



# Mental health treatment and service use

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## Summary

- In this chapter reported use of psychotropic medication and psychological therapy are examined, as well as the extent of use of health care services for a mental health reason (GP, inpatient and outpatient health care) and day and community service use. It should be noted that rates presented are based on participant self-reports, not health records. Misclassifications of type of treatment or service are possible, and which was the providing organisation was not established.
- Overall, one adult in eight (12.1%) reported being in receipt of mental health treatment (psychotropic medication, psychological therapy or both) at the time of interview. Medication was the most commonly used type of treatment.
- This chapter focuses mainly on rates of treatment and service use among people with symptoms of common mental disorder (CMD), as measured by the revised Clinical Interview Schedule (CIS-R). Treatment rates for other disorders are covered in the relevant chapters. Treatment use was strongly associated with severity of CMD symptoms; ranging from one person in twenty (5.6%) among those with few or no current symptoms (CIS-R score 0 to 5), to nearly half (45.8%) of those with severe symptoms (CIS-R score 18+).
- The proportion of people with CMD using mental health treatment has increased. Around one person in four aged 16–74 with CMD symptoms (CIS-R score 12+) was receiving some kind of mental health treatment in 2000 (23.1%) and 2007 (24.4%). By 2014, this had increased to more than one in three (37.3%).
- The increase in treatment since 2007 was mainly driven by a steep rise in the use of psychotropic medication. However, there has also been an increase in the proportion of people with severe CMD symptoms (CIS-R 18+) in receipt of psychological therapy.
- The use of primary and community care for a mental health reason has also increased over time. People have become more likely to discuss their mental health with a GP, and since 2000 there has been a slight – but steady – increase in the proportion of adults with CMD using community and day care services. Service contact was highest in people with depression, phobia and OCD.

- Demographic inequalities in mental health treatment are apparent in the APMS data. After controlling for differences in level of CMD symptoms, those most likely to report use of treatment were female, White British, and in midlife (especially aged between 35 and 54).
- Socioeconomic inequalities in who receives treatment were less evident and more mixed. Employed people with CMD were *less* likely to receive treatment than those who were economically inactive. People with CMD living in lower income households were more likely to have an unmet treatment request than those living in higher income households.
- Overall, one in ten (10.3%) adults with severe CMD symptoms (CIS-R 18+) had an unmet treatment request in the previous 12 months. The people who reported requesting but not getting a particular treatment were overwhelmingly those with symptoms of CMD, suggesting that such requests tended to be made by people who might have benefited from treatment. Half of people (53.2%) with an unmet treatment request were not receiving any other mental health treatment at the time of the interview.

### 3.1 Introduction

A central objective of the Adult Psychiatric Morbidity Surveys (APMS) since 1993 has been to describe patterns in the use of treatment and services by people with symptoms of common mental disorder (CMD) (Singleton et al. 2001; McManus et al. 2009).

A case has been made that over the last two decades beneficial changes in the delivery of mental health services have taken place (Torjesen 2016). Examples include increased availability of specialist community services, improved transition between children's services and adult mental health services, and more complete implementation of clinical guidelines. These have been paralleled by significant reductions from 1997 to 2012 in suicide rates in people cared for by mental health services (Kapur et al. 2016).

**Level of unmet need:** The relationship between people and services is described by the concepts of *demand*, *need*, and *utilisation* (Brewin et al. 1987). Demand

is the subjective perception of the requirement for services and treatments as viewed by clients or carers, and is based on personal experience and lay knowledge of disorder and treatment. Need has been defined as the requirement for services and treatments identified from the professional perspective. It presupposes the identification of problems for which there are potentially effective interventions (Brewin et al. 1987; Bebbington 1990). It is therefore a technical concept, although it often corresponds with the demand perspective. Finally, utilisation is the actual take-up of services and adherence to treatments. It is shaped by the availability of services, the attitude of people to their health, and their perception of the accessibility and utility of services on offer. Inadequate treatment may therefore arise because clients and service providers do not recognise needs, and/or because of inadequate provision of treatment resources. Over-treatment is also possible, defined as utilisation without need.

In APMS, need was not assessed directly. However, it is possible to estimate this by assuming that people with a particular level of symptoms of disorder are likely to benefit from treatment. The level of 'unmet need' in the population is then the proportion of people with symptoms who do not receive treatment. Unmet needs will be greater if the provision of treatments is insufficient, inappropriate, or inaccessible, or where service uptake is poor.

There are limitations to this approach to estimating unmet need. The APMS definition of common mental disorder (CMD) is broad: it thus conflates milder, potentially self-limiting conditions (i.e. those that will remit in the absence of treatment) with conditions that are more likely to persist and need treatment, including some that are severe and enduring. The interventions defined as treatment include a range of psychological therapies and medications, but exclude general support, for example, from a GP or community organisation. The findings are also based on cross-sectional data, and therefore include only those individuals with symptoms present at the time of assessment. Some of those classified as not receiving treatment may have had this in the past, or may have sought help shortly after taking part in the survey. Since psychological therapies tend to be of shorter duration than pharmacological treatments, this approach may underestimate provision and uptake of the former in particular. Furthermore, we cannot evaluate the effectiveness of treatment or recovery trajectories using cross-sectional data.

Finally, some people without current CMD symptoms may have recovered, perhaps as a result of treatments they are still receiving, or were receiving treatment for another type of mental disorder. Thus it cannot be assumed that such circumstances represent over-treatment.

Despite these limitations, a population-based survey like APMS provides unique insight. APMS measures symptoms of mental disorder in people with and without diagnosed conditions, independent of any help-seeking or treatment. These surveys collect information from people in contact with services, but also from those who are not, some of whom may not even be registered with a GP.

Headline findings from APMS 2000 and APMS 2007 were that only one-quarter of adults with CMD were receiving psychotropic (mental health) medication or psychological therapy. Thus three-quarters of people who might have benefited from treatment were not receiving this at the time of interview. 'One in four' represented the proportion of people assessed by those surveys as having a CMD and who reported that they were receiving treatment. These findings are consistent with the two-thirds to three-quarters of people identified in other epidemiological surveys as meeting criteria for mental disorder and who are not receiving treatment.

**Trends in receipt of treatment and services:** Analyses of the first three APMS surveys (1993, 2000 and 2007) found that the proportion of adults with CMD in receipt of any psychotropic medication increased between 1993 and 2000, and remained stable between 2000 and 2007 (Spiers et al. 2016; Alonso et al. 2007).

Analyses focused on reported use of hypnotics in the same surveys found a similar trend, with prevalence of hypnotic use double in 2000 (0.8%) compared to 1993 (0.4%); with no further evidence of an increase between 2000 and 2007 (Calem et al. 2012). A recent report using national prescribing data found very similar trends in relation to antidepressant prescribing, with increases in the 1990s and initially stability post-2000 (Spence et al. 2014). This was followed by steep increases in antidepressant prescribing from 2008, which the authors attributed in part to the effects of the financial crisis in that year and the subsequent global recession. This coincided with the introduction of the Improving Access to Psychological Therapies (IAPT) programme in 2007/8 (DH 2012). It might be expected that the onset of recession would have led to an increase in mental

disorder in the population, while recent changes in the development and delivery of services would result in a greater proportion of affected people receiving treatment. The first of these hypotheses is addressed in Chapter 2 (with some support for this position). The second hypothesis is considered in this chapter.

**Inequalities in receipt of treatment and services:** As well as comparing treatment rates over time, APMS data can also be used to examine whether particular groups are more (or less) likely to receive treatment after controlling for differences in levels of symptoms (Bebbington et al. 2000). Analyses of APMS 2007 data indicated that white people were the ethnic group most likely to receive mental health treatment (Cooper et al. 2013) and that people of working age were more likely than older people to get appropriate treatment, especially psychological therapy (Cooper et al. 2010). APMS 2014 allowed us to examine whether these inequalities have persisted, and (due to the introduction of a new question in 2014) whether some groups of people are more likely to have requested mental health treatment but not received it than other groups.

This chapter presents findings on:

- **The extent of unmet needs** (the proportion of the population with a treatable disorder who do not receive treatment or services), and how this has changed over time.
- **Inequalities in treatment use** (whether, after taking account of levels of need, people from certain demographic or socioeconomic groups are less likely to use medications or psychological therapies, or more likely to have their treatment requests refused).

These are covered in the following sections:

- 3.2 Definition and assessment
- 3.3 Results: Trends in mental health treatment and service use
- 3.4 Results: Inequalities in mental health treatment and service use
- 3.5 Results: Inequalities in unmet treatment requests
- 3.6 Discussion.

## 3.2 Definition and assessment

### Measuring mental health treatment

Participants were asked about any treatments they were receiving for a mental or emotional problem around the time of the interview. These included different types of psychotropic medication and counselling and other psychological therapies.

Trends in treatment presented in this chapter draw on the broadly comparable data from APMS 2000, 2007 and 2014; where there have been changes in data collection these are described in the sections below. Trends are based on those aged 16 to 74, as the 2000 survey did not interview people aged 75 and over. In the 1993 survey, receipt of psychological therapies was only asked of a sub-sample of participants. Consequently, no comparable 'any treatment' measure was available for the whole 1993 sample.

### Measuring psychotropic medications

There have been changes between the surveys in how medication data have been collected. In 2000, interviewers asked about and coded all prescribed drugs, including non-psychotropic medications. In 2007, a show card prompt list of psychotropic medications was used instead. People were also asked to show interviewers the packaging for each psychotropic medication reported, so that the interviewer could check it was correctly coded. The 2000 and 2007 surveys found similar rates of use of psychotropic medication, and this stability is consistent with prescribing data as well. This suggests that the change in method did not affect comparability.

A show card approach was also used in 2014. However, rather than listing drug brand names first, followed by the generic name (the approach taken in 2007), the generic name was listed first on the show card prompt. This change was made because a) a number of widely prescribed brand medications were approaching the end of their license; and b) there had been a shift in practice towards prescribing generic medications when available. More medications were asked about on the 2014 showcards than in 2007. This was due to the increased range of licensed and available psychotropic medications in 2014. Furthermore, in 2014, medications used in the treatment of bipolar disorder, epilepsy, dementia, and substance misuse were also asked about, although only the first of these was included in the 'any

psychotropic medication' derived variable used for trend analysis. The participants in 2014 who reported taking bipolar disorder medications usually also reported other psychotropic medication as well, and so their inclusion should not have had a significant impact on trends.

See the Glossary for a full list of the medications asked about and how they were grouped together. Groupings relate to the main reasons that medications are commonly prescribed, but they may have been prescribed to individuals for different reasons. Several medications were listed in more than one group.

### **Measuring psychological therapies**

Psychological therapies were asked about in broadly comparable ways in each survey. The main analyses of trends in their use are based on endorsement of an initial stem question, the wording of which has not changed between surveys:

*'Are you currently having any counselling or therapy listed on this card for a mental, nervous or emotional problem?'*

Follow-up questions established the types of therapy, and this list has changed slightly each survey year, reflecting the nature of current provision and terminology. For example, mindfulness therapy was added to the list in 2014, while 'marital therapy' was replaced with 'couple and family therapy'.

Survey development piloting work has found that participants are generally unable to state reliably which services provided treatments such as psychological therapies. Therefore, APMS data cannot be used to describe shifts between primary and specialist services in the source of such treatments.

### **Measuring health service use for a mental health reason**

Health service contact records were not examined in the survey. Health service use for a mental health reason was recorded if a survey participant reported any of the following:

- Having spoken with GP about being anxious, depressed, or about a mental, nervous or emotional problem in the past two weeks or past year;
- Being an inpatient for a mental, nervous or emotional reason in the past quarter; or

- Being an outpatient or day patient for a mental, nervous or emotional reason in the past quarter.

Although the reference periods varied between different types of health service, this approach was consistent with that used in previous years of the survey and so was retained to allow for trend analysis.

### **Measuring community and day care service use**

Survey participants were also asked questions on use of community and day-care services in the past year. To ensure comparability with previous surveys in the series, changes to items and terminology were minimal. The different types asked about are listed in the Glossary.

### **Measuring unmet treatment requests**

In APMS 2014, participants were asked a question that had not been included on previous surveys in the series:

*'In the past 12 months, have you asked for any type of counselling or mental health related medication, but not received it?'*

If the participant answered yes, follow-up questions were asked about what type of treatment had been requested and whether or not the participant was on a waiting list for it at the time of the interview.

### **Measuring treatment need**

The revised Clinical Interview Schedule (CIS-R) has been used in every wave of APMS to measure CMD symptoms and to identify people meeting CMD diagnostic criteria. This chapter focuses on differences in treatment rate by CMD. Treatment and service use among people with other types of mental disorder is addressed in the disorder-specific chapters.

#### *CMD symptoms*

The CIS-R score provides an indication of overall non-psychotic symptom severity, and is used in the analyses in this chapter to indicate level of mental health service required.

- **CIS-R score of 12 or more:** is used to indicate the presence of clinically significant symptoms of CMD, and identifies people with ‘symptoms of CMD’ sufficient to warrant recognition.
- **CIS-R score of 18 or more:** is also a threshold applied in this chapter and is used to indicate the presence of ‘severe symptoms of CMD’, sufficient to warrant intervention.

### *CMDs*

An algorithm applied to the responses on the CIS-R can also be used to identify likely presence of six different types of CMD. These were depression, generalised anxiety disorder (GAD), phobias, obsessive compulsive disorder (OCD), panic disorder, and CMD not otherwise specified (CMD-NOS).<sup>1</sup> The CIS-R cannot clinically diagnose CMD, as that would require detailed assessment by a trained professional. In this chapter those identified with ‘any CMD’ are considered, as well as those meeting the diagnostic criteria for particular CMDs. Everyone with a CIS-R score of 12 or more was classified with at least one type of CMD. However, it was possible to be identified with certain CMDs without having a score of 12 or more. The CIS-R and the individual CMDs are described more fully in Chapter 2 and the Glossary.

### **Measuring inequalities in use of mental health treatment**

APMS data can be used to examine whether particular groups are more (or less) likely to receive mental health treatment after controlling for differences in levels of symptoms (Bebbington et al. 2000). For example, analyses of APMS 2007 data found that white people were the ethnic group most likely to receive mental health treatment (Cooper et al. 2013) and that people of working-age were more likely than older people to get appropriate treatment, especially psychological therapy (Cooper et al. 2010). APMS 2014 allowed us to examine whether these inequalities have persisted, and (due to the introduction of a new question in 2014) whether some groups of people are more likely than others to have requested mental health treatment but not received it.

<sup>1</sup> Previously in the APMS series ‘CMD-NOS’ was referred to as ‘mixed anxiety and depression’.

For this chapter, multiple logistic regression modelling has been carried out to examine whether there are inequalities in mental health treatment use.<sup>2</sup> Without controlling for differences in the level of mental health symptoms, variation in treatment rate between groups might simply (and appropriately) reflect differences in level of need. In order to determine what characteristics independently predict use of mental health treatment after controlling for CMD symptoms, a range of variables were included in the final regression modelling. In summary, the multiple logistic regression analysis consisted of the following steps:

**Step 1:** Unadjusted analyses: a wide range of health and social factors were tested for association with use of mental health treatment using univariate logistic regressions. This step was necessary to estimate the unadjusted odds ratios (ORs) of receiving mental health treatment for each subgroup, to allow comparisons with the results of the next steps (e.g. after adjusting for presence and severity of CMD).

**Step 2:** Grouped CIS-R score was added to all the models from step 1 to control for differences in the level of mental health symptoms. Grouped CIS-R score was used, rather than a continuous score, to allow for comparison with treatment rates.

**Step 3:** Self-assessed general health was included in models from step 3 to control for differences in how people view their health in general.

**Step 4:** All health and social factors considered in previous steps were included as independent variables in the final multiple regression model.<sup>3</sup> For the full list of variables considered, see [Table 3.15](#).

This final step allowed us to identify the factors independently associated with mental health treatment use after controlling for other factors. The final results, in the form of adjusted ORs, are compared with unadjusted ORs (from step 1) and treatment rates for the groups found to be at elevated risk of not getting treatment.

- 2 Logistic regression, also known as logit regression, is a statistical model used to estimate the probability of an event occurring given certain information. The final model presented in this chapter was used to estimate whether people who share a particular characteristic (for example, age group) are more or less likely to receive treatment than those in a reference age group, when the other characteristics in the model are held constant. If the value is greater than one, the odds of the outcome occurring are greater for the given group compared to the reference group. Conversely, a value less than one indicates the odds of the outcome occurring are lower for the given group compared with the reference category.
- 3 The F-adjusted mean residual goodness-of-fit test was applied and suggested no evidence of lack of fit of the model (F-adjusted test statistic: 0.656; prob >F= 0.749).

### 3.3 Results: Mental health treatment and service use

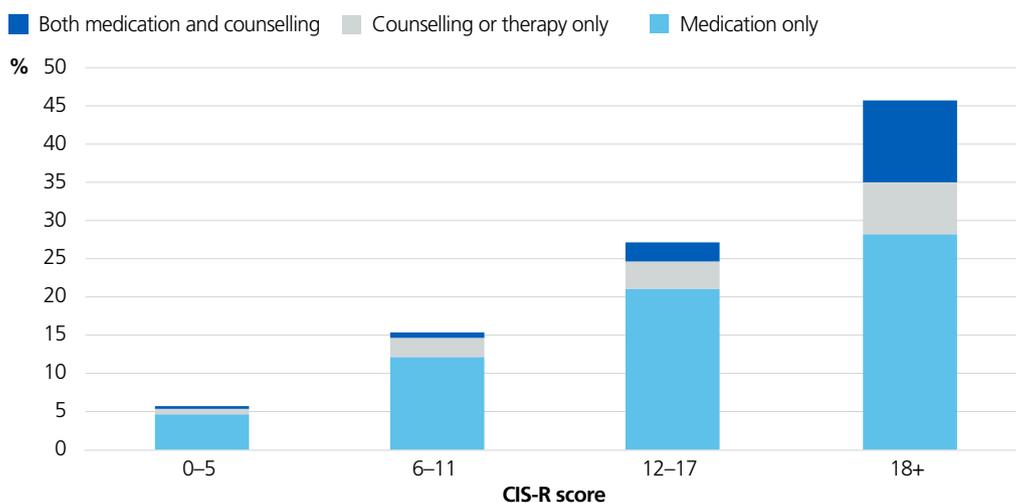
#### Mental health treatment use, by CIS-R score

Overall, 12.1% of participants reported receiving mental health treatment (psychotropic medication and/or psychological therapy) at the time of the APMS 2014 interview.<sup>4</sup> Reported treatment use was strongly associated with severity of mental health symptoms, ranging from one person in twenty (5.6%) among those with few or no current symptoms (CIS-R score 0 to 5), to nearly one-half (45.8%) of those with severe symptoms (CIS-R score 18+). Treatment use among those without CMD symptoms is not necessarily unwarranted, but could indicate, for example, recovery or an intermittent condition.

Medication was the most common form of mental health treatment, reported by 10.4% of people, compared with 3.0% who reported receiving psychological therapy. Medication was more common than psychological therapy both in those with current symptoms of CMD and in those without current symptoms. A small proportion of people (1.3%) reported receiving both medication and psychological therapy, and this figure was also higher among those with the most severe symptoms (10.7%), and for men (14.5%) compared with women (8.3%). [Table 3.1](#)

**Figure 3A: Current use of mental health treatment, by CIS-R score**

Base: all adults



<sup>4</sup> In this chapter rates of treatment and service use for a mental health reason are presented for the whole population, and by severity of mental health symptoms (as indicated by CIS-R score) and type of common mental disorder (CMD). Where numbers allow, rates are also broken down by sex.

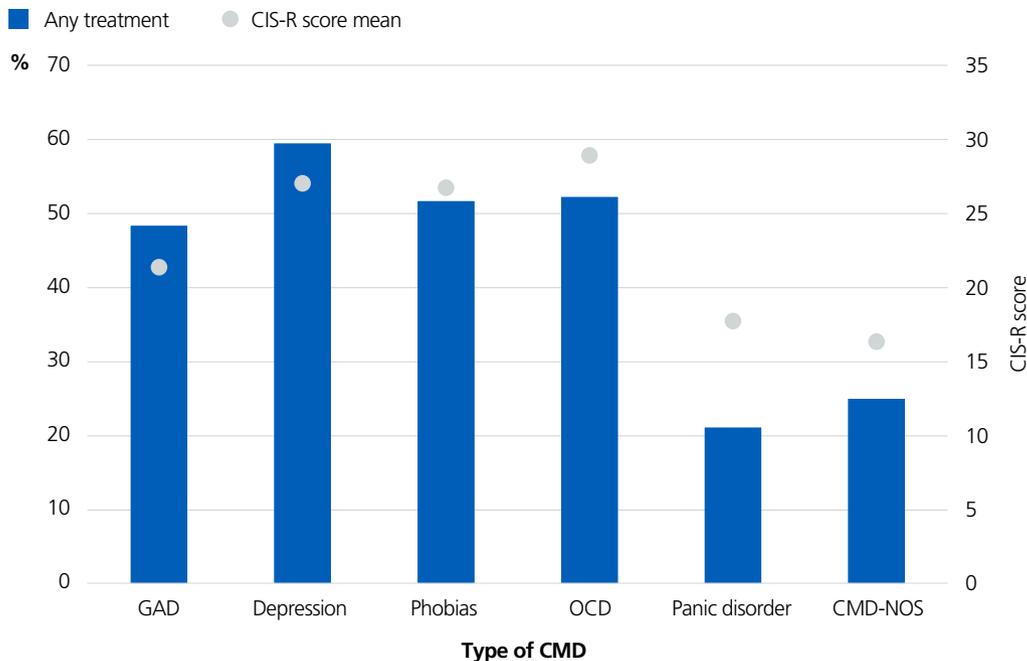
## Mental health treatment use, by type of CMD

About one-third (36.2%) of people meeting the diagnostic criteria for at least one CMD (mean CIS-R score 18.9) were receiving treatment at the time of the survey, compared with 7.1% of those without CMD (mean CIS-R score 2.5). The true figure for the wider population with CMD, the proportion receiving treatment would be likely to be between 33.5% and 38.9% (95% confidence interval).

Treatment rates varied by type of CMD, and were highest in those with depression (59.4%), OCD (52.1%), phobias (51.6%) and GAD (48.2%). In contrast, a quarter (24.7%) of people with CMD-NOS and a fifth (20.9%) of those with panic disorder were receiving treatment.<sup>5</sup> These CMD classifications, however, averaged lower levels of symptom severity: the mean CIS-R score for people with CMD-NOS was 16.2, compared with 26.8 for those with depression and 28.9 for people with OCD. It should also be noted that for disorders other than CMD-NOS, it was possible for more than one CMD to be present.

**Figure 3B: Current use of mental health treatment, by type of CMD**

Base: all adults



<sup>5</sup> Note small base size for those with panic disorder (43 participants) means that analyses by this group should be treated with caution.

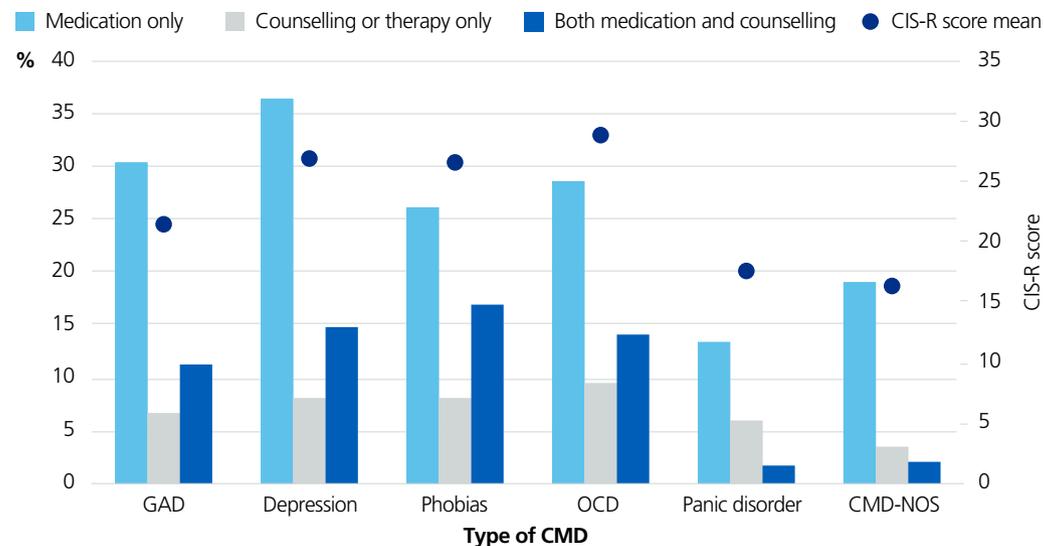
Medication was the most commonly reported treatment for people with each type of CMD. Its prevalence ranged from around one in two (51.4%) people with depression to one in five (21.3%) of those with CMD-NOS and one in seven (15.1%) with panic disorder (note that small base numbers mean figures for this group should be treated with caution).

Medication combined with psychological therapy was the second most common treatment among those with the most severe types of CMD (mean CIS-R score of 18 or more): reported by 17.1% of those with phobias and 14.9% of those with depression. Combined medication and psychological therapy was rare among those with panic disorder (1.9%) or CMD-NOS (2.2%) (mean CIS-R scores below 18).

[Tables 3.2, 3.4](#)

**Figure 3C: Type of mental health treatment, by type of CMD**

Base: all adults



### Psychotropic medication use, by CIS-R score

The most commonly reported psychotropic medications were those used primarily in the treatment of anxiety and depression.<sup>6</sup> Each was reported by 8.3% of adults

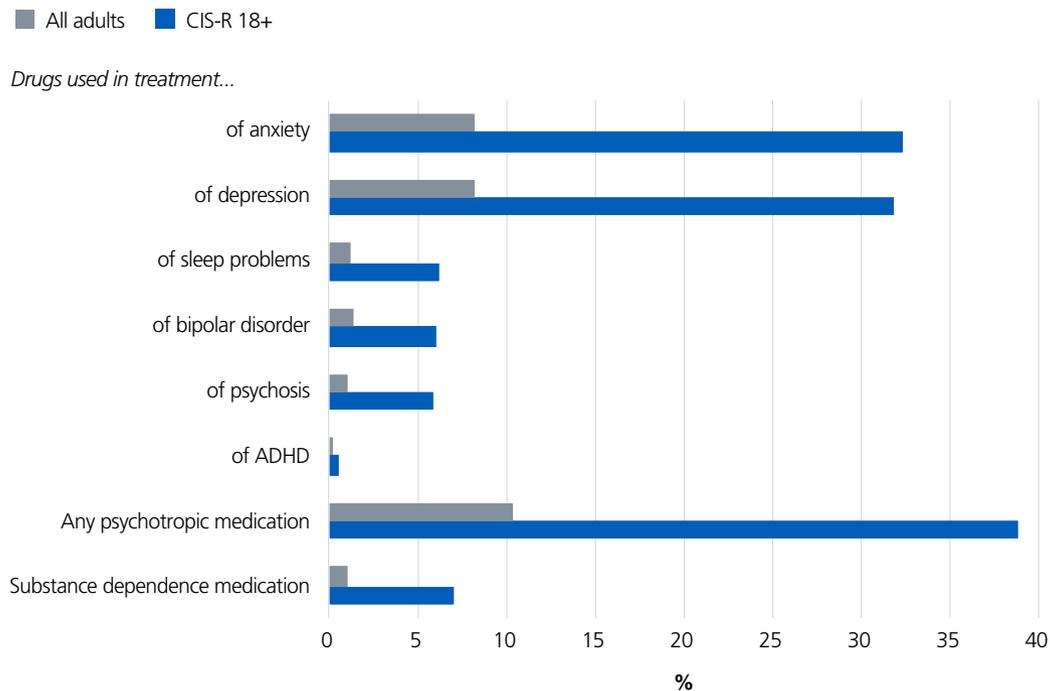
<sup>6</sup> See the Glossary for a list of how different medications were grouped together. Some medications were in more than one grouping. Note that medications can be prescribed for a range of symptoms, and their use does not indicate that particular symptoms are present. For example, antipsychotics (medications commonly used in the treatment of psychosis) are commonly used to augment antidepressants in the absence of psychotic symptoms.

overall. Medications commonly used in the treatment of psychosis, sleep problems, and bipolar disorder were taken by around 1% of the population overall (1.1%, 1.2% and 1.4% respectively), and in about 6% of those with a CIS-R score of 18 or more (5.9%, 6.2% and 6.0% respectively).

As well as different types of medication used in the treatment of mental disorders, drugs used in the treatment of substance dependence were also asked about. Overall, 1.0% of participants reported using substance dependence medication at the time of the interview. This was also strongly linked with severity of CMD symptoms; 7.1% of people with a CIS-R score of 18 or more were using medications used to treat substance dependence. Their use was associated with each type of CMD, although the highest rates were among those with depression (12.3%) and phobias (12.4%). [Tables 3.3, 3.4](#)

**Figure 3D: Type of psychotropic medication used, overall and in adults with a CIS-R score of 18 or more**

*Base: all adults*



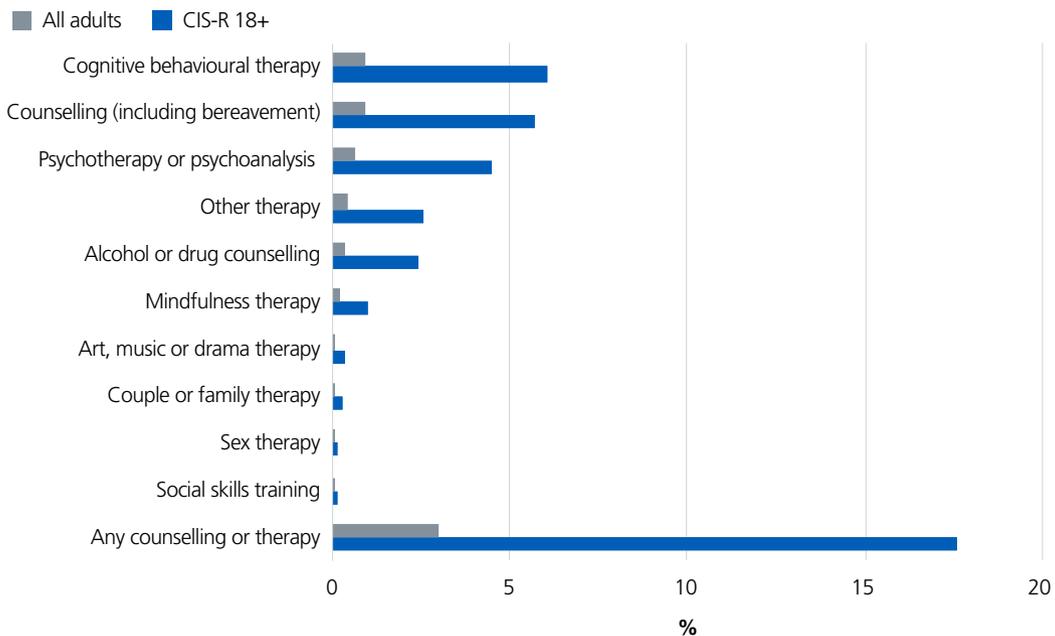
### Psychological therapy use, by CIS-R score

Overall, 3.0% of adults reported receiving psychological therapy around the time of the interview. Again, this was strongly associated with the severity of CMD symptoms. About one person in a hundred (0.9%) with few or no CMD symptoms (CIS-R score 0–5) reported psychological therapy, compared with one in six (17.6%) with the most severe symptoms (CIS-R score 18+).

Cognitive behavioural therapy (CBT) and counselling (including bereavement counselling) were the most common types of psychological therapy used, each reported by about 6% of people with a CIS-R score of 18 or more. Psychotherapy or psychoanalysis was mentioned by 0.7% of people, and by 4.5% of those with severe CMD symptoms (CIS-R 18+). [Table 3.5](#)

**Figure 3E: Type of psychological therapy used, overall and in adults with a CIS-R score of 18 or more**

Base: all adults



### Psychological therapy use, by type of CMD

Overall, 11.8% of people with CMD reported being in receipt of psychological therapy. This was reported most commonly by people with a phobia (25.4%), OCD (23.4%), and depression (22.9%). Rates were lower in people with CMD-NOS (5.6%), panic disorder (7.7%) and GAD (17.9%). [Table 3.6](#)

### **Health service use, by CIS-R score**

The use of health services for a mental or emotional problem included attending hospital in the last quarter, either as an inpatient or outpatient, for a mental health reason or speaking with a GP about a mental health problem (in the past year). Overall, 12.5% of adults reported discussing their mental health with a GP in the past year. All measures of health service use for a mental health reason were more common in those with the most severe symptoms. 56.2% of people with a CIS-R score of 18 or more had discussed their mental health with a GP in the past year, and 15.8% had done so in the last two weeks. 4.0% of people with a CIS-R score of 18 or more had been an outpatient, and 1.8% had been an inpatient, in the last quarter for a mental health reason. [Table 3.7](#)

### **Health service use, by type of CMD**

Nearly a half (44.1%) of people with a CMD reported discussing their mental health with a GP in the past year, compared with 6.0% of people without CMD. Service contact was most frequent in people with OCD (65.4%), phobia (65.4%), depression (66.1%) and GAD (54.8%). The same groups were also the most likely to have been hospital patients for mental health reasons. Rates of health service use for a mental health reason were lower in people with CMD-NOS (33.2%). [Table 3.8](#)

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

The reported use of community and day care services ranged from 4.3% of people with few or no symptoms (CIS-R score 0–5), up to 27.8% of those with a CIS-R score of 18 or more. Among people scoring 18 or more on the CIS-R, usage rates were similar for seeing a psychiatrist (6.8%), a community psychiatric nurse (5.4%), an outreach/family support worker (5.4%), a social worker (5.2%), and self-help/support group (4.8%). [Table 3.9](#)

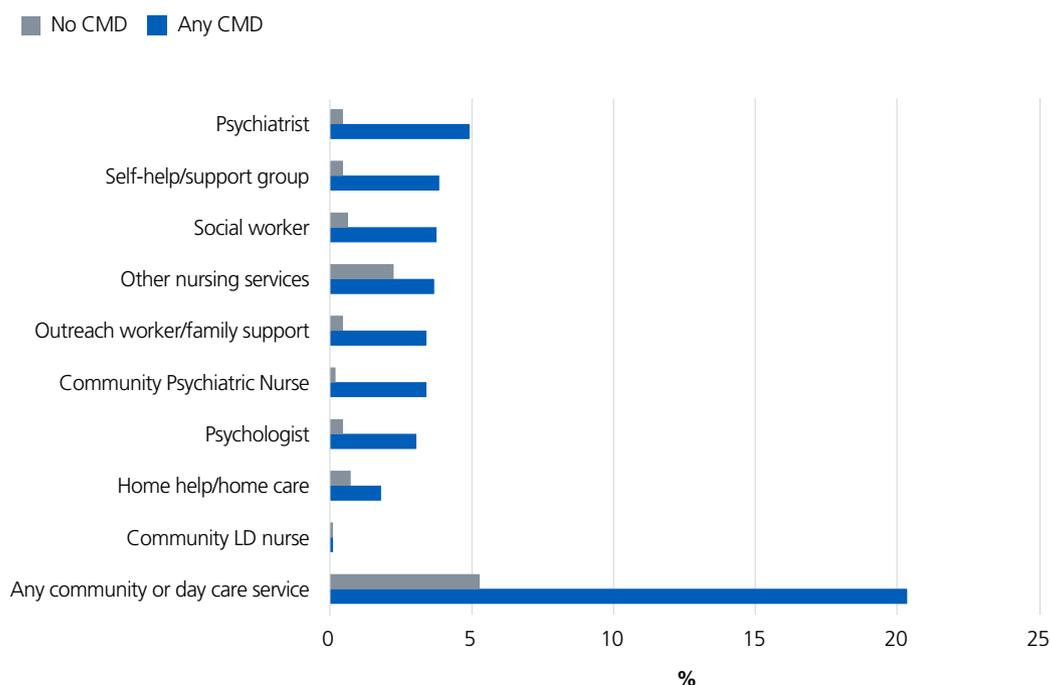
### **Community and day care services use, by type of CMD**

Consultation with a psychiatrist was reported most commonly by people with OCD (18.5%) or with phobia (14.3%). Other nursing services (not including the community psychiatric nurse (CPN) or community learning disability nurse) was the community and day care service used most by people without CMD (2.2%).

[Table 3.10](#)

### Figure 3F: Community and day care services used in past year in people with and without CMD

Base: all adults



### Trends in treatment in adults with CMD symptoms

Mental health treatment use was defined as reported receipt of psychotropic medication or psychological therapy at the time of interview. Trends are based on those aged 16–74, as the 2000 survey did not interview people aged 75 or more.

#### Any treatment: 2000, 2007 and 2014

The overall treatment rate in people aged 16–74 with CMD symptoms (CIS-R 12+) was relatively stable at around one in four between 2000 (23.1%) and 2007 (24.4%), and then increased sharply by 2014 to more than one in three (37.3%).

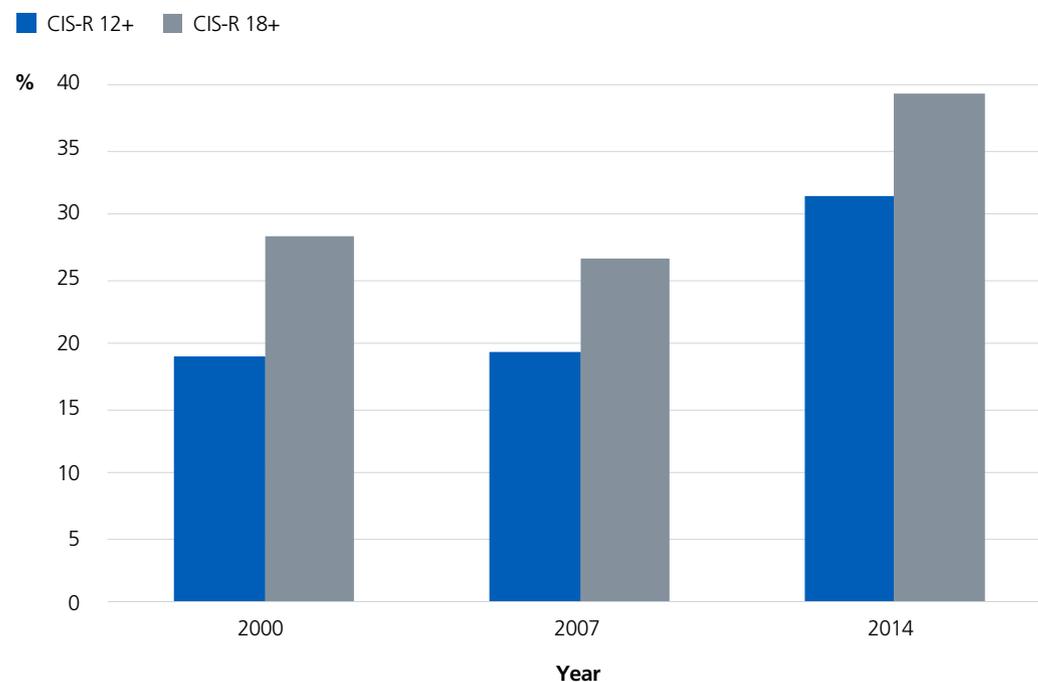
The same pattern was also evident among those with severe CMD symptoms (CIS-R 18+): one in three reported mental health treatment in 2000 (32.8%) and 2007 (32.4%), increasing to nearly a half in 2014 (46.7%). Both men and women were more likely to receive mental health treatment in 2014 than in 2007. [Table 3.11](#)

### Any psychotropic medication: 2000, 2007 and 2014

Much of this increase in treatment use is accounted for by a steep rise in reported use of psychotropic medication. One in five adults aged 16–74 with CMD symptoms (CIS-R 12+) reported psychotropic medication use in 2000 (19.3%) and 2007 (19.6%), compared with nearly one in three in 2014 (31.6%). While methodological changes to the survey cannot be ruled out as explaining some of this increase, the trend is also corroborated by trends in prescribing data.<sup>7</sup> Higher rates of psychotropic prescribing may be linked to the increase also observed in people with CMD who discussed their mental health with a GP. The increased rate of medication was evident in both men and women, as well as in people with severe CMD symptoms (28.5%, 26.5% and 39.4% of 16–74 year olds with CIS-R score of 18+ reported psychotropic medication in 2000, 2007 and 2014 respectively). [Table 3.11](#)

**Figure 3G: Psychotropic medication use in adults with CIS-R score 12+ and 18+, 2000, 2007, 2014**

Base: all aged 16–74 with CIS-R score of 12+



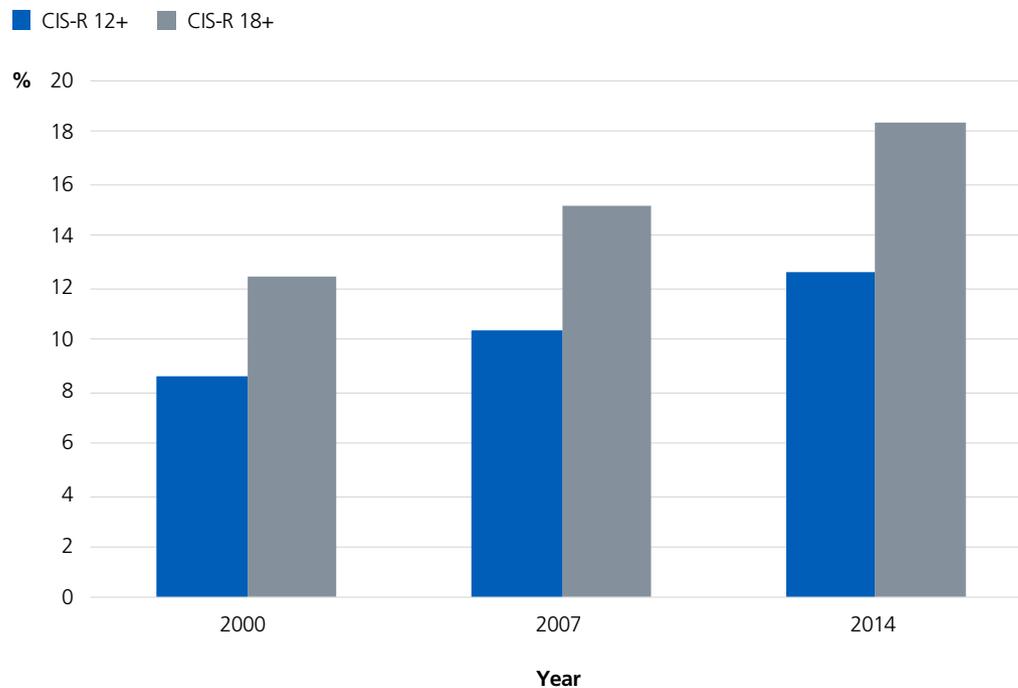
7 For example, the increase in prescribing presented here corresponds closely to trends identified in national antidepressant prescribing data for 1997 to 2012 (Spence et al. 2014).

### Any psychological therapy: 2000, 2007 and 2014

There were also increases in reported receipt of psychological therapy among adults with CMD symptoms. However, rather than the steep increase between 2007 and 2014 evident for medication, use of psychological therapies has risen more steadily since 2000 (12.5%, 15.2% and 18.4% of 16–74 year olds with CIS-R score of 18 or more reported use of psychological therapies in 2000, 2007 and 2014 respectively). [Table 3.11](#)

### Figure 3H: Psychological therapy use in adults with CIS-R score 12+ and 18+, 2000, 2007, 2014

Base: all aged 16–74 with CIS-R score of 12+



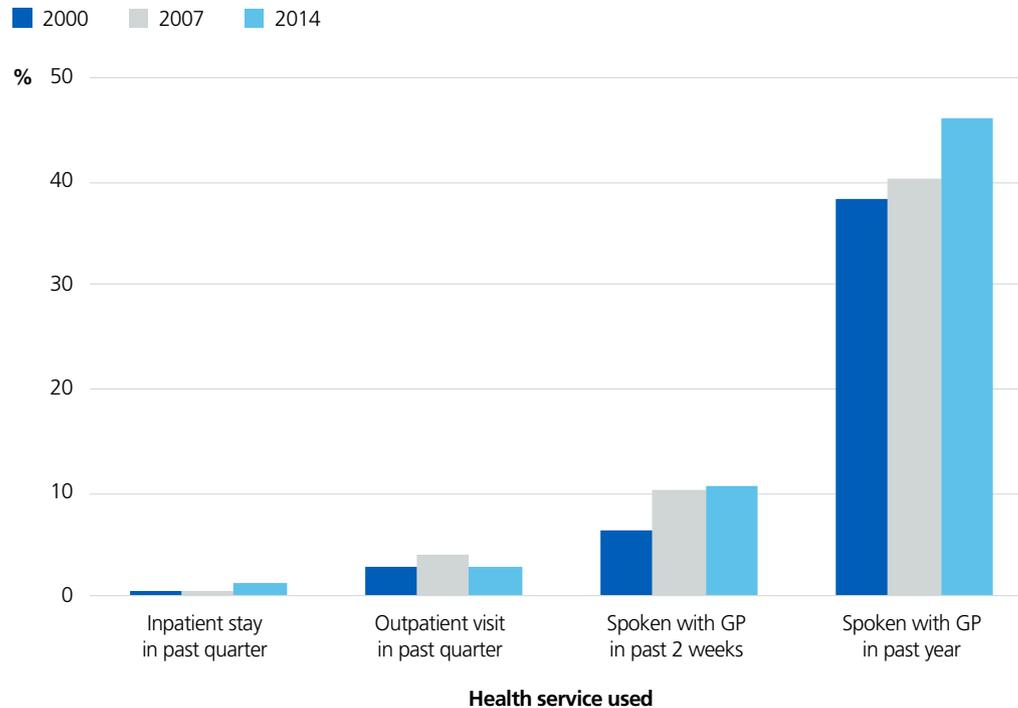
### Trends in health service use in adults with CMD symptoms

Among the types of health services used for a mental health reason covered by APMS, only use of primary care changed significantly over time. In 2000, 6.3% of 16–74 year olds with CMD symptoms reported discussing their mental health with a GP in the 2 weeks preceding interview. This increased to 10.1% in 2007 and stayed at this level in 2014 (10.6%). The proportion who had spoken to their

GP about their mental health in the past year increased from 38.2% in 2000 to 46.4% in 2014 (although in this case the increase occurred between 2007 and 2014). [Table 3.12](#)

**Figure 3I: Health services used for a mental health reason in people with a CIS-R score of 12 or more, 2000, 2007, 2014**

*Base: all aged 16–74 with CIS-R score of 12+*

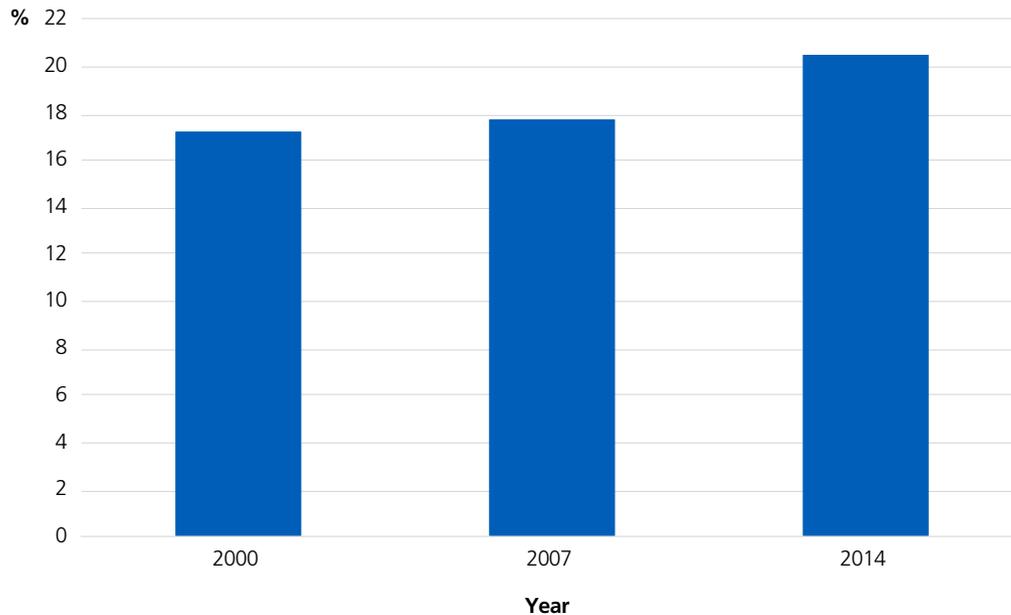


**Trends in community and day care services use in adults with CMD symptoms**

The proportion of 16–74 year olds with CMD symptoms (CIS-R score 12+) using any type of community or day care service appeared to increase (from 17.2% in 2000 to 20.6% in 2014), although this did not reach statistical significance ( $p=0.08$ ). There were no significant differences between men and women. [Table 3.13](#)

**Figure 3J: Community and day care service use in people with a CIS-R score of 12 or more, 2000, 2007, 2014**

*Base: all aged 16–74 with CIS-R score of 12+*



## 3.4 Results: Inequalities in use of mental health treatment

### Summary

In this section, groups in the population who were less likely to be in receipt of mental health treatment are identified. Treatment rates for different groups are presented first. However, without controlling for mental health symptoms, differences in treatment between groups might simply, and appropriately, reflect differences in level of need. Logistic regression therefore was also used to examine whether some groups were more likely than others to receive mental health treatment after controlling for CMD and other factors. For details of the methodology used see Section 3.2.

The results are presented in the form of ORs, which here indicate the relative odds of receiving mental health treatment for one group compared to another. They are compared to treatment rates for a given group, and with ORs coming from logistic

regression analysis that did not take account of other factors (Table 3.14, model 1). This helped us identify what factors explain the differences in rates of treatment between different groups.

We found that while CIS-R score was the strongest predictor of whether or not someone was in receipt of treatment, it did not fully explain the differences in treatment rates between groups (Table 3.14, model 2). When all factors were taken into account, the following remained significant predictors of treatment receipt (Table 3.14, model 4: final model):

- Sex
- Age group
- Ethnic group
- Employment status
- General health
- CIS-R score.

Treatment rates, and the unadjusted and adjusted regression analysis results, are discussed for each of these significant factors below.<sup>8</sup> The non-significant factors were retained in the final model and can be found in Table 3.15. [Tables 3.14, 3.15](#)

### **Variation in receipt of mental health treatment, by sex**

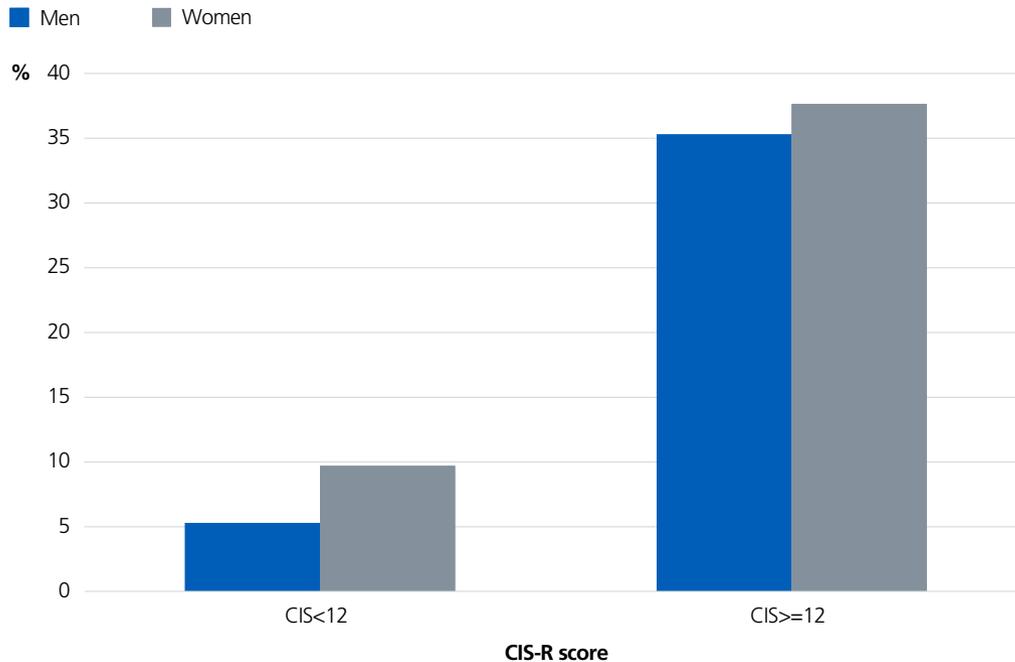
In unadjusted analysis, women in the population were more likely to report mental health treatment than men. This was true both for medication and for psychological therapy. Overall, 15.0% of women and 9.0% of men received treatment of some sort. The mean CIS-R score in women was 1.8 points higher than that in men. The treatment gap was, however, more evident among those with fewer CMD symptoms (CIS-R 12 or more). After controlling for differences in CIS-R, women remained significantly more likely to get treatment than men

<sup>8</sup> If the factor is significant (that is, if the overall p-value for a variable less than 0.05) we then looked at the p-values for each of the categories within the factor. If the p-value for a category is less than 0.05 then the category is significantly different from the reference category.

(OR 1.58, 95% CI 1.32 to 1.89, compared to unadjusted OR 1.80, 95% CI 1.53 to 2.12).<sup>9</sup> [Tables 3.14, 3.15, 3.16, 3.17](#)

### Figure 3K: Current use of mental health treatment, by sex and CIS-R score

Base: all adults



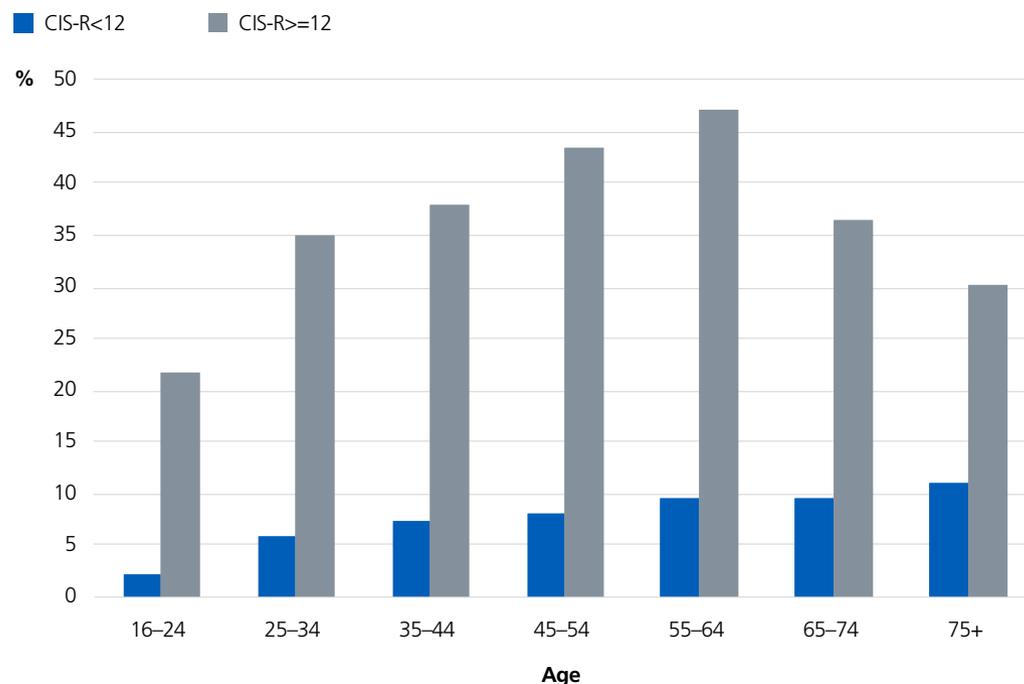
### Variation in receipt of mental health treatment, by age

In unadjusted analysis, receipt of mental health treatment varied with age. The proportion of people using treatment ranged from 5.5% of 16 to 24 year olds to 16.0% of those aged 55 to 64. The same pattern was evident both for people with and without CMD, and for men and women. [Tables 3.16, 3.17](#)

<sup>9</sup> Confidence intervals (CI) at the 95% level mean that if the same population is sampled on numerous occasions and interval estimates are made on each occasion, the resulting intervals would bracket the true population rate in approximately 95% of the cases. A CI includes information about the uncertainty associated with an estimate.

**Figure 3L: Current use of mental health treatment, by age and CIS-R score**

Base: all adults



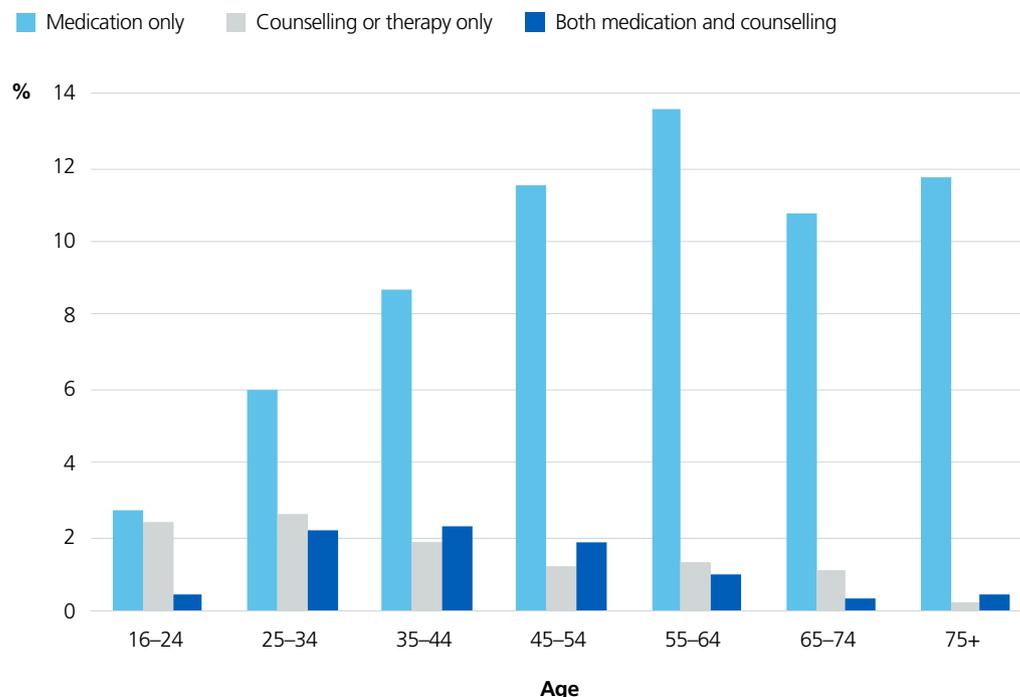
After controlling for CIS-R score, the youngest age group were even less likely to receive treatment than other age groups. Those aged 35 to 54 had the highest odds of receiving treatment (OR 3.11 for 35 to 44 year olds, OR 3.10 for 45 to 54 year olds). Except for those aged 75 or more, all age groups had significantly higher odds of receiving treatment than the youngest age-group (16 to 24 year olds).

**[Table 3.14](#)**

In terms of type of treatment, those aged 16–24 were the least likely to use psychotropic medication, while those aged 75 or more had the lowest rates of psychological therapy. Despite being more at risk due to medication side effects, those aged 75 or more were ten times more likely to receive medication than psychological therapy. [Table 3.16](#)

**Figure 3M: Types of mental health treatment currently used, by age**

Base: all adults



### Variation in receipt of mental health treatment, by ethnic group

Treatment rates varied by ethnic group, despite the fact that mean CIS-R score did not vary between ethnic groups. White British people were the ethnic group most likely to report receiving treatment; 13.3% reported this compared with around 7% of people in minority ethnic groups (including White non-British). Black adults had the lowest treatment rate (6.2%). [Table 3.18](#)

After further controlling for other factors in the final model, people in the Black/Black British group had the lowest odds of being in receipt of treatment (OR 0.27, compared with the White British group). Analysis by ethnic group should be treated with some caution due to small sample sizes, although these findings are consistent with results from APMS 2007 (Cooper et al. 2013). [Tables 3.14, 3.15](#)

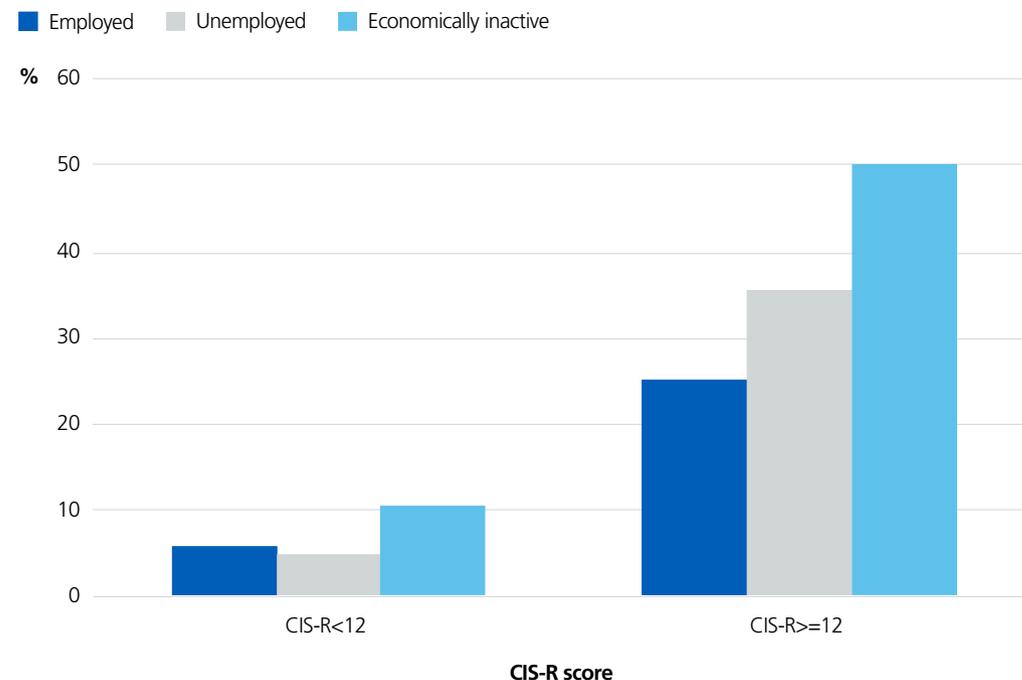
### Variation in receipt of mental health treatment, by employment status

Analysis that did not control for other factors shows that economically inactive people have higher rates of treatment: 18.2% compared with 12.6% of unemployed people and 8.2% of employed people. This pattern held true both for men and women.

After controlling for other factors, including CIS-R score, the difference in likelihood of treatment was no longer significant between unemployed and employed people. However, those who were economically inactive remained significantly more likely, with twice the odds of being in treatment than those who were employed (OR 2.04, 95% CI 1.64 to 2.54). [Tables 3.14, 3.19, 3.20](#)

**Figure 3N: Current use of treatment, by employment status and CIS-R score**

Base: all adults



With respect to type of treatment, among economically inactive people aged 16 to 64 (who were the employment status group with the highest mean CIS-R score and were the most likely to report treatment in general) combined medication and psychological therapy was not uncommon; 10.5% reported this compared with 4.9% of unemployed people and 3.5% of people in employment.

### Independent predictors of treatment receipt

In summary, as outlined above, after controlling for other factors the following were all associated with higher likelihood of mental health treatment use:

- **Female** (OR 1.58 compared with male, 95% CI 1.32 to 1.89)
- **White British** ethnicity as opposed to any other ethnic group (particularly Black, with OR 0.27 compared with White British, 95% CI 0.14 to 0.49)
- **25 to 74 years old**, especially 35 to 44 (OR 3.11 compared with 16–24 year olds, 95% CI 2.03 to 4.76) and 45–54 (OR 3.10, 95% CI 1.98 to 4.84)
- **Economically inactive** (OR 2.04 compared to employed, 95% CI 1.64 to 2.54)
- **Poor general health** (OR 3.28, 95% CI 2.59 to 4.15)
- **Poor mental health**, especially CIS-R score 18+ (OR 7.66 compared with CIS-R score 0–5, 95% CI 5.87 to 9.98). [Table 3.15](#)

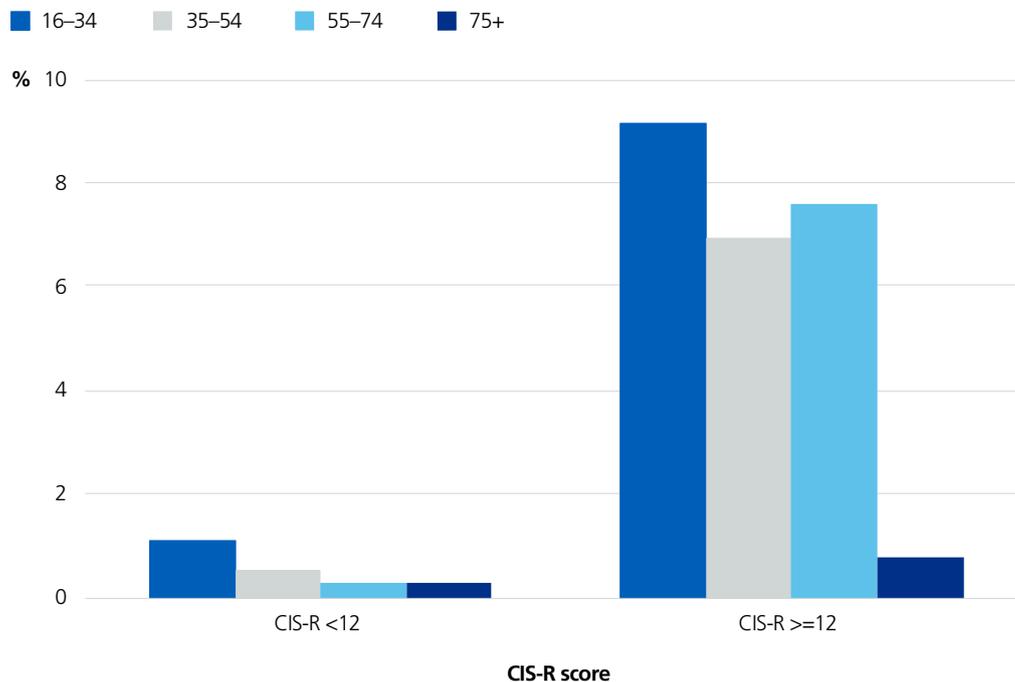
## 3.5 Results: Inequalities in unmet treatment requests

Overall, 1.7% of people reported having asked for, but not received, a particular mental health treatment in the past 12 months. This was strongly associated with CMD symptoms. One in ten (10.3%) adults with severe CMD symptoms (CIS-R 18+) had an unmet treatment request in the previous 12 months, compared with just 0.3% of people with very few or no CMD symptoms (CIS-R score 0–5). The people who had asked for but not received treatment were overwhelmingly those with symptoms of CMD, suggesting that such requests tended to be made by people who might have benefited from treatment. Half of people (53.2%) with an unmet treatment request were not receiving any other mental health treatment at the time of the interview. [Tables 3.22, 3.25](#)

Unmet treatment requests were most likely to be reported by people aged 16–34 (2.5%), and were hardly ever reported by those aged 75 and over (0.3%). A similar pattern by age was observed in people with CMD. [Table 3.23](#)

**Figure 30: Requested but not received treatment in the past 12 months, by age and CIS-R score**

Base: all adults

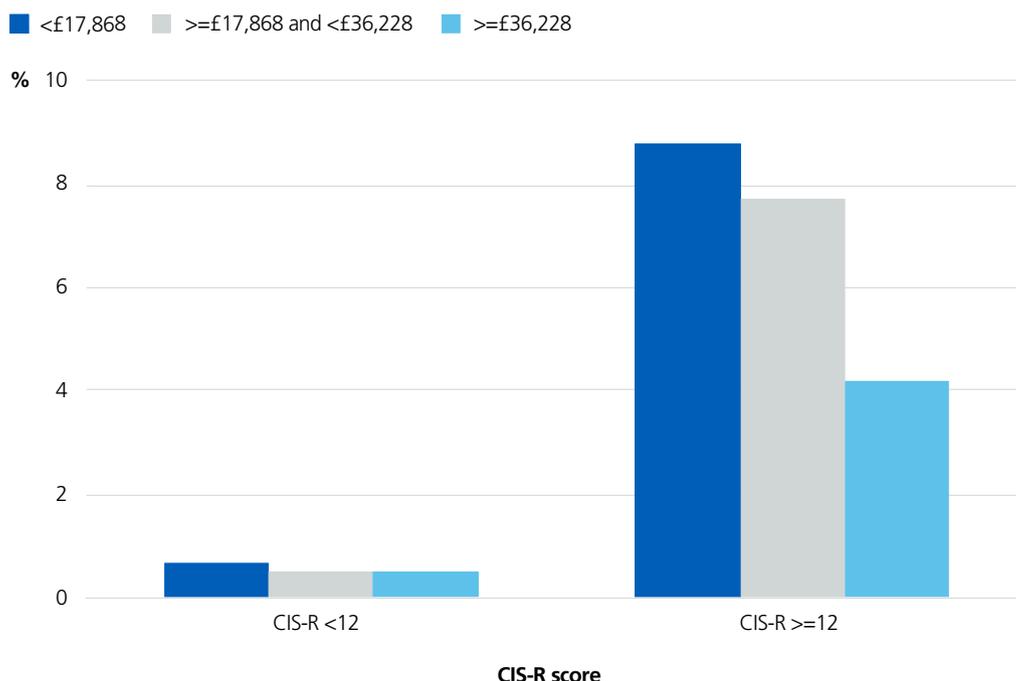


The proportion of people who reported an unmet treatment request varied by household income tertile. 8.8% of people with CMD living in households in the lowest income tertile reported requesting but not getting a particular mental health treatment in the past 12 months, compared with 4.2% of those with CMD living in the highest income households.<sup>10</sup> [Table 3.24](#)

<sup>10</sup> These results should be treated with caution due to the relatively small size of the CMD group and because the reported rates of unmet treatment requests are low.

**Figure 3P: Requested but not received particular treatment in the past 12 months, by equivalised income tertiles and CIS-R score**

*Base: adults providing information about income*



## 3.6 Discussion

This chapter presents information on trends and inequalities in treatment and service use, drawing on data collected in APMS 2000, 2007 and 2014. The survey series relies on self-report data and it should be noted that participants in such studies are not always aware themselves precisely what treatments and services they are using. Misclassifications, under-reporting, and even over-reporting are all possible. The checking of participants' medication packaging for drug names will have helped, but there was little that could be done to verify the classification of types of psychological therapy as health records were not checked. The survey series has also never sought to establish who provided each type of treatment or service, for example whether NHS or private.

It is also important to note that while there has been much consistency in how the data has been collected, a number of changes might have affected the trends presented. Surveys like APMS have to balance the consistent collection of information across the series, with ensuring that questions reflect current context and terminology. For example, between the 2007 and 2014 surveys several key psychotropic medications became available in generic form, while NICE guidelines to health professionals encouraged the prescription of generic medications (NICE 2016a). To reflect these changes in prescribing practice, the 2014 survey prioritised the listing of generic medication names, given these may become increasingly familiar to the public, and asked about a wider range of medications. More types of psychological therapy were also asked about, although the positioning of these questions at the start of the relevant section should have safeguarded against any impact on trend data.

These methodological limitations are important to highlight, as they may account for some of the steep increase in reported treatment rates between the 2007 and 2014 surveys. In 2007, one person in four with a CIS-R score of 12 or more reported receiving treatment. Seven years later this figure has risen to more than one in three. The increase is most pronounced for psychotropic medication, closely reflecting trends found in recent analyses of antidepressant prescribing data (Spence et al. 2014). This trend may indicate a material improvement in treatment access, but should also be considered in the context of NICE guidelines (2009/2011) not to offer antidepressants routinely for mild depression (NICE 2016b).

The increase in treatment was evident (among those with more severe CMD symptoms) for psychological therapies as well. This is also what might have been expected given the roll-out of the *Improving Access to Psychological Therapy* (IAPT) programme since the last survey took place. In addition it should be noted that lower intensity IAPT therapies such as computerised cognitive behaviour therapy and self-directed learning might not always have been captured by the survey questions.

While the figure of 'one-in-three' adults with CMD symptoms being in receipt of mental health treatment represents a major increase since the last survey, it is still

the case that a majority of people with symptoms are not receiving treatment. However, the threshold taken to indicate presence of CMD symptoms – a CIS-R score of 12 or more – might be considered quite low. Among those with more severe symptoms – the 8% of the population with a CIS-R score of 18 or more – closer to half reported receipt of mental health treatment of some kind.

This chapter has presented crucial evidence on inequalities in treatment access that remain after controlling for differences in levels of mental illness between groups. Surveys are ideally placed to examine treatment gaps, as data are collected both from people in treatment and from those who are not, and assessment tools enable undiagnosed conditions to be identified.

While demographic inequalities were sharply evident, socioeconomic inequalities were much less so. No significant associations were found between treatment rates and area level deprivation after controlling for level of symptoms, nor were there associations with several measures of material deprivation. There were indications that people with CMD living in lower income households were more likely to have unmet need in terms of requesting but not receiving a particular psychiatric treatment. But there were also indications that people with CMD who were employed, especially men, may struggle to access treatment, a finding with particular relevance for policy around the accessibility of services. Overall, there was relatively little evidence that treatment use was determined by socioeconomic factors. The APMS survey did, however, exclude some of the most vulnerable by drawing its participants from those living in private households, excluding, for example, people who are homeless.

The most pronounced inequalities in use of treatment related to age, sex and ethnic group. People with CMD who were Black, Asian, non-British White, or of mixed or other ethnicity were less likely to obtain treatment than those in the white British group. In terms of age, those in midlife had three times the odds of treatment use compared with the youngest. Younger people with CMD were less likely to get psychotropic medication than other age groups and were also the most likely to have their treatment requests unmet. Older people with CMD had the lowest rates of psychological therapy, but also the lowest rates of unmet treatment requests – suggesting that they may not be asking for what they need, or may not even be aware of what is available. It may also be the case that men with CMD are less

likely than women to be using treatment, in part due to longstanding stigma or reluctance to talk about mental health or to seek help from health professionals.

It is very striking how the proportion of people who had discussed their mental health with a GP increased since the 2007 survey. Increases over this same time frame in psychotropic medication prescribing may in part be explained by this change in the nature and extent of GP contact. Alongside this, Chapter 2 highlighted that there has been an increase in the prevalence of CMD in the population (specifically in women). It is possible that as the population has become more unwell, and as those who are unwell become more likely to be treated, much of the additional burden is falling on primary rather than secondary care. Resource allocations for primary care may need to reflect these changes in demand.

## 3.7 Tables

### Prevalence of and trends in treatment and service use

- 3.1 Treatment currently received for a mental or emotional problem, by severity of common mental disorder (CMD) symptoms
- 3.2 Treatment currently received for a mental or emotional problem, by CMD in past week
- 3.3 Types of psychotropic medication currently taken, by severity of CMD symptoms
- 3.4 Types of psychotropic medication currently taken, by CMD in past week
- 3.5 Current counselling or therapy for a mental or emotional problem, by severity of CMD symptoms
- 3.6 Current counselling or therapy for a mental or emotional problem, by CMD in past week
- 3.7 Health care services used for a mental or emotional problem, by severity of CMD symptoms
- 3.8 Health care services used for a mental or emotional problem, by CMD in past week

- 3.9 Community and day care services used in past year, by severity of CMD symptoms
- 3.10 Community and day care services used in past year, by CMD in past week
- 3.11 Treatment for mental or emotional problem in 2000, 2007 and 2014, among people with CMD symptoms (CIS-R 12+ and 18+)
- 3.12 Health care services used for mental or emotional problem in 2000, 2007 and 2014, among people with CMD symptoms (CIS-R 12+)
- 3.13 Community and day care services used in 2000, 2007 and 2014, among people with CMD symptoms (CIS-R 12+)

### **Inequalities in use of mental health treatment**

- 3.14 Logistic regression models identifying factors that predict whether or not someone is in receipt of mental health treatment
- 3.15 Results of final multiple logistic regression model (controlling for all factors) predicting receipt of treatment
- 3.16 Treatment for mental or emotional problem, by age and sex
- 3.17 Treatment for mental or emotional problem, by age, sex and CMD symptoms
- 3.18 Treatment for mental or emotional problem, by ethnic group
- 3.19 Treatment for mental or emotional problem, by employment status, sex and severity of mental health
- 3.20 Treatment for mental or emotional problem, by employment status and age
- 3.21 Treatment for mental or emotional problem, by equivalised household income tertiles and severity of CMD symptoms

### **Unmet treatment requests**

- 3.22 Requested but not received a particular mental health treatment in the past 12 months, by severity of CMD symptoms and sex

- 3.23 Requested but not received a particular mental health treatment in the past 12 months, by age, by severity of CMD symptoms
- 3.24 Requested but not received a particular mental health treatment in the past 12 months, by equivalised household income tertiles and severity of CMD symptoms
- 3.25 Requested but not received a particular mental health treatment in past 12 months, by current receipt of any mental health treatment and severity of CMD symptoms

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*This chapter should be cited as:*

Lubian K, Weich S, Stansfeld S, Bebbington P, Brugha T, Spiers N, McManus S, Cooper C. (2016) 'Chapter 3: Mental health treatment and services' in McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital.