

Mental Health Inequalities: Measuring what counts

PARTNERSHIP SEMINAR, 16 MARCH 2009

ROYAL INSTITUTE of BRITISH ARCHITECTS

Summary Report

1.1 Executive Summary

What gets measured by government is crucial to the way public services use their resources. If we measure what really affects people's chances of a mentally healthy life, services can be held to account for achieving improvements and reducing inequalities.

A WHO¹ report has posited that mental health is the lynchpin between economic and social inequalities and that poor mental health experienced by individuals is a significant cause of wider social and health problems

A wide range of mental health conditions are consistently associated with unemployment, less education, low income and standard of living, poor physical health and adverse life events. For example, some people with severe mental health problems experience inequalities in their physical health that can significantly reduce their average life expectancy.²

Mental health stigma and discrimination exacerbate broader social and health inequalities and present major challenges for people with mental health problems to live as equal citizens in society. Intolerance and prejudice are also damaging to whole populations, as those with mental health concerns are less likely to seek timely care and treatment from fear of being labelled and ostracised.³

Good mental health underpins all of health and its absence is strongly associated with inequalities in both health and wellbeing. As a consequence, a well-developed understanding of the factors that impact negatively or positively on mental health and wellbeing can inform the metrics and measures that exist, or might be developed. Only then will the wealth of data be able to capture effectively a sense of the lives that people lead; and provide public services with the tools to intervene when those lives fall short of what citizens should expect.

1.2 Seminar Overview

1.2.1 Background

This seminar was a collaborative project that brought together acknowledged experts across various mental health and related fields in order to help define a set of measures that government might use to bring about not only a reduction in inequalities in mental health and wellbeing, but also improvements in the life chances of people with mental health problems.

¹ Friedli, L (2009) *Mental health, resilience and inequalities*. London. Mental Health Foundation & WHO.

² Seymour L (2003) *Not all in the mind*. London. **mentality**.

³ See *Time to change* (www.time-to-change.org.uk)

The unifying theme of the day – and it emerged repeatedly in a number of different ways – was *What can be captured? What will make a difference?* The point was made very forcefully that indicators act as levers, as political drivers, as ‘tin openers’. Those that drive targets nationally can be interpreted in a range of ways locally as long as the target is being delivered. There is a tension between national and local targets, but that tension can be productive.

There are a plethora of data and data collection tools and agencies. It is critical to keep scrutinising multiple targets and not to overlook social care data. E.g. there is an NHS Information Centre project on social care data. There will also be targets set within the Sustainable Communities Act and these can help to engage locally elected members; many of the targets impact on local authorities more than they do on other agencies.

The seminar was resolutely about inequalities. In other words it’s impossible to separate out the person from the place and the issues that drive inequalities, their social determinants, are critical. But calls for government to redistribute income would be a waste of time and opportunity.

There now exists a chance to craft a vision beyond 2010 – never losing sight of the political context of a forthcoming election, and all political parties’ commitment to reduce public expenditure as a response to economic recession. But even this scenario offers an opening, to have something other than economic growth as the main political driver.

There are a range of developments that can support and enable this new vision e.g. the Care Quality Commission (CQC)⁴ will be undertaking area profiling; Comprehensive Area Assessment (CAA)⁵ will scrutinise the performance of whole areas, not just discrete services; Joint Strategic Needs Assessments (JSNAs)⁶ will also measure assets of an area; and the user-focused outcomes enshrined in World Class Commissioning (WCC)⁷ offer a different slant on equitable service delivery. The Mental health Minimum Data Set (MHMDS)⁸ will commence relevant data collection this autumn, as will CAMHSMDs - whose ownership will be with education. So some of the trenchant silos are being breached.

Participants posed as many questions as answers. How do we use the data once collected? At which tiers, at what level are data collected? What measures will really drive commissioners or service providers or Local Authority councillors? Do we need data that goes down to Ward level to have an impact? What is the meaning of what’s being collected? What matters most to local populations? Do different measures work together? What are those that would most effectively steer the system?

⁴ www.cqc.org.uk

⁵ www.audit-commission.gov.uk/localgov/audit/caa/Pages/default.aspx

⁶ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097

⁷ www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/index.htm

⁸ www.ic.nhs.uk/mhmds

Data must be able to be used locally as it can only be interpreted usefully at a local level. Only then can there be a reasonable approach to what the data is saying. There is a need for common ownership at the level of mental wellbeing as well as a sharing of the 'burden' of data collection. A genuine re-examination of the plethora of data that is being collected is overdue; perhaps the consequence of such a review would be a call to stop collecting some of it. The data that remains needs to be reinterpreted through the lens of mental health inequalities.

The low level of awareness and understanding of the Public Service Agreements (PSAs)⁹ was highlighted; over time these will be key drivers, and so key people and agencies need that knowledge.

But pragmatism compels the acknowledgement that targets are not an end in themselves, they are there to drive and leverage change.

1.2.2 Seminar Aims

This event had the following aims:-

- To influence the development over the coming year of national indicators, measures and metrics as part of the next round of Public Service Agreements (PSAs);¹⁰
- To inform the independent review for the Government on health inequalities, led by Professor Sir Michael Marmot, and due to report in early 2010;¹¹
- To influence the Government's *New Horizons* programme on the future of mental health policy after the National Service Framework for Mental Health completes its implementation at the end of 2009;¹²
- To feed into the continual development of work to support the World Class Commissioning agenda, specifically for mental health.¹³

1.2.3 Seminar Structure

The seminar was organized as a mix of plenary sessions and themed workshops on seven topics:-

A good start in life: early years and families: People's earliest years and their early emotional, social and educational experiences, both for them and those that care for them, have profound impacts upon their life course. What are the metrics and measures that best report and capture these years? How do we get the most people to adulthood, with the least possible inequalities, and in the best possible shape for a productive and fulfilling life?

⁹ www.cabinetoffice.gov.uk/about_the_cabinet_office/publicserviceagreements.aspx

¹⁰ See footnote 9 above.

¹¹ www.ucl.ac.uk/gheg/marmotreview

¹² www.dh.gov.uk/en/Healthcare/Mentalhealth/NewHorizons/index.htm

¹³ www.nmhd.org.uk

Working lives: Work is good for mental health, it can also be damaging. Those with severe or enduring mental health find it hard to access the workplace. Mental ill health makes up the single greatest number of incapacity benefits claimants. What key metrics and measures best capture and drive the levers, enablers, blocks, performance and outcomes that will lead to a mentally promoting, inclusive and thriving work environment.

The places we live: People's environment can either promote or hinder good mental health. What metrics and measures best report and drive change that creates a locally mental health-promoting place and the opportunities for people to engage with them?

Financial security: Debt can be a cause and a consequence of mental ill health. People with enduring mental illness remain vulnerable to debt and also live lives with access to few financial resources. What metrics and measures best capture those factors that protect people from becoming ill through debt or increase the likelihood that, through financial resilience, their emotional and social capital will increase?

Social connectedness and social capital: People's interconnectedness matters, as does the frequency and quality of their interactions. Individual and community social and emotional capital is both a consequence and predictor of whether individuals within it will thrive or survive. What metrics and measures best report and capture social connectedness and social capital?

Body and mind: The poor physical health and high levels of adverse lifestyle risk factors tolerated within individuals and communities experiencing high levels of mental health are not acceptable. Poor physical health predicts poorer mental health. Long-term poor mental health in turn is more likely to lead to others diseases including specific excesses of some cancers. What metrics and measures best report and capture this area and are likely to drive future change to make the physical health dimensions of mental health and mental illness recognised and acted upon.

Later life: A mentally healthy and fulfilled later life should be an expectation for all as we grow older. Older people have a huge amount to offer to society but frequently experience loneliness and isolation. Mental illnesses and conditions more commonly experienced in later life will, as society ages, create an increasing challenge for mental health and wider services. What metrics and measures best capture mental capital, illness and engagement in this period of life and which ones are most likely to drive change to improve people's mental health and capabilities and changes to the daily lives they lead?

The workshop sessions were designed to help draw out participants' experiences, views and ideas on the following:

- What measures do we already have? How are they used against current Public Service Agreements, National Indicator Sets¹⁴, Vital Signs¹⁵ and World Class Commissioning

¹⁴ <http://www.audit-commission.gov.uk/localgov/audit/nis/Pages/Default.aspx>

¹⁵ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082542

outcomes? Are there others that are relevant? How helpful are these as drivers for addressing mental health inequalities?

- What measures do we have and currently do not use in each thematic area that may help to capture the inequalities dimensions of mental health?
- What bespoke or alternative measures should be developed or amended, from existing data sets, to better influence reductions in mental health inequalities across each theme? And can the data be collected and reported on at a local level?
- What from the day's work, in each thematic area, are the key metrics and measures that are most likely to drive whole systems and cross public service?

1.3 Key Issues

Inequalities are not just about equality of access, but quality of access. The consequences of inequalities contribute down the line to both health and mental health inequalities and it is important to capture the effects across the life course.

There was a shared view that measuring service outcomes is not the same as measuring inequalities. There is a pressing need to look beyond data sources, given that they have limited coverage. If the only issues explored are those for people in contact with services, there will be persistent uncertainty about what the inequalities actually are.

There are perverse incentives in the system, often obstructing good data collection and its use; there is a need to make connections between data systems, as well as to develop data collection mechanisms that are transparent and simple.

There are core issues of whether national governments invest on the basis of what local people want or say they need. It is important that relevant indicators, metrics and measures that report and act as drivers to reduce mental health inequalities are central to the areas of work covered in the seven thematic groups.

It is also important that future measures, indicators and metrics are able to capture the full breadth of modern mental health policy and practice encompassing promotion, prevention and care and treatment.

For example, wellbeing, positive mental health and public mental health are likely to require the development and implementation of new ways of measuring and collecting relevant data. These are new and emerging area of 'scientific' inquiry and data and indicators development.

Similarly data and measures on social inclusion and social justice, including anti-discrimination measures are also important. Ascertaining employment and housing outcomes for people will also be critical.

Recognising and working with the social determinants of health, and the broader social impacts or outcomes of healthcare services, will involve both broader and subtler metrics that can recognise both the appropriate contribution of healthcare to other services' efforts, in performance management of healthcare, and the appropriate contribution of other services and factors to health, care and well-being outcomes.

The new integrative mechanisms such as Joint Strategic Needs Assessment (JSNA)¹⁶ and Comprehensive Area Assessment (CAA)¹⁷ will allow for more contextual interpretations of data than were possible under single sector accountability approaches, whilst still providing objectivity and external verification.

In the future, a combination of well-crafted nationally sanctioned metrics and the "soft intelligence" of locally identified meaning may be most effective. For example, the Audit Commission has a set of indicators on quality of life and there are the emerging Quality Accounts.¹⁸

There is an imperative to harness these positive data so that rather than rehearsing the problems one more time, we move into a more positive and hopeful landscape. Bottom line - we need to tell a more positive story that not only captures the lives that people lead, but also one that can lead to some practical changes to improve people's lives.

The report of the day's proceedings is based on who was there and what they brought to the discussion. A significant achievement was to engage a broad range of people to discuss the data for the discrete domains. The experience broadened horizons and connected different worlds. But not all those who might have made a contribution were able to attend. As a consequence, unique and important perspectives and contributions may have been missed.

The organisers attempted to identify seven domains around which to build the work of the day. But it remains to be seen whether these areas were well enough defined or sufficiently helpful for the measurement of mental health inequalities.

In other words, how well does the data collected against these domains articulate, define and measure mental health inequalities? Should we recommend these domains to the different audiences we want to influence?

Looking across the reports from the seven domains, some are clearly more advanced than others; some are getting there; and some are not even on the page yet. What have been the drivers for

¹⁶ See footnote 6 above.

¹⁷ www.audit-commission.gov.uk/localgov/audit/CAA/Pages/default.aspx

¹⁸ www.dh.gov.uk/en/Healthcare/Highqualitycareforall/Qualityaccounts/DH_098449

this uneven progress? Does a PSA target/National Indicator act as a catalyst e.g. PSA16 on socially excluded adults has provided a focus for local strategic partnerships to prioritise achieving the employment target (National Indicator 150) in their Local Area Agreements (LAAs)¹⁹?

The policy arena has been and continues to be very dynamic; even since the seminar in March the pace of change and innovation has continued. Against that background there is a need to drill down into the next stage, to ensure that each area includes more on mental health than was there before. It would be a major missed opportunity if measures for mental health inequalities were not coherent across a range of service and interest areas such as employment, housing and debt. And all of these elements should be mapped across existing measures e.g. Vital Signs, WCC, etc.

1.4 Metrics and Measures: Areas for inclusion and further development

Of the seven themed workshops, the following demonstrated differentially well- developed metrics and measures to support their inclusion and development as necessary.

1.4.1 BODY + MIND

This theme approached the topic across four axes:-

- People with severe and enduring mental illness and their physical health;
- The impact of poor mental health on physical health;
- The impact of poor physical health on mental health;
- The impact of medically unexplained symptoms on mental and physical health.

Existing measures and metrics included:-

- MHMDS
- NPSA
- PROMs
- NHSLA
- Standard mortality rates
- QOF
- HoNOS
- Smoking rates
- Prescribing data

Areas for development included:-

- Outcomes measures – already being utilised in IAPT;
- Clinical outcome measures more generally;

¹⁹ www.communities.gov.uk/localgovernment/performanceframeworkpartnerships/localareaagreements

- Impact of Care Quality Commission’s scrutiny;
- CPA assessments and recording to include physical health needs;
- LAA targets that measure joint working between PCTs and health and social care to improve standard mortality ratios for people with enduring mental illnesses;

1.4.2 PLACES WE LIVE

There has been a degree of achievement against this theme and current or potential metrics that were especially useful were:-

- MHMDS (of particular use for those in contact with secondary care mental health services and used to support PSA16)
- SITREPS (measures of delayed discharge – although these need considerably more work to capture housing needs more effectively)
- Summary Care Record (can capture presentations at A + E)
- Supporting People Client Record and Outcomes data (can capture the characteristics and recent history of people needing support to achieve or maintain independence)

Areas for development included:-

- Monitoring and analysis of Housing Benefit claims and delays in payment;
- Developing datasets for homelessness assessments and outreach; and for specialist supported housing and resettlement services;
- Adaptation of housing services’ datasets to incorporate terms better suited to identify mental health issues.

1.4.3 WORKING LIVES

PSA16 on adults and social exclusion has acted as a catalyst against delivery of NI150 on employment for those who have been in contact with secondary mental health services. There have been variable developments and current measures and metrics include:-

- MHMDS (new lines have been added re: employment to support PSA16 delivery);
- Electronic sickness certification;
- Survey of people using community mental health services;
- Census data

Areas for development included:

- Integration of electronic sickness certification and IAPT datasets;
- Enable mental health analysis of Benefits claimant count;
- Negotiate access so that different datasets can be linked or used together;
- Persuade DWP to use claimant count for measurement purposes.

1.4.4 A GOOD START IN LIFE

There was a lack of clarity on the metrics and data sets that might be of most use on this theme. Some of those suggested by participants included:

- Dartington model (data) for local authorities to prioritise what they want to achieve. (www.preventionaction.org);
- SDQ (strengths and difficulties questionnaire) linking in with CAMHS data;
- Health of the Nation Outcome Scores (HONOS);
- KIDSCREEN - generic quality of life measures for children and adolescent aged between 8 to 18 years;
- TAPQOL (TNO-AZL Preschool children Quality of Life).

An identified gap was a clear link with DCSF, e.g. their substantive work in development on links with emotional wellbeing. Similarly there was a gap in knowledge about ONS and its current work on children's wellbeing.

Early years, children and young people is one of the most critical areas for the development of robust metrics and measures on mental health inequalities. Once set in train, these inequalities follow a person throughout the life course.²⁰ A case for early action can be made most forcefully if data can support requisite investment.

1.4.5 FINANCIAL SECURITY

Few metrics or measures were offered by this thematic group, even though it is recognised as a key area.²¹

Group participants did clarify that:-

- Objective measure of problem debt = number of consecutive bill payments behind;
- Subjective measure of problem debt = management of debt repayment that produces significant negative outcomes.

Three national indicators were proposed and are in pressing need of development:

1. A reduction in the mental and physical impact of problem debt on:
 - people with debt and mental health problems
 - people with mental health problems who are at risk of becoming over-indebted
 - people who are over-indebted who may be at risk of developing mental health problems
2. The establishment and monitoring of partnerships between local agencies working on aspects of debt or mental health, including:
 - rates of referral from primary care/secondary care to accredited money advice agencies
 - numbers of individuals referred from primary/secondary care who were successfully 'received'/assisted at a money advice agency

²⁰ National Economics Foundation (2009) *Backing the future: Why investing in children is good for us all.* (www.neweconomics.org)

²¹ E.g. the Royal College of Psychiatrists facilitated a one-day debt and mental health seminar on 9 September 2009.

3. Numbers of people for whom an assessment is conducted (by health or advice sectors) of their entitlement to benefit, their uptake of relevant benefits and the financial impact of benefit uptake (i.e. additional income achieved).

1.4.6 LATER LIFE

Although there have been recent developments on mental health and later life,²² there has been insufficient work to date exploring mental health inequalities amongst this growing cohort of the population. A wealth of data on morbidity and mortality already exists, but the inequalities aspects must be incorporated and relevant data collected accordingly.

There is of course a need to cross reference with the Dementia strategy²³, as well as cross-government and DH work on later life. But it is imperative that a range of risk and protective factors are balanced and reflected in relevant metrics. For example, do we know the extent to which people in later life are physically active; or participating in lifelong learning; or socially connected across the generations?

Participants described a range of current indicators that could be utilised to capture a more accurate portrait of mental health inequalities amongst those in later life.

- Audit Commission/DWP PSA17 (wellbeing of older people) – ‘dashboard indicators’ e.g. good place to grow old; healthy life expectancy; use of adult/leisure; volunteering;
- +5 key themes from Age Concern/Mental health Foundation Later Life Inquiry e.g. income/poverty, meaningful activity, social relationships, physical health, age discrimination;
- Basket of measures in ‘Quality Accounts’ – Audit Commission;
- Discharge from hospital to care home;
- GP prescribing of anti-psychotics;
- Access to psychological therapies;
- PROMs;
- Count me in census – 65+;
- QOF for depression;
- Primary care rolls;
- Alcohol intake; obesity levels; nutrition; smoking;
- Suicide and self-harm rates;
- Welfare benefits uptake;

²² See for example the Mental Health in Later Life Inquiry (www.mhilli.org); or the Nice guidance on *Occupational therapy interventions and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care* (www.nice.org.uk/PH016).

²³ (www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Olderpeople/NationalDementiaStrategy/index.htm)

1.4.7 SOCIAL CONNECTEDNESS + SOCIAL CAPITAL

Metrics and measures associated with this theme were perhaps the most underdeveloped. Participants noted that even having a discussion of relevant issues and possible measures and metrics was in itself groundbreaking.

There were no existing measures that could easily be identified, but some of the possible areas for development included:-

- NI6 on national rates of volunteering;
- NEF's *National Accounts of Wellbeing*;
- DCLG surveys on citizenship;
- Data collected to support the *Independent Living* agenda;
- Process measures linked to *Place Shaping* agendas e.g. expecting public services to improve access for those with mental health conditions;
- A framework of interconnected indicators on *personal healing* – reduced readmission rates, reduced severity of admissions, improved housing; and *social healing* - access to local services and shared spaces.

Clear links between DCLG and LGA are paramount as they sit at the heart of the community wellbeing agenda with their place-shaping roles and responsibilities. Mental health inequalities sensibilities need to be developed and mapped against their current remits.

Note however that many of the issues raised under the theme of *Places we live* have an impact on social connectedness and social capital.

2. Workshop Reports

Each themed group met twice during the course of the workshop to discuss over-arching issues as well as specific measurement tools or potential indicators that might answer key questions on mental health inequalities.

2.1 A good start in life: early years and families

People's earliest years and their early emotional, social and educational experiences, both for them and those that care for them, have profound impacts upon their life course. What are the metrics and measures that best report and capture these years? How do we get the most people to adulthood, with the least possible inequalities, and in the best possible shape for a productive and fulfilling life?

WHAT DATA SOURCES DO WE HAVE? WHICH MIGHT WE DEVELOP?

Dartington model (data) helps local authorities to prioritise what they want to achieve. Measures include community based surveys (parents of children aged 0-6) and comparative data through online surveys of children 7 years and up.

(www.preventionaction.org)

SDQ (strengths and difficulties questionnaire) linking in with CAMHS data.

Health of the Nation Outcome Scores (HoNOS).

(SDQ, HONOS link in a meaningful way with both prevention and wellbeing measures at primary care level and at the other end where mental health problems go on into adulthood with adult tools.)

KIDSCREEN - The KIDSCREEN instruments are a family of generic quality of life measures that have been designed and normed for children and adolescent aged between 8 to 18 years.

TAPQOL (TNO-AZL Preschool children Quality of Life)

GAPS and LIMITATIONS

- We are missing a 'families measures' – services need to focus on families and the importance of considering not only the wellbeing of the child but the wellbeing of the family unit. Wellbeing is context specific. A family focus by all the work streams would be beneficial for outcomes for all across the lifespan and could if configured appropriately be cost neutral or over time have positive cost benefits.
- There needs to be a stronger link between Department for Children Schools

- and Families (DCSF), Local Authorities and local schools – connecting up the evidence base. This must include teacher knowledge, service delivery and quality of services.
- Directors of Children’s Services are the ‘lynchpin’ and need to focus at the local level with subset to be fed upstream.
- There needs to be greater engagement with children and young people – we should be asking them for their input in developing measures that are meaningful for them.
- Most service oriented interventions are about the service oriented groups and don’t necessarily contextualise within the whole population or explore what happens across the life course.
- This is an illustration of inequalities within mental health e.g. how do we measure risk and resilience? Risk factors are easier to correlate but it is often not clear how you measure resilience. Capturing the data from the teacher in primary education/primary is very important – primary school teachers know everything about the child and the parent. Schools are priority for wellbeing.
- Schools ‘buy-in’ interventions, however 50% of these interventions are not evidence based. There needs to be greater fidelity of interventions. This is not to say that all interventions without an evidence base are not effective and equally not all evidence based interventions are necessarily effective – you can have an accreditation that is only as good as the evidence available.
- Process of encouraging head teachers to think about what is best for their children. Bundles of protective factors – connection to home/school – what is the connection and how is it valued?

KEY ISSUES

A range of key issues needed addressing e.g.:

- Strategic thinking about why data is being collected, as there is an inherent danger in having too many measures;
- Focus on current utilisation of existing data and information systems before embarking on collecting more data, reinforcing data between social care and healthcare, while acknowledging that authorities’ boundaries are not always coterminous;
- Greater information exchange and sharing across departments;

- Improved cross-fertilisation and collaboration between IT and mental health specialists, many of whom do not understand each other's areas of expertise, to ensure that as far as possible, the data and the information systems are responsive to population level changes;
- National-local tensions e.g. improve information feedback loops to ensure adequate information exchange from the ground level up and from the national level down - local level action must be translated into national level indicators;
- Information needs to be contextual and to focus not only on children with mental health problems but on those children who do not have any mental health problems to ensure that measures of wellbeing are appropriate and relative and to learn from those children that are more vulnerable;
- Outcomes need to capture implications across the life span as the issues that arise in childhood and adolescence can have impact throughout the rest of the adult life.
- There was agreement of the need for greater alignment of outcomes and indicators – how do we improve the alignment between what we do on the ground with what we have as targets and ensure that this implementation is at the right level and utilises the right levers to ensure the optimal outcomes?

With reference to knowledge and practice participants thought that data sets and catchment systems are not 'talking to each other'. Information sharing protocols (a) are not established and (b) are open to interpretation and the default position is that if the information sharing protocols are not established then organisations and departments don't share.

There should be greater recognition of the mental health determinants of a good start in life and a synergy between knowledge and practice – currently policy is disconnected from input and outputs (joining and affect).

Fundamental considerations include:

- Who will use these measures?
- What are we trying to change?
- What is an outcome?
 - i. Service input
 - ii. Local authority
 - iii. Child's development, maturation
 - iv. Cross-government strategy
 - v. Indicatory?

2.2 Working lives

Work is good for mental health, it can also be damaging. Those with severe or enduring mental health find it hard to access the workplace. Mental ill health makes up the single greatest number of incapacity benefits claimants. What key metrics and measures best capture and drive the levers, enablers, blocks, performance and outcomes that will lead to a mentally promoting, inclusive and thriving work environment.

WHAT DATA SOURCES DO WE HAVE? WHICH MIGHT WE DEVELOP?

- Census data sources that monitor the whole population of the country, can provide small area information, an issue of particular relevance to local authority councillors, whose interest is in having specific data relating to the whole local authority.
- Benefits claimant count, currently is publicly available and can be easily interrogated in relation to health problems (e.g. via the NOMIS website), but does not distinguish mental health problems from learning disabilities; but (with political will) data could be analysed in separate categories.
 - The reporting system is in the process of being reorganised for requirements of the new Employment and Support Allowance (ESA).
 - Important issues are the complete percent reliability of diagnostic coding, and the failure to include evidence about whether local health or employment support services have been used.
- Electronic sickness certification could provide local and wider information for those in contact with primary care. Improving access to psychological therapies (IAPT) dataset could be developed and as the data on sickness certification would provide information about the practice level impact, it should be integrated with IAPT.
- Labour Force survey/annual population survey; weak source for monitoring services partly because of the much lower granularity e.g. small numbers of people who are limited or disabled by their mental health problems in many of the local authority areas, and also because of time lag in data becoming available. Data can be more useful regionally than locally if quality is a problem.
- The data from the (sample) survey of people who use community mental health services are relevant and informative in relation to assessing progress amongst people who use services e.g. receipt of help to find work or benefits/if people are in paid work. [NB: unclear as to whether this will continue on an annual basis as a survey of inpatients has been introduced this year.]

- The mental health minimum dataset (MHMDS) has information about individuals in contact with mental health services. New lines have been added re: employment and housing status to support relevant national indicators in PSA 16. Data quality is likely to be poor for some time as these are new items, and particularly its collection depends on whether a care review has happened as to whether the information has been collected / recorded.

KEY ISSUES

A range of critical issues were identified by group participants, including:-

- The small proportion of mental health service users in work;
 - Limited public understanding of the significant impact of mental health problems on employment;
 - employment is means for addressing mental health problems;
 - Awareness of the importance of enabling service users to stay in/ retain work may need boosting amongst mental health professionals;
 - These issues are compounded by, and exacerbate sensitivity amongst people with mental health problems about disclosing their mental health problems in work contexts;
 - Stigma is associated with low use of services that would enable take up of legal rights in respect of antidiscrimination legislation; it is evident in public services e.g. DWP contracts; working with people with mental health problems; confidence of services in dealing with these population groups.
 - There is also considerable stigma *within* some mental health services including low expectations of service users as a barrier to employment.
- The situation of being unemployed - what it means to people;
- Conversely the mental health impact of employment - some workplaces maybe deleterious for certain individual's mental health;
- The position of subgroups who are particularly disadvantaged (including people from black and minority ethnic groups, offenders, women);
- Differences in work rates between different disabled groups and between people with different diagnoses;
- The significance of employment history (e.g. absence of continuous employment and having worked recently linked to prospects) and educational inequalities (from pre-school, persistent disadvantage) for an individual's employability;
- The distinction between those who have never worked (e.g. young people) and those who have had a previous work history;

- The age of onset/detection of a mental health problem and the implications of this (e.g. young people who have never worked is an issue that arises particularly within early intervention services);
- The changing labour market and importance of transferable skills;
- The geographic variations in the types of difficulties/long term unemployment; should an **employability index** for local area populations be developed?
- The nature of schemes to help employment, how efficacious these are and the extent to which they need to be flexible in the context of the rapidly changing employment situation;
- Schemes for getting people with mental health issues into employment and supporting them in their work vary widely in their availability across the country, as does help with job retention (including access to in-work support and support from mental health services);
- Outcomes can only be satisfactory understood in relation to case mix of the groups through interventions being provided; more inclusive services are almost inevitably likely to have poorer overall outcomes;
- People on Incapacity Benefit/Employment and Support Allowance are being 'written off';
- Issues on accessing generic employment services (such as Access to Work) and their efficacy.

There is a need to:

- distinguish differences between groups in terms of employment rates/find out what groups are being disadvantaged and the extent to which the effectiveness of interventions varies by groups;
- identify the cause of unemployment – health vs. labour market?
- ask about employment as a routine part of healthcare.
- decide to whom people with mental health problems should be compared - the whole population or other groups of disabled people?
- decide whose priority is it? The data won't work unless services are integrated (IAPT is an example of this); mental health and employment cross lots of different silos.

GAPS and LIMITATIONS

The availability of data on mental health and inequalities was poor overall with particular gaps in relation to:

- Job retention
- People with a learning disability

- No workable dataset to measure impact of policy aimed at increasing labour market participation (MHMDS was the best hope for those in contact with services but it will take time before the data quality improves.)
- Longitudinal data (e.g. from Claimant Count if the diagnostic criteria issues could be resolved).

Should new datasets be created or should existing ones be developed? The scales used in different data sources vary – it may be easier to compare if these can be accounted for.

What about amending MHMDS to allow change over time to be measured. Claimant count could be used to greater effect.

If data gets used for measurement it can help to improve quality - e.g. Healthcare Commission has monitored the quality of data on ethnicity as a specific indicator- improvements have been noted over time. Having an interim indicator on quality of coding might therefore be an option.

There is a need to get separate data sets to work together. The electronic 'fit note' is an opportunity to do this e.g. to coordinate DH and DWP data.

What about the possibility of integrating: a) health and work and pensions data; b) education/training data with employment data (where do people end up?).

A key difficulty here is definitional incompatibility. Health data obviously only provide information about a small subset of individuals claiming benefits. What is needed are integrated definitions that are not restricted to service use.

There are different definitions of groups of people between different data sources; also of mental illness.

Agreeing definitions at least for mental health and using these across data sets is fundamental.

SUGGESTIONS FOR METRICS

There are key issues that would need to be addressed/resolved to progress any development of new metrics and measures:

- Resolve differences in definitions
- Negotiate access so that different datasets can be linked or used together
- Improve data availability, quality and consistency
- Compare with expected levels for each locality
- Persuade DWP to use claimant count for measurement purposes.

The claimant count

Proposals: A reduction in the number and proportion of people claiming benefits because of mental health problems

The advantage of claimant count data is that it is a universal data source incorporating longitudinal linkage of claims by individuals. The drawback of the data is that diagnostic detail is questionable in its accuracy. On balance we concluded that the most satisfactory metric could be obtained by seeking to supplement claimant data at the new Work Capability Assessment and subsequent Focused Interviews, with a slightly enhanced assessment protocol. These enhancements would seek to clarify the severity of mental illness (for example using an instrument such as the self-administered GHQ 12), questions about mental healthcare the individual had received since deciding they had a problem, specialist mental health employment support they had received/ whether this was helpful, and specific risk characteristics including their age, sex, ethnicity, educational attainment and household composition.

This would allow for calculation of:

1. Local population base rates of numbers of claimants with mental health problems and,
2. for geographic areas, the proportion of such claimants receiving support/a service in relation to their mental health or employment situation.

These should give some measure of the success of local services in preventing prolonged periods out of work and the extent to which services are successfully identifying and targeting people who need them.

Electronic sickness certification

Proposals: A reduction in the number and duration of sick notes issued for mental health problems

The new system for electronic certification of sickness absence from work, to be introduced as a result of Dame Carol Black's review (the 'e-Fit' note), was another possible source of relevant information and could allow statistics of population-based rates of individuals taking time off sick as a result of mental health problems.

A number of questions would need to be addressed:

- Should GPs collect data on this?
- What questions should go into this?
- How is it being handled?
- Can the data be used longitudinally and as prompt to GPs on risks of certain actions? Who would be responsible for this?
- Would the information go routinely to CQC?
- Would it be possible to link the data with DWP data on benefit entitlement; to link it with IAPT use and outcomes; to add ethnicity and other data?

PSA 16 target

Proposals:

- Extend PSA 16 to all people using mental health services/IAPT services
- Extend the lifetime of the PSA

- Increase the profile of the target within ***Vital Signs***

The current PSA target (NI150) is important because it specifically addresses the situation of a small but the particular group of individuals with severe mental health problems who often face the greatest barriers to getting back to work. The current collection mechanism (MHMDS) will only just be beginning to become stable by the time the first three years of the target expires and should be extended to allow time for useful work with it. The scope of the target should be extended, or another developed, to incorporate all people who use specialist mental health services and IAPT services. Moving it further up the operating framework Vital Signs (from local action to a national priority regarding local action) would also give it greater profile and ensure some attention to the issue particularly during a time of recession.

Access to evidence based employment support

Proposals:

- An increase in the commissioning/availability of evidence-based services that provide employment support (both placement and retention) for people with mental health problems
- An increase in the numbers and proportion of people with mental health problems receiving effective/evidence based support to secure or retain employment

Refinement of questions in the annual mental health service mapping about employment support services would produce useful information and form the basis of a process measure; specifically a fidelity criterion to identify whether services use the evidence-based IPS approach.

These indicators could be used to hold PCTs as commissioners to account and to identify if people have access to an effective IPS service. One option would be to add questions into the service mapping to ascertain whether commissioners have identified the needs of people locally in relation to employment support and whether the employment support commissioned is compliant with IPS (using the fidelity scale). Contracts for providers should include evaluation of the effectiveness of support so that commissioners can keep an eye on the process and outcome.

Fidelity scales might be applied to other services (such as learning and skills) and could be added to the service mapping.

Reduction in the differences in employment rates

Proposals:

- A reduction in the difference in the employment rate between the general population and all people with mental health problems
- A reduction in the difference in the employment rate between people who are limited and/or disabled by their mental health problem and other people who are limited and/or disabled by other health problems

As work rates are inevitably linked to the economic cycle, progress in improving work rates may be more limited during times of recession. One alternative is to compare work rates between groups where there are known inequalities.

Use the data from the Labour Force Survey/annual population survey, to focus on the comparison or gap between the employment rates for: a) the general population and people with any mental health problem (whether or not they were limited or disabled by their problem; b) people limited/disabled by their problem and other groups of people with disabilities. However, given the prevalence rates of mental health problems, the analysis would need to be at regional and national levels – at least for the second of these indicators.

Perceived ability to work

Proposals:

- A reduction in proportion of service users who consider they cannot work because of their mental health problem

The results of the Healthcare Commission service user survey have indicated that a substantial proportion of respondents (around 50%) consider that they cannot work because of their mental health problem. Although we need to be aware of people's own wishes and motivations and sense of their own abilities, views are shaped by experiences and many specialist mental health services can perpetuate low expectations of service users' capacity in this regard. Another suggestion was that questions could be added to staff surveys to try to ascertain whether workers believe that people can get back to work.

Based on the data from the survey of people who use community mental health services, this indicator could provide some measure of changes over time in perceptions of ability to work. This information could be seen alongside the results of survey on reported access to help to find work and whether there is a correlation between the two.

2.3 The places we live

People's environment can either promote or hinder good mental health. What metrics and measures best report and drive change that creates a locally mental health-promoting place and the opportunities for people to engage with them?

WHAT DATA SOURCES DO WE HAVE? WHICH MIGHT WE DEVELOP?

Five current or potential health service metrics were mentioned as having some especial utility – two (in primary care and public health) with no great precision as yet, partly as new services and approaches are still evolving. But amongst current data, the MHMDS, SITREPS, and the Summary Care Record data were singled out.

- For those in **secondary mental health** care, the recent work to support PSA16 has meant the introduction of new data items in the Mental Health Minimum Dataset (MHMDS) which will

provide a wealth of information on individuals' housing and employment circumstances never before collected.

- These data, once “bedded in” and reliable, can be analysed against a sociodemographic and clinical features in individual cases, and aggregated to form a picture of community mental health need analysable by both social groups and geographical areas.
- These clinical data can then be cross-correlated with data which housing services, ONS etc already collect on the quality of housing stock and other neighbourhood features, to give a richer picture both of the housing circumstances (i.e. not simply of security of tenure) of people with major mental health problems, and also of the concentrations of particular mental health needs in certain areas.
- Data from other related services, such as the local Housing Benefit section, are also relevant and will have information on individuals' benefits claims, including late return or non-renewal of claims. Information-sharing protocols between agencies have been shown to be effective in intercepting risks to the secure enjoyment of a home.
- SITREPS, the current dataset that measures delayed discharge is inappropriate to mental health needs and pathways and needs revision to make it suitable for both performance management and commissioning purposes.
- For those who are not well engaged in health and social care services, frequent call upon A&E and other crisis management services are a part of the presentation. The use of Summary Care Record data, including individuals' presentations at A&E, may need to be joined up with other information, to help identify the needs of those most marginalized.
- Survey-based measures of community quality form part of the National Indicator Set; and current measures of trust and security in neighbourhoods may be given greater weight in local area Comprehensive Area Assessment (which replaces individual service or sector assessment from April 2009). For the future, a comparable measure could also be considered as an aspect of public mental health in Care Quality/Audit Commission assessments of healthcare commissioning for public health.
- However, there is a need for caution over measures of social cohesion, as it is feared that strong, cohesive communities may nevertheless exclude those who are not seen as full or legitimate members of the community. It may be necessary to seek to include, in such surveys and measures in the future, further questions which ask how successful a community and its services are seen as being in welcoming and supporting newcomers, or those more vulnerable.
- **NB:** A forthcoming initiative from the Royal College of Psychiatrists Centre for Quality Improvement is attempting to derive a single set of common values and standards by which environments of all kinds, from acute wards to supported housing to communities, may be assessed (and self-assessing) for the extent to which they are truly enabling of the emotional

well-being of participants. This CQI initiative is an attempt to create an evidence-able qualitative measure. The initial consultations on this methodology are scheduled for the summer of 2009.

GAPS and LIMITATIONS

For the future, the removal of the “ring-fence” around Supporting People funding allows SP-funded services to identify needs with new flexibility and new language. The creation in 2008 of two new social housing regulators brings with it potentially new procedures and criteria for measures of need (for new housing) and of effective service delivery (in housing management) in social housing.

There are relatively few secondary care services which actively seek to engage those with the most complex needs, such as those who are to be found in homelessness services.

The evidence is strong for significant levels of untreated mental health problems in homelessness services, including high levels of personality and stress disorders (or “complex trauma”) compounded by substance abuse.

Social housing and support services, alongside primary care, may be better able to engage those most reluctant to engage with conventionally structured secondary mental health services, such as refugees and asylum seekers, women escaping domestic violence, and vulnerable young people.

The datasets for homelessness assessment and outreach, and for specialist supported housing and resettlement services, may be the best available evidence for these un-met needs. They are not currently constructed with a view to identifying mental health needs or commissioning for services for un-met needs; nor do they typically “join up” with other datasets in health care.

For the future, there is no reason why housing services’ datasets could not be adapted to use a vocabulary better suited to identify such mental health issues; and this data – combined with the experience of housing staff on what is working in developing more effective partnerships - should be used as part of Joint Strategic Needs Assessment, to help identify the healthcare needs of those currently excluded.

There is a strong case for further research to help identify how far various housing problems create mental health issues in their own right, and/or may stand proxy for other social disadvantage and environmental pathogens.

By marrying up area-based measures of need, including housing services’ information, we may seek to develop an area-based, population-based measure of anticipated need with greater refinement for local determinants and resilience factors. This measure can inform future calculations at local level for resources to meet needs available to primary care, and for the delegated budgets for practice based commissioning.

There is clearly a need for great care over data protection and client consent to any sharing of information. The seminar group expressed a clear preference for common terminology for improved information sharing protocols and channels, between agencies, rather than attempting a single register or mainframe database.

Nevertheless, in an era of community-based care, where successful outcomes are the product of good partnership work, the efforts of any one agency may be conscribed or supported by the efforts of another. It is therefore necessary to interpret all services' performance management data in the light of local knowledge of the ecology of provision and pressures in each area.

Similarly, it is necessary to hear a range of local stakeholders' views, to ensure that the improvement of performance measured on any set of metrics is not achieved by distortion of more rounded and sustainable priorities area. This *triangulation of data* can be seen as a form of quality assurance.

KEY ISSUES

The discussion revolved around two key themes:-

1. the areas of greatest challenge and potential for housing and mental health, i.e.: those areas where meeting needs had either not been addressed or not yet been achieved, but where significant improvement is possible.
2. the potential in other services' knowledge and datasets, in addition to DH's, for useful evidence both on the sources of ill health or failure to thrive, and of the success of health and social care services' efforts to promote well-being.

Four key areas for future work then emerged, ranging from "upstream" prevention work to alternative/modernisation approaches to those with significant mental health needs. The four target populations/areas for action are

- those with high levels of need in secondary mental healthcare;
- those with high need but marginalized or excluded from secondary care;
- those failing to thrive in primary care; and
- those interactions between people which reflect aspects of neighbourhood design and management, for positive public mental health.

Use of other services' data also holds great potential for a better recognition of needs and of successful partnership work, at local level. For each target area the role of housing and housing services was therefore explored, and the availability or negotiability between agencies of suitable metrics.

Much however also depends on the sophistication with which such metrics can be interpreted, in context. Identifying, assessing and encouraging inter-sector partnership work will be the key to tackling health inequalities. New metrics must be developed with a view to both specific national priorities and performance monitoring, and overall local priorities, local knowledge, and contextual interpretation.

The development of Joint Strategic Needs Assessment (JSNA) allows local authorities and primary care commissioners' areas to determine and review all data that they find most relevant to identify both strengths and weaknesses in their areas.

The new integrating structures of JSNA and CAA are therefore seen as the key to guaranteeing the meaningfulness of any nationally set metrics and measures, and preventing distortion of services and other such perverse outcomes of measurement. The scope for developing new and more meaningful metrics therefore depends in part on the opportunities presented as services evolve and new datasets emerge, and in part on the extent of political will and partnerships at both national and local level.

The estimates for the numbers attending GP appointments with mental health, or mental-health-related complaints, vary according to the breadth of definition of "mental health-related". But there is now ample evidence that socially impoverished and socially stressful environments can trigger, exacerbate and/or prolong ill-health and preclude recovery, in physical and mental health, and in the grey area between.

Medical priority re-housing is known to be particularly effective at relieving mental health problems, and housing-related support is effective in relieving the practical and emotional stresses that can arise in problematic housing.

The places we live – housing and neighbourhoods – are generally seen, alongside employment and family and close social networks, as one of the key loci and determinants of a sense of belonging and social well-being. The role of housing services in the construction (and/or subsequent re-modelling) of estates and areas as "social spaces", in which social capital can be "designed in", just as crime may be "designed out", has recently become an area of increasing interest.

There is similarly growing awareness of the extent to which housing management of the existing housing stock, working in and alongside community development approaches, can also foster a sense of local engagement and belonging, with social housing services in particular able to operate consciously as "community anchors".

The Darzi reforms encourage the creation of multi-service teams to provide more flexible and holistic services. Current DH policies also endorse Practice Based Commissioning, and allow for "social prescribing", where budget holders can agree criteria and procedures for accessing non-health budgets. But at this stage in the evolution of policy and practice, these processes have not yet formed datasets on innovative provision or mechanisms for commissioning that can respond to needs.

2. 4 Financial security

Debt can be a cause and a consequence of mental ill health. People with enduring mental illness remain vulnerable to debt and also live lives with access to few financial resources. What metrics and measures best capture those factors that protect people from becoming ill through debt or increase the likelihood that, through financial resilience, their emotional and social capital will increase?

WHAT DATA SOURCES DO WE HAVE? WHICH MIGHT WE DEVELOP?

- Objective measure of problem debt = number of consecutive bill payments behind;
- Subjective measure of problem debt = management of debt repayment that produces significant negative outcomes.

GAPS and LIMITATIONS

There was a sense that there are significant gaps and limitations in understanding on this theme. As a consequence the development of any indicators should be determined by and associated with:

- three **key definitions** – it was felt important that we precisely defined our key concepts;
- three **guiding principles** – the group identified three principles that anyone developing the proposed indicators should always keep in mind;
- three **populations** - the group identified three social groups who needed to be addressed through the proposed indicators.

KEY DEFINITIONS

There was consensus that key concepts and constructs required clarification, e.g.:-

Debt

When it can be repaid or managed, debt is not inherently problematic. Access to credit and financial services is increasingly a component of modern life, and can actively enhance individuals' lives. Furthermore, the majority of people with a mental health problem have the skills and capacity to manage their finances.

Consequently, it is important to distinguish between 'debt' and 'problem debt'. In this report we focus on those individuals experiencing mental health problems and 'problem debt'. We define 'debt' as having outstanding money to repay. We define problem debt in two different (but complementary) ways:

- an objective or 'hard' measure - where an individual is a number of consecutive payments behind with a bill or repayment (this is defined differently according to the evidence base, but 1-3 payments in arrears appears to be the common range);

- a subjective or 'softer' measure - where the management or repayment of the debt is perceived as having a significant negative effect on the individual and their quality of life.

For example, a person may be making payments but having to cut back on essentials and living in poverty. If the individual then engages with a money advice agency they will be informed that they have the right to feed themselves and their children and restrict payments to their creditors in order to enjoy a basic lifestyle. It may be at that point and only at that point that they may then enter the 'problem debt' definition of being behind on payments to a creditor, although the debt may have been a significant for the individual leading previous to this as the individual may have been harassed into making unaffordable payments to a creditor in order to satisfy them.

These types of impacts lead to the other less obvious links between debt problems and poor mental health such as when people have less money they may eat cheaper foods which are less good for them, resulting in obesity, poorer mental health, and poorer *physical health*; Having less money to spend can also result in people staying in more, which in some cases may contribute to isolation and mental health problems.

Mental health

We define mental health problems as including the common mental conditions (depression, anxiety etc), less prevalent mental illnesses, as well as intellectual/learning disabilities.

Money advice

We define money advice as an accredited service which provides information about how people can manage their debt; who can help individuals negotiate with creditors to establish an acceptable repayment schedule; who may advise clients on sources of help and their options; and which offer a service that is free to clients, independent, and confidential.

GUIDING PRINCIPLES

Mental health problems are common and debt is a serious issue

Government surveys report that in Britain:

- 1 in 6 adults is living with a mental health problem (ONS, 2001);
- 1 in 4 adults with a mental health problem is living with debt or arrears;
- 3 times as many adults with mental health problems report debt or arrears, compared to those without mental health problems (1 in 11) (ONS, 2002).
- Furthermore, 1 in 2 adults with debt problems also have a common mental health problem (Jenkins, 2009 forthcoming).

Debt may be a determinant and consequence of mental health problems.

Research studies indicate that debt can be both a determinant of mental health problems, as well as a consequence. This includes:

- anxiety and stress;
- depression;

- self-harm and suicidal thoughts;
- strain on personal relationships, social inclusion, and self-esteem.

This is a public health issue that involves not only the health and social sectors, but also links with money advice bodies and creditor organisations (e.g. banks, building societies, debt recovery agencies etc).

Any activity needs to address debt and mental health needs to take account of incentives and resources

It goes without saying, that activity needs to be fully resourced (i.e. expanding and developing links between health and money advice), and adequate incentives should exist for health and social care professionals to become involved (both in the activity and the measurement of this).

THREE POPULATIONS

The above principles can be applied to three distinct populations:

- a) people with debt and mental health problems;
- b) people with mental health problems who are at risk of becoming over-indebted;
- c) people who are over-indebted who may be at risk of developing mental health
- d) problems.

SUGGESTIONS FOR METRICS

It is critical that any indicators are understood, interpreted and developed with the definitions, principles, and populations that have been described.

Three national indicators were proposed:

1. A reduction in the mental and physical impact of problem debt on:

- people with debt and mental health problems
- people with mental health problems who are at risk of becoming over-indebted
- people who are over-indebted who may be at risk of developing mental health problems

2. The establishment and monitoring of partnerships between local agencies working on aspects of debt or mental health, including:

- rates of referral from primary care/secondary care to accredited money advice agencies
- numbers of individuals referred from primary/secondary care who were successfully 'received'/assisted at a money advice agency

3. Numbers of people for whom an assessment is conducted (by health or advice sectors) of their entitlement to benefit, their uptake of relevant benefits and the financial impact of benefit uptake (i.e. additional income achieved).

2.5 Social connectedness and social capital

People's interconnectedness matters, as does the frequency and quality of their interactions. Individual and community social and emotional capital is both a consequence and predictor of whether individuals within it will thrive or survive. What metrics and measures best report and capture social connectedness and social capital?

WHAT DATA SOURCES DO WE HAVE? WHICH MIGHT WE DEVELOP?

Local authority responsibility for citizenship is a key policy context. There was a thought that the DCLG undertakes citizenship surveys, and it would be worth a closer look at those for useful data. There are questions on belonging, place cohesion, and interactions. It is a national survey, so would not be analysable down to local authority areas.

An example could be targets for generally increasing levels of volunteering and occupation. (The NI6 indicator on rates of volunteering was seen as a starting point.) The possible drawback in this is that localities might exclude those we are seeking to include if it is deemed to be relatively too difficult to target them for more volunteering etc. A mixture of measures/data across population, domain (specific aspect of people's lives) and targeted group (e.g. people with mental health problems) levels would be needed.

For ward level data Local Authorities would have to undertake their own surveys. Could these be mandated with a core set or pool of questions set nationally? NEF, for example, have undertaken work on *National Accounts of Wellbeing* and drew on questions from the EU social survey. These could be a starting point for this pool of questions.

Questions include:

How often do you meet socially with friends, relatives or colleagues?

There are people in my life who really care about me.

How much of the time during the past week have you felt lonely?

To what extent do you feel that people in your local area help one another?

I feel close to the people in my local area.

A possible area for mental health service users specifically is those that having *hope*, for this in part springs from a sense of belonging.

We might ask people about who they saw in the last few days and how isolated they feel. This also brought to mind the potential better role for statutory services to help make people feel better socially connected. The example was raised of when a meals on wheels service was improved from the point of view of better meals, but its consumer ratings fell – because the staff had less time to spend with people. District nurses and chiropodists all know of cases of isolated people for whom their visit is one of the main social contacts for the week.

Existing policy and development frameworks the group felt would be useful to support this work include Local Area Agreements, Joint Strategic Needs Assessments and Comprehensive Area Assessments. A PSA target on this would be helpful too. The choice and personalisation agenda may be helpful too e.g. if people can use services and individual budgets to help pay for things which will increase their social connectedness. The DWP are undertaking a refresh of work on the ageing society and this may be a policy to connect to.

The government agenda on *place shaping* is an important starting point for this topic, related measures and data, but potentially conflicting issues need to be carefully handled. For example, in shaping local *shared spaces* people would say they want them to feel safe, which may mean them not welcoming others perceived to be strange. Those who are depressed may not feel they are worthy of using the spaces.

The *Independent Living* agenda is worth closer scrutiny with this issue of social connectedness in mind. There may be lessons to learn. What things in society limit a good life? For physical disabilities this can be issues of physical access, which can be measured and monitored. What would be mental health equivalents? Would a target on reducing stigma and discrimination be practical? Could hate crimes data explicitly include abuse of people with mental health problems? What about a target to improve people's understanding and perceptions of mental health problems?

Measuring *quantity and quality* of social connectedness. It is not just about the number of people an individual sees in a week, but about the quality of contact – including degree of choice. An evaluation of the *Capital Volunteering* project identified the qualitative changes in people's lives achieved from starting volunteering work.

Process measures could be expecting public services (including museums, libraries, public transport) to have means of improving access for people with mental health problems, or having in place models of support that help (perhaps peer support).

Outcomes could be measures of stigma and discrimination felt by individuals, ability to mix with people (friends, colleagues, neighbours), and the number of times in a given period people have felt able to access public services if they wanted to.

People's *perceptions and expectations* (helping people to feel 'because I'm worth it') would have to be considered in developing measures; but, no matter what the empirical measure of social connections, if someone says they don't feel connected that tells us something.

Measures would have to be carefully worded to not make people feel worse about their lives. Whilst not the fundamental issue, the cost of any measuring system and *value for money* would need to be considered.

GAPS and LIMITATIONS

Although the group could not think of good data already collected specifically on social connectedness and social capital, there are some useful measures in use. For example, tenant satisfaction surveys ask relevant questions about neighbourhoods. And the Adult Psychiatric Morbidity Survey²⁴ included questions on neighbourhoods and social connectedness.

A target on social connectedness needs to be mindful of *broader, inclusive social connectedness*, rather than develop a measure that pushes people into more social connection but only within a limited social circle of other mental health service users. The target(s) need to bear in mind the more generalised social privatisation and atomisation of people's lives. Similarly, the more general pressures on family life are very pertinent to the challenges set in this workshop.

A framework was proposed of a series of interconnected indicators in the realms of i) *personal healing* (e.g. reduced readmission rates, reduced severity of sections, good housing), with ii) *social healing* (e.g. access to local services and shared spaces).

KEY ISSUES

The inclusion of this theme at the workshop was *a welcome step forward* for social connectedness and social capital – possibly a first. Measuring social connectedness in relation to addressing mental health inequalities was seen as vital for progress as it is inextricably linked with better wellbeing. It was drawing attention to the right words and issues –e.g. connectedness, family, friends, relationships etc.

The basis for the claims to the importance of the issues needs to be assertive – human rights and equality were felt to be a better basis than economic arguments alone. It should draw attention to human qualities, such as warmth and kindness towards others. It should articulate a vision of 'this is what a good society does'.

This theme represents a complex issue and there are inherent dangers in trying to reduce complex things to overly simplistic measures, especially if these are coming from overly simplistic mental frameworks failing to do justice to the complexity of people's lives and social systems of connection and care services.

Rather difficult to achieve definitive definitions of measures in the time available on the workshop day, but it was within the realms of possibility. Some starting points for measures in similarly complex areas were raised, such as deprivation, which had taken a programme of work to fully develop from pilot measures.

A constant theme in the discussion was bridging consideration of social connectedness measures for the population and those specifically aimed at helping those with mental health problems.

²⁴ McManus S, Meltzer H, Brugha T, Bebbington P and Jenkins R (eds) *Adult Psychiatric Morbidity in 2007: Results of a household survey*. The NHS Information Centre. (www.ic.nhs.uk/pubs)

There are many challenges with either one of these aspects, and more so with trying to bridge them. Measures that *span the general population* were seen as desirable to help break mental health issues out from ghettos.

For those using mental health services the experience has sometimes been of services they use to feel a little more socially connected, such as day centres, being shut without proper planning for alternatives and a range of socially integrated support for them. Accessing a library or leisure centre can be more valuable than specific mental health services and act as a bridge to wider social connectedness, but some may need a pathway of support to get to this point.

The group discussed the issue of *who to make accountable* for the target(s). Social connectedness is not the responsibility of any one organisation so the key is to construct the target as a system-wide one spanning many local organisations. The target needs to act as a catalyst for cross-organisation working, to make organisations see why this is an important issue and spur them on to locally relevant action and innovation. How do you get local leisure centres, for example, to see it as something important for them? Connection with other social policies is one means to do this.

It is important to make the measure(s) relevant to what people want; *user defined outcomes*. *Public consultation* is important but (i) there is a significant amount known already about what people want; (ii) some feel over consulted; (iii) some feel they never see any changes anyway.

A theme running throughout all of the discussion was *the significant practical and methodological challenges with measures in this area*. All the points made deserved to be raised as they would need careful attention.

There was the broader issue of *perverse incentives* of measures and targets. We would need to avoid ridiculous and perverse incentives in measures – such as ‘social connectedness officers’ marching people in to meet someone to get the numbers up, or ‘cherry picking’ those most easily supported to better connected.

It would be best for measures to be grounded in sound *theoretical and empirical evidence*. Measures and data need to be *robust* to be believed and acted upon. *Process and outcome measures* combined in an *interconnected framework*.

2.6 Body and mind

The poor physical health and high levels of adverse lifestyle risk factors tolerated within individuals and communities experiencing high levels of mental health are not acceptable. Poor physical health predicts poorer mental health. Long term poor mental health in turn is more likely to lead to others diseases including specific excesses of some cancers. What metrics and measures best report and capture this area and are likely to drive future change to make the physical health dimensions of mental health and mental illness recognised and acted upon.

The theme approached the topic across four axes:-

- People with severe and enduring mental illness and their physical health;
- The impact of poor mental health on physical health;
- The impact of poor physical health on mental health;
- The impact of medically unexplained symptoms on mental and physical health.

WHAT DATA SOURCES DO WE HAVE? WHICH MIGHT WE DEVELOP?

- MHMDS
- NPSA
- PROMs
- NHSLA
- Standard mortality rates.
- QOF
- POM-UK
- HoNOS
- Smoking rates
- Prescribing data

What might make a difference? Systemic levers included:-

- Outcomes measures – already being utilised in IAPT;
- Clinical outcome measures more generally;
- Impact of Care Quality Commission’s scrutiny;
- CPA assessments and recording to include physical health needs;
- LAA targets that measure joint working between PCTs and health and social care to improve standard mortality ratios for people with enduring mental illnesses;
- Ensuring that physical health care is integrated into secondary and primary providers governance structures.

GAPS and LIMITATIONS

- Neglect the needs of those with more complex and severe health issues;
- Clear links between any form of physical activity - especially those which can be incorporated into daily life - and mental health is beneficial, but these are often overlooked.
- Measures for data collection must be meaningful to frontline staff who will be asked to collect data.
- People with complex needs only want to engage with one service at a time, collaboration between services vital to improve quality and outcomes. Too much working in silos.

- Care has improved in the recent past, but it has not been systematised, often depends on an individual to champion good care. Need 'sticks and carrots' – financial resources – to lubricate the system.
- Communication between professionals is not always as good as it could be.
- GPs need easier access to specialist mental health opinion, different models of collaboration not just referral. The referral management centres ('PCT mincer') can have adverse effects by making it harder for GPs to develop links and relationships with specialists.
- Trying to implement physical health checks on wards, described as an 'uphill battle'. Should be responsibility of care co-ordinator but this did not always happen. Needs to be systematic screening for physical health issues embedded into practice.
- Need a pathway through to physical health care from mental health system.
- Range of corresponding issues of people with medically unexplained symptoms (MUS) and somatisation.

KEY ISSUES

- Persistence of mind/body dualism
- Primary/secondary care interface and its inadequacies
- Systemic approach to these issues is critical, rather than the piecemeal one that exists in most places at present.
- Impact of prescribed medication on service users.
- Information essential to enable service users and lay people to access treatments that everyone should expect.
- There has been improvement but it is patchy across the services.
- The needs of those with e.g. dementia or offenders often go unmet as they have multiple and often unarticulated problems and issues.
- Creating the workforce to deliver the target
 - Systemic approaches are required to circumvent the ad hoc nature of addressing physical health needs;

- Clinical governance must apply to the performance measure of staff delivering these kinds of services;
- Staff must know, and demonstrate that they know, how to access physical health care and treatment for people with SMI e.g. being able to advise and guide on how to access appropriate care and treatment, to broker that access, or to ensure that it happens;
- There is a direct link with the previous target of achieving a reduction in all cause mortality through a comprehensive physical and mental health care plan.

SUGGESTIONS FOR METRICS

Improving access and monitoring receipt of physical health care to vulnerable groups:

- Revised NICE Schizophrenia guidance has been updated in 2009; puts main emphasis on primary care as lead and also key broker on physical health issues for SMI;
- Utilise QOF in primary care, in particular existing direction on establishing SMI registers;
- Utilise Rethink's PHC toolkit in secondary care;
- Every person's file should have detailed physical health notes, reviewed annually;
- Non-discriminatory access to routine screening e.g. mammograms, dentists, cervical smears etc.
- Information prescriptions with details on diet, exercise, nutrition, smoking, risks of not taking meds.
- CPA requires 7 day follow-up and this creates another lever;
- Exception reporting should be completely stopped
- MDS is a data source recommended in 'Vital Signs'
- Comprehensive mental and physical health care plan could achieve the reduction target.

Physical health and its impact on mental health

- The target would be a mental health assessment, on an annual basis, for all those with long term physical ill health conditions, as part of chronic disease management;
- There is a precedent in the QOF, where those with diabetes are currently screened for depression;
- Evidence shows that addressing the mental health issues improves the physical health outcomes;
- Imperative to have qualitative research findings to backup quantitative datasets i.e. explore issues that arise and stimulate ideas for future data collection.

Medically unexplained symptoms

- The target was for all PCTs to have in place social prescribing schemes;
- There is a good evidence base for these interventions – exercise, leisure, bibliotherapy, information prescriptions;
- There is also a strong evidence base for talking therapies in MUS;
- Key issue was that people presenting with physical symptoms that remain unexplained are neither written off as a nuisance, nor undermined by clinicians - 'it's all in your head'.

- There are interventions that can improve both physical and mental health outcomes for these groups of people.

Substance misuse

- Improvement in physical wellbeing of people with a dual diagnosis which is very common problem in people with mental health issues and vice versa.
- Majority overlooked or under-treated due to 'dual diagnosis' label and paucity of appropriate services.
- Guidance is that general psychiatry should lead on these issues, but can be difficult for primary care to refer to general psychiatry in these circumstances.
- Basic requirement is good data that captures and identifies the population

Without a baseline interventions cannot be appropriately targeted.

Life expectancy

- A national target on improving life expectancy, similar to that for suicide reduction;
- Important not only to increase expectancy, but also to reduce gaps between different quintiles of population.

2.7 Later life

A mentally healthy and fulfilled later life should be an expectation for all as we grow older. Older people have a huge amount to offer to society but frequently experience loneliness and isolation. Mental illnesses and conditions more commonly experienced in later life will, as society ages, create an increasing challenge for mental health and wider services. What metrics and measures best capture mental capital, illness and engagement in this period of life and which ones are most likely to drive change to improve people's mental health and capabilities and changes to the daily lives they lead?

Three population groups were identified (general population of older people, older people with mental health needs using generic health and social care services, and older people using specialist mental health services) and sets of corresponding measures were chosen for each group. Measures for one group may also be used for other groups (e.g. for older people using specialist mental health services measures used for both of the other groups also apply).

WHAT DATA SOURCES DO WE HAVE? WHICH MIGHT WE DEVELOP?

- Audit Commission/DWP PSA17 (wellbeing of older people) – 'dashboard indicators' e.g. good place to grow old; healthy life expectancy; use of adult/leisure; volunteering;
- +5 key themes from Age Concern/Mental health Foundation Later Life Inquiry e.g. income/poverty, meaningful activity, social relationships, physical health, age discrimination;
- Basket of measures in 'Quality Accounts' – Audit Commission;
- Discharge from hospital to care home;

- GP prescribing of anti-psychotics;
- Access to psychological therapies;
- PROMs;
- Count me in census – 65+;
- QOF for depression;
- Alcohol intake; obesity levels; nutrition; smoking;
- Suicide and self-harm rates;
- Welfare benefits uptake;

KEY ISSUES

- Unequal access to services (65+);
- Lack of access to mental health services in non-MH settings;
- People with dementia
- Attitudes to older people in MH system
- Exclusion from mental health promotion initiatives
- Race equality in later life
- Communities in which it's good to grow old – what can public services offer?
- Low expectations of ageing
- Poor mental health services
- Co-morbidities – mental and physical ill health
- Engagement in community life
- Lack of therapeutic models – especially in dementia
- Whole systems sustainability for health and wellbeing in later life
- General age inequality and age discrimination

WHAT MIGHT HELP

- Look across the whole system
- Closer links between DH and DWP and other government departments
- Links between New Horizons and the Older People's NSF
- Maximising the opportunities presented by the cross-Govt strategy for an ageing population which has now been published and is out for comment.
<http://www.hmg.gov.uk/media/33833/summary.pdf>
- Respect and dignity – positive steps to ensure equality of access.
- Workforce education and training (health, social care, housing)
- Reporting by age (including age ranges for older people) in all indicators
- Audit Commission working with DWP on basket of measures (from June 2009)
- Identification/prevention of problems
- Service access
- Include older people in e.g. assertive outreach measures
- Wellbeing indicators apply to all older people irrespective of circumstances
- Social inclusion – age proofing – place survey can be reported by age
- SHA outcomes already being developed for dementia strategy

- Intergenerational work
- Recording of mental health problems in general hospitals

SUGGESTIONS FOR METRICS

TARGET: OLDER PEOPLE WITH MENTAL HEALTH NEEDS USING GENERIC HEALTH AND SOCIAL CARE SERVICES

Age proofing existing/selected measures for mental health in generic health and social care services

Measures of:

- Obesity
- Nutrition
- Smoking
- Alcohol use

Numbers of older people with depression, dementia, delirium and other mental illnesses in hospital, care homes, using primary care – and measures of service responses/interventions:

- Basic mental health screening of all older people coming into contact with services?
- Nos. on dementia QOF v nos. registered with GP
- Referrals to MH services
- Length of stay
- Discharge destination (home or other institution)
- Anti-psychotic prescribing for dementia
- Referrals to direct payments/personal budgets
- Audit of nos. in workforce with older people's mental health training
- Cultural awareness/support for person's spirituality
- Carers' assessment/package of care?

TARGET: OLDER PEOPLE USING SPECIALIST MENTAL HEALTH SERVICES

Measures of:

- Obesity
- Nutrition
- Smoking
- Alcohol use

Measures of service responses/interventions:

- Length of stay
- Discharge destination (home or other institution)

Referrals to direct payments/personal budgets

***Age proofing existing/selected measures for mental health in adult mental health services
(including IAPT, assertive outreach, crisis resolution)***

- Access to primary care
- Physical health assessments
- Participation in care planning/goal setting
- Use of Mental Health Act, Mental Capacity Act
- Mental health interventions in non-specialist settings (e.g. care homes, community, general hospitals)
- Some service user-defined measures (e.g. satisfaction, quality of life)

APPENDIX: Current and emerging Mental Health Indicators

This annex provides a summary of quality indicators used across mental health services. It is not intended as an exhaustive list but aims to provide detail on service and clinical outcomes measures that are commonly used. Each section includes a link to further information; the accompanying spreadsheet details the indicators themselves and references original documentation. In some instances the indicators are beyond clinical or service data.

The Operating Framework Vital Signs

The operating framework details the DH approach to planning and managing national and local priorities – the Vital Signs. The guidance explains how organisations can use the Vital Signs to develop local operational plans to deliver against national priorities and how to select local priorities. It sets out how performance will be managed against each of the three tiers of the Vital Signs: tier 1 - national requirements, tier 2 - national priority for local action and tier 3 - local actions. All PCT's are required to set plans for Tier 1 & 2 indicators. PCT's are required to choose which of the tier 3 indicators to prioritize locally. For more information see:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082542

NSR Quality Indicators (proposed)

In response to 'High quality care for all' June 2008 DH has been working with the NHS in order to identify suitable core measures to help measure progress against mental health priorities. To this end a set of outcome indicators have been proposed, a consultation was conducted in December 2008 (coordinated by the IC) and feedback is currently being analysed. The 400 indicators in the consultation document contained 17 related to mental health and 2 further indicators that refer to children. For more information see:

www.ic.nhs.uk/cqi

World Class Commissioning MH indicators

A national commissioning assurance system has been developed to support World Class Commissioning; the system will allow flexibility to set local priorities. The details of the assurance system are set out in the commissioning assurance handbook which includes guidance on the content and process. The handbook is supported by a toolkit including all the tools and templates that PCTs and SHAs will need to implement the system. 57 indicators have been identified across all areas, 4 of which relate to mental health. For further details see:

<http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/Assurance/index.htm>.

Healthcare Commission MH indicators

The HCC use existing commitments and national priorities to assess whether levels of service set through the 2008-2011 planning round are being maintained. The Healthcare Commission's 'annual health check' assesses performance of primary care trusts (PCTs) and acute and specialist

trusts. Ambulance trusts, mental health trusts and learning disability trusts. The full set of indicators used can be found at:

<http://www.healthcarecommission.org.uk/guidanceforhealthcarestaff/nhsstaff/annualhealthcheck/annualhealthcheck2008/09/qualityofs/existingcommitmentsandnationalpriorities.cfm>

The indicators that specifically relate to mental health for PCTs are:

- Commissioning of crisis resolution/home treatment services
- Commissioning of early intervention in psychosis services
- Commissioning a comprehensive child and adolescent mental health service (CAMHS).

Further details can be found at:

http://www.healthcarecommission.org.uk/db/documents/PCT_EC_200810235227.pdf

http://www.healthcarecommission.org.uk/db/documents/PCT_NP_200810241524.pdf

14 indicators are used to assess mental health trust details can be found at:

http://www.healthcarecommission.org.uk/db/documents/MH_EC_and_NP_200810235038.pdf

Delivering Race Equality (DRE) dashboard

The DRE dashboard was developed to support measurement of progress in the DRE programme. It provides a detailed menu of indicators to support SHAs, PCTs and mental health trusts measurement. Full details of measures are detailed in

<http://www.northeast.csip.org.uk/silo/files/dre-dashboard.pdf>.

The programme has agreed to adopt a phased approach to collecting the information needed. Six headline priorities were identified and agreed by SHA Chief Execs and the NHS Management Board meeting (January 2008). These are:

- (i) Access to early intervention
- (ii) Access to crisis resolution/home treatment
- (iii) Use of assertive outreach services
- (iv) Access to psychological therapies
- (v) Implementation of Supervised Community Treatment (under the Mental Health Act 2008)
- (vi) Recruitment and impact of Community Development Workers (CDWs)

Data collection will commence end of Quarter 4, 2008/09 and is expected to report in summer 2009.

Better Metric Project

The Better Metrics project [managed by the HCC until 2007] was aimed at improving the measures used to assess and monitor the quality of healthcare that patients receive. The project was set up by senior members of the NHS in 2004, in response to concerns that NHS clinicians were not

always aware of, or contributing to, the metrics used to manage and assess the performance of NHS trusts.

In collaboration with national clinical directors, SHA's, PCT's and other NHS organisations, metrics were developed for the following areas: cancer, heart disease and stroke, children and maternity, diabetes, urgent care, public health and inequalities, long-term neurological conditions, learning disabilities, mental health, older people, improving the patient experience, primary care, and research and development.

The project report was completed in November 2007. Since then the HCC have been working with clinicians and clinical bodies to improve the focus on clinical quality in the design of the annual health check. The ultimate aim has been to ensure that the Healthcare Commission is measuring the sort of things that assist clinicians in their care and treatment of patients. As part of this process the HCC have drawn on the work done as part of the Better Metrics project as well as other indicators. For further information see:

<http://www.healthcarecommission.org.uk/guidanceforhealthcarestaff/nhsstaff/improvingclinicalquality/developingbettermetrics.cfm>

Mental Health Outcomes Compendium

The Outcomes Compendium has been developed to provide information on available measurement tools, their properties and their use in mental health services. It aims to help clinicians and their teams determine which of the widely available instruments best meet the needs of their service users. It is not intended to be an exhaustive or "recommended" list. But the intention is that this will provide a helpful starting point in outcome measurement for many teams and services as they try to understand and improve what they do. The compendium can be downloaded from:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093316

Improving Access to Psychological Therapies (IAPT)

The IAPT programme has agreed a set of outcomes measures to be routinely collected at therapy sessions. The IAPT toolkit provides guidance on the importance of routine outcome monitoring and outlines collection and reporting mechanisms. The toolkit includes the IAPT minimum data set and recommended disorder specific measures. The entire first wave of IAPT sites has agreed to collect the minimum data set. The programme has made an application to the Information Standards Board to make the minimum data set a national standard in 2011. The IAPT toolkit can be downloaded from:

<http://www.iapt.nhs.uk/2008/07/improving-access-to-psychological-therapies-iapt-outcomes-toolkit>

The DH Patient Reported Outcomes Measures (PROM's) programme are planning to include depression /anxiety in their next wave of development. It is anticipated that the IAPT toolkit will inform this work.

2. Emerging Indicators and Measures

In addition to the above, there are emerging ways of measuring other aspects of mental health. For example:

The Warwick Edinburgh Mental Wellbeing Scale (WEMWBS)

A 14 item survey instrument for use in measuring population mental wellbeing. Covering things such as confidence, optimism, happiness, clear thinking, and closeness to others etc. Closely correlated with emotional, social and psychological factors. Items combined to provide a score that ranges from 14 to 70 – poor to good mental wellbeing. In 2006 the mean scores for Scotland were 51.3 for men and 50.3 for women. WEMWBS is validated for use across UK.

For more information on the scale please see:

<http://www.healthscotland.com/scotlands-health/population/Measuring-positive-mental-health.aspx>

National Public Mental Health and Wellbeing Indicators (Scotland)

In Scotland, a national indicator set of 54 indicators has been developed to provide consistent and sustainable national monitoring of adult mental health and associated contextual, social and structural factors. The first data set of these indicators has just been published.

The full report and a briefing are available from:

<http://www.healthscotland.com/scotlands-health/population/mental-health-indicators-index.aspx>

A three year project is under way in Scotland to develop and establish children and young people's mental health indicators. See this link for more information:

<http://www.healthscotland.com/scotlands-health/population/mental-health-indicators/children.aspx>

DEFRA Indicators on wellbeing

DEFRA has produced a set of sustainable development indicators. These include indicators on wellbeing and can be viewed on line or in a pocket guide, see:

<http://www.defra.gov.uk/sustainable/government/progress/data-resources/sdiyp.htm>

New Economics Foundation (NEF) and Indicators on Wellbeing

NEF has been at the leading edge of wellbeing indicators in the UK. Their website has a whole section on indicators, including the results from the most comprehensive international survey of well-being to date. This is a European Commission funded survey used to construct the first ever set of national well-being indicators. For more information see:

<http://www.nationalaccountsofwellbeing.org/>