

North West Mental Wellbeing Survey 2009

Summary

Lynn Deacon, Helen Carlin, Joy Spalding, Susan Giles, Jude Stansfield,
Sara Hughes, Clare Perkins, Mark A Bellis



Acknowledgements

The authors would like to thank all those who have assisted with the production of this report, in particular Rebecca Harrison and Jennifer Mason of the North West Public Health Observatory for contributions towards proofreading, Lee Tisdall of the Centre for Public Health, Liverpool John Moores University for design and Tom Hennell of Government Office North West for analytical support.

We would like to thank the members of the North West Mental Wellbeing Survey Steering Group for their valuable support, advice and direction on this work. We also recognise the contribution of the PCTs and/or local authorities who commissioned interviews: Blackburn with Darwen; Blackpool; Central and Eastern Cheshire/Cheshire East; Central Lancashire; Western Cheshire/Cheshire West and Chester; Cumbria; East Lancashire; Halton and St Helens; Heywood, Middleton and Rochdale; Knowsley; Liverpool; Manchester; North Lancashire; Sefton; Stockport; Tameside and Glossop; Warrington; Wirral.

Foreword

We all like to feel good about ourselves and the lives we lead. Our mental wellbeing affects everything we do. Those with good mental wellbeing have a higher satisfaction with life and are much more likely to be in employment, be educated, be healthy and have closer relationships with others.

This survey has found stark differences in mental wellbeing across the North West; and that those living in disadvantaged circumstances have, in general, much lower levels of wellbeing. Now, more than ever, being resilient and flourishing is fundamental to the prosperity of the North West region.

This groundbreaking research has filled a much needed gap in helping us to understand the differences in wellbeing across our population and the different factors that influence it. It has found that an individual's connection and interaction with their community is critical; in particular having a sense of belonging to the neighbourhood and feeling one can influence decisions about the local area, make a big difference to mental wellbeing.

Whether your goal is improving health, tackling health inequalities, providing public services, reducing worklessness, community cohesion, providing education or running a business or a family – good mental wellbeing makes a difference to your success.

As individuals, we can also take note of the evidence base for personal health – **five ways to wellbeing** – to make sure our own wellbeing is maintained:

- *Connect with others*
- *Be active*
- *Give*
- *Take notice*
- *Keep learning*

I commend this report to you and urge that we focus on generating better health and wellbeing. Agencies in the North West need to work together to do more to place this at the top of their agendas.



Dr Ruth Hussey OBE

Regional Director of Public Health / Senior Medical Director
DH NW / NHS NW

Table of Contents

1.	Introduction and background	6
1.1	Defining mental health and wellbeing	7
1.2	Key impacts and determinants of mental wellbeing	7
1.3	Measuring mental wellbeing.....	8
1.3.1	Seven item Warwick-Edinburgh Mental Wellbeing Scale.....	8
2.	North West Mental Wellbeing Survey Methodology	9
3.	Regional distribution of WEMWBS scores	10
4.	Local WEMWBS scores.....	12
5.	Results.....	14
5.1	Feelings	14
5.1.1	Mental wellbeing	14
5.1.2	Life satisfaction	15
5.1.3	Having time to do enjoyable activities.....	15
5.2	Relationships	16
5.2.1	In a meaningful relationship	16
5.2.2	Speaking to non-household members	16
5.2.3	Speaking to neighbours.....	16
5.2.4	Meeting friends and relatives	16
5.2.5	Ability to rely on others	16
5.2.6	Satisfaction with personal relationships	17
5.3	Health.....	18
5.3.1	General health.....	18
5.3.2	Mobility	18
5.3.3	Self-care	18
5.3.4	Usual activities	18
5.3.5	Pain and discomfort	18
5.3.6	Anxiety or depression.....	18
5.3.7	Health state index (EQ-5D mean score)	19
5.3.8	Caring.....	19
5.4	Lifestyle and life events	20
5.4.1	Life events	20
5.4.2	Physical activity.....	20
5.4.3	Sedentary behaviour	20
5.4.4	Smoking status	20
5.4.5	Alcohol consumption.....	20
5.4.6	Cannabis use.....	21
5.4.7	Money	21
5.5	Place	22
5.5.1	Years lived in local area	22
5.5.2	Satisfaction with local area as a place to live	22
5.5.3	Belonging to the immediate neighbourhood	22
5.5.4	Organisation activities.....	22
5.5.5	Decisions affecting local area.....	22
5.5.6	Safety	22
5.6	Respondent characteristics	23
5.6.1	Work status	23
5.6.2	Sexual identity.....	23
5.6.3	Living in supported or assisted housing	23
5.6.4	Highest qualification level.....	23
5.6.5	Household economic status	23
5.6.6	Household type.....	24
6.	Conclusions and Recommendations	25
6.1	Mental wellbeing prevalence	25

6.2	Value of the baseline and potential comparative analysis	25
6.3	Factors that impact on wellbeing from the survey corroborated by existing research literature	26
6.3.1	Age.....	26
6.3.2	Deprivation.....	26
6.3.3	Ethnicity.....	26
6.3.4	Health.....	26
6.3.5	Relationships	27
6.3.6	Place	27
6.3.7	Education	27
6.3.8	Employment.....	27
6.4	Why these findings are important for policy and practice development in the North West	28
6.4.1	Investing in effective mental health promotion	28
6.4.2	Tackling health inequalities	28
6.4.3	Aligned wellbeing policy.....	28
6.4.4	Resilient communities.....	28
6.4.5	Sustainable employment	28
6.4.6	Five ways to wellbeing.....	29
6.4.7	Wellbeing Impact Assessment	29
6.5	Value of collaboration	30
6.6	Methodology: WEMWBS scale and distribution.....	30
6.7	Further analysis: methodological, regional comparisons, segmentation	30
6.8	Further research: measuring mental wellbeing.....	30
7.	Summary data.....	31
8.	References.....	37

1. Introduction and background

The North West Mental Wellbeing Survey was undertaken in 2009 in response to a growing need to understand more about the positive mental wellbeing of people in the region. Although there is increasing emphasis on the need to improve mental health and wellbeing, little data exists on the population's mental health status, or the means to measure it. This remains a local, regional, national and indeed a global challenge.

There is increasing evidence that positive mental wellbeing leads to a more flourishing and fulfilling life at home, school, work and in the community we live. It is central to individual and community resilience, our ability to function well, be productive, healthy and cope with adversity and change. This survey helps us to understand more about the different aspects of people's lives that lead to better mental wellbeing in order that resources can be targeted more efficiently and effectively to improve the wellbeing of the population of the North West. The Government Office for Science's Foresight report¹ found that action to improve mental wellbeing could have very high economic and social returns.

While there are data on a number of determinants of mental wellbeing, this study fills a gap in available data on positive mental wellbeing itself. The aim of the North West Mental Wellbeing Survey is to collect a consistent and comparable score of positive mental health. It has been coordinated by the Strategic Health Authority (NHS North West), Department of Health and the North West Public Health Observatory as a jointly-funded collaborative with primary care trusts (PCTs) and local authorities.

The survey includes a validated measure of mental wellbeing and so provides a new

baseline at local and regional level to support outcome based commissioning, Local Area Agreements (LAAs) and the evaluation of interventions, programmes and mental wellbeing impact assessments. The study also aims to provide intelligence to support more comprehensive Joint Strategic Needs Assessments (JSNAs) through the identification of population groups with lower and higher levels of wellbeing. The availability of positive outcome data is significant in supporting a shift to invest in prevention and health improvement. It will support better targeting of interventions to reduce inequalities and improve mental health and wellbeing. The intelligence provided on the wider determinants of wellbeing and individuals' lives is also of value in developing insight into the complex interrelationships between the factors that impact on wellbeing.

The Department of Health's recent *New Horizons* policy² prioritises cross-government action to improve the mental wellbeing of the population. It identifies the need for agreed measures of mental wellbeing to support local improvement.

Likewise, the World Health Organization European Action Plan³ includes a commitment to develop new indicators and data collection methods for mental health promotion, prevention, treatment and recovery. It states that information needs to be available about the current state of mental health across populations that is standardised and allows comparison locally, nationally and internationally.

This report provides a summary of the key findings from the survey. Detailed results, including comprehensive charts and tables, are available in the full North West Mental Wellbeing Survey 2009 report available at www.nwpho.org.uk.

1.1 Defining mental health and wellbeing

There are two main elements of mental wellbeing: feeling good and functioning well. This includes how we feel about ourselves, our future and the world around us and our ability to have positive relationships, a sense of control and purpose in life. Huppert⁵ explains how sustainable wellbeing does

not require individuals to feel good all the time, but the experience of painful emotions and the ability to manage them is essential for long-term wellbeing. If negative emotions become extreme or prolonged, however, they compromise our ability to function well.

The World Health Organization⁴ defines mental health as:

“a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.”

The Foresight report¹ defines mental wellbeing, or simply wellbeing, as:

“a dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their economy. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society.”

It is important to distinguish between mental health and mental illness. Mental health, or mental wellbeing, is something we all have and seek to improve. Mental illness or disorders affect up to one in four people.

Some of the determinants of mental wellbeing are not the same as the determinants of mental illness⁵ and as such, staying mentally healthy is more than treating or preventing mental illness.

1.2 Key impacts and determinants of mental wellbeing

Mental health and wellbeing influences a broad range of outcomes for individuals and communities, including better physical health, financial and personal security, relationships with friends and family and improved quality of life. In return, many of these factors may determine levels of

mental wellbeing and have been the focus of review for researchers and policy makers attempting to capture the relevant domains of, and evidence base for, mental wellbeing. The World Health Organization’s (WHO) Commission into the Social Determinants of Health argues:

“These inequities in health arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces. Closing the health gap requires concerted action across sectors by national governments, WHO, UN agencies, and civil society organisations. Better health and its fair distribution should be adopted as shared goals.”⁶

The work of Dolan, Peasgood and White⁷ addresses influences on wellbeing and their application to policy making. Factors affecting an individual’s wellbeing identified from the wider wellbeing literature include income, personal characteristics, socially developed characteristics, how people

spend their time, attitudes and belief towards ourselves and others, relationships and the economic, social and political environment, all of which this study has attempted to capture to provide a context to wellbeing scores.

1.3 Measuring mental wellbeing

Researchers at Warwick University undertook a review⁸ of different scales to measure mental health. The review found that the most accurate and robust scale of positive mental health was the Affectometer 2.⁹ This scale was used within Scotland's Health Education Population Survey in 2002¹⁰ and 2005¹¹ and its evaluation led to improvements, resulting in the development of the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS).¹² WEMWBS has since been used in two national population surveys both further validating the tool,^{13,14} and researchers have concluded that

WEMWBS is likely to be a user-friendly and robust tool for monitoring positive mental health at a population level in the UK.

WEMWBS focuses entirely on positive aspects of mental health. The 14 item scale covers different aspects of mental wellbeing including positive functioning (energy, clear thinking, self acceptance, personal development, mastery and autonomy), satisfying interpersonal relationships and positive feeling (feelings of optimism, cheerfulness, relaxation).^{15,16}

“What differentiates WEMWBS from all existing measures of mental health is that it has been developed specifically to measure positive mental health - all the items represent positive thoughts or feelings. Its positive focus offers a vision of future population mental health and enables others to see where mental health promotion programmes might be headed.”¹⁶

1.3.1 Seven item Warwick-Edinburgh Mental Wellbeing Scale

A shorter, seven item version has more recently been developed as a practical alternative to the full version of WEMWBS. Although the shorter version offers a more limited assessment of mental wellbeing, it has other advantages and has proved to be a valid and robust tool.¹⁷

It is also being used in large studies such as in the evaluation of Big Lottery funded projects.ⁱ

ⁱ WEMWBS has been included in the national evaluation tools for the Big Lottery Funded Wellbeing Programme 2008-2012.

2. North West Mental Wellbeing Survey Methodology

The questionnaire used for the North West Mental Wellbeing Survey was designed and developed by the North West Public Health Observatory in collaboration with NHS North West and local partners. The survey tool contains 44 questions that seek to measure a wide range of determinants of mental wellbeing such as feelings, relationships, health, life events, lifestyle and place, and incorporates the seven item WEMWBS. In addition, information describing the age, gender, ethnicity and place of residence of respondents was collected. The level of deprivation in each local area was subsequently added to the data, using the Index of Deprivation 2007.ⁱⁱ

Surveys were undertaken in every primary care trust area in the North West. A number of PCTs commissioned additional interviews (boosts) in order to gain robust information at a local level. In some cases, PCTs also wished to compare sub-groups of the local population such as the most deprived populations or local authorities within the PCT boundary. In order to obtain sufficient numbers to provide statistically significant results at a local level, at least 500 interviews were undertaken in these boost areas. The Post Office Address File (PAF) was used as the sampling frame as the most up to date source of households in the North West, using a clustered random sample.

A total of 18,500 face-to-face interviews were undertaken with a household member between April 1 and June 30 2009 using computer assisted personal interviewing (CAPI). Hand held computers allowed the respondent to answer questions confidentially and anonymously and the survey was conducted within the Market Research Society's (MRS) Code of Conduct.

The resulting dataset was weighted by gender, age group and deprivation level to ensure that the sample survey was representative of the North West region as a whole. During analysis, when sub-groups of the population were compared 95% confidence intervalsⁱⁱⁱ were applied to the results to indicate where there were 'significant' differences.

A copy of the survey tool and further detail of the methodology has been included in the main report available at www.nwpho.org.uk.

ⁱⁱ The Index of Multiple Deprivation 2007 combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for each small area in England. This allows responses to be categorised and subsequently analysed according to their level of deprivation.

ⁱⁱⁱ Confidence intervals indicate the reliability of the survey results. Sample surveys are always subject to some error, but it is possible to be 95% confident that the true result for the particular population segment in question is within the confidence limits calculated. In other words, where one measure is 'significantly' higher or lower than another, we are 95% confident that this is not due to random error or chance.

3. Regional distribution of WEMWBS scores

The seven item WEMWBS uses a five point Likert scoring system, with responses ranging from 'none of the time' through to 'all of the time'. A score is attributed to each response for each of the seven items in the scale:

- I've been feeling optimistic about the future
- I've been feeling useful
- I've been feeling relaxed
- I've been dealing with problems well
- I've been thinking clearly
- I've been feeling close to other people
- I've been able to make up my own mind about things

Scores:

None of the time = 1

Rarely = 2

Some of the time = 3

Often = 4

All of the time = 5

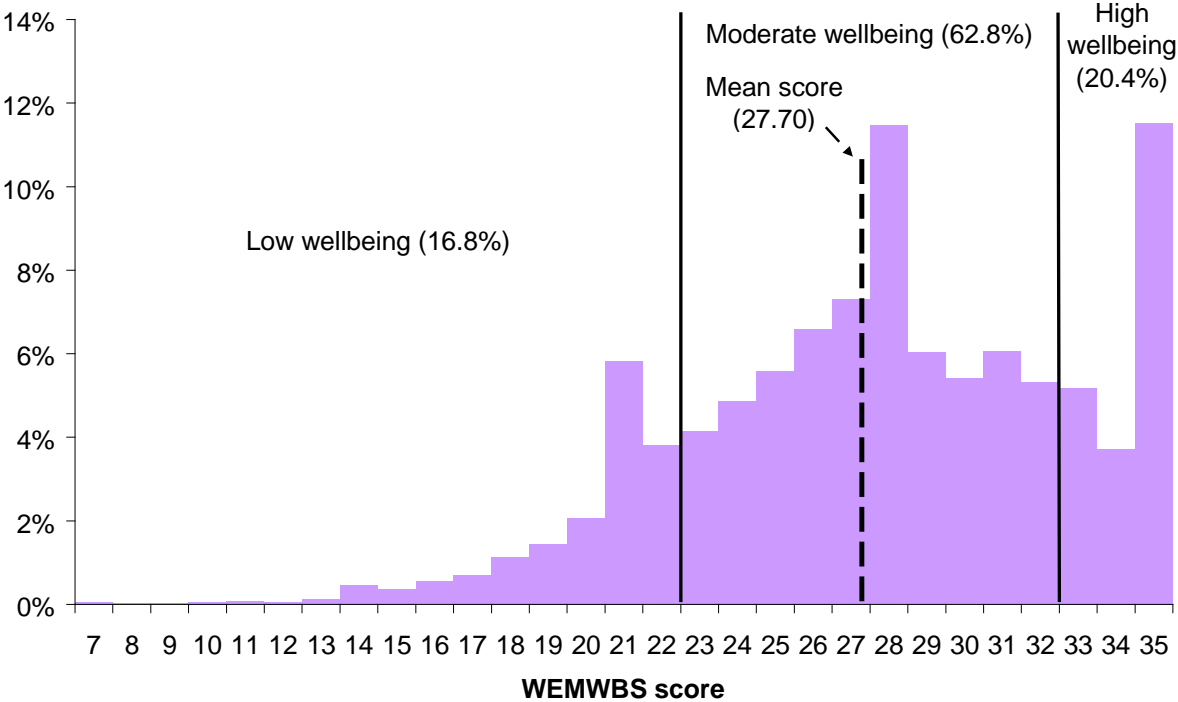
A total score for each respondent was calculated by summing the response scores of the seven items, provided there were valid responses to each item. If a response to one or more items was 'Don't know' or missing, a total score was not calculated and the respondent was excluded from the analysis connected to WEMWBS. Across the region, 281 respondents (1.6%) of respondents did not have a WEMWBS total score.

The highest possible WEMWBS score is 35, and the lowest score is 7. The distribution of scores across the region is shown in Figure 1. The distribution is non normal (bell shaped) with a clear peak at 35 suggesting that the 7 item scale may be displaying a ceiling effect; that is, if the scale was extended we may see a more graduated tail differentiating those with the highest levels of wellbeing. There is also the possibility that the peaks at multiples of 7 are a statistical artefact^{iv} that is more pronounced with a larger scale survey. This could be due to a blocking effect (respondents choosing to give the same score to each item in the scale) that is more pronounced with the 7 item scale than with the 14 item. There is methodological research suggesting the possibility of blocking, or of respondents tending to provide more positive responses.¹⁸

Cut off points were applied to the distribution to show high and low levels of mental wellbeing based on one standard deviation (which measures the spread of the distribution) above or below the mean. This was the same method used by the Scottish Government to report findings from a 2006 survey of public attitudes to mental health and mental wellbeing¹⁴ (although the survey used the 14 item WEMWBS scale) and is recognised as the best approach to date to present the data in a categorical way. These categories are used throughout the analysis. In total, 16.8% of people had a low level of mental wellbeing, 62.8% had a moderate level of mental wellbeing and 20.4% had a high level of mental wellbeing.

^{iv} An error resulting from bias in the collection of data.

Figure 1: Regional distribution of WEMWBS scores.



4. Local WEMWBS scores

It is possible to calculate a local mean WEMWBS score for the 18 PCT areas that had a survey sample of at least 500 individuals. Out of the 24 PCTs in the North West, 18 localities had a sample of this size.^v Therefore, mean PCT scores can be listed and displayed alongside each other and the North West regional mean score (Figure 2). However, due to the distributions being non normal, it is not possible to perform statistical tests on the data to infer which areas had significantly higher or lower scores than others. Areas that had samples larger than 500, however, will have a mean score with lower potential variation than those areas with a sample of 500. Therefore, suitable caution should be taken when interpreting the results.

Another way of comparing wellbeing levels in local areas is by assessing the proportions of populations with relatively high, moderate and low mental wellbeing according to the North West cut offs (Figure 3). This provides further insight into the differences between local areas as local distributions of scores (like for Figure 1, but for each PCT area) can be different and therefore pull the mean score one way or another. For example, Sefton has the tenth highest mean score out of the 18 PCT areas, but the third lowest proportion of people with high mental wellbeing. This is because a higher than average proportion of those surveyed in Sefton had a moderate level of mental wellbeing.

^v Mean scores were taken from each individual local area dataset, which had its own weighting variables calculated and applied to ensure that the sample surveyed was representative of the local population as a whole.

Figure 2: Mean WEMWBS scores, North West PCT areas.

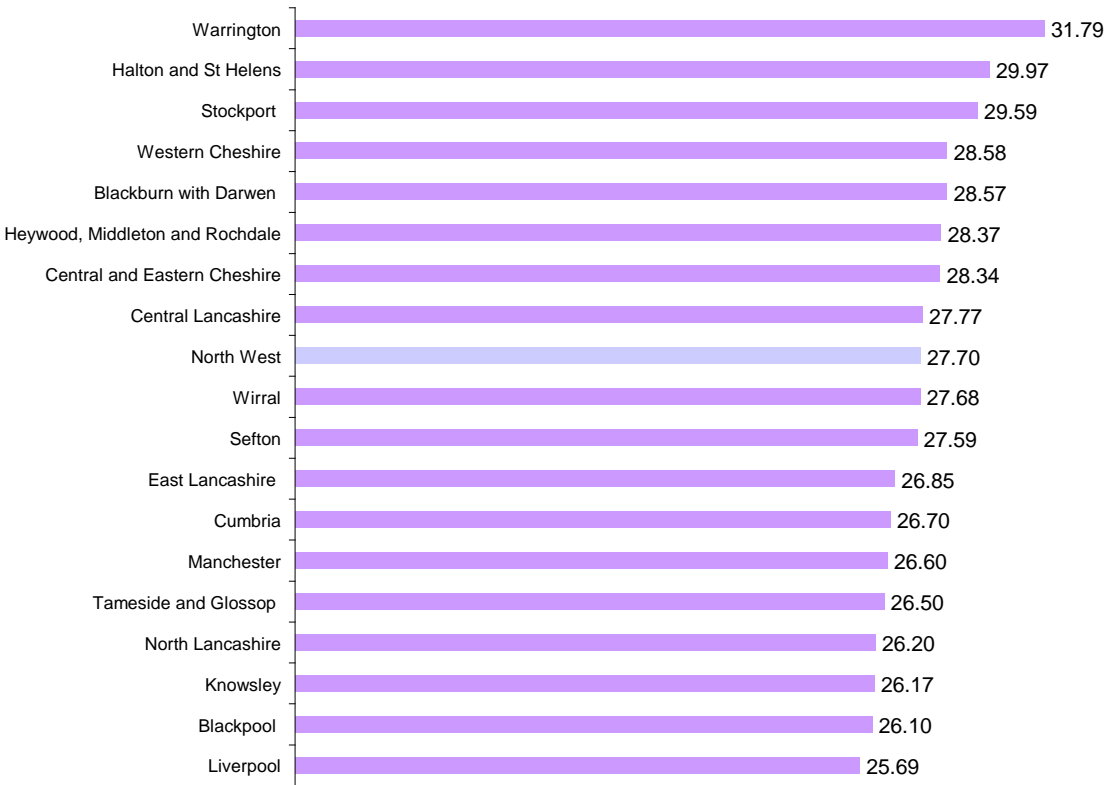
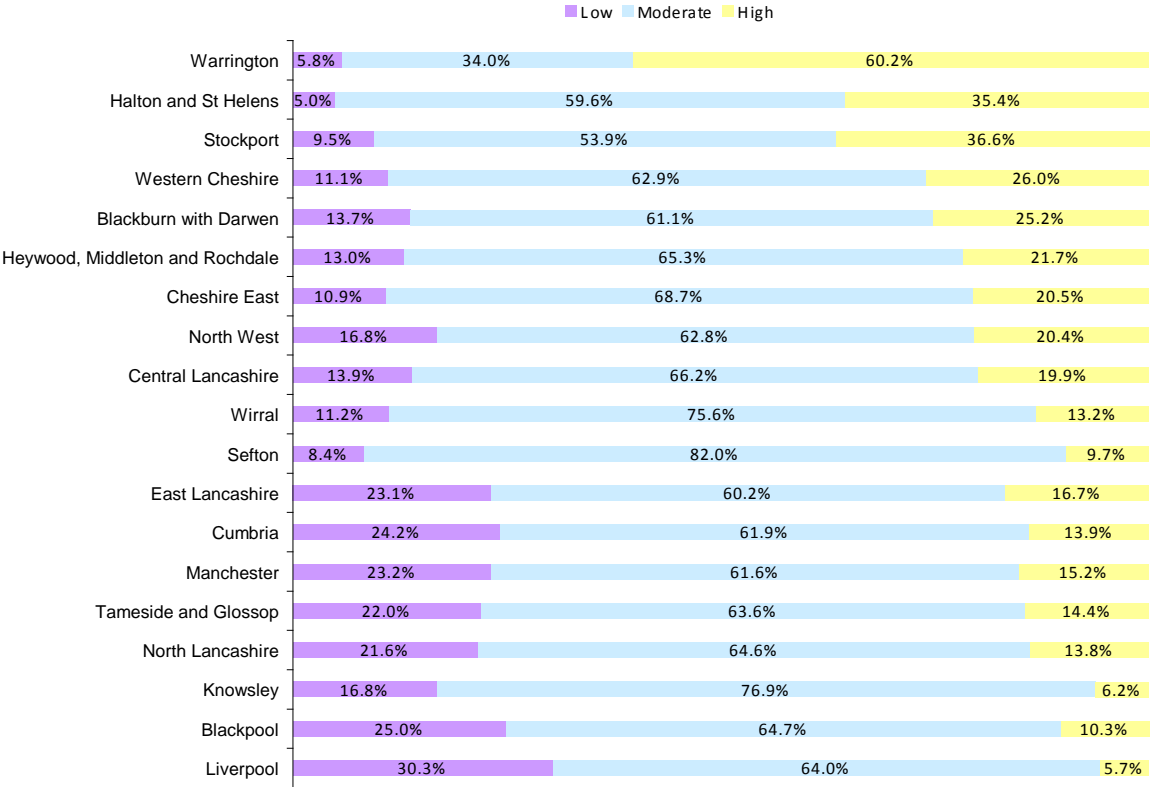


Figure 3: Proportion of respondents with low, moderate and high mental wellbeing, North West PCT areas.



5. Results

5.1 Feelings

5.1.1 Mental wellbeing

There was no difference in levels of mental wellbeing between men and women. However, there were differences by age group, deprivation and ethnic grouping. For instance, levels of mental wellbeing were more likely to be high among:

- 25-39 year olds (least likely among 40-54 year olds);
- Those living in the less deprived areas (least likely in the most deprived areas);
- Non-White adults (less likely among White adults).

Optimism

Around one-fifth of people had felt optimistic about the future all of the time over the past two weeks. Around 32% had felt optimistic often, 32% some of the time, 12% rarely, and 3% none of the time. There were few differences by gender. However, optimism about the future decreased as people aged, with those aged 65+ years least likely to feel optimistic all of the time. Furthermore, levels of optimism were higher among those living in the least deprived areas, and among non-White adults.

Feeling useful

Around a third of people had felt useful all of the time over the past two weeks. Around 35% said they had felt useful often, 25% some of the time, 7% rarely and 1% none of the time. The proportion of people who had felt useful all of the time was higher among women, those aged 25-39 years, those living in the least deprived areas, and non-White adults. Those aged 65+ years were most likely to have rarely felt useful compared with other age groups.

Feeling relaxed

Just over one-quarter of adults had felt relaxed all of the time over the past two weeks. Around 34% had felt relaxed often, 27% some of the time, 9% rarely and 3% none of the time. Proportions of people feeling relaxed all of the time were higher among men, younger (16-24 years) and older (65+ years) age groups, those living in the least deprived areas, and non-White

adults. Those aged 40-54 years were the most likely to report never or rarely feeling relaxed compared with other age groups.

Dealing with problems

Around a third of people had dealt well with problems all of the time over the past two weeks. Around 38% had done so often, 23% some of the time, 4% rarely and 1% none of the time. Proportions did not vary by gender. However, those aged 25-39 or 55+ years, those living in the least deprived areas, and non-White adults were the most likely to have dealt with problems well all of the time.

Thinking clearly

Just over two-fifths of adults had been thinking clearly all of the time over the past two weeks. Over a third had done so often, 20% some of the time, 3% rarely, and less than 1% none of the time. There were no differences in proportions by gender. However, those aged 40-54 years were less likely than other age groups to have been thinking clearly all of the time. Those living in the least deprived areas and non-White adults were most likely to have been thinking clearly all or most of the time.

Feeling close to people

Overall, around two-fifths of adults had felt close to others all of the time over the past two weeks. Around 35% had done so often, 21% some of the time, 4% rarely and 1% none of the time. Women, those aged 25-39 years, those living in areas of lower deprivation, and non-White adults were the most likely to have felt close to others all of the time. Although differences were slight, people aged 40-54 years felt close to others less frequently than other age groups.

Being able to make up own mind about things

Half of all adults surveyed had been able to make up their own mind about things all of the time over the last two weeks. Just under a third had done so often, 16% some

of the time, 2% rarely and less than 1% none of the time. Proportions did not vary by gender or ethnic grouping. However, those aged 40-54 years were less likely than other age groups to have made up

5.1.2 Life satisfaction

Around three-fifths of adults were satisfied with their life as a whole. Life satisfaction did not vary by gender or ethnic grouping. However, there were differences by level of mental wellbeing, age group, and deprivation. People with a high level of mental wellbeing were two-and-a-half times more likely to be satisfied with their lives compared with people with a low level of mental wellbeing. Individuals aged 16-24 or 65+ years and those living in the least deprived areas were also most likely to be satisfied with life. Those aged 40-54 years were less satisfied with their lives than other age groups.

their own mind about things all of the time. Furthermore, those living in the least deprived areas were most likely to have been able to make their own minds up often or all of the time.

5.1.3 Having time to do enjoyable activities

Overall, 36% of adults definitely agreed that they had time to do the things they really enjoyed, and 43% tended to agree. One in five adults disagreed. People with high levels of mental wellbeing were two-and-a-half times more likely to definitely agree that they had time to do the things they really enjoyed compared with people with low levels of mental wellbeing. The proportion of people definitely agreeing that they had time to do enjoyable activities was also higher for men, those aged 65+ years, those living in the least deprived areas and non-White adults.

5.2 Relationships

5.2.1 In a meaningful relationship

Around 62% of adults were in long-term meaningful relationships. There were no differences in this proportion by gender. However, individuals were more likely to be in a long-term relationship if they had higher levels of mental wellbeing, were aged between 25 and 64 years, were living in areas of lower deprivation, and were non-White adults.

5.2.2 Speaking to non-household members

Around 3% of adults surveyed had not spoken to someone outside their household during the last week. Individuals with low mental wellbeing were nearly three times more likely than those with high mental wellbeing to have not spoken to someone outside their household. People were also more likely to have not spoken to someone outside their household if they lived in more deprived areas or were non-White adults. There were no differences by age or gender overall. However, women aged 65+ years were the most likely group to have not spoken to a non-household member.

5.2.3 Speaking to neighbours

Just over half of adults said they speak to their neighbours on most days. A third speak to them once or twice a week, 4% less than once a month, and 3% not at all. Individuals are more likely to speak to their neighbours on most days if they have higher levels of mental wellbeing, are female, are of an older age (55+ years) or are White adults. Speaking to neighbours also varied with deprivation, with those living in the third most deprived areas being most likely to speak to neighbours on a daily basis. People with low mental wellbeing were over three-and-a-half times more likely to never speak to their neighbours than those with high mental wellbeing.

5.2.4 Meeting friends and relatives

Frequency of meeting with others

Just over half of adults meet friends or relatives on most days, and nine out of ten

meet them at least once or twice a week. Less than 1% never meet friends or relatives. The likelihood of meeting friends and relatives on most days was higher for those with higher levels of mental wellbeing, women, people of younger age (16-24 years), those living in the more deprived areas, and non-White adults. Conversely, people with low mental wellbeing were more likely to say they never met friends and relatives, or met them less frequently, than people with high mental wellbeing.

Seeing friends and family as often as they want

Around two-thirds of adults agreed that they saw their family and friends as often as they wanted to. There were no differences by gender or ethnic grouping. However, proportions agreeing varied by levels of mental wellbeing, age group and deprivation. For instance, those individuals most likely to agree that they saw family and friends as often as they wanted to had higher levels of mental wellbeing, were aged 16-24 years or 55+ years, or lived in the third most deprived fifth of areas.

Barriers to meeting with others

Among those who didn't see friends and family as often as they wanted to, the most common reasons were a lack of time due to paid work (cited by 24% of people who said they did not see their family and friends as often as they wanted to), and friends and family being too far away (23%). Other reasons included lack of time due to childcare responsibilities (9%), being unable to afford to (8%) and being too ill, sick or disabled (7%). People with low mental wellbeing who did not see their family and friends as often as they wanted to were more likely than everyone in this situation to say this was because they were not interested, couldn't afford to, they had no vehicle, they were too ill, sick or disabled, or they were too old.

5.2.5 Ability to rely on others

Ability to rely on others was high. Almost 90% of individuals felt able to ask someone for help if they needed a lift urgently, 90% if they were ill in bed and needed help at

home, 75% if they were in financial difficulties, and 94% if they had a serious personal crisis and needed comfort and support. All four answers were related to mental wellbeing and deprivation. Those with a higher level of mental wellbeing, or living in areas with lower levels of deprivation, felt more able to rely on others. There were some slight differences for some questions by gender and age group. For instance, women felt slightly more able than men to ask for help if they were ill or had a personal crisis. Those aged 40-59 years felt slightly less able to ask for a lift, ask for help if they were ill in bed, or ask for help through a personal crisis than other age groups. Additionally, those aged 55+ years felt less able than other age groups to rely on someone for financial help. While there were no differences by ethnic grouping for most questions, a significantly higher proportion of non-White adults than White adults felt able to ask for help in financial difficulty.

5.2.6 Satisfaction with personal relationships

Around three-fifths of those surveyed were very satisfied with their personal relationships and a further 28% were fairly satisfied. Less than 1% were very dissatisfied. Individuals were more likely to be very satisfied with their personal relationships if they had a high level of mental wellbeing or lived in areas of low deprivation. For example, people with a high level of mental wellbeing were twice as likely as those with a low level to be very satisfied with their personal relationships. Satisfaction also varied by age group, with those aged 55-64 years being most likely to be very satisfied with their personal relationships and those aged 40-54 years being most likely to be dissatisfied. There were no differences in satisfaction by gender or ethnic grouping.

5.3 Health

5.3.1 General health

In total, 32% of adults said that they were in very good health, with a further 40% saying they were in good health. Around one in five adults said they were in fair health, 6% said their health was bad, and a further 2% said it was very bad. Those with high mental wellbeing were three-and-a-half times more likely than those with low mental wellbeing to say they were in very good health. Conversely, although the proportions were small, those with low mental wellbeing were

5.3.2 Mobility

Four-fifths of people did not have any problems in walking about. The majority of the remainder said they had some problems with mobility and 0.2% said they were confined to bed. People with high mental wellbeing were significantly less likely to have problems walking about than people with moderate or low mental wellbeing levels. People were more likely to have some problems walking about if they were female, aged 65+ years, living in the most deprived areas, or were White adults.

5.3.3 Self-care

Overall, 95% of adults had no problems with self-care, while 5% had some problems washing or dressing themselves. People with low mental wellbeing were more than twice as likely as those with average mental wellbeing and more than three times as likely as those with high mental wellbeing to have some problems washing and dressing themselves. There was no difference by gender or by ethnicity. People aged 65+ years were most likely to have problems washing or dressing themselves, and people living in the most deprived areas were more likely than people living in other areas to have problems.

5.3.4 Usual activities

Nearly 84% of adults had no problems performing their usual activities, compared with just under 15% who experienced some difficulties and nearly 2% who were unable to perform their usual activities. People with low mental wellbeing were significantly

nearly six times more likely to say that their health was very bad or bad than those with high mental wellbeing. People were more likely to be in very good health if they were male, aged 16-24 years, lived in the least deprived areas, or were non-White adults. Those in very bad health were most likely to be 65+ years, living in the most deprived areas, or White adults. There was no gender difference for bad or very bad health.

more likely to have problems performing their usual activities compared with those with moderate and high levels of mental wellbeing. People who had some problems were most likely to be women, in an older age group, living in the most deprived areas, or were White adults.

5.3.5 Pain and discomfort

Around seven out of ten adults said that they experienced no pain or discomfort, while 23% had moderate pain or discomfort. A total of just under 7% of people said they experienced extreme pain or discomfort. People with low mental wellbeing were significantly more likely to have moderate pain or discomfort than people with moderate and high levels of mental wellbeing, and were more than twice as likely as those with high mental wellbeing to experience extreme pain or discomfort. Women were more likely than men to say they had moderate and extreme pain or discomfort. Pain and discomfort increased as age increased and generally increased as deprivation increased. White adults were more likely to have pain or discomfort than non-White adults.

5.3.6 Anxiety or depression

Just under 82% of adults said they were not anxious or depressed, compared with 15% of adults who said they were moderately anxious or depressed, and 3.5% who were extremely anxious and depressed. People with low mental wellbeing were more than three times as likely than those with higher levels of mental wellbeing to be moderately anxious or depressed, and were significantly more

likely to feel extremely anxious or depressed than those with average or high levels of mental wellbeing. However, six out of ten people with low mental wellbeing said that they were not anxious or depressed. Anxiety and depression were more common in women than men, among people aged 40-54 years, and among White adults. Anxiety and depression also increased as deprivation increased. People aged 16-24 years were more likely than any other age group to say that they were not anxious or depressed.

5.3.7 Health state index (EQ-5D mean score)

The health state of each individual was compiled into an index from their responses to questions on mobility, self-care, usual activities, pain and discomfort and anxiety or depression. The index runs from -0.0594 (worst imaginable health) to 1 (best imaginable or full health). The overall EQ-5D mean score across the North West was 0.84. The mean score increased as mental wellbeing increased: from 0.73 for adults with low mental wellbeing to 0.86 for adults with moderate mental wellbeing and then to 0.90 for those with high mental wellbeing. Men had a higher score than women, and scores decreased as age and deprivation increased. Non-White adults had a higher EQ-5D score than White adults.

5.3.8 Caring

Around one in ten adults care for somebody (not as part of their job). Carers were most likely to be women, aged 55-64 years or non-White individuals. There was no difference in the proportion of adults who were carers by level of mental wellbeing or deprivation level. Carers who were older or who lived in the most deprived areas tended to care for someone for longer hours.

5.4 Lifestyle and life events

5.4.1 Life events

Out of a list of potential life events that may occur in people's lives, respondents were most likely to have experienced bereavement (9.0%), moving house (8.7%), changing job (6.5%), birth of a child (4.5%) and birth of a grandchild (4.1%) over the last year. Out of the people with low mental wellbeing, significantly more than average had experienced divorce or separation and fewer than average had changed job in the last year. People with a high level of mental wellbeing were more likely than average to have experienced the birth of a child.

5.4.2 Physical activity

Overall, 69% of adults were currently not meeting physical activity targets, and 30% were achieving the Government's recommended guidelines, with the remainder not providing a definitive response to the questions asked. The likelihood of meeting recommended activity levels significantly increased as mental wellbeing increased and people with a high level of mental wellbeing were more than twice as likely to be meeting the physical activity target as those with a low level of mental wellbeing. Significantly more men than women and more White adults than non-White adults were meeting the physical activity target. Levels of physical activity decreased as age increased and fluctuated by deprivation, with those living in the third most deprived fifth of areas more likely to be meeting the physical activity target than those living in the least and most deprived areas.

5.4.3 Sedentary behaviour

In total, 8% of adults spent more than 8 hours sitting or reclining on a typical day. A further 32% spent between 4 and 8 hours, 37% spent between 2 and 4 hours, and 23% spent up to 2 hours sitting or reclining. In general, sedentary time decreased as mental wellbeing increased. Adults with low levels of mental wellbeing were more than four times as likely as those with high levels of mental wellbeing to be sedentary for more than 8 hours a day. Women were generally less sedentary than men, and

younger people were less sedentary than older people. Generally, as deprivation levels increased, sedentary time also increased. White adults were more likely than non-White adults to be very sedentary.

5.4.4 Smoking status

Overall, 30% of adults said they currently smoked, and a further 21% of adults were ex-smokers. The remainder had never smoked. Smoking prevalence in this survey was higher than may be expected, given other intelligence and recent surveys, but nevertheless results can still highlight differences between sub-groups of the population. People who were most likely to smoke included those with low levels of mental wellbeing, men, people aged 25-39 years and White adults. Those living in the most deprived areas were more than twice as likely to smoke as those living in the least deprived areas. The proportion of ex-smokers increased as age increased.

5.4.5 Alcohol consumption

Just over half of people said they were drinking within sensible limits, while 11% of individuals were classified as hazardous drinkers and a further 3% were harmful drinkers. In total, 36% said they never drink, a somewhat higher proportion than other recent surveys suggest. People with low mental wellbeing were significantly more likely to be drinking at harmful levels and significantly less likely to be drinking at sensible levels than people with moderate and high mental wellbeing. However, they were also significantly more likely to be non-drinkers in comparison to other people. Proportionately more men than women were hazardous or harmful drinkers and women were significantly more likely to be non-drinkers than men. Adults aged 16-24 years were most likely to be harmful drinkers and people aged 65+ years were most likely to be non-drinkers. People living in the most deprived areas were significantly more likely to be harmful drinkers than adults living in other areas, but were also most likely to be non-drinkers. Non-White adults were significantly more likely to be non-drinkers than White adults.

5.4.6 Cannabis use

Across the region, 88% of adults had never used cannabis. Of those that had used cannabis before, around one quarter said they had used it within the last 30 days. People with low mental wellbeing were significantly more likely than people with moderate and high mental wellbeing to have used cannabis in the last 30 days, while people with high mental wellbeing were most likely to have never used cannabis. Men were significantly more likely than women and White adults were more likely than non-White adults to have used cannabis. By age, people aged 16-24 years were most likely to have used cannabis during the past 30 days and as age increased, cannabis use decreased. Although the proportions were relatively small, adults in the most deprived areas were nearly four times as likely as adults in the least deprived areas to have used cannabis in the last 30 days.

5.4.7 Money

Feelings about household income

In total, 32% of people said that they were living comfortably on their present income and 49% said they were coping on their present income. However, nearly one in five adults said that they were finding it difficult or very difficult on their present income. People with a high level of mental wellbeing were 2.4 times more likely to say that they were living comfortably on their present income compared with people with low mental wellbeing, while people with low

mental wellbeing were five times more likely than people with high mental wellbeing to be finding it very difficult on their present income. There were no differences by gender. People were most likely to be living comfortably on their present income if they were over the age of 55 years or living in the least deprived two-fifths of areas. Over a quarter of adults in the most deprived areas were finding it difficult or very difficult on their present income, while significantly more non-White individuals than White individuals were finding it difficult on their present income.

Worries about money

Overall, 35% of people said that they had never worried about money during the last few weeks, and 34% said they had worried about money only sometimes. However, over three out of ten adults said that they had worried about money quite often or almost all the time. Nearly half the people with low mental wellbeing had been worried about money almost all the time or quite often over the last few weeks, 2.4 times the proportion of those with high mental wellbeing who fell into these categories. More women than men, and more than twice as many people living in the most deprived areas compared with the least deprived, had worried about money almost all the time over the last few weeks. People aged 65+ years were by far the least likely to have worried about money almost all the time and the most likely to have never worried over the last few weeks.

5.5 Place

5.5.1 Years lived in local area

Around three-fifths of adults had lived in their local area for 10 years or more, and 8% had lived there for less than one year. There were no differences in proportions by gender. However, individuals were more likely to have lived in their local area for 10 years or more if they had high or moderate levels of mental wellbeing, were older (aged 55+ years), lived in less deprived areas, and were White adults.

5.5.2 Satisfaction with local area as a place to live

Just over half of adults were very satisfied with their area as a place to live, and a further 34% were fairly satisfied. One in twenty adults (5%) were very or fairly dissatisfied with their area as a place to live. There were no significant differences between genders. However, satisfaction with the local area increased as mental wellbeing increased and decreased as deprivation increased. Additionally, older age groups (55+ years) and White adults were most likely to be very satisfied with their area as a place to live.

5.5.3 Belonging to the immediate neighbourhood

Around 44% of adults very strongly believed they belonged to their neighbourhood, and a further 36% fairly strongly believed. Around one-fifth (20%) felt not very, or not at all, strongly that they belonged to their neighbourhood. Very strong feelings of belonging were more likely to be reported among those with higher levels of mental wellbeing, women, older age groups, those living in less deprived areas, and White adults.

5.5.4 Organisation activities

Just over a quarter of adults participated in the activities of at least one organisation on a regular basis. The most popular type of organisations were sports clubs (11%), religious groups or church organisations (7%) and social clubs/working men's clubs (5%). The percentage of people participating in the activities of at least one

organisation was higher for those with higher levels of mental wellbeing, men, older age groups, those living in less deprived areas, and non-White adults. A higher proportion of people with high mental wellbeing than average participated in sports clubs.

5.5.5 Decisions affecting local area

Just over half of all adults tended to disagree, or definitely disagreed, that they could influence decisions in their local area. Around 30% tended to agree, 8% definitely agreed, and 11% did not know. Individuals with high levels of mental wellbeing were three times more likely than those with low levels to definitely agree they could influence decisions. Agreement was higher for those living in areas of lower deprivation. Agreement increased with age up to the 55-64 year age group, but was lower for those aged 65+ years. White adults were more likely to disagree that they could influence decisions than their non-White counterparts.

5.5.6 Safety

Around 97% of individuals felt very safe or fairly safe when outside during the day, 94% when home alone at night, and 74% when outside after dark. Only a small percentage of people felt very unsafe outside during the day (less than 1%) or when home alone at night (2%). However, around 10% of people felt very unsafe outside after dark. For all scenarios, people were more likely to report feeling very safe if they had higher levels of mental wellbeing, were male, were younger in age, or were living in less deprived areas. There were no differences between ethnic groups for feelings of safety during the day or when home alone at night. However, White adults were more likely than non-White adults to report feeling very safe after dark. While the proportions were relatively small, people with low mental wellbeing were far more likely (4.5 times) than those with high mental wellbeing to feel very unsafe outside after dark.

5.6 Respondent characteristics

5.6.1 Work status

In total, just over a third of people surveyed were in full-time employment and just over a quarter were retired. One in ten were in part-time work and a similar number were unemployed, and slightly more people who were unemployed were seeking work as opposed to not seeking work. People with high levels of mental wellbeing were more likely to be in paid full-time work, paid part-time work, self-employed or in full-time education than those with low mental wellbeing.

There is also evidence that there is a difference in mental wellbeing between people who had experienced redundancy (either voluntary or involuntary) in the last 12 months, but were currently working or in full-time education, compared with those people who had experienced redundancy, but were not currently working. The former group were significantly less likely to have low mental wellbeing compared with the latter.

5.6.2 Sexual identity

Across the region, 98.4% of respondents described themselves as heterosexual, with 0.8% describing themselves as lesbian or gay, 0.3% stating they were bisexual and 0.5% describing their sexual identity as 'other'. The overall proportion of the population not identifying themselves as heterosexual was therefore very small, and further analysis should be treated with some caution. People with high mental wellbeing were more likely to describe themselves as heterosexual than people with low mental wellbeing, but the difference was small. People were also more likely to state they were heterosexual if they were female, aged 40+ years, living in the least deprived areas or White individuals.

5.6.3 Living in supported or assisted housing

Across the North West, 9% of adults said they were living in supported or assisted housing. Significantly more people with low mental wellbeing were living in supported or assisted housing compared with people

with moderate or high mental wellbeing. People living in supported or assisted housing were more likely to be female, aged 65+ years or non-White adults. Five times more people in the most deprived areas than in the least deprived were living in supported or assisted housing.

5.6.4 Highest qualification level

Across the North West, nearly a third of adults had no qualifications, 12% of the population had a highest qualification level of Entry/Level 1 (1 GCSE or equivalent), 21% were qualified to Level 2 (5 GCSEs grades A*-C or equivalent), 12% to Level 3 (2 or more A levels or equivalent), and 17% had qualifications at Level 4+ (degree level or equivalent). A further 4% had other qualifications and 1% had foreign qualifications at levels that could not be determined. People with low levels of mental wellbeing were significantly more likely to have no qualifications than those with moderate and high mental wellbeing and were also around half as likely as people with average and above average mental wellbeing to have qualifications at Level 4+. People most likely to have no qualifications also included women, older adults and those living in the most deprived areas, while people most likely to be qualified to Level 4+ were most likely to be men, people aged 25-39 years, or those living in the least deprived areas. There were no differences by ethnic grouping in the proportions holding no qualifications or qualifications at Level 4+.

5.6.5 Household economic status

Six out of ten adults lived in households where at least one person was employed. A further 23% lived in retired households, 8% in households classified as unemployed, 3% in households that were economically inactive due to sickness or disability, 3% in households that were economically inactive for domestic reasons and 2% in full-time student status households.

There were differences, often as may be expected, by level of mental wellbeing, gender, age group, deprivation level and

ethnic grouping. For example, people most likely to live in employed status households were those who had high mental wellbeing, men, people aged 25-54 years, non-White adults or those who lived in locations outside the most deprived areas. Proportionately more people with high mental wellbeing than low mental wellbeing also lived in full-time student status households, while more people with low mental wellbeing than high mental wellbeing lived in households that were classified as unemployed, retired, or inactive for either domestic or sickness or disability reasons.

5.6.6 Household type

Nearly a third of adults lived in households with two adults, just under a quarter lived in single person households and around one-fifth lived in a small family household. Furthermore, 15% lived in multi-adult households, 5% in a large family and 4% were in lone parent households.

Again, there were differences by level of mental wellbeing, gender, age group, deprivation level and ethnic grouping. For example, proportionately more people with low mental wellbeing, or who were aged 65+ years, lived in the most deprived areas or who were White lived in a one adult household than their counterparts. Proportionately more people with high mental wellbeing than low mental wellbeing lived in multi adult, small family or large family households, while more people with low mental wellbeing than high mental wellbeing lived in one adult or lone parent households.

6. Conclusions and Recommendations

This report provides a reference point of the key descriptive statistics that have been derived from the regional survey. The survey is large and the possibility for investigating the data in more detail and constructing more complex analysis is significant. However, the results presented here

provide a first stage of analysis that gives us a picture of the level of wellbeing in the region and factors that influence it broken down by key variables of level of mental wellbeing, age group, gender and level of deprivation.

6.1 Mental wellbeing prevalence

The survey has provided important information on the state of the population's mental wellbeing. We can observe the strong associations that high levels of mental wellbeing have with work, education, relationships, health, life satisfaction and lifestyle. In the North West, 20.4% of the population have relatively high levels of mental wellbeing (classified as a score of more than 32 on the seven item WEMWBS scale, which has a total possible score of 35). In the United States 20% of

the population have been described as flourishing¹⁹ and in Scotland 14% were classified as having good mental wellbeing.¹⁴ Within localities in the North West, the proportion of people with relatively high wellbeing ranges from 60.2% to 5.7%, and the proportion of people with relatively low wellbeing ranges from 30.3% to 5.0%. In order to increase the numbers of people experiencing high mental wellbeing it is recommended that concerted attention is paid to this issue.

6.2 Value of the baseline and potential comparative analysis

The survey has provided a new baseline of wellbeing for the region of 27.70, which compares favourably with the Scottish survey (although the 14 item WEMWBS scale was used for this). Repetition of the survey in the future using the same sampling methodology is recommended to measure progress in improving mental wellbeing from the regional baseline that we have now established. Provision of local benchmarks will also allow comparison between geographies within the region and

again with repeatable sampling methods local areas can compare these over time and compare the scores of intervention groups for evaluation purposes. Local areas may choose to use the 14 item scale rather than the 7 item scale, but should be aware that while the 7 item scale has been proven to be an effective alternative for the 14 item, there may potentially be some loss of comparability as the 7 item presents a more restricted view.

6.3 Factors that impact on wellbeing from the survey corroborated by existing research literature

6.3.1 Age

The survey results show that there is a dip in levels of mental wellbeing around middle age (40-54 years) which is supported by wider literature. This is also particularly evident within the WEMWBS question relating to feelings of relaxation, as below average proportions of people this age had felt relaxed all of the time or often over the past two weeks. This suggests that further analysis could be undertaken of the survey data around this particular age group in relation to understanding this group and identifying whether there are particular sub-groups who are more susceptible to poor wellbeing (for example, by work, relationship status and health behaviours). This may indicate where interventions could be targeted. For example, some initial investigations suggest that while the 40-54 year age group are more likely to have a full-time job or to be self-employed, their higher levels of economic activity are less likely to be associated with higher levels of mental wellbeing. In particular, compared with those in other age groups, people who are in full-time employment or are self-employed in this age group are less likely to report satisfaction with their personal relationships, are more likely to have had a recent divorce or become separated, and are less likely to meet with or talk to people from outside their own household.

6.3.2 Deprivation

The survey found that living in more deprived communities is strongly associated with lower levels of mental wellbeing. Literature suggests a circular link, with poor mental wellbeing being both a cause and consequence of inequalities. The survey provides new data on the inequalities in mental wellbeing, including deprivation, age, ethnicity and so on that could usefully inform health inequalities strategies. It is further suggested that action to promote positive wellbeing will contribute to tackling inequalities. Within this rich dataset there may be pockets of respondents living in very deprived areas who do have higher levels of mental

wellbeing and the characteristics of these areas and the people living within them would be worthy of further investigation.

6.3.3 Ethnicity

Within this report, analysis has been undertaken only by White and non-White groupings, with minority ethnic groups within the non-White grouping not considered in detail as numbers were small. While the proportion of non-White individuals who have a high level of mental wellbeing is higher than the proportion of White individuals, findings supported by other research,¹⁹ there may be differences by individual non-White groups and so further analysis is needed. Consideration also needs to be given as to how effective the WEMWBS tool is in different cultural settings. A review of the literature on measuring mental wellbeing among minority ethnic groups goes beyond the scope of this report. However, further analysis of the regional dataset may be worthwhile.

6.3.4 Health

6.3.4.1 General health

The survey shows that those who do not report good health are significantly more likely to have a lower level of mental wellbeing, and those who score more poorly on the elements of the EQ-5D (walking about, self-care, performing usual activities, pain and discomfort, anxiety and depression) also appear to have lower levels of mental wellbeing. However, a significant proportion of people who are not anxious or depressed have low levels of mental wellbeing, supporting the notion that poor mental wellbeing and mental ill health are not the same.

6.3.4.2 Relationship between physical health and mental health

The wider literature supports the survey findings on the relationship between mental wellbeing and physical health, although it may be a circular relationship rather than linear i.e. levels of mental wellbeing impact on physical health and physical health

impacts on mental wellbeing. Existing analysis of the Health Survey for England suggests that there may be wellbeing factors that impact on an individual's ability to construct and recognise ill health and manage it effectively, suggesting the idea of a learned capacity to be well. There is scope to explore the relationship between mental wellbeing and physical health in more depth using this dataset to identify mitigating factors that may enable people with ill health to have higher levels of mental wellbeing. Action to promote mental wellbeing should be considered as part of programmes to improve general and physical health and prevent or manage physical illness. Likewise, action to improve physical health should be included in programmes to improve mental wellbeing.

6.3.5 Relationships

Relationships are clearly an important factor for wellbeing. Those in long term meaningful relationships and those with high levels of satisfaction with their relationships have higher levels of mental wellbeing. Those with higher levels of life satisfaction also clearly have higher levels of mental wellbeing. This is supported by the wider research literature particularly in relation to the association of high levels of social trust with life satisfaction. Social networks and contacts outside the immediate household and regular contact with neighbours are also associated with higher levels of mental wellbeing. Developing trust and maintaining positive and resilient relationships are clearly areas that offer opportunities to promote positive wellbeing.

6.3.6 Place

Having a poor sense of belonging and a low perception of ability to influence what goes on in an area are both strongly associated with lower levels of mental wellbeing and supported in wider literature. Satisfaction with a local area as a place to live is also far higher for those with a high level of mental wellbeing than those with low levels. Community level interventions are therefore central to action to promote positive wellbeing.

6.3.7 Education

Survey findings show that people with low levels of mental wellbeing were more likely than those with high levels of mental wellbeing to hold no qualifications, and were far less likely to hold qualifications at degree level or equivalent. However, the wider literature is inconclusive. Income and the social status that may be conferred by education may be acting as confounding factors which need to be separated out using multi-variate techniques that are beyond the scope of this report.

6.3.7.1 Lifestyle

There is a relationship between mental wellbeing and a number of health behaviours such as smoking, unhealthy alcohol consumption and low levels of physical activity, all of which contribute to lower life expectancy. It is not possible to say whether it is low mental wellbeing that contributes to the unhealthy behaviour, or the unhealthy behaviour that lowers mental wellbeing, and the relationship may even be circular. However, it is clear that tackling behaviour change cannot be seen in isolation from improving mental wellbeing and self belief.

At an individual level, a comprehensive approach to health is probably more effective if both mental and physical health and wellbeing are addressed for all individuals, whether part of assessment, intervention, self-care or behaviour change.

6.3.8 Employment

The survey found that adults with higher mental wellbeing levels were significantly more likely to be in full-time or part-time work than those with lower levels of mental wellbeing. A variety of research concludes that being in work is the one of the best ways to improve a person's wellbeing; conversely, being out of work (whether through unemployment or sickness) is strongly related to poor health, including mental ill health, poor general health, higher mortality and long-term limiting illness.²⁰

6.4 Why these findings are important for policy and practice development in the North West

6.4.1 Investing in effective mental health promotion

This survey was commissioned to understand more about the positive mental wellbeing of the population in order to improve it. The goal is now to increase the mean baseline score. As the Foresight report proposes, “achieving a small change in the average level of wellbeing across the population would produce a large decrease in the percentage with mental disorder, and also the percentage who have [low levels of mental wellbeing]”.

The findings can be used to inform local needs assessment and commissioning priorities. Historically, investment in improving mental wellbeing has been extremely low.^{21,22} These findings will therefore support a shift to more preventative spend. Improving mental wellbeing is not only a long-term investment. Many interventions result in immediate benefits for the individual or community and immediate improvements to people’s lives and their health and wellbeing. It is recommended that in order to achieve sustained improvements in population wellbeing there needs to be sustained investment in effective interventions that impact on mental wellbeing.

6.4.2 Tackling health inequalities

These findings are significant to the North West as levels of mental wellbeing clearly play an important role in tackling health inequalities, particularly in relation to tackling the social determinants of health. It is recommended that a comprehensive approach to health inequalities includes addressing inequalities in wellbeing, not only inequalities in illness and mortality rates. First, this focuses on the positive dimension of health and the desirable outcome; and second, it enables an exploration of the root causes of why people are experiencing poorer health outcomes and have poorer health behaviours.

6.4.3 Aligned wellbeing policy

There is a clear association in the findings to social outcomes broader than health policy. This presents some complexity in mental wellbeing being a cross-cutting issue and the need for policy development across different departments to be coherent and consistent through greater alignment and partnership working. It requires a mature commissioning system that invests in return realised in multiple parts of the system.

6.4.4 Resilient communities

The significance of where we live, belonging, satisfaction and trust are key to understanding ‘place’ and supporting resilient and empowered communities. Within the survey data collected there are likely to be pockets of deprived areas that buck the trend as far as mental wellbeing goes and it is recommended that these need to be identified and investigated further to understand what makes some individuals and communities more resilient than others in similar circumstances.

Significant findings include the importance of supporting people’s ability to build and manage relationships in all walks of life. Where people’s social networks are poor and social isolation exists there is opportunity for community development activity to build on this, along with availability of spaces and places that bring people together. The role of frontline staff and volunteers who have regular contact with communities and also who support individuals have a part to play here.

6.4.5 Sustainable employment

The associations between work and wellbeing suggest that improving mental wellbeing could support those out of work into employment as well as support those in work to be healthy and productive. The findings therefore support regional policy developments to increase employment and develop healthy workplace environments.

6.4.6 Five ways to wellbeing

Tackling behaviour change cannot be done in isolation from improving wellbeing and clearly there are policy implications for the approach that is taken here. Effective application of social marketing principles has shown that messaging alone is unlikely to change behaviours. Deeper understanding of individuals' motivations to change and exchange negative for positive behaviour is needed, and improving an individual's positive sense of self and ability to change is essential to this. Findings from the survey and further analysis of different target groups could be utilised in applying messages on steps that individuals can take to improve their mental wellbeing. The Foresight Report¹ evidenced the 'Five ways to wellbeing' as steps an individual can take to improve their own wellbeing. It is recommended that such individual

wellbeing messages are used alongside other behaviour change programmes as well as considered in bespoke wellbeing programmes.

6.4.7 Wellbeing Impact Assessment

Key documents put the citizen and patient experience at the heart of policy. This can mean taking account of the impact that service interactions can have on wellbeing and this has implications for mental wellbeing impact assessments. It is not just the health service that has opportunity here but also wider public services including local authorities and other statutory and third sector agencies that will need an awareness of how they can improve population wellbeing.

6.5 Value of collaboration

This piece of work was possible through the collaboration of many agencies. Individual localities chose to conduct the study together so consistency of approach and comparability would be gained between local areas, sub-regions and the region. Collaborating on a larger scale allowed

pooling of expertise and funding, resulting in a cost-effective approach. It is recommended that such collaboration continues in any ongoing analysis and crucially in the application of the findings to practice.

6.6 Methodology: WEMWBS scale and distribution

The survey has used a tool that has been validated for population surveys, but not used on such a large scale sample and so presents some interesting methodological issues. The 7 item scale appears to show a ceiling effect at the top end of the scale, suggesting that it may not differentiate well among those with the highest level of wellbeing, although it does show differentiation at the lower end. For this reason, it may be more useful for analysis of data collected using this scale to be undertaken categorically (i.e. by groups of

respondents, as the categories of high, moderate and low mental wellbeing have been presented in this report), rather than in a continuous form, as this reduces the ceiling effect. It is not clear why there may be a ceiling effect with the 7 item scale. The 14 item scale has not yet shown such an effect, but has not been tested with such a large sample. However, such methodological issues need to be investigated further and their impact on the interpretation of the results considered.

6.7 Further analysis: methodological, regional comparisons, segmentation

This report has presented a reference of initial descriptive findings. Clearly with a survey of this size there is far more work that can be undertaken to explore further relationships in the data and consider the wider research literature that already exists. A number of themed areas for further analysis have been suggested. These include understanding what happens to people's mental wellbeing in mid-life; understanding deprived communities that thrive, understanding the relationship to physical health and health behaviours, understanding the impact of life events and

resilience factors, understanding unemployment and getting back into employment, wellbeing and ethnicity.

In addition, further more complex multi-variate and clustering techniques could be undertaken to identify segments of the population who have similar characteristics in relation to mental wellbeing. This may help identify not just who is at higher risk of poor wellbeing, but also some insight as to how their mental wellbeing may be promoted.

6.8 Further research: measuring mental wellbeing

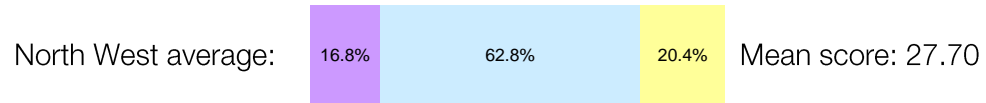
Measuring mental health and wellbeing is a developing science and dimension of service commissioning. Continued use and research of the WEMWBS scale and other measurements will improve the availability of valid instruments. The other questions asked in the survey can also inform the use of indicators of wellbeing. Ongoing research into mental wellbeing and the different

components will help to establish a comprehensive understanding of its determinants and how mental wellbeing is a determinant of other social outcomes. Other research would be needed with the public to further explore the causal relationships, associations and cultural differences.

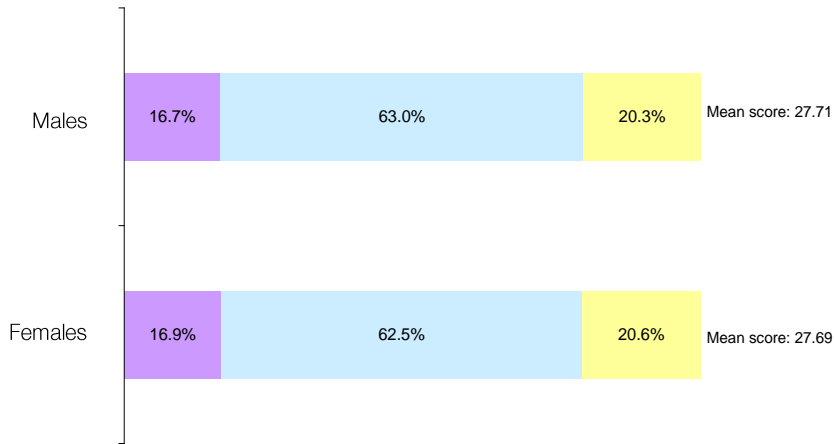
7. Summary data

Figure 4: Proportion of sub-groups of the population with low, moderate and high mental wellbeing, with mean WEMWBS score.

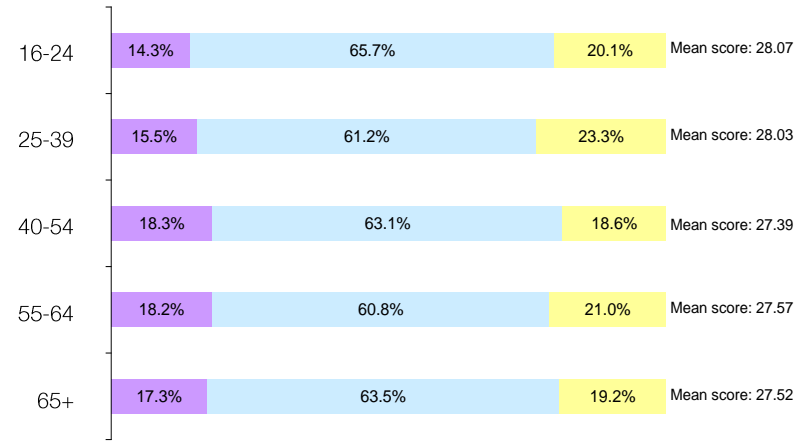
Key: ■ Low ■ Moderate ■ High



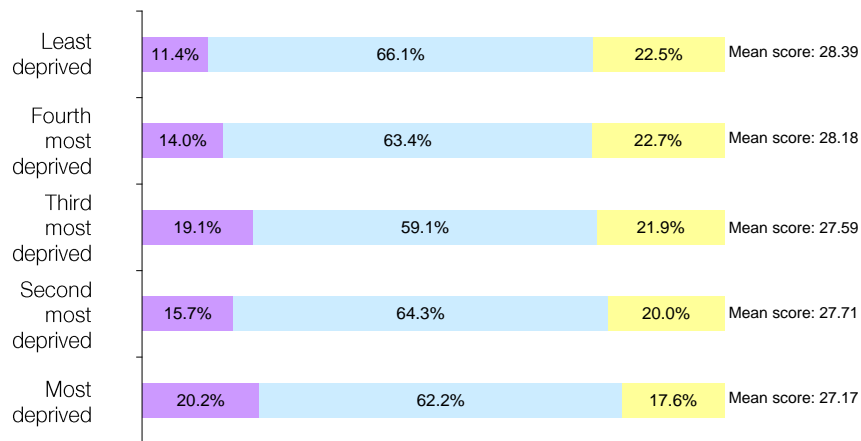
a) Gender



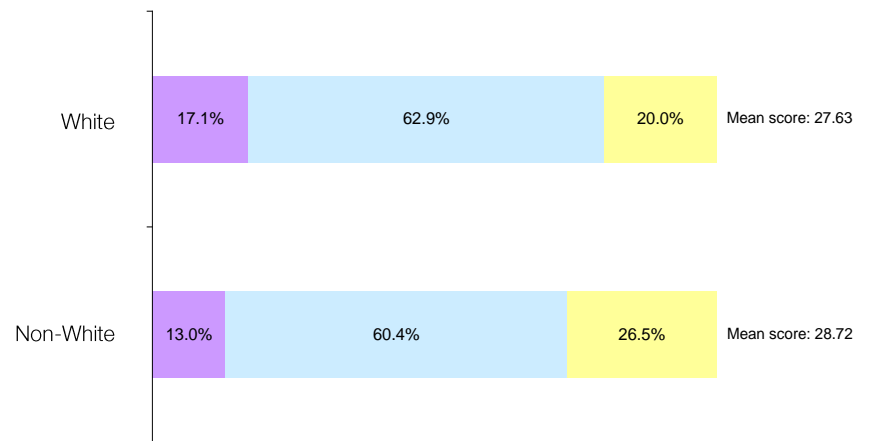
b) Age group



c) Deprivation level



d) Ethnic grouping



Participants' responses to the questions that comprise the WEMWBS scale are shown in Figure 5.

Figure 5: WEMWBS questions.

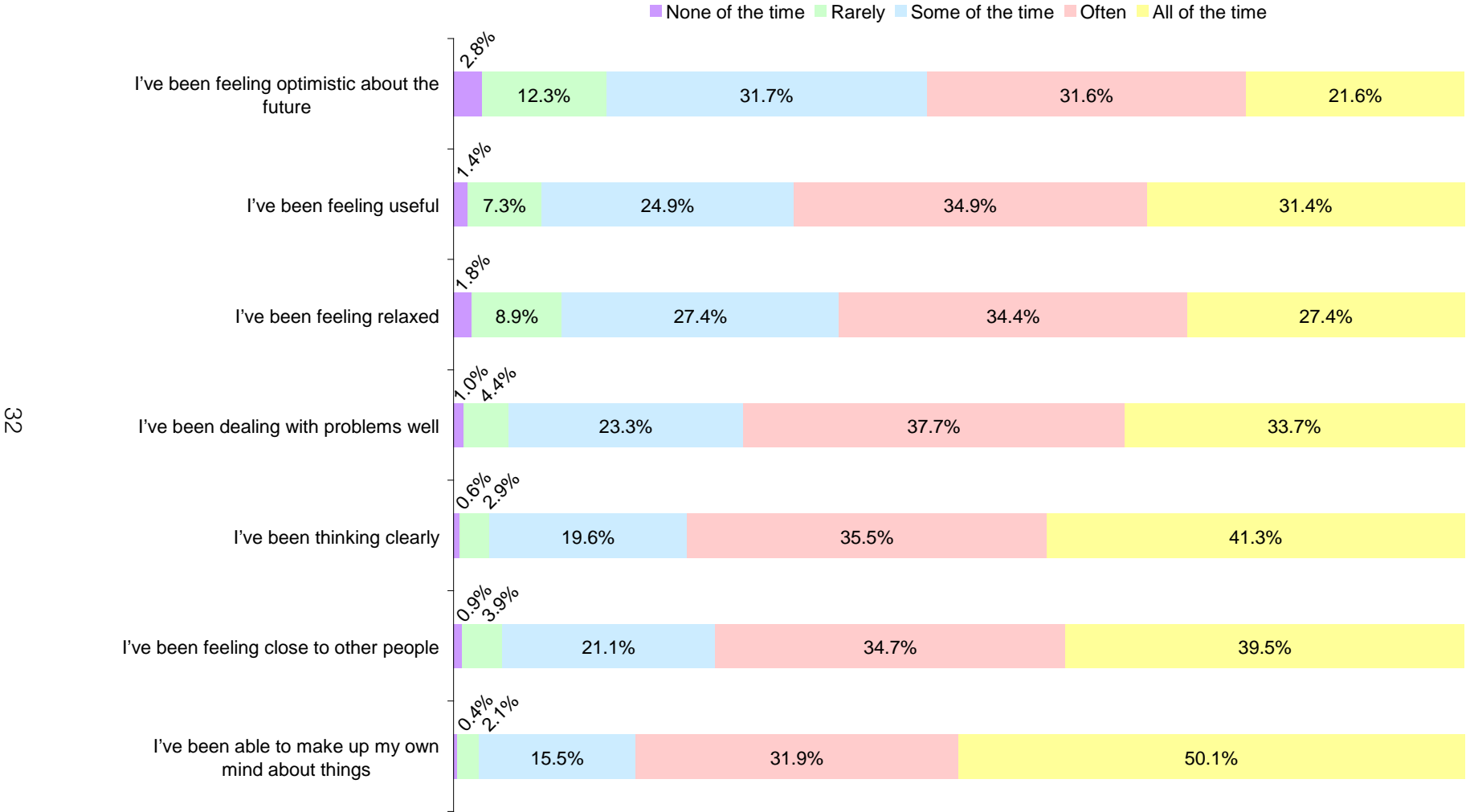


Table 1 shows the difference in responses to key questions in the survey by people with different levels of mental wellbeing. For example, for question 1 it is reported that overall, 60.1% of people had a satisfied life satisfaction score. However, 31.7% of those with low mental wellbeing had a satisfied life satisfaction score, compared with 61.3% of those with moderate mental wellbeing and 79.7% of those with high mental wellbeing.

Table 1: Key survey results by levels of mental wellbeing.

Survey question		Total	Level of mental wellbeing		
			Low	Moderate	High
FEELINGS					
1	Life satisfaction score: satisfied (those that gave a score of 8, 9 or 10 where 1 = extremely dissatisfied and 10 = extremely satisfied)	60.1%	31.7%	61.3%	79.7%
2	Life satisfaction mean score (where 1 = extremely dissatisfied and 10 = extremely satisfied)	7.58	6.27	7.66	8.42
3	To what extent do you agree that you have time to do the things that you really enjoy?: Definitely agree	35.7%	19.8%	35.4%	49.7%
4	To what extent do you agree that you have time to do the things that you really enjoy?: Tend to disagree	14.9%	20.9%	15.1%	9.2%
5	To what extent do you agree that you have time to do the things that you really enjoy?: Definitely disagree	6.1%	10.4%	5.6%	4.2%
RELATIONSHIPS					
6	Currently in a long term meaningful relationship	62.8%	50.5%	64.0%	69.3%
7	Not spoken, even if only on the telephone, to someone outside household (apart from interviewer) in last week	3.4%	6.6%	2.9%	2.3%
8	How often do you talk to any of your neighbours?: On most days	51.9%	42.7%	51.3%	61.3%
9	How often do you talk to any of your neighbours?: Less often than once a month	4.1%	6.5%	4.0%	2.2%
10	How often do you talk to any of your neighbours?: Never	2.6%	5.0%	2.4%	1.4%
11	How often do you meet friends or relatives who are not living with you?: On most days	53.9%	43.1%	52.9%	65.8%
12	How often do you meet friends or relatives who are not living with you?: Less often than once a month	2.7%	5.0%	2.6%	1.1%
13	How often do you meet friends or relatives who are not living with you?: Never	0.6%	1.7%	0.4%	0.1%
14	See family and friends as often as I want to	64.2%	58.6%	62.0%	75.4%
15	Able to ask someone for help if needed a lift to be somewhere urgently	89.6%	79.8%	91.1%	93.2%
16	Able to ask someone for help if ill in bed and need help at home	89.6%	79.1%	90.8%	94.8%
17	Able to ask someone for help if in financial difficulty and need to borrow £100	75.1%	55.9%	76.7%	86.2%
18	Have people to turn to for comfort and support if had a serious personal crisis	93.6%	83.3%	95.0%	97.9%
19	All things considered, how satisfied are you with your personal relationships?: Very satisfied	61.6%	37.3%	62.4%	78.9%
20	All things considered, how satisfied are you with your personal relationships?: Fairly dissatisfied	1.8%	5.3%	1.3%	0.6%
21	All things considered, how satisfied are you with your personal relationships?: Very dissatisfied	0.8%	2.8%	0.5%	0.4%

Survey question		Total	Level of mental wellbeing		
			Low	Moderate	High
HEALTH					
22	How is your health in general?: Very good	31.6%	13.2%	31.4%	47.6%
23	How is your health in general?: Bad	6.3%	13.5%	5.5%	3.0%
24	How is your health in general?: Very bad	1.6%	4.7%	1.1%	0.8%
25	Mobility: No problems in walking about	80.7%	70.3%	81.6%	86.5%
26	Mobility: I am confined to bed	0.2%	0.5%	0.1%	0.1%
27	Self-care: I have no problems with self-care	95.1%	90.3%	95.7%	97.1%
28	Self-care: I am unable to wash or dress myself	0.4%	0.8%	0.3%	0.2%
29	Usual activities: I have no problems with performing my usual activities	83.7%	71.5%	85.2%	89.4%
30	Usual activities: I am unable to perform my usual activities	1.7%	4.2%	1.4%	0.8%
31	Pain/discomfort: I have no pain or discomfort	70.6%	58.3%	71.4%	78.1%
32	Pain/discomfort: I have extreme pain or discomfort	6.7%	10.5%	6.1%	5.2%
33	Anxiety/depression: I am not anxious or depressed	81.8%	61.5%	84.0%	91.8%
34	Anxiety/depression: I am extremely anxious or depressed	3.5%	11.8%	2.2%	0.8%
35	EuroQoL mean score	0.84	0.73	0.86	0.90
36	Caring responsibilities: caring for someone with long term ill health or problems related to old age, other than as part of job	10.2%	9.5%	10.4%	10.0%
LIFE EVENTS AND LIFESTYLES					
37	Life events: Going to university	3.4%	2.5%	3.5%	3.7%
38	Life events: Getting married	1.2%	0.9%	1.2%	1.5%
39	Life events: Divorce/separation from long-term partner	2.2%	3.5%	1.9%	1.8%
40	Life events: Purchasing/selling a house/flat	1.6%	1.2%	1.7%	1.9%
41	Life events: Birth of a child	4.5%	3.9%	4.2%	5.7%
42	Life events: Involuntary/ voluntary bankruptcy	0.3%	0.5%	0.2%	0.2%
43	Meeting physical activity target	30.4%	19.1%	28.8%	44.9%
44	Time spent sitting or reclining on a typical day: Up to and including two hours	23.0%	17.9%	22.3%	29.3%
45	Time spent sitting or reclining on a typical day: More than eight hours	7.5%	14.4%	7.0%	3.3%
46	Current smoker	29.8%	37.3%	29.1%	25.9%
47	Harmful drinker	2.9%	4.3%	2.7%	2.3%
48	Hazardous drinker	10.7%	10.8%	11.0%	9.5%
49	Cannabis use: ever used	11.8%	14.7%	11.9%	9.0%
50	Cannabis use: used in the last 30 days	3.0%	4.4%	3.0%	2.0%

Survey question		Total	Level of mental wellbeing		
			Low	Moderate	High
51	Living comfortably on present income	31.8%	18.1%	31.6%	43.8%
52	Finding it very difficult on present income	4.3%	9.6%	3.7%	1.9%
53	Worried about money during the last few weeks: almost all of the time	9.9%	19.8%	8.7%	5.6%
54	Never worried about money during the last few weeks	35.2%	19.6%	35.7%	46.4%
PLACE					
55	Lived in local area less than one year	7.7%	8.2%	7.5%	8.1%
56	Lived in local area ten years or more	61.9%	56.1%	63.3%	62.4%
57	Very satisfied with local area as a place to live	55.6%	42.4%	55.8%	65.9%
58	Fairly dissatisfied with local area as a place to live	3.5%	7.0%	3.1%	2.1%
59	Very dissatisfied with local area as a place to live	1.5%	2.3%	1.5%	0.8%
60	How strongly do you feel you belong to your immediate neighbourhood?: Very strongly	43.5%	31.8%	43.3%	53.6%
61	How strongly do you feel you belong to your immediate neighbourhood?: Not very strongly	12.9%	19.5%	12.4%	9.2%
62	How strongly do you feel you belong to your immediate neighbourhood?: Not at all strongly	6.2%	10.8%	5.4%	4.7%
63	Definitely agree that you can influence decisions affecting your local area	7.9%	4.0%	7.6%	12.0%
64	Tend to disagree that you can influence decisions affecting your local area	24.0%	23.6%	25.5%	19.5%
65	Definitely disagree that you can influence decisions affecting your local area	27.0%	32.1%	26.0%	25.8%
66	Feel very safe outside after dark	37.4%	22.8%	38.5%	46.1%
67	Feel very unsafe outside after dark	10.1%	13.5%	9.5%	8.8%
68	Feel very safe outside during the day	79.5%	68.5%	80.1%	86.9%
69	Feel very unsafe outside during the day	0.8%	1.9%	0.6%	0.5%
70	Feel very safe home alone at night	71.9%	55.8%	72.4%	83.8%
71	Feel very unsafe home alone at night	1.6%	3.6%	1.3%	0.8%
RESPONDENT CHARACTERISTICS					
72	Working status of respondent – Paid work: Full-time	34.6%	26.0%	35.6%	38.6%
73	Working status of respondent – Self-employed	1.9%	1.3%	1.9%	2.2%
74	Working status of respondent – Full-time education	3.2%	2.3%	3.1%	4.5%
75	Working status of respondent – Out of work, registered unemployed and actively seeking work	5.9%	7.8%	6.0%	4.1%
76	Working status of respondent – Out of work, registered unemployed but not actively seeking work	4.1%	6.5%	3.7%	3.6%
77	Working status of respondent – Permanently sick or disabled	5.7%	13.2%	4.4%	3.2%
78	In supported or assisted housing	8.4%	13.2%	7.0%	8.7%
79	No qualifications	32.7%	41.8%	31.6%	28.9%

Survey question		Total	Level of mental wellbeing		
			Low	Moderate	High
80	Highest qualification level: Level 4+	17.0%	9.7%	18.0%	19.8%
81	Household type: One adult	23.9%	34.8%	22.4%	19.6%
82	Household type: Small family	19.8%	13.2%	20.6%	22.7%
82	Household type: Small family	19.8%	13.2%	20.6%	22.7%
83	Household type: Large family	5.1%	3.6%	5.2%	5.8%
84	Household type: Lone parent	4.4%	6.3%	4.2%	3.4%
85	Household economic status: Employed	60.8%	47.1%	62.6%	66.7%
86	Household economic status: Unemployed	7.6%	12.5%	6.9%	5.7%
87	Household economic status: Retired	22.7%	24.2%	22.8%	21.1%
88	Household economic status: Full-time student	1.9%	1.8%	1.7%	2.5%
89	Household economic status: Inactive (domestic)	2.7%	4.5%	2.4%	2.0%
90	Household economic status: inactive (sick)	3.1%	8.3%	2.2%	1.6%

8. References

- ¹ Foresight (2008). *Mental Capital and Wellbeing Project Final Project Report*. London: The Government Office for Science.
- ² Department of Health (2009). *New Horizons: A shared vision for mental health*. London: Department of Health.
- ³ World Health Organization (2005). *Mental Health Action Plan for Europe: Facing the Challenges, Building Solutions* [Online]. Available at: www.euro.who.int/document/mnh/edoc07.pdf [Accessed 30-10-2009].
- ⁴ World Health Organization (2001). *The World Health Report 2001. Mental Health: New Understanding, New Hope*. Geneva: World Health Organization.
- ⁵ Huppert F (2008). State of Science Review SRX-2: Psychological wellbeing: evidence regarding its causes and consequences. Office of Science and Innovation: Foresight Mental Capital and Wellbeing Project [Online]. Available at: www.foresight.gov.uk/Mental%20Capital/SR-X2_MCWv2.pdf [Accessed 8-11-2009].
- ⁶ World Health Organization (2008). *Closing the gap in a generation: health equity through action on the social determinants of health*. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization.
- ⁷ Dolan P, Peasgood T and White M (2006). Review of research on the influences on personal well-being and application to policy making [Online]. Available at: http://randd.defra.gov.uk/Document.aspx?Document=SD12005_4017_FRP.pdf [Accessed 21-11-2009].
- ⁸ Stewart-Brown S (2002). Measuring the parts most measures do not reach: a necessity for evaluation in mental health promotion. *Journal of Mental Health Promotion*, 1(2), 4-9.
- ⁹ Kammann R and Flett R (1983). Affectometer 2: A scale to measure current levels of general happiness. *Australian Journal of Psychology*, 35(2), 259-265.
- ¹⁰ Health Education Population Survey (2002) [Online]. Available at: <http://survey.net.ac.uk/sqb/qb/surveys/heps/heps02.htm> [Accessed 3-12-2009].
- ¹¹ Gosling R and BMRB Social Research (2006). *Health Education Population Survey: Update from 2005 Survey* [Online]. Available at: www.healthscotland.com/uploads/documents/2655-RE033Final%20Report.pdf [Accessed 3-12-2009].
- ¹² Tennant R, Hiller L, Fishwick R, Platt S, Joseph S, Weich S, Parkinson J, Secker J and Stewart-Brown S (2007). The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): development and UK validation. *Health and Quality of Life Outcomes*, 5, 63.
- ¹³ Gosling R, Bassett C, Gilby N, Angle H, BMRB Social Research and Catto S (2008). *Health Education Population Survey: Update from 2006 Survey*. Glasgow: NHS Scotland Publications.
- ¹⁴ Braunholtz S, Davidson S, Myant K and O'Conner R (2007). Well? What do you think? (2006): The Third National Scottish Survey of Public Attitudes to Mental Health, Mental Well-being and Mental Health Problems [Online]. Available at: www.scotland.gov.uk/Publications/2007/09/11092351/0 [Accessed 3-12-2009].
- ¹⁵ Keyes C (2002). The Mental Health Continuum, from Languishing to Flourishing in Life. *Journal of Health and Social Behaviour*, 43, 207-222.
- ¹⁶ Parkinson J (2006). Measuring Positive Mental Health: Developing a New Scale [Online]. Available at: www.healthscotland.com/uploads/documents/3046-Measuring%20mental%20well-being%20%20Affectometer%20%20-%20WEMWBS%20briefing.pdf [Accessed 10-11-2009].
- ¹⁷ Stewart-Brown S, Tennant A, Tennant R, Platt S, Parkinson J and Weich S (2009). Internal construct validity of the Warwick-Edinburgh Mental Well-being Scale (WEMWBS): a Rasch analysis using data from Scottish Health Education Population Survey. *Health and Quality of Life Outcomes*, 7(15).
- ¹⁸ Winkler D, Kanouse E and Ware J (1982). Controlling for Acquiescence Response Set in Scale Development. *Journal of Applied Psychology*, 67(5), 555-561.

¹⁹ Keyes C (2006). Promoting and Protecting Mental Health as Flourishing *American Psychologist*, 62(2), 1-14.

²⁰ Waddell G and Burton AK (2006). *Is work good for your wellbeing?* London: The Stationery Office.

²¹ Appleby L (2004). *The National Service Framework for Mental Health – five years on*. London: Department of Health.

²² Mental Health Strategies (2006). *The 2005/06 National survey of investment in mental health services*. Mental Health Strategies.

North West Public Health Observatory

Centre for Public Health

Research Directorate

Faculty of Health and Applied Social Sciences

Liverpool John Moores University

5th Floor Kingsway House

Hatton Garden

Liverpool

L3 2AJ

t: +44(0)151 904 6043

f: +44(0)151 231 8020

e: nwpho-contact@ljmu.ac.uk

www.nwpho.org.uk

www.cph.org.uk

ISBN: 978-1-907441-18-9 (Print version)

ISBN: 978-1-907441-19-6 (PDF version)