Introduction

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1.1 Policy context

Poor mental health has enormous economic and social impact. Mental illness is one of the largest single causes of disability (OECD 2014) and sickness absence in the UK (CMH 2010), accounting for 70 million sick days in 2007 (CMH 2007). On average, people with mental illness die 15 to 20 years earlier than those without (Thornicroft 2013; DH 2015). Yet while mental illness accounts for 28% of the national disease burden in England, only 13% of NHS spending is on mental health care (DH 2013).

In recent years there has been a strong policy narrative, with cross-party support, calling for a ‘parity of esteem’ in health service response to physical and mental illness. The Chief Medical Officer’s 2013 report, *Public Mental Health: Investing in the Evidence*, states that despite a welcome policy focus on mental illness, there has been a real-terms fall in investment (DH 2014). Previous APMS data has tended to find that, at any one time, about three-quarters of people with mental illness are in receipt of no treatment at all.

In key aspects, such as community outreach and early intervention, the provision of mental health services in England has been identified as among the best in Europe (WHO 2008). However, the independent Mental Health Taskforce to the NHS has highlighted that people living with mental health problems still experience stigma and discrimination, many people struggle to get the right help at the right time, and evidence-based care is significantly underfunded (2016). There is a need for prevention efforts and for closer working between primary care, social and occupational health services (GOS 2008). Furthermore, it is also recognised that little is known specifically of the prevalence and effects in adulthood of disorders better recognised in children, including attention-deficit/hyperactivity disorder (ADHD) and autism.

*No Health without Mental Health* is a cross-government mental health outcomes strategy for people of all ages (DH 2011a). It was launched in 2011 and aimed to ‘mainstream mental health’. It highlighted six overarching objectives:

- More people will have good mental health
- More people with mental health problems will recover
The strategy highlights the role of Improving Access to Psychological Therapies (IAPT) (DH 2011b) in improving outcomes in mental health. It also re-states the Government’s commitment to removing inequalities in access to services and to improving the lives of people with mental illness.

1.2 Survey background

The Psychiatric Morbidity Survey series provides key context for understanding mental illness in England and for informing initiatives in this area. The survey series has run since the early 1990s and covered a range of general population groups, including:

- Adults living in private households: aged 16 to 64 in 1993 (Meltzer et al. 1995), aged 16 to 74 in 2000 (Singleton et al. 2001), and 16 and over in 2007 (McManus et al. 2009)
- Residents of institutions providing care and support to people with mental health problems (Meltzer et al. 1996)
- Homeless adults (Gill et al. 1996; Kershaw et al. 2000)
- Adults with a psychotic disorder (Forster et al. 1996; Singleton and Lewis 2003)
- Prisoners and young offenders (Melzer et al. 2000; O’Brien et al. 2001; Lader et al. 2000)
- Young people in local authority care (Meltzer et al. 2004)
- Children and adolescents (Green et al. 2005; Clements et al. 2008) (with a new survey of children from age 2 to 19 currently being planned), and
- Carers (Singleton et al. 2002).
The 2014 Adult Psychiatric Morbidity Survey (APMS) is the fourth survey of psychiatric morbidity in adults living in private households. It was carried out by NatCen Social Research in collaboration with the University of Leicester, and was commissioned by NHS Digital (formerly the Health and Social Care Information Centre, HSCIC). The survey series is supported by psychiatrists and epidemiologists working in a number of UK universities.

APMS 2014 retains the same core questionnaire content and methodological approach as the 1993, 2000 and 2007 surveys to enable the examination of trends. The latest survey also included some new topics to reflect emerging policy priorities. In summary, the distinguishing attributes of the most recent two household surveys (2007 and 2014) were that they:

- Were conducted in England only
- Had no upper age limit for participation
- Were in the field over the course of a whole year, and
- Included additional conditions (such as bipolar disorder) and risk factors (such as experience of childhood neglect).

See Chapter 14, Methods, for details of topic coverage and a list of the differences across the surveys series. The full phase one questionnaire is in Appendix D.

1.3 Survey aims

The main aim of the survey series is to collect data on poor mental health among adults (aged 16 and over) living in private households in England. The specific objectives include:

- To estimate the prevalence of psychiatric morbidity according to diagnostic category in the adult household population of England. The survey includes assessment of common mental disorders, psychosis, autism, substance misuse and dependency, and suicidal thoughts, attempts and self-harm.
- To screen for attention-deficit/hyperactivity disorder (ADHD), posttraumatic stress disorder (PTSD), bipolar disorder and personality disorders.
• To examine trends in the psychiatric disorders that were included in previous survey years (1993, 2000, and 2007).

• To identify the nature and extent of social disadvantage associated with mental illness.

• To gauge the level and nature of treatment and service use in relation to mental health problems, with an emphasis on primary care.

• To collect data on key current and lifetime factors that might be associated with mental health problems, such as the experience of stressful life events, abusive relationships, and work stress.

• To collect data on factors that might protect against poor mental health, such as social support networks and neighbourhood cohesion.

1.4 Overview of the survey design

Fieldwork was carried out between May 2014 and September 2015. As with the preceding surveys, a two-phase approach was used for the assessment of several disorders.

The first phase interviews were carried out by NatCen Social Research interviewers. These included structured assessments and screening instruments for mental disorders, as well as questions about other topics, such as general health, service use, risk factors and demographics. These interviews lasted about an hour and a half on average.

The second phase interviews were carried out by clinically-trained research interviewers employed by the University of Leicester. A sub-sample of phase one respondents were invited to take part in the second phase interview to permit assessment of psychotic disorder, attention-deficit/hyperactivity disorder and autism. The assessment of these conditions requires a more detailed and flexible interview than was possible at the first phase, and the use of clinical judgement in establishing a diagnosis.
1.5 Summary of strengths and limitations

Details of and rationale for the sample design and methods are provided in Chapter 14. In summary, benefits of this study design include that:

- By sampling from the general population rather than from lists of patients, APMS data can be used to examine the ‘treatment gap’.

- The use of validated mental disorder screens and assessments allows for identification of people with sub-threshold symptoms and those with an undiagnosed disorder.

- The questionnaire collects details of social and economic circumstances, information which does not tend to be collected in a consistent or comprehensive way in administrative datasets.

- The use of a computer assisted self-completion module to cover the most sensitive topics means that the survey includes information that some participants may have never disclosed before.

- At the end of the survey a question is asked about permission for follow-up and data linkage. The study therefore presents an opportunity for longitudinal data collection and a sampling frame that allows a random sample of people with very specific experiences, who may not otherwise have been identifiable, to be invited for further research.

- The APMS dataset is being deposited at the UK Data Service and is designed to be suitable for extensive further analysis. There is only scope for a small part of the data collected to be covered in this report.

Surveys such as APMS, however, are subject to a number of limitations. These include:

- The sampling frame covers only those living in private households. Those living in institutional settings such as care homes, offender institutions, prisons, or in temporary housing or sleeping rough, would not have had a chance to be selected. People living in such settings are likely to have worse mental health than those living in private households.
• Some people selected could not be contacted or refused to take part. Adults with severe mental health problems who do live in private households may be less available or willing to respond to surveys.

• Some people selected were not able to take part in a long interview. These include those with serious physical health conditions or who were staying in hospital, and those whose mental capability may be impaired.

• Survey assessments of mental illness are not as reliable as a clinical interview. In a clinical interview, a trained psychologist or psychiatrist may take many sessions and clinical judgement to reach a diagnosis. In the context of a questionnaire administered by a lay interviewer, this is not possible. However, the assessments used have been validated and are among the best available for the purpose in hand. Rather than focus on the prevalence estimated for each disorder, the greater value of the survey is being able to examine how rates vary over time and between groups in the population.

• For low prevalence disorders, the number of positive cases in the sample is small which limits the scope for subgroup analysis. Confidence intervals for key estimates are provided in the methods chapter (Chapter 14).

1.6 Coverage of this report

Each of the main disorders and behaviours covered by APMS 2014 is discussed in a separate chapter. The chapters compare disorder rates by age, sex, ethnicity, employment and benefit status, region, household composition, and the level and nature of mental health treatment and service use. Where disorders were also covered in the 1993, 2000 and/or 2007 surveys, changes in rates are also considered. The tables for each chapter are provided in a separate spreadsheet. Further analyses of the data are planned.

Publications based on data collected in the previous surveys in the series are listed in Appendix A.
1.7 Access to the data

A copy of the anonymised 2014 APMS dataset will be deposited at the UK Data Service, and made available for specific research projects. The dataset will be accompanied with guidance on its use. Information on data access is available at the Data Service website. A list of the derived variables used in this report can be found in Appendix C.

1.8 Ethical clearance

Ethical approval for APMS 2014 was obtained from the West London National Research Ethics Committee.1

1.9 Further information

Further information about the adult psychiatric morbidity survey series is obtainable from a range of websites:

- UK Data Service – [https://discover.ukdataservice.ac.uk/series/?sn=2000044](https://discover.ukdataservice.ac.uk/series/?sn=2000044)
- Academic – [https://mentalhealthsurveys.org](https://mentalhealthsurveys.org)

1.10 References


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1 Ethical approval reference number 14/LO/0411.


The independent Mental Health Taskforce to the NHS in England (2016) *The Five Year Forward View for Mental Health.*
