From: [redacted]
[redacted]
Subject: APMS Update for Steering Group October 2024
Date: 18 October 2024 09:31:28
Attachments:
APMS - Chapter Outline - (01) Common mental health conditions v2.pdf
APMS - Chapter Outline - (02) Mental health treatment and service use v2.pdf
APMS - Chapter Outline - (03) Posttraumatic Stress Disorder v2.pdf
APMS - Chapter Outline - (04) Suicidal thoughts attempts and self harm v2.pdf
APMS - Chapter Outline - (05) Alcohol dependence v2.pdf
APMS - Chapter Outline - (06) Drug use and dependence v2.pdf
APMS - Chapter Outline - (07) Gambling behaviour v2.pdf
APMS - Chapter Outline - (08) Personality disorder v2.pdf
APMS - Chapter Outline - (09) Attention deficit hyperactivity disorder v2.pdf
APMS - Chapter Outline - (11) Bipolar disorder v2.pdf
APMS - Chapter Outline - (13) Eating problems and disorders v1.pdf
List of all Tables Specifications for APMS 2023-24 v2.pdf

Dear Steering Group members

You will be pleased to hear that work has begun on writing the APMS report. We are in the early stages of this work but anticipate a formal publication date of mid-2025. We would like to share with you the finalised list of chapter outlines and table specifications which are attached and relate to the chapters below.

Chapter Name
Common mental health conditions
Treatment and services
Post-traumatic stress disorder
Suicidal thoughts and suicide attempts and self-harm
Alcohol dependence
Drug use and dependence
Gambling behaviour
Personality Disorder
Attention deficit hyperactivity disorder
Autism spectrum disorder*
Bipolar disorder
Psychotic disorder*
Eating problems and disorders

Notes:
* these will be the last to be written and the table specifications and chapter outlines will be shared once ready.

For awareness, there will be an addendum to the main publication with the Eating Disorders (based on the SCAN and validation study) expected a month or so after the main publication.

We will aim to have a Steering Group meeting shortly after the APMS 23 publication and will confirm the publication date in due course and the process for pre-release access where applicable.

Best wishes
The Surveys team

Outlook

Re: GC speech - HSE

From [redacted]
Date Sun 1/19/2025 9:44 PM
To [redacted]@gamblingcommission.gov.uk>

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[redacted]

[redacted] I will see what I can find out in relation to the APMS.

[redacted]

[redacted]

[redacted]

[redacted]

On Sun, 19 Jan 2025 at 16:04, [redacted]@gamblingcommission.gov.uk> wrote:

> [redacted]
>
> [redacted]
>
> On your question about the APMS, I don't think it's for us to offer views what will be published by someone else so would suggest you speak to them directly to see what they can confirm about the data they expect to publish.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

On Mon, 13 Jan 2025 at 14:35, [redacted] > wrote:

> [redacted]
>
> [redacted]
>
> [redacted]
>
> Also, are you able to say whether you expect the APMS 2023/24 to contain gambling/PG statistics when it is published this summer; and what [redacted] was referring to when he said that the authors of the Health Surveys "*were clear it likely underestimated the problem gambling level*"?
>
> Thanks
>
> [redacted]
>
> [redacted]
>
> On Tue, Jan 7, 2025 at 4:05 PM [redacted] @gamblingcommission.gov.uk> wrote:
>
> > Hi [redacted]

I'm not sure there is a great deal more I can add to what I've already said, other than your first substantive para below really illustrates the heart of the issue, perhaps better than we ourselves have. The fact that it has been necessary to use England only data to inform the GB-wide policies that you reference does demonstrate the very problems that [redacted] speech touched upon.

Best

[redacted]

From: [redacted]
Sent: Monday, January 6, 2025 4:19 PM
To: [redacted]@gamblingcommission.gov.uk>
Subject: Re: GC speech - HSE

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Hi [redacted]

Thanks for the email and the helpful context. I am still a little puzzled.

The last time that all three home nations were surveyed simultaneously was in 2016. On this basis, it sounds as though the Commission is saying that the statistics referred to in the speech have not existed since 2016. This seems odd given the Commission's reliance on the HSE 2018 in recent consultations etc (including use of HSE 2018 estimates to calculate FRC and FVA thresholds, interaction quotas and - where the DCMS is concerned - levy tariffs) and to apply these stats to GB rather than solely to England.

In his speech, [redacted] said: "*So, when people quote older statistics or talk about how we should use that approach, we are actually talking about relying on something that no longer exists.*"

You appear to be suggesting that this comment refers to the Combined Health Surveys as well as the Scottish Health Survey and the Wales Omnibus/National Survey for Wales. On that basis, presumably the GC has no issue with people using statistics from the HSE 2018 or HSE 2021. It's odd because I am not aware of any people quoting figures from 2016.

The GC's page on 'Survey Improvements' (the Sturgis recommendations), currently carries the following statement:

"***Recommendation 7: The Gambling Commission should seek opportunities to benchmark the estimates from the GSGB against a contemporaneous face-to-face interview survey in the future.***

How we will implement the recommendation
This would be unaffordable to do as a standalone data collection exercise.

There may be an opportunity to benchmark a few questions via a Health Survey if the Health Survey continues with its face to face methodology, or via the Adult Psychiatric Morbidity Survey (APMS), although this may take several years for results to be available. It is also not certain that we would be able to place questions on these surveys and there will be a further cost implication.

We will consider value for money if the opportunity becomes available."

It seems odd that it makes no mention of the fact that both the APMS 2023/24 and the HSE 2024 carried gambling questions (and thus presents a very real opportunity to conduct these tests); or that uncertainty is expressed with regard to the GC's ability to place questions on these surveys. I know that the GC is on the steering body for the APMS so are you able to say whether or not the gambling data will be released with the survey in June (as it was in 2007)?

Finally, I wondered who [redacted] was referring to when he said that "*The authors of [The Health Surveys] were clear it likely underestimated the problem gambling level because of the methodological approach*". I have heard Heather say this of late but NatCen and NHS commentary on reliability has been far more circumspect.

We will probably publish something tomorrow but I have noted your comments and adjusted the copy accordingly.

Let me know if a quick chat would help.

Thanks again

[redacted]

On Mon, Jan 6, 2025 at 11:32 AM [redacted]@gamblingcommission.gov.uk> wrote:

Hi [redacted]

[redacted]

I think where the confusion comes is you are suggesting we said the HSE is not viable and no longer exists. In fact, we were talking about the health survey in the round, across the three nations. [redacted] specifically highlighted the fact one of its flaws was that it was conducted differently in different nations. Nowhere in the speech does [redacted] specifically name the Health Survey for England. GSGB is a Britain-wide survey so only comparing it to HSE would not be accurate.

It is worth noting that both the Scottish Health Survey and the Welsh Health Survey equivalents have changed methodology, moving increasingly to online with some telephone follow up. Alongside that there has been consultation on changing the HSE methodology. I think it is pretty fair to say, therefore, that the methodologies used in the past across Britain either no longer exist or will not exist in the future.

I know in previous conversations you had suggested that the HSE, because of England's relative size, was the more significant of the three. However, as the regulator in all three nations we give equal importance to having data from all parts of Britain and didn't make decisions on our methodological approach by only considering issues with the HSE. Given what we see in some of the data from Scotland it would seem increasingly sensible that we've moved to a model that gives us frequent and consistent data across the nations and regions.

I do think that the wording of the published speech could have been a bit sharper, by perhaps using Health Surveys in the plural, and spelling out the challenges in more detail that we have seen with data from each of the nations. However, I don't agree that the message we were delivering was untrue- that the approaches to gathering health survey data (across our geographical jurisdiction) is no longer viable.

Best wishes

[redacted]

From: [redacted]
Sent: Monday, January 6, 2025 10:30 AM

To: [redacted]@gamblingcommission.gov.uk>
Subject: Re: GC speech - HSE

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Hi [redacted]

[redacted]

We will probably publish something today or tomorrow on the GC's claim (which appears untrue) that the HSE is no longer viable. It would be good to know if we are missing any information which explains why it is not untrue.

[redacted]

[redacted]

On Tue, Dec 24, 2024 at 9:06 AM [redacted]@gamblingcommission.gov.uk> wrote:

> [redacted]
>
> [redacted]
>
> [redacted]
>
> [redacted]
>
> ---
>
> **From:** [redacted]
> **Sent:** Monday, December 23, 2024 6:17 PM
> **To:** [redacted]@gamblingcommission.gov.uk>
> **Subject:** Re: GC speech - HSE
>
> **CAUTION:** This email is from an external source - be careful of attachments and links

Hi [redacted]

[redacted]

Since I wrote to you on 12th December (in relation to comments made about the Health Surveys at the CEOs Briefing in November), I have learned that the Health Survey for England 2024 contains questions about gambling, including the PGSI questionnaire. The Gambling Commission has been aware of this since at least August 2023.

These facts make the Commission's comments at the CEOs Briefing (as well as at other events) even more difficult to understand. In particular, I wish to draw attention to the following comments from the speech made by Andrew Rhodes at the CEOs Briefing in November 2024.

1. *"The most recent 2023 survey could not be run because of this [the methodological approach followed in the HSE] and the authors have already consulted on moving away from their approach because it's no longer viable".*

2. *"So, when people quote older statistics or talk about how we should use that approach, we are actually talking about relying on something that no longer exists."*

The fact that the HSE 2024 has been run (as an in-person survey) with gambling questions, indicates that *"the approach"* referred to is not in fact *"no longer viable"*. The claim that the approach *"no longer exists"* is factually incorrect.

These statements, considered in the light of the fact that the HSE 2024 will provide estimates of gambling participation and the prevalence of PGSI 'problem gambling', appear to be misleading. I am concerned that the Commission is therefore in breach of the UKSA Code of Practice.

If there is any explanatory information that I am missing, it would be good to know.

[redacted]

[redacted]

[redacted] [redacted]

On Thu, Dec 12, 2024 at 12:08 PM [redacted] wrote:

> Hi [redacted]
>
> I trust you are well. I am writing to you in relation to comments made about the Health Survey for England ('HSE') and the Scottish Health Survey ('SHeS') at the Gambling Commission's CEO briefing on 15th November 2024.
>
> Based upon our review of publicly available information, I am concerned that some of the comments may be inaccurate and may have the unfortunate effect of undermining confidence in the NHS's Accredited Official Statistics.
>
> It would be good to discuss our analysis and in particular to understand if there is information of which we are unaware which might give the comments made at the CEO briefing a different complexion.
>
> Best wishes
>
> [redacted]
>
> --
>
> [redacted]
>
> [redacted]
>
> [redacted]
>
> [redacted]

Hiya - yes that's fine, thanks for the heads up.

From: [redacted]@gamblingcommission.gov.uk>
Sent: Thursday, May 8, 2025 10:07 AM
To: [redacted]@gamblingcommission.gov.uk>
Subject: APMS 2023/4 - scheduled publication 26 June 2025

Hiya,

I've just seen on the NHS Digital website that they've got a tab set-up for the publication of the APMS 2023/4 report on Thursday 26 June 2025.

Obviously, it's possible that the date will slip, but they must be relatively confident to have the date published in that way. It might be worth blocking out some time on that date to review the publication as there's a high chance of comms colleagues wanting a readout and guidance for suicidality-related queries that they may receive.

Hope that's okay with you?

[redacted]

Oh thank you for the info, very useful. Seems a long time since we were encouraging them to include gambling!

From: [redacted]@gamblingcommission.gov.uk>
Sent: Thursday, May 8, 2025 10:16 AM
To: [redacted]@gamblingcommission.gov.uk>
Subject: FYI: APMS 2023/4 - scheduled publication date, 26 June 2025
Importance: Low

Hi [redacted]

Hope you're well?

Just a quick email for information purposes of something that I've just seen and [redacted] mentioned that you might be interested - the NHS Digital website have got a tab set-up for the publication of the APMS 2023/4 report on Thursday 26 June 2025.

Obviously, it's possible that the date may slip, but they must be relatively confident to have the scheduled date published in that way. I've flagged it to [redacted] on our team to ask whether she can block out some time to review the report when it's published. I've also added it to our publication planner with Comms (even though the GC aren't involved in the publication and don't know any results) which we'll flag in our next bi-weekly meeting so that it's on their radar given the potential that they will receive queries.

All the best,
[redacted]

Outlook

Re: Adult Psychiatric Morbidity Survey Steering (APMS) Steering Group - update and next meeting

From [redacted]
Date Thu 5/29/2025 6:09 PM
To [redacted]

Thank you to everyone who has contributed to the Doodle poll so far. [redacted]

For those who have not done so, could I please remind you to add your availability by Wednesday 4 June.

Best wishes
[redacted]

[redacted]

From: [redacted]
Sent: Tuesday, May 20, 2025 10:04
To: [redacted]
Subject: RE: Adult Psychiatric Morbidity Survey Steering (APMS) Steering Group - update and next meeting

Dear all,

Please use the correct Doodle poll link: [redacted] (Sundays have been amended)

Apologies for any confusion.

Best wishes

[redacted]

From: [redacted]
Sent: 20 May 2025 09:49
To: [redacted]
Subject: RE: Adult Psychiatric Morbidity Survey Steering (APMS) Steering Group - update and next meeting

Dear Steering Group members

The Surveys team at NHSE are looking to schedule the next APMS Steering Group meeting for August/September 2025. The meeting will be held online, via MS Teams.

We would be most grateful if you could fill in the following doodle poll to indicate your availability for these dates: [redacted]. Could you please complete the poll with your availability by **Wednesday 4 June** to allow meeting invites to be organised and embedded in diaries without delay. If you are no longer able to

attend the meetings as a representative, or if you cannot attend the upcoming meeting and wish to deputise someone in your absence, please reach out to the Surveys team.

Survey updates
Due to the scope and complexity of reporting, the project team in conjunction with Department of Health and Social Care have agreed to split the publication into two parts.

The date for the APMS publication, part 1 has been confirmed for Thursday 26 June 2025. Part 2 is planned for October 2025.

Topics for part 1 will be:

- Common mental health conditions
- Mental health treatment and service use
- Post-traumatic stress disorder
- Suicidal thoughts, suicide attempts and non-suicidal self-harm
- Gambling behaviours
- Attention/deficit hyperactivity disorder

We will notify you next month once the publication is live on the NHS England Digital website.

Best wishes
The Surveys Team

[redacted]

****
** **********

APMS | Adult Psychiatric Morbidity Survey

Methodology

- Data on the prevalence of treated and untreated psychiatric disorder in the English population
- Commissioned by NHSE and carried out by NatCen
- Age 16 to 100 (different to GSGB that is 18+)
- 8,000 sample size
    - Likely that the sample of those experiencing problem gambling will be between 40-50 individuals
    - Oversampled deprived populations
- Stratified, multi stage probability sample of people living in private households
    - Interviewer is present in household as the survey is being completed but it is completed on a computer - same as HSE
    - Only 1 individual is interviewed per household (unsure if the chosen individual is randomly assigned or not)
    - Different to the HSE in that there is only the interviewee present when answering questions. In the HSE, there may be other people in the household around whilst the survey is being administered.
- Previous APMS surveys incl gambling stats was in 2007
    - 2007 survey used the DSM criteria, 2023/24 survey uses PGSI so the results are not comparable

Questions related to gambling

- Listed in blue below
- Shorter list of gambling activities presented than HSE
- Beyond gambling, also includes questions n work stress, life events, mental disorders etc
- No specific questions on suicide ideation or attempt in relation to gambling as far as we are aware
- There might be stats on comorbidities - showing PGSI scores and how they differ depending on individuals experiencing different mental health conditions

APMS Gambling Questions

ASK ALL

Gamb1

The next few questions are about gambling. By 'gambling' we mean things like:

- buying lottery tickets or scratchcards
- betting with a bookmaker on any event or sport, including online
- online casino, slots, poker or bingo playing slots/fruit machines/machines in a bookmakers
- bingo at a bingo hall
- table games at a casino
- playing football pools
- private betting, playing cards or games for money with friends, family or colleagues

Have you spent any money on any of these things in the last 12 months?

Commented [1]: Broadly similar to GSGB, but GSGB goes into more granular detail on examples of casino games, types of lottery, etc
APMS doesnt ask about online bingo (here) but does below
APMS does not ask about 'another form of gambling'

1 Yes
2 No

IF Gamb1 = No THEN
Gamb2
Just to check, does that mean that you haven't gambled at all in the last 12 months, or do you gamble very occasionally, perhaps to buy a lottery ticket, scratch card, or play on a fruit machine?
1 Very occasionally in last year
2 Not at all in the last year

IF (Gamb1 = 1 Yes) OR (Gamb2 = 1 Very occasionally in the last year) THEN
OnlineGamb
In the last 12 months, which of the following have you spent your own money on?
Please tick all that apply
1 Buying lottery tickets online
2 Online betting on any event or sport (including e-Sports)
3 Online casino games (e.g. slot games, roulette, cards or dice games) via a website or app
4 Online bingo via a website or app
5 Online poker via a website or app
6 Online instant wins via a website or app
7 None of these

IF (Gamb1 = Yes) OR (Gamb2 = Very occasionally in the past year) THEN
PGSI1
We ask the following questions of anyone who has gambled in the past 12 months. Please answer as best you can, even if some of the questions don't seem to apply.
In the past 12 months, how often have you bet more than you could really afford to lose?
1 Never
2 Sometimes
3 Often
4 Always

IF (Gamb1 = Yes) OR (Gamb2 = Very occasionally in the past year) THEN
PGSI2
In the past 12 months, how often have you needed to gamble with larger amounts of money to get the same feeling of excitement?
1 Never
2 Sometimes
3 Often
4 Always

IF (Gamb1 = Yes) OR (Gamb2 = Very occasionally in the past year) THEN
PGSI3
In the past 12 months, how often have you gone back another day to try to win back the money you lost?
1 Never
2 Sometimes
3 Often
4 Always

IF (Gamb1 = Yes) OR (Gamb2 = Very occasionally in the past year) THEN
PGSI4
In the past 12 months, how often have you borrowed money or sold anything to get money to gamble?
1 Never
2 Sometimes
3 Often
4 Always

IF (Gamb1 = Yes) OR (Gamb2 = Very occasionally in the past year) THEN

PGSI5
the past 12 months, how often have you felt that you might have a problem with gambling?
1 Never
2 Sometimes
3 Often
4 Always

IF (Gamb1 = Yes) OR (Gamb2 = Very occasionally in the past year) THEN
PGSI6
In the past 12 months, how often have you felt people criticised your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?
1 Never
2 Sometimes
3 Often
4 Always

IF (Gamb1 = Yes) OR (Gamb2 = Very occasionally in the past year) THEN
PGSI7
In the past 12 months, how often have you felt guilty about the way you gamble, or what happens when you gamble?
1 Never
2 Sometimes
3 Often
4 Always

IF (Gamb1 = Yes) OR (Gamb2 = Very occasionally in the past year) THEN
PGSI8
In the past 12 months, how often has your gambling caused you any health problems, including a feeling of stress or anxiety?
1 Never
2 Sometimes
3 Often
4 Always

IF (Gamb1 = Yes) OR (Gamb2 = Very occasionally in the past year) THEN
PGSI9
In the past 12 months, how often has your gambling caused any financial problems for you or your household?
1 Never
2 Sometimes
3 Often
4 Always

IF (Gamb1 = Yes) OR (Gamb2 = Very occasionally in the past year) THEN
GambTreat
Have you ever used any of the following for any reason related to your gambling?

1. GP practice
2. Counsellor, therapist or other mental health service
3. Social worker, youth worker or support worker
4. Specialist gambling treatment service
5. A support group (e.g. Gamblers Anonymous)
6. A faith group
7. Family/friends
8. Employer/college
9. Online communities
10. Self-guided help (e.g. books, leaflets, websites, apps)
11. A telephone helpline
12. Self-exclusion (e.g. blocking software or blocking bank transactions)
13. Another source

14. None of these :[EXCLUSUIVE]

IF GambTreat <> 14 THEN
GambTreatNow
Which of the following have you used **during the last 12 months**, for any reason related to your gambling?

1. GP practice
2. Counsellor, therapist or other mental health service
3. Social worker, youth worker or support worker
4. Specialist gambling treatment service
5. A support group (e.g. Gamblers Anonymous)
6. A faith group
7. Family/friends
8. Employer/college
9. Online communities
10. Self-guided help (e.g. books, leaflets, websites, apps)
11. A telephone helpline
12. Self-exclusion (e.g. blocking software or blocking bank transactions)
13. Another source
14. None of these :[EXCLUSIVE]

Outlook

Re: APMS survey follow up

From [redacted]
Date Thu 6/19/2025 5:16 PM
To [redacted]@gamblingcommission.gov.uk>
Cc [redacted]

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Absolutely, I would be keen to join that session, it sounds very useful.

Many thanks,
[redacted]

[redacted]

On Thu, 19 Jun 2025 at 13:31, [redacted]@gamblingcommission.gov.uk> wrote:

> Hi [redacted],
>
> Thanks for the introduction Jess, although I think we have spoken before in relation to the GSGB.
>
> We're eagerly awaiting the results of the APMS being published next week. My colleague, [redacted] has been on the steering group so I don't have any specific methodological questions at the moment but good to have your details if we do.
>
> Once the results are published we'd be keen to look at the comparability between the APMS and GSGB results. Perhaps we could set up a meeting to discuss? [redacted] is that something you'd be interested in joining too?
>
> [redacted]

Thanks. Interesting that they think there is only 40-50 in the sample classified as 'problem gamblers' but good that they've used the PGSI this time.

From: [redacted]@gamblingcommission.gov.uk>
Sent: Thursday, June 19, 2025 1:22 PM
To: [redacted]@gamblingcommission.gov.uk>
Subject: FW: Meeting follow up

Some useful info here from DCMS on the APMS….

From: [redacted]
Sent: Thursday, June 19, 2025 12:57 PM
To: [redacted]@gamblingcommission.gov.uk>
Subject: Re: Meeting follow up

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Hi [redacted]

Great, I will do an email intro to DHSC analysts now. I also wanted to share our notes on the APMS following our meeting with DHSC analysts yesterday, in case useful - please do not share outside GC.

Thanks,
[redacted]

[redacted]

On Wed, 18 Jun 2025 at 14:07, [redacted]
<[redacted]@gamblingcommission.gov.uk> wrote:

> Hi [redacted]
>
> [redacted]
>
> On APMS, would be great if you can do the intros after your meeting – we are keen to make the connections we can do a comparability piece between the different surveys.

Thanks

[redacted]

From: [redacted]
Sent: Wednesday, June 18, 2025 12:42 PM
To: [redacted]@gamblingcommission.gov.uk>
Subject: Re: Meeting follow up

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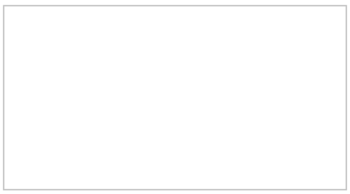
Hi [redacted]

[redacted]

[redacted]

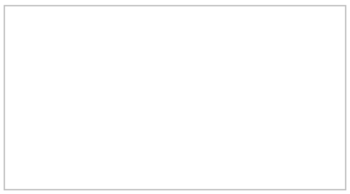
On the APMS, we are meeting with DHSC analysts this afternoon and they have suggested it might be useful to meet with you separately with NHS colleagues on methodology. Not too sure what the hesitation is there to have a joint meeting but I can feed back after our meeting today and do an email intro to the right people.

Thanks
[redacted]



[redacted]

On Tue, 17 Jun 2025 at 11:33, [redacted] wrote:

> Hi [redacted]
>
> [redacted]
>
> I have asked APMS analysts for a meeting but no word yet - if it happens, I will share the invite with you.
>
> [redacted]
>
> Many thanks,
> [redacted]
>
> 
>
> [redacted]
>
> On Fri, 13 Jun 2025 at 12:18, [redacted] [redacted]@gamblingcommission.gov.uk> wrote:
>
> > Hi [redacted]
> >
> > [redacted]
> >
> > [redacted]
> >
> > [redacted]
> >
> > and also in hearing if you get anything set up with the methodology team

at APMS.

Thanks

[redacted]

GAMBLING COMMISSION

[redacted]

www.gamblingcommission.gov.uk

Making gambling safer, fairer and crime free

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Hi [redacted]

A bit more information on the APMS release which has come via DCMS

Thanks

[redacted]

From: [redacted]
Sent: Tuesday, June 24, 2025 10:16 AM
To: [redacted]@gamblingcommission.gov.uk>
Subject: Fwd: APMS survey follow up

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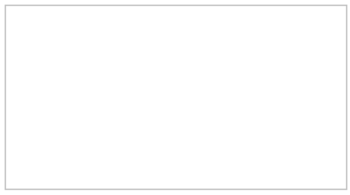
Morning [redacted]

Sharing a bit more information on the APMS from DHSC.

Thanks
[redacted]



[redacted]

---------- Forwarded message ---------
From: [redacted]
Date: Mon, 23 Jun 2025 at 18:03
Subject: Re: APMS survey follow up
To: [redacted]
Cc: [redacted]

Hi [redacted]

Thank you for your follow-up.

NHSE have said it would be best to contact **surveys.queries@nhs.net** for any questions on the survey methodology. Unfortunately, they don't have any documents with further detail that can be shared at the moment, but will be able to respond to queries at the email above.

They have also shared the list of gambling data tables that will be published alongside the report (see below).

Lastly, you asked about comparisons between the HSE 2024 and APMS 2023/24 methodology. Here is a high level summary of we know at the moment:

- The data collection method (self completion via CAWI or CASI) and sampling frame (two-stage stratified sample from PAF) don't differ between the two surveys.
- Multiple adults per household are selected in HSE 2024 compared to only one adult in APMS 2023/24, which could impact survey responses because other household members might be present during the interview or be aware of what questions are being asked.
- To identify those that have participated in gambling (and route these individuals to PGSI questions) the HSE uses a detailed list of 19 activities with Yes/No responses to each. Answering Yes to any routes to the PGSI questions. The APMS uses the two gambling questions I shared previously. The more detailed questions on HSE could result in more participants being asked the PGSI questions, and therefore higher prevalence estimates of gambling participation and 'problem gambling'.

Hope this helps

Best,
[redacted]

Table 7.1: Gambling behaviour in the past 12 months and Problem Gambling Severity Index (PGSI) scores among the whole sample, by age and gender
Table 7.2: Gambling behaviour in the past 12 months and Problem Gambling Severity Index (PGSI) scores by participation in any gambling, participation in online gambling, age and gender
Table 7.3 Problem Gambling Severity Index (PGSI) scores (observed and age-standardised), by ethnic group and gender
Table 7.4: Problem Gambling Severity Index (PGSI) scores (age-standardised), by employment status and gender
Table 7.5: Problem Gambling Severity Index (PGSI) scores (age-standardised), by has problem debt and gender
Table 7.6: Problem Gambling Severity Index (PGSI) scores (observed and age-standardised), by Index of Multiple Deprivation (IMD) and gender
Table 7.7: Problem Gambling Severity Index (PGSI) scores (observed and age-standardised), by region and gender

Table 7.8: Problem Gambling Severity Index (PGSI) scores (age-standardised), by limiting physical health condition, common mental health conditions (CMHC) and gender
Table 7.9: Problem Gambling Severity Index (PGSI) scores, by self diagnosis and professional diagnosis
Table 7.10: Treatment currently received for a mental or emotional problem in the past year, by Problem Gambling Severity Index (PGSI) scores
Table 7.11: Psychotropic and substance dependence medication currently taken, by Problem Gambling Severity Index (PGSI) scores
Table 7.12: Treatment ever used for gambling problems, by Problem Gambling Severity Index (PGSI) scores
Table A1: True standard errors and 95% confidence intervals for gambling behaviour in the past 12 months and Problem Gambling Severity Index (PGSI) scores among adults, by age and gender
Table A2: True standard errors and 95% confidence intervals for problem Gambling Severity Index (PGSI) scores (age-standardised) among adults, by ethnic group and gender

---

From: [redacted]
Sent: Thursday, June 19, 2025 13:02
To: [redacted]
Cc: [redacted]@gamblingcommission.gov.uk>; [redacted]
Subject: APMS survey follow up

Hi [redacted],

Thank you again for meeting myself and [redacted] yesterday to take us through the APMS in more detail, it was really helpful. You kindly offered to share the contact details of the APMS leads at NHS England for any further methodological questions.

I am copying [redacted], so that you have each other's details and so that she can pick up any specific questions with yourselves or the NHS England contacts.

Many thanks,
[redacted]

Hi [redacted]

I didn't hear back from them, but I can make 12.30 tomorrow – sounds good.

Thanks

[redacted]

From: [redacted]
Sent: Wednesday, June 25, 2025 2:43 PM
To: [redacted]@gamblingcommission.gov.uk>
Subject: APMS results: meeting with DHSC

CAUTION: This email is from an external source be careful of attachments and links

Hi [redacted]

[redacted] at DHSC has suggested a meeting tomorrow at 12:30 with both DCMS and GC on the APMS. They can answer any questions we have on the data / methodology and we can discuss how we plan to manage any media enquiries around the data and how we ensure we are all aligned in any responses. I assume you didn't hear back from [redacted] and [redacted] But they are in the same team as [redacted]

Are you able to make 12:30 tomorrow?

Thanks,
[redacted]

[redacted]

Thanks [redacted]

Just to note we're catching up with DCMS colleagues tomorrow on APMS which is published in the morning to ensure aligned response about comparisons with GSGB etc

[redacted]

From: [redacted]@gamblingcommission.gov.uk>
Sent: Monday, June 23, 2025 4:21 PM
To: [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>
Cc: [redacted]@gamblingcommission.gov.uk>
Subject: Fw: DCMS/GC Monthly agenda

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

From: [redacted]
Sent: 23 June 2025 16:11
To: [redacted]@gamblingcommission.gov.uk>
Cc: [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>
Subject: Re: DCMS/GC Monthly agenda

CAUTION: This email is from an external source be careful of attachments and links

Thanks [redacted] Please could we add the following:

- Adult Psychiatric Morbidity Survey - stats and reflections
- [redacted]

Thanks,

[redacted]

Outlook

APMS - Reactive line

From [redacted]

Date Thu 6/26/2025 6:01 PM

To [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>

Cc [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>

Hi All,

If we are contacted over the latest data released by the NHS, the approved line is below.

We welcome the publication of the Adult Psychiatric Morbidity Survey 2023/24 (APMS). We recognise there are differences in methodology and estimates in key areas, it's important to remember that the APMS and our own Gambling Survey for Great Britain are distinct vehicles, each designed to deliver their own valuable insights.

It is helpful to have this new dataset, which supports broader comparisons and enhances our understanding of gambling behaviours in the context of wider health inequalities

We will take the time to review and digest this new information and incorporate it into our continuous improvement cycle.

Thanks

[redacted]

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[redacted]

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Hi [redacted]

I thought you might be interested in the APMS results which were published today.

There is a gambling chapter in the report which you can access here [Chapter 7: Gambling behaviour - NHS England Digital]

This is a face to face survey about mental health, but they ask about gambling participation and the PGSI.

Thanks

[redacted]

GAMBLING COMMISSION

[redacted]

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Hi all,

I've pulled together this doc for [redacted] APMS 2023-24 Wednesday 25th June 2025.docx

Thanks,
[redacted]

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[redacted]

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[redacted]

Hi all,

Results from the Adult Psychiatric Morbidity Survey 2023/24 are being released on 26th July – as they are official statistics I doubt we will get any advanced notice of the findings, so [redacted] will be reviewing the release as soon as it comes out. Putting this time in to discuss our response.

@[redacted] – would you be able to start preparing some reactive lines for the different scenarios? Core figures will be:

- Overall PG rates
- Gambling-related suicide data (may not be analysed as such, but data provided could be used to calculate figures)

[redacted] – please forward on to anyone else in your team who should come along.

If we hear anything further in the meantime, I'll let you know.

Thanks,

[redacted]

Microsoft Teams Need help?

Join the meeting now

Meeting ID: 332 150 597 627 6

Passcode: R2Kk33Tm

Dial in by phone

+44 20 3855 4234,,256898635# United Kingdom, City of London

Find a local number

Phone conference ID: 256 898 635#

For organizers: Meeting options | Reset dial-in PIN

Outlook

(No subject)

From [redacted]@gmail.com>
Date Thu 6/26/2025 12:37 PM
To [redacted]@gamblingcommission.gov.uk>

CAUTION: This email is from an external source - be careful of attachments and links

We welcome the publication of the Adult Psychiatric Morbidity Survey 2023/24. While we recognise there are differences in methodology and estimates in key areas, it's important to remember that the APMS and our own Gambling Survey for Great Britain are distinct vehicles, each designed to deliver their own valuable insights. It is helpful to have this new dataset, which supports broader comparisons and enhances our understanding of gambling behaviours in the context of wider health inequalities

Sent from Gmail Mobile

Dear Steering Group

We are pleased to announce that Part 1 of the Adult Psychiatric Morbidity Survey (APMS) has now been published.

Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/4 - NHS England Digital

We would like to thank all the members of the group for their contribution so far and now look forward to publication of part 2 in the autumn.

With best wishes,
The Surveys team

Data & Analytics
NHS England

We will be the best insight-driven, health and care system in the world

Email: [redacted]
Team mailbox: surveys.queries@nhs.net
Teams: [redacted]

Website: www.england.nhs.uk
NHS England and NHS Digital have merged: Learn more

[redacted]

Outlook

Re: APMS - Reactive line

From [redacted]@gamblingcommission.gov.uk>
Date Thu 6/26/2025 5:58 PM
To [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>
Cc [redacted]@gamblingcommission.gov.uk>

Thanks All,

[redacted] your welcome to share with other stakeholders.

Thanks,
[redacted]

From: [redacted]@gamblingcommission.gov.uk>
Sent: Thursday, June 26, 2025 16:55
To: [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>; [redacted]gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>
Cc: [redacted]@gamblingcommission.gov.uk>
Subject: Re: APMS - Reactive line

[redacted]

[redacted]

From: [redacted]@gamblingcommission.gov.uk>
Sent: Thursday, June 26, 2025 4:50:39 PM
To: [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>
Cc: [redacted]@gamblingcommission.gov.uk>
Subject: RE: APMS - Reactive line

I'm happy with the reactive lines from [redacted]

We agreed with DHSC and DCMS that we would share reactive lines, are you happy for me to share these now?

Thanks

[redacted]

From: [redacted]@gamblingcommission.gov.uk>
Sent: Thursday, June 26, 2025 3:03 PM
To: [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>
Cc: [redacted]@gamblingcommission.gov.uk>
Subject: RE: APMS - Reactive line

Thanks both

I tend towards [redacted] version because:

- We do welcome robust research which helps to develop a triangulated evidence base [and indeed OSR would expect us to]

I've copied [redacted] in so he's sighted

[redacted]

From: [redacted]@gamblingcommission.gov.uk>
Sent: Thursday, June 26, 2025 2:06 PM
To: [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>
Cc: [redacted]@gamblingcommission.gov.uk>
Subject: Re: APMS - Reactive line

Hi all,

Sorry, jumping - been tied up.

As you know certain stakeholders are going to use this to say our GSGB date is rubbish... and may even say we have 'welcomed it'.

Could we just stick to:

> We look forward to thoroughly digesting the Adult Psychiatric Morbidity Survey 2023/24.
>
> However, it's important to remember that this survey uses very different methodology to our extremely robust Gambling Survey for Great Britain.

Best regards,

[redacted]

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[redacted]
[redacted]
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From: [redacted]@gamblingcommission.gov.uk>
Sent: 26 June 2025 13:42
To: [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>
Cc: [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>
Subject: APMS - Reactive line

Hi All,

Drafted a reactive line, should we be approached about the figures and data shared in APMS 2023/24.

We welcome the publication of the Adult Psychiatric Morbidity Survey 2023/24 (APMS). We recognise there are differences in methodology and estimates in key areas, it's important to remember that the APMS and our own Gambling Survey for Great Britain are distinct vehicles, each designed to deliver their own valuable insights.

It is helpful to have this new dataset, which supports broader comparisons and enhances our understanding of gambling behaviours in the context of wider health inequalities

We will take the time to review and digest this new information and incorporate it into our continuos improvement cycle.

Thanks

[redacted]

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[redacted]

From: [redacted]@gamblingcommission.gov.uk>
Sent: Thursday, June 26, 2025 6:23 PM
To: [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>
Subject: FW: APMS survey published today - key points arising

[redacted]

Thanks so much for what you produced - ideal.

You'll see that I've taken it and used it in a slightly different way.

I wanted to show to [redacted] and [redacted] the type of question that could get asked and how we'd respond. It's a style thing but helps I think an exec get to the heart of what they need to know quickly.

Thanks

[redacted]

From: [redacted]
Sent: Thursday, June 26, 2025 6:21 PM
To: [redacted] <[redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>
Cc: [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>
Subject: APMS survey published today - key points arising

Both

With particular thanks to [redacted] who has done the hard yards here.

Given it may get raised with you we wanted to provide a quick update on The Adult Psychiatric Morbidity Survey (APMS): Survey of Mental Health and Wellbeing, England, 2023/4 , published today (previous survey 2014). [redacted] sat on the steering group.

It provides data on the prevalence of both treated and untreated psychiatric disorder in the English adult population (aged 16 and over) including PTSD, suicide ideation, alcohol and drug dependence, ADHD etc

It's important because it includes gambling behaviour, prevalence using PGSI 8+, and associations can be made between gambling and suicide ideation. It helps us triangulate our evidence base here.

Claims that **could** be made:

- *Last 12 month gambling participation is more accurate than what GSGB captures (42.6% of adults aged 16+ living vs 61% for GSGB [18 years old +)*

    - The difference is likely due to:
        - smaller activity list than the GSGB. We know from our experiments that this makes a big difference and does not capture all gambling participation
        - Includes 16/17 year olds, GSGB does not
        - Social desirability bias from face to face methodology.

- *The APMS PGSI 0.4% figure found shows that the GSGB figure is too high*
    - Our pushback would be:
        - Not surprised a face to face methodology produces a lower number. Historic trends here and report notes the potential impact of social desirability on under reporting
        - The report itself recognises that it is likely an under-estimate, due to:
            - wider harms shown to also be experienced by those not registering 8+ on GSGB
            - Different wording on PGSI response
            - And lower than the HSE because HSE reports a mix of PGSI and DCMS screens

- *GSGB estimates in relation to suicide ideation/attempts are unreliable – GSGB 11.4%, APMS 7.7%*
    - We'd note:
        - It's not the primary purpose of GSGB to provide an official estimate of this and methodological differences will have an impact
        - The rate has significantly increased from 4.3% in 2000 to 7.7% in 2023/4, this sober statistic is surely resonant in terms of thinking about the number of gambling consumers who may need additional care compared to before

- *APMS shows that face to face still works as a gold plated methodology rather than GSGB*
    - We'd note that:
        - The response rate achieved (29.4%) was lower than previous surveys in the series (57% in 2014).
        - The fieldwork was delayed and took far longer because of the difficulties in achieving sample size
        - This further illustrates why we moved to a push to web approach.

We've talked today with DCMS and DHSC who both noted the different purpose between APMS and GSGB and how they complement rather than combat each other. No issues raised.

We developed a reactive line with Comms:

- *We welcome the publication of the Adult Psychiatric Morbidity Survey 2023/24 (APMS). We recognise there are differences in methodology and estimates in key areas, it's important to remember that the APMS and our own Gambling Survey for Great Britain are distinct vehicles, each designed to deliver their own valuable insights.*

- *It is helpful to have this new dataset, which supports broader comparisons and enhances our understanding of gambling behaviours in the context of wider health inequalities*
- *We will take the time to review and digest this new information and incorporate it into our continuous improvement cycle.*

We have more detail if needed but wanted to share the topline today.

You can read the full report here: Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/4 - NHS England Digital

[redacted]

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Hi [redacted]

Could you add:

- The Adult Psychiatric Morbidity Survey (APMS): Survey of Mental Health and Wellbeing, England was published on 26 June 2025 by NHS Digital. We have participated in the working group leading up to this publication and welcome the findings which provide data on the prevalence of treated and non-treated health conditions in England's adult population (age 16 and over). The survey also collects data in relation to the prevalence of problem gambling (measured by the PGSI) and suicide ideation and attempts. The findings will be incorporated not our evidence base around gambling and gambling harm.

Hi [redacted]

We don't know if APMS will be commissioned again yet I'm afraid, so that will be the first decision point, hopefully in the next 12 months.

Kind Regards,

[redacted]

From: [redacted]
Sent: Thursday, 26 June 2025 16:36
To: [redacted]
Cc: [redacted]
[redacted]@gamblingcommission.gov.uk>; [redacted]
Subject: Re: APMS clarification questions

Hi [redacted]

Thank you for this, that's useful. One final question from me - do you know if future waves of APMS will include gambling questions, or whether they will continue to be included on a more ad hoc basis?

Thanks,
[redacted]

[redacted]

On Thu, 26 Jun 2025 at 14:57, [redacted] wrote:

> Hi [redacted]
> Yes good thanks, hope you are well too.
> I have spoken to our consortium colleagues who have provided the responses in red below.
>
> 1. The Methods section states that 'Socially undesirable or stigmatised feelings and behaviours may be
> 2. underreported'. What is the reason for this? I assume it is because it is a self-report survey and there is an interviewer is present, but wanted to check.
>
> On all surveys socially undesirable behaviours, feelings, attitudes can be underreported. That can impact on any survey and is well documented in the methodological literature (the classic on this is Roger Tourangeau (2012), The Psychology of Survey Response. The fact that these items were in the self completion will have helped, but yes the presence of the interviewer in the room may have had an effect too.
>
> 3.
> 4. The Gambling section stated that 'the estimated prevalence of problem gambling, 0.4%, is likely to be
> 5. conservative'. Again, what is the reason for this? Is it simply comparing PGSI scores only to PGSI and DSM scores, or it is more wide-ranging?
>
> That is the key factor yes, this relied only on the PGSI. The DSM captures a different group, and a better estimate is obtained if both measures are used. The PGSI also doesn't cover all types of gambling harms.

Hope that helps,

[redacted]

From: [redacted]
Sent: Thursday, 26 June 2025 14:04
To: [redacted]
<[redacted]@gamblingcommission.gov.uk>
Subject: APMS clarification questions

You don't often get email from [redacted]. Learn why this is important
This message originated from outside of NHSmail. Please do not click links or open attachments unless you recognise the sender and know the content is safe.

Hi [redacted]

Hope you're well.

[redacted] kindly shared your email address as I have a couple of questions on the gambling chapter of APMS publication this morning. [redacted]

Do you have any official lines that we can use on the below?

1.
2.
3. The Methods section states that 'Socially undesirable or stigmatised feelings and behaviours may be
4. underreported'. What is the reason for this? I assume it is because it is a self-report survey and there is an interviewer is present, but wanted to check.
5.
6.
7.
8. The Gambling section stated that 'the estimated prevalence of problem gambling, 0.4%, is likely to be
9. conservative'. Again, what is the reason for this? Is it simply comparing PGSI scores only to PGSI and DSM scores, or it is more wide-ranging?
10.

Happy to have a call if it is easier to discuss these points.

Many thanks,
[redacted]

[redacted]

Outlook

Re: FW: APMS data on gambling and suicide thoughts/attempts

From [redacted]
Date Fri 6/27/2025 11:27 AM
To [redacted]
Cc [redacted]@gamblingcommission.gov.uk>; [redacted]

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Thanks [redacted] really helpful.

[redacted]

On Fri, 27 Jun 2025 at 09:36, [redacted] wrote:

> Morning all
>
> Following on from our conversation yesterday, [redacted] kindly followed up with NHSE regarding the lack of APMS data on gambling-related suicide. Their response is copied below.
>
> I hope this is helpful, but if anyone needs anything further, please do give me a shout.
>
> Best
>
> [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

From: [redacted]
Sent: 26 June 2025 16:40
To: [redacted]
Cc: [redacted]
Subject: Fw: APMS data on gambling and suicide thoughts/attempts

Hi [redacted]

NHS England have shared the lines below on why the association between suicide and gambling was not included in the APMS publication.

The sample of respondents experiencing problem gambling was lower in the APMS 2023/24 survey than the APMS 2007 survey used in the Wardle et al. study (likely less than 30) but it might be possible to do secondary analysis looking at different PGSI risk categories. This could be something we speak to the Addictions PRU or UKRI about.

Best,

[redacted]

From: [redacted]
Sent: Thursday, June 26, 2025 14:54
To: [redacted]
Subject: RE: APMS data on gambling and suicide thoughts/attempts

Hi [redacted]

We have asked the project team to comment on the point below.

They did not look at the association with suicidal thoughts and self-harm for any of the disorders, as a summary report the key analysis variables were demographics, socioeconomics, health and treatment. They recognised however, that this would be an excellent topic to examine in further secondary analyses, and would build well on this paper using APMS 2007 https://pubmed.ncbi.nlm.nih.gov/32409100/.

If you have or anticipate any further questions, please do let us know.

Best wishes

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

From: [redacted]
Sent: 26 June 2025 14:18
To: [redacted]
Subject: APMS data on gambling and suicide thoughts/attempts

Hello,

We are expecting a few queries about the relationship between suicide thoughts/attempts and at-risk gambling based on APMS 2023/24 survey results. We noticed that this relationship wasn't analysed in the part 1 publication. Is there a reason we can provide to stakeholders why this wasn't the case?

Many thanks,

[redacted]

Thanks [redacted] I have shared those additional lines with our Comms team.

From: [redacted]
Sent: Friday, June 27, 2025 11:30 AM
To: [redacted]
Cc: [redacted]@gamblingcommission.gov.uk>; [redacted]; [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>
Subject: Re: GC Comms Lines re: APMS

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Hi [redacted]

Agree, really helpful to see. We will use those lines as well as these additional lines:

- The Government considers the results in the APMS alongside the other surveys producing official statistics on gambling participation and the consequences from gambling, in the context of the wider evidence base.
- [When referring to PGSI 8+ rates] There are differing estimates of 'problem gambling' (PGSI 8+) rates, ranging from under 1% of adults in England to 2.5% of adults in Great Britain.

Many thanks,
[redacted]

[redacted]

On Fri, 27 Jun 2025 at 09:31, [redacted] wrote:

> Hi [redacted]
>
> Thanks so much for sharing. Really helpful to see.
>
> Best wishes
>
> [redacted]

[redacted]

From: [redacted]@gamblingcommission.gov.uk>
Sent: 26 June 2025 17:29
To: [redacted]
Cc: [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>
Subject: GC Comms Lines re: APMS

Hi All

Thanks for the catch up earlier on the APMS release, it was really helpful.

We discussed sharing our comms lines in response to the publication. Our reactive lines from the GC will be as follows:

We welcome the publication of the Adult Psychiatric Morbidity Survey 2023/24 (APMS). We recognise there are differences in methodology and estimates in key areas, it's important to remember that the APMS and our own Gambling Survey for Great Britain are distinct vehicles, each designed to deliver their own valuable insights.

It is helpful to have this new dataset, which supports broader comparisons and enhances our understanding of gambling behaviours in the context of wider health inequalities

We will take the time to review and digest this new information and incorporate it into our continuous improvement cycle.

Thanks

[redacted]

Hi [redacted]

Thanks so much for sharing. Really helpful to see.

Best wishes

[redacted]

From: [redacted]@gamblingcommission.gov.uk>
Sent: 26 June 2025 17:29
To: [redacted]
Cc: [redacted]@gamblingcommission.gov.uk>; [redacted]@gamblingcommission.gov.uk>
Subject: GC Comms Lines re: APMS

Hi All

Thanks for the catch up earlier on the APMS release, it was really helpful.

We discussed sharing our comms lines in response to the publication. Our reactive lines from the GC will be as follows:

We welcome the publication of the Adult Psychiatric Morbidity Survey 2023/24 (APMS). We recognise there are differences in methodology and estimates in key areas, it's important to remember that the APMS and our own Gambling Survey for Great Britain are distinct vehicles, each designed to deliver their own valuable insights.

It is helpful to have this new dataset, which supports broader comparisons and enhances our understanding of gambling behaviours in the context of wider health inequalities

We will take the time to review and digest this new information and incorporate it into our continuous improvement cycle.

Thanks

[redacted]

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[redacted]

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Adult Psychiatric Morbidity Survey 2023/24

Chapter 1: Common mental health conditions

Summary

Key findings

- X
- X
- X
- X
- x

1.1 Introduction

1. 2 Definitions and assessments

Common mental health conditions (CMHC)

The Clinical Interview Schedule – Revised (CIS-R)

1.3 Results

Prevalence of CMHC symptoms, by age and gender

Trends in CMHC symptoms, 1993 to 2023/24

Prevalence of CMHCs, by age and gender

Trends in CMHCs, 1993 to 2023/24

CMHCs, by CIS-R score

Variation in CMHCs by other characteristics

Ethnic group

Employment status

Problem debt

Area-level deprivation

Region

Comorbidity

Physical health conditions

Common mental health conditions

Self-diagnosis and professional diagnosis of CMHC

1.4 Discussion

1.5 References

Adult Psychiatric Morbidity Survey 2023/24

Chapter 2: Mental health treatment and service use

Summary

Key findings

- x
- x
- x
- x
- x

2.1 Introduction

2.2 Definitions and assessments

Measuring mental health treatment

Measuring psychotropic medications

Measuring psychological therapies

Measuring health service use for a mental health reason

Measuring community and day care service use

Measuring unmet treatment requests

Measuring treatment need

CMHC symptoms

CMHCs

2.3 Results

Mental health treatment use, by CIS-R score

Mental health treatment use, by type of CMHC

Psychotropic medication use, by CIS-R score

Types of psychotropic medication currently taken, by CMHC

Psychological therapy use, by CIS-R score

Psychological therapy use, by type of CMHC

Health service use, by CIS-R score

Health service use, by type of CMHC

Community and day care services use, by CIS-R score

Community and day care services used in past year, by type of CMHC

Trends in treatment in people with CMHC symptoms

Trends in health service use in people with CMHC symptoms

Trends in community and day care service use in people with CMHC symptoms

Treatment for mental or emotional problem, by age and gender

Treatment for mental or emotional problem, by other characteristics

Gender

Age

Ethnic group

Employment status

Problem debt

Area-level deprivation

Region

Comorbidity

Physical health conditions

Common mental health conditions

Unmet treatment requests

Gender

Age

Currently receiving any mental health treatment

Delays in receiving treatment

2.4 Discussion

2.5 References

Adult Psychiatric Morbidity Survey 2023/24

Chapter 3: Posttraumatic Stress Disorder

Summary

Key findings

- x
- x
- x
- x
- x

3.1 Introduction

3.2 Definitions and assessments

PTSD

PCL-C

Exposure to trauma

3.3 Results

Prevalence of trauma, by age and gender

Lifetime experience of trauma

Screening positive for PTSD in past month, by age and gender

Experience of PTSD symptoms, by age and gender

Adult Psychiatric Morbidity Survey 2023/24

Chapter 4: Suicidal thoughts, attempts and self-harm

Summary

Key findings

- x
- x
- x
- x
- x

4.1 Introduction

4.2 Definitions and assessments

Suicidal thoughts, suicide attempts and self-harm

Measuring suicidal thoughts, suicide attempts and self-harm

Face to face questions

Self completion questions

Questions used for results in this chapter

Measuring methods of self-harming

Measuring reasons for self-harming

4.3 Results

Suicidal thoughts, attempts and self-harm, by age and gender

Prevalence of suicidal thoughts

Prevalence of suicide attempts

Prevalence of self-harm without suicidal intent

Trends in suicidal thoughts and attempts in the past year and self-harm ever, 2000 to 2023/24

Note that the trend data in this chapter are based only on face to face reports. In 2007 and 2014 self-completion data on this topic was also collected, this tends to elicit higher reporting.

Trends in suicidal thoughts

Trends in suicide attempts

Trends in self-harm

Variation in suicidal thoughts, attempts and self-harm by other characteristics

Ethnic group

Employment status

Problem debt

Area-level deprivation

Region

Comorbidity

Physical health conditions

Common mental health conditions

Adult Psychiatric Morbidity Survey 2023/24

Chapter 5: Alcohol dependence

Summary

Key findings

- x
- x
- x
- x
- x

5.1 Introduction

5.2 Definitions and assessments

Alcohol use disorders

Alcohol Use Disorders Identification Test (AUDIT)

5.3 Results

Prevalence of hazardous, harmful or dependent drinking), by age and gender

Trends in hazardous, harmful or dependent drinking, 2000 to 2023/24

Variations in hazardous, harmful or dependent drinking by other characteristics

Ethnic group

Employment status

Problem debt

Area-level deprivation

Region

Comorbidity

Physical health conditions

Common mental health conditions

Self-diagnosis and professional diagnosis of alcohol dependence

Treatment and Delays

Treatment and service use for a mental or emotional problem

Treatment for alcohol dependence

Delays in receiving treatment

5.4 Discussion

5.5 References

Adult Psychiatric Morbidity Survey 2023/24

Chapter 6: Drug use and dependence

Summary

Key findings

- x
- x
- x
- x
- x

6.1 Introduction

6.2 Definitions and assessments

Drug misuse

Measuring drug use and dependence

6.3 Results

Prevalence of illicit drug use, by age and gender

Prevalence of illicit drug use in past year, by ethnic group and region

Prevalence of drug dependence, by age and gender

Trends in signs of drug dependence, 1993 to 2023/24

Drug dependence in the past year, by other characteristics

Ethnic group

Employment status

Problem debt

Area-level deprivation

Region

Comorbidity

Physical health conditions

Common mental health conditions

Self-diagnosis and professional diagnosis of drug dependence

Treatment and delays

Treatment and service use

Treatment for drug dependence

Psychotropic medication

Delays in receiving treatment

6.4 Discussion

6.5 References

Adult Psychiatric Morbidity Survey 2023/24

Chapter 7: Gambling behaviour

Summary

Key findings

- x
- x
- x
- x
- x

7.1 Introduction

7.2 Definitions and assessments

Past 12 months gambling

Online gambling

Problem Gambling Severity Index (PGSI)

7.3 Results

PGSI scores, by age and gender

PGSI scores by other characteristics

Ethnic group

Employment status

Problem debt

Area-level deprivation

Region

Comorbidity

Physical health conditions

Common mental health conditions

Self-diagnosis and professional diagnosis of problem gambling

Treatment and Delays

Treatment and service use for mental of emotional problems

Treatment for gambling problems

Psychotropic medication

Delays in receiving treatment

7.4 Discussion

7.5 References

Adult Psychiatric Morbidity Survey 2023/24

Chapter 8: Personality disorder

Summary

Key findings

- X
- X
- X
- X

8.1 Introduction

Antisocial personality disorder (ASPD)

Borderline personality disorder (BPD)

Personality disorder

8.2 Definitions and assessments

Antisocial, borderline and any personality disorders

ASPD

BPD

Personality disorder

Assessment

Screening positive for ASPD or BPD on the SCID-II

Screening positive for any personality disorder on the SAPAS

8.3 Results

Screening positive for ASPD, BPD and any PD, by age and gender

Trends in screening positive for ASPD, BPD and any PD, 2007 to 2023/24

ASPD and BPD screens by any PD screen

Screening positive for PD by other characteristics

Ethnic group

Employment status

Problem debt

Area-level deprivation

Region

Comorbidity

Physical health conditions

Common mental health conditions

Self-diagnosis and professional diagnosis of PD

Treatment and delays

Treatment and service use

Delays in receiving treatment

8.4 Discussion

8.5 References

Adult Psychiatric Morbidity Survey 2023/24

Chapter 9: Attention-deficit/hyperactivity disorder

Summary

Key findings

- x
- x
- x
- x
- x

9.1 Introduction

9.2 Definitions and assessments

Attention-deficit/hyperactivity disorder (ADHD)

Adult ADHD Self-Report Scale-v1.1 (ASRS)

9.3 Results

Screening positive for ADHD in past 6 months, by age and gender

Trends in screening positive for ADHD, 2007 to 2023/4

Variation in screening positive for ADHD by other characteristics

Ethnic group

Employment status

Problem debt

Area-level deprivation

Region

Comorbidity

Physical health conditions

Common mental health conditions

Self-diagnosis and professional diagnosis of ADHD

Treatment and delays

Treatment and service use

Psychotropic medication

Delays in receiving treatment

9.4 Discussion

9.5 References

Adult Psychiatric Morbidity Survey 2023/4

Chapter 11: Bipolar disorder

Summary

Key findings

- x
- x
- x
- x
- x

11.1 Introduction

11.2 Definitions and assessments

Bipolar disorder

Mood Disorder Questionnaire (MDQ)

11.3 Results

Screening positive for bipolar disorder, by age and gender

Change in screening positive for bipolar disorder, 2014 and 2023/4

Variations in screening positive for bipolar disorder by other characteristics

Ethnic group

Employment status

Problem debt

Area-level deprivation

Region

Comorbidity

Physical health conditions

Common mental health conditions

Self-diagnosis and professional diagnosis of bipolar disorder

Treatment and delays

Treatment and service use

Delays in receiving treatment

11.4 Discussion

11.5 References

Adult Psychiatric Morbidity Survey 2023/4

Chapter 13: Eating problems and disorders

Section A

Summary

Key findings

- X
- X
- X

13.1 Introduction

13.2 Definitions and assessments

Possible eating problems

SCOFF questionnaire

Estimation of Body Mass Index (BMI)

Possible eating disorders

Eating Disorder Examination Questionnaire Short (EDE-QS)

Eating disorders

Schedule*s for Clinical Assessment in Neuropsychiatry (Section 9)*

13.3 Results

Possible eating problems and disorders, by age and gender

Change in possible eating problems, 2007 and 2023-24

Variations in screening positive for possible eating problems and disorders by other characteristics

Ethnic group

Employment status

Problem debt

Area-level deprivation

Region

Comorbidity

Physical health conditions

Common mental health conditions

Body Mass Index (BMI)

Self-diagnosis and professional diagnosis of eating problems and disorders

Screen positive for possible eating problems (SCOFF), by screen for possible eating disorders (EDE-QS)

Treatment and delays

Treatment and service use

Psychotropic medication

Delays in receiving treatment

13.4 Discussion

13.5 References

Minutes

APMS Steering Group Meeting

Date: Tuesday 13 June 2023 **Time:** 11:00am-13:00pm **Location:** MS Teams

Attendees
[redacted]
Details taken from the recording

Apologies
No apologies mentioned in the recording and non-on sign- in sheet

1. Welcome and Introductions

[redacted] welcomed attendees to the APMS Steering Group meeting and introductions were made for the benefit of new members. [redacted] reminded the meeting that there last meeting was on Tuesday 19 July 2022, so the aim of this meeting is to update everyone on the AMPS Survey and to also collect your initial thoughts.

You should have received a copy of the minutes from the last meeting together with the agenda for this meeting as part of the invite – the slides will be shared on screen, and a copy will be issued following the meeting.

Please note that the meeting will be recorded.

2. Minutes and Actions from previous meeting

The minutes of the meeting held on Tuesday 19 July 2022 were approved, and all the current Actions *(refer to the Actions from the last APMS meeting slide)* were reviewed and updated accordingly – ***please refer to the updated Action Table at the end of these minutes***.

3. Project Plan Update - Timeline

[redacted] gave an update since the last meeting *(refer to the 2021 - 2022 Timeline slide 9)*

[redacted] commented that the last time the Group met the 'dress rehearsal' had just been completed and the following were some of the key actions:

- Questionnaire were reviewed, (including the Boost), edited and final versions produced
- All materials reviewed and finalised
- Fieldwork recruitment commenced – (including videos* as part of the recruitment process)
- HSE 2023 cancelled
- All approvals obtained

(*) link to videos is included in the slide pack

Current update *(refer to the current 2023 Timeline slide 10 & 11),* the following are the key points:

- Fieldwork commenced January 2023
- Phase 2 fieldwork and Ethnic Minority Boost also initiated

[redacted] commented that was the current situation and indicated that it should be noted the timetable is 'subject to change.'

[redacted] also advised the Group that the HSE 2023 Survey has been cancelled, to prioritise the APMS Survey - the HSE Survey has been re-scheduled for January 2024 start.

4. Fieldwork Update

[redacted] gave an overview of APMS Fieldwork and predicted achievements *(refer to slide 13)* and then proceeded to outline the background and context to the fieldwork *(refer to slide 14),* and made the additional points/comments:

- Face to Face Fieldwork:
  - The survey required experience interviewers
- Health Surveys:
  - The survey required experience interviewers
  - Although the survey had been reduced following the 'dress rehearsal,' it was still considered too long
  - The current pressure on the NHS seems to have had a negative effect on some households
- Ethnic Minorities:
  - These groups are particularly hard to engage with:
    - A general lack of trust in the government and a reluctance to hand over data to the authorities
    - A push back around the NHS
    - Some feedback has indicated that some groups do not like being 'singled out'

[redacted] prefaced the next few slides, (which contain the figures), with comments on why the figures they are reporting are lower than projected.

Phase 1 Fieldwork: The Core *(refer to slide 15):*

- The survey commenced in January 2023, with a smaller sample
- Currently 2 Waves of 7 Waves have been completed, so a quarter of the way through the fieldwork
- Achieved 1330 interviews as of 9 June 2023 out of a target of 8,000 - response rate of 32%, compared to a target rate of 55% - reasons for nor achieving target
  a) all cases are not being covered due to a lack of interviewer
  b) there is a much higher 'non-contact' rate being experienced, compared to 2014 – some of this reflects that more properties have Concierge services, and householders are not responding

c) refusal rate is significantly higher than 2014 - and higher than expected

Those numbers are well short of expected levels – the interviews were closer to 5,000 rather than 8,000 productive interviews for the Core sample. The situation is currently under review, and there will be discussion regarding the situation later.

[redacted] continued to go through the details Phase 1 Fieldwork: The Core *(refer to slide 16),* prior to discussing some of the remedial actions currently in place.

Key points raised were:

- Response Rate - there is a lower response rate in both types of samples but, the response rate in the deprived area Boost is lower than anticipated.
- Non-contact Rate - is extremely high in deprived areas of 29% compared with 18% in the main sample - reasons are:
    a) the Deprived Areas Boost concentrated on urban areas, which pose challenges i.e., parking access to apartment blocks etc.
    b) potentially in more deprived areas, the social trust is lower which can result in people less likely to open the door.
- Interview Length – this is broadly in line with what we expected with the median interview length being about 90mins. It is worth noting that the range of interview length varied, which was challenging.
- Fieldwork Proceeding as Expected:
    a) Confirmed Phase 2 – 76% consent against a target of 75%
    b) Majority of interviews undertaken face to face
    c) The proportion of people completing the 'self-completion' element of the interview is on target at 93% against a figure of 94% in 2014.

Improving Fieldwork Performance *(refer to slide 17)*

[redacted] gave a quick overview on ways the Core fieldwork is being improved, such as:

- Ongoing recruitment and maintaining interviewers, especially those with APMS experience
- Motivational Workshops have been organised and sharing experience
- Performance monitoring, (including re-allocation if appropriate and dependant on experience)
- To ensure 100% coverage, and with joint agreement, some fieldwork is to be sub-contracted to another agency – to commenced mid-June 2023.
- Interviewer fees were reviewed and increased – reflecting the increased interview length and complexity.
- Advanced Mailing system changes – mailing staggered to ensure interviewers available prior to issue.
- Reserve Sample – to review and consider

[redacted] did conclude by commenting that give the accumulative challenges encountered, it is extremely unlike that the target number of 8,000 interviews with the current sample numbers. So, there are discussing issuing a reserve sample.

It would have a cost and time implication, but more importantly for this group, it would require a further extension to the fieldwork. Currently there is work on establishing specific size of the reserve sample and estimated timescales.

Discussion – Fieldwork and Next steps

[redacted] thanked [redacted] for the fieldwork update and asked for questions and comments.

[redacted] informed the meeting that [redacted] questioned whether non-financial incentives / rewards for interviewers had been consider, e.g., access to training, mentoring etc.

[redacted] advised that the whole concept of reward packages, needed reviewing.

Reserve Sample

[redacted] commented that clearly it was challenging and asked irrespective of whether you are issuing a reserve, sample, are we talking about extending the life span of the field work to enable you to put your best people on it and get that coverage up by another six months in any case?

[redacted] replied that the current assumption was that the current sample would be covered in the current fieldwork period – if we covered 100% of the sample, and if we reduced the non-contact rate by ensuring that all interviewers make sufficient contact attempts at differing days and times, the high refusal rate would still mean that targets would not be achieved.

[redacted] add that the APMS work has recently been prioritised above several other surveys, so that gives us confidence that the 5,000 will be achieved within the current fieldwork time frame.

Next Steps – the Core and EMB

[redacted] summarised the next steps:

- The Current Sample - as [redacted] has commented, the current sample is under review, considering ways that it can be refined and improved.
- The Reserve Sample – all options are being reviewed and considered. You have been made aware what that would mean in terms of extending the fieldwork and that there would be additional cost implications.
- Different Levels of Reserve Sample – considering the impacts of differing levels of the reserve sample:
    - If only achieve 5,000 the impact on some of the key indicators that are reported on.
    - if we only achieve a medium reserve between 5,000 and 8,000 - options are being carefully considered.

[redacted] questioned, if the survey is a quarter of the way through and you are updating us with the progress to date, including actions / initiatives you have implemented to improve response rate - What are the 'trigger points' as we move forward? At what point would the reserve sample be used? Is there a cost implication to using the reserve sample and do you know what that is? Do you know the size of the reserve sample, that you would require? Is there a further discussion regarding finances required? And lastly what are the time constraints, if any?

[redacted] responded suggesting initialling by stating that there were two options:

a) stay with the current sample, which is within budget, **but** accept there will be a lower than target achieved – looking at 5,000, which will impact on reporting outcomes.
b) The other option would be to introduce a 'reserve sample' but that would then have cost implications and will also need a discussion with the DHSE about funding.

[redacted] continued regarding the reserve sample, currently in terms of a decision – there is not a decision to be made by the Group at this stage, we are updating the Steering Group on the current situation and next steps – options are being explored.

[redacted] acknowledged [redacted] response and commented about the Ethnicity Boost, and ensuring that targets were achieved, so would the strategy differ for the Boost?

[redacted] informed the meeting that currently it is not on track but again options are being considered to bring it back on track – options are available e.g., introduce a telephone interview to adjust – the telephone interview would be a last, but again there would be cot implications. The telephone interview would be a last option in obtaining a full survey, especially with the current high refusal rate.

[redacted] informed the meeting that currently it is not on track but again options are being considered to bring it back on track – options are available e.g., introduce the telephone interview – again there would be cost implication. The telephone interview would be a last option in obtaining a full survey, especially with the current high refusal rate.

[redacted] questioned concerning the high refusal rate if the participating sample would be representative? Also, from an eating orders perspective, do we have enough young people in the sample?

[redacted] replied that nothing had currently been looked at in detail as the main concerns are the numbers - the value in the numbers is in their representativeness, so that is something that continues to be monitored - it is recognised that lower numbers would hold a risk of a biased sample.

[redacted] commented that had consideration been given to 'respondents' being incentivised?

[redacted] replied that there was a £10 unconditional incentive for the Core, also, every household that is sampled receives a £10 Post Office voucher attached to the 'advanced mail letter'. Plus interviewers have two additional discretionary incentives of £25 each that can offer to respondents on the doorstep.

[redacted] made a further comment about using 'Sorry we missed your cards,' so interviews can be pre-booked.

[redacted] replied it was not currently the practice. [redacted] also added that one of the key pieces of training for any study, is reinforced as part of the APMS briefing, is the importance of calling at the right times - so interviewers should know their local area, and when might be good or bad times to call, ensuring that they call at different times of the day, and on different days of the week and on a weekend in the evening to try and maximise the chances of somebody being at home. Interviewers are used to

leaving their cards and / or details through doors in a kind of sorry I missed your way – there is also an APMS specific follow-up letter.

[redacted] suggested that the Steering Group could be a source of connections / organisations that could be shared and actively support the APMS Survey.

[redacted] agreed and would encourage support from the Steering Group. So would be good if we could explore ways / avenues using the media including social media.

Action:

Exploring with the Steering Group members ways of using / access media (including social media) e.g., Newsletters, web pages, twitter etc.

Phase 1 – Fieldwork: Ethnic Boost Screening *(refer to slide 19)*

[redacted] reminder the meeting that there were two stages to the Ethnicity Boost, the first stage is the screening phase:

- There are 12 Waves of fieldwork and currently about a third of the way through the screening. You can see from the figures there is a shortfall, due to several issues – completed screening target is 80% but actual is 73%.
    - there were some issues with the sample in Wave 1 & 2 of screening, which are now resolved
    - trying to understand why we are not 'finding' as many ethnic minority households as anticipated

Phase 1 – Fieldwork: Ethnic Boost Interviewing *(refer to slide 20)*

[redacted] continued, that the second stage is the interviewing phase and again there are three issues, two of which are the same as the Core:

- A coverage issue, not following up are quickly as they should – this is currently being reviewed
- High non-contact and refusal rates
- Currently 10% on households are being screened out, which was not expected

[redacted] commented that the issues are being reviewed and actioned where possible.

Improving Ethnic Boost Performance *(refer to slide 21)*

[redacted] advised that the following were some of the actions currently being implemented to improve EMB:

- Agreed to pause the EMB as this stage, (currently at Wave 5 of 12 Waves) to undertake a methodological review of the design:
    - Benefit of focusing on areas with higher concentrations of ethnic minorities based on Census 2021
    - Screen all ethnic groups
- Review the screening question
- Motivational Workshops and Top Tips for screeners around the doorstep approach
- What happens if targets are not achieved - reviewing alternative groups of EMB respondents

Discussion – Ethnic Minority Boost *(refer to slide 22)*

There followed some interesting and helpful discussions regarding the following area:

- The use of different channels of communication or 'champions'
- On-line materials etc are currently available
- Review sampling processes
- Quality control issues of screeners discussed
- Issues with level of response

[redacted] commented that these reviews and discussion were already taking place and thank people for their comments. The response is due to be delivers in the next few weeks.

[redacted] summarised that the EMB is to be pause whist this review takes place, but it was important to keep you as a Group updated.

Phase 2 – Fieldwork: Eligibility Criteria *(refer to slide 23*

[redacted] referred to the slide and highlighted the key points since the last meeting:

- Screening criteria finalised
- New screening criteria for eating disorder this time

Phase 2 – Fieldwork *(refer to slide 24)*

The University of Leicester are undertaking the fieldwork. [redacted] made it clear that these figures were dependant case being fed through from Phase1 – response rate target 65%.

Phase 2 – Fieldwork: Sample *(refer to slide 25)*

This slide was for information.

Eating Disorder Update – Phase 2 and NHS Accuracy Study

Summary of where we were and Development Stage *(refer to slides 27, 28 & 29)*

[redacted] gave an overview / summary of the Eating Disorder, Phase 2, and the NHS Accuracy Study, which is running alongside the survey.

[redacted] spoke to slides 27, 28 & 29, highlighting any key points, and concluded with the following points:

- Interviewers were specially recruited and trained
- NHS Research Ethics Committee approval was received for the NHS Study
- The Protocol for the NHS Accuracy Study has been developed and is currently ready for publication
- There have been negotiations with the Clinical Services in Leicestershire Partnership Trust and the Eating Disorders Service, and they are willing to participate with our Board, which has allowed us access to their eating disorder patients for the NHS study.

Delivery of Eating Disorder Study and Assessment *(refer to slide 30)*

[redacted] outlined the current delivery part of the Eating disorder Assessment Study:

- Successfully implemented the eating disorder assessment as part of Phase 2 – fieldwork

- Clinical Team currently recruiting
- Proposed start was July 2023
-

[redacted] commented that [redacted] wanted to validate the EDQS and the Scan v3 ch9 for interviews. [redacted] replied that the validation had been scheduled in.

[redacted] questioned regarding ensuring we encapsulate a diverse range of individuals affected be eating disorders, including ethnicity and other measurers?

[redacted] commented that there is a 'sampling frame,' based on the eating disorders criteria – so we will be validating and those that are referred will not be referred to the clinical assessment. Those that are referred to the services their details will be recorded

[redacted] commented that it is a tricky question to answer because it applies to all such studies, that their certain groups which are too small to be able to give a separate answer for them. One of the things we are aiming for is to ensure that the ventral prevalence rates we come up with estimates that we come up with bare a relationship to what clinicians are deciding in terms of which patients have a need for help with eating disorders and which do not.

[redacted] replied that the key part of why this exercise is important, is to try and shed light on that 'big group' that is not coming to the attention of the services - so, I think we would have an opposite opinion on that.

5. Reporting

Report Format *(refer to slide 32)* **and Report Structure** *(refer to slide 33)*

[redacted] advised the meeting that next two slides were to start the process of talking and thinking about the report and how it should be structured and what should be included, topics, chapters etc – included is a review of the previous report's content.

[redacted] outlined the next steps to the Group:

- The Ethnic Minority Boost will be paused
- Collate our discussions, review, and then present to this Group our next steps, including the core sample, and then pick up the reporting at that stage
- Arrange a further meeting after the summer break

[redacted] thanked the Group for their time today and their input into the discussions. You will all be contacted regarding arranging a further meeting, and the 'slide pack' will be distributed to the Group.

6. AOB

No further business [redacted] thanked and closed the meeting.

7. Date for Next Meeting

Date to be confirmed.

New and Outstanding Actions

Ref	Date	Action	Owner	Status
02	08/04/2021	**All members to review the ToR membership list and highlight areas not represented, suggest suitable people or groups to be involved, including voluntary sector organisations, and lived experience groups.** Update 24/06/21: Suggestion received for representative from the Gambling Commission. Request for representatives from 'Lived Experience' Groups – [redacted] agreed to follow-up with [redacted] for details. [redacted] suggested contacting the charity MQ Mental Health who had been involved in the focus groups as part of the consultation. Update 30/09/21: [redacted] welcomed gambling representatives, and mentioned they were contacting the charity [redacted] for Lived Experience representatives and will give an update at the next meeting. **Update 09/12/21**: If members have any suggestions for members with lived experience, please come forward and contact via surveys mailbox. **Update 19/7/22:** [redacted] to provide surveys team with potential lived experience advisors to join the group. Group were asked to provide recruitment strategies. **Update 13/6/23:** Currently trying to locate more individuals with lived experience. [redacted] requested more information about what their role would be, especially as they were being brought in at this late stage. Also, more clarity is required prior to recruitment commencing. [redacted] advised the meeting that there was a Team in HSE England that has been involved, for several years with 'lived experience members' and created a formalised process – which is being considered. To be carried forward	[redacted]	[redacted]
31	30/09/21	[redacted] **to share details for the National Drug Treatment Dataset (NDTDS) held by PHE (transferring to DHSC) and NHS Digital to explore options for future data linkage**. **Update 09/12/21:** PHE to provide update following the meeting. **Update 19/7/22:** [redacted] to follow up **Update 13/6/23**: [redacted] to arrange a conversation with [redacted] regarding 'future data linkages' when the final Dataset has been established. [redacted] to take this forward.	[redacted]	[redacted]
38	19/07/22	[redacted] **to forward on current proposal model for eating disorders validation study to** [redacted] **Update 13/6/23:** Talks have taken place around the eating disorders validation study – some of the feedback and actions are included in the slides today. Any further questions can be discussed at that point.	[redacted]	[redacted]

8. Closed Actions:

Ref:	Date	Action	Owner	Status
01	08/04/2021	**Members to send in any outstanding bios or photos to [redacted] at surveys.queries@nhs.net** Update 24/06/21: [redacted] were asked to submit outstanding biographies and photographs for the survey web page. **Update 30/09/21:** There are still eight members without biographies or pictures. NHSD to send a reminder. **Update 09/12/21:** 5 Outstanding Bio & Pics remaining for [redacted]. **Update 19.7.22:** Surveys team to recirculate email requesting bios/pictures from existing and new members. **Update 13.6.23:** The photos have been removed, leaving just the Bios - so everything has been updated.	All	Closed 13/06/23
09	24/06/21 Group M'ship	**NHSD to consider where areas of expertise are required when final survey content is decided and expand steering group membership and/or create an advisory reference group.** **Update 30/09/21:** NHSD updated that they will invite DWP representatives to the group if the deprivation boost goes ahead.	NHSD	Closed 09/12/21
23	30/09/21	**NatCen to check the inclusion of Spice in the new psychoactive substances in the drugs module.**	NatCen	Closed 09/12/21
24	30/09/21	**NatCen to clarify/confirm [redacted] suggestion to include AUDIT only in the survey and share his report comparing different measures with the group. Group consensus is; if the report recommendation is to use AUDIT, then drop SADQ from the 2022 survey.**	NatCen	Closed 09/12/21
25	30/09/21	**Share AUDIT questions with the group for context and information.**	NatCen	Closed 09/12/21
26	30/09/21	**NatCen to investigate whether the new alcohol questions to identify whether participants who reported as non-drinkers may have had former or sustained alcohol problems, could be asked of all, not just non-drinkers.** **Update 09/12/21**: NatCen have reviewed. The aim of the question is to understand if non-drinkers stopped drinking because they used to drink heavily or have, they always been non-drinkers. If we can ask current drinkers if they use to drink heavily, it will be subjective and not very useful. Therefore, this has not been included at all.	NatCen	Closed 09/12/21
27	30/09/21	**NatCen to share the revised gambling activity list with group members, and to ensure the HSE gambling activity list is reviewed and made consistent with the revised activity list to be used in APMS.**	NatCen	Closed 09/12/21
28	30/09/21	**NHSD to review what can be removed to allow for EDEQ or EDEQ-S.** **Update 09/12/21:** Update and discussion held in meeting. Dress rehearsal will confirm actual survey length, agreed to go with SCOFF and EDEQ-S and to review after the dress rehearsal if any content needs removing. **Update 19/7/22:** addressed under agenda item	NHSD	Closed
29	30/09/21	**[redacted] to liaise with [redacted] on the value of SCAN-ED, if Phase 2 funding is confirmed.**	[redacted] Leicester	Closed

Ref:	Date	Action	Owner	Status
		Update 09/12/21: Will be Carried Forward if confirmed funding **Update 19/07/22:** Confirmation of funding has been received. [redacted] presented slides at the meeting		
30	30/09/21	**All group members to suggest datasets or data collections not currently held by NHS Digital, which would be useful for future linkage with APMS survey data.** **Update 09/12/21:** No further update received but they are exploring the legal basis for HMRC and DWP linkage. If any members have further suggestions, please raise via surveys.queries@nhs.net by 24 December 2021 after which the action will be closed. **Update 19/7/22:** No other data linkage options provided.	All	Closed
32	30/09/21	**NHSD to investigate ethical approval for linkage to NHS health records.** **Update 09/12/21**: Carried Forward **Update 19/7/22:** Direction from MHCYP allows linkage	NHSD	Closed
33	30/09/21	**NHSD to investigate ONS Cause of Death/Mortality dataset for future data linkage and cover as a future agenda item at the next meeting.** **Update 09/12/21:** Data linkage covered on the agenda. NHSD receive a cut of ONS Cause of Death data and will be included in the linkage permissions.	NHSD	Closed 09/12/21
34	09/12/21	**Group members to submit questions and/or feedback on the proposals for an alternative data collection mode by the end of the week.** **Update 19/7/22:** Content for alternative modes has been agreed.	All	Closed
35	09/12/21	**NatCen to produce a document summarising the rational for priorities for including and excluding content in the alternative data collection mode.** **Update 19/7/22:** Shared with group.	NatCen	Closed
36	09/12/21	**NatCen to investigate the modules with sensitive content to see if they can be included in alternative modes.** **Update 19/7/22:** Alternative modes content agreed.	NatCen	Closed
37	09/12/21	**DHSC to confirm the order of priorities for funding for Phase 2 and the sample boosts and confirm with group members.** **Update 19/7/22:** Closed	NHSD	Closed
39	19/07/22	**Slide pack to be circulated to the steering group for feedback on proposed content removal and key recommendations from the dress rehearsal.** **Update 13/6/23:** [redacted] confirmed actioned and shared	ALL	Closed 13/06/23
40	19/07/22	**Group to review and consider the removal of IPAQ, COVID, work related stress and attitudes to working from home questions from the survey, along with any further suggestions.** **Update 13/623:** [redacted] confirmed that the final questionnaire was amended following the feedback and circulated.	ALL	Closed 13/6/23
41	19/07/22	**Group to provide examples of practical application to be used by interviewers during the survey to encourage response.** **Update 13/6/23:** [redacted] confirmed that people fed back how APMS is being used and that has now been included in the participants materials and into our videos.	ALL	*Closed 13/6/23*

Ref:	Date	Action	Owner	Status
42	19/07/22	**Group to consider the current definition for the mixed ethnicity group and whether this should be widened further, if so, what other groups should be included, and advice for appropriate language and phrasing for doorstep interviewers.** **Update 13/6/23:** [redacted] confirmed that there had been a full discussion regarding the definitions for mixed ethnicity groups.	ALL	Closed 13/6/23
43	19/07/22	**Group members asked to provide feedback on the importance of the ethnicity boost and how the findings may impact communities, to be used to help encourage participation (Slide 30).** **Update 13/6/23:** [redacted] the feedback on the ethnicity boost, has been included within the participants materials.	ALL	Closed 13/6/23
44	19/07/22	**Group to provide any knowledge of specific groups or charities that specifically cover mental health support for ethnic groups that can be included on leaflets (Slide 31).** **Update 13/6/23:** The feedback, (where appropriate), has been included within the participants materials.	ALL	Closed 13/6/23
45	19/07/22	**Group to provide suggestions for who could appear in soundbites/videos for the NatCen website and interviewer training to promote the ethnicity boost (pre-meet document)** **Update 13/6/23:** Several soundbites and videos were created to support the Survey.	ALL	Closed 13/6/23
46	19/07/22	**Following updates, NHSD to circulate proposed content reductions for the group to consider** **Update 13/6/23:** [redacted] advised actioned and circulated.	NHSD	Closed 13/6/23
47	19/07/22	**NHSD to update the APMS webpage to announce the boosts and eating disorders in phase 2** **Update 13/6/23:** [redacted] confirmed announcement uploaded onto the web page.	NHSD	Closed 13/6/23

Minutes

Meeting: APMS Steering Group
Dates: Thursday 27 July 2023 and Friday 28 July 2023
Time: 13:30-14:30 **Location:** MS Teams

NHSE

Attendees: Thursday 27 July 2023:

[redacted]

1. Welcome and Introduction

[redacted] welcomed everyone to the additional APMS Steering Group meetings and advised that two meetings were being held on Thursday 27 July 2023 and Friday 28 July 2023 to ensure that as many members as possible had the opportunity to take part given the short notice and summer holidays.

Background

[redacted] added that at the last APMS Steering group meeting fieldwork progress was discussed and that response rates were lower than anticipated, particularly for the Ethnic Minority Boost. It was agreed that the Ethnic Minority Boost would be paused whilst a review of the methodology undertaken to see how improvements could be introduced, prior to re-starting the fieldwork. Response rates to the Core survey were also lower than anticipated and this was also being reviewed, but fieldwork was continuing at the same time.

[redacted] confirmed that the review and recommendations have now been undertaken. These two meetings are around those findings in respect of the Core survey and the Ethnic Minority Boost (EMB). [redacted] will go through those findings and conclusions from the review and our recommendations for both the Core and the Ethnic Minority Boost. At that point we will collate your input, prior to making any formal decisions.

[redacted] confirmed that both meetings were being presented with the same information. This was to recognise that it was the holiday period, and the meetings were arranged at short notice. The slides would be circulated to all the members of the Steering Group following this meeting for further comments and additional time given for questions – if necessary, further meetings will be arranged.

2. Plans for APMS Core Survey

([redacted] referred to the slide presentation that was circulated to members of the Steering Group)

[redacted] informed the group of the current situation for the Core Survey:

- Currently halfway through the planned fieldwork
- The target is to deliver 8,000 Core interviews
- Achieved approx. 2,000 Core interviews to date
- At this point, the figures should have been closer to 3,500 Core interviews

[redacted] added we are behind target in terms of Core fieldwork and the reasons for this have not changed from the last Steering Group Meeting in June 2023. The target response rate for the Core is 55% but the current response rate is approximately 30%. NatCen have identified actions that they can try to improve the response rate but predict improvements of 2-3%. At the current trajectory, approximately 5,000 interviews would be achieved by the end of the fieldwork period, not near the 8,000 target interviews.

The preferred option for achieving target interviews would be to issue an 'additional sample. Consideration was given as to the additional sample size that would need to be to achieve the 8,000 Core interviews and the time implications for fieldwork.

- Given the current response rate the additional sample would need to be in the region of 11,000 extra addresses to achieve 8000 interviews
- The current plan is that fieldwork would end mid-January 2024, to achieve the new target the fieldwork would need to extend until the end of May 2024
- The additional funding required would be in the region of £145,000

[redacted] The other consideration is pressure to deliver this data, to keep the budget within the current scope and to also deliver robust data. [redacted] presented other options for number of target interviews and impact on confidence intervals for key estimates.

For a target of 7,000 interviews: -

- There would still need to be a large reserve sample, but it would be feasible to deliver the extra sample by the end of March 2024
- This could be achieved within the current budget
- there would not be a significant loss of precision for key estimates.

However, if we were to lower the target number of interviews to 7,000 this may impact on the delivery of Phase 2 interviews. Phase 2 fieldwork relies on being able to feed through enough people from Phase 1.

Based on 8000 Phase 1 interviews and current criteria for selection, Phase 1 would deliver 915 Phase 2 interviews. If Phase 1 was reduced to 7000 interviews and the current selection criteria were retained that 915 would also fall. However, the selection criteria can be modified to allow more people to flow through to phase 2. The proposal would be to allow scores between 4 and 11 to flow for ASQ17 females, and for SCOFF all those scoring 2+ rather than those with 2+ and impact on social interaction.

[redacted] informed the group that the recommendation is to issue a reserve sample and reduce the target number of Phase 1 interviews to 7,000 but to keep the number of Phase 2 interviews the same by modifying the sampling criteria. This will be delivered within the current budget. Phase 1 fieldwork would be extended until the end of March 2024, and Phase 2 until the end of May 2024.

Core Survey: Questions and Comments – Thursday 27 July 2023

[redacted] asked if it was possible to do the 'confidence interval' estimations for eating disorders on a sample of 7,000 or was this not possible as it was not covered in the 2014 survey.

[redacted] commented that without having the actual data or expected prevalence we would only be able to make estimates and rough confidence intervals on assumptions but that we can look at this based on prevalence within HSE which uses SCOFF.

[redacted] queried whether the eating disorders prevalence for the CI estimates was defined as the proportion of respondents that scored 2-plus on the SCOFF scale rather than the SCAN.

[redacted] Confirmed and added that the Phase 1 headline measure would be used.

[redacted] clarified that reporting may differ and will use Phase 2 SCAN questions. The APMS 2007 eating disorders may also be used for confidence interval estimations.

[redacted] also asked if there was any argument against dropping the quality-of-life point on SCOFF.

[redacted] replied that it has been discussed with the University of Leicester and with SMc who was involved in the previous APMS Survey – the conclusion was that there is no risk as the exclusion criteria for SCOFF can be changed at the analysis stage.

[redacted] queried whether the sample size difference between 7000 and 8000 impact in terms of being able to split the eating disorder sample for analysis.

[redacted] advised that a smaller sample, will give smaller sub-groups. Consideration has been given to looking at both sex and age as the key breakdown groups, there are potentially some other sub-groups where it might have an impact.

[redacted] enquired has income and ethnicity been considered.

[redacted] informed the meeting that income quintiles were not used due to the small numbers. Ethnicity makes a minor difference to the size of the groups between 7,000 and 8,000.

[redacted] commented that this approach, aiming for 7,000 is a good mid-point, and does not create too much of a delay in completing the core Survey.

Core Survey: Questions and Comments – Friday 28 July 2023

[redacted] commented that a lot of work and consideration was behind this recommendation and thanked the presenters for the detail

In summary the attendees at both meetings supported the recommendation for the Core Survey to lower the target to 7000 interviews but keep Phase 2 interviews at 915 by modifying the selection criteria and to extend the fieldwork for Phase 1 to the end of March 2024 and Phase 2 to the end of May 2024.

3. Plans for APMS Ethnic Minority Boost (EMB)

[redacted] At the June Steering Group Meeting there was discussion regarding 'pausing' the fieldwork, to assess and review the methodology, this had now been completed.

[redacted] commented that after 5 of 12 Waves of screening we are managing to complete screening in approximately 75% of households, which is higher than the target of 70%. However, the issue is that we anticipated that 20% of those households would screen in, but currently only achieving 12%. The first issue with the EMB is not enough households are being screened in, so there are not enough participants for the interview.

The potentially reasons for this:

- Firstly, the sample is extrapolated from areas where we know ethnic minorities are more likely to live. We are using the census 2021 data, but random sample from these areas and cannot guarantee it is an ethnic minority household.
- Secondly, potential issues with the screening questionnaire. The screening question was evaluated at the dress rehearsal successfully and is based on best practice from other EM screening surveys – however the screening question does not capture all ethnicity categories, the question asks if you belong to one of these six groups (target groups). It is possible that some households either were not sure where they needed to place themselves or their perception, we were targeting these groups and could see this as an option to screen themselves out.
- Thirdly, the non-contact or refusal screening rate is higher than anticipated. It was also noticed that fewer Bangladeshi households than we had expected were being screened, as these households tend to live in more deprived areas, so are harder to reach.

[redacted] Informed the meeting that the target for EMB interviews is 3,000, based on an assumed response rate of 45%. Core Survey rate is closer to 30% and currently achieved 181 interviews. So far 1,500 cases have been screened-in, and work is continuing to complete these interviews and given the current response rate this is anticipated to deliver 400 interviews. This is based on Waves 1 – 5 of potentially 12 x Waves of EMB fieldwork. If the fieldwork was to continue and screening completed within all 46,000 addresses and assuming the current response rates this would deliver an estimated 1,000 interviews against a target of 3,000. In respect of the individual ethnic groups, the target was to deliver 500 interviews per ethnic group, current predictions would be a minimum of 115 (Bangladeshi) and maximum 300 (Indian), no group would achieve the target of 500.

[redacted] moved on to outline potential improvements:

- to screen in all six of the ethnic groups in all areas as currently the more common groups were not being screened in. That would boost the overall numbers of ethnic minority households screened-in; the downside would be that all the benefit would be seen amongst the three most common ethnic groups.
- to screen in LSOAs with 10% of ethnic minorities rather than 5% this would increase screening rates but would bias the sample and the reporting.

[redacted] Even if both changes to the current sample design were implemented, it would still not achieve anywhere near the target of 3,000 interviews, but rather approximately 1,500 interviews. Again, none of the ethnic groups would achieve the targeted 500 per group.

[redacted] added that to achieve the target of 3,000 interviews, the size of the reserve sample would need to be large, e.g., to increase the sample by a further 35,000 addresses which equates to a 1.75% increase relative to the current sample that is being worked. This would impact both on costs and timescales.

[redacted] informed the meeting that in respect of the ethnic minority communications, work had been undertaken with an organisation called Words of Colour, who specialise in engaging with ethnic minority communities, and they had considered what additional materials might be required to deliver the EMB - in particular, a number of videos were created, focusing on the importance of the survey and what taking part involved. In addition, work had also been undertaken with the organisation in the recruiting of screeners and interviewers – recruiting people with links to the communities, to help potentially increase trust from the ethnic minority participants. Also, Words of Colour participated in the training of interviewers and screeners.

[redacted] commented that further revisions of the survey materials can be taken as we are aware poor survey material design can have a negative impact on individual participation, but generally once materials are good minor changes have limited impact.

[redacted] reminded the meeting that there had been previous discussions regarding using a more targeted communication approach, for example, promoting a survey via local media or media that

was aimed at a particular ethnic group. However, for the sample to be representative it needs to be drawn beforehand and not following a media campaign and volunteers, also as we are not targeting everyone it makes comms that go out to everyone difficult to manage.

[redacted] moved on to outline alternative screening approaches and other ways to achieve an Ethnic Minority Boost that were being considered:

1) Follow-up respondents to existing surveys where we know their ethnic group from previous survey responses. Focusing on surveys where either NatCen or NHS England controlled data. This would include the in-house NatCen Panel and the Health Survey for England – both these would deliver relatively few additional respondents and create an additional cost and complications for analysis and weighting.

2) Using administrative data as a sampling framework rather than the postcode address file, but currently there is no suitable source of administrative data which contains ethnicity information.

The recommendation is that the remainder of the EMB fieldwork should stop - as there is currently no cost or time effective approach to deliver the target number of interviews. Work will continue to complete the interviewing from those that have screened in during Waves 1 – 5 of fieldwork and the aim is to achieve around 400 ethnic minority interviews – this data will not be wasted. It is intended to 'fold' those into the Core dataset and boost the number of ethnic minority respondents from the Core dataset. Whilst this is disappointing, the EMB is costly and we need to be able to demonstrate a good use of public money, it is best to admit things are not working as intended and to consider different approaches.

EMB - Questions and Comments – Thursday 27 July 2023

[redacted] queried what other communication approaches can be used to help increase response, seeking suggestions from other different consultants, [redacted] commented specifically on Health Watch.

[redacted] commented that NatCen have been working with Words of Colour on the approach to EMB communications including - the advance letters, leaflets, review of the website, videos and with support on recruiting and training of interviewers. Targeted local communications are of limited use as would lead to a non-representative sample.

[redacted] stated that the recommendation is to stop EMB and look at using the Personal Demographic Service (known as PDS) to be used as a sampling framework. NHSE will need to work through the legal basis to access PDS records. However, the merger of NHSD and NHSE will impact the prioritisation of this work.

[redacted] commented that from the DHSC perspective, support will be given to stopping and to explore a different approach. The recommendations are supported.

[redacted] continued that the Steering Group will need to consider the outcomes of this and the transparency especially between the Public Accounts Committee and the NHS.

EMB - Questions and Comments – Friday 28 July 2023

[redacted] Asked for additional options considering that the last survey with ethnic minority data was in 2014, and potentially it will be another 7-years without specific ethnic minority data.

[redacted] Responded that the funding for this EM Boost could be retained and used to undertake development work such as obtain access to PDS data, appending ethnicity records to create a sampling dataset, and conducting a dress rehearsal.

After a review of the outcomes, consideration of an interim APMS collection around ethnic minorities could be an option.

[redacted] thanked [redacted] for the reassurance and having a sample framework with ethnicity included to allow specific targeting would be a real step forward.

[redacted] asked if the group need to consider if there are any gaps in expertise within this group, which will be needed for the next stage and any separate ethnic minority survey.

[redacted] commented that the review has been comprehensive and detailed. Core Survey is still delivering as intended. A key focus for this survey is on low-income areas and we must remember the survey is still over sampling these areas; this will provide a benefit in terms of the numbers of people that we have from low-income areas and that will lead to an increase in the number of people in the overall Core sample from minority ethnic groups as well. It is important how this is communicated to the wider community and to ensure that the value of the Core APMS is emphasised.

[redacted] informed the meeting that a paper had recently been issued that compared Census reported ethnic groups with ethnic groups from hospital records, the outcome was not a great match – this indicates that care must be shown around the identification for the mixed ethnic groups.

[redacted] stated It is important to remember whilst disappointing the EMB is stopping, the APMS still has a lot of value. The 2014 survey completed 7500 interviews, with the 7000 from 2023 Core plus the 400 from the EMB we will be very similar, this will also include more people from deprived areas and more phase 2 interviews than previously.

[redacted] Echoed the comments and asked if it will be possible to still do some analysis by ethnic minorities from the core sample.

[redacted] Advised that they will look at the predicted number of participants for ethnic minority groups and this can be considered as part of analysis planning with an option to combine previous APMS years.

[redacted] recapped the recommendations:

1) First recommendation is that a reserve sample is issued for the Core survey, the target interviews decreased from 8000 to 7,000 and fieldwork extended until March 2024 for Phase 1 and May 2024 for Phase 2.
2) Second recommendation is that the remainder of the Ethnic Minority Boost is stopped, no further Waves of screening are undertaken and interviewing for all those that have been screened to date is completed and the interviews are ‘folded’ into the main survey (extra to the 7000).
3) Third recommendation is to look at other options for delivering the ethnic minority survey and using admin data as the sampling source.

[redacted] thanked everyone for attending the meeting.

4. AOB

There was no other business raised.

Actions

Ref	Date	Action	Owner	Status
1	27/7/23	Provide 'Confidence Interval' estimates for eating disorders with difference samples to Steering Group members.	NatCen	New
2	27/7/23	Provide estimate of number of achieved interviews from main survey (7000) plus the additional EMB interviews for ethnic minority groups if EMB stopped to Steering Group members.	NatCen	New
3	27/7/23	Provide contact at Surveys Futures (data collection methods collaboration group) to NYJ.	NHSE	New
4	27/7/23	Consider the communication of EMB decision to wider stakeholders.	All	New
6	28/7/23	Consider expertise need in the Steering Group for future EMB work.	All	New
7	28/7/23	Consider increasing Ethnic Minority analysis in the core sample.	NHSE	New
8	28/7/23	Cascade the publication looking at matching census ethnicity to health record admin data	[redacted]	New

Minutes

Meeting: APMS Steering Group

Dates: Thursday 22 February 2024

Time: 10:00-12:00

Attendees: Thursday 22 February 2024

[redacted]

Welcome and Introductions.

[redacted] and [redacted] welcomed everyone to the APMS Steering Group on Thursday 22 February 2024, with a round of brief introductions in the group.

Previous meetings minutes and outstanding actions

Outstanding actions were discussed, in addition to minutes from the previous Steering group meeting.

NHS England Changes

[redacted] Provided an update of the NHSE & NHSD merger, in addition to the Ethnic minority boost (EMB) (found on slides shared).

[redacted] stated EMB was discussed at the previous Steering group meeting. Reviewing the EMB fieldwork performance highlighted that the response rate was low and not enough people were being screened. It was evident that EMB was not cost effective. In July the collective decision was to stop the EMB in the current format, wrap up those samples into the main core survey. It was suggested the best course of action for EMB is to explore looking at admin data as the sampling strategy, instead of using post code, census data to find areas with higher populations of ethnically diverse populations.

[redacted] Questioned how admin data would be used for EMB?

[redacted] NHSE's considering the personal demographic Service data, but it does not include ethnicity, therefore it can't be sampled. Hospital Episodes Statistics (HES) data for example does have ethnicity. We propose creating an ethnicity variable through the other healthcare datasets, that can be appended to Personal Demographic Service (PDS). Testing will need to be carried out to verify its accuracy.

[redacted] Asked if it would be cheaper to link PDS and the central ethnicity data? Could access to the data be streamlined?

[redacted] Confirmed Appointments and General Practice (AGP) data was used for Covid purposes and unfortunately cannot be used in this instance.

Project Update

[redacted] Confirmed we would like your input for the APMS reporting topics you would like us to cover. Phase 1 of the fieldwork is being completed by the end of March. Our target of 7000 interviews has nearly been achieved. Phase 2 will finish approximately around June; we are aiming to publish the final reports in Spring next year.

[redacted] Questions how does the eating disorders section fit into this timeline?

[redacted] Answered the timeline is being continually reviewed as part of the validation study, for the eating disorders work. There will be an eating disorder chapter in the final report, but its content depends on how field work progresses.

[redacted] Added how does the EMB sampling interact with this timeline?

[redacted] Responded if the EMB sampling goes ahead, a separate survey will need to run as feasibility testing of that methodology would need to be carried out. To confirm, that would mean there is a separate survey and timeline to the APMS survey now.

Survey Update

[redacted] Stated following the steering group last July, the target number of interviews has been lowered to 7000 productive interviews. Some additional reserve samples were issued to help with this target of 7260 additional addresses on top of the sample already selected in advance of the field work.

[redacted] The Survey fieldwork period is coming to an end. Overall, just over 25,000 addresses for APMS were issued, and interviewers have a final deadline of the 31st of March to complete their assignments for the Phase One interview.

[redacted] Continued as of Monday, we achieved 6252 interviews with the response rate currently sitting at 32%.

[redacted] After our last meeting in July the fieldwork. Several additional field work initiatives have been implemented on top of issuing this reserve sample. These initiatives were aimed at reducing the refusal rate and motivating the field workers. These included gathering feedback from interviewers,

introducing a token of appreciation at the end of an interview and a completion bonus for interviewers.

[redacted] Stated these initiatives have increased productive interviews over the last couple of months.

[redacted] Added approximately 89% of participants have completed their self-completion. 70% gave consent for their details to be passed to the University of Leicester (UoL) to be contacted for phase two, which is positive.

[redacted] Presented the final response numbers to the screening phase for the EMB are 75% of addresses completed the screening interview and overall, 12% of addresses were screened, which is lower than the target we needed of 20%.

[redacted] Continued, the final figures for the interviewing stage are 343 achieved interviews with people from our target ethnic minority backgrounds as part of the B sample, which was a response rate of 29%.

[redacted] Explained at the end of phase 1, NatCen asked for permission to be contacted by the University of Leicester for a phase two visit, the phase two interviewer administers assessments for ADHD and psychosis.

[redacted] Stated that 6252 productive phase one interviews were carried out. 1639 participants were issued to phase two interviewers, and phase two interviews have covered around 60%, 62% of those have ended in a fully productive phase two interview, with 611 phase two interviews completed.

[redacted] Overall, we were able to achieve 915 interviews. Phase two field work is currently due to complete towards [redacted] Explained University of Leicester are also leading on an eating disorder validation study. This involves carrying out eating difficulties assessments using the scan eating disorder Questionnaire (EDE-Q), the short EDE-Q and the scoff measures with 100 NHS patients. The study aims to provide a clinical benchmark for estimating APMS rates of eating disorders.

[redacted] Continued the study has been adopted onto the NIH clinical Research Network portfolio, which means they're able to support with the recruitment for the study and as this is a new study, recruitment methods are being trialled as we go along and improved on, and we're looking into extending to two additional East Midlands based sites to help to accelerate recruitment.

[redacted] Stated the importance of having inclusive and diverse data to represent communities when looking at EDE-Q. A lot of people in the community could meet a diagnostic threshold but have not managed to make it into specialist services because of health inequalities and literacy. How can it be ensured that this is incorporated when recruiting people?

[redacted] Answered that in phase 1 of the study NatCen did their best to cover the population as best as they could. This study however in the NHS is here to establish what level of severity is required for specialists to make a diagnosis.

APMS Reporting

[redacted] Advised the report is due to be published in spring 2025 next year, with data archived in the autumn. The title will be mental health and well-being in England, adult psychiatric morbidity survey 2023 to 24 and one of the key considerations and challenges for this report is that the format of the report will no longer be a PDF report containing all the chapters, appendices, and annexes. NatCen will be publishing tables alongside the report. The report will be available in HTML format via CMS.

[redacted] The format will be the same as all the other population health surveys recently released. It's bringing APMS in line with how NHS England are reporting on official statistics and publications. There will be Excel tables, PDFs such as the questionnaires and all the participant materials that will still be put out as a PDF. But the main chapters and the findings will be in HTML.

[redacted] Questioned whether there was a possibility of using this data for peer reviewed publications?

[redacted] Answered that NHSE hope there will be a possibility in the future to use the data for peer reviewed publications or academic research.

[redacted] Questioned if the findings of the APMS survey will be archived in libraries and if someone on the team could investigate it?

[redacted] Responded that it will eventually be archived in the new web archives the government has produced.

[redacted] voiced her concerns surrounding the new web archives and if researchers/academics are aware of this resource.

[redacted] Voiced her interest in how this study will impact policy.

[redacted] Responds that NHSE will have the important task of showcasing these findings and ensuring they are visible to different arm's length bodies.

[redacted] Stated its important technical information is retained in the report even if the audience is non-technical, and a supplementary report could be provided to support with this.

[redacted] Shares the outline of the chapters included in the report. Gambling behaviour was a new module in the 2324 survey, so we have proposed that that has its own chapter alongside eating problems and disorders.

[redacted] Explained that the report will be published as a series of web pages, this means it's imperative to consider how the content of each chapter can be reduced, without compromising the quality of the report. The standard structure is due to follow a short summary at the beginning of the chapter, the sections on methods and definitions, prevalence of disorders by cross break variables and other significant findings.

[redacted] Continued that tables would be produced for all the key areas mentioned above to support with the analytical findings and process. NatCen established cross break variables that are standard for each chapter; age group, sex, ethnicity, co-morbidity, cost of living & IMD quintiles.

[redacted] Questioned whether cross tabulation for the variables such as drinking/deprivation boost will be available as there is a lot of interest from DWP.

[redacted] Responded that NatCen will have a look into this query.

Data Access and Data Archiving

[redacted] Discussed that as part of the merger and the restructure, NHSE have been looking at addressing the resource issues and reviewing how we work with the data access request service, which is the DAS service within former NHS digital (NHSD).

[redacted] Commented that NHSE is working with the information asset owner (IAO) to remove the requirement of access via data access request service (DARS) to access survey datasets via the UK data service (UKDS).

[redacted] Continued NHSE is considering that UKDS will have control on who has access to its data. NHSE will be aiming to move the data set requests in the new financial year. Therefore, DARS would not have the resources to be able to perform data linkage for Population Health services at this time. This maybe a service in the future.

AOB

[redacted] Queried with the end of the fieldwork phase for APMS, will the steering groups occur at the same regularity, and what are the next steps?

[redacted] Responded that a reporting timeline will be produced with NatCen the timeline will show the key points where steering group feedback is needed.

[redacted] Questions how co-morbidities can be captured in mental disorders?

[redacted] Stated this is something they are not looking at in much detail for the current report, but that is an interesting point.

Actions

Ref	Date	Action	Owner	Status
2	4/8/2021	All members to review the ToR membership list and highlight areas not represented, suggest suitable people or groups to be involved, including voluntary sector organisations, and lived experience groups. Update 24/06/21: Suggestion received for representative from the Gambling Commission. Request for representatives from 'Lived Experience' Groups – [redacted] agreed to follow-up with [redacted] for details. [redacted] suggested contacting the charity MQ Mental Health who had been involved in the focus groups as part of the consultation. Update 30/09/21: [redacted] welcomed gambling representatives, and mentioned they were contacting the charity [redacted] for Lived Experience representatives and will give an update at the next meeting. Update 09/12/21: If members have any suggestions for members with lived experience, please come forward and contact via surveys mailbox. Update 19/7/22: [redacted] to provide surveys team with potential lived experience advisors to join the group. Group were asked to provide possible recruitment strategies. Update 13/6/23: Currently trying to locate more individuals with lived experience. [redacted] requested more information about what their role would be, especially as they were being brought in at this late stage. Also, more clarity is required prior to recruitment commencing. [redacted] advised the meeting that there was a Team in HSE England that has been involved, for several years with 'lived experience members' and created a formalised process – which is being considered. To be carried forward. Update 22/02/24: Due to NHSE merger not taken forward at this time.	All	On Hold
31	30/92021	[redacted] to share details for the National Drug Treatment Dataset (NDTDS) held by PHE (transferring to DHSC) and NHS Digital to explore options for future data linkage. Update 09/12/21: PHE to provide update following the meeting. Update 19/7/22: [redacted] to follow up Update 13/6/23: [redacted] to arrange a conversation with [redacted] regarding 'future data linkages' when the final Dataset has been established. [redacted] to take this forward. Update: NDTDS shared, linkage to be explored Update 22/02/24: [redacted]	[redacted] PHE	[redacted]

ESG 4	27/7/2023	Consider the communication of EMB decision to wider stakeholders. - Update 21.09.23 Brief on EMB decision added to NHSE website - Update Dec 23 NatCen participants webpages update - Update 22/02/24: More Communication to stakeholders planned	NatCen /NHSE	Open
ESG 5	28/7/2023	Consider expertise to add to Steering Group for EMB work in future Update 22/02/24: [redacted]	NHSE	Open
ESG 6	28/7/2023	Is NHSE considering increased Ethnic Minority analysis in core sample Update 22/02/24: [redacted]	NHSE	Open
48	22/02/2024	Head of Statistics to Investigate the production of a Full PDF version of the APMS report for academic purposes	NHSE	New
49	22/02/2024	[redacted] to share feedback from her colleagues with NatCen and NHSE on priority for crosstabs in the report.	NHSE	New
50	22/02/2024	Feedback on which APMS reporting chapters should be prioritised	All	New
51	22/02/2024	Feedback on what cross tabs should be prioritised in the APMS report	All	New
52	22/02/2024	Update on the Adult Psychiatric Morbidity Survey (APMS)— Ethnic Minority Boost Panel meeting:	NHSE	New
53	22/02/2024	Finalise the reporting timeline and distribute to the steering group	NHSE	New

Minutes

APMS Steering Group Meeting

Date: Tuesday 19th July 2022 **Time:** 11:00am-13:00pm **Location:** MS Teams

Attendees

[redacted]

Apologies

[redacted]

1. Welcome and Introductions

[redacted] welcomed attendees to the meeting and introductions were made for the benefit of new members. [redacted] updated members that she will be taking on future chairing responsibilities from [redacted] and [redacted] has joined the Surveys team as the new project lead from August 1st.

2. Previous meeting minutes and outstanding actions

It was raised that [redacted] organisation was incorrectly recorded as PHE in the last minutes. This has now been amended to reflect [redacted] organisation as OHID. There were no further comments regarding the accuracy of the last minutes and these were approved.

Outstanding actions from 09 December 2021 were addressed and updated accordingly, *please see actions table.*

3. Project Plan Update

[redacted] discussed the meeting agenda and noted that additional documents relating to the agenda had been circulated prior to the meeting for members to consider and comment on during the meeting. [redacted] informed members that findings from the dress rehearsal identified that the length of the survey is burdensome on participants and one of the aims of this meeting is to reduce the content and length of the survey down to 90 minutes.

Update on the progress of the project plan since the last steering group meeting held on the 09 December 2021 was given. Shortly after the finalising and testing of the questionnaire in December, the consortium focused on the participant materials and received sign off from DHSC to explore ethnicity boosts and eating disorder. The two dress rehearsals for Core APMS and Ethnicity Boost have now taken place, with the Phase 2 dress rehearsal in field.

The next period will be focusing on finishing the phase 2 dress rehearsal, further development of the questionnaire based on the feedback gathered from the meeting and the dress rehearsals as well as finalising participant materials. Fieldwork was initially projected to begin in September for Core and October 2022 for the EMB, but has now been postponed to January 2023 with a completion date in December 2023 due to the impact of the pandemic on fieldwork resource staff.

The reporting stage is expected to be publicised in Autumn 2024 and may take the approach of a staged report with core topics published first, ethnicity boost chapters followed by eating disorders, however, this will be discussed at the next steering group.

[redacted] inquired the reason for the delay in not having new data regarding eating disorders since 2007. [redacted] clarified that a validation study needs to be carried out with NHS patients to get a prevalence figure and due to timings with fieldwork, this work will take slightly longer to complete hence the suggestion for the eating disorders chapter to be published last.

[redacted] suggested the possibility of publishing the prevalence figures ASAP and release the validation study in due course. [redacted] voiced that the validation work would need to be carried out to determine what threshold would apply to the questionnaire and agreed to forward on to [redacted] the current model of the validation study.

Action 38: [redacted] to forward on current proposal model for eating disorders validation study to [redacted]

4. Survey Methodology Update *please refer to slide pack.*

[redacted] presented slides to the group which contained detailed information regarding the survey methodology, the expected samples results, and future fieldwork plans for Phase 1 and 2.

[redacted] also confirmed plans to translate the questionnaire to Urdu. In response to [redacted] question regarding the inclusion of eating disorders, [redacted] confirmed that eating disorders will be included in questioning for ethnic minorities in both phase 1 and phase 2.

[redacted] shared the eating disorders methodology and key themes from the dress rehearsal that was carried out. [redacted] further briefed on how the eating disorder assessment was carried out and touched on the actions and findings gathered from the patient and public involvement event. Feedback indicated that overall response from participants in the assessment was positive towards the planned research to be undertaken. The interview has since been updated to reflect the changes to the SCANV3s9 that were suggested during the event.

[redacted] queried whether the interview consists of any questions regarding height to accompany the BMI/Weight questions, and it was confirmed that self-reported height and weight is included in both phase 1 and 2 questionnaires. [redacted] also confirmed that the criteria for DSM 5 and the diagnostic guidelines for ICD 11 are thoroughly covered in the questionnaire. [redacted] voiced that any participant who may be diagnosed with anorexia, potentially could be more inclined to avoid disclosing their weight and questioned whether a diagnosis can still be inferred based on their answers provided to other height/weight related questions. [redacted] confirmed that the interviewers are trained to handle the topic sensitively yet not leave out any questions which would be required for diagnostic criteria.

5. DRH Update and Recommendations *please refer to slide pack*

[redacted] provided a detailed update on the dress rehearsals, the response rates, and key recommendations. The two dress rehearsals carried out were the ethnic minority boost (EMB DR) and the Core DR. Overall findings from the EMB DR were good, and there was a low refusal rate at

the screening phase but a higher refusal rate during the interviewing phase than anticipated, but overall numbers were similar to predicted. The Core DR, saw an overall lower response rate than hoped but a higher percentage for future contact.

The key recommendation is to reduce the length of the face-to-face interview by 13minutes from the initial 99 and 100 mins by removing some content. Feedback received from both participants and interviewers was that the questionnaire is lengthy and repetitive. It was highlighted that the survey did not yet include questions on data linkage or future contact consent but would be included in the mainstage and this needs to be taken into consideration when deliberating potential cuts as the consent questions take up to 4 minutes. The proposed options to reduce content would either be cutting subsets of questions across modules or cutting of entire modules or introducing a split sample. [redacted] presented some example topics which could be removed from the content as well as explaining how a split sample would potentially work.

[redacted] added that there were additional papers circulated prior to the steering group meeting which consists of further detailed information for members to consider including timings of modules. The group was asked to provide feedback/suggestions offline which will be collated into a proposal for finalisation at the next steering group meeting.

[redacted] queried the reasoning behind the suggestion to remove IPAQ from the content. [redacted] clarified that it was not included in 2014 so no trend data, and as it is a lengthy topic which is also collected in the Health Survey for England (HSE) it may be feasible to remove it as there is already data collected elsewhere.

[redacted] mentioned that APMS 2014 data showed a prevalence of Bipolar Disorder in 3.4% of 16-25 year olds but much lower rates in the older age ranges. This could mean rising prevalence rates or it may be due to reduced life expectancy for people with the condition, or a combination. This second APMS to include the Bipolar measure is therefore crucial to understanding the trends over time. Splitting the sample would not be ideal as it may lead to inaccurate prevalence figures for this group due to low sample numbers. [redacted] also justified the use of the ethnicity boost as black men are being detained under the Mental Health Act with psychosis, often due to bipolar or schizophrenia. We therefore need to use the measure for all participants in the ethnicity boost sample.

[redacted] conveyed comments from his peers at recent workshop he attended, who felt that accessing the data from NHSD has proven difficult. [redacted] mentioned that based on experience, other surveys such as MHCYP, the inclusion of future contact questions was used extensively and generated good uptake in terms of contacting for future follow up surveys. However, the removal of future contact questions could be considered, dependant on DHSC's providing funds for future follow up surveys for APMS. [redacted] pointed out that as the sample size has increased, the likelihood of following up with participants could also increase, however, [redacted] highlighted that due to the current governmental agreement in place to conduct prevalence surveys every 7 years and with MHCYP due to follow up in 2024, DHSC cannot guarantee or commitment to a follow up for APMS.

[redacted] voiced that to understand the population, the trend questions and prevalence screening questions should remain in the survey and look to remove supplementary questions. [redacted] also offered a suggestion of the interviewer retrospectively filling in certain, repeated questions based on the participants initial answers, to reduce the time of the interview. [redacted] clarified that the scan interview includes repeated questions to determine that correct answers are being provided for the right questions and cannot be filled in by the interviewer. [redacted] also commented that whilst questions may appear to ask related topics they are needed to be asked in full for the screening assessments.

A few key areas discussed were:

- Removal of the IPAQ questions
- The removal of COVID questions

- The removal of work-related stress and attitudes to working from home questions

[redacted] requested members to feed back any further suggestions for topics that could be cut.

[redacted] also asked the group about the definition for the mixed ethnic group as this had been initial set as Black African and White and Black Caribbean and White but is this the right groups to be considering. [redacted] also set an action for the group to provide any useful examples of practical application that would be suitable for interviewers to use to provide a stronger messaging to participants and contextualise how APMS data is used, to encourage greater uptake.

Action 39: Slide pack to be circulated to the steering group for feedback on proposed content removal and key recommendations from the dress rehearsal.
Action 40: Group to review and consider the removal of IPAQ, COVID, work related stress and attitudes to working from home questions from the survey, along with any further suggestions
Action 41: Group to provide examples of practical application to be used by interviewers during the survey to encourage response
Action 42: Group to consider the current definition for the mixed ethnicity group and whether this should be widened further, if so what other groups should be included, and advice for appropriate language and phrasing for doorstep interviewers

Other Actions from the Slides not discussed but for consideration for feedback.
Action 43: Group members asked to provide feedback on the importance of the ethnicity boost and how the findings may impact communities, to be used to help encourage participation (Slide 30)

Action 44: Group to provide any knowledge of specific groups or charities that specifically cover mental health support for ethnic groups that can be included on leaflets (Slide 31)

Action 45: Group to provide suggestions for who could appear in soundbites/videos for the NatCen website and interviewer training to promote the ethnicity boost (pre-meet document)

6. Alternative Mode Update

[redacted] described the alternative mode interview and presented slides for the final topics that were included in the dress rehearsal interview, which is reduced compared to the face-to-face survey to enable a shorter survey. The aim is to identify whether the alternative mode should continue to be offered to participants, despite the element of reduced content. The telephone survey was well received for those that took part.

The options are to continue to offer the alternative mode for the mainstage to those who refuse a face-to-face survey or only offer the alternative mode in extenuating circumstances e.g., Covid restrictions. [redacted] reported that having the alternative mode may help with lowering refusal rates but would impact on the data available as a shorter survey and possible impact on phase 2 uptake which has to be done face to face. It was highlighted that the alternative mode was positively received for the Deprived Area Boost (DAB) and EMB particularly where participants wanted a female interviewer and there was not one available or with shift workers.

[redacted] queried the possibility of offering other forms of communication via technology e.g., Video calls on Zoom or MS Teams. [redacted] confirmed that video calls were offered and trialled for the HSE survey during Covid restrictions and national lockdown. This was however proven ineffective compared to telephone interviews and subsequently it was withdrawn as an option. [redacted] reiterated [redacted] comments that NatCen have also trialled video calling for previous surveys and received limited uptake.

7. AOB

[redacted] thanked people for their comments and that these would be reviewed, and a summary of proposed content reductions would be circulated to the group for comments and offline dialogue. [redacted] questioned as to when the announcement for the next APMS survey would be published on the NHSD website. [redacted] confirmed that the announcement will be sent to the web team for publishing as soon as possible.

No further business addressed under this agenda item. [redacted] thanked and closed the meeting.

Action 46: Following updates, NHSD to circulate proposed content reductions for the group to consider
Action 47: NHSD to update the APMS webpage to announce the boosts and eating disorders in phase 2

8. Date for Next Meeting

Date to be confirmed.

New and Outstanding Actions

Ref	Date	Action	Owner	Status
01	08/04/2021	**Members to send in any outstanding bios or photos to [redacted] at surveys.queries@nhs.net** Update 24/06/21: [redacted] were asked to submit outstanding biographies and photographs for the survey web page. **Update 30/09/21:** There are still eight members without biographies or pictures. NHSD to send a reminder. **Update 09/12/21:** 5 Outstanding Bio & Pics remaining for [redacted] **Update 19.7.22:** Surveys team to recirculate email requesting bios/pictures from existing and new members.	All	[redacted]
02	08/04/2021	**All members to review the ToR membership list and highlight areas not represented, suggest suitable people or groups to be involved, including voluntary sector organisations, and lived experience groups.** Update 24/06/21: Suggestion received for representative from the Gambling Commission. Request for representatives from 'Lived Experience' Groups – [redacted] agreed to follow-up with [redacted] for details. [redacted] suggested contacting the charity [redacted] Mental Health who had been involved in the focus groups as part of the consultation. Update 30/09/21: [redacted] welcomed gambling representatives, and mentioned they were contacting the charity [redacted] for Lived Experience representatives and will give an update at the next meeting. **Update 09/12/21**: If members have any suggestions for members with lived experience, please come forward and contact via surveys mailbox. **Update 19/7/22:** [redacted] to provide surveys team with potential lived experience advisors to join the group. Group were asked to provide possible recruitment strategies.	All	[redacted]
31	30/09/21	[redacted] **to share details for the National Drug Treatment Dataset (NDTDS) held by PHE (transferring to DHSC) and NHS Digital to explore options for future data linkage**. **Update 09/12/21:** PHE to provide update following the meeting. **Update 19/7/22:** [redacted] to follow up	[redacted] PHE	[redacted]

Ref	Date	Action	Owner	Status
38	19/07/22	[redacted] to forward on current proposal model for eating disorders validation study to [redacted]	[redacted]	NEW
39	19/07/22	Slide pack to be circulated to the steering group for feedback on proposed content removal and key recommendations from the dress rehearsal	ALL	NEW
40	19/07/22	Group to review and consider the removal of IPAQ, COVID, work related stress and attitudes to working from home questions from the survey, along with any further suggestions	ALL	NEW
41	19/07/22	Group to provide examples of practical application to be used by interviewers during the survey to encourage response	ALL	NEW
42	19/07/22	Group to consider the current definition for the mixed ethnicity group and whether this should be widened further, if so what other groups should be included, and advice for appropriate language and phrasing for doorstep interviewers	ALL	NEW
43	19/07/22	Group members asked to provide feedback on the importance of the ethnicity boost and how the findings may impact communities, to be used to help encourage participation (Slide 30)	ALL	NEW
44	19/07/22	Group to provide any knowledge of specific groups or charities that specifically cover mental health support for ethnic groups that can be included on leaflets (Slide 31)	ALL	NEW
45	19/07/22	Group to provide suggestions for who could appear in soundbites/videos for the NatCen website and interviewer training to promote the ethnicity boost (pre-meet document)	ALL	NEW
46	19/07/22	Following updates, NHSD to circulate proposed content reductions for the group to consider	NHSD	NEW
47	19/07/22	NHSD to update the APMS webpage to announce the boosts and eating disorders in phase 2	NHSD	NEW

9. Closed Actions:

Ref:	Date	Action	Owner	Status
09	24/06/21 Group M'ship	**NHSD to consider where areas of expertise are required when final survey content is decided and expand steering group membership and/or create an advisory reference group.** **Update 30/09/21:** NHSD updated that they will invite [redacted] representatives to the group if the deprivation boost goes ahead.	NHSD	Closed 09/12/21
23	30/09/21	**NatCen to check the inclusion of Spice in the new psychoactive substances in the drugs module.**	NatCen	Closed 09/12/21
24	30/09/21	**NatCen to clarify/confirm [redacted] suggestion to include AUDIT only in the survey and share his report comparing different measures with the group. Group consensus is; if the report recommendation is to use AUDIT, then drop SADQ from the 2022 survey.**	NatCen	Closed 09/12/21

Ref:	Date	Action	Owner	Status
25	30/09/21	**Share AUDIT questions with the group for context and information.**	NatCen	Closed 09/12/21
26	30/09/21	**NatCen to investigate whether the new alcohol questions to identify whether participants who reported as non-drinkers may have had former or sustained alcohol problems, could be asked of all, not just non-drinkers.** **Update 09/12/21**: NatCen have reviewed. The aim of the question is to understand if non-drinkers stopped drinking because they used to drink heavily or have, they always been non-drinkers. If we can ask current drinkers if they use to drink heavily, it will be subjective and not very useful. Therefore, this has not been included at all.	NatCen	Closed 09/12/21
27	30/09/21	**NatCen to share the revised gambling activity list with group members, and to ensure the HSE gambling activity list is reviewed and made consistent with the revised activity list to be used in APMS.**	NatCen	Closed 09/12/21
28	30/09/21	**NHSD to review what can be removed to allow for EDEQ or EDEQ-S.** **Update 09/12/21:** Update and discussion held in meeting. Dress rehearsal will confirm actual survey length, agreed to go with SCOFF and EDEQ-S and to review after the dress rehearsal if any content needs removing. **Update 19/7/22:** addressed under agenda item	NHSD	Closed
30	30/09/21	**All group members to suggest datasets or data collections not currently held by NHS Digital, which would be useful for future linkage with APMS survey data.** **Update 09/12/21:** No further update received but they are exploring the legal basis for HMRC and DWP linkage. If any members have further suggestions, please raise via surveys.queries@nhs.net by 24 December 2021 after which the action will be closed. **Update 19/7/22:** No other data linkage options provided.	All	Closed
32	30/09/21	**NHSD to investigate ethical approval for linkage to NHS health records.** **Update 09/12/21**: Carried Forward **Update 19/7/22:** Direction from MHCYP allows linkage	NHSD	Closed
33	30/09/21	**NHSD to investigate ONS Cause of Death/Mortality dataset for future data linkage and cover as a future agenda item at the next meeting.** **Update 09/12/21:** Data linkage covered on the agenda. NHSD receive a cut of ONS Cause of Death data and will be included in the linkage permissions.	NHSD	Closed 09/12/21
34	09/12/21	**Group members to submit questions and/or feedback on the proposals for an alternative data collection mode by the end of the week.** **Update 19/7/22:** Content for alternative modes has been agreed.	All	Closed
35	09/12/21	**NatCen to produce a document summarising the rational for priorities for including and excluding content in the alternative data collection mode.** **Update 19/7/22:** Shared with group.	NatCen	Closed
36	09/12/21	**NatCen to investigate the modules with sensitive content to see if they can be included in alternative modes.** **Update 19/7/22:** Alternative modes content agreed.	NatCen	Closed

Ref:	Date	Action	Owner	Status
37	09/12/21	**DHSC to confirm the order of priorities for funding for Phase 2 and the sample boosts and confirm with group members.** **Update 19/7/22:**	NHSD	Closed
29	30/09/21	[redacted] **to liaise with** [redacted] **on the value of SCAN-ED, if Phase 2 funding is confirmed.** **Update 09/12/21:** Will be Carried Forward if confirmed funding **Update 19/07/22:** Confirmation of funding has been received. [redacted] presented slides at the meeting	[redacted] Leicester	Closed

List of all Tables Specifications for APMS 2023/24

The list below shows the list of tables by chapter as agreed as of 24/09/2024:

1. Common Mental Health Conditions*

Table 1.1: Severity of symptoms (CIS-R score) of common mental health conditions (CMHC), by age and gender

Table 1.2: Severity of CMHC symptoms (CIS-R score) of common mental health conditions (CMHC) in 1993, 2000, 2007, 2014 and 2023, by age and sex

Table 1.3: Common mental health conditions (CMHC) in past week, by age and gender

Table 1.4: Common mental health conditions (CMHC) in past week in 1993, 2000, 2007, 2014 and 2023-24, by age and sex

Table 1.5: Common mental health conditions (CMHC) in past week, by CIS-R score

Table 1.6: Common mental health conditions (CMHC) in past week (observed and age-standardised), by ethnic group and gender

Table 1.7: Common mental health conditions (CMHC) in past week (observed and age-standardised), by employment status and gender

Table 1.8: Common mental health conditions (CMHC) in past week, by has problem debt and gender

Table 1.9: Common mental health conditions (CMHC) in past week (observed and age-standardised), by Index of Multiple Deprivation (IMD) and gender

Table 1.10: Common mental health conditions (CMHC) in past week (observed and age-standardised), by region and gender

Table 1.11: Common mental health conditions (CMHC) in past week, by limiting chronic physical health conditions, CMHC and gender

Table 1.12: Self-diagnosed common mental health condition (CMHC), professional diagnosed CMHC, and presence of professional diagnosed CMHC in past 12 months, by CMHC in past week

2. Treatment & Services*

Table 2.15: Treatment for mental or emotional problem, by age, gender and severity of symptoms (CIS-R score) of common mental health conditions (CMHC)

Table 2.16: Treatment for mental or emotional problem, by ethnic group

Table 2.17: Treatment for mental or emotional problem, by employment status, gender and severity of symptoms (CIS-R score) of common mental health conditions (CMHC)

Table 2.18: Treatment for mental or emotional problem, by has problem debt and severity of symptoms (CIS-R score) of common mental health conditions (CMHC)

Table 2.19: Treatment for mental or emotional problem, by Index of Multiple Deprivation (IMD) and severity of symptoms (CIS-R) of common mental health conditions (CMHC)

Table 2.20: Treatment for mental or emotional problem, by region and severity of symptoms (CIS-R score) of common mental health conditions (CMHC)

Table 2.21: Treatment for mental or emotional problem, by limiting chronic physical health condition, common mental health conditions (CMHC) and severity of symptoms (CIS-R score) of common mental health conditions (CMHC)

Table 2.22: Requested but not received a particular mental health treatment in the past 12 months, by severity of symptoms (CIS-R score) of common mental health conditions (CMHC) and gender

Table 2.23: Requested but not received a particular mental health treatment in the past 12 months, by severity of symptoms (CIS-R score) of common mental health conditions (CMHC), age and gender

Table 2.24: Requested but not received a particular mental health treatment in past 12 months, by current receipt of any mental health treatment and severity of symptoms (CIS-R) of common mental health conditions (CMHC)

Table 2.25: Experienced delays and waiting times in receiving treatment for a mental or emotional problem, by severity of symptoms (CIS-R score) of common mental health conditions (CMHC)

3. Posttraumatic Stress Disorder (PTSD)*

Table 3.1: Domain, screen positive for probable PTSD in last month and whether experienced trauma, by age and gender

Table 3.2: Screen positive for probable PTSD in last month and whether experienced trauma in 2014 and 2023-24, by age and sex

Table 3.3: Screen positive for probable PTSD in past month and whether experienced trauma (observed and age-standardised), by ethnic group and gender

Table 3.4: Screen positive for probable PTSD in past month and whether experienced trauma, by employment status and gender

Table 3.5: Screen positive for probable PTSD in past month and whether experienced trauma, by has problem debt and gender

Table 3.6: Screen positive for probable PTSD in past month and whether experienced trauma (observed and age-standardised), by Index of Multiple Deprivation (IMD) and gender

Table 3.7: Screen positive for probable PTSD in past month and whether experienced trauma (observed and age-standardised), by region and gender

Table 3.8: Screen positive for probable PTSD in past month and whether experienced trauma, by limiting chronic physical health conditions, common mental health conditions (CMHC) and gender

Table 3.9: Screen positive for probable PTSD in the past month, by self-diagnosis and professional diagnosis of PTSD and gender

Table 3.10: Treatment and service use, among people with and without a positive screen for probable PTSD in past month

Table 3.11: Psychotropic medication currently taken, among people with and without a positive screen for probable PTSD in past month

Table 3.12: Experienced delays and waiting times in receiving treatment for a mental or emotional problem, among people with and without a positive screen for probable PTSD in past month

4. Suicidal thoughts suicide attempts and self-harm*

Table 4.1: Prevalence of lifetime suicidal thoughts, suicide attempts and self-harm, by age and gender

Table 4.2: Suicidal thoughts and suicide attempts in the past year and self-harm ever in 2000 to 2023-24, by age and sex

Table 4.3: Lifetime suicidal thoughts, suicide attempts and self-harm (observed and age-standardised), by ethnic group and gender

Table 4.4: Lifetime suicidal thoughts, suicide attempts and self-harm, by employment status and gender

Table 4.5: Lifetime suicidal thoughts, suicide attempts and self-harm, by has problem debt and gender

Table 4.6: Lifetime suicidal thoughts, suicide attempts and self-harm (observed and age-standardised), by Index of Multiple Deprivation (IMD) and gender

Table 4.7: Lifetime suicidal thoughts, suicide attempts and self-harm (observed and age-standardised), by region and gender

Table 4.8: Lifetime suicidal thoughts, suicide attempts and self-harm, by limiting chronic physical health conditions, common mental health conditions (CMHC) and gender

Table 4.9: Methods and reasons for self-harming, by gender

Table 4.10: Methods and reasons for self-harming, by age

Table 4.11: Sources sought help from following last suicide attempt, by gender

Table 4.12: Sources sought help from and whether received help following last suicide attempt, by age

Table 4.13: Sources sought help from following last suicide attempt, by gender

Table 4.14: Sources sought help from following last suicide attempt, by age

Table 4.15: Treatment and service use for a mental or emotional problem, by lifetime suicidal thoughts, suicide attempts and self-harm

Table 4.16: Psychotropic medication currently taken, by lifetime suicidal thoughts, suicide attempts and self-harm

Table 4.17: Experienced delays and waiting times in receiving treatment for a mental or emotional problem, by lifetime suicidal thoughts, suicide attempts and self-harm

5. Alcohol Dependence*

Table 5.1: Harmful and dependent drinking in the past year, by age and gender

Table 5.2: Trends in harmful and dependent drinking in the past year, by age and sex: 2000 to 2023-24

Table 5.3: Harmful and dependent drinking in the past year (observed and age-standardised), by ethnic group and gender

Table 5.4: Harmful and dependent drinking in the past year, by employment status and gender

Table 5.5: Harmful and dependent drinking in the past year, by has problem debt and gender

Table 5.6: Harmful and dependent drinking in the past year, by Index of Multiple Deprivation (IMD) and gender

Table 5.7: Harmful and dependent drinking in the past year (observed and age-standardised), by region and gender

Table 5.8: Harmful and dependent drinking in the past year, by limiting chronic physical health conditions, common mental health conditions (CMHC) and gender

Table 5.9: Harmful and dependent drinking in the past year, by self-diagnosis and professional diagnosis of alcohol dependence

Table 5.10: Treatment and service use for a mental or emotional problem, by AUDIT score

Table 5.11: Treatment ever received for alcohol dependence, by AUDIT score

Table 5.12: Psychotropic medication currently taken, by AUDIT score

Table 5.13: Experienced delays and waiting times in receiving treatment for a mental or emotional problem, by AUDIT score

6. Drug Use and Dependence*

Table 6.1: Lifetime experience of illicit drug use, by age and gender

Table 6.2: Illicit drug use in the past year, by age and gender

Table 6.3: Illicit drug use in the past year (age-standardised), by ethnic group and gender

Table 6.4: Illicit drug use in the past year (age-standardised), by region and gender

Table 6.5: Drug dependence in the past year, by age and gender

Table 6.6: Drug dependence in the past year in 1993, 2000, 2007, 2014 and 2023-24 by age and sex

Table 6.7: Drug dependence in the past year (age-standardised), by ethnic group and gender

Table 6.8: Drug dependence in the past year (age-standardised), by employment status and gender

Table 6.9: Drug dependence in the past year (age standardised), by has problem debt and gender

Table 6.10: Drug dependence in the past year (age standardised), by Index of Multiple Deprivation (IMD) and gender

Table 6.11: Drug dependence in the past year (observed and age-standardised), by region and gender

Table 6.12: Drug dependence in the past year (age-standardised), by limiting chronic physical health conditions, common mental health conditions (CHMC) and gender

Table 6.13: Drug dependence in the past year, by self-diagnosis and professional diagnosis

Table 6.14: Treatment currently received for mental or emotional problem, by drug dependence in the past year

Table 6.15: Treatment currently received for drug dependence, by drug dependence in the past year year

Table 6.16: Psychotropic medication currently taken, by drug dependence in the past year

Table 6.17: Experienced delays and waiting times in receiving treatment for a mental or emotional problem, by drug dependence in the past year

7. Gambling Behaviour*

Table 7.1: Gambling behaviour in the past 12 months and Problem Gambling Severity Index (PGSI) scores by age and gender

Table 7.2: Gambling behaviour in the past 12 months and Problem Gambling Severity Index (PGSI) scores by participation in any gambling, participation in online gambling, age and gender

Table 7.3: Problem Gambling Severity Index (PGSI) scores, by ethnic group and gender

Table 7.4: Problem Gambling Severity Index (PGSI) scores, by employment status and gender

Table 8.24: Experienced delays and waiting times in receiving treatment for a mental or emotional problem, by any personality disorder screen (SAPAS)

9. Attention Deficit Hyperactivity Disorder (ADHD)*

Table 9.1: Number of attention-deficit/hyperactivity disorder (ADHD) characteristics present in the past six months, by age and gender

Table 9.2: Screen positive for ADHD in past six months in 2007, 2014 and 2023-24, by age and sex

Table 9.3: Screen positive for ADHD in the past six months (observed and age-standardised), by ethnic group and gender

Table 9.4: Screen positive for ADHD in the past six months, by employment status and gender

Table 9.5: Screen positive for ADHD in the past six months, by has problem debt and gender

Table 9.6: Screen positive for ADHD in the past six months (observed and age-standardised), by Index of Multiple Deprivation (IMD) and gender

Table 9.7: Screen positive for ADHD in the past six months (observed and age-standardised), by region and gender

Table 9.8: Screen positive for ADHD in the past six months, by limiting chronic physical health conditions, common mental health conditions (CMHC) and gender

Table 9.9: Screen positive for ADHD in the past six months, by self-diagnosis and professional diagnosis of ADHD and gender

Table 9.10: Treatment currently received for a mental or emotional problem, by ASRS score

Table 9.11: Psychotropic medication currently taken, by ASRS score

Table 9.12: Experienced delays and waiting times in receiving treatment for a mental or emotional problem, by ASRS score

10. Autism*

Table specifications pending

11. Bipolar*

Table 11.1: Screen positive for bipolar disorder in 2014 and 2023, by age and sex

Table 11.2: Screen positive for bipolar disorder (observed and age-standardised), by ethnic group and gender

Table 11.3: Screen positive for bipolar disorder, by employment status and gender

Table 11.4: Screen positive for bipolar disorder, by has problem debt and gender

Table 11.5: Screen positive for bipolar disorder (observed and age-standardised), by Index of Multiple Deprivation (IMD) and gender

Table 11.6: Screen positive for bipolar disorder (observed and age-standardised), by region and gender

Table 11.7: Screen positive for bipolar disorder, by limiting chronic physical health conditions, common mental health conditions (CMHC) and gender

Table 11.8: Screen positive for bipolar disorder, by self-diagnosis and professional diagnosis and gender

Table 11.9: Treatment and service use for a mental or emotional problem, by bipolar disorder screen

Table 11.10: Psychotropic medication currently taken, by bipolar disorder screen

Table 11.11: Experienced delays and waiting times in receiving treatment for a mental or emotional problem, by bipolar disorder screen

12. Psychosis*

Table specifications pending

13. Eating Disorder*

Table 13.1: Screen positive for possible eating problems and possible eating disorders (SCOFF and EDE-QS), by age and gender

Table 13.2: Screen positive for possible eating problems (SCOFF) in 2007 and 2023-24, by age and sex

Table 13.3: Screen positive for possible eating problems (SCOFF) and possible eating disorders (EDE-QS) (age-standardised), by ethnic group and gender

Table 13.4: Screen positive for possible eating problems (SCOFF) and possible eating disorders (EDE-QS) (age-standardised), by employment status and gender

Table 13.5: Screen positive for possible eating problems (SCOFF) and possible eating disorders (EDE-QS) (age-standardised), by has problem debt and gender

Table 13.6: Screen positive for possible eating problems (SCOFF) and possible eating disorders (EDE-QS) (age-standardised), by Index of Multiple Deprivation (IMD) and gender

Table 13.7: Screen positive for possible eating problems (SCOFF) and possible eating disorders (EDE-QS) (observed and age-standardised), by region and gender

Table 13.8: Screen positive for possible eating problems (SCOFF) and possible eating disorders (EDE-QS) (age-standardised), by limiting chronic physical health conditions, common mental health conditions (CMHC) and gender

Table 13.9: Screen positive for possible eating problems (SCOFF) and possible eating disorders (EDE-QS) (age-standardised), by Body Mass Index (BMI) and gender

Table 13.10: Screen positive for possible eating problems (SCOFF) and possible eating disorders (EDE-QS), by self-diagnosis and professional diagnosis of an eating disorder and gender

Table 13.11: Screen positive for possible eating problems (SCOFF), by screen for possible eating disorders (EDE-QS)

Table 13.12: Treatment currently received for a mental or emotional problem, by screen positive for possible eating problems (SCOFF) and possible eating disorders (EDE-QS)

Table 13.13: Psychotropic medication currently taken, by screen positive for possible eating problems (SCOFF) and possible eating disorders (EDE-QS)

Table 13.14: Experienced delays and waiting times in receiving treatment for a mental or emotional problem, by screen positive for possible eating problems (SCOFF) and possible eating disorders (EDE-QS)

*** Common to all**

Table A1: True standard errors and 95% confidence intervals for screen positive for bipolar disorder among adults, by age and gender

Table A2: True standard errors and 95% confidence intervals for screen positive for bipolar disorder among adults, by ethnic group and gender

Table B1: Population number estimates for screening positive for bipolar disorder among adults, by survey year, age and sex (thousands)

The Adult Psychiatric Morbidity Survey (APMS): Survey of Mental Health and Wellbeing, England, 2023/4 was published today (previous survey 2014)

It provides data on the prevalence of both treated and untreated psychiatric disorder in the English adult population (aged 16 and over) including PTSD, suicide ideation, alcohol and drug dependence, ADHD etc

It's important because it includes gambling behaviour, prevalence using PGSI 8+, and associations can be made between gambling and suicide ideation.

Claims that could be made:

- Last 12 month gambling participation is more accurate than what GSGB captures (42.6% of adults aged 16+ living vs 61% for GSGB [18 years old +)
    - The difference is likely due to:
        - smaller activity list than the GSGB. We know from our experiments that makes a big difference and does not capture all gambling participation
        - Includes 16/17 year olds
        - Social desirability bias from face to face methodology.
- The PGSI 0.4% figure found shows that GSGB is incorrect
    - Our pushback would be:
        - Not surprised a face to face methodology produces a lower number. Historic trend here and report notes the potential impact of social desirability
        - Impact on responses of a 90 minute mental health survey, including 16/17 year olds in terms of comparability, issues with participation question
        - The report itself recognises that it is likely an under-estimate, due to:
            - wider harms shown to be experienced by those not registering 8+ on GSGB
            - Different wording on PGSI response
            - And lower than the HSE because HSE reports a mix of PGSI
- GSGB estimates in relation to suicide ideation/attempts are unreliable – GSGB 11.4%, APMS 7.7%
    - We'd note:
        - Methodological differences would have an impact

        - The rate has significantly increased from 4.3% in 2000 to 7.7% in 2023/4, this sober statistic is surely resonant in terms of thinking about the level of care gambling consumers may need
    - APMS shows that face to face still works as a gold plated methodoloy
        - We'd note that:
            - The response rate achieved (29.4%) was lower than previous surveys in the series (57% in 2014).
            - The fieldwork was delayed and took far longer because of the difficulties in achieving sample size
            - This further illustrates why we moved to a push to web approach.

We've talked with DCMS and DHSC who both noted the different purpose between APMS and GSGB and how they complement rather than combat each other

We developed a reactive line with Comms:

We welcome the publication of the Adult Psychiatric Morbidity Survey 2023/24 (APMS). We recognise there are differences in methodology and estimates in key areas, it's important to remember that the APMS and our own Gambling Survey for Great Britain are distinct vehicles, each designed to deliver their own valuable insights.

It is helpful to have this new dataset, which supports broader comparisons and enhances our understanding of gambling behaviours in the context of wider health inequalities

We will take the time to review and digest this new information and incorporate it into our continuous improvement cycle.

We have more detail if needed but wanted to share the topline today.

[redacted]

This is a gold-plated methodology and the

[redacted] sat on the steering group and is named in the published report.

- The purpose of the APMS is not to measure the participation rate of gambling but to examine the relationship between gambling-related harm and other mental health conditions. For example, the 2023/4 results have found PGSI score is strongly associated with problem debt.

- Gambling participation: 42.6% of adults aged 16+ living in England had gambled in the past 12 months (the equivalent figure on the GSGB (2023) was 61%)
    - The difference is likely due to the way participation was asked on the APMS. The activity list was much smaller than the activity list in the GSGB and we know from the experimental phase of the GSGB that a shortened list does not capture all gambling participation.

- PGSI 8+: 0.4% of adults aged 16+ living in England experienced problem gambling (as indicated by a PGSI score of 8+) (the equivalent figure on the GSGB (2023) was 2.5%)
    - The difference is likely due to the methodological differences between APMS (random probability face to face survey) and GSGB (a push to web approach).
    - The sample size (<40) is too small for meaningful analysis between the relationship in PG and suicide ideation. The APMS report focuses on those with a PGSI score of 3 or more which indicates that the participant was experiencing **at least** moderate risk gambling.
    - The report acknowledges this is likely to be underestimating by stating ***"The estimated prevalence of problem gambling, 0.4%, is likely to be conservative****. Overall, 0.4% of participants had a PGSI score of 8+, indicating the experience of problem gambling. This is broadly in line with estimates from the Health Survey for England (HSE) series. The HSE used slightly different PGSI response option wording and included two different instruments to estimate problem gambling, of which the PGSI produced somewhat lower estimates than the DSM-IV. Reporting of problem gambling from the HSE typically focused on people who were identified according to either instrument, as they capture a different range of behavioural symptoms and adverse consequences (NHS England 2023). APMS 2023/4 only includes the PGSI and thus the estimates presented here should be treated as conservative."*

- Suicide: 7.7% of adults aged 16-74 living in England reported suicidal thoughts or attempts in the last 12 months (the equivalent figure on the GSGB (2023) was 11.4%)
    - Note the suicide rate has significantly increased from 4.3% in 2000 to 7.7% in 2023/4
    - The difference from the APMS to GSGB is likely due to methodological differences.

- The response rate achieved (29.4%) was lower than previous surveys in the series (57% in 2014). This further illustrates why we moved to a push to web approach.