



# Mental health and wellbeing in England

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ADULT PSYCHIATRIC MORBIDITY SURVEY 2014 EXECUTIVE SUMMARY

# Key findings from the fourth in a series of surveys of the mental health of people living in England

## Trends in mental illness

- One adult in six had a common mental disorder (CMD): about one woman in five and one man in eight. Since 2000, overall rates of CMD in England steadily increased in women and remained largely stable in men.
- Reported rates of self-harming increased in men and women and across age groups since 2007. However, much of this increase in reporting may have been due to greater awareness about the behaviour.
- Young women have emerged as a high-risk group, with high rates of CMD, self-harm, and positive screens for posttraumatic stress disorder (PTSD) and bipolar disorder. The gap between young women and young men increased.
- Most mental disorders were more common in people living alone, in poor physical health, and not employed. Claimants of Employment and Support Allowance (ESA), a benefit aimed at those unable to work due to poor health or disability, experienced particularly high rates of all the disorders assessed.

## Trends in treatment and service use

- One person in three with CMD reported current use of mental health treatment in 2014, an increase from the one in four who reported this in 2000 and 2007. This was driven by steep increases in reported use of psychotropic medication. Increased use of psychological therapies was also evident among people with more severe CMD symptoms.
- There were demographic inequalities in who received treatment. After controlling for level of need, people who were White British, female, or in mid-life (especially aged 35 to 54) were more likely to receive treatment. People in the Black ethnic group had particularly low treatment rates.
- Socioeconomic inequalities in treatment use were less evident, although people living in lower income households were more likely to have requested but not received a particular mental health treatment.
- Since 2007, people with CMD had become more likely to use community services and more likely to discuss their mental health with a GP.

## About the survey

*Every seven years a rigorous assessment of the nation's mental health is carried out. England has the longest running programme using consistent methods in the world.*

The Adult Psychiatric Morbidity Survey (APMS) provides England's National Statistics for the monitoring of mental illness and treatment access in the household population. The data series is unique and valuable because:

- A range of mental disorders, substance disorders and self-harm behaviours is covered.
- High quality screening and assessment tools are used and undiagnosed conditions identified. A two phase design is used.
- Surveys have been carried out in 1993, 2000, 2007 and 2014 using comparable methods so trends can be examined.
- A large representative sample of the household population was interviewed, 7,500 people aged 16 or more, including those who do not access services.

**As with all surveys, it should be acknowledged that prevalence rates are only estimates.** If everyone in the population had been assessed the rate found may be higher or lower than the survey estimate. 95% confidence intervals (CIs) are given for key estimates in the individual chapters and Chapter 14 (Methods). For low prevalence disorders, relatively few positive cases were identified. Particular attention should be given to uncertainty around these estimates and to subgroup analysis based on these small samples. Comparisons made in the text have been tested and only statistically significant differences are described.

This latest survey, with fieldwork carried out in 2014 and 2015, presents the most reliable profile available of mental health in England. It was commissioned by NHS Digital, funded by the Department of Health, and carried out by NatCen Social Research and the University of Leicester. The survey includes data on mental health not available from any other source, and complements the range of statistics routinely published by NHS Digital. Reports on the use of Psychological Therapies

can be found at [www.digital.nhs.uk/iaptreports](http://www.digital.nhs.uk/iaptreports). Reports on the use of specialist Mental Health and Learning Disability health services can be found at [www.digital.nhs.uk/mhldsreports](http://www.digital.nhs.uk/mhldsreports).

## Context

***Changes in the economy and models of mental health service delivery mean that the context of mental health in England has evolved since the last survey.***

- Since the 2007, society has experienced changes in technology and media and the onset of recession.
- Treatment services have undergone change, including the introduction of the Improving Access to Psychological Therapy (IAPT) programme.
- The cross-government strategy *No Health without Mental Health* has sought to mainstream mental health and give it parity with physical health (DH 2011).

The APMS series is made up of cross-sectional surveys. While it cannot tell us whether these changes have impacted on mental health, it does provide us with a recent profile of mental health in England.

## Extent of mental illness in England

***One adult in six had a CMD: one in five women and one in eight men.***

The presence of CMD in the past week was assessed using the revised Clinical Interview Schedule (CIS-R). Disorders such as depression and generalised anxiety disorder (GAD) were identified, and a severity score produced. A score of 12 or more indicated symptoms warranting clinical recognition, a score of 18 or more is considered severe and requiring intervention.

One adult in six (17.0%) had a CMD. Throughout the survey series, rates have been higher in women than men: one woman in five had CMD (20.7%) compared with about one man in eight (13.2%).

Other disorders were rarer, for example psychotic disorder and autism each affected about one adult in a hundred. Bipolar disorder was covered for the first time in the survey series in 2014, the Mood Disorder Questionnaire identified traits in about one adult in fifty. Signs of drug dependence were evident in one adult in thirty, with a similar level found for probable alcohol dependence (an AUDIT score of 16 or more). Both types of substance dependence were twice as likely in men as women.

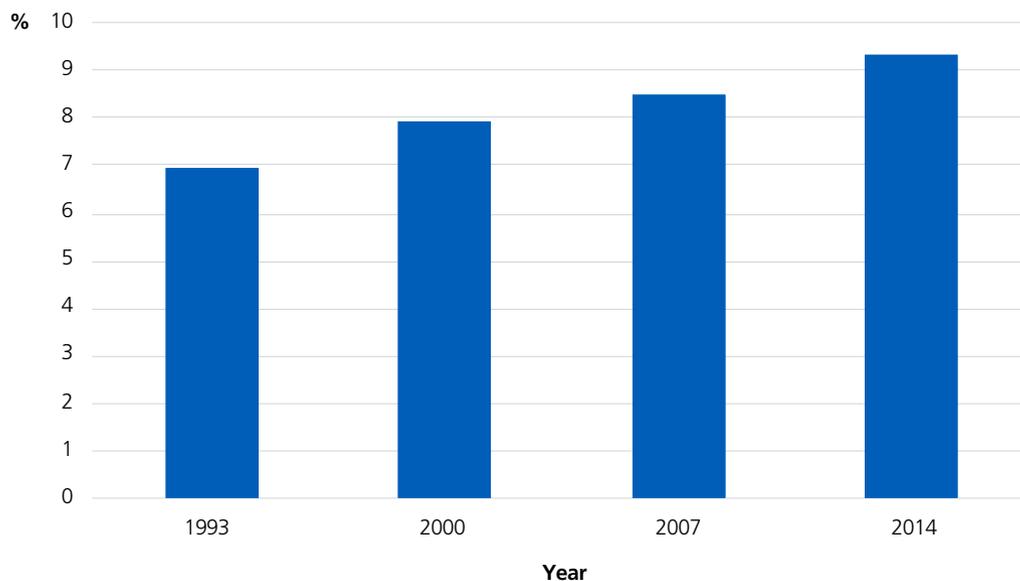
## Trends in mental illness

### *Mental illness has increased in women, and remained largely stable in men.*

The proportion of people with severe CMD symptoms (CIS-R score of 18+) did not change significantly between 2007 and 2014. However, the longer term trend has been one of steady increase (6.9% of 16 to 64 year olds in 1993, 7.9% in 2000; 8.5% in 2007; 9.3% in 2014).<sup>1</sup>

### **Severe CMD symptoms in past week (CIS-R score 18+), 1993 to 2014**

*Base: adults aged 16–64*

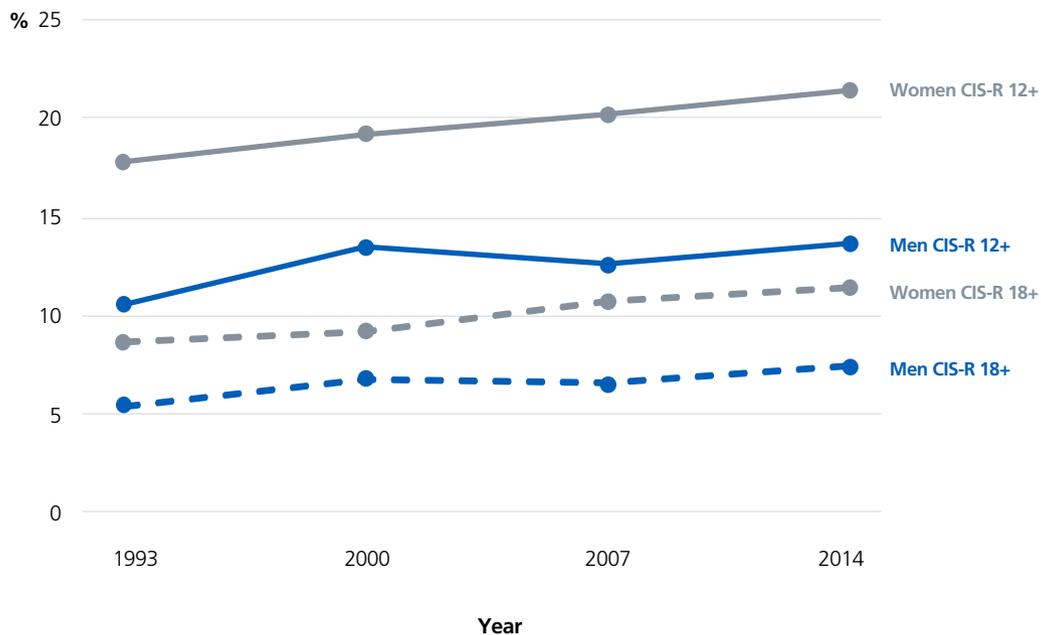


<sup>1</sup> Trends are based on people aged 16–64, as this age-group has been covered by every survey in the series.

Increases in CMD symptoms were driven by rises in women; the prevalence of CMD symptoms in men had remained broadly stable since 2000. Reports of self-harming doubled in men and women and across age groups between 2007 and 2014. This increase in reporting may be due (at least in part) to changes in reporting behaviour, that minor self-injury which people had not included as self-harm in previous surveys had started to be labelled as such. It is also likely that people felt more able to disclose self-harm. This might have happened if self-harming had become more normalised and less stigmatised. Finally, it is possible that increased reporting of self-harm reflects a real increase in the behaviour. A combination of these factors was probably at play.

### CMD symptoms in past week (CIS-R score 12+ and 18+) by sex: 1993 to 2014

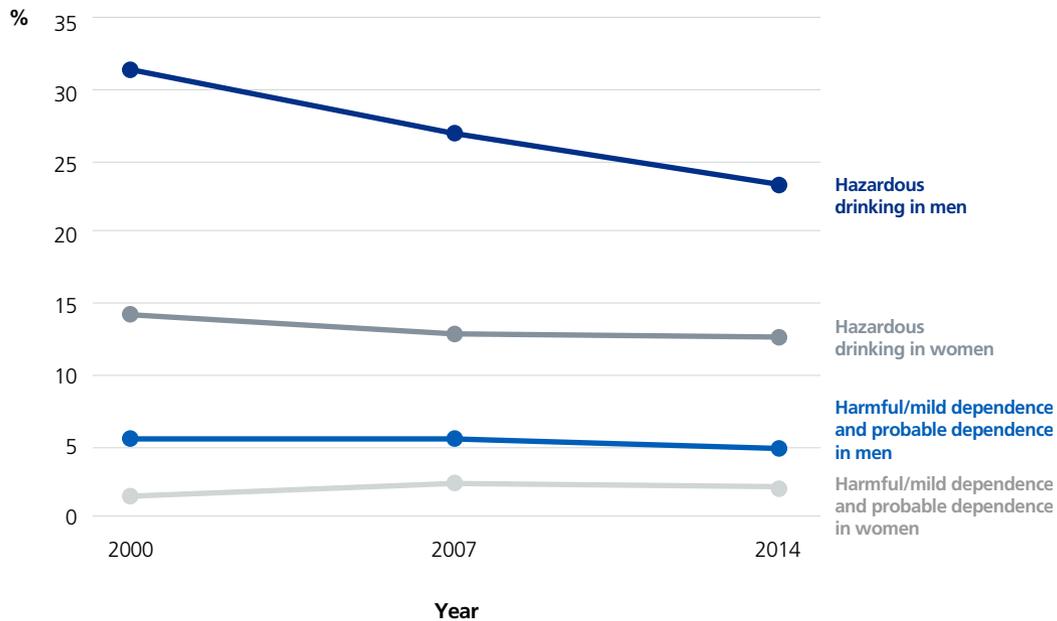
Base: adults aged 16–64



Since 2000, rates of hazardous drinking (AUDIT scores 8–15) declined in men and remained (at a lower level) stable in women. Levels of harmful or dependent drinking (AUDIT 16+) had not experienced a corresponding fall.

### Hazardous and harmful/dependent drinking (AUDIT score 8+ and 16+) in past year by sex: 2000, 2007 and 2014

Base: adults aged 16–74



## Inequalities and high risk groups

A key objective of the *No Health Without Mental Health Strategy* is tackling inequalities in mental illness; APMS provides data for monitoring progress towards this.

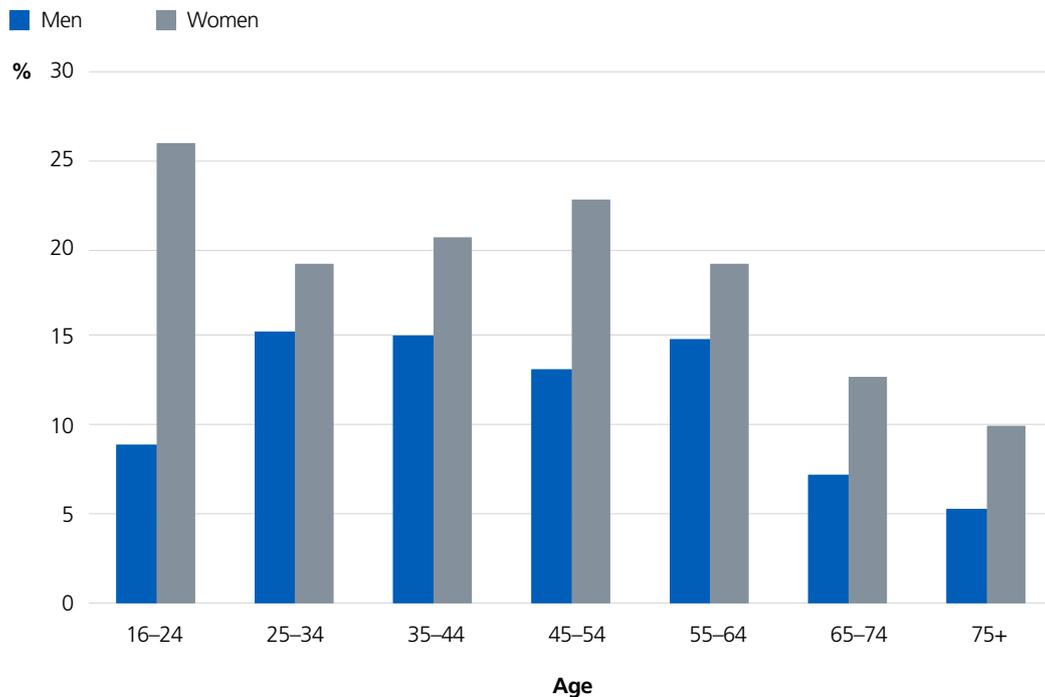
### *Young women have become a key high risk group.*

The gender gap in mental illness had become most pronounced in young people, and there is evidence that this gap has widened in recent years. Due to small base sizes, caution is needed with interpretation of results for age-by-sex

subgroups. However, the pattern here is consistent with other recent data sources (Knudsen 2016; The Children’s Society 2016; Lessof et al. 2016).

### **CMD symptoms in past week (CIS-R score 12+), by age and sex**

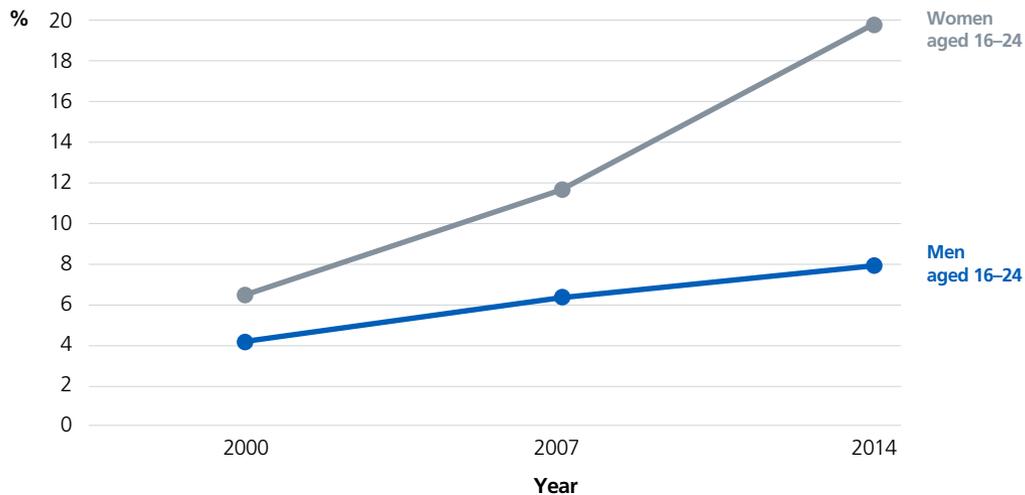
*Base: all adults*



In 2014, one in five 16 to 24 year old women reported having self-harmed at some point in her life when asked face-to-face and one in four reported this in the self-completion section of the survey. Most of the young people who reported self-harming did not seek professional help afterwards. Individuals who start to self-harm when young might adopt the behaviour as a long-term strategy for coping; there is a risk that the behaviour will spread to others; and also that greater engagement with the behaviour may lead in time to a higher suicide rate.

## Self-harm ever (reported face-to-face) in 16–24 year olds, by sex: 2000, 2007 and 2014

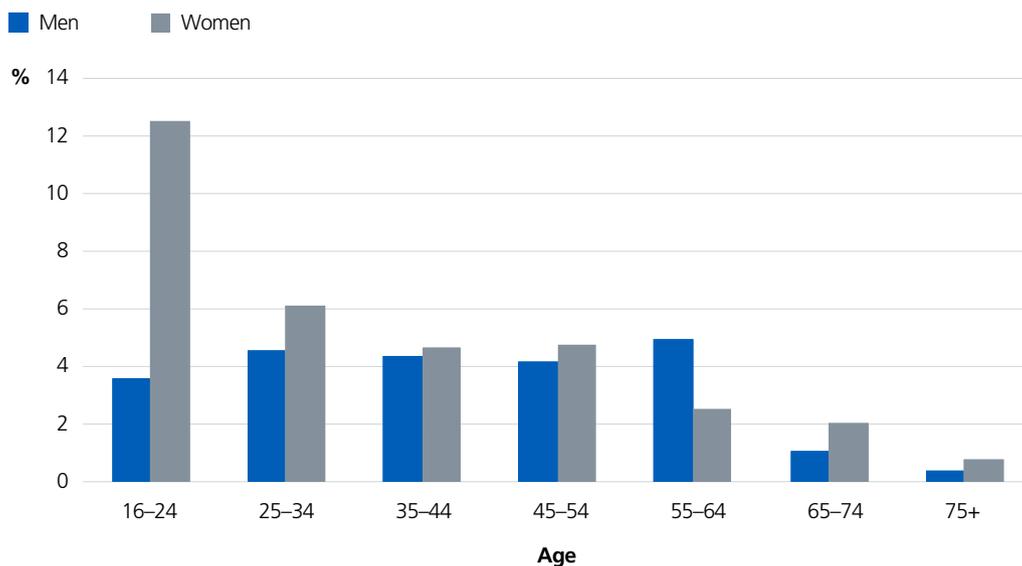
Base: adults aged 16–24 and living in England



Young women had high rates of screening positive for posttraumatic stress disorder (PTSD) (12.6% compared with 3.6% of men of the same age).

## Screening positive for posttraumatic stress disorder (PTSD), by age and sex

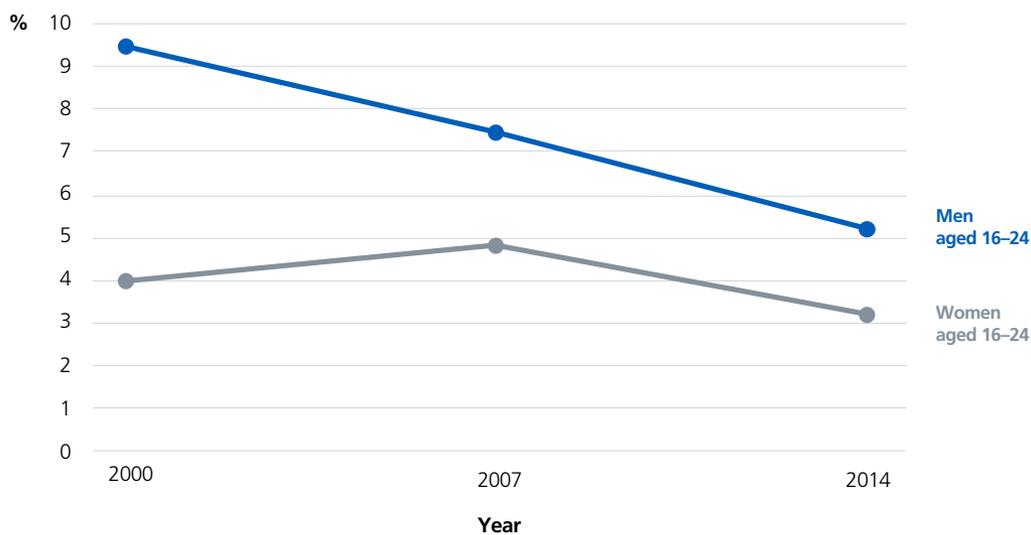
Base: all adults



While a decline in rates of harmful and probable dependent drinking since 2000 is clear in young men, such improvements are less evident in young women. Survey data on drug dependence trends in young people are likely to be incomplete, due to changes in the types of drugs becoming available, in particular the emergence of new psychoactive substances (NPS) which are challenging to research and regulate.

### **Harmful/dependent drinking in past year (AUDIT score 16+) in 16 to 24 year olds by sex: 2000, 2007 and 2014**

*Base: adults aged 16–24*

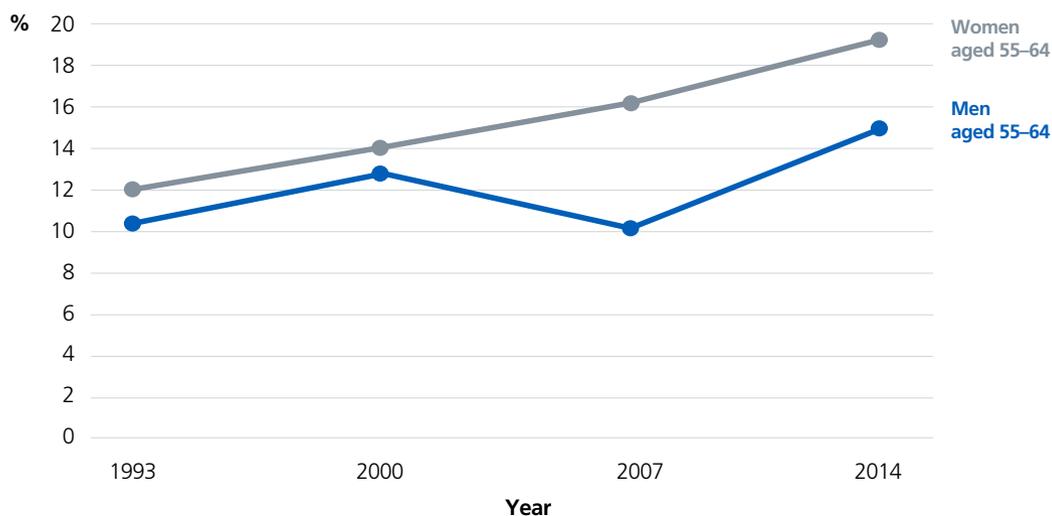


### ***Rates of mental illness increased in men and women aged 55 to 64.***

Since 2007, there had been increases in CMD symptoms in late midlife men and women (aged 55 to 64). This continued an upward trend in CMD in midlife women since 1993 (the longer term trend in men is less clear). Like young people, those in late life had also seen a steep increase in rates of reported lifetime self-harm. Men in this age-group have the highest rates of registered suicide, and have been identified as a priority group in England’s National Suicide Prevention Strategy (DH 2015).

## CMD symptoms in past week (CIS-R score 12+) in 55 to 64 year olds by sex: 1993 to 2014

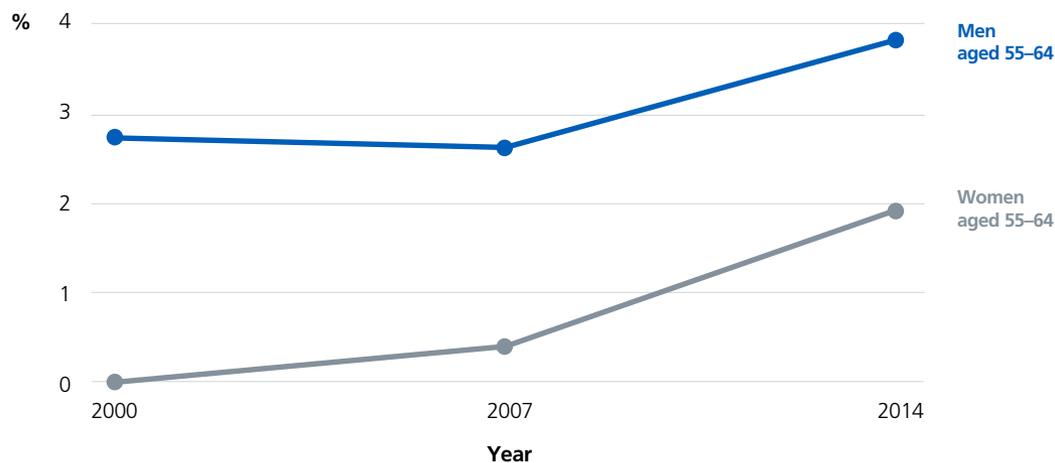
Base: adults aged 55–64



In contrast with the decline in rates of probable alcohol dependence in young men since 2000, there was no evidence of any decline in alcohol dependence rates in men and women aged 55 to 64.

## Harmful/dependent drinking in the past year (AUDIT score 16+) in 55 to 64 year olds by sex: 2000, 2007 and 2014

Base: adults aged 55–64



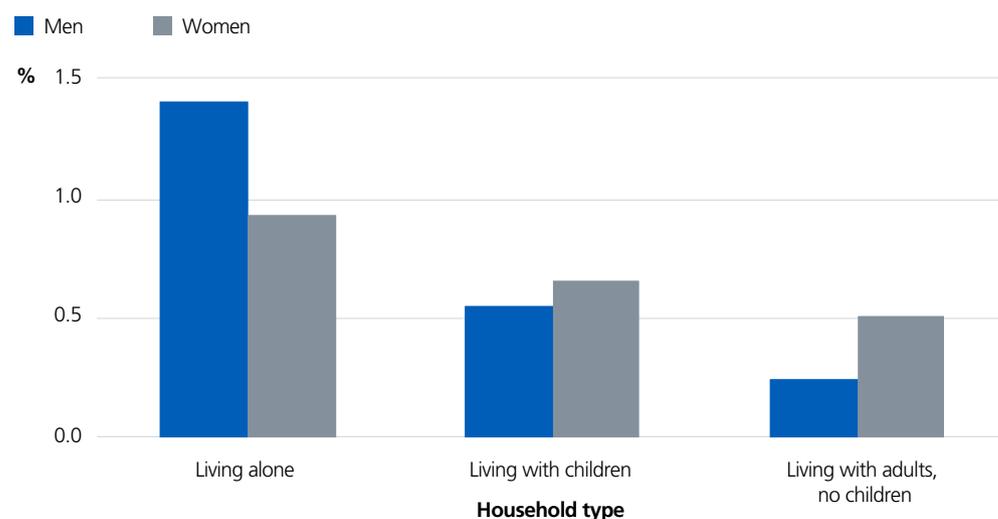
## Mental illness in context

### Living alone

Links between mental illness and social context are well established, for example rates tend to be higher in people who are single or divorced. Increasingly people live alone. Those that do live alone were identified in APMS 2014 as having experienced higher rates of most different mental disorders, including CMD, PTSD, psychotic disorder, personality disorder, and bipolar disorder.<sup>2</sup>

### Psychotic disorder in the past year (2007 and 2014 combined), by household type and sex

Base: all adults



### Living in socioeconomic adversity

Links between mental illness and socioeconomic context are also well-established, and APMS 2014 findings are consistent with this.

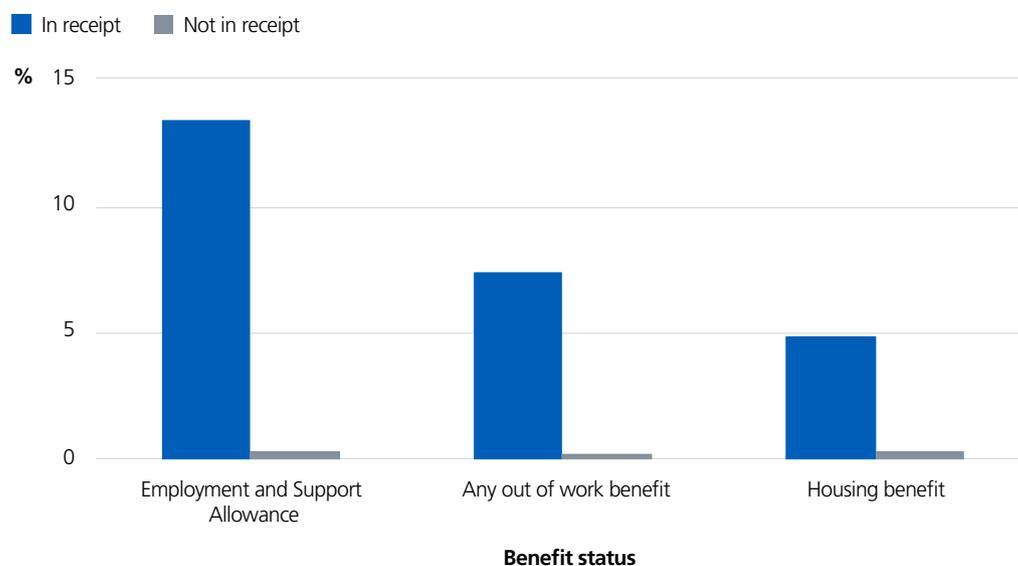
In the APMS 2014 data, it emerged that people in receipt of Employment and Support Allowance (ESA), a benefit aimed at those unable to work due to poor health or disability, were a particularly vulnerable group. While many will have

<sup>2</sup> APMS is a cross-sectional survey, capturing one moment in time, and cannot confirm whether living alone contributes to people having worse mental health or if people with poor mental health are more likely to choose to or end up living alone.

received ESA primarily for a physical health reason the great majority of this group had very high levels of psychiatric comorbidity. People in receipt of ESA experienced particularly high rates of most disorders: one in eight screened positive for bipolar disorder, a third for attention-deficit/hyperactivity disorder (ADHD), and approaching half had made a suicide attempt at some point.

### Psychotic disorder in the past year (2014), by benefit status

Base: 16–64 years (out of work benefits); all adults (housing benefit)



### Comorbidity with chronic physical conditions, low mental wellbeing and intellectual impairment

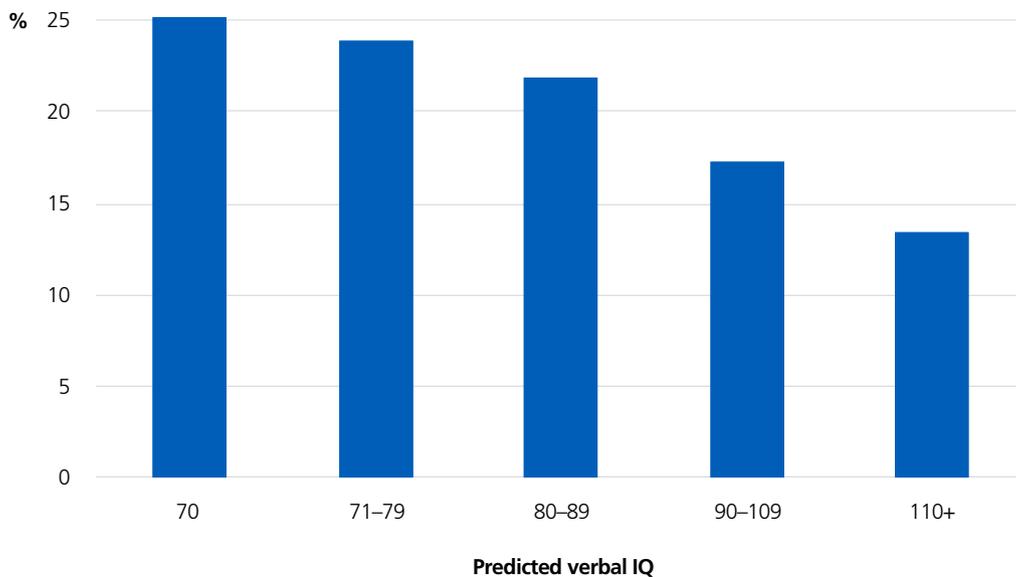
- APMS data can be used to examine comorbidity between physical and mental illnesses. The report focuses on five chronic physical conditions: asthma, cancer, diabetes, epilepsy, and high blood pressure. All had some association with at least one mental disorder. Even subthreshold levels of CMD symptoms were associated with higher rates of chronic physical conditions.
- Mental wellbeing was assessed using the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS). Low mental wellbeing was associated with presence of chronic physical conditions, but links with mental disorders were far stronger.

- Predicted verbal IQ was estimated using the National Adult Reading Test (NART). Those with a lower score, indicating borderline intelligence of a level where assistance with functioning may be needed, had higher rates of most of the mental disorders assessed on the survey.

These associations support the need for treatment and health service delivery in a general setting, addressing physical and mental health needs together.

### **Presence of any CMD, by predicted verbal IQ score (based on the National Adult Reading Test)**

*Base: all adults*



## **Use of mental health treatment**

***More than one person in three with CMD was in receipt of treatment.***

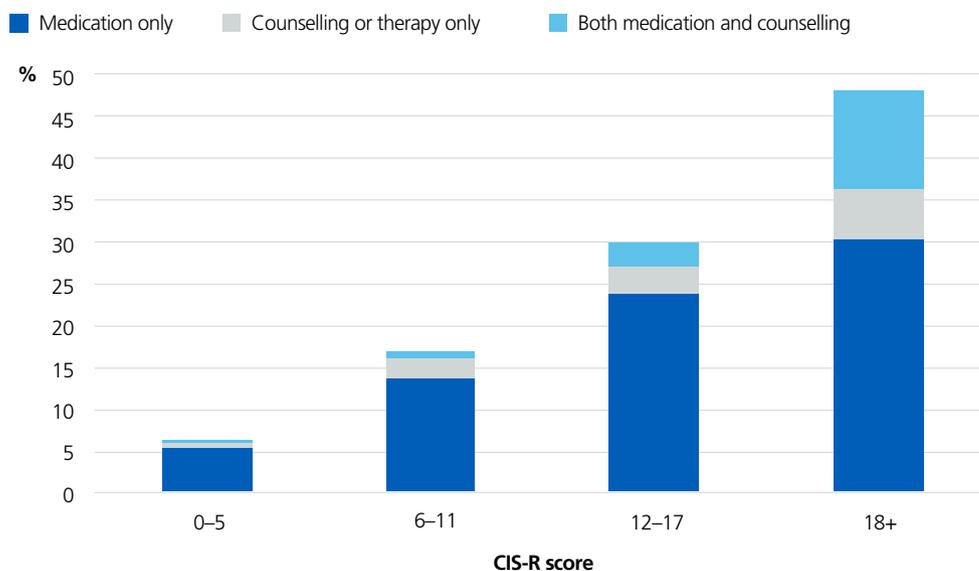
Treatment was defined as current receipt of psychotropic medication and/or counselling or other psychological therapy.<sup>3</sup>

<sup>3</sup> It was not established who provided the treatment, it could have been NHS or private.

The more severe people's current symptoms of CMD were, the more likely it was that they were using treatment. Treatment rates were higher for some disorders than others. The majority of people identified with psychotic disorder were in treatment, and around half of those with depression, obsessive compulsive disorder (OCD), phobias, GAD, a positive screen for PTSD, or signs of dependence on drugs other than cannabis. Very few people with autism were in receipt of mental health treatment, despite high levels of psychiatric comorbidity in this group.

### Current use of mental health treatment, by CIS-R score

Base: all adults

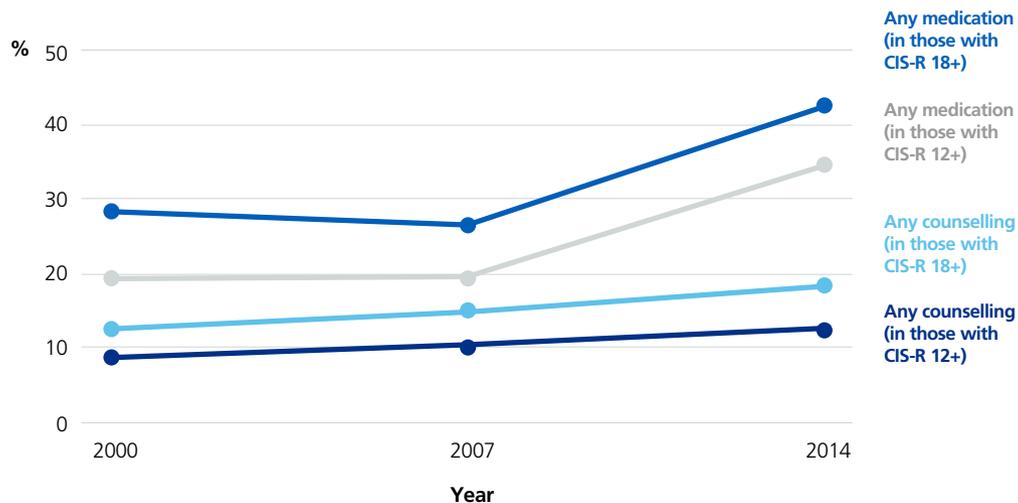


### *The proportion of people with CMD using treatment increased.*

People with CMD were more likely to use treatment in 2014 than at any time in the survey series. This was driven by steep increases in the use of psychotropic medication since 2007. Increased use of psychological therapies was also evident among people with more severe symptoms.

## Current use of treatment in adults with CIS-R score 12+ and 18+: 2000, 2007, 2014

Base: 16–74 year olds with CIS-R score of 12+/18+



Changes in data collection methodology could have played a part in this increased reporting of medication. However, this is unlikely to account for all of the rise. Furthermore, this increase is consistent with other data sources, for example analyses of prescribing data (Spence et al. 2014).

Alongside increases in receipt of treatment, the use of primary and community care for a mental health reason also increased over time. People with CMD became more likely to discuss their mental health with a GP, and since 2000 there had been a slight – but steady – increase in the proportion of adults with CMD using community and day care services.

## Inequalities in mental health treatment

***Among people with CMD, those who were female, White British, or in midlife were more likely than others to receive treatment.***

There were demographic inequalities in who received treatment. After accounting for differences in level of need between groups, people who were White British,

female or in mid-life (especially aged 35 to 54) were more likely to receive treatment than others. People in the Black/ Black British group had particularly low treatment rates. After an episode of self-harm, older people were more likely than younger people to seek professional help.

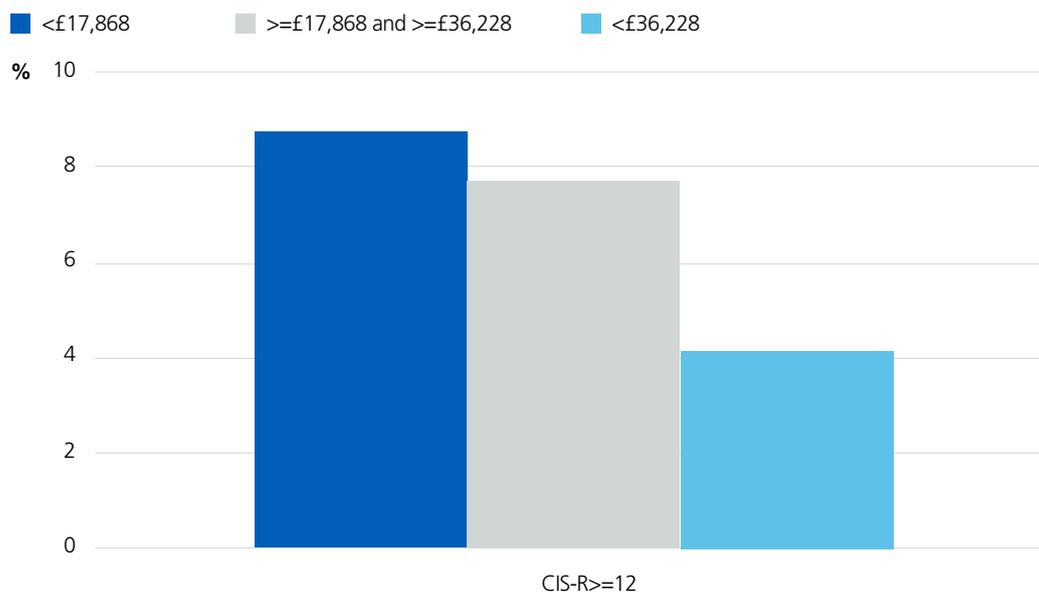
Autism was the only condition where people with the condition were no more likely to use treatment than the rest of the population, suggesting that this group may not be having their needs met by existing service provision.

***One adult in ten with severe CMD symptoms (CIS-R 18+) asked for a particular mental health treatment in the past 12 months but did not receive it.***

Among people with CMD, those who were young and those living in a low income household were particularly likely to have unmet treatment requests. About half of people with CMD and an unmet treatment request were not receiving any other type of treatment at the time of the interview.

**Requested but not received particular mental health treatment in past 12 months in adults with CIS-R score 12+, by equivalised household income**

*Base: all adults*



## Further information

### Limitations

All surveys are subject to bias. Some people, for example those who live in an institution, could not have been selected to take part. Non-response means that some selected households or individuals could either not be contacted or declined to take part. Others may not have been well enough or lacked the cognitive capabilities to complete a long survey interview. Social desirability biases may mean some people, especially in the face-to-face section of the interview, did not answer fully or honestly. Survey screening and assessment tools should also not be considered the equivalent of an assessment conducted by a psychiatrist or other trained professional over a number of sessions. These limitations, while ameliorated to some extent with use of validated measures, self-completion data entry, weights, understanding of the population they relate to and how the data should appropriately be applied, should be acknowledged.

### Coverage and data access: the survey report includes the following chapters:

1. Introduction to the survey series
2. Common mental disorders (CMD)
3. Mental health treatment and service use
4. Posttraumatic stress disorder (PTSD)
5. Psychotic disorder
6. Autism
7. Personality disorder
8. Attention-deficit/hyperactivity disorder (ADHD)
9. Bipolar disorder
10. Alcohol misuse and dependence
11. Drug misuse and dependence
12. Suicidal thoughts, suicide attempts and self-harm
13. Comorbidity in mental and physical illness
14. Methodology

The long interview, carried out in people's own homes, covered a wealth of other topics. Researchers can access the data for free from the UK Data Service. It can take three months from the date of report publication for the data to be released.

The full survey report can be accessed: [www.digital.nhs.uk/pubs/apmsurvey14](http://www.digital.nhs.uk/pubs/apmsurvey14)

Survey website with information about how the data has been used:  
[www.mentalhealthsurveys.org](http://www.mentalhealthsurveys.org)

In case of questions please contact: [enquiries@nhsdigital.nhs.uk](mailto:enquiries@nhsdigital.nhs.uk)

## References

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