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Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey)

Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/4

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Summary

This survey screened for a range of mental health conditions, including common mental

health conditions (using the CIS-R), attention deficit hyperactivity disorder (ADHD, ASRS), posttraumatic stress disorder (PTSD, PLC-C), signs of dependence on drugs and alcohol (AUDIT), gambling harms (PGSI), personality disorder (SAPAS, SCID-II Q) and bipolar disorder (MDQ). Clinical examinations assessed autism (ADOS), psychotic disorders (SCAN) and eating disorders (SCAN ED). See the relevant chapters for further details on each condition or health behaviour and how it was examined.

Highlights

Key findings

Increased prevalence evident for some indicators of poor mental health

• The proportion of 16 to 64 year olds with a common mental health condition increased from 17.6% in 2007 and 18.9% in 2014, to 22.6% in 2023/4. The proportion was higher in women than men at each point.
• Lifetime non-suicidal self-harm was reported by 3.8% of 16 to 74 year olds in 2007, rising to 6.4% in 2014 and 10.3% in 2023/4.
• The proportion of adults screening positive rose for ADHD from 8.2% in 2007 and 9.7% in 2014, to 13.9% in 2023/4.

Stability in prevalence evident for other conditions

- Autism (examined using ADOS) has remained stable in prevalence since 2007, at about one in a hundred adults (0.8%).
- Psychotic disorder (examined using SCAN) also remained stable since 2007, identified in less than one in a hundred adults (0.5%).
- One in fifty adults screened positive for bipolar disorder in both 2014 and 2023/4 (using the MDQ).
- Similar stability over time was evident for personality disorders (using both the SCID-II Q and SAPAS).

Young adults remain a key group

- The proportion of 16 to 24 year olds with a common mental health condition rose from 17.5% in 2007 to 25.8% in 2023/4.
- Younger adults were also more likely to report lifetime non-suicidal self-harm and to screen positive for disordered eating symptoms, PTSD and ADHD than older age groups.
- There was a decline in drinking at hazardous levels or above. It halved among 16 to 24 year olds (from 40.7% in 2000 to 18.1% in 2023/4) and also fell among those aged 25 to 44.

Socioeconomic inequalities in mental health persist

• The proportion of adults with common mental health conditions was higher in those living in the most deprived fifth of areas (26.2%), with problem debt (39.0%) and not in employment (40.0% in unemployed adults and 38.8% in economically inactive adults).
• The proportion of adults with bipolar disorder was higher in those living in the most deprived fifth of areas (3.6%), with problem debt (6.4%) and not in employment (9.0% in unemployed adults and 4.9% in economically inactive adults).
• The proportion of adults with clinically examined psychotic disorder was higher in those living in the most deprived fifth of neighbourhoods (1.0%), with problem debt (1.7%) and varied by employment status (2.6% in economically inactive adults).

Treatment use for common mental health conditions increased in prevalence

• The proportion of 16 to 74 year olds, with common mental health condition symptoms (CIS-R 12+), reporting receipt of treatment rose from 24.4% in 2007 and 39.4% in 2014, to 47.7% in 2023/4.
• Receipt of psychological therapies, among those with symptoms (CIS-R 12+), rose from 10.4% in 2007 to 17.9% in 2023/4; and receipt of medication rose from 19.6% in 2007 to 38.4% in 2023/4.

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Data Sets

- Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/4: Data tables (Link: /data-and-information/publications/

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Introduction

The Adult Psychiatric Morbidity Survey series

The Adult Psychiatric Morbidity Survey (APMS) series provides data on the prevalence of treated and non-treated mental health conditions in England's adult population (age 16 and over).

The 2023/4 survey is the fifth in the series, with previous surveys conducted in 1993, 2000, 2007 and 2014. The surveys all used a robust probability sample of adults living in residential households.

The aims of the series are to:

- Estimate the prevalence of a range of mental health conditions according to diagnostic category, including common mental health conditions, psychosis, autism, eating disorder, and substance dependence.
- Screen for attention deficit hyperactivity disorder (ADHD), posttraumatic stress disorder (PTSD), bipolar disorder, gambling behaviour, personality disorder, and suicidal thoughts, suicide attempts and non-suicidal self-harm.
- Examine trends over time in mental health conditions.
- Identify the nature and extent of inequalities in mental health conditions.
- Gauge the level and nature of treatment and service use in relation to mental health conditions.

Adult Psychiatric Morbidity Survey 2023/4

Fieldwork was carried out between March 2023 and July 2024. As with the preceding surveys, a two-phase approach was used for the assessment of several disorders.

6,912 phase one interviews were carried out by interviewers from the National Centre for Social Research and included structured assessments and screening instruments for mental health conditions and disorders as well as questions covering demographics, general health, service use and risk factors.

880 phase two interviews were carried out by clinically trained research interviewers employed by the University of Leicester. A sub-sample of phase one participants were invited to take part in the second phase assessment, which included assessment of psychosis, autism and eating disorders. 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.

As in preceding surveys, APMS 2023/4 data was mostly collected through face-to-face interviewer visits. In 2023/4, an option for remote interviews for phase one was available if required. Full details of fieldwork processes can be found in the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

Each chapter of the report focuses on a specific mental health condition or behaviour. The chapters compare prevalence of mental health conditions by:

- age
- gender identity
- ethnicity

- employment status
- problem debt
- area-level deprivation
- region
- comorbidity
- level and nature of self-reported mental health treatment and service use.

Where conditions or disorders were included in the previous surveys in the series, changes in prevalence are also covered.

This study was funded by the Department for Health and Social Care (DHSC) and commissioned by NHS Digital (now merged into NHS England). It was carried out by the National Centre for Social Research, University of Leicester and City St George's, University of London.

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How to interpret the findings

About the survey estimates

The Adult Psychiatric Morbidity Survey (APMS), in common with other surveys, collects information from a sample of the population. The sample was designed to represent the whole population of adults living in residential households in England as accurately as possible within practical constraints, such as time and cost. Consequently, statistics based on the survey are estimates, rather than precise figures, and are subject to a margin of error, shown as a 95% confidence interval.

For example, the survey estimate might be 24.1% with a 95% confidence interval of 22.2% to 26.4%. A different sample might have given a different estimate, but we expect that the true value of the statistic in the population would be within the range given by the 95% confidence interval in 95 cases out of 100.

Where differences are commented on in this report, these reflect the same degree of certainty that these differences are real, and not just within the margins of sampling error. These differences can be described as statistically significant implying no more than a 5% chance that any reported difference is not a real one but a consequence of sampling error. Statistical significance does not imply substantive importance; differences that are statistically significant are not necessarily meaningful or relevant.

Confidence intervals are shown for key statistics and trends within this report and in the accompanying Excel data tables. Confidence intervals are affected by the size of the sample on which the estimate is based. Generally, the larger the sample, the smaller the confidence interval, and hence the more precise the estimate.

Comparisons with past survey estimates

The APMS 2023/4 data collection methodology was similar to the methodology used in previous surveys in the series (1993, 2000, 2007, 2014). Findings from 2023/4 can be compared to previous years, and thus trend tables are included in this report.

To determine whether differences in prevalence across survey years indicate change over time, confidence intervals were compared for overall and subgroup estimates. Non-overlapping confidence estimates were used to indicate that changes in prevalence over time were significant. In some instances, slightly overlapping confidence intervals might still be significant according to a generated p-value, which provides an alternative indication of statistical significance. In these instances, this is explained in the commentary. This is a cautious but transparent approach to assessing change over time in this report.

Data in trend tables and associated commentary are presented by sex, defined as male or female at birth.

Further details on changes to the APMS 2023/4 methodology can be found in the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

Population size estimates

Across the APMS chapters the prevalence of mental health conditions has been converted into estimates of the number of people in the population in England that they represent.

For population size estimates, the prevalence for each year (expressed as a proportion)

was multiplied by a scaling factor equal to the total mid-year population estimate for 2022 (Link: https://www.ons.gov.uk/releases/populationestimatesfortheukenglandwalesscotlandandnorthernirelandmid202 then multiplied by the proportion of people in the relevant age and sex group in APMS. The mid-year population estimate was adjusted to represent the population living in private households excluding those aged 65 and over living in institutions. Details of the method used to compute the population size estimates are provided in the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

Analysis breaks

Gender and sex

In this report, results are mostly broken down by gender identity, that is whether participants identified as a man, a woman or another gender identity such as non-binary. This report uses the terms men and women when describing analysis based on gender identity. Those identifying in another way, such as non-binary, are not included as a separate group due to small base sizes and disclosure risk. They are included in totals and in tables without a gender break. Therefore, where data are presented by gender, the combined number of men and women may total less than the number of all adults due to inclusion of other gender identities. The base for all tables that cover the whole population is described as 'all adults'.

Data in trend tables and associated commentary are presented by sex, defined as male or female at birth and described as male and female in the commentary. The psychotic disorder (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/psychotic-disorder) and autism spectrum disorder (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/autism-spectrum-disorder) chapters also present data by sex (rather than gender) to facilitate analysis of the combined samples from 2007, 2014 and 2023/4.

More information about demographic data collection can be found in the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

Other analysis breaks

Most of the mental health conditions and behaviours covered in these results are analysed by a core set of breaks in addition to gender or sex:

- age
- ethnic group
- employment status
- problem debt
- area-level deprivation (Index of Multiple Deprivation quintile)
- region
- presence of common mental health conditions and limiting physical health conditions

Chapters also include crossbreaks for mental health treatment received and service use. This could be treatment received for any mental health or emotional problem, not necessarily the one covered by the chapter.

More information about analysis breaks and associated definitions can be found in the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

Rounding of estimates

Estimates presented in the text are rounded to one decimal place, which is equivalent to reporting rates per thousand. Population estimates are presented to the nearest two significant figures.

Age-standardisation

Data within this report have been age-standardised to allow comparisons between groups after adjusting for the effects of any differences in their age distributions. When different subgroups are compared in respect of a variable on which age has an important influence, any differences in age distributions between these subgroups are likely to affect the observed differences in the proportions of interest. For information about the method used, see the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

Weighted analysis and unweighted bases

Data presented in the substantive chapters of this report are weighted to account for likelihood of selection and non-response. Both weighted and unweighted bases are shown in the tables. Where data are age-standardised, the age-standardised bases are presented. Observed and age-standardised bases differ slightly because observed bases include cases with missing data on age and sex, which are required for age-standardisation.

Mental health conditions covered by APMS

The survey uses a range of tools to assess or screen participants for different mental health conditions. A summary of the measures used for each of the mental health conditions covered is listed in the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

In APMS 2023/4, the term common mental health condition (CMHC) is used in place of common mental disorder (CMD) as the word 'condition' is sometimes felt to be less stigmatising. For further information see the NHS Mental health conditions (Link: https://www.nhs.uk/mental-health/conditions/) webpage and Appendix B (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods#appendices) of the APMS 2023/4 Methods documentation.

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Chapter 1: Common mental health conditions

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Overview

Common mental health conditions (CMHCs) comprise different types of depression and anxiety disorder. They cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. CMHCs are usually less disabling than major psychiatric disorders.

The Clinical Interview Schedule-Revised (CIS-R) has been used in each Adult Psychiatric Morbidity Survey (APMS) in the series to assess six types of CMHCs:

- Depression
- Generalised anxiety disorder (GAD)
- Panic disorder
- Phobias
- Obsessive compulsive disorder (OCD)
- CMHC not otherwise specified (CMHC-NOS).

Some people meet the criteria for more than one CMHC. The CIS-R is also used to produce a score that reflects overall severity of CMHC symptoms. A CIS-R score of 12 or more is used to indicate a clinically significant level of CMHC symptoms, and of 18 or more to indicate severe CMHC symptoms.

Key findings

- **One in five (20.2%) adults in England had a CMHC**, with prevalence higher in women (24.2%) than men (15.4%). The most prevalent CMHCs were GAD (7.5%), depression (3.8%), and the general category of CMHC-NOS (8.6%).
- **CMHCs have increased in prevalence** among 16 to 64 year olds: from 15.5% in 1993, 17.5% in 2000, 17.6% in 2007, and 18.9% in 2014, to 22.6% in 2023/4. Increases since 2014 were evident in males and females, and most age groups.
- **Young people were more likely to have a CMHC than older people**. Among 16 to 24 year olds, CMHC prevalence rose from 17.5% in 2007 and 18.9% in 2014, to 25.8% in 2023/4. While among those aged 75 and over, prevalence was lower and stable (9.9% in 2007, 8.8% in 2014, 10.2% in 2023/4).
- **Prevalence of severe CMHC symptoms has also increased:** 11.6% of 16 to 64 year olds scored 18 or more on the CIS-R in 2023/4, compared with 9.3% in 2014.
- **There is a socioeconomic gradient in CMHCs**, with prevalence higher in the most deprived fifth of areas (26.2%) than in the least deprived fifth of areas (16.0%). People with problem debt were twice as likely to have a CMHC (39.0%) as those with no problem debt (18.4%). This pattern of association was similar for men and women. Among working age adults, unemployed (40.0%) and economically inactive (38.8%) people were more likely to have a CMHC than those in employment (18.3%). This association was stronger for men than women.
- **Regional disparities in CMHCs were evident**, with people in the North East (24.6%) and East Midlands (24.6%) more likely to have a CMHC than those in the South East (16.3%) and South West (18.7%).
- **Physical and mental health are strongly linked**. 32.9% of people with a physical health condition that limited their activities had a CMHC, compared with 12.6% of those without a limiting physical health condition. This association was stronger for men than women.
- **Most people identified by the CIS-R with a CMHC also perceived themselves to have had a CMHC** at some point (84.0%). Two-thirds (66.5%) reported that they had been diagnosed by a professional. Adults identified with anxiety disorders had lower levels of professional diagnosis for those conditions, such as OCD with only 9.6% being professionally diagnosed and 3.3% for those identified with a phobia. However, such individuals had often received a professional diagnosis of depression.

1.1 Introduction

CMHCs include a range of anxiety and depressive disorders. They vary in severity from mild to severe and are associated with social and physical impairments and difficulties with occupational functioning (Goldberg and Huxley 1992). Although a significant source of distress to individuals and those around them, anxiety disorders and depression often

remain undiagnosed (Kessler et al. 2002). Sometimes people do not seek or receive treatment (Lowther-Payne et al. 2023), sometimes they may get but do not adhere to treatment (Cooper et al. 2007). If left untreated, CMHCs can lead to long term physical, social and occupational disability (Collins et al. 2023) and premature mortality (Plana-Ripoll et al. 2019). Comorbidity between mental disorders is common (McGrath et al. 2020) and has implications for treatment pathways (Bhavsar et al. 2021). CMHCs can be relapsing conditions, especially where the stressors that caused them continue to exist (Solmi et al. 2023). For example, about half of people treated for depression experienced a recurrence within 12 months of initial improvement (Beshai et al. 2011).

There is a strong economic case for investing in the prevention of CMHCs. The societal costs of mental health conditions were estimated at £117.9 billion in the UK in 2019 (McDaid et al. 2022 (Link: https://www.mentalhealth.org.uk/sites/default/files/2022-06/MHF-Investing-in-Prevention-Full-Report.pdf)). Most of this was due to the lost productivity of people living with mental health conditions, as well as costs incurred by unpaid informal carers. Mental illness impacts on labour force engagement, accounting for 7.9% of UK sickness absence in 2022 (ONS 2023 (Link: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/labourproductivity/articles/sicknessabsenceinthelabourmarket/2022)). In the same year, 69% of Work Capability Assessments had a 'mental or behavioural disorder' recorded as the primary condition (Department for Work and Pensions 2024 (Link: https://www.gov.uk/government/statistics/universal-credit-work-capability-assessment-statistics-april-2019-to-december-2023/universal-credit-work-capability-assessment-april-2019-to-december-2023)). Analysis of APMS 2014 found that two thirds (65.2%) of Employment and Support Allowance (ESA) recipients (a benefit aimed at people with a health condition or disability that affects how much they can work) had a CMHC, four times that of employed people (14.6%) (Lapham et al. 2024 (Link: https://www.gov.uk/government/publications/a-health-social-and-economic-profile-of-esa-recipients-adult-psychiatric-morbidity-survey-2014/a-health-social-and-economic-profile-of-esa-recipients-adult-psychiatric-morbidity-survey-2014)). Between 2013 and 2019, one in four specialist mental health service users received Universal Credit, a welfare benefit rolled out in the UK from 2013 (Stevelink et al. 2024). Some studies have suggested the introduction of Universal Credit may have led to an increase in psychological distress among unemployed people affected by the policy (Wickham et al. 2020; Brewer et al. 2024).

The social determinants of mental disorder are well established (Kirkbride et al. 2024). Data from the APMS series have helped quantify the extent to which a range of characteristics and experiences have been associated with CMHC in England (McManus et al. 2020), including those related to:

- Demographics: gender (Weich et al. 1998), ethnicity (Ahmad et al. 2022), age (Bogdanova et al. 2022), sexual identity (Pitman et al. 2022)
- Early years: bullying (Meltzer et al. 2011), child sexual abuse (Bebbington et al. 2011), adversity (Meltzer et al. 2012b)
- Social relationships: loneliness (Meltzer et al. 2013b), family adversity (Cook et al. 2024), caring responsibilities (Stansfeld et al. 2014)
- Violence and abuse: physical (Fadeeva et al. 2024), sexual (McManus et al. 2022), threats (McManus et al. 2021), domestic abuse (Hashemi et al. 2025; Bhavsar et al. 2023)
- Health risk behaviours: gambling (Wardle et al. 2020), drug use (Bebbington et al. 2020), alcohol use (Puddephatt et al. 2021)
- Physical health and impairments: disability (Meltzer et al. 2012a), menopause (Adji et al. 2023), sensory impairments (Shoham et al. 2019), epilepsy (Nimmo-Smith et al. 2016)
- Stressful life events: discrimination (Rhead et al. 2022), incarceration (Bebbington et al. 2021), homelessness (Chilman et al. 2024), flooding (Graham et al. 2019)
- Occupational environment: workplace bullying (Bunce et al. 2024), job quality (Butterworth et al. 2013), being a student (McManus and Gunnell 2020) or veteran (Woodhead et al. 2011)
- Financial strain: poor housing (Harris et al. 2010 (Link: https://www.fuelpovertylibrary.info/sites/default/files/EAGA14%20%282010%29%20%20REPORT%20Health%20mental%20health%20and%20housing%20conditio debt (Meltzer et al. 2013a), unemployment (Lapham et al. 2024 (Link: https://www.gov.uk/government/publications/a-health-social-and-economic-profile-of-esa-recipients-adult-psychiatric-morbidity-survey-2014/a-health-social-and-economic-profile-of-esa-recipients-adult-psychiatric-morbidity-survey-2014)).

Concern about population mental health came to the fore during the COVID-19 pandemic. Studies found an initial increase in psychological distress in the UK (Pierce et al. 2020), particularly for those who already had a CMHC (Pierce et al. 2021). There was evidence of a widening in mental health inequalities (Taxiarchi et al. 2023), alongside disruptions to mental health treatment access and modes of delivery (Abel et al. 2021). The pandemic may have a lasting impact on mental health risks, for example through persisting increases in remote working and consequent concerns about social isolation (Parry et al. 2022). However, signals of rising rates of CMHC predate the pandemic (Dykxhoorn et al. 2024), with a variety of potential drivers noted such as recession and subsequent austerity (Curtis et al. 2021), precarity and the cost-of-living crisis (ONS 2022 (Link: http://Office for National Statistics. (2022, December 6). Cost of living

and depression in adults, Great Britain: 29 September to 23 October 2022. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/mentalhealth/articles/costoflivinganddepressioninadultsgreatbritain/29septemberto23october2022)) and digital technology use (Orben et al. 2024). Lord Darzi noted in his investigation of the NHS in England that 'many of the social determinants of health – such as poor quality housing, low income, insecure employment – have moved in the wrong direction over the past 15 years with the result that the NHS has faced rising demand for healthcare from a society in distress' (Darzi 2024 (Link: http:// https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england)).

Reducing CMHCs is a major public health challenge (Public Health England 2018 (Link: https://www.gov.uk/government/publications/health-matters-reducing-health-inequalities-in-mental-illness/health-matters-reducing-health-inequalities-in-mental-illness)). England's Prevention Concordat for Better Mental Health was developed to support cross-sector adoption of public mental health approaches (Office for Health Improvement and Disparities (OHID) 2024 (Link: https://www.gov.uk/government/publications/prevention-concordat-for-better-mental-health-consensus-statement/prevention-concordat-for-better-mental-health#about-the-prevention-concordat)). Its consensus statement highlights that improving population mental health requires preventive action by local authorities; integrated care systems (ICSs); public, private, and voluntary, community and social enterprise (VCSE) sector organisations; educational settings; employers; emergency services; justice systems; and social care, as well as the NHS. As well as addressing risk and protective factors, the Prevention Concordat also supports the aims of the NHS Long Term Plan (Link: https://www.longtermplan.nhs.uk/areas-of-work/mental-health/) to increase and widen access to care for those needing mental health support (NHS 2019 (Link: https://https://www.longtermplan.nhs.uk/)). For information on use of treatment and services among people with CMHCs, see Chapter 2 Mental health treatment and service use (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/mental-health-treatment-and-service-use).

1.2 Definitions and assessments

Common mental health conditions (CMHCs, also known as common mental disorders (CMD) and neurotic disorders), cause marked emotional distress and interfere with daily function. CMHCs comprise different types of depression and anxiety disorder:

- 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 (NICE 2022 (Link: https://www.nice.org.uk/guidance/ng222)).
- Anxiety disorders include generalised anxiety disorder (GAD), panic disorder, phobias, and obsessive compulsive disorder (OCD) (NICE 2011, updated 2020 (Link: https://www.nice.org.uk/guidance/cg113/)).

Symptoms of depression and anxiety frequently co-exist, with the result that many people meet criteria for more than one CMHC.

The Clinical Interview Schedule – Revised (CIS-R)

Different types of CMHCs and symptoms of CMHC were assessed in the first phase interview using the 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 CMHC symptoms and six types of CMHCs, together with a continuous scale that reflects the overall severity of CMHC psychopathology (Lewis et al. 1992).

Each section of the CIS-R assesses one type of CMHC 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.

Although minor changes were made to the questions to improve comparability with the International Classification of Diseases 11th Revision (ICD-11) diagnostic classification, results in this chapter use diagnoses generated by the 10th International Classification of

Disease (ICD-10) to allow comparability across the APMS survey series (World Health Organization (WHO) 1993; 2019 (Link: https://icd.who.int/)). 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 A (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods#appendices) of the APMS 2023/4 Methods documentation. Data on the symptom scores are not presented in this chapter but are available in the archived dataset.

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

- *CIS-R score of 12 or more* is the threshold applied to indicate that a level of CMHC symptoms is present such that primary care recognition is likely to be warranted. In this chapter, 'presence of CMHC symptoms' includes all participants with a CIS-R score of 12 or more (including those with a score of 18 or more).
- *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 CMHC 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 ICD-10 diagnoses of CMHC using the computer algorithms described in Appendix A (Link: /pagenotfound#appendices) of the APMS 2023/4 Methods documentation (WHO 1993). ICD-10 diagnoses were used throughout the chapter to enable comparison across the APMS survey series. 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
- CMHC not otherwise specified (CMHC-NOS).

CIS-R scores of 12 or more are conventionally taken to indicate a CMHC. Participants with such a score who did not meet the criteria for any of the specific disorders assessed were categorised with CMHC not otherwise specified (CMHC-NOS). 'CMHC-NOS' is also known

as mixed anxiety and depression or cothymia (Das-Munshi et al. 2008). By definition, participants with this diagnosis could not be classed as having any other CMHC measured by the CIS-R. For the other five ICD-10 disorders, participants could be classed in more than one category. Some adults identified with a CMHC did not score 12 or more on the CIS-R. Participants with a CIS-R score of 11 or less could still meet the criteria for some specific CMHC. All of those with a CIS-R score of 12 or above were classed as having a CMHC, compared with 0.3% of those with a score of 5 or below (few or no CMHC symptoms), and 9.6% of those with a score of between 6 and 11 (some evidence of CMHC symptoms). Most of those with a CMHC with a CIS-R score below 12 were classed as having GAD.

The CIS-R was used to assess CMHCs in the 1993, 2000, 2007 and 2014 APMS. The schedule was administered using computer assisted interviewing in the 2000, 2007, 2014 and 2023/4 surveys, and by paper in 1993. The approach has otherwise remained consistent, and the data are comparable across survey years. Trends over time presented in this chapter focus on 16 to 64 year olds, because the 1993 survey did not sample adults aged 65 and over. In APMS 2007, 2014 and 2023/4, there was no an upper age limit to participation and the sample covered England only (the first two surveys also covered Scotland and Wales).

Calculation of CIS-R scores are described in detail in Appendix A (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods#appendices) of the APMS 2023/4 Methods documentation.

1.3 Results

Prevalence of CMHC symptoms, by age and gender

Nearly one in five adults (18.3%) were identified with CMHC symptoms of a level likely to benefit from acknowledgement and possible intervention (as indicated by a CIS-R score of 12 or more). Prevalence in the wider population is likely to be between 17.0% and 19.6%, referred to as the 95% confidence interval (95% CI). This equates to about 8.5 million adults in England. One in ten (10.0%, CI 9.1, 11.0) adults had severe CMHC symptoms (CIS-R 18+), approximately 4.7 million adults in England.

Women (21.8%, CI 20.1, 23.5) were more likely than men (14.0%, CI 12.4, 15.8) to score 12 or more on the CIS-R. Women (11.9%, CI 10.6, 13.4) were also more likely than men (7.5%, CI 6.4, 8.9) to have severe CMHC symptoms (CISR 18+).

CIS-R score of 12-17 and 18 or more, by gender (Base: All adults)

Download the data for this chart CIS-R score of 12-17 and 18 or more, by

gender (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/common-mental-health-conditions/common-mental-health-conditions/publicationsystem%3AbodySections%5B7%5D/publicationsystem%3AdataFile)

The proportion scoring 12 or more on the CIS-R declined with age, from 22.8% (CI 18.0, 28.6) of those aged 16 to 24 to 9.4% (CI 7.5, 11.7) of those aged 75 and over. A similar pattern was observed for severe CMHC symptoms: 14.2% (CI 10.4, 19.0) of those aged 16 to 24 scored 18 or more on the CIS-R, compared with 3.8% (CI 2.5, 5.6) of those aged 75 and over).

The overall pattern of association between age and CMHC symptoms was not significantly different for men and women, with prevalence generally higher in women than men in each age group.

For more information: Table 1.1 and Table A1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals.

CIS-R score of 12-17 and 18 or more, by age (Base: All adults)

Download the data for this chart CIS-R score of 12-17 and 18 or more, by age (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/common-mental-health-conditions/common-mental-health-conditions/publicationsystem%3AbodySections%5B9%5D/publicationsystem%3AdataFile)

Trends in CMHC symptoms, 1993, 2000, 2007, 2014 and 2023/4

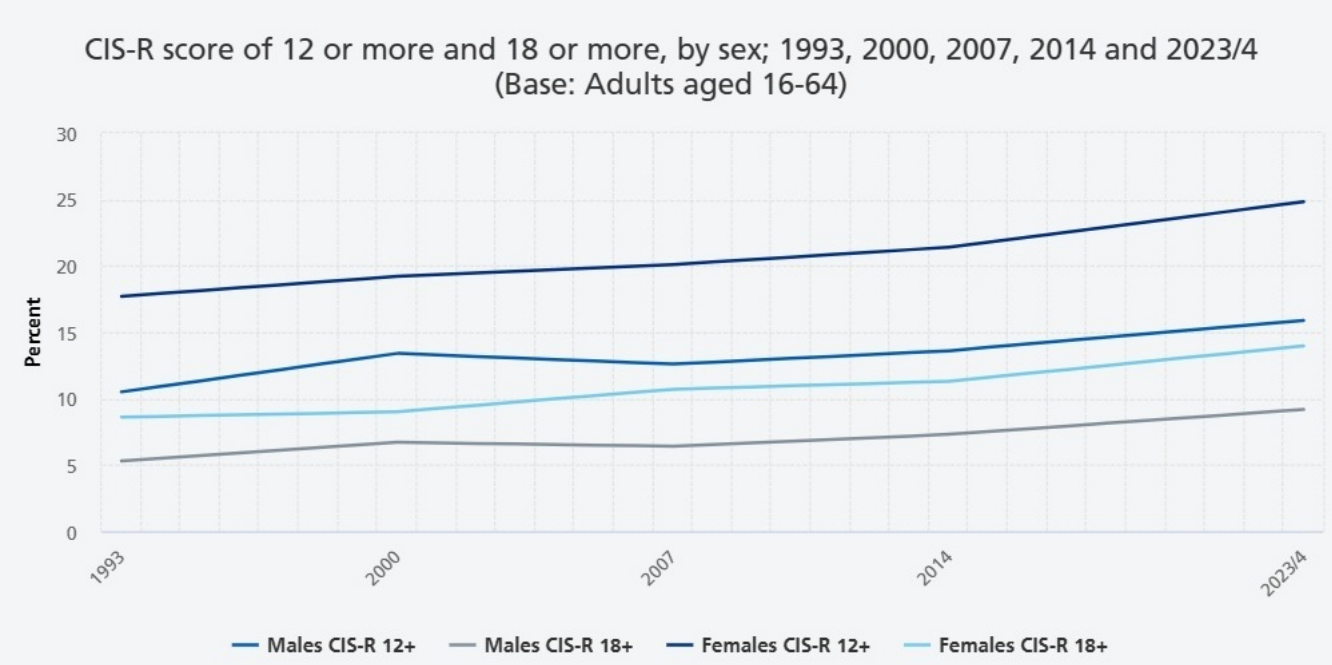
Note that the trends in this chapter are based on 16 to 64 year olds, to allow for comparison with 1993, and analysed by sex (male and female) rather than gender (men and women). See How to interpret the findings (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/how-to-interpret-the-findings) for

information on how changes over time were assessed.

Among 16 to 64 year olds, the proportion with CMHC symptoms (CIS-R 12+) has increased over time. It was 14.1% (95% CI 13.4, 14.9) in 1993, 16.3% (CI 15.3, 17.3) in 2000, 16.4% (CI 15.3, 17.5) in 2007 and 17.5% (CI 16.4, 18.7) in 2014, increasing to 20.4% (CI 18.9, 22.0) in 2023/4.

Severe CMHC symptoms (CIS-R 18+) also rose in prevalence, from 6.9% (CI 6.4, 7.5) in 1993 and 8.5% (CI 7.8, 9.3) in 2007, up to 11.6% (CI 10.5, 12.8) in 2023/4.

The upward trend in CMHC symptoms was evident in both males and females, with scores consistently higher in females.



The upward trend in CMHC symptoms was evident across the 16 to 64 age range. In each age group, the proportion scoring 12 or more was higher in 2023/4 than it was in 1993. This was also true for the proportion scoring 18 or more.

There is evidence of different patterns of change over time among males and females in different age groups. 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.

For more information: Table 1.2 and Table B1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals.

Prevalence of CMHCs, by age and gender

One in five (20.2%) adults were identified with a CMHC in the past week, based on the

CIS-R. If all adults in the population had been assessed, it is likely that the proportion would be between 18.9% and 21.6% (95% CI). This equates to an estimated 9.4 million adults living in England having a CMHC.

The most common CMHC, as in previous years of the survey, was CMHC-NOS (CMHC not otherwise specified) (8.6%, 95% CI 7.8, 9.5). Prevalence of other conditions was:

- 7.5% for generalised anxiety disorder (GAD) (CI 6.7, 8.4)
- 3.8% for depressive episode (CI 3.3, 4.5)
- 2.6% for phobias (CI 2.2, 3.2)
- 2.2% for OCD (CI 1.7, 2.8)
- 1.0% for panic disorder (CI 0.7, 1.5).

Women (24.2%) were more likely than men (15.4%) to have a CMHC. Specific CMHCs that were more prevalent in women than men were GAD (8.9%, CI 7.8, 10.2, compared with 5.7%, CI 4.7, 6.8), depression (4.5%, CI 3.7, 5.5, compared with 3.1%, CI 2.4, 3.9) and CMHC-NOS (10.5%, CI 9.3, 11.8, compared with 6.4%, CI 5.3, 7.7). The prevalence of phobias, OCD and panic disorder was similar among men and women.

Prevalence of common mental health conditions (CMHCs) in past week, by gender (Base: All adults)

Download the data for this chart Prevalence of common mental health conditions (CMHCs) in past week, by gender (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/common-mental-health-conditions/common-mental-health-conditions/publicationsystem%3AbodySections%5B13%5D/publicationsystem%3AdataFile)

People of working age (16 to 64) were more likely to have a CMHC than those aged 65 and over. This was also true for each type of CMHC (except for panic disorder). CMHC prevalence among those aged 75 and over was 10.2% (CI 8.3, 12.5), less than half that for those aged 16 to 64 (22.6%, CI 21.0, 24.3).

The pattern of association between age and depression was different for women and men. For women, prevalence of depression decreased with age, from 7.4% (CI 3.8, 14.1) of 16 to 24 year olds to 2.5% (CI 1.0, 5.8) of women aged 75 and over. For men, there was no clear association between depression and age. For other CMHCs, the pattern of association with age was similar for men and women.

For more information: Table 1.3, Table 1.4 and Table A2 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/

survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals.

Prevalence of common mental health conditions (CMHCs) in past week among men, by age (Base: All men)

Download the data for this chart Prevalence of common mental health conditions (CMHCs) in past week among men, by age (Base: All men) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/common-mental-health-conditions/common-mental-health-conditions/publicationsystem%3AbodySections%5B15%5D/publicationsystem%3AdataFile)

Prevalence of common mental health conditions (CMHCs) in past week among women, by age (Base: All women)

Download the data for this chart Prevalence of common mental health conditions (CMHCs) in past week among women, by age (Base: All women) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/common-mental-health-conditions/common-mental-health-conditions/publicationsystem%3AbodySections%5B16%5D/publicationsystem%3AdataFile)

Trends in CMHCs, 1993, 2000, 2007, 2014 and 2023/4

Note that the trends in this chapter are based on 16 to 64 year olds, to allow for comparison with 1993, and analysed by sex (male and female) rather than gender (men and women). See How to interpret the findings (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/how-to-interpret-the-findings) for information on how changes over time were assessed.

Among 16 to 64 year olds, CMHC prevalence increased over time, from 15.5% (95% CI 14.7, 16.3) in 1993, 17.5% in 2000 (CI 16.5, 18.5), 17.6% in 2007 (CI 16.5, 18.8) and 18.9% in 2014 (CI 17.7, 20.1), up to 22.6% (CI 21.0, 24.3) in 2023/4.

CMHC prevalence increased in both males and females aged 16 to 64. The proportion of males with a CMHC rose from 11.9% (10.9,12.9) in 1993 to 17.3% (15.2,19.5) in 2023/4.

Among females, prevalence rose from 19.1% (18.0, 20.4) in 1993 to 27.8% (25.7, 30.1) in 2023/4. CMHC prevalence was consistently higher among females than males.

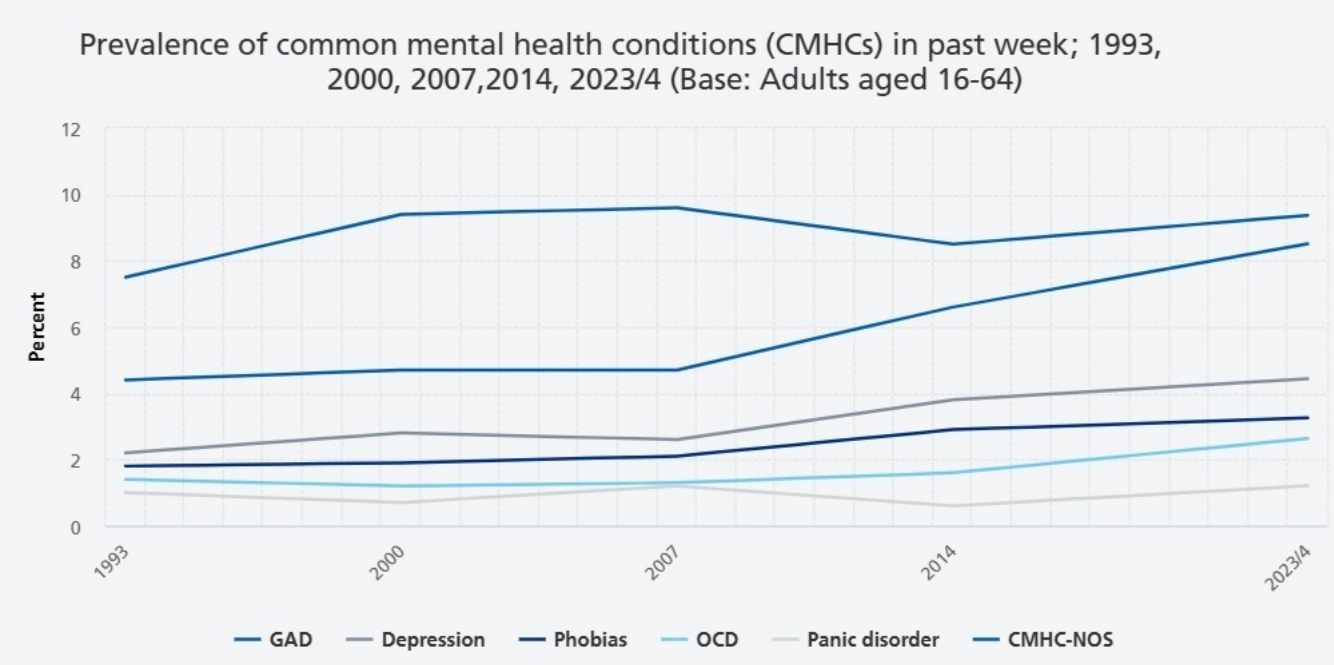
Patterns of change over time varied by type of CMHC. A particularly pronounced change was evident for GAD. Among 16 to 64 year olds, GAD prevalence was stable between 1993 (4.4%, CI 3.9, 4.8), 2000 (4.7%, CI 4.2, 5.3) and 2007 (4.7%, CI 4.2, 5.3), before increasing to 6.6% (CI 5.9, 7.4) in 2014 and 8.5% (7.5, 9.5) in 2023/4. The increase was in both males and females.

Depression, phobias, and OCD also increased significantly in prevalence since 2007.

- Depression rose from 2.6% (2.2, 3.1) in 2007 to 4.4% (3.8, 5.2) in 2023/4
- Phobias rose from 2.1% (1.8, 2.6) in 2007 to 3.3% (2.7, 4.0) in 2023/4
- OCD rose from 1.3% (1.0, 1.7) in 2007 to 2.6% (2.0, 3.4) in 2023/4.

The rise in depression was steeper for females than males, while for phobias the rise was steeper for males than females.

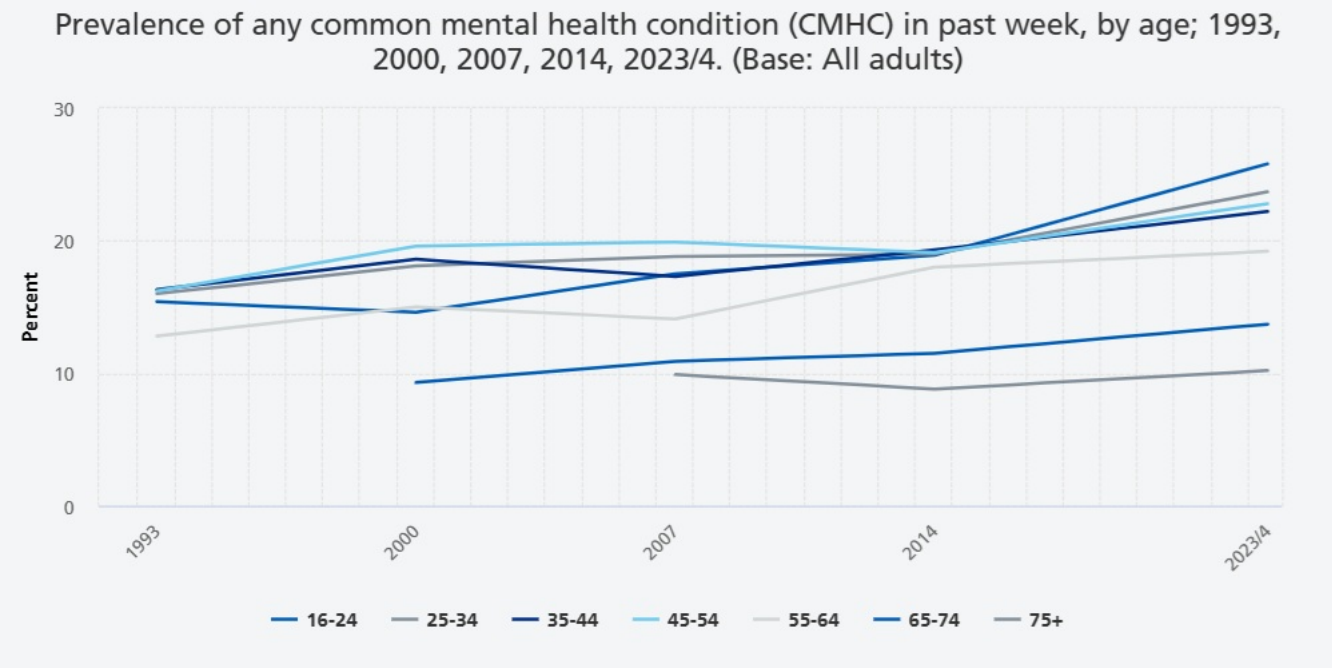
Prevalence of CMHC-NOS has remained broadly stable since 2000.



The upward trend in CMHCs was evident across the 16 to 64 age range. For every age group in this range, the proportion with a CMHC was higher in 2023/4 than it was in 1993.

There is evidence of different patterns of change since 2000 in different age groups and in males and females. These trends need to be treated with some caution as the base sizes for some age by sex combinations are small.

Increase in prevalence of any CMHC since 2000 was particularly prominent in those aged 16 to 24, from 14.6% (CI 12.0, 17.7) in 2000 to 25.8% (CI 20.8, 31.9) in 2023/4.



The increased prevalence of specific CMHCs since 2000 was also particularly steep for younger age groups.

The proportion of 16 to 24 year olds with GAD rose from 1.1% (CI 0.6, 2.1) in 2000 to 7.6% (CI 5.0, 11.6) in 2023/4. In 25 to 34 year olds, GAD rose in prevalence from 4.5% (CI 3.5, 5.8) in 2000, to 10.1% (CI 7.8, 12.6) in 2023/4.

The proportion of 16 to 24 year olds with OCD increased from 1.5% (CI 0.8, 2.9) in 2000 to 5.7% (CI 3.3, 9.6) in 2023/4.

For more information: Table 1.4 and Table B2 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals.

CMHCs, by CIS-R score

Among people with a CIS-R score of 18 or more, most met the criteria for a specific CMHC, and a quarter (27.9%) were classed as having CMHC-NOS. About half (48.4%) of those with severe CMHC symptoms (CIS-R 18+) were identified with GAD, a third (32.5%) with depression, and about a quarter (22.0%) with phobias.

Among those with a CIS-R score of 12 to 17, 70.5% were identified with CMHC-NOS.

For more information: Table 1.5 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Variation in CMHCs by other characteristics

Ethnic group

Using age-standardised figures, overall variation in CMHC prevalence by ethnic group was not statistically significant. However, the number of participants in some ethnic groups was small and the confidence intervals around estimates were wide.

For more information: Table 1.6 and Table A3 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals.

Employment status

Age-standardised analyses of having a CMHC varied by employment status for those of working age (16 to 64 years). Prevalence of a CMHC in unemployed (40.0%) and economically inactive (38.8%) adults was twice that of employed adults (18.3%).

The strength of association between employment status and presence of a CMHC was stronger for men than women. Among employed adults, women (23.7%) were twice as likely as men (12.3%) to have a CMHC, while CMHC prevalence was similar in unemployed men (40.1%) and women (39.8%), and economically inactive men (38.4%) and women (38.3%).

For more information: Table 1.7 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Prevalence of common mental health conditions (CMHCs) in past week, by employment status (age-standardised) (Base: Adults aged 16-64)

Download the data for this chart Prevalence of common mental health conditions (CMHCs) in past week, by employment status (age-standardised) (Base: Adults aged 16-64) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/common-mental-health-conditions/common-mental-health-conditions/publicationsystem%3AbodySections%5B22%5D/publicationsystem%3AdataFile)

Problem debt

In age-standardised analyses, being seriously behind on at least one debt repayment or having utilities cut off was associated with greater likelihood of having a CMHC, as well

as each type of CMHC. Adults with problem debt were more than twice as likely to have a CMHC (39.0%) as those without problem debt (18.4%). See the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods) for more information on how problem debt was derived.

The pattern of association between having a CMHC and having problem debt was similar in men and women.

For more information: Table 1.8 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Prevalence of common mental health conditions (CMHCs) in past week, by problem debt (age-standardised) (Base: All adults)

Download the data for this chart Prevalence of common mental health conditions (CMHCs) in past week, by problem debt (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/common-mental-health-conditions/common-mental-health-conditions/publicationsystem%3AbodySections%5B24%5D/publicationsystem%3AdataFile)

Area-level deprivation

How has deprivation been defined?

Area-level deprivation has been defined using the English Indices of Deprivation 2019, commonly known as the Index of Multiple Deprivation (IMD).

IMD is the official measure of relative deprivation for Lower Super Output Areas (LSOAs) in England. LSOAs comprise between 400 and 1,200 households and usually have a resident population between 1,000 and 3,000 persons. IMD ranks every LSOA in England from 1 (most deprived area) to 32,844 (least deprived area). Deprivation quintiles are calculated by ranking the 32,844 neighbourhoods in England from most deprived to least deprived and dividing them into five equal groups. These range from the most deprived 20% of neighbourhoods nationally to the least deprived 20% of neighbourhoods nationally.

For further information see: English indices of deprivation 2019 (Link: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019)

Likelihood of having a CMHC was associated with area-level deprivation. Prevalence of a CMHC was highest among those living in areas in the most deprived quintile (age-standardised 26.2%) and lowest among those living in areas in the least deprived quintile (16.0%).

The pattern of association between having a CMHC and area-level deprivation was similar in men and women.

For more information: Table 1.9 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Prevalence of common mental health conditions (CMHCs) in past week, by area-level deprivation (age-standardised) (Base: All adults)

Download the data for this chart Prevalence of common mental health conditions (CMHCs) in past week, by area-level deprivation (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/common-mental-health-conditions/common-mental-health-conditions/publicationsystem%3AbodySections%5B28%5D/publicationsystem%3AdataFile)

Region

The age-standardised prevalence of having a CMHC varied across regions in England. The proportion of adults with a CMHC was greatest in the East Midlands (24.6%) and the North East (24.6%) of England and lowest in the South East (16.3%) and South West (18.7%) of England.

For more information: Table 1.10 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Prevalence of common mental health conditions (CMHCs) in past week, by region (age-standardised) (Base: All adults)

Download the data for this chart Prevalence of common mental health conditions (CMHCs) in past week, by region (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/common-mental-health-conditions/common-mental-health-conditions/publicationsystem%3AbodySections%5B30%5D/publicationsystem%3AdataFile)

Comorbidity

Physical health conditions

How have physical health conditions been defined?

Participants were asked if they had any of 25 physical health conditions listed on a card, including asthma, cancer, diabetes, epilepsy and high blood pressure. Participants were coded as having a limiting physical health condition, if they reported having one or more physical health conditions in the past 12 months that had been diagnosed by a doctor and that this had limited their ability to carry out day-to-day activities. More details on the questions on physical health conditions can be found in the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

Age-standardised prevalence of having a CMHC varied by the presence of a limiting physical health condition. Those with a limiting physical health condition (32.9%) were more likely than those without (12.6%) to have a CMHC. This association was stronger for men than women.

For more information: Table 1.11 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Prevalence of common mental health conditions (CMHCs) in past week, by limiting physical health condition and gender (age-standardised) (Base: All adults)

Download the data for this chart Prevalence of common mental health conditions (CMHCs) in past week, by limiting physical health condition and gender (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/common-mental-health-conditions/common-mental-health-conditions/publicationsystem%3AbodySections%5B34%5D/publicationsystem%3AdataFile)

Self-diagnosis and professional diagnosis of CMHCs

Participants were asked whether they thought they had ever had specific CMHCs (phobias, panic attacks, post-traumatic stress disorder, depression, postnatal depression, a 'nervous breakdown', obsessive compulsive disorder, seasonal affective disorder, or 'any other anxiety disorder'). For each reported condition, they were asked if the condition had ever been diagnosed by a professional and whether the condition had been present in the past 12 months.

Overall, 45.4% of adults reported that they believed they have had a CMHC at some point in their life (36.1% of men, and 53.7% of women). 31.1% of all adults reported that they had received a diagnosis from a professional (22.1% of men and 39.3% of women), and 18.9% reported the presence of a professionally diagnosed CMHC in the past 12 months (13.3% of men and 24.0% of women). Women were more likely than men to believe they had ever had a CMHC, to report a professional diagnosis, and to report having symptoms of a diagnosed CMHC in the past 12 months.

Most (84.0%) participants identified by the CIS-R as having a CMHC believed that they have had a CMHC at some point and 66.5% reported that they had received a professional diagnosis. Over half (55.6%) of those with a current CMHC reported having

a diagnosed CMHC with symptoms in the past year.

Among those identified by the CIS-R as having a CMHC, most (66.6%) felt that they have had depression, 45.8% felt that they have had 'panic attacks', and 29.4% felt that they have had 'any other anxiety disorder'. Similarly, these were also the most common professional diagnoses that those identified by the CIS-R reported having been given: 55.1% reported having been diagnosed with depression, 29.4% reported having been diagnosed with panic attacks, and 21.0% reported having been diagnosed with 'any other anxiety disorder'.

Self-diagnosed CMHC, professional diagnosed CMHC and presence of diagnosed CMHC in past year, among adults with CMHC in the past week (Base: Adults with a CMHC as identified by CIS-R)

Download the data for this chart Self-diagnosed CMHC, professional diagnosed CMHC and presence of diagnosed CMHC in past year, among adults with CMHC in the past week (Base: Adults with a CMHC as identified by CIS-R) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/common-mental-health-conditions/common-mental-health-conditions/publicationsystem%3AbodySections%5B36%5D/publicationsystem%3AdataFile)

Of those identified by the CIS-R as having a depressive episode in the past week, 81.9% reported ever having depression. 72.2% had ever received a professional diagnosis of depression, and 67.7% reported the presence of diagnosed depression in the past 12 months.

Of adults identified by the CIS-R with panic disorder, 63.4% reported ever having 'panic attacks', 42.3% had ever received a professional diagnosis, and 35.2% reported the presence of diagnosed panic attacks within the past year.

Of adults identified by the CIS-R with GAD, 40.2% reported ever having 'any other anxiety disorder'. Of those, 30.4% had received a professional diagnosis and 29.6% reported having symptoms of this other diagnosed anxiety disorder in the past year.

Among adults with less prevalent conditions, reports of having ever received a professional diagnosis were low. 29.7% of participants identified by the CIS-R with OCD reported ever having OCD, and 9.6% had ever received a professional diagnosis. Similarly, 12.5% of adults identified with a phobia reported ever having a phobia, and 3.3% had ever received a professional diagnosis for one.

Professional diagnosed CMHC (self-reported), by CMHC in past week (as identified by CIS-R)

	CMHC in past week, as identified by CIS-R			
	Depression	Phobias	OCD	Panic disorder
Ever diagnosed with CMHC by professional (self-reported)	%	%	%	%
Depression	72.2	73.6	51.1	52.4
Phobia	3.2	3.3	10.0	-
OCD	6.8	6.7	9.6	9.2
Panic attacks	37.2	52.1	39.2	42.3
Bases	*308*	*183*	*134*	*65*

For more information: Table 1.12 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

1.4 Discussion

CMHCs are among the most prevalent health conditions in England. The results in this chapter show that at any recent point in time, about one in five adults in England had a CMHC in the past week; one in four women and almost one in six men. Around half of these people had symptoms severe enough to warrant active intervention (CIS-R 18+), and the rest would likely have benefited from at least clinical recognition (CIS-R 12-17). After the general category of CMHC-NOS (8.6%), generalised anxiety disorder (GAD) (7.5%) stands out as the most prevalent type of CMHC in England, followed by depression (3.8%), phobias (2.6%), obsessive compulsive disorder (OCD) (2.2%) and panic disorder (1.0%).

CMHCs have increased in prevalence over time, up from 15.5% of working age adults in 1993 to 22.6% in 2023/4. The small increase in CMHCs observed between 1993 and 2007 and the greater increase since then are likely to indicate a real shift in population prevalence of symptoms of anxiety and depression. This has occurred alongside various societal shifts and stresses, including global recession and subsequent policies of austerity (Curtis et al. 2021). For example, a cost of living crisis has led to increased rates of unmanageable personal debt (Financial Conduct Authority 2023 (Link: https://

www.fca.org.uk/publication/financial-lives/financial-lives-survey-2022-key-findings.pdf)), a known powerful risk factor for mental disorders (Jenkins et al. 2008, Meltzer et al. 2013a, ONS 2022 (Link: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/mentalhealth/articles/costofliving anddepressioninadultsgreatbritain/29septemberto23october2022#cost-of-living-and-depressive-symptoms)). Increases in psychological distress were observed during the COVID-19 pandemic, however, evidence for the UK suggests that among adults this has largely returned to pre-pandemic levels (Pierce et al. 2021). It is also possible that overall increased public awareness and reduced stigma (Foulkes and Andrews 2023) may have also influenced response to CIS-R questions in survey participants, although generally the CIS-R is thought to perform well in multiple environments (Das-Munshi et al. 2014).

High levels of CMHC recognition and awareness. Four fifths of those identified by the CIS-R as having a CMHC also felt that they have had a CMHC, and two thirds reported that they had been diagnosed with a CMHC by a professional. However, results also indicate that anxiety disorders may be less well recognised, both by the public and by professionals, than depression. The symptoms identified by the survey instrument did not always match the diagnoses that participants reported being given by professionals. Most of those reporting a professional CMHC diagnosis said that they had been diagnosed with depression or panic attacks. This may reflect the language used by people when discussing their mental health with professionals, and may reflect 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'. Differences between disorders identified by the CIS-R and disorders that people report having had or having been diagnosed with may - but do not necessarily mean - that people have been misdiagnosed.

Increases across age groups, but particularly the young. Evidence from the Mental Health of Children and Young People surveys suggests that for young people, the COVID-19 pandemic had both a significant and a sustained effect on mental health (Newlove-Delgado et al. 2021; 2023 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2023-wave-4-follow-up)). The results in this chapter show that a quarter of 16 to 24 year olds had a CMHC, the highest level observed in the APMS series. The upward trend in CMHCs among young people however was evident even before the COVID-19 pandemic, alongside indications that the profile of CMHCs among young people has been changing, with increases notable at the higher severity threshold (CIS-R 18+). Anxiety disorders, including generalized anxiety disorder, OCD and phobias, characterise CMHC presentation in 16 to 24 year olds. This chapter shows a notable

proportion of young women identified with depression, although it must be noted that the sample size was small for comparing men and women in this age group. These trends also need to be understood in the context of results from other APMS chapters, especially in relation to increased levels of self-harming (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/suicidal-thoughts-suicide-attempts-and-self-harm). While concerns about young people's mental health have often been linked to digital technology and social media use, evidence for this as a key causal factor are weak (Orben et al. 2024). Issues spanning environmental, social, economic and political - as well as technological - change are likely to be factors (McGorry et al. 2024). Changes in parenting styles, especially increased risk aversion, have also been cited. One study found reductions between generations in young people's home range, variety of outdoor spaces visited, range of activities undertaken, and in number of companions (Woolley and Griffin 2015).

Public health approaches and a cross-sectoral prevention role. The results presented in this chapter are consistent with the emphasis placed by England's Prevention Concordat for Better Mental Health (Link: https://www.gov.uk/government/publications/prevention-concordat-for-better-mental-health-consensus-statement/prevention-concordat-for-better-mental-health#about-the-prevention-concordat) on addressing the social determinants of health. CMHCs were more prevalent in people struggling financially and in those with a limiting physical health condition. About 40% of people who were unemployed or economically inactive had a CMHC, with associated reliance on changing welfare support systems (Wickham et al. 2020). The results in this chapter show that area-level disparities persist, with CMHCs being more prevalent among people living in the most deprived neighbourhoods. Pronounced regional disparities in CMHCs are also evident: people in the North East (24.6%) and East Midlands (24.6%) were more likely to have a CMHC than those in the South East (16.3%) and South West (18.7%), highlighting the need for locally informed responses. The Prevention Concordat for Better Mental Health (Link: https://www.gov.uk/government/publications/prevention-concordat-for-better-mental-health-consensus-statement/prevention-concordat-for-better-mental-health#about-the-prevention-concordat) highlights the need for local areas to put in place effective prevention planning arrangements, aimed at health and wellbeing boards, local authorities, integrated care systems and other health partnerships (OHID 2024 (Link: https://www.gov.uk/government/publications/prevention-concordat-for-better-mental-health-consensus-statement/prevention-concordat-for-better-mental-health#about-the-prevention-concordat)).

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Chapter 2: Mental health treatment and service use

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Overview

This chapter describes mental health treatment and service use in England, among people with a common mental health condition (CMHC) as measured by the Clinical Interview Schedule-Revised (CIS-R). The proportion of people with other conditions in receipt of treatment is covered in the relevant chapters.

Current receipt of psychotropic medication and psychological therapy are examined, as well as use of health care services for a mental health reason (GP, inpatient and outpatient) and day and community care services in the past year. Prevalence estimates presented are based on participant self-reports, not health records.

Key findings

- **Overall, one in six adults (15.7%) reported being in receipt of mental health treatment** (psychotropic medication, psychological therapy or both) at the time of interview. Use of medication (12.5%) was more commonly reported than psychological therapies (5.1%).
- **Treatment receipt was strongly associated with severity of symptoms**; ranging from 6.1% of those with few or no CMHC symptoms (CIS-R 0-5), to 55.7% of those with severe symptoms (CIS-R 18+).
- **The proportion in receipt of treatment increased since 2007**. Among 16 to 74 year olds with CMHC symptoms (CIS-R 12+), receipt of either psychotropic medication or psychological therapies was stable between 2000 (23.1%) and 2007 (24.4%), increasing to 39.4% in 2014 and 47.7% in 2023/4. The proportion reporting psychological therapies rose from 10.4% in 2007 to 17.9% in 2023/4; and the proportion using medication rose from 19.6% in 2007 to 38.4% in 2023/4.
- **Likelihood of treatment receipt varied between groups** and was lower among people who were older (aged 75 and over) or in Asian/Asian British and Black/Black British ethnic groups. Among people with CMHC symptoms, men and women had a similar likelihood of receiving mental health treatment.

2.1 Introduction

A central aim of the Adult Psychiatric Morbidity Surveys (APMS) since 1993 has been to describe patterns in the use of treatment and services by people with symptoms of CMHC (McManus et al. 2020). The APMS questionnaire covered a range of treatment types, delivered in primary, secondary, specialist and community care settings, as well as by private providers. While the data can be used to compare what people report receiving with what National Institute for Health and Care Excellence (NICE) recommends people receive, the data cannot determine whether individual participants' treatment plans were appropriate or not. The APMS series is, however, uniquely well-placed for describing:

- trends in mental health treatment and service use among adults with and without symptoms,
- potential levels of unmet need in the population, and
- whether some groups with need are more likely to receive treatments and services

than others.

Developments in mental health treatment in England

Over the past thirty years, there have been shifts in how mental health treatment and services are delivered in England.

Psychological therapies: NHS Talking Therapies (formerly Improving Access to Psychological Therapies, or IAPT) is a service to which adults aged 18 or over can self-refer or be referred to by a GP. It was launched in 2008 to improve access to evidence-based therapies for conditions such as mild to moderate anxiety and depression (Clark 2012). Referrals to the service have increased over time and in 2023/4 1.83 million people were referred to the service and it was accessed by 1.26 million (NHS England 2024 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-talking-therapies-for-anxiety-and-depression-annual-reports/2023-24)). Psychological therapies in England may be delivered in a range of settings, including by community, perinatal and acute mental health services (NHS 2019 (Link: https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/)) as well as from charities, via workplaces and educational institutions, or private practitioners (Mind 2025 (Link: https://www.mind.org.uk/information-support/drugs-and-treatments/talking-therapy-and-counselling/how-to-find-a-therapist/)).

Psychotropic medication: Antidepressants, especially selective serotonin reuptake inhibitors (SSRIs), are among the most widely prescribed medications in England (NICE 2011, updated 2020 (Link: https://www.nice.org.uk/guidance/cg113/chapter/Recommendations#stepped-care-for-people-with-panic-disorder)). The average amount of time people use an antidepressant for is about a year (Sehmi et al. 2019). The number of antidepressant prescriptions issued tripled between 1998 and 2018 (Bogowicz et al. 2021), and an estimated 8.75 million people were prescribed at least one antidepressant medication in 2023/4 (NHS Business Services Authority 2024 (Link: http://ttps://www.nhsbsa.nhs.uk/statistical-collections/medicines-used-mental-health-england/medicines-used-mental-health-england-201516-202324)). Some antidepressants are also used to treat anxiety. Other medications sometimes prescribed for anxiety symptoms include benzodiazepines and beta-blockers. Although less widely used, the use of anxiety medications as a whole are also increasing: from 24.9/1000 person-years-at-risk in 2003 to 43.6/1000 in 2018 (Archer et al. 2022).

Lord Darzi noted in his investigation of the NHS in England that ‘general practice, mental health and community services will need to expand and adapt to the needs of those with long-term conditions whose prevalence is growing rapidly as the population age’ (Darzi 2024 (Link: https://www.gov.uk/government/publications/independent-

investigation-of-the-nhs-in-england)). The NHS Long Term Plan (Link: https://www.longtermplan.nhs.uk/areas-of-work/mental-health/), published in 2019, outlined goals to expand mental health treatment and service provision, including in community services and crisis care (NHS 2019 (Link: https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/)). However, workforce shortages, increased demand, waiting times and regional disparities have been highlighted as challenges in meeting these goals (Royal College of Psychiatrists 2024 (Link: https://www.rcpsych.ac.uk/docs/default-source/improving-care/workforce/rcpsych-workforce-strategic-plan-2020-2023.pdf?sfvrsn=16ad2fa3_4); Darzi 2024 (Link: https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england)). Shifts in how mental health treatment and services were provided also occurred during the COVID-19 pandemic, with some changes, such as increased use of remote contact, remaining (Taxiarchi et al. 2023).

Levels of unmet need

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

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

There are limitations to this approach to estimating unmet need. The APMS definition of CMHC is broad: it thus conflates milder, potentially self-limiting conditions (i.e. those that will remit in the absence of treatment) with conditions that are more likely to persist and need treatment, including some that are severe and enduring. The interventions defined as treatment include a range of psychological therapies and medications, but exclude

general support, for example, from a GP or community organisations. APMS findings are also based on cross-sectional data and therefore include only those individuals with symptoms present at the time of the interview. Some of those classified as not receiving treatment may have had this in the past or may have sought help shortly after taking part in the survey. Likewise, some of those found to have mild, moderate or no symptoms may be recovering from a condition which has responded to recent treatment. Thus, it cannot be assumed that such circumstances represent over-treatment. Since psychological therapies tend to be of shorter duration than pharmacological treatments, this approach may underestimate provision and uptake of the former in particular. APMS data, which are cross-sectional, cannot be used to evaluate the effectiveness of treatment or recovery trajectories. However, outcome data on almost all people who have a course of psychological therapy in the NHS Talking Therapies programme (Link: https://www.nhs.uk/mental-health/talking-therapies-medicine-treatments/talking-therapies-and-counselling/nhs-talking-therapies/) (NHS England 2024 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-talking-therapies-for-anxiety-and-depression-annual-reports/2023-24)) is published and informs the evidence base on efficacy.

Despite limitations, a population-based survey like APMS provides unique insight into likely levels of unmet need in England. APMS measures symptoms of mental disorder in people with and without diagnosed conditions, independent of any help-seeking or treatment. The surveys collect information from people in contact with services, but also from those who are not (some may not be registered with a GP).

Inequalities in receipt of treatment and services

APMS data is also ideal for identifying whether some groups are less likely to receive treatment after controlling for differences in levels of symptoms (Cooper et al. 2013; McManus and Brugha 2025). Previous analyses have shown that people of working age were more likely than older people to get appropriate treatment, especially psychological therapy (Cooper et al. 2010). The survey also provided evidence that treatment receipt was lower for all minoritised ethnic groups compared with the White British group, and lowest among Black people, for whom inequalities appeared to have widened between the 2007 and 2014 surveys (Ahmad et al. 2022). APMS data can also be used to identify area-level variations: while people living in less urban areas were half as likely to receive psychological therapies as those living in urban areas, no association between urbanicity and antidepressant receipt was found (Hiepko et al. 2024). Bogdanova and colleagues used APMS 2014 data to look at variation in whether people with symptoms of mental health conditions had these recognised by professionals. They found that White people were the ethnic group most likely, and those over 75 the age group least likely, to get diagnosed by a health professional - an important step towards receiving treatment (Bogdanova et al. 2022).

2.2 Definitions and assessments

Measuring mental health treatment

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

Measuring psychotropic medications

There have been changes between the surveys in how medication data have been collected. In 2000, interviewers asked about and coded all prescribed drugs, including non-psychotropic medications. In 2007, a show card listing brand names and generic names of psychotropic medications was used instead. People were also asked to show interviewers the packaging for each psychotropic medication reported, so that the interviewer could check it was correctly coded. The 2000 and 2007 surveys found similar rates of psychotropic medication use, suggesting that the change in methodology did not affect comparability. A show card approach was also used in 2014. However, rather than listing drug brand names first, followed by the generic name (the approach taken in 2007), the generic name was listed first on the show card prompt. See the APMS 2014 report (Link: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014) for more information.

In APMS 2023/4, a show card was not used and instead participants who reported taking medication for a mental health reason were asked to provide the name of the medication and the medication packet if possible. Interviewers recorded the medication by typing the medication name into the Computer Assisted Personal Interviewing (CAPI) software and selecting the correct name and dosage from a look-up file of medications. This method was used to improve the quality of the data collected, improve accessibility and reduce interview length.

The medications were coded into the following categories:

Drugs used primarily to treat…

- Depression
- Anxiety
- Bipolar disorder
- Psychosis
- Sleep problems
- Attention deficit hyperactivity disorder (ADHD).

Groupings relate to the main reasons that medications are commonly prescribed, but

they may have been prescribed to individuals for different reasons. Several medications were listed in more than one group.

In addition, in 2023/4 participants were asked about substance dependence medication. Substance dependence medications are reported on separately and not included in the 'any psychotropic medication' measure.

A list of the specific medications (generic and brand name) included in each category is in the (Link: /pagenotfound)APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

Measuring psychological therapies

Psychological therapies were asked about in broadly comparable ways in each survey. Although there were some minor changes across the years, the key estimate used to measure change in overall psychological therapy use over time is based on an initial stem question, which has remained consistent across the surveys:

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

Follow-up questions established the type of therapy received. The list of therapy types has changed slightly over survey years, reflecting the nature of current provision and terminology. Below is the list of therapy types asked about in APMS 2023/4:

- Psychotherapy or psychoanalysis
- Cognitive behavioural therapy (CBT)
- Art, music or drama therapy
- Social skills training
- Couple or family therapy
- Sex therapy
- Mindfulness therapy
- Alcohol or drug counselling
- Counselling (including bereavement)
- Another type of therapy.

Survey development work found that participants in pilots were generally unable to state reliably which services provided treatments such as psychological therapies. Therefore, APMS data has not been used to describe shifts, for example between primary and specialist services, in the provision of such treatments.

Measuring health service use for a mental health reason

Health service contact records were not examined in the survey. Health service use for a mental health reason related to certain types of primary or secondary health service use. This was recorded if a survey participant reported any of the following:

- Having spoken with a GP about being anxious, depressed, or about a mental, nervous or emotional problem in the past two weeks or the past year, respectively
- Being an inpatient for a mental, nervous or emotional reason in the past three months
- Being an outpatient or day patient for a mental, nervous or emotional reason in the past three months.

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

Measuring community and day care service use

Participants were also asked questions on their use of community and day-care services in the past year, excluding treatment and service use they had already reported. Community care services included use of the following in the past year: a psychiatrist, psychologist, community psychiatric nurse, community learning disability nurse, other nursing services, social worker, self-help/support group, home help/homecare worker or outreach worker. Day care service use included use of a community mental health centre, day activity centre, sheltered workshop and other nursing services in the past year. To ensure comparability with previous surveys in the series, changes to items and terminology were minimal.

The different types asked about are listed in the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

Measuring unmet treatment requests

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

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

Measuring treatment need

The CIS-R has been used in every APMS to measure CMHC symptoms and to identify people meeting CMHC diagnostic criteria. This chapter focuses on differences in treatment rate by symptoms and types of CMHC. Treatment and service use among

people with other types of mental health conditions are addressed in the condition-specific chapters.

CMHC symptoms

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

- *CIS-R score of 12 or more (CIS-R 12+)*: is used to indicate the presence of clinically significant symptoms of CMHC, and identifies people with 'symptoms of CMHC' sufficient to warrant recognition.
- *CIS-R score of 18 or more (CIS-R 18+)*: is used to indicate the presence of 'severe symptoms of CMHC', sufficient to warrant intervention.

Types of CMHCs

The CIS-R has been used on each APMS in the series to assess six types of CMHC:

- Depression
- Generalised anxiety disorder (GAD)
- Phobias
- Obsessive compulsive disorder (OCD)
- Panic disorder
- CMHC not otherwise specified (CMHC-NOS).

In this chapter those identified with 'any CMHC' are considered, as well as those identified with specific CMHCs. Everyone with a CIS-R score of 12 or more was classified with at least one type of CMHC. However, it was possible for individuals with specific CMHCs to be identified without having a CIS-R score of 12 or more. The CIS-R and the individual CMHCs are described in more detail in the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

2.3 Results

Mental health treatment, by CIS-R score

Overall, 15.7% of adults reported receiving mental health treatment (psychotropic medication and/or psychological therapy) provided by the NHS or other providers. The proportion in the overall population was likely to be between 14.5% and 17.0% (referred to as the 95% confidence interval (95% CI)). This equates to an estimated 7.3

million adults in England reporting receipt of some form of treatment for a mental health or emotional problem.

Reported treatment use was strongly associated with severity of mental health symptoms, ranging from one in sixteen adults (6.1%) among those with few or no current symptoms (CIS-R 0-5), to one in three (34.8%) of those with a CIS-R score of 12-17, and over half (55.7%) of those with severe symptoms (CIS-R 18+). Treatment use among those without CMHC symptoms is not necessarily unwarranted, as it could indicate, for example, recovery, relapse prevention or an intermittent condition.

Medication was the most common form of mental health treatment, reported by 12.5% of adults, while 5.1% reported receiving psychological therapy. Receipt of medication increased with severity of mental health symptoms, with 44.8% of those with severe CMHC symptoms receiving medication, compared with 4.7% among those with few or no CMHC symptoms. Similarly, 22.3% of those with severe symptoms were receiving psychological therapy, compared with 1.6% of those with few or no current symptoms.

1.9% (CI 1.5, 2.3) of adults reported receiving both medication and psychological therapy. This proportion increased with severity of CMHC symptoms. Prevalence was highest among those with severe CMHC symptoms (11.7%), and lowest among those with few or no current symptoms (0.3%).

For more information: Table 2.1 and Table A1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals.

Current use of mental health treatment, by CIS-R score (Base: All adults)

Download the data for this chart Current use of mental health treatment, by CIS-R score (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/mental-health-treatment-and-service-use/mental-health-treatment-and-service-use/publicationsystem%3AbodySections%5B7%5D/publicationsystem%3AdataFile)

Mental health treatment, by type of CMHC

44.6% of adults meeting the diagnostic criteria for at least one CMHC were receiving treatment, compared with 15.7% of the population as a whole.

Prevalence of treatment use varied by type of CMHC and was highest among those identified with phobias (65.6%), OCD (64.3%) and depression (62.2%). About half of those identified with GAD (55.3%) and panic disorder (52.7%) were in receipt of

treatment, and treatment rates were lowest among people with CMHC-NOS (30.8%). The small base size for those with panic disorder (65 participants) means that analyses by this group should be treated with caution. It should also be noted that for conditions other than CMHC-NOS, it was possible for a person to be identified with more than one CMHC.

Medication was the most commonly reported treatment for adults with each type of CMHC. Prevalence ranged from about half of those with phobias (56.1%), OCD (53.0%), depression (51.8%) and GAD (46.7%) to one in four with CMHC-NOS (23.4%).

Rates of receiving psychological therapy were highest among those with phobias (30.4%), depression (27.3%) and OCD (25.3%) and lowest among those with CMHC-NOS (11.9%).

For more information: Table 2.2 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Current use of mental health treatment, by CMHC and gender (Base: All adults)

Download the data for this chart Current use of mental health treatment, by CMHC and gender (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/mental-health-treatment-and-service-use/mental-health-treatment-and-service-use/publicationsystem%3AbodySections%5B9%5D/publicationsystem%3AdataFile)

Psychotropic and substance dependence medication, by CIS-R score

One in eight adults (12.5%) reported currently taking psychotropic medication. The most commonly reported psychotropic medications were those used primarily to treat depression (11.7%) and anxiety (10.7%). Medications commonly used to treat bipolar disorder (1.1%), psychosis (1.0%), ADHD (0.4%) or sleep problems (0.2%) were each reported by about one in a hundred adults or less. Substance dependence medication was also asked about on the survey and was reported by 0.3% of adults.

The prevalence of psychotropic medication use increased with severity of CMHC symptoms. 4.7% of those with few or no current symptoms (CIS-R 0-5) were taking psychotropic medication, compared with 44.8% of those with severe symptoms (CIS-R 18+).

Use of substance dependence medication was also linked to severity of CMHC symptoms,

with 1.3% of those with severe symptoms reporting taking them, compared with 0.1% of those with few or no current symptoms.

For more information: Table 2.3 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Types of psychotropic medication and substance dependence medication used, overall and in adults with a CIS-R score of 18 or more (Base: All adults)

Download the data for this chart Types of psychotropic medication and substance dependence medication used, overall and in adults with a CIS-R score of 18 or more (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/mental-health-treatment-and-service-use/mental-health-treatment-and-service-use/publicationsystem%3AbodySections%5B11%5D/publicationsystem%3AdataFile)

Psychotropic and substance dependence medication, by CMHC

Among adults with a CMHC, about one in three (36.0%) reported current psychotropic medication use, and one in a hundred (1.1%) reported use of substance dependence medication. The use of psychotropic medication was highest among those with phobias (56.1%) and lowest among those with CMHC-NOS (23.4%).

For more information: Table 2.4 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Psychological therapy, by CIS-R score

One in twenty adults (5.1%) reported currently receiving psychological therapy. The use of psychological therapy was associated with severity of CMHC symptoms, with 22.3% of adults with severe CMHC symptoms (CIS-R 18+) in receipt of psychological therapy, compared with 1.6% of those with few or no symptoms (CIS-R 0-5).

The most common types of psychological therapy received by those with severe symptoms were counselling (including bereavement counselling) (8.0%), cognitive behavioural therapy (CBT) (6.0%), psychotherapy or psychoanalysis (5.5%) and

mindfulness therapy (5.3%).

For more information: Table 2.5 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Type of psychological therapy received, overall and in adults with a CIS-R score of 18 or more (Base: All adults)

Download the data for this chart Type of psychological therapy received, overall and in adults with a CIS-R score of 18 or more (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/mental-health-treatment-and-service-use/mental-health-treatment-and-service-use/publicationsystem%3AbodySections%5B13%5D/publicationsystem%3AdataFile)

Psychological therapy, by type of CMHC

Among adults with a CMHC, 16.2% reported currently being in receipt of psychological therapy. Prevalence of receiving psychological therapy was highest among those with phobias (30.4%), depression (27.3%) and OCD (25.3%). It was lowest among those with CMHC-NOS (11.9%).

For more information: Table 2.6 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Health care service use, by CIS-R score

The use of health services for a mental or emotional problem included attending hospital in the last quarter, either as an inpatient or outpatient, for a mental health reason or speaking with a GP about a mental health problem (in the past year or past two weeks).

13.5% of adults reported using any health service for a mental health reason. This mostly involved speaking with a GP about a mental or emotional problem in the past year (13.2%).

The likelihood of using health services was associated with severity of symptoms. About half of adults (52.9%) with severe CMHC symptoms (CIS-R 18+) had used health services for a mental health reason, compared with 5.0% of those with few or no current symptoms (CIS-R 0-5).

All types of health service use for a mental health reason were most common among those with severe CMHC symptoms (CIS-R 18+), compared with those with fewer or no symptoms. One in nine (11.2%) adults with severe symptoms had spoken with a GP in the past two weeks, 3.5% had attended hospital as an outpatient and 1.0% had attended as an inpatient in the past quarter for a mental health reason.

For more information: Table 2.7 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Health care services used for a mental or emotional reason, overall and in adults with a CIS-R score of 18 or more (Base: All adults)

Download the data for this chart Health care services used for a mental or emotional reason, overall and in adults with a CIS-R score of 18 or more (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/mental-health-treatment-and-service-use/mental-health-treatment-and-service-use/publicationsystem%3AbodySections%5B15%5D/publicationsystem%3AdataFile)

Health care service use, by type of CMHC

Four in ten (40.0%) adults with a CMHC reported using health care services for a mental health reason. Use of health care services for a mental health reason was highest among those with depression (58.9%), phobias (58.7%), and OCD (58.2%). Those with panic disorder (33.0%) and CMHC-NOS (32.8%) were less likely to have used health care services for a mental health reason.

Among those with a CMHC, 39.2% reported having spoken with their GP in the past year about a mental health problem, and 7.1% had done so in the past two weeks. 2.3% attended hospital as an outpatient and 0.5% as an inpatient for a mental health reason in the past quarter.

For more information: Table 2.8 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

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

One in twelve adults (8.1%) reported having used a community or day care service in the

past year. The use of community and day care services was most common among those with more severe CMHC symptoms (CIS-R 18+), with more than a quarter (28.7%) having used such services, compared with 3.6% of those with few or no symptoms (CIS-R 0-5).

Among those with a CIS-R score of 18 or more, the most common types of services used were self-help or being part of a support group (8.4%), contact with a psychiatrist (6.7%), contact with a social worker (5.5%) and contact with a psychologist (5.3%).

For more information: Table 2.9 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Community and day care services use, by type of CMHC

Contact with community or day care services in the past year was reported by 22.4% of adults with a CMHC. The proportion was highest among those with phobias (36.8%), depression (33.8%) and OCD (33.6%) and lowest among those with CMHC-NOS (18.7%). Contact with a psychiatrist was highest among those with phobias (11.7%), while 6.8% of those with phobias reported contact with other nursing services (excluding community psychiatric and learning disability nurses).

For more information: Table 2.10 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Community and day care services used in past year in adults with a CMHC (Base: All adults with a CMHC)

Download the data for this chart Community and day care services used in past year in adults with a CMHC (Base: All adults with a CMHC) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/mental-health-treatment-and-service-use/mental-health-treatment-and-service-use/publicationsystem%3AbodySections%5B17%5D/publicationsystem%3AdataFile)

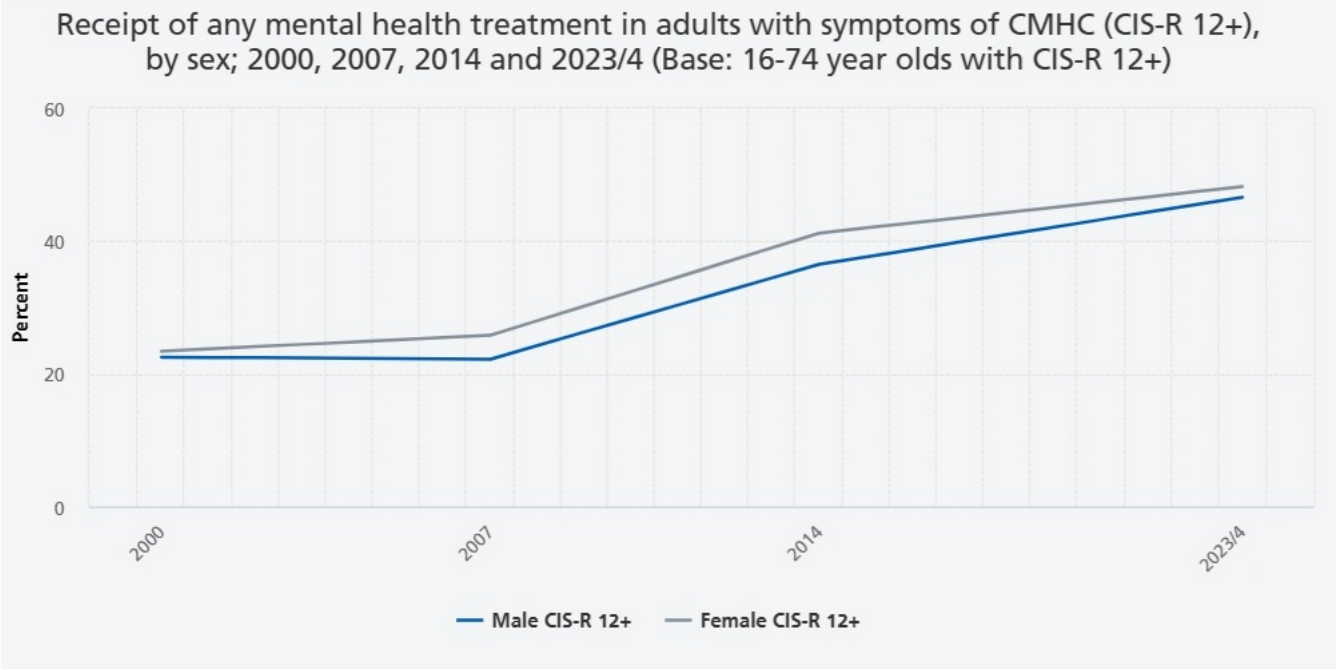
Mental health treatment in adults with CMHC symptoms, 2000, 2007, 2014 and 2023/4

Mental health treatment use was defined as being in receipt of psychotropic medication or psychological therapy around the time of interview. The method for collecting medication data changed across survey years. For further information see Section 2.2

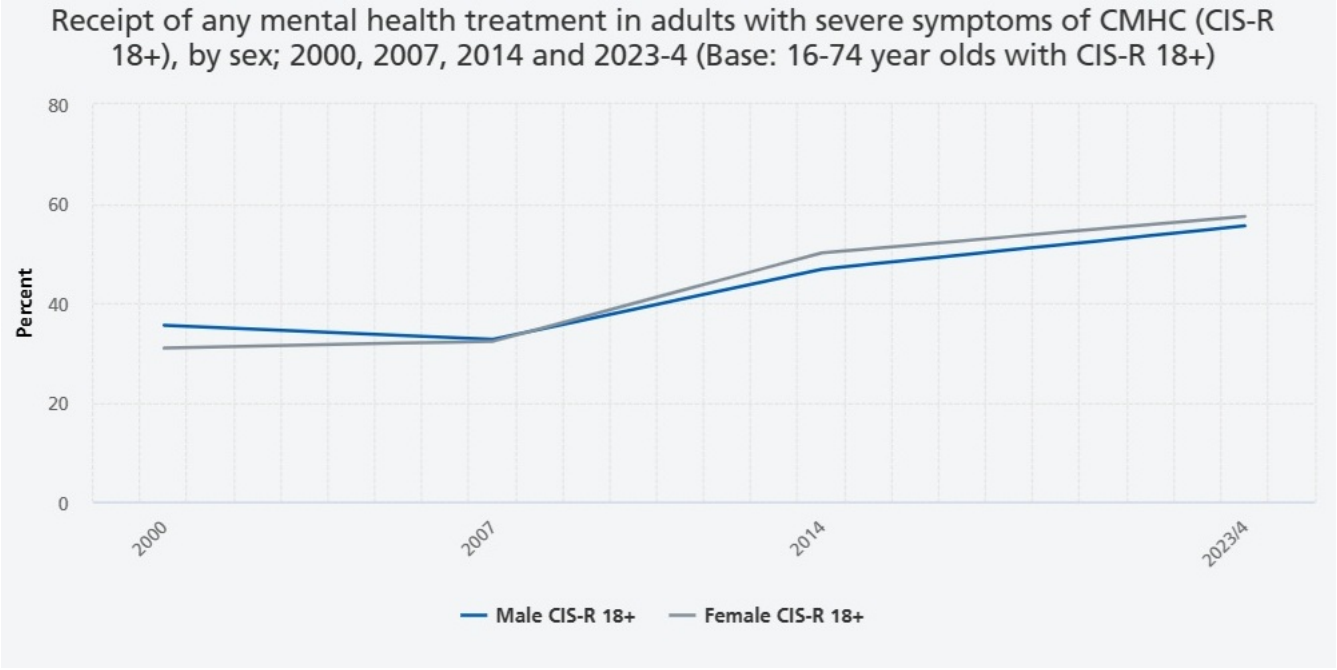
Definitions and assessments and the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

Comparisons of 2023/4 with previous survey years (2000, 2007 and 2014) are based on adults aged 16 to 74, as the 2000 survey did not include those aged 75 and over, and are analysed by sex (male and female) rather than gender (men and women). See How to interpret the findings (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/how-to-interpret-the-findings) for information on how changes over time were assessed.

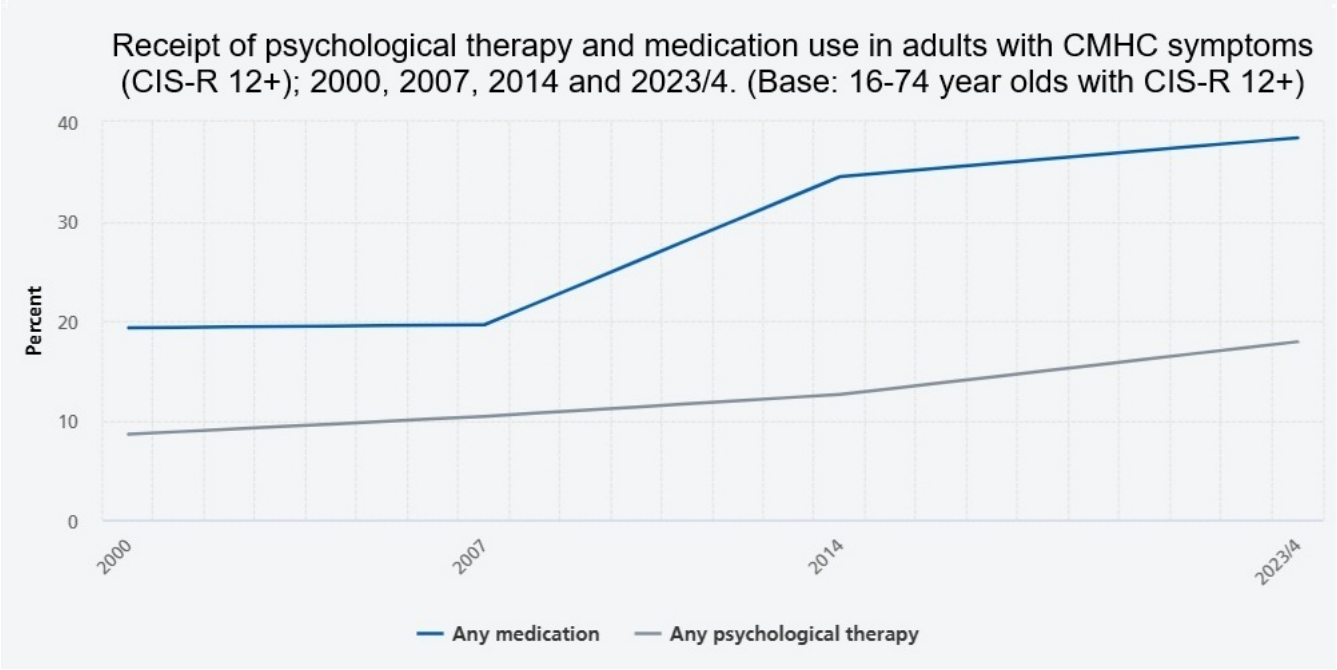
Among those with CMHC symptoms (CIS-R 12+), the proportion receiving treatment was about one in four in 2000 (23.1%, 95% CI 20.6, 25.7) and 2007 (24.4%, CI 21.9, 27.2), before increasing to 39.4% (CI 36.5, 42.4) in 2014 and 47.7% (CI 43.8, 51.6) in 2023/4. The pattern was similar for males and females.



Among those with severe symptoms (CIS-R 18+), one in three reported mental health treatment in 2000 (32.8%, CI 28.8, 37.1) and 2007 (32.4%, CI 28.8, 36.2), increasing to nearly half in 2014 (48.8%, CI 45.1, 52.5) and over half in 2023/4 (56.8%, CI 51.8, 61.8). The pattern was similar for males and females.

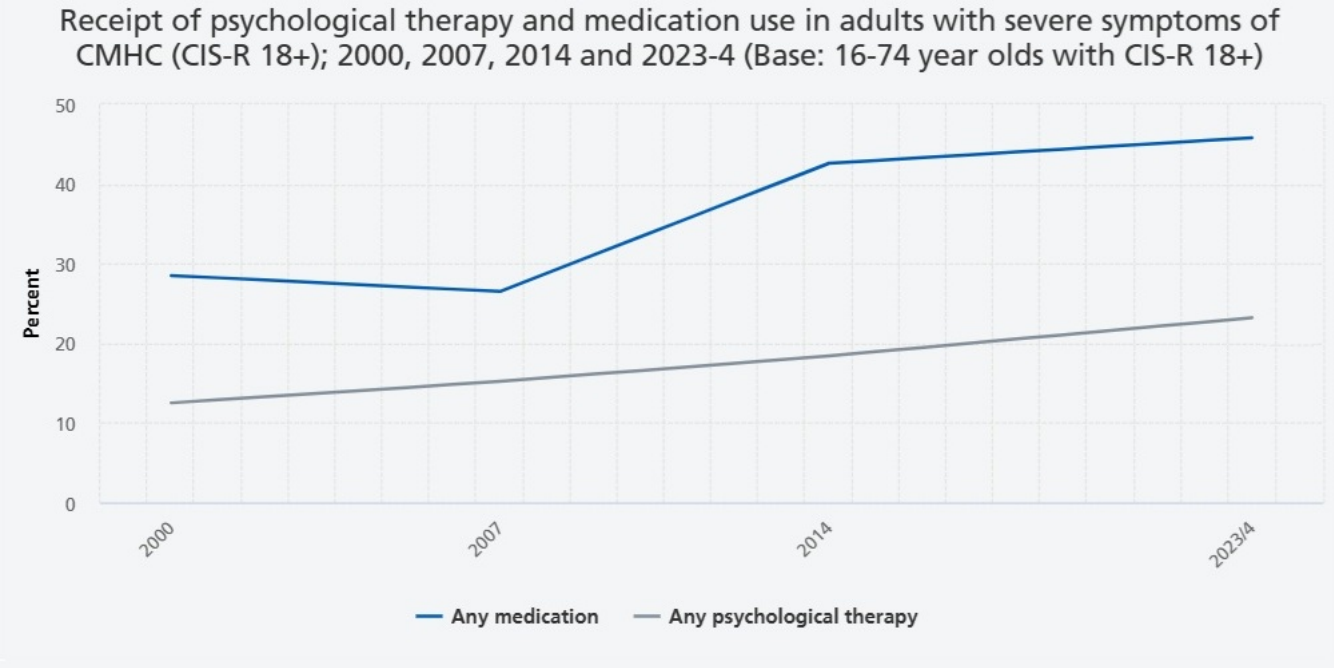


These increases reflect rises in both the use of psychotropic medication and psychological therapies. Among people with CMHC symptoms (CIS-R 12+) the proportion reporting psychological therapies has risen steadily: 8.6% in 2000, 10.4% in 2007, 12.6% in 2014, and 17.9% in 2023/4. Medication use in those with CMHC symptoms was reported by 19.3% in 2000 and 19.6% in 2007, before increasing to 34.5% in 2014 and 38.4% in 2023/4.



Similar upward trajectories were evident among adults with severe CMHC symptoms (CIS-R 18+). There was a steady upward trend in the proportion receiving psychological therapies: 12.5% in 2000, 15.2% in 2007, 18.4% in 2014 and 23.2% in 2023/4. The proportion using medication for a mental or emotional problem was 28.5% in 2000 and 26.5% in 2007, before increasing to 42.6% in 2014 and 45.8% in 2023/4.

For more information: Table 2.11 and Table B1 (Link: /pagenotfound) for confidence intervals.



Health service use in adults with CMHC symptoms, 2000, 2007, 2014 and 2023/4

Among adults aged 16 to 74 with CMHC symptoms (CIS-R 12+), the proportion using health care services for a mental health reason increased between 2000 (39.1%, 95% CI 36.1, 42.2) and 2014 (47.0%, CI 43.8, 50.2). The proportion reporting health care services use in 2023/4 was 43.5% (CI 40.4, 46.7), remaining fairly stable since 2014.

For more information: Table 2.12 and Table B2 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals.

Community and day care service use in adults with CMHC symptoms, 2000, 2007, 2014 and 2023/4

In 2023/4, 22.9% (95% CI 19.9, 26.3) of adults aged 16 to 74 with CMHC symptoms (CIS-R 12+) used a community or day service. This was an increase from 17.2% (CI 15.1, 19.6) in 2000.

For more information: Table 2.13 and Table B3 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals.

Mental health treatment in adults with CMHC symptoms, by gender and age

Gender

Among those with CMHC symptoms (CIS-R 12+), the proportion of men (43.3%) and women (46.7%) receiving mental health treatment was similar. This was the case for both use of psychotropic medication (36.3% of men, 36.2% of women) and psychological therapy (17.5% of men, 17.3% of women).

Age

Among those with CMHC symptoms, the proportion receiving treatment varied by age. Treatment use was highest in 16 to 24 (49.9%), 25 to 34 (53.5%), 45 to 54 (52.3%), and 55 to 64 (47.8%) year olds, and lowest in the older age groups (33.2% of those aged 65 to 74 and 21.9% of those aged 75 and over).

Use of psychotropic medication among those with CMHC symptoms was highest in those aged 25 to 34 (43.4%), 45 to 54 (40.9%) and 55 to 64 (40.1%), and lowest in those aged 75 and over (19.1%).

Receipt of psychological therapies among those with CMHC symptoms was highest among those aged 25 to 34 (23.1%), 35 to 44 (21.8%), and 45 to 54 (20.6%), and lowest in the oldest age groups: 5.1% of 65 to 74 year olds and 2.8% of those aged 75 and over.

For more information: Table 2.14 and Table 2.15 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Current use of mental health treatment among those with CMHC symptoms (CIS-R 12+), by age (Base: Adults with CIS-R 12+)

Download the data for this chart Current use of mental health treatment among those with CMHC symptoms (CIS-R 12+), by age (Base: Adults with CIS-R 12+) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/mental-health-treatment-and-service-use/mental-health-treatment-and-service-use/publicationsystem%3AbodySections%5B27%5D/publicationsystem%3AdataFile)

Mental health treatment in adults with CMHC

symptoms, by other characteristics

Ethnic group

The proportion in receipt of treatment for a mental or emotional problem varied between ethnic groups (age-standardised). However, due to the small number of participants in some ethnic groups, these comparisons are based on the whole sample and not restricted to those with CMHC symptoms. Variations in treatment use may therefore reflect different levels of need in the different groups.

White British (18.4%, 95% CI 16.9, 20.0) adults and those from another White background (16.7%, CI 11.7, 23.4) were most likely to be receiving treatment. Adults in the Asian/Asian British (4.1%, CI 2.4, 7.0), Black/Black British (8.2%, CI 5.0, 13.3) and Mixed/multiple or other (9.5%, CI 5.8, 15.2) groups were less likely than their White British counterparts to be in receipt of mental health related treatment.

15.2% of White British adults were taking medication for a mental or emotional problem, compared with 3.1% of Asian/Asian British adults and 4.3% of Black/Black British adults.

Receipt of psychological therapy was highest among adults from another White background (6.4%) and lowest among Asian/Asian British adults (1.3%).

For more information: Table 2.16 and Table A2 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals.

Employment status

In age-standardised analyses, receiving treatment for a mental or emotional problem among working age (16-64) adults varied by employment status. Due to the small number of participants in the unemployed group, these comparisons are based on the whole sample and not restricted to those with CMHC symptoms. The mean CIS-R score among people who were unemployed (12.6) or economically inactive (10.4) was twice that of people in employment (5.6), indicating different levels of need in the different groups.

Those who were economically inactive (31.9%) or unemployed (29.8%) were twice as likely as those in employment to be in receipt of treatment for a mental or emotional problem (14.4%).

One in four (27.5%) adults who were economically inactive and one in five (21.7%) of those who were unemployed were taking medication for a mental or emotional problem, compared with one in nine (11.0%) of those who were in employment.

One in seven (14.4%) unemployed adults and one in ten (10.0%) of those who were economically inactive were receiving psychological therapy, compared with one in

twenty (5.1%) among employed adults.

For more information: Table 2.17 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Problem debt

Problem debt was defined as being seriously behind with debt repayments or having utilities cut off. See the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods) for more information on how problem debt was derived.

Being seriously behind with debt repayments or having utilities cut off was associated with greater likelihood of being in receipt of treatment for a mental or emotional problem (age-standardised) in those with CMHC symptoms.

Among adults with CMHC symptoms, 56.1% of those with problem debt were receiving mental health treatment compared with 43.3% of those without.

For more information: Table 2.18 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Area-level deprivation

How has deprivation been defined?

Area-level deprivation has been defined using the English Indices of Deprivation 2019, commonly known as the Index of Multiple Deprivation (IMD).

IMD is the official measure of relative deprivation for Lower Super Output Areas (LSOAs) in England. LSOAs comprise between 400 and 1,200 households and usually have a resident population between 1,000 and 3,000 persons. IMD ranks every LSOA in England from 1 (most deprived area) to 32,844 (least deprived area). Deprivation quintiles are calculated by ranking the 32,844 neighbourhoods in England from most deprived to least deprived and dividing them into five equal groups. These range from the most deprived 20% of neighbourhoods nationally to the least deprived 20% of neighbourhoods nationally.

For further information see: English indices of deprivation 2019 (Link: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019)

Comparisons between IMD quintiles are based on age-standardised estimates. Among adults with CMHC symptoms, the proportion in receipt of mental health treatment was similar across IMD quintiles.

For more information: Table 2.19 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Region

In age-standardised analyses, apparent variation by region in the proportion of adults with CMHC symptoms receiving any treatment for a mental or emotional problem did not reach statistical significance. Caution is needed with these results given some base sizes are quite small. However, receipt of psychological therapy varied by region and was highest in the East of England (22.8%), the West Midlands (22.7%) and the South West (22.7%) and lowest in the East Midlands (5.5%).

For more information: Table 2.20 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Comorbidity

Physical health conditions

How have physical health conditions been defined?

Participants were asked if they had any of 25 physical health conditions listed on a card, including asthma, cancer, diabetes, epilepsy and high blood pressure. Participants were coded as having a limiting physical health condition, if they reported having one or more physical health conditions in the past 12 months that had been diagnosed by a doctor and that this had limited their ability to carry out day-to-day activities. More details on the questions on physical health conditions can be found in the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

Receipt of treatment for a mental or emotional problem in those with CMHC symptoms (CIS-R 12+) was similar among those with (47.0%) and without (44.6%) a limiting physical health condition, in age-standardised analyses.

For more information: Table 2.21 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Unmet treatment requests

Overall, 2.8% of adults reported having asked for, but not received, a particular mental health treatment in the past 12 months. The proportion was similar in men (2.0%) and women (3.1%). Having an unmet treatment request was associated with severity of symptoms. Among adults with severe CMHC symptoms (CIS-R 18+), 13.6% had an unmet treatment request in the past 12 months, compared with 0.6% of those with few or no CMHC symptoms (CIS-R 0-5).

For more information: Table 2.22 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Among adults with CMHC symptoms (CIS-R 12+) there was an association between unmet treatment requests and age. This ranged from 19.6% of 16 to 34 year olds with CMHC symptoms requesting but not receiving a particular mental health treatment, to 2.3% of those aged 75 and over.

For more information: Table 2.23 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-

wellbeing-england-2023-24/dataset)

Among adults with CMHC symptoms and an unmet treatment request, a quarter (26.2%) were not receiving any psychotropic medication or psychological therapy around the time of the interview.

For more information: Table 2.24 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

2.4 Discussion

This chapter presents information on trends and inequalities in mental health treatment and service use in England, drawing on APMS 2000, 2007, 2014 and 2023/4.

The APMS series has strengths and weaknesses. APMS relies on self-report data and survey participants are not always aware precisely what treatments and services they use or are able to recall exactly when they used them. Misclassifications, under-reporting, and over-reporting are all possible. The checking of participants' medication packaging for drug names will have helped, but there was little that could be done to verify the classification of types of psychological therapy and health records were not checked. While there has been much consistency in how the data have been collected, there were some changes between survey years. APMS has to balance the need for consistency with ensuring that questions reflect current context, provision and terminology. For example, the 2023/4 survey did not use a showcard to ask about psychotropic medications, instead recording medications using a computer-based directory. Changes like this can affect comparability between surveys and the robustness of trends. The questionnaire covered a wide range of types of treatments and services, delivered in NHS primary, secondary, acute and community care settings, as well as by private therapists and other providers. The 2023/4 survey also covered additional types of community services, such as social prescribing.

Unmet treatment requests largely came from people reporting symptoms, and rarely from those without symptoms, indicating requests for treatment were driven by unmet need. One in seven adults with severe CMHC symptoms reported requesting a treatment in the past year which they did not receive. A quarter of those with symptoms and an unmet treatment request were receiving no other form of mental health medication or therapy.

The proportion receiving treatment has increased. While there may be a substantial amount of unmet mental health treatment need in the population, this appears to be at its lowest ever level. Almost half of people with a CMHC were receiving medication and/or psychological therapy, compared with one in three in 2014 and one in four in 2007. Although medication use is more prevalent than use of psychological therapies, the

proportion reporting each has doubled over the past twenty years. This steep rise closely reflects upward trends in both antidepressant prescribing (NHS Business Services Authority 2024 (Link: https://www.nhsbsa.nhs.uk/statistical-collections/medicines-used-mental-health-england/medicines-used-mental-health-england-201516-202324); Bogowicz et al. 2021) and NHS Talking Therapies outcome data (NHS England 2024 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-talking-therapies-for-anxiety-and-depression-annual-reports/2023-24)). The increased use of psychotropic medications should, however, be considered in the context of NICE guidelines not to offer antidepressants routinely for mild depression (NICE 2022 (Link: https://www.nice.org.uk/guidance/ng222)).

There is little evidence of socioeconomic inequalities in treatment. That is, while those who struggled financially or lived in more deprived neighbourhoods were much more likely to have poor mental health, they did not appear to be less likely than others with symptoms to get treatment. It should be noted, however, that while this comparison was based on adults with CMHC symptoms, the analysis did not fully adjust for the extent of higher and more complex need among those in poverty or facing socioeconomic adversity.

Patterns of treatment use by gender and age have changed. The previous survey in the APMS series found that among people with CMHC, women with CMHC symptoms were more likely than men to receive treatment (Lubian et al. 2016): this difference was no longer evident in 2023/4. It may be that services have become better at recognising and responding to mental health need in men, it could also be that reduced stigma around mental health has contributed to greater help-seeking among men (Sagar-Ouriaghli et al. 2019). Age-related patterns in treatment use may have also changed. In previous APMS, both the youngest and oldest age groups were the least likely to use mental health treatment (Lubian et al. 2016). Treatment use among 16 to 24 year olds, especially among women, is now more similar to those in midlife. People aged 75 or more, however, continue to be the least likely age group to receive treatment while also being the least likely to report an unmet treatment need, suggesting that lack of treatment use may stem, at least in part, from lack of help-seeking.

Ethnic inequalities persist in mental health treatment receipt. Consistent with analyses of previous surveys in the APMS series (Ahmad et al. 2022), people in Black, Asian and Mixed/multiple/other ethnic groups were found to be less likely to get mental health treatment than those who identified as White British. Due to small numbers of adults in some ethnic groups with CMHC symptoms, it was not possible to analyse the variation in mental health treatment use. Therefore, it is unclear whether the observed differences represent a real disparity in unmet need. Ethnic inequalities in treatment access have also been noted in linked primary care data (Catalao et al. 2024), and may have been exacerbated during the COVID-19 pandemic (Taxiarchi et al. 2023). Bansal and colleagues

argue that strategies to tackle entrenched ethnic inequalities in mental healthcare requires addressing barriers at individual, systemic, and structural levels (Bansal et al. 2022).

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Previous Chapter

Chapter 1: Common mental health conditions (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/common-mental-health-conditions)

Next Chapter

Chapter 3: Posttraumatic stress disorder (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/posttraumatic-stress-disorder)

Chapter 3: Posttraumatic stress disorder

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Overview

Lifetime traumatic events were defined as experiences that put a person – or someone close to them – at risk of serious harm or death. Examples include experiencing a major natural disaster, serious car accident, physical and sexual abuse and assault or a loved one dying by murder or suicide. Individuals who experience such an event may go on to develop PTSD. PTSD can be severe and disabling, characterised by flashbacks, nightmares, avoidance, numbing and hypervigilance.

As in APMS 2014, all participants completed the 17-item PTSD Checklist - Civilian (PCL-C) irrespective of whether they reported a traumatic event. Those scoring 50 or more who also scored positively for specific domains in the Diagnostic Statistical Manual (DSM) IV were identified as screening positive for PTSD in the past month. A positive screen did not indicate presence of PTSD, rather the presence of sufficient symptoms to warrant further investigation.

Key findings

- **The proportion reporting a lifetime trauma increased from 31.2% in 2014 to 37.4% in 2023/4 for females**. It remained stable for males (31.5% in 2014 and 32.0% in 2023/4). Self-reported lifetime trauma was similar across age groups in 2023/4.
- **Overall, one in twenty adults screened positive for PTSD using the PCL-C**. Prevalence was 4.4% in 2014 (95% CI 3.8, 5.0) and 5.7% in 2023/4 (95% CI 4.9, 6.6).
- **Screening positive for PTSD varied between demographic groups**. Women (6.1%) were more likely than men (5.0%) to screen positive for PTSD, and prevalence was higher in younger than older age groups. In terms of variation by ethnicity, prevalence was highest for the Mixed/multiple and other group (8.1%) and lowest for the Asian/Asian British group (2.4%).
- **There was a strong socioeconomic association** with both self-reported trauma and screening positive for PTSD. Those with problem debt (16.4%) were three times more likely to screen positive for PTSD than those with no problem debt (4.6%). Screening positive for PTSD was also more likely among adults living in the most deprived fifth of areas (9.4%), and among those who were unemployed (19.9%) or economically inactive (15.1%).
- **One in ten adults in poor physical health screened positive for PTSD**. People with a limiting physical health condition (44.7%) were more likely than those without (29.5%) to report a traumatic event, and about three times more likely to screen positive for PTSD (10.1% compared with 3.4%).
- **Over half (55.7%) of those screening positive for PTSD were receiving mental health treatment**. This was more likely to take the form of medication (45.6%) than psychological therapy (23.8%). Some were receiving both medication and psychological therapy (13.8%).

3.1 Introduction

Many people will experience traumatic events during their life, such as road traffic accidents, assaults or natural disasters. Traumatic events are defined as those sufficiently severe to make individuals fear for their own – or their loved ones' – lives or safety. They are not randomly distributed among the general population. Certain groups or individuals are at higher risk of exposure (Breslau et al. 2008), including military

personnel, emergency service workers and refugees. Prevalence of reported traumatic events has been found to be higher among people with low income, low social support and a history of mental health conditions (Brewin et al. 2000; Knipscheer et al. 2020; NICE 2025 (Link: https://cks.nice.org.uk/topics/post-traumatic-stress-disorder/background-information/risk-factors/)). In addition, research has shown that subjective perception of threat is more important for the development and maintenance of PTSD than objective severity of the trauma itself (Ehlers and Clarke 2000).

People commonly feel distressed during and immediately after traumatic events, experiencing, for example, symptoms of insomnia and anxiety. These symptoms usually dissipate with time. Although this is the usual response, symptoms may sometimes persist, and some individuals go on to develop posttraumatic stress disorder (PTSD) (Royal College of Psychiatrists 2021 (Link: https://www.rcpsych.ac.uk/mental-health/mental-illnesses-and-mental-health-problems/post-traumatic-stress-disorder)). This can be a severe and disabling condition, characterised by flashbacks, nightmares, avoidance, numbing and hypervigilance. PTSD is often comorbid with other mental (Rytwinski et al. 2013) and physical (Sareen 2014) health conditions.

Epidemiological studies of PTSD typically rely on a subjective assessment by the participant as to whether a particular event was sufficiently severe to justify being a trauma, as well as relying on self-reported assessment of their symptoms. This raises the possibility of reporting bias (Roemer et al. 1998). In the 2014 and 2023/4 Adult Psychiatric Morbidity Surveys (APMS), PTSD screening questions were therefore asked of everyone irrespective of whether they reported trauma. This chapter presents the proportion of the whole sample screening positive for PTSD, without adjustment for whether traumatic experiences were reported. Self-reported trauma and screening positive for PTSD were analysed independently of each other.

The National Institute for Health and Care Excellence (NICE) guidelines highlight that people with PTSD may feel apprehensive, anxious, or ashamed. They may avoid treatment, believe that PTSD is untreatable, or have difficulty developing trust. The guidelines recommend active monitoring with people in the first month after a trauma is experienced, and that trauma focused cognitive behavioural therapy should be offered to those diagnosed with PTSD or who have symptoms. Eye movement desensitisation and reprocessing (EMDR) should be considered for those who prefer it (NICE 2018 (Link: https://www.nice.org.uk/guidance/ng116)).

In this chapter, the prevalence of self-reported exposure to trauma and screening positive for PTSD are reported, overall and in relation to demographic and socioeconomic factors. Levels of comorbidity with mental and physical health conditions are presented, as well as mental health related service use and treatment.

3.2 Definitions and assessments

PTSD

Individuals who have experienced, witnessed, or been confronted with an event or events involving actual or threatened death or serious injury, or a threat to the physical integrity of self or others may go on to develop PTSD (American Psychiatric Association 1994). Their response must have involved intense fear, helplessness, or horror. Symptoms can develop within weeks but according to the 10th Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) (World Health Organization 1993) onset is almost always within six months. It may take months or even years for individuals to recognise the symptoms and to seek help from appropriate services. Delayed presentation is common but there is also some evidence that PTSD may have a delayed onset (Andrews et al. 2007).

According to the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV, APA 1994) the symptoms are grouped into three clusters:

- **Re-experiencing** (including recurrent distressing images, thoughts, dreams or perceptions of the event)
- **Avoidance** and numbing (avoiding thoughts, feelings, activities or conversations associated with the trauma, diminished interest or participation in activities, feelings of detachment or estrangement from others)
- **Hyperarousal** (including difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance and an exaggerated startle response)

A key aim of the APMS series is to understand trends over time, so the DSM-IV scoring approach has been applied to the data for the purposes of current reporting (Pai et al. 2017). While DSM-5 (APA 2013) separates the avoidance and numbing symptoms into different groups, this report has not followed this approach to ensure consistency across the series. For a diagnosis of PTSD, symptoms must have been evident for more than one month and must cause clinically significant distress or impairment in social, occupational, or other areas of functioning.

PTSD Checklist - Civilian (PCL-C)

The PTSD Checklist (PCL) is a 17-item self-report measure reflecting DSM-IV symptoms of PTSD (Blanchard et al. 1996). It was used in both APMS 2014 and 2023/4 and formed part of the self-completion section of the interview.

The PCL has a variety of clinical and research purposes, including:

- Identifying individuals with probable PTSD
- Aiding in diagnostic assessment of PTSD
- Monitoring change in PTSD symptoms over time.

The PCL-C (civilian) asks about symptoms in relation to ‘a stressful experience’ (i.e.

generic “stressful experiences”) and can be used with any population. This version simplifies assessment based on multiple traumas because symptoms are not attributed to a specific event.

The response options are:

- not at all (scored 1)
- a little bit (2)
- moderately (3)
- quite a bit (4)
- extremely (5).

A total symptom severity score (ranging from 17 to 85) can be obtained by summing the scores from each of the 17 items listed below. There are several ways of scoring the PCL. For this report, a positive screen was defined as a score of 50 or more, together with endorsement of the DSM-IV criteria, identified as positive responses to:

- at least one B item (questions 1–5, re-experiencing symptoms)
- three C items (questions 6–12, avoidance and numbing)
- two D items (questions 13–17, hyperarousal symptoms).

Where a participant missed three or more items, for example due to responding ‘don’t know’ or refusing to answer, no score was derived. This applied in 62 cases (1.0%).

The PCL-C is referred to in this chapter as a screen for reasons of convention. However, it is not currently recommended as part of an official screening programme in England. A positive screen for PTSD does not mean that someone necessarily has the disorder; instead, it indicates that someone has sufficient symptoms to warrant a clinical assessment.

Note that all participants undertaking the self-completion section of the interview were asked the PCL-C items, and screening positive for PTSD was not conditional on reporting a traumatic event or experience. This was because assessment of whether an experience counts as traumatic is subjective and can vary between groups, potentially introducing bias.

The PTSD Checklist - Civilian (PCL-C)

Below is a list of problems and complaints that individuals sometimes have in response to stressful life experiences. Please read each one carefully, and indicate how much you have been bothered by that problem in the last month:

---

1. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past

---

2. Repeated, disturbing dreams of a stressful experience from the past

3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)
4. Feeling very upset when something reminded you of a stressful experience from the past
5. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past
6. Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it
7. Avoid activities or situations because they remind you of a stressful experience from the past
8. Trouble remembering important parts of a stressful experience from the past
9. Loss of interest in things that you used to enjoy
10. Feeling distant or cut off from other people
11. Feeling emotionally numb or being unable to have loving feelings for those close to you
12. Feeling as if your future will somehow be cut short
13. Trouble falling or staying asleep
14. Feeling irritable or having angry outbursts
15. Having difficulty concentrating
16. Being “super alert” or watchful on guard
17. Feeling jumpy or easily startled

Exposure to traumatic events or experiences

Irrespective of responses to the PCL-C, all participants were asked, after completing the PCL-C, whether a traumatic event or experience had happened to them at any time in their life. This was also part of the self-completion section of the interview. To clarify the nature and severity of traumatic stressor that should be included, the following was stated:

‘The term traumatic event or experience means something like a major natural disaster, a serious automobile accident, being raped, seeing someone killed or seriously injured,

having a loved one die by murder or suicide, or any other experience that either put you or someone close to you at risk of serious harm or death.'

Participants were not asked to specify the nature or number of events experienced. Screening positive for PTSD was not conditional on reporting a traumatic event or experience.

3.3 Results

Self-reported Trauma, by age and gender

Lifetime experience of self-reported trauma

Overall, about one in three (34.8%) adults reported having experienced at least one major trauma during their lifetime. If all adults in the population had been asked this, it is likely that the proportion reporting that they had ever experienced a trauma would be between 33.2% and 36.4% (referred to as the 95% confidence interval (CI)). It should be noted that whether a participant reports having experienced a traumatic event involves a subjective assessment and is dependent on recall.

This proportion varied by gender. Women (37.2%, 95% CI 35.1, 39.3) were more likely than men (31.9%, CI 29.5, 34.3) to report a traumatic event in their lifetime. The proportion of adults reporting a traumatic event was similar across age groups.

In 2023/4, based on self-reported data, an estimated 16.2 million adults living in England had experienced at least one major trauma during their lifetime.

Lifetime experience of self-reported trauma, by gender (Base: All adults)

Download the data for this chart Lifetime experience of self-reported trauma, by gender (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/posttraumatic-stress-disorder/posttraumatic-stress-disorder/publicationsystem%3AbodySections%5B7%5D/publicationsystem%3AdataFile)

Screening positive for PTSD in past month, by age and gender

About one in twenty (5.7%) adults screened positive for PTSD in the past month (95% CI 4.9, 6.5). This equates in the general population in England to an estimated 2.6 million adults screening positive for PTSD.

Women (6.1%, CI 5.1, 7.2) were more likely to screen positive for PTSD than men (5.0%, CI 3.8, 6.4). The proportion with a positive PTSD screen varied by age, from 11.4% (CI 7.8, 16.4) of those aged 16 to 24 years, decreasing to 0.5% (CI 0.2, 1.2) of those aged 75 years and over.

Screening positive for PTSD in past month, by age (Base: All adults)

Download the data for this chart Screening positive for PTSD in past month, by age (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/posttraumatic-stress-disorder/posttraumatic-stress-disorder/publicationsystem%3AbodySections%5B9%5D/publicationsystem%3AdataFile)

Experience of PTSD symptoms, by age and gender

To identify people screening positive for PTSD, all participants were asked about a range of symptoms in the past month. A quarter (25.0%) reported re-experiencing a traumatic event and 22.6% reported symptoms of arousal such as difficulty with sleep, irritability, concentration and hypervigilance. 13.9% reported avoidance.

Women (27.8%) were more likely than men (21.6%) to report re-experiencing a traumatic event. A similar pattern was observed for arousal (experienced by 24.5% of women and 20.3% of men). There was no difference by gender in the reporting of avoidance.

The prevalence of individual PTSD symptoms varied by age. For all symptoms, prevalence was highest in younger people and decreased with age. For example, 36.6% of those aged 16 to 24 reported re-experiencing a trauma, decreasing to 17.6% of those aged 65 to 74 and 17.9% of those aged 75 and over.

For more information: Table 3.1 and Table A1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals.

Re-experiencing a traumatic event in past month, by age (Base: All adults)

Download the data for this chart Re-experiencing a traumatic event in past month, by age (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/posttraumatic-

stress-disorder/posttraumatic-stress-disorder/publicationsystem%3AbodySections%5B11%5D/publicationsystem%3AdataFile)

Self-reported Trauma and screening positive for PTSD in 2014 and 2023/4

Note that the trend data analyses were carried out by sex (male and female) rather than gender (men and women) to allow for comparison with 2014. See How to interpret the findings (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/how-to-interpret-the-findings) for information on how changes over time were assessed.

The proportion of adults reporting having experienced at least one traumatic event during their lifetime was higher in 2023/4 (34.8%, 95% CI 33.2 to 36.4) than in 2014 (31.4%, CI 30.0, 32.7). This upward trend was evident among females (31.2% in 2014, CI 29.6, 32.8; 37.4% in 2023/4, CI 35.4, 39.5) but not among males (31.5% in 2014, CI 29.5, 33.6; and 32.0% in 2023/4, CI 29.7, 34.5).

Lifetime experience of self-reported trauma in 2014 and 2023/24, by sex (Base: All adults)

Download the data for this chart Lifetime experience of self-reported trauma in 2014 and 2023/24, by sex (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/posttraumatic-stress-disorder/posttraumatic-stress-disorder/publicationsystem%3AbodySections%5B13%5D/publicationsystem%3AdataFile)

The proportion of adults screening positive for PTSD was 4.4% in 2014 (CI 3.8, 5.0) and 5.7% in 2023/4 (CI 4.9, 6.6). The pattern was similar for male and female participants.

For more information: Table 3.2 and Table B1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals.

Screening positive for PTSD in 2014 and 2023/24, by sex (Base: All adults)

Download the data for this chart Screening positive for PTSD in 2014 and 2023/24, by sex (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/posttraumatic-stress-disorder/posttraumatic-stress-disorder/publicationsystem%3AbodySections%5B15%5D/publicationsystem%3AdataFile)

Variation in self-reported Trauma and screening positive for PTSD by other characteristics

Ethnic group

The age-standardised prevalence of self-reported trauma varied between ethnic groups. It was highest among Black/Black British adults (37.8%, 95% CI 29.3, 47.2) and lowest among Asian/Asian British adults (20.0%, CI 14.7 26.6).

There was also variation by ethnic group in the proportion screening positive for PTSD. 8.1% of adults from a Mixed/multiple or other background screened positive for PTSD (CI 4.3, 14.8), 6.4% of White British adults (CI 5.4, 7.6) and 4.4% of Black/Black British adults (CI 2.3, 8.5). Screening positive for PTSD was lowest among the Asian/Asian British group (2.4%, CI 1.3, 4.4). It should be noted that the confidence intervals for some estimates were wide and overlapping, so apparent differences between ethnic groups should be treated with caution.

For more information: Table 3.3 and A2 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals.

Lifetime experience of self-reported trauma and screening positive for PTSD in past month, by ethnic group (age-standardised) (Base: All adults)

Download the data for this chart Lifetime experience of self-reported trauma and screening positive for PTSD in past month, by ethnic group (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/posttraumatic-stress-disorder/posttraumatic-stress-disorder/publicationsystem%3AbodySections%5B17%5D/publicationsystem%3AdataFile)

Employment status

Among participants of working age (those aged 16 to 64 years), the age-standardised prevalence of self-reported trauma and of screening positive for PTSD both varied by employment status.

- Those who were economically inactive were more likely to recall experiencing a traumatic event (41.5%) than those who were unemployed (31.2%) or in employment (32.7%).
- The proportion screening positive for PTSD was higher in people who were unemployed (19.9%) or economically inactive (15.1%) than among those who were in employment (4.7%).

For more information: Table 3.4 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Lifetime experience of self reported trauma and screening positive for PTSD, by employment status (age-standardised) (Base: Adults aged 16 to 64)

Download the data for this chart Lifetime experience of self reported trauma and screening positive for PTSD, by employment status (age-standardised) (Base: Adults aged 16 to 64) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/posttraumatic-stress-disorder/posttraumatic-stress-disorder/publicationsystem%3AbodySections%5B19%5D/publicationsystem%3AdataFile)

Problem debt

In age-standardised analyses, being seriously behind with debt repayments or having utilities cut off was associated with both having experienced a traumatic event and screening positive for PTSD. See the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods) for more information on how problem debt was derived.

- One in two (50.5%) adults with problem debt had experienced a traumatic event, compared with one in three (33.4%) of those not experiencing problem debt.
- One in six (16.4%) adults with problem debt screened positive for PTSD, compared

with one in twenty (4.6%) among those not experiencing problem debt.

For more information: Table 3.5 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Lifetime experience of self-reported trauma and screening positive for PTSD, by problem debt (age-standardised) (Base: All adults)

Download the data for this chart Lifetime experience of self-reported trauma and screening positive for PTSD, by problem debt (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/posttraumatic-stress-disorder/posttraumatic-stress-disorder/publicationsystem%3AbodySections%5B21%5D/publicationsystem%3AdataFile)

Area-level deprivation

How has deprivation been defined?

Area-level deprivation has been defined using the English Indices of Deprivation 2019, commonly known as the Index of Multiple Deprivation (IMD).

IMD is the official measure of relative deprivation for Lower Super Output Areas (LSOAs) in England. LSOAs comprise between 400 and 1,200 households and usually have a resident population between 1,000 and 3,000 persons. IMD ranks every LSOA in England from 1 (most deprived area) to 32,844 (least deprived area). Deprivation quintiles are calculated by ranking the 32,844 neighbourhoods in England from most deprived to least deprived and dividing them into five equal groups. These range from the most deprived 20% of neighbourhoods nationally to the least deprived 20% of neighbourhoods nationally.

For further information see: English indices of deprivation 2019 (Link: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019).

Age-standardised comparisons showed that the likelihood of experiencing a trauma and of screening positive for PTSD both varied by IMD quintile.

- The proportion reporting a traumatic event ranged from 39.9% of adults living in the most deprived areas to 32.8% of those living in the least.
- One adult in ten living in the most deprived areas (9.4%) screened positive for PTSD, compared with 3.9% of those in the least deprived areas.

For more information: Table 3.6 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Lifetime experience of self reported trauma and screening positive for PTSD, by area-level deprivation (age-standardised) (Base: All adults)

Download the data for this chart Lifetime experience of self reported trauma and screening positive for PTSD, by area-level deprivation (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/posttraumatic-stress-disorder/posttraumatic-stress-disorder/publicationsystem%3AbodySections%5B25%5D/publicationsystem%3AdataFile)

Region

There was no statistically significant variation in levels of exposure to traumatic events or screening positive for PTSD across regions.

For more information: Table 3.7 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Comorbidity

Physical health conditions

How have physical health conditions been defined?

Participants were asked if they had any of 25 physical health conditions listed on a card, including asthma, cancer, diabetes, epilepsy and high blood pressure. Participants were coded as having a limiting physical health condition, if they reported having one or more physical health conditions in the past 12 months that had been diagnosed by a doctor and that this had limited their ability to carry out day-to-day activities. More details on the questions on physical health conditions can be found in the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

Those with a limiting physical health condition were more likely than those without a limiting physical health condition to have experienced trauma (44.7% compared with 29.5%) and three times as likely to screen positive for PTSD (10.1% compared with 3.4%).

For more information: Table 3.8 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Lifetime experience of self-reported trauma and screening positive for PTSD, by limiting physical health condition (age-standardised) (Base: All adults)

Download the data for this chart Lifetime experience of self-reported trauma and screening positive for PTSD, by limiting physical health condition (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/posttraumatic-stress-disorder/posttraumatic-stress-disorder/publicationsystem%3AbodySections%5B29%5D/publicationsystem%3AdataFile)

Common mental health conditions

How have common mental health conditions been defined?

The revised Clinical Interview Schedule (CIS-R) was used to assess six types of common mental health conditions (CMHC): depression, generalised anxiety disorder, panic disorder, phobias, obsessive compulsive disorder, and CMHC not otherwise specified. Participants identified with at least one of these were defined as having a CMHC. See Section 1.2 of the Common mental health conditions chapter (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/common-mental-health-conditions) for more detail.

- About half (53.2%) of people with a CMHC reported experiencing a major lifetime trauma, compared with 30.1% of those without a CMHC.
- Among people with a CMHC, 22.2% screened positive for PTSD. At 1.1%, screening positive for PTSD was rare among those not identified with a CMHC.

For more information: Table 3.8 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Lifetime experience of self-reported trauma and screening positive for PTSD, by common mental health condition (CMHC) (age-standardised) (Base: All adults)

Download the data for this chart Lifetime experience of self-reported trauma and screening positive for PTSD, by common mental health condition (CMHC) (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/posttraumatic-stress-disorder/posttraumatic-stress-disorder/publicationsystem%3AbodySections%5B33%5D/publicationsystem%3AdataFile)

Self-diagnosis and professional diagnosis of PTSD

Participants were shown a list of mental health conditions and asked whether they thought that they had ever had any of them. The list included ‘posttraumatic stress disorder’. Those who reported that they thought that they have had posttraumatic stress disorder were asked if this had been diagnosed by a professional, and if so, whether the

condition had been present in the past 12 months.

Overall, 4.9% of adults reported that they felt that they have had PTSD, and 3.1% of adults reported that they had been diagnosed with PTSD by a professional.

Among those screening positive for PTSD, 27.9% believed that they have had PTSD (compared with 3.5% of those who screened negative). 18.9% of those who screened positive reported that they had been diagnosed with PTSD by a professional, and 17.1% of those who screened positive reported that they had been diagnosed by a professional and had experienced symptoms in the past 12 months.

For more information: Table 3.9 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Self diagnosis, professional diagnosis and recent symptoms of PTSD, by PTSD screen (Base: All adults)

Download the data for this chart Self diagnosis, professional diagnosis and recent symptoms of PTSD, by PTSD screen (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/posttraumatic-stress-disorder/posttraumatic-stress-disorder/publicationsystem%3AbodySections%5B35%5D/publicationsystem%3AdataFile)

Treatment

Treatment and service use

Participants were asked about use of different types of mental health treatment and services. Two types of mental health treatment were asked about: current medication and psychological therapy for a mental or emotional problem. The use of a range of health, community and day care services over the past year were also asked about. This treatment and service use could have been for any mental health condition and was not necessarily related to their PTSD.

Over half of those who screened positive for PTSD (55.7%) were currently receiving some form of treatment for a mental or emotional problem, compared with 13.1% of those who screened negative.

The most common form of treatment among those who screened positive for PTSD was psychotropic (mental health) medication, either on its own (31.9%), or in combination with psychological therapy (13.8%). About one quarter of those who screened positive

for PTSD were currently having psychological therapy (23.8%). Psychological therapy without medication was the least common form of treatment (10.1%).

Treatment currently received for a mental or emotional problem, by PTSD screen (Base: All adults)

Download the data for this chart Treatment currently received for a mental or emotional problem, by PTSD screen (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/posttraumatic-stress-disorder/posttraumatic-stress-disorder/publicationsystem%3AbodySections%5B37%5D/publicationsystem%3AdataFile)

People screening positive for PTSD were five times more likely than those who screened negative to have used a healthcare service in the past year for a mental or emotional problem (53.7% compared with 10.8%). They were also five times more likely to have used community care services (29.0% compared with 5.8%) and three times as likely to have used day care services in the past year (10.9% compared with 3.4%).

For more information: Table 3.10 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Service use in past year for a mental or emotional problem, by PTSD screen (Base: All adults)

Download the data for this chart Service use in past year for a mental or emotional problem, by PTSD screen (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/posttraumatic-stress-disorder/posttraumatic-stress-disorder/publicationsystem%3AbodySections%5B39%5D/publicationsystem%3AdataFile)

Psychotropic medication

Participants were asked which psychotropic medications, used to treat mental health conditions, they take. These could have been for any mental health condition and were not necessarily related to PTSD.

About one in two adults who screened positive for PTSD were currently taking psychotropic medication (45.6%), compared with one in ten (10.4%) among those who screened negative. The most common types of medication used among adults who screened positive for PTSD were those primarily used for the treatment of depression (43.2%) or anxiety (38.5%). These were also the most commonly reported psychotropic medications used by those who screened negative for PTSD (9.8% and 9.0% respectively).

For more information: Table 3.11 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

3.4 Discussion

APMS provides insight on self-reported trauma and PTSD, but the data are limited by being subjective and cross-sectional. Epidemiological studies on PTSD in the general population are relatively rare, as most studies have focused on groups at high risk of exposure to trauma, notably military personnel (Palmer et al. 2019), other specific occupational groups like police (Stevelink et al. 2020), firefighters (Boffa et al. 2017) and content moderators (Zalta et al. 2021), or populations exposed to natural disasters (Wang et al. 2019) or war (Johnson et al. 2022). This chapter presents the prevalence of self-reported lifetime trauma and screening positive for PTSD in the past month based on a general population sample of adults living in England. This is the second time the PTSD Checklist - Civilian (PCL-C) has been used in APMS, enabling comparison between 2014 and 2023/4.

Around a third (34.8%) of adults reported a major trauma in their lifetime, similar to the 31.4% reporting this in 2014. Both figures are lower than the World Mental Health (WMH) surveys multi-country estimate of 70%. The APMS and WMH survey methodology differed: WMHS covered 29 specific types of events (Kessler et al. 2017) while APMS had a single question in the PTSD section of the interview. This question gave examples of types of events and specified that they involved the participant, or someone close to them, being at risk of severe harm or death. Major challenges, however, have been noted with both approaches given their reliance on subjectivity and recall (Frissa et al. 2016).

In APMS 2023/4, women were more likely than men to report traumatic exposure, while in 2014 they had been equally likely to report this (Fear et al. 2016). When comparing results for APMS 2014 and 2023/4, the proportion recalling trauma increased for female participants but not for male participants. The WMH surveys considered the types of traumatic experiences reported and found that women were much more likely than men to report exposure to intimate partner sexual violence, equally likely to report the unexpected death of a loved one, but less likely than men to report other specific trauma types. It also found that sexual violence was a form of trauma with particularly strong associations with subsequent PTSD (Kessler et al. 2017). The APMS did not ask

participants in the PTSD section of the interview about the nature of the specific trauma (or traumas) they had experienced, given concern that this may cause distress in the interview (McManus and Brugha 2025).

One in twenty adults screened positive for PTSD in the past month (5.7%), while prevalence in 2014 was 4.4% (Fear et al. 2016). The confidence intervals for these two results overlap slightly. As described in How to Interpret the Findings (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/how-to-interpret-the-findings), this was not considered an increase in prevalence since 2014. Consequently these results were not considered to be a significant change over time. It should be noted that this is the proportion of all adults, and the prevalence estimates presented in this chapter were not conditional on participants reporting trauma exposure. A quarter of those screening positive for PTSD reported that they thought they have had PTSD at some point in their life and 17.1% reported having been professionally diagnosed with PTSD and having symptoms in the past year. Examination of the PTSD symptom clusters showed that the most commonly reported were re-experiencing symptoms, more often reported by women than men. Screening positive for PTSD varied by age, with the younger age groups being more likely to screen positive. Younger people were as likely as older age groups to report having experienced trauma in their lives. It is possible that traumatic experiences have increased, that younger people are more likely to describe events as traumatic or that memory of traumatic experiences can decline over time.

Patterns of association between screening positive for PTSD and sex and ethnicity may be shifting. In 2014, the proportion screening positive for PTSD was similar for male and female participants, while in 2023/4 prevalence was higher in female than male participants. Similarly, while in 2014 differences across ethnic groups did not reach statistical significance (although appeared highest among Black/Black British adults), in 2023/4 prevalence was highest among adults in the Mixed/multiple and other ethnic group and lowest among those from an Asian or Asian British background.

People who may be more likely to be experiencing socioeconomic adversity were more likely to report trauma and screen positive for PTSD. Socioeconomic factors are known to be associated with a range of mental health problems, but due to the cross-sectional nature of these data it is not possible to examine causality. Recall of a traumatic lifetime event and screening positive for PTSD were both higher for those who were economically inactive and those with problem debt, while screening positive for PTSD was additionally associated with being unemployed. This is consistent with results from a longitudinal study in the Netherlands which found that, after controlling for pre-trauma mental health problems and lack of support, pre- and post-trauma financial problems further increased the risk of probable PTSD (van der Velden et al. 2023).

Over half of those screening positive for PTSD were receiving mental health treatment, a similar level to APMS 2014. NICE guidelines for treatment for people with PTSD (NICE

2018 (Link: https://www.nice.org.uk/guidance/ng116)) recommend psychological interventions, with medication use not recommended as the primary treatment. In the current study, of those screening positive for PTSD, about a third were receiving antidepressants and/or anxiolytics (medication to treat anxiety) and a quarter were receiving some form of psychological therapy either on its own (the NICE recommended treatment for PTSD) or in combination with medication. It is important to note that APMS data cannot be used to assess the appropriateness or not of the treatment participants reported receiving, especially given the survey only used a brief screening tool for PTSD, not a detailed assessment. There were also inequalities in who received psychological therapies. APMS 2014 showed that people in the Black/Black British group were the least likely to be in receipt of any mental health treatment (Ahmad et al. 2022). A review of services provided by NHS Talking Therapies found that people from Black and other minoritised ethnic backgrounds experienced poorer access to, and outcomes from, NHS Talking Therapies (National Collaborating Centre for Mental Health 2023).

Screening positive for PTSD is prevalent and there remain inequalities, but these data go some way towards improving the evidence base for England.

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Previous Chapter

Chapter 2: Mental health treatment and service use (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/mental-health-treatment-and-service-use)

Next Chapter

Chapter 4: Suicidal thoughts, suicide attempts and non-suicidal self-harm (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/suicidal-thoughts-suicide-attempts-and-self-harm)

Chapter 4: Suicidal thoughts, suicide attempts and non-suicidal self-harm

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Overview

Suicidal thoughts, suicide attempts, and non-suicidal self-harm are associated with great distress for the people who experience them, as well as for the people around them. Although associated with poor mental health, they can be experienced by people with and without mental health conditions.

The Adult Psychiatric Morbidity Survey (APMS) included questions on suicidal thoughts and suicide attempts. It also asked participants about self-harm which they considered to be without suicidal intent, referred to here as self-harm or as non-suicidal self-harm. Some questions were asked in both the face-to-face and self-completion parts of the interview. For reasons of comparability, trends over time draw on face-to-face reports, which tend to be lower than those based on self-completion. A variable combining face-to-face and self-completion data was used for examining differences in prevalence between groups in 2023/4.

Key findings

- **Prevalence of suicidal thoughts and suicide attempts has increased**. The proportion of 16 to 74 year olds reporting suicidal thoughts in the past year has increased from 3.8% in 2000 to 6.7% in 2023/4. The proportion having made a past year suicide attempt also appears to have risen, from 0.5% in 2000 to 1.0% (95% CI 0.7, 1.4) in 2023/4.
- **Prevalence of self-harm has increased.** Lifetime self-harm was reported by 2.4% of 16 to 74 year olds in 2000, 3.8% in 2007, rising to 6.4% in 2014 and 10.3% in 2023/4. This increase was evident in men and women and across age-groups.
- **Women were more likely than men to have ever made a suicide attempt** (8.6% compared with 6.9%) or self-harmed (12.6% compared with 8.5%). Among 16 to 24 year olds, 31.7% of women and 15.4% of men reported having ever self-harmed.
- **There were demographic and socioeconomic inequalities.** Younger people, those of White British or 'Mixed, multiple or other' ethnicity, and those in problem debt or who were unemployed or economically inactive, were more likely to report lifetime suicidal thoughts, suicide attempts and self-harm.
- **There were strong associations with physical and mental health**. Over a third (35.8%) of people with a physical health condition that limited their activities had had suicidal thoughts in their life, 14.4% had made a suicide attempt, and 16.0% had self-harmed.
- **Most people who self-harmed did so to relieve unpleasant feelings.** 83.1% of those who had self-harmed reported doing so to relieve unpleasant feelings of anger, tension, anxiety or depression. Among people who had self-harmed, cutting was the most reported method.

4.1 Introduction

The suicide rate in England and Wales fell from the early 1980s through to the 2000s, reaching a low point in 2007 (9.0 deaths per 100,000 people). Since then, the downward trend has not been maintained and a change in 2018 to the definition of suicide at inquest increased subsequent reported rates. In 2023, the rate was the highest figure since 1999, with 6,069 suicides registered in England and Wales (11.4 deaths per 100,000 people) (ONS 2024 (Link: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2023)).

A refreshed cross-sector strategy for suicide prevention in England was launched in 2023 (DHSC 2023 (Link: https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028/suicide-prevention-in-england-5-year-cross-sector-strategy)). This highlighted progress made since the previous strategy was published over a decade before (Department of Health 2015 (Link: http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/405407/Annual_Report_acc.pdf)). It raised the need for epidemiological evidence and data to underpin service planning and identified several priority groups for tailored, targeted support. These include children and young people, middle-aged men, and people in contact with mental health services. The strategy also highlighted people who have made a suicide attempt or who self-harm as priority groups at elevated risk of suicide.

The relationship between suicidal thoughts, self-harm and suicide is not straightforward. The age and gender/sex of people reporting suicidal thoughts, suicide attempts and self-harm differs from that of people who die by suicide, and the majority of people who engage in these thoughts and behaviours do not go on to die by suicide. Suicidal thoughts and self-harming behaviours, as well as indicating potential suicide risk (World Health Organization (WHO) 2014), warrant intervention on their own account. They are associated with high levels of distress, both for the people engaging in them and for those around them.

The National Institute for Health and Care Excellence (NICE) guidelines define self-harm as self-injury or self-poisoning regardless of motivation or suicidal intent (NICE 2022 (Link: https://www.nice.org.uk/guidance/ng225)). Establishing suicide intention can be difficult; people's understandings of their behaviour can be ambiguous or change with hindsight (Kapur et al. 2013). However, the APMS series examines these behaviours (suicide attempts and non-suicidal self-harm) separately, based on participants' own reported understanding of their intention (McManus et al. 2019). Administering these questions consistently in each survey does allow for meaningful assessment of change over time.

Among those who engaged in self-harm (with suicidal intent or not) many do not consult health services and, if they do, they may not be identified as needing or may not receive care. Health service records provide a unique understanding of patterns of service use but give a different understanding to community prevalence studies. Studies of people attending health services will be affected by the factors associated with clinic and hospital attendance (Geulayov et al. 2016). Some people attend health services but have poor experiences and so do not attend after subsequent self-harm (O'Keeffe et al. 2021).

Official statistics on recorded suicides (official suicides and undetermined deaths) provide a profile of people who have taken their own life, but not systematically coded detail about their life and socioeconomic circumstances. While this can be obtained from surveys, survey samples exclude those people, mostly male, who take their own life at the first attempt (Jordan and McNeil 2020). There is therefore a need to look across a range of data sources, and at suicidal thoughts, suicide attempts and non-suicidal self-harm.

This chapter provides nationally representative estimates of the prevalence of suicidal thoughts, suicide attempts, and non-suicidal self-harm (also referred to as self-harm), and trends in these using comparable measures since 2000. Their relationship to age, gender and other characteristics is described alongside findings on the methods and reasons reported for self-harming. Finally, results are presented on the help-seeking behaviours of people who have made a suicide attempt, and on the types of professional help received by those who have self-harmed.

4.2 Definitions and Assessments

Suicidal thoughts, suicide attempts and self-harm

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (APA 2013) includes two types of self-harming behaviour as conditions for further study: non-suicidal self-injury (NSSI) and suicidal behaviour disorder (SBD). While intentionality can be difficult to establish (Kapur et al. 2013), this is broadly the approach that has also been adopted in the APMS series, with a separate focus on thinking about suicide; making a suicide attempt with the intention of taking one's own life; and harming oneself without the intent to die (referred to here as non-suicidal self-harm or self-harm). This approach has remained consistent across the APMS series to enable assessment of changes over time.

Measuring suicidal thoughts, suicide attempts and self-harm

Face-to-face questions

As in APMS 2000, 2007 and 2014, all participants in 2023/4 were asked in the face-to-face section of the interview several questions about suicidal thoughts, suicide attempts, and

self-harm without suicidal intent. These questions form part of the revised Clinical Interview Schedule (CIS-R). For the purposes of the analysis in this chapter, suicidal thoughts, suicide attempts, and non-suicidal self-harm were assessed using the following questions:

- Have you ever thought of taking your life, even though you would not actually do it?
- Have you ever made an attempt to take your life, by taking an overdose of tablets or in some other way?
- Have you ever harmed yourself in any way on purpose but not with the intention of killing yourself?

Note that the question used for self-harm in 2023/4 was slightly different from that used in the earlier surveys. The previous version of the question - 'Have you ever deliberately harmed yourself in any way but not with the intention of killing yourself?'' - included the word 'deliberately' which has been considered problematic in this context.

A positive response to each was followed up with a question on whether this last occurred in the past week, the past year, or longer ago.

Self-completion questions

While questions about suicidal thoughts, suicide attempts and self-harm were asked face-to-face to retain comparability with the previous APMS surveys, it was recognised that some participants might choose not to report them if asked face-to-face. For this reason, in the 2007, 2014 and 2023/4 surveys, some questions were also asked of all participants a second time, later in the interview, using laptop self-completion. In 2007 this consisted of the three lifetime prevalence questions listed above (a subset of the full section administered face-to-face). In 2014 and 2023/4, most of the questions on suicidal thoughts, attempts and self-harm were administered in the self-completion section, with some retained in the face-to-face section for trends and for use in scoring the CIS-R.

In 2023/4, the questions asked a second time in the self-completion part of the interview were not asked of the small number of participants who completed the interview by phone, for ethical and safeguarding reasons.

Questions used for results in this chapter

In 2014 and 2023/4, a question was included on when the participant had last self-harmed. In previous surveys in the series, participants were asked if they had ever self-harmed, but not when this had last happened. Trends in self-harm, therefore, are based only on reports of lifetime experience. Also to retain comparability of method with the 2000 and 2007 surveys, only data collected in the face-to-face interviews were used to assess change over time. The other analyses of suicidal thoughts, attempts and self-harm in this chapter draw on derived variables that combine positive responses in the face-to-face interview with positive responses in the self-completion section, as we believe this approach to be the most accurate (Bowling 2005; Tipping et al. 2010). Generally, reporting in the self-completion was higher than reporting face-to-face, but not all

participants agreed to the self-completion.

Measuring methods of self-harming

In the self-completion section of the interview, participants who reported that they had self-harmed at some point, were asked which of a list of methods they had used. It was possible to give more than one response.

Did you… (You may give more than one response)

1. Cut yourself
2. Or burn yourself
3. Or swallow anything
4. Or harm yourself some other way.

Measuring reasons for self-harming

Participants who reported in the self-completion that they had self-harmed were also asked two questions about their motivation. It was possible to select neither, one, or both of these reasons:

- Did you do any of these things to raise awareness of your situation or to change your situation?
- Did you do any of these things because it relieved unpleasant feelings of anger, tension, anxiety or depression?

Note that the first of these questions differed from that used in the previous surveys. The revised version replaces the words ‘draw attention to’ with ‘raise awareness of’. This is because of the stigmatising associations with 'attention’. The issue of intent is very complex; these questions are therefore necessarily reductive, and the reasons given by participants for self-harming may reflect subsequent rationalisations (Kapur et al. 2013). The data presented on this should be treated as only indicative.

Measuring help-seeking after a suicide attempt

Participants reporting a suicide attempt were asked whether they had tried to get help following their most recent attempt, and if so which, from a list of formal and informal sources. They were also asked if they had ever received medical attention or seen a mental health professional following a suicide attempt.

Measuring help-seeking for self-harm

Participants reporting self-harm were asked whether they had received medical attention and whether they had seen a psychiatrist, psychologist or counsellor because of self-harming.

4.3 Results

Suicidal thoughts, attempts and self-harm, by age and gender

Prevalence of suicidal thoughts (ever)

A quarter of adults (25.2%) reported that they had thoughts of taking their own life at some point. If all adults in the population had been assessed, it is likely that this proportion would be between 23.7% and 26.7% (referred to as the 95% confidence interval or 95% CI). This equates to an estimated 11.7 million adults living in England. The prevalence was similar in men and women.

The proportion reporting lifetime suicidal thoughts decreased with age. It was highest in people aged 16 to 24 (31.5%, 95% CI 25.8, 37.8) and 25 to 34 (32.9%, CI 29.1, 36.9) and lowest in those aged 75 and over (11.0%, CI 9.0, 13.5). The survey questions related to suicidal thoughts across the participant's lifetime. The higher reporting by younger participants might be explained by generational differences, with young people now being more likely to have suicidal thoughts than their counterparts in the past. However, age group variations in recall, perception, and willingness to report, together with healthy-survivor effects, may explain some of this association with age.

For more information: Table 4.1 and Table A1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals.

Suicidal thoughts ever, by age (Base: All adults)

Download the data for this chart Suicidal thoughts ever, by age (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/suicidal-thoughts-suicide-attempts-and-self-harm/suicidal-thoughts-suicide-attempts-and-self-harm/publicationsystem%3AbodySections%5B7%5D/publicationsystem%3AdataFile)

Prevalence of suicide attempts (ever)

One in thirteen adults (7.8%) reported having made a suicide attempt at some point in their life, with the proportion of the wider population likely to respond in this way being between 7.0% and 8.7% (95% CI). This equates to an estimated 3.6 million adults.

Despite men being three times more likely than women to die by suicide (ONS 2024),

women (8.6%, 95% CI 7.6, 9.7) were more likely to report an attempt than men (6.9%, CI 5.7, 8.3). Similar to suicidal thoughts, lifetime suicide attempts were more likely to be reported by people aged 16 to 24 (10.3%, CI 6.9, 15.2) and 25 to 34 (11.4%, CI 8.8, 14.6), and less likely to be reported by those aged 75 and over (2.3%, CI 1.4, 3.6).

For more information: Table 4.1 and Table A1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals.

Suicide attempts ever, by age and gender (Base: All adults)

Download the data for this chart Suicide attempts ever, by age and gender (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/suicidal-thoughts-suicide-attempts-and-self-harm/suicidal-thoughts-suicide-attempts-and-self-harm/publicationsystem%3AbodySections%5B9%5D/publicationsystem%3AdataFile)

Prevalence of self-harm without suicidal intent (ever)

About one adult in nine (10.8%) reported having self-harmed without suicidal intent at some point in their life. Prevalence in the wider population is likely to be between 9.7% and 12.1% (95% CI). This equates to around 5 million adults living in England. Women (12.6%, 95% CI 11.1, 14.3) were more likely to report self-harm than men (8.5%, CI 7.0, 10.4).

There was a steep decline with increasing age. One in four 16 to 24 year olds (24.6%, CI 19.0, 31.1) reported having self-harmed, compared with less than one in a hundred (0.6%, CI 0.3, 1.3) of those aged 75 and over. Among both men and women prevalence was highest in 16 to 24 year olds, with 15.4% (CI 9.2, 24.7) of men and 31.7% (CI 23.8, 40.8) of women of this age reporting having self-harmed.

For more information: Table 4.1 and Table A1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals.

Self-harm without suicidal intent ever, by age and gender (Base: All adults)

Download the data for this chart Self-harm without suicidal intent ever, by age and gender (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/

survey-of-mental-health-and-wellbeing-england-2023-24/suicidal-thoughts-suicide-attempts-and-self-harm/suicidal-thoughts-suicide-attempts-and-self-harm/publicationsystem%3AbodySections%5B11%5D/publicationsystem%3AdataFile)

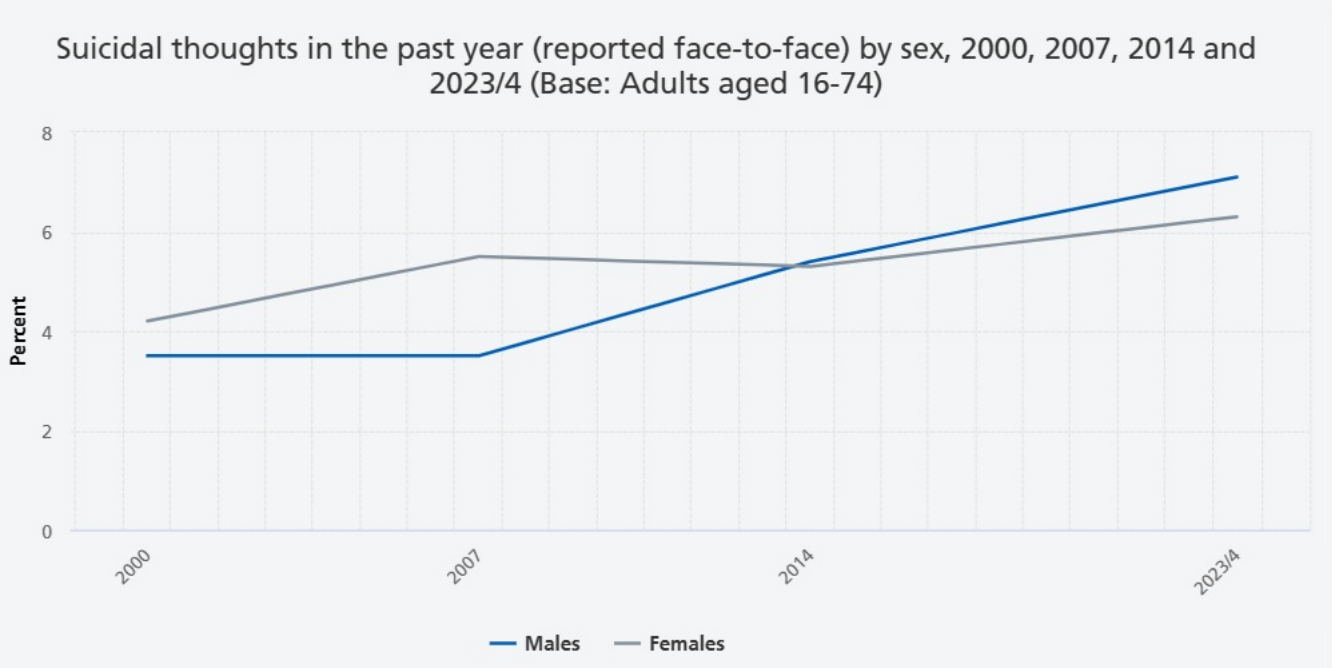
Suicidal thoughts and attempts in the past year and self-harm ever, 2000, 2007, 2014 and 2023/4

Note that the trend data in this chapter were based only on the face-to-face section of the interview among 16 to 74 year olds, to allow for comparison back to 2000, and analyses by sex (male and female) rather than gender (men and women). See How to interpret the findings (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/how-to-interpret-the-findings) for information on how changes over time were assessed. In 2007, 2014 and 2023/4 self-completion data on this topic was also collected, which tends to elicit higher reporting.

Suicidal thoughts in the past year, 2000, 2007, 2014 and 2023/4

The proportion of adults aged 16 to 74 who reported suicidal thoughts in the past year increased from 3.8% in 2000 (95% CI 3.4, 4.4) to 6.7% in 2023/4 (CI 5.9, 7.7). Prevalence increased over this period among both males (from 3.5% (CI 2.9, 4.3) to 7.1% (CI 5.9, 8.7)) and females (from 4.2% (CI 3.5, 4.9) to 6.3% (CI 5.3, 7.6)).

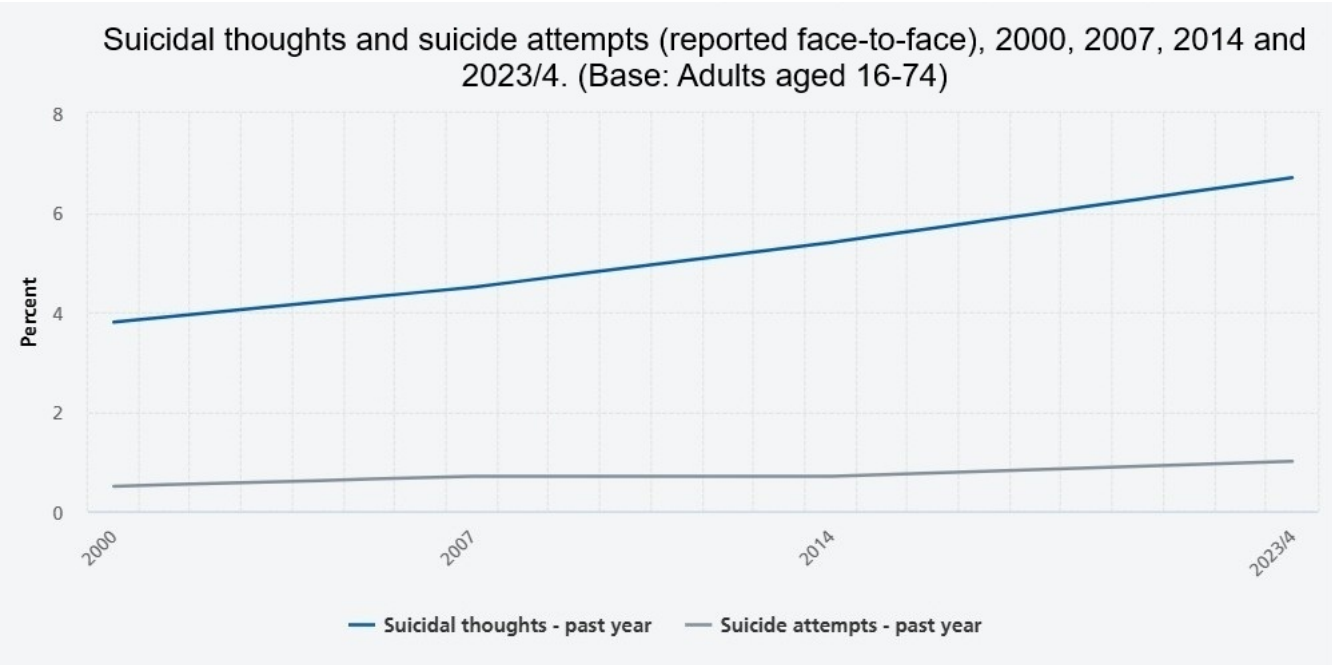
For more information: Table 4.2 and Table B1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals.



Suicide attempts in the past year, 2000, 2007, 2014 and 2023/4

The proportion of adults aged 16 to 74 who had attempted suicide in the past year appears to have increased, from 0.5% in 2000 (95% CI 0.4, 0.7) to 1.0% in 2023/4 (CI 0.7, 1.4). The same upward trend can be observed for both males (0.5% CI 0.3, 0.8) in 2000; 1.0% (CI 0.6, 1.6) in 2023/4) and females (also 0.5% (CI 0.3, 0.9) in 2000; 1.0% (CI 0.6, 1.5) in 2023/4). Confidence intervals around these estimates overlap, so caution is warranted.

For more information: Table 4.2 and Table B1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals.



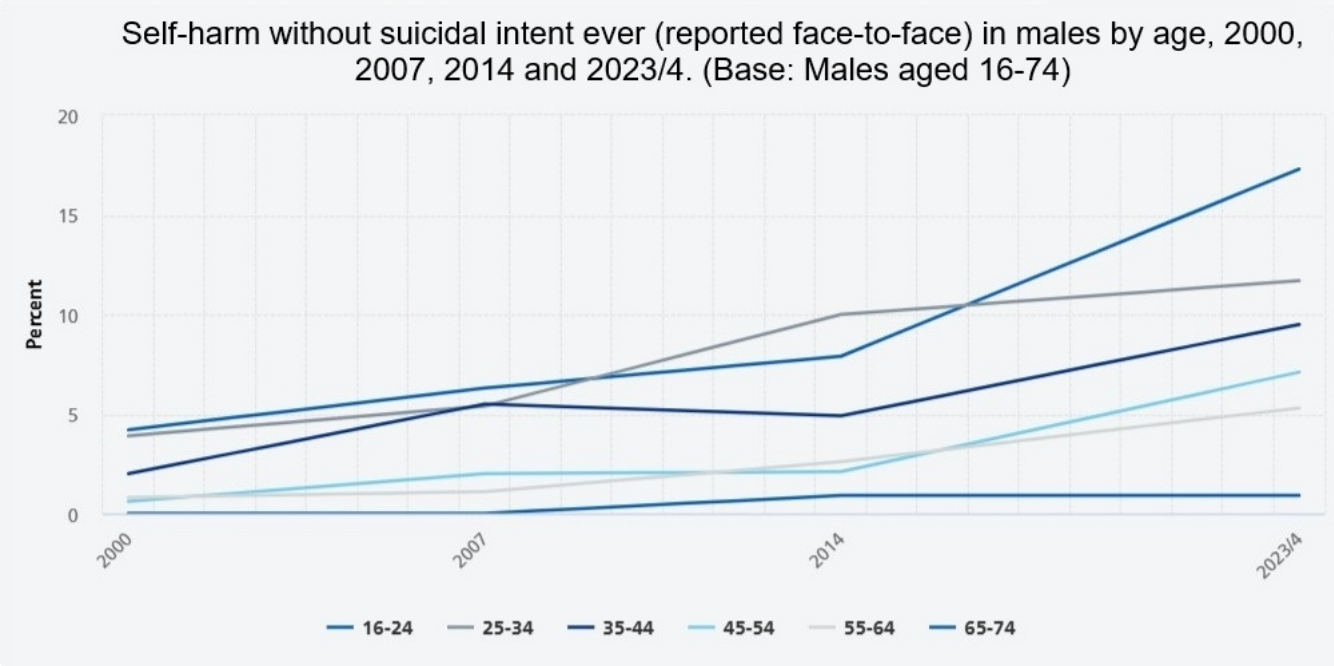
Self-harm without suicidal intent (ever), 2000, 2007, 2014 and 2023/4

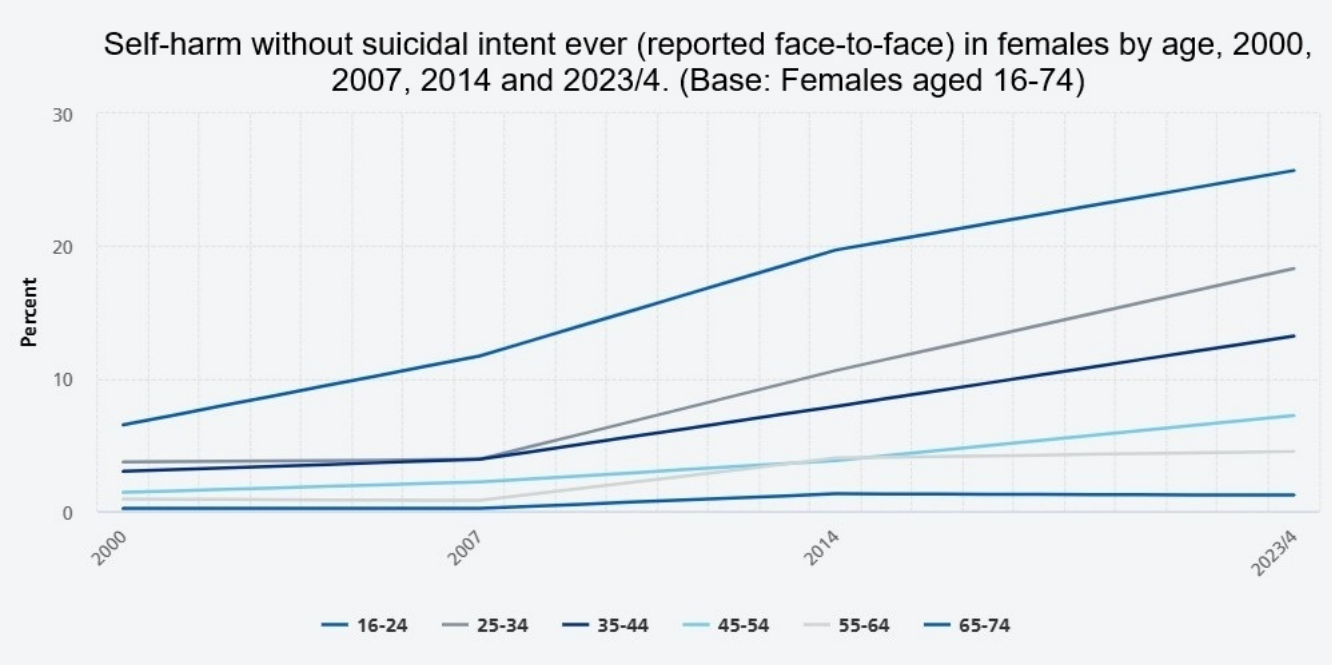
There has been a steady increase in the proportion of adults aged 16 to 74 who had ever self-harmed, from 2.4% in 2000 (95% CI 2.0, 2.8) to 10.3% in 2023/4 (CI 9.1, 11.6).

Prevalence of self-harm has increased in both females and males. 2.7% of females aged 16 to 74 said they had ever self-harmed in 2000 (CI 2.2, 3.4) compared with 11.7% in 2023/4 (CI 10.1, 13.4). The equivalent proportions for males aged 16 to 74 were 2.1% in 2000 (CI 1.6, 2.7) and 8.8% in 2023/4 (CI 7.2, 10.8).

Prevalence of self-harm has increased in every age group. While the absolute rise was greatest in 16 to 24 year olds (from 5.3% (CI 3.7, 7.6) in 2000 to 21.2% (CI 16.0, 27.9) in 2023/4), the relative increase was similar or even greater in other age groups. For example, among 45 to 54 year olds, reported self-harm rose from 1.0% (CI 0.6, 1.7) in 2000 to 7.2% (CI 5.6, 9.1) in 2023/4.

For more information: Table 4.2 and Table B1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals.





Variation in suicidal thoughts, suicide attempts and self-harm by other characteristics

Ethnic group

Age-standardised prevalence of lifetime suicidal thoughts, attempted suicide and self-harm varied by ethnic group. It should be noted that the confidence intervals for some estimates were wide and overlapping, so apparent differences between ethnic groups should be treated with caution.

- Suicidal thoughts were more commonly reported among those in the Mixed/multiple/other ethnicity (30.8%, 95% CI 21.2, 42.3), White British (28.2%, CI 26.4, 30.1) and White Other (27.2%, CI 21.6, 33.8) groups, and less so among those in the Black/Black British (15.8%, CI 11.3, 21.6) and Asian/Asian British (8.9%, CI 6.4, 12.2) groups.
- Suicide attempts were more commonly reported in the Mixed/multiple/other (11.0%, CI 5.2, 21.7), White British (9.2%, CI 8.2, 10.4) and White Other (7.5%, CI 4.2, 12.8) groups, and less so in the Black/Black British (3.0%, CI 1.5, 6.0) and Asian/Asian British (2.1%, CI 1.1, 4.0) groups.
- Self-harm was more common in the White British (13.5%, CI 12.0, 15.2) and White Other (9.9%, CI 6.2, 15.4), and Mixed/multiple/other (9.1%, CI 5.4, 15.0) groups and less so in the Black/Black British (4.3%, CI 1.9, 9.4) and Asian/Asian British (1.8%, CI 1.1, 3.1) groups.

For more information: Table 4.3 and Table A2 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals.

Suicidal thoughts, suicide attempts and self-harm without suicidal intent ever, by ethnic group (age-standardised) (Base: All adults)

Download the data for this chart Suicidal thoughts, suicide attempts and self-harm without suicidal intent ever, by ethnic group (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/suicidal-thoughts-suicide-attempts-and-self-harm/suicidal-thoughts-suicide-attempts-and-self-harm/publicationsystem%3AbodySections%5B20%5D/publicationsystem%3AdataFile)

Employment status

Among participants of working age (16 to 64), age-standardised prevalence of lifetime suicidal thoughts, attempted suicide and self-harm varied by employment status. Economically inactive and unemployed adults were more likely to report having ever had suicidal thoughts, attempted suicide or self-harmed, than adults who were in employment.

- Unemployed (42.3%) and economically inactive (37.5%) adults were more likely to have experienced suicidal thoughts than adults in employment (26.3%).
- Unemployed (20.3%) and economically inactive (19.1%) adults were more likely to have attempted suicide than adults in employment (6.6%).
- Unemployed (23.2%) and economically inactive (19.4%) adults were more likely to have self-harmed than adults in employment (12.8%).

The relationship between employment status and attempted suicide was stronger for men than for women.

For more information: Table 4.4 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Suicidal thoughts, suicide attempts and self-harm without suicidal intent ever, by employment status (age-standardised) (Base: Adults aged 16-64)

Download the data for this chart Suicidal thoughts, suicide attempts and self-harm without suicidal intent ever, by employment status (age-standardised) (Base: Adults aged 16-64) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/

survey-of-mental-health-and-wellbeing-england-2023-24/suicidal-thoughts-suicide-attempts-and-self-harm/suicidal-thoughts-suicide-attempts-and-self-harm/publicationsystem%3AbodySections%5B22%5D/publicationsystem%3AdataFile)

Problem debt

In age-standardised analyses, being seriously behind with debt repayments or having utilities cut off was associated with higher lifetime prevalence of suicidal thoughts, attempted suicide or self-harm.

See the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods) for more information on how problem debt was derived.

- Adults with problem debt (39.4%) were more likely to experience suicidal thoughts (ever) than those who were not experiencing problem debt (23.8%).
- Adults with problem debt (21.2%) were three times more likely to report having attempted suicide (ever) than those not experiencing problem debt (6.6%).
- Adults with problem debt (19.3%) were twice as likely to report having self-harmed (ever) compared with those not experiencing problem debt (10.0%).

The pattern of association between problem debt and suicidal thoughts, suicide attempts, and self-harm was similar for men and women.

For more information: Table 4.5 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Suicidal thoughts, suicide attempts and self harm without suicidal intent ever, by problem debt (age-standardised) (Base: All adults)

Download the data for this chart Suicidal thoughts, suicide attempts and self harm without suicidal intent ever, by problem debt (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/suicidal-thoughts-suicide-attempts-and-self-harm/suicidal-thoughts-suicide-attempts-and-self-harm/publicationsystem%3AbodySections%5B24%5D/

publicationsystem%3AdataFile)

Area-level deprivation

How has deprivation been defined?

Area-level deprivation has been defined using the English Indices of Deprivation 2019, commonly known as the Index of Multiple Deprivation (IMD).

IMD is the official measure of relative deprivation for Lower Super Output Areas (LSOAs) in England. LSOAs comprise between 400 and 1,200 households and usually have a resident population between 1,000 and 3,000 persons. IMD ranks every LSOA in England from 1 (most deprived area) to 32,844 (least deprived area). Deprivation quintiles are calculated by ranking the 32,844 neighbourhoods in England from most deprived to least deprived and dividing them into five equal groups. These range from the most deprived 20% of neighbourhoods nationally to the least deprived 20% of neighbourhoods nationally.

For further information see: English indices of deprivation 2019 (Link: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019)

In age-standardised analyses, the prevalence of attempted suicide varied by area-level deprivation. Having ever made a suicide attempt was more common among adults living in the most deprived areas (12.9%) and less common among those living in the least deprived areas (5.3%). The prevalence of lifetime suicidal thoughts and self-harm by area deprivation overall did not meet the required levels of significance.

For more information: Table 4.6 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Suicide attempts ever, by area-level deprivation (age-standardised) (Base: All adults)

Download the data for this chart Suicide attempts ever, by area-level deprivation (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/suicidal-thoughts-suicide-attempts-and-self-harm/suicidal-thoughts-suicide-attempts-and-self-harm/

publicationsystem%3AbodySections%5B28%5D/publicationsystem%3AdataFile)

Region

The prevalence of having ever experienced suicidal thoughts, attempted suicide and self-harm were not significantly associated with region.

For more information: Table 4.7 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Comorbidity

Physical health conditions

How have physical health conditions been defined?

Participants were asked if they had any of 25 physical health conditions listed on a card, including asthma, cancer, diabetes, epilepsy and high blood pressure. Participants were coded as having a limiting physical health condition, if they reported having one or more physical health conditions in the past 12 months that had been diagnosed by a doctor and that this had limited their ability to carry out day-to-day activities. More details on the questions on physical health conditions can be found in the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

Adults with a limiting physical health condition were more likely to have ever experienced thoughts of suicide (35.8%), attempted suicide (14.4%), or self-harmed (16.0%) than adults without a limiting physical health condition (19.9%, 4.9% and 8.7% respectively).

For more information: Table 4.8 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Suicidal thoughts, suicide attempts and self-harm without suicidal intent ever, by limiting physical health conditions (age-standardised) (Base: All adults)

Download the data for this chart Suicidal thoughts, suicide attempts and self-harm without suicidal intent ever, by limiting physical health conditions (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/suicidal-thoughts-suicide-attempts-and-self-harm/suicidal-thoughts-suicide-attempts-and-self-harm/publicationsystem%3AbodySections%5B32%5D/publicationsystem%3AdataFile)

Common mental health conditions

How have common mental health conditions been defined?

The revised Clinical Interview Schedule (CIS-R) was used to assess six types of common mental health conditions (CMHC): depression, generalised anxiety disorder, panic disorder, phobias, obsessive compulsive disorder, and CMHC not otherwise specified. Participants identified with at least one of these were defined as having a CMHC. See Section 1.2 of the Common mental health conditions chapter (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/common-mental-health-conditions) for more detail.

Adults with a CMHC were more likely to report having ever had thoughts of suicide, attempted suicide, or self-harmed than adults without a CMHC.

- Adults with a CMHC were three times more likely to have ever experienced suicidal thoughts than adults without a CMHC (55.6% compared with 17.0%).
- Adults with a CMHC were five times more likely to have ever attempted suicide than adults without a CMHC (21.8% compared with 3.9%).
- Adults with a CMHC were four times more likely to have ever self-harmed than adults without a CMHC (27.2% compared with 6.0%).

The relationship between having ever had suicidal thoughts and CMHC was stronger for men than for women.

For more information: Table 4.8 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Suicidal thoughts, suicide attempts and self harm without suicidal intent ever, by common mental health condition (age-standardised) (Base: All adults)

Download the data for this chart Suicidal thoughts, suicide attempts and self harm without suicidal intent ever, by common mental health condition (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/suicidal-thoughts-suicide-attempts-and-self-harm/suicidal-thoughts-suicide-attempts-and-self-harm/publicationsystem%3AbodySections%5B36%5D/publicationsystem%3AdataFile)

Methods of self-harming

Questions about the methods used to self-harm and reasons for self-harming (covered in the next section) were asked only of participants who reported in the self-completion section of the interview that they had ever self-harmed. Most, but not all, participants completed the self-completion section. Participants could report more than one method and more than one reason.

The most reported method of self-harming was cutting, with 72.7% of those who had ever self-harmed saying that they had cut themselves. A smaller proportion said they had burned themselves (13.4%) or swallowed something (10.0%). A third (33.2%) reported that they had harmed themselves in 'some other way'.

Women (79.5%) were more likely than men (60.1%) to report cutting themselves. Men (45.0%) were more likely than women (27.2%) to report harming themselves in ‘some other way’, that is, in a way other than cutting, burning or swallowing something.

Younger age groups were more likely to report burning themselves than older age groups, with 17.0% of those aged 16 to 34 reporting having done so ever compared with 7.8% of those aged 35 to 54 and 6.0% of those aged 55 and over.

For more information: Table 4.9 and Table 4.10 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Method of self harming without suicidal intent, by gender (Base: Adults who reported having ever self-harmed in self-completion questionnaire)

Download the data for this chart Method of self harming without suicidal intent, by gender (Base: Adults who reported having ever self-harmed in self-

completion questionnaire) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/suicidal-thoughts-suicide-attempts-and-self-harm/suicidal-thoughts-suicide-attempts-and-self-harm/publicationsystem%3AbodySections%5B38%5D/publicationsystem%3AdataFile)

Reported reasons for self-harming

When asked if they had self-harmed to relieve unpleasant feelings of anger, tension, anxiety or depression, 83.1% of adults who had self-harmed ever said that this was the case. A smaller proportion (25.4%) said they had self-harmed to raise awareness of or a change in their situation.

Women (88.5%) were more likely than men (72.5%) to say they had self-harmed ever to relieve unpleasant feelings. There was no significant difference in the proportion of women and men saying they had self-harmed to raise awareness of their situation. The proportion reporting each reason for self-harm did not vary significantly between age groups.

For more information: Table 4.9 and Table 4.10 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Help-seeking behaviour

Participants who reported in the self-completion section of the questionnaire that they had ever attempted suicide or self-harmed were asked whether they had sought or received help afterwards, this is discussed below. Most (89%) participants completed the self-completion section.

Help-seeking following most recent suicide attempt

Around half (51.6%) of adults who reported a suicide attempt ever said that they had sought help after the last attempt. The question captured help-seeking, participants may not have received the help sought.

The most common sources people turned to for help were "friends, partner, family or neighbours" (27.3%); a GP practice or family doctor (25.6%); a counsellor, therapist or mental health professional (23.8%) and hospital, emergency services or A&E (20.9%). Women (59.1%) were more likely than men (41.0%) to have sought help from at least one source. In particular, women (31.0%) were more likely than men (17.5%) to have sought help from a GP practice or family doctor, a counsellor, therapist or mental health professional (28.5% and 16.8% respectively) or a telephone or crisis helpline (9.0% and

2.7% respectively). Among those who sought help, men and women sought help from similar sources.

Type of help sought following most recent suicide attempt, by gender (Base: Adults who reported attempted suicide in self-completion)

Download the data for this chart Type of help sought following most recent suicide attempt, by gender (Base: Adults who reported attempted suicide in self-completion) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/suicidal-thoughts-suicide-attempts-and-self-harm/suicidal-thoughts-suicide-attempts-and-self-harm/publicationsystem%3AbodySections%5B40%5D/publicationsystem%3AdataFile)

The likelihood of seeking help also varied with age.

- Those aged 35 to 54 (61.2%) were the most likely to have sought help from at least one source, compared with 47.8% of 16 to 34 year olds and 43.8% of those aged 55 and over.
- While friends, partner, family or neighbours were the most common source of help sought by 16 to 34 year olds (33.3%) and 35 to 54 year olds (29.6%), 12.9% of those aged 55 and over sought help from this source.
- The most common source of help sought by those aged 55 and over was a GP practice or family doctor (22.1%).
- 1.1% of those aged 55 and over had sought help from a telephone helpline compared with 6.6% of 35 to 54 year olds and 9.0% of 16 to 34 year olds.

For more information: Table 4.11 and Table 4.12 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Type of help sought following most recent suicide attempt, by age group (Base: Adults who reported attempted suicide in self-completion)

Download the data for this chart Type of help sought following most recent suicide attempt, by age group (Base: Adults who reported attempted suicide in self-completion) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/suicidal-thoughts-suicide-

attempts-and-self-harm/suicidal-thoughts-suicide-attempts-and-self-harm/publicationsystem%3AbodySections%5B42%5D/publicationsystem%3AdataFile)

Medical and psychological help following any suicide attempt

Three-fifths of adults (60.6%) who had made a suicide attempt (ever) received medical and/or psychological help after an attempt: half (51.6%) had psychological help and about two-fifths (42.1%) received medical help.

The proportion receiving help was similar for men and women and for different age groups.

For more information: Table 4.13 and Table 4.14 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Medical and psychological help ever received for self-harming

Among adults who had ever self-harmed, 37.9% had received medical and/or psychological help at some point as a result: 34.9% had received psychological help and 17.5% medical help.

Women (42.6%) were more likely than men (26.7%) to have received help. In particular, women (40.6%) were around twice as likely as men (21.6%) to have received psychological help.

Received psychological help after self-harm without suicidal intent, by gender (Base: Adults who reported having ever self-harmed in self-completion)

Download the data for this chart Received psychological help after self-harm without suicidal intent, by gender (Base: Adults who reported having ever self-harmed in self-completion) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/suicidal-thoughts-suicide-attempts-and-self-harm/suicidal-thoughts-suicide-attempts-and-self-harm/publicationsystem%3AbodySections%5B44%5D/publicationsystem%3AdataFile)

Receipt of psychological help also varied by age. 16 to 34 year olds (39.2%) were twice as likely as those aged 55 and over (20.0%) to have received psychological help.

For more information: Table 4.15 and Table 4.16 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Received psychological help after self-harm without suicidal intent, by age (Base: Adults who reported having ever self-harmed in self-completion)

Download the data for this chart Received psychological help after self-harm without suicidal intent, by age (Base: Adults who reported having ever self-harmed in self-completion) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/suicidal-thoughts-suicide-attempts-and-self-harm/suicidal-thoughts-suicide-attempts-and-self-harm/publicationsystem%3AbodySections%5B46%5D/publicationsystem%3AdataFile)

Treatment

Treatment and service use

Participants were asked about different types of mental health treatment and service use. Two types of mental health treatment were asked about: current medication and psychological therapy for a mental or emotional problem. Participants were also asked about their use of a range of health, community and day care services over the past year. This treatment and service use could have been for any mental health condition, not necessarily related to suicidal thoughts, suicide attempts or self-harm.

Half (50.6%) of adults who had attempted suicide at some point in their life were currently receiving treatment for some form of mental or emotional problem. This was the case for almost half (47.7%) of those who had ever self-harmed. It was less common for adults who reported ever having suicidal thoughts to currently be receiving treatment, although over a third were (36.9%). In comparison, 15.7% of adults overall were currently receiving treatment for a mental or emotional problem.

In all three cases, the most common form of treatment was psychotropic medication. The proportion of adults in receipt of medication ranged from about two fifths of those who had attempted suicide (43.9%) or self-harmed (38.6%) to about a third of those who had experienced suicidal thoughts (30.9%). The proportions receiving psychological therapy – either alone or in combination with medication – were 15.3% (both suicide attempts and self-harm) and 11.4% (suicidal thoughts).

Treatment currently received for a mental or emotional problem, by suicidal thoughts, suicide attempts and self-harm without suicidal intent ever (Base: All adults)

Download the data for this chart Treatment currently received for a mental or emotional problem, by suicidal thoughts, suicide attempts and self-harm without suicidal intent ever (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/suicidal-thoughts-suicide-attempts-and-self-harm/suicidal-thoughts-suicide-attempts-and-self-harm/publicationsystem%3AbodySections%5B48%5D/publicationsystem%3AdataFile)

About four in ten adults who had ever attempted suicide (41.1%) or self-harmed (40.5%) had used healthcare services in the past year for a mental or emotional problem. This was also the case for three in ten of those who had suicidal thoughts (30.8%). In comparison, 13.5% of adults overall had used healthcare services for a mental or emotional problem in the past year.

For more information: Table 4.17 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Psychotropic medication

Participants were asked which (if any) psychotropic medications they currently take. These included any medications taken for a mental or emotional reason and not necessarily relating to suicidal thoughts, suicide attempts or self-harm.

Overall, 12.5% of all adults were taking some form of psychotropic medication, with the most common medication types those primarily used to treat depression (11.7%) and anxiety (10.7%). See Chapter 2 Mental health treatment and service use (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/mental-health-treatment-and-service-use) for more details.

Among adults who had attempted suicide, more than four in ten (43.9%) were currently taking psychotropic medication. The equivalent figures for those who had ever self-harmed or had suicidal thoughts were 38.6% and 30.9% respectively.

In all three cases, the most common types of psychotropic medication being taken were

those used to treat anxiety or depression.

- 41.6% of those who had ever attempted suicide were taking drugs used to treat depression as were 36.3% of those who had self-harmed and 29.2% of those who had had suicidal thoughts.
- Similar proportions were taking drugs used to treat anxiety, with these being taken by 38.3% of those who had ever attempted suicide, 34.0% of those who had self-harmed and 26.3% of those who had had suicidal thoughts.
- A minority were taking drugs used to treat bipolar disorder (7.3% of those who had attempted suicide) or psychosis (7.2% of those who had attempted suicide).

For more information: Table 4.18 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

4.4 Discussion

APMS data provides unique insights into trends and patterns in suicidal thoughts, attempted suicide and non-suicidal self-harming behaviours in England. Information has been collected from samples of the general population in comparable ways since 2000, enabling an understanding of changes in the population over time.

A number of key findings emerge from the results presented in this chapter.

Suicidal thoughts, suicide attempts and non-suicidal self-harm have increased. This century has seen a sustained rise in the proportion of the adult England population reporting having thought about suicide or having made a suicide attempt, and a steeper increase in having self-harmed without suicidal intent. This is a continuation of trends observed in previous surveys in the APMS series (McManus et al. 2019), and is consistent with more recent studies of trends in numbers of people attending health service settings (Cybulski et al. 2021; Trafford et al. 2023). These increases have followed different patterns to the suicide rate in timing (which reached the lowest recorded rate in 2007) and in age-sex profile. Suicidal ideation, suicide attempts, non-suicidal self-harm and suicide are related, but they are distinct and should not be treated as proxies (ONS 2024 (Link: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2023)). It is possible that some of the increased survey reporting may be attributable to changes in reporting behaviour, that some forms of self-injury which people had not included as self-harm in previous surveys have started to be labelled as such. It is also likely that people now feel more able to disclose suicidal thoughts, suicide attempts and self-harm, which might happen if these have become less stigmatised in wider public discourse (Ronaldson and Henderson 2024). However, it is

likely that the survey trends also reflect a real increase in such thoughts and behaviours.

Increases evident in both men and women and across all age groups. The absolute rise, particularly for self-harm, is greatest among young people: 6.5% of 16 to 24 year old women reported in the face-to-face section of the APMS 2000 interview, having self-harmed, in APMS 2023/4 this was 25.7%. When participant disclosures made in the self-completion section of the interview are also included in the estimate: one in three 16 to 24 year old women and one in six 16 to 24 year old men reported self-harm in the most recent survey. However, in terms of relative rises, increases are just as pronounced (or even more so) in older age groups. Those aged 45 to 54 in 2023/4 – were seven times more likely to report having ever self-harmed (7.2%) than those who were 45 to 54 in 2000 (1.0%). Among men, the prevalence of suicidal thoughts and suicide attempts was highest in those aged 25 to 34.

Self-harming takes many forms. Around three-quarters of adults who self-harm reported cutting. However, nearly half (45.0%) of the men in the 2023/4 survey sample who reported having self-harmed, said that this included a form other than cutting, burning, or swallowing something like pills. The comparable figure among men in 2014 was 32.2%, indicating that use of 'other' methods may be increasing (McManus et al. 2016). The options presented on the APMS questionnaire did not capture the behaviours participants included in their own understanding of self-harm. It is possible these included risky or self-destructive behaviours such as reckless driving (Witt et al. 2019). Tofthagen and colleagues (2022) found that acts such as head banging or punching a wall may be forms of self-injury particularly experienced by men. In future, the questions asked in surveys (Cook et al. 2022) and the probes used in clinical and other settings may need to be reviewed to be more open-ended, to ensure that they capture the range of behaviours that people engage in and consider to be self-harm (McCabe et al. 2017).

Self-harm as a coping mechanism. A minority of people who self-harmed reported doing so in order to change their situation, while the great majority (83.1%) reported having done so to manage and relieve feelings of anger and distress. It appears this proportion may have increased (McManus et al. 2019). Interventions to reduce self-harming need to consider ways of supporting healthy strategies for coping and managing distress (Witt et al. 2021), as this appears to be a key driver.

Prevention efforts need to address poverty and debt. The results in this chapter show that those struggling with financial debt or who were unemployed or economically inactive at the time of the interview were more likely to report lifetime suicidal thoughts, suicide attempts and self-harm (Meltzer et al. 2011; Richardson et al. 2013). These associations were especially pronounced for men. The risks posed by individual economic hardship is well established (Barnes et al. 2016), especially during periods of wider recession, indicating that people attending health services may benefit from signposting to local debt and advice services (Hawton et al. 2016). The resourcing and targeting of services and support should reflect how those living in the most deprived neighbourhoods (12.9%) were more than twice as likely to have attempted suicide compared to those in the least deprived areas (5.3%) (Cairns et al. 2017).

People presenting to services in poor physical health may be experiencing suicidal thoughts, suicide attempts and self-harm. The strong link between mental health and these thoughts and behaviours is well established, consistent with recent work by Nafilyan and colleagues (2023); the results in this chapter reinforce how these associations extend to physical health. Over a third (35.8%) of adults with a limiting physical health condition reported that they have had suicidal thoughts and 14.4% had made a suicide attempt. The interaction of physical and mental illness emphasises the importance of collaborative physical and mental health care, with health service contact for physical health reasons providing an opportunity for intervention.

There are gaps in help-seeking. Half of adults who attempted suicide (48.4%) did not seek help after their most recent attempt. The gaps in accessing health service support were especially pronounced for men and older people.

Addressing variations by ethnicity. Understanding of ethnic disparities in suicide in England is hampered by ethnicity not being recorded on death certificates (Knipe et al. 2024). The elevated prevalence found for those in the 'Mixed/ multiple/ other' group is consistent with Knipe and colleagues analyses using linked census and mortality data. In APMS 2014, there had been little variation by ethnic group in the proportion reporting suicidal thoughts, suicide attempts or self-harm, so emergence of variation in the APMS 2023/4 survey may be new. However, the small number of participants from ethnic minority backgrounds in survey samples means there is some uncertainty in the estimates by ethnicity and highlights the need for improved data collection, especially important given evidence of reduced service access for many groups (Ahmad et al. 2022). There is an urgent need to better understand the reasons for and best ways to respond to these variations by ethnic group.

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4.6 Citation

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Previous Chapter

Chapter 3: Posttraumatic stress disorder (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/posttraumatic-stress-disorder)

Next Chapter

Chapter 5: Alcohol: hazardous, harmful and dependent patterns of drinking (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/alcohol-dependence)

Chapter 5: Alcohol: hazardous, harmful and dependent patterns of drinking

Authors

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Overview

This chapter describes the prevalence of hazardous, harmful and dependent patterns of drinking in the general population. As in 2014, all participants in 2023/4 completed the Alcohol Use Disorders Identification Test (AUDIT) questionnaire in the self-completion part of the interview. The AUDIT was used to screen for clinically relevant alcohol use disorders, including alcohol dependence.

Key findings

- **18.0% of adults drank at hazardous levels or above**, as indicated by an Alcohol Use Disorders Identification Test (AUDIT) score of 8 or more. 1.8% scored 16 to 19, indicating harmful levels of drinking, and 0.9% scored 20 or more, indicating probable alcohol dependence. One in four (23.6%) had not drunk alcohol in the past year.
- **Drinking at hazardous levels or above (AUDIT 8+) varied by gender and age**. Men

(24.8%) were twice as likely as women (11.7%) to drink at this level. Adults aged 75 and over were less likely to drink at hazardous levels or above (10.2%) than other age groups (ranging from 15.6% in 65 to 74 year olds to 21.0% in 55 to 64 year olds).

- **Overall, drinking at hazardous levels or above fell in prevalence** from 26.1% of 16 to 74 year olds in 2000 to 18.9% in 2023/4. The decline was evident in both male (36.8% in 2000, 25.6% in 2023/4) and female (15.5% in 2000, 12.6% in 2023/4) participants.
- **Trends in drinking at hazardous levels or above varied markedly by age group**. Prevalence halved among 16 to 24 year olds (40.7% in 2000, 18.1% in 2023/4) and also fell among those aged 25 to 34 and 35 to 44. In contrast, the proportion of adults aged 45 to 54, 55 to 64, and 65 to 74 drinking at this level did not change between 2000 and 2023/4, and data available for adults aged 75 and over indicates an increase in this group from 6.0% (CI 4.6, 7.7) in 2007 to 10.2% (CI 8.2, 12.6) in 2023/4.
- **Drinking at hazardous levels or above was more prevalent in more affluent areas**. 23.5% of adults living in the least deprived quintile of areas drank at hazardous levels or above, compared with 16.5% of adults in the most deprived areas. Prevalence also varied by region (and was highest in the North of England) and by ethnicity (and was highest among White British adults).
- **Having a common mental health condition (CMHC) was associated with drinking at harmful and dependent levels**. 3.0% of adults with a CMHC were drinking at harmful levels (AUDIT 16-19) and 2.3% had probable dependence (AUDIT 20+), compared with 1.4% and 0.6% of those without a CMHC.
- **Most adults with probable alcohol dependence had not received treatment related to their drinking**. 43.3% of adults with an AUDIT score of 20 or more reported receiving treatment or support for drinking at some point in their life. This mostly comprised self-help or peer support (30.6%), counselling (20.9%), and detoxification or rehabilitation (13.4%).

5.1 Introduction

The impact of alcohol consumption

In England, drinks containing alcohol are widely available and consumed by the majority of the adult population (NHS England 2024a (Link: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2022-part-1)). Alcohol is responsible for a considerable degree of health and social harm. Alcohol-related harms exist on a continuum, and include acute and chronic health and social consequences, as well as harm to people other than the drinker. According to the World Health Organization (WHO), alcohol is wholly or partly responsible for over 200 different disease conditions (WHO 2024 (Link: https://www.who.int/news-room/fact-sheets/detail/alcohol)). Alcohol is identified as a Grade 1 carcinogen (the most

carcinogenic type) and, in 2019/20, was responsible for over 4% of all new cancer cases worldwide (WHO 2024 (Link: http://www.who.int/news-room/fact-sheets/detail/alcohol); Rumgay et al. 2021). Excessive alcohol consumption is a leading cause of disability in the UK and Europe (GBD 2016 Alcohol Collaborators 2018; Forouzanfar et al. 2016).

Acute harms from alcohol include accidents, injuries, collapse, self-harm and in severe cases, acute alcohol poisoning. Alcohol use does not only harm those who drink. In 2022, 5% of all road traffic accidents and 18% of all deaths reported in road traffic accidents involved at least one driver over the drink-driving limit (Department for Transport 2024 (Link: https://www.gov.uk/government/statistics/reported-road-casualties-in-great-britain-involving-illegal-alcohol-levels-2022/reported-road-casualties-in-great-britain-involving-illegal-alcohol-levels-2022)). In the year ending March 2024 alcohol use was related to 39% of violent incidents in England and Wales (Office for National Statistics (ONS) 2025 (Link: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/natureofcrimetablesviolence)). Alcohol misuse is associated with both domestic violence and marital breakdown, and children of problem drinkers are more likely to suffer emotional and behavioural problems, and to perform poorly at school (Cuijpers et al. 2006).

Alcohol misuse often co-exists with common mental disorders, such as depression and anxiety, as well as with use of other substances (Grant et al. 2004; Weich et al. 2011; McManus et al. 2016 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014); Awaworyi Churchill and Farrell 2017; Puddephatt et al. 2021). High levels of hazardous and dependent drinking have been recorded in people with serious mental health problems, while non-drinking was also more common in people with psychosis (Puddephatt et al. 2023). Alcohol dependence and other problems associated with alcohol use are also frequent in homeless people and prisoners, again often in combination with poor mental health (Drummond et al. 2008; Light et al. 2013 (Link: https://assets.publishing.service.gov.uk/media/5a7ccb2940f0b65b3de0b33c/gender-substance-misuse-mental-health-prisoners.pdf)).

In 2023/24, there were 280,750 estimated admissions where the main reason for hospital admission was primarily attributable to alcohol (described as the ‘narrow measure’). The most common causes of admissions attributable to alcohol were for cancer (85,400), followed by cardiovascular disease (41,430) and mental and behavioural disorders due to use of alcohol (34,810). A further 193,660 were partially attributable to alcohol (using

the 'broad measure') (Department of Health and Social Care 2025 (Link: https://fingertips.phe.org.uk/documents/LAPE_Statistical_Tables_for_England_2025.xlsx)). In 2023, there were 8,274 alcohol-specific deaths, the highest rate since 2006 and 4.6% higher than 2022 (Office for Health Improvement and Disparities 2024 (Link: https://www.gov.uk/government/statistics/alcohol-profiles-for-england-december-2024-update/alcohol-profiles-for-england-short-statistical-commentary-december-2024)).

In 2024, it was estimated that the cost of alcohol harm in England was £27.44 billion a year; as well as costs to the health service, this included the costs of crime and disorder, reduced workplace productivity, unemployment and social services (Institute of Alcohol Studies 2024 (Link: https://www.ias.org.uk/report/the-costs-of-alcohol-to-society/)).

Policy and guidance

In recent years, the government has acknowledged the significant social, economic, and health costs of alcohol misuse, which remains a key public health focus. In 2012, the UK Chief Medical Officer published guidelines on alcohol, based on the recommendation of an expert review of the association between alcohol consumption and health harms (Department of Health 2012 (Link: https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency)). This review identified a lower beneficial effect of alcohol and evidence of a stronger association with certain types of cancer and other health harms than was previously identified. Based on this evidence, the guidelines advised that for both men and women, it is safest not to drink more than 14 UK units of alcohol per week (112g of pure ethanol), and within that to avoid alcohol binges by spreading drinking over 3 or more days per week. Drinking above the recommended limits and alcohol binges would be categorised as hazardous levels of drinking and above using the AUDIT. The revised advice in pregnancy is that the safest approach is to abstain.

In 2012, the UK government initiated a significant shift in the commissioning of drug and alcohol services, transferring responsibilities from the NHS to local authorities. This change was part of the broader reforms introduced by the Health and Social Care Act 2012, which aimed to decentralise public health functions and integrate them more closely with local governance. A study published by Roberts and colleagues in 2020 indicated that since then there was a year-on-year increase in alcohol-related hospital admissions and year-on-year reductions in the number of adults entering specialist treatment and net local authority expenditure for treatment of alcohol misuse (Roberts et al. 2020).

In 2021, the UK government launched a 10-year drug strategy From Harm to Hope, which

included improvements to treatment for drug and alcohol use. This included proposals to enhance the skills of the workforce in relation to drug and alcohol treatments, reduce staff caseloads, provide 54,500 new drug and alcohol treatment places, integrate physical and mental health care with substance misuse services and to improve access to treatment for adults experiencing multiple disadvantage (including combinations of homelessness, addiction, mental ill health, domestic abuse and contact with the criminal justice system) (HM Government 2021 (Link: https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives)).

The National Institute for Health and Care Excellence (NICE) recommends referral for specialist treatment for adults with features of alcohol dependence or signs of severe alcohol-related impairment. Primary care management should include offering advice on alcohol consumption or a brief intervention, including psychological interventions. Pharmacological interventions could be offered to harmful drinkers and people with mild alcohol dependence who have not responded to psychological interventions alone, or who have specifically requested a pharmacological intervention (NICE 2011 (Link: https://www.nice.org.uk/guidance/cg115), updated 2014).

5.2 Definitions and assessments

'Alcohol use disorders' encompass a range of conditions defined in the ICD-11 (WHO 2019 (Link: https://icd.who.int/en/)). In this chapter we consider 'harmful alcohol use' (an established pattern of drinking causing damage to health) and 'alcohol dependence' (including signs of addiction to alcohol). We also consider hazardous drinking (an established pattern of drinking which increases the risk of health harm). Despite changes in diagnostic systems from ICD-10 to ICD-11 (WHO 1993 (Link: https://icd.who.int/browse10/2019/en), 2019 (Link: https://icd.who.int/en/)), the way in which alcohol use disorders have been measured on APMS since 2000 has remained consistent.

Initial questions about alcohol consumption were asked by the interviewer either face to face or via telephone. Additional questions were asked of non-drinkers to establish if they had ever been a drinker and reasons for not drinking now. All participants who drank alcohol now, even if just occasionally, were routed to the remaining alcohol use questions. These were administered in the self-completion section of the interview, consistent with the approach used in APMS since 2000.

The Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al. 1993) is a questionnaire used to measure, identify and categorise clinically relevant alcohol use disorders, including alcohol dependence. The AUDIT takes the year before the interview as a reference period, consists of 10 items and includes questions on alcohol

consumption, measuring the social impact of alcohol consumption, symptoms of alcohol dependence and whether friends or health professionals have suggested a need to cut down. Questions were also asked about treatment or support received in relation to drinking.

The AUDIT score thresholds used in this chapter are as follows:

AUDIT score	Category description
0	Non-drinkers
1 to 7	Low risk drinking
8 to 15	Hazardous drinking (also known as 'increasing risk')
16 to 19	Harmful drinking (also known as 'higher risk')
20 or above	Probable dependence

An AUDIT score of 8-15 suggests probable need of brief alcohol intervention (e.g. in primary care); those scoring 16-19 may warrant an 'extended brief intervention' and referral to specialist treatment for those who don't respond to the initial intervention (stepped care); 20+ indicates a need for referral to specialist services for further assessment and treatment (Office for Health Improvement and Disparities 2023 (Link: https://www.gov.uk/government/consultations/uk-clinical-guidelines-for-alcohol-treatment/uk-clinical-guidelines-for-alcohol-treatment-core-elements-of-alcohol-treatment#identification-and-brief-interventions)). Surveys tend to under-estimate the 20+ population due to sampling and participation issues (Boniface et al. 2014).

An AUDIT score of 8 or more is used in this chapter to indicate 'drinking at hazardous levels or above', and a score of 16 or more to denote 'drinking at harmful or dependent levels'.

5.3 Results

Prevalence of hazardous, harmful or dependent drinking, by age and gender

In 2023/4, the majority (82.0%) of adults had either not drunk alcohol in the past year

(23.6%) or had a low risk pattern of drinking behaviour (AUDIT 1-7) (58.4%).

The proportion of adults who drank at hazardous levels or above (AUDIT 8+) was 18.0%:

- 15.3% of adults drank at hazardous levels (AUDIT 8-15)
- 1.8% had a harmful pattern of drinking behaviour (AUDIT 16-19)
- 0.9% had probable alcohol dependence (AUDIT 20+).

If all adults in the population had been screened, it is likely that the proportion drinking at hazardous levels or above (AUDIT 8+) would have been between 16.7% and 19.4% (referred to as the 95% confidence interval (CI)). This is equivalent to an estimated 8.4 million adults in England. The estimated proportion of drinking at harmful or dependent levels (2.7%) would have been between 2.2% and 3.4% if all adults in the population had been screened, equivalent to an estimated 1.3 million adults in England.

Drinking patterns varied by gender. Men (24.8%, 95% CI 22.6, 27.1) were twice as likely as women (11.7%, CI 10.3, 13.2) to drink at hazardous levels or above (AUDIT 8+). Men (3.8%, CI 2.9, 5.0) were also twice as likely as women (1.7%, CI 1.2, 2.4) to drink at harmful levels or above (AUDIT 16+).

Drinking at hazardous levels or above in the past year (AUDIT 8 or more), by age (Base: All adults)

Download the data for this chart Drinking at hazardous levels or above in the past year (AUDIT 8 or more), by age (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/alcohol-dependence/alcohol-dependence/publicationsystem%3AbodySections%5B7%5D/publicationsystem%3AdataFile)

Drinking at hazardous levels or above (AUDIT 8+) varied by age. Prevalence was lowest among those aged 75 or over (10.2%, CI 8.1, 12.8), and broadly similar across other age groups. The pattern of association between drinking at hazardous levels or above and age did not significantly differ between men and women.

Drinking at harmful levels or above (AUDIT 16+) varied by age, with prevalence highest among adults aged 25 to 34 (3.7%, CI 2.2, 6.1), 35 to 44 (3.7%, CI 2.4, 5.6), and 45 to 54 (3.9%, CI 2.6, 5.8) and lowest among those aged 75 and over (0.9%, CI 0.4, 2.5).

Probable alcohol dependence (AUDIT 20+) also varied by age. Prevalence was highest for adults aged 35 to 44 (1.4%, CI 0.8, 2.3) and 45 to 54 (1.8%, CI 1.0, 3.1). No participants aged 16 to 24 were identified with probable alcohol dependence.

For more information: Table 5.1 and Table A1 (Link: /data-and-information/

publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals

Drinking at harmful levels or above in the past year (AUDIT 16 or more), by age (Base: All adults)

Download the data for this chart Drinking at harmful levels or above in the past year (AUDIT 16 or more), by age (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/alcohol-dependence/alcohol-dependence/publicationsystem%3AbodySections%5B9%5D/publicationsystem%3AdataFile)

Trends in hazardous, harmful or dependent drinking, 2000 to 2023/4

Note that the trends in this chapter are based on 16 to 74 year olds, to allow for comparison with 2000, and analysed by sex (male and female) rather than gender (men and women). See How to interpret the findings (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/how-to-interpret-the-findings) for information on how changes over time were assessed.

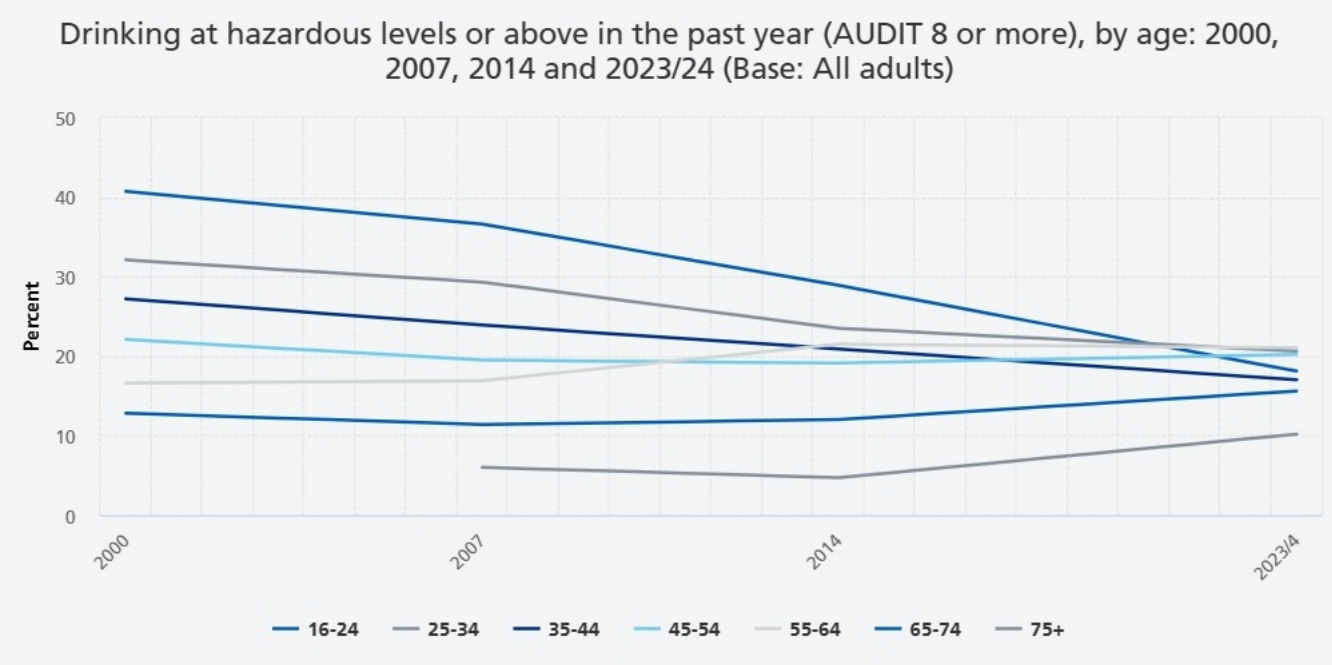
Hazardous levels or above

Drinking at hazardous levels or above (AUDIT 8+) fell in prevalence over time, from 26.1% (95% CI 24.8, 27.5) of 16 to 74 year olds in 2000, 23.5% (CI 22.3, 24.8) in 2007 and 21.3% (CI 20.0, 22.5) in 2014, to 18.9% (CI 17.5, 20.5) in 2023/4. Prevalence overall fell among both male (36.8%, CI 34.7, 38.8 in 2000; 25.6%, CI 23.3, 28.0 in 2023/4) and female (15.5%, CI 14.3, 16.8 in 2000; 12.6%, CI 11.1, 14.2 in 2023/4) 16 to 74 year olds.

The decline since 2000 has been driven by changes in the drinking patterns of younger adults. Prevalence more than halved among male 16 to 24 year olds (51.3%, CI 44.9, 57.7 in 2000; 19.6%, CI 12.5, 29.3 in 2023/4) and almost halved among female 16 to 24 year olds (29.9% in 2000, CI 24.9, 35.4; 16.8%, CI 10.4, 25.8 in 2023/4). Among 25 to 34 year olds, drinking at this level fell from 32.1% (CI 29.5, 34.9) in 2000 to 20.6% (CI 17.1, 24.7) in 2023/4, and in 35 to 44 year olds it fell from 27.2% (CI 24.9, 29.7) in 2000 to 17.0% (CI 14.4, 20.0) in 2023/4.

In contrast, there was no significant change between 2000 and 2023/4 in the overall proportion of adults aged 45 to 54, 55 to 64, and 65 to 74 drinking at hazardous levels or

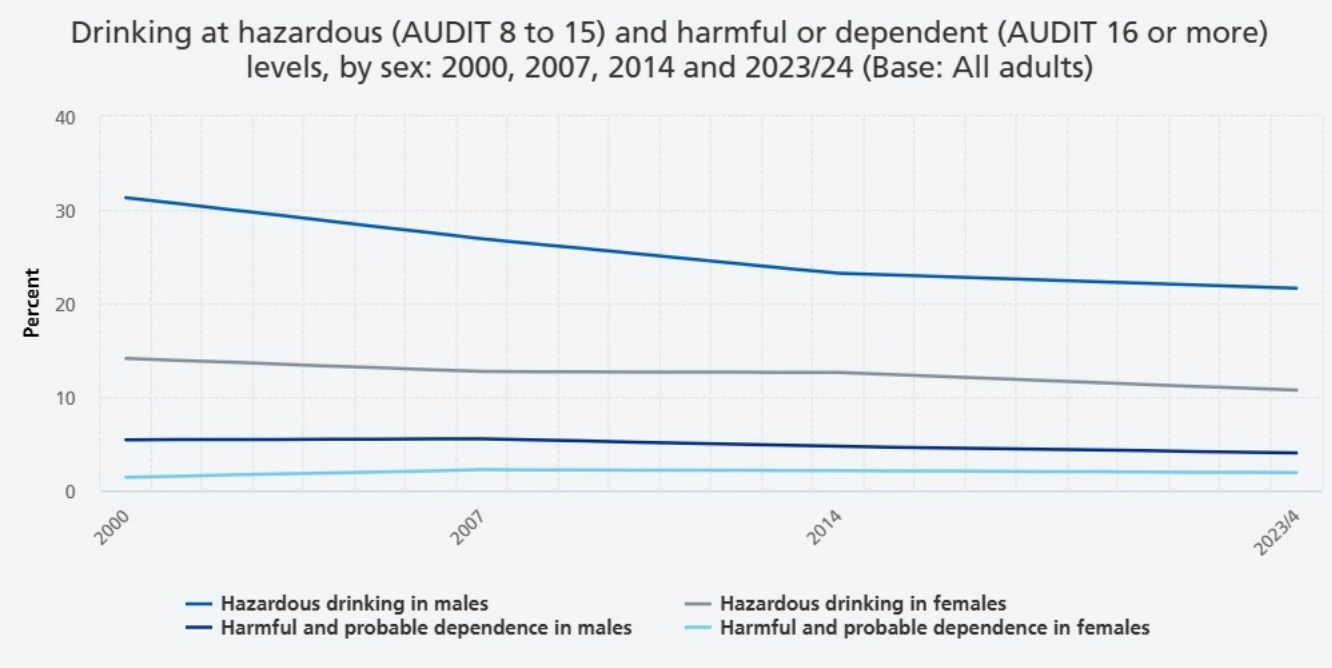
above. Data available for adults aged 75 and over indicates an increase in this group from 6.0% (CI 4.6, 7.7) in 2007 to 10.2% (CI 8.2, 12.6). A significant increase was also evident for female 55 to 64 year olds, in whom the proportion drinking at hazardous levels or above rose from 7.9% (CI 6.0, 10.3) in 2000 to 14.2% (CI 11.2, 17.8) in 2023/4.



Harmful levels or above

The proportion of 16 to 74 year olds drinking at harmful levels or above did not vary significantly over time. However, it should be noted that the confidence intervals around these estimates were wide.

For more information: Table 5.2 and Table B1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals



Variation in hazardous, harmful or dependent drinking by other characteristics

Ethnic group

In 2023/4, the age-standardised prevalence of drinking at hazardous levels or above (AUDIT 8+) varied between ethnic groups.

Prevalence ranged from 21.3% of White British (95% CI 19.7, 23.1) and 16.4% of Mixed/multiple/other (CI 9.3, 27.1) adults, to 5.8% of Black/Black British (CI 2.8, 11.9) and 4.3% of Asian/Asian British (CI 2.1, 8.4) adults. It should be noted that the confidence intervals for some estimates were wide and overlapping, so apparent differences between ethnic groups should be treated with caution.

For more information: Table 5.3 and Table A2 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals

Drinking at hazardous levels or above in the past year (AUDIT 8 or more), by ethnic group (age-standardised) (Base: All adults)

Download the data for this chart Drinking at hazardous levels or above in the past year (AUDIT 8 or more), by ethnic group (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/alcohol-dependence/alcohol-dependence/

publicationsystem%3AbodySections%5B15%5D/publicationsystem%3AdataFile)

Employment status

In age-standardised analyses, there was no significant variation by employment status either in the proportion of working age adults with an AUDIT score of 8 or more, or the proportion with an AUDIT score of 16 or more.

For more information: Table 5.4 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Problem debt

Problem debt was defined as being seriously behind with debt repayments or having utilities cut off. See the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods) for more information on how problem debt was derived. Age-standardised proportions of adults drinking at hazardous drinking levels and above (AUDIT 8+) by problem debt did not reach the required level of statistical significance.

The proportion of adults drinking at harmful levels and above (AUDIT 16+) was higher in adults with problem debt (5.8%) than those without problem debt (2.4%).

For more information: Table 5.5 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Drinking at harmful levels or above in the past year (AUDIT 16 or more), by problem debt (age-standardised) (Base: All adults)

Download the data for this chart Drinking at harmful levels or above in the past year (AUDIT 16 or more), by problem debt (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/alcohol-dependence/alcohol-dependence/publicationsystem%3AbodySections%5B17%5D/publicationsystem%3AdataFile)

Area-level deprivation

How has deprivation been defined?

Area-level deprivation has been defined using the English Indices of Deprivation 2019, commonly known as the Index of Multiple Deprivation (IMD).

IMD is the official measure of relative deprivation for Lower Super Output Areas (LSOAs) in England. LSOAs comprise between 400 and 1,200 households and usually have a resident population between 1,000 and 3,000 persons. IMD ranks every LSOA in England from 1 (most deprived area) to 32,844 (least deprived area). Deprivation quintiles are calculated by ranking the 32,844 neighbourhoods in England from most deprived to least deprived and dividing them into five equal groups. These range from the most deprived 20% of neighbourhoods nationally to the least deprived 20% of neighbourhoods nationally.

For further information see: English indices of deprivation 2019 (Link: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019).

Comparisons between IMD quintiles are based on age-standardised estimates. Those living in the least deprived quintile (23.5%) were more likely to drink at hazardous levels and above (AUDIT 8+) than those in the fourth (13.9%) and fifth (16.5%) most deprived quintiles.

The age-standardised proportions of harmful drinking and above (AUDIT 16+) by area-level deprivation did not reach the required level of statistical significance.

For more information: Table 5.6 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Drinking at hazardous levels or above in the past year (AUDIT score of 8 or more), by area-level deprivation (age-standardised) (Base: All adults)

Download the data for this chart Drinking at hazardous levels or above in the past year (AUDIT score of 8 or more), by area-level deprivation (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/alcohol-dependence/alcohol-dependence/

publicationsystem%3AbodySections%5B21%5D/publicationsystem%3AdataFile)

Region

In age-standardised analyses, the proportion of adults drinking at hazardous levels and above (AUDIT 8+) varied across regions. Those living in Yorkshire and the Humber were most likely to drink alcohol at hazardous levels or above (22.3%), and those living in the East of England were least likely (13.4%).

The proportion with harmful drinking and above (AUDIT 16+) did not vary significantly by region.

For more information: Table 5.7 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Drinking at hazardous levels or above in the past year (AUDIT 8 or more), by region (age-standardised) (Base: All adults)

Download the data for this chart Drinking at hazardous levels or above in the past year (AUDIT 8 or more), by region (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/alcohol-dependence/alcohol-dependence/publicationsystem%3AbodySections%5B23%5D/publicationsystem%3AdataFile)

Comorbidity

Physical health conditions

How have physical health conditions been defined?

Participants were asked if they had any of 25 physical health conditions listed on a card, including asthma, cancer, diabetes, epilepsy and high blood pressure. Participants were coded as having a limiting physical health condition, if they reported having one or more physical health conditions in the past 12 months that had been diagnosed by a doctor and that this had limited their ability to carry out day-to-day activities. More details on the questions on physical health conditions can be found in the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

The age-standardised prevalence of drinking at hazardous levels and above (AUDIT 8+), or at harmful levels and above (AUDIT 16+), did not significantly vary by presence of a limiting physical health condition.

For more information: Table 5.8 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Common mental health conditions

How have common mental health conditions been defined?

The revised Clinical Interview Schedule (CIS-R) was used to assess six types of common mental health conditions (CMHC): depression, generalised anxiety disorder, panic disorder, phobias, obsessive compulsive disorder, and CMHC not otherwise specified. Participants identified with at least one of these were defined as having a CMHC. See Section 1.2 of the Common mental health conditions (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/common-mental-health-conditions#1-2-definitions-and-assessments) chapter for more detail.

20.7% of adults with a common mental health condition (CMHC) drank at hazardous levels or above (AUDIT 8+), compared with 17.1% of those without a CMHC.

Adults with a CMHC were also more likely to drink at harmful levels or above (AUDIT

16+) (5.3%) than those who did not have a CMHC (2.0%). They were also more likely to meet the threshold for probable dependence (AUDIT 20+) (2.3%) than those who did not have a CMHC (0.6%).

For more information: Table 5.8 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Drinking at hazardous, harmful or probable dependent levels in the past year, by common mental health condition (CMHC) (age-standardised) (Base: All adults)

Download the data for this chart Drinking at hazardous, harmful or probable dependent levels in the past year, by common mental health condition (CMHC) (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/alcohol-dependence/alcohol-dependence/publicationsystem%3AbodySections%5B29%5D/publicationsystem%3AdataFile)

Self-diagnosis and professional diagnosis of alcohol dependence

Participants were shown a list of mental health conditions and asked whether they thought that they had ever had any of them. The list included ‘alcohol dependence’. Those who reported that they thought that they have been alcohol dependent were asked if this had been diagnosed by a professional, and if so, whether they had experienced alcohol dependence in the past 12 months.

Overall, 3.7% of adults said they felt they had been alcohol dependent at some point in their life. Men (5.2%) were twice as likely to report this as women (2.4%).

Among those with an AUDIT score indicative of harmful drinking (AUDIT 16-19) 29.3% believed that they have been alcohol dependent. Among those with an AUDIT score indicating probable alcohol dependence (AUDIT 20+), half (48.7%) believed that they have been alcohol dependent.

Self-identified as having ever experienced alcohol dependence, by AUDIT category (Base: All adults)

Download the data for this chart Self-identified as having ever experienced

alcohol dependence, by AUDIT category (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/alcohol-dependence/alcohol-dependence/publicationsystem%3AbodySections%5B31%5D/publicationsystem%3AdataFile)

Participants who felt they had been alcohol dependent were asked whether they had been diagnosed with alcohol dependence by a doctor, psychiatrist or other professional. Overall, 1.2% of adults reported that they had been diagnosed as alcohol dependent. The prevalence was similar in men and women.

One in ten (9.9%) of those with an AUDIT score indicating harmful drinking and one in four (24.5%) of those with an AUDIT score indicating probable alcohol dependence (AUDIT 20+) reported that they had been diagnosed with alcohol dependence by a professional.

Ever diagnosed by a professional as having experienced alcohol dependence, by AUDIT category (Base: All adults)

Download the data for this chart Ever diagnosed by a professional as having experienced alcohol dependence, by AUDIT category (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/alcohol-dependence/alcohol-dependence/publicationsystem%3AbodySections%5B33%5D/publicationsystem%3AdataFile)

A small proportion (0.4%) of participants reported that they had been diagnosed with alcohol dependence and this condition had been present in the past 12 months. This included 7.3% of adults with harmful drinking levels (AUDIT 16-19) and 22.7% of adults with probable dependence (AUDIT 20+).

For more information: Table 5.9 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Treatment

Treatment and service use for mental or emotional problems

Participants were asked about use of different types of mental health treatment and services. Two types of mental health treatment were asked about: current medication and psychological therapy for a mental or emotional problem. The use of a range of health, community and day care services over the past year were also asked about. This treatment and service use could have been for any mental health condition and was not necessarily related to their alcohol use.

Among adults with a harmful pattern of drinking (AUDIT 16-19), 26.1% were in receipt of treatment (23.7% received medication and 4.7% psychological therapy). Mental health treatment receipt was higher among adults with probable alcohol dependence (AUDIT 20+), among whom 55.9% received treatment for a mental or emotional problem (46.4% medication, 16.2% psychological therapy). 2.3% of those drinking at harmful levels and 6.6% of those with probable dependence received both medication and psychological therapy.

Current treatment for a mental or emotional problem, by harmful and probable dependence AUDIT categories (Base: All adults)

Download the data for this chart Current treatment for a mental or emotional problem, by harmful and probable dependence AUDIT categories (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/alcohol-dependence/alcohol-dependence/publicationsystem%3AbodySections%5B35%5D/publicationsystem%3AdataFile)

Health care service use for a mental health related reason was reported by 18.4% of adults drinking at harmful levels (AUDIT 16-19) and 38.8% of those with probable dependence (AUDIT 20+).

For more information: Table 5.10 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Psychotropic medication

Participants were asked which psychotropic medications, used to treat mental health conditions, they take. These could have been for any mental health condition and were not necessarily related to their alcohol use. The most common medication types reported by all adults were those primarily used to treat depression (11.7%) and anxiety (10.7%). See Chapter 2 Mental health treatment and service use (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/

survey-of-mental-health-and-wellbeing-england-2023-24/mental-health-treatment-and-service-use) for more details.

- The most common medications taken by those drinking at harmful levels (AUDIT 16-19) were those used to treat depression (22.7%) or anxiety (22.1%). This group was about twice as likely as non-drinkers and low risk drinkers (AUDIT 0-7) to be taking medication used to treat depression (11.0%) and anxiety (10.0%).
- Adults with probable alcohol dependence (AUDIT 20+) were about four times more likely than non-drinkers and low risk drinkers to be taking depression (44.7%) or anxiety (43.3%) medication.
- 1.0% of adults drinking at harmful levels and 1.2% of those with probable dependence were taking medication for substance dependence, compared with 0.2% of non-drinkers and low risk drinkers.

For more information: Table 5.11 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Treatment and support specifically for alcohol dependence

Participants who reported that they currently or used to drink alcohol were asked whether they had ever received a range of treatment and support services specifically related to drinking alcohol, including self-help advice or peer support, alcohol-related counselling or talking therapy, medication, detoxification or rehabilitation or other types of support.

Alcohol specific treatment categories

- Advice and information including self-help
- Talking therapy/counselling
- Medication
- Detoxification
- Rehabilitation
- Alcoholics Anonymous or other peer-support
- Other (including any treatment of alcohol-related injuries or illness)

About one in four (27.9%) adults drinking at harmful levels (AUDIT 16-19) and approaching one in two (43.3%) of those with probable dependence (AUDIT 20+) reported that they had received treatment or support specifically related to their drinking at some point in their life. Types of treatment and support used in relation to alcohol included:

- Advice or information, including self-help or peer support such as Alcoholics Anonymous (reported by 16.5% of those with harmful drinking; 30.6% with probable dependence)
- Counselling or talking therapy (10.9% of those with harmful drinking; 20.9% of those with probable dependence)
- Detoxication or rehabilitation (5.9% of those with harmful drinking; 13.4% of those with probable dependence)
- Medication (1.0% of those with harmful drinking; 4.8% of those with probable dependence).

For more information: Table 5.12 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

5.4 Discussion

Drinking at hazardous levels or above has fallen in prevalence in England from about one in four 16 to 74 year olds in 2000 to less than one in five in 2023/4. The decline was evident in both males and females and is broadly consistent with sources of data on trends in alcohol consumption. For example, the Health Survey for England (HSE) has shown a gradual decline in the maximum amount of alcohol consumed on any day in the past week (8 units for men, 6 units for women) between 2009 and 2019 (NHS Digital 2020 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2019)).

Trends in drinking at hazardous levels or above differ markedly by age group. APMS finds that 16 to 24 year olds in 2023/4 were about half as likely as 16 to 24 year olds at the start of the century to drink at hazardous levels or above, with substantial declines also evident for 25 to 44 year olds. Research from the UK aiming to explain the decline in alcohol use in young people has proposed changing patterns in socialisation and increasing costs of alcohol as the key explanations (Whitaker et al. 2023). In contrast, no decline was evident among 45 to 74 year olds, and data for those aged 75 and older reveals significant increases since 2007. Notable rises since 2000 also emerged in the proportion of 55 to 64 year old women drinking at hazardous levels. It is likely that these trends reflect pronounced cohort effects consistent with evidence from across high-income countries indicating that alcohol use and related harms are increasing among older adults (Calvo et al. 2021). Birth cohort studies show that older cohorts have higher drinking participation than younger cohorts (Livingston et al. 2016), and alcohol-related hospitalisations and alcohol-induced deaths among Australians aged 50 and over have increased over the past two decades (Sutherland et al. 2024). Sutherland and colleagues described how higher rates of substance use among baby boomers, compared with earlier generations, have been documented. Alcohol has become 91% more affordable

in the UK between 1989 and 2023 (NHS England 2024b (Link: https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-public-health/2023/part-4-affordability-and-expenditure)), which may have impacted older adults' spending on alcohol, with alcohol becoming more inexpensive over their lifetime (Crome and Rao 2018 (Link: https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2018-college-reports/our-invisible-addicts-2nd-edition-cr211-mar-2018)). While some posited that many would 'mature out' of such use, others hypothesised that as the baby boomer generation aged, elevated levels of alcohol use and related harms among older adults would be sustained (Patterson et al. 1999). This appears to have been borne out and raises concerns about the impact of this ageing demographic on health services, including harm reduction and substance use treatment services (Sutherland et al. 2024).

Despite falling rates overall, hazardous drinking remains common in England. Almost one in five adults drank at this level, one in twenty drank at harmful levels and one in a hundred were likely to be alcohol dependent, with rates higher in men than women. APMS results differ somewhat from HSE, which also used the AUDIT but with some differences in wording and method. It is also likely that both APMS and HSE, as household surveys, significantly underestimate prevalence, especially of the most harmful and dependent levels of drinking. Not only may these be underreported by participants due to stigma, but alcohol dependent adults may also be more likely to be homeless or in an institutional setting and therefore not included in the survey sample. Harmful or dependent drinkers living in private households may, like those with other substance dependence, be relatively less likely to respond to surveys, as they may be somewhat less available, able or willing to answer survey questions. There is also an issue due to the relatively small numbers of participants identified with harmful and dependent patterns of drinking. APMS 2023/4 had a particularly small number of young men in the sample, and the wide confidence intervals around estimates for this group should be noted.

There are pronounced subgroup variations in the prevalence of alcohol misuse, with prevalence highest among adults in White British and Mixed/multiple/other ethnic groups, and among those living in the North of England (especially in Yorkshire and the Humber). APMS findings were consistent with the alcohol harm paradox (Puddephatt et al. 2021): those living in the most deprived areas were less likely to drink alcohol at hazardous levels, and yet no less likely to have a harmful or dependent level of alcohol use. There is a need for prevention and support to address inequalities in harms.

Tailoring services and support to meet needs. APMS also confirms the strong co-occurrence of mental health and alcohol conditions, highlighting the need for mental health treatment and support services to recognize and respond to the treatment needs of people drinking at hazardous levels and above. Only a quarter of adults identified by the AUDIT with probable alcohol dependence reported that they had been diagnosed with alcohol dependence by a professional, and a small proportion (1.2%) were currently being prescribed medication for substance dependence. Less than half of those with

probable dependence reported having ever received treatment or support specifically for their drinking, and this mostly comprised self-help or peer support. Overall these findings suggest that alcohol dependence may be both under-diagnosed and under-treated in England (Cheeta et al. 2008; Brown et al. 2015).

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Previous Chapter

Chapter 4: Suicidal thoughts, suicide attempts and non-suicidal self-harm (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/suicidal-thoughts-suicide-attempts-and-self-harm)

Next Chapter

Chapter 6: Drug use and dependence (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/drug-use-and-dependence)

Chapter 6: Drug use and dependence

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Overview

Drug use, as addressed in this chapter, refers to the use of a substance for a purpose not consistent with legal or medical guidelines, for example the non-medical use of prescription medications or the recreational use of illicit drugs.

Participants were asked about lifetime and past year use of a range of illicit drugs including, for the first time in the survey series, the non-medical use of prescription opioids. Those who reported use of particular drugs in the past year were asked about signs of dependence on each drug used. The signs asked about were: daily use for two weeks or more, having a sense of need or dependence, inability to abstain, increased tolerance, and withdrawal symptoms.

This chapter draws on self-completion data to profile the prevalence and trends in illicit drug use and signs of dependence in the adult population of England.

Key findings

- **Lifetime use of illicit drugs is common.** One in three (33.0%) adults had used illicit

drugs at some point in their life, with prevalence higher in men (38.9%) than women (27.5%). 3.1% of men and 3.2% of women reported having used an opioid medication (buprenorphine, fentanyl, morphine, oxycodone, or tramadol) that had not been prescribed to them.

- **Illicit drug use in the past year was reported by one in nine adults (10.6%).** This mostly comprised of cannabis, used in the past year by 11.4% of men and 6.1% of women. Past year use of any drug was highest in those aged 16 to 24 (18.1%) and 25 to 34 (19.2%).
- **Signs of dependence on illicit drugs increased in prevalence** from 3.8% of 16 to 64 year olds in 2014 to 6.7% in 2023/4. This rise mostly related to an increase in adults reporting signs of dependence on cannabis.
- **Signs of dependence were more common in younger people and some ethnic groups.** Among men, signs of drug dependence were most common in 25 to 34 year olds (14.2%). In women, they were most common in 16 to 24 year olds (9.4%). Prevalence was higher among adults in the Mixed/multiple/other ethnic group (7.8%) and lower among those identifying as Asian/Asian British (1.4%).
- **Signs of dependence were associated with disadvantage,** being more prevalent among adults struggling with debt (15.9%), those living in a more deprived area (7.3%), and those who were unemployed (12.9%) or economically inactive (9.9%).
- **Signs of dependence were associated with poor mental health:** 10.5% of adults with a common mental health condition reported signs of drug dependence, compared with 3.7% of those without a common mental health condition.
- **A minority got support or treatment.** One in five (21.2%) adults with signs of drug dependence had received support or treatment related to their drug use at some point in their life.

6.1 Introduction

Illicit drug use is common, but data sources on dependence are scarce. Estimates based on the 2024 Crime Survey for England and Wales (CSEW) indicate that one in twelve (8.8%) 16 to 59 year olds, and one in six (16.5%) 16 to 24 year olds, had used an illicit drug in the past 12 months (Office for National Statistics (ONS) 2024b (Link: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/drugmisuseinenglandandwales/yearendingmarch2024)). The CSEW found that the rate had been stable over time, with the same prevalence recorded in 2014 (8.8%). As a crime survey, however, the CSEW focuses on illegal activities, which can lead to underreporting. While it collects information on frequency of drug use, this is not a comprehensive indicator of drug dependence, and unlike APMS, the CSEW does not ask about other signs of dependence. While some people use drugs recreationally without long-term consequences, others develop dependence, which can lead to multiple health, social, and economic consequences.

Use and dependence on illicit drugs is associated with harms to health and premature mortality. In 2023, 5,448 deaths related to drug poisoning were registered in England and Wales, the highest number recorded since records began (ONS 2024a (Link: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2023registrations)). Of these deaths, 3,618 were identified as drug misuse. There were also 9,690 hospital admissions for poisoning by drug misuse, with admissions almost five times more likely in the most - compared with the least - deprived areas. Hospital admissions for drug-related mental and behavioural disorders were also eight times more likely in the most, compared with the least deprived areas. They were also highest in ages 25 to 54, with this age group accounting for 70% of patients admitted for drug-related disorders (NHS England 2023 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-public-health/2023)). Substance use disorders have also been linked to poor health outcomes across a wide range of physical health conditions, with hospitalisation for substance use disorders associated with higher mortality rates and reduced life expectancy (Formánek et al. 2022).

Use and dependence on illicit drugs incurs high costs for society. The government estimated that illegal drugs cost society over £19 billion per year, with drug-related crime making up half of these costs (Black 2020 (Link: https://www.gov.uk/government/publications/review-of-drugs-phase-one-report)). Data from the Home Office Homicide Index shows that between April 2018 and March 2023, there were 3,148 homicides recorded by the police, 1,627 of which were drug-related (52%) according to the current definition of drug-related homicide (ONS 2024c (Link: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/methodologies/measuringdrugrelatedhomicidemethodologyfebruary2024)).

Drug dependence often forms a part of a profile of multiple adversity and disadvantage. In England, 336,000 people face at least three out of four of: substance use, homelessness, violence and abuse, and mental ill-health (Sosenko et al. 2020). A fifth of people starting substance use treatment had no home of their own in 2022/3, with the proportion highest among those starting treatment for opioid problems (Office for Health Improvement and Disparities (OHID) 2024 (Link: https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2023-to-2024/adult-substance-misuse-treatment-statistics-2023-to-2024-report)).

Co-occurence of drug dependence and other mental health conditions is common but can cause challenges for treatment (Han et al. 2017; Delgadillo et al. 2013). Significant proportions of those treated as inpatients or in the community for severe mental illness also have problematic substance use (Phillips and Johnson 2003; Weaver et al. 2003).

Likewise, over two-thirds of adults starting treatment for substance use said they had a mental health treatment need, an increase since 2018/19 (OHID 2024 (Link: https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2023-to-2024/adult-substance-misuse-treatment-statistics-2023-to-2024-report)). The National Institute for Health and Care Excellence (NICE) guidelines for drug misuse prevention encompass targeted prevention efforts including educational programmes and family and community interventions (NICE 2017 (Link: https://www.nice.org.uk/guidance/ng64)). The NICE guidelines are to be used in conjunction with DHSC's Drug misuse and dependence: UK guidelines on clinical management (DHSC 2017 (Link: https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management)), also known as the 'Orange Book', which provides advice to healthcare professionals on the delivery and implementation of a broad range of interventions for drug use dependence.

In 2021, Dame Carol Black's independent review for drug treatment and recovery set out recommendations for increased focus on primary and early intervention and drug treatment and recovery, including reforms to policy, commissioning and practice (Black 2021 (Link: https://www.gov.uk/government/publications/review-of-drugs-phase-two-report)). In the same year, the UK government launched a 10-year drug strategy From Harm to Hope, which proposed improvements to treatments for drug and alcohol use. This included enhancing the skills of the workforce in relation to drugs and alcohol treatments, reducing staff caseloads, provision of new drug and alcohol treatment places, integration of physical and mental health care with substance use services and improving access to treatment for adults experiencing multiple disadvantage (including combinations of homelessness, addiction, mental ill health, domestic abuse and contact with the criminal justice system) (HM Government 2021 (Link: https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives)).

This chapter presents the prevalence of reported use of illicit drugs and signs of drug dependence in the adult general population and examines associations and the use of treatment and services. It is important to note that using a household survey to measure drug use and dependence will underestimate several key groups whose patterns and levels of drug use may be atypical. These include students in halls of residence, and those who are homeless or living in institutional settings (Chilman et al. 2024), including hospitals and prisons (Bebbington et al. 2021). Additionally, those experiencing drug dependence and living in private households may be less likely to participate in surveys, given that they may lead less stable lives or may be less able or willing to answer survey questions (Lader 2015 (Link: https://assets.publishing.service.gov.uk/media/5a7f1514e5274a2e8ab4a009/drug-misuse-1415.pdf)). Hence household

surveys are likely to underestimate the prevalence of drug dependence (Charles et al. 2021).

6.2 Definitions and assessments

Drug use and dependence

Drug misuse has been defined as the use of a substance for a purpose not consistent with legal or medical guidelines, for example the non-medical use of prescription medications or the recreational use of illicit drugs (ACMD 2008 (Link: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/119174/acmd-cannabis-report-2008.pdf)).

Drug use may impact negatively on people's lives leading to problematic drug use, and potentially to dependence. Dependence syndrome is defined in the International Classification of Diseases, 10th edition (ICD-10) as:

> 'a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persistence in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state.' (WHO 1993)

Diagnostic criteria for dependent drug use are covered by the substance dependence codes F10 to F19 of the ICD-10, and are similar to the criteria specified in the fourth Diagnostic and Statistical Manual (DSM-IV; APA 1994). DSM-5 was launched in 2013 (APA 2013). The drug dependence questions used in the survey series were designed to DSM-IV criteria and have been used across the series to enable monitoring of trends over time.

A threshold of three or more of the following occurring together for at least one month, or occurring together repeatedly in the past 12 months is required for a diagnosis of substance dependence in ICD-10:

- Preoccupation with substance use
- Sense of need or dependence
- Impaired capacity to control substance-taking behaviour
- Increased tolerance
- Withdrawal symptoms, and
- Persistent substance use despite evidence of harm.

Measuring drug use and dependence

Questions about drug use were asked in the self-completion part of the interview, as in the 2000, 2007 and 2014 surveys (Roberts et al. 2016). They covered lifetime experience

of over twenty types of named drug, together with use in the past year. Alongside the main drug name, a variety of informal terms were provided to help with recognition, for example '(marijuana, grass, hash, ganja, draw, skunk, weed, spliff)' was listed in brackets after cannabis and '(laughing gas, whippets, nos, bulbs)' was listed in brackets after nitrous oxide.

The drugs asked about are those considered to be mostly widely used and largely match those included on recent waves of the CSEW, with the addition of some further drug types such as volatile substances (described on the survey as 'glues, solvents, gas or aerosols (to sniff)') and amyl nitrite. Additional drugs were added to the questionnaire in 2023/4, such as khat, synthetic cannabinoids and non-medical use of prescription opioids, and were included in the summary use and dependence variables. As in 2014, new psychoactive substances (NPS) as a distinct category was not included, although some of the drugs asked about (such as mephedrone), could be classified as NPS.

For each of the following eleven types of drugs, further questions about signs of dependence were also asked:

- Amphetamines
- Cannabis
- Cocaine powder
- Crack cocaine
- Ecstasy
- Heroin or methadone
- Methamphetamine
- Non-medical use of prescription opioids (buprenorphine, fentanyl, morphine, oxycodone or tramadol)
- Synthetic cannabinoids
- Tranquillisers, and
- Volatile substances (glue, gas, aerosols or solvents).

Reported use in the past year was followed for these relevant drug types by five questions based on the Diagnostic Interview Schedule and designed to assess symptoms of drug dependence (Malgady et al. 1992). These questions asked about the past month and year, and covered:

- Daily use for two weeks or more
- Sense of need or dependence
- Inability to abstain
- Increased tolerance, and
- Withdrawal symptoms.

A positive response to any of the items was used as an indicator of possible drug dependence. This is a lower threshold than that recommended by ICD-10 and DSM-IV, and the set of questions does not include the diagnostic criteria of preoccupation and

persistent use despite evidence of harm. However, the same approach and wording was used in the previous surveys in the APMS series and comparability has been maintained. Because people can be dependent on more than one type of drug, and because cannabis use accounts for such a large component of overall drug use, dependence was grouped into three categories, those:

- With no signs of dependence
- Who had one or more sign of dependence on cannabis only, and
- Who had one or more sign of dependence on another drug (including some who had signs of dependence on cannabis as well).

Measuring treatment

Participants who reported having ever used illicit drugs were asked whether they had ever received treatment and support services specifically related to drug dependence, including self-help advice or peer support, drug-related counselling or talking therapy, medication, detoxification or rehabilitation or other types of support.

In addition, all participants were asked about different types of mental health treatment and service use. These included current medication or psychological therapy for any mental or emotional problem, not necessarily for drug use or dependence, and a range of health, community and day care services over the past year.

6.3 Results

Prevalence of having ever used illicit drugs, by age and gender

A third (33.0%) of adults had used an illicit drug at some point in their life. Lifetime experience of drug use was associated with age and gender. Overall, 38.9% of men and 27.5% of women had taken an illicit drug at least once. Drug use was more likely to be reported by those aged 25 to 34 (46.3%) and 35 to 44 (44.2%), and less likely by those aged 75 and over (7.2%).

Ever used an illicit drug, by age and gender (Base: All adults)

Download the data for this chart Ever used an illicit drug, by age and gender (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/drug-use-and-dependence/drug-use-and-dependence/publicationsystem%3AbodySections%5B7%5D/publicationsystem%3AdataFile)

Men and women were more likely to have used cannabis than other drugs. Overall, 35.0% of men had used cannabis, 13.6% had used cocaine powder, 11.2% ecstasy, and 8.6% magic mushrooms (the next most commonly used drugs). Among women, 24.5% had used cannabis, followed by cocaine powder (7.2%), ecstasy (6.1%), and magic mushrooms (4.6%).

The age profile of users varied by type of drug. Those reporting that they had ever used amphetamines, amyl nitrite (poppers), heroin, khat, LSD, and methadone were more likely to be aged 45 to 54. While those reporting that they had ever used cocaine powder, ecstasy, ketamine, mephedrone, methamphetamine, nitrous oxide (laughing gas), and synthetic cannabinoids were more likely to be younger: aged 25 to 34.

Nitrous oxide (7.1%) was the third most cited drug taken by 16 to 24 year olds after cannabis (32.6%) and cocaine powder (7.7%), followed by ecstasy (6.6%) and ketamine (6.5%). While drug use has usually been found to be higher in men than women, this did not appear to be the case for all drug types among 16 to 24 year olds. For example, amyl nitrite (poppers) was reported by 4.1% of women and none of the men in this age group in the sample. Similarly, among 16 to 24 year olds, illicit use of tranquilisers was reported by 2.5% of women and 0.1% of men.

Six most common drugs ever taken (excluding cannabis), by age (Base: All adults)

Download the data for this chart Six most common drugs ever taken (excluding cannabis), by age (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/drug-use-and-dependence/drug-use-and-dependence/publicationsystem%3AbodySections%5B9%5D/publicationsystem%3AdataFile)

Introduced to the 2023/4 survey were new questions on whether participants had used any of a list of controlled prescription opioids that had not been prescribed to them. These were buprenorphine, fentanyl, morphine, oxycodone, and tramadol.

Overall, 3.2% of adults reported non-medical use of at least one of these types of prescription opioids. Men (3.1%) and women (3.2%) were equally likely to report having ever done this. Lifetime use was associated with age, being highest among 25 to 34 year olds (4.5%) and declining with age.

For more information: Table 6.1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Non-medical use of prescription opioids, by age and gender (Base: All adults)

Download the data for this chart Non-medical use of prescription opioids, by age and gender (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/drug-use-and-dependence/drug-use-and-dependence/publicationsystem%3AbodySections%5B11%5D/publicationsystem%3AdataFile)

Prevalence of illicit drug use in the past year, by age and gender

Overall, 10.6% of adults reported using an illicit drug in the past year. Drug use in the past year varied by age and gender. 13.8% of men and 7.5% of women had taken an illicit drug in the past year. Men aged 25 to 34 (26.9%) and women aged 16 to 24 (16.7%) were most likely to have taken any drug in the past year. For both men and women, the prevalence of drug use in the past year broadly declined with age.

Illicit drug use in the past year, by age and gender (Base: All adults)

Download the data for this chart Illicit drug use in the past year, by age and gender (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/drug-use-and-dependence/drug-use-and-dependence/publicationsystem%3AbodySections%5B13%5D/publicationsystem%3AdataFile)

Men and women were more likely to have used cannabis than other drugs in the past year. 11.4% of men had used cannabis, 3.6% cocaine powder, 2.1% ecstasy and 1.7% magic mushrooms (the next most commonly used drugs). Among women, 6.1% had used cannabis in the past year, followed by cocaine powder (1.2%) and ketamine (0.8%). Overall, 0.7% of adults reported misuse of prescription opioid medications in the past year.

After cannabis (17.9%), ketamine (4.3%), and ecstasy (4.1%), the types of drugs most likely to be used in the past year by 16 to 24 year olds were cocaine powder (3.8%), amyl nitrite (2.9%), and nitrous oxide (2.9%). The only participants to report past year use of volatile substances (such as glue) were women aged 16 to 24, 1.7% of whom reported

this.

For more information: Table 6.2 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Prevalence of illicit drug use in the past year, by ethnic group

Age-standardised prevalence of illicit drug use in the past year varied by ethnic group. Prevalence was highest among adults in the Mixed/multiple/other (15.2%) and White other (14.5%) groups and lowest among Asian/Asian British adults (3.1%).

For more information: Table 6.3 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Use of illicit drug in the past year, by ethnic group (age-standardised) (Base: All adults)

Download the data for this chart Use of illicit drug in the past year, by ethnic group (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/drug-use-and-dependence/drug-use-and-dependence/publicationsystem%3AbodySections%5B15%5D/publicationsystem%3AdataFile)

Prevalence of illicit drug use in the past year, by region

Prevalence of illicit drug use in the past year did not vary significantly by region.

For more information: Table 6.4 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Prevalence of drug dependence, by age and gender

The prevalence of signs of drug dependence was measured for each of eleven types of drug:

- Amphetamines
- Cannabis
- Cocaine powder
- Crack cocaine
- Ecstasy
- Heroin or methadone
- Methamphetamine
- Non-medical use of prescription opioids that had not been prescribed to the participant (buprenorphine, fentanyl, morphine, oxycodone and tramadol)
- Synthetic cannabinoids
- Tranquillisers, and
- Volatile substances (glue, gas, aerosols or solvents).

For each drug, signs of dependence was defined as endorsing at least one of five questions about use of the drug (see Section 6.2 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/drug-use-and-dependence#6-2-definitions-and-assessments)). Dependent users were grouped into those who were dependent on cannabis only and those who were dependent on other drugs (including those who were also dependent on cannabis).

Overall, 5.4% of adults (95% CI 4.6, 6.3) showed signs of dependence on illicit drugs, which equates to approximately 2.5 million adults in England. This includes 4.3% (CI 3.6, 5.2) who showed signs of dependence on cannabis only and 1.1% (CI 0.8, 1.5) with signs of dependence on other drugs (with or without cannabis dependence as well).

Prevalence of dependence on any drug was higher in men (6.7%, CI 5.4, 8.4) than women (4.0%, CI 3.1, 5.0). Among men, signs of drug dependence were most likely in 25 to 34 year olds (14.2%, CI 9.5, 20.8), while in women, prevalence was highest among those aged 16 to 24 (9.4%, CI 5.4, 15.8).

For more information: Table 6.5 and Table A1 for confidence intervals (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Signs of drug dependence in the past year, by age and gender (Base: All adults)

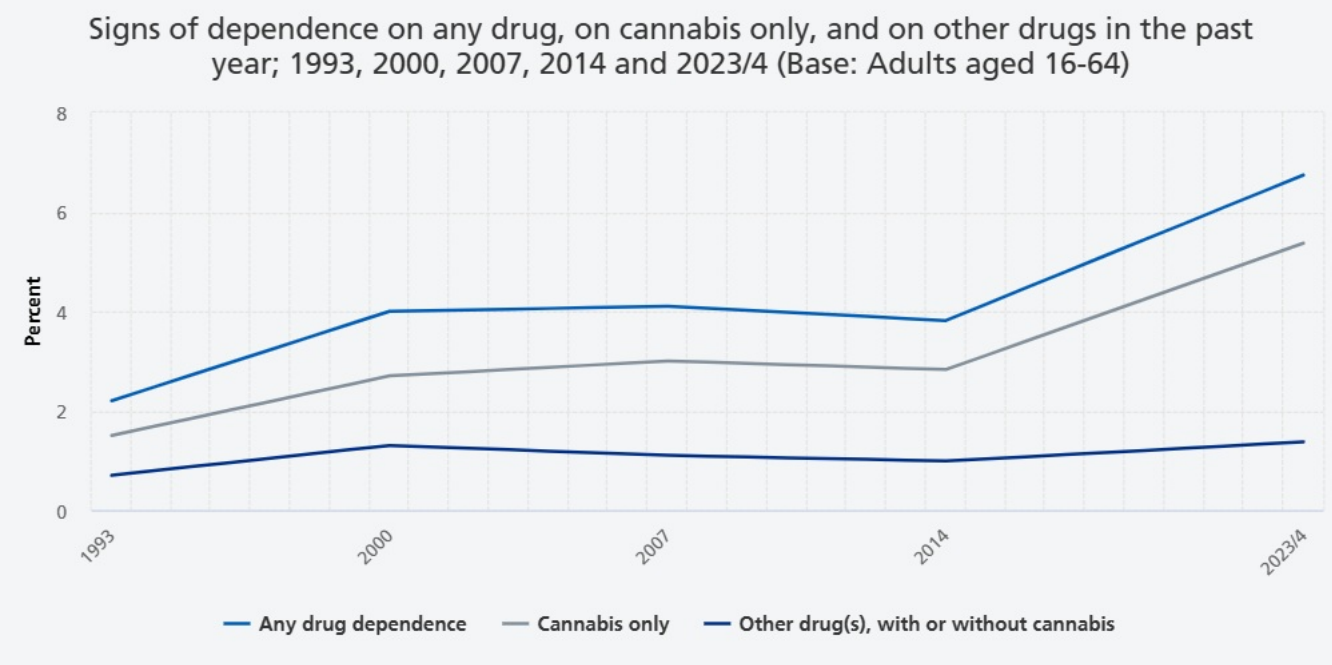
Download the data for this chart Signs of drug dependence in the past year, by age and gender (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/drug-use-and-dependence/drug-use-and-dependence/

publicationsystem%3AbodySections%5B17%5D/publicationsystem%3AdataFile)

Signs of drug dependence in 1993, 2000, 2007, 2014, 2023/4

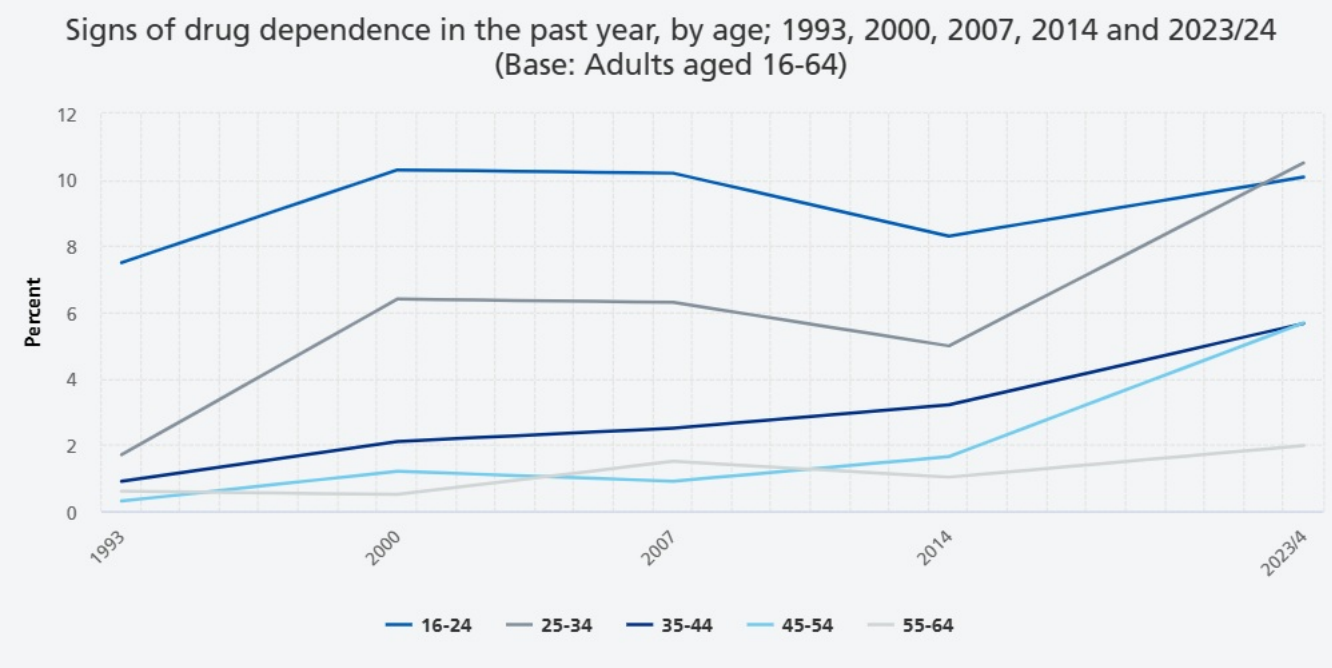
Note that the trend analyses were carried out by sex (male and female) rather than gender (men and women) to allow for comparison with 2014. See How to interpret the findings (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/how-to-interpret-the-findings) for information on how changes over time were assessed.

Between 2014 and 2023/4 signs of drug dependence increased in prevalence from 3.8% (95% CI 3.2, 4.5) to 6.7% (CI 5.7, 7.9), after a period of stability.



The increase in prevalence of signs of drug dependence was evident in both males (from 5.2% in 2014, CI 4.2, 6.5, to 8.3% in 2023/4, CI 6.6, 10.4) and females (from 2.4% in 2014, CI 1.9, 3.2 to 5.2% in 2023/4, CI 4.1, 6.5), and across most age groups. Signs of dependence related to cannabis use largely accounted for the upward trend, increasing from 2.8% (CI 2.3, 3.5) in 2014 to 5.4% (CI 4.4, 6.5) in 2023/4.

For more information: Table 6.6 and Table B1 for confidence intervals (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)



Signs of drug dependence in the past year, by other characteristics

Ethnic group

Like the pattern observed for drug use, the prevalence of reported signs of drug dependence also varied between ethnic groups. In age-standardised analyses, the proportion reporting signs of dependence was highest among adults in the Mixed/multiple/other group (7.8%, 95% CI 4.0, 14.8) and lowest among adults in the Asian/Asian British group (1.4%, CI 0.5, 3.7). It should be noted that the confidence intervals for some estimates were wide and overlapping, so apparent differences between ethnic groups should be treated with caution.

For more information: Table 6.7 and Table A2 for confidence intervals (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Signs of drug dependence in the past year, by ethnic group (age-standardised) (Base: All adults)

Download the data for this chart Signs of drug dependence in the past year, by ethnic group (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/drug-use-and-dependence/drug-use-and-dependence/publicationsystem%3AbodySections%5B23%5D/

publicationsystem%3AdataFile)

Employment status

The prevalence of reported signs of drug dependence varied by employment status. According to age-standardised analyses, 12.9% of working age adults (16 to 64) who were unemployed reported signs of drug dependence, compared with 9.9% of those who were economically inactive and 6.5% of those who were in employment.

For more information: Table 6.8 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Signs of drug dependence in the past year, by employment status (age-standardised) (Base: Adults aged 16-64)

Download the data for this chart Signs of drug dependence in the past year, by employment status (age-standardised) (Base: Adults aged 16-64) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/drug-use-and-dependence/drug-use-and-dependence/publicationsystem%3AbodySections%5B25%5D/publicationsystem%3AdataFile)

Problem debt

Problem debt was defined as being seriously behind with debt repayments or having utilities cut off. See the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods) for more information on how problem debt was derived.

In age-standardised analyses, the proportion of adults reporting signs of drug dependence was over three times higher among those with problem debt (15.9%) compared with those not experiencing problem debt (4.2%).

For more information: Table 6.9 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Area-level deprivation

How has deprivation been defined?

Area-level deprivation has been defined using the English Indices of Deprivation 2019, commonly known as the Index of Multiple Deprivation (IMD).

IMD is the official measure of relative deprivation for Lower Super Output Areas (LSOAs) in England. LSOAs comprise between 400 and 1,200 households and usually have a resident population between 1,000 and 3,000 persons. IMD ranks every LSOA in England from 1 (most deprived area) to 32,844 (least deprived area). Deprivation quintiles are calculated by ranking the 32,844 neighbourhoods in England from most deprived to least deprived and dividing them into five equal groups. These range from the most deprived 20% of neighbourhoods nationally to the least deprived 20% of neighbourhoods nationally.

For further information see: English indices of deprivation 2019 (Link: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019).

The proportion of adults reporting signs of drug dependence varied by area deprivation. Age-standardised prevalence was highest in the fourth (6.2%) and fifth (7.3%) most deprived quintiles.

For more information: Table 6.10 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Signs of drug dependence in the past year, by area-level deprivation (age-standardised) (Base: All adults)

Download the data for this chart Signs of drug dependence in the past year, by area-level deprivation (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/drug-use-and-dependence/drug-use-and-dependence/publicationsystem%3AbodySections%5B29%5D/publicationsystem%3AdataFile)

Region

The age-standardised prevalence of drug dependence in different English regions did not reach statistical significance.

For more information: Table 6.11 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Comorbidity

Physical health conditions

How have physical health conditions been defined?

Participants were asked if they had any of 25 physical health conditions listed on a card, including asthma, cancer, diabetes, epilepsy and high blood pressure. Participants were coded as having a limiting physical health condition, if they reported having one or more physical health conditions in the past 12 months that had been diagnosed by a doctor and that this had limited their ability to carry out day-to-day activities. More details on the questions on physical health conditions can be found in the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

In age-standardised analyses, adults with a limiting physical health condition were more likely to report signs of drug dependence (7.9%) than those without a limiting physical health condition (4.4%).

For more information: Table 6.12 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Common mental health conditions

How have common mental health conditions been defined?

The revised Clinical Interview Schedule (CIS-R) was used to assess six types of common mental health conditions (CMHC): depression, generalised anxiety disorder, panic disorder, phobias, obsessive compulsive disorder, and CMHC not otherwise specified. Participants identified with at least one of these were defined as having a CMHC. See Section 1.2 of the Common mental health conditions chapter (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/common-mental-health-conditions) for more detail.

The age-standardised prevalence of drug dependence was 10.5% among adults with a common mental health condition, compared with 3.7% of those without a common mental health condition.

For more information: Table 6.12 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Signs of drug dependence in the past year, by common mental health condition (CMHC) (age-standardised) (Base: All adults)

Download the data for this chart Signs of drug dependence in the past year, by common mental health condition (CMHC) (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/drug-use-and-dependence/drug-use-and-dependence/publicationsystem%3AbodySections%5B35%5D/publicationsystem%3AdataFile)

Self-diagnosis and professional diagnosis of drug dependence

All participants were asked whether they had ever had any of a list of mental health conditions, including drug dependence. Participants who reported having experienced drug dependence were then asked whether they had ever been diagnosed as drug dependent by a professional, and whether they had experienced drug dependence in the past 12 months.

Overall, 2.2% of adults reported they thought they had been drug dependent at some point in their life and 0.7% reported that they had been professionally diagnosed with drug dependence. 0.4% of all adults had been diagnosed with drug dependence at some point and reported signs of drug dependence in the past 12 months.

Among those showing signs of drug dependence, one in four (24.9%) said they felt they had been drug dependent at some point in their life, compared with 1.0% of those with no signs of drug dependence. Men (28.8%) were more likely to self-diagnose drug dependence than women (16.4%).

6.3% of adults reporting signs of drug dependence had been professionally diagnosed at some point in their life. 4.1% of those reporting signs of drug dependence and who had been professionally diagnosed reported having had symptoms in the past 12 months.

For more information: Table 6.13 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Self-diagnosis and professional diagnosis of drug dependence by signs of drug dependence in the past year (Base: All adults)

Download the data for this chart Self-diagnosis and professional diagnosis of drug dependence by signs of drug dependence in the past year (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/drug-use-and-dependence/drug-use-and-dependence/publicationsystem%3AbodySections%5B37%5D/publicationsystem%3AdataFile)

Treatment

Treatment and service use

Participants were asked about use of different types of mental health treatment and services. Two types of mental health treatment were asked about: current medication and psychological therapy for a mental or emotional problem. The use of a range of health, community and day care services over the past year were also asked about. This treatment and service use could have been for any mental health condition and was not necessarily related to drug use or drug dependence.

A third (33.4%) of adults reporting signs of drug dependence were receiving treatment for a mental or emotional problem, compared with 14.6% of those without signs of drug dependence. Adults reporting signs of drug dependence were more likely to be in

receipt of medication (24.6%) than psychological therapy (12.9%), with 4.1% in receipt of both.

Treatment currently received for a mental or emotional problem, by level of drug dependence in the past year (Base: All adults)

Download the data for this chart Treatment currently received for a mental or emotional problem, by level of drug dependence in the past year (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/drug-use-and-dependence/drug-use-and-dependence/publicationsystem%3AbodySections%5B39%5D/publicationsystem%3AdataFile)

27.8% of those with drug dependence had used health care services for a mental or emotional problem in the past year, while 15.7% used community care services and 6.0% used day care services. Of those without drug dependence, 12.5% used health care services, 6.8% used community care services, and 3.7% used day care services.

For more information: Table 6.14 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Psychotropic medication

Participants were asked which psychotropic medications, used to treat mental health conditions, they currently take (not necessarily relating to drug use and dependence). Overall, 12.5% of all adults were taking some form of psychotropic medication, with the most common medication types being those primarily used to treat depression (11.7%) and anxiety (10.7%). See Chapter 2 Mental health treatment and service use (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/mental-health-treatment-and-service-use) for more details.

A quarter (24.6%) of those reporting signs of drug dependence were taking psychotropic medication compared with 11.7% of those with no signs of drug dependence. The most common medications taken among adults reporting signs of drug dependence were those used to treat depression (22.4%) or anxiety (21.5%). 0.8% of those with signs of drug dependence were taking medication for substance dependence.

For more information: Table 6.15 (Link: /data-and-information/publications/

statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Psychotropic medication currently taken, by drug dependence in the past year (Base: All adults)

Download the data for this chart Psychotropic medication currently taken, by drug dependence in the past year (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/drug-use-and-dependence/drug-use-and-dependence/publicationsystem%3AbodySections%5B41%5D/publicationsystem%3AdataFile)

Treatment and support specifically for drug dependence

Participants who reported having used illicit drugs in their lifetime were asked whether they had ever received treatment and support services specifically related to drug dependence, including self-help advice or peer support, drug-related counselling or talking therapy, medication, detoxification or rehabilitation or other types of support.

Drug dependence specific treatment categories

- Advice and information (Self-help; Narcotic Anonymous or other peer support)
- Counselling or talking therapy
- Medication
- Detoxification or rehabilitation
- Other treatment or support (including any other treatment of drug-related injuries or illness)

One in five (21.2%) adults reporting signs of drug dependence had received support or treatment related to their drug use at some point. Types of treatment and support used in relation to drug dependence included:

- Advice or information, including self-help or peer support such as Narcotics Anonymous (17.0%)
- Counselling or talking therapy (7.3%)
- Medication (4.3%)
- Detoxication or rehabilitation (2.7%)

- Other treatment or support (0.1%)

For more information: Table 6.16 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

6.4 Discussion

APMS is a key data source on drug use and dependence in England. While the annual Crime Survey for England and Wales (CSEW) provides key official statistics on trends in the prevalence of illicit drug use (ONS 2024b (Link: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/drugmisuseinenglandandwales/yearendingmarch2024)), APMS is also an essential resource in this field. Firstly, APMS data provide useful comparisons and a validity check on the CSEW drug use figures, and secondly because APMS includes questions related to drug use that are not available on the CSEW or elsewhere. These questions include: asking about types of drugs not currently included on the CSEW, questions that can identify people with signs of dependence on drugs, and data on comorbidities and use of treatment and services related to drug use.

Drug use may be more common than official statistics indicate. The results presented in this chapter suggest that a higher proportion of adults in England use drugs than official statistics from the CSEW might indicate. For example, while APMS found that 18.1% of 16 to 24 year olds used an illicit drug in the past 12 months, the CSEW figure for the same time period was 16.5% (ONS 2024b (Link: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/drugmisuseinenglandandwales/yearendingmarch2024)). Factors accounting for the difference might include variation in geographic coverage as the APMS sample did not include Wales. APMS also included drug types not covered on the CSEW, such as amyl nitrites, prescription opioids, synthetic cannabinoids, and volatile substances. However, even when comparing reported use of one drug type apparent differences seem evident: 4.3% of 16 to 24 year old participants on APMS reported use of ketamine in the past 12 months, compared with 2.9% of 16 to 24 year olds in CSEW. This suggests that relying on statistics based on reporting to a crime survey – which may experience greater social desirability bias in the disclosure of illegal behaviours – may lead to underestimating the true prevalence of drug use.

Monitor non-medical use of prescription opioids. There has been concern in other countries, in particular the United States, about non-medical use of prescription opioids (Hudgins et al. 2019). Until questions on this were added to the APMS 2023/4, relatively little was known about the extent to which prescription opioid medications were being

used in England by people to whom they had not been prescribed. 3.2% of adults reported non-prescribed use of at least one of buprenorphine, fentanyl, morphine, oxycodone, and tramadol. The proportion is far higher than that for having ever used the opioid heroin (0.7%), indicating that use of non-prescribed opioids is currently distinct from that of heroin. The profile of those reporting such use is noteworthy for the lack of association with gender. That lifetime use was found to be highest among 25 to 34 year olds (4.5%) indicates that it's unlikely to be explained by self-medication of medical disorders.

A changing gender profile. Among 25 to 34 year olds, men were twice as likely as women to report signs of drug dependence, which could in part reflect gender differences in age and nature of family formation responsibilities. However, in 16 to 24 year olds, rates of drug dependence were similar in men and women. In previous years of the APMS series, drug use and dependence were highest in 16 to 24 year old men. The apparent shift in profile of this youngest age group may indicate that men and women are becoming more similar to each other in these risk-taking behaviours. It is also possible that rather than convergence, drug use is starting at a later age in men and that subsequent problems with use may be developing in young men later than seen previously. Given the relatively small number of 16 to 24 year old participants in the sample, these patterns need to be examined further using other data sources.

The proportion of adults with signs of cannabis dependence nearly doubled this decade (from 2.8% in 2014 to 5.4% in 2023/4). This is despite no similar rise in the proportion of adults reporting past year cannabis use (7.2% in 2014 (Link: https://files.digital.nhs.uk/pdf/3/k/adult_psychiatric_study_ch11_web.pdf), 8.7% in 2023/4). This upward trend might reflect known increases in cannabis potency. An analysis of drug seizures published in 2018 indicates the United Kingdom's cannabis street market has become increasingly populated by high-potency varieties of cannabis (Potter et al. 2018). A recent systematic review found more potent forms of cannabis were associated with greater likelihood of addiction (Petrilli et al. 2022). Innovation in terms of number and type of cannabis products and routes of administration available may have also led to increased availability and be associated with increased rates of dependence (e.g. cannabinoid vaping) (Freeman et al. 2015).

A minority of people with signs of drug dependence get drug-related support. The results presented in this chapter indicate that about one in five with signs of drug dependence had ever received support or treatment specifically related to their drug use. Furthermore, among people with a common mental health condition such as depression or an anxiety disorder, one in ten had signs of drug dependence. This may present challenges for mental health services in terms of engagement and recovery.

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Previous Chapter

Chapter 5: Alcohol: hazardous, harmful and dependent patterns of drinking (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/alcohol-dependence)

Next Chapter

Chapter 7: Gambling behaviour (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/gambling-behaviour)

Chapter 7: Gambling behaviour

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Overview

Participation in gambling activities can lead to a wide range of harms, including

experience of gambling disorder.

APMS 2023/4 used the 9-item Problem Gambling Severity Index (PGSI) which measures behavioural symptoms of gambling disorder and experience of some adverse consequences of gambling. Scores on the measure are grouped into different levels of risk from gambling, up to and including likely experience of problem gambling. This chapter focuses on those with a PGSI score of 3 or more (3+), which indicates that the participant was experiencing at least moderate risk gambling.

Key findings

- **Overall, 1.6% of adults experienced at least moderate risk gambling** (PGSI score of 3+). 0.4% of adults experienced problem gambling (as indicated by a PGSI score of 8+).
- **Men (2.2%) were more likely than women (1.0%) to score 3+ on the PGSI**. Prevalence varied by age, and was highest among 25 to 34 year olds (3.5%) and lowest among those aged 75 and over (0.3%).
- **PGSI score was strongly associated with problem debt**. Adults who were seriously behind on debt repayments or who have had their utilities cut off were more likely to have a PGSI score of 3+ (5.1%) than those not in debt (1.2%).
- **PGSI score was associated with mental health**. People with a common mental health condition were more likely to have a PGSI score of 3+ (2.6%) than those without such a condition (1.3%). Three in ten (30.1%) of those with a PGSI score of 3+ were receiving treatment for a mental health or emotional problem. A quarter (25.5%) reported taking psychotropic medication and 7.0% were receiving psychological therapy.
- **Few with signs of gambling harm were recognised by healthcare services**. Among those with a PGSI score of 3+, one in three (35.0%) reported that they felt that they had experienced problem gambling, yet only one in fifteen (6.3%) with a PGSI score of 3+ reported that a professional had diagnosed them with gambling problems.
- **Most people experiencing moderate risk gambling had never used services or support specifically related to gambling**. While a quarter (25.0%) of adults with a PGSI score of 3+ reported having used some form of gambling-specific treatment or service, this mostly comprised of self-exclusion tools such as blocking software. One participant (1.0%) reported having ever used specialist gambling treatment services or peer support such as Gamblers Anonymous.

7.1 Introduction

Participation in gambling activities can lead to a wide range of harms including financial difficulties, negative effects on physical and mental health, and relationship breakdown

(Langham et al. 2016). These adverse consequences range in severity and include experience of gambling disorder, a recognised behavioural addiction (World Health Organization (WHO) 2019 (Link: https://icd.who.int/en/)).

Gambling behaviours were last included in the APMS series in 2007 and were measured then using the Diagnostic and Statistics Manual of Mental Disorders IV (DSM-IV) (McManus et al. 2009 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-in-england-2007-results-of-a-household-survey); Wardle et al. 2020). Other studies, like the Health Survey for England and the Gambling Survey for Great Britain have included the Problem Gambling Severity Index (PGSI) to measure adverse consequences from gambling (NHS England 2023 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2021-part-2); Wardle et al. 2024b (Link: https://www.gamblingcommission.gov.uk/report/gambling-survey-for-great-britain-annual-report-2023-official-statistics)). The PGSI has some advantages over the DSM-IV in that it was specifically developed to be used in population settings (like general population surveys). The PGSI conceptualises gambling behaviours as existing on a spectrum of severity, ranging from no risk to the experience of problem gambling (see Section 7.2 Definitions and assessments). A growing body of evidence shows that those who are below the threshold for the experience of problem gambling can also experience harms and that some in the subthreshold group experience a high level of harm (Browne and Rockloff 2018; Browne et al. 2020; Volberg et al. 2021). Using the PGSI, as APMS 2023/4 does, allows for examination of the wider spectrum of gambling behaviour. However, this means that APMS 2007 and APMS 2023/4 findings are not directly comparable.

Gambling activity, and in particular experience of adverse consequences from gambling, is a major public health concern and of great policy interest (Wardle et al. 2024a; Marionneau et al. 2022). Better understanding of the extent and nature of adverse consequences from gambling is needed to inform strategies to minimise and prevent harm (Ukhova et al. 2024).

The National Institute for Health and Care Excellence (NICE) recently published guidance on identification, assessment and management of gambling-related harms (NICE 2025 (Link: https://www.nice.org.uk/guidance/ng248)). This included recommendations for healthcare professionals and social care practitioners to ask about gambling across a wide range of settings. The NICE guidelines also recognise the role health and social care professionals can play in raising awareness of and increasing use of treatment and support services for gambling and in advising the public that recovery is possible. As of December 2024, the NHS has 15 specialist gambling treatment clinics with service use having increased 130% over the preceding year. Between April and September 2024, nearly 2,000 referrals were made to these services, compared with 800 referrals for the

same period in 2023 (NHS England 2024 (Link: https://digital.nhs.uk/supplementary-information/2024/nhs-gambling-referrals-data)).

This report provides an overview of gambling among adults in England, along with associations with sociodemographic characteristics and treatment and service use.

7.2 Definitions and assessments

Gambling in the past 12 months

In the self-completion section of the phase one interview, participants were shown a list of example gambling activities and asked whether they had spent money on any of them in the past 12 months. Participants responding 'yes' to this question, or 'yes' to a further check question on whether they had gambled even 'very occasionally', were classed as people who had gambled in the past 12 months.

The examples of gambling activities provided were:

- buying lottery tickets or scratchcards
- betting with a bookmaker on any event or sport, including online
- online casino, slots, poker or bingo, playing slots/fruit machines/machines in a bookmakers
- bingo at a bingo hall
- table games at a casino
- playing football pools
- private betting, playing cards or games for money with friends, family or colleagues.

Online gambling

Participants were asked whether they had spent any of their own money gambling online, for example buying lottery tickets online, online instant win games, betting online or via an app, and playing games like bingo or online slots either online or via an app. Participants who had gambled online may also have participated in in-person gambling activities.

Problem Gambling Severity Index (PGSI)

The PGSI was designed for use among the general population rather than in a clinical context. It was developed, tested and validated within a general population survey of over 3,000 Canadian residents (Ferris and Wynne 2001).

The PGSI consists of nine items relating to experiences such as 'chasing losses', 'gambling related health problems' and 'feeling guilty about gambling'. The questions measure both behavioural symptoms of gambling disorder and certain adverse consequences from

gambling. The PGSI was asked of everyone who had gambled in the past 12 months, capturing the current experience of each of these items.

Problem Gambling Severity Index (never, sometimes, often, always)
In the past 12 months, how often…
• have you bet more than you could really afford to lose?
• have you needed to gamble with larger amounts of money to get the same feeling of excitement?
• have you gone back another day to try to win back the money you lost?
• have you borrowed money or sold anything to get money to gamble?
• have you felt that you might have a problem with gambling?
• have you felt people criticised your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?
• have you felt guilty about the way you gamble, or what happens when you gamble?
• has your gambling caused you any health problems, including a feeling of stress or anxiety?
• has your gambling caused any financial problems for you or your household?

Answer options were ‘never’, ‘sometimes’, ‘often’ and ‘always’. These response options differ slightly from the standard PGSI answer options of ‘never’, ‘sometimes’, ‘most of the time’ and ‘almost always’. Sensitivity analyses comparing data from APMS and the Health Survey for England 2018 (which used the standard format) indicate that the different wording may have very slightly underestimated the proportion of people experiencing at least moderate risk gambling in APMS. For example, we estimate that the use of standard response options on APMS may have increased the proportion of people with a PGSI score of 8+ by around 0.06 percentage points.

Responses to the nine questions were summed, and a score ranging from 0 to 27 computed. Scores were grouped into the following categories:

- **PGSI score 0** - indicating a person who gambles (including heavily) but does not report experiencing any of the nine symptoms or adverse consequences asked about. In population prevalence analysis, participants who had not gambled in the past 12 months were also given a PGSI score of 0. For some analysis in this chapter, those who had not gambled in the past 12 months are included separately allowing

comparisons to be made between those who had not gambled at all and those who had gambled but had a PGSI score of 0.

- **PGSI score 1 to 2 - indicating low risk gambling**, by which a person is unlikely to have experienced adverse consequences from gambling but may be at risk if they are heavily involved in gambling.
- **PGSI score 3 to 7 - indicating moderate risk gambling**, by which a person may or may not have experienced adverse consequences from gambling but may be at risk if they are heavily involved in gambling.
- **PGSI score 8 to 27 - indicating problem gambling**, by which a person will have experienced adverse consequences from their gambling and may have lost control of their behaviour. Involvement in gambling can be at any level but is likely to be heavy.

Due to small base sizes (<40) in the PGSI score of 8+ group, subgroup analysis in this chapter focuses on those scoring 3 or more (PGSI 3+ hereafter). This combined group (PGSI 3+) includes those experiencing moderate risk gambling (who may have experienced adverse consequences from gambling or are at greater risk of experiencing adverse consequences if they are heavily involved in gambling) and those who have definitely experienced adverse gambling consequences (PGSI score of 8+).

7.3 Results

PGSI scores among all adults, by age and gender

The majority of adults had not gambled in the past 12 months (57.4%, 95% CI 55.7, 59.2) or had gambled but had a PGSI score of 0 (38.2%, CI 36.5, 39.9). A further 2.8% (CI 2.3, 3.5) had a PGSI score of 1 or 2, indicative of low risk gambling.

Overall, 1.6% of adults (CI 1.2, 2.1) were identified as experiencing at least moderate risk gambling, with a PGSI score of 3 to 27. This group is made up of 1.2% (CI 0.8, 1.7) with a PGSI score of 3 to 7 (indicative of moderate risk gambling), and 0.4% (CI 0.2, 0.6) with a PGSI score of 8+ (indicative of experiencing adverse consequences from their gambling and potential loss of control of behaviour).

Men (2.2%, CI 1.5, 3.0) were more likely than women (1.0%, CI 0.6, 1.7) to have a PGSI score of 3+.

Problem Gambling Severity Index (PGSI) score of 3+, by gender (Base: All adults)

Download the data for this chart Problem Gambling Severity Index (PGSI) score of 3+, by gender (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/gambling-

behaviour/gambling-behaviour/publicationsystem%3AbodySections%5B7%5D/publicationsystem%3AdataFile)

The proportion of adults with a PGSI score of 3+ varied by age being more common among younger age groups: 2.0% (CI 0.7, 5.7) of those aged 16 to 24 and 3.5% (CI 2.2, 5.5) of those aged 25 to 34 had a PGSI score of 3+, compared with between 0.9% (CI 0.4, 1.7) and 1.5% (CI 0.9, 2.7) of those aged 35 to 44 and 0.3% (CI 0.1, 1.0) of those aged 75 and over. While the proportion scoring 3+ appeared to be lower in 16 to 24 year old men (1.7%, 0.4, 7.0) than women of the same age (2.4%, 0.5, 10.1), the base sizes for these subgroups were small and confidence intervals overlapped greatly.

For more information: Table 7.1 and Table A1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals.

Problem Gambling Severity Index (PGSI) score of 3+, by age (Base: All adults)

Download the data for this chart Problem Gambling Severity Index (PGSI) score of 3+, by age (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/gambling-behaviour/gambling-behaviour/publicationsystem%3AbodySections%5B9%5D/publicationsystem%3AdataFile)

PGSI scores among adults who had gambled in the past 12 months, by age and gender

PGSI scores among those participating in any gambling

About two fifths (42.6%) of adults reported taking part in some form of gambling in the past 12 months.

Among those who had gambled, most had a PGSI score of 0 (89.7%), indicating no experience of adverse consequences, and 6.6% had a score of 1 or 2, indicating low risk gambling. The remaining 3.7% scored 3 to 27, indicating experiencing at least moderate risk gambling. Of these, 0.9% had PGSI scores of 8+.

The proportion of those who had gambled with a PGSI score of 3+ varied by age, ranging from 8.1% for those aged 16 to 34 to 0.9% for those aged 75 and over. Mean PGSI scores followed a similar pattern, decreasing with advancing age (0.6 for those aged 16 to 34;

0.1 for those aged 75 and over).

PGSI scores among those participating in online gambling

Overall, 28.9% of adults who had gambled in the past 12 months reported gambling online (including purchase of National Lottery tickets online). Of these, the majority had a PGSI score of 0 (87.0%) and a further 8.4% were identified as experiencing low risk gambling with a PGSI score of 1 or 2. Almost one in twenty (4.6%) of those who gambled online had a PGSI score of 3+, indicating that they experienced at least moderate risk gambling. Of these, 1.2% had a PGSI score of 8+.

Among those who had gambled online, PGSI scores of 3+ were more common among men (5.9%) than women (3.0%). PGSI scores of 3+ were also more common among younger adults who had gambled online. One in ten adults aged 16 to 34, who had gambled online, had a PGSI score of 3+ (9.5%). This decreased with age to 1.5% for those aged 75 and above.

For more information: Table 7.2 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Problem Gambling Severity Index (PGSI) score of 3+, by gambling participation in the past 12 months and age (Base: All adults who have gambled in the past 12 months)

Download the data for this chart Problem Gambling Severity Index (PGSI) score of 3+, by gambling participation in the past 12 months and age (Base: All adults who have gambled in the past 12 months) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/gambling-behaviour/gambling-behaviour/publicationsystem%3AbodySections%5B11%5D/publicationsystem%3AdataFile)

PGSI score of 3+ by other characteristics

Ethnic group

In age-standardised analyses based on all adults, the proportion with a PGSI score of 3+ varied by ethnic group, being highest among those in the Mixed/multiple or other ethnic group (3.5%, 95% CI 1.2, 10.2) and lowest among Asian/Asian British (0.4%, CI 0.1, 1.5) and Black/Black British (0.5%, CI 0.2, 1.8) adults.

These estimates may be affected by subgroup differences in the level of engagement in gambling. The ethnic groups least likely to have a PGSI score of 3+ were also the least likely to gamble. For example, 81.3% (CI 75.6, 85.9) of Asian/Asian British adults had not gambled, compared with 52.3% (CI 50.3, 54.4) of White British adults. Mean PGSI scores among those who gambled in the past 12 months were similar (0.3) for both White British and Asian/Asian British groups meaning that among those who did gamble, PGSI scores were similar. It should be noted that the confidence intervals for some estimates were wide and overlapping, so apparent differences between ethnic groups should be treated with caution.

For more information: Table 7.3 and Table A2 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals.

Problem Gambling Severity Index (PGSI) score of 3+, by ethnic group (age-standardised) (Base: All adults)

Download the data for this chart Problem Gambling Severity Index (PGSI) score of 3+, by ethnic group (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/gambling-behaviour/gambling-behaviour/publicationsystem%3AbodySections%5B13%5D/publicationsystem%3AdataFile)

Employment status

There were no statistically significant differences in the proportion of adults with PGSI scores of 3+ by employment status (age-standardised).

For more information: Table 7.4 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Problem debt

In age-standardised analyses, being seriously behind on at least one debt repayment or having utilities cut off was associated with PGSI scores of 3+. 7.4% of men and 3.5% of women with problem debt had a PGSI score of 3+, compared with 1.7% of men and 0.8% of women without problem debt. See the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-

morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods) for more information on how problem debt was derived.

For more information: Table 7.5 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Problem Gambling Severity Index (PGSI) score of 3+, by problem debt (age-standardised) (Base: All adults)

Download the data for this chart Problem Gambling Severity Index (PGSI) score of 3+, by problem debt (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/gambling-behaviour/gambling-behaviour/publicationsystem%3AbodySections%5B15%5D/publicationsystem%3AdataFile)

Area-level deprivation

How has deprivation been defined?

Area-level deprivation has been defined using the English Indices of Deprivation 2019, commonly known as the Index of Multiple Deprivation (IMD).

IMD is the official measure of relative deprivation for Lower Super Output Areas (LSOAs) in England. LSOAs comprise between 400 and 1,200 households and usually have a resident population between 1,000 and 3,000 persons. IMD ranks every LSOA in England from 1 (most deprived area) to 32,844 (least deprived area). Deprivation quintiles are calculated by ranking the 32,844 neighbourhoods in England from most deprived to least deprived and dividing them into five equal groups. These range from the most deprived 20% of neighbourhoods nationally to the least deprived 20% of neighbourhoods nationally.

For further information see: English indices of deprivation 2019 (Link: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019)

There were no statistically significant differences in the proportion of adults with PGSI scores of 3+ by area level deprivation (age-standardised).

For more information: Table 7.6 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Region

There were no statistically significant differences in the proportion of adults with PGSI scores of 3+ by region (age-standardised).

For more information: Table 7.7 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Comorbidity

Physical health conditions

How have physical health conditions been defined?

Participants were asked if they had any of 25 physical health conditions listed on a card, including asthma, cancer, diabetes, epilepsy and high blood pressure. Participants were coded as having a limiting physical health condition, if they reported having one or more physical health condition in the past 12 months that had been diagnosed by a doctor and that this had limited their ability to carry out day-to-day activities. More details on the questions on physical health conditions can be found in the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

In age-standardised analyses, adults with a limiting physical health condition were more likely to have a PGSI score of 3+ (2.6%) than those without a limiting physical health condition (1.3%).

Common mental health conditions

How have common mental health conditions been defined?

The revised Clinical Interview Schedule (CIS-R) was used to assess six types of common mental health conditions (CMHC): depression, generalised anxiety disorder, panic disorder, phobias, obsessive compulsive disorder, and CMHC not otherwise specified. Participants identified with at least one of these were defined as having a CMHC.

See Section 1.2 of the Common mental health conditions chapter (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/common-mental-health-conditions#1-2-definitions-and-assessments) for more detail.

Adults with a common mental health condition were more likely to have a PGSI score of 3+ (2.6%) than those without a common mental health disorder (1.3%).

For more information: Table 7.8 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Problem Gambling Severity Index (PGSI) score of 3+, by common mental health condition (CMHC) (age-standardised) (Base: All adults)

Download the data for this chart Problem Gambling Severity Index (PGSI) score of 3+, by common mental health condition (CMHC) (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/gambling-behaviour/gambling-behaviour/publicationsystem%3AbodySections%5B24%5D/publicationsystem%3AdataFile)

Self-diagnosis and professional diagnosis of gambling problems

Participants were asked whether they thought they had ever experienced ‘gambling problems’. Those who responded yes were asked whether this had been diagnosed by a professional, and if so, whether diagnosed gambling problems had been present in the past 12 months.

Overall, 1.0% of adults reported that they felt they had experienced gambling problems at some point in their life (self-diagnosed), and 0.1% of adults stated that they had been diagnosed with gambling problems by a professional.

Adults with higher PGSI scores were more likely to report that they felt they had experienced gambling problems. Among those with a PGSI score of 3+, a third (35.0%) thought that they have had gambling problems (self-diagnosed) and 6.3% reported that gambling problems had been diagnosed by a professional. 1.4% reported the presence of diagnosed gambling problems in the past 12 months.

Among those who gambled but had a PGSI score of 0, 0.7% felt that they have experienced gambling problems and none reported that a professional had ever diagnosed them with gambling problems.

Among those who had not gambled in the past 12 months, 0.4% reported that they felt they have had gambling problems and 0.1% (or about one in four of those reporting having ever experienced gambling problems) stated that gambling problems had been diagnosed by a professional.

For more information: Table 7.9 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Self-diagnosed gambling problem, by PGSI score (Base: All adults)

Download the data for this chart Self-diagnosed gambling problem, by PGSI score (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/gambling-behaviour/gambling-behaviour/publicationsystem%3AbodySections%5B26%5D/publicationsystem%3AdataFile)

Treatment

Treatment and service use for mental or emotional problems

Participants were asked about use of different types of mental health treatment and services. Two types of mental health treatment were asked about: current medication and psychological therapy for a mental or emotional problem. Use of a range of health, community and day care services over the past year were also asked about. This treatment and service use could have been for any mental health condition and was not necessarily related to gambling.

Of those with a PGSI score of 3+:

- 30.1% reported that they were currently receiving treatment (psychological therapy and/or medication) for a mental or emotional problem (compared with less than 17% of those in all other PGSI groups).
- 33.1% reported having used a health care service for a mental health related reason (compared with 11.8% of those with a PGSI score of 0).
- 8.0% reported community care and 4.7% reported day care services used in the past year. Those with a PGSI score of 3+ were not significantly more likely to use such services than those in other PGSI groups.

Among those with a PGSI score of 3+, 25.5% reported they were receiving medication compared with 10.8% with a PGSI score of 0, while receipt of psychological therapy was similar (7.0% with a PGSI score of 3+, 4.8% with a PGSI score of 0).

For more information: Table 7.10 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Types of psychotropic medication

Participants were asked which (if any) psychotropic medications they were taking for a mental health reason (not necessarily for symptoms relating to gambling behaviour). The most common medication types reported by all adults were those primarily used to treat depression (11.7%) and anxiety (10.7%). See Chapter 2 Mental health treatment and service use (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/mental-health-treatment-and-service-use) for more details.

Those with higher PGSI scores were more likely to report currently taking medication used to treat mental health conditions than those with lower PGSI scores (25.5% for those with a PGSI score of 3+; 10.8% for those with a PGSI score of 0).

Among those with a PGSI score of 3+ the most common types were those primarily used to treat depression (25.0%) or anxiety (20.7%).

For more information: Table 7.11 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Treatment and support specifically for gambling problems

Participants who reported gambling in the past 12 months were asked whether they had ever received any treatment or support specifically related to gambling. The list of types of treatment and support that they were asked about included specialist gambling treatment services or peer support, gambling related counselling or talking therapy, self-

exclusion (such as use of blocking software or blocking bank transactions), or other treatment or support.

Gambling specific treatment categories

- Specialist gambling treatment services or peer support (Specialist gambling treatment service; A support group e.g. Gamblers Anonymous).
- Counsellor, therapist or other mental health service.
- Self-exclusion tools (Self-exclusion (e.g. blocking software or blocking bank transactions)).
- Other gambling related treatment or support (GP practice; Social worker, youth worker or support worker; A faith group; Family/friends; Employer/college; Online communities; Self-guided help (e.g. books, leaflets, websites, apps); A telephone helpline; Another source).

Adults with higher PGSI scores were more likely to report receiving gambling treatment and/or services than those with lower scores. One quarter (25.0%) of adults with a PGSI score of 3+ had received support or treatment related to their gambling, compared with 0.9% of those with a PGSI score of 0.

Among those with a PGSI score of 3+, the most commonly reported treatment or support action was self-exclusion tools (such as blocking software or blocking bank transactions (14.6%)). The proportion of those with a PGSI score of 3+ having ever accessed formal gambling treatment and support services was lower, with 1.0% reporting use of specialist gambling support services including peer support, and 3.2% reporting use of gambling related counselling, therapist or other mental health services.

For more information: Table 7.12 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Treatment ever used for gambling problems among those with PGSI score 3+ (Base: All adults with a PGSI score 3+)

Download the data for this chart Treatment ever used for gambling problems among those with PGSI score 3+ (Base: All adults with a PGSI score 3+) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/gambling-behaviour/gambling-behaviour/publicationsystem%3AbodySections%5B30%5D/

publicationsystem%3AdataFile)

7.4 Discussion

The estimated prevalence of problem gambling, 0.4%, is likely to be conservative. Overall, 0.4% of participants had a PGSI score of 8+, indicating the experience of problem gambling. This is broadly in line with estimates from the Health Survey for England (HSE) series. The HSE used slightly different PGSI response option wording and included two different instruments to estimate problem gambling, of which the PGSI produced somewhat lower estimates than the DSM-IV. Reporting of problem gambling from the HSE typically focused on people who were identified according to either instrument, as they capture a different range of behavioural symptoms and adverse consequences (NHS England 2023 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2021-part-2)). APMS 2023/4 only includes the PGSI and thus the estimates presented here should be treated as conservative.

At least moderate risk gambling was evident in 1.6% of adults, as indicated by PGSI scores of 3+. The Gambling Survey for Great Britain showed that 40% of people who experienced one or more severe adverse consequences from gambling (relationship breakdown, crime, experience of violence or losing something of significant financial value) had PGSI scores of less than 8, demonstrating how experience of harms is more widely distributed across the PGSI spectrum (Wardle et al. 2024b (Link: https://www.gamblingcommission.gov.uk/report/gambling-survey-for-great-britain-annual-report-2023-official-statistics)). Sole focus on PGSI scores of 8+ misses the wider experience of these harms.

The results provide insight into gambling harms across the life course. APMS 2023/4 also shows a wider range of people who report ever having experienced adverse consequences from gambling. While estimates may seem low (0.7% for those with a PGSI score of 0 and 0.4% of those who had not gambled) these groups represent the majority of the population, further demonstrating that harms from gambling are more widely dispersed than a focus on those with a current PGSI score of 8+ alone may suggest.

There is substantial unmet need for gambling treatment and services. Data produced for the Office for Health Improvement and Disparities (OHID) suggested that anyone with a PGSI score of 3+ might benefit from at least brief interventions for gambling harms, with those with PGSI scores of 8+ potentially benefiting from more extensive cognitive behavioural therapies (OHID 2024 (Link: https://www.gov.uk/government/publications/gambling-treatment-need-and-support-prevalence-estimates/gambling-treatment-need-and-support-in-england-main-findings-and-

methodology)). However, data from APMS 2023/4 shows that only a very small minority of people with these scores are accessing these kinds of services – less than 4% of people with a PGSI score of 3+ reported accessing talking therapies or counselling services for gambling. There remains substantial unmet need for gambling treatment and support services, with the most common support action among those with PGSI scores of 3+ being self-exclusion using tools such as blocking software or blocking bank transactions.

There is a need for a coordinated response to identify and support people experiencing gambling harms. While those with PGSI scores of 3+ were typically not receiving any support or treatment for gambling, some reported receiving support and treatment for other emotional or mental health issues. A third (33.1%) of those with a PGSI score of 3+ reported using health services for a mental or emotional issue. It is not clear whether these services were sought in relation to adverse consequences from gambling, for other mental or emotional issues, or for some combination of the two. Nonetheless, it is essential that service providers treating people for mental and emotional health issues are aware of concurrent gambling harms as this can complicate treatment outcomes. The National Institute for Health and Care Excellence (NICE) guidelines on gambling harm identification, assessment and management recognise this and recommend that mental and physical health services and gambling harm treatments services, including the support provided by local authorities and social care, are coordinated (NICE 2025 (Link: https://www.nice.org.uk/guidance/ng248)).

Among people with PGSI scores of 3+ 35.0% recognised they had gambling problems but just 6.3% had a professional diagnosis. In terms of gambling specific treatment, 14.6% had used self-exclusion tools while 1.0% had received specialist gambling treatment or peer support, suggesting self-recognition of and proactive attempts to reduce gambling related harms. Gambling is often termed the 'hidden' addiction, with people not seeking support until they reach crisis point (Hing 2012; Itäpuisto 2019; Suurvali et al. 2009). Embedding the identification of gambling harms, as recommended by NICE, into health and social care service pathways is key to addressing the lack of service use identified within this report.

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Previous Chapter

Chapter 6: Drug use and dependence (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/drug-use-and-dependence)

Next Chapter

Chapter 8: Personality disorder (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/personality-disorder)

Chapter 8: Personality disorder

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Overview

Personality disorders are described in diagnostic systems as enduring patterns of thoughts, feelings, and behaviours that deviate from cultural expectations, are pervasive and inflexible, and lead to distress or impairment in functioning. How personality disorders are classified, and whether the diagnosis is a valid or helpful way to describe a person's difficulties, is complex and contested. Nonetheless, the association between meeting diagnostic criteria for personality disorder and substantial long-term distress and health and societal impact, makes investigation of their prevalence a public health concern.

The Structured Clinical Interview for the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) Personality Disorders Questionnaire (SCID-II Q) was

used in the self-completion section of the phase one interview, to screen for antisocial personality disorder (ASPD) and borderline personality disorder (BPD) traits. ASPD is defined as a pervasive pattern of disregard for and violation of the rights of others in people aged at least 18, which has persisted since the age of 15. BPD is defined as a pervasive pattern of instability in interpersonal relationships, self-image, and emotional regulation, coupled with marked impulsivity.

Personality disorder (PD) has also been conceptualised under the International Classification of Diseases (ICD-11) as a unitary syndrome, characterised by core interpersonal dysfunction and the presence of a range of other traits. The Standardised Assessment of Personality: Abbreviated Scale (SAPAS) was therefore also used on APMS to screen for 'general PD traits'. A positive screen indicated that someone may have sufficient relevant traits to warrant further investigation.

Key findings

- **One adult in fifty reported ASPD traits.** 2.0% of adults aged 18 and over screened positive for ASPD on the SCID-II Q. Men (2.9%) were more likely than women (1.2%) to screen positive for ASPD.
- **Nearly one adult in fifty reported BPD traits.** 1.9% of adults aged 16 and over screened positive for BPD on the SCID-II Q. Women were more likely to screen positive for BPD (2.5%) than men (1.3%).
- **One adult in seven reported general PD traits.** 14.9% of adults screened positive for general PD traits using the SAPAS. Prevalence was similar for men (14.0%) and women (15.6%).
- **The general population prevalence of ASPD, BPD and general PD traits remained stable over time.** The proportion of 18 to 64 year olds screening positive for ASPD remained fairly stable between 2014 and 2023/4. The proportion of 16 to 64 year olds screening positive for BPD also remained stable, as did the proportion of all adults (16 and over) with general PD traits.
- **People reporting PD traits often experienced socioeconomic adversity.** Screening positive for ASPD, BPD and general PD traits were all more common among people struggling with debt or who were unemployed.
- **PD traits were common in people with depression or an anxiety disorder.** Over a third of adults (37.6%) with a common mental health condition screened positive for general PD traits, compared with 8.7% of adults without a common mental health condition.
- **Within the general population, a minority of people reporting PD traits received mental health treatment.** About two thirds of adults screening positive for ASPD (62.1%) or general personality disorder traits (66.1%) and half of those who screened positive for BPD (47.8%) were not receiving any treatment for a mental or emotional problem or disorder.
- **For those who did receive treatment, this was more likely to consist of medication**

rather than psychological therapy. People screening positive for ASPD, BPD and general PD traits, were all about twice as likely to be in receipt of mental health medication than psychological therapy.

8.1 Introduction

Personality disorders are described in international diagnostic systems as a group of mental health conditions characterised by enduring patterns of thoughts, feelings, and behaviours that deviate significantly from cultural expectations, are pervasive and inflexible, and lead to distress or impairment in social, occupational, or other areas of functioning. People receiving a diagnosis of personality disorder often experience stigma within the healthcare system (Foye et al. 2022). It has been argued that the diagnostic construct itself contributes to this stigma and causes harm (Watts 2019). Nonetheless, the association between meeting diagnostic criteria for personality disorders, and substantial long-term distress, health and societal impacts, makes investigation of their prevalence and associations a public health concern.

People meeting diagnostic criteria for personality disorder (PD) often experience enduring difficulties in relationships with others (Skodol et al. 2005). Along with substantial social difficulties (Moran et al. 2016; Yang et al. 2010), people meeting diagnostic criteria for PD also experience poor general health and reduced life expectancy (Ekselius 2018). It has been argued that antisocial personality disorder (ASPD) and borderline personality disorder (BPD) are types of PD with particular relevance to society and the health service (Coid et al. 2006). This is because meeting diagnostic criteria for either condition is associated with substantial health and economic burden on affected individuals, their families and wider society (Coid et al. 2009).

People who meet diagnostic criteria for PD often also experience mood and anxiety disorders (Grant et al. 2005; Leichsenring et al. 2023, Shah et al. 2023). However, research shows that, even after accounting for the effects of concurrent mood and anxiety disorder, screening positive for PD is an independent risk factor for poor future mental health and serious relational difficulties (Moran et al. 2016). Therefore, mapping the prevalence and correlates of PD traits among the general population may help to identify a subsection who are at particularly high risk of future health problems.

Antisocial personality disorder (ASPD)

The diagnostic criteria for ASPD describe a pattern of impulsive, aggressive and irresponsible behaviour, and a disregard for the rights of others, emerging in childhood or early adolescence (Goldstein et al. 2006). The diagnostic criteria have been criticised as difficult to distinguish from general antisocial behaviour, and hence in danger of being over-applied to individuals in the criminal justice system, alongside the broader issues of the medicalisation of criminality, stigma, and potential neglect of the role of social structures (Pickersgill 2009; Jones 2023; Wayland et al. 2013). Conversely, the UK National

Offender Personality Disorder Pathway for offenders deemed likely to have a personality disorder, has enabled access to psychological formulation and interventions for thousands of prisoners (Vamvakas et al. 2024, Skett and Lewis 2019). About half of the offenders accessing the Pathway are likely to meet diagnostic criteria for ASPD (Bali et al. 2023).

In general population studies, meeting diagnostic criteria for ASPD is associated with increased morbidity and mortality due, among other things, to increased rates of injury from assaults, alcohol and drug use, suicidal behaviour, and road accidents (Krasnova et al. 2019; Shepherd and Farrington 2003; Ullrich and Coid 2009), along with increased deaths from health conditions such as chronic lower respiratory disease and cancer (Krasnova et al. 2019).

In the general population, the estimated prevalence of ASPD varies with diagnostic classification system, method of assessment and place (for example, the rate is higher in urban than rural areas (Coid et al. 2006)). Despite these differences, there is similarity in the estimates generated by community surveys of PD based on full clinical assessment: 0.7% of 18 to 65 year olds in Oslo, Norway (Torgersen et al. 2001), 0.6% in the US (Lenzenweger et al. 2007), and 0.3% in England (McManus et al. 2009). Compared with women, men are more likely to meet diagnostic criteria for ASPD. People meeting criteria for ASPD have often grown up in families where parenting was characterised by conflict and inconsistency, with care sometimes transferred to outside agencies (Holmes et al. 2001; Black et al. 1995). There is a strong association with experiences of emotional, sexual and physical abuse in childhood (DeLisi et al. 2019; Schorr et al. 2021). Meeting diagnostic criteria for ASPD is associated with multiple medical and social problems, including low educational attainment, substance misuse, self-harm and crime (Moran et al. 2001; Moran et al. 2016).

While the diagnosis of ASPD is conceptually distinct from general antisocial behaviour, Diagnostic and Statistical Manual of Mental Disorders (DSM-IV and 5) (APA 1994; 2013) criteria require childhood antisocial behaviour (to the level of conduct disorder) for the full diagnosis in adulthood. The evidence for working with children and young people who are at risk, and their families, points to the potential value of preventative measures (National Institute for Health and Care Excellence (NICE) 2013 (Link: https://www.nice.org.uk/guidance/cg77)). Criminality is strongly associated with, but not essential for, the diagnosis of ASPD, which includes a broad range of antisocial behaviours and personality traits. The prevalence of ASPD among prisoners is very high: 63% of male remand prisoners and 49% of male sentenced prisoners were assessed to have ASPD (Singleton et al. 1998). In the general population, 36.9% of people who have been in prison screen positive for ASPD, which is ten times higher than the rest of the population (Bebbington et al. 2021). People meeting diagnostic criteria for the disorder account for a disproportionately large proportion of crime and violence committed.

The extended harm and costs associated with meeting diagnostic criteria for ASPD include high levels of personal injury and financial damage to victims, as well as increased costs of policing, and the impact on the criminal justice system and prison

services (Welsh et al. 2008). Additional costs linked to ASPD include increased use of healthcare, lost employment opportunities, and family breakdown.

Despite the societal and personal impacts, there is limited evidence of effective treatments for people meeting diagnostic criteria for ASPD (van den Bosch et al. 2018). NICE guidelines outline treatment options, focusing on treatment for any comorbid disorders and psychological interventions such as group-based cognitive and behavioural therapies and alcohol or substance use therapy. NICE recommends that pharmacological interventions should not be routinely used for the treatment of ASPD or its associated behaviours. Where they are used for comorbid conditions, it is recommended that attention is paid to levels of adherence and risks of misuse or overdose (NICE 2013 (Link: https://www.nice.org.uk/guidance/cg77)). More recent research has shown that Mentalisation-Based Treatment may be an effective intervention for individuals with antisocial personality disorder within forensic populations (Fonagy et al. 2025).

Borderline personality disorder (BPD)

BPD, also unofficially yet frequently referred to in the UK as emotionally unstable personality disorder (EUPD), is defined as a pervasive pattern of instability in interpersonal relationships, self-image, and emotional regulation, coupled with marked impulsivity. People meeting diagnostic criteria for BPD may have severe difficulties with sustaining relationships and experience high rates of self-harm and suicidal behaviour (Paris 2019). It has been argued that the diagnosis of BPD lacks coherence and construct validity (Tyrer 2009; Tyrer et al. 2019), and that it may lead to stigma, testimonial injustice, denial of victimhood and re-traumatisation when applied to trauma survivors (Hartley et al. 2022; Lomani 2022; Watts 2024a; Watts 2024b). While trauma is an important risk factor for developing all types of mental health difficulties, BPD has been found to be three times more strongly associated with a history of childhood trauma than other psychiatric diagnoses, including mood disorders, other personality disorders, and psychosis (Porter et al. 2020). Trauma is more strongly associated with BPD in clinical than in general population samples (Porter et al. 2020). For example, a study in the USA found that 61% of inpatients meeting diagnostic criteria for BPD reported childhood sexual abuse, and 59% reported childhood physical abuse (Zanarini et al. 1997). An evaluation of people given the diagnosis in UK personality disorder services found that 93% reported a history of trauma, most commonly sexual trauma or violence (Barnicot and Crawford 2018). Despite the criticism and debate surrounding the diagnosis, it has been retained in some form in both the DSM and ICD diagnostic systems and is used by NICE in their clinical guidelines (American Psychiatric Association (APA) 2013; NICE 2009 (Link: https://www.nice.org.uk/guidance/cg78); NICE 2015 (Link: https://www.nice.org.uk/guidance/qs88); World Health Organization (WHO) 2019 (Link: https://icd.who.int/en/)).

The diagnosis has important public health implications. The suicide rate among people meeting diagnostic criteria for BPD is many times higher than in the general population

(Chesney et al. 2014). In a case register study of 2,440 individuals diagnosed with a personality disorder in South London, 3% had died within a 5 year period; 62% were from natural causes and 38% were accidental deaths or deaths by suicide (Fok et al. 2014). Alcohol or drug use, physical illness, and impairment in activities of daily living were all independently associated with all-cause mortality. In an overlapping cohort of people with a PD diagnosis, life expectancy was estimated to be 18 years shorter than among the general population (Fok et al. 2012). The majority of patients in these studies were likely to have had a BPD diagnosis, since this is the most common PD diagnosis given by mental health services (Tyrer 2018).

In the general population and clinical samples, BPD traits can be measured from early adolescence onwards (Videler et al. 2019). The fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) requires symptoms to have been present since late adolescence or early adult life for a diagnosis of BPD to be given (APA 2013). However, controversially, diagnosis from early adolescence has been permitted since the latest DSM revision (Hartley et al. 2022). It has particularly been cautioned that adolescents may meet diagnostic criteria for BPD through impulsivity, emotional instability and self-harm, which represent common adolescent behaviours that overlap with other types of mental health difficulties and neurodiversity (Sharp et al. 2019). Cohort studies have shown that the symptoms associated with BPD fluctuate but generally improve over time, particularly when treated with an effective psychological intervention (Stoffers-Winterling et al. 2022). Among those receiving treatment, one longitudinal study of a clinical cohort reported that 88% of treated patients improved sufficiently not to meet the criteria for BPD ten years after first diagnosis (Zanarini et al. 2006).

As with ASPD, the prevalence of BPD identified through community-based surveys is sensitive to the diagnostic classification system used and the method of assessment. The rates identified have, however, been broadly similar across studies: 0.7% in Oslo, Norway (Torgersen et al. 2001), 1.3% in the US (Lenzenweger et al. 2007), 0.4% in England (McManus et al. 2009), and 1.9% across high income countries (Volkert et al. 2018). In some instances, prevalence has been found to be higher in women than men (Skodol et al. 2005), although this was not the case in APMS 2014 (McManus et al. 2016 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014)). Among clinical populations, a higher rate among women is consistently observed. It has been argued this reflects the fact that women are substantially more likely to seek treatment for this condition (Kulacaoglu et al. 2018) or, alternatively, that the diagnosis is a social construction used to pathologise the strategies which some women use to survive and resist oppression and abuse (Shaw and Proctor 2005).

General personality disorder traits

The classification of personality disorder remains hotly debated. Arguments against the

categorical classification include the fact that there is substantial co-morbidity between subtypes of personality disorder, and that, to be considered to relate to 'personality', diagnostic criteria should relate to personality traits that can be observed on a continuum within the general population. A large amount of empirical evidence supports the view that dimensional assessment of personality traits - which are normative in their central tendency and atypical/problematic in their extremes - has robust construct validity across both clinical and non-clinical samples. Yet, there has been considerable resistance to the adoption of a dimensional classification of personality disorder, due to concerns about its clinical utility and ease of application (Livesley 2007). Increasingly, however, it has been proposed that PD should be classified as a unitary disorder, characterised by core interpersonal dysfunction (of varying degrees of severity), accompanied by the presence of a range of adaptive and maladaptive traits (Tyrer et al. 2015). This view has become embedded in the WHO ICD-11 (Link: https://icd.who.int/en/) classification of PD. Additionally, the classification of ICD-11 PD relies primarily on a general definition of PD, and reduces the importance of subclassification by particular "types" or "domains" of PD. In light of these developments, in APMS 2014 a general PD traits screen was added to the assessment battery. This set of screening questions (SAPAS) was retained in APMS 2023/4.

In this chapter, prevalence of screening positive for ASPD, BPD and for 'general personality disorder' traits (as screened for using the SAPAS) are presented for the adult population living in private households in England. Associations with age, gender, ethnicity, employment status, problem debt, area-level deprivation and region are examined. Comorbidities with physical and mental health conditions are presented, as well as levels of mental health service use and treatment among people screening positive.

8.2 Definitions and assessments

Antisocial and borderline personality disorder

As in APMS 2014, the measures used to screen for ASPD and BPD in APMS 2023/4 relate to DSM-IV criteria. This is to enable changes over time to be assessed across the APMS series. DSM-5 was released shortly after APMS 2014 fieldwork was carried out and introduced an Alternative Model for Personality Disorders. However, the ten personality disorder subtypes and their criteria remained unchanged between the DSM-IV and the DSM-5.

DSM-IV and DSM-5 define a personality disorder as 'an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment'. DSM-IV and DSM-5 identify ten types of personality disorder grouped into three clusters (APA 1994; 2013):

- Cluster A includes the 'odd or eccentric' types
- Cluster B disorders are the 'dramatic, emotional or erratic' types, and
- Cluster C is the 'anxious-fearful' group.

ASPD and BPD are both cluster B disorders. The other 'dramatic, emotional or erratic' types (narcissistic and histrionic) yielded no positive cases when assessed in APMS 2000 and were not included in subsequent surveys.

ASPD

DSM-IV characterises ASPD as a pervasive pattern of disregard for and violation of the rights of others that has persisted in the individual since the age of 15 or earlier, as indicated by three (or more) of seven criteria:

- Failure to conform to social norms
- Irresponsibility
- Deceitfulness
- Indifference to the welfare of others
- Recklessness
- Failure to plan ahead
- Irritability and aggressiveness (Millon and Davis 1993).

A feature of ASPD in the DSM-IV is that it requires the individual to meet diagnostic criteria in childhood (presence of conduct disorder before age 15) as well as adulthood. Because particular behaviours must have persisted beyond the age of 18, people younger than this cannot be given the diagnosis. For this reason, participants aged 16 or 17 were excluded from the base for the ASPD analysis.

BPD

According to the DSM-IV diagnostic criteria for BPD, the key features are instability of interpersonal relationships, self-image and mood, combined with marked impulsivity, beginning by early adulthood. It is indicated by five (or more) of the following criteria:

- Frantic efforts to avoid real or imagined abandonment
- Pattern of unstable and intense personal relationships
- Unstable self-image
- Impulsivity in more than one way that is self-damaging (e.g. spending, sex, substance abuse, binge eating, reckless driving)
- Suicidal or self-harming behaviour
- Affective instability
- Chronic feelings of emptiness
- Anger
- Paranoid thoughts or severe dissociative symptoms (quasi-psychotic).

Unlike ASPD, a DSM-IV diagnosis of BPD is possible before the age of 18, and the BPD

analysis therefore included all APMS participants aged 16 and over.

Assessment

Previous surveys have covered all ten types of personality disorder, including APMS 2000 which used the full Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II) in phase two (First et al. 1997; Singleton et al. 2002). However, population surveys of mental disorder often limit the assessment of personality disorder to briefer screening assessments because fully structured interviews are time-consuming. APMS 2007 covered ASPD and BPD in the phase one and two interviews, but not other PD. This was made possible by the modular structure of the SCID-II interview which covers each PD subtype separately. As in APMS 2014, APMS 2023/4 did not include the SCID-II at phase two, but rather screened for BPD and ASPD based only on phase one self-report data using the SCID-II Q. The prevalence figures presented in this chapter are therefore not comparable with the two-phase prevalence figures in the 2007 report due to this change in methods. APMS 2014 and 2023/4 also screened for general PD traits, using the SAPAS.

A positive screen for personality disorder only indicates that someone may have sufficient traits to warrant further and fuller investigation. Screened positive prevalence estimates are usually higher than the true prevalence of a disorder. It should also be noted that the term 'screened' is used as a convention and does not indicate that the screening tests used in the survey are used as part of a national screening programme.

Screening positive for ASPD or BPD on the SCID-II Q

As in previous years, the SCID-II screening questionnaire (SCID-II Q) was included in phase one in the self-completion section of the interview. In 2023/4, all personality disorder questions were asked of participants of all ages (in 2014, the SCID-II Q was asked of participants aged between 16 and 64).

The ASPD module covered childhood conduct disorder and adult antisocial personality, as a diagnosis of ASPD requires both to be present. The questions used to screen for these disorders are listed in the questionnaire in Appendix C (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods#appendices). Each question asked the participant to indicate whether they had a particular personality characteristic, for example: 'Are you the kind of person who…'. All questions had three response categories: 'yes', 'no', and 'don't know/does not apply'. A score of one was given for each item where the participant answered 'yes'.

Screening positive for general personality disorder traits using the SAPAS

In APMS 2014, the Standardised Assessment of Personality: Abbreviated Scale (SAPAS) (Moran et al. 2003) was added to assess for the likely presence of general PD traits from any of the three DSM clusters.

The SAPAS was chosen on the grounds that it was, at that time, the best performing rapid screen for PD (Germans et al. 2012) and has been validated for use in general population samples (Fok et al. 2015).

Each of the eight questions on the SAPAS asked participants to indicate whether they had a particular personality characteristic, for example 'Are you normally an impulsive sort of person?' Participants could answer either 'yes' or 'no'. A score of one was given for each item for which the participant responded 'yes', generating a score of 0–8. Those scoring four or more, were defined as screening positive for general PD traits. This cut-point was chosen as it provides the best balance between sensitivity and specificity in a general population sample (Fok et al. 2015). Participants with more than two SAPAS items missing were not given a SAPAS score.

In summary, in this chapter:

- A positive screen for ASPD or BPD draws on the phase one SCID-II screening questionnaire (SCID-II Q).
- A positive screen for general personality disorder traits draws on the phase one SAPAS.

8.3 Results

Screening positive for ASPD and BPD, by age and gender

2.0% of adults aged 18 and over screened positive for ASPD on the SCID-II Q. If everyone in the population had been screened, it is likely that between 1.7% and 2.5% of those aged 18 and over would have screened positive (95% confidence interval (CI)). This equates to about 950 thousand adults living in England meeting the diagnostic criteria for ASPD.

The prevalence of ASPD was higher among men (2.9%, 95% CI 2.3, 3.7) than women (1.2%, CI 0.8, 1.8). Screening positive for ASPD was associated with age. Prevalence was highest among those aged 25 to 34 (2.8%, CI 1.7, 4.6), 35 to 44 (3.5%, CI 2.2, 5.5) and 45 to 54 (2.4%, CI 1.5, 3.7), and lowest among younger (1.3%, CI 0.8, 2.1, of 18 to 24 year olds) and older age groups (between 1.2%, CI 0.7, 2.1, of 65 to 74 year olds, and 0.3%, CI 0.1, 1.2, of those aged 75+). This pattern was evident among both men and women.

1.9% of adults aged 16 and over screened positive for BPD on the SCID-II Q. If everyone in the population had been screened, it is likely that between 1.5% and 2.5% of adults would have screened positive (95% CI). This equates to about 900 thousand adults living in England meeting diagnostic criteria for BPD.

The proportion screening positive for BPD was 2.5% among women (CI 1.9, 3.3) and 1.3% among men (CI 0.8, 2.1). Prevalence was highest among 16 to 24 year olds (6.1%, CI

3.8, 9.6) and decreased with age.

For more information: Table 8.1 and Table A1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals

Screening positive for antisocial and borderline personality disorder (SCID-II Q), by age (Base: Adults aged 18+ ASPD, 16+ BPD)

Download the data for this chart Screening positive for antisocial and borderline personality disorder (SCID-II Q), by age (Base: Adults aged 18+ ASPD, 16+ BPD) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/personality-disorder/personality-disorder/publicationsystem%3AbodySections%5B7%5D/publicationsystem%3AdataFile)

Screening positive for general PD traits, by age and gender

The SAPAS classified one in seven adults (14.9%, 95% CI 13.6, 16.2) as screening positive for 'general PD traits'. This equates to about 6.9 million adults living in England screening positive for general PD traits.

The proportion screening positive for general PD traits was similar for men (14.0%, CI 12.1, 16.2) and women (15.6%, CI 13.9, 17.4). The likelihood of screening positive for general PD traits declined with age from 26.4% (CI 21.2, 32.4) of those aged 16 to 24 to 5.6% (CI 4.1, 7.6) of those aged 75 and over. The pattern of association between screening positive and age was different for men and women. In women, the decline was more pronounced: 35.3% (CI 26.8, 44.7) of those aged 16 to 24 screened positive for general PD traits, compared with 22.9% (CI 18.3, 28.2) of women aged 25 to 34 and 5.8% (CI 3.6, 9.3) of women aged 75 or over.

For more information: Table 8.3 and Table A1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals

Screening positive for general personality disorder traits (SAPAS), by age and gender (Base: All adults)

Download the data for this chart Screening positive for general personality

disorder traits (SAPAS), by age and gender (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/personality-disorder/personality-disorder/publicationsystem%3AbodySections%5B9%5D/publicationsystem%3AdataFile)

Screening positive for ASPD, BPD and general PD traits, 2014 and 2023/4

Note that the trend data analyses were carried out by sex (male and female) rather than gender (men and women) to allow for comparison with 2014. See How to interpret the findings (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/how-to-interpret-the-findings) for information on how changes over time were assessed.

The proportion screening positive for ASPD among adults aged 18 to 64 appeared to remain stable: 3.3% (95% CI 2.8, 4.0) in 2014 and 2.4% (CI 1.9, 3.1) in 2023/4 with confidence intervals overlapping slightly.

The proportion of adults aged 16 to 64 screening positive for BPD has remained stable: 2.4% (CI 2.0, 2.9) in 2014 and 2.5% (CI 1.9, 3.2) in 2023/4.

For more information: Table 8.2 and Table B1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals

The proportion of adults aged 16 or over screening positive for general PD traits has also remained stable over time (13.7%, CI 12.7, 14.6 in 2014,14.9% CI 13.6, 16.2 in 2023/4).

For more information: Table 8.4 and Table B2 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals

ASPD and BPD screens by general PD traits screen

Among people screening positive on the SAPAS for general PD traits (at a cut point of 4), a minority also met the criteria for ASPD or BPD. 12.0% of those who screened positive for general PD traits also screened positive for BPD, and 7.3% screened positive for ASPD.

For more information: Table 8.5 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Screening positive for PD by other characteristics

Ethnic group

The age-standardised proportion screening positive for ASPD varied by ethnic group. The prevalence was highest among White British (2.1%, 95% CI 1.6, 2.7) and White other adults (2.9%, CI 1.4, 5.9). 1.5% of Black/Black British adults screened positive (CI 0.3, 7.8) and 1.5% in those from Mixed/multiple/other groups (CI 0.5, 4.7), while no Asian participants in the sample screened positive for ASPD. It should be noted that the confidence intervals for some estimates were wide and overlapping, so apparent differences between ethnic groups should be treated with caution.

Screening positive for antisocial personality disorder (SCID-II Q), by ethnic group (age-standardised) (Base: Adults aged 18+)

Download the data for this chart Screening positive for antisocial personality disorder (SCID-II Q), by ethnic group (age-standardised) (Base: Adults aged 18+) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/personality-disorder/personality-disorder/publicationsystem%3AbodySections%5B12%5D/publicationsystem%3AdataFile)

The age-standardised proportion of screening positive for BPD also varied by ethnic group. The prevalence was highest among White British (2.3%, CI 1.7, 3.1) and those of Mixed/multiple/other ethnicity (3.7%, CI 1.0, 13.2), and lowest among those in the Asian/Asian British (0.6%, CI 0.2, 1.7) and White other (0.6%, CI 0.1, 2.3) groups.

For more information: Tables 8.6 and Table A2 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals

Screening positive for general personality disorder traits was associated with ethnic group in age-standardised analyses, with adults from a Mixed/multiple/other group being most likely to screen positive for general personality disorder traits (23.5%, CI 14.7, 35.2) and Asian/Asian British adults being least likely (7.9%, CI 5.4, 11.4).

For more information: Tables 8.7 and Table A2 (Link: /data-and-information/

publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals

Screening positive for general personality disorder traits (SAPAS), by ethnic group (age-standardised) (Base: All adults)

Download the data for this chart Screening positive for general personality disorder traits (SAPAS), by ethnic group (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/personality-disorder/personality-disorder/publicationsystem%3AbodySections%5B14%5D/publicationsystem%3AdataFile)

Employment status

Employment status was associated with all age-standardised measures of PD among adults of working age (16 to 64).

Those who were unemployed were more likely to screen positive for ASPD (8.6%), BPD (8.4%) and general personality disorder traits (36.5%).

For more information: Table 8.8 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) and Table 8.9 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Screening positive for antisocial, borderline and general personality disorder traits, by employment status (age-standardised) (Base: Adults aged 18+ ASPD, 16+ BPD and general PD traits)

Download the data for this chart Screening positive for antisocial, borderline and general personality disorder traits, by employment status (age-standardised) (Base: Adults aged 18+ ASPD, 16+ BPD and general PD traits) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/personality-disorder/personality-disorder/publicationsystem%3AbodySections%5B16%5D/

publicationsystem%3AdataFile)

Problem debt

In age-standardised analyses, being seriously behind with debt repayments or having utilities cut off was associated with greater likelihood of screening positive for ASPD, BPD and general personality disorder traits. See the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods) for more information on how problem debt was derived.

Adults who reported experiencing problem debt were more than twice as likely to screen positive for ASPD (4.6%), BPD (5.2%) and general personality disorder traits (28.1%) than those without problem debt (1.7%, 1.6% and 13.6%, respectively).

For more information: Table 8.10 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) and Table 8.11 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Screening positive for antisocial, borderline and general personality disorder traits, by problem debt (age-standardised) (Base: Adults aged 18+ ASPD, 16+ BPD and general PD traits)

Download the data for this chart Screening positive for antisocial, borderline and general personality disorder traits, by problem debt (age-standardised) (Base: Adults aged 18+ ASPD, 16+ BPD and general PD traits) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/personality-disorder/personality-disorder/publicationsystem%3AbodySections%5B18%5D/publicationsystem%3AdataFile)

Area-level deprivation

How has deprivation been defined?

Area-level deprivation has been defined using the English Indices of Deprivation 2019, commonly known as the Index of Multiple Deprivation (IMD).

IMD is the official measure of relative deprivation for Lower Super Output Areas (LSOAs) in England. LSOAs comprise between 400 and 1,200 households and usually have a resident population between 1,000 and 3,000 persons. IMD ranks every LSOA in England from 1 (most deprived area) to 32,844 (least deprived area). Deprivation quintiles are calculated by ranking the 32,844 neighbourhoods in England from most deprived to least deprived and dividing them into five equal groups. These range from the most deprived 20% of neighbourhoods nationally to the least deprived 20% of neighbourhoods nationally.

For further information see: English indices of deprivation 2019 (Link: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019).

Age-standardised prevalence of screening positive for ASPD and BPD was not significantly associated with living in a more or less deprived neighbourhood.

An association, however, was significant for general personality disorder traits. 19.9% of adults living in the most deprived IMD quintile screened positive for general personality disorder traits, compared with 12.7% of those living in the least deprived quintile.

For more information: Table 8.12 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) and Table 8.13 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Screening positive for general personality disorder traits (SAPAS), by area-level deprivation (age-standardised) (Base: All adults)

Download the data for this chart Screening positive for general personality disorder traits (SAPAS), by area-level deprivation (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/personality-disorder/personality-disorder/publicationsystem%3AbodySections%5B22%5D/publicationsystem%3AdataFile)

Region

The age-standardised proportion of adults screening positive for ASPD and BPD did not significantly vary by region.

Screening positive for general personality disorder traits was, however, associated with region. Adults living in the North East (21.4%), East of England (18.8%) and the North West (18.2%) were the most likely to screen positive, and those living in the South West (9.5%) were the least.

For more information: Table 8.14 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) and Table 8.15 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Screening positive for general personality disorder traits (SAPAS), by region (age-standardised) (Base: All adults)

Download the data for this chart Screening positive for general personality disorder traits (SAPAS), by region (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/personality-disorder/personality-disorder/publicationsystem%3AbodySections%5B24%5D/publicationsystem%3AdataFile)

Comorbidity

Physical health conditions

How have physical health conditions been defined?

Participants were asked if they had any of 25 physical health conditions listed on a card, including asthma, cancer, diabetes, epilepsy and high blood pressure. Participants were coded as having a limiting physical health condition, if they reported having one or more physical health conditions in the past 12 months that had been diagnosed by a doctor and that this had limited their ability to carry out day-to-day activities. More details on the questions on physical health conditions can be found in the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

- Adults with a limiting physical health condition (3.1%) were more likely than those without (1.4%) to screen positive for ASPD in age-standardised analyses.
- Adults with a limiting physical health condition (3.6%) were more likely than those without (1.3%) to screen positive for BPD.
- Adults with a limiting physical health condition (23.1%) were more likely than those without (10.8%) to screen positive for general personality disorder traits.

For more information: Table 8.16 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) and Table 8.17 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Screening positive for antisocial, borderline and general personality disorder traits, by presence of limiting physical health condition (age-standardised) (Base: Adults aged 18+ ASPD, 16+ BPD and general PD traits)

Download the data for this chart Screening positive for antisocial, borderline and general personality disorder traits, by presence of limiting physical health condition (age-standardised) (Base: Adults aged 18+ ASPD, 16+ BPD and general PD traits) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/personality-disorder/personality-disorder/publicationsystem%3AbodySections%5B28%5D/publicationsystem%3AdataFile)

Common mental health conditions

How have common mental health conditions been defined?

The revised Clinical Interview Schedule (CIS-R) was used to assess six types of common mental health conditions (CMHC): depression, generalised anxiety disorder, panic disorder, phobias, obsessive compulsive disorder, and CMHC not otherwise specified. Participants identified with at least one of these were defined as having a CMHC. See Section 1.2 of the Common mental health conditions chapter (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/common-mental-health-conditions#1-2-definitions-and-assessments) for more detail.

Participants with a common mental health condition (CMHC) were more likely than those without to screen positive on each PD measure.

- 4.9% of adults with a CMHC screened positive for ASPD, compared with 1.2% of those without a CMHC.
- 7.5% of participants with a CMHC screened positive for BPD, compared with 0.2% of those without a CMHC.
- Adults with a CMHC were also more likely than those without to screen positive for general PD traits (37.6%, compared with 8.7%).

For more information: Table 8.16 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) and Table 8.17 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Screening positive for antisocial, borderline and general personality disorder traits, by common mental health condition (age-standardised) (Base: Adults aged 18+ ASPD, 16+ BPD and general PD traits)

Download the data for this chart Screening positive for antisocial, borderline and general personality disorder traits, by common mental health condition (age-standardised) (Base: Adults aged 18+ ASPD, 16+ BPD and general PD traits) (Link: /binaries/content/documents/corporate-website/publication-

system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/personality-disorder/personality-disorder/publicationsystem%3AbodySections%5B32%5D/publicationsystem%3AdataFile)

Self-diagnosis and professional diagnosis of PD

Participants were shown a list of mental health conditions and asked whether they thought that they had ever had any of them. The list included 'a personality disorder'. Those who reported that they thought that they have had a personality disorder were asked if this had been diagnosed by a professional, and if so, whether the condition had been present in the past 12 months.

- 1.2% of adults overall reported that they thought they had had a personality disorder at some point. 0.9% of adults reported that they had been professionally diagnosed with a personality disorder and 0.8% of adults reported having a diagnosed personality disorder present in the past 12 months.
- 8.3% of adults who screened positive for ASPD reported that they thought they had had a personality disorder at some point, 7.7% reported that this had been diagnosed by a professional, and 6.6% reported that the disorder had been present in the past 12 months.
- 13.9% of adults who screened positive for BPD reported that they thought they had had a personality disorder at some point, 10.5% reported that this had been diagnosed by a professional, and 10.5% reported that the disorder had been present in the past 12 months.
- Among adults who screened positive for general PD traits, 5.0% thought that they had had a personality disorder, 3.7% reported that this had been diagnosed by a professional, and 3.5% reported that the disorder had been present in the past 12 months.

For more information: Table 8.18 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Self-identified as having ever had 'a personality disorder', by antisocial, borderline and general personality disorder traits screen (Base: Adults aged 18+ ASPD, 16+ BPD and general PD traits)

Download the data for this chart Self-identified as having ever had 'a personality disorder', by antisocial, borderline and general personality disorder

traits screen (Base: Adults aged 18+ ASPD, 16+ BPD and general PD traits) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/personality-disorder/personality-disorder/publicationsystem%3AbodySections%5B34%5D/publicationsystem%3AdataFile)

Treatment

Treatment and service use

Participants were asked about different types of mental health treatment and service use. These included current psychotropic medication or psychological therapy for any mental or emotional problem (not necessarily related to personality disorder traits). Participants were also asked about their use of a range of health, community and day care services over the past year.

About two thirds of adults who screened positive for ASPD (62.1%) or general personality disorder traits (66.1%), and half of those who screened positive for BPD (47.8%), were not receiving any treatment for an emotional problem or disorder around the time of the interview. Those with a positive screen for ASPD and BPD were twice as likely to be in receipt of medication (31.7% and 43.8%, respectively) than psychological therapy (15.8% and 21.6%, respectively). Similarly, adults screening positive for general PD traits on the SAPAS were more likely to be in receipt of medication (28.2%) than psychological therapy (12.1%).

Treatment currently received for a mental or emotional problem, by antisocial, borderline and general personality disorder traits screen (Base: Adults aged 18+ ASPD, 16+ BPD and general PD traits)

Download the data for this chart Treatment currently received for a mental or emotional problem, by antisocial, borderline and general personality disorder traits screen (Base: Adults aged 18+ ASPD, 16+ BPD and general PD traits) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/personality-disorder/personality-disorder/publicationsystem%3AbodySections%5B36%5D/publicationsystem%3AdataFile)

About one in four adults (26.3%) who screened positive for ASPD and 59.5% of those who screened positive for BPD had used health care services for a mental health related reason in the past year. This was one in three (32.1%) among adults with a positive screen for general PD traits, and one in ten (9.8%) of those screening negative for general PD traits.

Community care services were used in the past year by one in three of those meeting BPD criteria (33.2%), one in five of those meeting ASPD criteria (20.2%) and one in six (15.6%) of those with general PD traits.

For more information: Table 8.19 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) and Table 8.20 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Psychotropic medication

Participants were asked which (if any) psychotropic medications they were taking for a mental health reason (not necessarily for symptoms related to personality disorder). Overall, 12.5% of all adults were taking some form of psychotropic medication, with the most common medication types being those primarily used to treat depression (11.7%) and anxiety (10.7%). See Chapter 2 Mental health treatment and service use (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/mental-health-treatment-and-service-use) for more details.

The most common medications taken among those screening positive for ASPD or BPD, were those used to treat depression (29.2% and 41.5%, respectively) and anxiety (23.7% and 38.6%, respectively). These were also the most commonly used psychotropic medications used by those who screened negative for ASPD (11.5% and 10.5%, respectively) and BPD (11.0% and 10.0%, respectively).

The pattern was similar among those screening positive for general personality disorder traits, with about one in four taking medication used to treat depression (26.7%) or anxiety (23.5%).

For more information: Table 8.21 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) and Table 8.22 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

8.4 Discussion

The concept, measurement and diagnosis of personality disorder are contested. The epidemiological data generated from this survey has limitations, chiefly in terms of the reliance on being self-reported and cross-sectional. Further, how one interprets screening positive for personality disorder on any of the measures is a matter for debate. It has been noted, with concern in some quarters, that the introduction of a general personality disorder descriptor alongside dimensionality in ICD-11, will greatly increase the numbers of people deemed to be meeting diagnostic criteria (Tyrer et al. 2014; Watts 2019). In line with this, 14.9% of the sample screened positive for general personality disorder traits, while screening positive for ASPD (2.0%) and BPD (1.9%) was considerably less likely.

Diagnostic criteria for BPD and general PD traits overlap with, and hence are more likely to be endorsed by, people with complex PTSD or by people who are autistic (WHO 2019; Lai and Baron-Cohen 2015). This potentially contributes to diagnostic overshadowing (where a healthcare professional misattributes the symptoms of one condition to another that has previously been diagnosed). Those in this sample with physical health conditions or other common mental health conditions (like depression or an anxiety disorder), were more than twice as likely to screen positive for PD as those without a physical or common mental health condition. Although some caution is warranted as the numbers of people who screened positive for ASPD (117) and BPD (99) in this survey were relatively small, several clear public health implications of screening positive on the personality disorder measures are evident.

People screening positive for PD often experience socioeconomic adversity. Those reporting personality disorder traits were more likely to not be in employment, to be seriously behind with debt repayments or have had their utilities cut off, or (for those with general PD traits) to live in more deprived neighbourhoods, compared with those who did not screen positively for personality disorder. Screening positive for ASPD was more common in men than women and among non-British white adults, while adults from a Mixed/multiple/other ethnic group were particularly likely to screen positive for general personality disorder traits.

Screening positive for PD is associated with younger age and being a woman. In keeping with other research (Newton-Howes et al. 2015; Zanarini et al. 2003), general PD traits (as measured by the SAPAS) were associated with age. Prevalence was higher in younger age groups than older: in particular, one in three (35.3%) women 16 to 24 screened positive for general PD traits. Further, 9.8% of women aged 16 to 24 met diagnostic criteria for BPD according to the SCID-II Q. The very high identified prevalence of general PD traits in young women is noteworthy. It is known that this is one of the highest risk demographic groups for experiencing psychological distress (Alonso et al. 2004). However, the association with this demographic is also consistent with feminist critiques of the diagnosis which view it as a means to pathologise the responses of young women to oppression (Shaw and Proctor 2005).

Likelihood of meeting diagnostic criteria for PD may decrease over time. Stability within the individual has been a defining feature of both the ICD-10 (WHO 1992) and DSM definitions of personality disorder (NICE 2009 (Link: https://www.nice.org.uk/guidance/qs88)). The cross-sectional association with age in APMS data is therefore intriguing as it raises a prospective research question about whether the diagnostic criteria for personality disorder truly persist across the life course. ICD-11 indicates that the likelihood of meeting diagnostic criteria for PD may decrease over time, and the diagnosis should be regarded only as 'relatively' stable after early adulthood. Certainly, there is evidence of fluctuation over time in the presence of criteria within individuals (Livesley et al. 1992), and the course of the disorder is susceptible to treatment (Marcus et al. 2006; Storebø et al. 2020). Moreover, clinical trials have shown that some psychological therapies can be effective in the treatment of borderline personality disorders (Storebø et al. 2020), although the results of pharmacological trials have been less conclusive (Paris 2008).

Most people screening positive for personality disorder in the APMS sample were not receiving treatment for any kind of mental or emotional problem. Of those that were receiving treatment, twice as many cited medication than psychological therapies, which may reflect treatment of comorbid conditions. This is despite NICE guidelines recommending psychological therapies as the first line of treatment. NICE quality standards for both people with BPD or ASPD include being offered a choice of psychological therapies (NICE 2015 (Link: https://www.nice.org.uk/guidance/qs88)). As noted previously, the sample size and cross-sectional nature of these data, alongside the limitations of self-reported screening tools and the debate around the diagnostic constructs, require us to treat these findings with some caution. Nevertheless, they suggest that improvements in treatment and service provision may be required to achieve satisfactory levels of therapeutic help for people meeting diagnostic criteria for personality disorder as recommended by NICE.

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Previous Chapter

Chapter 7: Gambling behaviour (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/gambling-behaviour)

Next Chapter

Chapter 9: Attention deficit hyperactivity disorder (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/attention-deficit-hyperactivity-disorder)

Chapter 9: Attention deficit hyperactivity disorder

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Overview

Attention deficit hyperactivity disorder (ADHD) is a complex neurodevelopmental disorder, which starts in childhood and often persists into adulthood. It is associated with significant impairment.

The 2007, 2014 and 2023/4 APMS included the six-item Adult ADHD Self-Report Scale (ASRS). The screening tool assesses ADHD characteristics of inattention, hyperactivity and

impulsivity during the six months prior to interview. Screening positive for ADHD (a score of four or more on the ASRS) does not mean that someone has the condition, rather that they warrant a more comprehensive assessment.

Key findings

- **One in seven (13.9%) adults screened positive for ADHD using the Adult ADHD Self-Report Scale (ASRS)**, with prevalence higher in women (14.9%) than men (12.4%).
- **One in twenty (5.8%) adults thought that they had ADHD**, and 1.8% of adults reported that they have been diagnosed with ADHD by a professional.
- **Adults screening positive for ADHD were more likely to have been diagnosed.** Among those screening positive for ADHD on the ASRS, 9.6% reported having been diagnosed with ADHD by a professional and 2.6% were taking ADHD medication. Among those screening negative for ADHD, 0.5% reported having been diagnosed by a professional at some point during their lives and almost none (0.0%) were taking ADHD medication.
- **The proportion of adults screening positive for ADHD using the ASRS has increased,** from 8.2% in 2007 and 9.7% in 2014, to 13.9% in 2023/4.
- **The proportion of adults screening positive for ADHD varied between groups** and was higher among younger adults, those not in employment, and adults with problem debt: 28.1% of adults experiencing problem debt screened positive for ADHD, compared with 12.7% of those with no problem debt.
- **Over a third of adults with a common mental health condition (CMHC) screened positive for ADHD**. Those with a CMHC were five times more likely to screen positive for ADHD (38.5%) than adults without a CMHC (7.2%).

9.1 Introduction

Attention deficit hyperactivity disorder (ADHD) is widely recognised as a complex neurodevelopmental disorder in childhood. It is marked by a 'persistent pattern (at least six months) of inattention and/or hyperactivity-impulsivity that has a direct negative impact in more than one setting on academic, occupational, or social functioning' (ICD-11; World Health Organization 2019). The eleventh revision of the International Classification of Diseases (ICD-11) identifies more indicative symptoms but is less prescriptive about diagnostic thresholds and allows milder presentations than the tenth version (ICD-10), which brings it more in line with the definition and criteria for ADHD in the fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association 2013; Gomez et al. 2023).

A recent meta-analysis estimated the prevalence of childhood ADHD (in children aged 3 to 12 years) as 7.6% and adolescent ADHD (young people aged 12 to 18 years) as 5.6%

(Salari et al. 2023). The persistence of ADHD into adulthood has only gained significant recognition – and become a focus for research and clinical management – over the past two decades (Nutt et al. 2007). The National Institute for Health and Care Excellence (NICE) reviewed the diagnostic construct of ADHD across the lifespan and concluded that when ADHD persists into adulthood, it is often associated with significant impairment (NICE 2018, updated 2019 (Link: https://www.nice.org.uk/guidance/ng87)). A meta-analysis focused on adults estimated the prevalence of persistent adult ADHD (with childhood onset) as 2.58% and symptomatic adult ADHD (regardless of childhood onset) as 6.76%, translating to 139.84 million and 366.33 million affected adults in 2020 globally (Song et al. 2021). The prevalence of both were found to decrease with advancing age.

Adults with ADHD tend to have fewer academic qualifications, probably because of difficulties with distractibility and restlessness, as well as problems with organising time, prioritising tasks and meeting deadlines (Nutt et al. 2007). Academic achievement and performance, however, can be improved with intervention (Arnold et al. 2020). APMS 2007 provided the first epidemiological data on the prevalence of ADHD characteristics in the adult population in England. Findings from APMS 2007 and 2014 found that screening positive for ADHD varied by relationship and household circumstances, and was more prevalent among those who were unemployed, in receipt of out-of-work benefits, or who had substance misuse disorders (McManus et al. 2009 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-in-england-2007-results-of-a-household-survey); McManus et al. 2016 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014)). 12% of treatment-seeking patients with substance abuse disorders (van de Glind et al. 2014) and 31% of ex-prisoners (Bebbington et al. 2021) have been found to screen positive for ADHD. It is associated with increased rates of criminal convictions (Lichtenstein et al. 2012), transport accidents (Chang et al. 2014), early mortality (Dalsgaard et al. 2015) and suicidal behaviour (Forte et al. 2020; Balazs et al. 2017). Additional costs to society may be incurred through absenteeism, reduced productivity and poorer work performance (Kessler et al. 2005a).

Findings from the 2007 and 2014 surveys indicated strong associations between screening positive for ADHD and other mental health conditions (McManus et al. 2009 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-in-england-2007-results-of-a-household-survey); McManus et al. 2016 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014)). Substantial increased risk for a range of other secondary

mental health conditions has been found in people with ADHD (Nigg et al. 2020). These include meeting criteria for personality disorders, particularly those characterised by emotional instability such as antisocial personality disorder and borderline personality disorder. ADHD symptoms also commonly co-occur with other neurodevelopmental disorders such as autism and intellectual (learning) disability, and specific learning difficulties (Rong et al. 2021). This may result in additional or alternative diagnoses (Nutt et al. 2007; Asherson et al. 2022). ADHD in adults may also go unrecognised or be misdiagnosed by mental health professionals (Asherson 2005; Asherson et al. 2022) given that some characteristic features of ADHD are also seen in other psychiatric conditions, such as the disrupted concentration or agitation that can occur with depression, bipolar disorder, and generalized anxiety disorder (Choi et al. 2022; Milberger et al. 1995). If ADHD in adulthood is unrecognised due to comorbidity, service provision and treatment of other comorbid mental health conditions may be ineffective. Undiagnosed adults with ADHD have been found to experience worse general health than their diagnosed peers (Able et al. 2007).

Timely detection and treatment may moderate risks and improve outcomes in individuals diagnosed with ADHD (Shaw et al. 2012). Service provision and treatment for ADHD in childhood is now well established, but is much less available for adults with the condition including those seeking a diagnosis in adulthood (Smith et al. 2024; Price et al. 2024). In 2024, NHS England launched a new ADHD taskforce, bringing together expertise from across a range of sectors, including health, education and justice, to better understand the challenges affecting those with ADHD and help provide a joined-up approach in response to concerns around rising demand for services. ADHD was the second most viewed health condition on the NHS website in 2023, after COVID-19, with 4.3 million page views over the course of the year (NHS England 2024 (Link: https://www.england.nhs.uk/2024/03/nhs-to-launch-cross-sector-adhd-taskforce-to-boost-care-for-patients-in-england/)).

Information about the prevalence of screening positive for possible ADHD and the use of mental health services by adults presenting with characteristic features of ADHD in the population is essential for planning improvements in diagnosis and service provision. This chapter describes the general population distribution of characteristic behavioural symptoms associated with ADHD and changes over time, examines their association with age, gender, and sociodemographic characteristics, and profiles the use of mental health treatment and services.

9.2 Definitions and assessments

Attention deficit hyperactivity disorder (ADHD)

ADHD is a neurodevelopmental disorder described by ICD-11 (World Health Organization

(WHO) 2019 (Link: https://icd.who.int/en/)) as being characterised by a persistent pattern (at least 6 months) of inattention and/or hyperactivity-impulsivity that has a direct negative impact on academic, occupational, or social functioning. The role of ancillary characteristics has been highlighted in recent years; these include emotional dysregulation, sleep onset insomnia and problems with the self-regulation of behaviour (Asherson et al. 2016). While these are not used to define ADHD, they are commonly seen in the condition and often lead to impairment. They are also seen in other mental disorders.

The relevant sets of diagnostic criteria are the World Health Organization's (WHO) official International Classification of Diseases (ICD) 10th and 11th Revision (WHO 1993, 2019 (Link: https://icd.who.int/en/)) and the Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5) of the American Psychiatric Association (APA 2013; Gomez et al. 2023). The ICD-10 has used a more restricted set of criteria, for hyperkinetic disorder when all three characteristics of inattention, hyperactivity and impulsivity must be present and lead to impairment across multiple domains (such as home and work). The narrowness of this definition has been seen as a limitation, as it did not identify people with all the features of adult ADHD if the criteria for other conditions are also met and will only detect the most severe cases. On the other hand, given the severity of ICD-10 hyperkinetic disorder, people meeting these criteria represent a clear priority for service providers. DSM-5 in contrast sets out a broader definition of the disorder and allows the presence both of comorbid disorders and of impairing symptoms in the inattentive or hyperactive-impulsive domains. This approach might therefore be seen as overidentifying ADHD in individuals who are primarily suffering from other disorders (Nutt et al. 2007). The ICD-11 provided an update on the diagnostic guidelines for ADHD and this is more aligned with DSM-5 (WHO 2019 (Link: https://icd.who.int/en/); Gomez et al. 2023). Despite changes in diagnostic systems, the way in which ADHD characteristics have been measured on APMS since 2007 has remained consistent.

Adult ADHD Self-Report Scale-v1.1 (ASRS)

The Adult ADHD Self-Report Scale (ASRS), developed in collaboration with the WHO, has been used on APMS 2007, 2014 and 2023/4 to estimate the prevalence of possible ADHD (WHO 2003). The scale is referred to in this chapter as a screening test for reasons of convention, although it is not currently recommended as part of an official screening programme in England.

The ASRS is based on the WHO Composite International Diagnostic Interview (2003), and the questions are consistent with both DSM-IV and DSM-5-TR criteria (APA 1994, 2013) specifically worded to reflect symptom manifestation in adults (Kessler et al. 2005b).The six-item ASRS is a shortened version of the 18-item Symptom Checklist scale, which measures the frequency of recent symptoms of adult ADHD. This short screen appears to out-perform the full 18-question ASRS in terms of sensitivity (68.7% versus 56.3%), specificity (99.5% versus 98.3%), and total classification accuracy (97.9% versus 96.2%) (Kessler et al. 2007). Its use and validity have been established predominantly in

community samples, although it has been suggested that the scale could also prove to be a useful complement to more accurate clinical diagnostic assessments (Kessler 2005b). However, it may lack sufficient predictive validity in some populations, such as those with substance use disorders (van de Glind et al. 2013).

The ASRS screen was administered face-to-face to all participants. The six questions assess the ADHD characteristics of inattention, hyperactivity and impulsivity during the six months prior to interview. Participants were asked to rate the frequency of these characteristics using a five-point response scale: 'never', 'rarely', 'sometimes', 'often' and 'very often'. In this chapter we report 1) the proportion of adults reporting four or more characteristics at or above the specified frequency threshold described below, and 2) the proportion reporting all six characteristics. The four-item threshold is the threshold recommended for indicating a need for a clinical assessment for ADHD (Fayyad et al. 2007). However, the developers of the scale also emphasise that the higher the score the more likely it is that ADHD is present, and for this reason we also show the proportion of the sample meeting the threshold frequency for all six items. This reveals subgroups with the greatest likelihood of a positive diagnosis at clinical assessment.

The questions in the ASRS scale used to screen for possible adult ADHD and the threshold frequencies are displayed below.

Adult Self-Report Scale-v1.1 (ASRS-V1.1) Screen

Thinking about now and the past six months…	***Responses indicating symptom is significant***
… how often do you have trouble wrapping up the fine details of a project, once the challenging parts have been done?	Sometimes, often, very often
… how often do you have difficulty getting things in order when you have to do a task that requires organisation?	Sometimes, often, very often
… how often do you have problems remembering appointments or things you have agreed to do?	Sometimes, often, very often
… when you have a task that requires a lot of thought, how often do you avoid or delay getting started?	Often, very often
… how often do you fidget or squirm with your hands or your feet when you have to sit down for a long time?	Often, very often
… how often do you feel overly active and compelled to do things, like you were driven by a motor?	Often, very often

Although the ASRS screen shows strong concordance with clinical diagnosis in US population surveys (Adler et al. 2019), caution is required in interpreting ASRS-based findings. First, self-reported information is always subject to some social desirability biases (Greenfield et al. 2001). Second, adults may under-report their ADHD symptoms in comparison to informant observations (Abrams et al. 2018; Cheung et al. 2016; Moffitt et al. 2015). Third, the age of onset, the level of impairment resulting from the symptoms of hyperactivity and inattention, and the degree of pervasiveness across situations such as home and work are criteria informing the diagnosis of ADHD, and the ASRS does not include an assessment of these.

It is important to note that for the purposes of this chapter, scoring four or more on the ASRS is counted as a 'positive screen for ADHD' (Dunlop et al. 2018). Proportions are also presented for those who endorsed all six items on the ASRS. Screening positive for ADHD (with a score of four or more) indicates that an individual has sufficient symptoms to warrant a further and more detailed ADHD assessment. The prevalence of ADHD is likely to be considerably lower than the proportion screening positive for ADHD.

9.3 Results

Screening positive for ADHD in past 6 months, by age and gender

One in seven (13.9%) adults scored four or more on the ASRS screen, the threshold at which clinical assessment for ADHD may be warranted. If all adults in the household population had been screened it is likely (95% confidence) that the proportion screening positive would be between 12.8% and 15.1%. This equates to an estimated 6.5 million adults in England. The proportion reporting all six characteristics was one in fifty (1.9%). Women were more likely than men to screen positive for ADHD; 14.9% (95% CI 13.5, 16.4) of women and 12.4% (CI 10.8, 14.2) of men scored four or more on the ASRS.

The proportion of adults screening positive for ADHD broadly decreased with age. This was true for both women and men. The proportion was highest among adults aged 16 to 24 (25.0%, CI 20.4, 30.2), and lowest among those aged 75 and over (3.7%, 2.5, 5.5).

For more information: Table 9.1 and Table A1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals.

Screening positive for ADHD (scoring four or more on the ASRS), by age (Base: All adults)

Download the data for this chart Screening positive for ADHD (scoring four or

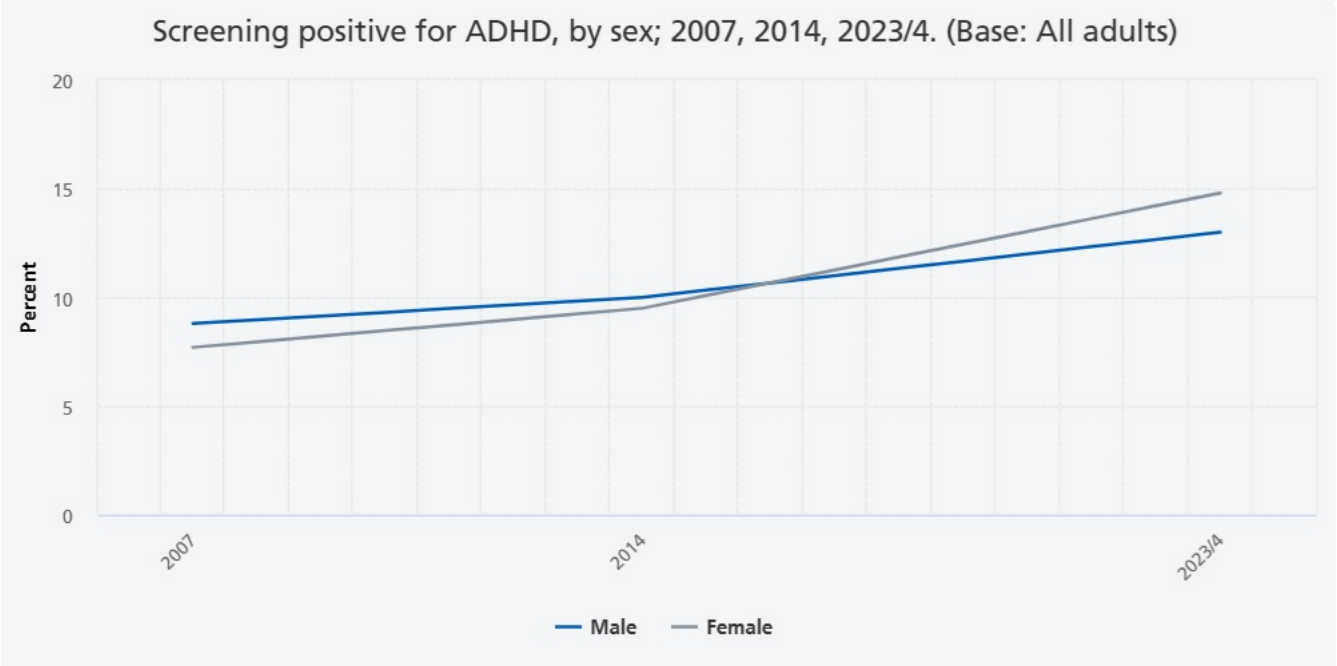
more on the ASRS), by age (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/attention-deficit-hyperactivity-disorder/attention-deficit-hyperactivity-disorder/publicationsystem%3AbodySections%5B7%5D/publicationsystem%3AdataFile)

Trends in screening positive for ADHD, 2007, 2014 and 2023/4

Note that the trend data analyses were carried out by sex (male and female) rather than gender (men and women) to allow for comparison back to 2007. See How to interpret the findings (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/how-to-interpret-the-findings) for information on how changes over time were assessed.

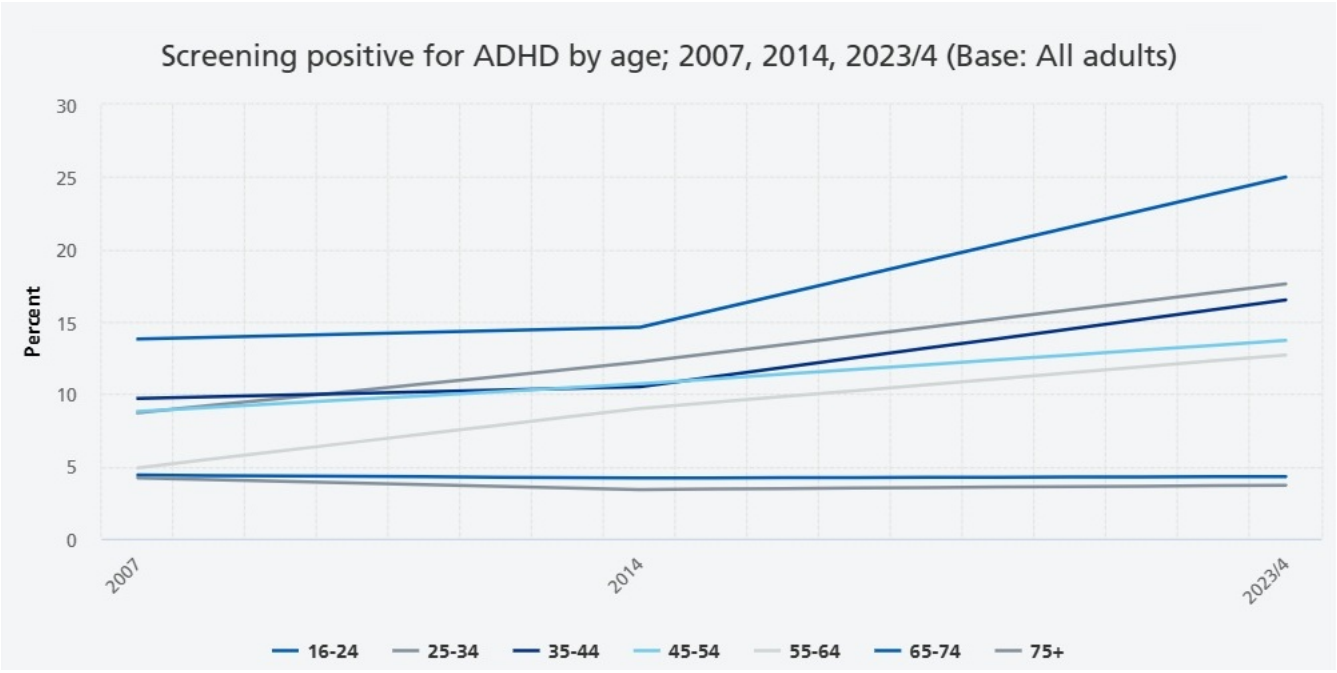
There has been an increase in the prevalence of adults screening positive for ADHD over time. The proportion of adults scoring four or more on the ASRS rose from 8.2% in 2007 and 9.7% in 2014, to 13.9% in 2023/4 (95% CIs: 2007: 7.6, 8.9; 2014: 8.9, 10.6; 2023/4: 12.8, 15.2).

The increase over time was evident in both males (8.8% in 2007, CI 7.8, 9.8; 10.0% in 2014, CI 8.8, 11.4; 13.0% in 2023/4, CI 11.3, 14.9) and females (7.7% in 2007, CI 6.8, 8.7; 9.5% in 2014, CI 8.5, 10.5; 14.8% in 2023/4, CI 13.4, 16.4).



All age groups under 65 increased in prevalence of screening positive for ADHD between 2007 and 2023/4, while no increase over time was evident for those aged 65 and over.

For more information: Table 9.2 and Table B1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals.



Variation in screening positive for ADHD by other characteristics

Ethnic group

There were differences between ethnic groups in age-standardised prevalence of screening positive for ADHD. Those identifying as White British were most likely to score four or more on the ASRS (16.2%, 95% CI 14.8, 17.8), and those identifying as Asian/ Asian British were least likely to screen positive (7.5%, CI 4.8, 11.4). It should be noted that the confidence intervals for some estimates were wide and overlapping, so apparent differences between ethnic groups should be treated with caution.

For more information: Table 9.3 and Table A2 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals.

Screening positive for ADHD, by ethnic group (age-standardsised) (Base: All adults)

Download the data for this chart Screening positive for ADHD, by ethnic group

(age-standardsised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/attention-deficit-hyperactivity-disorder/attention-deficit-hyperactivity-disorder/publicationsystem%3AbodySections%5B13%5D/publicationsystem%3AdataFile)

Employment status

Screening positive for ADHD varied by employment status in age-standardised analyses. Working-age adults (aged 16 to 64) who were unemployed (29.6%) or economically inactive (26.1%) were more likely to screen positive than those in employment (14.1%).

For more information: Table 9.4 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Screening positive for ADHD, by employment status (age-standardised) (Base: Adults aged 16-64)

Download the data for this chart Screening positive for ADHD, by employment status (age-standardised) (Base: Adults aged 16-64) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/attention-deficit-hyperactivity-disorder/attention-deficit-hyperactivity-disorder/publicationsystem%3AbodySections%5B15%5D/publicationsystem%3AdataFile)

Problem debt

Adults reporting being seriously behind on at least one debt repayment or having their utilities cut off were more likely to screen positive for ADHD (age-standardised). 28.1% of adults with problem debt scored four or more on the ASRS, compared with 12.7% of those without problem debt. See the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods) for more information on how problem debt was derived.

For more information: Table 9.5 (Link: /data-and-information/publications/

statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Screening positive for ADHD, by problem debt (age standardised) (Base: All adults)

Download the data for this chart Screening positive for ADHD, by problem debt (age standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/attention-deficit-hyperactivity-disorder/attention-deficit-hyperactivity-disorder/publicationsystem%3AbodySections%5B17%5D/publicationsystem%3AdataFile)

Area-level deprivation

How has deprivation been defined?

Area-level deprivation has been defined using the English Indices of Deprivation 2019, commonly known as the Index of Multiple Deprivation (IMD).

IMD is the official measure of relative deprivation for Lower Super Output Areas (LSOAs) in England. LSOAs comprise between 400 and 1,200 households and usually have a resident population between 1,000 and 3,000 persons. IMD ranks every LSOA in England from 1 (most deprived area) to 32,844 (least deprived area). Deprivation quintiles are calculated by ranking the 32,844 neighbourhoods in England from most deprived to least deprived and dividing them into five equal groups. These range from the most deprived 20% of neighbourhoods nationally to the least deprived 20% of neighbourhoods nationally.

For further information see: English indices of deprivation 2019 (Link: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019)

Screening positive for ADHD did not vary significantly by area-level deprivation.

For more information: Table 9.6 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Region

Prevalence of screening positive for ADHD did not vary significantly across regions.

For more information: Table 9.7 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Comorbidity

Physical health conditions

How have physical health conditions been defined?

Participants were asked if they had any of 25 physical health conditions listed on a card, including asthma, cancer, diabetes, epilepsy and high blood pressure. Participants were coded as having a limiting physical health condition, if they reported having one or more physical health conditions in the past 12 months that had been diagnosed by a doctor and that this had limited their ability to carry out day-to-day activities. More details on the questions on physical health conditions can be found in the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

Adults with a limiting physical health condition were more likely to screen positive for ADHD than adults without a limiting physical health condition. 21.2% of adults with a limiting physical health condition scored four or more on the ASRS compared with 10.2% of adults without a limiting physical health condition.

For more information: Table 9.8 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Screening postive for ADHD, by limiting physical health condition (age-standardised) (Base: All adults)

Download the data for this chart Screening postive for ADHD, by limiting physical health condition (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-

psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/attention-deficit-hyperactivity-disorder/attention-deficit-hyperactivity-disorder/publicationsystem%3AbodySections%5B23%5D/publicationsystem%3AdataFile)

Common mental health conditions

How have common mental health conditions been defined?

The revised Clinical Interview Schedule (CIS-R) was used to assess six types of common mental health conditions (CMHC): depression, generalised anxiety disorder, panic disorder, phobias, obsessive compulsive disorder, and CMHC not otherwise specified. Participants identified with at least one of these were defined as having a CMHC. See Section 1.2 of the Common mental health conditions chapter (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/common-mental-health-conditions#1-2-definitions-and-assessments) for more detail.

More than one in three (38.5%) adults with a common mental health condition (CMHC) screened positive for ADHD. Those with a CMHC were five times more likely to screen positive for ADHD than adults without a CMHC (38.5% and 7.2% respectively).

For more information: Table 9.8 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Self-diagnosis and professional diagnosis of ADHD

Participants were asked whether they thought they had ever had ADHD and, if so, whether they had been diagnosed by a professional. If participants reported they had been diagnosed, they were asked if they had symptoms in the past 12 months.

One in twenty (5.8%) adults reported they thought they had ADHD, 1.8% of adults reported that they had been diagnosed with ADHD by a professional, and 1.5% of adults reported they also had symptoms present in the past 12 months.

Men (5.8%) and women (5.5%) were equally likely to think they have had ADHD, to have had ADHD diagnosed by a professional (men 1.7%, women 1.7%), and to have had symptoms present in the past 12 months (men 1.4%, women 1.4%).

Among people scoring four or more on the ASRS, one in four (27.1%) reported that they thought they had ADHD. Among those scoring six on the ASRS, 55.9% reported that they thought they had ADHD, compared with 2.3% of adults with a score of 0 to 3.

Adults scoring four or more (9.6%) or six (27.1%) on the ASRS were also more likely to report having received a professional diagnosis for ADHD than those who did not screen positive for ADHD (0.5%).

For more information: Table 9.9 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Self-diagnosed and professional diagnosed ADHD, by ASRS score (Base: All adults)

Download the data for this chart Self-diagnosed and professional diagnosed ADHD, by ASRS score (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/attention-deficit-hyperactivity-disorder/attention-deficit-hyperactivity-disorder/publicationsystem%3AbodySections%5B27%5D/publicationsystem%3AdataFile)

Treatment

Treatment and service use

Participants were asked about different types of mental health treatment and service use. Two types of mental health treatment were asked about: current medication and psychological therapy for a mental or emotional problem. A range of health, community and day care services over the past year were also asked about. This treatment and service use could have been for any mental health condition, not necessarily ADHD.

Most (62.2%) adults scoring four or more on the ASRS, and half (51.1%) of those scoring six, reported that they were not currently receiving any treatment for a mental or emotional problem. Where adults screening positive for ADHD did receive treatment, this was more likely to be medication (31.5%) than psychological therapy (12.3%).

Treatment currently received for a mental or emotional problem, by ASRS score (Base: All adults)

Download the data for this chart Treatment currently received for a mental or

emotional problem, by ASRS score (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/attention-deficit-hyperactivity-disorder/attention-deficit-hyperactivity-disorder/publicationsystem%3AbodySections%5B29%5D/publicationsystem%3AdataFile)

A third (34.7%) of adults screening positive for ADHD reported using health care services for a mental or emotional problem, compared with one in ten (10.1%) adults who did not screen positive for ADHD.

A fifth (19.3%) of adults screening positive for ADHD used community care services in the past year, and 7.1% used day care services, compared with 5.7% and 3.3% of those scoring 0 to 3 on the ASRS, respectively.

For more information: Table 9.10 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Psychotropic medication

Participants were asked which psychotropic medications (used to treat mental health related symptoms and conditions) they currently take (not necessarily for symptoms relating to ADHD). The most common medication types reported were those primarily used to treat depression (11.7%) and anxiety (10.7%). See Chapter 2 Mental health treatment and service use (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/mental-health-treatment-and-service-use) for more details. For further information about how medication data was collected, see the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

The most frequently reported types of psychotropic medication taken by adults screening positive for ADHD were those for depression (28.7%) and anxiety (25.5%).

2.6% of adults who scored four or more on the ASRS, and 8.0% of adults who scored six, were currently taking medication specifically indicated for ADHD (Amfexa, atomoxetine, Concerta XL, Delmosart, dexamfetamine, Medikinet, methylphenidate, Tranquilyn, Xaggitin XL or Xenidate XL). However, it is possible that some participants may have been taking an ADHD medication not asked about, may have taken an ADHD medication

in the past, or could be currently taking ADHD medication and not reported it (either because they chose to withhold this information or because they were unaware). Among those screening negative for ADHD, 0.0% reported taking ADHD medication.

For more information: Table 9.11 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

9.4 Discussion

The APMS provides unique data on possible ADHD among adults in England. This chapter presents results on the prevalence of possible ADHD as measured by the six-item ASRS screen used in the 2007, 2014 and 2023/4 APMS. The ASRS does not take account of whether the symptoms persist across different aspects of a person's life, nor how impairing the symptoms are. Despite these limitations, the APMS findings are valuable in identifying the population distribution of characteristics associated with possible ADHD and provide comparable data spanning almost two decades. The results presented in this chapter indicate that there have been shifts in prevalence, recognition, service response, and in the characteristics of adults screening positive.

The proportion of adults screening positive for ADHD has increased. There has been an increase this decade in the proportion of adults in England screening positive for possible ADHD as indicated by reporting four or more of the items on the ASRS. This rose from one in ten in 2014 to one in seven in 2023/4. There may be reasons other than an increase in ADHD for why an increase in screening positive on the ASRS has been found. For example, reduced stigma related to neurodevelopmental conditions such as ADHD might contribute to an increased likelihood that people feel able to report symptoms (Speerforck et al. 2019). It is also possible that increased awareness of ADHD characteristics might have led to a change in recognition and reporting. Further, the 2023/4 APMS had a lower response rate than the previous surveys in the series, and there may have been changes in the profile of the sample that participated.

People have become more likely to think that they have ADHD. The results in this chapter show that adults have become more likely to think that they have ADHD. In the 2023/4 survey, among those screening positive on the ASRS, over one in four thought they had ADHD. While in the 2014 survey, this had been one in twenty-five (Brugha et al. 2016). This suggests there may have been a shift this decade in awareness and recognition of the condition among adults in England.

Professionals appear to be more likely to diagnose and treat ADHD. The findings suggest that there has also been an increase in professional diagnosis of ADHD. In the 2023/4 survey, among people screening positive on the ASRS, one in ten had an ADHD diagnosis from a health professional. The comparable figure from the 2014 survey was one in forty. Alongside the increased recognition by health professionals, those screening positive for

ADHD were also more likely to be in receipt of ADHD medication. In the 2023/4 survey, 2.6% were being prescribed medication for ADHD, five times the rate reporting this in 2014 (0.5%) (Brugha et al. 2016). Note that the method of collecting medications data was revised in 2023/4 (see APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods)). However, the results in this chapter indicate that very few adults who screened negative for ADHD thought that they might have it, very few of those in turn had ever been diagnosed by a professional with ADHD, and almost none of them were taking ADHD medication.

The changes are consistent with a picture of increased demand for treatment and services for people with ADHD symptoms. People screening positive for ADHD were more likely than those screening negative to get mental health treatment in general. This may reflect the fact that adults screening positive for ADHD often have comorbid diagnoses of other psychiatric conditions; in 2023/4 more than one in three adults screening positive for ADHD were also identified with a common mental health condition such as depression or an anxiety disorder. Alternatively, their ADHD characteristics may be misdiagnosed by doctors who are not trained to recognise and treat adult ADHD. This interpretation is supported by the lower levels of ADHD medication currently being taken by participants screening positive for ADHD, compared with their higher levels of anxiolytic and antidepressant use. It is worth noting, however, that the APMS cannot be used to estimate how many adults would be likely to benefit from treatment. Progress is being made with the development of best practice advice and guidelines on care for adults with ADHD, which identifies key priorities for treatment and management of the disorder (Adamou et al. 2024; Nutt et al. 2007). These APMS findings may indicate a need for further work in improving the diagnosis and treatment of adult ADHD, both at the population level where precise screening tools need to be developed in relation to clinical assessments of the general population, and in clinical practice.

Some groups are more likely than others to screen positive for ADHD. The survey provides unique insight into the characteristics and circumstances of people screening positive for ADHD. The results confirm several established and expected associations, for example with socioeconomic disadvantage and comorbidity with other mental health conditions. Although no significant variation by area-level deprivation or region was observed, screening positive for ADHD was found to be higher in younger age groups, White British adults, the unemployed and in those with problem debt. Many factors might contribute to the higher prevalence in younger people, including adapting to symptoms over the course of life. However, one factor that has been highlighted by O'Nions and colleagues (2025) is the reduced life expectancy for people with ADHD relative to the general population; around 7 years for males and 9 years for females.

Changes in the profile of people screening positive for ADHD have emerged. In the 2007 and 2014 surveys, men and women were equally likely to screen positive for ADHD. This has also been found in community-based surveys in other parts of the world (Kessler et

al. 2006), while in 2023/4 women were more likely than men to screen positive on the ASRS. Despite the probable under recognition of ADHD by health services in girls and women, most research has found that they are indeed less likely to meet diagnostic criteria. Russell and colleagues in analysis of community cohort data found that girls with the same symptoms as boys were less likely to access services, but also more likely to be prescribed medication if they do (Russell et al. 2014). Martin and colleagues (2024) examined Welsh health survey data and found that females with ADHD tend to experience later recognition and treatment of ADHD. Their results indicate that this may be partly because of diagnostic overshadowing from other mental health conditions, such as anxiety and depression, or initial misdiagnosis.

There is a lack of survey data describing the presence of possible ADHD in the general adult population in England and the circumstances of adults with ADHD are poorly understood. The APMS series helps to address these data gaps.

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Previous Chapter
Chapter 8: Personality disorder (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/personality-disorder)

Next Chapter
Chapter 10: Autism spectrum disorder (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/autism-spectrum-disorder)

Chapter 10: Autism spectrum disorder

Official Statistic

The APMS publication has an overall statistical badging as an Accredited Official Statistic (previously National Statistic). However, this chapter was previously badged as an Official Statistic in Development but has been upgraded to an Official Statistic for this publication. Find out more about this change in classification here (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/autism-classification).

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Overview

Autism spectrum disorders (ASDs), also referred to as autism, are characterised by persistent difficulties in social interaction and communication, as well as restricted, repetitive, and inflexible patterns of behaviour, interests or activities (World Health Organization (WHO) 2023 (Link: https://www.who.int/news-room/fact-sheets/detail/autism-spectrum-disorders)).

In the phase one interview, autism was screened for using an adapted version of the 20-item Autism Spectrum Quotient (AQ-20). In the phase two interview, full examinations were carried out with a subset of participants by clinically trained interviewers using the Autism Diagnostic Observation Schedule, 2nd edition (ADOS). The ADOS results were weighted to generate a prevalence estimate for the general population.

This chapter presents data on the profile of ADOS-examined autism among adults living in private households.

Key findings

- **Prevalence of autism in adults remained stable at about one adult in a hundred**: ADOS-examined autism was present in 1.0% of adults in 2007 (95% confidence interval (CI) 0.5, 2.0), 0.7% in 2014 (CI 0.3, 1.3), and 0.9% in 2023/4 (CI 0.5, 1.7).
- **Autism was more common in males** (1.5%, CI 1.0, 2.3) than females (0.2%, CI 0.1, 0.5), and may be higher in White (0.9%, CI 0.6, 1.3) and Asian (1.0%, CI 0.2, 4.9) adults than in those from Mixed/multiple or other (0.1%, CI 0.0, 0.5) ethnic backgrounds. No autistic adults from a Black ethnic background were identified in the survey sample.
- **Living in more deprived neighbourhoods was associated with autism**. 1.8% of those in the most deprived areas were identified as autistic compared with 0.2% of those in the least deprived areas.
- **Few adults had an autism diagnosis**. Overall, 3.4% of adults thought that they were autistic and 1.2% reported that this had been diagnosed by a professional.
- **Autistic adults were no more likely to use health services for a mental health reason** or receive mental health treatment than the rest of the population.

10.1 Introduction

Being autistic can have an impact on learning, and, among those most profoundly affected, on the ability to live independently in adulthood (Howlin et al. 2004). Autistic

adults often experience isolation and adverse experiences such as being bullied and socially excluded (Brugha et al. 2016b). Furthermore, diagnosed autistic people have been found to have higher rates of a wide range of common mental and physical illnesses compared with the general population (Croen et al. 2015; Lai et al. 2019).

The lifetime cost of supporting an individual diagnosed as autistic without intellectual disability was estimated in 2014 as £0.92 million in the United Kingdom and higher for those with intellectual disability. Residential care, supportive living accommodation and individual productivity loss contribute the highest costs for autistic adults with intellectual disability (Buescher et al. 2014). However, people based in these care settings, as well as, for example, those in prison or homeless, are not included in the APMS. Quantifying such costs requires reliable estimates of the number of adults with the condition, and the proportion who have a diagnosis. APMS 2007 was the first general population probability sample survey to produce such estimates using an examination for autism in a large representative sample of adults living in private households (Brugha et al. 2009 (Link: https://files.digital.nhs.uk/publicationimport/pub02xxx/pub02931/adul-psyc-morb-res-hou-sur-eng-2007-rep-v2.pdf)). The 2007 and 2014 APMS estimated the prevalence of autism in England to be about one in a hundred. The 2021 Global Burden of Disease study found a similar prevalence of about one in every 127 people, with an estimated 61.8 million autistic people globally in 2021 (Santomauro et al. 2025).

Data from the APMS series is consistent with prevalence being higher in men than women, in adults without educational qualifications (Brugha et al. 2016a (Link: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014)) or living in rented social housing (Brugha et al. 2011), and in those with epilepsy (Rai et al. 2012). Autism is also known to be strongly associated with intellectual disability (Cooper et al. 2007), particularly among those with moderate to profound intellectual disability (Brugha et al. 2016b). The 2007 APMS was extended to cover a sample of people with intellectual disability, including some living in residential settings, and found the prevalence of autism to be substantially higher (7.5%) in this group (Brugha et al. 2016b). While circumstances for autistic adults continue to be under-researched (Tromans et al. 2024), including research involving older autistic people (Mason et al. 2022), the condition clearly has a significant impact across the life course, with adults with autistic traits experiencing barriers to accessing healthcare (Tromans et al. 2024) and found to be significantly over-represented in those who die by suicide (Cassidy et al. 2022). Among diagnosed autistic people, higher rates of a range of common mental and physical health conditions have been reported (Croen et al. 2015; Lai et al. 2019), however the burden of these conditions among undiagnosed autistic people is largely unknown outside of the present work.

Autism was also assessed, using the Development and Wellbeing Assessment (DAWBA), in the 2004 and 2017 Mental Health of Children and Young People Surveys (MHCYP).

Similar to the APMS estimate of prevalence in adults, MHCYP identified autism in 1.2% of 5 to 19 year olds and found it to be more common in boys (1.9%) than girls (0.4%) (Marcheselli et al. 2018 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017)). It is often easier to involve autistic children in research, in part because the diagnosis of autism should include presence of autistic features in childhood and parent and teacher observations of this are more likely to be accurate and available for this group. Both parent and teacher observations were collected in MHCYP.

There is a widespread consensus that the proportion of people who are diagnosed with autism is increasing (O'Nions et al. 2023; Russell et al. 2022). However, evidence suggests that the prevalence of autism has remained stable. In England, the prevalence of autism on the survey of Mental Health of Children and Young People was 1.2% in 5 to 19 year olds (Marcheselli et al. 2018 (Link: http://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017)) and was similar to one in a hundred identified in APMS 2007 and 2014 for adults of all ages and both studies noted stability in prevalence over time. These findings were also comparable with rates found by the Avon Longitudinal Study of Parents and Children and the Millennium Cohort Study (Brugha et al. 2016b). It is likely that increases in diagnosed cases are due to changes in public and professional awareness of the condition, different diagnostic definitions and practices, availability of services and referrals, and earlier age at diagnosis (Fombonne 2009; Russell et al. 2015; Brugha et al. 2018). Additionally, increased autism diagnosis in women and adults could be a contributing factor (Russell et al. 2022). Although increased autism prevalence cannot be ruled out (Rutter 2005; Lord et al. 2020), Lundström and colleagues concluded that this is unlikely to be a driving factor in the increase of diagnosed cases in children (Lundström et al. 2015). Evidence suggests that most autistic adults in England are undiagnosed, particularly among women and in older age groups, with one population-based cohort study concluding that over 90% of autistic people aged 50 years or older were undiagnosed (O'Nions et al. 2023).

Under the 2009 Autism Act (Link: https://www.legislation.gov.uk/ukpga/2009/15/contents), local authorities and NHS organisations gained new responsibilities to develop services to support autistic people, and their families and carers. Since then, the National Institute for Health and Care Excellence (NICE) published guidelines on diagnosis and management of autism in adults (NICE 2012, updated 2021 (Link: https://www.nice.org.uk/guidance/cg142)). The Autism Self-Assessment Framework survey of local authorities throughout England reported that autism assessment services were available in all areas, but that waiting times were increasing beyond the NICE recommended limit of three months (Public Health England 2017, updated 2019 (Link: https://www.gov.uk/government/publications/autism-self-assessment-

framework-exercise)). New government funding for autistic children, young people and adults was announced for the period 2021-2026 with almost £75 million allocated in the first year in England (Department of Health and Social Care and Department for Education 2021 (Link: https://www.gov.uk/government/publications/national-strategy-for-autistic-children-young-people-and-adults-2021-to-2026)).

Psychosocial interventions and autism psychoeducation are recommended for core features of autism and for developing life skills, but evidence for their benefits is needed (Lord et al. 2020). Large scale randomised controlled trials of treatment of anxiety (STRATA) (Rai et al. 2024) and of depression (ADEPT-2) in autistic adults are due to report soon (McKeon et al. 2024). For autistic adults without a learning disability or with a mild learning disability and who are having difficulty obtaining or maintaining employment, NICE recommends considering an individual supported employment programme (NICE 2012, updated 2021 (Link: https://www.nice.org.uk/guidance/cg142)).

10.2 Definitions and assessments

Autism

The concept of autism gained recognition in the mid-20th century and is still evolving (Frith 1991; Silberman 2015; Lord et al. 2020). It remains unclear whether autism comprises one condition or a range of similar inter-related neurodevelopmental conditions, with separate subtypes. Experts have achieved a broad consensus on what constitutes the category of autism, and diagnostic guidance set out in the fourth and fifth Diagnostic and Statistical Manual (DSM-IV and -5) (APA 1994; 2013) and the World Health Organization (WHO) International Classification of Diseases (ICD-10 and ICD-11) (WHO 1993, 2019 (Link: https://icd.who.int/en/), 2024 (Link: https://www.who.int/publications/b/68103)) are similar. Both systems require information on early childhood development and significant impact on functioning for diagnosis.

Assessment of autism

Case assessment of autism

In surveys of autism in childhood, information on behaviour and development is collected from parents and teachers. For adults, the ideal scenario would involve assessments of directly observed current behaviour and information on both early development and on current day to day functioning over an extended period. This is not a practical option for a large general population survey of adults. Therefore, the assessment process used on APMS 2007, and replicated on APMS 2014 and APMS 2023/4, was based on a combination of self-report screening data collected at the phase one interview and a semi-structured examination carried out by a clinically trained research

interviewer at the phase two interview (Brugha et al. 2009 (Link: https://files.digital.nhs.uk/publicationimport/pub02xxx/pub02931/adul-psyc-morb-res-hou-sur-eng-2007-rep-v2.pdf)). This multi-stage case assessment for autism is similar in structure to that used in the APMS series since 1993 for the assessment of psychotic disorders.

The process used in APMS since 2007 involves a detailed validation assessment (Brugha et al. 2011). It included the following stages:

A. Phase one AQ-20 self-completion questionnaire

B. Selection of cases for phase two assessment

C. Phase two ADOS examination of a subset of selected adults

D. Weighting to adjust for selection probabilities and non-response.

This approach has undergone an extensive programme of validation work at the University of Leicester supported by the NHS and Department of Health and Social Care (Brugha et al. 2009 (Link: https://files.digital.nhs.uk/publicationimport/pub02xxx/pub02931/adul-psyc-morb-res-hou-sur-eng-2007-rep-v2.pdf); 2011; 2012; 2016a (Link: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014)). The validation programme involved calibration of the ADOS with other research instruments for autism assessment; interviews with participants' parents and other family members; comparison with further data collected from community, learning impairment, and patient samples; consensus ratings of participant vignettes with autism practitioners; and engagement with psychiatrists and epidemiologists with expertise in this field. The validation of the APMS process for identifying autism has been more extensive than that of other conditions covered on the survey.

A. Phase one screening: Autism Spectrum Quotient

The full Autism Spectrum Quotient (AQ-50) is one of few fully structured questionnaires designed to fulfill the aim of screening for possible autism in adult participants (Baron-Cohen et al. 2001). The AQ-50 was reported in clinical populations to have good correspondence with a full autism diagnosis (Baron-Cohen et al. 2001). Other available validated questionnaires tend to be longer (Constantino et al. 2003; Ritvo et al. 2008). A clinical diagnosis cannot be derived from the AQ-50 - it is a test designed to identify potential underlying autistic traits.

The full AQ consists of 50 items. To minimise participant burden on the already long APMS 2007 questionnaire, a shorter 20 item version was derived using data collected by two of the AQ authors in the development of the full schedule. Details of the modelling

undertaken to select the best subset of items are given in a separate technical report (Brugha et al. 2011). The AQ-50 questionnaire is composed of items designed to assess five broad dimensions: social functioning, imagination, communication, attention switching and attention to detail. The 20 adopted items selected by the modelling procedure as the best predictors of a positive autism assessment spread quite evenly across these categories: six were social functioning items; four, communication; four, attention to detail; three, attention switching; and three, imagination. The AQ-20 was discussed by an expert panel and tested in the cognitive pilot conducted as part of the APMS 2007 development work. Further modelling took place using a random sample of adults in contact with mental health services. This identified the 17 most predictive AQ items used in the 2007 survey, these were retained and three (which had performed poorly in the 2007 data) were replaced with items with improved prediction selected from the original AQ-50 (Tyrer et al. 2013). The revised 20 item version of the AQ is reproduced in full in the questionnaire in Appendix D of the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

A score was generated for each participant based on their responses to the 17 AQ items included in both the 2007 and 2014 surveys. Each response indicative of autism was given one point, so that a higher score indicated greater likelihood that the person may be autistic. The AQ-20 is a self-completion questionnaire, and it was administered via a laptop in the phase one interview. Because AQ-20 is a brief test and not a diagnostic measure, a clinical examination was included in the phase two interview. On APMS, the AQ was used only to exclude participants with an extremely low likelihood of being autistic (those with an AQ-20 score of between zero and three) and to inform the selection probabilities for phase two. It was not used to positively identify autism.

B. Selection of cases for phase two assessment

To produce estimates of the prevalence of autism amongst adults living in private households in England, a two-phase approach was adopted consisting of a phase one screen followed by a phase two clinical examination for a subset of participants, described in the APMS 2023/4 Methods chapter (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

Participants were selected for phase two based on their phase one responses and agreement to be contacted by the University of Leicester, who conducted the phase two examination. Those with a higher AQ score had a higher chance of being selected. In APMS 2014 the selection probabilities were based on participants' AQ score and whether they were male or female. In APMS 2023/4 the same autism sampling fractions were applied to both male and female participants, to ensure that a sufficient number of women were examined.

In summary:

- No participants with an **AQ score of 0 to 3** were selected for a phase two ADOS examination.
- A subsample of participants (16%) with an **AQ score between 4 and 7** were selected for phase two.

All participants with an **AQ score of 8 or more** were selected for phase two. It was not feasible for all phase one participants to have a phase two assessment, and this approach was designed so that those predicted to have the highest likelihood of being autistic had the highest likelihood of being assessed, combined with having a large enough sample size to be able to generate estimated rates of autism for the population as a whole.

C. Phase 2 assessment: Autism Diagnostic Observation Schedule (ADOS) 4

The second phase examinations were carried out by clinically trained research interviewers from the University of Leicester. The assessment of conditions such as autism required a more flexible interview than was possible at the first phase, and the use of judgement in rating clinical criteria for diagnostic classification. The Autism Diagnostic Observation Schedule (ADOS), Module 4, was completed with 884 participants at the APMS 2023/4 phase two; 628 in APMS 2014 and 618 in 2007). The ADOS is a semi-structured clinical examination of whether current behaviour is consistent with a diagnosis of autism. It is a widely recommended 'gold standard' clinical research examination instrument for autism that is used to rate information on adult functioning, which does not require involvement of an informant, which would have been impractical in an adult household survey (Lord et al. 2002).

Because the ADOS does not offer sufficient opportunity to measure restricted and repetitive behaviours, which are emphasised in DSM-5 and ICD-11, additional questions on restricted, repetitive patterns of behaviour and sensory differences were included in the phase two interview.

The ADOS and its algorithm have been validated in previous clinic-based testing, but prior to APMS 2007 they had rarely been used with older adults or in a general population setting (Gotham et al. 2008). The methods and results of a quality assurance and validation study made use of clinician ratings and developmental interviews with parents and other informants to guide severity and clinical significance thresholds (Brugha et al. 2009). That study found that the ADOS performed well, and its results have informed the case threshold used in this report. The ADOS consists of a series of tasks that evaluate communication, reciprocal social interaction (social functioning), creativity, imagination and stereotyped interests and restricted interests. These tasks are rated by a trained examiner. The ADOS ratings that correspond to autism criteria are summed to produce an overall score. The recommended threshold of 10 or more is applied in this report to indicate a case of autism, validated in the same population (Brugha et al. 2012). It is possible that using the threshold of 10, rather than 7, could potentially lead to missing some cases with less observable autism features, as discussed more fully by

Brugha et al. (Brugha et al. 2011).

D. Weighting to adjust for selection probabilities and non-response

For the designation of an autism outcome the following approach was used:

- Adults with a phase one AQ score of 4 or more who had an ADOS examination, the results of the ADOS were used.
- Adults with a phase one AQ score of 3 or less were designated autism-negative, regardless of whether an ADOS examination was completed.
- Adults with a phase one AQ score of 4 or more who did not have an ADOS examination (e.g. due to non-selection, refusal or non-contact) were excluded from the analysis, and a weighting strategy was applied to take account of their absence and to address non-response biases.

For analysis of estimated prevalence of disorders assessed at phase two (autism, psychosis and eating disorders), the weighted phase two participants were added to the set of phase one participants who were not eligible for phase two, the prevalence being assumed to be zero for the not eligible group. Those not eligible were given their phase one weights. The sampling and weighting strategy is described in more detail in Section 4 Weighting the data in the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

For the analyses presented in this report, the 2007, 2014 and 2023/4 samples were combined to increase the sample size available for subgroup analysis. The survey series has been designed with the intention that samples can be combined, especially for analyses of low prevalence disorders or subgroups. This approach is also taken in the chapter on psychotic disorder.

10.3 Results

Autism prevalence in 2007, 2014 and 2023/4, by age and sex

The estimated prevalence of autism in 2023/4, as indicated by a score of 10 or more on the ADOS, was 0.9% of the adult population in England (equivalent to 9 per thousand adults). Prevalence in the wider adult population is likely to be between 0.5% and 1.7%, referred to as the 95% confidence interval (95% CI). This equates to about 430 thousand adults in England. There was no indication that there has been any change in prevalence over time. The prevalence of autism in the 2023/4 survey was similar to that for the 2007 (1.0%, 95% CI 0.5, 2.0) and 2014 (0.7%, CI 0.3, 1.3) surveys, with largely overlapping

confidence intervals.

A total of 30 probable cases were identified in the 2023/4 sample, because a sub-sample of respondents was selected for a phase two interview. This small base means that great caution is required in interpreting the population distribution of autism. To improve how robust the estimates are, the 2007, 2014 and 2023/4 samples have been combined, yielding 61 participants identified with autism. Estimates based on the combined sample are more robust than those based on the separate 2007, 2014 and 2023/4 samples.

For more information: Table 10.1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Where data on demographic and socio-economic characteristics were collected consistently since 2007, the results in this chapter draw on a dataset that combines the 2007, 2014 and 2023/4 samples and are analysed by sex (male and female) rather than gender (men and women). See How to interpret the findings (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/how-to-interpret-the-findings) for information on how changes over time were assessed.

The overall prevalence of autism using this combined data was 0.8% (CI 0.6, 1.2). The size of this confidence interval is similar to that of some of the other low prevalence disorders considered on APMS.

Autism prevalence varied by sex with males (1.5%, CI 1.0, 2.3) more likely than females (0.2%, CI 0.1, 0.5) to be assessed as autistic. Prevalence of a positive autism assessment varied by age, although there was no clear pattern.

For more information: Table 10.2 and Table A1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals

Autism, by sex (Base: All adults, 2007, 2014 and 2023/4 combined)

Download the data for this chart Autism, by sex (Base: All adults, 2007, 2014 and 2023/4 combined) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/autism-spectrum-disorder/autism-spectrum-disorder/publicationsystem%3AbodySections%5B8%5D/publicationsystem%3AdataFile)

Variation by other characteristics in combined 2007, 2014 and 2023/4 sample

Ethnic group

In age-standardised analyses, prevalence of autism varied between ethnic groups. It was higher among White adults (0.9%, CI 0.6, 1.3) and Asian/Asian British adults (1.0%, CI 0.2, 4.9) and lowest in those identifying to a Mixed/multiple or other ethnic group (0.1%, CI 0.0, 0.5). No Black/Black British participants in the sample were assessed as autistic. It should be noted that the number of participants in some ethnic groups was small and the confidence intervals around estimates were wide.

For more information: Table 10.3 and Table A2 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals.

Autism, by ethnic group (age-standardised) (Base: All adults, 2007, 2014 and 2023/4 combined)

Download the data for this chart Autism, by ethnic group (age-standardised) (Base: All adults, 2007, 2014 and 2023/4 combined) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/autism-spectrum-disorder/autism-spectrum-disorder/publicationsystem%3AbodySections%5B10%5D/publicationsystem%3AdataFile)

Employment status

In age-standardised analysis based on working age adults (aged 16 to 64), there were no statistically significant differences in adults assessed as autistic by employment status.

For more information: Table 10.4 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Problem debt

Problem debt was defined as being seriously behind with debt repayments or having one's utilities cut off. In age-standardised analysis, using the 2023/4 sample only, no statistically significant variation in autism prevalence was found by experiences of

problem debt. See the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods) for more information on how problem debt was derived.

For more information: Table 10.5 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Area-level deprivation

How has deprivation been defined?

Area-level deprivation has been defined using the English Indices of Deprivation 2019, commonly known as the Index of Multiple Deprivation (IMD).

IMD is the official measure of relative deprivation for Lower Super Output Areas (LSOAs) in England. LSOAs comprise between 400 and 1,200 households and usually have a resident population between 1,000 and 3,000 persons. IMD ranks every LSOA in England from 1 (most deprived area) to 32,844 (least deprived area). Deprivation quintiles are calculated by ranking the 32,844 neighbourhoods in England from most deprived to least deprived and dividing them into five equal groups. These range from the most deprived 20% of neighbourhoods nationally to the least deprived 20% of neighbourhoods nationally.

For further information see: English indices of deprivation 2019 (Link: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019).

In age-standardised analyses, autism prevalence was highest among those living in the two most deprived quintiles, compared with those living in less deprived areas. 1.8% of those living in areas in the most deprived quintile and 1.6% of those living in the second most deprived quintile were assessed as autistic, compared with between 0.2% of those living in areas in the least deprived quintile.

For more information: Table 10.6 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Autism, by area-level deprivation (age-standardised) (Base: All adults, 2007, 2014 and 2023/4 combined)

Download the data for this chart Autism, by area-level deprivation (age-standardised) (Base: All adults, 2007, 2014 and 2023/4 combined) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/autism-spectrum-disorder/autism-spectrum-disorder/publicationsystem%3AbodySections%5B14%5D/publicationsystem%3AdataFile)

Region

Due to small base sizes, regions were grouped into four areas (North, Midlands and East, South, and London) for this analysis due to the low number of cases of adults assessed as autistic in APMS. In age-standardised analyses, the proportion of adults assessed with autism was highest in the North (1.3%) of England and lowest in among adults in London (0.4%).

For more information: Table 10.7 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Autism, by region (age-standardised) (Base: All adults, 2007, 2014 and 2023/4 combined)

Download the data for this chart Autism, by region (age-standardised) (Base: All adults, 2007, 2014 and 2023/4 combined) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/autism-spectrum-disorder/autism-spectrum-disorder/publicationsystem%3AbodySections%5B16%5D/publicationsystem%3AdataFile)

Co-occurring conditions

Physical health conditions

How have physical health conditions been defined?

Participants were asked if they had any of 25 physical health conditions listed on a card, including asthma, cancer, diabetes, epilepsy and high blood pressure. Participants were coded as having a limiting physical health condition, if they reported having one or more physical health conditions in the past 12 months that had been diagnosed by a doctor and that this had limited their ability to carry out day-to-day activities. More details on the questions on physical health conditions can be found in the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

In age-standardised analysis of APMS 2023/4 data, those without a limiting health condition (1.2%) were more likely to be autistic than those with a physical health condition (0.4%).

For more information: Table 10.8 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Autism, by limiting physical health condition (age-standardised) (Base: All adults)

Download the data for this chart Autism, by limiting physical health condition (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/autism-spectrum-disorder/autism-spectrum-disorder/publicationsystem%3AbodySections%5B20%5D/publicationsystem%3AdataFile)

Common mental health conditions

How have common mental health conditions been defined?

The revised Clinical Interview Schedule (CIS-R) was used to assess six types of common mental health conditions (CMHC): depression, generalised anxiety disorder, panic disorder, phobias, obsessive compulsive disorder, and CMHC not otherwise specified. Participants identified with at least one of these were defined as having a CMHC. See Section 1.2 of the Common mental health conditions (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/common-mental-health-conditions) chapter for more detail.

In age-standardised analysis, there was no statistically significant variation by common mental health condition.

For more information: Table 10.8 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Self-diagnosis and professional diagnosis of autism

Participants were shown a list of mental health conditions and asked whether they thought that they had ever had any of them. In APMS 2023/4 the list was expanded to include 'autism spectrum disorder'. Those who reported that they thought that they were autistic were asked if this had been diagnosed by a professional, and if so, whether this condition had been present in the past 12 months.

Overall, 165 adults (3.4%) thought that they were autistic and 59 adults (1.2%) reported that this had been diagnosed by a professional.

Due to small sample sizes, the presentation of results was constrained. However, initial analysis identified little correspondence between professionally diagnosed autism and ADOS-identified autism.

For more information: Table 10.9 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Treatment and service use

Participants were asked about use of different types of mental health treatment and

services. Two types of mental health treatment were asked about: current medication and psychological therapy for a mental or emotional problem. The use of a range of health, community and day care services over the past year were also asked about. This treatment and service use could have been for any condition and was not necessarily related to autism.

In combined data from 2007, 2014, and 2023/4, people identified as autistic were no more likely than non-autistic people to report currently receiving treatment for a mental or emotional problem, including medication, psychological therapy, or a combination of these two types of treatment. One in ten autistic adults (10.4%) reported current receipt of any mental health treatment.

Adults identified as autistic were less likely than non-autistic adults to have used health services for a mental health reason. 6.7% of adults identified as autistic reported using any health care service for a mental or emotional problem, compared with 12.9% of those who were non-autistic. Those who were autistic were no more or less likely to report having used community care or day care services in the past year.

For more information: Table 10.10 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

10.4 Discussion

APMS is one of the best available sources of data on the prevalence of autism in the general population. The combined autism prevalence in adults in private households in England based on the 2007, 2014 and 2023/4 APMS surveys was about one adult in a hundred (0.8%, CI 0.6, 1.2). In these surveys, adults were interviewed if they were able to participate fully in a general population survey. Adults who would be unable to participate in the APMS because of intellectual disability were represented in an extension to the 2007 APMS (Brugha et al. 2016b). Taking account of the higher prevalence of autism in the intellectual disability population only raised the overall prevalence slightly, given the low proportion of the population living in such settings (from 1.0% in private households in 2007 to 1.1% including those living in group residential settings (Brugha et al. 2012)).

In the discussion that follows, comparisons with other studies are almost entirely based on research on people with identified (recorded, diagnosed) autism or on people who self-identify as being autistic.

Prevalence has remained stable over time. There was no significant difference between the prevalence of autism identified in 2007, 2014 and 2023/4. Two previous studies in children have shown that rates of independently assessed autism remain stable over multiple time points. The prevalence of autism in 5 to 15 year old children remained

stable in general population surveys in England conducted in 2004 and 2017 (Marcheselli et al. 2018 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017)). The annual prevalence of the autism symptom phenotype in children assessed by a validated parental telephone interview was found to be stable during a 10-year period in Sweden during which registered diagnoses rose significantly (Lundström et al. 2015). NHS England figures, which analyses patient GP records, found that the percentage of patients with a diagnosis of autism increased from 0.6% in 2017-18 to 1.2% in 2022-23 and 1.3% in 2023-24 (NHS England 2024 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/health-and-care-of-people-with-learning-disabilities/experimental-statistics-2023-to-2024?utm_source=chatgpt.com)). Unlike APMS, these figures do not cover adults who are not in touch with NHS services and the APMS results show that autistic adults are less likely to use NHS services than the non-autistic population.

A higher prevalence of autism in men than women was found in all three APMS surveys. This is consistent with most research on autism (Brugha et al. 2011, Tromans et al. 2024). It is likely that while autism is more common in men than women, the difference between males and females may have been overstated and there has been a greater level of underdiagnosis in women. A meta-analysis in 2017 by Loomes and colleagues reported that males had closer to three times higher prevalence than females, rather than four times higher as previously reported (Loomes et al. 2017). In a survey extending the coverage of the 2007 APMS, no difference in autism prevalence was found between adult males and females with moderate, severe or profound intellectual disability (Brugha et al. 2016b). Autism assessments, including ADOS, focus on observable features. This may insufficiently consider less clearly manifested autistic traits (Cook et al. 2024), which may be more likely among women than men (Hull et al. 2020). Additionally, assessments for autism may draw more on how the condition manifests in men, leading to further under identification of autism in women (Trubanova et al. 2014). For example, Rynkiewicz et al. (2016) report that autistic females present with more vivid and energetic gestures on ADOS-2 examination and thus may be at risk of underdiagnosis.

There was variation in autism prevalence among adults of Asian and White ethnicity. Combined data from 2007, 2014 and 2023/4 allowed analysis of autism prevalence by ethnic group for the first time in the series. Autism prevalence was higher among White adults (0.9%) and Asian/Asian British adults (1.0%) and lowest in those identifying to a Mixed/multiple or other ethnic group (0.1%) although the causal relationship is unclear. Secondary analysis of a survey of adults registered with NHS GP surgeries in England showed higher rates of self-identified autism among White adults, but a lower prevalence in Asian or Asian British participants (Tromans et al. 2024). In contrast, national experimental statistics (NHS England 2024 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/health-and-care-of-people-with-

learning-disabilities/experimental-statistics-2023-to-2024?utm_source=chatgpt.com)) report a high percentage of registered patients with a diagnosis of autism who are of mixed/multiple ethnic groups (1.87%; 95% CI 1.85, 1.90), compared to White patients (1.49%, CI 1.48, 1.49), Asian or Asian British patients (0.67, CI 0.66, 0.68), and those classified as Other ethnic group (0.71%, CI 0.70, 0.73), though this data reflects clinically identified autistic cases, in contrast to the research-identified autistic cases reported in the APMS. In general, autism prevalence studies across different countries tend to identify the highest autism prevalence in the majority ethnic group of the population in which the prevalence study took place, with lower estimates for minority ethnic groups (Tromans et al. 2021).

People living in deprived areas were more likely to be autistic. 1.8% of those living in areas in the most deprived quintile and 1.6% of those living in the second most deprived quintile were assessed as autistic, compared with between 0.2% of those living in areas in the least deprived quintile. This is consistent with existing evidence finding that higher levels of socioeconomic deprivation are associated with higher rates of diagnosed autism (O'Nions et al. 2023). This has also been shown in children in a national school census in England (Roman-Urrestarazu et al. 2021).

Few autistic adults had an autism diagnosis. Adults interviewed in the APMS in 2007 and 2014 were not asked if they were autistic. However, it was reported that none of the participants identified as having autism in the 2007 APMS had previously been given a formal autism assessment or diagnosis (Brugha et al. 2011). In primary care in England, autism identification and diagnosis rates have been rising exponentially between 1998 and 2018, with relative rises in new diagnoses in adults (Russell et al. 2022). Further year on year rises have been observed in NHS England analyses of GP records, with 1.3% of adults diagnosed with autism in 2023-4 (NHS England 2024 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/health-and-care-of-people-with-learning-disabilities/experimental-statistics-2023-to-2024?utm_source=chatgpt.com)). These data are in line with APMS autism prevalence in 2007, 2014 and 2023/4. Lundström and colleagues (2015) also found diagnosis rates in children to be rising during the 10-year period from 1993 to 2002 during which parent reported autism traits in the population remained stable.

Autistic adults were no more likely to have a co-occurring common mental health condition or to report using health services. Autistic adults in the survey were no more likely than non-autistic adults to be identified with a physical or common mental health condition. This result was surprising and might reflect a lack of insight and disclosure in autistic adults, or that the tool used to identify common mental health conditions in the survey did not work as well with autistic adults. They were also no more likely to use treatment or services for a mental health reason than non-autistic adults. In contrast, every other condition examined in this and previous APMS has been shown to be associated with increased use of treatment and health services (Brugha et al. 2016a

(Link: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014)). This finding appears at odds with a prior systematic review on healthcare service use among autistic adults (Gilmore et al. 2022), which reported that most eligible articles described 'autistic adults had equal or higher use of healthcare services than non-autistic adults.' However, this may be a reflection on group differences that may exist between research-identified autistic adults (as reported in the APMS), and autism surveillance work that reports on autistic people identified through the educational system and/or clinical practice. It may also reflect barriers to accessing health services faced by autistic people (Tromans et al. 2024), and the possibility that the lack of a formal diagnosis may exacerbate such barriers.

Autism is a life-long condition, and autistic adults may need life-long support. Autistic adults have enduring difficulties with communication and social understanding, though they can also have additional capabilities such as special memory skills and pitch perception (Meilleur et al., 2015). There are no effective medication-based interventions for core autistic features in autistic adults (NICE 2012, updated 2021 (Link: https://www.nice.org.uk/guidance/cg142/chapter/Key-priorities-for-implementation)). NHS specialist autism teams have been developed throughout England to improve identification of autism and to support people through extra provision of psychology, speech and language, and occupational therapy. Care services for identifying and supporting autistic people have been developed throughout England. Training in autism (and in learning disability) is now mandatory for all health and social care staff. These public services are based on the principle that carers and health and social care staff can recognise autism and learn how to understand and communicate with autistic people. Providing informed health and social care to autistic adults could lead to real improvements in their quality of life.

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Previous Chapter

Chapter 9: Attention deficit hyperactivity disorder (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/attention-deficit-hyperactivity-disorder)

Next Chapter

Chapter 11: Bipolar disorder (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/bipolar-disorder)

Chapter 11: Bipolar disorder

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Overview

Bipolar disorder is an often long-term condition, characterised by recurrent periods of depression, mania, hypomania and mixed episodes.

As in 2014, APMS 2023/4 used the 15-item Mood Disorder Questionnaire to screen for bipolar disorder. Screening positive for bipolar disorder required occurrence over the life course of at least 7 manic/hypomanic symptoms, as well as several co-occurring symptoms, together with functional impairment. A positive screen did not indicate presence of bipolar disorder, rather that fuller assessment would be warranted.

Key findings

- **Prevalence of screening positive for bipolar disorder using the 15-item Mood Disorder Questionnaire has remained stable.** The proportion of adults screening positive was similar in 2014 (2.0%) and 2023/4 (1.9%), and consistent with studies using a more comprehensive assessment.
- **Among both men and women about one in fifty screened positive.** Prevalence of screening positive for bipolar disorder was similar for men and women, and generally

higher in younger age groups (especially those aged 25 to 44) than older.

- **People screening positive for bipolar disorder often face socioeconomic adversity.** Screening positive was more likely among those seriously behind with debt repayments (6.4%), those living in a more deprived local area (3.6%) and - among people of working age - those who were unemployed (9.0%) or economically inactive (4.9%).
- **People in poor health were more likely to screen positive for bipolar disorder.** Those with a limiting physical health condition were twice as likely to screen positive for bipolar disorder (3.0%) as those without such a condition (1.5%).

11.1 Introduction

Bipolar disorder is a long-term mental health condition. It is generally characterised by recurring episodes of depression (feelings of low mood and lethargy) and of mania (feelings of elation and overactivity) or hypomania (a milder form of mania) (Royal College of Psychiatrists 2020 (Link: https://www.rcpsych.ac.uk/mental-health/mental-illnesses-and-mental-health-problems/bipolar-disorder)). Several bipolar disorder subtypes can be identified, diagnoses of which are based on the extent and time over which the symptoms are sustained.

The global prevalence of bipolar disorder is estimated to be between around 1 in 150 adults (GBD 2019 Mental Disorders Collaborators 2022 (Link: https://www.sciencedirect.com/science/article/pii/S2215036621003953)) and 2.4% of the global population (Merikangas et al. 2011). Figures varied depending on the part of the bipolar spectrum researchers assess and whether a screening tool or diagnostic tool was used. Prevalence rates have been found to be comparable in men and women, with younger people more likely to screen positive than older people (Merikangas et al. 2011; Pini et al. 2005; GBD 2019 Mental Disorders Collaborators 2022 (Link: https://www.sciencedirect.com/science/article/pii/S2215036621003953)). Prior to APMS 2014, there was a lack of epidemiological data on the prevalence of bipolar disorder in the UK (Gupta and Guest 2002).

Bipolar disorder is one of the leading causes of disability in the world (World Health Organization 2024 (Link: https://www.who.int/news-room/fact-sheets/detail/bipolar-disorder)). It leads to significant psychosocial impairment, such as fewer employment prospects and lower annual income (Coryell et al. 1993; Judd et al. 2005; Marwaha et al. 2013), as well as placing a great burden on health care services (Pini et al. 2005). The annual economic costs for bipolar disorder in England were estimated, in 2018-19, to be £6.43 billion, with 68% of the total costs attributed to lost productivity and informal care, and 31% to health care costs (Simon et al. 2021).

Bipolar disorder is often comorbid with poor physical health, substance misuse, personality disorders, attention-deficit/hyperactivity disorder (ADHD) (National Institute for Health and Care Excellence (NICE) 2014 (Link: https://www.nice.org.uk/guidance/cg185)) and anxiety disorders including posttraumatic stress disorder (Freeman et al. 2002). Furthermore, the risk of suicide among those with bipolar disorder is approximately 10–30 times greater than that in the general population (Dome et al. 2019). The peak incidence (for approximately 50% of people with bipolar disorder) is around the age of 25 years, with a younger peak incidence of 17 years for another 28% (Bellivier et al. 2003). There is often considerable delay between onset and identification and treatment, with those seeking help not receiving a correct diagnosis for six years from the onset of symptoms and very often longer (NICE 2014 (Link: https://www.nice.org.uk/guidance/cg185)). Diagnosis of bipolar disorder is challenging in that it cannot be confidently differentiated from unipolar depression until an episode of mania and/or hypomania is identified.

Treatment options, as based on NICE guidelines, vary depending on whether the individual is experiencing a depressive or manic (or a hypomanic) episode. For manic or hypomanic episodes, treatment will usually involve some form of mood stabilising medication. For depressive episodes, NICE currently recommends psychological therapies such as cognitive behavioural therapy (CBT), and/or medication. Long term treatment with mood stabilising medication such as lithium is also recommended as maintenance treatment to reduce the risk of relapse (NICE 2014 (Link: https://www.nice.org.uk/guidance/cg185)). Analysis using APMS 2014 data found that 40% of adults who screened positive for bipolar disorder had not received health care for a mental health reason in the past year and 14.5% were in receipt of bipolar disorder specific medication (Humpston et al. 2021; McManus et al. 2016 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014)).

11.2 Definitions and assessments

Bipolar disorder

Several subtypes of bipolar disorder are recognised in the US-based Diagnostic and Statistical Manual of Mental Disorders (DSM-5) with the major groupings being bipolar I, bipolar II and cyclothymia (APA 2013). In the World Health Organization's (WHO) International Classification of Diseases version 10 (ICD-10) (WHO 1993), no distinction was made between type I and II, although in ICD-11 bipolar disorders are now subdivided into bipolar I and bipolar II disorder (Severus and Bauer 2020):

- People with **bipolar type I disorder** experience one or more manic episodes (periods of elevated mood and increased energy including such symptoms as increased talkativeness, inflated self-esteem, feelings of grandiosity, and a decreased need for sleep, which last at least one week and causes significant impairment in social or occupational functioning) interspaced with episodes of depression.
- People with **bipolar type II disorder** have had one or more hypomanic episodes (which are less intense than manic episodes) and at least one depressive episode, but no history of manic episodes and less impairment in social or occupational functioning.

Mood Disorder Questionnaire (MDQ)

The term 'screening' is used throughout this report to refer to identifying people with a higher likelihood of having a disorder. A definitive diagnosis of bipolar disorder would require a comprehensive clinical assessment which was not carried out in this survey. Instead, on both the APMS 2014 and 2023/4, bipolar disorder was screened for as part of the self-completion section of the interview using the Mood Disorder Questionnaire (MDQ). The MDQ is a 15-item scale based on DSM-IV criteria. The DSM-IV was designed to screen for bipolar spectrum disorders across the lifespan, i.e. bipolar I, bipolar II, and bipolar NOS although it does not differentiate between the bipolar disorder subtypes (APA 1994).

The MDQ assesses lifetime experience of manic or hypomanic symptoms by way of 13 yes/no items. The DSM-IV, like other diagnostic systems, do not require a depressive episode to screen positive for bipolar disorder, and so this is not part of the MDQ. Two further items establish whether several of the symptoms have been experienced at the same time, and whether they have caused moderate to serious problems (Hirschfeld et al. 2000 (Link: https://psychiatryonline.org/doi/10.1176/appi.ajp.157.11.1873)). A positive screen for bipolar disorder requires reporting at least seven lifetime manic/hypomanic symptoms, as well as several co-occurring symptoms, and moderate or serious associated impairment in life.

Widely used in epidemiological studies, the MDQ has been found to have a low sensitivity of 0.28 (indicating false negatives may be likely) and a high specificity of 0.97 (which suggests that false positives are unlikely) (Hirschfeld et al. 2003 (Link: https://psychiatryonline.org/doi/10.1176/appi.ajp.160.1.178)). All APMS participants were asked the first 13 items on the MDQ. Those who answered yes to at least seven items were asked whether they had experienced several symptoms at the same time, and if so, how much of a problem this caused in terms of being unable to work; having family, money or legal troubles; or getting into arguments or fights.

Mood Disorder Questionnaire (yes/no)
Has there ever been a period of time when you were not your usual self and…

a) … you felt so good or so hyper that other people thought you were not your normal s you were so hyper that you got into trouble?
b) … you were so irritable that you shouted at people or started fights or arguments?
c) … you felt much more self-confident than usual?
d) … you got much less sleep than usual and found you didn't really miss it?
e) … you were much more talkative or spoke much faster than usual?
f) … thoughts raced through your head or you couldn't slow your mind down?
g) … you were so easily distracted by things around you that you had trouble concentrat staying on track?
h) … you had much more energy than usual?
i) … you were much more interested in sex than usual?
j) … you were much more active or did many more things than usual?
k) … you were much more social or outgoing than usual, for example, you telephoned fr the middle of the night?
l) … you did things that were unusual for you or that other people might have thought v excessive, foolish, or risky
m) … spending money got you or your family into trouble?
Have several of these ever happened during the same period of time?
How much of a problem did any of these cause you - like being unable to work; having money or legal troubles; getting into arguments or fights?

11.3 Results

Screening positive for bipolar disorder, by age and gender

Overall, 1.9% of participants in 2023/4 screened positive for bipolar disorder, with the proportion in the wider population likely to be between 1.5% and 2.4% (referred to as the 95% confidence interval (CI)). This equates to an estimated 890 thousand adults

living in private households in England.

The proportion screening positive for bipolar disorder was similar for men (1.7%, CI 1.2, 2.5) and women (2.1%, 95% CI 1.5, 2.8), but varied by age. Positive screens were most common among those aged 25 to 34 (3.5%, CI 2.2, 5.4) and 35 to 44 (3.1%, CI 2.0, 4.7), and least common in those 65 to 74 (0.5%, CI 0.2, 1.0) and 75 and over (0.9%, CI 0.3, 2.8).

For more information: Table 11.1 and Table A1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals

Screening positive for bipolar disorder, by age (Base: All adults)

Download the data for this chart Screening positive for bipolar disorder, by age (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/bipolar-disorder/bipolar-disorder/publicationsystem%3AbodySections%5B7%5D/publicationsystem%3AdataFile)

Screening positive for bipolar disorder in 2014 and 2023/4

The proportion of adults screening positive for bipolar disorder was similar in 2014 (2.0%, CI 1.6, 2.4) and 2023/4 (1.9%, CI 1.5, 2.4). See How to interpret the findings (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/how-to-interpret-the-findings) for information on how changes over time were assessed.

For more information: Table 11.2 and Table B1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals

Variation in screening positive for bipolar disorder by other characteristics

Ethnic group

Age-standardised prevalence of screening positive for bipolar disorder varied by ethnic group. Screening positive for bipolar disorder was lower among those in the White other (0.3%, 95% CI 0.1, 1.2), Black/Black British (0.7%, CI 0.2, 2.1) and Asian/Asian British

(0.7%, CI 0.2, 2.3) groups, and higher among those in the Mixed/multiple/other group (5.1%, CI 1.1, 20.7). 2.4% of those in the White British group screened positive (CI 1.8, 3.0). It should be noted that the confidence intervals for some estimates were wide and overlapping, so apparent differences between ethnic groups should be treated with caution.

For more information: Table 11.3 and Table A2 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals

Screening positive for bipolar disorder, by ethnic group (age-standardised) (Base: All adults)

Download the data for this chart Screening positive for bipolar disorder, by ethnic group (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/bipolar-disorder/bipolar-disorder/publicationsystem%3AbodySections%5B9%5D/publicationsystem%3AdataFile)

Employment status

Age-standardised proportions of screening positive for bipolar disorder varied by employment status for those of working age (16 to 64 years). 9.0% of adults who were unemployed and 4.9% of adults who were economically inactive screened positive for bipolar disorder, compared with 1.6% among those who were employed.

For more information: Table 11.4 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Screening positive for bipolar disorder, by employment status (age-standardised) (Base: Adults aged 16-64)

Download the data for this chart Screening positive for bipolar disorder, by employment status (age-standardised) (Base: Adults aged 16-64) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/bipolar-disorder/bipolar-disorder/

publicationsystem%3AbodySections%5B11%5D/publicationsystem%3AdataFile)

Problem debt

In age-standardised analyses, being seriously behind on at least one debt repayment or having utilities cut off was associated with greater likelihood of screening positive for bipolar disorder. 6.4% of those with problem debt screened positive for bipolar disorder compared with 1.5% of the rest of the population. See the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods) for more information on how problem debt was derived.

For more information: Table 11.5 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Screening positive for bipolar disorder, by problem debt (age-standardised) (Base: All adults)

Download the data for this chart Screening positive for bipolar disorder, by problem debt (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/bipolar-disorder/bipolar-disorder/publicationsystem%3AbodySections%5B13%5D/publicationsystem%3AdataFile)

Area-level deprivation

How has deprivation been defined?

Area-level deprivation has been defined using the English Indices of Deprivation 2019, commonly known as the Index of Multiple Deprivation (IMD).

IMD is the official measure of relative deprivation for Lower Super Output Areas (LSOAs) in England. LSOAs comprise between 400 and 1,200 households and usually have a resident population between 1,000 and 3,000 persons. IMD ranks every LSOA in England from 1 (most deprived area) to 32,844 (least deprived area). Deprivation quintiles are calculated by ranking the 32,844 neighbourhoods in England from most deprived to least deprived and dividing them into five equal groups. These range from the most deprived 20% of neighbourhoods nationally to the least deprived 20% of neighbourhoods nationally.

For further information see: English indices of deprivation 2019 (Link: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019).

Screening positive for bipolar disorder was associated with area-level deprivation. 3.6% of those living in areas in the most deprived quintile screened positive for bipolar disorder, compared with between 1.2% and 1.7% of those living in other IMD quintiles.

For more information: Table 11.6 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Screening positive for bipolar disorder, by area-level deprivation (age-standardised) (Base: All adults)

Download the data for this chart Screening positive for bipolar disorder, by area-level deprivation (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/bipolar-disorder/bipolar-disorder/publicationsystem%3AbodySections%5B17%5D/publicationsystem%3AdataFile)

Region

The proportion of adults screening positive for bipolar disorder did not vary significantly by region.

For more information: Table 11.7 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Comorbidity

Physical health conditions

How have physical health conditions been defined?

Participants were asked if they had any of 25 physical health conditions listed on a card, including asthma, cancer, diabetes, epilepsy and high blood pressure. Participants were coded as having a limiting physical health condition, if they reported having one or more physical health conditions in the past 12 months that had been diagnosed by a doctor and that this had limited their ability to carry out day-to-day activities. More details on the questions on physical health conditions can be found in the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

Age-standardised prevalence of screening positive for bipolar disorder varied by the presence of a limiting physical health condition. 3.0% of those with a limiting physical health condition screened positive for bipolar disorder, compared with 1.5% of those without.

Screening positive for bipolar disorder, by limiting physical health condition (age-standardised) (Base: All adults)

Download the data for this chart Screening positive for bipolar disorder, by limiting physical health condition (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/bipolar-disorder/bipolar-disorder/publicationsystem%3AbodySections%5B21%5D/publicationsystem%3AdataFile)

Common mental health conditions

How have common mental health conditions been defined?

The revised Clinical Interview Schedule (CIS-R) was used to assess six types of common mental health conditions (CMHC): depression, generalised anxiety disorder, panic disorder, phobias, obsessive compulsive disorder, and CMHC not otherwise specified. Participants identified with at least one of these were defined as having a CMHC. See Section 1.2 of the Common mental health conditions (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/common-mental-health-conditions#1-2-definitions-and-assessments) chapter for more detail.

Presence of a CMHC was associated in age-standardised analyses with screening positive for bipolar disorder. 6.2% of adults with a common mental health condition screened positive for bipolar disorder, compared with 0.7% of those without.

For more information: Table 11.8 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Screening positive for bipolar disorder, by common mental health condition (CMHC) (age-standardised) (Base: All adults)

Download the data for this chart Screening positive for bipolar disorder, by common mental health condition (CMHC) (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/bipolar-disorder/bipolar-disorder/publicationsystem%3AbodySections%5B25%5D/publicationsystem%3AdataFile)

Self-diagnosis and professional diagnosis of bipolar disorder

Participants were asked whether they themselves thought they had ever experienced bipolar disorder. If they did, they were asked whether this had been diagnosed by a professional, and whether they thought that the disorder had been present in the past 12 months.

80 people (1.4%) in the 2023/4 APMS sample reported thinking that they had had 'bipolar disorder or manic depression' at some point. About half of these participants (44, 0.7%) had had this diagnosis confirmed by a professional.

One in four (26.5%) of those screening positive for bipolar disorder on the MDQ reported thinking they had had bipolar disorder or manic depression at some point in their life, compared with 0.8% of those who screened negative on the MDQ. One in six (17.8%) adults screening positive for bipolar disorder reported that they had been diagnosed with bipolar disorder by a professional.

For more information: Table 11.9 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Treatment

Treatment and service use

Participants were asked about different types of mental health treatment and service use. These included current medication or psychological therapy for a mental or emotional problem, not necessarily specifically for bipolar disorder, together with the use of a range of health, community and day care services over the past year. These are detailed in the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

Of those who screened positive for bipolar disorder, 50.0% were currently receiving treatment for a mental or emotional problem, compared with 14.9% of those who screened negative. People screening positive for bipolar were more likely to be in receipt of psychotropic medication (40.9%) than psychological therapy (22.2%). 13.6% were in receipt of both.

Among those screening positive for bipolar disorder, 54.9% used health services for a mental health related reason in the past year, 30.8% used community care services, and 14.1% used a day care service.

For more information: Table 11.10 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Treatment currently received for a mental or emotional problem, by bipolar disorder screen (Base: All adults)

Download the data for this chart Treatment currently received for a mental or

emotional problem, by bipolar disorder screen (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/bipolar-disorder/bipolar-disorder/publicationsystem%3AbodySections%5B27%5D/publicationsystem%3AdataFile)

Psychotropic medication

Participants were asked which psychotropic (mental health related) medications that they take. These were not necessarily taken in relation to bipolar disorder. Overall, 12.5% of all adults were taking some form of psychotropic medication, with the most common medication types those primarily used to treat depression (11.7%) and anxiety (10.7%). See Chapter 2 Mental health treatment and service use (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/mental-health-treatment-and-service-use) for more details.

About two-thirds (40.9%) of those screening positive for bipolar disorder were in receipt of psychotropic medication. The most common among those screening positive for bipolar disorder were medications used to treat depression (37.7%) or anxiety (35.6%). 5.1% of those who screened positive for bipolar disorder reported taking medication for bipolar disorder.

For more information: Table 11.11 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

11.4 Discussion

Prevalence remained stable, with one adult in fifty screening positive for bipolar disorder. The prevalence of possible bipolar disorder in the APMS 2023/4 was 1.9%, consistent with findings from epidemiological studies in other countries (GBD 2019 Mental Disorders Collaborator 2022 (Link: http://www.sciencedirect.com/science/article/pii/S2215036621003953); Merikangas et al. 2011). For example, the World Mental Health Survey Initiative found the lifetime aggregate prevalence from 11 countries (not UK) to be 2.4% for bipolar disorders (BP-I, BP-II, and subthreshold BP) (Merikangas et al. 2011). The proportion screening positive was also similar in APMS 2014, indicating stability in the population prevalence in England over time (McManus et

al. 2016 (Link: http://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014)).

Caution is required, screening positive is not the same as having the disorder. The instrument used to screen for bipolar disorder, while designed to cover all bipolar spectrum disorders, does have limitations. The MDQ is less sensitive at identifying bipolar II disorders than the longer Hypomania Checklist, another widely used instrument (Meyer et al. 2011). There are also limitations on its use in general population studies (APA 1994). While showing excellent specificity (suggesting a positive result is useful for ruling in bipolar disorder), the instrument has been shown to have limited sensitivity (the proportion of people with the condition who have a positive result) (Swift et al. 2020). The results in this chapter may therefore be underestimates. Overall, the MDQ, appears to have performed well in the APMS 2014 and 2023/4.

The demographic profiles indicate association with ethnicity. APMS 2023/4 data show an association between screening positive for bipolar disorder and ethnicity, with prevalence highest among those in the Mixed/multiple/other ethnic group. Given these comparisons are based on small numbers and that age-standardisation had a large impact on the results, the finding should be interpreted with caution. The association is noteworthy, as it was not evident in APMS 2014 data, although elevated incidence rates for people from black and other minoritised groups have been found before in patient populations in England (Lloyd et al. 2005). Previous research has also noted how some minoritised groups with bipolar disorder are more likely to be misdiagnosed by professionals with other conditions, especially psychosis (Akinhanmi et al. 2018; Haeri et al. 2011).

Prevalence was highest among those aged 25 to 44, and lowest among those aged 65 and over. As bipolar disorder is screened for in relation to symptoms across the life course, prevalence might be expected to gradually increase with age. The survey findings may reflect problems with recall, as well as the increased mortality associated with the disorder. People with bipolar disorder or psychosis experience marked reductions in life expectancy compared with the general population: 14.5 years loss in men with schizophrenia-spectrum and bipolar disorders, and 13.2 years in women (Das-Munshi et al. 2021). Comorbidities contribute to this reduced life expectancy, consistent with the results in this chapter showing greater likelihood of both limiting physical health conditions and common mental health conditions among people who screened positive for bipolar disorder.

Results here confirm the associations with financial difficulties. The findings here are consistent with the strong associations between bipolar disorder and financial difficulties that previous research has found (Richardson et al. 2018). The likelihood of screening positive was higher for those experiencing problem debt, who were unemployed or economically inactive, or living in the most deprived neighbourhoods. Stressful circumstances, including job loss and separation, have been identified by people with the

condition as potential triggers for bipolar episodes (Bipolar UK 2022 (Link: https://www.bipolaruk.org/get-involved/research/our-research/the-bipolar-commission/)).

One in six screening positive reported that they had been diagnosed with bipolar disorder. The APMS data presented here shows that around a quarter of people screening positive for bipolar disorder thought that they had the condition, and about one in six had been diagnosed by a professional. Existing research shows that some people with bipolar disorder experience substantial delays in diagnosis and treatment after presentation to mental health services, particularly those with other conditions such as alcohol and substance disorders (Patel et al. 2015). Research by Bipolar UK indicates it takes an average of nine and a half years for a diagnosis of bipolar disorder to be made after first telling a clinician about symptoms (Bipolar UK 2022 (Link: https://www.bipolaruk.org/get-involved/research/our-research/the-bipolar-commission/); Scott et al. 2022). In part, initial diagnostic challenges can lead to delayed diagnosis as symptoms of depressive episodes can overlap with major depressive disorder, which can lead to inappropriate treatment. Stigma associated with mental health conditions and misinformation and attitudes can play a part in delayed recognition (Oliva et al. 2025).

Half of those screening positive were not receiving mental health treatment, either psychological therapy or psychotropic (mental health) medication. 40.9% of adults screening positive for bipolar disorder were currently taking some form of psychotropic medication, and 22.2% were in receipt of some form of psychological therapy. Recommendations for treatment vary, depending on whether the individual is experiencing a manic or depressive episode. Manic episodes are usually treated pharmacologically with mood stabilisers and antipsychotics, whereas depressive episodes are treated either psychologically or with medication (NICE 2014 (Link: http://www.nice.org.uk/guidance/cg185)). The depressive symptoms tend to be important in explaining the functional consequences of the disorder (Gilbert and Marwaha 2013).

APMS provides unique community-level data on an under researched group. The findings discussed in this chapter are consistent with prevalence studies internationally, despite the limitations of the survey screening method. They offer much needed information on the characteristics, difficulties and health service contact of people screening positive for bipolar disorder living in the community. Future study is warranted to establish the prevalence of bipolar disorder using more detailed examination, and of bipolar subtypes. Research is also needed into why people do not obtain help and inequalities in this, and how health services might adapt to better meet their needs.

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Next Chapter
Chapter 12: Psychotic Disorder (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/psychotic-disorder)

Chapter 12: Psychotic Disorder

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Overview

Psychotic disorders are characterised by severe disturbances in perception, belief, and thought, including hallucinations and delusions. Examples of psychotic disorders include schizophrenia, schizoaffective disorder, acute and transient psychotic disorder, and delusional disorder.

Participants were identified with ‘psychotic disorder in the past year’ using the Schedules for Clinical Assessment in Neuropsychiatry (SCAN), administered during the phase two

examination. Because psychotic disorders have a low prevalence, data from the 2007, 2014 and 2023/4 Adult Psychiatric Morbidity Surveys (APMS) were combined to increase the number of positive cases for analysis.

Key findings

- **Prevalence of psychotic disorder in the past year remained at less than one in a hundred adults** across the 2007, 2014 and 2023/4 surveys (0.4%, 0.7% and 0.4%, respectively), indicating broad stability among adults living in private households in England.
- **Psychotic disorder was associated with deprivation.** Adults living in the most deprived fifth of neighbourhoods were more likely to be identified with psychotic disorder (1.0%) than adults living in the least deprived fifth of neighbourhoods (close to 0.0%). Adults with problem debt were more likely to have a psychotic disorder (1.7%) than those without problem debt (0.4%).
- **Most participants identified by the SCAN examination with psychotic disorder did not think they have/had the condition.** Among those identified with psychotic disorder in the past year, about one in three (37.1%) reported that they thought they have had psychotic disorder or schizophrenia at some point in their life.
- **There was a strong association between psychotic disorder and common mental health conditions.** Adults with a common mental health condition were much more likely to be identified with a psychotic disorder in the past year (2.1%) than those without (0.1%).

12.1 Introduction

Psychotic disorders are characterised by experiences and symptoms that involve disturbances in thoughts and perception. Symptoms include hallucinations, delusional beliefs, and disorganised thinking. People with psychotic disorders also often experience a range of negative symptoms, such as flattened affect (reduced outward expression of emotions), social withdrawal, and anhedonia (lack of interest/enjoyment in activities). Fervaha and colleagues noted how primary negative symptoms significantly contribute to the functional impairment seen in people with schizophrenia (Fervaha et al. 2014).

The course and outcome of psychotic disorders over the short, medium, and long-term are varied. While many people experience periods of sustained symptomatic remission, social outcomes tend to be poor (Morgan et al. 2014). Psychotic disorders can be serious and debilitating conditions, associated with high rates of suicide (Fu et al. 2023; Appleby et al. 2025 (Link: https://sites.manchester.ac.uk/ncish/reports/annual-report-2025/)) and increased mortality; people with schizophrenia die on average 15 to 20 years prematurely (Correll et al. 2022).

The Adult Psychiatric Morbidity Surveys (APMS) measure psychosis by assessing the presence of symptoms of disorders such as schizophrenia, schizoaffective disorder, and affective psychosis (Singleton et al. 2001 (Link: https://webarchive.nationalarchives.gov.uk/ukgwa/20151014063541/http://www.ons.gov.uk/ons/rel/psychiatric-morbidity/psychiatric-morbidity-among-adults-living-in-private-households/2000/index.html); McManus et al. 2016 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014); McManus et al. 2009 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-in-england-2007-results-of-a-household-survey)). Psychotic disorders due to another medical condition, such as those associated with dementia and Alzheimer's disease, are not discussed in this chapter. Systematic reviews of the incidence (Kirkbride et al. 2012) and prevalence (Moreno-Küstner et al. 2018) of psychotic disorders show considerable variation in methodology, quality, and results, which makes them difficult to pool for meta-analyses. In a meta-analysis of psychotic disorder prevalence (Moreno-Küstner et al. 2018) the pooled median point and 12-month prevalence was 3.89 and 4.30 per 1,000 individuals respectively, and the median lifetime prevalence was 7.49 per 1,000. However, specific general population surveys have estimated a higher lifetime prevalence of psychotic disorder, such as over 3% (Perälä et al. 2007).

Despite being less common than anxiety and mood disorders, psychotic disorders are associated with high levels of service and societal costs (Knapp 2003; Jinn and Mosweu 2017). Findings from the 2016 Global Burden of Disease Study estimated that around 21 million people were living with schizophrenia worldwide, with schizophrenia contributing to 13.4 million years of life lived with disability (Charlson et al. 2018). People with a psychotic illness who live in the community have low rates of employment (Morgan et al. 2014), and when employed are often in poorly paid and less secure jobs (Marwaha et al. 2007). A recent meta-analysis reported employer discrimination towards people with psychosis, where they are frequently viewed as less employable compared to people with other health conditions or no disabilities (Crestois et al. 2025). People living with schizophrenia experience greater social adversity than those without the condition (Moffa et al. 2023), and subgroup variations in prevalence are evident, such by ethnicity (Qassem et al. 2015).

Treatment for psychotic disorders includes antipsychotic medication and cognitive behavioural therapy, with important additional ancillary management measures, such as monitoring physical health, promotion of healthy eating, physical activity and smoking cessation, employment support, family interventions and support for carers and families (National Institute for Health and Care Excellence (NICE) 2015 (Link: https://www.nice.org.uk/guidance/qs80)). One key recommendation has been for the early

delivery of intervention services to people experiencing their first psychotic episode (NICE 2014 (Link: https://www.nice.org.uk/guidance/cg178/chapter/Recommendations)), as early intervention services have been shown to be superior to treatment as usual, across a wide range of outcomes, including all-cause treatment discontinuation, risk of psychiatric hospitalization, involvement in school or work, and total symptom severity (Correll et al. 2018).

In this chapter, we present estimates of the prevalence of past year psychotic disorder in the general population. Variation by factors such as age, sex, ethnicity and socioeconomic circumstance are discussed, as well as levels of treatment and service use.

12.2 Definitions and assessments

Psychotic disorders

The disorders discussed in this chapter are based on the World Health Organization (WHO) International Classification of Diseases chapter on Mental and Behavioural Disorders Diagnostic Criteria for Research (ICD-10-DCR), including conditions coded under the category of 'schizophrenia, schizotypal, and delusional disorders (F20-29)' (WHO 1993).

F20-29 ICD-10 Category breakdown

This category includes schizophrenia (F20), schizotypal disorder (F21), persistent delusional disorders (F22), acute and transient psychotic disorders (F23), induced delusional disorder (F24), schizoaffective disorders (F25), other nonorganic psychotic disorders (F28), and unspecified nonorganic psychosis (F29).

There could be participants with co-occurring conditions that manifest with psychotic symptoms. For example, if all conditions were examined in phase two, a participant might have been assessed with bipolar affective disorder with psychotic symptoms (e.g. F31.2). However, co-occurring conditions were not assessed during the phase two examination so will instead be classified as having conditions falling under F20-29.

The reference period for psychotic disorder was the 12 months prior to interview.

Case assessment

To produce estimates of the prevalence of psychotic disorder in the past year among adults living in private households in England, a two-phase approach was adopted consisting of a phase one screen followed by a phase two clinical examination for a

subset of participants, as described in the sections below.

Phase one screen

Participants who met one or more of the following screening criteria in the phase one interview were identified as having experiences or symptoms possibly indicative of psychosis:

- Currently taking any antipsychotic medication (orally or by injection). See the Glossary in the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods) for a list of antipsychotic medications.
- Reporting an inpatient stay for a mental or emotional problem in the past three months or having been admitted to a hospital or a ward specialising in mental health problems at any time.
- A positive response to question 5a in the Psychosis Screening Questionnaire (PSQ) (Bebbington and Nayani 1995). The PSQ is a series of five probe and five secondary questions about mania, thought insertion, paranoia, strange experiences, and hallucinations in the past year. Question 5a refers to auditory hallucinations, where the participant is asked, 'Did you at any time hear voices saying quite a few words or sentences when there was no one around that might account for it?'
- Reporting symptoms suggestive of possible psychotic disorder (such as severe depression, manic depression, mood swings, hallucinations and psychosis) and/or discussing such symptoms with a GP in the past year.
- Self-reported identification with having had a 'nervous breakdown' was included as a phase one psychosis screening criterion in APMS 2023/4 only. In APMS 2023/4 127 people were selected for psychosis based on this single criterion, who wouldn't have been selected using the APMS 2014 selection criteria.

Phase two assessment

Overall, 678 participants (10%) reported at least one phase one screening criterion indicative of psychosis and so were eligible for a phase two assessment. Not all, however, were examined at phase two. A quarter (26%) of phase one participants meeting at least one phase one psychosis criterion refused to be contacted for a phase two examination and were thus not assessed in phase two. Of the 504 eligible participants who agreed to be contacted about phase two, 20% refused the University of Leicester interviewer and 13% could not be contacted. Because much was known about the characteristics of non-responders to phase two, a nuanced psychosis specific weighting strategy was developed to address non-response bias and enable the generation of prevalence estimates that could be generalised to the whole population. In total, 276 participants (41%) who met at least one phase one criterion indicative of psychosis in phase one took part in a phase two examination. Participants could also be selected for phase two if they met the

screening criteria for other conditions. See the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods) for more information.

The phase two assessment of psychosis was made using the Schedule for Clinical Assessment in Neuropsychiatry (SCAN) version 2.1, a semi-structured examination that provides outputs in the form of ICD-10 diagnostic categories of psychotic disorder (WHO 1999). Because the SCAN involves interviewer judgement of whether symptoms are present (hence an 'examination' as opposed to reliance on self-reports or on a fixed set of interview questions), the assessments were conducted by clinically trained interviewers from the University of Leicester (Brugha et al. 1999). The presence of psychotic disorder in the year before examination was established by applying ICD-10 diagnostic algorithms to the SCAN generated symptom ratings. Using combinations of phase one and phase two data, two differently calculated measures of psychotic illness were generated 'psychotic disorder in the past year' and 'probable psychotic disorder', as detailed below.

The full SCAN examination was administered to all participants who took part in phase two, regardless of the condition(s) they were selected for.

Measuring 'psychotic disorder in the past year'

For the identification of psychotic disorder in the past year, the following approach was used:

- For those who screened positive for psychosis at phase one and had a SCAN examination, the results of the SCAN were used.
- For those who screened negative for psychosis at phase one, it was assumed that these were true negatives, regardless of whether they were identified with psychosis in the SCAN examination.
- For those who screened positive for psychosis at phase one but did not have a SCAN assessment (e.g. due to refusal or non-contact) a weighting strategy was applied to take account of non-response. The weighting strategy meant that the SCAN results for the participants assessed at phase two were weighted to reflect the profile of all participants identified as eligible.

Measuring 'probable psychotic disorder'

For the identification of an alternative measure of probable psychotic disorder, phase one screening criteria for psychosis were used where there was an absence of phase two data. This reduces missing data and avoids the need for specific psychosis weights to be used. The difference between the 'psychotic disorder in the past year' and the 'probable psychotic disorder' variables is the way in which non-response to phase two is accounted for. A positive categorisation was only possible for 'psychotic disorder in the past year' if the participant had a positive SCAN examination; while a positive categorisation of 'probable psychotic disorder' could also be made based on phase one screening

questions, where no SCAN examination was carried out.

For the measure of probable psychotic disorder, the following approach was used:

- For those who screened positive for psychotic disorder at phase one and had a SCAN examination, the results of the SCAN were used.
- For those who screened negative for psychotic disorder at phase one, it was assumed that these were true negatives, regardless of whether they were identified with psychosis in the SCAN examination.
- For those who screened positive for psychotic disorder at phase one but did not have a SCAN examination (e.g. due to refusal or non-contact), those meeting just one psychosis screen criterion at phase one were assigned a negative probable psychotic disorder outcome, and those meeting two or more psychosis screening criteria were assigned a positive outcome. A limitation of this approach is that some of the psychosis screening criteria may be more reliable predictors of psychotic disorder than others. For more detail see the section below on 'Whether to use psychotic disorder in the past year or probable psychotic disorder'.

There have been changes to the psychosis screening criteria used in the 2007, 2014 and 2023/4 surveys. Firstly, in APMS 2007 and 2014 prompt cards were used that listed psychotropic medications. In 2023/4 the interviewer asked the participant what medication they were currently taking for a mental health condition and recorded the medication directly into the Computer Assisted Personal Interviewing (CAPI) questionnaire, which contained a database of medications listed in the British National Formulary (BNF). Secondly, a different screening criterion was included in the 2023/4 survey (self-reported 'nervous breakdown' at some point in their life). These changes, alongside the steep increases in prescribing of antipsychotic medication (Newman et al. 2025) and the fact that the probable psychotic disorder variable is less tied to experiences in the past year, mean that the 'probable psychotic disorder' measure is less suitable for looking at trends over time than the 'psychotic disorder in the past year' measure.

Whether to use 'psychotic disorder in the past year' or 'probable psychotic disorder'

There are concerns about the validity of assigning a positive assessment to those meeting two or more phase one screening criteria but not having a SCAN examination (as in 'probable psychotic disorder'). For example, some of the psychosis screening criteria relate to:

- events that happened long ago (such as having ever been admitted to a ward specialising in mental health, even if this was decades ago)
- the presence of symptoms that could also be linked to different disorders (such as mood swings)
- taking particular medication (which while indicated as an antipsychotic, could also have been prescribed for other reasons, such as for acute delirium, bipolar disorder, tic disorder or nausea and vomiting) e.g. haloperidol (British National Formulary 2025

(Link: https://bnf.nice.org.uk/drugs/haloperidol/#indications-and-dose)).

The 'probable psychotic disorder' variable may also be more likely to exclude those at an early stage of development of psychosis (and thus possibly not yet in contact with services).

The 'probable psychotic disorder' outcome is likely to include people with a history of psychosis who are currently stable on treatment, even where there had been no symptoms in the past year (and thus they may have not been assessed as positive for psychotic disorder using the SCAN, which specifically enquires about the past year).

The 'psychotic disorder in the past year' measure has been used as the main psychosis outcome in APMS 2007, 2014 and 2023/4. However, the 'psychotic disorder in the past year' variable does have drawbacks.

- It is likely to be a conservative estimate of the size of the population affected by psychosis, as the definition of psychotic disorder in the past year based on the SCAN examination is quite narrow (although appropriate for a study such as this).
- The phase one screening criteria still have the same drawbacks as covered for the 'probable psychotic disorder' variable.
- It requires a disorder-specific weighting variable (due to non-response to phase two) and the number of positive cases identified is small.

It was decided to prioritise use of the 'psychotic disorder in the past year' measure in this chapter, to present prevalence estimates, perform subgroup comparisons, and examine treatment use for psychotic disorder in the past year using 2007, 2014 and 2023/4 data combined.

12.3 Results

Prevalence of psychotic disorder in the past year in 2007, 2014 and 2023/4

In 2007, 2014 and 2023/4, fewer than one adult in a hundred was identified with a psychotic disorder in the past year: 0.4% (95% CI 0.3, 0.6) in 2007, 0.7% (CI 0.4, 1.1) in 2014 and 0.4% (CI 0.2, 0.7) in 2023/4. These figures show a continued trend of broad stability in the past-year prevalence of psychotic disorder in adults living in private households in England. Any conclusions about trends should be treated with caution considering the numbers of confirmed cases were low (23 adults in 2007; 26 in 2014; and 16 in 2023/4). See How to interpret the findings (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/how-to-interpret-the-findings) for information on how changes over time were assessed.

Pooling data from the 2007, 2014 and 2023/4 surveys created a larger sample. Estimates drawing on the combined dataset can be considered more robust, and are used in the rest of this chapter where consistency over the survey years allows. Using the combined dataset, overall past-year prevalence of psychotic disorder was estimated at 0.5% of the adult general population. We are 95% confident that the 'true' population prevalance, based on our sampling design and methodology, would lie between 0.4% and 0.7%. This is equivalent to an estimated 190 thousand adults living in private households in England.

Prevalence of 'probable psychotic disorder', which includes both those assessed as positive using the SCAN or who screened positive for psychosis in phase one (by meeting two or more psychosis criteria) but did not complete a SCAN interview, was 0.8% using the combined dataset.

For more information: Table 12.1 and Table B1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals, Table 12.2 and Table A1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals

Prevalence of psychotic disorder in the past year and probable psychotic disorder (2007, 2014 and 2023/4 combined), by age and sex

Where data on demographic and socioeconomic characteristics were collected consistently since 2007, the results in this chapter draw on a dataset that combines the 2007, 2014 and 2023/4 samples and are analysed by sex (male and female).

Using data pooled from 2007, 2014 and 2023/4 surveys, the prevalence of psychotic disorder in the past year was 0.5% (95% CI 0.4, 0.7); and was similar in males (0.4%, CI 0.3, 0.7) and females (0.6%, CI 0.4, 0.8).

The prevalence of psychotic disorder in the past year using data pooled across the surveys varied by age and was highest in adults aged 35 to 44 (0.9%, CI 0.5, 1.4) and lowest in adults aged 75 and over (0.1%, CI 0.0, 0.5).

For more information: Table 12.2 and Table A1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals

Psychotic disorder in the past year (2007, 2014 and 2023/4 combined), by age (Base: All adults)

Download the data for this chart Psychotic disorder in the past year (2007, 2014 and 2023/4 combined), by age (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/psychotic-disorder/psychotic-disorder/publicationsystem%3AbodySections%5B9%5D/publicationsystem%3AdataFile)

Variation in psychotic disorder in the past year by other characteristics in combined 2007, 2014 and 2023/4 data

Ethnic group

Using age-standardised analyses, the prevalence of psychotic disorder in the past year did not vary significantly by ethnic group. However, the number of adults with psychotic disorders in some groups was very small and the confidence intervals around estimates were wide.

For more information: Table 12.3 and Table A2 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals

Employment status

In age-standardised analyses, the prevalence of psychotic disorder in the past year among working age adults (aged 16 to 64) varied by employment status. Economically inactive adults were more likely to be identified with psychotic disorder in the past year (2.6%) than those in employment (0.1%). The corresponding figure for adults classified as unemployed was 0.5%.

For more information: Table 12.4 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Psychotic disorder in the past year (2007, 2014 and 2023/4 combined) (age-standardised), by employment status (Base: Adults aged 16-64)

Download the data for this chart Psychotic disorder in the past year (2007, 2014

and 2023/4 combined) (age-standardised), by employment status (Base: Adults aged 16-64) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/psychotic-disorder/psychotic-disorder/publicationsystem%3AbodySections%5B11%5D/publicationsystem%3AdataFile)

Problem debt

In age-standardised analyses, being seriously behind on at least one debt repayment or having utilities cut off was associated with psychotic disorder in the past year. See the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods) for more information on how problem debt was derived. Adults who reported having problem debt were more likely to have a psychotic disorder (1.7%) than those who did not report problem debt (0.4%).

For more information: Table 12.5 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Psychotic disorder in the past year (2007, 2014 and 2023/4 combined), by problem debt (age-standardised) (Base: All adults)

Download the data for this chart Psychotic disorder in the past year (2007, 2014 and 2023/4 combined), by problem debt (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/psychotic-disorder/psychotic-disorder/publicationsystem%3AbodySections%5B13%5D/publicationsystem%3AdataFile)

Area-level deprivation

How has deprivation been defined?

Area-level deprivation has been defined using the English Indices of Deprivation 2019, commonly known as the Index of Multiple Deprivation (IMD).

IMD is the official measure of relative deprivation for Lower Super Output Areas (LSOAs) in England. LSOAs comprise between 400 and 1,200 households and usually have a resident population between 1,000 and 3,000 persons. IMD ranks every LSOA in England from 1 (most deprived area) to 32,844 (least deprived area). Deprivation quintiles are calculated by ranking the 32,844 neighbourhoods in England from most deprived to least deprived and dividing them into five equal groups. These range from the most deprived 20% of neighbourhoods nationally to the least deprived 20% of neighbourhoods nationally.

For further information see: English indices of deprivation 2019 (Link: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019).

In age-standardised analyses, being identified with psychotic disorder was associated with area-level deprivation. Adults living in the most deprived neighbourhoods were more likely to be assessed as positive for psychotic disorder in the past year than adults living in the least deprived neighbourhoods (based on quintiles) (1.0% and close to 0.0%, respectively).

For more information: Table 12.6 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Psychotic disorders in the past year (2007, 2014 and 2023/4 combined) (age-standardised), by area-level deprivation (Base: All adults)

Download the data for this chart Psychotic disorders in the past year (2007, 2014 and 2023/4 combined) (age-standardised), by area-level deprivation (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/psychotic-disorder/psychotic-disorder/publicationsystem%3AbodySections%5B17%5D/publicationsystem%3AdataFile)

Region

Although there were apparent differences in the prevalence of psychotic disorder (age-standardised) and English regions, these did not meet the required levels of significance. This could be due to the small number of adults assessed with psychotic disorder.

For more information: Table 12.7 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Comorbidity

Physical health conditions

How have physical health conditions been defined?

Participants were asked if they had any of 25 physical health conditions listed on a card, including asthma, cancer, diabetes, epilepsy and high blood pressure. Participants were coded as having a limiting physical health condition, if they reported having one or more physical health conditions in the past 12 months that had been diagnosed by a doctor and that this had limited their ability to carry out day-to-day activities. More details on the questions on physical health conditions can be found in the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

In age-standardised analysis of APMS 2023/4 data, those with a limiting physical health condition (0.9%) were more likely to be identified with psychotic disorder than those without (0.2%).

For more information: Table 12.8 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Psychotic disorder in the past year, by limiting physical health condition (age-standardised) (Base: All adults (2023/4 only)

Download the data for this chart Psychotic disorder in the past year, by limiting physical health condition (age-standardised) (Base: All adults (2023/4 only) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-

wellbeing-england-2023-24/psychotic-disorder/psychotic-disorder/publicationsystem%3AbodySections%5B21%5D/publicationsystem%3AdataFile)

Common mental health conditions

How have common mental health conditions been defined?

The revised Clinical Interview Schedule (CIS-R) was used to assess six types of common mental health conditions (CMHC): depression, generalised anxiety disorder, panic disorder, phobias, obsessive compulsive disorder, and CMHC not otherwise specified. Participants identified with at least one of these were defined as having a CMHC. See Section 1.2 of the Common mental health conditions (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/common-mental-health-conditions) chapter for more detail.

Age-standardised analyses of combined data from 2007, 2014 and 2023/4 showed that adults with a common mental health condition (CMHC) were more likely than those without to be identified with psychotic disorder in the past year. 2.1% of adults with a CMHC were assessed as positive for psychotic disorder, compared with 0.1% without a CMHC.

For more information: Table 12.8 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Psychotic disorder in the past year (2007, 2014 and 2023/4 combined), by common mental health condition (age-standardised) (Base: All adults)

Download the data for this chart Psychotic disorder in the past year (2007, 2014 and 2023/4 combined), by common mental health condition (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/psychotic-disorder/psychotic-disorder/publicationsystem%3AbodySections%5B25%5D/

publicationsystem%3AdataFile)

Self-diagnosis and professional diagnosis of psychotic disorder

Participants were asked whether they thought they had ever experienced 'psychotic disorder or schizophrenia'. Those who said yes were asked whether this had been diagnosed by a professional, and if so, whether this had occurred in the past 12 months.

Of adults included in the 2014 and 2023/4 surveys, 0.7% reported that they thought that they have had a psychotic disorder or schizophrenia at some point in their life, and 0.5% (a subset of the 0.7%) of adults stated that this had been diagnosed by a professional.

Among those identified with psychotic disorder in the past year, 17 people (37.1%) reported that they thought they have had psychotic disorder or schizophrenia at some point in their life, all of whom (37.1%) reported that they have had this diagnosed by a professional. 15 people (31.9%) who reported that a health professional had diagnosed psychotic disorder or schizophrenia had experienced symptoms in the past year.

Base sizes of those identified with psychotic disorder in the past year by the survey are fairly small and these figures should be treated with some caution.

For more information: Table 12.9 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Treatment and service use

Mental health treatment and service use

Participants were asked about different types of mental health treatment and service use. These included current psychotropic medication or psychological therapy for any mental or emotional problem (not necessarily related to psychotic disorder). Participants were also asked about their use of a range of health, community and day care services over the past year.

In combined data from 2007, 2014, and 2023/4, a fifth (21.0%) of adults identified with psychotic disorder in the past year (based on SCAN examination) were not receiving any treatment for a mental or emotional problem. Three in four adults identified with psychotic disorder were in receipt of psychotropic medication (74.6%) and nearly half were in receipt of psychological therapy (43.3%).

Adults identified with psychotic disorder in the past year were more likely to use health care services for a mental or emotional problem (68.4%) than those without psychotic disorder (12.3%). Among those identified with psychotic disorder, two in three (62.7%) had used community care services and about one in three (36.3%) had used day care

services in the past year.

For more information: Table 12.10 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Treatment currently received for a mental or emotional problem (2007, 2014 and 2023/4 combined), by psychotic disorder in past year (Base: All adults)

Download the data for this chart Treatment currently received for a mental or emotional problem (2007, 2014 and 2023/4 combined), by psychotic disorder in past year (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/psychotic-disorder/psychotic-disorder/publicationsystem%3AbodySections%5B27%5D/publicationsystem%3AdataFile)

Psychotropic medication

Participants were asked which (if any) psychotropic medications they were currently taking for a mental health reason. These were not necessarily medications being taken for symptoms related to psychotic disorder. For further information about how medication data was collected, see the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods). Overall, 12.5% of all adults were taking some form of psychotropic medication, with the most common medication types being those primarily used to treat depression (11.7%) and anxiety (10.7%). See Chapter 2 Mental health treatment and service use (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/mental-health-treatment-and-service-use) for more details.

Three quarters of people with psychotic disorder in the past year were taking psychotropic medication (74.6%). This was eight times higher than in those without psychotic disorder (9.6%).

Among those with psychotic disorder, psychotropic medications taken were those primarily used to treat:

- depression (53.4%)
- bipolar disorder (46.1%)

- psychosis (43.2%)
- anxiety (39.0%)

Use of substance dependence medication was more prevalent among those with psychotic disorder (9.4%) than in those without psychotic disorder (0.6%).

For more information: Table 12.11 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

12.4 Discussion

Less than one in a hundred adults met diagnostic criteria for a psychotic disorder in the past year in 2007, 2014, and 2023/4. The approach to psychosis measurement across the APMS series has remained largely consistent over time, and the estimated prevalence across surveys has ranged from 0.4 to 0.7, indicating relative stability or at most modest variation over time in the annual prevalence of psychotic disorders among adults living in private households in England. This is despite evidence of more substantive increases in the prescribing of antipsychotic medication (Shoham et al. 2021) and some evidence of increases in the incidence (rate of new cases) of these conditions over time in some populations (Oduola et al. 2021). One possible explanation is that this increased incidence may be offset by more adults being in recovery from their psychotic disorder as a consequence of heightened levels of antipsychotic prescribing.

APMS may underestimate the prevalence of psychotic disorder in the adult population. Studies drawing on medical notes as well as interview data tend to identify more cases of psychotic disorder than studies like APMS, which rely on interview information alone (Kirkbride et al. 2012; Isohanni et al. 1997). People experiencing a psychotic episode may also be less likely to take part in a survey, either because they feel too unwell to take part or because of a heightened guardedness (Subotnik et al. 2005). The relatively rare and complex nature of psychosis makes it harder to recruit a representative sample of people with the disorder, especially given their higher likelihood of being homeless (Chilman et al. 2024), in prison (Bebbington et al. 2021), or in other non-household settings.

People with psychotic disorder often experienced disadvantage and deprivation. This is consistent with evidence from Sweden that has shown that people who grow up in more deprived areas are more likely to be diagnosed with a psychotic disorder later in life (Logeswaran et al. 2023); this association is stronger than the reverse pattern where people with psychotic disorders may move into more deprived areas due to their condition. In APMS, adults identified with a psychotic disorder were also more likely to be experiencing problem debt. Across the 2007, 2014, and 2023/4 surveys, the prevalence of psychotic disorder was highest in adults who were economically inactive. These findings are broadly consistent with a Swedish nationwide population-based study,

which reported that only 3-4% of people with schizophrenia were in paid employment (Holm et al. 2021). A systematic review by Bouwmans et al. (2015) found that employment of people with schizophrenia was associated with better health-related quality of life, although the direction of causality of this relationship is unclear. Unlike studies of incidence which have reported large disparities in psychotic disorder by ethnicity (Kirkbride et al. 2012), we did not find significant differences in the prevalence of psychotic disorder in the past year between ethnic groups. This may be due to differences between ethnic groups in factors that influence prevalence estimates (incidence, remission and recovery, emigration, death), small sample sizes in some ethnic groups in APMS, and methodological differences in case ascertainment and identification between clinical studies of incidence and population-based surveys such as APMS. Further research is required to understand these processes in more detail.

People with psychotic disorder often had other physical and mental health conditions. High prevalence of anxiety disorders (Achim et al. 2011) and major depressive disorder (Etchecopar-Etchart et al. 2021) has previously been reported among patients with schizophrenia. This demonstrates a need for many people with psychotic disorders to have a comprehensive treatment plan that addresses the presence of multiple co-occurring mental health conditions. Overlapping mental health conditions may also partially account for their higher usage of psychotropic medication (eight times higher than for adults without psychotic disorder), including medications prescribed for depression (53.4%), bipolar disorder (46.1%), psychosis (43.2%), and anxiety (39.0%). The strong associations found with physical health conditions are also consistent with wider evidence, including elevated rates of sensory impairment among people with psychotic disorder (e.g. Shoham et al. 2020).

Most survey participants identified with psychotic disorder did not think they had the condition. Among those identified with psychotic disorder in the past year, around a third reported that they thought they have had 'psychotic disorder or schizophrenia' at some point in their life, all of whom reported that a professional had told them they had the condition. The fact that most people identified with the condition did not report thinking they have had it may reflect stigma and a reluctance to disclose, or poor mental-illness related insight, which has been observed in almost half of all participants with a first episode of psychosis in a previous study (Ayesa-Arriola et al. 2014).

While limited by sample size, APMS data provides unique context on psychosis in England. The findings in this chapter provide support for a continued focus on improving community services, including early intervention and support for people with a first episode of psychosis (NHS England 2023 (Link: https://www.england.nhs.uk/wp-content/uploads/2023/03/B1954-implementing-the-early-intervention-in-psychosis-access-and-waiting-time-standard.pdf); De Girolamo et al. 2012; Kahn et al. 2015), and ensuring they have access to support around their finances, employment (Carmona et al. 2017), and physical health needs (Teh et al. 2021).

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Previous Chapter

Chapter 11: Bipolar disorder (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/bipolar-disorder)

Next Chapter

Chapter 13: Eating disorders (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/eating-disorders)

Chapter 13: Eating disorders

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Overview

Eating disorders include a range of serious mental health conditions characterised by disturbances in eating and food-related behaviours, as well as disturbances in the experience of weight and shape.

In the phase one interview, eating disorder features were screened for using the SCOFF questionnaire, a brief self-report screening tool designed to screen for possible cases of anorexia nervosa and bulimia nervosa. In the phase two interview, examinations were carried out with a subset of participants by clinically trained interviewers using the Eating Disorders module of the Schedule for Clinical Assessment in Neuropsychiatry (SCAN ED), designed to assess ICD-11 eating disorder diagnoses, including avoidant restrictive food intake disorder (ARFID). The SCAN examination results were weighted to estimate the prevalence of eating disorders meeting diagnostic criteria in the adult population.

This chapter presents two outcomes: (1) the proportion of adults screening positive on the SCOFF in 2007 and 2023/4, and (2) the proportion of adults in 2023/4 both screening positive on the SCOFF and identified with a diagnosable eating disorder based on the SCAN ED examination.

Key findings

- **The proportion of adults screening positive on the SCOFF increased from 6.4% in 2007 to 9.1% in 2023/4, indicative of possible eating disorder.** A rise was evident in both males and females, and in most age groups.
- **Screening positive on the SCOFF was more common in women (11.8%) than men (6.1%)**, and in younger adults compared with older age groups.
- **Based on those with a positive SCOFF screen and a positive clinical examination on the SCAN ED, 1.3% of adults (95% CI 0.8, 2.2) met the diagnostic criteria for an eating disorder in the past year.** Because just 26 participants both scored 2+ on the SCOFF and were identified by the SCAN with an eating disorder, confidence intervals around estimates are wide, and the sample is underpowered for examining subgroup differences. A further 13 participants were identified with an eating disorder by the SCAN ED but did not screen positive on the SCOFF and were therefore excluded from

the analysis. This prevalence may be an underestimate for several reasons, which are described in the chapter.

- **Eating disorder (SCOFF+SCAN ED) prevalence varied by age.** It was highest in 16 to 24 year olds (2.5%, CI 0.8, 7.4) and lowest in those aged 65 and over (0.2%, CI 0.0, 0.7).
- **Prevalence of eating disorder (SCOFF+SCAN ED) varied by employment status**, with a higher proportion of unemployed adults (11.4%) having an eating disorder, compared with those who were employed (1.0%) or economically inactive (2.8%).
- **Eating disorder prevalence was strongly associated with common mental health conditions such as anxiety and depression.** Adults with a common mental health condition were more likely to have an eating disorder (4.5%) than those without (0.5%).

13.1 Introduction

Eating disorders are described in the World Health Organization's (WHO) 11th edition of the International Classification of Diseases (ICD-11) as psychiatric conditions involving abnormal eating behaviour and preoccupation with food accompanied in most instances by body weight or shape concerns (WHO 2019 (Link: https://icd.who.int/en/)). Eating disorders include anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), avoidant restrictive food intake disorder (ARFID), pica, rumination disorder, and other specified feeding or eating disorder (OSFED) all of which have a significant impact on the quality of life of affected individuals and are associated with increased healthcare utilisation and costs (Ágh et al. 2016; Hay et al. 2023; Liu et al. 2025; Santomauro et al. 2021; Wang et al. 2024).

Eating disorders are more common in women (Udo and Grillo 2018), though under recognition may be an issue among men and nonbinary people, who may present with different symptomatology and have been historically overlooked in eating disorders research (Murray et al. 2017; Rasmussen et al. 2025). The vast majority of first episodes of eating disorders occur in adolescence or early adulthood (Solmi et al. 2022), though many people go on to experience recurrent episodes later in life (Ward et al. 2019). Minoritised ethnic groups are underrepresented in eating disorders research. As such, there is limited understanding of prevalence and treatment outcomes in these populations (Williams-Ridgway et al. 2025; Barakat et al. 2023). Eating disorders are associated with other health problems, both related to mental health (e.g., anxiety disorders, mood disorders, substance abuse disorders, and post-traumatic stress disorder) and physical health (e.g., involving the skeletal, neuroendocrine, gastrointestinal, and dental systems) (Hambleton et al. 2022; Barakat et al. 2023). Eating disorders are also associated with a substantially increased risk of mortality. A recent large meta-analysis by Solmi and colleagues (2024) found that people with anorexia nervosa have around five times higher mortality rates than the general population, while standardised mortality ratios for other eating disorders are approximately double that of the general

population (Solmi et al. 2024). Additionally, eating disorders can have wider impacts, such as on fertility (Tabler et al. 2018), work participation and performance (Ubhi et al. 2025).

To date, no population-level study has provided a comprehensive assessment of the full diagnostic spectrum of eating disorders in the UK. Current understanding relies heavily on global prevalence estimates and screening tools that fail to encompass the entire range of disorders. Epidemiological studies have typically focused on anorexia nervosa and bulimia nervosa, with eating disorders such as binge eating disorder and OFSED often excluded (Santomauro et al. 2021). No prevalence studies for ARFID have yet been conducted in UK adults, and good quality data in children and adolescents are sparse (Sanchez-Cerezo et al. 2023). A systematic analysis for the Global Burden of Disease (GBD) Study 2019 estimated an age-standardised prevalence of 174.0 per 100,000 people (GBD 2019 Mental Disorders Collaborators 2022). While the GBD figures included just anorexia nervosa and bulimia nervosa, a subsequent further analysis was carried out by Santomauro et al. (2021) to make the case for inclusion of binge eating disorder and OFSED in GBD. They estimated that this wider definition of eating disorders would increase the GBD 2019 global prevalence from 0.2% of the population to 0.7%. A systematic review describing the prevalence of eating disorders reported lifetime prevalence estimates of 8.4% for women and 2.2% for men, and 12-month prevalence estimates of 2.2% for women and 0.7% for men (Galmiche et al. 2019).

An upward trend in the prevalence of eating disorders over time is evident from analyses of general population surveys of children and adults living in England. Although no increase was evident between the 2004 and 2017 Mental Health of Children and Young People surveys (Marcheselli et al. 2018 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017)), the prevalence of eating disorders according to screening items increased from 0.5% in 2017 to 2.6% in the 2023 follow-up survey among 11 to 16 year olds. A more marked rise was reported for the 17 to 19 year age group (Newlove-Delgado et al. 2023 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2023-wave-4-follow-up/part-5-eating-problems-and-disorders)). In APMS 2007, 6.4% of adults in England screened positive for a possible eating disorder using the SCOFF questionnaire (McManus et al. 2009 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-in-england-2007-results-of-a-household-survey)), compared with 16% in 2019 in the Health Survey for England (NHS Digital 2020 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2019)). Alongside this survey evidence of rising prevalence, the number of hospital admissions where the main reason

for admission was an eating disorder diagnosis also increased, by about 50%, between 2013/14 and 2023/4 (NHS England 2024 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity)).

Various reasons have been proposed as contributing to a rising prevalence of eating disorders and disordered eating in England. The rising rate of obesity has been cited as a factor contributing to the increased rate of disordered eating, though there is currently very limited guidance for clinicians and researchers relating to effective identification and risk monitoring of eating disorders among the higher weight groups (McMaster et al. 2023). Additionally, social media usage may contribute to eating disorders through multiple pathways, including engaging in social comparison, internalising thin/fit ideals and experiencing self-objectification (Dane and Bhatia 2023). The COVID-19 pandemic was associated with an increase in referrals to eating disorders services as well as longer waiting times (Ayton et al. 2022), though the more recent post-pandemic period has shown a subsequent decline in referrals (Gallagher et al. 2025). Additionally, the diagnostic concept of eating disorders has broadened in recent years, to include newly formally recognised conditions such as binge-eating disorder and ARFID, in addition to broadening the criteria for pre-existing conditions, including anorexia nervosa and bulimia nervosa (Hay 2020).

A report by the All-Party Parliamentary Group on Eating Disorders called for a national eating disorders strategy to address the rise in eating disorders in the UK (All-Party Parliamentary Group on Eating Disorders 2025 (Link: https://www.yumpu.com/en/document/read/69681888/appg-report-the-right-to-health-final-one-all-checked)). The report recommended that the strategy have several key components, including mandatory eating disorder training for all front-line staff, investment in public health messaging around obesity and eating disorders, funding for the implementation and integration of evidence-based treatment practices, mandatory health screening for high risk groups and training for carers.

The National Institute for Health and Care Excellence (NICE) guidelines covering eating disorders recommend that initial assessments should not be based solely on screening tools (such as the SCOFF) and a range of factors should be taken into account, for example unusually low or high body mass index (BMI), rapid weight loss, comorbidity with physical or mental health conditions and social withdrawal, especially around food. If an eating disorder is suspected, people should be referred immediately to a community-based, age-appropriate eating disorder service for further assessment or treatment. NICE also recommends encouraging family members, carers, teachers, and peers of children to provide support during treatment. Treatment varies by the type of eating disorder, with a range of psychological treatments recommended, as well as collaboration to support physical and mental health comorbidities (NICE 2017, updated 2020 (Link: https://www.nice.org.uk/guidance/ng69)).

This chapter aims to provide further insight into the distribution of eating disorders

among community-based adults living in England, as well as associations with key demographic characteristics, including age, gender, ethnicity, employment status, problem debt, area-level deprivation, region, physical and mental health comorbidity, and BMI.

13.2 Definitions and assessments

Eating disorders

There are two primary sets of diagnostic criteria in current use: the ICD-11 (WHO 2019 (Link: https://icd.who.int/en/)) and the Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5, American Psychiatric Association 2013). The ICD-11 lists eight categories of feeding and eating disorders: anorexia nervosa, bulimia nervosa, binge eating disorder, ARFID, pica, rumination-regurgitation disorder, OSFED, and unspecified feeding or eating disorders. These correspond closely to the DSM-5 categories.

Description of five eating disorders covered by ICD-11

Anorexia nervosa (AN) is defined by significantly low body weight (or, in ICD-11, clinically significant weight loss), an intense fear of gaining weight, and disturbances in body perception. People with AN typically restrict food intake and may over-exercise or use other methods to control weight. The DSM-5 distinguishes between restricting and binge-eating/purging subtypes.

Bulimia nervosa (BN) involves repeated episodes of binge eating followed by compensatory behaviours such as vomiting, laxative misuse, fasting, or excessive exercise. Self-evaluation is overly influenced by body shape and weight. People with BN usually maintain a body weight within or near the normal range but may experience serious medical complications.

Binge eating disorder (BED) is characterised by recurrent episodes of eating unusually large amounts of food accompanied by a sense of loss of control, but without compensatory behaviours. These episodes are associated with marked distress.

Avoidant/restrictive food intake disorder (ARFID) describes restricted food intake leading to weight loss, nutritional deficiency, or dependence on supplements, but without body image disturbance.

Other specified feeding or eating disorders (OSFED) refers to clinically significant eating disorders that do not meet the full criteria for the above categories but still cause substantial impairment or distress. The type of OSFED should be specified (e.g. purging disorder).

Features of an eating disorder

SCOFF questionnaire

The SCOFF screening tool was used in both the 2007 and 2023/4 APMS to screen for possible eating problems. The letters included in SCOFF represent the first letter of the words; Sick, Control, One stone, Fat, and Food. The SCOFF questions were developed and validated in the UK as a short and simple tool to raise the suspicion that an eating disorder might exist among non-specialists, rather than to make a diagnosis (Morgan et al. 1999 (Link: https://www.bmj.com/content/319/7223/1467.extract)). A recent systematic review of two decades of research (Coop et al. 2024) found that the SCOFF has often been used inappropriately as a diagnostic or prevalence measure rather than as a brief screening tool. The authors, including the original developers, emphasised that a full clinical assessment is required to confirm any diagnosis and that results should be interpreted with caution. Consistent with this, the National Institute for Health and Care Excellence (NICE 2024 (Link: https://cks.nice.org.uk/topics/eating-disorders/); NICE

2017, updated 2020 (Link: https://www.nice.org.uk/guidance/ng69)) recognises the SCOFF as a useful short screening instrument for identifying possible eating disorders in community settings, but advises that it should not be used in isolation to determine whether a person has an eating disorder.

The SCOFF questionnaire was administered to all APMS 2023/4 participants in the self-completion part of the interview. The tool uses five questions from which the word SCOFF was devised, with yes/no response codes, as outlined in the table below. The word SCOFF is intended to act as a memory prompt for the screening items. Responding yes to two or more items indicates a case of possible eating problems, warranting further clinical assessment.

The table below lists the questions used. The APMS 2023/4 adopted that same approach used in the 2007 survey and the 2019 Health Survey for England (HSE) (McManus et al. 2009 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-in-england-2007-results-of-a-household-survey); NHS Digital 2020 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2019)). The original SCOFF wording was amended slightly to relate the questions to a specified time frame: the last year. The order of presentation was also amended. These changes mean that the APMS 2023/4 data is comparable to the 2007 data and the HSE 2019 data but may not be directly comparable with other studies that have used the scale.

The SCOFF screening items	
In the last year…	
…have you lost more than **one stone** in a three month period?	Yes/No
…have you made yourself be **sick** because you felt uncomfortably full?	Yes/No
…did you worry you had lost **control** over how much you eat?	Yes/No
…did you believe yourself to be **fat** when others said you were too thin?	Yes/No
…would you say that **food** dominated your life?	Yes/No

An additional question was asked of participants scoring two or more on the SCOFF: 'Did your feelings about food interfere with your ability to work, meet personal responsibilities and/or enjoy a social life?' This question was asked to get an indication of

whether the presence of attitudes and behaviours associated with eating disorders were having an impact on social participation and integration.

In this chapter, a positive screen for **features of an eating disorder** is a SCOFF score of two or more. The proportion of participants screening positive and reporting that feelings about food interfere with life (with significant impact) is also presented in the tables.

Eating disorder in the past year

Eating disorders module of the Schedule for Clinical Assessment in Neuropsychiatry (SCAN ED)

The Eating disorders module was a new addition to the Schedule for Clinical Assessment in Neuropsychiatry (SCAN) 3.0 (WHO unpublished), administered in the phase two examination, and has not been used in the APMS-series before. It covers DSM-5 criteria and ICD-11 clinical descriptions for eating disorders and subtypes in the past year. The SCAN (SCAN ED) was designed to cover probable anorexia nervosa, bulimia nervosa, and binge eating disorder, possible ARFID, and other specified feeding or eating disorders (OFSED), but did not detect pica or rumination-regurgitation disorder. For the purposes of this chapter, these identified eating disorder types were considered collectively in the analysis. SCAN ED was included in the existing phase two examination, which already used SCAN to assess psychosis in the APMS.

Because SCAN involves interviewer judgement of whether symptoms are present (hence an ‘examination’ as opposed to reliance on self-reports or on a fixed set of interview questions), the assessments were conducted by clinically trained interviewers from the University of Leicester (Brugha et al. 1999). The presence of an eating disorder in the year before examination was established by applying ICD-11 diagnostic algorithms to the SCAN generated symptom ratings. As SCAN ED is a new module, a separate validation study was carried out with adults seen by an eating disorder specialist at two NHS sites specialising in eating disorders. The results from the validation study were used to set a threshold for the SCAN algorithm to identify any eating disorder. More detailed results from the validation study will be published separately.

Participants were eligible for the SCAN ED module if they answered ‘yes’ to at least two SCOFF questions in the phase one questionnaire. Overall, 468 participants scored at least two on the SCOFF questionnaire in the in-person phase one self-completion part of the interview and were therefore eligible for a phase two assessment. Of these, 87 participants (19%) did not consent to be contacted for a phase two interview. In total, 187 (40%) participants who scored at least two on the SCOFF questionnaire in phase one and agreed to be contacted about phase two took part in the phase two examination. The remainder either later declined to participate (37%) or could not be contacted (23%). Of those selected for phase two based on a score of two or more on the SCOFF questionnaire and who completed a phase two interview, 26 participants were classified as having an eating disorder in the past year based on their SCAN ED results.

The full SCAN questionnaire was administered to all participants who took part in the phase two examination, regardless of the condition(s) they were selected for. 13 participants with a SCOFF score of less than 2, who had been selected for phase two interview based on screening positive for autism and/or psychosis, were identified as having an eating disorder. Thus, while 39 participants were identified as having an eating disorder based on SCAN ED, 13 cases are counted as negative for the purposes of the prevalence estimates presented in this chapter due to their low SCOFF score. The fact that a third of them were identified from a group of participants who scored less than 2 on SCOFF indicates that SCOFF has low sensitivity and may not perform well in identifying people with the full range of ICD-11 eating disorders. For example, the SCOFF would not detect ARFID cases, which may be particularly overrepresented in those with autism (Bourne et al. 2022).

It is possible that other participants who scored less than 2 on SCOFF but were not selected for a phase two examination may have had an eating disorder but are not included in the probable eating disorder prevalence. It was decided to limit the eating disorder cases used in analysis in this chapter to the 26 that were identified based on the initially agreed study protocol (i.e., only those who had additionally scored two or more on the SCOFF). The estimates presented in this chapter are thus conservative. Because much was known about the characteristics of non-responders to phase two, a nuanced eating disorders specific weighting strategy was developed to address non-response. See the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods) for more information.

Results using the SCOFF screening questionnaire should be treated with caution, as they class at least some participants with a probable eating disorder (as identified by SCAN ED), as not having eating problems. Our results cannot evaluate the specificity and sensitivity of SCOFF, i.e., how many participants were incorrectly identified as having or not having an eating disorder.

Estimation of body mass index (BMI)

In the face-to-face part of the interview, participants were asked about their height and weight. Where provided, this information has been used to estimate each participant's body mass index (BMI). BMI is defined as body weight in kilograms divided by the square of height in metres (kg/m^2).

Self-reported height and weight is recognised to be less accurate than direct measurement, with men likely to overestimate their height and women underestimate their weight (Merrill and Richardson 2009). To account for this, prediction equations developed using Health Survey for England data were used to adjust for possible inaccuracies in height and weight (Scholes et al. 2023). In this chapter, participants were grouped into the following five BMI categories; less than 18.5 (underweight), 18.5 to less than 25 (healthy weight), 25 to less than 30 (overweight), 30 to less than 40 (obese,

excluding severe obesity), and 40 or more (severe obesity).

The upper threshold of the underweight category used in APMS was 18.5 kg/m^2 as defined in the ICD-11 (WHO 2019) and the DSM-5 (APA 2013).

13.3 Results

Features of an eating disorder (SCOFF 2+), by age and gender

9.1% of adults scored 2+ on the SCOFF, and 2.2% of adults scored 2+ on the SCOFF and also reported that their feelings about food had interfered with their ability to work, meet personal responsibilities or enjoy a social life. If all adults in the population had been assessed, it is likely that the proportion scoring 2+ on the SCOFF would be between 8.1% and 10.2% (95% CI). This equates to approximately 4.2 million adults living in England.

Women (11.8%, 95% CI 10.4, 13.4) were more likely than men (6.1%, CI 4.9, 7.5) to score 2+ on the SCOFF. 3.2% of women (CI 2.4, 4.2) and 1.2% of men (CI 0.7, 2.0) scored 2+ on the SCOFF and reported that their feelings about food had a significant impact on their life. Among both men and women, prevalence of screening positive on the SCOFF was highest in 16 to 24 year olds (20.1%, CI 15.4, 25.7) and declined with increasing age to 2.2% (CI 1.2, 3.9) in those aged 75 and over.

For more information: Table 13.1 and Table A1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals

Features of an eating disorder (SCOFF 2+), by age (Base: All adults)

Download the data for this chart Features of an eating disorder (SCOFF 2+), by age (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/eating-disorders/eating-disorders/publicationsystem%3AbodySections%5B9%5D/publicationsystem%3AdataFile)

Features of an eating disorder (SCOFF 2+) in 2007 and 2023/4

Note that the trends in this chapter are analysed by sex (male and female) rather than

gender (men and women) to allow for comparison with 2007. See How to interpret the findings (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/how-to-interpret-the-findings) for information on how changes over time were assessed.

The proportion of adults scoring 2+ on the SCOFF rose from 6.4% (95% CI 5.8, 7.1) in 2007 to 9.1% (CI 8.1, 10.1) in 2023/4. This rise was observed in both males and females, increasing in males from 3.5% in 2007 (CI 2.9, 4.3) to 6.1% (CI 4.9, 7.5) in 2023/4, and in females from 9.2% in 2007 (CI 8.2, 10.3) to 11.9% (CI 10.5, 13.5) in 2023/4. Apparent rises in age and sex subgroups over time have wide and overlapping confidence intervals.

For more information: Table 13.2 and Table B1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals

Features of an eating disorder (SCOFF 2+) in 2007 and 2023/4, by sex (Base: All adults)

Download the data for this chart Features of an eating disorder (SCOFF 2+) in 2007 and 2023/4, by sex (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/eating-disorders/eating-disorders/publicationsystem%3AbodySections%5B11%5D/publicationsystem%3AdataFile)

Prevalence of eating disorders in the past year (SCOFF+SCAN ED), by age and gender

The prevalence of eating disorders in the past year in England was 1.3%, as indicated by both a positive SCOFF screen combined with a positive eating disorder examination using the SCAN ED. Prevalence in the wider adult population is likely to be between 0.8% and 2.2%, referred to as the 95% confidence interval (95% CI). This equates to about 600 thousand adults living in England. The size of this confidence interval is similar to that of some of the other lower prevalence disorders considered on APMS.

Because just 26 participants both scored 2+ on the SCOFF and were identified by the SCAN with an eating disorder, confidence intervals around estimates are wide, and the sample is underpowered for examining subgroup differences. A further 13 participants were identified with an eating disorder by the SCAN ED but did not screen positive on the SCOFF and are therefore excluded from the analysis, which should be taken into consideration when interpreting the results in this chapter.

The prevalence of eating disorder appeared to be higher in women (1.9%, CI 1.1, 3.5) than men (0.5%, CI 0.2, 1.6) although confidence intervals were wide and overlapped. Some variation in prevalence of eating disorder by age was evident, with prevalence highest in those aged 16 to 24 (2.5%, CI 0.8, 7.4) and lowest in those aged 65 and over (0.2%, CI 0.0, 0.7).

For more information: Table 13.3 and Table A2 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals

Eating disorder in the past year (SCOFF+SCAN ED), by gender (Base: All adults)

Download the data for this chart Eating disorder in the past year (SCOFF+SCAN ED), by gender (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/eating-disorders/eating-disorders/publicationsystem%3AbodySections%5B13%5D/publicationsystem%3AdataFile)

Variations in prevalence of eating disorders (SCOFF+SCAN ED) by other characteristics

Ethnic group

Eating disorder prevalence (based on SCOFF+SCAN ED) did not vary significantly between ethnic groups in age-standardised analyses. However, the number of adults with eating disorders in some groups was very small and the confidence intervals around estimates were wide.

For more information: Table 13.4 and Table A3 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) for confidence intervals

Employment status

Eating disorder prevalence (based on SCOFF+SCAN ED) varied by employment status (age-standardised) among working age adults (16 to 64). It was highest in unemployed (11.4%) and lower in employed (1.0%) and economically inactive (2.8%) adults.

For more information: Table 13.5 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Eating disorder in the past year (SCOFF + SCAN ED), by employment status (age-standardised) (Base: Adults aged 16-64)

Download the data for this chart Eating disorder in the past year (SCOFF + SCAN ED), by employment status (age-standardised) (Base: Adults aged 16-64) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/eating-disorders/eating-disorders/publicationsystem%3AbodySections%5B15%5D/publicationsystem%3AdataFile)

Problem debt

Problem debt was defined as being seriously behind on at least one debt repayment or having utilities cut off. See the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods) for more information on how problem debt was derived.

Eating disorder prevalence (based on SCOFF+SCAN ED) was not significantly associated with problem debt in age-standardised analyses. However, the number of adults with eating disorders in some groups was very small and the confidence intervals around estimates were wide.

For more information: Table 13.6 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Area-level deprivation

How has deprivation been defined?

Area-level deprivation has been defined using the English Indices of Deprivation 2019, commonly known as the Index of Multiple Deprivation (IMD).

IMD is the official measure of relative deprivation for Lower Super Output Areas (LSOAs) in England. LSOAs comprise between 400 and 1,200 households and usually have a resident population between 1,000 and 3,000 persons. IMD ranks every LSOA in England from 1 (most deprived area) to 32,844 (least deprived area). Deprivation quintiles are calculated by ranking the 32,844 neighbourhoods in England from most deprived to least deprived and dividing them into five equal groups. These range from the most deprived 20% of neighbourhoods nationally to the least deprived 20% of neighbourhoods nationally.

For further information see: English indices of deprivation 2019 (Link: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019).

Eating disorder prevalence (based on SCOFF+SCAN ED) was not significantly associated with area-level deprivation in age-standardised analyses.

For more information: Table 13.7 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Region

Regions were grouped into four areas (North, Midlands and East, South, and London) for this analysis due to the small number of participants identified with an eating disorder. Eating disorder prevalence (based on SCOFF+SCAN ED) varied by region (age-standardised) and was highest in the South of England (2.3%) and lowest in the North of England (0.2%). However, the number of adults with eating disorders in some groups was very small and the confidence intervals around estimates were wide.

For more information: Table 13.8 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Eating disorder in the past year (SCOFF+SCAN ED), by region (age-standardised) (Base: All adults)

Download the data for this chart Eating disorder in the past year (SCOFF+SCAN

ED), by region (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/eating-disorders/eating-disorders/publicationsystem%3AbodySections%5B19%5D/publicationsystem%3AdataFile)

Comorbidity

Physical health conditions

How have physical health conditions been defined?

Participants were asked if they had any of 25 physical health conditions listed on a card, including asthma, cancer, diabetes, epilepsy and high blood pressure. Participants were coded as having a limiting physical health condition, if they reported having one or more physical health conditions in the past 12 months that had been diagnosed by a doctor and that this had limited their ability to carry out day-to-day activities. More details on the questions on physical health conditions can be found in the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

In age-standardised analyses, adults with a limiting physical health condition (2.7%) were more likely than those without (0.6%) to have an eating disorder (based on SCOFF+SCAN ED).

For more information: Table 13.9 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Eating disorder in the past year (SCOFF+SCAN ED), by limiting physical health condition (age-standardised) (Base: All adults)

Download the data for this chart Eating disorder in the past year (SCOFF+SCAN ED), by limiting physical health condition (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-

wellbeing-england-2023-24/eating-disorders/eating-disorders/publicationsystem%3AbodySections%5B23%5D/publicationsystem%3AdataFile)

Common mental health conditions

How have common mental health conditions been defined?

The revised Clinical Interview Schedule (CIS-R) was used to assess six types of common mental health conditions (CMHC): depression, generalised anxiety disorder, panic disorder, phobias, obsessive compulsive disorder, and CMHC not otherwise specified. Participants identified with at least one of these were defined as having a CMHC. See Section 1.2 of the Common mental health conditions chapter (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/common-mental-health-conditions) for more detail.

In age-standardised analyses, adults with a common mental health condition (CMHC) were more likely to have an eating disorder (4.5%) according to SCOFF+SCAN ED than those without a CMHC (0.5%).

For more information: Table 13.9 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Eating disorder in the past year (SCOFF+SCAN ED), by common mental health condition (CMHC) (age-standardised) (Base: All adults)

Download the data for this chart Eating disorder in the past year (SCOFF+SCAN ED), by common mental health condition (CMHC) (age-standardised) (Base: All adults) (Link: /binaries/content/documents/corporate-website/publication-system/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/eating-disorders/eating-disorders/publicationsystem%3AbodySections%5B27%5D/publicationsystem%3AdataFile)

Body mass index (BMI)

BMI was estimated based on participants' self-reported height and weight at phase one, and adjusted for possible inaccuracies in self-reported height and weight. For more information Section 13.2 Definitions and assessments. (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/eating-disorders#13-2-definitions-and-assessments)

In age-standardised analyses, the prevalence of eating disorder (SCOFF+SCAN ED) did not vary between BMI groups. No APMS participants identified with an eating disorder (SCAN ED) met the criteria for the 'underweight' category.

For more information: Table 13.10 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

13.4 Discussion

1.3% of adults in England had a diagnosable eating disorder in the past year (95% CI 0.8, 2.2). This estimate required both a positive screen using the SCOFF and a positive examination using the Eating Disorders module of the Schedule for Clinical Assessment in Neuropsychiatry (SCAN ED). APMS 2023/4 is the first national survey to include a two stage ascertainment like this. Prevalence appeared to be higher in women (1.9%) than men (0.5%), and higher in younger than older adults. However, the small number of identified cases limits the statistical power of this analysis, the confidence intervals were wide and overlapping. This apparent higher prevalence of eating disorders in women is consistent with the majority of prior evidence, though the sex ratios for individual eating disorders likely vary (Qian et al. 2022). Further research is needed to better understand the differences in sex ratio across different eating disorder diagnoses.

The SCOFF screening questionnaire may miss some eating disorder cases. The SCOFF was originally designed to screen just for anorexia nervosa and bulimia nervosa (Morgan et al. 1999), and thus it may be less effective with other eating disorders, especially ARFID. A meta-analysis of 25 SCOFF validation studies (Kutz et al. 2020) found it was most sensitive in studies of young women with anorexia nervosa or bulimia nervosa, and less sensitive in studies with more men, participants with binge-eating disorder, and with large community samples. These findings are consistent with a study validating the SCOFF in a multiethnic general population sample of adults (Solmi et al. 2015). This found that most validation studies relied on young, mostly female, and ethnically homogeneous samples, with limited generalisability to more diverse populations. The study concluded that specificity of the SCOFF was higher than its sensitivity, and that its sensitivity was lower than previously found in other studies (Solmi et al. 2015; Kutz et al. 2020). APMS 2023/4 drew on a large and heterogeneous community sample, it is possible

that the SCOFF had poor sensitivity.

The approach taken to identify eating disorder cases - requiring both a positive SCOFF screen and a positive SCAN ED examination - may underestimate prevalence. APMS 2023/4 comprised a large and heterogeneous community sample. If the sensitivity of the SCOFF was poor, some participants with an eating disorder may have screened negative on the SCOFF and not been selected for a phase two SCAN ED examination. This is evidenced by participants who underwent a SCAN examination for reasons other than screening positive on the SCOFF questionnaire (i.e., based on screening positive on psychosis and/or autism measures), and who were found to have an eating disorder following a SCAN examination. In this chapter all SCOFF negative participants were classified as not having an eating disorder, even if they had a positive SCAN ED examination. Thus, the prevalence estimate reported in this chapter is likely an underestimate. A detailed analysis of all the eating disorder cases identified by SCAN ED will be undertaken in due course.

The proportion of adults screening positive on the SCOFF has increased over time, from 6.4% (CI 5.8, 7.1) in 2007 to 9.1% in 2023/4 (CI 8.1, 10.1), indicating an upward trend. This increase in the proportion of adults reporting features of an eating disorder is consistent with results from the Mental Health of Children and Young People in England survey series, which found a rise between 2017 and 2023 among children and young people living in England (Newlove-Delgado et al. 2023 (Link: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2023-wave-4-follow-up)). While there are signals that the COVID-19 pandemic has further intensified eating-disorder symptoms and related service demand (Devoe et al. 2023; Madigan et al. 2025), it remains uncertain whether these elevated levels will decline, underlining the need for targeted prevention and early-intervention strategies to reduce suffering and associated economic and societal costs.

Eating disorders were associated with co-occurring physical and mental health conditions. Adults with a limiting physical health condition were more likely than those without to have an eating disorder, consistent with previous research (Momen et al. 2022). Eating disorders can be life threatening and have significant implications for physical health including cardiovascular, gastrointestinal, reproductive and other issues (Rome and Ammerman 2003). Adults with a common mental health condition were also more likely than those without to have an eating disorder, reflecting established research highlighting a range of psychiatric comorbidities (Tan et al. 2023; Garcia et al. 2020; Swinbourne and Touyz 2007) as well as evidence of the substantial impact of having an eating disorder on a person's quality of life (Jenkins et al. 2011).

Eating disorders were more common in adults who were unemployed, than among those in work or economically inactive. However, the number of unemployed adults with an eating disorder was small and confidence intervals were wide. Prior evidence exploring the relationship between eating disorders and employment status is relatively limited, but an exploratory analysis of US medical expenditures survey data also found an

association between eating disorders and lower rates of employment, as well as lower earnings, though comorbid mental health problems contributed significantly to these differences (Samnaliev et al. 2015). Eating disorder prevalence was not found to vary significantly between ethnic groups, although small numbers limited this analysis. It is essential to collect ethnicity data when conducting eating disorders research, as little is known in relation to the prevalence and treatment experiences of members of minority ethnic groups (Williams-Ridgway et al. 2025; Barakat et al. 2023).

Although limited by sample size, the eating disorder prevalence data presented in this chapter represent a significant step forward in eating disorder research and provides valuable insights regarding the needs of the general population, informing health service resourcing. The inclusion of the SCAN examination in APMS 2023/4 provides the first clinically diagnosable eating disorder prevalence estimates. However, important limitations to this chapter should be noted. Firstly, the reliance on the SCOFF as a screening tool may have excluded a number of participants from a SCAN examination, therefore the eating disorder prevalence presented here is likely to be an underestimate. And as a screening tool, the SCOFF results in isolation will overestimate the prevalence of eating disorders. Secondly, subgroup comparisons within the chapter are based on just 26 participants who both screened positive on the SCOFF and were identified by the SCAN ED, resulting in a lack of statistical power and/or wide and overlapping confidence intervals. Thirdly, the number of participants in the underweight range was small, with none of the 26 positive SCOFF and SCAN cases in the underweight BMI category. Possible reasons for this could include that the screening approach resulted in small numbers of identified cases; or lower participation rates or willingness to provide self-reported height and weight among those with eating disorders often associated with an underweight BMI such as anorexia nervosa. Further methodological work is required to explore these limitations for future eating disorders general population studies.

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Previous Chapter
Chapter 12: Psychotic Disorder (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/psychotic-disorder)

Next Chapter
Methods (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods)

Methods

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1. Introduction

1.1 The Adult Psychiatric Morbidity Survey series

The Adult Psychiatric Morbidity Survey (APMS) 2023/4 is the fifth in a series of national mental health surveys. The APMS series began in 1993, with surveys conducted about every seven years: 2000, 2007 and 2014. Due to the COVID-19 pandemic, fieldwork for the fifth survey was postponed to 2023/4.

The APMS series is designed to:

- Estimate the prevalence of a range of types of common and rare mental health neurodevelopmental conditions and disorders in the population.
- Estimate the proportion of people with each disorder in receipt of treatment and

services.
- Produce trends in disorder and treatment through comparisons with previous surveys in the series.
- Enable the circumstances of people with different mental disorders to be compared with those of people without disorder.

The first two surveys in the series were carried out by the Office for National Statistics (ONS) in 1993 and 2000, and covered England, Scotland and Wales. Since 2007, the APMS covered England only and had no upper age limit to participation (which was 64 in 1993 and 74 in 2000). The 2007, 2014 and 2023/4 surveys were designed and carried out by the National Centre for Social Research (NatCen), the University of Leicester, and City St George's, University of London, on behalf of NHS England (previously NHS Digital, the trading name of the Health and Social Care Information Centre).

1.2 The 2023/4 survey

1.2.1 Summary of survey design

APMS 2023/4 is a random probability face-to-face survey, covering adults living in residential households in England. To enable comparisons over time, APMS 2023/4 largely replicated the design of previous surveys in the series.

Fieldwork for APMS took place between March 2023 and July 2024. One adult aged 16 and over was randomly selected from one eligible household at each selected address. For further information on the sample design, see Section 2.2 of this chapter. The survey consisted of two phases. The first phase was a face-to-face interview conducted by NatCen interviewers. A remote telephone interview was offered if a participant was not able to have a face-to-face visit. Most (96.5%) participants proceeded with a face-to-face interview. A sub-sample of phase one participants were selected to take part in phase two, which was a face-to-face assessment conducted by clinically trained interviewers coordinated by the University of Leicester.

The phase one questionnaire included screening tools and diagnostic schedules for different mental health disorders, as well as questions on service use, aspects of life related to mental health and participants' sociodemographic characteristics. Around a third of the interview, including the most sensitive questions, was completed by participants on interviewers' laptops. The rest of the interview was administered by an interviewer.

A household response rate of 29.4% was achieved, with 6,912 people interviewed for phase one. Of these, 1,742 (25.2%) participants were issued to phase two and 887 (50.9% of those issued) took part in a phase two examination.

The chapters in this publication provide prevalence estimates of common and rare mental conditions and disorders for people aged 16 and over living in England. Given known associations between disadvantage and mental health, deprived areas were oversampled in APMS 2023/4. The data in this report have been weighted to present a

representative picture of mental health across adults in England.

1.2.2 The APMS 2023/4 report

Findings from APMS 2023/4 are published here (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24).

Excel tables accompany each chapter and can be found via the data tables (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset) links on the summary page or in each chapter.

1. Common mental health conditions
2. Mental health treatment and service use
3. Posttraumatic stress disorder
4. Suicidal thoughts, suicide attempts and non-suicidal self-harm
5. Alcohol: hazardous, harmful and dependent patterns of drinking
6. Drug use and dependence
7. Gambling behaviour
8. Personality disorder
9. Attention deficit hyperactivity disorder
10. Autism spectrum disorder
11. Bipolar disorder
12. Psychotic disorder
13. Eating disorders

1.2.3 Availability of datasets

APMS is a long survey and only some of the results are included in this report. Pseudonymised and disclosure-controlled datasets are available a few months after the publication for all the surveys in the series for specific secondary analysis projects under Special User Licence agreement from the UK Data Service at https://ukdataservice.ac.uk/ (Link: https://ukdataservice.ac.uk/)

2. Survey design

2.1 Overview of the survey design

Each survey in the APMS series involved interviewing a large, stratified, probability sample of the general population, covering people living in residential households. The two-phase survey design involved an initial phase one interview with the whole sample, followed up with a phase two semi-structured assessment carried out by clinically trained interviewers with a subset of participants (McManus et al. 2020).

Participants were screened for a range of different types of mental health conditions, from common conditions like depression and anxiety disorder through to rarer neurological and mental health conditions such as psychotic disorder, attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD). The long phase one questionnaire also covered many aspects of people's lives that are linked to mental health, and this information can be used to profile the circumstances and inequalities experienced by people with mental disorders.

Design strengths

This design has several strengths:

- **By sampling from the general population rather than from lists of patients**, APMS data can be used to examine the 'treatment gap'. That is, the survey data can be used to explore what proportion of people with a condition are not in contact with services or in receipt of any treatment, or who are in receipt of inappropriate treatment.
- **The use of validated mental disorder screens and assessments** allows for identification of people with sub-threshold symptoms and those with an undiagnosed disorder.
- **Consistent methodology and coverage over time** allows for trends in a number of conditions to be monitored.
- **Collection of a large amount of data on a range of topics** so that relationships between different domains can be examined. In particular, the questionnaire covers detailed and current information about people's social and economic circumstances, which does not tend to be collected in a consistent or comprehensive way in administrative datasets.
- **The use of a self-completion mode** to cover the most sensitive topics – such as suicide attempts, illegal behaviours, and experience of abuse and violence – 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**. 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 gets deposited with 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 publication.

Design limitations

The design also has its limitations:

- **The sampling frame covers only those living in private households**, and therefore those who were living in institutional settings such as large residential care homes, offender institutions, prisons, in temporary housing (such as hostels or bed and breakfasts) or sleeping rough, did not have a chance to be selected. People living in such settings are likely to have worse mental health than those living in private households (Bebbington et al. 2021; Chilman et al. 2024). However, the proportion of the overall population not living in private households is so small that this would have little (or no significant) impact on the prevalence estimates for the disorders covered by APMS (Brugha et al. 2012, 2016).
- **Some people selected for the survey were not able to take part in a long interview.** These include those with serious physical health conditions, who may feel unwell or be staying in hospital during the fieldwork period, and those whose capability may be impaired, for example due to cognitive decline because of dementia or injury, or because of a learning impairment. Reasonable adjustments could be made such as dividing the interview between two visits.
- **Some people selected for the survey could not be contacted or refused to take part.** The response rate achieved (29.4%) was lower than previous surveys in the series (57% in 2014), consistent with broader trends in survey non-response rates (de Leeuw, Hox & Luiten 2018; Williams & Brick 2018). A problem for all such studies is how to take account of those who do not take part, either because contact could not be established with the selected household or individual or because they refused to take part. It may be partially attributable to increased numbers of survey requests (Eggleston 2024). The weighting (outlined in Section 4) addresses this to some extent.
- **Younger age groups were underrepresented in the achieved sample.** Participation in surveys has always tended to be lower among younger age groups and higher among older age groups. An estimated 13% of England's population were aged 16 to 24 in 2022, whereas 4.6% of survey responses came from this age group. Males aged 16 to 24 were most likely to be underrepresented in the achieved sample with 3.3% of survey responses achieved among this age-sex group, compared with an estimated 6.6% of England's population being in this group. Conversely, 7.6% of responses were from males aged 75 and over and 9% from females aged 75 and over, while the respective population proportions were 4.8% and 6.3%. Although weighting (Section 4) addressed this to some extent, confidence intervals were fairly wide for some subgroup analysis among younger adults.
- **The mental health assessments used are not as valid as a clinical interview.** In a clinical interview, a trained psychologist or psychiatrist may take many sessions and much explorative questioning and clinical judgement to reach a diagnosis. In the context of a questionnaire administered by a lay interviewer, this is not possible.

However, phase two interviewers undertook extensive clinical interview training as part of their role. In addition, the assessments used have been validated and are among the best available for the purpose in hand (Brugha et al. 1999, 2012).

- **Socially undesirable or stigmatised feelings and behaviours may be underreported.** While this is a risk for any study based on self-report data, the study goes some way to minimise this by collecting particularly sensitive information in a self-completion format.
- **As for all surveys, it should be acknowledged that prevalence rates reported are only estimates.** If everyone in the population had been assessed, the rate found may have been higher or lower than the survey estimate. Confidence intervals are given for key estimates in a design effects table in the Excel tables accompanying each chapter. For low prevalence disorders, relatively few positive cases were identified. Particular attention should be given to uncertainty around these estimates and to any subgroup analysis based on these small samples. All comparisons made in the text have been statistically tested and only statistically significant differences are described.

Changes to the 2023/4 survey

While the aim was to keep the 2023/4 survey as similar to the previous surveys in the series as possible to allow for trend analysis, some methodological and content changes were planned for APMS 2023/4 from the outset. These included:

- Changes to certain parts of the questionnaire following a review of the survey content, including a consultation on the content and outputs.
- Development of an alternative interview mode following the COVID-19 pandemic.
- Inclusion of a clinical eating disorders comparison study carried out by the University of Leicester. The aims were to clinically calibrate the analytical thresholds used within the Schedules for Clinical Assessment in Neuropsychiatry (Section 9), which covers eating disorders, and to inform how data on possible and probable eating disorders are collected in the future.

Initially the intention was to achieve a sample of about 11,000 participants resident in England, comprising:

- A general population sample of adults aged 16 and over. Target sample size 8,000, including the oversampling addresses from the most deprived quintile of the Index of Multiple Deprivation 2019 (IMD).
- An ethnic minority boost sample. Target sample size 3,000.

Ethnic minority boost

Mental health is known to vary by ethnicity, but due to the low prevalence of some ethnic groups in the overall population, most surveys contain too few participants to be able to robustly report on specific groups. Instead, participants from different minoritised groups tend to be combined into larger heterogenous categories for analysis. Recognising the importance of mental health data that could be analysed by granular

ethnic categories, an ethnic minority boost was designed to run alongside the main survey. The goal was to provide an evidence base to inform planning and design of mental health services to be inclusive of the needs of ethnic minority groups.

The ethnic minority boost fieldwork ran in parallel to the main survey fieldwork for four months, after which it was discontinued, as the actual 'screening in' rates differed from the assumptions too much to make the boost economically viable. The data from the ethnic minority boost will be archived, but has not been included in the APMS 2023/4 report. The design and delivery of the ethnic minority boost will be described in separate technical documentation.

Ethical approval

For APMS 2023/4, ethical approval for phase one was obtained from NatCen's internal Research Ethics Committee (NatCen: 1st November 2022), phase two from University of Leicester Medicine and Biological Sciences Research Ethics Committee (29th June 2022), and the clinical eating disorders comparison study from the NHS Health Research Authority (18th April 2023).

2.2 Sample design

Overview of the sample design

The sample for APMS 2023/4 was designed to be representative of the population living in private households (that is, people not living in communal establishments or sleeping rough) in England. As with previous surveys in the series, APMS 2023/4 adopted a multi-stage stratified probability sampling design. At the first stage, a random sample of primary sampling units (PSUs), based on postcode sectors, was selected. Within each selected PSU, a random sample of postal addresses (known as delivery points) was then drawn.

The sample consisted of the core and deprived area boost samples. The deprived area boost sample was drawn from Lower layer Super Output Areas (LSOAs) in the most deprived quintile of England's Index of Multiple Deprivation (IMD).

Additional sample was drawn from the core and deprived area boost samples and assigned as reserve sample, which was later issued when fieldwork did not progress as expected. Due to the lower-than-expected response rate, a further reserve sample for both samples was drawn during the fieldwork period.

Sampling frame

The sampling frame used was the small user Postcode Address File (PAF) because it has excellent coverage of private households in England. The small user PAF consists of those Royal Mail delivery points which receive fewer than 50 items of mail each day. Therefore, most large institutions and businesses are excluded from the sample, but businesses and institutions that receive fewer than 50 items each day are included. When interviewers visited an address that did not contain a private household, they recorded it as ineligible.

The small proportion of households living at addresses not on the PAF (estimated to be less than 1%) were not covered by the sample frame (ONS 2023b (Link: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/methodologies/evaluationofaddressingqualitycensus2021)).

As with previous surveys in the series, APMS 2023/4 did not include adults not residing in private households. People living in communal or institutional establishments tend to be either aged 16 to 24 years (and living in higher education halls of residence) or aged 65 years or over (and living in a nursing or care home setting) (ONS 2023a (Link: https://www.ons.gov.uk/peoplepopulationandcommunity/housing/bulletins/communalestablishmentresidentsenglandandwales/census2021)). Older people living in communal settings are likely to have worse mental health than older people living in private housing, and this should be borne in mind when considering the survey's account of the older population's mental health. Overall, communal establishment residents represented less than 2% of all usual residents in England (ONS 2023a (Link: https://www.ons.gov.uk/peoplepopulationandcommunity/housing/bulletins/communalestablishmentresidentsenglandandwales/census2021)).

Selection of primary sampling units

Core sample

PSUs were defined at the postcode sector level. Postcode sectors with fewer than 500 PAF addresses were combined with neighbouring sectors to form the PSUs. This was done to prevent addresses being too clustered within a PSU.

Before selection, the list of PSUs in the population was ordered (stratified) by a number of strata and a systematic random sample was selected from the ordered list. This ensures the different strata in the population are correctly represented and increases the precision of survey estimates. APMS 2023/4 core sample used a sampling methodology that was consistent with previous surveys in the series, and very similar to that used in 2014.

The sampling frame was sorted by three stratification variables in the following order:

- 9-category former Government Office Region.
- quintiles of the percentage of the population in National Statistics Socio-economic Classification (NS-SEC) categories 1 and 2 (which denote professional and higher technical occupations).
- population density at grouped postcode sector level.

When the initial core sample was drawn, Census 2021 data was not available, so Census 2011 data was used to create the stratification variables. When the additional reserve

sample was subsequently drawn, Census 2021 data had been released, so this was used to update the stratification variables used. PSUs were systematically selected with probability proportional to the delivery point count of each grouped postcode sector.

710 PSUs were drawn for the initial core sample (64 of which formed the initial reserve), during the fieldwork a further 200 were drawn for the additional reserve, a total of 910 core PSUs. Prior to selecting the additional reserve, postcode sectors already included in the main or deprived area boost samples were excluded from the sampling frame to avoid duplication.

Deprived areas boost sample

The deprived areas boost sampling frame was based on LSOAs. LSOAs were ranked on the IMD score (Index of Multiple Deprivation 2019) and divided into quintiles. For the deprived areas boost the sample was restricted to the most deprived quintile.

First, any LSOAs already selected for the core sample were excluded. LSOAs were then selected from the most deprived quintile of IMD with probability proportional to the delivery point count of each LSOA. Prior to selection of PSUs, the sampling frame was sorted by three variables in the following order:

- 9-category government office region (consistent with the core sample).
- quintiles of IMD rank.
- population density per square kilometre.

When the initial deprived areas boost sample was selected, LSOA boundaries for Census 2021 were not yet available, so Census 2011 LSOA boundaries were used. When the additional deprived area boost LSOAs were sampled, Census 2021 boundaries were available, so these were used. 180 LSOAs were systematically selected for the initial deprived area boost (16 of which were put in reserve) and 50 LSOAs for the additional reserve, a total of 230 deprived areas boost PSUs. LSOAs that had already been selected for the core or initial deprived areas boost sample were excluded from the sampling frame for the additional deprived areas boost, to avoid duplication.

For more information: Table 1 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

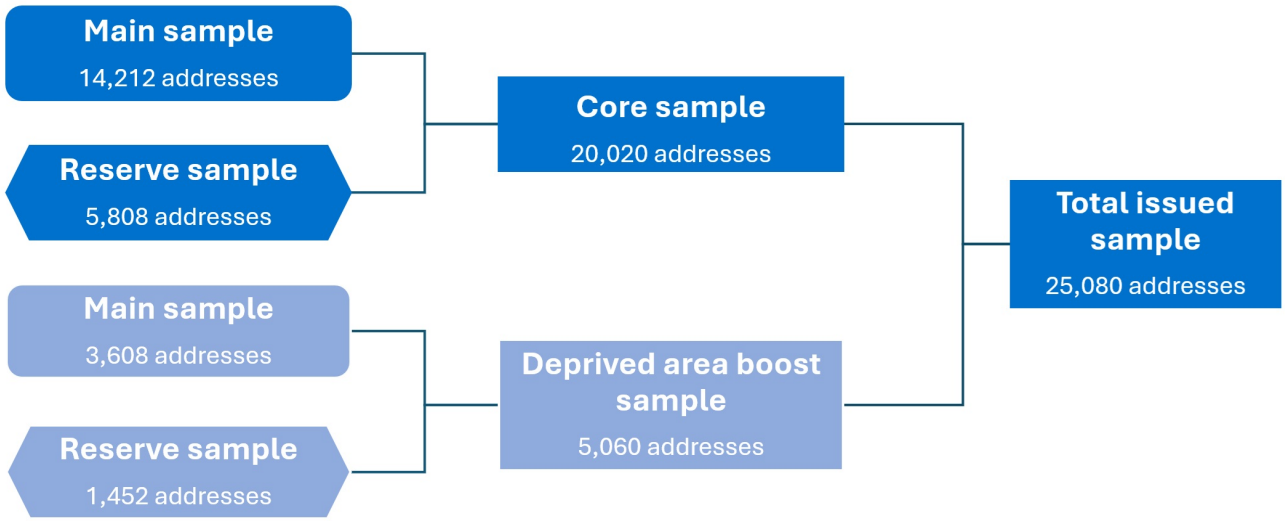
Sampling addresses and households

In the second stage of sampling 22 delivery points were randomly selected within each of the selected PSUs or LSOAs. The total sample of issued addresses was 25,080, consisting of 1,140 PSUs.

Interviewers visited the addresses to identify private households with at least one resident aged 16 or over. When visited by an interviewer, 1,580 of the selected addresses were found not to contain private households. These addresses were ineligible and were

excluded from the survey sample. At eligible addresses found to contain more than one dwelling/household, interviewers entered the number of dwelling units or households into the electric address record form and one dwelling/household was automatically selected at random.

Sample design: Addresses issued by sample type



Sampling individuals

One adult aged 16 years or over was randomly selected for interview in each eligible household. This was preferred over interviewing all eligible adults because:

- It helped interviewers to conduct the interview in privacy and thereby obtain more reliable information.
- Individuals within households tend to be similar to each other and the resultant clustering can lead to an increase in standard errors around survey estimates. By selecting one person in each household, this clustering effect was overcome.
- Given the length of the interview, interviewing one household member helped to reduce the burden placed on each household.

Selecting participants for phase two

Some participants who responded to the phase one interview (and agreed to be followed up) were invited to take part in phase two of the survey. Participants who based on their phase one answers were more likely to have autism, psychosis or eating disorders were eligible for phase two examination. This differed from the approach taken in 2007 and 2014 surveys when only those more likely to have autism and psychosis were eligible.

For each phase one participant, the probability of selection for a phase two assessment was calculated as the higher of three disorder-specific probabilities: psychosis probability, autism probability and eating disorder probabilities. The probabilities were generated

based on participants' responses to screening questions in the phase one questionnaire. Participants were selected for phase two on this basis and those who agreed to be contacted by the University of Leicester were selected for a phase two visit. Screening criteria used for APMS 2023/4 are summarised below.

Psychotic disorder phase two selection criteria

Participants needed to meet one or more of the below criteria:

- Currently taking antipsychotic medication.
- Reporting an inpatient stay for a mental or emotional problem in the past 3 months.
- Positive response to 5a in Psychosis Screening Questionnaire (PSQ).
- Self-reported diagnosis or symptoms of psychotic disorder.
- Self-reported identification of panic attacks.

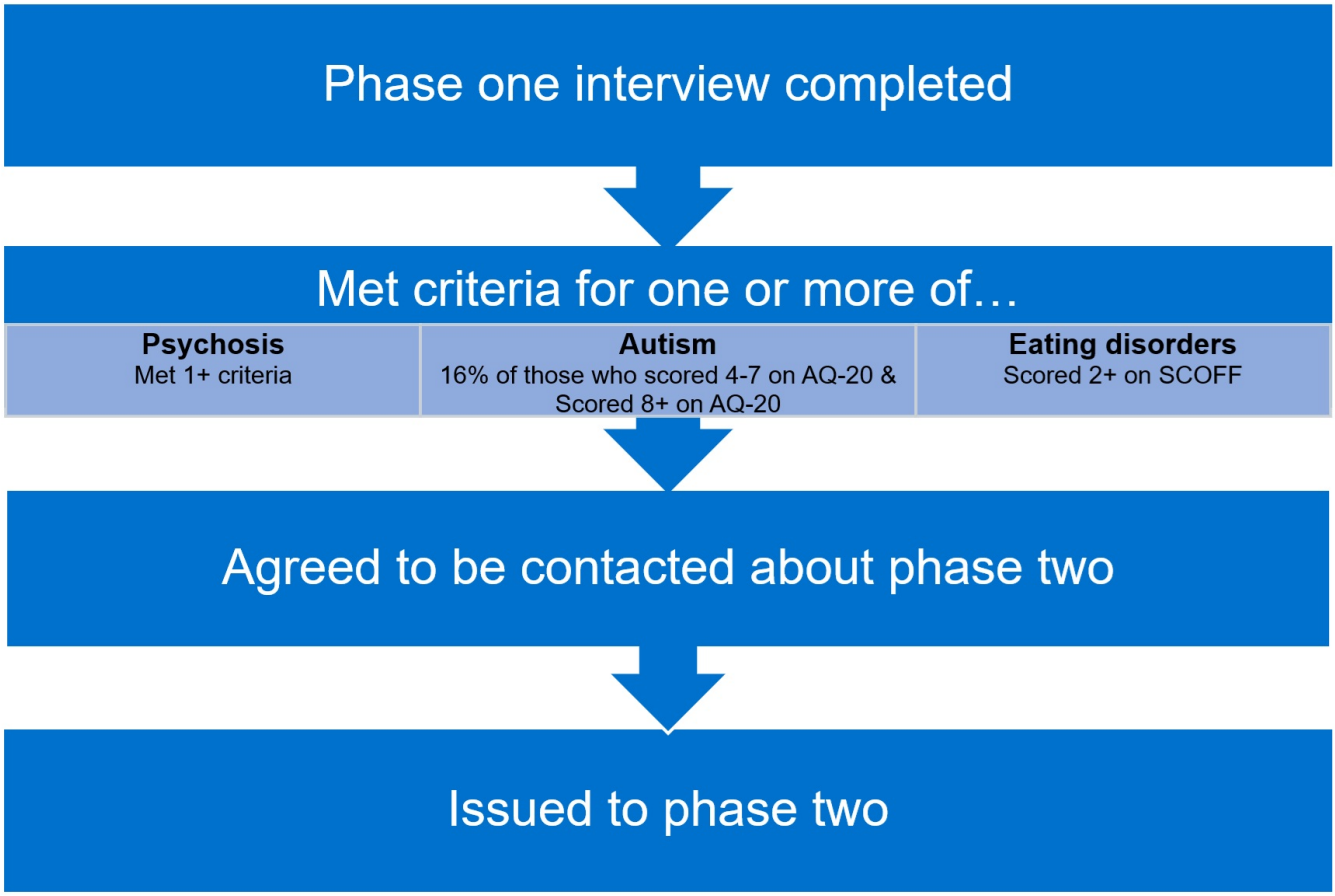
Autism phase two selection criteria

- All adults scoring 8 or more on AQ-20.
- 16% of adults scoring 4 to 7 on AQ-20.

Eating disorders phase two selection criteria

- All adults scoring 2 or more on the SCOFF questionnaire.

Phase two: Participant selection



Further detail on selection, definitions, analysis and changes across survey years can be found in Chapter 10 Autism spectrum disorder (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/autism-spectrum-disorder), Chapter 12 Psychotic disorder (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/psychotic-disorder) and Chapter 13 Eating disorders (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/eating-disorders).

2.3 Piloting and questionnaire development

Guidance and consultation

The APMS series is long-established and the 2023/4 survey design was based on that used in previous surveys in the series. The survey development that did take place, to ensure that the survey meets current needs, drew on the expertise of a wide range of advisors and data users. These included:

- Project oversight and management from NHS England.
- A Steering Group comprised of representatives from NHS England, Department of Health and Social Care, Office for Health Improvement and Disparities, Royal College of Psychiatrists, Gambling Commission, charities (Mind and Beat Eating disorders), and academic leads in psychiatric epidemiology. This group was coordinated by NHS England.
- An APMS Academic Group, co-ordinated by the research team, and drawing on the expertise of leading academics from a range of universities and medical schools.
- A group of senior NatCen interviewers with practical experience of survey delivery in the field.
- Consultation focus groups were carried out with different stakeholder groups, including government research and policy officials, third sector organisations focused on mental health or mental health risk factors, data analysts, academics, health care providers and people with lived experience (Gill et al. 2021 (Link: https://digital.nhs.uk/data-and-information/areas-of-interest/public-health/national-study-of-health-and-wellbeing/adult-psychiatric-morbidity-survey-2022-survey-consultation-findings)). Some guided feedback interviews were also conducted. Focus groups and interviews were aimed at understanding the priority of different topics included or to be included in the questionnaire.
- A public consultation survey on the questionnaire content, where anyone with interest in the topic could respond.

Based on feedback from these sources, a few changes were made to the survey content. These are summarised in Section 2.4. Participants were able to take part by a remote telephone interview when a face-to-face interview was not possible. Some questions asked in the face-to-face interview were not included in the remote telephone interview to minimise participant burden.

Full detail on topic coverage is included in Section 2.4.

Cognitive testing

Cognitive interviewing methods provide an insight into the mental processes used by participants when answering survey questions, thus helping to identify problems with question wording and design (Collins 2015). These methods investigate four cognitive stages:

- How participants understand and interpret survey questions.
- How they recall information that applies to the question.
- The judgements they make as to what information to use when formulating their answers.
- The response mapping process.

Cognitive testing was carried out in 2021 to test new and adapted questions. Not all new or adapted questions could be tested, and priority was given to those identified as potentially problematic and were suited to cognitive testing methods.

Cognitive interviews were conducted with 18 people. The participants varied in terms of gender, age, mental health, substance use, gambling behaviour and whether they receive care.

Data were thematically analysed and a debrief session was conducted where recommendations for alterations were discussed and agreed. A written report on the findings and recommendations was submitted to NHS England and amendments were made to questions where agreed.

Dress rehearsal

Following the cognitive testing, the questionnaire was refined in preparation for a full-dress rehearsal. At this stage, an alternative telephone mode was added for participants who could not take part in a face-to-face interview for COVID-19 related reasons. The dress rehearsal enabled testing of the flow, alternative telephone mode, content and timings of the interview as a whole, and of individual modules, together with the operation of fieldwork procedures and materials. Recommendations were implemented for the mainstage where appropriate.

The dress rehearsal tested both phase one and phase two procedures.

For phase one, 13 postcode sectors were selected for convenience based on interviewer availability. 22 addresses were then selected at random per postcode sector. 71 full

interviews were completed, 9 of which were completed by phone.

At the end of the phase one interview, participants were asked whether they were happy to be contacted about a phase two interview. 42 (76%) phase one participants agreed to be contacted about phase two. 11 phase two interviews were completed.

Phase two interviews were conducted by clinically trained interviewers co-ordinated by the University of Leicester. The phase two dress rehearsal sample included people both men and women of a range of ages. A report covering the dress rehearsal was submitted to NHS England.

Overall, the dress rehearsal ran smoothly with no major issues and received positive feedback from the interviewers. Other findings from the dress rehearsal were:

Phase one

- The face-to-face interview took an average of 99 minutes to complete. This was longer than the target length of 90 minutes. As a result, questionnaire content needed to be reduced.
- Minor amendments to the interview were recommended to improve the flow, including 'emergency exits' in the violence module for participants who preferred not to complete the questions.
- Clarifications and explanations for interviewers during the training were suggested.
- Minor changes were recommended for participant communications.

Phase two

- Practical issues were identified that needed to be resolved for the mainstage, related to kit and entering administrative information.
- Interviewers provided feedback for administrative improvements to be made to the interview software.

2.4 Interview mode and topic coverage

Phase one interview

Interview mode

In APMS 2023/4 the phase one interview could either be conducted face-to-face or remotely over the phone. Face-to-face interviews consisted of interviewers asking questions and recording answers in-person, with a self-completion section partway through the interview.

An alternative remote interview by telephone was implemented following the COVID-19 pandemic, for participants who felt unable to take part in person. If a participant needed to use an alternative mode, they agreed a suitable date and time with the interviewer, who then contacted them by phone. Before leaving, the interviewer left behind showcards and other survey materials, so that participants could refer to these during the

interview. Participants completing the survey remotely had the option to complete the self-completion section of the questionnaire online using a web questionnaire. While they completed this, the interviewer waited on the line for them to finish, optimising response and minimising non-completion. To reduce participant burden and encourage active participation, remote interviews did not include all the modules included in the face-to-face interview.

In person interview structure

Part 1: Face-to-face	Part 2: Self-completion	Part 3: Face-to-face
Interviewer asked questions and recorded answers using Computer Assisted Personal Interviewing (CAPI).	Participant encouraged to answer these questions using Computer Assisted Self Interviewing (CASI). If participant refused or needed assistance, the interviewer could read out the questions instead.	Final section of the interview conducted by interviewer using CAPI.

Remote interview structure

Part 1: Telephone interview	Part 2: Online questionnaire	Part 3: Telephone interview
Remote interviews included a subset of questions. Interviewer asked questions over the phone and recorded answers using Computer Assisted Personal Interviewing (CAPI).	Participant encouraged to answer these questions using an online questionnaire. A web link and unique identifier were sent to the participant by email, which they used to access the questionnaire. Interviewer remained on the phone while they completed the web questionnaire.	Final section of the interview conducted by interviewer over the phone using CAPI.

Interview content

The table below summarises the topic coverage of the phase one interviews by interview section and mode. The interview consisted of initial modules of questions administrated by the interviewer using Computer Assisted Personal Interviewing (CAPI), a self-completion section (Computer Assisted Self Interviewing or CASI), and further interviewer administered modules. A few sections were asked only of particular age-groups, for example questions on cognitive function were restricted to those aged 60 or over.

The full phase one questionnaire is reproduced in Appendix C (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods#appendices) and documentation that will be lodged with the UK Data Service describes each of the survey items.

Phase one, Part 1 interview content (interviewer administered)

Questionnaire module	Included in remote interview (y/n)	Age inclusion criteria
Details of household members and relationships	y	All
General health and activities of daily living	y	All
Caring responsibilities	n	All
Mental wellbeing (SWEMWBS)	n	All
Physical health conditions	y	All
Sensory impairment	n	All
Self-reported diagnoses of mental health conditions	y	All
Self-reported height and weight	y	All
Treatment and service use	y	All
Common mental disorders	y	All
Suicidal behaviour and self-harm	y	All
Psychosis screening questionnaire	y	All
Attention deficit hyperactivity disorder	y	All
Work related stress	y	Aged 16-69
Tobacco use and vaping	n	All
Alcohol – any drinking	y	All

Phase one, Part 2 interview content (self-completion)

Questionnaire module	Included in remote interview (y/n)	Age inclusion criteria
Alcohol (AUDIT)	y	All
Drug use and dependence	y	All
Gambling behaviour	y	All
Eating disorders	y	All
Personality disorder	n	All
Social functioning	y	All
Bipolar disorder	y	All
Autism spectrum disorder	y	All
Posttraumatic stress disorder	y	All
Military experience	y	All
Interpersonal violence and abuse	y	All
Child neglect	n	All
Suicidal behaviour and self-harm	y	All
Discrimination	n	Aged 16-69
Prison experience	n	All
Sexual orientation and behaviour	n	All

Phase one, Part 3 interview content (interviewer administered)

Questionnaire module	Included in remote interview (y/n)	Age inclusion criteria
Cognitive and intellectual functioning: TICS-M	n	Aged 60 or over

Cognitive and intellectual functioning: National Adult Reading Test	n	All
Stressful life events	y	All
Parenting	n	All
Social support networks	n	All
Religion	n	All
Social capital and participation	n	All
Socio-demographics	n	All
Consents (for data linkage, phase two contact and follow-up research)	y	All

Mental health conditions covered by APMS 2023/4

A summary of the measures used to assess or screen each of the mental health conditions and disorders included in APMS 2023/4 phases one and two is listed below, with further technical detail in Appendix A (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods#appendices). To enable meaningful temporal trends to be captured, the ways in which measures are scored have not changed in line with changes in diagnostic classification systems. However, additional items have often been used to enable researchers to do this in secondary analyses.

Measures used to assess and screen for mental disorder.

Condition	Diagnostic status	Classification system	Assessment tool	Survey phase	Reference period
Generalised anxiety disorder (GAD)	Present to diagnostic criteria	International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) (World Health	Clinical Interview Schedule – Revised (CIS-R) (Lewis et al. 1992)	1	Past week

		Organization 1993)			
Common mental health condition (CMHC) not otherwise specified (NOS)	Present to diagnostic	ICD-10	CIS-R	1	Past week
Obsessive and compulsive disorder (OCD)	Present to diagnostic criteria	ICD-10	CIS-R	1	Past week
Depressive episode	Present to diagnostic criteria	ICD-10	CIS-R	1	Past week
Panic disorder	Present to diagnostic criteria	ICD-10	CIS-R	1	Past week
Phobia	Present to diagnostic criteria	ICD-10	CIS-R	1	Past week
Posttraumatic stress disorder (PTSD)	Screen positive	Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV, American Psychiatric Association 1994)	PTSD Check List (Blanchard et al 1996)	1	Past week
Attempted suicide	Occurrence of behaviour	-	Self-completion	1	Past year
Alcohol use disorders	Screen positive	ICD-10	Alcohol Use Disorder	1	Past six months

			Identification Test (AUDIT) (Saunders et al. 1993)		
Problem gambling	Screen positive	DSM-IV	Problem Gambling Severity Index (PGSI) (Ferris and Wynne 2001)	1	Past year
Drug dependence	Screen positive	-	Based on Diagnostic Interview Schedule (DIS) (Malgady et al. 1992)	1	Past year
General personality disorder traits	Screen positive	International classification of diseases for mortality and morbidity statistics 11th Revision (ICD-11, WHO 2019)	Standardised Assessment of Personality (SAPAS) (Moran et al. 2003)	1	Lifetime
Borderline personality disorder (BPD)	Present to diagnostic criteria	DSM-IV	Self-completion Structured Clinical Interview for DSM IV (SCID-II-Q) (First 1997)	1	Lifetime
Antisocial personality disorder (ASPD)	Present to diagnostic criteria	DSM-IV	Self-report SCID-II-Q	1	Lifetime

Attention deficit hyper-activity disorder (ADHD)	Screen positive	DSM-IV	Adult ADHD Self-Report Scale (ASRS v1.1) (WHO 2003)	1/2	Past six months
Autism	Present to diagnostic criteria	DSM-V	Autism Diagnostic Observation Schedule (ADOS-2 Module 4: Lord et al. 2012)	1/2	Lifetime
Bipolar disorder (BD)	Screen positive	DSM-IV	Mood Disorder Questionnaire (MDQ) (Hirschfeld et al. 2000)	1	Lifetime
Psychotic disorder	Present to diagnostic criteria	ICD-10	Schedules of Clinical Assessment in Neuropsychiatry (SCAN) (WHO 1999)	1/2	Past year
Eating disorders	Screen positive/ Present to diagnostic criteria	ICD-10	SCOFF eating disorders questionnaire (Morgan et al. 1999), Eating Disorder Examination – Questionnaire Short (EDE-QS) (Gideon et al. (2016), Schedules for Clinical Assessment in Neuropsychiatry (SCAN) 3.0 (WHO in press)	1/2	Past year and past week

Coverage of the 1993, 2000, 2007, 2014 and 2023/4 APMS

interviews

The following table summarises the topic coverage of 1993, 2000, 2007, 2014 and 2023/4 APMS phase one questionnaires. In 1993 the survey was administered by paper and pen, from 2000 a computer assisted interviewing approach was used. The aim has been to have consistent core coverage, with additional modules covered in different years.

Summary of APMS coverage in 1993, 2000, 2007, 2014 and 2023/4: face to face interview

Face-to-face interview	1993	2000	2007	2014	2023/4
General health		♦	♦	♦	♦
Activities of daily living			♦	♦	♦
Caring responsibilities			♦	♦	♦
Service use and medication	♦[a]	♦	♦	♦	♦
Self-reported height and weight			♦		♦
Common mental disorders	♦	♦	♦	♦	♦
Suicidal behaviour and self-harm	♦[b]	♦	♦	♦	♦
Psychosis screening questionnaire	♦	♦	♦	♦	♦
Attention deficit hyperactivity disorder			♦	♦	♦
Work related stress			♦	♦	♦
Smoking	♦	♦	♦	♦	♦
Drinking	♦	♦	♦	♦	♦
Intellectual functioning:					
TICS-M		♦	♦	♦	♦
National Adult Reading Test (NART)		♦	♦	♦	♦
Animal naming test		♦	♦	♦	
Key life events	♦	♦	♦	♦	♦

Social support networks	♦	♦	♦	♦	♦
Religion			♦	♦	♦
Social capital and participation			♦	♦	♦
Socio-demographics	♦	♦	♦	♦	♦

Table notes

[a] In APMS 1993 only participants who screened positive for CMHC were asked about use of services and receipt of treatment.

[b] In APMS 1993 only participants with depression in the past week were asked about suicidal behaviour.

Summary of APMS coverage in 1993, 2000, 2007, 2014 and 2023/4: self-completion

Self-completion	**1993**	**2000**	**2007**	**2014**	**2023/4**
Problem drinking	♦[a]	♦	♦	♦	♦
Drug use and dependence	♦	♦	♦	♦	♦
Personality disorder		♦	♦	♦	♦
Social functioning			♦	♦	♦
Gambling behaviour			♦		♦
Autism			♦	♦	♦
Posttraumatic stress disorder			♦	♦	♦
Military experience			♦	♦	♦
Bipolar disorder				♦	♦

Interpersonal violence, abuse and neglect	♦	♦	♦
Suicidal behaviour and self-harm (repeated)	♦	♦	♦
Eating disorder	♦		♦
Discrimination	♦	♦	♦
Prison experience		♦	♦

Table notes

[a] APMS 1993 data on problem drinking is not compatible with that collected in 2000, 2007, 2014 and 2023/4.

Topics added

The following topics not in APMS 2014 were reintroduced in APMS 2023/4 as a result of the survey consultation:

- Self-reported height and weight was added back in for 2023/4. It was last included in 2007.
- Gambling was added back in for 2023/4. It was last included in 2007, however PGSI was used in 2023/4 instead of the DSM-IV measure used in 2007.
- Eating disorders was added back in for 2023/4. It was last included in 2007, both years included the SCOFF questionnaire. In 2023/4 the EDE-QS was also included.

Summary of amendments to existing modules

All questionnaire changes are described in the archived dataset documentation, including information on the rationale for changes, and summarised below:

- **Household demographics:** Participants were asked about the gender identity of all residents in the household. Sex at birth was asked only of the selected participant. Relationship status options were updated.
- **General health:** Additional question on receiving care at home in the past month.
- **Caring responsibilities:** Additional question on type of condition or impairment the person they provide care for has.
- **Mental wellbeing:** The 14 item Warwick Edinburgh Mental Well-Being Scale (WEMWBS) (Tennant et al. 2007 (Link: https://hqlo.biomedcentral.com/

articles/10.1186/1477-7525-5-63)) was replaced with the 7 item Short Warwick Edinburgh Mental Well-Being Scale (SWEMWBS) (Stewart-Brown et al. 2009 (Link: http://link.springer.com/article/10.1186/1477-7525-7-15); Ng Fat et al. 2017).

- **Physical health conditions:** Some additional health conditions were added to the list and additional questions covering long COVID were included.
- **Mental health condition diagnoses:** Some additional mental, emotional and neurological conditions were added to the list.
- **Mental health treatment:** Additional questions on barriers to treatment and waiting times for treatment.
- **Common mental health conditions:** Minor changes were made to the CIS-R to improve comparability with the ICD-11 diagnostics classification.
- **Work related stress:** Additional questions on remote working.
- **Tobacco:** New questions on vaping and smoking cessation.
- **Alcohol:** Additional questions on whether non-drinkers have ever drunk alcohol and reasons for not drinking. New questions covering treatment received for drinking. Some questions updated asking about units drunk in line with latest AUDIT. Severity of Alcohol Dependence Questionnaire (SADQ) not included.
- **Drug use:** New questions included on use of synthetic cannabinoids, methamphetamine, khat, fentanyl, morphine, oxycodone, tramadol and nitrous oxide. Additional questions on consequences of and treatment for drug use.
- **Autism:** New question on sensory sensitivity added.
- **PTSD:** Added 5 items from the PCL-5 questionnaire (Blevins et al. 2015).
- **Military experience:** Additional questions on the branch of the forces served in and impact of serving in the armed forces.
- **Interpersonal violence and abuse:** The module was extensively revised, including changes to the language, overall structure and additional questions, including a wider range of types and characteristics of perpetrators and dimensions of violence. Participants were also able to click on a link to take them to the BBC News website as an escape from the questionnaire if required. They were able to exit the series of questions if they preferred not to answer.
- **Childhood abuse and neglect:** 5 additional questions were added so all 10 of the core ACEs (Adverse Childhood Experiences) were covered.
- **Suicidal thought attempts and self-harm:** Additional questions on help sought and received after self-harm, repetition of self-harm or suicide attempts and age of onset.
- **Discrimination:** Additional questions on the type of discrimination and where the discrimination took place.
- **Prison experience:** Moved from a list of life events that may have been experienced, asked by the interviewer, to the self-completion section. Additional questions on prison experience were also asked including number of times, length of sentence, receipt of mental health treatment and whether they were put into segregation.
- **Sexual orientation and behaviour:** Sexual orientation was asked of all adults, not just those under the age of 65 years. New question on whether participant identifies as

trans or has trans history.

- **Stressful life events:** Questions added on whether the life event had happened more than once, the age they were when the event happened, whether any family had experienced a stressful life event and if so the impact on participant.
- **Parenting:** An additional question asking the age of the participants youngest child.
- **Social support:** 5 additional questions to measure loneliness were included.
- **Religion:** New questions on how important religion is to participant and frequency of attending religious services.
- **Social capital and participation:** Additional questions including access to green spaces and social media use.
- **Ethnicity and migration:** Questions included on country of birth of parents and immigration status.
- **Education:** Questions were aligned to the Government Statistical Service and Statistician Group (GSS) harmonised education questions.
- **Employment:** The module was extensively revised. Questions on current employment and student status were updated. Additional questions on shift patterns and remote working were included.
- **Financial and housing circumstances:** Questions on sources of household income and benefits received were revised to make sure they were up to date.

Phase two examination

The phase two examination assessed psychotic disorder, autism and symptoms of eating disorders. The approach taken for autism and psychotic disorder will be described in further detail in the relevant chapters of the report.

The phase two examination consisted of semi-structured standardised clinical assessments. The measures collected in phase two, which are included in the APMS chapters on autism, psychotic disorders and eating disorders, were:

- Schedules for Clinical Assessment in Neuropsychiatry (SCAN) (WHO 2014).
- Module 4 of the Autism Diagnostic Observation Schedule (ADOS-2 Mod4) (Lord et al. 2012).
- Schedules for Clinical Assessment in Neuropsychiatry 3.0 (WHO in press).

In addition, SCAN items covering ADHD and autism were included in the examination but are not used for analysis within this report.

2.5 Fieldwork procedures

Training and supervision of interviewers

Phase one interviewers

NatCen interviewers were made aware of the sensitive nature of the interviews before choosing to work on the first phase of the survey. All interviewers selected to work on

the survey were briefed on its administration. Topics covered on the 1-day survey-specific training included introducing the survey, questionnaire content, confidentiality and responding to participant distress.

Interviewers were provided with written instructions. As the fieldwork took place over the course of a year, training sessions for new interviewers starting on the project were conducted throughout the fieldwork period. Bi-weekly drop-in sessions were also provided for interviewers if further support was required. Less experienced 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 for quality control purposes.

Phase two interviewers

The phase two interviewers were recruited and co-ordinated by the University of Leicester. The interviewers had either previous interviewing and/or clinical experience in a medical, social science or related field and some had a degree in behavioural sciences. Phase two interviewers received an extensive, month-long induction and training programme, run by a senior research psychologist and a psychiatrist. They also received training sessions from NatCen on using computer assisted interviewing. Whilst in the field, these interviewers received regular supervision sessions, both by observing interviews and at weekly team meetings, and technical support.

Contacting participants

An advance letter was sent to each sampled address before fieldwork began. This introduced the survey and stated that an interviewer would be visiting the address to seek permission to interview one person aged 16 or over living there. A £10 voucher was attached to the bottom of the advance letter. A sample advance letter is provided in Appendix D (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods#appendices).

Once the advance letters had been sent, interviewers were asked to visit all addresses in their sample. The interviewer used an electronic Address Record Form to record all attempts to visit the address. At initial contact, the interviewer established the number of households at the address and made any selections necessary (see Section 2.2 Sample design). The interviewer randomly selected one adult per household, and then attempted to book either a face-to-face, or as a last resort a telephone interview, with that person. As in previous waves of the survey, the survey title used in the field was the 'National Study of Health and Wellbeing'. This was felt to be more readily understandable than 'psychiatric morbidity'. Interviewers had various materials they could use on the doorstep and leave with participants, including a survey leaflet that introduced the study and provided a number that people could call for more information (see Appendix D (Link: /data-and-information/publications/statistical/adult-

psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods#appendices)).

If the selected participant was not capable of undertaking the interview alone, for reasons of mental or physical incapacity, in the 2023/4 survey no information from this participant was collected. This differed from previous surveys, where proxy reporting by family or carer was allowed.

Collecting the data

The phase one interview took around 90 minutes to complete on average, although some were shorter, and others took as long as three hours. The interview involved computer assisted personal interviewing (CAPI) where interviewers asked the questions using a laptop and entered participants' responses. A third of the interview was collected by self-completion. Partway through the interview, participants used the interviewer laptop (CASI) to complete the self-completion section. For remote interviews, the self-completion was reduced slightly and was completed using an online questionnaire (known as computer assisted web interview or CAWI).

At the end of the phase one interview, signed consent was sought for the participant's survey responses to be linked with other health datasets, including medical and health records held by NHS Digital (now NHS England)/UK Health Security Agency. The documentation for this is included in Appendix D (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods#appendices). Written consent was also requested for participants to be contacted by NHS Digital and/or NatCen to take part in future research.

Verbal permission was sought for a University of Leicester interviewer to contact the participant again in order to explain the phase two interview, should they be selected: 70.4% agreed.

The gap between phase one interview completion and phase two contact was minimised as far as possible, although inevitably there were some delays between the visits. Phase two interviewers were provided with some background information about participants such as age, gender, marital status and household composition. The interviewers contacted participants by phone to arrange an appointment.

All phase two interviews took place in person and took 90 minutes to complete on average. Some of the phase two content was collected using CAPI software but the majority of the interview involved clinical assessments using the SCAN v3 standalone software. All participants had the same examination, regardless of the condition selection for phase two was based on.

Incentives

A voucher that could be exchanged for £10 in cash at any Post Office was attached to all advance letters, to make the letter more memorable and to generate interest. Due to lower than expected response rates, from November 2023 until the end of fieldwork an additional £10 high street voucher was given to those who took part in a phase one interview, as part of a response improvement campaign. Those who were selected and took part in a phase 2 interview were also given a £10 high street voucher at the end of the interview.

Signposting to further support

All participants at the end of the phase one and phase two interview were offered a list of helpline numbers and websites. These included the details for organisations providing information about the conditions covered by the survey as well as organisations providing support to people in crisis. The leaflet also emphasised contacting a GP for support and advice as a first step (see Appendix D (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods#appendices)).

Translation

The phase one computer-assisted questionnaire was translated to Urdu, which has in recent years been the most used alternative language in face-to-face surveys in England, to facilitate participation from those who did not feel confident responding in English. Interviewers who were Urdu speakers underwent an accreditation process and acted as interpreters where required. Urdu speakers were included in the phase two assessment team at the University of Leicester.

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3. Survey response

3.1 Phase one response

Of the 25,080 addresses issued, 23,500 (93.7%) were found to include at least one private household and were therefore eligible for participation. Of these 8,571 (36.5%) were refusals in field and 1,498 (6.4%) were refusals direct to the office. 3,086 (13.1%) were coded as non-contacts and 3,433 (14.6%) were unproductive for another reason. 6,912 productive interviews were achieved, representing a 29.4% response rate. This included 42 (0.2%) partial interviews where the participant completed the treatment, service use and CIS-R modules, but did not reach the end of the interview.

Response rates at phase one

	Number	Percentage

Potentially eligible households	**23,500**	
Field refusals	8,571	36.5%
Office refusals	1,498	6.4%
Non-contacts	3,086	13.1%
Other unable/unproductive	3,433	14.6%
Productive adults	**6,912**	**29.4%**
Full interviews	6,870	29.2%
Partial interviews	42	0.2%

Of the 6,912 productive interviews, 6,669 (96.5%) were carried out in-person and 243 (3.5%) were carried out remotely over the phone.

Despite the self-completion section being very long, 89.0% of participants completed it. 68.9% of participants completed this entirely by themselves (via CASI or CAWI). In 20.1% of interviews the participant was assisted, either by the interviewer reading out the questions and entering the participant's responses, or the interviewer reading out the questions, but the participant entering their own responses. 11.0% of participants did not complete the self-completion section of the interview at all. Most of these participants were older.

72.6% of participants gave permission to be contacted for follow-up research and 68.1% consented to data linkage.

For more information: Table 2 and Table 3 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Phase one interview mode

	Number of adults	Percentage
Productive interviews	**6,912**	
In-person interviews	6,669	96.5%
Remote (telephone) interviews	243	3.5%
Productive self-completion	**6,153**	**89.0%**

Independent self-completion	4,761	68.9%
Interviewer assisted self-completion	1,392	20.1%
Consents		
Agreed to follow up research	5,019	72.6%
Agreed to data linkage	4,708	68.1%

Response rates by age and sex

Comparison of the unweighted responding sample profile with ONS 2022 mid-year population estimates demonstrates that survey response was lower among younger age groups (ONS 2022b (Link: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/ annualmidyearpopulationestimates/mid2022)). An estimated 13% of England's population were aged 16 to 24 in 2022, whereas 4.6% of survey responses came from this age group. The divergence between population estimates and response profile was slightly higher for males than females, suggesting that males aged 16 to 24 were the age-sex group least likely to respond to the survey. An estimated 6.6% of England's population were males aged 16 to 24, compared with 3.3% of survey responses coming from this group.

Conversely, older age groups were overrepresented in the achieved sample. 7.6% of responses were from males aged 75 and over and 9% from females aged 75 and over, while the respective population proportions were 4.8% and 6.3%. The groups with response most closely aligned to population estimates were males aged 55 to 64 and females aged 45 to 54. The proportion of responses from both of these groups differed by 0.5 percentage points or less from population estimates.

For more information: Table 7 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

3.2 Phase two response

6,912 participants provided a phase one interview. A probability of selection was calculated for each participant based on their answers to the phase one screening questions on psychosis, autism and eating disorders as outlined in Section 2.2 Sample design. Overall, 70.4% of phase one participants agreed to be contacted about the phase two interview. After the application of the highest of the three disorder specific sampling fractions, 1,742 participants were issued for a phase two interview. Phase two interviews were conducted with 887 of these (50.9%), and there were 364 refusals and

491 non-contacts.

For more information: Table 4 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

Response rates of adults at phase two

	Number of adults	Percentage
Agreed to contact about phase two	**4,863**	**70.4%**
Selected for phase two	**2,330**	**33.7%**
Issued for phase two	**1,742**	**25.2%**
Refusal	364	20.9%
Non-contacts	491	28.2%
Productive interviews	**887**	**50.9%**
Full interviews	880	50.5%
Partial interviews	7	0.4%

4. Weighting the data

4.1 Weighting the phase one data

The survey data from the main and deprived area boost samples were weighted to take account of selection probabilities and non-response, so that the results were representative of the household population aged 16 years and over. Weighting occurred in four steps.

First, selection weights (wt_1) were applied to take account of the differential selection probabilities of addresses and households within addresses. For each of the 25,080 addresses sampled from a total of 1,140 sampled PSUs, the address selection weight (wt_a) was calculated as follows:

$$wt_a = \frac{1}{\big(\frac{a_R}{a_{PAF}}\big)}$$

a_R = number of addresses selected from region and IMD quintile

a_{PAF} = number of addresses within PAF in region and IMD quintile

The selection probability varied by IMD quintile and region because of the deprived area boost. As the number of addresses selected from each PSU did not vary, this weight could be calculated at address level.

Household selection weights were then calculated to take account of addresses in which the interviewer found multiple dwelling units and/or households. The dwelling unit selection weight (wt_d) consisted of the number of dwelling units within the address. The household selection weight (wt_h) consisted of the number of households within the dwelling unit. These two weights were multiplied together to create the overall household selection weight and trimmed at 4 to avoid extreme weights. The address and overall household selection weights were then multiplied together to produce wt1, the selection weight.

Second, to reduce household non-response bias, a household level non-response model was fitted using forward and backward stepwise logistic regression. Deadwood and known ineligible addresses were not included in the model's base. The dependent variable was whether the household responded or not. The independent variables considered for inclusion in the model included interview observations of physical barriers to entry (e.g. a locked common entrance or the presence of security staff), small area-level Census 2021 measures, population density, Government Office Region (GOR), Census 2021 Output Area Classifications (OAC), urban-rural status, and IMD quintiles, all available for responding and non-responding households. Census 2021 area-level measures tested included percentage of owner occupiers, percentage of adults educated to degree level, percentage of adults in work, percentage of households with children, and percentage of households with access to a car or van. All models were run weighted by wt_1, the selection weight.

Not all the variables tested were retained for the final model: variables not significantly related to the propensity of households to respond were dropped. The variables in the final model were: GOR, IMD quintiles, whether there were entry barriers to the selected address, quintiles of postcode sector-level population density, urban-rural status, OAC group, Local Authority-level population density, percentage of adults in managerial occupations (NS-SEC categories 1 and 2), percentage of adults educated to degree level, percentage of persons aged 55 or older, percentage of persons who were not white, percentage of households with children, and percentage of households with access to a car or van.

The non-response weight (wt_2) for each eligible household was calculated as the inverse of the probability of response estimated from the final model. The non-response weight was trimmed at the 99th percentile to improve efficiency and reduce the design effect.

Third, selection weights (wt_3) were applied to take account of the different probabilities of selecting participants in different sized households. The weight was equal to the number of adults (16+) in the household, the inverse of the probability of selection. This was trimmed at 4 to avoid a small number of very high weights which would inflate the

standard errors, reduce the precision of the survey estimates and cause the weighted sample to be less efficient.

The composite weight for selection and participation was calculated as the product of the weights from the previous stages:

$$wt_4 = wt_1 \times wt_2 \times wt_3$$

This composite weight was then checked for outliers and the top three weights trimmed to improve efficiency and reduce the design effect.

The final stage of the weighting was to adjust the composite weight (wt_4) using calibration weighting. Calibration takes an initial weight (in this case wt_4) and adjusts (or calibrates) it to given control totals. The process generates a weight which produces survey estimates that exactly match the population for the specific characteristics (control totals) used in the adjustment. Calibration reduces any residual non-response bias and any impact of sampling and coverage error for the measures used in the adjustment. The population control totals used were the ONS 2022 mid-year population estimates for age-by-sex and region, as well as Labour Force Survey Q4 2023 estimates of ethnicity and tenure (ONS 2025). After calibration, the APMS 2023/4 weighted data matched the estimated population in terms of age-by-sex as shown in Table 7 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset). Outliers were trimmed after calibration to improve efficiency, so totals do not match exactly for the other calibration variables, however the maximum residual bias is less than 0.1 percentage points. To adjust the response profile to match population estimates required assigning higher weights to the youngest survey participants and lower weights to the oldest. See Section 3 Survey response for more information.

The final weights for the main and deprived area boost data have a DEFF of 1.75, a NEFF of 3,951, and efficiency of 57%.

For more information: Table 5, Table 6 and Table 7 (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/dataset)

4.2 Weighting the phase two data

Three weighting variables were developed specifically for use when analysing outcomes derived from phase two data: presence of psychosis, presence of autism, and presence of probable eating disorder. These weights were designed to generate condition-specific datasets that are representative of the general population, based on all the participants with relevant information. Participants received a phase two weight if they were eligible for phase two, were selected, and then responded.

For analysis of prevalence of each of the disorders assessed at phase two (autism,

psychosis, and eating disorders), a new dataset was created combining phase two participants with phase two weight and phase one participants not eligible for phase two with their phase one weight. Participants who were selected for phase two, but did not respond, were removed. Phase one participants who were not eligible for phase two for a specific disorder were assumed not to have that specific disorder.

The phase two weights account for two factors:

1. Not all those eligible for phase two were selected with equal probability: all those screened in with a positive psychosis score or a SCOFF questionnaire score of 2+ were selected as were all adults scoring 8 or more on the Autism-Spectrum Quotient (AQ-20). For adults scoring 4-7 on the AQ-20, sub-sampling was used to select 16% for phase two.
2. Some of the eligible phase one participants did not agree to be contacted for phase two during their phase one interview, so were automatically excluded from the phase two selection. Others were selected for phase two but then declined to take part. These refusals introduce the possibility of phase two non-response bias. The phase two weights incorporate a non-response adjustment to ensure that those responding have a similar weighted profile to those eligible.

The phase two weights were calculated by modelling, via stepwise logistic regression, the probability of being selected and responding to phase two, conditional on being eligible for selection. The weight per phase two participant was then calculated as the inverse of the predicted probability from the model, multiplied by their phase one weight. The predicted probabilities simultaneously account for selection probabilities and for observable non-response biases.

The variables included in the final phase two non-response model were:

- IMD quintiles.
- Whether participant was screened in for psychosis.
- Whether participant was screened in for eating disorders.
- AQ-20 scores by sex, ethnic group (five categories).
- Equivalised income quintiles.

Other variables, such as age, employment status, qualification, and marital status, were tested in the regression model, but were excluded because they were not significantly associated with response to phase two. The non-response weights were trimmed at the 99th percentile to remove extreme weights and reduce the design effect.

To create the final phase two weights for each condition, phase one participants ineligible for phase two were assigned their phase one weight. Cases screened into phase two that did not respond were assigned a weight of 0. Cases screened into phase two that did respond were initially assigned a weight multiplying their phase one weight by the phase two non-response weight described above. This composite weight was then rescaled up, so that the sum weights for phase two participants in each phase two stratum matched the sum weights of all eligible cases in that stratum who responded in

phase one. For example, the phase two participants screened in for psychosis had the sum of their phase two psychosis weights rescaled from 140 to 606, as this is the sum of phase one weights for those screened in for psychosis (including non-respondents). For the autism weights, this rescaling was split by the four phase two sampling strata, as the probability of selection for phase two varied by AQ-20 score and gender.

The three sets of final weights were checked for efficiency, residual bias, and impact on phase two survey outcomes. The final weights were not trimmed to preserve the accuracy of the rescaling.

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5. Data analysis and reporting

5.1 Introduction

APMS 2023/4 is a cross-sectional survey of the general population. While it allows for associations between mental disorder and personal characteristics and behaviour to be explored, it is important to emphasise that such associations cannot be assumed to imply causality. A list of the variables used in the analysis in this report will be included in the archived dataset.

5.2 Weighted analysis and bases

As outlined in Section 4 Weighting the data above, all the data presented in the substantive chapters of this report are weighted to account for likelihood of selection and non-response. Bases are presented as weighted and unweighted. The unweighted bases show the number of participants included. The weighted bases show the relative size of the various sample elements after weighting, reflecting their proportions in the population in England.

5.3 Age-standardisation

Data have been age-standardised in most tables to allow comparisons between groups after adjusting for the effects of any differences in their age distributions. When different sub-groups are compared in respect of a variable on which age has an important influence, any differences in age distributions between these sub-groups are likely to affect the observed differences in the proportions of interest.

Observed data can be used to examine actual prevalence or mean values within a group, needed, for example, for planning services and is provided in the accompanying tables. Where data have been age standardised, the age-standardised estimates are discussed in the report text.

Age and sex were unknown for a small number of participants, which means they could not be included in the age-standardised analysis. As a result, the base sizes for age-standardised and observed tables are slightly different.

All age-standardised analyses in the report are presented separately for men and women, and age standardisation was undertaken within each sex, expressing male data to the overall male population and female data to the overall female population. When comparing data for the two sexes, it should be remembered that no standardisation has been introduced to remove the effects of the sexes' different age distributions.

Age standardisation was carried out using the direct standardisation method. The standard population to which the age distribution of sub-groups was adjusted was the mid-year 2022 population estimates for England. The age-standardised proportion p' was calculated as follows, where p_i is the age-specific proportion in age group i and N_i is the standard population size in age group i:

$$p' = \frac {\sum_i N_i p_i}{\sum_i N_i}$$

Therefore p' can be viewed as a weighted mean of p_i using the weights N_i. Age standardisation was carried out using the age groups 16 to 24, 25 to 34, 35 to 44, 45 to 54, 55 to 64, 65 to 74 and 75 and over. The variance of the standardised proportion can be estimated by:

$$var(p') = \frac {\sum_i (N_i^2 p_i q_i / n_i)}{(\sum_i N_i)^2}$$

where $q_i = 1 – p_i$ and n_i is the sample number in age-sex group i.

Both observed and age-standardised data are provided in tables by ethnic group and gender, IMD and gender, and region and gender. Only age-standardised data are presented in tables by employment status, problem debt, limiting physical health conditions, and common mental health conditions.

5.4 Standard analysis breaks

Most of the mental health conditions covered in this report are analysed by a core set of breaks: age, gender, ethnic group, employment status, problem debt, Index of Multiple Deprivation (IMD) quintile, comorbidity and region. These are described briefly below and defined in more detail in Appendix B Glossary (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods#appendices).

Gender and sex

Participants were asked their gender identity in the household demographics section of the interview. A follow-up question also asked participants about their sex at birth. In this report, results are mostly broken down by gender, that is whether participants identified as a man, a woman or as another category such as non-binary. Where data are presented by gender, the number of men and the number of women combined may total less than the number of all adults. Those identifying in another way, such as non-binary, are not included as a separate group due to small base sizes and disclosure risk. They are included in totals and in tables without a gender break. Note that the base for all tables

that cover the whole population is described as 'all adults'.

Age-standardisation calculations use ONS 2022 mid-year population estimates, which are based on sex (ONS 2022b). Age-standardised results exclude adults for whom age or sex is missing. This group are included in the observed tables.

Data in trend tables are presented by sex (defined as male or female at birth) to enable comparisons with previous surveys in the series. For key estimates, the report includes estimated population size totals, which are calculated using ONS 2022 mid-year population estimates and therefore were also based on sex.

Ethnic group

Participants identified their ethnicity according to one of fifteen groups presented on a show card, including 'other – please state'. These groups are based on those used in the 2021 Census and are drawn from the Government Statistical Service (GSS) ethnicity harmonised standard (Link: https://analysisfunction.civilservice.gov.uk/policy-store/ethnicity-harmonised-standard/), for use on national surveys. The groups were subsumed under four headings: White; Black/Black British; Asian/Asian British; and those who reported their ethnic group as mixed, multiple or other. For some analyses by ethnic group the White group was further divided into 'White British' (which included those giving their ethnic group as White and English, Scottish, Welsh or from Northern Ireland) and White other.

About 20% of the sample (1,375 participants) identified with an ethnic group other than White British. This is in line with the combined prevalence of these groups in the adult population resident in England (18%) (ONS 2022a (Link: https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/bulletins/ethnicgroupenglandandwales/census2021)). It should be noted that these small groups are highly heterogeneous, for example the 'Black/Black British' group could include both recent migrants from Somalia and Black people born in Britain to British parents. The results of analysis by ethnic group should therefore be treated with caution.

Employment status

Detailed information was collected from participants on the nature of their employment status in the previous week. Participants were classified as either employed (including working in a family business); unemployed (and therefore looking and available for work); or economically inactive (including those who are unable to work due to disability or illness, students, retired, or looking after the home). The standard International Labour Organization (Link: https://www.ilo.org/international-labour-standards#standards) definition was used and is described fully in Appendix B Glossary (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/

methods#appendices). Where this analysis break has been used, the base has been restricted to participants aged between 16 and 64.

Problem debt

Participants were classified as having a 'problem debt' if they indicated being 'seriously' behind on paying at least one type of bill and/or had been disconnected from their gas or electricity because they could not afford it, in the past year.

Area-level deprivation

Area-level deprivation has been defined using the English Indices of Deprivation 2019, commonly known as the Index of Multiple Deprivation (IMD).

IMD is the official measure of relative deprivation for Lower Super Output Areas (LSOAs) in England. LSOAs comprise between 400 and 1,200 households and usually have a resident population between 1,000 and 3,000 persons. IMD ranks every LSOA in England from 1 (most deprived area) to 32,844 (least deprived area). Deprivation quintiles are calculated by ranking the 32,844 neighbourhoods in England from most deprived to least deprived and dividing them into five equal groups. These range from the most deprived 20% of neighbourhoods nationally to the least deprived 20% of neighbourhoods nationally.

The Index of Multiple Deprivation (IMD) (Link: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019) was revised in 2019. It combines several indicators, chosen to cover a range of economic, social, and housing issues, into a single deprivation score for each small area in England. Seven distinct domains (Link: https://www.gov.uk/government/publications/english-indices-of-deprivation-2019-research-report) have been identified in the English Indices of Deprivation:

- income
- employment
- health deprivation and disability
- education, skills and training
- crime
- barriers to housing and services
- living environment.

In this report, quintiles of IMD are used to give an area-level measure of deprivation related to where participants live.

For further information see: English indices of deprivation 2019 (Link: https://www.gov.uk/government/collections/english-indices-of-deprivation)

Region

Analysis by region is based on the nine former Government Office Regions (GORs).

Base sizes for regions can be relatively small, and caution should be exercised in examining regional differences.

Comorbidity

Within each chapter, age-standardised analyses by presence of one or more limiting physical health conditions and presence of one or more common mental health conditions (CMHCs).

Participants were asked if since the age of 16 they had any of 25 physical health conditions listed on a card, including asthma, cancer, diabetes, epilepsy and high blood pressure. Participants were coded as having a limiting physical health condition if they reported having one or more physical health condition in the past 12 months that had been diagnosed by a doctor and that this had limited their ability to carry out day-to-day activities.

The revised Clinical Interview Schedule (CIS-R) was used to assess six types of CMHCs: depression, generalised anxiety disorder, panic disorder, phobias, obsessive compulsive disorder, and CMHC not otherwise specified. Participants identified with at least one of these were defined as having a CMHC.

Treatment and service use

See Chapter 2 Mental Health Treatment and Service Use (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/mental-health-treatment-and-service-use) chapter for a description of how the various forms of treatment and service use were derived. These include forms of treatment and service use provided, for a mental or emotional condition, by the NHS, private or other providers. When looking at treatment and service use, participants who screened positive for each disorder were compared with those who did not. Because of the relatively low prevalence of many of the disorders assessed in APMS 2023/4, this generally meant that the base size for the group with the disorder was usually small. Age-standardising a small group can be problematic, for the reasons outlined above, and so the treatment and service use analyses were not age-standardised.

5.5 Testing for statistical significance

Significance testing was carried out on the results in the 2023/4 report. The term ‘significant’ refers to statistical significance at the 95% level and is not intended to imply substantive importance. The significance tests were carried out in order to test the relationship between variables in a table, usually an outcome variable nested within

gender, by an explanatory variable such as age (in categories), employment status and region. The test is for the main effects only (using a Wald test). For example, the test might examine whether there is a statistically significant relationship between bipolar disorder and age (after controlling for gender) and between bipolar disorder and gender (after controlling for age).

More about the Wald test

The Wald test is a statistical test used to calculate the significance of parameters in a statistical model. The Wald test is used in analysis of APMS data in this report to establish whether the association among particular variables is statistically significant. The test calculates the statistical significance of parameters in a logistic regression model of prevalence of common mental health conditions in order to establish whether age and gender are significantly associated with prevalence of common mental health conditions.

It is worth noting that the test does not establish whether there is a statistically significant difference between any particular pair of subgroups (e.g. the second and third IMD quintiles). Rather it seeks to establish whether there is a significant pattern of association across a variable's categories (e.g. across the five IMD quintiles). Significance testing gives some insight into whether the variation in the outcome between groups that is observed could have happened by chance or whether it is likely to reflect some 'real' differences in the population.

A p-value is the probability of the observed difference in results occurring due to chance alone. A probability of less than 5% is conventionally taken to indicate a statistically significant result ($p<0.05$). It should be noted that the p-value is dependent on the sample size, so that with large samples, differences or associations which are very small may still be statistically significant.

Using this method of statistical testing, differences which are significant at the 5% level indicate that there is sufficient evidence in the data to suggest that the differences in the sample reflect a true difference in the population.

A second test of significance looks at the interaction between gender and the variable under consideration. If the interaction is statistically significant ($p<0.05$) this indicates that there is likely to be an underlying difference in the pattern of results for men and women, and this will normally be commented on in the report text.

For key estimates in each chapter, the text and tables also include confidence intervals, to give readers more information on statistical significance.

5.6 Time series

In most chapters, 2023/4 results are compared to results from previous survey years. To

allow for comparisons over time, the 2023/4 results in trend tables use sex rather than gender, as gender was not explicitly collected in previous surveys. The results in trend tables are also sometimes restricted to specific age ranges depending on the estimate, as some of the 1993 (64 years) and 2000 (74 years) surveys had an upper age limit. This means that 2023/4 estimates in trend tables are not directly comparable to tables disaggregated by gender and age within the same chapter.

Estimates from different survey years are considered significantly different if the confidence intervals for the two estimates do not overlap. In some instances, slightly overlapping confidence intervals might still be significant according to a generated p-value, which provides an alternative indication of statistical significance. In these instances, this is explained in the commentary. This is a cautious but transparent approach to assessing change over time in this report.

5.7 Sampling errors and design factors

The percentages quoted in the main report are estimates for the population based on the information from the sample of people who took part in this survey. All such survey estimates are subject to some degree of error. The confidence interval (CI) is calculated from the sampling error, which is a measure of how such a survey estimate would vary if it were calculated for many different samples. If the survey was repeated many times, such a 95% CI would contain the true value 95% of the time. For this survey, a multi-phase stratified design was used, rather than a simple random sample, and the sampling errors need to reflect this.

The effect of a complex sample design on estimates is quantified by the design factor (deft). It is the ratio of the standard error for a complex design to the standard error which would have resulted from a simple random sample. A deft of 2, for example, indicates that the standard errors are twice as large as they would have been had the sample design been a simple random sample. The sampling errors, design effects and CI for key prevalence variables can be found in accompanying data tables for each chapter.

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6. Quality assurance

Quality assurance processes were adhered to throughout APMS 2023/4, from preparation and sampling through data collection and data analysis to report writing, as detailed in this chapter. NatCen has a quality management system with sets of procedures that were followed throughout. The purpose of establishing standard procedures, as highlighted by the WHO in relation to its World Health Survey (Üstun et al. 2005), is to help ensure that:

- Data collection is relevant and meaningful.
- Data can be compared across surveys and between subgroups.
- Practical implementation of the survey adheres to proper practice.

- Errors in data collection are minimised.
- Data collection capability is improved over time.

Examples of quality control measures that were built into, or checked after, the survey process included:

- The computer programme used by interviewers had in-built soft checks (which can be suppressed) and hard checks (which cannot be suppressed). These included querying uncommon or unlikely answers, and answers out of the acceptable range.
- For phase one interviewers, telephone checks were carried out with participants at 10% of productive households to ensure that the interview had been conducted in a proper manner.
- The phase two interview was less structured and required clinical skill and assessment. The work of the phase two interviewers was supervised by a senior research psychologist. They also accompanied all interviewers on at least one of their participant visits three months into fieldwork, to ensure that they were conducting the interview as per protocol and to validate the coding. If a further supervised visit was felt necessary, this was also carried out.
- All phase two interviewers were observed on a number of occasions during fieldwork, for their ADOS interviewing to be validated, in addition to weekly meetings to discuss individual cases and queries throughout.
- During the analysis stage, the table syntax and accompanying text were reviewed by both the author and a second checker. In the final stages, the complete report underwent quality assurance by the quality assurance lead.

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Appendices

Appendix A - Assessment of disorders (pdf)

PDF 229 KB

(Link: /binaries/content/assets/website-assets/publications/apms-2023-4/appendix-a---assessment-of-disorders.pdf)

Appendix B - Abbreviations and glossary (pdf)

PDF 298 KB

(Link: /binaries/content/assets/website-assets/publications/apms-2023-4/appendix-b---abbreviations-and-glossary.pdf)

Appendix C - Phase one questionnaire

PDF 2 MB

(Link: /binaries/content/assets/website-assets/publications/apms-2023-4/appendix-c---phase-one-questionnaire.pdf)

Appendix D - Fieldwork documents

PDF 986 KB

(Link: /binaries/content/assets/website-assets/publications/apms-2023-4/appendix-d---fieldwork-documents.pdf)

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Next Chapter
Data quality statement (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/data-quality-statement)

Data quality statement

Introduction

This statement aims to provide users with an evidence-based assessment of quality of the statistical output included in this report.

It reports against those of the nine European Statistical System (ESS) quality dimensions and principles appropriate to this output. In doing so, this meets NHS England's

obligation to comply with the UK Statistics Authority (UKSA) Code of Practice for Statistics (Link: https://code.statisticsauthority.gov.uk/), and the following principles in particular:

- Trustworthiness pillar, principle 6 (Data governance) which states "Organisations should look after people's information securely and manage data in ways that are consistent with relevant legislation and serve the public good."
- Quality pillar, principle 3 (Assured Quality) which states "Producers of statistics and data should explain clearly how they assure themselves that statistics and data are accurate, reliable, coherent and timely."
- Value pillar, principle 1 (Relevance to Users) which states "Users of statistics and data should be at the centre of statistical production; their needs should be understood, their views sought and acted upon, and their use of statistics supported."
- Value pillar, principle 2 (Accessibility) which states "Statistics and data should be equally available to all, not given to some people before others. They should be published at a sufficient level of detail and remain publicly available."

The National Study of Health and Wellbeing in England: Adult Psychiatric Morbidity Survey was assessed in May 2016 by the UK Statistical Authority (UKSA) for compliance with the Code of Practice and the publication was recommended for continued designation as National Statistics.

Background

The Adult Psychiatric Morbidity Survey (APMS) series provides data on the prevalence of treated and non-treated mental health conditions in England's adult population (age 16 and over).

The APMS 2023/4 is the fifth in a series of national mental health surveys. Each survey involved interviewing a large, stratified probability sample of the general population, covering people living in private households. The two-phase survey design involved an initial interview with the whole sample, followed up with a structured assessment carried out by clinically trained interviewers with a subset of participants.

The survey was commissioned by NHS England, funded by the Department of Health and Social Care (DHSC), and carried out by National Centre for Social Research, the University of Leicester, and City St George's, University of London.

Relevance

This dimension covers the degree to which the statistical product meets user needs in both coverage and content.

The data published are used by the Department of Health and Social Care, NHS

organisations, charities, academics, the public and the media. Uses of the data include:

- informing and monitoring policy
- monitoring the prevalence of health or illness and changes in health or health related behaviours;
- informing the planning of services
- writing media articles

Universities, charities and the commercial sector use the data for health and social research. The survey data are also used for teaching purposes and by students in their work.

NHS England regularly consults the APMS Steering Group (consisting of Department of Health and Social Care (DHSC), Department for Work and Pensions (DWP), academics and charities to try and ensure most users' needs are met. In 2021, a public consultation (Link: https://digital.nhs.uk/data-and-information/areas-of-interest/public-health/national-study-of-health-and-wellbeing/adult-psychiatric-morbidity-survey-2022-survey-consultation-findings) was held to inform the content and outputs of the 2023/4 survey.

Accuracy and reliability

This dimension covers, with respect to the statistics, their proximity between an estimate and the unknown true value.

The figures in this publication come from surveys, which gather information from a sample rather than from the whole population. The sample is designed to be as accurate as possible given practical limitations such as time and cost constraints. Results from sample surveys are always estimates, not precise figures. This can have an impact on how changes in the estimates should be interpreted.

As the number of people available in the sample gets smaller, the variability of the estimates that we can make from that sample size gets larger. Estimates for small groups are less reliable and tend to be more volatile than for larger aggregated groups. For some of the low prevalence disorders the uncertainty in how reflective the estimates produced are of the resident population is relatively large compared to size of the estimate. For these disorders particularly the prevalence estimate must be understood to sit inside confidence intervals, giving a range of likely true prevalence values for the population.

As the data are based on a sample (rather than a census) of the population, the estimates are subject to sampling error. The APMS 2023/4 used a clustered, stratified multi-stage sample design and in addition, weights were applied when obtaining survey estimates. One of the effects of using the complex design and weighting is that standard errors for survey estimates are generally higher than the standard errors that would be derived

from an unweighted simple random sample of the same size. The calculation of standard errors shown in the tables, and comments on statistical significance have been included in the report, all of which have considered the clustering, stratification and weighting of the data.

In general, attention is drawn to differences between estimates only when they are significant at the 95% confidence level, thus indicating that there is less than 5% probability that the observed difference could be due to random sampling variation when no difference occurred in the population from which the sample is drawn.

A total of 6,912 adults (aged 16 and over) were interviewed during phase one of the 2023/4 survey. 880 phase two interviews were carried out by clinically trained research interviewers employed by the University of Leicester. Details of the sample design and survey methods and sampling errors and design effects are in the publication's Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods) which accompanies this publication.

The sample was designed to be representative of the population living in private households in England. People living in institutional settings such as residential care homes, offender institutions, prisons, in temporary housing (such as hostels or bed and breakfasts) or sleeping rough are outside the scope of the survey. This should be borne in mind when considering survey findings.

Timeliness and punctuality

Timeliness refers to the time gap between publication and the reference period. Punctuality refers to the gap between planned and actual publication dates.

The fifth iteration of the APMS, due to take place 7 years after the 2014 survey, was delayed due to the COVID-19 pandemic.

A report about the survey findings and trend data tables are published as soon as possible following completion of fieldwork data collection, data validation and analysis. Fieldwork for the APMS 2023/24 took place in 2023 and 2024.

To improve the timeliness of the publication a decision was made to publish in two parts with Part 1 being released on 26th June covering:

- Common mental health conditions
- Mental health treatment and service use
- Posttraumatic stress disorder
- Suicidal thoughts, suicide attempts and non-suicidal self-harm
- Gambling behaviour
- Attention deficit hyperactivity disorder

Part 2 was released on 27th November covering:

- Alcohol: hazardous, harmful and dependent patterns of drinking
- Drug use and dependence
- Personality disorder
- Autism spectrum disorder
- Bipolar disorder
- Psychotic disorder
- Eating disorders

This publication has not suffered any delay compared to the planned and preannounced release date.

Accessibility and clarity

Accessibility is the ease with which users are able to access the data, also reflecting the format in which the data are available and the availability of supporting information. Clarity refers to the quality and sufficiency of the metadata, illustrations and accompanying advice.

The 2023/4 reports have been published in HTML format, with tables provided in Excel format. Methods and Survey documentation materials are available for download in pdf format.

Approved researchers seeking to undertake secondary analysis of the Health Survey for England will be able to apply for access via the UK Data Service, more information is available on the Population Health Data Access Webpage (Link: https://digital.nhs.uk/services/data-access-request-service-dars/dars-products-and-services/population-health-surveys).

Coherence and comparability

Coherence is the degree to which data, which have been derived from different sources or methods but refer to the same topic, are similar. Comparability is the degree to which data can be compared over time and domain.

This is the fifth survey in the APMS series. Certain core themes and methodologies have been kept consistent or comparable throughout the survey series to provide a consistent time series for core mental disorders.

Details of specific decisions made to enable comparability over time, such as the use of sex or gender as a cross break are in the publication's Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods)

which accompanies this publication.

The comparability of the results in this publication with other studies conducted nationally and internationally, where such studies are available, is discussed in each topic-specific chapter. These comparisons are mainly outlined in the Introduction and Discussion sections of each chapter, but also highlighted throughout where appropriate.

Trade-offs between output quality components

This dimension describes the extent to which different aspects of quality are balanced against each other.

Within this publication different aspects of quality have been balanced against each other to best meet the aims of the survey.

Due to the sensitive nature of the survey focus, it is possible that some question may be susceptible to social desirability bias, where the individual is tempted to give an answer which is more socially acceptable. Participants are assured that their answers will be kept private to reduce this temptation.

Assessment of user needs and perceptions

This dimension covers the processes for finding out about users and uses and their views on the statistical products.

From our engagement with customers, we know that there are many users and uses of these statistics. Details of these uses and users have been included in the 'Relevance' section of this Data Quality Statement, along with details of previous consultation on this survey series.

Regular consultation with customers and stakeholders is undertaken to ensure that developments introduced to this publication and other NHS England publications meet their requirements.

NHS England tries to engage with users of these statistics to gain a better understanding of the uses and users and to ensure these statistics remain relevant and useful. We capture information on the number of unique page views the reports and tables receive, alongside coverage in the media.

NHS England is keen to gain a better understanding of the users of this publication and of their needs; feedback is welcome and may be sent to (Link: /cdn-cgi/l/email-protection#d3b6bda2a6baa1b6a093b7bab4baa7b2bffdbdbba0fda6b8).

Performance, cost and respondent burden

This dimension describes the effectiveness, efficiency and economy of the statistical output.

Data for the APMS 2023/24 were collected from the population living in private households in England. Due to the scale of this collection it is currently carried out once every seven years.

As with all previous surveys the APMS 2014 involved a stratified random probability sample of households. One adult aged 16 years or over was randomly selected for interview in each eligible household. Given the length of the interview process, interviewing one household member helped to reduce the burden placed on each household.

The two-phase survey design involved an initial interview with the whole sample, followed up with a structured assessment carried out by clinically trained interviewers with a subset of participants. The achieved sample for the first phase of the 2023/4 survey was 6,912 adults (aged 16 and over), a response rate of 29.4%. 1,742 of these were selected for the second phase interview, 887 (50.9%) of whom were interviewed. Full details of the survey methodology and associated burden can be found in the APMS 2023/4 Methods documentation (Link: /data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/methods).

Confidentiality, transparency and security

The procedures and policy used to ensure sound confidentiality, security and transparent practices.

The data contained in this publication are National Statistics. The Code of Practice for Statistics (Link: https://code.statisticsauthority.gov.uk/) is adhered to from collecting the data to publishing.

No personal/individual level information is contained in the report. Information is presented at a high level of aggregation. As for all NHS England publications the risk of disclosing an individual's identity in this publication series has been assessed and the data are published in line with a Disclosure Control Method for the dataset.

Please see links below to relevant NHS Digital policies:

Statistical Governance Policy

https://digital.nhs.uk/data-and-information/find-data-and-publications/statement-of-administrative-sources/a-z-of-nhs-digital-official-and-national-statistics-publications#user-documents (Link: https://digital.nhs.uk/data-and-information/find-data-and-publications/statement-of-administrative-sources/a-z-of-nhs-digital-official-

and-national-statistics-publications#user-documents)

Freedom of Information Process

https://digital.nhs.uk/about-nhs-digital/contact-us/freedom-of-information (Link: https://digital.nhs.uk/about-nhs-digital/contact-us/freedom-of-information)

A Guide to Confidentiality in Health and Social Care

https://digital.nhs.uk/about-nhs-digital/our-work/keeping-patient-data-safe (Link: https://digital.nhs.uk/about-nhs-digital/our-work/keeping-patient-data-safe)

Privacy and Data Protection

https://digital.nhs.uk/about-nhs-digital/privacy-and-cookies (Link: https://digital.nhs.uk/about-nhs-digital/privacy-and-cookies)

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