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Research report

The treatment of common mental disorders across age groups: Results from the 2007 adult psychiatric morbidity survey

Claudia Cooper [a,*], Paul Bebbington [a], Sally McManus [b], Howard Meltzer [c], Robert Stewart [d], Michael Farrell [e], Michael King [a], Rachel Jenkins [d], Gill Livingston [a]

[a] UCL Department of Mental Health Sciences (Bloomsbury campus), 67-73 Riding House Street, 2nd Floor, Charles Bell House, London W1W 7EJ, UK
[b] NatCen, 35 Northampton Square, London EC1V 0AX, UK
[c] Department of Health Sciences, University of Leicester, UK
[d] Institute of Psychiatry, Box P035, De Crespigny Park, London, SE5 8AF, UK
[e] National Addiction Centre, BOX 78, Institute of Psychiatry, 4 Windsor Walk, London SE5, UK

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ABSTRACT

Background: We investigated for the first time in a national survey whether older people were less likely than younger adults with the same symptom severity to receive treatment for Common Mental Disorders (CMD).
Method: We analysed data from the 2007 English Adult Psychiatric Morbidity Survey, representative of people living in private homes. 7461 (57%) people approached took part. We used the revised Clinical Interview Schedule to measure CMD symptom severity.
Results: Older participants were less likely than younger adults to receive talking therapy and to have seen their GP in the last year about mental health, and more likely to receive benzodiazepines, after adjusting for CMD symptoms. Adults aged 35–74 were the most likely to take antidepressants. There was also preliminary evidence that people from non-white ethnicities were less likely to be taking antidepressants and to have seen their GP in the last year about their mental health.
Limitations: We only recorded current treatment, and it is possible that older adults were less likely to be receiving treatments they had found unhelpful earlier in their lives. We asked people whether they had seen their GP about a mental health problem in the last year, but this question may not have detected those who attended for somatic manifestations of their anxieties.
Conclusions: Older people are less likely to receive evidence-based treatment for CMD. Managers and clinicians should prioritise reducing this inequality.

1. Introduction

The forthcoming UK Equality Bill requires that access to health and social care services should be based on need, and not discriminate on grounds of age, race, religion or other personal characteristics (House of Commons, 2009). There is concern in all Western countries that people from older age groups with mental health problems are less likely to receive treatment, but treatment rates have never been compared using data from a national population survey. In 2009, the UK Healthcare Commission identified challenges to implementing the Equality Bill in mental health, including "a lack of awareness of the mental health needs of older people and proper diagnosis in primary care" and "variable quality and availability of some services", including psychological therapies (Healthcare Commission, 2009). It has been estimated that eliminating age discrimination from UK mental health services would require additional expenditure of £2.0 billion (Beecham et al., 2008).

* Corresponding author. Tel.: +44 207 288 5931.
E-mail address: c.cooper@ucl.ac.uk (C. Cooper).

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Beliefs that common mental disorders (CMDs) in older people are a natural consequence of ageing, physical illness, isolation, bereavement or other losses may prevent their active treatment. This is concerning, because CMDs in older people impact on quality of life, and are related to greater cost of care, obesity (Kivimaki et al., 2009), and worsening physical illness (Han, 2002), as well as attempted and completed suicide (NHS, 2009b). In USA and Australian national surveys, older adults with mental health problems were less likely to be in receipt of specialist mental health care, compared with those in middle age (Bogner et al., 2009; Burgess et al., 2009; Neighbors et al., 2007). In the Adult Psychiatric Morbidity Survey (APMS) 2000, which included adults aged 16–74, older men used less mental health services than younger men, although no such difference was identified in women (Beecham et al., 2008; Jenkins et al., 2009). In a UK study, primary care doctors were less likely to refer patients aged 65+ who were depressed to specialist services, but no less likely to prescribe antidepressant medication (Kendrick et al., 2009).

There is good evidence that psychological therapies are effective treatments for CMDs (such as anxiety and depressive disorders). Antidepressants are recommended for treatment of moderate and severe depression (National Institute for Clinical Excellence (NICE), 2007). Their prescription rates in primary care increased between 1993 and 2000 in a British survey, as did those of hypnotics and anxiolytics (mainly benzodiazepines) (Brugha et al., 2004). In the current study, we investigated whether receipt of medication and psychological treatment for CMD differs across age groups using data from a national probability survey, while controlling for level of neurotic (anxiety and depressive) symptoms.

2. Methods

2.1. Procedures

The third Adult Psychiatric Morbidity Survey was carried out in England in 2007. The interviewers underwent one day of survey-specific training that included introducing the survey, questionnaire content, confidentiality and managing respondent distress, and were provided with full sets of written instructions. Interviews took place in participants' homes. The structured assessments were conducted using laptops, which interviewers used to enter data. All interviewers were accompanied by a project supervisor during the early stages of their fieldwork to ensure that the interviews were administered correctly. Routine supervision of 10% of interviewer work was subsequently carried out.

The survey was designed to be representative of people living in private households. The sampling frame was the Small User Postcode Address File. The Primary Sampling Units (PSUs) were postcode sectors. The population was stratified before sampling by region (Strategic Health Authorities) and manual and non-manual socio-economic grouping. In households with more than one adult aged 16 or over, one adult was randomly selected for interview. More details are available in the APMS main report (The NHS Information Centre for Health and Social Care, 2009).

Ethics approval for APMS 2007 was obtained from one of the Research Ethics Committees of the National Research Ethics Service appropriate for non-clinical populations. In line with standard British ethics guidance on non-clinical populations, only verbal permission was required once the project had been fully described to potential respondents, both verbally and in leaflets. Respondents could rescind their permission to use their data at any time.

2.2. Measures

Participants were asked standardised questions about age, sex, marital status, ethnic origin, highest educational qualifications and tenure (whether they owned or part-owned, or rented their home). The revised Clinical Interview Schedule (CIS-R) was completed. This measures neurotic symptoms and disorders, such as anxiety and depression. It provides an overall score for the level of neurotic symptoms. A score of 12+ indicates the presence of a CMD. Reliability and validity are reported (Jordanova et al., 2004; Lewis et al., 1992).

Participants were shown a card with a list of medication and asked to indicate if they were taking any of them. The interviewer then asked to see the packaging of any medication to verify the name. We asked about: 13 commonly prescribed antidepressants; diazepam, temazepam and nitrazepam (hypnotics), lorazepam, diazepam, chlordiazepoxide and buspirone (anxiolytics). Participants were also asked whether they were having any type of talking therapy, in primary care, secondary care or with a private practitioner.

Participants were asked which, if any, of seven ADLs they needed help with, and the total number recorded. The ADLs were: personal care; mobility; medical care such as taking pills, having injections or changes of dressing; preparing meals, shopping, laundry and housework; practical activities such as gardening, decorating, or household repairs; dealing with paperwork; and managing money. This was developed from a previous measure (Bebbington et al., 2000).

Participants were asked whether, in the last year, they had spoken to a primary care doctor, in person or by telephone, about being anxious or depressed or having a mental, nervous or emotional problem. They were asked to exclude telephone calls to NHS direct.

2.3. Data analysis

The survey data were weighted to represent the national population by taking account of age, sex and region, different sized households, and the different characteristics of responding and non-responding households. The likelihood of a household responding to the survey was not associated with the following area-level variables: Index of Multiple Deprivation quintiles, population density (number of persons per hectare), percentage of persons of non-white ethnic background, and the percentage of adults in a non-manual occupation. Response rate did vary by region, with a lower propensity for a household to respond in the West Midlands, East of England, London, South East and the SouthWest (relative to the NorthEast), and was higher in areas where a relatively high percentage of households were owner-occupied; and in households with no physical barriers to entry to the property (as observed by interviewers). These variables were included in a logistic regression model, from which a household level weight was calculated for responding and