Scotland's Mental Health and its Context: Adults 2009

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Contents

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Scottish Public Health Observatory (ScotPHO) collaboration

The Public Health Observatory Division at NHS Health Scotland is part of this collaboration, led by ISD Scotland and NHS Health Scotland, that brings together key national organisations in public health intelligence in Scotland. We are working closely together to ensure that the public health community has easy access to clear and relevant information and statistics to support decision making. For further information, please see the ScotPHO website at www.scotpho.org.uk.

Abbreviations

ACORN	A Classification Of Residential Neighbourhoods
APMS	*Adult Psychiatric Morbidity Survey*
CIS-R	Revised Clinical Interview Schedule
ESS	*European Social Survey*
GHQ-12	12-item General Health Questionnaire
GHS	*General Household Survey*
GROS	General Register Office for Scotland
HEPS	*Health Education Population Survey*
ICD	International Classification of Diseases
ISD	Information Services Division
LFS (APS)	*Labour Force Survey (Annual Population Survey)*
NS-SEC	National Statistics Socio-Economic Classification
PTI	Practice Team Information
PWCS	*Psychosocial Working Conditions Survey*
SCVS	*Scottish Crime and Victimisation Survey*
SHCS	*Scottish House Condition Survey*
SHeS	*Scottish Health Survey*
SHoS	*Scottish Household Survey*
SIMD	Scottish Index of Multiple Deprivation
SOC	Standard Occupational Classification
WEMWBS	Warwick–Edinburgh Mental Well-being Scale
WHASS	*Workplace Health and Safety Survey*

Executive summary

Improving mental health is a national priority in Scotland. NHS Health Scotland was commissioned by the Scottish Government to establish a core set of sustainable mental health indicators to enable national monitoring. This report provides the first ever systematic assessment of the adult population's overall mental health.

Definitions for an adult indicator set were published in December 2007. The set comprises 54 indicators plus a cross-cutting equalities analysis. The indicators cover both positive mental health and mental health problems. This report uses these indicators to present an overview of adult mental health in Scotland, covering both the state of mental health itself and the contextual factors associated with it. Unless otherwise stated, indicators cover adults aged 16 and above.

The report has three objectives:

- to provide a description of the state of mental health and the associated contextual factors that influence it at a single point in time, using the most recent available data
- to analyse time trends for each indicator over the last decade, where possible
- to identify differences within the adult population by selected dimensions of equality, where possible.

Point-in-time estimates (i.e. prevalence) were calculated for 45 indicators, equalities analysis for 44 and examination of change in recent years for 33. Equalities analysis covered gender, age and either area deprivation or, where this was not possible, individual markers of socio-economic status. No data were available for five indicators, and a further four indicators are not yet operationalised.

Analysis was constrained by a lack of recent data, relatively short time series and small sample sizes. The potential for equalities analysis, in particular, was limited by small sample sizes. Interim data sources (pending data becoming available from questions introduced to national surveys in 2008) were used for 19 out of the 45 indicators analysed and for 12 out of the 33 for which trends over time were examined. A lack of time trend data for positive mental health, a new and important area of development, limits our current understanding. In addition, there are gaps in our knowledge around time trends for a number of community and structural indicators.

A six-colour 'traffic light' system is used to illustrate the results from the time trends analysis. This gives a clear visual impression, based on statistical analysis of significance, of which indicators suggest that adult mental health has improved, worsened or remained stable (Table 1).

Overall, the results suggest a picture of broad stability in the last decade. Around half of the indicators for which time trend data were available – 16 out of 33 – showed no significant change over the period of analysis.

Improvement over time was seen in 12 indicators. As well as the state of mental health (common mental health problems, suicide), these encompassed individual (adult learning, physical activity, healthy eating), community (involvement in local community, home safety) and structural (worklessness, education, financial management, financial inclusion, neighbourhood satisfaction) contextual factors. However, for several indicators the change, although

Table 1 **Scotland's adult mental health: summary of trends over time**

			Indicator	Time trend
HIGH LEVEL		Positive mental health	**Positive mental health**[a]	No trend data
		Positive mental health	**Life satisfaction**[a]	No significant change
		Mental health problems	**Common mental health problems**	Improved
		Mental health problems	**Depression**[a]	No significant change
		Mental health problems	**Anxiety**[a]	No significant change
		Mental health problems	**Alcohol dependency**	Worsened
		Mental health problems	**Psychoactive substance-related deaths**	Worsened
		Mental health problems	**Suicide**	Improved
		Mental health problems	**Deliberate self-harm**[a]	No trend data
CONTEXTUAL	Individual	Learning and development	**Adult learning**	Improved
		Healthy living	**Physical activity**	Improved
		Healthy living	**Healthy eating**[a]	Improved
		Healthy living	**Alcohol consumption**	No significant change
		Healthy living	**Drug use**	No trend data
		General health	**Self-reported health**	No significant change
		General health	**Long-standing physical condition or disability**	No significant change
		General health	**Limiting long-standing physical condition or disability**	No significant change
		Spirituality	**Spirituality – Indicator to be identified**	Undefined
		Emotional intelligence	**Emotional intelligence – Indicator to be identified**	Undefined
	Community	Participation	**Volunteering**	No trend data
		Participation	**Involvement in local community**[a]	Improved
		Participation	**Influencing local decisions**[a]	No trend data
		Social networks	**Social contact**[a]	No significant change
		Social support	**Social support**[a]	No significant change
		Social support	**Caring**[a]	No trend data
		Trust	**General trust**[a]	No trend data
		Trust	**Neighbourhood trust**[a]	No trend data
		Safety	**Neighbourhood safety**	No significant change
		Safety	**Home safety**	Improved
		Safety	**Non-violent neighbourhood crime**	No data
		Safety	**Perception of local crime**	No trend data

			Indicator	Time trend
CONTEXTUAL	Structural	Equality	**Income inequality**	No significant change
		Social inclusion	**Worklessness**	Improved
		Social inclusion	**Education**	Improved
		Discrimination	**Discrimination**	No data
		Discrimination	**Racial discrimination**	No trend data
		Discrimination	**Harassment**	No data
		Financial security/debt	**Financial management**	Improved
		Financial security/debt	**Financial inclusion**	Improved
		hysical environment	**Neighbourhood satisfaction**	Improved
		Physical environment	**Noise**	No significant change
		Physical environment	**Escape facility – Indicator to be identified**	Undefined
		Physical environment	**Greenspace**	No data
		Physical environment	**House condition**	Worsened
		Physical environment	**Overcrowding**	Worsened
		Working life	**Stress**[a]	No significant change
		Working life	**Work–life balance**[a]	No trend data
		Working life	**Demand**[a]	No significant change
		Working life	**Control**[a]	No significant change
		Working life	**Manager support**[a]	Worsened
		Working life	**Colleague support**[a]	No significant change
		Violence	**Partner abuse**	No trend data
		Violence	**Neighbourhood violence**	No data
		Violence	**Attitude to violence – Indicator to be identified**	Undefined

[a]'Interim' data source analysed for this indicator. For full details see relevant indicator summaries.

statistically significant, amounted to only around one percentage point over a period of years. This applied to common mental health problems, involvement in local community, home safety and neighbourhood satisfaction.

Just five indicators – alcohol dependency, psychoactive substance-related deaths, house condition, overcrowding and manager support – showed a worsening of mental health in the last decade. The deterioration in perceived overcrowding was small and not consistent with an alternative objective measure of overcrowding. However, the subjective measure used in this report may be more effective at capturing the impact of overcrowding on mental health.

The report also highlights clear inequalities in mental health within the Scottish population, by socio-economic status, age and gender. Of the 44 indicators for which equalities analysis was possible, a poorer state of mental health and less favourable contextual factors were associated with greater socio-economic disadvantage for 32. Age was associated with differences in mental health for 30 indicators and gender associated with differences for 31. No difference was observed in positive mental health by either gender or area deprivation. This is very different from the picture for mental health problems. As more data accumulate in this new area of positive mental health measurement, it will be important to explore this paradox for the insights it might provide for health improvement action.

The balance of the indicators suggests that modest progress is being made in mental health and the conditions that underpin or undermine it. There remains substantial scope for action, building on the range of national policies already in place. These include policies that are not primarily directed towards mental health (e.g. poverty, inequality, criminal justice) but which foster a mentally flourishing Scotland, as well as specific action on topics such as alcohol and drug misuse.

Inequalities in mental health and contextual factors are substantial. Both population-wide and more targeted (based on area and individual characteristics) strategies are necessary to ensure overall improvement in mental health and greater equality between genders, ages and socio-economic groups. Consistent data are lacking on other dimensions of inequality, which therefore remain largely uncharted territory.

This report demonstrates the breadth of indicators that are associated with mental health outcomes and the factors that influence them. It is clear that a very wide range of organisations and individuals can play a role in creating a mentally flourishing Scotland. We hope that this report has contributed to this process, by establishing a robust standard for monitoring adult mental health and its context in Scotland.

Annual updates to the adult mental health indicators data file will be available through the Scottish Public Health Observatory website (www.scotpho.org.uk). It is likely that summary 'highlights' will accompany these annual updates, with full reports in the present format produced less frequently.

Introduction

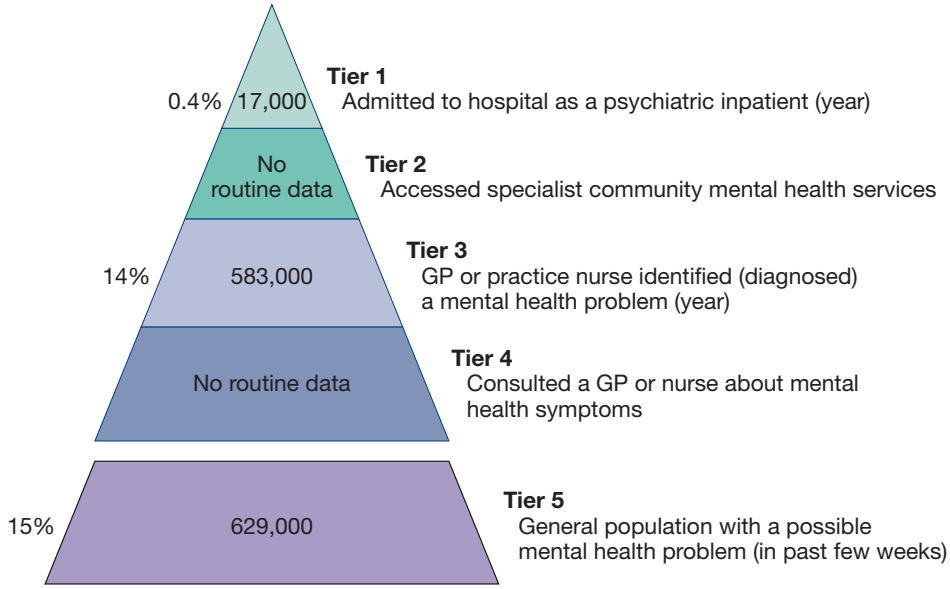
Background to the adult mental health indicators for Scotland

NHS Health Scotland was commissioned by the Scottish Government's *National Programme for Improving Mental Health and Wellbeing* (the National Programme) to establish a core set of national, sustainable mental health indicators to enable national monitoring.[1] This was a support activity to the National Programme, as outlined in its 2003–2006 Action Plan.[2] These indicators are intended to allow national monitoring of the state of mental health and the associated contextual factors, and are vital to the development of a comprehensive health monitoring system.[3] A final indicator set for adults was published in December 2007.

The indicators work took mental health to be an overarching term covering both mental health problems and positive mental health.[1] Good mental health is more than the absence of mental health problems and includes positive mental health (mental wellbeing). Historically, however, assessment of population mental health has focused largely on the prevalence of mental health problems using surveys and scales to do so.[4,5] Even in this respect, as Figure A shows, routinely collected data on mental health problems in Scotland are limited.

Growing recognition of the importance of positive mental health has generated increased interest in developing indicators to measure it to accompany those for mental health problems.[4] Accordingly, the Scottish *Indicators of Mental Health Programme* has established adult mental health indicators that encompass both mental health problems and positive mental health.

Figure A **Estimated prevalence of mental health problems in the Scottish adult general population (individuals aged 16+; Scottish population = 4,195,000 in 2006)**



Source: The figure populates the tiers of the Goldberg and Huxley model[6] with available routine data. Data for tier 1 (SMR04 data for 2005/06, provisional data) and tier 3 (practice team information (PTI) 2005/06) were produced by ISD Scotland. Data for tier 5 (score of 4+ on GHQ-12) are from the Scottish Health Survey 2003.

Development process

A mixed approach (taking into account current data, policy, evidence, expert opinion and theory) was used to obtain measurable, meaningful indicators relevant to the policy-making process and for which, as far as possible, data are available at a national level. The process involved:

- identifying a desirable set of indicators
- scoping relevant data currently collected at national level in Scotland (both administrative and survey data)
- identifying which indicators could be reported on using existing data
- identifying data gaps
- exploring and influencing data collection systems to fill those gaps
- ensuring sustainability of data for the indicator set by liaising with the national survey teams to facilitate their continued collection.

The indicator set

The indicators are structured into two categories (Table 2):

- High level – covering the state of mental health.
- Contextual – covering the factors associated with mental health at an individual, community or structural level. The direction of causality is often unknown so these may be determinants (the risk and protective factors) or consequences of mental health.

Unless otherwise stated, indicators cover adults aged 16 years and above.

The full adult indicator set – 54 plus one that involves analysing each of the rest by selected dimensions of equality to give a total of 55 – is summarised in Table 1 in the Executive summary. Of the 54 indicators, 29 use pre-existing data, 20 are based upon questions new to the *Scottish Health Survey* from 2008 and one is based upon a question new to the *Scottish Household Survey* from 2007. There are currently four indicators for which either the concept behind the indicator has yet to be fully defined or for which a suitable question(s) needs to be developed (and a vehicle to embed the question(s) identified). Where data are not currently available, we have used interim sources to give as full a picture as possible (see p. 7).

Table 2 **Framework of adult mental health indicators (number of indicators in brackets)**

HIGH LEVEL	
Positive mental health (2)	Mental health problems (7)

CONTEXTUAL		
Individual	**Community**	**Structural**
Learning and development (1)	Participation (3)	Equality (1)
Healthy living (4)	Social networks (1)	Social inclusion (2)
General health (3)	Social support (2)	Discrimination (3)
Spirituality (1)	Trust (2)	Financial security/debt (2)
Emotional intelligence (1)	Safety (4)	Physical environment (6)
		Working life (6)
		Violence (3)
Socio-demographic analysis across all indicators, where possible, by gender, age and area deprivation or socio-economic status.		

Outputs from the mental health indicators programme are available from www.healthscotland.com/understanding/population/mental-health-indicators.aspx. These include the following, which may be of interest to readers of this report.

- *Establishing a Core Set of National, Sustainable Mental Health Indicators for Adults in Scotland: Rationale Paper*. This outlines and documents the thinking and reasons behind, and the constraints involved in, decisions that were taken during the course of the work.[1]
- *Establishing a Core Set of National, Sustainable Mental Health Indicators for Adults in Scotland: Final Report*. This sets out the background, objectives, process and achievements of the Indicators of Mental Health Programme for adults. This includes the rationale and an overview of the evidence base for the indicators, working understandings and the indicators, measures and data sources themselves. Also provided are the questions and scales used in the national surveys to obtain the data for the indicators.[7]
- *National Adult Mental Health and Well-being Indicators for Scotland: Final Briefing December 2007*. This provides a summary of the final output from the adult mental health indicators work including the recommendations, the indicators, their measures and associated data sources.[8]

Aim and objectives

This report and its companion data file aim to provide a comprehensive and up-to-date description of the state of mental health of adults in Scotland and associated factors. For each indicator, the objective has been to:

- describe mental health and the associated factors at a single point in time (referred to throughout as 'point estimates'), using the most recent available data
- analyse time trends over the last decade, using data from the mid-1990s to that most recently available, where possible
- identify differences within the adult population by selected dimensions of equality: age, gender and the Scottish Index of Multiple Deprivation (SIMD), or where this was not possible by alternative markers of area deprivation or individual markers of socio-economic status, using the most recent available data.

The report is concerned with mental health at a national level. It does not provide local analysis (although Appendix 1 shows the main sub-national geographies at which the indicators will be available) or international comparisons. Furthermore, it focuses on *describing* the mental health of the adult population of Scotland, not on practice or policy implications.

Methods

Out of the 54 indicators in total, data availability allowed point estimates (i.e. prevalence) to be calculated for 45 indicators, examination of change over the last decade for 33 and equalities analysis for 44.

Data source

The results presented in this report are based upon the latest data available at the time of analysis. Wherever possible, analyses are based on sources identified in the national adult mental health indicator set. These include the *Scottish Health Survey* (SHeS), the *Scottish Household Survey* (SHoS), the *Scottish House Condition Survey* (SHCS), the *Scottish Crime*

and Victimisation Survey (SCVS) and administrative data from the General Register Office for Scotland (GROS). For the 20 indicators that will be based upon SHeS data from 2008, interim data sources were identified for 18 and are presented in this report, although the results may not be comparable with those obtained in the future. An interim data source with a longer time series was used for one indicator, healthy eating, for which only 2003 SHeS data were available. Appendix 2 shows annual sample sizes for the data sources used in the report.

The most recent available data were usually from 2006, although it has been necessary to use earlier data for a number of indicators. When sample size or the number of cases in a single year was small, several years of data have been combined to allow robust analysis of the equalities dimensions. Full details are given in the text of relevant indicators.

Target population

Although the term 'adults' is generally taken throughout the report to denote all of those aged 16+, in some cases data limitations have made it necessary to analyse the indicators for a narrower age range (e.g. 16–64 or 16–74). The majority of the survey data are from either a random adult or all adults in a household. However, for a few indicators survey data are obtained from the highest income householder or their partner.

Data description and analysis

Mortality data (psychoactive substance-related deaths and suicides) are described using rates per 100,000 adults in the population (to one decimal place) and the Gini coefficient for income inequality (to two decimal places). All three indicators were analysed using Spearman's rank correlation to determine differences over time (e.g. the strength and direction of association between mortality rates and year) and differences between equalities subgroups at a single point in time (e.g. the strength of association between mortality rates and gender). All other data are categorical and are described using percentages, rounded to the nearest whole number. The Chi-squared test of association for comparisons was used to test for between-group differences between men and women. The same test was used for differences over time when data were only available for two time points, i.e. for 2-by-2 tables. Where categorical indicators were broken down into more than two levels (area deprivation/individual socio-economic status and age group) or the analysis of trend over time involved more than two time points, the Chi-squared test for trend was used to identify differences. Numeric variables (life satisfaction, positive mental health and work–life balance) have been described using the mean, with differences over time and between equalities subgroups identified using the Kruskal–Wallis test.

Statistical significance was set at $p < 0.05$ for all comparisons. Where significant associations were identified in Chi-squared comparisons involving more than two subgroups or time points, the 95% confidence intervals were used to determine the form of the association. Any use of the term 'significant' is taken to mean statistically significant, but this does not imply practical significance or importance.

Time trend analysis was undertaken for both the adult population as a whole and for men and women separately. Unless different trends emerged for men and women, only the results for adults generally are presented. When analysing data, the more comparisons that are made, the greater is the chance of obtaining statistically significant results when in fact there are no real differences in the population (type 1 errors). In order to minimise the number of comparisons and the risk of these errors, time trend analysis was not undertaken separately within age groups or SIMD quintiles.

Appendix 3 summarises the equalities issues highlighted in the report. Ideally, indicators would be analysed by all seven Scottish Government equality strands: age, gender, ethnicity, disability, sexual orientation, transgender, and religion and belief. However, owing to limited data availability at present, analysis was restricted to breakdown by age and gender. Appendix 4 lists the dimensions of equality by which it will be possible to analyse the indicators in the future. In addition, 27 indicators were analysed by SIMD quintile.[i] Where SIMD data were not available, A Classification Of Residential Neighbourhoods (ACORN)[ii] was used as an alternative marker of area-level deprivation (six indicators) or the indicator was analysed by individual-level markers of socio-economic status: three by social class, five by Standard Occupational Classification (SOC), three by National Statistics Socio-Economic Classification (NS-SEC) and two by educational attainment. The specific marker used is detailed in each indicator section.

A six-colour 'traffic light' system has been used to illustrate the results from the time trend analysis for the adult population as a whole (Table 3). Indicator time series most often span the period from the mid-1990s to the mid-2000s. Where no statistically significant change has occurred, an amber traffic light has been assigned. This might reflect relative stability over time, or a level of change that does not reach statistical significance. It is important to note that, although an indicator may not have changed significantly over time, either for the population as a whole or for men or women separately, this may conceal diverging trends for other equalities subgroups (e.g. worsening for older individuals, improvement for young people).

Table 3 **Time trend traffic light system and summary**

Traffic light	Trend over time	No. of indicators
	Statistically significant improvement	12
	No significant change – may reflect stability or non-significant fluctuation	16
	Statistically significant deterioration	5
	No trend data	12
	No data currently available	5
	Indicator definition not yet agreed or suitable survey question(s) not yet identified	4

Presentation of findings

A standard approach has been used to present the results for each of the 45 indicators for which data are currently available. For each indicator there is:

- a boxed summary of the key findings for the indicator
- a description of the measure used to define the indicator in the indicator set (where an interim data source has been used, the measure used in this report may be slightly different from that in the agreed indicator set)
- the data source – where an interim source has been used, this is stated
- a point-in-time estimate, referred to throughout as a 'point estimate', gives results for the indicator using the most recent available data

i For more information on the SIMD, see www.scotland.gov.uk/Topics/Statistics/SIMD/.
ii Appendix 5 provides more detail on Scottish ACORN groups.

- results of time trend analysis – the traffic light classification for the trend is given in the top right-hand corner of each page
- results of equalities analysis
- limitations of the data.

The main points emerging from analysis of the indicators are presented in the Discussion, including a table summarising the trends over time.

The appendices contain information on:

- available sub-national geographies for the adult mental health indicators
- sample sizes of the data sources used in this report
- equalities issues identified in Scottish adult mental health
- equalities analysis for the indicators in the future
- types of households included within each ACORN group.

The data file will be updated and reported on annually. The data for the charts presented in this report are available on the ScotPHO website (www.scotpho.org.uk).

High level

Positive mental health (2)

Mental health problems (7)

Positive mental health

Key findings

- In 2006/07, the mean score on the Warwick–Edinburgh Mental Well-being Scale (WEMWBS) for the adult population (aged 16-74) was 50.4 (on a scale from 14 to 70).
- Trend data are not yet available for this indicator.
- Gender and area deprivation were not significantly associated with differences in positive mental health.
- Age was significantly associated with positive mental health: older adults (aged 55–74) had higher mean WEMWBS scores.

Measure

Mean adult score on the Warwick–Edinburgh Mental Well-being Scale

The Warwick–Edinburgh Mental Well-being Scale (WEMWBS) is a new scale that has been developed to capture the breadth of components that make up positive mental health, including positive affect, satisfying interpersonal relationships and positive functioning. Based on their responses to a series of questions, people receive a score from 14 (the lowest level of positive mental health) to 70 (the highest).

Data source

An interim source has been used for this indicator. The analysis here combines data from Waves 12 and 13 of the *Health Education Population Survey* (HEPS) (autumn 2006 and spring 2007) for adults aged 16–74.

From 2008, the source for this indicator will be the *Scottish Health Survey* (SHeS) for adults aged 16+.

Point estimate

- In 2006/07, the mean WEMWBS score for adults (aged 16–74) was 50.4.

Time trend

- Time trend analysis was not undertaken, since WEMWBS data are currently available only for a single year.

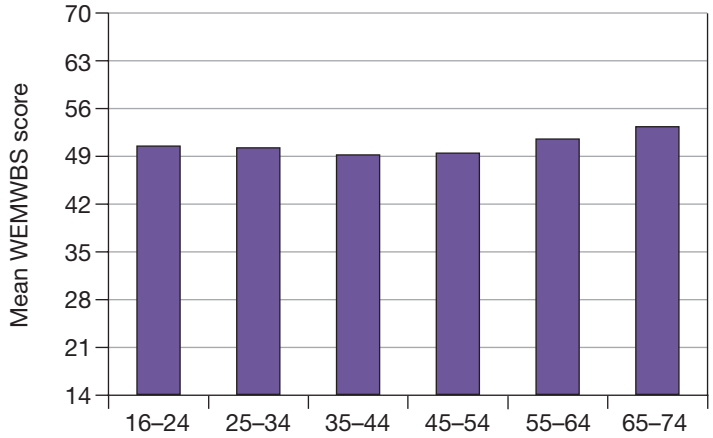
Equalities

- In 2006/07, age was significantly associated with positive mental health. Older adults (aged 55–74) had higher WEMWBS scores than those aged 16–54 (Figure PMH1).
- There were no significant differences by gender.
- Analysis by Scottish Index of Multiple Deprivation (SIMD) quintile showed no significant association between area deprivation and positive mental health. Previous analysis has however indicated an association between household/individual-level socio-economic status (e.g. reported household income, ease of management on household income) and positive mental health as measured by WEMWBS.[9]

Limitations of the data

The HEPS collected data for adults aged 16–74 only. The inclusion of WEMWBS in the SHeS will provide annual data for adults aged 16+ and an increased sample size.

Figure PMH1 **Mean WEMWBS score for adults aged 16–74, by age band: 2006/07**



POSITIVE MENTAL HEALTH

Life satisfaction

Key findings

- The mean life satisfaction score among adults (aged 16+) was 7.4 in 2006 [on a scale from zero (extremely dissatisfied) to 10 (extremely satisfied)].
- There was no statistically significant change in the level of life satisfaction between 2002 and 2006.
- Using combined data from 2002, 2004 and 2006, gender, age and highest level of educational qualification were not significantly associated with differences in life satisfaction.

Measure

Mean adult score of how satisfied individuals are with their life as a whole nowadays

Respondents are asked to indicate satisfaction on an 11-point scale [from zero (extremely dissatisfied) to 10 (extremely satisfied)].

Data source

An interim source has been used for this indicator. Data presented here are from the Scottish sample of the *European Social Survey* (ESS), 2002, 2004 and 2006 for adults aged 16+. Owing to the small numbers, data from 2002, 2004 and 2006 are combined for equalities analysis.

From 2008, the source for this indicator will be the *Scottish Health Survey* (SHeS) for adults aged 16+.

Point estimate

- In 2006, the mean life satisfaction score for adults was 7.4.

Time trend

- Levels of recorded life satisfaction have remained largely unchanged since 2002 (Figure PMH2). The small rise shown in the graph is not statistically significant.

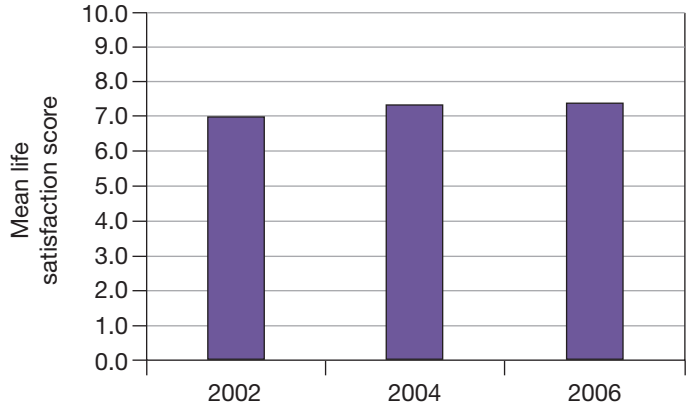
Equalities

- Using 2002, 2004 and 2006 combined data, gender, age and highest level of educational attainment were not significantly associated with differences in mean life satisfaction scores, although this may be due to small sample sizes.

Limitations of the data

The ESS was designed to produce robust results at EU member state (e.g. at UK) level. Scottish sample sizes are small (fewer than 200 people in 2002 and 2004, and fewer than 300 people in 2006), limiting its ability to detect real differences over time and particularly between population subgroups. In addition, the survey has been conducted only three times, allowing limited time trend analysis. The ESS does not allow analysis by Scottish Index of Multiple Deprivation quintile because it does not record respondents' data-zone of residence.

Figure PMH2 **Mean life satisfaction score for adults aged 16+: 2002, 2004 and 2006**



MENTAL HEALTH PROBLEMS

Common mental health problems

Key findings

- In 2003, 15% of adults (aged 16+) scored 4+ on the General Health Questionnaire (GHQ-12), indicating a possible mental health problem.
- Between 1995 and 2003, the proportion of adults (aged 16–64) with a possible mental health problem decreased slightly but significantly from 16% to 15%.
- Women and those living in deprived communities were significantly more likely to have a possible mental health problem.
- There was no significant association between age and the likelihood of a common mental health problem.

Measure

Percentage of adults who score 4 or more on the GHQ-12

The GHQ-12 is widely used to detect the presence of non-psychotic psychiatric morbidity in community settings. It was originally designed for use in general practice settings as a screening tool and cannot be used to diagnose specific psychiatric problems. A score of 4 or more can be interpreted as indicating a possible mental health problem over the past few weeks.

Data source

Data used here are from the *Scottish Health Survey* (SHeS), 1995, 1998 and 2003. Results for 2003 (point estimate and equalities) relate to adults aged 16+, whereas time trends are presented for those aged 16–64.

From 2008, the source for this indicator will be the SHeS for adults aged 16+.

Point estimate

- In 2003, 15% of adults (aged 16+) scored 4+ on the GHQ-12, indicating a possible mental health problem.

Time trend

- Between 1995 and 2003, the overall proportion of adults (aged 16–64) scoring 4+ on the GHQ-12 decreased slightly, but significantly, from 16% to 15% (Figure MHP1).

Equalities

- In 2003, women were significantly more likely than men to have possible mental health problems: 17% of women (aged 16+) scored 4+ on the GHQ-12 compared with 13% of men (Figure MHP2).
- There was no significant association between age and the likelihood of possible mental health problems.
- There was a significant association between area deprivation as measured by the Scottish Index of Multiple Deprivation (SIMD) and possible mental health problems. The proportion of adults scoring 4+ on the GHQ-12 was significantly higher in the two most deprived quintiles (16% and 20%) compared with the two least deprived quintiles (11%) (Figure MHP3).

Limitations of the data

The GHQ-12 looks at deviation from 'usual functioning' in the last few weeks, so will not pick up chronic mental health problems. There is also some evidence that the GHQ-12 works less well for older people. The latest data from the SHeS are from 2003 and therefore five years old. Time trend data from the SHeS are currently limited; they are available for three time points only and comparability restricts analysis to adults aged 16–64.

Figure MHP1 **Percentage of adults aged 16–64 with a GHQ-12 score of 4 or more: 1995, 1998 and 2003**

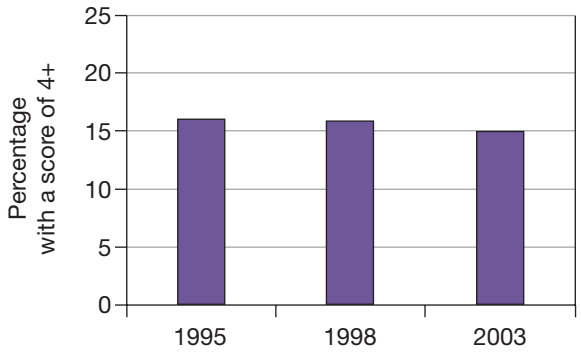


Figure MHP2 **Percentage of adults aged 16+ with a GHQ-12 score of 4 or more, by gender: 2003**

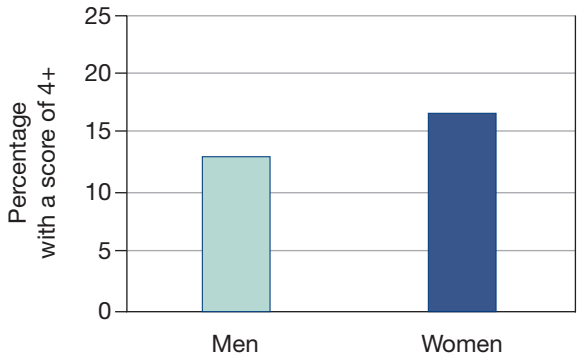
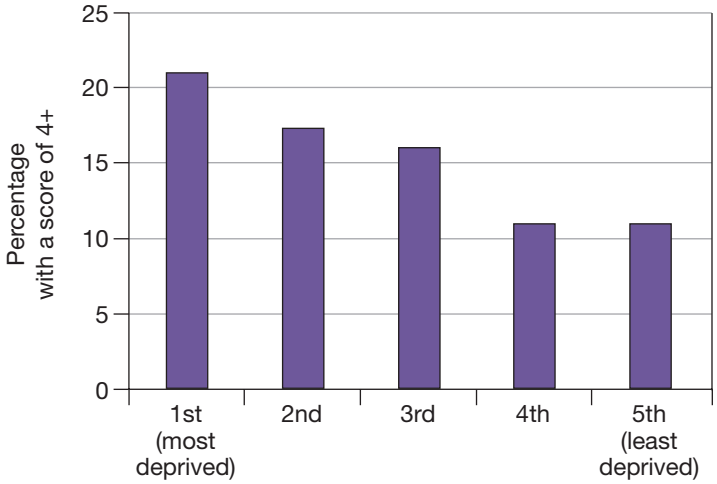


Figure MHP3 **Percentage of adults aged 16+ with a GHQ-12 score of 4 or more, by SIMD quintile: 2003**



MENTAL HEALTH PROBLEMS

Depression

Key findings

- In 2000, 10% of adults (aged 16–74) experienced symptoms of depression of moderate to high severity in the previous week.
- There was no significant change in the proportion of adults (aged 16–64) with moderate to high severity symptoms of depression in 2000 compared with 1993.
- Moderate to high severity symptoms of depression did not vary significantly by gender or age.
- Adults in social classes IIIm–V (manual occupations) were significantly more likely to have moderate to high severity symptoms of depression than those in social classes I–IIIn (non-manual occupations).

Measure

Percentage of adults who have a symptom score of 2 or more on the depression section of the Revised Clinical Interview Schedule (CIS-R)

This section of the CIS-R provides interviewees with a score from zero to 4 for symptoms of depression, based on their responses to four questions. A score of 2 or more indicates symptoms of depression of moderate to high severity experienced in the previous week. The CIS-R indicates symptoms of depression only and used alone will not allow a clinical diagnosis.

Data source

An interim source has been used for this indicator. Data used here are from the British *Adult Psychiatric Morbidity Survey* (APMS), 1993 and 2000. The point estimate and equalities results use data for 2000 for adults aged 16–74. Time trend results are based on adults aged 16–64.

From 2008, the source for this indicator will be the *Scottish Health Survey* (SHeS) for adults aged 16+.

Point estimate

- In 2000, 10% of adults (aged 16–74) scored 2 or more on the depression section of the CIS-R, indicating moderate to high severity symptoms of depression in the previous week.

Time trend

- There was no significant change in the proportion of adults (aged 16–64) scoring 2 or more on the depression section of the CIS-R in 2000 compared with 1993 (Figure MHP4).

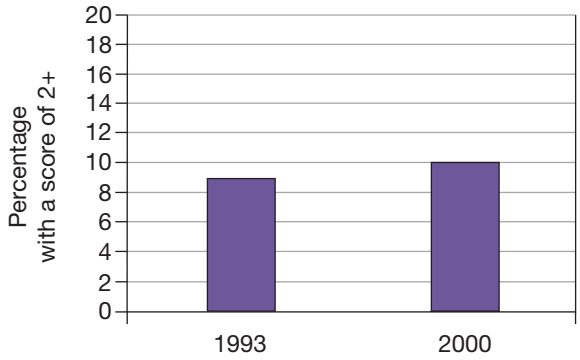
Equalities

- In 2000, the prevalence of moderate to high severity symptoms of depression among adults aged 16–74 did not vary significantly by gender or age.
- Analysis was undertaken by social class.[iii] Data were coded into two groups: social classes I, II and IIIn [professional (I), managerial (II) and skilled non-manual (IIIn)] and social classes IIIm, IV and V [skilled manual (IIIm), partly skilled manual (IV) and unskilled manual (V) plus a small number of respondents in the military or unclassified]. Adults in social classes IIIm–V were significantly more likely to have moderate to high severity symptoms of depression than adults in social classes I–IIIn (12% compared with 8% – Figure MHP5).

Limitations of the data

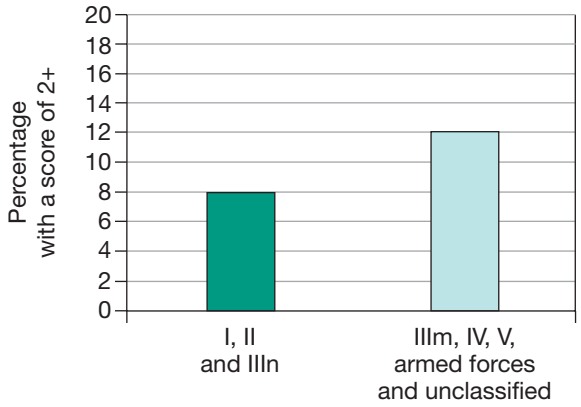
The latest data from the APMS are from 2000 and are therefore now eight years old. The APMS was designed as a Britain-wide survey. As Scottish sample sizes are small (800–900 people), its power to detect real differences over time and particularly between population subgroups is low. The survey has been conducted only twice, allowing limited time trend analysis. It also used an upper age limit of 74. It was not possible to analyse results by area deprivation as these surveys pre-date development of the Scottish Index of Multiple Deprivation and did not include the Carstairs deprivation category. The incorporation of the depression section of the CIS-R into the SHeS from 2008 will provide better and more frequent data in the future.

Figure MHP4 **Percentage of adults aged 16-64 with a score of 2+ on the depression section of the CIS-R: 1993 and 2000**



iii The Social Class scale, which was used officially until 2001 and continues to be used for longitudinal studies, divides individuals into six major classes on the basis of their occupation, ranging from 'Professionals' in class I to 'Unskilled' and 'Other' in classes V and VI, respectively.

Figure MHP5 **Percentage of adults aged 16–74 with a score of 2+ on the depression section of the CIS-R, by social class: 2000**



MENTAL HEALTH PROBLEMS

Anxiety

Key findings

- In 2000, 7% of adults (aged 16–74) experienced symptoms of anxiety of moderate to high severity in the previous week.
- There was no significant change in the proportion of adults (aged 16–64) with moderate to high severity symptoms of anxiety in 2000 compared with 1993.
- Moderate to high severity symptoms of anxiety did not differ significantly by age, gender or social class.

Measure

Percentage of adults who have a symptom score of 2 or more on the anxiety section of the Revised Clinical Interview Schedule (CIS-R)

The anxiety section of the CIS-R provides interviewees with a score from zero to 4 for symptoms of anxiety, based on their responses to four questions. A score of 2 or more indicates symptoms of moderate to high severity experienced in the previous week. Using the anxiety section of CIS-R alone indicates symptoms of anxiety only and will not allow for a clinical diagnosis.

Data source

An interim source has been used for this indicator. Data used here are from the British *Adult Psychiatric Morbidity Surveys* (APMS), 1993 and 2000. The point estimate and equalities results are from 2000 for adults aged 16–74, whereas time trend results are based on adults aged 16–64.

From 2008, the source for this indicator will be the *Scottish Health Survey* (SHeS) for adults aged 16+.

Point estimate

- In 2000, 7% of adults (aged 16–74) scored 2 or more on the anxiety section of the CIS-R, indicating moderate to high severity symptoms of anxiety in the previous week.

Time trend

- In 1993, 9% of adults (aged 16–64) scored 2+ on the anxiety section of the CIS-R, signalling symptoms of moderate to high severity. This fell slightly, though not significantly, to 7% in 2000 (Figure MHP6).

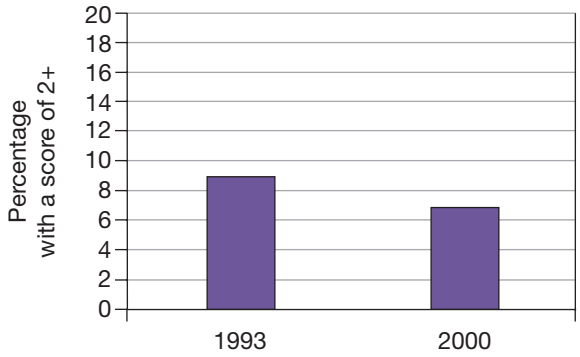
Equalities

- In 2000, prevalence of moderate to high severity symptoms of anxiety among adults (aged 16–74) did not differ significantly between the genders or between age groups. This may in part be due to the small Scottish sample size.
- Analysis was undertaken by social class.[iv] Data were coded into two groups: social classes I, II and IIIn [professional (I), managerial (II) and skilled non-manual (IIIn)] and social classes IIIm, IV and V [skilled manual (IIIm), partly skilled manual (IV) and unskilled manual (V) plus a small number of respondents in the military or unclassified]. There were no significant differences in symptoms of anxiety of moderate to high severity by social class.

Limitations of the data

The latest data from the APMS are from 2000 and are therefore now eight years old. The APMS was designed as a Britain-wide survey. As Scottish sample sizes are small (800–900 people), its power to detect real differences over time and particularly between population subgroups is low. The survey has been conducted only twice, allowing limited time trend analysis. It also used an upper age limit of 74 years. It was not possible to analyse results by area deprivation as these surveys pre-date development of the Scottish Index of Multiple Deprivation and did not include the Carstairs deprivation category. The incorporation of the anxiety section of the CIS-R into the SHeS from 2008 will provide better and more frequent data in the future.

Figure MHP6 **Percentage adults with a score of 2+ on the anxiety section of the CIS-R: 1993 and 2000**



iv The Social Class scale, which was used officially until 2001 and continues to be used for longitudinal studies, divides individuals into six major classes on the basis of their occupation, ranging from 'Professionals' in class I to 'Unskilled' and 'Other' in classes V and VI, respectively.

MENTAL HEALTH PROBLEMS

Alcohol dependency

Key findings

- In 2003, 6% of adults (aged 16+) scored 2+ on the CAGE questionnaire, indicating possible alcohol dependency in the previous three months.
- The proportion of adults (aged 16–74) with possible alcohol dependency increased slightly but significantly from 6% in 1998 to 7% in 2003.
- Gender, age and area deprivation were significantly associated with possible alcohol dependency. Men, adults aged 25–44 and those living in the most deprived communities were most likely to score 2+ on CAGE, indicating possible alcohol dependency.

Measure

Percentage of adults who score 2 or more on the CAGE questionnaire

Based on answers to four key questions, CAGE is scored from zero to 4. A score of 2 or more indicates possible alcohol dependency in the previous three months.

Data source

Data for this indicator are from the *Scottish Health Survey* (SHeS), 1998 and 2003. The comparison over time uses data for adults aged 16–74, whereas the 2003 point estimate and equalities breakdown are for adults aged 16+.

From 2008, the source for this indicator will be the *Scottish Health Survey* (SHeS) for adults aged 16+.

Point estimate

- In 2003, 6% of adults (aged 16+) had a CAGE score of 2+, indicating possible alcohol dependency in the previous three months.

Time trend

- The proportion of adults (aged 16–74) with possible alcohol dependency increased slightly but significantly from 6% in 1998 to 7% in 2003 (Figure MHP7).
- This was driven by a small but statistically significant increase in the proportion of women who scored 2+ on CAGE: from 3% to 5%. There was no significant change over the two time points for men.

Equalities

- In 2003, men aged 16+ were significantly more likely to have possible alcohol dependency than women (8% compared with 4% – Figure MHP8).
- Possible alcohol dependency was more common in younger than in older individuals. Those aged 25–44 were significantly more likely to score 2+ on the CAGE questionnaire than those aged 65 or more (8–9% compared with 1–2% – Figure MHP8).
- Area deprivation was significantly associated with alcohol dependency. Adults living in the most deprived Scottish Index of Multiple Deprivation (SIMD) quintile were most likely to have a possible alcohol dependency problem: 8% scored 2+ compared with 6% or less in the other four quintiles (Figure MHP9).

Limitations of the data

The CAGE questionnaire is not a diagnostic tool and does not allow alcohol dependence to be diagnosed conclusively; rather it detects only possible alcohol dependency. The latest data from the SHeS are from 2003 and are therefore now five years old. Time trend data from the SHeS are currently limited; they are available for two time points only and comparability restricts analysis to adults aged 16–74.

Figure MHP7 **Percentage of adults aged 16–74 with a CAGE score of 2+: 1998 and 2003**

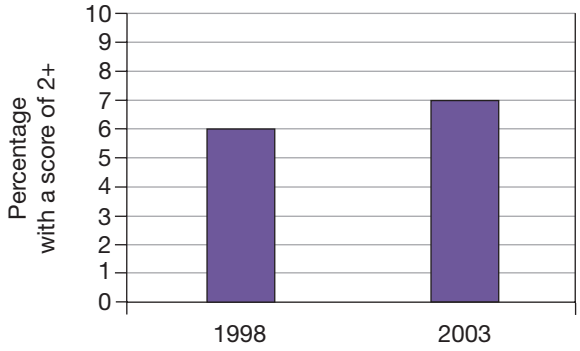


Figure MHP8 **Percentage of adults aged 16+ with a CAGE score of 2+ by gender and by age band: 2003**

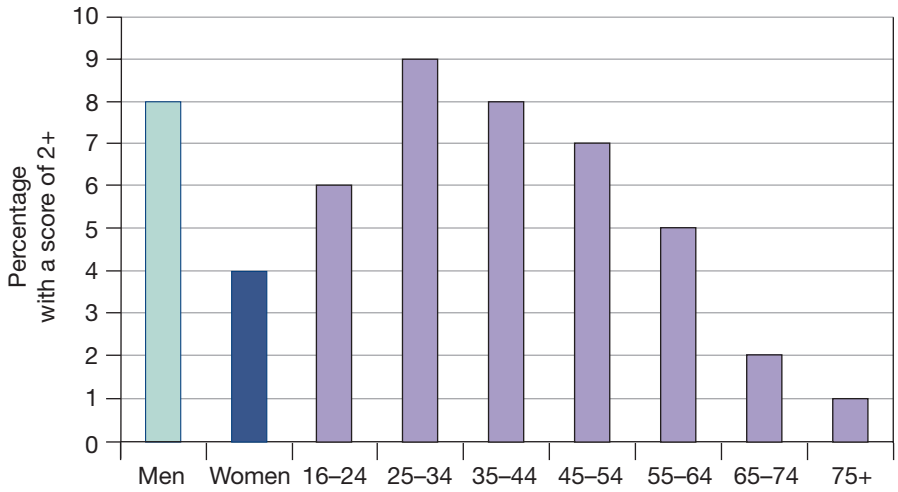
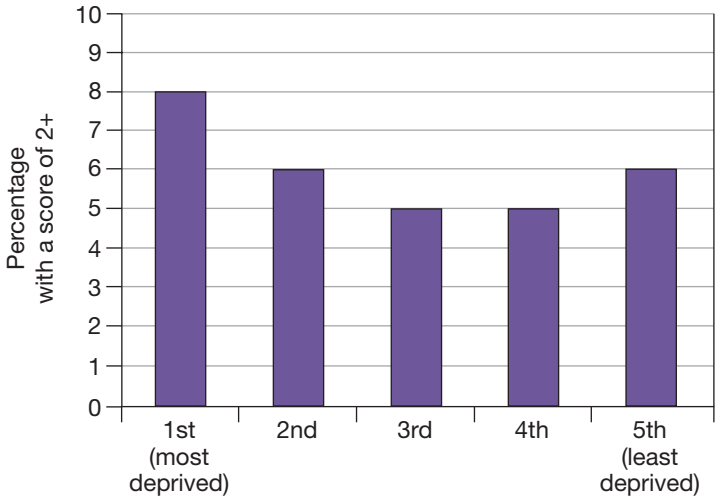


Figure MHP9 **Percentage of adults aged 16+ with a CAGE score of 2+, by SIMD quintile: 2003**



MENTAL HEALTH PROBLEMS

Psychoactive substance-related deaths

Key findings

- In 2006, the psychoactive substance-related death rate (from mental and behavioural disorders due to psychoactive substance use) was 7.8 per 100,000 adults (aged 16+).
- The psychoactive substance-related death rate increased significantly between 1997 and 2006, from 3.7 to 7.8 deaths per 100,000 adults.
- Psychoactive substance-related deaths were significantly associated with gender, being significantly higher for men.
- Using combined data for 1997 to 2006, age was significantly associated with psychoactive substance-related deaths. Deaths were significantly higher amongst those aged 16–44.
- Using combined data for 2003 to 2006, area deprivation was significantly associated with psychoactive substance-related deaths. Deaths were significantly higher in more deprived areas.

Measure

Deaths per 100,000 adults in the past year from 'mental and behavioural disorders due to psychoactive substance use'

This includes International Classification of Diseases (ICD) diagnosis codes ICD9 304 (excluding 304.6) (1997–99) and ICD10 F11–16, F19 (2000–06). Rates have been standardised using the European Standard Population.

Data source

Deaths and population data for this indicator are from the General Register Office for Scotland (GROS) 1997–2006 for adults aged 16+. Due to the small number of deaths, several years of data are combined for equalities analysis by age (1997 to 2006) and area deprivation (2003 to 2006).

Point estimate

- In 2006, the European age-standardised rate of adult (aged 16+) deaths from mental and behavioural disorders due to psychoactive substance use was 7.8 per 100,000.

Time trend

- Between 1997 and 2006, the rate of psychoactive substance-related deaths doubled from 3.7 to 7.8 deaths per 100,000 adults (aged 16+). This change was significant (Figure MHP10).

Equalities

- In 2006, rates of psychoactive substance-related deaths were significantly higher among men than among women (12.7 compared with 3.0 per 100,000 – Figure MHP11).
- Using combined data for 1997 to 2006, the incidence of psychoactive substance-related deaths was significantly associated with age. Adults aged 16–44 were significantly more likely to die from psychoactive substance-related causes (10.5 per 100,000) than those aged 45–64 and 65+. Incidence in the 45–64 age group, although very low (1.2 per 100,000), was significantly higher than among those in the group aged 65 and over, in which there were no deaths from these causes (Figure MHP12).
- Using combined data for 2003 to 2006, psychoactive substance-related deaths were also significantly associated with area deprivation as measured by Scottish Index of Multiple Deprivation (SIMD). The rate lowered from 17.2 per 100,000 in the most deprived quintile to 1.3 per 100,000 in the least deprived. There was a particularly steep and significant drop in rates between the first and second most deprived quintiles (17.2 to 7.5) (Figure MHP13).

Limitations of the data

Small numbers of deaths (around 200–300 per annum) required data from several years to be combined for equalities analysis.

Figure MHP10 **Death rate from psychoactive substance use per 100,000 adults aged 16+: 1997–2006**

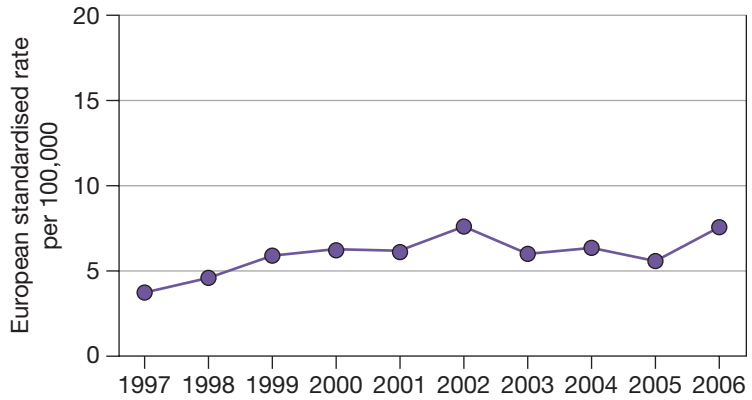


Figure MHP11 **Death rate from psychoactive substance use per 100,000 adults aged 16+, by gender: 2006**

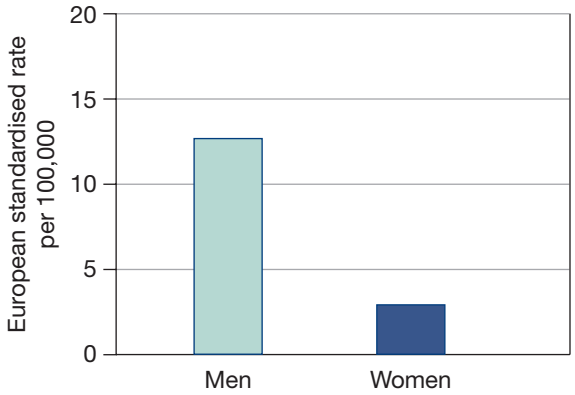


Figure MHP12 **Death rate from psychoactive substance use per 100,000 adults aged 16+, by broad age group: 1997 to 2006 combined**

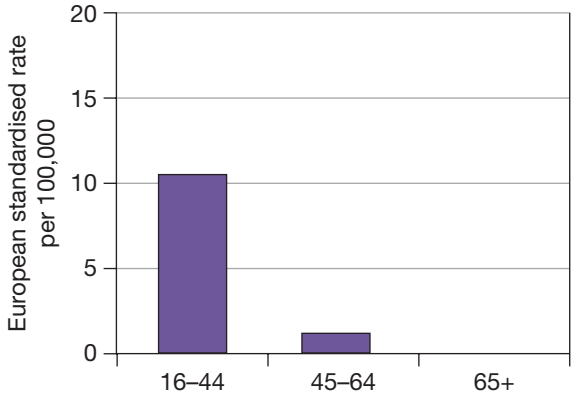
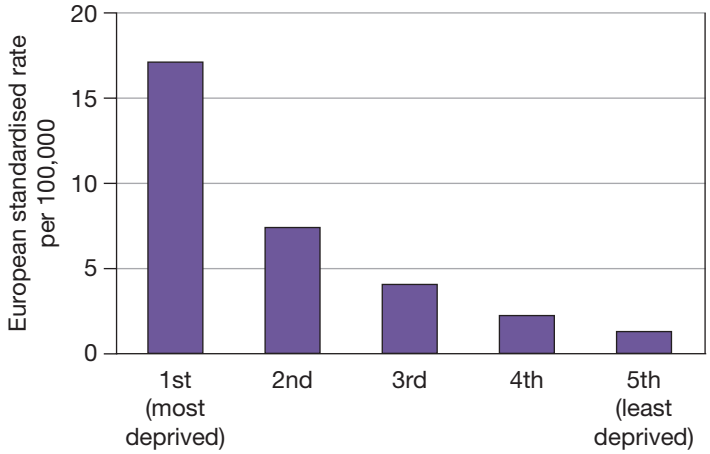


Figure MHP13 **Death rate from psychoactive substance use per 100,000 adults aged 16+, by SIMD quintile: 2003 to 2006 combined**



MENTAL HEALTH PROBLEMS

Suicide

Key findings

- In 2006, the suicide rate was 18.9 per 100,000 adults (aged 16+).
- Suicide rates for adults improved significantly between 1997 and 2006, driven particularly by a significant improvement for men.
- Rates of suicide were significantly associated with gender, with men most at risk.
- Using combined data for 1997 to 2006, age was significantly associated with suicide rates for men but not for women. For men, suicide was significantly higher amongst those under the age of 45.
- Using combined data for 2003 to 2006, rates of suicide were significantly associated with area deprivation, with those living in the most deprived parts of Scotland most at risk.

Measure

Deaths per 100,000 adults in the past year from intentional self-harm and of undetermined intent

The definition follows the international convention of including deaths recorded as 'of undetermined intent' with suicides. This includes International Classification of Diseases (ICD) diagnosis codes ICD9 E950–E959, E980–E989, ICD10 X60–X84, Y10–Y34, Y87.0 (intentional self-harm) and Y87.2 (event of undetermined intent). Rates have been standardised using the European Standard Population.

Data source

Deaths and population data for this indicator are from the General Register Office for Scotland (GROS) 1997–2006 for adults aged 16+. Due to the small number of events, several years of data are combined for equalities analysis by age (1997 to 2006) and area deprivation (2003 to 2006).

Point estimate

- In 2006, the European age-standardised suicide rate was 18.9 per 100,000 adults (aged 16+).

Time trends

- Between 1997 and 2006, there was a significant fall in the suicide rate for adults overall (21.6 to 18.9 per 100,000 deaths) (Figure MHP14).

- However, different pictures were observed for men and women; suicide rates for men improved significantly (from 33.6 per 100,000 to 30.2 per 100,000), whereas rates for women did not.

Equalities

- In 2006, suicide was significantly higher among men than among women: 30.2 deaths per 100,000 men compared with 8.2 per 100,000 women (Figure MHP15).
- Using combined data for 1997 to 2006, age was significantly associated with suicide rates for men but not for women (Figures MHP16 and 17). For men, suicide was significantly higher amongst those aged 16–44 than in those aged 45–64 and 65+ (38.2 per 100,000 compared with 27.3 and 21.2 per 100,000, respectively).
- Using combined data for 2003 to 2006, suicide was also significantly associated with area deprivation as measured by Scottish Index of Multiple Deprivation (SIMD). The suicide rate in the most deprived SIMD quintile was more than three times that of the least deprived quintile (32.4 compared with 9.5 per 100,000) and rates decreased significantly with each subsequent deprivation quintile (Figure MHP18).

Limitations of the data

Small numbers of deaths (around 750–900 death per annum) required data from several years to be combined for equalities analysis.

Figure MHP14 **Suicide rate per 100,000, adults aged 16+, by gender: 1997–2006**

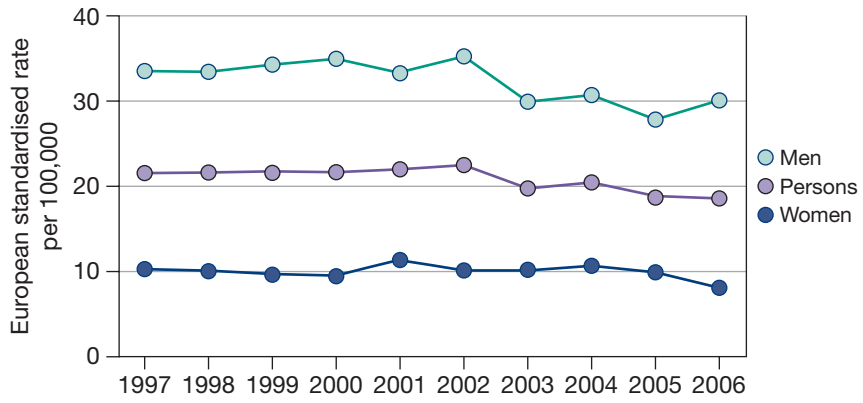


Figure MHP15 **Suicide rate per 100,000, adults aged 16+, by gender: 2006**

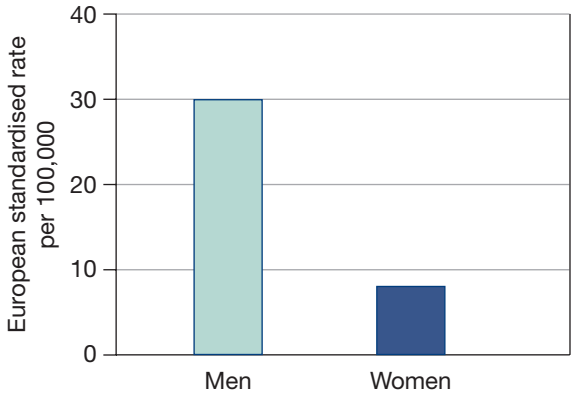


Figure MHP16 **Suicide rate per 100,000, men aged 16+, by age group: 1997 to 2006 combined**

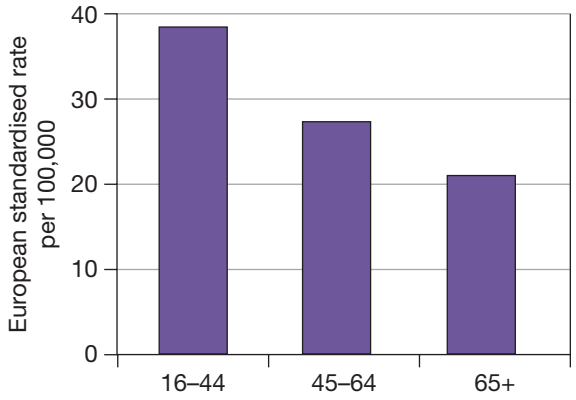


Figure MHP17 **Suicide rate per 100,000, women aged 16+, by age group: 1997 to 2006 combined**

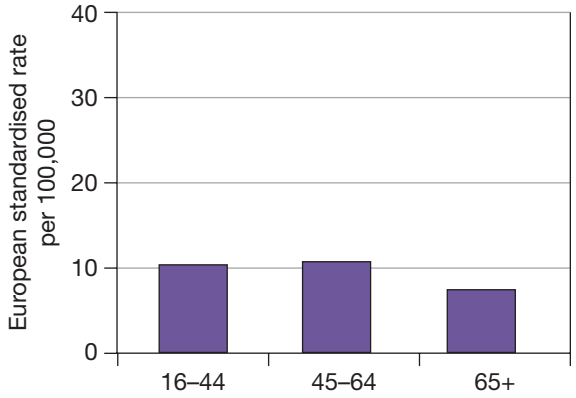
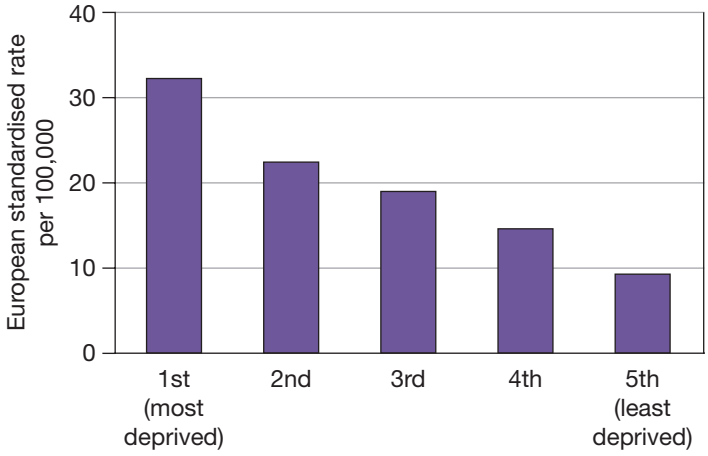


Figure MHP18 **Suicide rate per 100,000, by SIMD quintile: 2003 to 2006 combined**



MENTAL HEALTH PROBLEMS

Deliberate self-harm

Key findings

- In 2000, 2% of adults (aged 16–74) reported that they had deliberately self-harmed in the past year.
- Time trend data are not yet available for this indicator.
- Rates of deliberate self-harm did not vary significantly by gender or social class.
- The likelihood of deliberate self-harm varied significantly by age, with the highest rates among those aged 16–34.

Measure

Percentage of adults who in the past year have deliberately harmed themselves but not with the intention of killing themselves

Data source

An interim source has been used for this indicator. Data are from the British *Adult Psychiatric Morbidity Survey* (APMS) 2000 for adults aged 16–74.

From 2008, the source for this indicator will be the *Scottish Health Survey* (SHeS) for adults aged 16+.

Point estimate

- In 2000, 2% of adults (aged 16–74) reported deliberately harming themselves in the past year but not with the intention of killing themselves.

Time trend

- Time trend analysis was not undertaken as deliberate self-harm estimates are currently available for only a single year.

Equalities

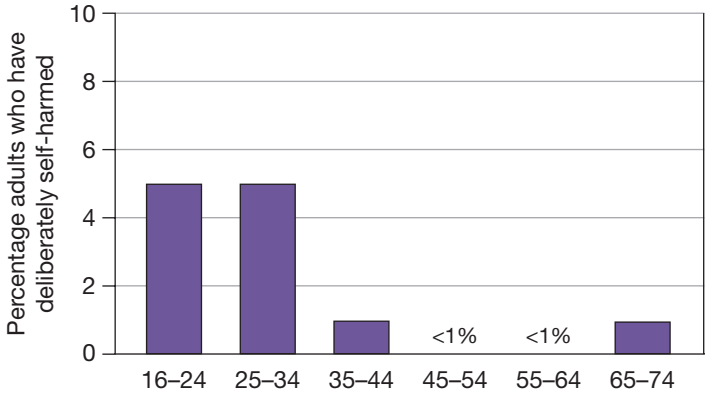
- In 2000, there was no significant difference in the rates of deliberate self-harm between Scottish men and women. This may be due to the small Scottish sample size ($n = 920$), since data for the survey as a whole (i.e. Britain) suggest that women were more likely to report deliberate self-harm.

- Age was significantly associated with deliberate self-harm, with a higher prevalence in younger individuals – 5% among those aged 16–34 compared with 1% or less among those aged 35–74 (Figure MHP19).
- Analysis was undertaken by social class.[v] Data were coded into two groups: social classes I, II and IIIn [professional (I), managerial (II) and skilled non-manual (IIIn)] and social classes IIIm, IV and V [skilled manual (IIIm), partly-skilled manual (IV) and unskilled manual (V) plus a small number of respondents in the military or unclassified]. No significant association was found between social class and deliberate self-harm.

Limitations of the data

The data from the APMS are from 2000 and are therefore now eight years old. The APMS was designed as a Britain-wide survey. As Scottish sample sizes are small (920 people in 2000), its power to detect real differences between population subgroups is low. It was not possible to analyse results by area deprivation as the 2000 APMS pre-dates development of the Scottish Index of Multiple Deprivation and did not include the Carstairs deprivation category. The inclusion of questions on deliberate self-harm in the SHeS from 2008 will provide better and more frequent data in the future.

Figure MHP19 **Percentage of adults aged 16+ who have deliberately self-harmed in past year, by age band: 2000**



v The Social Class scale, which was used officially until 2001 and continues to be used for longitudinal studies, divides individuals into six major classes on the basis of their occupation, ranging from 'Professionals' in class I to 'Unskilled' and 'Other' in classes V and VI, respectively.

Contextual

Individual

Learning and development (1)

Healthy living (4)

General health (3)

Spirituality (1)

Emotional intelligence (1)

LEARNING AND DEVELOPMENT

Adult learning

Key findings

- In 2006, 52% of adults (aged 16+) no longer in continuous full-time education had participated in adult learning in the last year.
- Participation in adult learning increased slightly but significantly between 2003 and 2006, from 48% to 52%.
- Participation in adult learning was significantly associated with gender, age and area deprivation. Women, those aged 50 and above and those living in more deprived communities were significantly less likely to participate.

Measure

Percentage of adults (no longer in continuous full-time education) who participated in some type of adult learning (taught or non-taught) in the last year

Data source

Data for this indicator are from the *Labour Force Survey/Annual Population Survey* 2003–2006 for adults aged 16+. Data for 2003 are from the *Labour Force Survey*. From 2004, results are from the *Annual Population Survey*, which is the *Labour Force Survey* plus a Scottish 'boost' to increase the sample size.

Point estimate

- In 2006, 52% of adults (aged 16+) no longer in full-time education had participated in adult learning in the last year.

Time trend

- Between 2003 and 2004, the proportion of adults (aged 16+) no longer in full-time education participating in adult learning increased significantly from 48% to 52% and remained stable thereafter (Figure AL1).

Equalities

- In 2006, participation in adult learning was significantly associated with gender, age and area deprivation assessed by the Scottish Index of Multiple Deprivation (SIMD).

- Men were significantly more likely to participate in adult learning than women (57% compared with 48% – Figure AL2).
- Adults aged 50+ were significantly less likely to participate in adult learning. More than six in every ten adults aged 16–49 participated in adult learning in 2006 (64%), but this rate fell to four in ten (42%) among those aged 50+ (Figure AL2).
- Participation in adult learning increased as area deprivation decreased. Adults in the least deprived SIMD quintile were significantly more likely to have participated in adult learning in the last year than those in the most deprived quintile (66% compared with 37% – Figure AL3).

Limitations of the data

No limitations were identified.

Figure AL1 **Percentage of adults aged 16+ no longer in full-time education participating in adult learning in last year: 2003–2006**

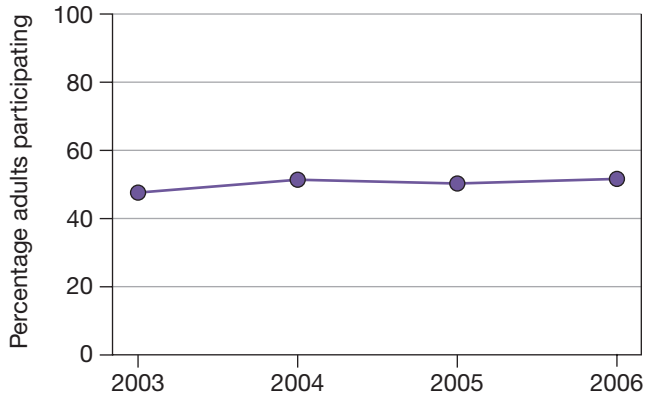


Figure AL2 **Percentage of adults aged 16+ no longer in full-time education participating in adult learning in last year, by gender and by age band: 2006**

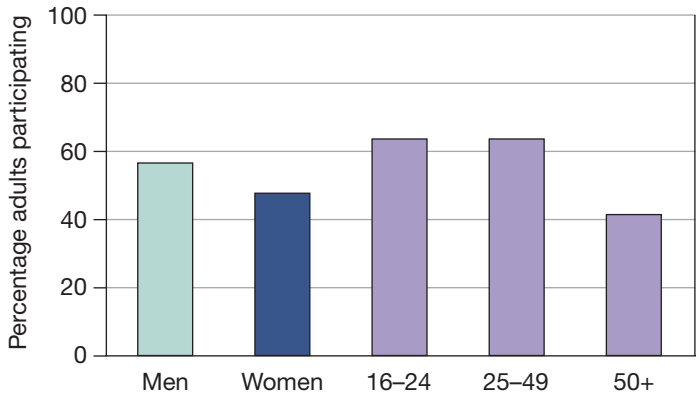
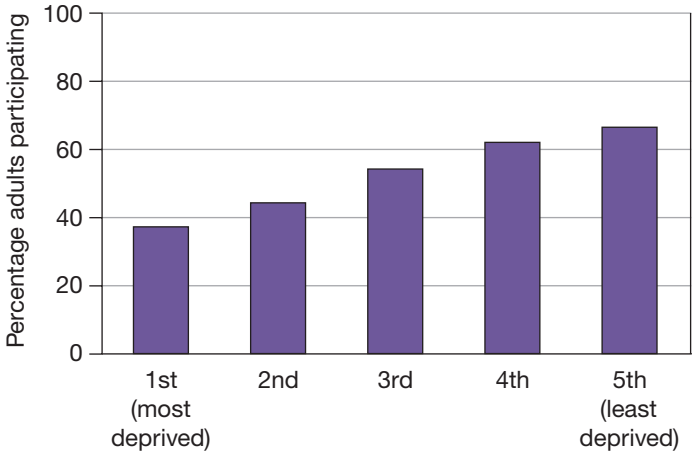


Figure AL3 **Percentage of adults aged 16+ no longer in full-time education participating in adult learning in last year, by SIMD quintile: 2006**



HEALTHY LIVING

Physical activity

Key findings

- In 2003, 36% of adults (aged 16+) reported that they met the recommended physical activity levels.
- Between 1998 and 2003, the proportion of adults (aged 16–74) meeting the recommended physical activity levels increased significantly from 35% to 39%.
- Likelihood of meeting the recommended physical activity level was significantly associated with gender and age. Men and younger people age 16–34 were more likely to meet the recommended physical activity levels.
- Physical activity was significantly associated with area deprivation, with adults living in the most deprived quintile being significantly less likely than those in the remaining four quintiles to meet the recommendations.

Measure

Percentage of adults who met the recommended level of physical activity for adults in the previous four weeks

The recommended level of physical activity is defined as participation in 30 minutes or more of moderate to vigorous physical activity on at least five days per week.

Data source

Data presented here are from the *Scottish Health Survey* (SHeS), 1998 and 2003. Time trend data relate to adults aged 16–74, whereas the point estimate and equalities analysis relate to adults aged 16+.

From 2008, the source for this indicator will be the SHeS for adults aged 16+.

Point estimate

- In 2003, 36% of adults (aged 16+) reported that they met the recommended physical activity levels.

Time trend

- Between 1998 and 2003, the proportion of adults (aged 16–74) meeting the recommended levels of physical activity increased significantly from 35% to 39% (Figure HL1).

- For men (aged 16–74) this was an increase from 41% to 44%, and for women (aged 16–74) from 30% to 33%. Both increases were statistically significant.

Equalities

- In 2003, men were significantly more likely than women to report meeting the recommended physical activity levels (42% of men compared with 30% of women – Figure HL2).
- Age was also significantly associated with physical activity. People age 16–34 were significantly more likely to meet the physical activity recommendations than those aged 35–74 (Figure HL2).
- There was a significant association between Scottish Index of Multiple Deprivation (SIMD) area deprivation and physical activity. Adults in the most deprived quintile were significantly less likely to meet the physical activity recommendations than those in the remaining four quintiles (Figure HL3).

Limitations of the data

The latest data from the SHeS are from 2003 and are therefore now five years old. Time trend data from the SHeS are currently limited; they are available for only two time points and comparability restricts analysis to adults aged 16–74.

Figure HL1 **Percentage of adults aged 16–74 meeting the recommended physical activity levels: 1998 and 2003**

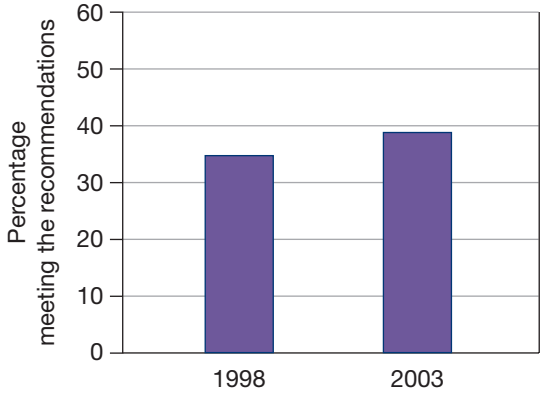


Figure HL2 **Percentage of adults aged 16+ meeting the recommended physical activity levels, by gender and by age band: 2003**

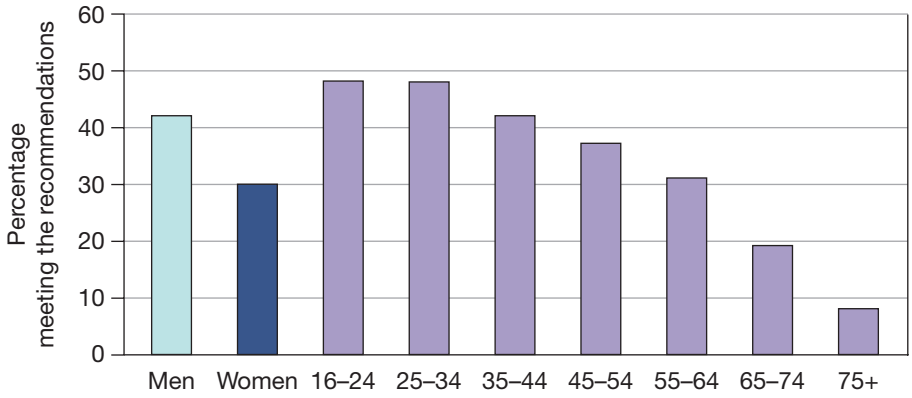
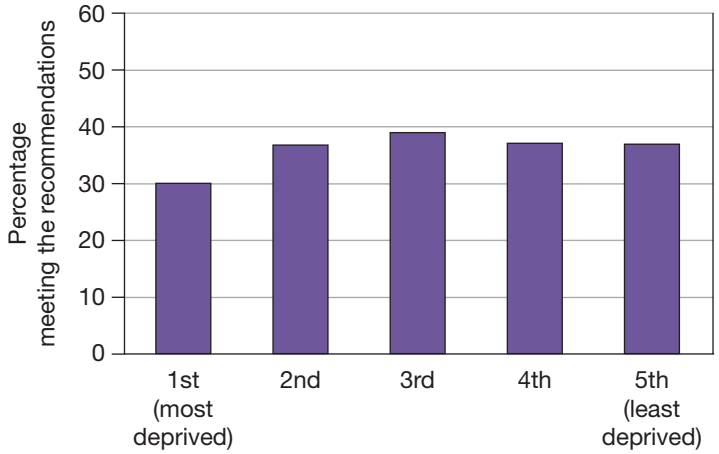


Figure HL3 **Percentage of adults aged 16+ meeting the recommended physical activity levels, by SIMD quintile: 2003**



HEALTHY LIVING

Healthy eating

Key findings

- In 2007, 34% of adults (aged 16–74) reported eating at least five portions of fruit and vegetables in the previous day.
- Between 1996 and 2007, the proportion of adults eating 'five a day' increased significantly from 18% to 34%.
- Gender, age and area deprivation were significantly associated with eating 'five a day'. Men, people aged 25–34 and those living in more deprived communities were less likely to be eating 'five a day'.

Measure

Percentage of adults who ate five or more portions of fruit and vegetables in the previous day

Data source

An interim source has been used for this indicator. Data presented here are from the *Health Education Population Survey* (HEPS) 1996–2007 for adults aged 16–74.[vi]

From 2008, the source for this indicator will be the *Scottish Health Survey* (SHeS) for adults aged 16+.

Point estimate

- In 2007, 34% of adults (aged 16–74) reported eating at least five portions of fruit and vegetables in the previous day – 'five a day'.

Time trend

- Between 1996 and 2007, the percentage of adults (aged 16–74) eating 'five a day' increased significantly, from 18% to 34% (Figure HL4).

Equalities

- In 2007, women (aged 16–74) were significantly more likely to be eating 'five a day' (42%) than men (26%) (Figure HL5).

vi HEPS was used in preference to SHeS as the latter has data for 2003 only.

- There was a significant association between age and eating 'five a day'. Consumption of 'five a day' was significantly lower among adults aged 25–34 than among adults aged 55–74 (27% compared with 39% or more – Figure HL5).
- Consumption of five or more portions of fruit and vegetables in the previous day was significantly associated with Scottish Index of Multiple Deprivation (SIMD) area deprivation. Adults in the most deprived SIMD quintile were significantly less likely to be eating 'five a day' than those in the two least deprived quintiles (25% compared with 36% and 44% – Figure HL6).

Limitations of the data

Trend results here are for adults aged 16–74 and there was a gap in the data in 2000 because no survey took place in that year. The sample size for the SHeS will be larger and data will be available annually from 2008.

Figure HL4 **Percentage of adults aged 16–74 eating five or more portions fruit/vegetables a day: 1996–2007**

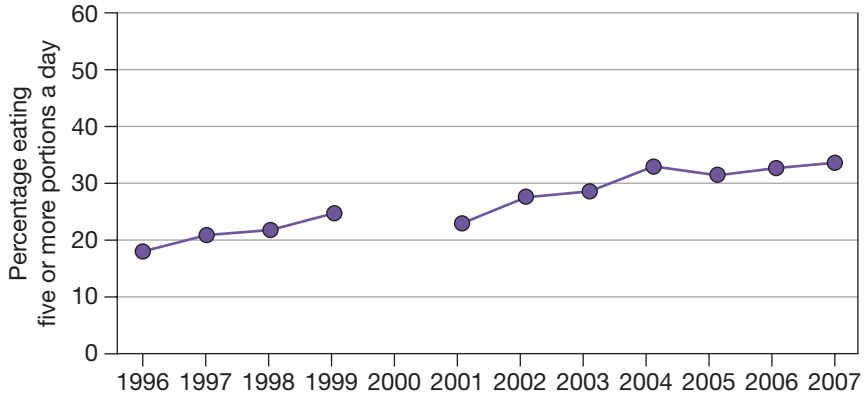


Figure HL5 **Percentage of adults aged 16–74 eating five or more portions fruit/vegetables a day, by gender and by age band: 2007**

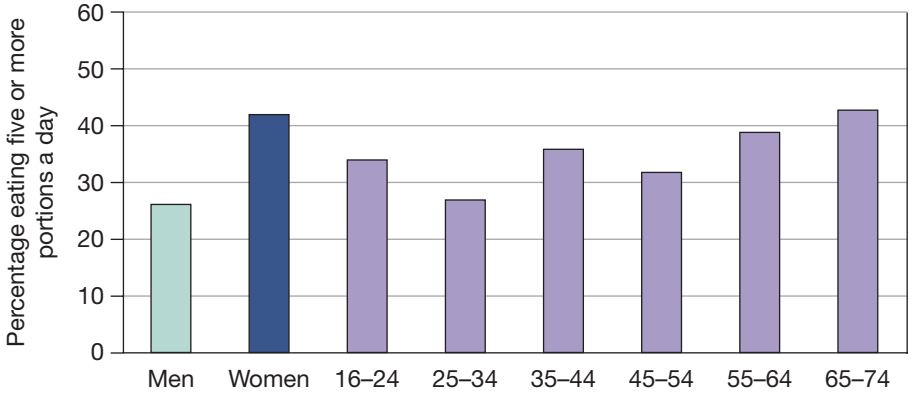
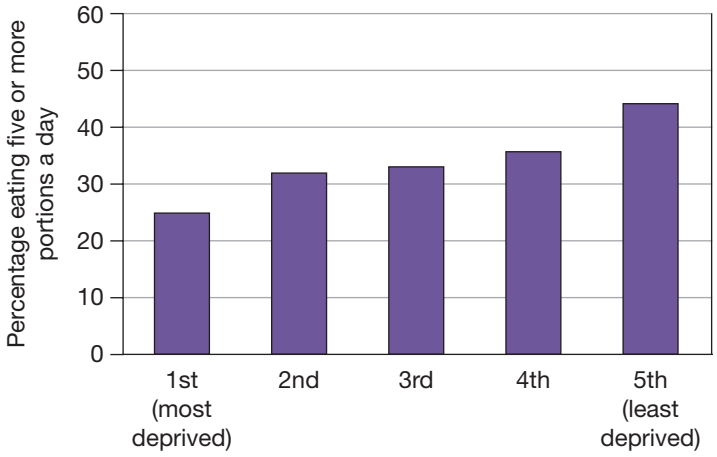


Figure HL6 **Percentage of adults aged 16–74 eating five or more portions fruit/vegetables a day, by SIMD quintile: 2007**



HEALTHY LIVING

Alcohol consumption

Key findings

- In 2003, 66% of men and 77% of women (aged 16+) reported drinking within the recommended weekly drinking limits.
- The best available evidence suggests that there has been no significant change in the proportion of men (aged 16–64) drinking within the recommended weekly limits between 1995 and 2003, but that the proportion of women has declined significantly. As these results differ, no change was observed for the population overall, i.e. for men and women combined.
- Alcohol consumption is significantly associated with gender, age and area deprivation. In 2003, women, older individuals and people living in the most deprived quintile were more likely to report drinking within the recommended weekly limits.

Measure

Percentage of adults whose usual weekly consumption of alcohol in the past year was within the recommended weekly limits (i.e. 21 units or fewer for men and 14 units or fewer for women)

Data source

Data presented here are from the *Scottish Health Survey* (SHeS), 1995, 1998 and 2003. Point estimates and equalities analysis are for adults aged 16+ and use data from the 2003 survey, which has been recalculated to take account of recent increases in drink strength.[10] Time trend analysis is for adults aged 16–64 and is presented using both the original and revised estimates from 2003.

From 2008, the source for this indicator will be the SHeS for adults aged 16+.

Point estimates

- In 2003, based upon the **revised** alcohol consumption estimates, 66% of men and 77% of women (aged 16+) reported drinking within the recommended weekly limits. These figures are lower than the original estimates for 2003 (73% and 86%), especially for women (Figure HL7).

Time trends

- Between 1995 and 2003, using the **original** alcohol consumption estimates for 2003, the proportion of men (aged 16–64) drinking within the recommended weekly limits increased

significantly (67% to 71%), whereas the proportion of women declined significantly (87% to 83%). However, these figures are likely to be misleading in terms of real population change due to progressive survey underestimation of alcohol intake linked to recent increases in drink strength and size.[11]

- In December 2007, the Office for National Statistics published updated conversion factors for converting drink volumes to units of alcohol.[12] These are based upon the strength of alcohol products in 2006 and have been applied to the original estimates from the 2003 SHeS in order to obtain more accurate information on alcohol consumption.[10] However, they were not applied to the data collected in 1995 and 1998 as they are unlikely to reflect drink strengths at these points. Without recalculating the 1995 and 1998 estimates using appropriately revised conversion factors, or detailed knowledge about when survey assumptions of drink size and strength began to diverge from what was actually available to people, it is not possible to be definitive about drinking trends in Scotland.
- Comparing the revised estimates for 2003 with the original 1995 and 1998 figures is problematic, but it provides a better picture of drinking in Scotland than allowed by the previous data.[10] This comparison leads to different conclusions from those based upon the original 2003 estimates. It suggests that there was no significant change in the proportion of men (aged 16–64) drinking within the recommended weekly limits between 1995 and 2003 (67% to 64%) and that the decline amongst women (87% to 72%) was greater than previously thought (Figures HL8 and HL9). As these results differ for men and women, no change was observed for the population overall, i.e. for men and women combined.

Equalities

- In 2003, using the **revised** alcohol consumption estimates, men were significantly less likely than women to report drinking within the recommended weekly alcohol limits: 66% compared with 77% (Figure HL7).
- Alcohol consumption is significantly associated with age: men aged 65+ and women aged 55+ were significantly more likely to report drinking within the recommended weekly limits (Figure HL10).
- Area deprivation, as measured by the Scottish Index of Multiple Deprivation (SIMD), is also significantly associated with alcohol consumption. The proportion of men and women drinking within the weekly limits was highest in the most deprived SIMD quintile and lowest in the least deprived quintile (Figure HL11).

Limitations of the data

Time trend data from the SHeS are currently available for three time points only; the most recent estimates are now five years old and comparability restricts analysis to adults aged 16–64. They are also subject to progressive survey underestimation of alcohol consumption, which means that the original estimates are likely to be misleading in terms of real population change.[11] Figures from the 2003 survey have been revised to correct for recent increases in drink strength but even they understate the true extent of Scotland's drinking challenge as they do not take account of other sources of survey underestimation, many of which it is not possible to correct for.

Figure HL7 **Percentage of men and women aged 16+ drinking within the recommended weekly alcohol limits, original and revised estimates: 2003**

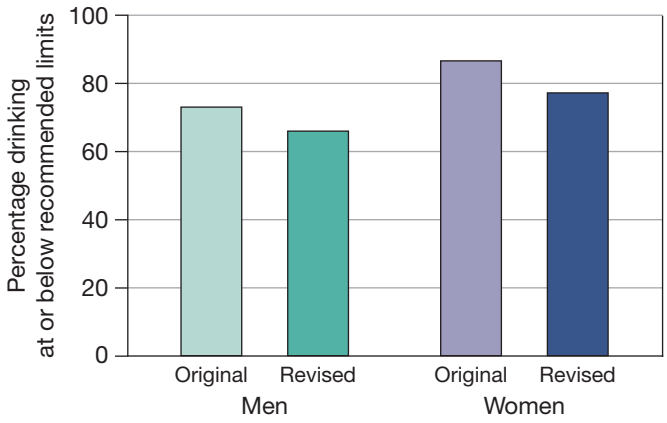


Figure HL8 **Percentage of men aged 16-64 drinking 21 units of alcohol per week or fewer: 1995 and 1998 (original estimates) and 2003 (original and revised estimates)**

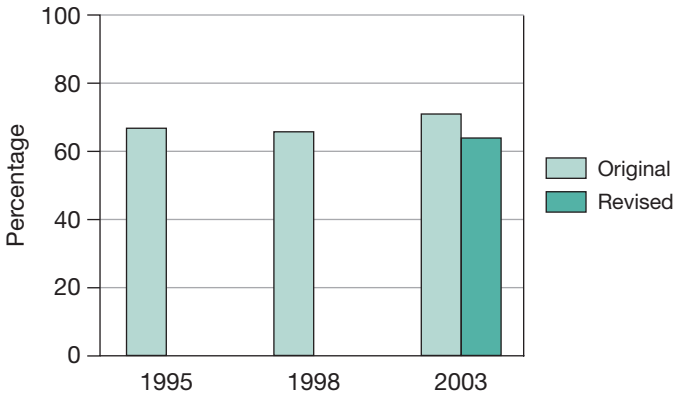


Figure HL9 **Percentage of women aged 16-64 drinking 14 units of alcohol per week or fewer: 1995 and 1998 (original estimates) and 2003 (original and revised estimates)**

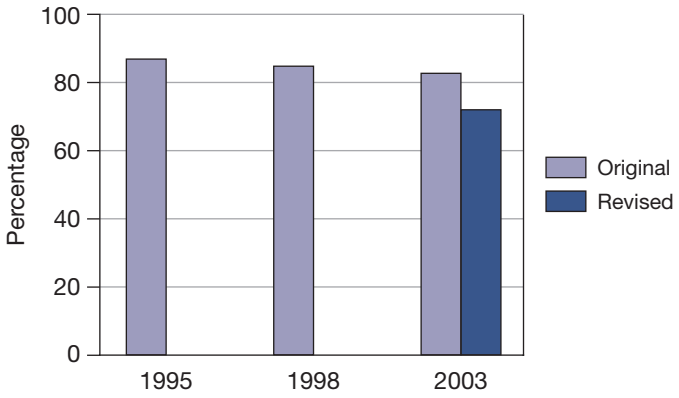


Figure HL10 **Percentage of men and women aged 16+ drinking within the recommended weekly alcohol limits, by age band: 2003 (revised estimates)**

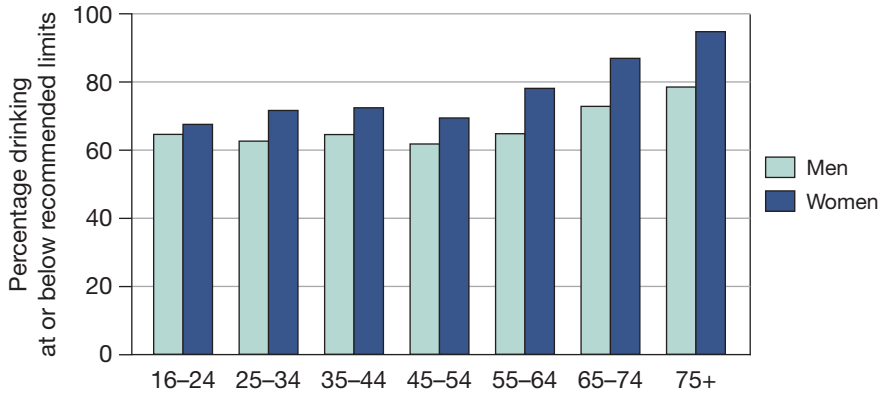
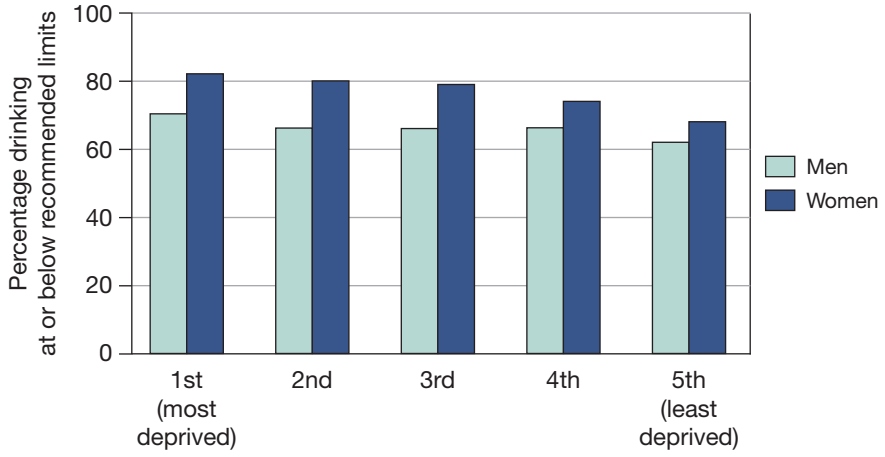


Figure HL11 **Percentage of men and women aged 16+ drinking within the recommended weekly alcohol limits, by SIMD quintile: 2003 (revised estimates)**



HEALTHY LIVING

Drug use

Key findings

- In 2006, 13% of adults (aged 16–59) had taken drugs in the last 12 months.
- Time trend analysis was not undertaken, because changes to the survey methodology mean that it is not possible to produce comparable results through time.
- Drug use was significantly associated with gender, age and ACORN (A Classification Of Residential Neighbourhoods) area type. Men, people under the age of 20, and those living in areas classified as 'city lifestyle' and 'struggling singles' were more likely to have used drugs in the last 12 months.

Measure

Percentage of adults (aged 16–59) who have taken drugs in the last 12 months

The measure used in this report, as given above, is an interim one that differs from that used in the indicator set.

Drugs included are amphetamine, cannabis, cocaine, crack, ecstasy, heroin, LSD, magic mushrooms, methadone/physeptone, temazepam, valium, anabolic steroids, poppers, crystal meth, ketamine, glues, solvents, gas or aerosols. The survey covers illicit drug use (i.e. non-prescribed). The negligible number of respondents who reporting taking semeron (a non-existent drug used for control purposes) was included in the respondent base.

From 2008, the measure will be *percentage of adults who have taken drugs in the past year.* Results presented in this report will not be directly comparable with data available from 2008.

Data source

Data used here are from the *Scottish Crime and Victimisation Survey* (SCVS) 2006 for adults aged 16–59.

From 2008, the SCVS has been renamed the *Scottish Crime and Justice Survey*.

Point estimate

- In 2006, 13% of adults (aged 16–59) had taken drugs in the last 12 months.

Time trend

- Time trend analysis was not undertaken, because changes to the survey methodology over the series mean it is not possible to produce comparable trends for this indicator.

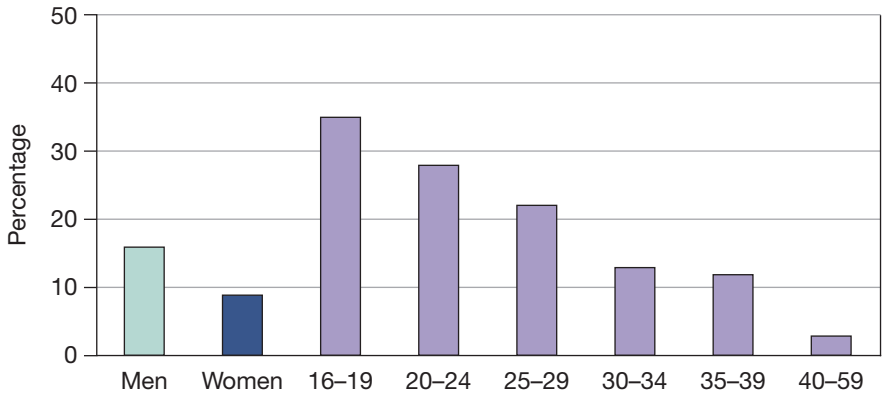
Equalities

- In 2006, drug use was significantly associated with age, gender and area type [as defined by A Classification Of Residential Neighbourhoods (ACORN)].[vii]
- Men (16%) were significantly more likely than women (9%) to have taken drugs in the last 12 months. Reported drug use was highest among the under-20s, with 35% reporting use in the past 12 months. Thereafter, prevalence fell off steadily to less than 3% among adults aged 40–59 (Figure HL12).
- Drug use was significantly higher among those living in areas classified by ACORN as 'struggling singles' (19%) and 'city lifestyles' (27%) (Figure HL13).

Limitations of the data

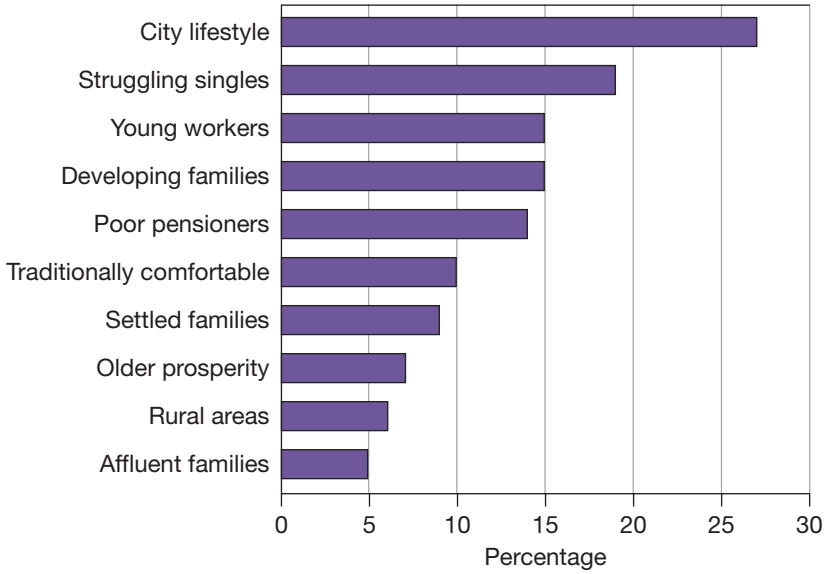
Figures presented here will underestimate true prevalence due to lower representation in surveys of problem drug users, respondent concerns about the implications of admitting to an illegal activity and recall issues. It was not possible to analyse results by Scottish Index of Multiple Deprivation (SIMD) quintile since the SCVS did not record respondents' data-zone of residence.

Figure HL12 **Percentage of adults aged 16–59 who have taken drugs in last year, by gender and by age band: 2006**



vii ACORN is a geographical market research tool. It describes neighbourhoods by the characteristics of the people who live there. Originally developed by Richard Webber, it uses a mix of Census, financial and survey data to group UK postcodes into 10 main categories. Appendix 5 gives examples of the types of household in each ACORN group.

Figure HL13 **Percentage of adults aged 16–59 who have taken drugs in last year, by ACORN group: 2006**



GENERAL HEALTH

Self-reported health

Key findings

- In 2003, 74% of adults (aged 16+) reported that their health in general was good or very good.
- Between 1995 and 2003 there was no significant change in the proportion of adults (aged 16–64) reporting that their health in general was good or very good.
- Age and area deprivation were significantly associated with the likelihood of good self-reported general health. Older people (aged 45+) and those living in deprived communities were significantly less likely to report that their health was good or very good.

Measure

Percentage of adults who perceive their health in general to be good or very good

Data source

Data for this indicator are from the *Scottish Health Survey* (SHeS), 1995, 1998 and 2003. Point estimate and equalities data include adults aged 16+, whereas time trend data refer to adults aged 16–64.

From 2008, the source for this indicator will be the SHeS for adults aged 16+.

Point estimate

- In 2003, 74% of adults (aged 16+) reported that their health in general was good or very good.

Time trend

- In 2003, 78% of adults (aged 16–64) reported that their health in general was good or very good. This figure has not changed significantly since 1995, when 77% reported that their general health was good or very good (Figure GH1).

Equalities

- In 2003, the proportion of adults (aged 16+) reporting that their health in general was good or very good did not vary significantly by gender (74% of men compared with 73% of women).
- Self-reported general health was significantly associated with age. The proportion of adults reporting that their general health as good or very good was significantly lower among those aged 45+. Self-reported general health decreased significantly with each subsequent 10-year age band from ages 45–54 (Figure GH2).
- Levels of self-reported general health were also significantly and negatively associated with Scottish Index of Multiple Deprivation (SIMD) area deprivation. In the most deprived quintile, 59% reported that their health in general was good or very good, compared with 83% in the least deprived quintile (Figure GH3).

Limitations of the data

The latest data from the SHeS are from 2003 and are therefore now five years old. Time trend data from the SHeS are currently limited; they are available for three time points only and comparability restricts analysis to adults aged 16–64.

Figure GH1 **Percentage of adults aged 16-64 who perceive their general health to be good or very good: 1995, 1998 and 2003**

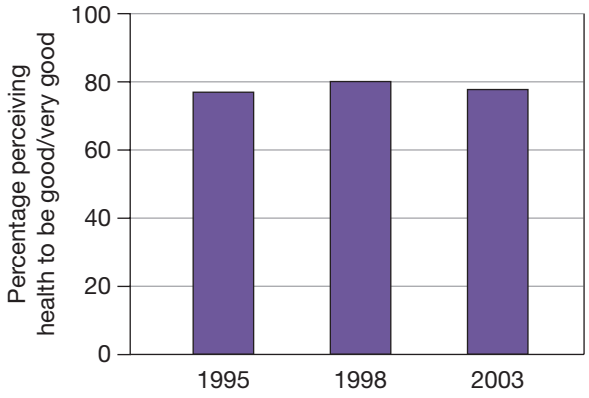


Figure GH2 **Percentage of adults aged 16+ who perceive their general health to be good or very good, by age band: 2003**

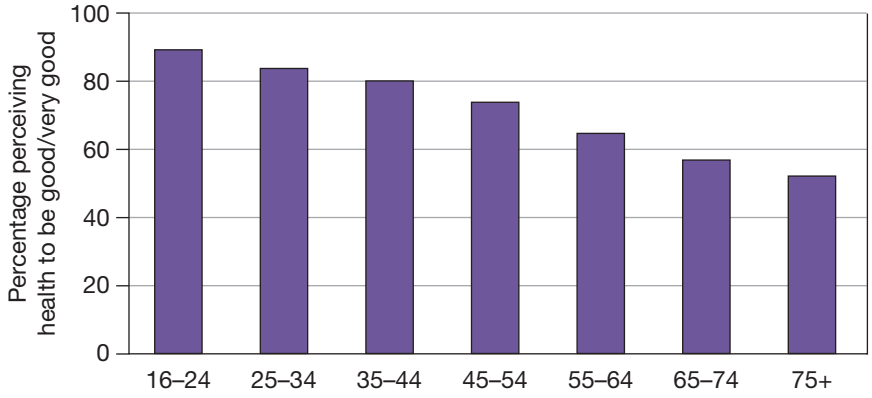
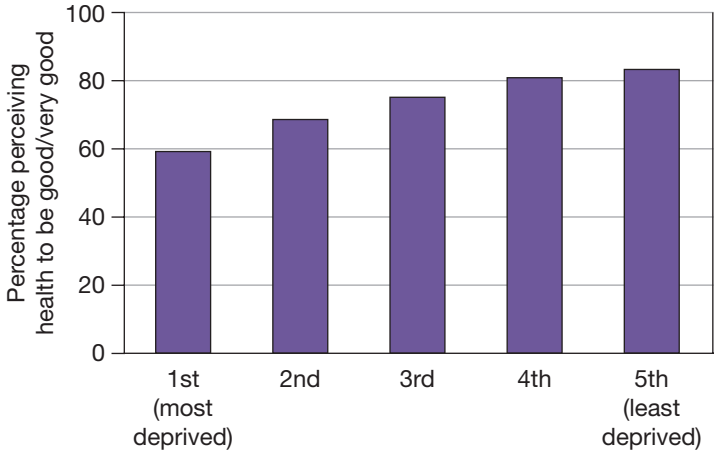


Figure GH3 **Percentage of adults aged 16+ who perceive their general health to be good or very good, by SIMD quintile: 2003**



GENERAL HEALTH

Long-standing physical condition or disability

Key findings

- In 2003, 37% of adults (aged 16+) reported a long-standing physical illness, disability or infirmity.
- Between 1995 and 2003, the proportion of adults (aged 16–64) reporting a long-standing physical illness, disability or infirmity did not change significantly.
- Age and area deprivation were significantly associated with having a long-standing physical illness, disability or infirmity. Prevalence increased significantly with age. It was also significantly higher among adults in the most deprived communities.

Measure

Percentage of adults who have a long-standing physical illness, disability or infirmity

The measure used in this report, as given above, is an interim one that differs from the one used in the indicator set. The question used asked about 'long-standing illness, disability or infirmity', with 'long-standing' being defined as having troubled a person over a period of time, or likely to affect them for period of time.

From 2008, the measure will be: *percentage of adults who have a long-standing physical condition or disability*. A long-standing physical condition or disability is defined as one that has troubled the person for at least 12 months or is likely to affect them for at least 12 months. Results presented in this report will not be directly comparable with data available from 2008.

Data source

Data for this indicator are from the *Scottish Health Survey* (SHeS) 1995, 1998 and 2003. Mental health problems were excluded from the analysis. Time trend data related to adults aged 16–64, whereas point estimate and equalities analysis are for adults aged 16+.

Point estimate

- In 2003, 37% of adults (aged 16+) reported a long-standing physical illness, disability or infirmity.

Time trend

- In 2003, 31% of adults (aged 16–64) reported a long-standing physical illness, disability or infirmity. This figure has not changed significantly since 1995 (Figure GH4).

Equalities

- In 2003, the proportion of adults (aged 16+) reporting a long-standing physical illness, disability or infirmity did not vary significantly by gender.
- Prevalence of long-standing physical illness, disability or infirmity increased significantly with age. Although 14% of young adults (aged 16–24) reported a long-standing physical illness, disability or infirmity, this increased to 37% among those aged 45–54 and 65% for those aged 75+ (Figure GH5).
- There was a significant association between Scottish Index of Multiple Deprivation (SIMD) area deprivation and the likelihood of a long-standing physical illness, disability or infirmity. In the least deprived quintile 31% of adults (aged 16+) reported a long-standing physical illness, disability or infirmity. This rose to 43% in the most deprived quintile (Figure GH6).

Limitations of the data

The latest data from the SHeS are from 2003 and are therefore now five years old. Time trend data from the SHeS are currently limited; they are available for three time points only and comparability restricts analysis to adults aged 16–64. The phrasing of this question and definition of long-standing will change from 2008.

Figure GH4 **Percentage of adults aged 16-64 with a long-standing physical illness, disability or infirmity: 1995, 1998 and 2003**

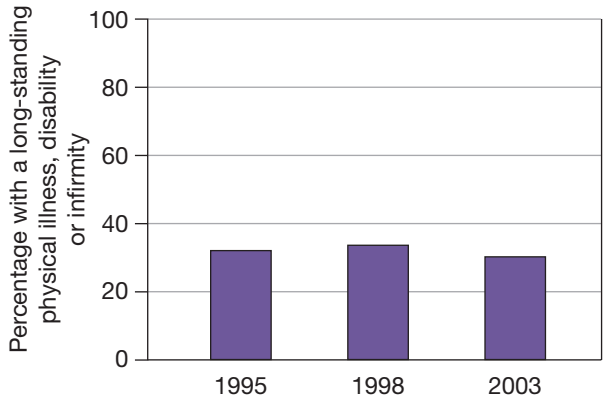


Figure GH5 **Percentage of adults aged 16+ with a long-standing physical illness, disability or infirmity, by age band: 2003**

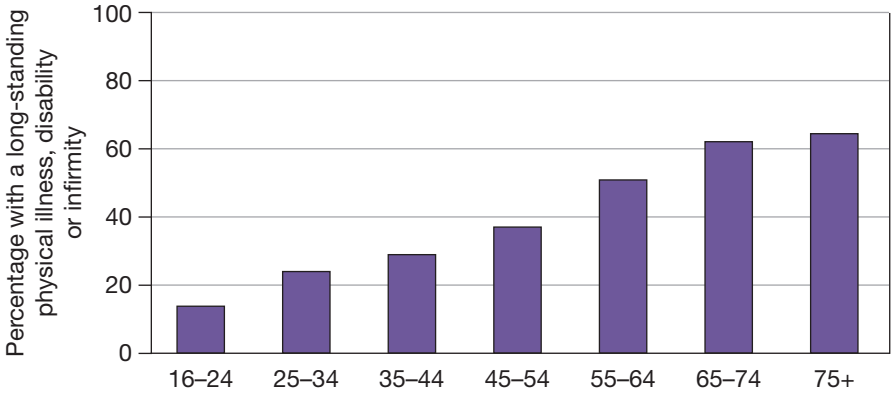
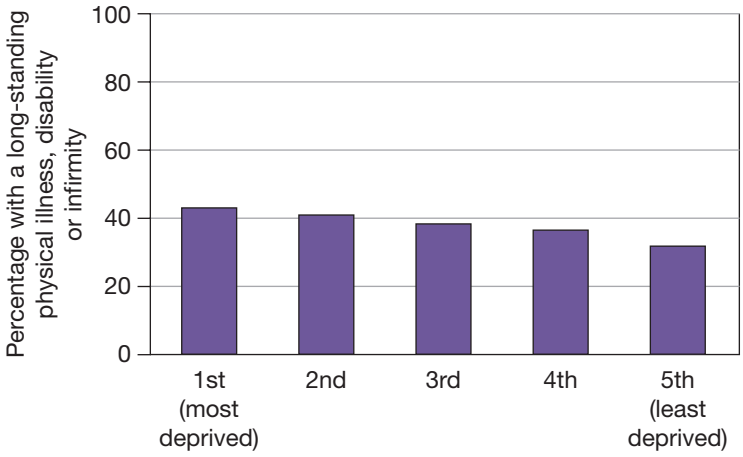


Figure GH6 **Percentage of adults aged 16+ with a long-standing physical illness, disability or infirmity, by SIMD quintile: 2003**



GENERAL HEALTH

Limiting long-standing physical condition or disability

Key findings

- In 2003, 23% of adults (aged 16+) reported a long-standing physical illness, disability or infirmity which limited their daily activities.
- Between 1995 and 2003, the proportion of adults (aged 16–64) with a limiting long-standing physical illness, disability or infirmity did not change significantly.
- Age and area deprivation were significantly associated with having a limiting long-standing physical illness, disability or infirmity. Older adults and those in the most deprived areas were significantly more likely to have a limiting long-standing physical illness, disability or infirmity.

Measure

Percentage of adults who have a long-standing physical illness, disease or infirmity which limits their daily activities

The measure used in this report, as given above, is an interim one that differs from the one used in the indicator set. The question used asked about 'limiting long-standing illness, disability or infirmity', where 'long-standing' was defined as having troubled a person over a period of time, or likely to affect them for period of time.

From 2008, the measure will be: *percentage of adults who have a long-standing physical condition or disability that limits their daily activities*. A limiting long-standing physical condition or disability is defined as one having troubled the person for at least 12 months or that is likely to affect them for at least 12 months, and limits their daily activities. Results presented in this report will not be directly comparable with data available from 2008.

Data source

Data for this indicator are from the *Scottish Health Survey* (SHeS) 1995, 1998 and 2003. Time trend data relate to adults aged 16–64, whereas point estimate and equalities analyses are for adults aged 16+.

Point estimate

- In 2003, 23% of adults (aged 16+) reported a long-standing physical illness, disability or infirmity that limited their daily activities.

Time trend

- In 2003, 18% of adults (aged 16–64) reported a limiting long-standing physical illness, disability or infirmity. This figure has not changed significantly since 1995 (Figure GH7).

Equalities

- In 2003, the proportion of adults (aged 16+) reporting a limiting long-standing physical illness, disability or infirmity did not vary significantly by gender.
- However, age was significantly and positively associated with the likelihood of having a limiting long-standing physical illness, disability or infirmity. Just 7% of young adults (aged 16–24) reported a limiting long-standing physical illness, disability or infirmity in 2003, but this increased to 22% of those aged 45–54 and almost half (48%) of adults aged 75+ (Figure GH8).
- Limiting long-standing illness, disability or infirmity was also significantly associated with area deprivation. In the least deprived Scottish Index of Multiple Deprivation (SIMD) quintile, 16% of adults reported a limiting long-standing illness, disability or infirmity – but this proportion increased to 31% in the most deprived quintile (Figure GH9).

Limitations of the data

The latest data from the SHeS are from 2003 and are therefore now five years old. Time trend data from the SHeS are currently limited; they are available for three time points only and comparability restricts analysis to adults aged 16–64. The phrasing of this question and definition of long-standing will change from 2008.

Figure GH7 **Percentage of adults aged 16-64 with limiting long-standing physical illness, disability or infirmity: 1995, 1998 and 2003**

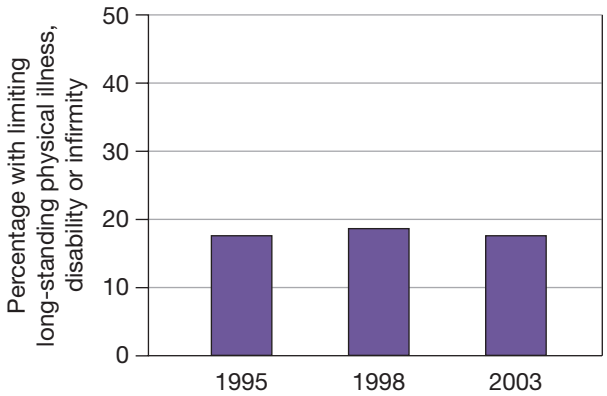


Figure GH8 **Percentage of adults aged 16+ with limiting long-standing physical illness, disability or infirmity, by age band: 2003**

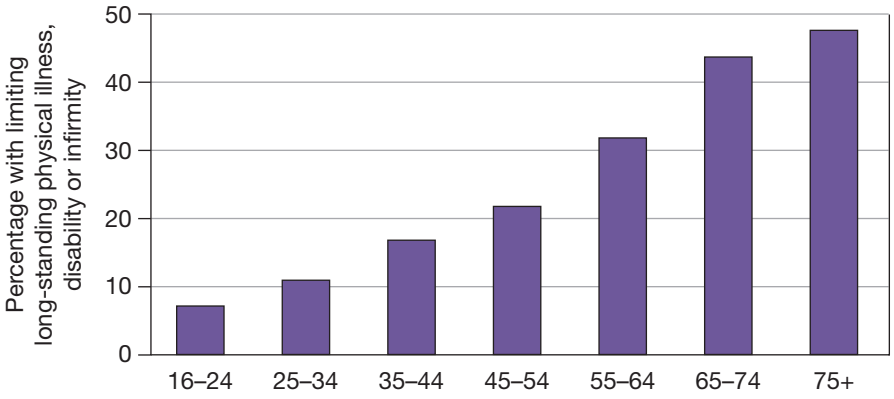
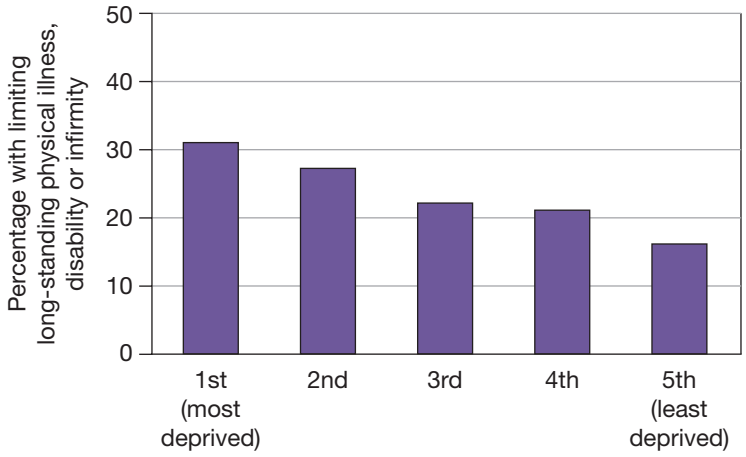


Figure GH9 **Percentage of adults aged 16+ with limiting long-standing physical illness, disability or infirmity, by SIMD quintile: 2003**



Spirituality

Measure

Assessment of spirituality

No data currently exist for this indicator. There is a need to clarify the concept of spirituality and develop questions that adequately capture its contribution to mental health. This will allow an appropriate measure to be developed and relevant data on spirituality to be collected in the future.

Emotional intelligence

Measure

Assessment of emotional intelligence

No data currently exist for this indicator. There is a need to clarify the concept of emotional intelligence and develop questions that adequately capture its contribution to mental health. This will allow an appropriate measure to be developed and relevant data on emotional intelligence to be collected in the future.

Contextual

Community

Participation (3)

Social networks (1)

Social support (2)

Trust (2)

Safety (4)

PARTICIPATION

Volunteering

Key findings

- In 2006, 17% of adults (aged 16+) reported having volunteered at least once every other month during the past year.
- Changes over the survey series mean that time trend analysis is not possible.
- Frequency of volunteering was significantly associated with gender, age and area deprivation. Women, adults in less deprived areas and those aged 35–74 were more likely to volunteer at least once every other month.

Measure

Percentage of adults who reported volunteering at least once every other month during the past year

The measure used in this report, as given above, is an interim one that differs from that used in the indicator set.

From 2007, the measure will be: *percentage of adults who participated in volunteering at least five or six times in the past year*. Results presented here will not be directly comparable with data available from 2007.

Data source

Data for this indicator are from the *Scottish Household Survey* (SHoS) 2006 for adults aged 16+.

Point estimate

- In 2006, 17% of adults (aged 16+) volunteered at least once every other month.

Time trend

- Changes in the question format mean that it has not been possible to measure time trends for this indicator.

Equalities

- In 2006, women were significantly more likely then men to report volunteering at least once every other month (18% against 16% – Figure P1).

- Age was significantly associated with volunteering. Adults aged 35–74 were significantly more likely to report volunteering at least once every other month (18% or more) than those aged 16–24, 25–34 (both 13%) or 75+ (11%) (Figure P1).
- There was a significant association between Scottish Index of Multiple Deprivation (SIMD) area deprivation and volunteering. The proportion of adults volunteering at least once every other month was significantly higher in the two least deprived SIMD quintiles (23% and 21%) than in the two most deprived quintiles (9% and 14%) (Figure P2).

Limitations of the data

Due to alterations in the question over the survey series, time trend analysis has not been possible.

Figure P1 **Percentage of adults aged 16+ who volunteered at least once every other month in the past year, by gender and by age band: 2006**

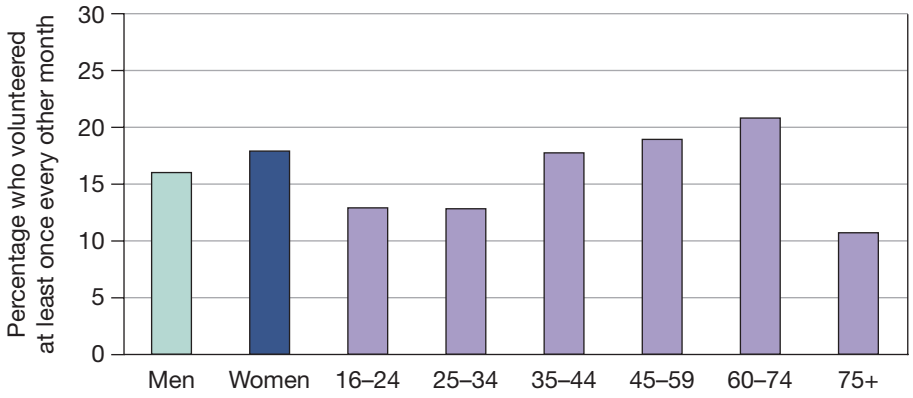
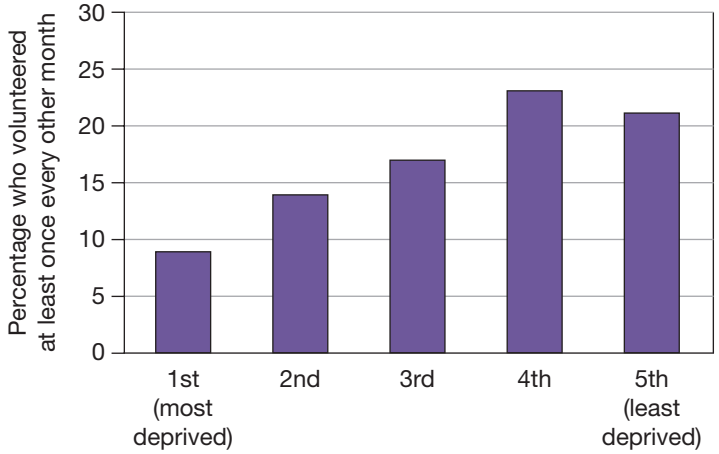


Figure P2 **Percentage of adults aged 16+ who volunteered at least once every other month in the past year, by SIMD quintile: 2006**



PARTICIPATION

Involvement in local community

Key findings

- In 2002, 26% of adults (aged 16+) reported feeling involved a great deal or a fair amount in their local community.
- Between 2000 and 2002, the proportion feeling involved a great deal or a fair amount in their local community increased slightly, but significantly, from 24% to 26%.
- Reported involvement in local community was significantly associated with age, gender and area deprivation. Those aged 16–24, men and adults resident in the two most deprived quintiles were significantly less likely to feel involved.

Measure

Percentage of adults who feel involved in their local community a great deal or a fair amount

Data source

An interim source has been used for this indicator. Data are taken from the *Scottish Household Survey* (SHoS) 2000–2002 for adults aged 16+.

From 2009, the source for this indicator will be the *Scottish Health Survey* (SHeS) for adults aged 16+.

Point estimate

- In 2002, 26% of adults (aged 16+) reported that they felt involved in their local community a great deal or a fair amount.

Time trend

- Between 2000 and 2002, the proportion of adults who reported feeling involved in their local community increased slightly, but significantly, from 24% to 26% (Figure P3).

Equalities

- In 2002, gender, age and Scottish Index of Multiple Deprivation (SIMD) area deprivation were all significantly associated with differences in levels of feeling involved in the local community.

- Women were significantly more likely than men to report feeling involved in their local community (28% compared with 24% – Figure P4).
- Sense of involvement in the local community was significantly lower among young adults aged 16–24 (19%) than in those aged 25 and older (23% or more). Involvement rose significantly with each 10-year age band, reaching a plateau between the ages of 45 and 74, then declining slightly for those aged 75+ (Figure P4).
- Adults' involvement in their local community was significantly associated with SIMD area deprivation. The likelihood of feeling involved was significantly lower in the two most deprived quintiles (23% or less) than in the three less deprived quintiles (28% or more) (Figure P5).

Limitations of the data

The latest data from the SHoS for this indicator are from 2002 and are therefore now six years old. Time trend data for this indicator are available for only three years (2000–2002). The series break and switch between sources between 2002 and 2009 will make future interpretation of time trends problematic.

Figure P3 **Percentage of adults aged 16+ who feel involved a great deal or a fair amount in their local community: 2000, 2001 and 2002**

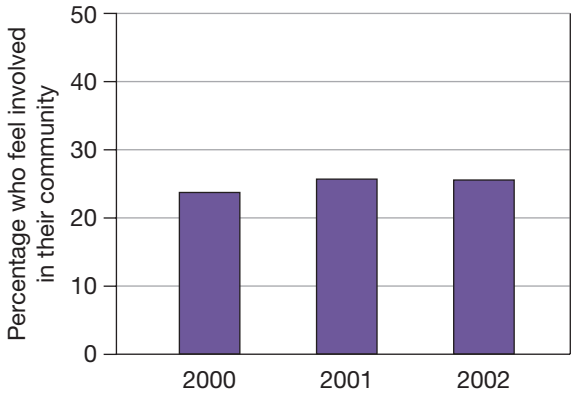


Figure P4 **Percentage of adults aged 16+ who feel involved in their community a great deal or a fair amount, by gender and by age band: 2002**

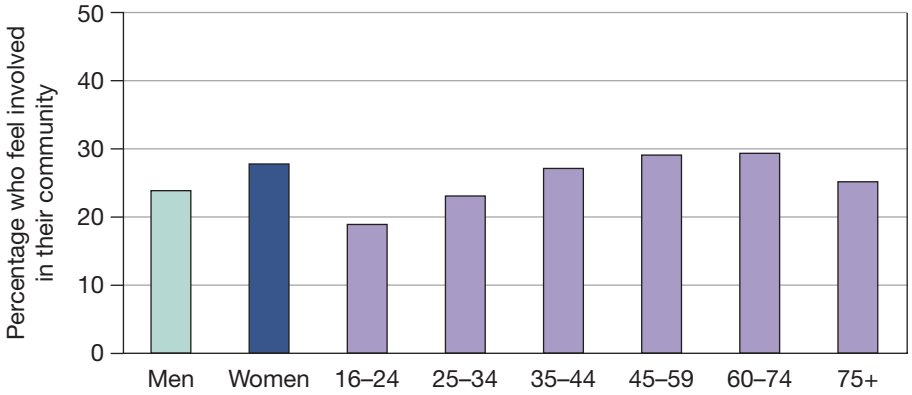
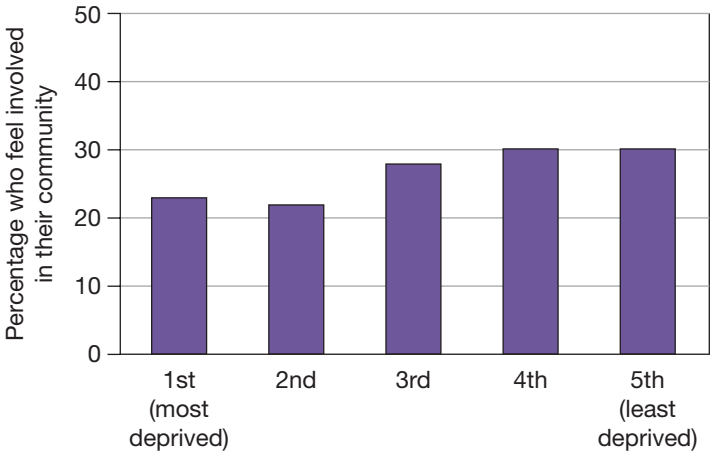


Figure P5 **Percentage of adults aged 16+ who feel involved in their community a great deal or a fair amount, by SIMD quintile: 2002**



PARTICIPATION

Influencing local decisions

Key findings

- In 2004/05, 24% of adults (aged 16+) strongly agreed or agreed that they could influence decisions affecting their local area.
- Time trend data are not yet available for this indicator.
- Perceived influence on local decisions was significantly associated with gender, age and socio-economic position. Women, those aged 45–74 and adults in professional/ managerial jobs were significantly more likely to strongly agree or agree that they could influence local decisions.

Measure

Percentage of adults who strongly agree or agree that they can influence decisions affecting their local area

Data source

An interim source has been used for this indicator. Data used here are taken from the Scottish sample of the *General Household Survey* (GHS) social capital module 2004/05 (financial year) for adults aged 16+.

From 2009, the source for this indicator will be the *Scottish Health Survey* (SHeS) for adults aged 16+.

Point estimate

- In 2004/05, 24% of adults (aged 16+) strongly agreed or agreed that they could influence decisions affecting their local area.

Time trend

- Time trend data are not yet available for this indicator.

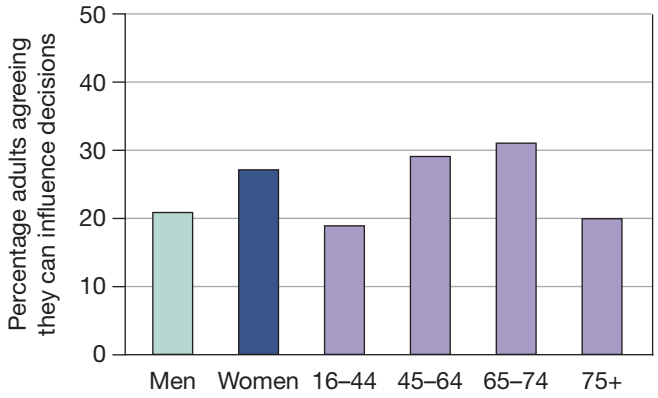
Equalities

- In 2004/05, gender, age and socio-economic position assessed by National Statistics Socio-Economic Classification (NS-SEC)[viii] were significantly associated with agreement that people could influence decisions affecting their local area.
- Women were significantly more likely than men (27% compared with 21%) to strongly agree or agree that they could influence local decisions (Figure P6).
- Agreement that people could influence decisions affecting their local area was higher in the 45–74 age group than in those aged 16–44 or 75+ (Figure P6).
- Analysis by NS-SEC showed that people in managerial and professional occupations (35%) were significantly more likely to strongly agree or agree that they could influence local decisions than those in lower supervisory and technical occupations, semi-routine and routine occupations (18%) and those who have never worked and the long-term unemployed (11%) (Figure P7).

Limitations of the data

The latest data from the GHS for this indicator are from 2004/05 and are therefore now three years old. The Scottish sample from the GHS was relatively small (<900), since it is taken from a British survey. Analysis by Scottish Index of Multiple Deprivation (SIMD) quintile was not possible since the GHS does not record respondents' data-zone of residence. Data from the SHeS from 2009 will provide more precise estimates and allow subsequent time trend and SIMD analyses.

Figure P6 **Percentage of adults aged 16+ who strongly agree/agree that they can influence decisions in their local area, by gender and by age band: 2004/05**



viii The NS-SEC (National Statistics Socio-economic Classification) replaced social class-based and socio-economic groups as the official measure of socio-economic status in 2001. NS-SEC classifies individuals into 17 socio-economic categories based on information about the type of work they do.

Figure P7 **Percentage of adults who strongly agree/agree that they can influence decisions in their local area, by NS-SEC: 2004/05**

SOCIAL NETWORKS

Social contact

Key findings

- In 2006, 83% of adults (aged 16+) reported that they saw friends or relatives not living with them at least once a week.
- There was no significant change in the proportion of adults reporting this level of social contact in 2004 compared with 2006.
- Gender, age and area deprivation were not significantly associated with rates of social contact.

Measure

Percentage of adults who saw friends or relatives not living with them at least once a week

The measure used in this report, as given above, is an interim one that that differs from that used in the indicator set.

From 2009, the measure will be: *percentage of adults who have contact (in person, by phone, letter, email or through the internet) at least once a week with family, friends or neighbours who do not live with them.* Results shown here will not be directly comparable with data available from 2009.

Data source

An interim source has been used for this indicator. Data used are from the *Well? What do you think?* surveys, 2004 and 2006 for adults 16+. The point estimate and equalities analysis used 2006 data.

From 2009, the data source will be the *Scottish Health Survey* (SHeS) for adults aged 16+.

Point estimate

- In 2006, 83% of adults (aged 16+) reported that they saw friends or relatives not living with them at least once a week.

Time trend

- There was no significant change in the proportion of adults reporting this rate of social contact in 2006 compared with 2004 (Figure SN1).

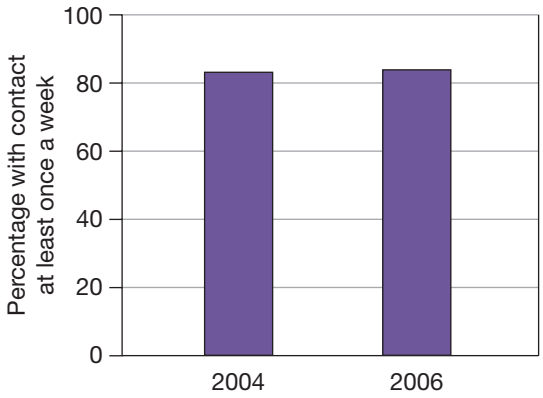
Equalities

- In 2006, gender, age and area deprivation (assessed by Scottish Index of Multiple Deprivation) did not significantly influence the likelihood of adults seeing friends or family not living with them at least once in a week.

Limitations of the data

Time trend data from the *Well? What do you think?* survey are available for only two time points. Future data from the SHeS (2009 onwards) will not be comparable with those presented here due to differences in the question asked.

Figure SN1 **Percentage of adults aged 16+ who saw friends or relatives at least once per week: 2004 and 2006**



SOCIAL SUPPORT

Social support

Key findings

- In 2006, 82% of adults (aged 16+) reported having three or more people to rely on in a crisis.
- There was no significant change in the proportion of adults reporting having three or more people to rely on in 2004 compared with 2006.
- Rates of social support did not differ significantly by age or gender.
- However, the likelihood of having three or more people to rely on was significantly associated with area deprivation. Adults in more deprived Scottish Index of Multiple Deprivation quintiles were significantly less likely to have a support group of three or more to rely on in a personal crisis.

Measure

Percentage of adults with a primary support group of three or more to rely on for comfort and support in a personal crisis

Data source

An interim source has been used for this indicator. Data presented here are from the *Well? What do you think?* surveys, 2004 and 2006 for adults aged 16+.

From 2009, the source for this indicator will be the *Scottish Health Survey* (SHeS) for adults aged 16+.

Point estimate

- In 2006, 82% of adults (aged 16+) reported having three or more people to rely on in a crisis.

Time trend

- There was no significant change in the proportion of adults reporting a support group of three or more in 2006 compared with 2004 (Figure SOC1).
- However within this, the proportion of women reporting having had three or more people to rely on in a crisis decreased significantly from 85% to 81%, whereas for men there was no significant change.

Equalities

- In 2006, rates of social support did not differ significantly by age or gender.
- However, Scottish Index of Multiple Deprivation (SIMD) area deprivation was significantly associated with having three or more people to rely on in a crisis. Adults in the most deprived quintile were significantly less likely than those in the least deprived quintile to have three or more people to rely on in a crisis (72% compared with 87% – Figure SOC2).

Limitations of the data

Time trend data from the *Well? What do you think?* survey are available for only two time points. Future data from the SHeS (2009 onwards) will not be directly comparable with those presented here.

Figure SOC1 **Percentage of adults aged 16+ with three or more people to turn to in a crisis: 2004 and 2006**

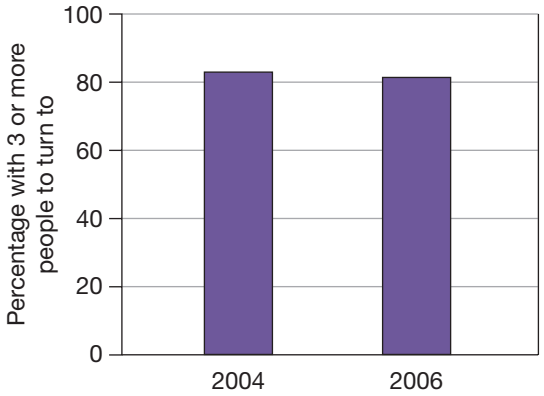
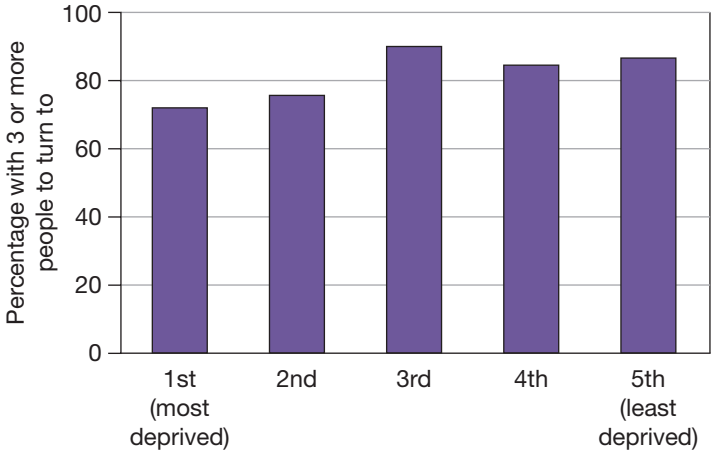


Figure SOC2 **Percentage of adults aged 16+ with three or more people to turn to in a crisis, by SIMD quintile: 2006**



SOCIAL SUPPORT

Caring

Key findings

- In 2006, 3% of adults (aged 16+) provided a significant amount of unpaid care (20+ hours per week) to a member of their household or to someone not living with them.
- Time trend data are not yet available for this indicator.
- The likelihood of providing 20+ hours of unpaid care per week differed significantly by age and area deprivation. Adults aged 45–74 and those in more deprived communities were more likely to be providing 20+ hours of care each week.

Measure

Percentage of adults who provide 20 or more hours of care per week to a member of their household or to someone not living with them, excluding help provided in the course of employment

Data source

An interim source has been used for this indicator. Results presented are from the *Scottish Household Survey* (SHoS) 2006 for adults aged 16+.

From 2008, the source for this indicator will be the *Scottish Health Survey* (SHeS) for adults aged 16+.

Point estimate

- In 2006, 3% of adults (aged 16+) provided 20 or more hours of unpaid care per week.

Time trend

- Time trend analysis was not undertaken due to changes in the SHoS survey series question over time.

Equalities

- In 2006, the percentage of adults providing 20 or more hours of unpaid care per week did not vary significantly by gender.

- Age was significantly associated with provision of 20+ hours of unpaid care per week. Adults aged 45–74 were more likely to provide this level of care than the other age groups (Figure SOC3).
- Area deprivation was also significantly associated with providing care. The likelihood of providing 20+ hours of unpaid caring per week increased significantly as Scottish Index of Multiple Deprivation (SIMD) increased (Figure SOC4).

Limitations of the data

Future data from the SHeS will not be directly comparable with those presented here.

Figure SOC3 **Percentage of adults aged 16+ providing 20+ hours of unpaid care each week, by age band: 2006**

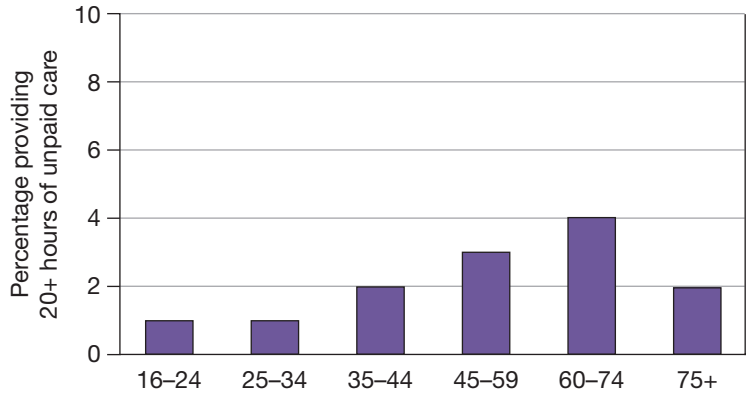
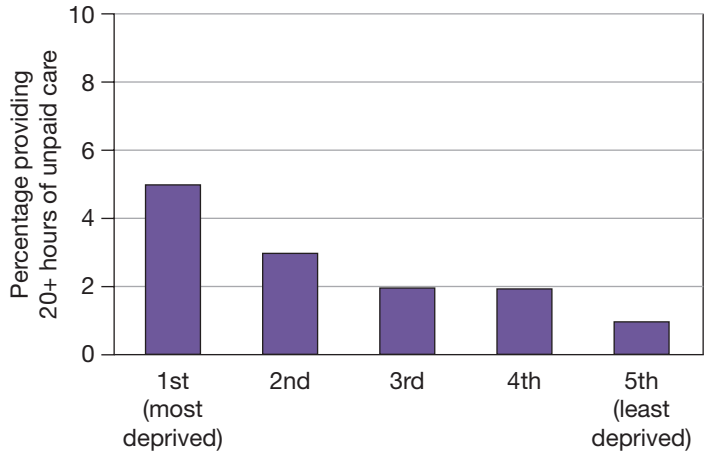


Figure SOC4 **Percentage of adults aged 16+ providing 20+ hours of unpaid care each week, by SIMD quintile: 2006**



TRUST

General trust

Key findings

- In 2004/05, 40% of adults (aged 16+) agreed that most people can be trusted.
- Time trend data are not yet available for this indicator.
- Trust in people was not significantly associated with gender, age or socio-economic group.

Measure

Percentage of adults who trust most people

Respondents were asked 'Generally speaking, would you say that most people can be trusted, or that you can't be too careful in dealing with people?'.

Data source

An interim source has been used for this indicator. Results presented here are from the Scottish sample of the *General Household Survey* (GHS) social capital module 2004/05 (financial year) for adults aged 16+.

From 2009, the source for this indicator will be the *Scottish Health Survey* (SHeS) for adults aged 16+.

Point estimate

- In 2004/05, 40% of adults (aged 16+) agreed that most people can be trusted.

Time trend

- Time trend data are not yet available for this indicator.

Equalities

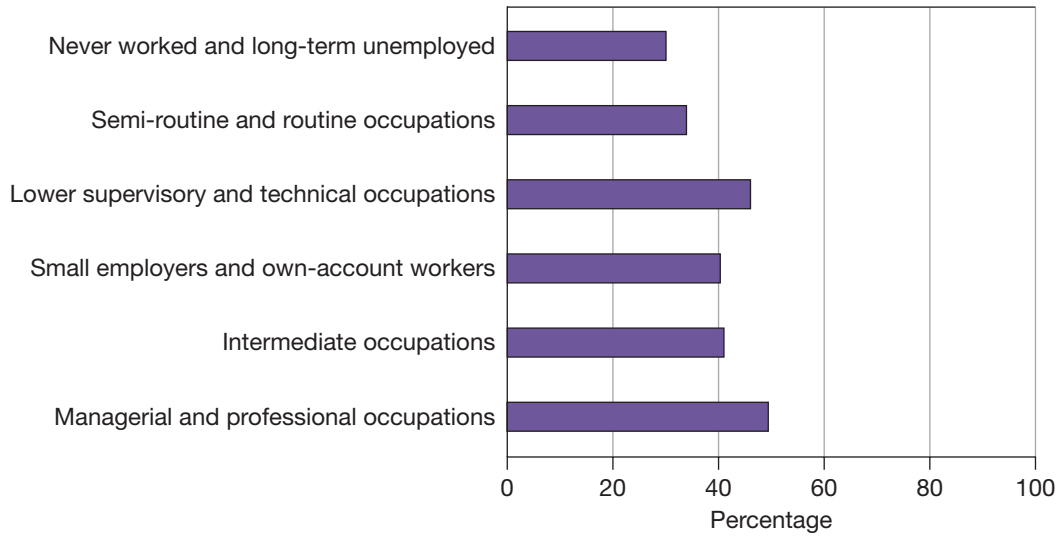
- In 2004/05, reported levels of general trust among adults did not vary significantly by gender or age.

- Analysis by socio-economic group assessed by National Statistics Socio-Economic Classification (NS-SEC)[ix] showed no significant association between NS-SEC and differences in the level of general trust (Figure T1).

Limitations of the data

The latest data from the GHS for this indicator are from 2004/05 and are therefore now three years old. The Scottish sample for the GHS was relatively small (<900), since it was taken from a British survey. Analysis by Scottish Index of Multiple Deprivation (SIMD) quintile was not possible, since the GHS does not record respondents' data-zone of residence. Data from the SHeS from 2009 will provide more precise estimates and allow subsequent time trend and SIMD analyses.

Figure T1 **Percentage of adults aged 16+ who believe most people can be trusted, by NS-SEC: 2004/05**



ix The NS-SEC replaced social class-based and socio-economic groups as the official measure of socio-economic status in 2001. NS-SEC classifies individuals into 17 socio-economic categories based on information about the type of work they do.

TRUST

Neighbourhood trust

Key findings

- In 2004/05, 61% of adults (aged 16+) thought that most people in their neighbourhood could be trusted.
- Time trend data are not yet available for this indicator.
- Neighbourhood trust was significantly associated with age and socio-economic group. A higher proportion of older adults and those from higher socio-economic groups were likely to report that most people in their neighbourhood could be trusted.

Measure

Percentage of adults who trust most people in their neighbourhood

The measure shows the proportion of respondents agreeing that 'most of the people in your neighbourhood can be trusted'.

Data source

An interim source has been used for this indicator. Results presented here are from the Scottish sample of the *General Household Survey* (GHS) social capital module 2004/05 (financial year) for adults aged 16+. People who had just moved to the neighbourhood were excluded from the analysis.

From 2009, the source for this indicator will be the *Scottish Health Survey* (SHeS) for adults aged 16+.

Point estimate

- In 2004/05, 61% of adults (aged 16+) agreed that most of the people in their neighbourhood could be trusted. This figure was higher than that reported for general trust (40%).

Time trend

- Time trend data are not yet available for this indicator.

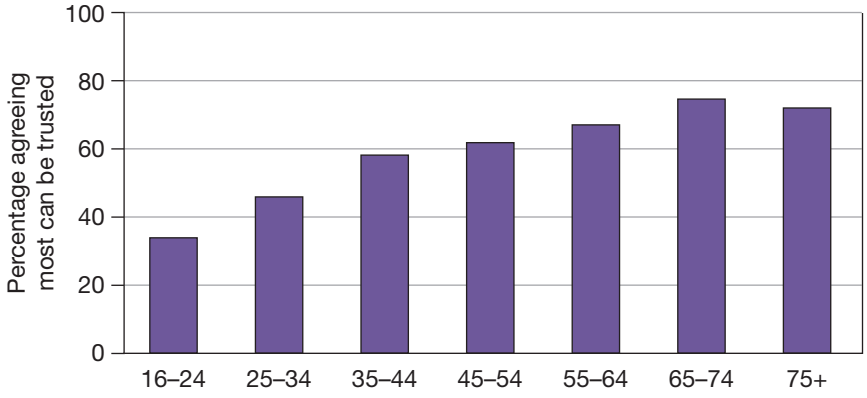
Equalities

- In 2004/05, there was no significant difference in levels of neighbourhood trust between men and women.
- Levels of neighbourhood trust were significantly associated with age. Neighbourhood trust was significantly lower among adults aged 16–34 than those aged 35+. Neighbourhood trust was significantly higher among adults aged 65+ than those aged 35–54 (Figure T2).
- Analysis by National Statistics Socio-Economic Classification (NS-SEC)[x] showed significant differences in the levels of neighbourhood trust by NS-SEC. Those in managerial/ professional occupations (71%), intermediate occupations (65%) and small employers/ own account workers (75%) were significantly more likely to trust most people in their neighbourhood than those in lower supervisory/technical (50%), semi-routine occupations (55%) and the never worked and long-term unemployed (44%) (Figure T3).

Limitations of the data

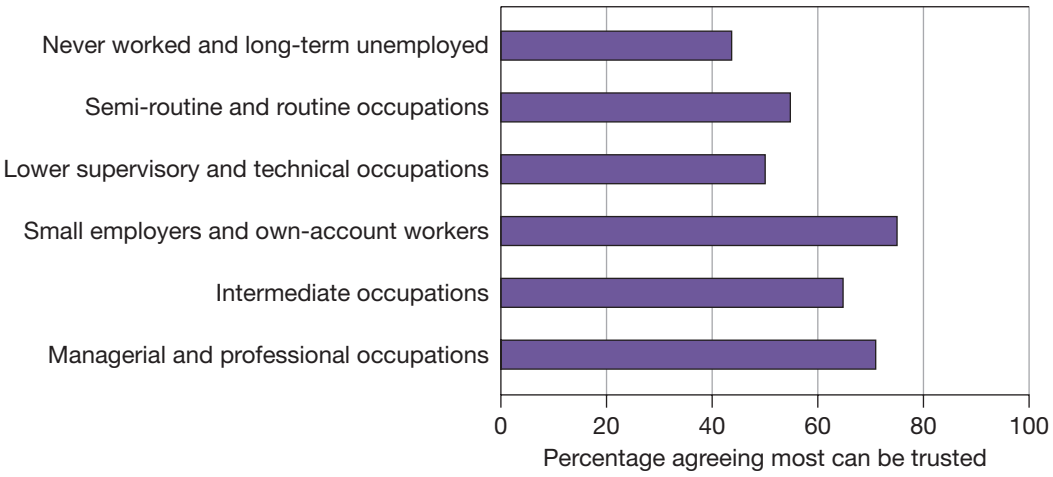
The latest data from the GHS for this indicator are from 2004/05 and are therefore now three years old. The Scottish sample for the GHS was relatively small (<900), since it is taken from a British survey. Analysis by Scottish Index of Multiple Deprivation (SIMD) quintile was not possible since the GHS does not record respondents' data-zone of residence. Data from the SHeS from 2009 will provide more precise estimates and allow subsequent time trend and SIMD analyses.

Figure T2 **Percentage of adults aged 16+ who believe most people in their neighbourhood can be trusted, by age band: 2004/05**



x The NS-SEC replaced social class-based and socio-economic groups as the official measure of socio-economic status in 2001. NS-SEC classifies individuals into 17 socio-economic categories based on information about the type of work they do.

Figure T3 **Percentage of adults aged 16+ who believe most people in their neighbourhood can be trusted, by NS-SEC: 2004/05**



SAFETY

Neighbourhood safety

Key findings

- In 2006, 73% of adults (aged 16+) felt very or fairly safe walking alone in their neighbourhood after dark.
- Since 2002, the percentage of adults who felt safe or very safe has not changed significantly.
- Gender, age and area deprivation were significantly associated with neighbourhood safety. Women, those over 60 years of age and adults living in the most deprived communities were significantly less likely to report feeling very or fairly safe walking alone in their neighbourhood after dark.

Measure

Percentage of adults who feel very or fairly safe walking alone in their neighbourhood after dark

Data source

Data for this indicator are from the *Scottish Household Survey* (SHoS) 2002–2006 for adults aged 16+.

Point estimate

- In 2006, 73% of adults (aged 16+) felt very or fairly safe when walking alone in the local neighbourhood after dark.

Time trend

- Since 2002, the percentage of adults who felt very or fairly safe when walking alone in the local neighbourhood after dark has not changed significantly (Figure SAF1).

Equalities

- In 2006, women were significantly less likely to feel very or fairly safe in their local neighbourhood after dark than men (63% compared with 84% in 2006).
- Adults aged 60–74 and 75+ were significantly less likely to feel very or fairly safe than those aged 16–59 (Figure SAF2).

- Neighbourhood safety was significantly associated with area deprivation; 57% of those in the most deprived Scottish Index of Multiple Deprivation (SIMD) quintile felt safe walking alone after dark in their neighbourhood, compared with more than 80% in the two least deprived quintiles (Figure SAF3).

Limitations of the data

The *Scottish Crime and Victimisation Survey* (SCVS) has collected identical data for this indicator. Relative to the SCVS, the *Scottish Household Survey* (SHoS) may underestimate levels of concern about crime. The same question asked in the SCVS 2006 produced a higher proportion of residents who felt unsafe. However, the SCVS lacks consistent time series data.

At the moment the SHoS is identified as the best data source for this indicator. However, more robust questions on safety are being developed for the *Scottish Crime and Justice Survey* (the renamed SCVS) and may be a better data source in the future. If this is the case then this indicator may need to be revised accordingly. Until such time the data source will be the SHoS.

Figure SAF1 **Percentage of adults aged 16+ who feel very or fairly safe walking alone in their local neighbourhood after dark: 2002–2006**

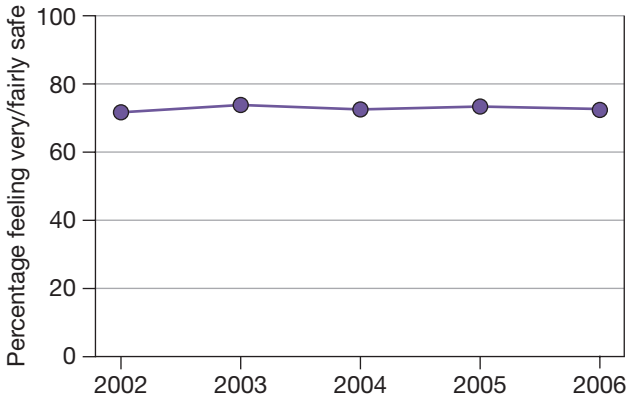


Figure SAF2 **Percentage of adults aged 16+ who feel very or fairly safe walking alone in their local neighbourhood after dark, by gender and by age band: 2006**

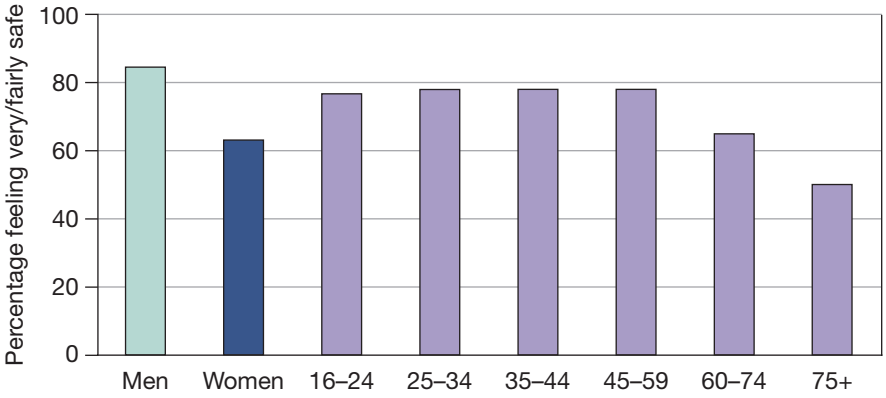
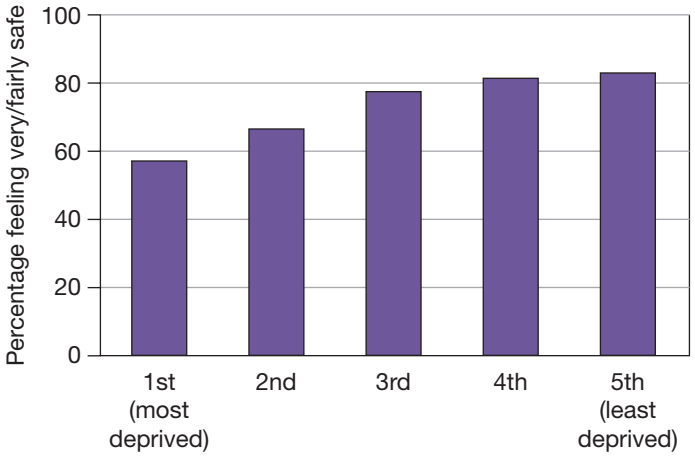


Figure SAF3 **Percentage of adults aged 16+ who feel very or fairly safe walking alone in their local neighbourhood after dark, by SIMD quintile: 2006**



SAFETY

Home safety

Key findings

- In 2006, 97% of adults (aged 16+) felt very or fairly safe when at home alone at night.
- Between 2002 and 2006, the proportion of adults reporting that they felt safe when at home alone at night increased from 96% to 97% – a small but statistically significant improvement.
- Gender, age and area deprivation were significantly associated with home safety. Women, those aged 16–24 and adults living in more deprived communities were significantly less likely to report feeling very or fairly safe at home alone at night.

Measure

Percentage of adults who feel very or fairly safe when at home alone at night

Data source

Data for this indicator are from the *Scottish Household Survey* (SHoS) 2002–06 for adults aged 16+.

Point estimate

- In 2006, 97% of adults (aged 16+) felt very or fairly safe when home alone at night.

Time trend

- Between 2002 and 2006, the percentage of adults who felt very or fairly safe when at home alone at night increased from 96% to 97%, a slight, but statistically significant, improvement (Figure SAF4).

Equalities

- In 2006, women were significantly less likely than men to report feeling safe when at home alone at night (96% compared with 98%) (Figure SAF5).
- Age was also significantly associated with differences in levels of perceived home safety. Adults aged 16–24 were significantly less likely, and adults aged 45–59 significantly more likely, to report feeling safe when at home alone at night than other age groups (Figure SAF5).

- Perceived levels of home safety are significantly higher in the three least deprived Scottish Index of Multiple Deprivation quintiles than in the most deprived quintile (94%) (Figure SAF6).

Limitations of the data

The *Scottish Crime and Victimisation Survey* (SCVS) has collected identical data for this indicator. Relative to the SCVS, the *Scottish Household Survey* (SHoS) may underestimate levels of concern about crime. The same question asked in the SCVS 2006 produced a higher proportion of residents who felt unsafe. However, the SCVS lacks consistent time series data.

At the moment the SHoS is identified as the best data source for this indicator. However, more robust questions on safety are being developed for the *Scottish Crime and Justice Survey* (the renamed SCVS) and may be a better data source in the future. If this is the case then this indicator may need to be revised accordingly. Until such time the data source will be the SHoS.

Figure SAF4 **Percentage of adults aged 16+ who feel very or fairly safe when home alone at night: 2002–2006**

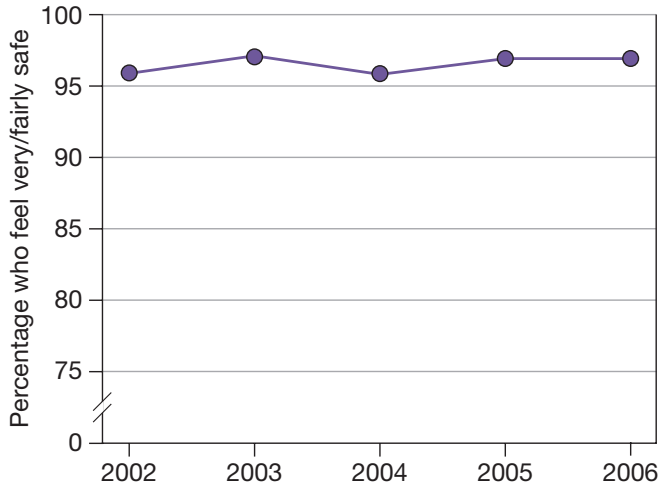


Figure SAF5 **Percentage of adults aged 16+ who feel very or fairly safe when home alone at night, by gender and by age band: 2006**

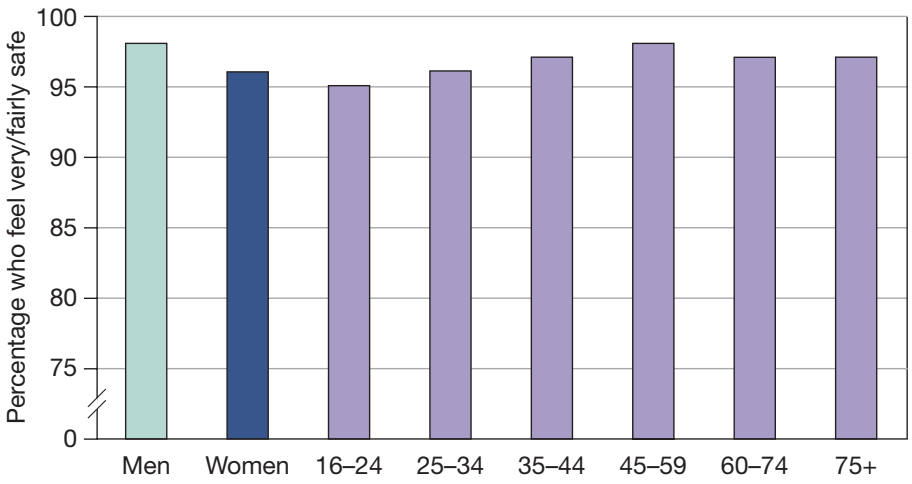
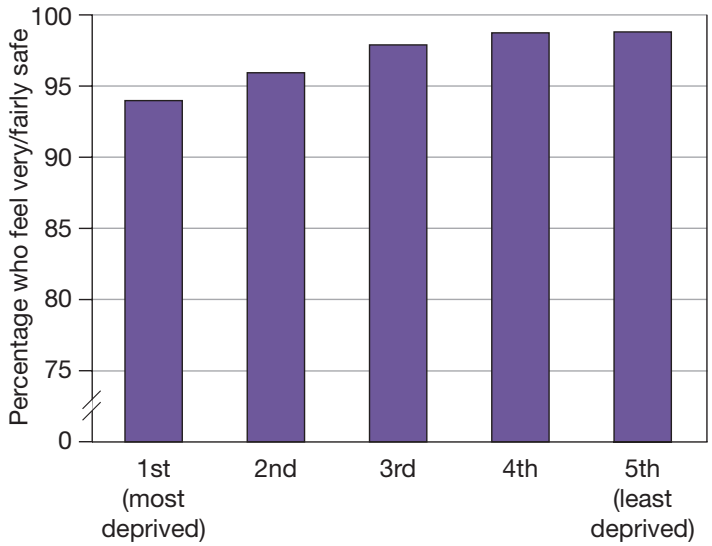


Figure SAF6 **Percentage of adults aged 16+ who feel very or fairly safe when home alone at night, by SIMD quintile: 2006**



SAFETY

Non-violent neighbourhood crime

Measure

Percentage of adults who have been a victim of non-violent crime occurring locally

'Non-violent crimes' include household crime, theft from the person and other personal theft occurring within 15 minutes' walk from the victim's home, as defined by the *Scottish Crime and Victimisation Survey* (http://openscotland.gov.uk/Publications/2007/10/12094216/11).

Data source

The source for this indicator is the *Scottish Crime and Victimisation Survey* (SCVS) 2006 for adults aged 16+. A complication with the 2006 SCVS data sets identified by Scottish Government statisticians meant that it was not possible to derive this indicator in time for publication.

From 2008, the SCVS has been renamed the *Scottish Crime and Justice Survey* (SCJS).

SAFETY

Perception of local crime

Key findings

- In 2006, 61% of adults (aged 16+) thought that crime was very or fairly common in their local area.
- Time trend data are not yet available for this indicator.
- Perceptions that crime was very or fairly common in the local area did not vary significantly by gender.
- Age and area type were significantly associated with perception of local crime. Young adults and those living in 'developing families' and 'struggling singles' areas were significantly more likely to think that crime was very or fairly common in their local area.

Measure

Percentage of adults who perceive crime to be very or fairly common in their local area

Respondents were shown a list of crimes that might affect people – having their homes broken into, being mugged/robbed, having their property or vehicle damaged, experiencing theft of or theft from their car or vehicle, being assaulted/attacked in public, drug dealing and drug abuse – and asked how common they thought each was in their local area. The indicator presents the proportion who thought that at least one of these crimes was very or fairly common in their local area.

Data source

Data for this indicator are from the *Scottish Crime and Victimisation Survey* (SCVS) 2006 for adults aged 16+.

From 2008, the SCVS has been renamed the *Scottish Crime and Justice Survey* (SCJS).

Point estimate

- In 2006, 61% of adults (aged 16+) thought crime to be very or fairly common in their local area.

Time trend

- Changes to the question wording and SCVS methodology preclude time trend analysis of this indicator.

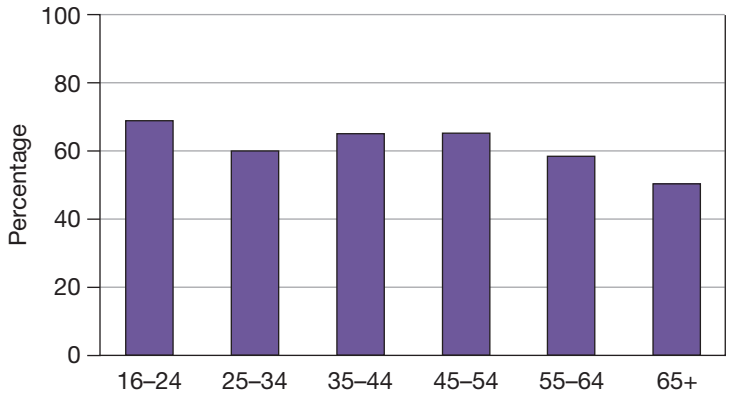
Equalities

- In 2006, perception of local crime did not vary significantly between men and women. However, age and area type had a significant association with differences in perception of local crime.
- Perceptions of crime were significantly associated with age. Young people (aged 16–24) were significantly more likely to perceive crime to be very or fairly common in their local area (69%) than adults aged 25–34 (60%), 55–64 (58%) or 65+ (50%). Adults aged 65+ were significantly less likely than other age groups to perceive crime as very or fairly common in their local area (Figure SAF7).
- Analysis of area type using ACORN (A Classification Of Residential Neighbourhoods)[xi] showed that adults living in areas classified as 'struggling singles' (73%) or 'developing families' (66%) were significantly more likely to perceive crimes to be very or fairly common in their local area than those in areas classified as 'rural areas' (33%), 'affluent families' (44%), 'older prosperity' (47%) and 'settled families' (47%) (Figure SAF8).

Limitations of the data

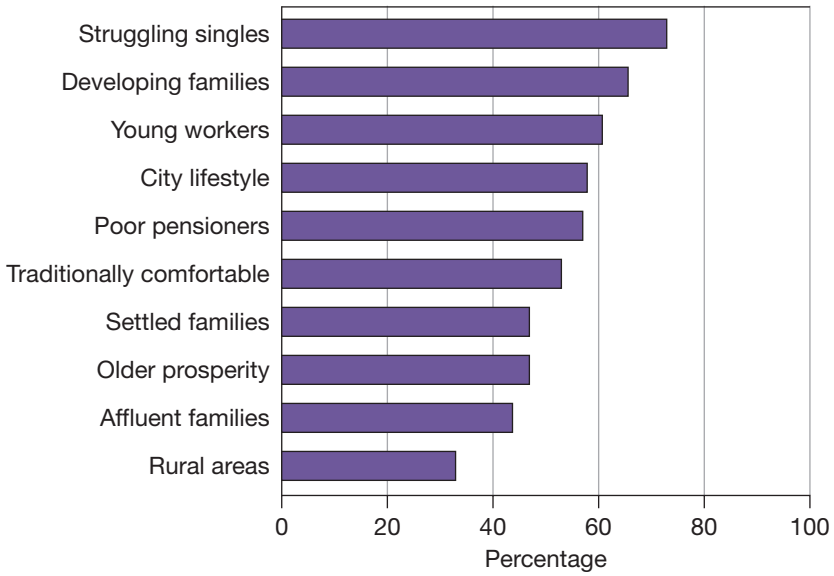
No time trend data are available and this question may be revised in future years. The larger sample size of the future SCJS will provide more robust data. It was not possible to analyse results by Scottish Index of Multiple Deprivation (SIMD) quintile since the SCVS did not record respondents' data-zone of residence.

Figure SAF7 **Percentage of adults aged 16+ who perceive crime to be very/fairly common in their local area, by age band: 2006**



xi ACORN is a geographical market research tool. It describes neighbourhoods by the characteristics of the people who live there. Originally developed by Richard Webber, it uses a mix of Census, financial and survey data to group UK postcodes into 10 main categories. Appendix 5 gives examples of the types of household in each ACORN group.

Figure SAF8 **Percentage of adults aged 16+ who perceive crime to be very/fairly common in their local area, by ACORN group: 2006**



Contextual

Structural

Equality (1)

Social inclusion (2)

Discrimination (3)

Financial security/debt (2)

Physical environment (6)

Working life (6)

Violence (3)

EQUALITY

Income inequality

Key findings

- In 2005/06, the Scottish Gini coefficient (a key measure of income inequality between households) stood at 0.32, where 'zero' indicates maximum equality and '1' indicates maximum inequality of income distribution.
- Between 1996/97 and 2005/06, despite fluctuations, there was no significant change in income inequality, as measured by the Gini coefficient.
- Analysis by gender, age or deprivation was not possible.

Measure

The Gini coefficient

The Gini coefficient is a widely used measure of income inequality, which measures how evenly incomes are distributed between households in a particular population. A lower Gini coefficient (closer to zero) indicates greater equality of income distribution, a higher value (closer to 1), greater inequality. Thus, a Gini score of zero would reflect complete equality of income distribution within a population, whereas a score of 1 would reflect perfect inequality, with one household receiving all the income.

Data source

The data are from the Income and Poverty – Main Analyses page of the Social Welfare Statistics section of the Scottish Government website, financial years 1996/97–2005/06. The original sources are the Family Resources Survey and Households Below Average Income, Department of Work and Pensions data set.

Point estimate

- In 2005/06, the Gini coefficient for Scotland was 0.32, slightly lower than that recorded for the UK as a whole (0.35).

Time trend

- Between 1996/97 and 2005/06, despite fluctuations, there was no significant change in income inequality as measured by the Gini coefficient (Figure E1).

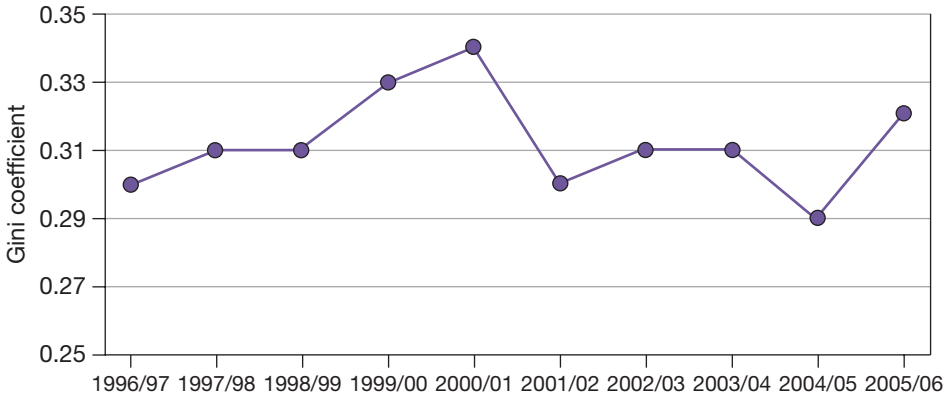
Equalities

- It has not been possible to look at equalities for the Gini coefficient because of risk of disclosure and sample size when disaggregating the Family Resources Survey into smaller units.

Limitations of the data

Equalities analysis was not possible on the basis of current information for the reasons outlined above.

Figure E1 **Gini coefficient, Scotland: 1996/97–2005/06**



SOCIAL INCLUSION

Worklessness

Key findings

- In 2006, 9% of adults (aged 16–59/64 but excluding students) reported that they were 'workless': either unemployed or economically inactive and wanting work.
- Between 1999 and 2006, worklessness among adults reduced significantly from 12% to 9%.
- Age and area deprivation were significantly associated with worklessness. Worklessness was significantly higher among young adults (aged 16–24) and those living in the most deprived communities.

Measure

Percentage of adults (women aged 16–59 and men aged 16–64), excluding students, who are unemployed or economically inactive and who want to work

Data source

Data for this indicator are from the *Labour Force Survey/Annual Population Survey* 1999–2006. Data for 1999 to 2003 are from the *Labour Force Survey*. From 2004, results are from the *Annual Population Survey* (APS), which is the *Labour Force Survey* plus a Scottish 'boost' to increase the sample size. Results relate to working-age adults (women aged 16–59, men aged 16–64).

Point estimate

- In 2006, 9% of adults (women aged 16–59 and men aged 16–64) were 'workless' (unemployed or economically active and wanting work).

Time trend

- Between 1999 and 2006, there was a significant reduction in the proportion of adults (aged 16–59/64) classified as 'workless', from 12% to 9% (Figure SI1).

Equalities

- In 2006, there were no significant differences in rates of worklessness between men and women.
- Age was significantly associated with worklessness. Adults aged 16–24 had a significantly higher rate of worklessness (13%) than those aged 25–49 and 50+ (both 8%) (Figure SI2).

- Area deprivation was also significantly associated with worklessness. Rates of worklessness in the two most deprived Scottish Index of Multiple Deprivation (SIMD) quintiles (19% and 10%) were significantly higher than in the two least deprived quintiles (6% and 4%) (Figure SI3).

Limitations of the data

No limitations were identified.

Figure SI1 **Percentage of working-age adults (aged 16–59/64) who were workless: 1999–2006**

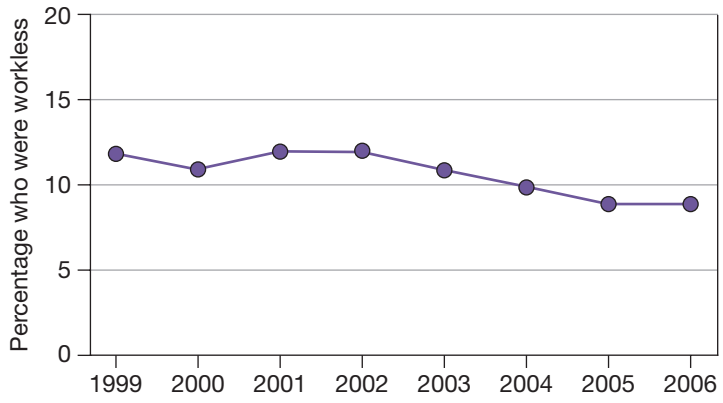


Figure SI2 **Percentage of working-age adults (aged 16–59/64) who were workless, by age band: 2006**

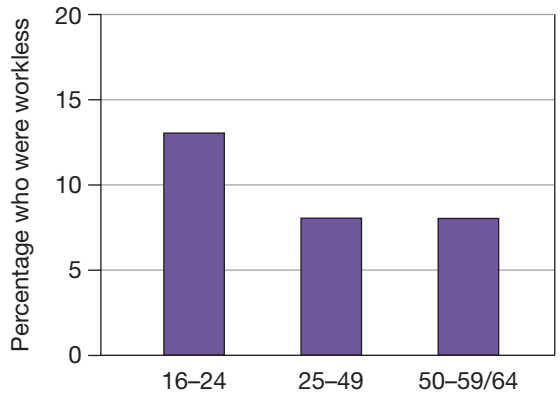
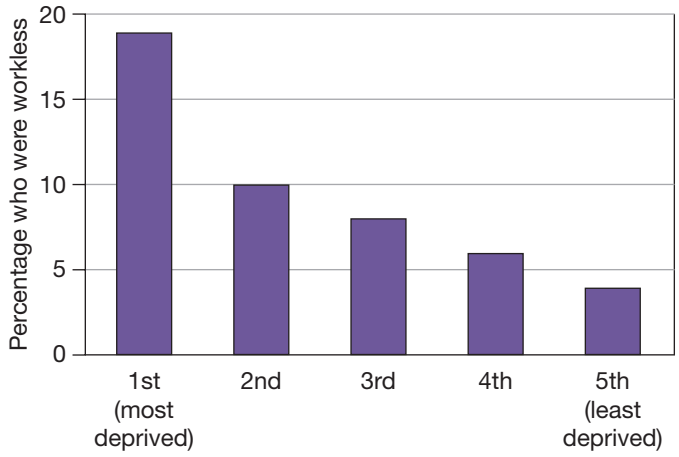


Figure SI3 **Percentage of working-age adults (aged 16–59/64) who were workless, by SIMD quintile: 2006**



SOCIAL INCLUSION

Education

Key findings

- In 2006, 86% of working-age adults (aged 16–59/64) held at least one academic or vocational qualification.
- Between 1999 and 2006, there was a statistically significant increase in the proportion of adults with at least one qualification, from 82% to 86%.
- Gender, age and area deprivation were significantly associated with education. Women, the over-50s and those living in deprived areas were more likely to lack qualifications.

Measure

Percentage of adults (women aged 16–59 and men aged 16–64) with at least one academic or vocational educational qualification

Data source

Data for this indicator are from the *Labour Force Survey/Annual Population Survey* 1999–2006. Data for 1999 to 2003 are from the *Labour Force Survey*. From 2004, results are from the *Annual Population Survey* (APS), which is the *Labour Force Survey* plus a Scottish 'boost' to increase the sample size. Results relate to working-age adults (women aged 16–59, men aged 16–64).

Point estimate

- In 2006, 86% of adults (women aged 16–59 and men aged 16–64) held at least one academic or vocational qualification.

Time trend

- Between 1999 and 2006, the proportion of adults aged 16–59/64 with at least one formal qualification increased significantly from 82% to 86% (Figure SI4).

Equalities

- In 2006, gender, age and Scottish Index of Multiple Deprivation (SIMD) area deprivation were significantly associated with likelihood of holding formal qualifications.
- Men were significantly more likely than women to have at least one formal qualification (88% compared with 85% – Figure SI5).

- Older working-age people (aged 50–59/64) were significantly less likely to have formal qualifications: 78% held formal qualifications (Figure SI5).
- The proportion of working-age adults with at least one qualification decreased significantly with each subsequent SIMD deprivation quintile. Although nearly 95% of working-age adults in the least deprived SIMD quintile held at least one qualification, this fell to 72% in the most deprived quintile (Figure SI6).

Limitations of the data

No limitations were identified.

Figure SI4 **Percentage of working-age adults (16–59/64) with at least one academic or vocational qualification: 1999–2006**

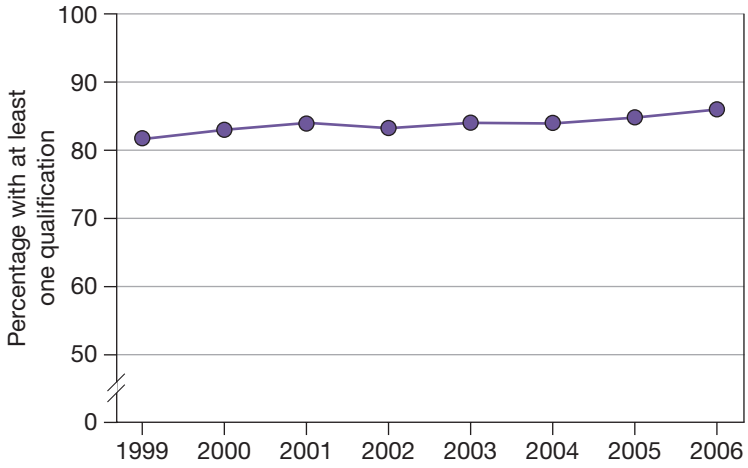


Figure SI5 **Percentage of working-age adults (16–59/64) with at least one academic or vocational qualification, by gender and by age band: 2006**

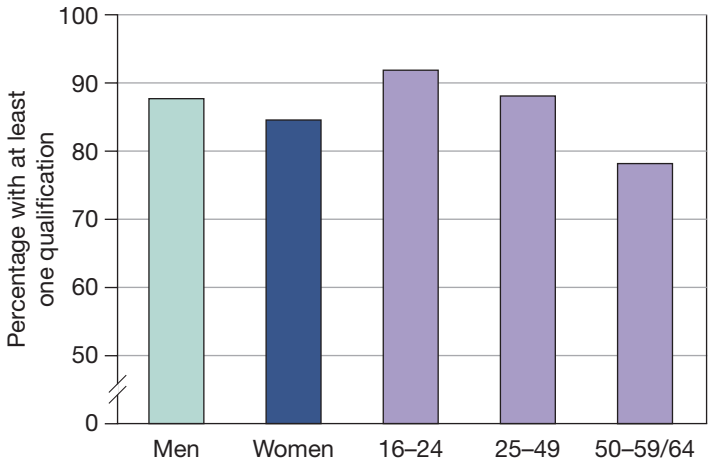
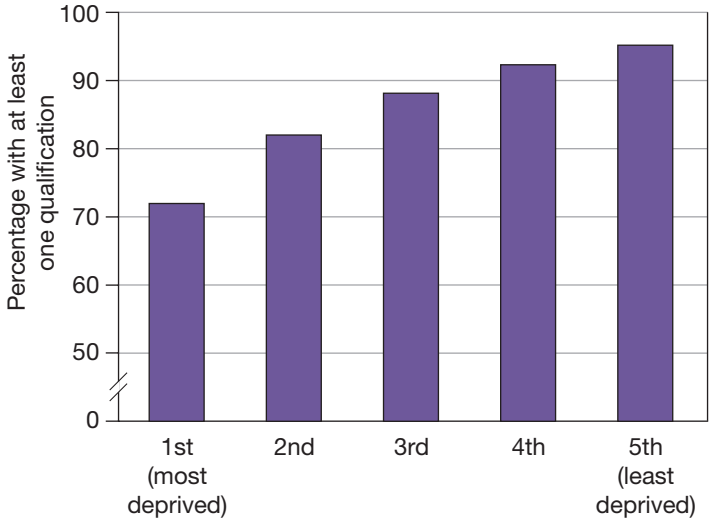


Figure SI6 **Percentage of working-age adults (16–59/64) with at least one academic or vocational qualification, by SIMD quintile: 2006**



Discrimination

Measure

Percentage of adults who report having been unfairly treated or discriminated against in the past year

Data source

No data currently exist for this indicator. From 2009, the source for this indicator will be the *Scottish Health Survey* for adults aged 16+.

DISCRIMINATION

Racial discrimination

Key findings

- In 2006, 19% of adults (aged 16+) believed that racial discrimination was a big problem in Scotland.
- Time trend data are not yet available for this indicator.
- Women, young adults and those classified as living in 'struggling singles' areas were significantly more likely to believe that racial discrimination was a big problem in Scotland.

Measure

Percentage of adults who think that racial discrimination is a big problem in Scotland

Data source

Data for this indicator are from the *Scottish Crime and Victimisation Survey* (SCVS) 2006 for adults aged 16+.

From 2008, the SCVS has been renamed the *Scottish Crime and Justice Survey*.

Point estimate

- In 2006, 19% of adults (aged 16+) reported that they thought racial discrimination was a big problem in Scotland.

Time trend

- Changes to this question over the survey series precluded time trend analysis.

Equalities

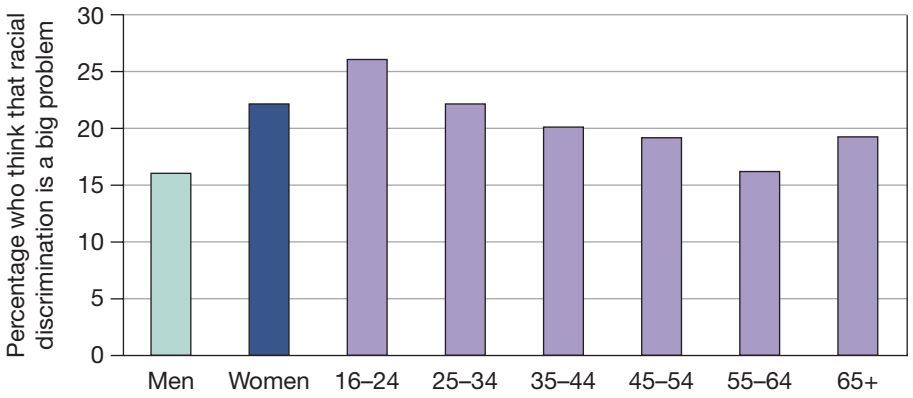
- In 2006, women were significantly more likely than men (22% compared with 16%) to think that racial discrimination was a big problem (Figure D1).
- Young adults (aged 16–24) were significantly more likely than those aged 65+ to think that racial discrimination was a big problem in Scotland: 26% compared with 19% (Figure D1).

- Analysis of area type using ACORN (A Classification Of Residential Neighbourhoods)[xii] showed a significant association between area type and perceiving racial discrimination as a big problem. Those living in 'struggling singles' areas were more likely (28%) to believe that racial discrimination was a big problem than those living in areas classified as 'traditionally comfortable' (18%), 'rural areas' (15%), 'older prosperity' (15%) or 'affluent families' (13%) (Figure D2).

Limitations of the data

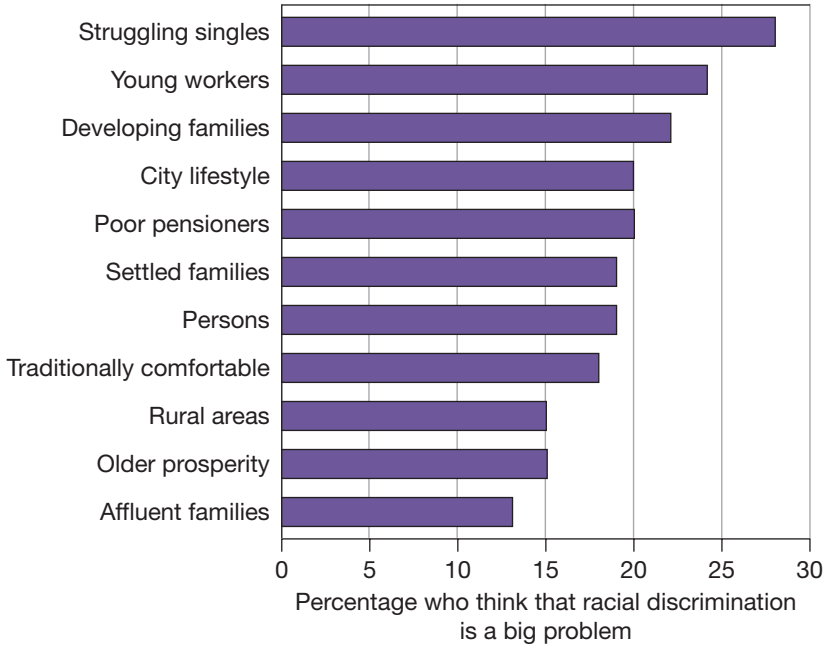
Time trend analysis was not possible due to changes in the question and the SCVS series. It was not possible to analyse results by Scottish Index of Multiple Deprivation quintile since the SCVS did not record respondents' data-zone of residence.

Figure D1 **Percentage of adults aged 16+ who think that racial discrimination is a big problem in Scotland, by gender and by age band: 2006**



xii ACORN is a geographical market research tool. It describes neighbourhoods by the characteristics of the people who live there. Originally developed by Richard Webber, it uses a mix of Census, financial and survey data to group UK postcodes into 10 main categories. Appendix 5 gives examples of the types of households in each ACORN group.

Figure D2 **Percentage of adults aged 16+ who think that racial discrimination is a big problem in Scotland, by ACORN group: 2006**



DISCRIMINATION

Harassment

Measure

Percentage of adults who have personally experienced harassment or abuse in the past year due to discrimination

Data source

No data currently exist for this indicator. From 2009, the source for this indicator will be the *Scottish Health Survey* for adults aged 16+.

FINANCIAL SECURITY/DEBT

Financial management

Key findings

- In 2006, 49% of adults (aged 16+) reported that their household managed very or quite well financially.
- Between 1999 and 2006, the proportion of adults reporting that their household managed very or quite well financially increased significantly from 41% to 49%.
- Gender, age and area deprivation were significantly associated with differences in the level of financial management. Women, young people (aged 16–24) and those in more deprived communities were significantly less likely to report that their household was managing very or quite well financially.

Measure

Percentage of households managing very or quite well financially these days

Data source

Data for this indicator are from the *Scottish Household Survey* (SHoS) 1999–2006 for adults aged 16+, highest income householder or spouse/partner.

Point estimate

- In 2006, 49% of adults (aged 16+) reported that their household managed very or quite well financially.

Time trend

- Between 1999 and 2006, the proportion of adults reporting that their household managed very or quite well financially increased significantly from 41% to 49% (Figure FSD1).

Equalities

- In 2006, gender and age were both significantly associated with financial management. Young adults (aged 16–24) and women were least likely to report that their household managed well financially (Figure FSD2).
- There was a significant association between Scottish Index of Multiple Deprivation (SIMD) area deprivation and financial management. The proportion of adults reporting that they managed well financially increased as deprivation decreased (Figure FSD3).

Limitations of the data

There is a break in the time series. The SHoS did not ask this question in 2003.

Figure FSD1 **Percentage of adults aged 16+ reporting that their household was managing very or quite well financially: 1999–2006**

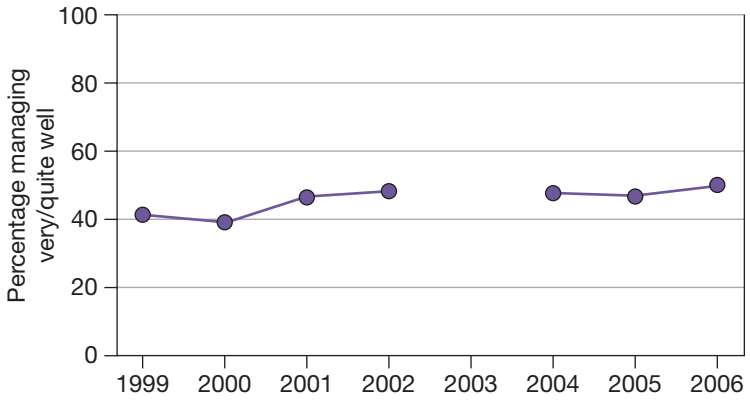


Figure FSD2 **Percentage of adults aged 16+ reporting that their household was managing very or quite well financially, by gender and by age band: 2006**

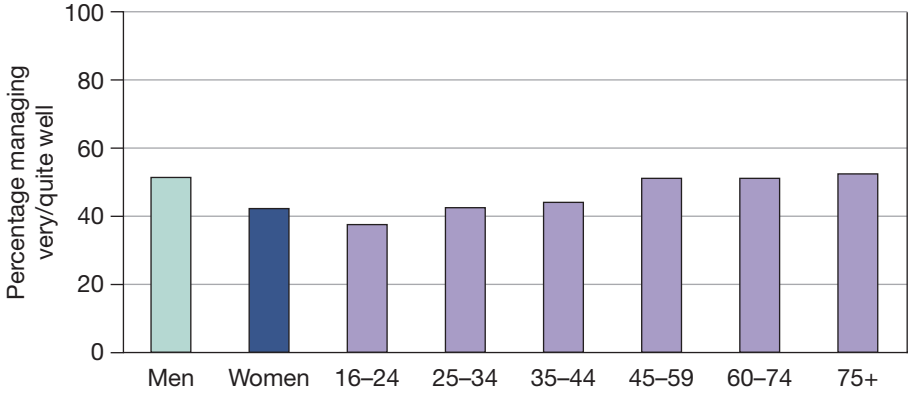
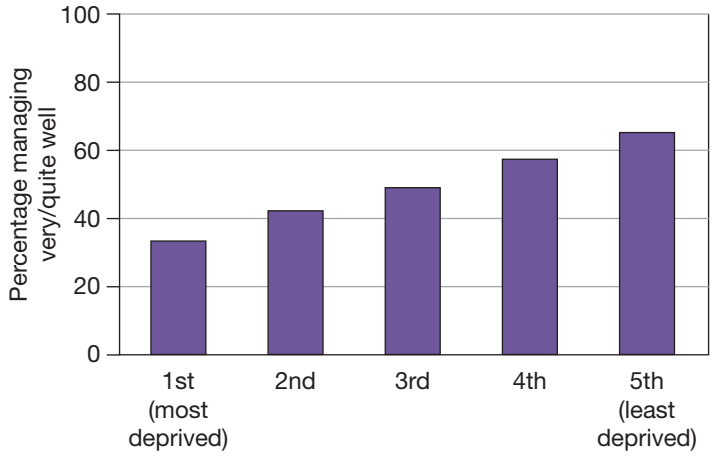


Figure FSD3 **Percentage of adults aged 16+ reporting their household was managing very or quite well financially, by SIMD quintile: 2006**



FINANCIAL SECURITY/DEBT

Financial inclusion

Key findings

- In 2006, levels of financial inclusion were high: 98% of households had access to a bank, building society, credit union or post office card account.
- Between 1999 and 2006, the proportion of households with access to a bank or building society account increased significantly from 86% to 91%.
- Gender and area deprivation were all significantly associated with differences in levels of financial inclusion. Households headed by women and adults resident in more deprived areas were less likely to have access to a bank, building society, credit union or post office card account.

Measure

Percentage of households with access to a bank account, building society account, credit union account or post office card account

Data source

Data for this indicator are from the *Scottish Household Survey* 1999–2006 for adults aged 16+, highest income householder or spouse/partner.

The 2006 point estimate and Scottish Index of Multiple Deprivation (SIMD) analysis is based on households with access to a bank/building society/credit union account or post office card account. Due to changes in response options, time trend data show the proportion of Scottish households with access to a bank or building society account only.

Point estimate

- In 2006, 98% of households reported that they had access to a bank/building society/credit union account or post office card account.

Time trend

- Looking at bank/building society accounts only, between 1999 and 2006 the proportion of households with an account increased significantly from 86% to 91% (Figure FSD4).

Equalities

- In 2006, women were less likely than men to have access to a bank/building society/credit union or post office card account (97% compared with 98%), a small, but statistically significant, difference (Figure FSD5).
- Age was not associated with significant differences in access to a bank/building society/ credit union or post office card account.
- Access to a bank/building society/credit union or post office card account was significantly associated with Scottish Index of Multiple Deprivation (SIMD) area deprivation. In the most deprived quintile, 95% of households had access to an account, compared with 98% or higher in the other quintiles (Figure FSD6).

Limitations of the data

Respondents were asked about credit union accounts only from 2002 and post office card accounts from 2004, creating discontinuity in the time series, unless, as has been done here, data are adjusted to show bank/building society details only.

Figure FSD4 **Percentage of households with access to a bank or building society account: 1999–2006**

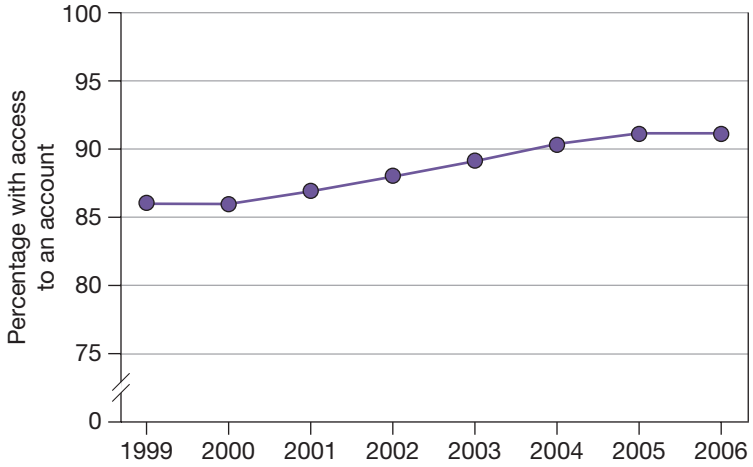


Figure FSD5 **Percentage of households with access to a bank, building society, post office or credit union account, by gender of highest income householder: 2006**

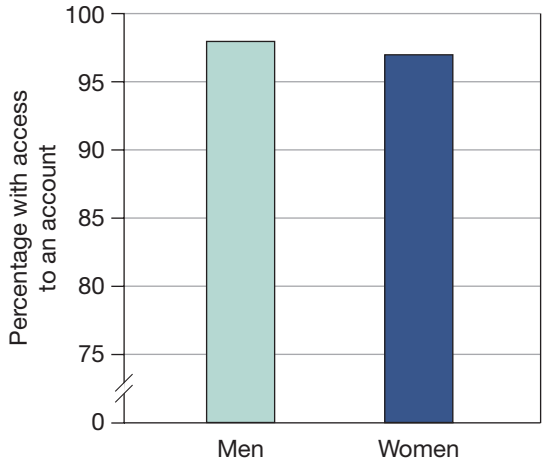
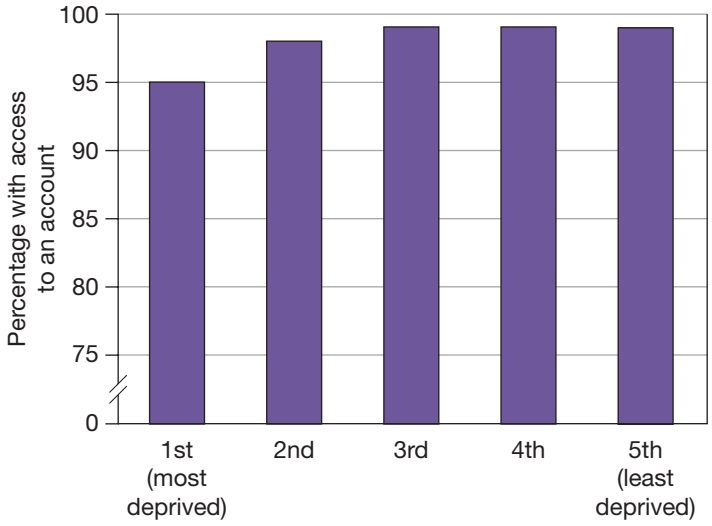


Figure FSD6 **Percentage of households with access to a bank, building society, post office or credit union account, by SIMD quintile: 2006**



PHYSICAL ENVIRONMENT

Neighbourhood satisfaction

Key findings

- In 2006, 92% of adults (aged 16+) rated their neighbourhood as a very or fairly good place to live.
- Between 1999 and 2006, neighbourhood satisfaction increased slightly, but significantly, from 91% to 92%.
- Gender, age and area deprivation were significantly associated with neighbourhood satisfaction. Neighbourhood satisfaction was significantly lower among women, those aged 16–34 and adults living in the most deprived communities.

Measure

Percentage of adults who rate their neighbourhood as a very or fairly good place to live

Data source

Data for this indicator are from the *Scottish Household Survey* (SHoS) 1999–2006 for adults aged 16+.

Point estimate

- In 2006, 92% of adults (aged 16+) rated their neighbourhood as a very or fairly good place to live.

Time trend

- Between 1999 and 2006, neighbourhood satisfaction among adults increased slightly but significantly, from 91% to 92% (Figure PE1).

Equalities

- In 2006, men were slightly but significantly more likely than women to rate their neighbourhood as a very or fairly good place to live (93% compared with 92% – Figure PE2).
- The proportion of adults who thought that their neighbourhood was a very or fairly good place to live increased with each 10-year age band, from 86% among those aged 16–24 to 96% among those aged 75+. Adults aged 16–34 were significantly less likely to rate their neighbourhood as very or fairly good than those aged 45 and above (Figure PE2).

- Neighbourhood satisfaction was also significantly associated with Scottish Index of Multiple Deprivation (SIMD) area deprivation. Neighbourhood satisfaction was significantly lower in the two most deprived quintiles than in the two least deprived quintiles. Neighbourhood satisfaction was lowest of all (78%) in the most deprived quintile, which was also significantly lower than the second most deprived quintile (Figure PE3).

Limitations of the data

No limitations were identified.

Figure PE1 **Percentage of adults aged 16+ rating neighbourhood as very/fairly good place to live: 1999–2006**

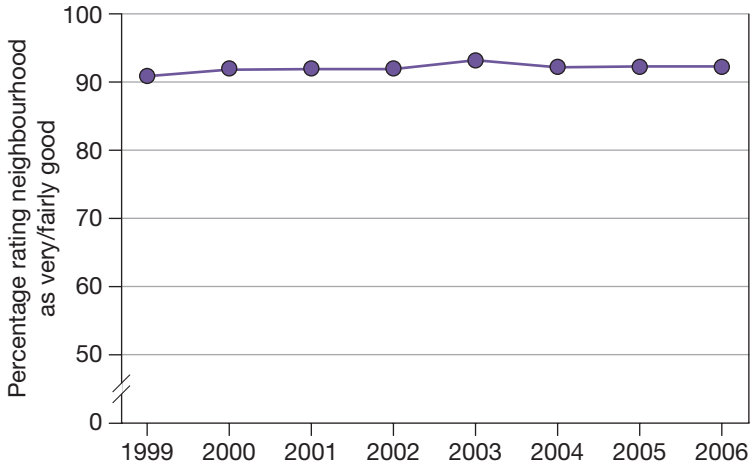


Figure PE2 **Percentage of adults aged 16+ rating neighbourhood as very/fairly good place to live, by gender and by age band: 2006**

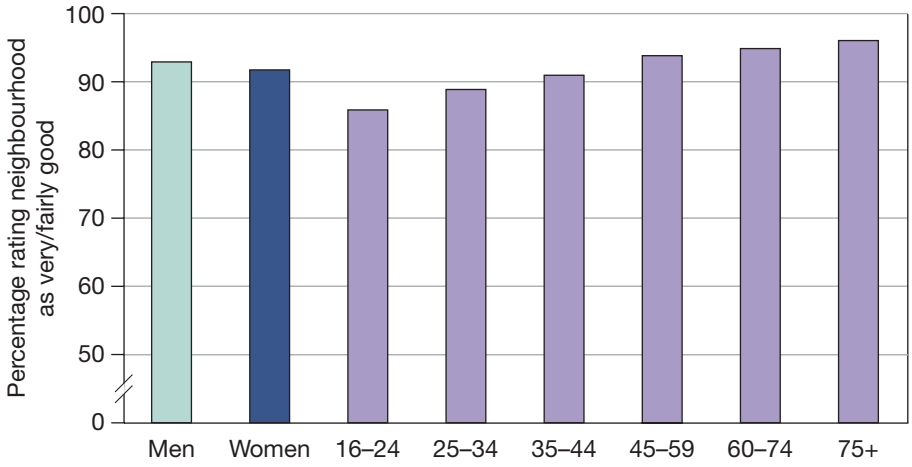
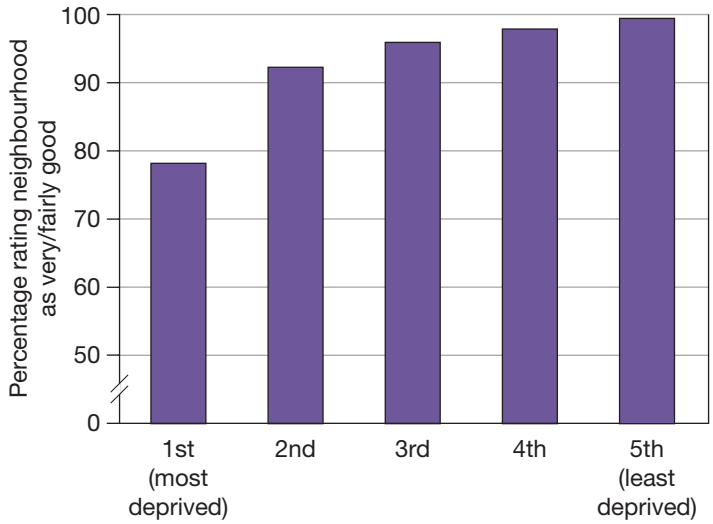


Figure PE3 **Percentage of adults aged 16+ rating neighbourhood as a very/fairly good place to live, by SIMD quintile: 2006**



PHYSICAL ENVIRONMENT

Noise

Key findings

- In 2005/06, 13% of adults (aged 16+) reported that they were bothered often or fairly often by noise when home indoors.
- Between 2002 and 2005/06, the proportion of adults reporting that they were bothered by noise often or fairly often did not change significantly.
- Gender, age and area deprivation were significantly associated with likelihood of being bothered by noise. Women, adults under the age of 60 and those living in deprived communities were more likely to be bothered by noise.

Measure

Percentage of adults who are bothered often or fairly often by noise when home indoors

Data source

Data are from the *Scottish House Condition Survey* (SHCS) 2002, 2003/04 (October 2003 to September 2004) 2004/05 (October 2004 to September 2005) and 2005/06 (October 2005 to September 2006). Respondents are adults aged 16+ who are the highest income householder or spouse/partner.

Point estimate

- In 2005/06, 13% of adults (aged 16+) reported that they were bothered often or fairly often by noise when indoors at home.

Time trend

- Between 2002 and 2005/06, the proportion of adults reporting that they were bothered often or fairly often by noise when indoors at home did not change significantly (Figure PE4).

Equalities

- In 2005/06, age, gender and area deprivation were significantly associated with being bothered often or fairly often by noise indoors.

- Men were significantly less likely than women (12% compared with 15%) and those aged 60+ were significantly less likely than the under-60s (9% compared with 16%) to report that they were often bothered by noise (Figure PE5).
- 21% of adults living in the most deprived Scottish Index of Multiple Deprivation (SIMD) quintiles reported being bothered by noise when indoors at home. This compared with 7% in the least deprived quintile (Figure PE6).

Limitations of the data

The sample size of SHCS was reduced from 18,000 in 2002 to 3,800 in 2003/04–2005/06 with the move to a continuous survey.

Figure PE4 **Percentage of adults aged 16+ often bothered by noise indoors at home: 2002–2005/06**

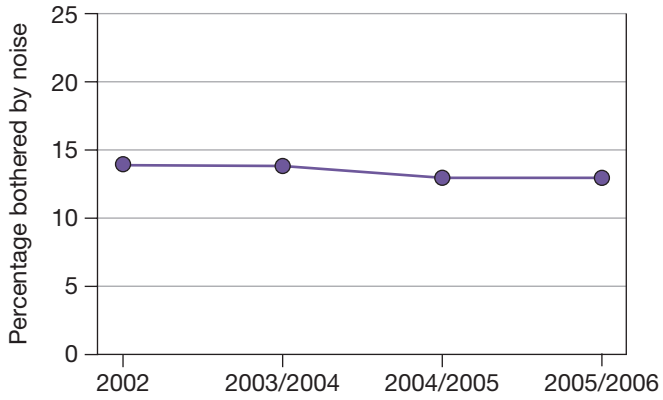


Figure PE5 **Percentage of adults aged 16+ often bothered by noise indoors at home, by gender and by age band: 2005/06**

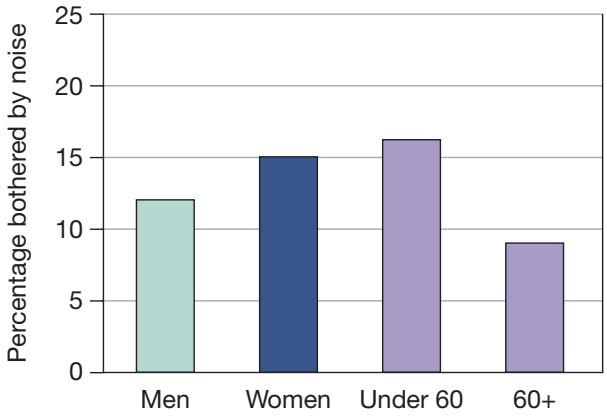
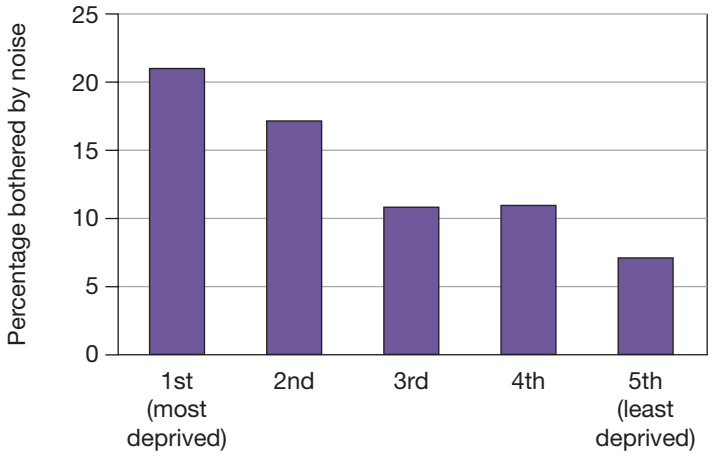


Figure PE6 **Percentage of adults aged 16+ often bothered by noise indoors at home, by SIMD quintile: 2005/06**



PHYSICAL ENVIRONMENT

Escape facility

Measure

Assessment of perceived availability of a valued safe place where an individual can and wants to go to to 'escape' from things

No data currently exist for this indicator. There is a need to develop a question that adequately captures its contribution to mental health (taking account of the fact that an escape facility may vary depending on individuals' living environment). This will allow relevant data on escape facilities to be collected.

PHYSICAL ENVIRONMENT

Greenspace

Measure

Percentage of adults who feel that they have a safe and pleasant park, green or other area of grass in their neighbourhood, excluding personal private garden space, which they and their family can use

Data source

The source for this indicator is the *Scottish Household Survey* (SHoS) from 2007.

Data were not available at the time of writing this report.

PHYSICAL ENVIRONMENT

House condition

Key findings

- In 2005/06, 84% of adults (aged 16+) rated the condition of their home as fairly or very good.
- Between 1996 and 2005/06, the proportion of adults rating their house condition as very or fairly good decreased significantly from 89% to 84%.
- Age, gender and area deprivation were significantly associated with perceived house condition. Adults aged 60+, men and people living in the two least deprived quintiles, were more likely to rate the condition of their home as fairly or very good.

Measure

Percentage of adults rating the condition of their house or flat as very or fairly good

Data source

Data are from the *Scottish House Condition Survey* (SHCS) 1996, 2002, 2003/04 (October 2003 to September 2004), 2004/05 (October 2004 to September 2005) and 2005/06 (October 2005 to September 2006). Respondents are adults aged 16+ who are the highest income householder or spouse/partner.

Point estimate

- In 2005/06, 84% of adults (aged 16+) rated the condition of their home as fairly or very good.

Time trend

- From 1996 to 2005/06, the proportion of adults rating their home condition as fairly or very good decreased significantly from 89% to 84% (Figure PE7).

Equalities

- In 2005/06, age, gender and Scottish Index of Multiple Deprivation (SIMD) area deprivation were significantly associated with rating house condition as fairly or very good.
- Men were significantly more likely than women to rate the condition of their home as very or fairly good (86% compared with 83% – Figure PE8). Adults aged 60+ were also significantly more likely than those aged under 60 to rate the condition of their home as very or fairly good (91% compared with 80% – Figure PE8).

- Adults in the two most deprived SIMD quintiles were significantly less likely to rate their house condition as fairly or very good than adults in the two least deprived quintiles. In the most deprived quintile, 73% of adults rated the condition of their home as fairly or very good, significantly lower than even the second most deprived quintile (Figure PE9).

Limitations of the data

The sample size of SHCS was reduced from 18,000 in 2002 to 3,800 in 2003/04–2005/06 with the move to a continuous survey.

Figure PE7 **Percentage of adults aged 16+ rating the condition of their home as fairly or very good: 1996–2005/06**

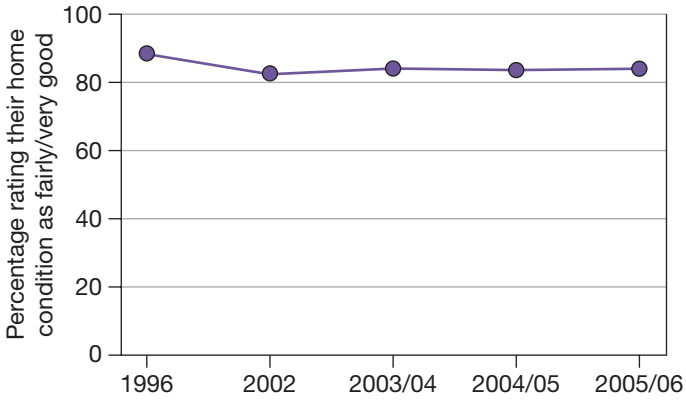


Figure PE8 **Percentage of adults aged 16+ rating the condition of their home as fairly or very good, by gender and by age band: 2005/06**

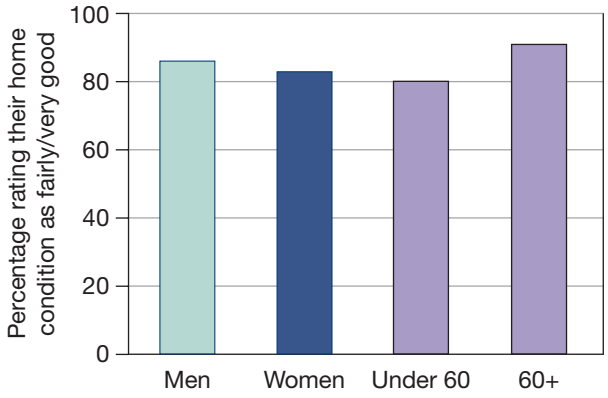
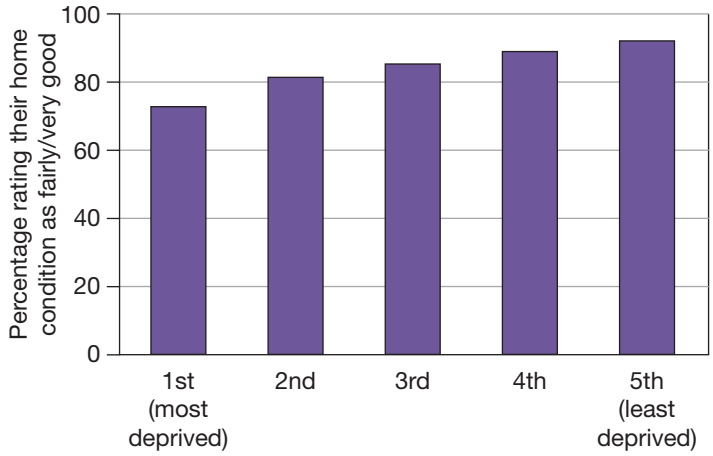


Figure PE9 **Percentage of adults aged 16+ rating the condition of their home as fairly or very good, by SIMD quintile: 2005/06**



PHYSICAL ENVIRONMENT

Overcrowding

Key findings

- In 2005/06, 16% of adults (aged 16+) thought that their home had too few rooms.
- Between 1996 and 2005/06, the proportion of adults who thought that their home had too few rooms increased slightly, but significantly, from 15% to 16%.
- The proportion of adults who thought that their home had too few rooms was significantly associated with gender, age and area deprivation. Men, those over the age of 60 and those living in the least deprived quintile were less likely to think that their home had too few rooms.

Measure

Percentage of adults who feel their home has too few rooms

Data source

Data are from *Scottish House Condition Survey* (SHCS) 1996, 2002, 2003/04 (October 2003 to September 2004), 2004/05 (October 2004 to September 2005) and 2005/06 (October 2005 to September 2006). Respondents are adults aged 16+ who are the highest income householder or spouse/partner.

Point estimate

- In 2005/06, 16% of adults (aged 16+) thought that their home had too few rooms.

Time trend

- Between 1996 and 2005/06, the proportion of adults who thought that their home had too few rooms increased slightly, but significantly, from 15% to 16% (Figure PE10).

Equalities

- In 2005/06, the proportion of adults who thought that their home had too few rooms was significantly related to age and gender. Women were significantly more likely than men to feel that their home has too few rooms (17% compared with 14%). On the other hand, adults aged 60+ were significantly less likely than those under the age of 60 to feel that their home has too few rooms (7% compared with 21%) (Figure PE11).

- Adults in the least deprived Scottish Index of Multiple Deprivation (SIMD) quintile were significantly less likely to feel that their home had too few rooms (10%) than those in the four remaining quintiles (16% or more) (Figure PE12).

Limitations of the data

The sample size of SHCS was reduced from 18,000 in 2002 to 3,800 in 2003/04–2005/06 with the move to a continuous survey.

Figure PE10 **Percentage of adults aged 16+ who feel that their home has too few rooms: 1996–2005/06**

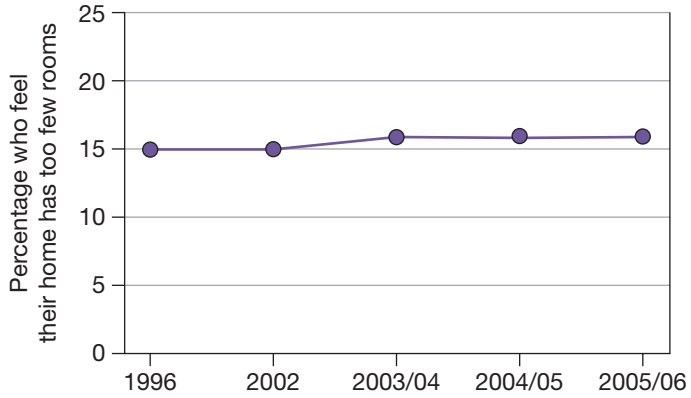


Figure PE11 **Percentage of adults aged 16+ who feel that their home has too few rooms, by gender and by age band: 2005/06**

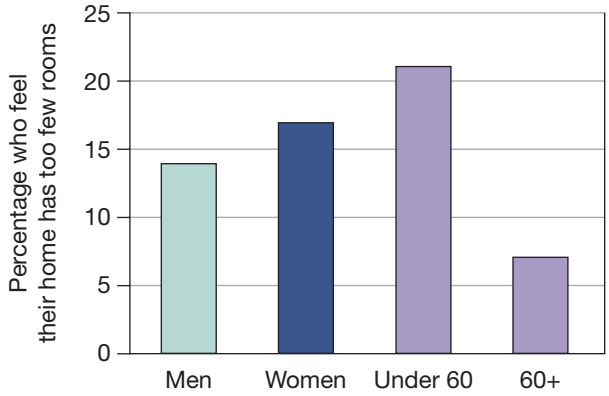
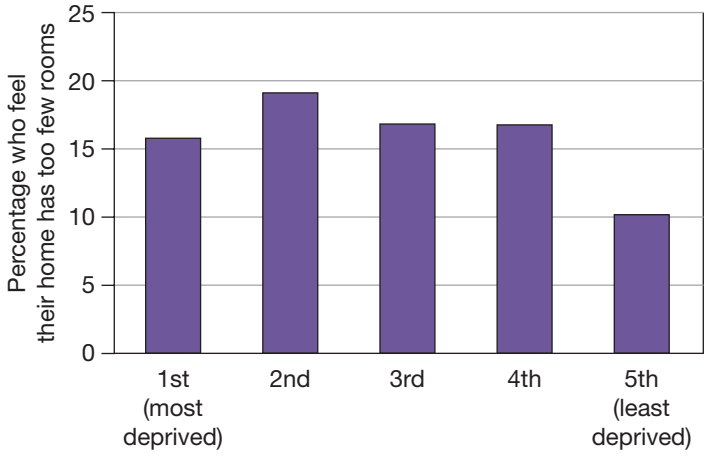


Figure PE12 **Percentage of adults aged 16+ who feel that their home has too few rooms, by SIMD quintile: 2005/06**



WORKING LIFE

Stress

Key findings

- In 2007, 10% of adults (aged 16–64) thought that their job was very or extremely stressful.
- Between 2004 and 2007, the proportion of adults reporting that their job was very or extremely stressful showed a tendency to decrease from 15% to 10% but this change was not significant.
- Using data combined from 2004 to 2007, adults working in managerial, professional or associate professional occupations were significantly more likely to report that their job was very or extremely stressful.

Measure

Percentage of adults who find their job very or extremely stressful

Data source

An interim source has been used for this indicator. Data are from the *Psychosocial Working Conditions Survey* (PWCS) 2004–2007 for adults aged 16–64. This included those in paid employment who stated that they were classified as employees or those who were self-employed and reported that they worked like an employee. Due to small sample sizes, equalities analysis combines data for the years 2004 to 2007.

From 2009, the source for this indicator will be the *Scottish Health Survey* (SHeS) for adults aged 16+.

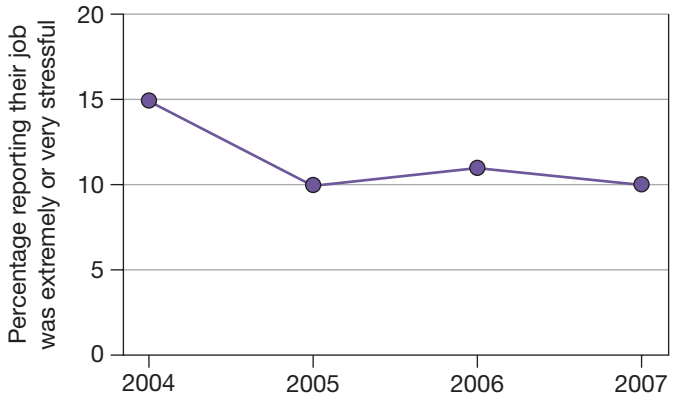
Point estimate

- In 2007, 10% of adults (aged 16–64) thought that their job was very or extremely stressful.

Time trend

- Between 2004 and 2007, the proportion of adults (aged 16–64) reporting that their job was very or extremely stressful fell from 15% to 10%. This change was not significant (Figure WL1), possibly because of the small Scottish sample size (around 100). The survey showed a significant reduction in stress over the same time period for the British population as a whole.

Figure WL1 **Percentage of adults aged 16–64 reporting that their job was extremely or very stressful: 2004–2007**



Equalities

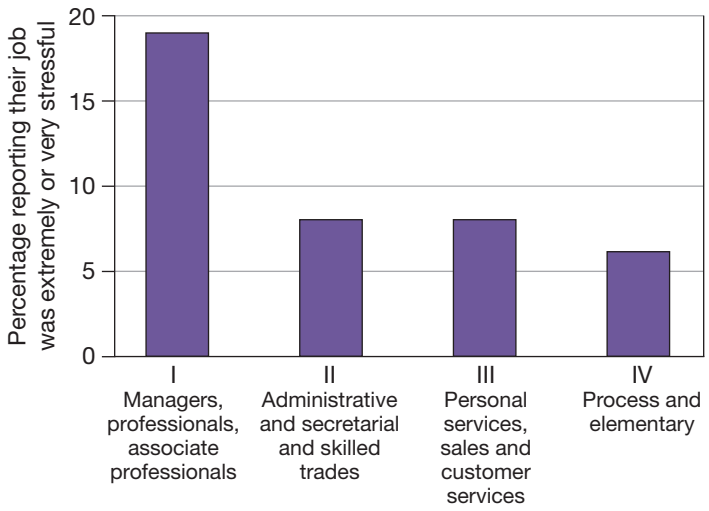
- In the period 2004 to 2007 (combined years), gender and age were not associated with significant differences in workplace stress.
- Likelihood of reporting that their job was very or extremely stressful was associated with broad occupation group.[xiii] People employed in category I occupations (managers, professionals and associate professionals) were significantly more likely to report that their job was very or extremely stressful (19%) than were those in other categories (5–8%) (Figure WL2).

Limitations of the data

The PWCS is a British survey with a very small Scottish sample, even when data from four years were combined for analysis. Analysis by Scottish Index of Multiple Deprivation was not possible as the PWCS did not record respondents' data-zone of residence. The inclusion of the question in the SHeS will provide better data in the future.

xiii The Standard Occupational Classification (SOC) divides individuals into nine categories based on job type, from managers and senior officials (1) to elementary occupations (9). For our analysis, occupations were divided by SOC into four broad categories: managers, professionals and associate professionals (I); administrative and secretarial staff and skilled workers (II); personal services, sales and customer service occupations (III); and process, plant and machine operatives and elementary occupations (IV).

Figure WL2 **Percentage of adults aged 16–64 reporting that their job was extremely or very stressful, by broad occupation: 2004 to 2007 combined**



WORKING LIFE

Work-life balance

Key findings

- In 2006, the mean score of satisfaction with work–life balance for adults (aged 16+) was 6.1 [measured on an 11-point scale, from zero (extremely dissatisfied) to 10 (extremely satisfied)].
- Time trend data are not yet available for this indicator.
- Level of satisfaction with work–life balance was not significantly associated with gender, age or highest level of educational attainment.

Measure

Mean score for how satisfied adults are with their work–life balance (paid work)

Respondents were asked to indicate how satisfied they were with the balance between the time they spend on their paid work and the time they spend on other aspects of their life, on an 11-point scale from zero (extremely dissatisfied) to 10 (extremely satisfied).

Data source

An interim source has been used for this indicator. Data are from the 2006 round of the *European Social Survey* (ESS) for adults aged 16+.

From 2009, the source for this indicator will be the *Scottish Health Survey* (SHeS) for adults aged 16+.

Point estimate

- In 2006, the mean score for satisfaction with their work–life balance for adults (aged 16+) was 6.1.

Time trend

- Time trend analysis was not possible for this indicator, since this question has only been asked in the 2006 round of the ESS.

Equalities

- In 2006, gender, age and educational attainment were not significantly associated with differences in satisfaction with work–life balance. This may, however, reflect small Scottish sample sizes.

Limitations of the data

The ESS was designed to produce robust results at EU member state (e.g. at UK) level. Scottish sample sizes are small, limiting its ability to detect real differences between population subgroups. The work–life balance question has been asked in one year only. Analysis by Scottish Index of Multiple Deprivation was not possible. The inclusion of the question in the SHeS will provide better data in the future.

WORKING LIFE

Demand

Key findings

- In 2007, 12% of adults (aged 16–64) reported that they often or always had unrealistic time pressures at work.
- Between 2004 and 2007, the proportion of adults reporting that they had unrealistic time pressures at work did not change significantly.
- Using combined data from 2004 to 2007, the proportion of adults reporting that they had unrealistic time pressures at work did not vary significantly by gender, age or broad occupational group.

Measure

Percentage of adults who often or always have unrealistic time pressures at work

Data source

An interim source has been used for this indicator. Data are from the *Psychosocial Working Conditions Survey* (PWCS) 2004–2007 for adults aged 16–64. This included those in paid employment who stated that they were classified as employees or those who were self-employed and reported that they worked like an employee. Due to small sample sizes, equalities analysis combines data for the years 2004 to 2007.

From 2009, the source for this indicator will be the *Scottish Health Survey* (SHeS) for adults aged 16+.

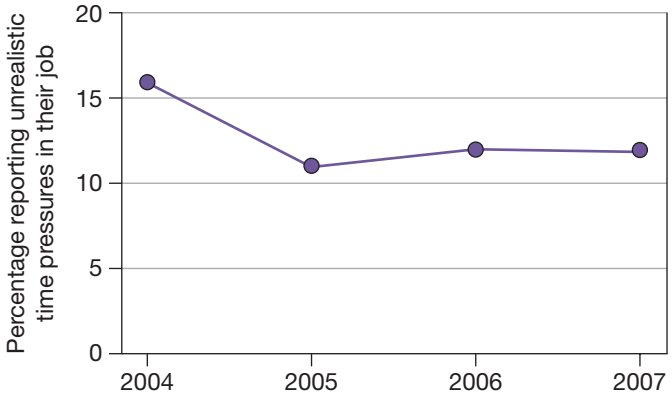
Point estimate

- In 2007, 12% of adults (aged 16–64) reported that they often or always had unrealistic time pressures at work.

Time trend

- Between 2004 and 2007, the proportion of adults reporting unrealistic time pressures at work reduced from 16% to 12%. However, this was not statistically significant (Figure WL3).

Figure WL3 **Percentage of adults aged 16–64 reporting that they often or always have unrealistic time pressures in their job: 2004–2007**



Equalities

- Using combined data from 2004 to 2007, neither gender nor age was associated with differences in the proportion of adults reporting that they had unrealistic time pressures at work.
- Broad occupational group[xiv] was not associated with significant differences in unrealistic time pressures at work.

Limitations of the data

The PWCS is a British survey with a very small Scottish sample, even when data from four years were combined for analysis. Analysis by Scottish Index of Multiple Deprivation was not possible as the PWCS does not record respondents' data-zones of residence. The inclusion of the question in the SHeS will provide better data in the future.

xiv The Standard Occupational Classification (SOC) divides individuals into nine categories based on job type, from managers and senior officials (1) to elementary occupations (9). For our analysis, occupations were divided by SOC into four broad categories: managers, professionals and associate professionals (I); administrative and secretarial staff and skilled workers (II); personal services, sales and customer service occupations (III); and process, plant and machine operatives and elementary occupations (IV).

WORKING LIFE

Control

Key findings

- In 2007, 59% of adults (aged 16–64) reported that they often or always had a choice in deciding the way that they do their work.
- Between 2004 and 2007, the proportion of adults with a choice over the way they do their work did not change significantly.
- Neither gender nor age was associated with significant differences in the level of choice adults reported having over the way they do their work.
- Using combined data from 2004 to 2007, occupation group was significantly associated with choice at work. Managers, professionals and associate professionals were significantly more likely to have choice over the way they do their work than those in other occupations.

Measure

Percentage of adults who often or always have a choice in deciding the way that they do their work

Data source

An interim source has been used for this indicator. Data are from the *Psychosocial Working Conditions Survey* (PWCS) 2004–2007 for adults aged 16–64. This included those in paid employment who stated that they were classified as employees or those who were self-employed and reported that they worked like an employee. Due to small sample sizes, equalities analysis combines data for the years 2004 to 2007.

From 2009, the source for this indicator will be the *Scottish Health Survey* (SHeS) for adults aged 16+.

Point estimate

- In 2007, 59% of adults (aged 16–64) reported that they often or always had a choice in deciding the way that they do their work.

Time trend

- The proportion of adults with choice over the way they do their work did not change significantly between 2004 and 2007 (Figure WL4).

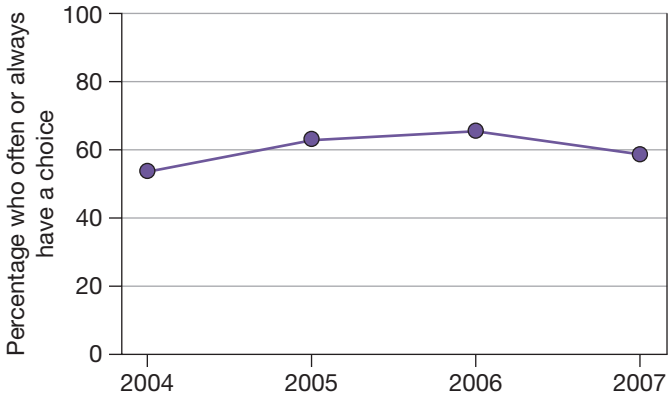
Equalities

- For the period 2004 to 2007 (combined), neither age nor gender was significantly associated with differences in the proportions of adults reporting control over their work. This may be because of small sample sizes.
- Broad occupation group[xv] was significantly associated with control at work. People employed in category I occupations (managers, professionals and associate professionals) were significantly more likely to have control over the way that they did their job (68%) than those in category III (personal services and sales and customer service occupations) (49%) and category IV (plant and machine operatives and elementary) occupations (55%) (Figure WL5).

Limitations of the data

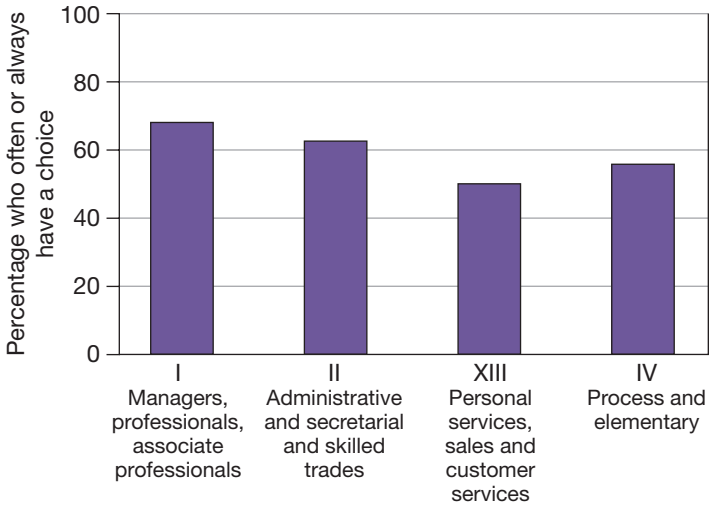
The PWCS is a British survey with a very small Scottish sample, even when data from four years were combined for analysis. The very small Scottish sample size limits its ability to detect real change over time. Analysis by Scottish Index of Multiple Deprivation was not possible as the PWCS did not record respondents' data-zones of residence. The inclusion of the question in the SHeS will provide better data in the future.

Figure WL4 **Percentage of adults aged 16–64 reporting that they often or always have a choice in deciding the way they do their work: 2004–2007**



xv The Standard Occupational Classification (SOC) divides individuals into nine categories based on job type, from managers and senior officials (1) to elementary occupations (9). For our analysis, occupations were divided by SOC into four broad categories: managers, professionals and associate professionals (I); administrative and secretarial staff and skilled workers (II); personal services, sales and customer service occupations (III); and process, plant and machine operatives and elementary occupations (IV).

Figure WL5 **Percentage of adults aged 16–64 reporting that they often or always have a choice in deciding the way that they do their work, by broad occupation: 2004 to 2007 combined**



WORKING LIFE

Manager support

Key findings

- In 2007, 62% of adults (aged 16–64) strongly or tended to agree that their line manager encourages them at work.
- Between 2004 and 2007, the proportion of adults who agreed that their line manager encourages them at work decreased significantly from 74% to 62%.
- Manager support did not differ significantly by gender, age or broad occupational group.

Measure

Percentage of adults who strongly or tend to agree that their line manager encourages them at work

Data source

An interim source has been used for this indicator. Data are from the *Psychosocial Working Conditions Survey* (PWCS) 2004–2007 for adults aged 16–64. This included those in paid employment who stated that they were classified as employees or those who were self-employed and reported that they worked like an employee. Equalities analysis combines data for the years 2004 to 2007.

From 2009, the source for this indicator will be the *Scottish Health Survey* (SHeS) for adults aged 16+.

Point estimate

- In 2007, 62% of adults (aged 16–64) agreed that their manager encourages them at work.

Time trend

- Between 2004 and 2007, the proportion of adults who agreed that their manager encourages them at work decreased significantly from 74% to 62% (Figure WL6).

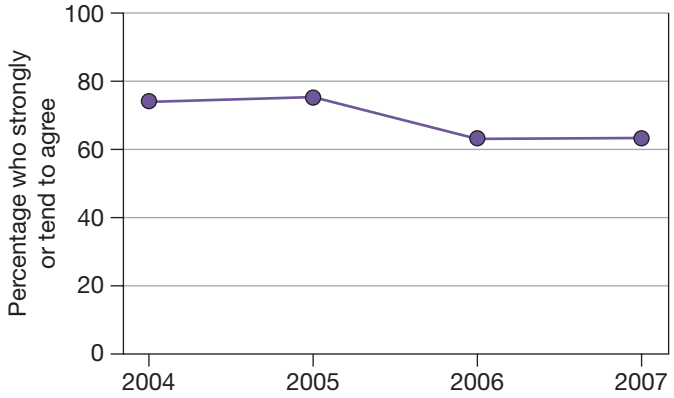
Equalities

- For the period 2004 to 2007 (combined data), there were no significant differences in reported levels of manager support between men and women, by age or by broad occupation group.[xvi]

Limitations of the data

The PWCS is a British survey with a very small Scottish sample, even when data from four years were combined for analysis. Analysis by Scottish Index of Multiple Deprivation was not possible as the PWCS does not record respondents' data-zones of residence. The inclusion of the question in the SHeS will provide better data in the future.

Figure WL6 **Percentage of adults aged 16–64 who strongly or tend to agree that their line manager encourages them: 2004–2007**



xvi The Standard Occupational Classification (SOC) divides individuals into nine categories based on job type, from managers and senior officials (1) to elementary occupations (9). For our analysis, occupations were divided by SOC into four broad categories: managers, professionals and associate professionals (I); administrative and secretarial staff and skilled workers (II); personal services, sales and customer service occupations (III); and process, plant and machine operatives and elementary occupations (IV).

WORKING LIFE

Colleague support

Key findings

- In 2007, 75% of adults (aged 16–64) strongly or tended to agree that they got the help and support they need from colleagues at work.
- Between 2004 and 2007, the proportion of adults reporting that they got the help and support they need from work colleagues did not change significantly.
- Using combined data from 2004 to 2007, differences in the level of colleague support were not significantly associated with gender, age or occupation group.

Measure

Percentage of adults who strongly or tend to agree that they get the help and support they need from colleagues at work

Data source

An interim source has been used for this indicator. Data are from the *Psychosocial Working Conditions Survey* (PWCS) 2004–2007 for adults aged 16–64. This included those in paid employment who stated that they were classified as employees or those who were self-employed and reported that they worked like an employee. Equalities analysis combines data for the years 2004 to 2007.

From 2009, the source for this indicator will be the *Scottish Health Survey* (SHeS) for adults aged 16+.

Point estimate

- In 2007, 75% of adults (aged 16–64) agreed that they got the help and support they need from colleagues.

Time trend

- Between 2004 and 2007, levels of reported colleague support did not change significantly (Figure WL7).

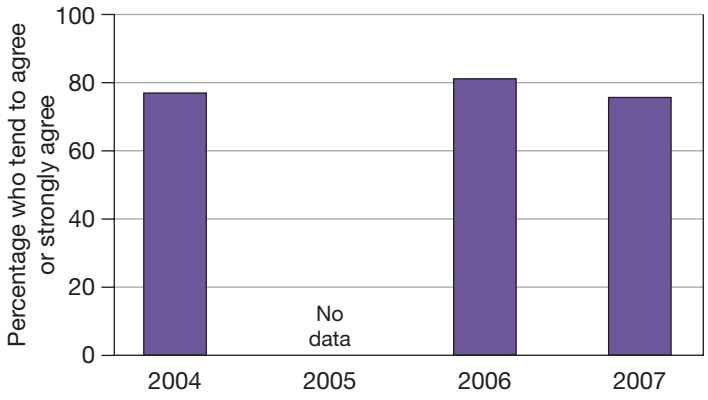
Equalities

- Using combined data for the period 2004 to 2007, neither gender nor age was significantly associated with differences in the level of reported colleague support.
- Broad occupational group[xvii] was not significantly associated with differences in the level of colleague support.

Limitations of the data

The question on support from colleagues at work was not included in the 2005 survey. The PWCS is a British survey with a very small Scottish sample, even when data from three years were combined for analysis. The small yearly Scottish sample size of the PWCS limits its ability to detect real change over time. Analysis by Scottish Index of Multiple Deprivation was not possible as the PWCS does not record respondents' data-zones of residence. The inclusion of the question in the SHeS will provide better data in the future.

Figure WL7 **Percentage of adults aged 16–64 who tend to agree/strongly agree that they get the help and support they need from work colleagues: 2004, 2006 and 2007**



xvii The Standard Occupational Classification (SOC) divides individuals into nine categories based on job type, from managers and senior officials (1) to elementary occupations (9). For our analysis, occupations were divided by SOC into four broad categories: managers, professionals and associate professionals (I); administrative and secretarial staff and skilled workers (II); personal services, sales and customer service occupations (III); and process, plant and machine operatives and elementary occupations (IV).

VIOLENCE

Partner abuse

Key findings

- In 2006, 3% of adults (aged 16+) reported being physically or emotionally abused by a partner or an ex-partner in the last 14–20 months.
- Time trend data are not yet available for this indicator.
- Gender, age and area type were significantly associated with partner abuse. Women, those aged 16–34 and adults in neighbourhoods classified as 'struggling singles' were significantly more likely to have been abused by their partner or ex-partner in the last 14–20 months.

Measure

Percentage of adults physically or emotionally abused by a partner or an ex-partner in the last 14–20 months

The 2006 measure used in this report, as given above, is an interim one that differs from the one used in the indicator set.

From 2008, the measure will be: *percentage of adults (aged 16+) reporting being physically or emotionally abused by a partner or ex-partner in the past year.* Results presented in this report will not be directly comparable with data available from 2008.

Data source

Data presented here are from the partner abuse module of the *Scottish Crime and Victimisation Survey* (SCVS) 2006 for adults aged 16+.

From 2008, the SCVS has been renamed the *Scottish Crime and Justice Survey*.

Point estimate

- In 2006, 3% of adults (aged 16+) reported having been physically or emotionally abused by a partner or an ex-partner in the last 14–20 months.

Time trend

- Changes to the SCVS survey methodology over the years mean that it is not possible to produce a time trend for this indicator.

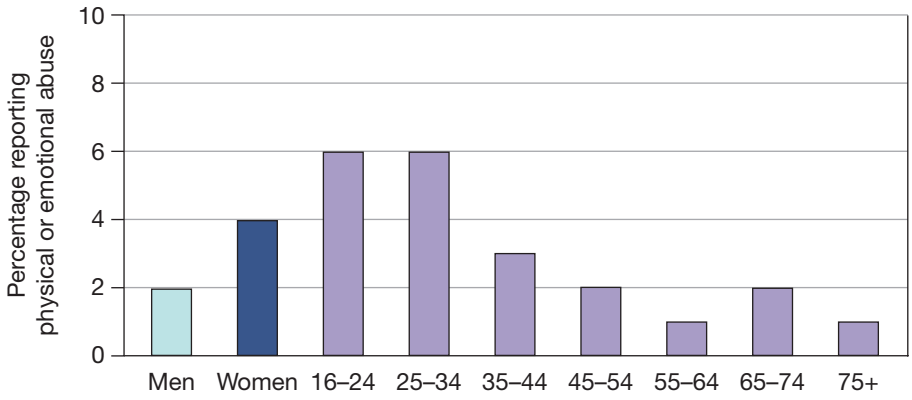
Equalities

- In 2006, women were twice as likely as men (4% compared with 2%) to have experienced partner abuse (Figure V1). This is a statistically significant difference.
- Prevalence of partner abuse was significantly associated with age and more common in younger than in older individuals. Adults aged 16–34 were significantly more likely (6%) to report having experienced partner abuse than those aged 35 and older (Figure V1).
- Analysis of area type using ACORN (A Classification Of Residential Neighbourhoods)[xviii] showed that adults living in areas classified as 'struggling singles' were significantly more likely to have experienced partner abuse than those classified as 'affluent families', 'older prosperity', 'traditionally comfortable' and 'rural areas' (Figure V2).

Limitations of the data

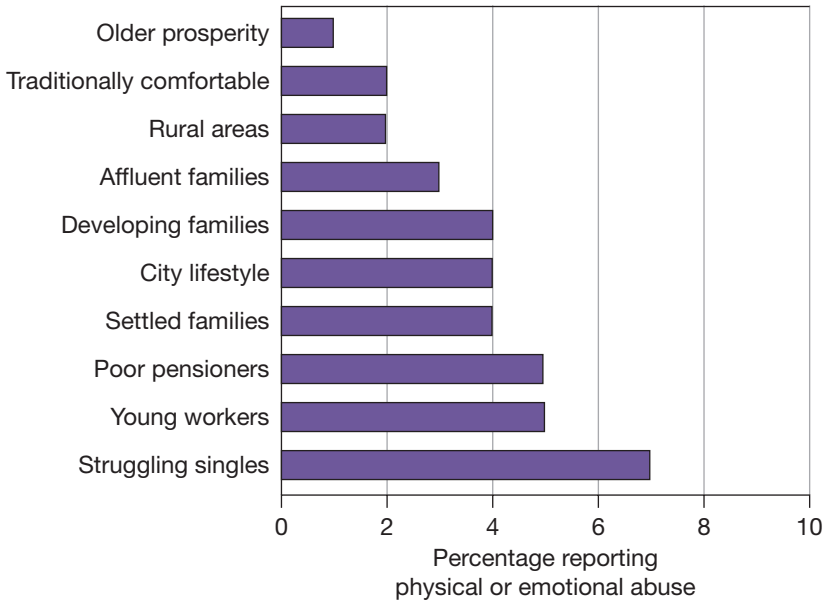
The definition of partner abuse used in the SCVS is slightly narrower than that used by the police and the National Strategy to Address Domestic Abuse in Scotland and it is therefore likely that it underestimates the true level of abuse. It was not possible to analyse results by Scottish Index of Multiple Deprivation quintile since the SCVS did not record respondents' data-zone of residence.

Figure V1 **Percentage of adults aged 16+ reporting physical or emotional abuse by a partner, by gender and by age band: 2006**



xviii ACORN (A Classification Of Residential Neighbourhoods) is a geographical market research tool. It describes neighbourhoods by the characteristics of the people who live there. Originally developed by Richard Webber, it uses a mix of Census, financial and survey data to group UK postcodes into 10 main categories. Appendix 5 gives examples of the types of household in each ACORN group.

Figure V2 **Percentage of adults aged 16+ reporting physical or emotional abuse by a partner, by ACORN group: 2006**



VIOLENCE

Neighbourhood violence

Measure

Percentage of adults who have experienced violence, excluding violence by a household member, occurring locally in the past year

The definition of 'violence' used here covers assault and robbery and 'locally' means within 15 minutes' walk from the victim's home, as defined by the *Scottish Crime and Victimisation Survey* (SCVS) (http://openscotland.gov.uk/Publications/2007/10/12094216/11).

Data source

The source for this indicator is the *Scottish Crime and Victimisation Survey* (SCVS) 2006 for adults aged 16+. A complication with the 2006 SCVS data sets identified by Scottish Government statisticians meant that it was not possible to derive this indicator in time for publication.

From 2008, the SCVS has been renamed the *Scottish Crime and Justice Survey*.

VIOLENCE

Attitude to violence

Measure

Percentage of adults who think that violence is acceptable in some circumstances

No data currently exist for this indicator. There is a need to develop a question in line with the measure and incorporate this into an appropriate national survey in order to allow relevant data on attitudes to violence to be collected in the future.

Discussion

Improving mental health is a national priority in Scotland. NHS Health Scotland was commissioned by the Scottish Government to establish a core set of indicators to enable regular national monitoring. Definitions for the adult indicator set were published in December 2007. This report now provides the first analysis of these indicators. It presents an overview of adult mental health in Scotland, covering both the state of mental health itself (positive mental health and mental health problems) and the contextual factors associated with it. Where the data allow, trends over time and equalities analysis are also presented.

Some data were available for a total of 45 out of the 54 indicators. This permitted point-in-time estimates (i.e. prevalence) to be calculated for all 45 indicators, equalities analysis for 44 and examination of change over time for 33. Equalities analysis covered gender, age and either area-based deprivation or individual markers of socio-economic status. No data were available for five indicators and a further four indicators are not yet operationalised. Table 4 shows the six-colour 'traffic light' system used to illustrate the results from the time trends analysis and also gives the number of indicators within each category. The result for each indicator is given in Table 5.

Drawing on a rigorous and sustainable set of indicators, this analysis provides a unique insight into the overall mental health of the adult population of Scotland. Along with the accompanying data file (available at www.scotpho.org.uk), it provides a robust reference point for organisations, partnerships and policy-makers driving progress towards a mentally flourishing Scotland.

Table 4 **Time trend traffic light system and summary**

Traffic light	Trend over time	No. of indicators
	Statistically significant improvement	12
	No significant change – may reflect stability or non-significant fluctuation	16
	Statistically significant deterioration	5
	No trend data	12
	No data currently available	5
	Indicator definition not yet agreed or suitable survey question(s) not yet identified	4

Time trends

Taken overall, the results suggest a picture of broad stability in the last decade. Around half of the indicators for which time trend data were available – 16 out of 33 – showed no significant change over the period of analysis:

- Mental health status
  - life satisfaction
  - depression
  - anxiety
- Individual level
  - alcohol consumption
  - self-reported health
  - long-standing physical condition or disability
  - limiting long-standing physical condition or disability
- Community level
  - social contact
  - social support
  - neighbourhood safety
- Structural level
  - income inequality
  - noise
  - work stress
  - work demand
  - work control
  - work colleague support.

An improvement was seen in 12 out of the 33 indicators analysed over time:

- Mental health status
  - common mental health problems
  - suicide
- Individual level
  - adult learning
  - physical activity
  - healthy eating
- Community level
  - involvement in local community
  - home safety
- Structural level
  - worklessness
  - education
  - financial management
  - financial inclusion
  - neighbourhood satisfaction.

Just five indicators show a worsening in mental health over the last decade:

- Mental health status
  - alcohol dependency
  - psychoactive substance-related deaths

- Structural level
  - house condition
  - overcrowding
  - manager support.

Overall, the picture over the last decade can be summed up as broadly stable, with a promising level of positive change and only a small, but important, number of negative trends.

For the 12 indicators that show a positive change there is continuing scope for action to secure further improvement. This is particularly so where the scale of change is modest. For four of the indicators – common mental health problems, involvement in local community, home safety and neighbourhood satisfaction – the change, though statistically significant, was only around one percentage point over a period of years. This is unlikely to have substantive significance, particularly when other data or interpretations suggest no meaningful change.[13,14]

Although few indicators deteriorated, action in the areas of tackling alcohol and drug misuse, both of which are government priorities, remains desirable.[15,16] The change in overcrowding was very small – less than 1% – and is not consistent with an alternative objective measure of overcrowding.[17] However, the subjective measure used in this report may be more effective at capturing the impact of overcrowding on mental health.

There remain substantial opportunities to improve mental health and the conditions in which it can flourish to enable Scotland's population to reach its full potential. A range of national policies give direction to and support this agenda. These include policies on nutrition and physical activity, drugs, alcohol, suicide prevention, criminal justice, poverty, inequality and local promotion of wellbeing and social development and also many others that less directly shape the context for mental health.[15,16,18–22] Such an approach is consistent with the aspiration within *Better Health, Better Care*: 'to build a country in which we understand that there is no health without good mental health and know how to support and improve our own and others' mental health and wellbeing'.[23]

Inequalities

The report highlights clear inequalities in mental health within the Scottish population, especially in terms of mental health problems and contextual factors at individual and structural levels. Adult mental health in Scotland is strongly patterned by socio-economic status. Three-quarters of the indicators (32 out of 44) for which equalities analysis was possible show an association between poorer mental health (including associated contextual factors) and increasing socio-economic disadvantage. Both age (30 out of 44 indicators) and gender (31 out of 44) were significantly associated with differences in mental health. However, no difference was observed in positive mental health by either gender or area deprivation status, which is surprising given that mental health problems are so clearly patterned by each of these variables. This paradox will be an important topic for exploration as data accumulate in the new area of positive mental health measurement.

The repetition of inequalities across a wide range of mental health and contextual indicators demonstrates the need for both targeted and whole population strategies, to promote more equal opportunities and outcomes as well as achieving overall gain in mental health and the conditions that foster it.[24] The existence of substantial inequalities in both person- and area-based indicators suggests that targeting should also be guided by both personal and area characteristics.

Limitations and future development

These first analyses were constrained by a lack of recent data, relatively short time series and small sample sizes. Both lack of data and small sample sizes particularly limited the potential for equalities analysis. Interim data sources were used for 19 out of the 45 indicators analysed and for 12 out of the 33 for which trends over time were examined. Time series were most frequently absent for the community- and structural-level contextual factors, leaving major uncertainty about progress in these areas.

During the development of the indicator set, work was undertaken to enhance the quality of existing data sources and to embed new and sustainable measures of mental health in national surveys. A particularly important development has been the inclusion of an increased number of relevant questions in the *Scottish Health Survey*, especially for positive mental health. The redevelopment of the *Scottish Crime and Justice Survey* should also improve future data availability. These changes will allow a more robust, rounded and consistent account of adult mental health in the future.

The adult indicator set was developed in order to monitor adult mental health at a national level. A national analysis can conceal important regional or other local differences. In theory, scope exists for NHS boards, local authorities and other local agencies to use the national indicator set to monitor the mental health of their local population, but in practice very few data are currently available at the required geographic levels. The position is improving, for example through the new *Scottish Health Survey*. Appendix 4 lists the sub-national availability of data from 2008 onwards. In the short term, and in the longer term for some indicators, only local surveys will be able to provide the necessary data for local monitoring. Further information on sub-national monitoring of mental health is provided in a separate briefing paper.[25]

Table 5 **Scotland's adult mental health: summary of trends over time**

			Indicator	Time trend
HIGH LEVEL		Positive mental health	**Positive mental health[a]**	No trend data
		Positive mental health	**Life satisfaction[a]**	No significant change
		Mental health problems	**Common mental health problems**	Improved
		Mental health problems	**Depression[a]**	No significant change
		Mental health problems	**Anxiety[a]**	No significant change
		Mental health problems	**Alcohol dependency**	Worsened
		Mental health problems	**Psychoactive substance-related deaths**	Worsened
		Mental health problems	**Suicide**	Improved
		Mental health problems	**Deliberate self-harm[a]**	No trend data
CONTEXTUAL	Individual	Learning and development	**Adult learning**	Improved
		Healthy living	**Physical activity**	Improved
		Healthy living	**Healthy eating[a]**	Improved
		Healthy living	**Alcohol consumption**	No significant change
		Healthy living	**Drug use**	No trend data
		General health	**Self-reported health**	No significant change
		General health	**Long-standing physical condition or disability**	No significant change
		General health	**Limiting long-standing physical condition or disability**	No significant change
		Spirituality	**Spirituality – Indicator to be identified**	Undefined
		Emotional intelligence	**Emotional intelligence – Indicator to be identified**	Undefined
	Community	Participation	**Volunteering**	No trend data
		Participation	**Involvement in local community[a]**	Improved
		Participation	**Influencing local decisions[a]**	No trend data
		Social networks	**Social contact[a]**	No significant change
		Social support	**Social support[a]**	No significant change
		Social support	**Caring[a]**	No trend data
		Trust	**General trust[a]**	No trend data
		Trust	**Neighbourhood trust[a]**	No trend data
		Safety	**Neighbourhood safety**	No significant change
		Safety	**Home safety**	Improved
		Safety	**Non-violent neighbourhood crime**	No data
		Safety	**Perception of local crime**	No trend data
	Structural	Equality	**Income inequality**	No significant change
		Social inclusion	**Worklessness**	Improved
		Social inclusion	**Education**	Improved
		Discrimination	**Discrimination**	No data
		Discrimination	**Racial discrimination**	No trend data
		Discrimination	**Harassment**	No data
		Financial security/debt	**Financial management**	Improved
		Financial security/debt	**Financial inclusion**	Improved
		Physical environment	**Neighbourhood satisfaction**	Improved
		Physical environment	**Noise**	No significant change
		Physical environment	**Escape facility – Indicator to be identified**	Undefined
		Physical environment	**Greenspace**	No data
		Physical environment	**House condition**	Worsened
		Physical environment	**Overcrowding**	Worsened
		Working life	**Stress[a]**	No significant change
		Working life	**Work–life balance[a]**	No trend data
		Working life	**Demand[a]**	No significant change
		Working life	**Control[a]**	No significant change
		Working life	**Manager support[a]**	Worsened
		Working life	**Colleague support[a]**	No significant change
		Violence	**Partner abuse**	No trend data
		Violence	**Neighbourhood violence**	No data
		Violence	**Attitude to violence – Indicator to be identified**	Undefined

[a]'Interim' data source analysed for this indicator.

Conclusion

This report provides a benchmark for mental health improvement in Scotland. In years to come, as data availability and quality improve, the benchmark can be re-examined and refined but with the constant benefit of a systematic, theory-based, framework to organise the indicators.

The overall picture over the last decade – for those indicators for which data are currently available – can be summed up as broadly stable, with a promising level of positive change and only a small, but important, number of negative trends. There are strong patterns of inequality by area deprivation/socio-economic status, gender and age.

It was not the purpose of this report to analyse trends over time by inequalities, and such analysis would be restricted by limited data availability. Similarly, analysis of other dimensions of inequality has not been attempted because the data are known to be very limited. These are both areas for potential future development.

The Scottish Public Health Observatory will update the data file annually and make it available as Excel spreadsheets for download. It is likely that a summary 'highlights' report will be produced annually, possibly focusing on areas where new data allow a re-examination of the position. A full report, such as the present one, will be produced less frequently so that we can be sure that any trends being reported are statistically robust and truly reflect change in adult mental health in Scotland.

Mental health affects every aspect of every individual's life. The breadth of the range of indicators included in the framework reported here reflects this. This means that an equally wide range of policies, strategies and actions of the Scottish Government, NHS boards, local authorities, other public sector organisations, the voluntary sector, the private sector and, not least, people themselves acting as a collective engine of change in society have an impact upon the state of mental health and associated factors. If this report has done nothing other than to demonstrate this breadth and complexity then it will have served a useful purpose. We hope that it has done more: that it has established a robust standard for monitoring overall adult mental health in Scotland.

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Appendices

Appendix 1: Available sub-national geographies for the mental health indicators

The table that follows shows the **main** sub-national geographies for which the data for the indicators are available from 2008. In the case of national survey data, the main reporting geography that the survey has been designed for is highlighted in bold. This is the sub-national geography at which the survey is designed to be representative. For the surveys, it may be possible to obtain either more frequent analysis at a sub-national level (for example for larger local authorities or NHS boards) or analyses at smaller/other geographies, but this will depend on the following points that need to be taken into account to assess the robustness of the required analysis:

1. the question being asked
2. the number of respondents
3. the size of the geographical area of interest
4. the representativeness of the data for the new geographical area. The survey may not be designed to be representative at the required geography and this may need to be investigated.

To establish whether a required analysis is possible please refer to the national survey team.

Details for each survey are given following the table.

Note: Geographies listed in the table on the following two pages refer to the main sub-national geographies that are possible with future data sources. For other geographies that may be possible but require investigation for robustness and representativeness, see the notes on each survey following the table. Data can be reported annually at the geographical level shown unless indicated that pooled data from several years are required.

		Indicator	Data source	Sub-national geographies for data
HIGH LEVEL		Positive mental health	Scottish Health Survey core	**NHS board**, larger local authorities and those coincident with an NHS board (four years' pooled data from 2008)
		Life satisfaction	Scottish Health Survey core	**NHS board**, larger local authorities and those coincident with an NHS board (four years' pooled data from 2008)
		Common mental health problems	Scottish Health Survey core	**NHS board**, larger local authorities and those coincident with an NHS board (four years' pooled data from 2008)
		Depression	Scottish Health Survey nurse module	n/a
		Anxiety	Scottish Health Survey nurse module	n/a
		Alcohol dependency	Scottish Health Survey core	**NHS board**, larger local authorities and those coincident with an NHS board (four years' pooled data from 2008)
		Psychoactive substance-related deaths	General Register Office for Scotland	Local authority, NHS board and larger community health partnerships (5 years' pooled data)
		Suicide	General Register Office for Scotland	Local authority, NHS board and larger community health partnerships (5 years' pooled data)
		Deliberate self-harm	Scottish Health Survey nurse module	n/a
CONTEXTUAL	Individual	Adult learning	Annual Population Survey	**Local authority**, NHS board
		Physical activity	Scottish Health Survey core	**NHS board**, larger local authorities and those coincident with an NHS board (four years' pooled data from 2008)
		Healthy eating	Scottish Health Survey core	**NHS board**, larger local authorities and those coincident with an NHS board (four years' pooled data from 2008)
		Alcohol consumption	Scottish Health Survey core	**NHS board**, larger local authorities and those coincident with an NHS Board (four years' pooled data from 2008)
		Drug use	Scottish Crime and Justice Survey (previously known as the Scottish Crime and Victimisation Survey)	**Police force area, community justice authority area**, larger local authorities and those coincident with a police force area
		Self-reported health	Scottish Health Survey core	**NHS board**, larger local authorities and those coincident with an NHS board (four years' pooled data from 2008)
		Long-standing physical condition or disability	Scottish Health Survey core	**NHS board**, larger local authorities and those coincident with an NHS board (four years' pooled data from 2008)
		Limiting long-standing physical condition or disability	Scottish Health Survey core	**NHS board**, larger local authorities and those coincident with an NHS board (four years' pooled data from 2008)
		Spirituality	Indicator and data source to be identified	–
		Emotional intelligence	Indicator and data source to be identified	–

		Indicator	Data source	Sub-national geographies for data
CONTEXTUAL	Community	Volunteering	Scottish Household Survey (one-quarter sample from 1 June 2007)	Larger **local authorities** and NHS boards (four years' combined data)
		Involvement in local community	Scottish Health Survey biennial module from 2009	n/a
		Influencing local decisions	Scottish Health Survey biennial module from 2009	n/a
		Social contact	Scottish Health Survey biennial module from 2009	n/a
		Social support	Scottish Health Survey biennial module from 2009	n/a
		Caring	Scottish Health Survey core	**NHS board**, larger local authorities and those coincident with an NHS board (four years' pooled data from 2008)
		General trust	Scottish Health Survey biennial module from 2009	n/a
		Neighbourhood trust	Scottish Health Survey biennial module from 2009	n/a
		Neighbourhood safety	Scottish Household Survey (three-quarters sample from 1 June 2007)	Majority of **local authorities** and NHS boards (two years' pooled data)
		Home safety	Scottish Household Survey (three-quarters sample from 1 June 2007)	Majority of **local authorities** and NHS boards (two years' pooled data)
		Non-violent neighbourhood crime	Scottish Crime and Justice Survey (previously known as Scottish Crime and Victimisation Survey)	**Police force area, community justice authority area**, larger local authorities and those coincident with a police force area
		Perception of local crime	Scottish Crime and Justice Survey (previously known as Scottish Crime and Victimisation Survey)	**Police force area, community justice authority area**, larger local authorities and those coincident with a police force area

		Indicator	Data source	Sub-national geographies for data
CONTEXTUAL	Structural	Income inequality	Scottish Government Income & Poverty Statistics	n/a
		Worklessness	Annual Population Survey	**Local authority**, NHS board
		Education	Annual Population Survey	**Local authority**, NHS board
		Discrimination	Scottish Health Survey biennial module from 2009	n/a
		Racial discrimination	Scottish Crime and Justice Survey (previously known as Scottish Crime and Victimisation Survey)	**Police force area, community justice authority area**, larger local authorities and those coincident with a police force area
		Harassment	Scottish Health Survey biennial module from 2009	n/a
		Financial management	Scottish Household Survey (3/4 sample from 1 June 2007)	Majority of **local authorities** and NHS boards (2 years' pooled data)
		Financial inclusion	Scottish Household Survey (3/4 sample from 1 June 2007)	Majority of **local authorities** and NHS boards (2 years' pooled data)
		Neighbourhood satisfaction	Scottish Household Survey (3/4 sample from 1 June 2007)	Majority of **local authorities** and NHS boards (2 years' pooled data)
		Noise	Scottish House Condition Survey	**Local authority**, NHS board (3 years' pooled data)
		Escape facility	Question to be developed and data source to be identified	–
		Greenspace	Scottish Household Survey (3/4 sample from 1 June 2007)	**Local authority** (2 years' pooled data), NHS board
		House condition	Scottish House Condition Survey	**Local authority**, NHS board (3 years' pooled data)
		Overcrowding	Scottish House Condition Survey	**Local authority**, NHS board (3 years' pooled data)
		Stress	Scottish Health Survey biennial module from 2009	n/a
		Work–life balance	Scottish Health Survey biennial module from 2009	n/a
		Demand	Scottish Health Survey biennial module from 2009	n/a
		Control	Scottish Health Survey biennial module from 2009	n/a
		Manager support	Scottish Health Survey biennial module from 2009	n/a
		Colleague support	Scottish Health Survey biennial module from 2009	n/a
		Partner abuse	Scottish Crime and Justice Survey (previously known as the Scottish Crime and Victimisation Survey)	**Police force area, community justice authority area**, larger local authorities and those coincident with a police force area
		Neighbourhood violence	Scottish Crime and Justice Survey (previously known as Scottish Crime and Victimisation Survey)	**Police force area, community justice authority area**, larger local authorities and those coincident with a police force area
		Attitude to violence	Question to be developed and data source to be identified	–

Survey details

Scottish Health Survey

- Designed to be representative at NHS board level.
- Analysis for questions in the core (asked annually to all the adult sample) possible for all NHS boards after four years, from 2008.
- Analysis for larger NHS boards may be available sooner.
- As postcode information is collected, local authority analysis will be possible for the larger local authorities after four years – again it may be available sooner for the largest.
- Where local authority boundaries coincide with an NHS board, analysis will be possible at the same time as NHS board analysis.
- Analysis may never be possible for some of the smaller local authorities.
- Sub-national analysis for questions in the nurse and biennial module is not possible/advised due to the small sample numbers.
- To establish if analysis at your required geographical area is possible please email ScottishHealthSurvey@scotland.gsi.gov.uk.

Scottish House Condition Survey

- Designed to be representative at national level annually for main indicators [e.g. fuel poverty, Scottish Housing Quality Standard (SHQS) by housing sector, energy ratings].
- Information for all local authorities and NHS boards possible every three years (since the survey went continuous in 2003).
- Analysis may be possible for the larger local authorities and NHS boards annually or every two years.
- Postcode information is collected in the survey allowing different geographical analyses to be created.
- To establish whether a required geographical analysis is possible please email SHCS@scotland.gsi.gov.uk.

Scottish Household Survey

- Designed to be representative at local authority level.
- Information for all local authorities is possible every two years for data from the full survey sample.
- Analysis for larger local authorities may be available sooner.
- As postcode information is collected, NHS board analysis will be possible after two years; again it may be available sooner for the largest NHS boards.
- For a three-quarter sample size, analysis should be available for the majority of local authorities and NHS boards using two years' combined data, and possibly sooner for the largest.
- For a one-quarter sample size, analysis should be possible for the larger local authorities and NHS boards using four years' combined data, and possibly sooner for the largest.
- As postcode information is collected, it is possible to obtain analyses for bespoke geographies [e.g. there has been analysis in the past specifically for a (large) Community Health Partnership (CHP)] provided that the data at this geography are considered reliable.
- To establish whether a required geographical analysis is possible please email shs@scotland.gsi.gov.uk.

Annual Population Survey

- Designed to provide robust estimates at a local authority level, there is a target for the number of economically active adults who are surveyed in each local authority.
- Information for all local authorities and NHS boards annually.
- As postcode information is collected, it is possible to obtain analyses for bespoke geographies provided the data at this geography are considered reliable.
- In theory, analyses are possible at sub-local authority level, NHS board level, parliamentary constituency and some larger CHPs. Analyses for larger regeneration outcome agreement areas have been undertaken in the past.
- To establish if analysis at your required geography is possible please email labour-market.statistics@scotland.gsi.gov.uk.

Scottish Crime and Justice Survey

- From the 2008/2009 survey (financial year) designed to be representative at police force area and community justice authority area.
- Analysis for all police force areas and community justice authority areas available annually from 2008/2009 survey (first set of data available autumn 2009).
- Analysis is possible annually for larger local authorities and those that are coincident with a police force area, e.g. Dumfries & Galloway and Fife.
- Analysis may be possible for other local authorities using several years' pooled data, although this may still not allow analysis for the smaller local authorities.
- As postcode information is collected, in theory analysis is possible annually at NHS board level although not for the smaller NHS boards. However, as the survey is not designed to be representative at NHS board level the representativeness of the data would need to be assessed.
- To establish if analysis at your required geography is available please email scottishcrimeandjusticesurvey@scotland.gsi.gov.uk.

General Register Office for Scotland indicators

- Information for all NHS boards and local authorities for the indicators using five years' combined data.
- For larger NHS boards and local authorities, three years of data can be combined.
- For larger CHPs, five years of data can be combined.

Appendix 2: Sample sizes of the data sources used in this report

Survey	Approx. achieved sample size	Approx. response rate (%)	Indicators
Adult Psychiatric Morbidity Surveys	1993 (16–64): 700 2000 (16–74): 900	1993: 83 2000: 70	• Depression • Anxiety • Deliberate self-harm
Labour Force Survey/Annual Population Survey	2003–2006 (16+): 33,000 1999–2002 (16–59/64): 12,000 2003–2006 (16–59/64): 31,000	1999–2002: 70 2003–2006: 60	• Adult learning • Worklessness • Education
European Social Survey	2002 (16+): 180 2004 (16+): 170 2006 (16+): 230 2006 (16–64): 140	70	• Life satisfaction • Work–life balance
General Household Survey Social Capital Module	2004/05 (16+): 800	72 (Britain)	• General trust • Neighbourhood trust • Influencing local decisions
General Register Office for Scotland	Number of deaths per annum, not sample size Suicide (16+): 750–800 Psychoactive substance related (16+): 200–300	n/a	• Psychoactive substance-related deaths • Suicide
Health Education Population Survey	1996–2007 (16–74): 1,800[a] 2006/07 (16–74): 1,650[b]	70	• Healthy eating • Positive mental health
Psychosocial Working Conditions Survey	2004–2007 (16–64): 110	65 (Britain)	• Stress • Demand • Control • Colleague support[c] • Manager support
Scottish Crime and Victimisation Survey: Main survey	2006 (16+): 5,000	71	• Non-violent neighbourhood crime[d] • Racial discrimination • Neighbourhood violence[d]
Scottish Crime and Victimisation Survey: Follow-up Module A	2006 (16+): 2,500	71	• Perception of local crime
Scottish Crime and Victimisation Survey: Self-completion partner abuse module	2006 (16+): 2,900	66	• Partner abuse

Survey	Approx. achieved sample size	Approx. response rate (%)	Indicators
Scottish Crime and Victimisation Survey: Self-completion drug use module	2006 (16–59): 3,100	66	• Drug use
Scottish Health Survey	1995 (16–64): 7,900 1998 (16–74): 9,000 2003 (16+): 8,100	1995: 81 1998: 76 2003: 60	• Common mental health problems • Alcohol dependency • Physical activity • Alcohol consumption • Self-reported general health • Long-standing physical condition or disability • Limiting long-standing physical condition or disability
Scottish House Condition Survey	1996, 2002 (16+): 18,000 2003/04 – 2005/06 (16+): 4,000	60	• Noise • House condition • Overcrowding
Scottish Household Survey	1999 – 2006 (16+): 14,000	70	• Volunteering • Caring • Involvement in local community • Home safety • Neighbourhood safety • Financial management • Financial inclusion
Well? What do you think?	2004 (16+): 1,400 2006 (16+): 1,200	2004: 58 2006: 57	• Social contact • Social support

[a]Sample was only 900 in 1999. There was no HEPS Survey in 2000.
[b]Sample covers Autumn 2006 and Spring 2007 Waves.
[c]No data for 2005.
[d]Data set unable to be analysed for this report.

Appendix 3: Equalities issues in Scottish adult mental health

		Indicator	Equalities issues identified
HIGH LEVEL		Positive mental health: **Positive mental health**	Significantly associated with age: older adults (aged 55–74) had higher mean WEMWBS scores.
		Positive mental health: **Life satisfaction**	None identified, although this may partly reflect a small Scottish sample size.
		Mental health problems: **Common mental health problems**	Women and those living in deprived communities were significantly more likely to have a possible mental health problem.
		Mental health problems: **Depression**	Adults in lower social classes were significantly more likely to have moderate to high severity symptoms of depression than those in higher social classes. Note that Scottish sample sizes are low.
		Mental health problems: **Anxiety**	None identified, although this may partly reflect small Scottish samples.
		Mental health problems: **Alcohol dependency**	Gender, age and area deprivation were significantly associated with possible alcohol dependency. Men, adults aged 25–44 and those living in the most deprived communities were most likely to have a possible alcohol dependency.
		Mental health problems: **Psychoactive substance-related deaths**	Psychoactive substance-related deaths were significantly higher amongst men, those aged 16–44 and those living in the more deprived areas.
		Mental health problems: **Suicide**	Rates of suicide were significantly associated with gender and area deprivation, with men and those living in the most deprived parts of Scotland most at risk. For men, suicide was significantly higher among those under the age of 45.
		Mental health problems: **Deliberate self-harm**	The likelihood of deliberate self-harm varied significantly by age, with the highest rates (5% or more) among those aged 16–34. Note that Scottish sample sizes are small.
CONTEXTUAL	Individual	Learning and development: **Adult learning**	Women, those aged 50 and above and those living in more deprived communities were significantly less likely to participate in adult learning.
		Healthy living: **Physical activity**	Men and younger people were more likely to meet the recommended physical activity levels. Adults in the most deprived quintile were significantly less likely than those in the remaining four quintiles to meet the recommendations.
		Healthy living: **Healthy eating**	Men, people aged 25–34 and those living in more deprived communities were less likely to be eating 'five a day'.
		Healthy living: **Alcohol consumption**	Women, those aged 65+ and people living in the most deprived quintile were more likely to be drinking at or below the recommended weekly limits.
		Healthy living: **Drug use**	Men, people under the age of 20 and those living in areas classified as 'city lifestyle' and 'struggling singles' were more likely to have used drugs in the last 12 months.
		General health: **Self-reported health**	Older people (aged 45+) and those living in deprived communities were significantly less likely to report that their health in general was good or very good.
		General health: **Long-standing physical condition or disability**	Prevalence of long-standing physical illness, disability or infirmity increased significantly with age and area deprivation.
		General health: **Limiting long-standing physical condition or disability**	Older adults and those in the most deprived areas were significantly more likely to have a limiting long-standing physical illness, disability or infirmity.
		Spirituality: **Spirituality**	n/a – indicator to be identified.
		Emotional intelligence: **Emotional intelligence**	n/a – indicator to be identified.

		Indicator	Equalities issues identified
CONTEXTUAL	Community	Participation: **Volunteering**	Women, those aged 35–74 and adults in less deprived areas were more likely to volunteer at least once every other month.
		Participation: **Involvement in local community**	Men, those aged 16–24 and adults resident in the two most deprived communities were significantly less likely to feel involved.
		Participation: **Influencing local decisions**	Women, those aged 45–74 and adults in professional/managerial jobs were significantly more likely to believe that they could influence local decisions.
		Social networks: **Social contact**	Gender, age and area deprivation were not significantly associated with rates of social contact.
		Social support: **Social support**	Rates of social support did not differ significantly by gender or age. Social support was significantly lower in more deprived areas.
		Social support: **Caring**	Adults aged 45–74 and those in more deprived communities were more likely to be providing 20+ hours of care each week.
		Trust: **General trust**	Gender, age and socio-economic group were not significantly associated with differences in the level of general trust.
		Trust: **Neighbourhood trust**	Older adults and those from higher socio-economic groups had significantly higher levels of neighbourhood trust.
		Safety: **Neighbourhood safety**	Women, those over 60 years of age and adults living in the most deprived communities were significantly less likely to report feeling very or fairly safe walking alone in their neighbourhood after dark.
		Safety: **Home safety**	Women, those aged 16–24 and adults living in more deprived communities were significantly less likely to report feeling very or fairly safe at home alone at night.
		Safety: **Non-violent neighbourhood crime**	Data set unable to be analysed for this report.
		Safety: **Perception of local crime**	Young adults (aged 16–24) and those in 'developing families' and 'struggling singles' areas were significantly more likely to think that crime was very or fairly common in their local area.

		Indicator	Equalities issues identified
CONTEXTUAL	Structural	Equality: **Income inequality**	n/a.
		Social inclusion: **Worklessness**	Worklessness was significantly higher among young adults (aged 16–24) and those living in the most deprived communities.
		Social inclusion: **Education**	Women, the over-50s and those living in deprived areas were significantly more likely to lack qualifications.
		Discrimination: **Discrimination**	n/a – data currently unavailable.
		Discrimination: **Racial discrimination**	Women and young adults (aged 16–24) were significantly more likely to think that racial discrimination is a big problem in Scotland, as were adults living in areas classified as 'struggling singles'.
		Discrimination: **Harassment**	n/a – data currently unavailable.
		Financial security/debt: **Financial management**	Women, young people (aged 16–24) and those in more deprived communities were significantly less likely to report that their household was managing very or quite well financially.
		Financial security/debt: **Financial inclusion**	Households headed by women and adults resident in more deprived areas were less likely to have access to a bank, building society, credit union or post office card account.
		Physical environment: **Neighbourhood satisfaction**	Women, those aged 16–34 and those living in the most deprived communities were less likely to rate their neighbourhood as a very or fairly good place to live.
		Physical environment: **Noise**	Women, adults under the age of 60 and those living in deprived communities were more likely to be bothered by noise.
		Physical environment: **Escape facility**	n/a – data source to be identified.
		Physical environment: **Greenspace**	n/a – data currently unavailable.
		Physical environment: **House condition**	Adults aged 60+, men and people living in the two least deprived quintiles were more likely to rate the condition of their home as fairly or very good.
		Physical environment: **Overcrowding**	Adults aged 60+, men and those living in the least deprived quintile were less likely to think that their home had too few rooms.
		Working life: **Stress**	Adults working in managerial, professional or associate professional occupations were significantly more likely to report that their job was very or extremely stressful.
		Working life: **Work–life balance**	None identified, although this may partly reflect small sample sizes.
		Working life: **Demand**	None identified, although this may partly reflect small sample sizes.
		Working life: **Control**	Managers, professionals and associate professionals were significantly more likely to have choice over the way they do their work than those in other occupations.
		Working life: **Manager support**	None identified, although this may partly reflect small sample sizes.
		Working life: **Colleague support**	None identified, although this may partly reflect small sample sizes.
		Violence: **Partner abuse**	Women, those aged 16–34 and adults in areas classified as 'struggling singles' were significantly more likely to have been abused by their partner in the last 14–20 months.
		Violence: **Neighbourhood violence**	Data set unable to be analysed for this report.
		Violence: **Attitude to violence**	n/a – data source to be identified.

Appendix 4: Equalities analysis possible for the indicators in the future

Please refer to the table on the following two pages.

		Indicator	Age	Gender	SIMD	Disability	Ethnicity	Sexual orientation	Religion and belief
HIGH LEVEL		Positive mental health	Y (2008)	Y (2008)	Y (2008)	Y (2008)	Y (2008)	Y (2008)	Y (2008)
		Life satisfaction	Y (2008)	Y (2008)	Y (2008)	Y (2008)	Y (2008)	Y (2008)	Y (2008)
		Common mental health problems	Y	Y	Y	Y	Y	Y (2008)	Y (2008)
		Depression	Y	Y	Y	Y	Y	Y	Y
		Anxiety	Y	Y	Y	Y	Y	Y	Y
		Alcohol dependency	Y	Y	Y	Y	Y	Y (2008)	Y(2008)
		Psychoactive substance-related deaths	Y	Y	Y	N	N	N	N
		Suicide	Y	Y	Y	N	N	N	N
		Deliberate self-harm	Y	Y	Y	Y	Y	Y	Y
CONTEXTUAL	Individual	Adult learning	Y	Y	Y	Y	Y	N	N
		Physical activity	Y	Y	Y	Y	Y	Y (2008)	Y (2008)
		Healthy eating	Y	Y	Y	Y	Y	Y (2008)	Y (2008)
		Alcohol consumption	Y	Y	Y	Y	Y	Y (2008)	Y (2008)
		Drug use	Y	Y	Y (2008)	N	N	N	N
		Self-reported health	Y	Y	Y	Y	Y	Y (2008)	Y (2008)
		Long-standing physical condition or disability	Y	Y	Y	Y	Y	Y (2008)	Y (2008)
		Limiting long-standing physical condition or disability	Y	Y	Y	Y	Y	Y (2008)	Y (2008)
		Spirituality	n/a	n/a	n/a	n/a	n/a	n/a	n/a
		Emotional intelligence	n/a	n/a	n/a	n/a	n/a	n/a	n/a
CONTEXTUAL	Community	Volunteering	Y	Y	Y	Y	Y	N	Y
		Involvement in local community	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)
		Influencing local decisions	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)
		Social contact	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)
		Social support	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)
		Caring	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)
		General trust	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)
		Neighbourhood trust	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)
		Neighbourhood safety	Y	Y	Y	Y	Y	N	Y
		Home safety	Y	Y	Y	Y	Y	N	Y
		Non-violent neighbourhood crime	Y	Y	Y (2008)	N	N	N	N
		Perception of local crime	Y	Y	Y (2008)	N	N	N	N

		Indicator	Age	Gender	SIMD	Disability	Ethnicity	Sexual orientation	Religion and belief
CONTEXTUAL	Structural	Income inequality	N	N	N	N	N	N	N
		Worklessness	Y	Y	Y	Y	Y	N	N
		Education	Y	Y	Y	Y	Y	N	N
		Discrimination	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)
		Racial discrimination	Y	Y	Y (2008)	N	N	N	N
		Harassment	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)	Y (2009)
		Financial management	Y	Y	Y	Y	Y	N	Y
		Financial inclusion	Y	Y	Y	Y	Y	N	Y
		Neighbourhood satisfaction	Y	Y	Y	Y	Y	N	Y
		Noise	Y	Y	Y	Y	Y	N	Y
		Escape facility	n/a	n/a	n/a	n/a	n/a	n/a	n/a
		Greenspace	Y	Y	Y	Y	Y	N	Y
		House condition	Y	Y	Y	Y	Y	N	Y
		Overcrowding	Y	Y	Y	Y	Y	N	Y
		Stress	Y (2009)	Y (2009)	Y	Y (2009)	Y (2009)	Y (2009)	Y (2009)
		Work–life balance	Y (2009)	Y (2009)	Y	Y (2009)	Y (2009)	Y (2009)	Y (2009)
		Demand	Y (2009)	Y (2009)	Y	Y (2009)	Y (2009)	Y (2009)	Y (2009)
		Control	Y (2009)	Y (2009)	Y	Y (2009)	Y (2009)	Y (2009)	Y (2009)
		Manager support	Y (2009)	Y (2009)	Y	Y (2009)	Y (2009)	Y (2009)	Y (2009)
		Colleague support	Y (2009)	Y (2009)	Y	Y (2009)	Y (2009)	Y (2009)	Y (2009)
		Partner abuse	Y	Y	Y (2008)	N	N	N	N
		Neighbourhood violence	Y	Y	Y (2008)	N	N	N	N
		Attitude to violence	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Y, yes; N, no; n/a, not applicable; SIMD, Scottish Index of Multiple Deprivation.

Note: if not currently available, the year when data from the future data source will first be collected is shown in parentheses.

Appendix 5: Scottish ACORN groups defined

ACORN group	Types of households included
A: Affluent families	Wealthy families, largest houses, affluent families with children, working families with mortgages
B: Older prosperity	Wealthy owners, large semi-detached housing; well-off professionals, large houses and converted flats; well-off older professionals, wealthy older couples and comfortable older couples, villages
C: Settled families	Young families with mortgages, well-off terraced housing; middle management, semi-detached houses
D: Rural areas	Large families and houses in rural areas; older couples in large houses, remote areas
E: City lifestyle	Young professionals owning or renting converted flats; elderly people and singles in private flats; professionals and students, flats and tenements; students and young workers sharing tenements; small flats, young singles and sharers
F: Young workers	Younger families and couples, some flats; young working singles and couples in flats; young people in tenements
G: Traditionally comfortable	Older owners, terraced housing; retired couples, semi-detached housing; retired couples and singles, mixed housing; older families, traditional occupations; singles and retired in low-rise estates; working families, owning terraced houses; families in traditional terraces
H: Developing families	Young families in small council flats; large families, some unemployment; young families, mixed dwellings, some single parents; large families, council terraces, some single parents; families with older children, terraces; older larger families
I: Poor pensioners	Older people, rented terraces; retired people, council terraces; single pensioners, health problems, flats; old singles, council flats, often high-rise
J: Struggling singles	Old and young singles, small flats; many single people, high unemployment, high-rise flats; singles, unemployment, low-rise flats; single parents in council flats; most single parents, hardship

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