



Common mental disorders

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Summary

- Common mental disorders (CMDs) comprise different types of depression and anxiety. They cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. Although usually less disabling than major psychiatric disorders, their higher prevalence means the cumulative cost of CMDs to society is great.
- The revised Clinical Interview Schedule (CIS-R) has been used on each Adult Psychiatric Morbidity Survey (APMS) in the series to assess six types of CMD: depression, generalised anxiety disorder (GAD), panic disorder, phobias, obsessive compulsive disorder (OCD), and CMD not otherwise specified (CMD-NOS). Many people meet the criteria for more than one CMD. The CIS-R is also used to produce a score that reflects overall severity of CMD symptoms.
- Since 2000, there has been a slight but steady increase in the proportion of women with CMD symptoms (as indicated by a CIS-R score of 12 or more), but overall stability at this level among men. The increase in prevalence was evident mostly at the more severe end of the scale (CIS-R score 18 or more).
- Since the last survey (2007), increases in CMD have also been evident among late midlife men and women (aged 55 to 64), and approached significance in young women (aged 16 to 24).
- The gap in rates of CMD symptoms between young men and women appears to have grown. In 1993, 16 to 24 year old women (19.2%) were twice as likely as 16 to 24 year old men (8.4%) to have symptoms of CMD (CIS-R score 12 or more). In 2014, CMD symptoms were about three times more common in women of that age (26.0%) than men (9.1%).
- CMDs were more prevalent in certain groups of the population. These included Black women, adults under the age of 60 who lived alone, women who lived in large households, adults not in employment, those in receipt of benefits and those who smoked cigarettes. These associations are in keeping with increased social disadvantage and poverty being associated with higher risk of CMD.

- Most people identified by the CIS-R with a CMD also perceived themselves to have a CMD. This was not the case for most of the other disorders assessed in the APMS.
- While most of these people had been diagnosed with a mental disorder by a professional, the disorders they reported having been diagnosed with tended to be 'depression' or 'panic attacks'. However, the disorder most commonly identified by the CIS-R was GAD. This difference may reflect the language and terminology used by people when discussing their mental health with a professional.

2.1 Introduction

Reducing the prevalence of common mental disorders such as depression and anxiety is a major public health challenge (Davies 2014). CMDs range in severity from mild to severe and are often associated with physical and social problems (Goldberg and Huxley 1992). They can result in physical impairment and problems with social and occupational functioning, and are a significant source of distress to individuals and those around them. Both anxiety and depression often remain undiagnosed (Kessler et al. 2002) and sometimes individuals do not seek or receive treatment. If left untreated, CMDs are more likely to lead to long term physical, social and occupational disability and premature mortality (Zivin et al. 2015). Although evidence exists for effective treatment of depression and anxiety (NICE 2004), this seems to have had little impact on the prevalence of these disorders. This may be because CMDs are relapsing conditions that can recur many years after an earlier episode, because the stressors that cause them endure, and because people with CMD do not always adhere to or seek treatment (Weich et al. 2007; Cooper et al. 2007). In the case of depression, relapse ten years from first presentation frequently occurs (Thornicroft and Sartorius 1993).

Although poverty and unemployment tend to increase the duration of episodes of CMD, it is not clear whether or not they cause the onset of an episode. Debt and financial strain are certainly associated with depression and anxiety, and increasingly the evidence is suggestive of a causal association (Meltzer et al. 2013;

Mind 2008). There are a wide range of other known associations, including: being female (Weich et al. 1998); work stress (Stansfeld et al. 1999); social isolation (Bruce and Hoff 1994); being a member of some ethnic groups (Weich et al. 2004); poor housing and fuel poverty (Harris et al. 2010; Hills 2012); negative life events (such as bullying, violence, bereavement, job loss); childhood adversity including emotional neglect, physical and sexual abuse (Fryers and Brugha 2013); institutional care, low birth weight (Loret de Mola et al. 2014); poor physical health; a family history of depression (Angst et al. 2003); poor interpersonal and family relationships, a partner in poor health, being a carer (Stansfeld et al. 2014); and problems with alcohol and illicit drugs (Salokangas and Poutanen 1998). Development of effective strategies for prevention of CMD has been limited by a lack of evidence on how risk factors act in combination (Clark et al. 2012). However, multifactorial risk algorithms for predicting major depression and anxiety disorders have been published (King et al. 2011a; King et al. 2011b) and are already influencing prevention efforts in primary care (Bellón et al. 2016).

Although usually less disabling than major psychiatric disorders such as psychotic disorder, the higher prevalence of CMDs mean that their cumulative cost to society is great (Zivin et al. 2015). These costs are even higher if CMD co-occurs with a personality disorder (Rendu et al. 2002). Mixed anxiety and depression (referred to here as 'CMD not otherwise specified' (NOS)) has been estimated to cause one fifth of days lost from work in Britain (Das-Munshi et al. 2008). In the United Kingdom, every year mental illness, largely CMD, costs the economy an estimated £70 billion (equivalent to 4.5% of GDP) (OECD 2014). Mental illness is the leading cause of UK sickness absence, accounting for 70 million sick days in 2013 (ONS 2014). In 2013, 41% of people receiving Employment and Support Allowance (ESA) had a 'mental or behavioural disorder' coded as their primary condition (OECD 2014). See Chapter 3 for use of treatment in people with CMD and Chapter 13 for comorbidity with CMD.

2.2 Definition and assessment

Common mental disorders (CMDs)

CMDs, also known as neurotic disorders, cause marked emotional distress and interfere with daily function, although they do not usually affect insight or cognition. CMDs comprise different types of depression and anxiety. Symptoms of depressive episodes include low mood and a loss of interest and enjoyment in ordinary things and experiences. They impair emotional and physical wellbeing and behaviour. Anxiety disorders include generalised anxiety disorder (GAD), panic disorder, phobias, and obsessive compulsive disorder (OCD). Symptoms of depression and anxiety frequently co-exist, with the result that many people meet criteria for more than one CMD. OCD is characterised by a combination of obsessive thoughts and compulsive behaviours. Obsessions are defined as recurrent and persistent thoughts, impulses or images that are experienced as intrusive and inappropriate, are resisted, and cause marked anxiety or distress. Compulsions are repetitive, purposeful and ritualistic behaviours or mental acts, performed in response to obsessive intrusion and to a set of rigidly prescribed rules (NICE 2006).

The Clinical Interview Schedule – Revised (CIS-R)

Specific CMDs and symptoms of CMD were assessed in the first phase interview using the Clinical Interview Schedule – Revised (CIS-R). The CIS-R is an interviewer administered structured interview schedule covering the presence of non-psychotic symptoms in the week prior to interview. It can be used to provide prevalence estimates for 14 types of CMD symptoms and six types of CMD, together with a continuous scale that reflects the overall severity of CMD psychopathology (Lewis et al. 1992).

Each section of the CIS-R assesses one type of CMD symptom. These are:

- Somatic symptoms
- Fatigue
- Concentration and forgetfulness
- Sleep problems
- Irritability
- Worry about physical health

- Depression
- Depressive ideas
- Worry
- Anxiety
- Phobias
- Panic
- Compulsions
- Obsessions

Each section starts with two filter questions to establish the presence of the particular symptom in the past month. A positive response leads to further questions enabling a more detailed assessment of the symptom in the past week including frequency, duration, severity, and time since onset. Answers to these questions determine the scores for each symptom. Symptom scores range from zero to four, except for depressive ideas, which has a maximum score of five. Descriptions of the items that make up the scores for each of the symptoms measured by the CIS-R can be found in Appendix B. Data on the symptom scores are not presented in this chapter, but are available in the archived dataset.

The scores for each section are summed to produce a total CIS-R score, which is an indication of the overall severity of symptoms.

- *CIS-R score of 12 or more* is the threshold applied to indicate that a level of CMD symptoms is present such that primary care recognition is warranted. In this chapter, 'presence of CMD symptoms' includes all participants with a CIS-R score of 12 or more (including those with a score of 18 and above).
- *CIS-R score of 18 or more* denotes more severe or pervasive symptoms of a level very likely to warrant intervention such as medication or psychological therapy. In this chapter 'severe CMD symptoms' is used to indicate those with a CIS-R score of 18 or more.

The participants' answers to the CIS-R were used to generate 10th International Classification of Disease (ICD-10) diagnoses of CMD using the computer algorithms described in Appendix B (WHO 1992). These ICD-10 diagnoses were then amalgamated to produce the six categories of disorder used in this report:

- Generalised anxiety disorder (GAD)
- Depression (including mild, moderate and severe)
- Phobias
- Obsessive compulsive disorder (OCD)
- Panic disorder
- CMD not otherwise specified (CMD-NOS, referred to in previous surveys in the APMS series as 'mixed-anxiety and depression').

It should be noted that 'CMD-NOS' was defined as having a CIS-R score of 12 or more but falling short of the criteria for any specific CMD. By definition, participants with this diagnosis therefore could not be classed as having any other CMD measured by the CIS-R. For the other five ICD-10 disorders, participants could be classed in more than one category (although phobias and panic disorder have diagnostic criteria that are mutually exclusive).

The CIS-R was also used to assess CMDs in the 1993, 2000 and 2007 APMS. The schedule was administered using computer assisted interviewing in the 2000, 2007 and 2014 surveys, and by paper in 1993. The approach has otherwise remained consistent and the data are comparable across survey years. The comparisons between survey years reported in this chapter are limited to participants aged 16–64 years and living in England (the first two surveys also covered Scotland and Wales). This age range was used because the 1993 survey did not sample adults aged 65 and over.

Self-diagnosis and professional diagnosis

In the 2014 survey, new questions were added. Participants were presented with a show card listing different mental disorders and were asked: a) which they thought they had had at some point in their life; b) whether this had also been diagnosed by a professional; and c) whether a diagnosed disorder had been present in the past 12 months. It should be noted that the rates presented are estimates based entirely on self-reports, and have not been checked against health records.

2.3 Results

Prevalence of CMD symptoms, by age and sex

Around one adult in six (15.7%) were identified with symptoms of CMD (as indicated by a CIS-R score of 12 or more). See Table 14.6 for 95% confidence intervals around some of these estimates. It is likely that if all adults in the population had been assessed using the CIS-R, the proportion scoring 12 or more would be between 14.7% and 16.7%. One in twelve (8.1%) had severe symptoms of CMD (CIS-R score of 18 or more, 95% CI: 7.4% to 8.9%).

Women were more likely than men to be affected. One in five (19.1%) women had CMD symptoms, compared with one in eight men (12.2%). Women were also more likely than men to have severe symptoms of CMD (9.8% of women scored 18 or more on the CIS-R, compared with 6.4% of men).

CMD symptoms were associated with age. Overall, working-age people were around twice as likely to have symptoms of CMD as those aged 65 and over. Between 16 and 64, the proportion with CMD symptoms remained around 17%–18%. But among those aged 65 and over the rate was much lower (10.2% of 65 to 74 year olds and 8.1% of those aged 75 and over). A similar pattern was observed for severe symptoms of CMD.¹

The pattern of association between age and CMD symptoms was different for men and women. In women, rates of CMD symptoms peaked in the youngest group (26.0% of 16 to 24 year olds). This was three times the rate for 16 to 24 year old men (9.1%). In men the rate of CMD symptoms remained quite stable between the ages of 25 and 64, while in women a second (less-pronounced) peak was evident around midlife (45 to 54 year olds). Both men and women experienced a tailing off of CMD symptoms in later life. This pattern was similar, although even more pronounced, in rates of severe symptoms (a CIS-R score of 18 or more). [Table 2.1](#)

¹ Around 8% to 10% of people in age groups in the 16 to 64 range scored 18 or more on the CIS-R, compared with 4.2% of those aged 65 to 74 and 3.3% of those aged 75 and over.

Figure 2A: CIS-R score of 12 or more, by age and sex

Base: all adults

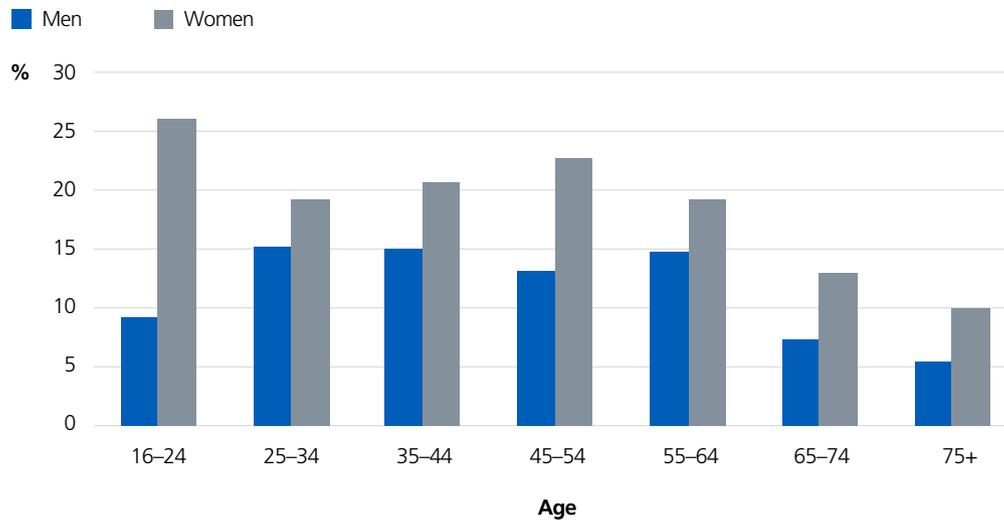
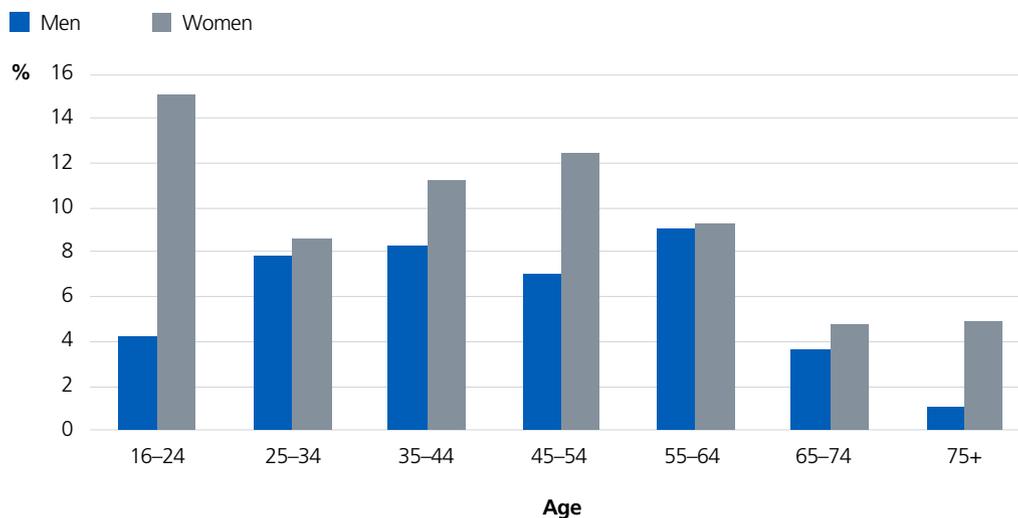


Figure 2B: CIS-R score of 18 or more, by age and sex

Base: all adults

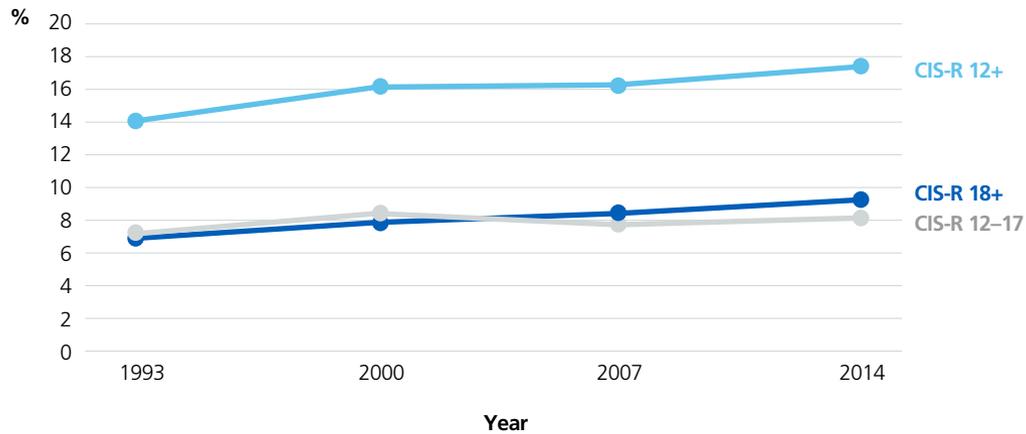


Trends in CMD symptoms, 1993 to 2014

There was an increase in CMD symptoms (CIS-R score of 12 or more) in 16–64 year olds between 1993 (14.1%) and 2000 (16.3%), but since then there has been stability in the proportion with a CIS-R score of 12 or more. In 2014, 17.5% of working-age adults had symptoms of CMD.

Figure 2C: CIS-R score, 1993 to 2014

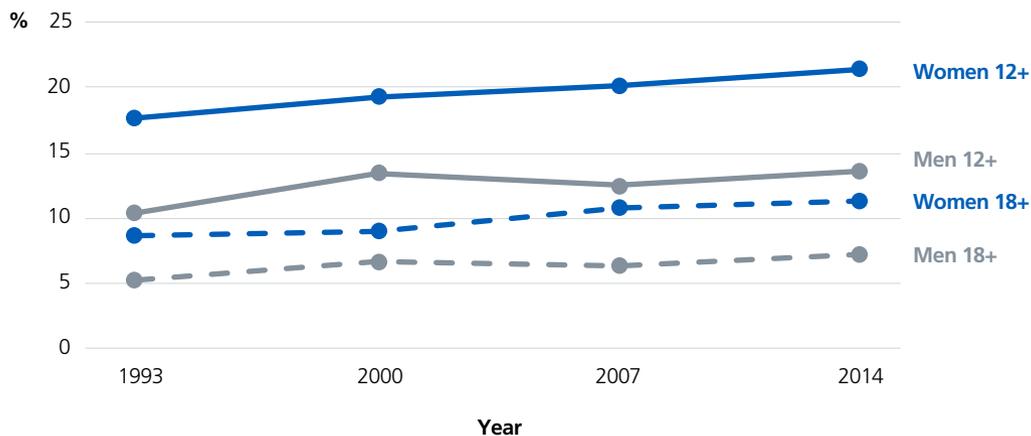
Base: adults aged 16–64



While the overall prevalence of symptoms of CMD (CIS-R score 12 or more) remained stable between 2000 and 2014, the proportion with severe CMD symptoms (CIS-R score of 18 or more) increased (7.9% in 2000; 8.5% in 2007; 9.3% in 2014). While rates of severe symptoms of CMD did not significantly differ between 2007 and 2014, the trend since 1993 has been one of slow but steady increase (from 6.9% to 9.3%). No equivalent trend is evident for rates of less severe symptoms (CIS-R 12–17), which have remained remarkably stable over time (Figure 2C). [Table 2.2](#)

Figure 2D: CIS-R score of 12 or more and 18 or more by sex, 1993 to 2014

Base: adults aged 16–64



There is evidence of different patterns of change over time in different age groups and in men and women. These trends need to be treated with some caution as the base sizes for some age by sex combinations are small. However, it seems that in women, increases in rates over time have been steady and evident across different age groups, while the trends for men are less clear. [Table 2.2](#)

Figure 2E: Severe CMD symptoms (CIS-R 18+) in men, 1993 to 2014

Base: men aged 16–64

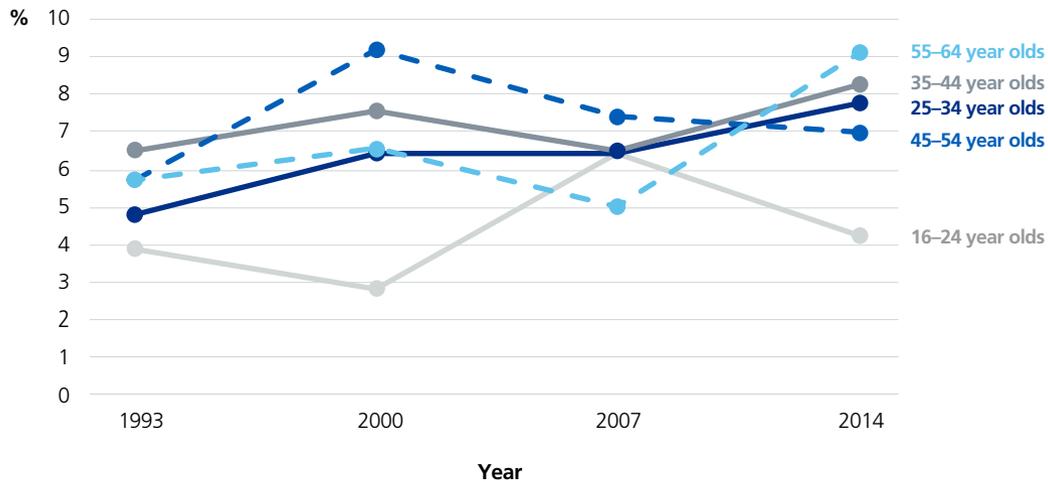
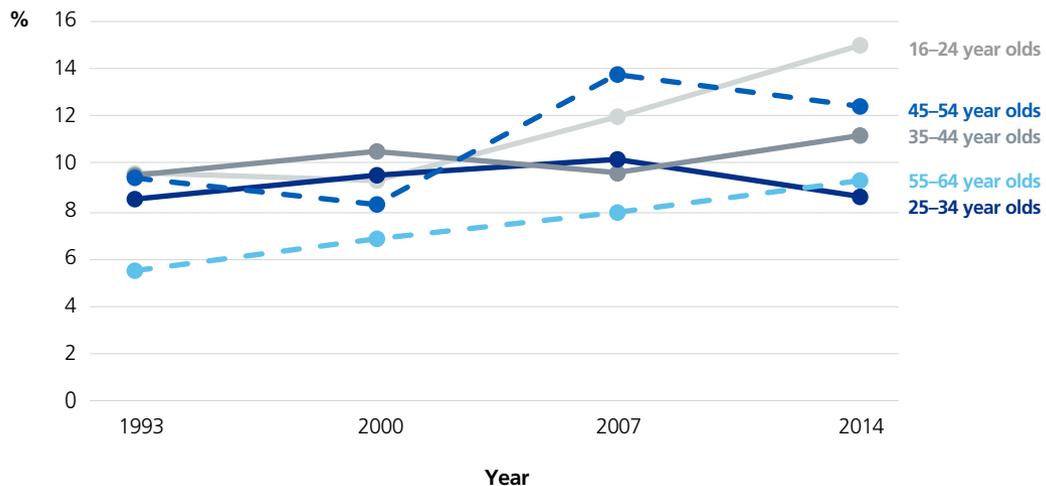


Figure 2F: Severe CMD symptoms (CIS-R 18+) in women, 1993 to 2014

Base: women aged 16–64



Increases in rates of severe CMD symptoms were most pronounced in women aged 16 to 24 (from 9.6% in 1993 to 15.1% in 2014) and 55 to 64 (from 5.5% to 9.3%),

and for men aged 55 to 64 (from 5.7% to 9.1%). Overall, and for men, the recent change in rates of severe CMD symptoms between 2007 and 2014 in 55 to 64 year olds was statistically significant. This increase may relate to people of this age being particularly vulnerable at time of economic recession (Frasquilho et al. 2015). The apparent increase in rate among young women does not quite meet statistical significance at the 95% level, and so should be treated with caution unless corroborated by other data sources.

The gap in rates of CMD symptoms between young men and women has grown. In 1993, 16 to 24 year old women (19.2%) were twice as likely as 16 to 24 year old men (8.4%) to have symptoms of CMD. By 2014, CMD symptoms were almost three times more common in women of that age (26.0%) than men (9.1%).

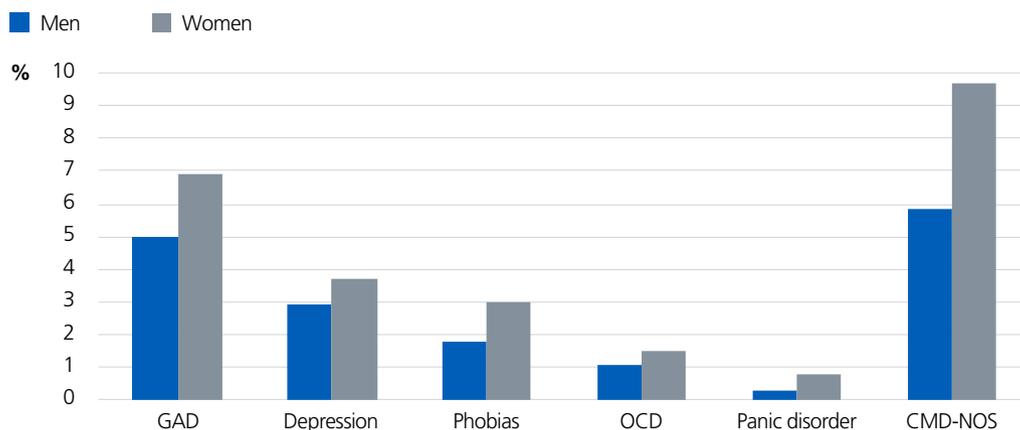
Table 2.2

Prevalence of CMDs, by age and sex

One in six (17.0%) people (aged 16 and over) were identified with a CMD in the week before interview. The largest category of CMD, as in previous years of the survey, was CMD-NOS (7.8%). GAD remained the next most commonly identified CMD (5.9%), followed by depression (3.3%), phobias (2.4%), OCD (1.3%) and panic disorder (0.6%). All types of CMD were more prevalent in women than in men, with differences by sex reaching statistical significance for GAD, phobias, panic disorder and CMD-NOS. [Table 2.3](#)

Figure 2G: Prevalence of common mental disorders (CMDs), by sex

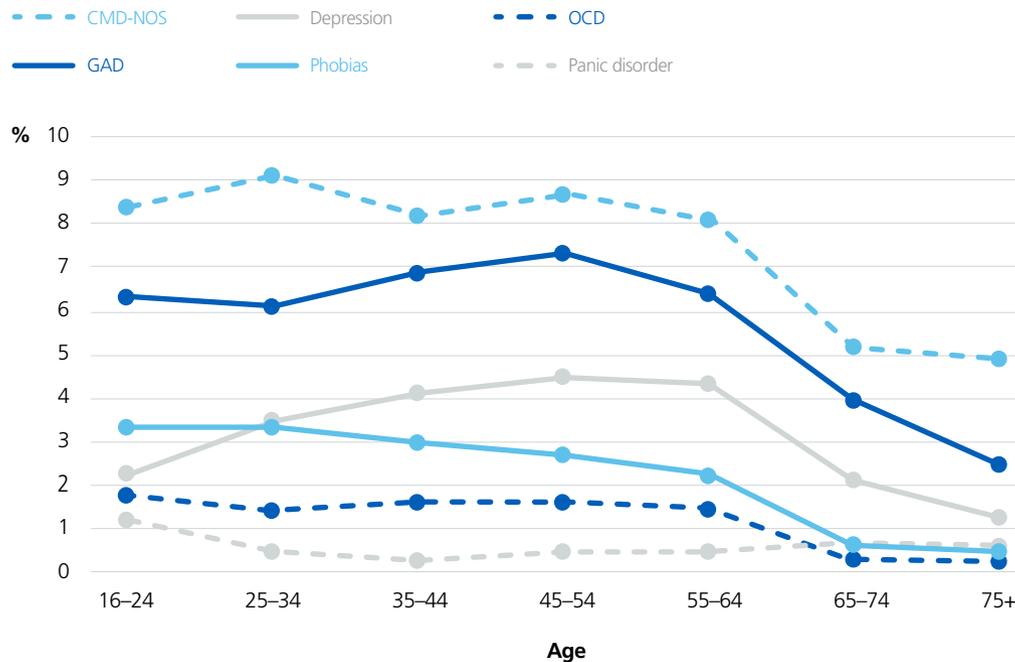
Base: all adults



With the exception of panic disorder (which had a low prevalence), each type of CMD was more common in people of working age (aged 16 to 64) than in those aged 65 and above.

Figure 2H: Prevalence of common mental disorders (CMDs), by age

Base: all adults



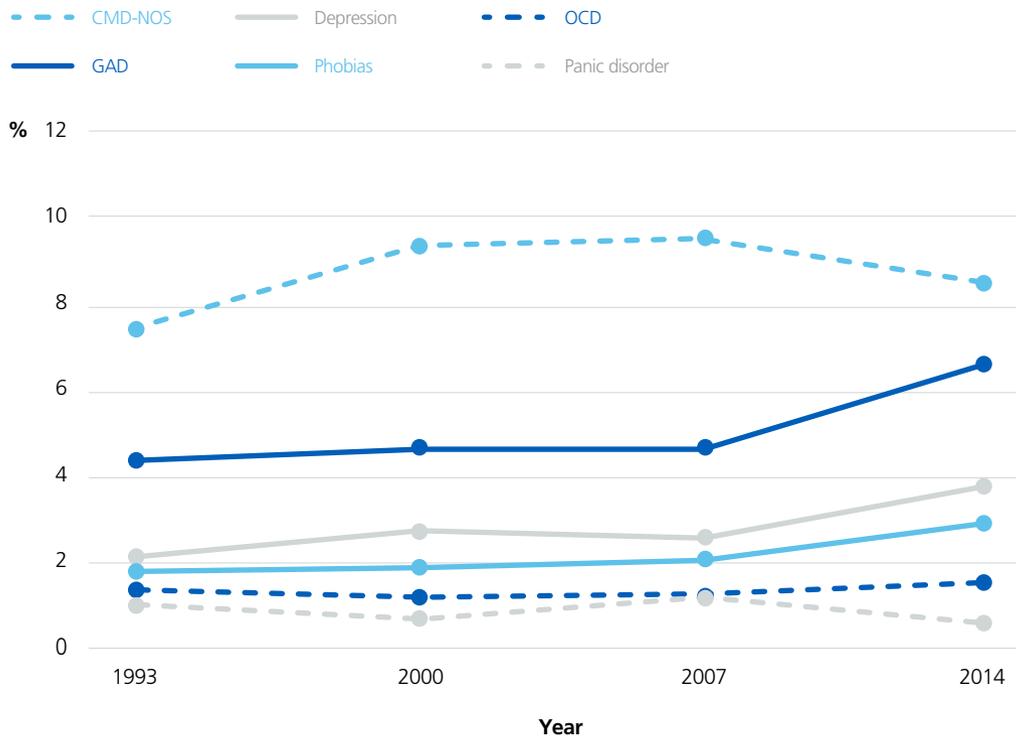
Anxiety disorders were more common among young women aged 16 to 24 (GAD 9.0%; phobias 5.4%; OCD 2.4%; and panic disorder 2.2%) than in other age-sex groups. [Table 2.3](#)

Trends in CMDs, 1993 to 2014

GAD, depression, and phobias were more common in people aged 16 to 64 in 2014 than in previous years of the survey, while rates of OCD, panic disorder and CMD-NOS remained more stable. The prevalence of GAD increased from 4.7% in 2007 (and 4.4% in 1993) to 6.6% in 2014 and depression rose from 2.6% in 2007 (and 2.2% in 1993) to 3.8% in 2014. Phobias increased from 2.1% in 2007 (and 1.8% in 1993) to 2.9% in 2014. These increases were apparent in both men and women, except in the phobia rate which remained unchanged in men. [Table 2.4](#)

Figure 2I: Prevalence of common mental disorders (CMDs), 1993 to 2014

Base: adults aged 16–64



CMD, by CIS-R score

Having a high symptom score on the CIS-R does not necessarily mean that the criteria for a specific diagnosis are fulfilled. Conversely, some adults who receive a diagnosis do not necessarily score 12 or more on the CIS-R. CIS-R scores of 12 and above are conventionally taken to indicate a CMD. All participants with such a score who did not meet the criteria for any of the specific disorders assessed on the survey were categorised with CMD-NOS. Participants with a CIS-R score of 11 or less might nevertheless meet criteria for one of the specific CMDs. Hence all of those with a CIS-R score of 12 or above were classed as having a CMD in the previous week, compared with only 0.4% of those with a score of 5 or below, and 6.4% of those with a score of between 6 and 11. Most of those with a specific CMD who scored below 12 were classed as having GAD.

Around three quarters of people with a CIS-R score of between 12 and 17 (73.3%) were identified with CMD-NOS. For adults with a CIS-R score of 18 or above, most met the criteria for a specific disorder and only a quarter (27.2%) were classed as having CMD-NOS. Nearly half of those with a CIS-R score of 18 or more (46.3%) were identified with GAD, a third (35.0%) with depression, and a quarter (24.0%) with phobias (it was possible to be identified with more than one CMD). [Table 2.5](#)

Self-diagnosed and professional diagnosed CMD, by CMD in past week

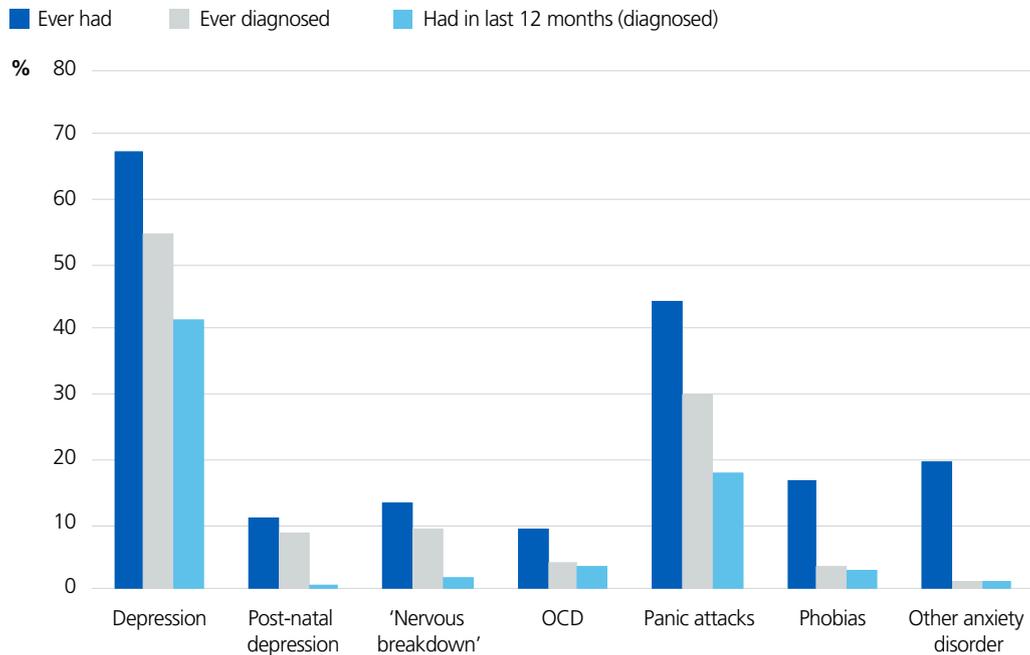
Nearly half of adults (43.4%) think that they have had a mental disorder at some point, 35.2% of men and 51.2% of women. A fifth of men (19.5%) and a third of women (33.7%) have also had diagnoses confirmed by a professional. 13.3% of adults reported presence of a diagnosed mental disorder in the past 12 months.

Most participants identified by the CIS-R interview as having CMD already thought that they had CMD, and in many cases they had also been so diagnosed by a professional. Of those identified with CMD symptoms in the week before interview, 84.2% reported that they had had a mental disorder at some point, and 63.8% had been given this diagnosis by a professional. The corollary of this is that a third (36.2%) of people identified by the survey as currently having a disorder had never been diagnosed with one. Just under half (47.9%) reported having a diagnosed CMD in the last year.

Of those identified with CMD, two thirds (67.2%) reported that they had had depression at some point. This included 54.8% who reported being diagnosed by a professional. Of those with CMD, 44.6% mentioned having 'panic attacks': 30.2% of whom reported that this had been diagnosed by a professional, 18.0% within the last year. Other CMDs were mentioned less frequently. [Table 2.6](#)

Figure 2J: Self-diagnosed CMD, professional diagnosed CMD and presence of diagnosed CMD in past year, among adults with CMD in the past week

Base: all adults with a CMD as identified by CIS-R



Whatever the type of disorder identified by the CIS-R assessment, the most common professional diagnosis (as reported by survey participants) was depression, ranging from 43.8% of those identified with panic disorder (albeit a very small sample) to 83.0% of those with OCD. People identified as having OCD in the CIS-R assessment rarely reported being diagnosed as such by a professional (in only 13.2% of cases). There was an even greater apparent mismatch among those identified as having some form of phobia, of whom only 7.2% reported having a professional diagnosis of phobia. [Table 2.6](#)

Professional diagnosed CMD, by CMD in past week (as identified by CIS-R)

	CMD in past week, as identified by CIS-R			
	Depression	Phobias	OCD	Panic disorder
Ever diagnosed with CMD by professional (self-reported)	%	%	%	%
Depression	70.0	72.1	83.0	43.8
Phobia	5.9	7.2	6.0	–
OCD	7.1	7.9	13.2	–
Panic attacks	42.7	45.5	41.9	22.3
<i>Bases</i>	<i>284</i>	<i>201</i>	<i>103</i>	<i>43^a</i>

^a Note small base for panic disorder.

Variation in CMDs by other characteristics

Ethnic group

In men, prevalence of CMD did not vary significantly by ethnic group, whereas it did in women. Using age-standardised figures, non-British White women were less likely than White British women to have a CMD (15.6%, compared with 20.9% respectively), while CMDs were more common in Black and Black British women (29.3%).

Perhaps because of small sample sizes, differences between ethnic groups in rates of specific disorders were not statistically significant. However, depression appeared to be more prevalent among Black women, while panic disorder appeared to be more prevalent among women in Black, Asian and mixed or other ethnic groups. Conclusions about any apparent but non-significant differences in rates should not be made without further evidence. [Table 2.7](#)

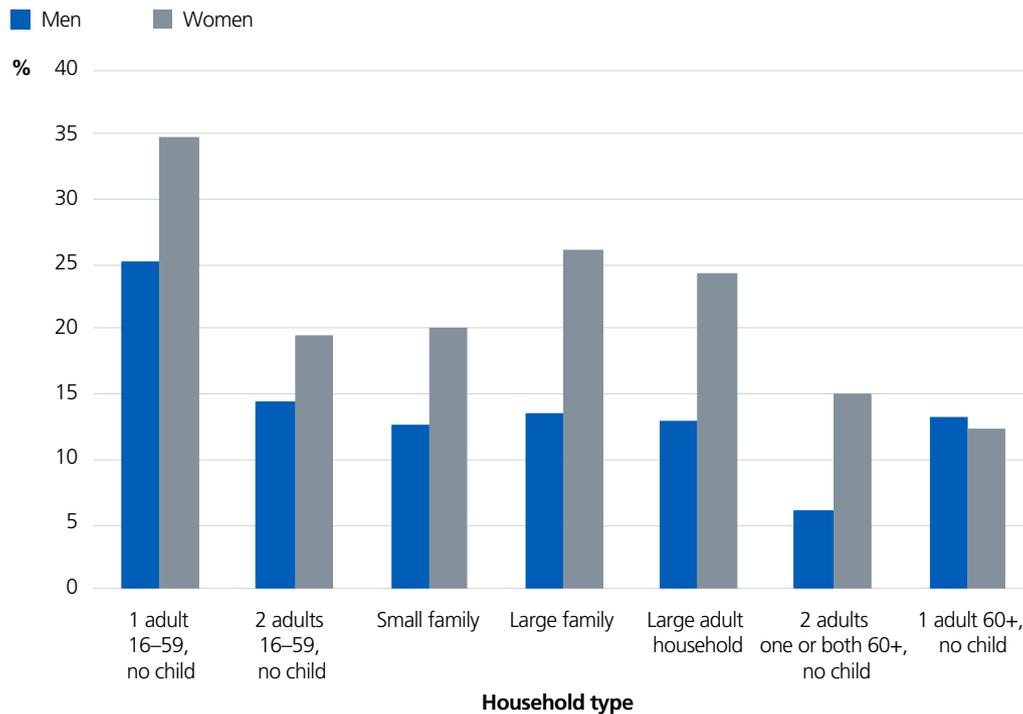
Household type

Adults aged between 16 and 59 who lived alone were significantly more likely to have CMD than people who lived with others. A quarter of men (25.5%) and a third of women (35.0%) aged less than 60 who lived alone were assessed as having a CMD, compared with 13.2% of all men and 20.7% of all women.

Differences between the sexes in the prevalence of CMD were most noticeable in large family households, large adult households, and older couple households. The overall prevalence of CMD in women who lived in large family households was 26.4%, compared with 13.7% of men who lived in such households; in large adult households it was 24.6% of women and 13.1% of men; and in older couple households it was 15.1% of women and 6.1% of men. [Table 2.8](#)

Figure 2K: Prevalence of common mental disorder (CMD), by household type and sex

Base: all adults



Employment status

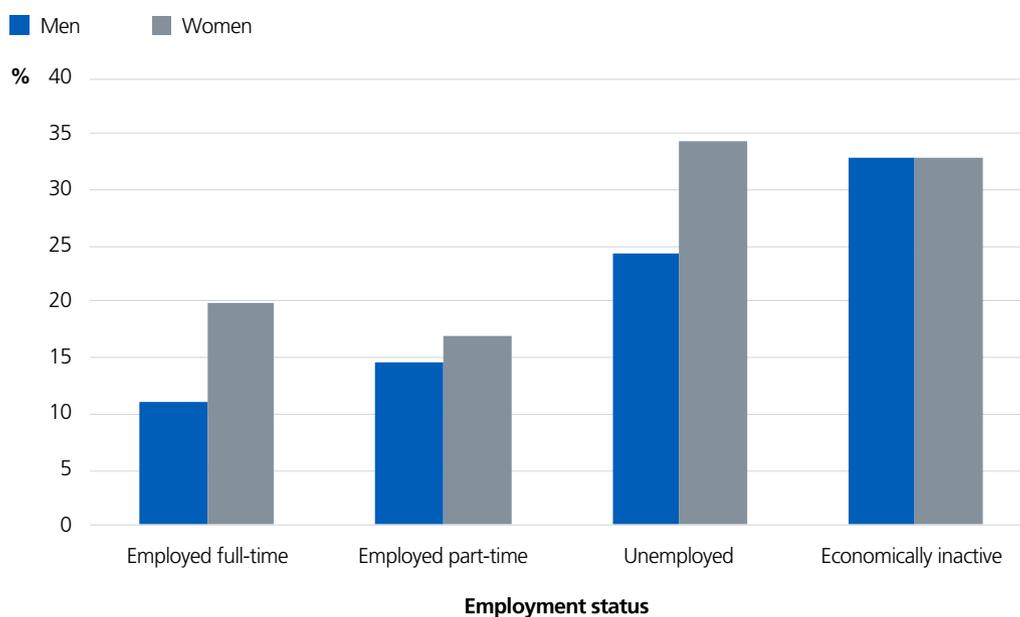
Employed adults were less likely to have a CMD than those who were economically inactive or unemployed. There was no difference in the overall prevalence of CMDs between those in full-time and in part-time employment.

Using age-standardised figures, the CMD rate in employed people aged 16 to 64 was half that of their non-employed counterparts (14.1% of those in full-time employment and 16.3% of those in part-time employment, compared with 28.8% of unemployed people looking for work, and 33.1% of the economically inactive).

Women in full-time employment were twice as likely to have CMD as full-time employed men (age-standardised 19.8%, compared with 10.9% respectively). Unemployed women were also more likely to have CMD than unemployed men (34.6% of women and 24.5% of men). However, there was no significant difference in prevalence between men and women employed part-time (14.7% and 16.9% respectively), nor was there a difference between economically inactive men and women (33.1% and 33.0% respectively). [Table 2.9](#)

Figure 2L: Prevalence of common mental disorder (CMD), by employment status (age-standardised) and sex

Base: adults aged 16–64



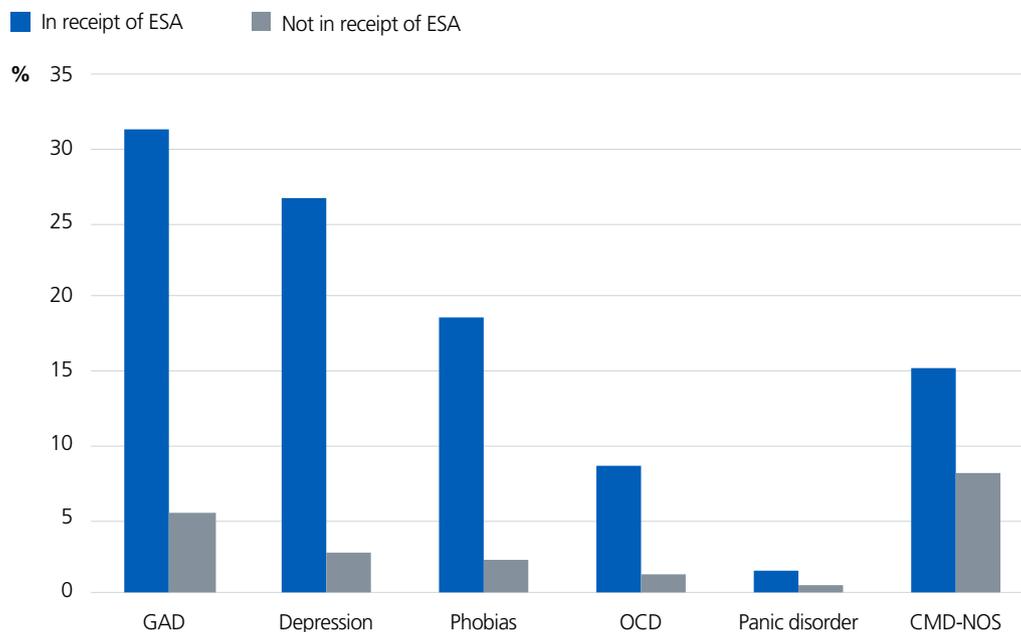
Benefit status

There were very large differences in the prevalence of CMD between those in receipt of particular benefits and those who were not. This was true for all types of CMD. Patterns of prevalence were similar for men and women and are discussed below in terms of their age-standardised rates.

Two-thirds of adults aged 16 to 64 in receipt of Employment and Support Allowance (ESA, a disability-related out-of-work benefit) had a CMD (66.1%), compared with one in six adults not in receipt of this benefit (16.9%). More than four in five women in receipt of ESA had a CMD (81.0%), compared with one in five (21.1%) of those not in receipt. GAD (41.1%), phobias (31.2%) and depression (28.5%) were all particularly prevalent among female ESA recipients, as were GAD (24.3%) and depression (25.3%) for men. [Table 2.10](#)

Figure 2M: Prevalence of common mental disorders (CMDs), by receipt of Employment and Support Allowance (age-standardised)

Base: adults aged 16–64



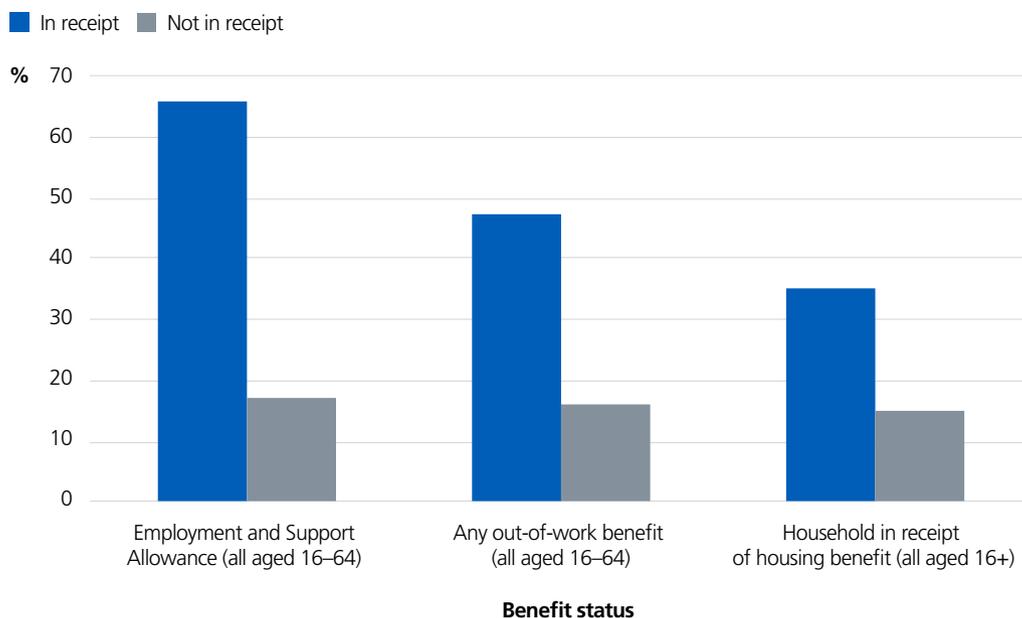
Out-of-work benefits include those aimed at people who are unemployed and looking for work, such as Jobseeker’s Allowance, as well as those aimed at people who are out of work for reasons of illness or disability, such as ESA. Hence figures for those in receipt of any out-of-work benefit reflect a combination of those shown in Table 2.9 for unemployed adults and those in Table 2.10 for adults in receipt of ESA.

Almost half of adults aged 16 to 64 in receipt of some kind of out-of-work benefit were identified as having a CMD (age-standardised 47.4%, compared with 15.8% of those not in receipt of such benefits). Differences in prevalence between those in receipt and those not in receipt of out-of-work benefits were statistically significant for each of the six types of CMD.

Housing benefit is available to certain low-income households to help with rent payments. It is not restricted to those of working age. The prevalence of CMD among those in receipt of housing benefit was more than twice that among those not in receipt of it (age-standardised 35.1%, compared with 14.9% of those not in receipt). [Table 2.10](#)

Figure 2N: Prevalence of common mental disorder (CMD), by receipt of benefits (age-standardised)

Base: adults aged 16–64/all adults



Region

CMDs were more prevalent in certain regions of England. This was driven partly by differences in the prevalence of the less common disorders, OCD and panic disorder, as well as by CMD-NOS. Rates of CMD were highest in the South West of England (age-standardised 20.9%), North West (19.0%), West Midlands (18.4%) and London (18.0%). They were lowest in the South East (13.6%) and East of England (14.4%).

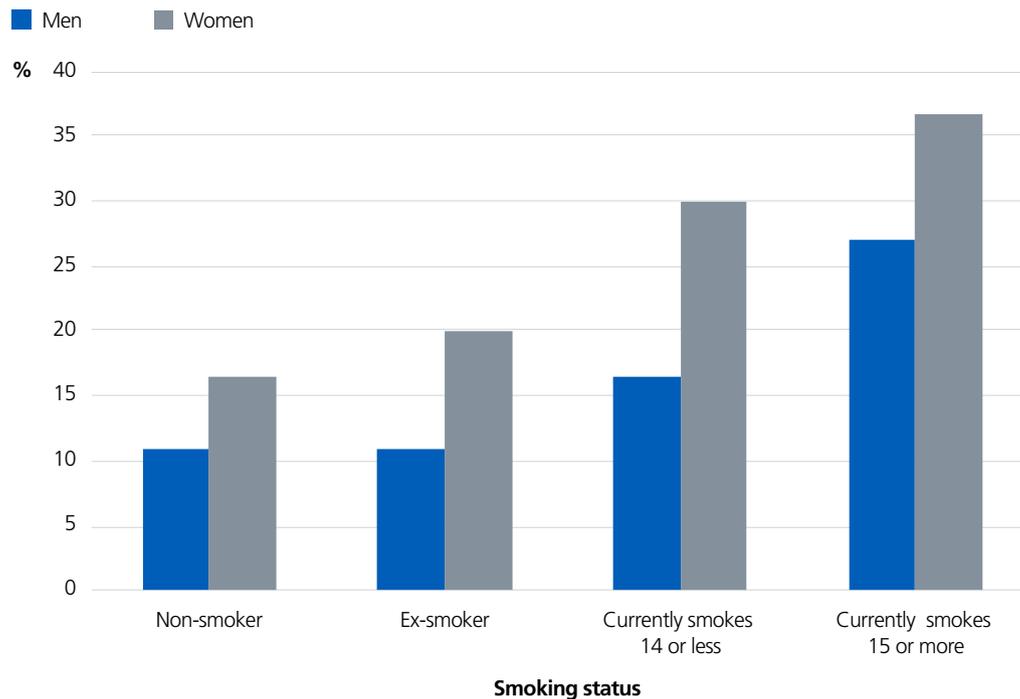
The prevalence of panic disorder was 1.3% in the North West, 0.9% in the South West, 0.8% in London, and 0.5% or less in other regions (age-standardised figures). OCD was particularly prevalent among women in the East Midlands, compared with other areas (age-standardised 4.4% in the East Midlands, 2.5% in the South West, and 1.6% or less in other regions). CMD-NOS were most common in the South West (age-standardised 9.8%) and the West Midlands (9.3%), and least common in the South East (5.4%), the East of England (5.6%) and the North East (5.9%). [Table 2.11](#)

Cigarette smoking status

Smokers were significantly more likely than non-smokers to have a CMD. Among smokers, those smoking 15 or more cigarettes a day were more likely to have a CMD than those who smoked fewer (age-standardised prevalence: 14.1% of those who had never smoked and 15.2% of ex-smokers had a CMD, compared with 23.3% of those smoking fewer than 15 cigarettes a day and 31.3% of those smoking 15 or more). A similar pattern among smokers and non-smokers was present when looking at the prevalence of each type of CMD (although not all differences were significant). [Table 2.12](#)

Figure 2O: Prevalence of common mental disorder (CMD), by smoking status (age-standardised)

Base: all adults



2.4 Discussion

CMDs are among the most prevalent health conditions affecting people in the UK. The one week prevalence rates reported in this chapter suggest around one in six adults in England has a CMD at any one time. Around half of these have symptoms severe enough to warrant active intervention, and the rest would likely benefit at least from clinical recognition. The most prevalent of the CMDs was CMD-NOS, identified in 7.8% of adults, followed by generalised anxiety disorder (GAD) (5.9%), depression (3.3%), phobias (2.4%), obsessive compulsive disorder (OCD) (1.3%) and panic disorder (0.6%).

As in previous studies, rates of CMD were higher in women than men. Prevalence was also higher for both men and women in 2014 than in 1993. However, while prevalence remained broadly stable between 2000 and 2014 for men, there has been a steady increase among women. 20.4% of women were identified with CMD in 2000, 21.5% in 2007, and 23.1% in 2014. This could represent an increased likelihood for women to report symptoms compared to men, or an increase in risk factors for CMD in women such as exposure to domestic violence (Trevillion et al. 2012), increased work and home stressors such as caring (Pinquart and Sörensen 2006), financial problems, unemployment or social isolation (Clark et al. 2012). There is evidence that the onset of recession around 2008 in the US and Europe led to increasing rates of mental disorder (Riumallo-Herl et al. 2014) and suicide (Chang et al. 2013). This is an area which requires further research (Payne and Doyal 2010).

All types of CMD (with the exception of panic disorder, which had a very low prevalence) were more common in adults of working age than in those aged 65 and above. Below the age of 65, overall rates of CMD were fairly constant, at around 18% to 19%. Prevalence among those aged 75 and above was half this rate (8.8%). Although this was similar to the findings in the 2007 survey, it is striking that older people suffer much lower rates of mental disorder than their younger counterparts (Streiner et al. 2006), despite the increasing social isolation and poorer physical health that ageing may bring (Luanaigh and Lawlor 2008). Rates of dementia complicate the picture of mental health in this older group. Nevertheless, this relatively lower level of CMD is reassuring, given that older adults with mental health problems incur greater disability than those with physical illness alone (Bartels and Naslund 2013).

Compared with previous years, CMD rates in those aged 55 to 64 have increased (Spiers et al. 2011). One interpretation of this may be that the recession, which began in 2008, has had more of an impact on the mental health of adults approaching retirement than of those who had already reached retirement age. Those currently aged less than 65 also face different uncertainties about the future in relation to extended working lives. Various chapters show evidence of a cohort effect, with those currently aged 55 to 64 reporting levels of disorder potentially higher than that of 55 to 64 year olds in previous surveys in the APMS series.

This chapter also presents data that suggests a recent increase in prevalence of CMD among young women, from 22.2% in 2007 to 28.2% in 2014. The sample size for this subgroup was small, and the apparent change in rate did not quite reach statistical significance, however it is consistent with trends reported elsewhere and warrants more detailed investigation (Knudsen 2016; Lessof et al. 2016). This is the first cohort to come of age in the context of social media. There is some limited evidence on links between mental illness and social media exposure (Primack et al. 2009) and that excessive use of computers and mobile phones may be linked to a higher risk of mental disorder in young women, possibly mediated by sleep loss (Thomé et al. 2012). There is also some research on use of the Internet and mental distress in women (Derbyshire et al. 2013), but this is an area that needs further research.

CMDs were more prevalent in certain groups of the population. These included Black women, adults under the age of 60 living alone, women living in large households, adults who were not in employment or who were in receipt of benefits and those who smoked cigarettes. These associations are in keeping with increased social disadvantage and poverty being associated with increased risks of CMD (Cooper 2011; Gabbay et al. 2015). There is scope for further research and social intervention here (WHO 2014). Although we confirmed the well-known association between lack of paid employment and CMD, we found no significant association with part-time working. There has been some concern in the UK in recent years about part-time and zero hours contracts. However, our evidence would suggest that less than full-time working is not necessarily a risk factor for poor mental health. This is notable given other UK evidence that poor mental health may induce people to work fewer hours (Dawson et al. 2015). What may matter even more is working excessive hours (Kleiner et al. 2015).

Most of the participants identified with CMD using the survey assessment recognised that they had a CMD. Just under two-thirds also said that they had, at some point, been diagnosed with a CMD by a professional. This adds weight to the use of diagnostic measures of mental health and suggests that surveys such as this are using criteria that accord with participants' experiences.

Nevertheless, the symptoms identified by the survey instrument did not always match the diagnoses participants reported being given by professionals. Most of those reporting some kind of professional CMD diagnosis said that they had been diagnosed with depression or panic attacks. It is likely that this reflects the language used by people when discussing their mental health with professionals, and reflects people's understanding of their own experiences of mental illness. When doctors and patients talk about mental health, it is likely that they use widely understood terms and symptoms such as 'depression' and 'panic attacks'. That is to say, any differences between disorders identified by the CIS-R and disorders that people report having been diagnosed with, does not necessarily mean that people have been misdiagnosed.

2.5 Tables

Prevalence and trends

Table 2.1	Severity of symptoms of common mental disorder (CMD), by age and sex
Table 2.2	Severity of CMD symptoms (CIS-R score) in 1993, 2000, 2007 and 2014, by age and sex
Table 2.3	CMD in past week, by age and sex
Table 2.4	CMD in past week in 1993, 2000, 2007 and 2014, by age and sex
Table 2.5	CMD in past week, by CIS-R score
Table 2.6	Self-diagnosed CMD, professional diagnosed CMD, and presence of professional diagnosed CMD in past 12 months, by CMD in past week

Characteristics

Table 2.7	CMD in past week (observed and age-standardised), by ethnic group and sex
Table 2.8	CMD in past week, by household type and sex

- Table 2.9 CMD in past week (observed and age-standardised), by employment status and sex
- Table 2.10 CMD in past week (observed and age-standardised), by benefit status and sex
- Table 2.11 CMD in past week (observed and age-standardised), by region and sex
- Table 2.12 CMD in past week (observed and age-standardised), by cigarette consumption and sex

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