

## 6.1 Introduction

Whether someone with a common mental disorder receives appropriate treatment depends on a number of factors that include willingness to seek help (Goldberg and Huxley, 1992), the ability of professionals to recognise the disorder (Paykel and Priest, 1992), knowledge about and application of evidence based treatments (Kendrick 2000) and preparedness to accept treatment (Lin and Parikh, 1999). Studying how people access treatments and whether they are effective is complex and depends on data from a mix of cohort and experimental studies. The national surveys of psychiatric morbidity among adults living in private households in Great Britain (Meltzer *et al*, 1995; Singleton *et al*, 2001) present an opportunity to study the factors that determine which people with common mental disorders access primary or secondary care treatment services (Bebbington *et al*, 2000a and b).

The main predictors of whether people with common mental disorders had sought primary care services in the 1993 survey were: severity of neurotic symptoms; degree of social dysfunction; and a number of demographic factors such as sex, marital status, age and employment (Bebbington *et al*, 2000b). However 74% of men and 60% of women with a common mental disorder had not consulted their general practitioners for a mental complaint and less than 30% of those who did so were actually receiving treatment. The picture with regard to receipt of psychiatric treatment was similar; just over one quarter of people with a diagnosis of depression were receiving any form of psychiatric treatment, while one-fifth were prescribed medication. Corresponding figures for other common mental disorders such as anxiety were only 11% and 8% respectively (Bebbington *et al*, 2000b). The main factor predicting receipt of treatment was severity; sex and social class were not determinants.

Evidence on who receives treatment has also arisen from a number of population surveys in Europe and North America (ten Have *et al*, 2001). All have

analysed the relationship between care utilisation and mental health problems while taking account of functional ability, and social and demographic factors. Only one has managed to differentiate factors that predict take-up of new treatments or use of services for the first time from factors that predict current or frequent treatments (ten Have *et al*, 2001). Results of two waves of the NEMESIS study revealed that indicators of new use of care were quite different to those of frequent use of care. The main predictors of new care use were lower education and receiving treatment for a physical disorder. Predictors of receiving new and frequent care were female sex, greater restriction of activity, poorer social function and unmet care needs (ten Have *et al*, 2001).

The current longitudinal study provides an opportunity for studying associations between mental disorders and treatments received that has advantages over earlier cross-sectional research (Bebbington *et al*, 2000a and b). We can investigate receipt of treatment in relation to the longitudinal course of disorder. It is also possible to study associations between treatment and outcome. However, it is well known that such associations cannot provide evidence on the effectiveness of treatments. This is because clinicians do not randomly allocate treatments but reserve them for the most severely ill who tend to have a worse outcome. However, this analysis can be used to see if treatments are being successfully targeted on those people with the poorest outcome.

As well as describing the pattern of treatment and health service use by people with common mental disorder and people who have alcohol problems or have used illicit drugs, the analysis presented here aimed to determine:

- a) the factors associated with receipt of treatments and services for people with psychological distress at the time of first interview (T1);
- b) whether recovery was associated with receipt of treatment at time T1; and

- c) the extent of respondents' needs for psychiatric treatments and the extent to which these were met.

- General practice contacts for mental health reasons for the two weeks prior to T1 and/or at any time between T1 and T2.

## 6.2 Definitions and methods

In order to achieve the first aim, two principal approaches to the data were taken. Firstly, the associations between the presence of a common mental disorder (score on or above a threshold of 12 on the CIS-R) at T1 and the treatments participants reported that they received were examined. One immediate difficulty was to define over what time period such data should be applicable. In order to take account of all possible interventions, treatments and service contacts reported by respondents at T1 and at follow-up (T2) were both included. Thus a patient might report a treatment or service contact at T1 and the same at T2, or just contacts at either T1 or T2. The time periods covered for each type of contact were those thought to be most accurately recalled, but it must be emphasised that they differ in duration and not all cover the whole time elapsed between interviews. Coverage and content of treatments and service contacts were as follows:

- Treatment was defined as psychotropic medication (any medication in classes 4.1, 4.2 and 4.3 of the British National Formulary, ie hypnotics and anxiolytics; drugs used in psychoses and related disorders; and antidepressant drugs) and psychological therapies, such as counselling or psychotherapy. Data were available for all current treatments at each interview, but were not available for the whole 18-month period between interviews.
- Service contacts were defined as:
  - Inpatient hospital stays or outpatient/day patient<sup>1</sup> psychiatric contacts in the three months prior to T1 and/or the three months prior to T2.
  - Day care service<sup>1</sup> contacts in the three months prior to T1 and/or at any time between T1 and T2.
  - Community care contacts in the three months prior to T1 and/or at any time between T1 and T2.

Secondly an analysis was carried out to determine the factors associated with receipt of treatment or services as defined above and report unadjusted Odds Ratios for each of these, as well as Odds Ratios adjusted for age and CIS-R score at T1.

In order to address the second aim, the data on treatments and services received at T1 were combined into one variable in order to examine whether treatment at T1, broadly classified in this manner, was associated with recovery at follow-up after controlling for socio-demographic and other confounders. Recovery was defined in symptom terms as those people who scored above the threshold of the CIS-R at T1 but no longer did so at T2, as in Chapter 3. Thus, only participants who had a common mental disorder at T1 were considered in this analysis. First the proportions recovering among those who reported receiving at least some treatment were compared with those who did not. Then socio-economic factors, CIS-R scores at T1 and receipt of treatment at T1 were entered into a multivariate model to predict recovery, using logistic regression. In this way, the independent effect of treatment on recovery could be examined.

The level of need for treatment and the extent to which these needs are being met has been addressed using the second-stage telephone interview data. These interviews were conducted by eleven junior doctors using the community version of the MRC Needs for Care Assessment (NFCAS-C). Clinical judgement is used to assess whether a clinical problem exists in one of seven areas of function. If so, need is defined in terms of appropriate actions to be taken by clinicians in the categories: met need; unmet need; no need; and no meetable need. The category 'no meetable need' includes those who have a potential need but have refused treatment or would refuse it if offered. The assessment also provides information on over-provision. Further details of these assessment procedures are provided in Chapter 1.

### 6.3 Extent of treatment and service provision

In this chapter we examine treatments received, and service contacts made, by people with common mental disorder over 18-24 months. This provides a longer-term perspective than the cross-sectional assessments conducted to date in the two national surveys of psychiatric morbidity. However, the proportion of people reporting service contacts in primary and secondary care or receiving treatments throughout the follow-up period remained similar to those reported at T1 (Singleton *et al*, 2001).

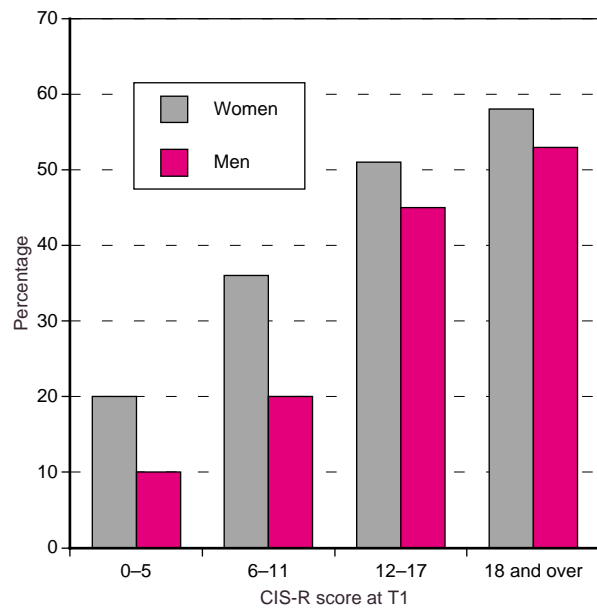
Nearly a quarter of the population (23%) had received some treatment or services for a mental health problem either at T1 or T2. Some sort of treatment, either psychoactive medication or some sort of psychological therapy or counselling, was reported by 11% of people. The most commonly used services were the GP or family doctor (mentioned by 13% of people) and community care services (10%), while 1% or less had used out-patient, in-patient or day care services during the period under consideration. Women were more likely to have received treatment or used services of all types than men: 29% of women had received either treatment or services compared with 17% of men. (Table 6.1)

People with common mental disorder at T1 were far more likely to have received treatment or services in the time period under consideration than those who did not have a disorder at that time. Just over one third of people scoring on or above the CIS-R threshold at T1 had consulted their GP for mental health reasons and one quarter to one third had received medication and/or counselling for their disorder from primary or secondary care services. People with severer psychiatric symptoms at T1 were more likely to have received some form of treatment or service contact: the proportion of people receiving any service or treatment rose from 15% of those scoring 0-5, to 29% of those scoring 6-11, 48% of those with scores of 12-17 and 56% of those with scores of 18 or above on the CIS-R.

(Table 6.1 and Figure 6.1)

In general, those with persistence of psychiatric disorder over the 18 months were most likely to have received some form of treatment or service contacts (62% had done so) and those who were

**Figure 6.1** Receipt of treatment at T1 or between T1 and T2 by level of CIS-R score and sex



well at both interviews least likely to have done so (15% had). Those with onset of disorder (51%) or who had recovered by T2 (42%) fell between these two extremes. Women with onset of disorder were more likely than those who had recovered at T2 to have received treatment but this was not true for men. (Table 6.2)

Men or women with hazardous or dependent alcohol consumption, or recreational drug use were no more likely than the remainder to have received any form of assistance, although there was some indication that women drug users may have had greater service contacts. (Tables 6.3 and 6.4)

Like several other studies (eg ten Have *et al*, 2001, Katz *et al*, 1997), these results show that the presence of a psychiatric disorder is associated with receipt of treatment and use of services. However, a sizeable proportion of people still fail to receive any treatment or service, even among the more severely ill. For example, 56% of adults who scored over 17 on the clinical interview schedule at T1 (a level usually associated with people treated in secondary care) reported that they received no assistance whatever. It is also noteworthy that only a fraction of men and women with alcohol dependence are accessing care. Although a similar pattern emerges for recreational drug use, our data are less clear about when such use was problematic or when treatment might have been indicated.

## 6.4 Factors associated with reporting treatment or service contacts

### *Socio-demographic factors*

The descriptive tables presented so far merely indicate who had been in receipt of treatment or in contact with services, without always taking account of their mental state at T1. Through logistic regression modelling we examined which factors predicted receipt of treatment by comparing the odds of receiving treatment in different groups of participants before and after mental state and other key factors were taken into account. Women had a greater chance of receiving any form of psychiatric treatment or service than men: 29% had done so compared with 17% of men. These increased odds of receiving treatment remained after controlling for illness severity and age. (Table 6.5)

Our finding that women are more likely than men to be in receipt of treatment and/or in contact with services is a common finding (Lin *et al*, 1996) and applies to either first or persistent use (ten Have *et al*, 2001). There are many suggested explanations, such as women's greater preparedness to accept that they have a mental health problem, talk about it or seek help.

Younger men were less likely to have been in touch with primary or secondary care services or to have received a mental health treatment, whereas age was not a factor in women. The proportion of men who had received treatment or services rose from 8% of 16- to 24-year-olds to 24% of men aged 65–74, whereas for women the corresponding figures were 29% and 30%. The increased likelihood of receiving treatment or services among older men remained after adjustment for the severity of mental disorder. Compared with men aged 16–24 years those aged 65–74 had over four times greater odds of receiving treatment (adjusted OR 4.68, 95% CI 2.10–10.42). (Table 6.5)

The greater likelihood of older men receiving help for mental health problems is a factor that has not been described for incident use of services (ten Have *et al*, 2001). This may relate to their higher use of services in general and the result that detection of mental health problems may be easier. Younger men in particular are less likely to visit their general practitioners (Goldberg and Huxley 1992).

As noted above, people with common mental disorder were more likely to be in receipt of services and treatment. There was a direct relationship between increasing levels of symptoms and receipt of treatment or services, which was seen among both men and women and did not change when age was taken in to account. Compared with people with none or very low levels of symptoms (scored 0–5 on the CIS-R), the odds of receiving treatment rose to 2.31 (95% CI 1.77–3.00) among those scoring 6–11, 5.38 (95% CI 3.94–7.34) among those scoring 12–17 and to 7.49 (95% CI 5.33–10.53) among those scoring 18 or above. (Table 6.5)

After adjusting for sex, age and CIS-R score at T1, it can be seen that White people, the widowed or divorced, those living alone and lone parents with children had greater chances of receiving any mental health treatment and/or services. Overall, about a quarter of those who classed themselves as White (24%) had received services or treatment compared with 10% of those in other ethnic groups. There was no change in the level of association when age, sex and CIS-R score were controlled for. This suggests that people from ethnic groups other than white are disadvantaged when it comes to receipt of services or mental health treatments. Although it has frequently been suggested that cultural differences may be responsible for misinterpretation of behaviour, a recent study of the mental health of ethnic minorities did not bear this out (Sproston and Nazroo 2002, O'Connor and Nazroo 2002). Thus, it is likely that less willingness to seek help or a greater likelihood that the disorder is not recognised by professionals may be responsible for this differential.

A greater proportion (about two-fifths) of those who were widowed, divorced or separated had received treatment or services than other groups, among whom about one fifth had done so. However, when age, sex and CIS-R score were taken into account the association was not quite so strong and only the widowed and divorced had significantly increased odds (approximately doubled) of treatment or service receipt compared with married people. While the relationship between marital status and receipt of treatment was broadly similar for men and women the increased odds of receiving help for the small group of widowed men were particularly striking (adjusted OR 6.20, 95% CI 1.95–19.76).

A similar picture was apparent when family unit type was considered. A significantly higher proportion of people living in lone parent with children or one person family units had received treatment or services than those in other family types but the association decreased when age, sex and CIS-R score were controlled for. As might be expected given that finding, people in single person households also had a higher chance of receiving treatment or services than those who lived with other people. (Table 6.6)

#### Economic factors

Being unemployed due to long term sickness or disability and, to a lesser extent, being economically inactive were both associated with an increased likelihood of having received help for a mental or emotional problem after sex, age and CIS-R score at T1 were taken into account. For example over half (53%) of those who were classed as long term sick or disabled had received help of some kind compared with 17% of those working full time. Similarly, those who were not working at both interviews were more likely to have received treatment or services than those who were working on both occasions. (Table 6.7)

A low household income was weakly associated with an increased chance of receiving any form of treatment after age, sex and baseline CIS-R score were accounted for. Other indicators of socio-economic status, lower social class, manual occupations and living in rented accommodation also showed a weak association with receipt of help, which largely disappeared when age, sex and the level of neurotic symptoms were taken into account. (Table 6.7)

The observed association between economic inactivity and a low income and an increased likelihood of receiving mental health services and/or treatments, after controlling for illness severity, has not been reported uniformly in other countries (Lefebvre *et al*, 1998), and may reflect the presence of a health service free at the point of delivery. Furthermore, research in Holland suggests that these factors more closely predict *frequent* rather than *incident* service utilisation (ten Have *et al*, 2001). This is an important finding, given that poverty, unemployment and financial strain appear to extend the duration of depressive episodes (Weich and Lewis 1998).

## 6.5 Associations between treatment and service contacts and outcome of common mental disorder

Specific factors related to recovery from common mental disorder are examined more fully in Chapter 3. In this section we are specifically concerned with describing the relationship between treatment and recovery. There are several ways of defining recovery but clearly an important outcome is improvement in symptoms of common mental disorder.

#### Recovery from disorder

As expected, people with a poorer outcome were more likely to have been in receipt of treatments. So in the unadjusted analysis, there was an association between receiving treatments and a lower proportion recovered. Fifty-five per cent of people who had scored above the threshold 11/12 on the CIS-R at T1 and who did not receive any treatment had recovered by T2 (their score had dropped below the threshold at T2) compared to 38% of those who received any type of treatment. In order to take account of the severity of disorder at baseline, as well as social and demographic factors that have been shown to be important determinants of receiving treatment or making service contacts an analysis was carried out adjusting for these factors. We studied the association between receipt of treatment and recovery after adjustment, using logistic regression, for sex, age, employment status, ethnicity, marital status, score on the CIS-R at baseline and stressful life events before T1 and between T1 and T2 interviews. After adjustment for these variables there was no significant association between treatment and recovery and the Odds Ratio was 0.88 (95% CI 0.59–1.32). (Table 6.8)

At first glance it appears that treatments are not associated with recovery of common mental disorders in the population. However, as mentioned above the primary and secondary care services are taking great efforts to ensure that treatments are targeted on individuals with more severe disorder and who have a poor outcome. There is no purpose in treating individuals who will get better in any case. Decisions by doctors to recommend treatment, and by patients to accept them, are not random but based upon a judgement about whether the condition will resolve

spontaneously. The results of our analysis indicate that the unadjusted inverse association between treatment and recovery was severely confounded by severity and the other variables we used for adjustment. The present results therefore simply reflect the fact that those with a more severe and more persistent condition are more likely to be receiving treatment. It is apparent that large-scale surveys such as this are not really suitable for investigating the effectiveness of treatments because of the large number of potentially confounding factors and the difficulties of accurately measuring treatment and service use in interviews. Randomised clinical trials have already provided a great deal of evidence that pharmacological and psychological treatments for common mental disorders are effective in speeding recovery and reducing the likelihood of relapse and recurrence.

### 6.6 Results of the sub-study of met and unmet needs

The main procedures for assessing common mental disorder using the CIS-R (see Chapter 1) are designed to assess the presence or absence of symptoms. The telephone interview, in contrast, was designed to assess whether any disorder that was present would benefit from treatment, in other words that there was a 'need' for treatment. The telephone interview was therefore designed to establish what treatments had been provided as well as make a judgement about any likely benefit. It is to be expected that some people with milder symptoms of common mental disorder would not benefit from treatment. A limitation of the data is that there was often a substantial time delay between the follow-up or T2 interview and the telephone interview. This will mean that at times the clinical state of the individual interviewed would have changed between the two assessments and it may have been difficult for respondents to recall how they had felt at the time of the original interview. A further limitation is that the MRC Needs for Care Assessment (NFCAS-C) requires judgements on the part of the interviewer about whether someone would benefit from treatment. This part of the study can therefore address the following questions.

- the relationship between the level of functioning as judged by the interviewing psychiatrists and common mental disorder;

- the relationship between the level of functioning and whether or not respondents had visited their GPs for mental problems;
- the relationship between primary need status and whether or not respondents had visited their GPs for mental problems; and
- the nature of treatments given and the extent to which needs are met for common mental disorder.

#### *Comparisons of assessments from the main follow-up and telephone interviews*

The level of functioning and of need obtained from the NFCAS-C can be related to the symptoms of common mental disorder assessed in the initial interviews. An analysis was done investigating the relationship between level of functioning from the NFCAS-C and common mental disorder assessed using the CIS-R and alcohol dependence assessed with the SAD-Q (Severity of Alcohol Dependence Questionnaire). It is clear that clinicians only identified a problematic level of functioning (that is a clinically significant level of distress from symptoms) in a proportion of those with assessed as having common mental disorder or alcohol problems in the initial interviews. Around half of all cases identified by the structured questionnaires were not considered to have a problem by the clinicians. *(Table 6.9)*

Table 6.10 shows the distribution of different levels of functioning on the NFCAS-C according to CIS-R scores at the baseline interview, among those people in the telephone sample selected because they had a common mental disorder or because they were receiving psychoactive medication or psychological therapies. The telephone interviewers used the information they had from the respondent's T1 and T2 interviews as a basis for further questioning to identify the respondent's level of functioning during the study period. A 'current problem' is a problem that existed at the time of the first ONS interview.

Overall, about three-quarters (73%) of the people who received a telephone interview and who had been identified as having a common mental disorder at T1 or receiving treatment for such problems were considered to have a current or past problem in the clinical interview. The proportion

of participants adjudged to have a current problem increased with increasing CIS-R score at T1. Even so, 17% of those with a CIS-R score of 18 or above were rated as having no problem as were over a third (36%) of those with CIS-R scores of between 12 and 17. However, clinical interviews tend to provide lower rates of disorder than structured assessment instruments and the considerable time delay between the assessments might also be expected to increase the likelihood of a discrepancy between the assessments. (Table 6.10)

Some of the people who were selected for telephone interview because they had a common mental disorder or were receiving treatment were also assessed as having an alcohol problem, and anyone else assessed as alcohol dependent was also included in the telephone interview sample. The association of level of functioning and need obtained from the NFCAS-C and the assessments available from the initial interview was therefore considered across the whole telephone interview sample. The AUDIT (Alcohol Use Disorder Identification Test) and SAD-Q scores were combined to provide a single measure of the level of alcohol problem, with four categories. These were then cross-tabulated with the level of functioning and primary need status, as judged by the clinical interviewers. Of those with the lowest scores on the composite measure, 98% were judged to have no alcohol problem and no need for treatment. Of respondents on the next level of the composite measure, 35% were felt to have a current, past, or likely problem with alcohol. This rose to 47% in the next category. The most striking thing about this table, however, is the large majority of those with some kind of need where need was felt to be unmetable, usually due to their rejection of any idea that treatment was needed. This is quite a contrast with respondents who had common mental disorder shown in Table 6.10.

(Table 6.11)

#### *Help-seeking and treatment need*

In this section, level of functioning and of need is related to whether the respondent had visited their GP or family doctor because of a mental health problem in the two weeks prior to the baseline interview or at sometime between the T1 and T2 interviews.

Among those selected for telephone interview because they were assessed as having a common mental disorder or were receiving treatment at T1, respondents who had an impaired level of functioning were more likely to have visited their GP for a mental health reason. While 46% of those assessed as having a current problem and 49% of those with a past problem or likely problem had consulted their GP, only 12% of those assessed as having no problem had done so. Likewise, those without a need for treatment were less likely to have been in contact with their GP, although 16% had done so. Around half of those with needs, whether met or not, had seen their family doctor for a mental health problem in the fortnight before the baseline interview or at some time between baseline and follow-up. A quarter of those considered to have no meetable need (most of whom themselves rejected any need for treatment) had even so been in recent contact with their GP about mental health issues. (Table 6.12)

The same analyses were carried out in relation to alcohol problems but because a significant proportion of those selected for the telephone interview survey because of a common mental disorder also had alcohol problems the whole telephone interview sample is included. Of the total sample, those with some level of problem related to alcohol were less likely than those with no problem to have visited their GP for a mental health reason. This is likely to be because a substantial proportion of those adjudged to have no alcohol problem had a common mental disorder rather than a problem with alcohol. However, it emphasises that people with alcohol problems do not seek help from GPs. The relationship between GP contact and primary need status is obscured by the small numbers with a meetable need. Very few of those with no meetable need had visited their GP for a mental health problem, underlining the tendency for this group not to acknowledge problems. (Table 6.13)

#### *Individual treatments: needs and levels of delivery*

Participants who were identified with an impaired level of functioning on the basis of the telephone interview are described in the following tables. In each table, individual treatments with likely effectiveness have been identified and the delivery, possible effectiveness and acceptability are described. People with common mental disorder were assessed with respect to their need for

treatment for depression and for anxiety separately. Treatments for alcohol problems were also considered. Only people deemed to have a need for treatment for these conditions are included in these analyses.

For depression, apart from assessment, the treatments most commonly seen as appropriate are general support and counselling (appropriate for 81%), cognitive therapy (CBT, appropriate for 31%), and antidepressant medication (appropriate for 83%). While the 20% of respondents who rejected the idea of medication is not surprising, an appreciable proportion of respondents also rejected the idea of counselling or CBT. There was, however, considerably more unmet need ('appropriate but not given') for CBT than for medication. Nearly two-thirds of those judged to have a need for medication were in fact receiving it, while the equivalent figure for CBT is only 10%. Less specific psychological treatment in the form of general support and counselling was considerably more available: 55% of those who were felt to need it were receiving it. (Table 6.14)

The pattern for respondents judged to have anxiety problems (including obsessional disorders) by the clinical interviewer was rather similar. Again the commonest treatments were for support/counselling (appropriate for 82%), CBT (48%), and medication (67%), and again a surprising number rejected the idea of these treatments: 27% rejecting the idea of support or counselling, 24% CBT and 20% medication. Once more the ratio between treatment given and treatment thought to be appropriate but not given was very low for CBT, 6% were receiving treatment compared with 17% for whom it was deemed appropriate but not given. (Table 6.15)

Respondents judged to have problems in relation to alcohol were particularly likely to reject the idea of any kind of treatment. The ratio between rejection of treatment and unmet need for treatment was by far the highest for any group of participants. A minority of survey participants with alcohol problems were receiving effective treatment, most often in the form of simple advice. The respondents with alcohol problems appear to be especially difficult to help. (Table 6.16)

## 6.7 Conclusions

Our results suggest that those with severe and more long lasting disorders were more likely to be treated than those with milder conditions. Though these results are reassuring and suggest that treatment is being correctly targeted, there were a considerable number of respondents with substantial symptoms of common mental disorder that were not receiving any treatment. In particular, younger people, those from ethnic minorities and alcohol misusers were less likely to receive treatment and this is a matter of some concern. There have been many suggestions why this might be so. Some people have a reluctance to disclose symptoms (Goldberg and Huxley 1992) and there is a reported aversion to certain treatments, particularly drug treatments (Priest *et al*, 1996).

The more detailed assessment of met and unmet needs that was conducted suggests some explanation of why such a large number of people were not in receipt of treatment. One important point is that in the judgement of the interviewing psychiatrists, a number of people with significant symptoms did not have a sufficient degree of functional disability to require the kind of pharmacological and psychological treatments currently available. However another important reason was that a large number, especially those with alcohol problems, refused treatment, presumably because they did not regard themselves as having a sufficiently severe problem. Despite this it was apparent that there was considerably more unmet need in relation to psychological treatments such as cognitive behavioural treatment than for pharmacological treatment.

It appears from this study that there are a large number of people in Great Britain who would benefit from treatment for common mental disorder but are not currently receiving it. In part this is because people with CMD are not seeking or accepting treatment. Interventions to change these attitudes might have some benefit. However, there may also be ways of changing practice in both primary and secondary care in order to ensure that psychological treatments are provided for those who would benefit and accept treatment.



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**Table 6.1 Treatment or health care services received at either T1 or T2  
by CIS-R score at T1**

	CIS-R score at T1				All adults and over
	0-5	6-11	12-17	18 and over	
<i>Percentage reporting different types of treatment or services</i>					
<b>Women</b>					
<b>Treatment</b>					
No treatment	92	81	72	63	85
Psychotropic medication only	5	12	20	20	9
Counselling only	2	5	6	6	4
Both psychotropic medication and counselling	1	2	2	11	2
<b>Healthcare services</b>					
Seen GP for mental reason last 2 wks at T1, T1-T2	10	20	36	41	17
Had community care in last qtr at T1, T1-T2	8	11	17	27	11
Had day care in last qtr at T1, T1-T2	1	2	2	5	1
Inpatient stay for mental reason, last qtr at T1, last qtr at T2	–	–	–	–	–
Outpatient visit for mental reason, last qtr at T1, last qtr at T2	1	1	3	6	1
<b>Any treatment / services at T1 or T2</b>	<b>20</b>	<b>36</b>	<b>51</b>	<b>58</b>	<b>29</b>
<i>Base</i>	<i>365</i>	<i>546</i>	<i>245</i>	<i>230</i>	<i>1386</i>
<b>Men</b>					
<b>Treatment</b>					
No treatment	97	92	80	60	93
Psychotropic medication only	1	5	7	20	3
Counselling only	2	2	9	5	2
Both psychotropic medication and counselling	1	1	4	14	2
<b>Healthcare services</b>					
Seen GP for mental reason last 2 wks at T1, T1-T2	4	10	29	38	8
Had community care in last qtr at T1, T1-T2	6	7	19	25	8
Had day care in last qtr at T1, T1-T2	1	1	1	5	1
Inpatient stay for mental reason, last qtr at T1, last qtr at T2	–	–	0	2	0
Outpatient visit for mental reason, last qtr at T1, last qtr at T2	1	0	1	7	1
<b>Any treatment / services at T1 or T2</b>	<b>10</b>	<b>20</b>	<b>45</b>	<b>53</b>	<b>17</b>
<i>Base</i>	<i>429</i>	<i>316</i>	<i>137</i>	<i>138</i>	<i>1020</i>
<b>All adults</b>					
<b>Treatment</b>					
No treatment	95	86	75	61	89
Psychotropic medication only	3	9	15	20	6
Counselling only	2	4	7	6	3
Both psychotropic medication and counselling	1	2	3	13	2
<b>Healthcare services</b>					
Seen GP for mental reason last 2 wks at T1, T1-T2	7	16	33	40	13
Had community care in last qtr at T1, T1-T2	7	10	18	26	10
Had day care in last qtr at T1, T1-T2	1	1	2	5	1
Inpatient stay for mental reason, last qtr at T1, last qtr at T2	–	–	0	1	0
Outpatient visit for mental reason, last qtr at T1, last qtr at T2	1	1	2	6	1
<b>Any treatment / services at T1 or T2</b>	<b>15</b>	<b>29</b>	<b>48</b>	<b>56</b>	<b>23</b>
<i>Base</i>	<i>794</i>	<i>862</i>	<i>382</i>	<i>368</i>	<i>2406</i>

**Table 6.2 Treatment or health care services received at either T1 or T2  
by change in CIS–R caseness**

	Change in CIS–R caseness from T1 to T2				All adults
	Not CIS–R case at T1 or T2	Onset	Recovery	Persistence	
<i>Percentage reporting different types of treatment or services</i>					
<b>Women</b>					
<b>Treatment</b>					
No treatment	91	66	81	55	85
Psychotropic medication only	6	21	13	27	9
Counselling only	3	10	3	8	4
Both psychotropic medication and counselling	1	3	3	10	2
<b>Healthcare services</b>					
Seen GP for mental reason last 2 wks at T1, T1–T2	10	44	26	50	17
Had community care in last qtr at T1, T1–T2	8	14	16	27	11
Had day care in last qtr at T1, T1–T2	0	6	2	6	1
Inpatient stay for mental reason, last qtr at T1, last qtr at T2	–	–	–	–	–
Outpatient visit for mental reason, last qtr at T1, last qtr at T2	1	3	1	7	1
<b>Any treatment / services at T1 or T2</b>	<b>21</b>	<b>59</b>	<b>42</b>	<b>66</b>	<b>29</b>
<i>Base</i>	<i>799</i>	<i>112</i>	<i>229</i>	<i>246</i>	<i>1386</i>
<b>Men</b>					
<b>Treatment</b>					
No treatment	97	87	81	59	93
Psychotropic medication only	1	4	8	20	3
Counselling only	1	7	7	7	2
Both psychotropic medication and counselling	1	2	4	15	2
<b>Healthcare services</b>					
Seen GP for mental reason last 2 wks at T1, T1–T2	3	32	24	44	8
Had community care in last qtr at T1, T1–T2	5	13	16	28	8
Had day care in last qtr at T1, T1–T2	1	8	2	4	1
Inpatient stay for mental reason, last qtr at T1, last qtr at T2	–	–	1	2	0
Outpatient visit for mental reason, last qtr at T1, last qtr at T2	1	6	2	6	1
<b>Any treatment / services at T1 or T2</b>	<b>10</b>	<b>41</b>	<b>42</b>	<b>56</b>	<b>17</b>
<i>Base</i>	<i>673</i>	<i>72</i>	<i>138</i>	<i>137</i>	<i>1020</i>
<b>All adults</b>					
<b>Treatment</b>					
No treatment	94	76	81	56	89
Psychotropic medication only	3	13	11	24	6
Counselling only	2	8	5	8	3
Both psychotropic medication and counselling	1	3	3	12	2
<b>Healthcare services</b>					
Seen GP for mental reason last 2 wks at T1, T1–T2	7	39	25	47	13
Had community care in last qtr at T1, T1–T2	7	14	16	28	10
Had day care in last qtr at T1, T1–T2	0	7	2	5	1
Inpatient stay for mental reason, last qtr at T1, last qtr at T2	–	–	0	1	0
Outpatient visit for mental reason, last qtr at T1, last qtr at T2	1	4	1	7	1
<b>Any treatment / services at T1 or T2</b>	<b>15</b>	<b>51</b>	<b>42</b>	<b>62</b>	<b>23</b>
<i>Base</i>	<i>1472</i>	<i>184</i>	<i>367</i>	<i>383</i>	<i>2406</i>

**Table 6.3 Treatment or health care services received at either T1 or T2  
by alcohol problems at T1**

	Alcohol use at T1			All adults
	No hazardous alcohol use	Hazardous use but no dependency	Alcohol dependence	
<i>Percentage reporting different types of treatment or services</i>				
<b>Women</b>				
<b>Treatment</b>				
No treatment	86	82	82	85
Psychotropic medication only	9	9	5	9
Counselling only	3	7	4	3
Both psychotropic medication and counselling	2	2	9	2
<b>Healthcare services</b>				
Seen GP for mental reason last 2 wks at T1, 1–T2	16	20	21	17
Had community care in last qtr at T1, T1–T2	11	8	13	11
Had day care in last qtr at T1, T1–T2	1	1	5	1
Inpatient stay for mental reason, last qtr at T1, last qtr at T2	–	–	–	–
Outpatient visit for mental reason, last qtr at T1, last qtr at T2	1	2	2	1
<b>Any treatment / services at T1 or T2</b>	<b>29</b>	<b>32</b>	<b>33</b>	<b>29</b>
<i>Base</i>	1139	164	76	1379
<b>Men</b>				
<b>Treatment</b>				
No treatment	92	97	88	93
Psychotropic medication only	3	2	6	3
Counselling only	3	1	4	2
Both psychotropic medication and counselling	2	0	2	2
<b>Healthcare services</b>				
Seen GP for mental reason last 2 wks at T1, T1–T2	8	8	13	8
Had community care in last qtr at T1, T1–T2	7	10	7	8
Had day care in last qtr at T1, T1–T2	2	0	1	1
Inpatient stay for mental reason, last qtr at T1, last qtr at T2	0	0	0	0
Outpatient visit for mental reason, last qtr at T1, last qtr at T2	2	0	1	1
<b>Any treatment / services at T1 or T2</b>	<b>16</b>	<b>17</b>	<b>20</b>	<b>16</b>
<i>Base</i>	588	196	233	1017
<b>All adults</b>				
<b>Treatment</b>				
No treatment	89	92	87	89
Psychotropic medication only	6	4	6	6
Counselling only	3	3	4	3
Both psychotropic medication and counselling	2	1	3	2
<b>Healthcare services</b>				
Seen GP for mental reason last 2 wks at T1, T1–T2	13	13	14	13
Had community care in last qtr at T1, T1–T2	10	10	8	10
Had day care in last qtr at T1, T1–T2	1	1	2	1
Inpatient stay for mental reason, last qtr at T1, last qtr at T2	0	0	0	0
Outpatient visit for mental reason, last qtr at T1, last qtr at T2	1	1	1	1
<b>Any treatment / services at T1 or T2</b>	<b>23</b>	<b>22</b>	<b>22</b>	<b>23</b>
<i>Base</i>	1727	360	309	2396

**Table 6.4 Treatment or health care services received at either T1 or T2  
by illicit drug use in the previous year at T1**

	Illicit drug use in last year at T1		All adults
	No	Yes	
<i>Percentage reporting different types of treatment or services</i>			
<b>Women</b>			
<b>Treatment</b>			
No treatment	86	79	85
Psychotropic medication only	9	8	9
Counselling only	3	8	3
Both psychotropic medication and counselling	2	5	2
<b>Healthcare services</b>			
Seen GP for mental reason last 2 wks at T1, T1–T2	17	22	17
Had community care in last qtr at T1, T1–T2	11	16	11
Had day care in last qtr at T1, T1–T2	1	2	1
Inpatient stay for mental reason, last qtr at T1, last qtr at T2	–	–	–
Outpatient visit for mental reason, last qtr at T1, last qtr at T2	1	1	1
<b>Any treatment / services at T1 or T2</b>	<b>29</b>	<b>38</b>	<b>29</b>
<i>Base</i>	<i>1257</i>	<i>122</i>	<i>1379</i>
<b>Men</b>			
<b>Treatment</b>			
No treatment	93	94	93
Psychotropic medication only	3	4	3
Counselling only	3	1	2
Both psychotropic medication and counselling	2	1	2
<b>Healthcare services</b>			
Seen GP for mental reason last 2 wks at T1, T1–T2	8	11	9
Had community care in last qtr at T1, T1–T2	8	7	8
Had day care in last qtr at T1, T1–T2	1	1	1
Inpatient stay for mental reason, last qtr at T1, last qtr at T2	0	0	0
Outpatient visit for mental reason, last qtr at T1, last qtr at T2	1	1	1
<b>Any treatment / services at T1 or T2</b>	<b>17</b>	<b>15</b>	<b>16</b>
<i>Base</i>	<i>847</i>	<i>171</i>	<i>1018</i>
<b>All adults</b>			
<b>Treatment</b>			
No treatment	89	89	89
Psychotropic medication only	6	5	6
Counselling only	3	3	3
Both psychotropic medication and counselling	2	3	2
<b>Healthcare services</b>			
Seen GP for mental reason last 2 wks at T1, T1–T2	13	15	13
Had community care in last qtr at T1, T1–T2	9	10	10
Had day care in last qtr at T1, T1–T2	1	2	1
Inpatient stay for mental reason, last qtr at T1, last qtr at T2	0	0	0
Outpatient visit for mental reason, last qtr at T1, last qtr at T2	1	1	1
<b>Any treatment / services at T1 or T2</b>	<b>23</b>	<b>23</b>	<b>23</b>
<i>Base</i>	<i>2104</i>	<i>293</i>	<i>2397</i>

Table 6.5 Odds Ratios associated with receiving any treatment or service at T1 or T2

	Base	% with treatment	Unadjusted regression			Adjusted regression		
			Overall significance of variable	Odds Ratio	95% Confidence Interval	Overall significance of variable	Adjusted Odds Ratio#	95% Confidence Interval
<b>Women</b>								
<b>All women</b>	1386	29						
<b>Age at T1</b>			n.s.			n.s.		
16–24	115	29		1.00	—		1.00	—
25–34	302	35		1.30	(0.61–2.78)		1.63	(0.67–3.95)
35–44	301	27		0.89	(0.44–1.82)		0.97	(0.44–2.18)
45–54	271	30		1.03	(0.51–2.10)		1.21	(0.54–2.73)
55–64	212	21		0.66	(0.31–1.39)		0.77	(0.33–1.81)
65–74	185	30		1.02	(0.48–2.17)		1.48	(0.62–3.53)
<b>CIS–R score at T1</b>			+++			+++		
0–5	365	20		1.00	—		1.00	—
6–11	546	36		2.21 ***	(1.56–3.12)		2.21 ***	(1.54–3.17)
12–17	245	51		4.10 ***	(2.78–6.06)		4.11 ***	(2.75–6.15)
18 and over	230	58		5.49 ***	(3.64–8.28)		5.51 ***	(3.61–8.40)
<b>Men</b>								
<b>All men</b>	1020	17						
<b>Age at T1</b>			n.s.			++		
16–24	103	8		1.00	—		1.00	—
25–34	183	16		2.02	(0.89–4.56)		1.56	(0.66–3.69)
35–44	225	15		1.97	(0.92–4.22)		1.73	(0.81–3.72)
45–54	226	17		2.22 *	(1.06–4.65)		1.97	(0.92–4.21)
55–64	164	20		2.73 *	(1.27–5.87)		2.67 *	(1.20–5.93)
65–74	119	24		3.36 **	(1.49–7.55)		4.68 ***	(2.10–10.42)
<b>CIS–R score at T1</b>			+++			+++		
0–5	429	10		1.00	—		1.00	—
6–11	316	20		2.19 **	(1.38–3.48)		2.40 ***	(1.50–3.84)
12–17	137	45		7.25 ***	(4.42–11.90)		8.44 ***	(5.04–14.14)
18 and over	138	53		10.14 ***	(5.80–17.75)		11.74 ***	(6.54–21.10)
<b>All adults</b>								
<b>All adults</b>	2406	23						
<b>Sex</b>			+++			+++		
Male	1020	17		1.00	—		1.00	—
Female	1386	29		2.09 ***	(1.63–2.69)		1.98 ***	(1.52–2.57)
<b>Age at T1</b>			n.s.			n.s.		
16–24	218	18		1.00	—		1.00	—
25–34	485	27		1.63	(0.90–2.94)		1.68	(0.87–3.21)
35–44	526	21		1.21	(0.68–2.13)		1.21	(0.66–2.23)
45–54	497	23		1.38	(0.80–2.40)		1.46	(0.81–2.63)
55–64	376	21		1.18	(0.68–2.06)		1.29	(0.71–2.38)
65–74	304	27		1.65	(0.91–2.99)		2.31 *	(1.22–4.40)
<b>CIS–R score at T1</b>			+++			+++		
0–5	794	15		1.00	—		1.00	—
6–11	862	29		2.35 ***	(1.82–3.02)		2.31 ***	(1.77–3.00)
12–17	382	48		5.42 ***	(4.02–7.30)		5.38 ***	(3.94–7.34)
18 and over	368	56		7.31 ***	(5.26–10.16)		7.49 ***	(5.33–10.53)

# Odds Ratios adjusted for the other variables in this table

\*\*\* p&lt;0.001, \*\* p&lt;0.01, \* p&lt;0.05

+++ p&lt;0.001, ++ p&lt;0.01, + p&lt;0.05, n.s. = not significant

Table 6.6 Odds Ratios associated with receiving any treatment or service at T1 or T2

## Demographic variables

	Base	% with treatment	Unadjusted regression			Adjusted regression		
			Overall significance of variable	Odds Ratio	95% Confidence Interval	Overall significance of variable	Adjusted Odds Ratio#	95% Confidence Interval
<b>Women</b>								
<b>Ethnicity</b>								
			+			+		
White	1311	30		1.00	————		1.00	————
Other	66	14		0.39 *	(0.16–0.92)		0.36 *	(0.15–0.86)
<b>Area type</b>								
			n.s.			n.s.		
Urban	915	29		1.00	————		1.00	————
Semi-rural	329	28		0.94	(0.64–1.39)		1.11	(0.73–1.67)
Rural	142	36		1.40	(0.81–2.43)		1.67	(0.94–2.99)
<b>Educational qualifications</b>								
			n.s.			n.s.		
Degree	190	30		1.00	————		1.00	————
Teaching, HND, nursing	126	35		1.30	(0.68–2.50)		1.25	(0.62–2.51)
A Level	160	24		0.73	(0.37–1.45)		0.72	(0.34–1.50)
GCSE or equivalent	506	31		1.09	(0.66–1.80)		1.09	(0.63–1.87)
No qualifications	395	27		0.88	(0.52–1.49)		0.72	(0.42–1.26)
<b>De facto marital status at T1</b>								
			++			+		
Married	698	26		1.00	————		1.00	————
Cohabiting	117	32		1.35	(0.82–2.22)		1.04	(0.57–1.88)
Single	211	30		1.25	(0.71–2.20)		0.97	(0.49–1.94)
Widowed	126	37		1.70	(0.97–2.98)		1.99 *	(1.05–3.76)
Divorced	161	45		2.34 ***	(1.46–3.74)		1.98 ***	(1.24–3.18)
Separated	73	42		2.09 *	(1.03–4.23)		1.74	(0.74–4.10)
<b>Family type at T1</b>								
			++			+		
Couple, no child	410	26		1.00	————		1.00	————
Couple and child(ren)	404	27		1.06	(0.71–1.58)		0.94	(0.61–1.43)
Lone parent and child(ren)	194	39		1.80 *	(1.08–3.01)		1.49	(0.83–2.66)
One person only	315	39		1.87 **	(1.23–2.85)		1.72 *	(1.10–2.69)
Adult and parent(s)	63	26		1.01	(0.39–2.61)		0.76	(0.24–2.39)
<b>Household size at T1</b>								
			n.s.			n.s.		
1	286	38		1.00	————		1.00	————
2	508	28		0.64 *	(0.43–0.96)		0.70	(0.46–1.08)
3	266	27		0.61 *	(0.38–0.99)		0.56 *	(0.33–0.95)
4	230	26		0.57	(0.33–1.00)		0.56	(0.31–1.01)
5 and over	96	36		0.94	(0.51–1.73)		0.78	(0.38–1.57)

Table 6.6 (continued) Odds Ratios associated with receiving any treatment or service at T1 or T2

## Demographic variables

	Base	% with treatment	Unadjusted regression			Adjusted regression		
			Overall significance of variable	Odds Ratio	95% Confidence Interval	Overall significance of variable	Adjusted Odds Ratio#	95% Confidence Interval
<b>Men</b>								
<b>Ethnicity</b>								
			n.s.			+		
White	960	17		1.00	————		1.00	————
Other	56	7		0.34	(0.11–1.01)		0.33 *	(0.13–0.87)
<b>Area type</b>								
			n.s.			n.s.		
Urban	667	18		1.00	————		1.00	————
Semi-rural	256	14		0.73	(0.47–1.14)		0.76	(0.48–1.20)
Rural	97	13		0.68	(0.36–1.29)		0.69	(0.35–1.38)
<b>Educational qualifications</b>								
			n.s.			n.s.		
Degree	189	14		1.00	————		1.00	————
Teaching, HND, nursing	84	11		0.78	(0.34–1.75)		0.67	(0.28–1.59)
A Level	155	19		1.42	(0.70–2.87)		1.25	(0.57–2.73)
GCSE or equivalent	332	18		1.37	(0.76–2.48)		1.23	(0.62–2.44)
No qualifications	255	16		1.17	(0.63–2.16)		0.79	(0.41–1.51)
<b>De facto marital status at T1</b>								
			+++			+		
Married	519	16		1.00	————		1.00	————
Cohabiting	104	12		0.74	(0.36–1.50)		0.92	(0.39–2.17)
Single	236	14		0.86	(0.52–1.40)		1.33	(0.67–2.64)
Widowed	32	58		7.54 ***	(2.88–19.78)		6.20 **	(1.95–19.76)
Divorced	101	36		2.99 **	(1.48–6.04)		2.09	(0.97–4.52)
Separated	28	[9]		1.48	(0.46–4.79)		1.41	(0.47–4.20)
<b>Family type at T1</b>								
			+++			++		
Couple, no child	305	15		1.00	————		1.00	————
Couple and child(ren)	318	15		1.04	(0.65–1.68)		1.14	(0.65–1.99)
Lone parent and child(ren)	25	47		5.05 **	(1.67–15.29)		4.33 *	(1.12–16.72)
One person only	256	30		2.43 ***	(1.55–3.82)		2.22 **	(1.31–3.74)
Adult and parent(s)	116	10		0.61	(0.32–1.18)		1.25	(0.53–2.92)
<b>Household size at T1</b>								
			+++			+		
1	233	31		1.00	————		1.00	————
2	345	17		0.45 ***	(0.29–0.70)		0.55 *	(0.34–0.89)
3	188	14		0.35 **	(0.19–0.65)		0.49 *	(0.25–0.97)
4	188	12		0.30 ***	(0.17–0.53)		0.43 **	(0.24–0.77)
5 and over	66	17		0.44	(0.19–1.02)		0.81	(0.35–1.87)

# Odds Ratios adjusted for the other variables in this table

Table continues on page 138.

\*\*\* p&lt;0.001, \*\* p&lt;0.01, \* p&lt;0.05

+++ p&lt;0.001, ++ p&lt;0.01, + p&lt;0.05, n.s. = not significant



Table 6.6 (continued) Odds Ratios associated with receiving any treatment or service at T1 or T2

		Unadjusted regression			Adjusted regression			
	Base	% with treatment	Overall significance of variable	Odds Ratio	95% Confidence Interval	Overall significance of variable	Adjusted Odds Ratio#	95% Confidence Interval
<b>All adults</b>								
<b>Ethnicity</b>								
			++			++		
White	2271	24		1.00	—————		1.00	—————
Other	122	10		0.35 **	(0.18–0.67)		0.36 **	(0.19–0.67)
<b>Area type</b>								
			n.s.			n.s.		
Urban	1582	23		1.00	—————		1.00	—————
Semi-rural	585	21		0.86	(0.65–1.14)		0.97	(0.72–1.31)
Rural	239	26		1.13	(0.74–1.73)		1.27	(0.81–1.97)
<b>Educational qualifications</b>								
			n.s.			n.s.		
Degree	379	20		1.00	—————		1.00	—————
Teaching, HND, nursing	210	23		1.19	(0.69–2.03)		1.01	(0.57–1.76)
A Level	315	21		1.05	(0.66–1.69)		0.94	(0.56–1.57)
GCSE or equivalent	838	26		1.36	(0.94–1.97)		1.16	(0.77–1.75)
No qualifications	650	22		1.10	(0.74–1.62)		0.74	(0.49–1.12)
<b>De facto marital status at T1</b>								
			+++			+++		
Married	1217	21		1.00	—————		1.00	—————
Cohabiting	221	21		1.03	(0.69–1.53)		0.96	(0.59–1.56)
Single	447	20		0.97	(0.66–1.43)		1.04	(0.64–1.69)
Widowed	158	41		2.70 ***	(1.64–4.43)		2.34 **	(1.33–4.12)
Divorced	262	41		2.62 ***	(1.75–3.92)		2.05 **	(1.35–3.09)
Separated	101	36		2.12 *	(1.12–4.02)		1.69	(0.83–3.44)
<b>Family type at T1</b>								
			+++			+++		
Couple, no child	715	20		1.00	—————		1.00	—————
Couple and child(ren)	722	21		1.05	(0.77–1.42)		1.01	(0.72–1.42)
Lone parent and child(ren)	219	40		2.60 ***	(1.61–4.19)		1.95 *	(1.09–3.47)
One person only	571	35		2.08 ***	(1.51–2.87)		1.81 **	(1.28–2.56)
Adult and parent(s)	179	15		0.69	(0.38–1.28)		0.86	(0.41–1.78)
<b>Household size at T1</b>								
			+++			+		
1	519	35		1.00	—————		1.00	—————
2	853	23		0.56 ***	(0.42–0.76)		0.67 *	(0.49–0.92)
3	454	20		0.47 ***	(0.32–0.70)		0.55 **	(0.36–0.86)
4	418	19		0.44 ***	(0.29–0.66)		0.52 **	(0.34–0.81)
5 and over	162	26		0.66	(0.39–1.11)		0.78	(0.46–1.31)

# Odds Ratios adjusted for sex, age and CIS-R score at T1

\*\*\* p<0.001, \*\*p<0.01, \*p<0.05

+++ p<0.001, ++ p<0.01, + p<0.05, n.s. = not significant

Table 6.7 Odds Ratios associated with receiving any treatment or service at T1 or T2

## Economic variables

	Base	% with treatment	Unadjusted regression			Adjusted regression		
			Overall significance of variable	Odds Ratio	95% Confidence Interval	Overall significance of variable	Adjusted Odds Ratio#	95% Confidence Interval
<b>Women</b>								
<b>Social class at T1</b>								
			+			+		
I	34	12		1.00	—		1.00	—
II	429	167		0.75	(0.28–2.04)		0.66	(0.23–1.86)
IIINM	458	159		0.49	(0.18–1.31)		0.40	(0.14–1.11)
IIIM	123	58		1.05	(0.36–3.09)		0.89	(0.29–2.73)
IV	204	100		0.97	(0.34–2.81)		0.66	(0.22–2.01)
V	97	48		1.01	(0.29–3.51)		0.76	(0.19–3.10)
Armed forces	–	–		–	–		–	–
<b>Manual or non-manual work at T1</b>								
			+			n.s.		
Non-manual	921	27		1.00	—		1.00	—
Manual	424	37		1.61 *	(1.10–2.36)		1.42	(0.93–2.16)
<b>Employment status at T1</b>								
			+++			n.s.		
Working full time	415	26		1.00	—		1.00	—
Working part time	367	28		1.10	(0.70–1.75)		1.11	(0.68–1.83)
Unemployed	41	31		1.27	(0.52–3.11)		1.04	(0.44–2.46)
Long term sick or disabled	118	62		4.50 ***	(2.54–7.97)		2.42 **	(1.31–4.45)
Other economically inactive	436	29		1.14	(0.79–1.65)		1.20	(0.78–1.85)
<b>Change in employment status</b>								
			+			n.s.		
Employed at T1 and T2	703	27		1.00	—		1.00	—
Not employed at T1 and T2	525	35		1.48 *	(1.09–2.01)		1.49 *	(1.02–2.19)
Not employed at T1, employed at T2	70	21		0.74	(0.38–1.43)		0.65	(0.34–1.24)
Employed at T1, not employed at T2	79	32		1.32	(0.54–3.24)		1.34	(0.48–3.72)
<b>Tenure of accommodation at T1</b>								
			+++			++		
Owned outright	314	28		1.00	—		1.00	—
Owned with mortgage	649	23		0.79	(0.51–1.21)		0.67	(0.39–1.15)
Rented from LA or HA	312	46		2.19 **	(1.29–3.70)		1.60	(0.88–2.90)
Rented from other source	101	41		1.82	(0.95–3.48)		1.31	(0.62–2.77)
<b>Respondent's grouped weekly gross income at T1</b>								
			n.s.			n.s.		
£400 and over	147	33		1.00	—		1.00	—
£200 but under £400	298	26		0.69	(0.39–1.22)		0.65	(0.36–1.20)
£100 but under £200	418	29		0.83	(0.48–1.43)		0.74	(0.42–1.31)
Under £100	486	30		0.86	(0.51–1.44)		0.75	(0.42–1.32)
<b>Change in respondent's income</b>								
			n.s.			n.s.		
About the same	813	30		1.00	—		1.00	—
Around 20% or more fall	193	29		0.96	(0.60–1.54)		1.07	(0.66–1.73)
Around 20% or more increase	324	28		0.92	(0.63–1.34)		0.86	(0.57–1.30)
<b>Household's grouped weekly gross income at T1</b>								
			++			n.s.		
£400 and over	515	24		1.00	—		1.00	—
£200 but under £400	341	31		1.42	(0.95–2.12)		1.25	(0.82–1.90)
£100 but under £200	285	33		1.51	(0.99–2.30)		1.17	(0.74–1.85)
Under £100	130	45		2.57 **	(1.50–4.40)		2.12 *	(1.14–3.95)

# Odds Ratios adjusted for sex, age and CIS-R score at T1

Table continues on page 140.

\*\*\* p&lt;0.001, \*\*p&lt;0.01, \*p&lt;0.05

+++ p&lt;0.001, ++ p&lt;0.01, + p&lt;0.05, n.s. = not significant

Table 6.7 (continued) Odds Ratios associated with receiving any treatment or service at T1 or T2

## Economic variables

	Base	% with treatment	Unadjusted regression			Adjusted regression		
			Overall significance of variable	Odds Ratio	95% Confidence Interval	Overall significance of variable	Adjusted Odds Ratio#	95% Confidence Interval
<b>Men</b>								
<b>Social class at T1</b>								
			n.s.			+		
I	91	11		1.00	————		1.00	————
II	325	17		1.77	(0.78–3.99)		1.63	(0.63–4.18)
IIINM	97	19		1.95	(0.73–5.25)		1.89	(0.64–5.60)
IIIM	304	14		1.37	(0.61–3.08)		1.07	(0.43–2.67)
IV	128	22		2.42	(0.92–6.38)		2.33	(0.78–6.95)
V	43	20		2.15	(0.73–6.36)		1.66	(0.51–5.36)
Armed forces	2	[1]		48.00 **	(2.68–859.14)		53.89 **	(3.58–811.21)
<b>Manual or non-manual work at T1</b>								
			n.s.			n.s.		
Non-manual	513	16		1.00	————		1.00	————
Manual	477	17		1.06	(0.73–1.53)		0.93	(0.62–1.39)
<b>Employment status at T1</b>								
			+++			+		
Working full time	612	13		1.00	————		1.00	————
Working part time	74	11		0.82	(0.39–1.73)		0.87	(0.42–1.80)
Unemployed	39	11		0.88	(0.35–2.21)		0.79	(0.34–1.86)
Long term sick or disabled	120	47		5.99 ***	(3.32–10.81)		2.03 *	(1.19–3.47)
Other economically inactive	171	22		1.94 *	(1.15–3.29)		2.06 *	(1.13–3.76)
<b>Change in employment status</b>								
			+++			+		
Employed at T1 and T2	648	12		1.00	————		1.00	————
Not employed at T1 and T2	286	29		3.00 ***	(1.93–4.66)		2.10 **	(1.25–3.53)
Not employed at T1, employed at T2	43	14		1.23	(0.45–3.35)		1.51	(0.57–4.00)
Employed at T1, not employed at T2	38	26		2.56 *	(1.02–6.45)		1.95	(0.81–4.70)
<b>Tenure of accommodation at T1</b>								
			+++			+		
Owned outright	233	18		1.00	————		1.00	————
Owned with mortgage	510	13		0.68	(0.41–1.11)		0.75	(0.41–1.36)
Rented from LA or HA	198	29		1.79	(0.97–3.30)		1.63	(0.85–3.12)
Rented from other source	71	10		0.47	(0.20–1.10)		0.54	(0.23–1.29)
<b>Respondent's grouped weekly gross income at T1</b>								
			n.s.			n.s.		
£400 and over	323	15		1.00	————		1.00	————
£200 but under £400	327	14		0.95	(0.55–1.66)		0.84	(0.46–1.55)
£100 but under £200	181	23		1.77	(0.99–3.17)		1.29	(0.70–2.38)
Under £100	171	19		1.32	(0.73–2.42)		1.13	(0.64–1.99)
<b>Change in respondent's income</b>								
			n.s.			n.s.		
About the same	650	17		1.00	————		1.00	————
Around 20% or more fall	102	18		1.09	(0.58–2.01)		1.11	(0.59–2.08)
Around 20% or more increase	228	15		0.85	(0.54–1.34)		0.86	(0.51–1.45)
<b>Household's grouped weekly gross income at T1</b>								
			+++			++		
£400 and over	422	14		1.00	————		1.00	————
£200 but under £400	238	12		0.83	(0.48–1.42)		0.69	(0.39–1.20)
£100 but under £200	128	29		2.43 **	(1.36–4.33)		1.41	(0.78–2.54)
Under £100	81	41		4.22 ***	(2.08–8.57)		2.56 *	(1.13–5.80)

Table 6.7 (continued) Odds Ratios associated with receiving any treatment or service at T1 or T2

			Unadjusted regression			Adjusted regression		
			Overall significance of variable	Odds Ratio	95% Confidence Interval	Overall significance of variable	Adjusted Odds Ratio#	95% Confidence Interval
	Base	% with treatment						
<b>All adults</b>								
<b>Social class at T1</b>								
			+			+		
I	125	17		1.00	————		1.00	————
II	754	24		1.57	(0.85–2.90)		1.12	(0.57–2.20)
IIINM	555	22		1.36	(0.72–2.57)		0.75	(0.37–1.56)
IIIM	427	20		1.21	(0.63–2.32)		0.98	(0.50–1.93)
IV	332	30		2.10 *	(1.06–4.19)		1.26	(0.59–2.70)
V	140	32		2.35	(0.99–5.58)		1.27	(0.44–3.66)
<b>Manual or non-manual work at T1</b>								
			n.s.			n.s.		
Non-manual	1434	22		1.00	————		1.00	————
Manual	901	25		1.17	(0.89–1.54)		1.19	(0.87–1.64)
<b>Employment status at T1</b>								
			+++			++		
Working full time	1027	17		1.00	————		1.00	————
Working part time	441	25		1.55 *	(1.08–2.25)		1.15	(0.76–1.74)
Unemployed	80	20		1.22	(0.64–2.34)		0.96	(0.52–1.79)
Long term sick or disabled	238	53		5.32 ***	(3.48–8.13)		2.35 ***	(1.57–3.50)
Other economically inactive	607	26		1.70 **	(1.25–2.31)		1.45 *	(1.01–2.09)
<b>Change in employment status</b>								
			+++			+		
Employed at T1 and T2	1351	19		1.00	————		1.00	————
Not employed at T1 and T2	811	32		2.09 ***	(1.61–2.72)		1.72 **	(1.24–2.38)
Not employed at T1, employed at T2	113	18		0.95	(0.53–1.70)		0.89	(0.51–1.54)
Employed at T1, not employed at T2	117	30		1.90	(0.95–3.82)		1.57	(0.70–3.49)
<b>Tenure of accommodation at T1</b>								
			+++			+++		
Owned outright	547	23		1.00	————		1.00	————
Owned with mortgage	1159	18		0.75	(0.55–1.04)		0.70	(0.46–1.05)
Rented from LA or HA	510	38		2.04 **	(1.34–3.11)		1.57	(0.99–2.49)
Rented from other source	172	24		1.07	(0.61–1.84)		0.94	(0.52–1.70)
<b>Respondent's grouped weekly gross income at T1</b>								
			+			n.s.		
£400 and over	470	19		1.00	————		1.00	————
£200 but under £400	625	19		0.98	(0.67–1.44)		0.80	(0.53–1.22)
£100 but under £200	599	27		1.59 *	(1.10–2.30)		0.98	(0.65–1.48)
Under £100	657	26		1.52 *	(1.03–2.25)		0.92	(0.60–1.41)
<b>Change in respondent's income</b>								
			n.s.			n.s.		
About the same	1463	23		1.00	————		1.00	————
Around 20% or more fall	295	24		1.09	(0.74–1.61)		1.08	(0.72–1.62)
Around 20% or more increase	552	21		0.92	(0.69–1.23)		0.86	(0.62–1.19)
<b>Household's grouped weekly gross income at T1</b>								
			+++			++		
£400 and over	937	20		1.00	————		1.00	————
£200 but under £400	579	22		1.14	(0.82–1.58)		1.02	(0.72–1.43)
£100 but under £200	413	31		1.87 ***	(1.33–2.63)		1.23	(0.86–1.77)
Under £100	211	44		3.19 ***	(2.11–4.83)		2.32 **	(1.42–3.79)

# Odds Ratios adjusted for sex, age and CIS-R score at T1

\*\*\* p&lt;0.001, \*\*p&lt;0.01, \*p&lt;0.05

+++ p&lt;0.001, ++ p&lt;0.01, + p&lt;0.05, n.s. = not significant

**Table 6.8 Association between recovery from common mental disorder and treatment**

	Base	% with recovery	Unadjusted regression			Adjusted regression		
			Overall significance of variable	Odds Ratio	95% Confidence Interval	Overall significance of variable	Adjusted Odds Ratio#	95% Confidence Interval
<b>Received treatment</b>			+++			n.s.		
No	495	55		1.00			1.00	
Yes	255	38		0.49 ***	(0.35–0.70)		0.88	(0.59–1.32)
<b># Adjusted for the following variables</b>								
Sex	CIS-R score							
Age (grouped)	Stressful life events prior to T1							
Economic activity status	Stressful life events between T1 and T2							
Ethnicity								
Marital status								

\*\*\* p<0.001, \*\*p<0.01, \*p<0.05

+++ p<0.001, ++ p<0.01, + p<0.05, n.s. = not significant

**Table 6.9 Relationship between level of functioning assessed on the Need for Care Assessment and the diagnostic categories obtained in the baseline interviews**

	CIS-R diagnostic categories		
	Depressive*	Anxiety**	Alcohol dependence
	%	%	%
<b>NFCAS-C Level of functioning</b>			
No problem	54	43	49
Past problem	7	13	1
Current problem	38	42	46
Insufficient information	2	2	3
<i>Bases</i>	123	86	71

\* Depressive episode and mixed anxiety and depression.

\*\* All other CIS-R diagnostic categories.

**Table 6.10 Level of functioning and primary need status with respect to common mental disorders (depression, anxiety/obsession or adjustment disorder) assessed in telephone interviews**

by CIS-R score at T1

	CIS-R score at T1				
	0–5	6–11	12–17	18 and over	Total
	%	%	%	%	%
<b>CMD: level of functioning</b>					
No problem or mild problem	[3]	26	36	17	26
Past problem or likely problem	[5]	31	14	19	21
Current significant problem	[4]	41	49	64	52
Insufficient information	-	2	1	-	1
<b>CMD: Primary need status</b>					
No need	[3]	28	38	18	28
Met need	[7]	54	26	36	38
Some unmet need	[2]	11	15	24	17
No meetable need	-	7	22	22	17
<i>Base*</i>	12	54	88	88	242

\* People who had a common mental disorder at T1 or with no disorder but in receipt of psychotropic medication or psychological therapy.

**Table 6.11 Level of functioning and assessed need with respect to alcohol problems assessed in telephone interviews**

**by level of alcohol problem at T1**

	Level of alcohol problem			Total
	No problem (AUDIT score of 0–7)	Hazardous drinking no dependence (AUDIT score >7 & SAD-Q score 0–3)	Alcohol dependence (SAD-Q score 4+)	
	%	%	%	%
<b>Alcohol problem: level of functioning</b>				
No problem or mild problem	98	65	49	83
Past problem or likely problem	1	8	1	2
Current significant problem	1	28	46	15
Insufficient information	-	-	3	1
<b>Alcohol problem: primary need status</b>				
No need	98	65	52	83
Met need	1	8	6	3
Some unmet need	-	2	6	2
No meetable need	1	25	37	12
<i>Base</i>	193	40	71	304

**Table 6.12 GP consultations for mental or emotional problems in the 2 weeks prior to T1 or between T1 and T2**

**by level of functioning and assessed need for treatment for common mental disorders**

	Level of functioning				Total
	No problem or mild problem	Past problem or likely problem	Current significant problem	Insufficient information	
	%	%	%	%	%
<b>Consulted GP</b>					
No	88	51	54	[2]	63
Yes	12	49	46	-	37
<i>Base</i>	64	51	125	2	242
	Primary need				Total
	No need	Met need	Some unmet need	No meetable need	
	%	%	%	%	%
<b>Consulted GP</b>					
No	84	45	55	76	63
Yes	16	55	45	24	37
<i>Base</i>	67	91	42	42	242

**Table 6.13 GP consultations for mental or emotional problems in the 2 weeks prior to T1 or between T1 and T2 by level of functioning and assessed need for treatment for alcohol problems**

	Alcohol problems: Level of functioning				Total
	No problem or mild problem	Past problem or likely problem	Current significant problem	Insufficient information	
	%	%	%	%	%
<b>Consulted GP</b>					
No	65	[4]	87	[2]	69
Yes	35	[1]	13	-	31
<i>Base</i>	252	5	46	2	305

	Alcohol problems: Primary need				Total
	No need	Met need	Some unmet need	No meetable need	
	%	%	%	%	%
<b>Consulted GP</b>					
No	65	[5]	[5]	92	69
Yes	35	[4]	-	8	31
<i>Base</i>	254	9	5	37	305

**Table 6.14 Assessment of levels of delivery of different types of care for those assessed as having current, past or likely depressive symptoms**

	Types of care for depressive symptoms							Other
	Assessment	Support	Cognitive therapy	Psychotherapy	Marital therapy	Medication	ECT	
	%	%	%	%	%	%	%	%
Not appropriate and not given	53	19	69	85	94	17	97	98
Appropriate and effective	24	31	-	2	1	39	2	2
Appropriate and partly effective	12	13	3	1	-	15	1	-
Non compliance	-	5	1	-	-	5	-	-
Ineffective	-	1	-	-	-	1	-	-
Rejection of idea of treatment	7	19	14	6	2	20	1	-
Overprovision	-	-	-	1	-	1	-	-
Appropriate but not given	3	11	13	2	2	2	-	-
Not known	-	1	1	2	1	2	-	-
<i>Base</i>	124	124	124	124	124	124	124	124

**Table 6.15** Assessment of levels of delivery of different types of care for those assessed as having current, past or likely anxiety or symptoms

Assessment	Types of care for anxiety or obsessional symptoms						
	Support, reassurance, counselling	Cognitive or behavioural therapy	Other structured psychotherapy	Marital or family therapy	Medication	Other	
	%	%	%	%	%	%	
Not appropriate and not given	60	18	52	90	95	33	96
Appropriate and effective	19	28	1	2	1	22	3
Appropriate and partly effective	6	11	4	-	-	11	1
Non compliance	-	2	-	-	-	5	-
Ineffective	-	1	1	-	-	1	-
Rejection of idea of treatment	11	27	24	3	2	20	-
Overprovision	-	-	-	-	-	-	-
Appropriate but not given	3	12	17	4	2	3	-
Rated elsewhere	-	1	1	-	-	1	-
<i>Base</i>	93	93	93	93	93	93	93

**Table 6.16** Assessment of levels of delivery of different types of care for those assessed as having current, past or likely alcohol problems

Assessment	Types of care for alcohol problems							
	Advice	Counselling	Marital or family therapy	Self-help group	Group therapy	Detox	Medication	
	%	%	%	%	%	%	%	
Not appropriate and not given	74	25	57	87	53	89	77	94
Appropriate and effective	11	13	-	-	-	2	4	2
Appropriate and partly effective	2	6	2	-	-	-	-	-
Non compliance	-	-	-	-	-	-	-	-
Ineffective	-	-	-	-	-	-	-	-
Rejection of idea of treatment	13	55	32	9	45	9	19	4
Overprovision	-	-	-	-	-	-	-	-
Appropriate but not given	-	2	8	-	2	-	-	-
Not known	-	-	-	4	-	-	-	-
<i>Base</i>	53	53	53	53	53	53	53	53