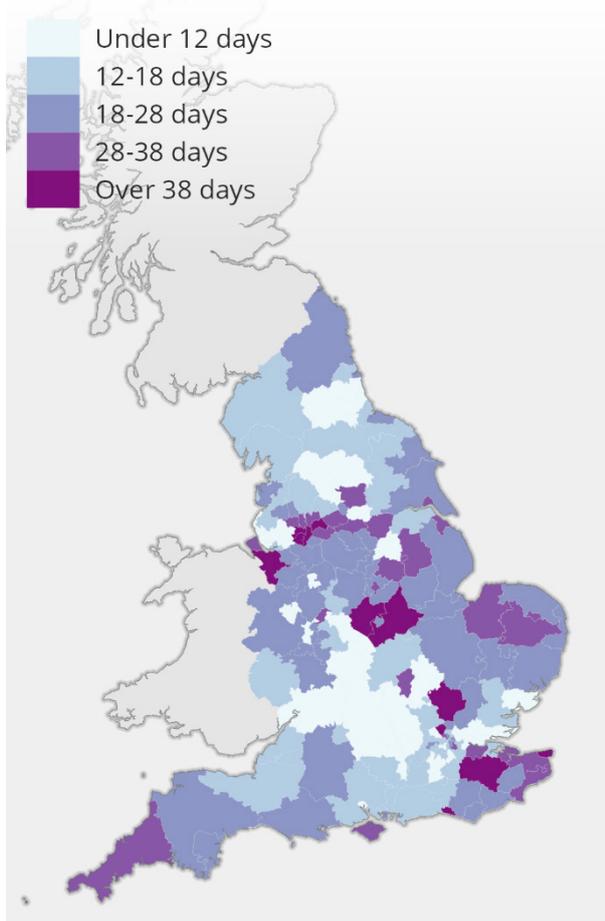
IAPT waits: average wait between referral and second treatment

England, NHS Digital, 2018/19

Under 48 days
48-72 days
72-91 days
91-110 days
Over 110 days
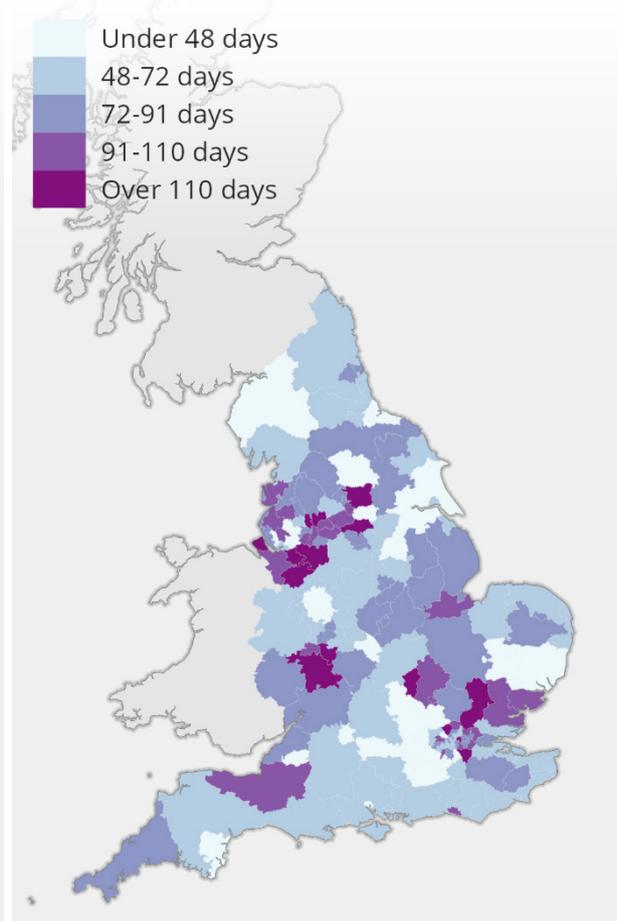
NHS England's two IAPT waiting time targets are that **75% of patients should wait less than 6 weeks** between referral and first treatment and that **95% of patients should start treatment within 18 weeks** of referral. These targets were met nationally, but 19 out of 195 CCGs breached the 6-week target, while five CCGs breached the 18-week target. The lowest performers on each measure are shown below.

Worst IAPT waiting time performance against 6-week and 18-week targets, 2018/19			
Treated in less than 6 weeks	%	Treated in less than 18 weeks	%
Barnet	51%	Salford	84%
Manchester	54%	Manchester	88%
Brighton & Hove	56%	Barnet	89%
West Cheshire	59%	East & North Hertfordshire	92%
Trafford	60%	West Kent	94%
West Leicestershire	60%		
East & North Hertfordshire	61%		
Thanet	62%		

3.4 IAPT outcomes: local data

The proportion of patients improving after IAPT treatment varied from 81% in East Staffordshire and South Kent Coast CCGs to 53% in Swindon CCG.

The proportion of patients moving to recovery after IAPT therapy ranged from 66% in Stoke on Trent to 33% in Wirral. Three quarters of CCGs met the target for 50% of those finishing a course of IAPT to move to recovery.

The percentage of patients showing a deterioration in their condition ranged from lows of 3% (Swale, South Kent Coast, North Staffs, Stoke on Trent) to highs of 9% (St Helens, East Lancs, Newham, Cambridgeshire, and West Cheshire).

There is no relationship between average waiting times and the proportion of patients showing improvement after treatment. However, there is a weak relationship between the total waiting time to second treatment and the percentage of patients who show deterioration of their condition.

The table and maps below show the highest and lowest rates of recovery and improvement.

IAPT outcomes, 2018/19
Percentage of those finishing treatment who moved to recovery, reliably improveed, or reliably deteriorated

HIGHEST % Moved to recovery		HIGHEST % Condition Improved		HIGHEST % Condition Deteriorated	
Stoke On Trent	66%	South Kent Coast	81%	East Lancashire	9%
Rushcliffe	62%	East Staffordshire	81%	St Helens	9%
Portsmouth	61%	Swale	79%	Newham	9%
Sandwell & West Birmingham	60%	Dartford, Gravesham & Swanley	77%	West Cheshire	9%
Telford & Wrekin	60%	Thanet	76%	Cambridgeshire & Peterborough	9%
East Staffordshire	60%	Canterbury & Coastal	76%	Blackburn With Darwen	8%
North Staffordshire	60%	Stoke On Trent	76%	Luton	8%
Buckinghamshire	59%	Darlington	75%	Southwark	8%
Westminster	59%	Mansfield & Ashfield	75%	Greater Preston	8%
City & Hackney	59%	South West Lincolnshire	75%	Manchester	8%

LOWEST % Moved to recovery		LOWEST Condition Improved		LOWEST Condition Deteriorated	
Wirral	33%	Swindon	53%	North Staffordshire	3%
Luton	40%	Vale Royal	57%	Stoke On Trent	3%
Vale Royal	40%	Camden	58%	Swale	3%
Bexley	42%	Wirral	59%	South Kent Coast	3%
Salford	44%	Blackburn With Darwen	59%	Stafford & Surrounds	4%
Wakefield	44%	Wakefield	60%	Cannock Chase	4%
Blackburn With Darwen	45%	Norwich	60%	Hartlepool & Stockton-On-Tees	4%
Manchester	45%	Bath & North East Somerset	60%	East Surrey	4%
Bradford City	45%	Luton	61%	South Tees	4%
Dudley	46%	Salford	61%	Shropshire	4%

IAPT outcomes: patients experiencing improvement

England, NHS Digital, 2018/19

53% to 62%
62% to 66%
66% to 69%
69% to 73%
73% to 81%
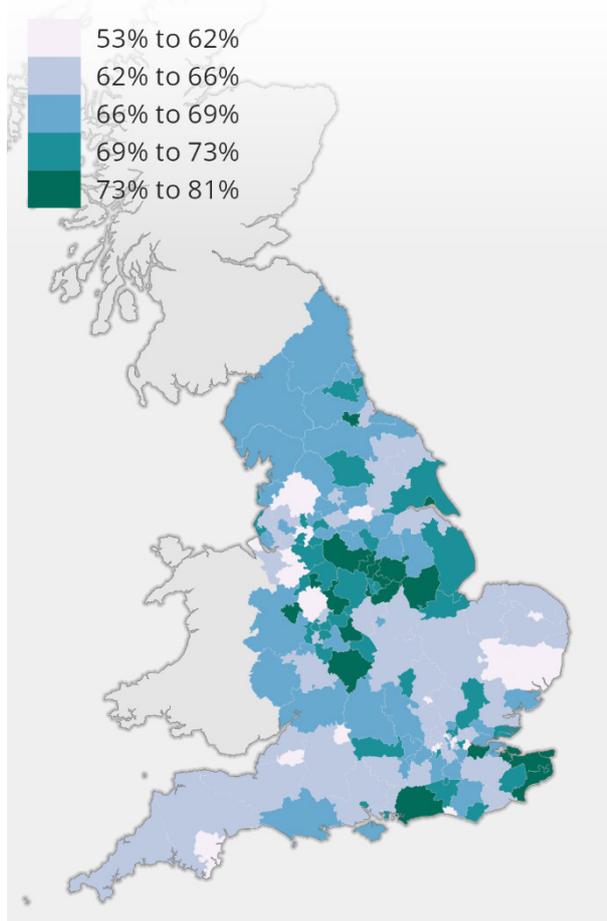
IAPT outcomes: patients moving to recovery

England, NHS Digital, 2018/19

33% to 44%
44% to 49%
49% to 53%
53% to 58%
58% to 66%
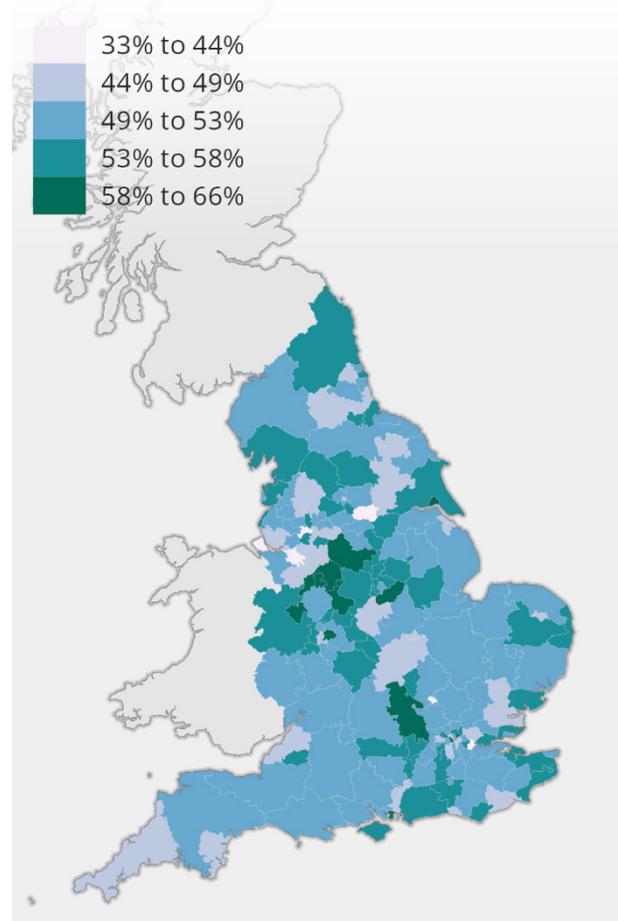
Patient Experience

75% of those completing a patient experience questionnaire after treatment in 2018/19 said that they "got the help that mattered to them at all times".

This varied in different parts of the country. 29% of respondents in Greater Huddersfield said they got the help that mattered to them at all times, compared with 93% in four CCGs in Staffordshire and Warwickshire.[12]

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[12] These figures, and the table below, exclude CCGs which had less than 100 respondents to their patient experience surveys in 2018/19.

Psychological therapies: patient experience
Percentage of patients saying they got the help that mattered to them "at all times" after IAPT treatment in 2018/19

Best (Highest)	%	Worst (Lowest)	%
Cannock Chase	93%	Greater Huddersfield	29%
North Staffordshire	93%	Ipswich & East Suffolk	37%
Warwickshire North	93%	West Essex	39%
SE Staffs & Seisdon Peninsula	93%	West Suffolk	39%
North East Lincolnshire	92%	Mid Essex	40%
South Tyneside	91%	South Norfolk	46%
Bolton	91%	Richmond	47%
Thurrock	91%	Norwich	49%
Basildon & Brentwood	91%	Bath & North East Somerset	50%
Knowsley	90%	North Norfolk	53%

3.5 Other local IAPT data

Demand and referral rates

Demand for IAPT services varies substantially across the country. In 2018/19, there were 35 referrals for every 1,000 people aged 16+ in England as a whole. In some areas, however, referral rates were more than double this. In Salford, the referral rate was 85 per 1,000 people. This is almost 5 times higher than Vale of York, which had the lowest rates at 17.3 per 1,000 population.

Some of the CCGs with the highest demand for IAPT are also those with among the highest waiting times for first treatment. However, outside of these outliers, there is little relationship between demand and waiting times.

Demand for psychological therapies
Referrals per 1,000 population aged 16+, 2018/19

Highest		Lowest	
Salford	86	Vale Of York	17
Manchester	75	Redbridge	17
West Cheshire	70	Herefordshire	19
Oldham	67	Shropshire	19
Bolton	66	Havering	19
Hull	65	Barking And Dagenham	20
Bury	64	South Warwickshire	20
Trafford	60	Hambleton, Richmonds & Whitby	21
Stockport	57	Dartford, Gravesham & Swanley	22
Hartlepool & Stockton-On-Tees	55	SE Staffs & Seisdon Peninsula	22

**Severity of conditions among those referred to IAPT**

When people are referred to IAPT, the severity of a patient's condition is measured. One metric for this is the 'Work and Social Adjustment Scale', which is an assessment of how depression impacts on their ability to perform day-to-day tasks.

The average WSAS score of those starting treatment varies in different parts of the country, as the map to the right shows. This may indicate that mental health problems are more severe in some parts of the country than others, but this is not the only interpretation. A higher average WSAS score among referrals in an area may instead mean that those with only moderate conditions are less likely to seek help in that area.

WSAS is also measured after treatment in order to gauge improvement in the patient's condition.

IAPT referrals: average WSAS score (work and social adjustment)

England, NHS Digital, 2018/19

16 to 18
18 to 20
20 to 21
Over 21
No data

Scores over 20 suggest 'moderately severe psychopathology'
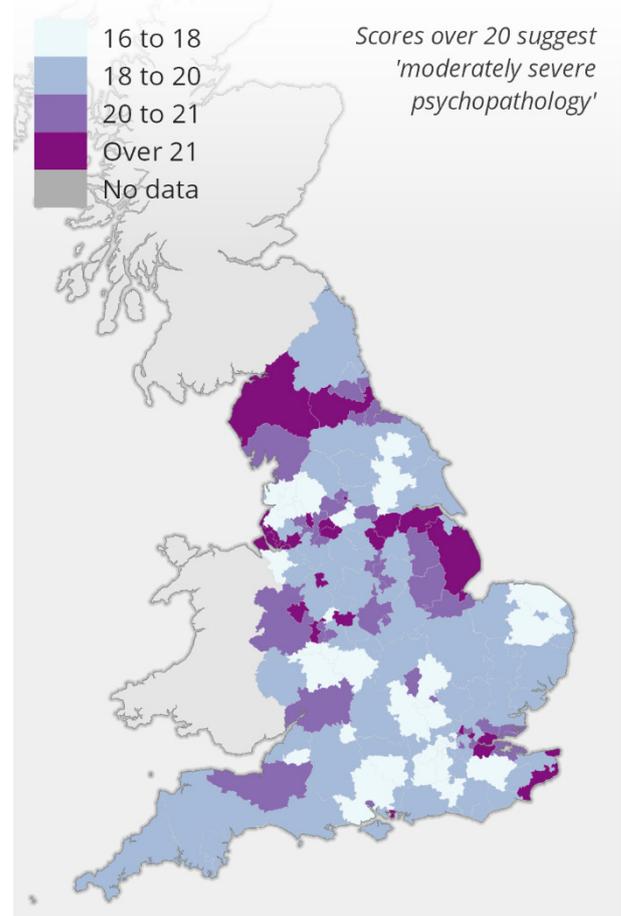
4. Other waiting times

4.1 Early Intervention in Psychosis

Since April 2016, the Government and NHS England have been committed to the standard that 50% of people experiencing a first episode of psychosis should have access to early intervention care within two weeks. In particular, people should be able to access a care package which conforms to NICE clinical guidelines and quality standards within two weeks of referral. This target is due to rise to 60% in 2020/21.

The chart below shows performance on this measure since December 2015. The 50% target has been met each month. Performance rose during 2016 and early 2017 – in February 2017 performance peaked at 80%.[13]

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[13] NHS England, Early Intervention in Psychosis Waiting Times

Early intervention in psychosis:
Patients treated within 2 weeks of referral

A substantial minority of patients wait longer than twelve weeks for treatment. In September 2019 there were 150 patients still waiting to start treatment who had been waiting for over twelve weeks. 45% of these were in Leeds, Liverpool and Oxfordshire.

Activity levels vary substantially across the country. In September 2019, for instance, 33 people started EIP treatment in Leeds, 23 in Liverpool, and 20 in Bristol, North Somerset & South Gloucestershire. Meanwhile there were ten areas where nobody started treatment and a further 19 areas in which only one person started EIP treatment. Overall, 20 CCGs accounted for around 30% of treatments in September 2019.

4.2 Children and young people's eating disorder services

In 2016 the Government introduced waiting time standards to improve access to eating disorders services for children and young people. The target is that by 2020/21, 95% of children and young people with an eating disorder will receive treatment within one week for urgent cases and within four weeks for routine cases.

These targets are not yet being met. In the second quarter of 2019/20, 75% of urgent cases received treatment within one week. This is down slightly from a year earlier. 86% of routine cases started treatment within four weeks – higher than a year earlier.[14]

In each quarter, around 1,500 children and young people in England are treated for routine cases and 300 are treated for urgent cases.

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[14] NHS England, Children and Young People with an Eating Disorder Waiting Times

5. Funding for mental health services

NHS England's Mental Health Five Year Forward View Dashboard provides a national overview of spending on mental health services. It provides information on total spending, as well as breakdowns for some specific areas like IAPT, Early Intervention in Psychosis, and eating disorder services for children and young people.

£13 billion is planned to be spent on mental health, learning disability and dementia services in 2019/20. This is 14.1% of total CCG funding allocations. Spending has increased from £11 billion in 2015/16 (13.1% of total allocations). Most of this money is spent by local CCGs. The remainder is spent by NHS England through specialised commissioning.

Most local mental health funding is not ring-fenced, meaning that each Clinical Commissioning Group determines its own mental health budget from its overall funding allocation. However, CCGs are expected to meet the 'mental health investment standard', which requires increases in local mental health spending to be at least as large, proportionally speaking, as overall increases in local funding. So if a CCG receives a 5% increase in its funding allocation, it must increase its mental health spending by at least 5% to meet the mental health investment standard.

The latest data shows that 186 of 191 CCGs are due to meet this standard in 2019/20. However, data on local CCG mental health spending isn't published. Instead, figures are available on a wider spending category that includes learning disability and dementia services. Learning disability and dementia spending isn't counted in the mental health investment standard.

The mental health investment standard only measures changes in spending, rather than giving an assessment of how spending is adequate relative to local needs and demand for services.

Spending commitments from the NHS long-term plan also include a "new ring-fenced investment fund worth at least £2.3 billion a year by 2023/24".[15]

Previous spending data

Data was previously published for individual CCGs through NHS England's Programme Budgeting Tool, but this has been discontinued since 2013/14.[16] Earlier figures for Primary Care Trusts, which are not directly comparable, show that expenditure on mental health disorders increased by 47% between 2004/05 and 2009/10, and by 6% between 2009/10 and 2012/13.

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[15] NHS England, Mental Health Five Year Forward View Dashboard
[16] NHS England, Programme Budgeting Tool

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