Mental health statistics
(England)

Summary
1 How widespread are mental health problems?
2 NHS mental health services
3 IAPT: talking therapies for depression and anxiety
4 Other waiting times
5 Funding for mental health services
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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 6 children aged 6 to 16** had at least one probable mental health problem in 2021, up from **1 in 9 in 2017**.

**2.0 million adults and 0.8 million children** accessed NHS mental health, learning disability and autism services in 2020/21.

Waiting times for NHS psychological therapy (IAPT) vary from 4 days to 86 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 spent **£14.3 billion** on mental health services in 2020/21 - 14.8% of local NHS funding allocations.

Waiting time for a first IAPT treatment

Days (average), England, 2020/21

- Under 10 days
- 10 - 18 days
- 18 - 28 days
- 28 - 40 days
- Over 42 days

See the full briefing paper for more information and data sources @commonslibrary
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 (with follow-ups in 2020 and 2021).

These surveys give a national and regional picture of mental health, but don’t contain information for smaller areas like constituencies or local authorities. However, some local estimates of mental health problems from the GP patient survey are also outlined 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.

¹ NHS Digital, APMS, Common Mental Disorders
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 men and women. The gender gap has not changed substantially since 1993.

Types of common mental disorder

Generalised anxiety disorder was the most common 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.
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 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](chart)

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 by employment status](chart)

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.
Local prevalence estimates from the GP patient survey

As part of the GP patient survey, patients are asked about their health. This includes a question asking patients to say which long-term conditions they have from a list.

The table and map overleaf show the percentage of respondents who said that they had a mental health problem. Overall, 11% of patients said that they had a mental health problem. Reported prevalence was highest in parts of the North, as well as Norfolk and Brighton. Most areas with lower reported prevalence were in London and neighbouring counties.

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.

This is not the only estimate of mental health prevalence made through GP practice data. The Quality and Outcomes Framework includes data on the proportion of patients diagnosed with depression by their GP. You can view estimates of depression prevalence for local areas on our health conditions dashboard.

However, as Public Health England note, it’s estimated that 50% of patients attending GPs with depressive disorders do not have their symptoms recognised.
1.2 Other mental disorders among adults

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”.

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%). Age 55-64 was the only category where men were more likely to screen positive than women.

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NHS Digital, APMS, Post-Traumatic Stress Disorder
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.  

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.

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3 NHS Digital, APMS, Bipolar disorder
Psychotic disorder

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

In the 2014 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”. ¹

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

¹ NHS Digital, APMS, Psychotic disorder
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”.

- 5.4% 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.

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%).

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5 NHS Digital, APMS, Suicidal Thoughts
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.

More data on suicide is available from the Office for National Statistics, and is summarised in our briefing paper on suicide statistics.

**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’.
Mental health statistics (England)

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.

1.3 Children and young people’s mental health

A survey of children and young people’s mental health in England was undertaken in 2017 and followed up in 2020 and 2021. 6

The surveys found that 17.4% of children aged 6-16 had a probable mental disorder in 2021, up from 11.6% in 2017. Among those aged 17-19, 10.1% had a probable mental disorder in 2017, rising to 17.4% in 2021. Rates remained similar between 2020 and 2021.

Among children aged 6-10, boys were more likely than girls to have a probable mental disorder in 2021 (21.9% of boys compared with 12.0% of girls). This gender gap reverses in older age groups, with girls aged 11-16 more likely (19.8%) to have a probable mental disorder than boys (15.6%).

Children in White ethnic groups were more likely (20.1%) to have a probable mental disorder than those in minority ethnic groups (9.7%) in 2021. Data was also recorded for more detailed ethnicity categories, but these estimates are imprecise due to a small number of respondents in some ethnic groups.

Children with special educational needs and disabilities (SEND) were more likely (56.7%) to have a probable mental disorder than those without SEND (12.5%).

1.4 Depression during the coronavirus pandemic

The Office for National Statistics (ONS) have monitored the prevalence of depression among adults during the COVID-19 pandemic. 7

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6 NHS Digital, Children and Young People’s Mental Health in England
7 Coronavirus and depression in adults, Great Britain: July to August 2021
They found that the prevalence of moderate or severe depressive symptoms among adults in Great Britain rose after the start of the pandemic. In surveys taken between July 2019 and March 2020, the proportion was 10%, but this rose to 19% by June 2020 and 21% by January-March 2021. By July-August 2021 the proportion with moderate or severe depressive symptoms had fallen to 17%.

In July-August 2021, prevalence of depressive symptoms was highest among those aged 16-24 (29%) and lowest among those aged 70 or above (9%). It was higher among women (20%) than men (14%). It was also higher among people with lower incomes.
NHS mental health services

NHS Digital publishes statistics on NHS-funded mental health, learning disability and autism services, showing the number of people in contact with services and many other details. These cover services such as community mental health and hospital mental health activity. They do not include people who receiving treatment via the Improving Access to Psychological Therapies (IAPT) programme – see chapter 3 below for details on this.

During 2020/21 around 2.8 million people had contact with NHS-funded secondary mental health, learning disability or autism services in England. This is around 5% of the population.

The number of people in contact with services was 75,000 lower than the previous year – a fall of 2.7%. This is likely to be due to the effects of the coronavirus pandemic. The number of adults in contact with services fell by 3.7%, while the number of children in contact with services rose by 0.5%.

<table>
<thead>
<tr>
<th>Age group</th>
<th>% of population</th>
<th>Number</th>
<th>% of all in contact with services</th>
</tr>
</thead>
<tbody>
<tr>
<td>All ages</td>
<td>5.0%</td>
<td>2,803,244</td>
<td>3.5%</td>
</tr>
<tr>
<td>0 to 5</td>
<td>1.2%</td>
<td>48,696</td>
<td>0.0%</td>
</tr>
<tr>
<td>6 to 10</td>
<td>5.2%</td>
<td>184,920</td>
<td>0.1%</td>
</tr>
<tr>
<td>11 to 15</td>
<td>10.7%</td>
<td>359,681</td>
<td>0.3%</td>
</tr>
<tr>
<td>16 to 19</td>
<td>11.3%</td>
<td>281,057</td>
<td>1.6%</td>
</tr>
<tr>
<td>20 to 24</td>
<td>6.3%</td>
<td>218,633</td>
<td>4.0%</td>
</tr>
<tr>
<td>25 to 29</td>
<td>5.3%</td>
<td>199,025</td>
<td>5.0%</td>
</tr>
<tr>
<td>30 to 34</td>
<td>4.9%</td>
<td>186,486</td>
<td>5.7%</td>
</tr>
<tr>
<td>35 to 39</td>
<td>4.3%</td>
<td>159,699</td>
<td>5.9%</td>
</tr>
<tr>
<td>40 to 44</td>
<td>3.9%</td>
<td>134,038</td>
<td>6.3%</td>
</tr>
<tr>
<td>45 to 49</td>
<td>3.6%</td>
<td>130,294</td>
<td>5.8%</td>
</tr>
<tr>
<td>50 to 54</td>
<td>3.3%</td>
<td>129,513</td>
<td>5.7%</td>
</tr>
<tr>
<td>55 to 59</td>
<td>3.1%</td>
<td>114,876</td>
<td>5.9%</td>
</tr>
<tr>
<td>60 to 64</td>
<td>2.7%</td>
<td>86,922</td>
<td>5.8%</td>
</tr>
<tr>
<td>65 to 69</td>
<td>2.5%</td>
<td>69,400</td>
<td>5.9%</td>
</tr>
<tr>
<td>70 to 74</td>
<td>2.1%</td>
<td>86,128</td>
<td>5.0%</td>
</tr>
<tr>
<td>75 to 79</td>
<td>5.1%</td>
<td>102,678</td>
<td>3.7%</td>
</tr>
<tr>
<td>80 to 84</td>
<td>8.2%</td>
<td>119,210</td>
<td>2.4%</td>
</tr>
<tr>
<td>85 to 89</td>
<td>12.4%</td>
<td>109,900</td>
<td>1.5%</td>
</tr>
<tr>
<td>90 or over</td>
<td>14.7%</td>
<td>76,495</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

Source: NHS Digital, Mental Health Bulletin 2020/21 Annual Report
Age and sex

The table above shows the number of people in each age group in contact with services during 2020/21, as well as the percentage of the population in each age group. It also shows the proportion of those in contact with services in each age group who were admitted as an inpatient at some point during the year.

People aged 11-19 and 85+ were most likely to be in contact with NHS mental health, learning disability and autism services. People aged 0-5 and 65-69 were least likely to be in contact.

Meanwhile, of those who were in contact with services, those aged 30-69 were most likely to be admitted patients.

Service contact fell the most in people aged 75+, compared with 2019/20. Meanwhile the largest rises were among ages 0-5 and 17-18.

Women were slightly more likely than men to have been in contact with services during 2020/21 (5.1% of women and 4.7% of men).

Ethnicity

People from Black or Black British ethnic groups were around 20% more likely to be in contact with mental health services than those in White ethnic groups. Meanwhile, those in Asian or Asian British ethnic groups were around 12% less likely to be in contact with services than those in White ethnic groups.

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

Data for more detailed ethnic categories is available in NHS Digital’s source tables (Outpatients - Table 6).8

Local areas

8.9% of the adult population of Hull was in contact with mental health, learning disability or autism services at some point during 2020/21 – the highest of any local authority in England. The proportion was lowest, at 2.8% of the population, in South Gloucestershire and Mid Suffolk.

Among children, the area with the highest proportion in contact with services with South Tyneside (12.7%) and the lowest was North Somerset (0.5%).

8 NHS Digital, Mental Health Bulletin 2020-21 Annual Report
Local authority data on mental health service use

% in contact with mental health, learning disability and autism services during 2020/21 compared with mid-2020 population estimates

**HIGHEST - Adults**
- Kingston upon Hull: 8.9%
- Blackpool: 7.7%
- Birmingham: 6.5%
- Stoke-on-Trent: 6.5%
- Middlesbrough: 6.4%
- Northampton: 6.3%
- Lincoln: 6.3%
- Liverpool: 6.3%
- Sefton: 6.2%
- Knowsley: 6.2%

**HIGHEST - Children**
- South Tyneside: 12.0%
- Nuneaton and Bedworth: 10.7%
- Sunderland: 10.6%
- Thanet: 9.8%
- Wirral: 9.7%
- Gravesham: 9.7%
- Hartlepool: 9.6%
- Central Bedfordshire: 9.6%
- County Durham: 9.5%
- Redcar and Cleveland: 9.3%

**LOWEST - Adults**
- South Gloucestershire: 2.8%
- Mid Suffolk: 2.8%
- Ribble Valley: 2.9%
- Hart: 2.9%
- East Cambridgeshire: 2.9%
- Stroud: 2.9%
- Vale of White Horse: 3.0%
- Wiltshire: 3.0%
- Tewkesbury: 3.0%
- Maldon: 3.0%

**LOWEST - Children**
- North Somerset: 0.5%
- Bristol: 1.6%
- Bromley: 2.4%
- Hillingdon: 2.8%
- Sedgeemoor: 2.9%
- Barking and Dagenham: 2.9%
- South Somerset: 3.0%
- Redbridge: 3.0%
- Ealing: 3.0%
- South Gloucestershire: 3.1%

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 also likely to also reflect the nature and extent of mental health service provision in different areas, and potentially also differing impacts of the pandemic on mental health services in different areas.

The population-based cartogram maps overleaf show this data for all of England.
Percentage of people in contact with NHS-funded mental health, learning disability and autism services during 2020/21: population-based map

On this map, local authority areas are approximately scaled in size according to their populations. Areas are grouped by ceremonial counties, conurbations and other recognisable sub-national areas. These groups include unitary authorities (e.g. Nottingham City UA inside the Notts group) and don’t all reflect current local government structures.

Lines between adjacent areas represent local authority boundaries. Extra labels are provided for large towns & cities to help you locate particular cities and towns (e.g. ‘Lut.’ = Luton). Grey shading between county groups doesn’t represent data and serve only as a background.
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.

Section 4.4 outlines several proposed new access and waiting time standards.

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.

3.1 Summary of national IAPT data

Referrals and treatments

In 2020/21 there were 1.46 million referrals to IAPT in England. This was down 15% on the number referred in 2019/20. This and other figures below reflect the impact of the coronavirus pandemic. The number of referrals fell more among older people, with 30% fewer referrals among ages 65+.9

1.02 million people entered treatment in 2020/21, down 12% on 2019/20. However, 658,000 people finished a course of treatment, which is up 9% on the number finishing a course of treatment in 2019/20.

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9 NHS Digital, Psychological Therapies, Annual report on the use of IAPT services, 2020-21
### Waiting times

90.0% of those finishing a course of treatment in 2020/21 had their first appointment within six weeks of referral – above the target of 75% and an improvement on 2019/20 (87.4%).

98.0% of those finishing a course of treatment in 2020/21 had their first appointment within 18 weeks of referral – above the target of 95% but a fall compared with 2019/20 (98.4%).

The average waiting time for a first treatment in 2020/21 was 21 days (among those finishing a course of treatment). The average waiting time between a first treatment and a second treatment was 53 days. Both of these measures were around 2 days less than in 2019/20.

However, there is substantial variation in different parts of England – the wait for a first treatment varies from 4 days in Castle Point and Rochford (Essex) to 86 days in Bristol, North Somerset and South Gloucestershire. Differences across the country are detailed below.

These waiting times are measured between referral and first treatment. NHS England says that a treatment appointment would not just be an assessment, and that it should include some IAPT compliant treatment. However, they also say that the precise definition of “first treatment” is a local decision. As such, it’s possible that some variation in waiting times between areas reflects different practices as to what counts as the first treatment.

### Outcomes: improvement and recovery

68.3% of patients had an improvement in their condition after finishing IAPT therapy in 2020/21. 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 a mental health condition to not having a clinical case. In 2020/21, 51.4% of those finishing a course of treatment moved to recovery, up from 51.1% in 2019/20.

Recovery rates were higher for anxiety related disorders (53.2%) than for depression (50.0%). The conditions with the lowest recovery rates after IAPT were agoraphobia (34.1%), social phobias (35.9%), post-traumatic stress disorder (36.4%), and hypochondria (39.8%). These differences 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 having a clinical case.

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10 NHS England, [IAPT Waiting Times Guidance and FAQs](#)
3.2 Age, sex, ethnicity, and other characteristics

Referrals and treatments by age and sex

67.5% of those referred to IAPT in 2020/21 were women. This is higher than previous years when the proportion was around 65%. Women made up over 60% of referrals in every local CCG area in England. The areas with the highest gender imbalance were all in the South of England. The areas with the lowest gender imbalance were in the West Midlands and the North of England.

The table below shows referral and treatment statistics broken down by age and sex in England in 2020/21. The 18-35 age group has the highest referral rate to IAPT, at double the average for all ages.

<table>
<thead>
<tr>
<th>Age/sex</th>
<th>Referrals</th>
<th>Referrals per 1,000 population</th>
<th>Number of referrals</th>
<th>Percent of referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Entering treatment</td>
<td>Finishing treatment</td>
</tr>
<tr>
<td>All adults</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 to 17</td>
<td>25,718</td>
<td>21</td>
<td>14,863</td>
<td>6,846</td>
</tr>
<tr>
<td>18 to 35</td>
<td>790,690</td>
<td>64</td>
<td>539,223</td>
<td>320,439</td>
</tr>
<tr>
<td>36 to 64</td>
<td>564,557</td>
<td>26</td>
<td>414,437</td>
<td>271,453</td>
</tr>
<tr>
<td>65 and over</td>
<td>74,565</td>
<td>7</td>
<td>55,364</td>
<td>35,771</td>
</tr>
<tr>
<td>Total</td>
<td>1,456,446</td>
<td>32</td>
<td>1,024,014</td>
<td>634,649</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 to 17</td>
<td>17,943</td>
<td>28</td>
<td>10,644</td>
<td>4,947</td>
</tr>
<tr>
<td>18 to 35</td>
<td>545,614</td>
<td>87</td>
<td>377,514</td>
<td>227,246</td>
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<td>36 to 64</td>
<td>361,842</td>
<td>34</td>
<td>268,073</td>
<td>176,589</td>
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<tr>
<td>65 and over</td>
<td>49,338</td>
<td>10</td>
<td>36,930</td>
<td>24,155</td>
</tr>
<tr>
<td>Total</td>
<td>975,399</td>
<td>42</td>
<td>693,249</td>
<td>433,036</td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 to 17</td>
<td>7,313</td>
<td>12</td>
<td>3,990</td>
<td>1,827</td>
</tr>
<tr>
<td>18 to 35</td>
<td>238,078</td>
<td>39</td>
<td>157,869</td>
<td>91,451</td>
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<tr>
<td>36 to 64</td>
<td>199,406</td>
<td>18</td>
<td>144,456</td>
<td>93,959</td>
</tr>
<tr>
<td>65 and over</td>
<td>24,713</td>
<td>4</td>
<td>18,156</td>
<td>11,501</td>
</tr>
<tr>
<td>Total</td>
<td>469,756</td>
<td>21</td>
<td>324,508</td>
<td>198,778</td>
</tr>
</tbody>
</table>

Note: totals do not match the sum of parts due to unknown records for sex and gender and a small number of referrals among under-16s which are not shown here

Source: NHS Digital, Psychological Therapies, Annual report on the use of IAPT services, 2020-21

The table also shows the number of people entering treatment/finishing treatment as a percentage of the number of referrals. This is not a straightforward treatment rate/completion rate, because people finishing treatment in 2020/21 may have been referred in the previous year, and some of those referred in 2020/21 may not yet have been treated by the end of that
year. However, the percentages give an indication of differing tendencies for entering and completing treatment among different groups.

Older age groups have a higher proportion of referrals entering and finishing treatment than younger age groups. The proportion of women entering and finishing treatment is slightly higher than men in all age groups.

Outcomes by age and sex

The table below shows IAPT improvement and recovery rates in 2020/21 broken down by age and sex.

<table>
<thead>
<tr>
<th>Age group</th>
<th>Total</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 to 17</td>
<td>60.0%</td>
<td>60.4%</td>
<td>59.2%</td>
<td>40.9%</td>
<td>39.8%</td>
<td>44.6%</td>
</tr>
<tr>
<td>18 to 35</td>
<td>67.9%</td>
<td>68.3%</td>
<td>67.1%</td>
<td>49.8%</td>
<td>49.6%</td>
<td>50.5%</td>
</tr>
<tr>
<td>36 to 64</td>
<td>68.7%</td>
<td>69.1%</td>
<td>68.0%</td>
<td>52.3%</td>
<td>52.2%</td>
<td>52.7%</td>
</tr>
<tr>
<td>65 and over</td>
<td>69.8%</td>
<td>70.6%</td>
<td>68.3%</td>
<td>61.2%</td>
<td>60.4%</td>
<td>63.1%</td>
</tr>
<tr>
<td>Total</td>
<td>68.3%</td>
<td>68.7%</td>
<td>67.5%</td>
<td>51.4%</td>
<td>51.1%</td>
<td>52.2%</td>
</tr>
</tbody>
</table>

Younger people were less likely to show improvement and recovery from IAPT than older people. The 50% recovery target was not met for those aged 35 and under.

Women were slightly more likely to show improvement after therapy than men. However, men were slightly more likely to move to recovery after therapy than women. This could be due to differences in the average magnitude of recovery - or it might indicate that women’s mental health conditions are on average more severe than men’s, so that more improvement is required to cross the recovery threshold.

Deprivation

Referrals to IAPT are higher in deprived areas. In 2020/21, referral rates were 76% higher in the most deprived areas than the least deprived areas. Compared with 2019/20, referrals fell most in the most deprived areas - 17% compared with an overall average of 15%.
The table below shows statistics on referrals, treatments and outcomes by deprivation decile. This data divides England into ten parts based on deprivation, with the 10% most deprived areas in the “most deprived decile”, the 10% least deprived areas in the “least deprived decile”, and the others in the deciles between.

People living in deprived areas are less likely to enter or finish treatment after referral than those living in less deprived areas. They are also less likely to see their conditions improve after therapy, and less likely to recover after therapy. Recovery is below the 50% target for the three most deprived deciles.

Note that these figures are not age-standardised. The most deprived areas of England have a younger average age than the least deprived, so some of the deprivation differences shown here may be explained by age differences (and, indeed, vice versa).

### Ethnicity

Information on self-declared ethnicity was collected for around nine in ten of those referred to IAPT in 2020/21. The table below shows data on referrals, treatments and outcomes.

White people made up 83.6% of referrals with a known ethnicity in 2020/21 compared with 85.5% in 2019/20. It’s possible that this shows that referrals fell more among White ethnic groups than others during 2020/21, but it might also be an artefact of better data coverage.
The inequalities between ethnic groups are similar to previous years and show little change. However, in 2019/20 only the White ethnic group had a recovery rate over 50%. This has now changed, with the Black or Black British group now also having a recovery rate over 50%.

The table below shows data for detailed ethnic groups, which shows some differences within the broad groups shown above.

Bangladeshi people are less likely to move to recovery after IAPT treatment than any other ethnic group (43%), followed by Pakistani people (45%). Both have substantially lower recovery rates than Indian people (53%). Differences between ethnic groups were larger for recovery rates than for improvement.

Looking at the gender breakdown of referrals – Black, Mixed and Chinese and non-British/Irish White ethnic groups had the largest gender imbalance with over 70% of referrals being women.
Disability

Around 11% of those referred to IAPT in 2020/21 reported a disability. Those reporting a disability were less likely to experience improvement after IAPT (66% compared with 69% of those reporting no disability) and less likely to recover from their conditions (41% compared with 54% of those reporting no disability). The table below shows this data.

<table>
<thead>
<tr>
<th>Disability</th>
<th>Number of referrals</th>
<th>Improved</th>
<th>Moved to recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any recorded disability</td>
<td>170,635</td>
<td>66%</td>
<td>41%</td>
</tr>
<tr>
<td>Mobility and Gross Motor</td>
<td>44,593</td>
<td>62%</td>
<td>38%</td>
</tr>
<tr>
<td>Other</td>
<td>42,328</td>
<td>64%</td>
<td>42%</td>
</tr>
<tr>
<td>Behaviour and Emotional</td>
<td>24,320</td>
<td>62%</td>
<td>37%</td>
</tr>
<tr>
<td>Learning Disability¹</td>
<td>24,156</td>
<td>65%</td>
<td>43%</td>
</tr>
<tr>
<td>Hearing</td>
<td>12,589</td>
<td>67%</td>
<td>50%</td>
</tr>
<tr>
<td>Progressive Conditions and Physical Health²</td>
<td>7,910</td>
<td>64%</td>
<td>42%</td>
</tr>
<tr>
<td>Sight</td>
<td>6,728</td>
<td>67%</td>
<td>47%</td>
</tr>
<tr>
<td>Manual Dexterity</td>
<td>2,907</td>
<td>62%</td>
<td>41%</td>
</tr>
<tr>
<td>Personal, Self Care and Continence</td>
<td>2,381</td>
<td>58%</td>
<td>33%</td>
</tr>
<tr>
<td>Speech</td>
<td>2,262</td>
<td>66%</td>
<td>48%</td>
</tr>
<tr>
<td>Perception of Physical Danger</td>
<td>461</td>
<td>56%</td>
<td>36%</td>
</tr>
<tr>
<td>No Disability</td>
<td>695,166</td>
<td>70%</td>
<td>54%</td>
</tr>
<tr>
<td>Declined to respond</td>
<td>79,889</td>
<td>65%</td>
<td>48%</td>
</tr>
<tr>
<td>No Code Recorded</td>
<td>538,014</td>
<td>69%</td>
<td>52%</td>
</tr>
</tbody>
</table>

¹ Memory or ability to concentrate, learn or understand
² Such as HIV, cancer, multiple sclerosis, fits etc

Note that over one third of referrals were listed as ‘No code recorded’ – i.e., it was not stated whether the person had a disability. As shown above, these referrals had broadly similar outcomes to people with no disabilities.

Religion

Information on patient religion was collected for 53% of IAPT referrals in 2020/21. This is a notable fall from 65% in 2019/20. The table below shows IAPT referrals and outcomes by religion.

Those identifying as Christian were most likely to experience improvement and/or recover from their condition after IAPT treatment. Muslims were least likely to improve/recover. Recovery rates were over 50% for all religions except Muslim and Pagan.
Note that Baha’i, Jain and Zoroastrian are not shown here as there were only a small number of referrals, meaning that outcomes may not be representative.

**Sexual orientation**

Information on sexual orientation was collected for 59% of referrals in 2020/21, down from 68% in 2019/20. Overall, 4.6% of those referred to IAPT in 2020/21 said that they were lesbian, gay or bisexual.

Those identifying as bisexual were less likely to experience improvement in their condition after IAPT and recovery after IAPT than others. Those identifying as gay or lesbian were less likely than heterosexual people to recover from their condition after IAPT.
3.3 Waiting times for local areas

Average waiting times

On average, IAPT patients wait 3 weeks (21 days) between their referral and their first treatment, and then 7½ weeks (53 days) between their first and second treatment. Over the years, waits for first treatments have changed little, but waits between first and second treatment have increased. In 2016/17 the average wait between first and second treatment was 41 days and in 2018/19 it was 49.

The table below shows the average waiting time in days at CCG level for patients finishing treatment in 2020/21. It shows waiting times from referral to first treatment, from first to second treatment, and a total wait from referral to second treatment. The top row shows the ten CCGs with the lowest waiting times and the bottom row shows the ten CCGs with the highest.

Waiting times varied substantially across the country. In Castle Point & Rochford (Essex), the average wait between referral and treatment was four days, while in Bristol, North Somerset and South Gloucestershire it was 86.

<table>
<thead>
<tr>
<th>Lowest waiting times (average waiting time in days)</th>
<th>Highest and lowest IAPT waiting times by CCG, 2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral to first treatment</td>
<td>First to second treatment</td>
</tr>
<tr>
<td>Castle Point &amp; Rochford</td>
<td>4 days</td>
</tr>
<tr>
<td>Redbridge</td>
<td>4</td>
</tr>
<tr>
<td>Havering</td>
<td>5</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>6</td>
</tr>
<tr>
<td>Bedfordshire</td>
<td>6</td>
</tr>
<tr>
<td>Wakefield</td>
<td>6</td>
</tr>
<tr>
<td>Thurrock</td>
<td>6</td>
</tr>
<tr>
<td>Harrow</td>
<td>7</td>
</tr>
<tr>
<td>Southend</td>
<td>7</td>
</tr>
<tr>
<td>East Staffordshire</td>
<td>7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Highest waiting times (average waiting time in days)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral to first treatment</td>
<td>First to second treatment</td>
</tr>
<tr>
<td>Bristol, N Somerset &amp; S Gloucs</td>
<td>86</td>
</tr>
<tr>
<td>Stoke on Trent</td>
<td>71</td>
</tr>
<tr>
<td>Tees Valley</td>
<td>59</td>
</tr>
<tr>
<td>Southport &amp; Formby</td>
<td>50</td>
</tr>
<tr>
<td>East &amp; North Hertfordshire</td>
<td>47</td>
</tr>
<tr>
<td>Dorset</td>
<td>47</td>
</tr>
<tr>
<td>Manchester</td>
<td>47</td>
</tr>
<tr>
<td>South Sefton</td>
<td>44</td>
</tr>
<tr>
<td>Bury</td>
<td>42</td>
</tr>
<tr>
<td>Salford</td>
<td>39</td>
</tr>
</tbody>
</table>
As noted above, what counts as a “first treatment” is a local decision. As a result, some variation in waiting times may be due to differences in practice.

In 92% of areas, patients waited longer between their first and second treatments than they had waited for their first treatment. In 76% of areas the wait for a second treatment was more than double the wait between referral and first treatment, and in 53% of areas it was more than three times as long.

There were 18 areas (out of 135) where patients waited an average of over three months between their first and second treatment, and 57 areas where this wait was over two months.

In England as a whole, patients waited a total of 73 days on average between an IAPT referral and their second treatment. This varied between 30 days in Brent (North London) and 182 days in Bristol, North Somerset and South Gloucestershire.

The maps overleaf show data for all CCGs in England.

Waiting time targets

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. There is no target for waiting times for second treatments.

Nationally, these targets were met in 2020/21. However, there were 9 CCGs not meeting the 6-week target and 11 not meeting the 18-week target. These are shown in the table below.

<table>
<thead>
<tr>
<th>CCGs not meeting the IAPT waiting time targets in 2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6-week target (&gt;75%)</strong></td>
</tr>
<tr>
<td>CCG, %</td>
</tr>
<tr>
<td>Bristol, N Somerset &amp; S Gloucs 62</td>
</tr>
<tr>
<td>Bury 63</td>
</tr>
<tr>
<td>Stoke on Trent 63</td>
</tr>
<tr>
<td>Leeds 63</td>
</tr>
<tr>
<td>East &amp; North Hertfordshire 65</td>
</tr>
<tr>
<td>East Riding of Yorkshire 67</td>
</tr>
<tr>
<td>Tees Valley 71</td>
</tr>
<tr>
<td>Isle of Wight 73</td>
</tr>
<tr>
<td>Manchester 74</td>
</tr>
<tr>
<td><strong>18 week target (&gt;95%)</strong></td>
</tr>
<tr>
<td>CCG, %</td>
</tr>
<tr>
<td>Stoke on Trent 75</td>
</tr>
<tr>
<td>Tees Valley 82</td>
</tr>
<tr>
<td>Bristol, N Somerset &amp; S Gloucs 85</td>
</tr>
<tr>
<td>Southport &amp; Formby 86</td>
</tr>
<tr>
<td>Dorset 86</td>
</tr>
<tr>
<td>South Sefton 89</td>
</tr>
<tr>
<td>Southampton 90</td>
</tr>
<tr>
<td>East &amp; North Hertfordshire 92</td>
</tr>
<tr>
<td>Herts Valleys 92</td>
</tr>
<tr>
<td>Manchester 93</td>
</tr>
<tr>
<td>Cheshire 94</td>
</tr>
</tbody>
</table>

NHS England, IAPT Service Standards
IAPT average waiting times, 2020/21

Referral to first treatment

- Under 10 days
- 10 - 18 days
- 18 - 28 days
- 28 - 40 days
- Over 42 days

First treatment to second treatment

- Under 30 days
- 30 - 50 days
- 50 - 75 days
- 75 - 100 days
- Over 100 days

Data: NHS Digital. Maps: @commonslibrary
3.4 IAPT outcomes for local areas

In 2020/21, the percentage of patients whose conditions improved after IAPT treatment varied from a low of 55% in Sheffield to 79% in Warwickshire North and West Sussex. Meanwhile, the proportion of patients whose conditions deteriorated after IAPT treatment varied between a low of 3% in five CCG areas to a high of 10% in Liverpool.

The percentage of people recovering from their conditions after IAPT varied from a low of 34% in Brighton & Hove to a high of 64% in Stoke-on-Trent. Note that the recovery measure may depend on the severity of conditions that patients present with. If conditions are on average more serious in some areas than others, then it will take a greater amount of improvement to lead to recovery.

The table below shows data for the CCGs with the best and worst outcomes in England in 2020/21.

<table>
<thead>
<tr>
<th>Worst outcomes</th>
<th>Improved after treatment (%)</th>
<th>Deteriorated after treatment (%)</th>
<th>Moved to recovery (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sheffield</td>
<td>55</td>
<td>Liverpool</td>
<td>Brighton &amp; Hove 34</td>
</tr>
<tr>
<td>Chorley &amp; South Ribble</td>
<td>56</td>
<td>Bolton</td>
<td>Wirral 37</td>
</tr>
<tr>
<td>Greater Preston</td>
<td>57</td>
<td>North Kirkles</td>
<td>Sheffield 40</td>
</tr>
<tr>
<td>West Lancashire</td>
<td>59</td>
<td>Hounslow</td>
<td>Dudley 41</td>
</tr>
<tr>
<td>Fylde &amp; Wyre</td>
<td>59</td>
<td>Hammersmith &amp; Fulham</td>
<td>Kernow 41</td>
</tr>
<tr>
<td>Central London</td>
<td>59</td>
<td>Dudley</td>
<td>Chorley &amp; South Ribble 43</td>
</tr>
<tr>
<td>Blackburn With Darwen</td>
<td>60</td>
<td>Brent</td>
<td>Salford 43</td>
</tr>
<tr>
<td>East Lancashire</td>
<td>60</td>
<td>Central London</td>
<td>Manchester 44</td>
</tr>
<tr>
<td>Brighton &amp; Hove</td>
<td>60</td>
<td>Bath &amp; NE Somerset, Swindon &amp; Wilts 7</td>
<td>South Sefton 44</td>
</tr>
<tr>
<td>Bolton</td>
<td>61</td>
<td>Newham</td>
<td>Greater Preston 45</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Best outcomes</th>
<th>Improved after treatment (%)</th>
<th>Deteriorated after treatment (%)</th>
<th>Moved to recovery (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warwickshire North</td>
<td>79</td>
<td>Warwickshire North</td>
<td>Stoke On Trent 64</td>
</tr>
<tr>
<td>West Sussex</td>
<td>79</td>
<td>West Sussex</td>
<td>City &amp; Hackney 61</td>
</tr>
<tr>
<td>Bassetlaw</td>
<td>77</td>
<td>City &amp; Hackney</td>
<td>Warwickshire North 60</td>
</tr>
<tr>
<td>Hull</td>
<td>77</td>
<td>Stoke On Trent</td>
<td>Buckinghamshire 59</td>
</tr>
<tr>
<td>Sunderland</td>
<td>75</td>
<td>North Staffordshire</td>
<td>Portsmouth 59</td>
</tr>
<tr>
<td>Coventry &amp; Rugby</td>
<td>75</td>
<td>Bassetlaw</td>
<td>West Sussex 59</td>
</tr>
<tr>
<td>South East Staffs &amp; Seisdon</td>
<td>75</td>
<td>Coventry &amp; Rugby</td>
<td>Thurrock 58</td>
</tr>
<tr>
<td>Havering</td>
<td>75</td>
<td>South East Staffs &amp; Seisdon</td>
<td>North Yorkshire 58</td>
</tr>
<tr>
<td>Trafford</td>
<td>74</td>
<td>Telford &amp; Wrekin</td>
<td>Norfolk &amp; Waveney 57</td>
</tr>
<tr>
<td>East Riding Of Yorkshire</td>
<td>74</td>
<td>Morecambe Bay</td>
<td>Trafford 57</td>
</tr>
</tbody>
</table>

Source: NHS Digital, Psychological Therapies, Annual report on the use of IAPT services, 2020-21

At CCG level there is no relationship between waiting times and outcomes measures. The maps overleaf show data for all CCGs in England.
Patient experience survey

76% of those completing a patient experience questionnaire after IAPT treatment in 2020/21 said that they “got the help that mattered to them at all times”. This percentage varied substantially across the country.

The table below shows the ten CCGs in England and Wales with the highest and lowest percentage of patients saying that they got the help that mattered to them at all times. Note that these tables exclude the 33 CCGs where fewer than 100 patients completed a patient experience questionnaire during 2020/21. This is only one of several questions in the patient experience questionnaire. Full data is available in the NHS Digital data release.

### IAPT patient experience, 2020/21

<table>
<thead>
<tr>
<th>Lowest</th>
<th>%</th>
<th>Highest</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wigan Borough</td>
<td>41</td>
<td>North East Lincolnshire</td>
<td>96</td>
</tr>
<tr>
<td>Lincolnshire</td>
<td>46</td>
<td>East Riding of Yorkshire</td>
<td>93</td>
</tr>
<tr>
<td>Halton</td>
<td>47</td>
<td>Stafford &amp; Surrounds</td>
<td>93</td>
</tr>
<tr>
<td>Ipswich &amp; East Suffolk</td>
<td>47</td>
<td>Havering</td>
<td>93</td>
</tr>
<tr>
<td>Bristol, N Somerset &amp; S Gloucs</td>
<td>48</td>
<td>Sunderland</td>
<td>92</td>
</tr>
<tr>
<td>Portsmouth</td>
<td>51</td>
<td>Hull</td>
<td>92</td>
</tr>
<tr>
<td>Leicester City</td>
<td>52</td>
<td>Dudley</td>
<td>92</td>
</tr>
<tr>
<td>Ealing</td>
<td>52</td>
<td>Sandwell &amp; West Birmingham</td>
<td>92</td>
</tr>
<tr>
<td>Leeds</td>
<td>52</td>
<td>South Tyneside</td>
<td>91</td>
</tr>
<tr>
<td>West Suffolk</td>
<td>53</td>
<td>Wolverhampton</td>
<td>90</td>
</tr>
</tbody>
</table>


3.5 Local data on referral rates and severity

Differences in referral rates

The table below shows the CCG levels with the highest IAPT referral rate per 1,000 population in 2020/21. A higher rate indicates that more of the local population was referred to IAPT during the year.

Referral rates in Coventry and Warwickshire were notably lower than anywhere else in the country. Rates were highest in four Greater Manchester boroughs (Manchester, Salford, Oldham, Bolton). While some of the areas with higher referral rates also had high waiting times, there is little overall relationship between CCG referral rates and waiting times.

Note that these figures may reflect provision of services and access to services as well as demand.
Severity of conditions for those referred

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’ (WSAS), which is an assessment of how their condition impacts on their ability to perform day-to-day tasks. A score of 20 or above indicates moderate to severe psychopathology.

The average WSAS score of those starting treatment varies in different parts of the country. The table below shows the ten highest and ten lowest average scores. 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.

The maps overleaf show data on referral rates and WSAS scores for each CCG in England.
4 Other waiting times

The NHS in England measures a small number of other mental health waiting times. These are outlined below.

4.1 Early intervention in psychosis

60% 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 was originally introduced in 2016 at 50% and subsequently rose to 60%.

In the quarter ending August 2021 this target was being met nationally, with 62.4% of patients waiting for two weeks or less. This represents a fall in performance compared with two years ago, when 75.5% of patients waited two weeks or less for treatment.

However, there is substantial variation between local areas. The target was not met for 20 of the 95 CCGs for whom data was available. Performance was as low as 12% in one CCG (Cambridgeshire and Peterborough, with a further five CCGs also below 20%: St Helens, Knowsley, East Lancashire, Warrington and Morecambe Bay.

Data is published through the NHS Digital monthly mental health statistics report. Data prior to September 2019 is available on the NHS England website.

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 quarter ending September 2021, 62.6% of urgent referrals were seen within one week and 64.8% of routine referrals were seen within four weeks. Both of these figures represent a rise in waiting times compared with 2020 and 2019.\textsuperscript{14}

4.3 Children’s Commissioner report

The Children’s Commissioner provides an annual report on the state of children's mental health services. This provides a range of information sourced from the NHS which is not part of other routine publications. This includes information on waiting times for children's mental health services.

The report notes that 20% of children referred to services in 2019/20 started treatment within four weeks.\textsuperscript{15}

\textsuperscript{14} NHS England, \textit{Children and Young People with and Eating Disorder Waiting Times}

\textsuperscript{15} Children’s Commissioner, \textit{State of Children’s Mental Health Services 2020/21}
4.4 Proposed new waiting time standards

As noted previously, many NHS mental health services do not have waiting time standards and for these services no published data is available on how long people wait for treatment.

NHS England is proposing several new mental health access and waiting time standards, as follows:16

- For an ‘urgent’ referral to a community based mental health crisis service, a patient should be seen within 24 hours from referral, across all ages;
- For a ‘very urgent’ referral to a community based mental health crisis service, a patient should be seen within four hours from referral, for all age groups;
- Patients referred from Accident and Emergency should be seen face to face within one hour, by mental health liaison or children and young people’s equivalent service;
- Children, young people and their families/carers presenting to community-based mental health services, should start to receive care within four weeks from referral. This may involve immediate advice, support or a brief intervention, help to access another more appropriate service, the start of a longer-term intervention or agreement about a patient care plan, or the start of a specialist assessment that may take longer and,
- Adults and older adults presenting to community-based mental health services should start to receive help within four weeks from referral. This may involve the start of a therapeutic intervention or a social intervention, or agreement about a patient care plan.

16 NHS England, NHS England proposes new mental health access standards
5

Funding for mental health services

NHS England’s Mental Health 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. It also contains a range of indicators aside from funding.

How much is spent on mental health?

In 2020/21, local NHS CCGs spent £12.1 billion on mental health, learning disability and dementia services in England. This is 14.8% of the total funding allocated to CCGs for health services. NHS England spent a further £2.2 billion on specialised commissioning for mental health services, for a total of £14.3 billion. This figure has risen from £12.0 billion in 2017/18.17

Figures for mental health spend by CCG alone – independently of learning disability and dementia services – are not published. But for England as a whole, we know that £2.6 billion of the total CCG spend in 2020/21 was spent on dementia or learning disability services and not mental health.

CCGs plan to spend £12.6 billion on mental health, learning disability and dementia services in 2021/22. No figure is yet available for NHS England specialised commissioning spending.

The Children’s Commissioner report mentioned above contains analysis of spend on children and young people’s mental health by CCG. It notes that spending is slowly increasing but is highly variable across the country. The Children’s Commissioner describes spending levels as “still inadequate”.

How is mental health funded?

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. This means that neither the Government nor NHS England determines how much funding goes to mental health services in local areas.

17 NHS England, Mental health dashboard
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”.\(^\text{18}\)

**Mental Health Investment Standard**

While mental health spending is not ring-fenced, CCGs are expected to meet the ‘mental health investment standard’ (MHIS). This 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 MHIS.

All CCGs met the MHIS in 2020/21. In previous years, 10-20 CCGs did not meet the standard, but it has been met on a national basis each year since its introduction in 2015/16.

The mental health investment standard only measures changes in spending and provides no assessment of whether spending is adequate relative to local needs and demand for services.

**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.\(^\text{19}\) 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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\(^\text{18}\) NHS England, Mental Health Five Year Forward View Dashboard
\(^\text{19}\) NHS England, Programme Budgeting Tool
6 Where to find data on mental health for UK nations

Because health is a devolved policy area, data is collected and published separately for each UK nation.

England

- NHS England’s [Mental Health 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 of this data.
- NHS Digital publishes detailed figures on the [Improving Access to Psychological Therapies](#) programme. Monthly and quarterly reports are also available.
- 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](#).

Scotland

- [Scottish Health Survey chapter 2: mental wellbeing](#)
- Public Health Scotland, [Mental health inpatient activity](#)
- Public Health Scotland, [Child and Adolescent Mental Health Services (CAMHS) waiting times](#)
- Public Health Scotland, [Psychological therapies waiting times](#)

Wales

- Gov.Wales, [Mental health data sources](#)
- StatsWales, [Mental health admissions](#)
- StatsWales, [Detentions under the Mental Health Act](#)
- Gov.Wales, [Specialist Children and Adolescent Mental Health Service first appointment waiting times](#)
Northern Ireland

- Office for Statistics Regulation, [Review of mental health statistics in Northern Ireland](#)
- Health and Social Care Board, [Youth Wellbeing Prevalence Survey](#)
- Department of Health NI, [Health Survey 2020/21](#)
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