Prevalence, Risk Factors, and Use of Health Care in Depression: A Survey in a Large Region of France Between 1991 and 2005

Viviane Kovess-Masfety, MD, PhD[1]; Xavier Briffault, PhD[2]; David Sapinho, MSc[1]

Objective: To compare the prevalence, risk factors, and use of care for depression between 2 periods, concerning changes in social factors and health care provision.

Method: We compared data from 2 surveys carried out in a large urbanized French region (Île-de-France) 15 years apart (1991, $n = 1192$; 2005, $n = 5308$), using comparable methodology and tools.

Results: The overall prevalence of depression has slightly increased over this period. In contrast, the tendency of people who claim they feel depressed has dramatically increased. At-risk populations have also changed during this period. The proportion of people consulting a psychiatrist for depression has not changed, while general practitioner (GP) consultations have decreased and psychologist consultations have increased 3-fold. Psychotropic use by people who are depressed has decreased significantly.

Conclusion: The trend toward increased depressive symptoms does not correspond to an increase in depressed disorders. In a well-staffed urbanized French region, psychologists are playing a growing role in managing depression at the expense of GPs, when the use of a psychiatrist remains unchanged; decreased use of psychotropic drugs may be a consequence.

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Clinical Implications

- Although people are much more likely to admit depressive symptoms, the prevalence of depressive disorders has not changed.
- In an urban region of France with extensive medical resources, psychologists (whose numbers are not state-regulated) are playing a growing role in the management of such disorders.
- Psychotropic drug use is decreasing, mainly as a consequence of a decreasing role of the main prescribers, the GPs.

Limitations

- Although questions and sampling were identical, there are some methodological differences that may hamper comparisons.
- Our study was carried out in an urban region well covered in health care resources, which is not representative of the country as a whole.
- Use of care was self-reported and therefore unverified.

Key Words: *depression, surveys, time trends, use of care*

Recent studies in the United Kingdom and the United States have indicated that the prevalence of depression has not changed over the past 15 years but that access to care has improved considerably.

Two different national studies[1,2] that have evaluated the prevalence of mental health problems in representative sample populations using standardized methodologies have reported that this prevalence has not changed over a 10-year period. In particular, the prevalence of depressive disorders[3] and suicidal behaviour[4] remained stable over time in 2 consecutive surveys from the United States. This stability in mental health was also found over a 40-year period by Murphy et al[5] in their Stirling County study. However, these authors noticed a redistribution between social categories of people with a high risk of experiencing mental health problems during the 1990s. The most recent study demonstrated an increase in the relative risk of depression or anxiety among young women, while in previous studies elderly people had the highest risk of depression.

Another study,[6–8] based on the Lundby cohort, has studied the evolution of rates and risk factors of depression and neurosis over 50 years (1947 to 1997). Annual standardized incidence rates were found to be lower over the 1972 to 1997 period, compared with 1947 to 1972. However, unlike what was found in the Stirling County study, incidence rates increased in the oldest age groups (age interval of 70 to 99 years). These differences may be owing to large differences in the social systems in the 2 countries as well as the method for attributing major depressive disorders in the 2 studies.

Further, the Kessler study[2] also reported a significant increase in the proportion of people who turned to professionals for help with mental health problems from 20.3% to 32.9%. This increase was particularly marked for consultations with mental health specialists.

No such data are available concerning the French population. The aim of our study was to examine the changes in prevalence rates for depression rates, in groups at risk, and in access to professionals in France, between 1991 and 2005.

The French Context

In France, direct access to specialist care is unrestricted. As a result, the number of psychiatrists practicing in France is relatively high, compared with other countries. There are around 13 000 practising psychiatrists (23 per 100 000 inhabitants) of whom 52% are community-based and the rest are working in hospitals in the public sector.[9,10] This number has remained stable over the last 2 decades. The number of GPs has also remained relatively stable over this period at a density of around 171 per 100 000 inhabitants.[11] However, important differences in access to specialist and generalist care exist between geographical areas.

Available data on care provision by clinical psychologists are less reliable and difficult to compare. A 1999 national census identified around 20 800 clinical and educational psychologists (38.5 per 100 000) of whom 5800 were working in psychiatric hospitals or community psychiatry, 3000 in city councils, 7750 in schools, and 4000 in private practice. In addition, psychologists without extensive clinical training work in schools, universities, or research facilities (1200); in human resources departments (5000); as well as in the judiciary sector (620); totalled 27 000.

In contrast to the medical profession, which is regulated, the number of psychologists is not restricted. Each year, around 3700 psychologists enter the workplace and the number of clinical psychologists has increased by as much as 5600 between 1990 and 1999.[12–14]

Compared with other European countries, management of mental health problems in France is very medically oriented.[15] GPs and psychiatrists play a prominent role, as their services are, for the most part, reimbursed by national medical insurance. In contrast, consultation with psychologists is not reimbursed, except in the public sector, meaning either waiting lists are long or patients have to pay.

Regular decennial health surveys[16,17] have indicated that consultations with community psychiatrists increased from 14.9 to 17.5 million between 1993 and 2003 (an increase of 17%), while the total population only increased from 57 to 60 million (5%). In addition, the proportion of people who consulted their GP for help with mental and sleep problems increased from 19% to 28% between 1992 and 2000, a more rapid rise than all other reasons for consultation.

Abbreviations used in this article

CIDI	Composite International Diagnostic Interview
DSM	Diagnostic and Statistical Manual of Mental Disorders
INSEE	National Institute of Statistics and Economic Studies
GP	general practitioner
MDE	major depressive episode

Methods

The objective of our study was to evaluate changes in the prevalence, risk factors, and treatment of depression in an urban area of France, Île-de-France, containing one-fifth of the population of France, and which has the highest cover in terms of doctors, psychiatrists, and psychologists in the country.

A comparison was made between 2 surveys conducted in 1991[18] and 2005[19] on 2 representative samples of the general population in the Île-de-France region, in which the prevalence of depression and sociodemographic variables were

evaluated in a comparable and standardized manner. The 2 studies conducted 14 years apart used relatively comparable methodology.

The investigation carried out in 1991 was a face-to-face study and all household members surveyed were interviewed, while the 2005 study was carried out by telephone from a random sample of telephone numbers that took into account numbers with restricted access. In addition, a sample of people who did not possess a mobile phone was integrated in proportion to the expected percentage in this region. Listed and unlisted telephone numbers were covered by a list-assisted sampling method: the last digit of listed numbers was replaced by a randomly chosen digit. In addition, random-digit dialing was used to extend the coverage to households equipped with mobile telephones only. Subjects were selected if their household was unequipped with a telephone. Among the 3698 subjects contacted, 2061 gave a complete interview (participant response rate was 55.7%). Among them, only those living in Île-de-France were selected for our study ($n = 370$) and combined with the telephone sample (final $n = 5382$). However, the sample with mobile phone only was weighted by the expected proportion of mobile phone only households in the Île-de-France region.

One adult per family was then chosen according to the method of Kish[20]; this same method was used retrospectively on the 1991 population for which the familial composition was known and this permitted identical sampling. The 2 surveys received a Commission Nationale Informatique et Libertés (French National Committee for Data Processing and Freedom: an independent administrative authority protecting privacy and personal data) authorization that ensures that confidentiality and ethical rules were respected to protect privacy. Before the interview, a letter explaining that participation was not mandatory was either sent home or read to the participant.

The response rates in 1991 were 79% for households and 90% for the household members, yielding a global response rate of 71%. In 2005, 86.7% of households and 65% of household members replied, yielding a global response rate of 57%.[21] The Île-de-France study population consisted of 1183 people in 1991 and 5382 people in 2005 (1192 and 5308 after weighting for the Kish correction and for the mobile phone only sample).

Data were weighted according to age, sex, and department (an administrative area in France: the Île-de-France region is composed of 8 departments, 7 located around Paris and Paris itself), according to the most recent available INSEE demographic census data (2004). The structure of the unweighted sample is provided in Table 1.

In the 2 studies, an abridged version of CIDI, CIDI Short Form,[22] was used. Screening questions first assessed the presence of an episode of sadness or anhedonia lasting at least 2 weeks. In the case of a positive response to one of these 2 criteria, the interviewer asked a series of questions on symptoms and health care use (type of professionals and medication). DSM-IV criteria were used to assign a diagnosis of MDE. These specify the presence of at least 5 features, including either depressed mood or anhedonia, together with some kind of impairment. Three DSM-IV criteria, namely, B (presence of mania), D (due to substances or medical disease), and E (due to bereavement in the first 2 months), were not investigated in either survey.

The 2 surveys differed in the time frame of evaluation of depression. In the 1991 survey, a lifetime approach was used with prevalence estimated over the year in which the last episode occurred, whereas in 2005 symptoms were evaluated only for the year preceding the study. Further, although the screening questions were identical in 1991 and 2005, in 2005 further questions on the symptoms of depression were only given to subjects reporting sadness or anhedonia for at least half the day and most of the days during the 2-week period. In addition, impairment due to depression was not evaluated identically in the 2 studies. In the 1991 investigation, 2 questions (difficulty with activities and working or going out), with a yes or no response, allowed a diagnosis to be assigned and collection of further data. In the 2005 study, impairment was evaluated with the Sheehan scale,[23] which rates 4 domains of activity from 0 to 10. These domains are household tasks, ability to work, relationships, and social life. A score of 4 or more in one of these domains is considered as a significant impairment and a score of 7 or more as severe impairment. It was only possible to compare severe impairment in the 2005 survey with impairment data in the 1991 survey.

The demographic characteristics of the Île-de-France population varied slightly between 1991 and 2005. In particular, the proportion of young people, aged 20 to 39 years, decreased by 3.2%, with a concomitant increase in the proportion of people aged 40 to 59 years (16.4% increase) and of people aged 60 years or older (13.8% increase). However, both samples were weighted to reflect the demographic composition of the region in the 2 time periods.

All statistical analyses, percentage comparisons, and logistic univariate and multivariate models were performed using Stata SE 8.1 (Stata Corporation, College Station, Texas).

Results

The percentage of interviewees who replied positively to one or more of the 2 primary screening criteria (sadness or anhedonia) was very different in the 2 studies, with almost 3

Table 1 Structure of the weighted and unweighted samples

	1991		2005	
Variables	Weighted	Unweighted	Weighted	Unweighted
Age, years				
20–39	41.5	45.1	41.5	43.0
40–59	36.4	30.9	36.4	34.0
60	22.1	24.1	22.1	23.0
Sex				
Men	47.6	46.2	47.6	41.9
Women	52.4	53.8	52.4	58.1
Department				
75	20.9	20.8	20.9	18.4
77	10.7	7.9	10.7	10.8
78	12.0	11.2	12.0	13.1
91	10.1	11.2	10.1	11.4
92	13.4	15.6	13.4	13.5
93	12.0	12.4	12.0	11.1
94	11.2	12.8	11.2	11.4
95	9.6	8.1	9.6	10.3
Employment status				
Working	59.0	60.2	56.2	57.0
Unemployed	3.6	3.5	7.2	7.3
Student or armed forces	6.6	5.0	9.9	7.9
At home	10.6	9.5	4.5	4.5
Retired	18.4	20.0	20.8	21.8
Other or inactive	1.9	1.8	1.4	1.6
Marital status				
Single	26.0	29.5	25.8	28.2
Married	59.2	50.6	61.4	53.0
Widowed	6.4	9.2	6.0	8.6
Divorced	8.5	10.7	6.8	10.2

times more people replying positively in 2005. However, the relative proportion of these selected people who qualified for a diagnosis of depression by presenting 4 symptoms or more in addition to sadness or anhedonia (criteria A; Table 1) during the same period was 2-fold less in 2005, irrespective of the period of time considered for the comparison. The overall presence of MDEs was slightly higher in 2005. When the level of severity of depression was considered, the prevalence of mild and severe depression was identical, while that of moderate depression was higher and was responsible for the difference in the prevalence of depression as a whole.

Groups at Risk

Table 2 shows the change in groups at risk of depression over this period. A comparison between the 2 surveys shows that the main at-risk groups were not the same in 1991 and 2005. Although women have a higher risk than men, the relative risk has tended to decrease, and the differences are only significant in univariate analysis where the relative risk is divided by 2. The situation with retired people and people aged 60 years or older has also changed: in 1991 people aged 60 years or older were at risk of major depression, whereas 14 years later they seem to be protected, when compared with other age groups. Although the risk among separated, divorced, and widowed people has not changed, compared with married people, it should be noted that single people now have a higher risk of depression. The social gap seems to have widened during this period, as people with university degrees seem to be protected, compared with people who have not achieved this level of education. Unemployed people also had a greater risk of depression in the 2005 study.

Table 2 Percentage of positive depressive symptoms and levels of severity of major depression in 1991 (*n* = 1192) and 2005 (*n* = 5308) (95% CI)

	Year of study		
Major depression	1991 % (95% CI)	2005 % (95% CI)	*P*
Positive screening (sadness or anhedonia)	10.8 (8.9–12.9)	28.3 (27.0–29.6)	<0.01
Criteria A (4 symptoms, minimum) among people screened	82.8 (73.8–89.0)	41.0 (38.4–43.7)	<0.01
Prevalence of major depression (at least 5 symptoms, including either sadness or anhedonia)	8.9 (7.3–10.9)	11.7 (10.8–12.6)	0.01
Mild: 5 symptoms without impairment	2.0 (1.3–3.1)	2.2 (1.8–2.7)	0.64
Moderate: major depression, neither mild nor severe	4.1 (2.9–5.6)	6.2 (5.5–6.9)	0.02
Severe: 6 symptoms or more and serious impairment	2.8 (2.0–4.0)	3.1 (2.6–3.6)	0.72

Use of the Health Care System for Depression

Among people who suffered from depression, the proportion of those who turned to any health professional for help decreased between 1991 and 2005 (Table 4). In fact, this decrease concerned GPs only, as psychiatrist access remained identical, and access to psychologists actually increased.

In addition, the reduction in consultation rates for any health care professional only concerned young people, people who were married, people without university degrees, and the unemployed. For all other groups, the proportion of people who sought help was not statistically different.

In contrast to the stability of access to psychiatrists and to GPs, at least for most of population categories, the number of people who turned to a psychologist for help increased almost 3-fold, particularly women (OR 4, $P = 0.09$) aged 40 to 59 years (OR 8, $P = 0.05$) and people without a high school diploma (OR 4, $P = 0.02$).

Self-reported use of psychotropic drugs decreased overall, but not by all groups. People aged 40 to 59 years who were single; widowed, divorced, or separated, and who had a high school diploma (at least 12 years of formal education) or higher qualifications had not significantly reduced their consumption of psychotropic drugs. A comparison of the 2 studies is not possible regarding the type of drugs because of differences in the method of data collection.

Therefore, the overall changes observed between the 2 studies consist of a decreased role for GPs, no change in psychiatrist access, an increased role for psychologists, and a decrease in consumption of psychotropic drugs.

Analysis by degree of severity (data not shown) allowed us to clarify these results. The decrease in the proportion of people who sought help with their depression only concerned those with moderate depression (75%, compared with 60.8%; $P = 0.049$) and this decrease only concerned GPs. GP consultation rates remained unchanged for mild and severe depression. Psychiatrist consultation rates were unchanged, irrespective of the degree of severity, and psychologist consultation only increased for severe depression, from 7.45% to 23.52% ($P = 0.03$). Finally, consumption of psychotropic drugs only decreased for moderate depression (64%, compared with 36%; $P = 0.001$) and was unchanged for severe depression.

Discussion

The comparison of the 2 surveys reported here has several limitations. For example, in 1991 the interviews were carried out face to face, while in 2005 they were done by telephone. Nonetheless, the validity of telephone interviews for gathering information on mental disorders has been well-established,[24,25] and indeed in some surveys data collected by telephone and by face-to-face interview have been pooled together.[26] Secondly, the response rates in 2005 were slightly lower than in 1991. However, 2 studies[27,28] on attrition in large mental health surveys showed such attrition is related to the demographic characteristics of the sample, rather than to psychopathology. In addition, the samples were weighted according to the demographic structure of the study population 2004 INSEE census data as reference. This contributes to reduce bias due to nonresponse rates.

There are also other differences between the 2 studies whose influence on our findings are more difficult to evaluate. In particular, the evaluation of the prevalence of depression in 1991 was primarily made about lifetime prevalence, with the prevalence of depression in the previous year only determined secondarily as a function of the response of the respondent for the last episode of depression. While this bias could affect the comparison of prevalence, it is unlikely to affect the change in relative risk, nor the number of people who sought help with any level of severity of depression. In addition, the

Table 3 Change in risk factors for depression between 1991 and 2005

	1991 (n = 106)		2005 (n = 621)	
Major depression	UV, 95% CI	MV, 95% CI	UV, 95% CI	MV, 95% CI
Sex				
Male	1	1	1	1
Female	3.1, 1.9–5.1 (P < 0.01)	2.8, 1.6–4.8 (P < 0.01)	1.6, 1.3–1.9 (P < 0.01)	1.6, 1.3–2.0 (P < 0.01)
Age, years				
20–39	1	1	1	1
40–59	0.9, 0.5–1.5 (P = 0.65)	0.7, 0.4–1.3 (P = 0.30)	0.9, 0.7–1.1 (P = 0.25)	0.8, 0.6–1.0 (P = 0.05)
>60	1.3, 0.8–2.1 (P = 0.31)	1.4, 0.6–3.3 (P = 0.47)	0.5, 0.4–0.6 (P < 0.01)	0.4, 0.2–0.6 (P < 0.01)
Marital status				
Single	0.9, 0.6–1.6 (P = 0.82)	1.0, 0.5–1.9 (P = 0.94)	1.5, 1.2–1.9 (P < 0.01)	1.4, 1.1–1.8 (P = 0.002)
Married or cohabiting	1	1	1	1
Widowed	2.3, 1.2–4.5 (P = 0.01)	1.8, 0.9–3.8 (P = 0.13)	1.3, 0.9–1.8 (P = 0.16)	1.8, 1.2–2.6 (P < 0.01)
Separated or divorced	2.8, 1.5–5.3 (P < 0.01)	3.0, 1.5–5.7 (P < 0.01)	2.1, 1.6–2.7 (P < 0.01)	2.0, 1.5–2.6 (P < 0.01)
Level of education, years				
<12	1	1	1	1
12	1.3, 0.7–2.4 (P = 0.33)	1.8, 0.9–3.4 (P = 0.07)	1.0, 0.8–1.3 (P = 0.88)	0.9, 0.7–1.2 (P = 0.40)
>12	1.3, 0.8–2.3 (P = 0.32)	1.6, 0.8–2.9 (P = 0.16)	0.8, 0.6–0.9 (P = 0.02)	0.7, 0.6–0.9 (P < 0.01)
Professional status				
Work	1	1	1	1
Unemployed	1.7, 0.6–4.6 (P = 0.32)	2.2, 0.7–6.4 (P = 0.16)	2.6, 2.0–3.3 (P < 0.01)	2.3, 1.7–3.2 (P < 0.01)
Student	0.4, 0.1–1.6 (P = 0.17)	0.3, 0.1–1.2 (P = 0.09)	0.9, 0.7–1.3 (P = 0.61)	0.6, 0.4–0.9 (P = 0.03)
At home	2.2, 1.2–4.3 (P = 0.02)	1.5, 0.7–3.3 (P = 0.28)	1.2, 0.8–1.9 (P = 0.30)	1.2, 0.8–1.9 (P = 0.37)
Retired	1.2, 0.7–2.1 (P = 0.48)	0.7, 0.3–1.7 (P = 0.42)	0.6, 0.5–0.8 (P 0.01)	1.0, 0.7–1.7 (P = 0.84)
Other	2.0, 0.6–6.5 (P = 0.26)	1.4, 0.3–5.8 (P = 0.65)	1.9, 1.0–3.3 (P = 0.04)	1.7, 0.9–3.0 (P = 0.09)

MV = multivariate analysis (logistic regression including all factors); UV = univariate analysis

differences in the prevalence of respondants screening positively and on respondents fulfilling criteria A for major depression between the 2 studies are so large that it is extremely unlikely that they are artefactual. It should be noted that the 2 studies compared here were regional studies and cannot be considered representative of the whole of France, even though the Île-de-France contains one-fifth of the French population. Finally, for some sociodemographic categories, the numbers were too small in one of the reference years to calculate the relative risk this was the case for access to psychologists in 5 such categories.

The combined effects of these methodological differences between the 2 studies may contribute a certain imprecision to the comparison of the data, which should be taken into account in interpreting the findings.

Despite these reservations, the stability of levels of depression observed is remarkable and is similar to that described in the United States and the United Kingdom. In contrast, declaration of symptoms of depression (sadness, anhedonia), which do not correspond to significant clinical depression, has greatly increased. The constant interest of the media in the subject and the general tendency to be more introspective and to think and speak about difficulties in life in psychological terms are probably partly responsible for this change.[29] This net tendency to report psychological problems more frequently was also observed by Murphy et al[5] in their Stirling County study.

This stability in mental health is consistent with reported changes in suicide rates and alcohol consumption, which have improved at both the regional and national level.[30]

Table 4 Change in the type of professional approached for help with depression from 1991 to 2005 (*n* = 790, 721 weighted—number of people presenting an MDE in 1991 and 2005)

	Any professional	GP	Psychiatrist	Psychologist	Psychotropic drugs
2005/1991	0.52 (*P* = 0.02)	0.53 (*P* = 0.01)	1.08 (*P* = 0.78)	2.79 (*P* = 0.02)	0.37 (*P* < 0.01)
	(60.44/74.5)	(41.88/57.59)	(19.38/18.24)	(16.73/6.71)	(40.12/64.44)
Sex					
Male	0.41 (*P* = 0.07)	0.53 (*P* = 0.16)	0.87 (*P* = 0.81)	1.26 (*P* = 0.74)	0.35 (*P* = 0.02)
Female	0.65 (*P* = 0.19)	0.60 (*P* = 0.07)	1.17 (*P* = 0.65)	4.18 (*P* = 0.09)	0.40 (*P* < 0.01)
Age, years					
20–39	0.45 (*P* = 0.02)	0.36 (*P* < 0.01)	1.07 (*P* = 0.88)	2.13 (*P* = 0.19)	0.37 (*P* < 0.01)
40–59	1.01 (*P* = 0.98)	1.11 (*P* = 0.83)	1.41 (*P* = 0.52)	8.00 (*P* = 0.05)	0.72 (*P* = 0.52)
>60	0.34 (*P* = 0.06)	0.56 (*P* = 0.23)	0.62 (*P* = 0.42)	2.05 (*P* = 0.39)	0.11 (*P* < 0.01)
Marital status					
Single	0.76 (*P* = 0.54)	0.79 (*P* = 0.59)	2.15 (*P* = 0.25)	2.04 (*P* = 0.27)	0.49 (*P* = 0.09)
Married	0.29 (*P* = 0.01)	0.29 (*P* < 0.01)	0.71 (*P* = 0.44)	1.42 (*P* = 0.54)	0.24 (*P* < 0.01)
Widowed	0.64 (*P* = 0.52)	1.29 (*P* = 0.69)	2.03 (*P* = 0.53)	n/a	0.34 (*P* = 0.10)
Divorced	2.74 (*P* = 0.10)	1.88 (*P* = 0.22)	1.59 (*P* = 0.41)	n/a	1.35 (*P* = 0.58)
Level of education, years					
<12	0.45 (*P* = 0.03)	0.50 (*P* = 0.03)	1.06 (*P* = 0.88)	4.20 (*P* = 0.02)	0.27 (*P* < 0.01)
12	0.56 (*P* = 0.31)	0.67 (*P* = 0.45)	0.95 (*P* = 0.94)	1.98 (*P* = 0.52)	0.50 (*P* = 0.20)
>12	0.69 (*P* = 0.51)	0.59 (*P* = 0.28)	0.91 (*P* = 0.86)	2.28 (*P* = 0.32)	0.58 (*P* = 0.26)
Employment status					
Working	0.65 (*P* = 0.24)	0.58 (*P* = 0.11)	1.30 (*P* = 0.55)	2.16 (*P* = 0.18)	0.43 (*P* = 0.01)
Unemployed	0.09 (*P* = 0.04)	0.37 (*P* = 0.33)	2.35 (*P* = 0.47)	n/a	0.05 (*P* = 0.01)
Student	1.05 (*P* = 0.97)	0.43 (*P* = 0.57)	n/a	n/a	0.54 (*P* = 0.68)
At home	0.33 (*P* = 0.19)	0.37 (*P* = 0.15)	0.38 (*P* = 0.21)	n/a	0.50 (*P* = 0.32)
Retired	0.50 (*P* = 0.24)	0.69 (*P* = 0.46)	0.82 (*P* = 0.77)	1.20 (*P* = 0.83)	0.18 (*P* < 0.01)
Other	1.33 (*P* = 0.84)	1.57 (*P* = 0.7)	2.08 (*P* = 0.57)	2.19 (*P* = 0.55)	0.51 (*P* = 0.6)

Data are presented as the odds ratio of the proportion of subjects consulting a given health care professional between 1991 and 2005.
n/a = not applicable

The decline over time in the relative difference in the prevalence of depression between men and women has already been reported in other studies, particularly in the United States.[31]

In most recent studies, elderly people have a much lower frequency of depression, although this was not the case in Île-de-France in 1991, a time when many elderly people lived in poverty.[32] In 2005, people aged 60 years and older had a more comfortable economic and social situation than before and had a lower risk of depression (OR 0.4, 95% CI 0.2 to 0.6; $P < 0.01$) than younger people who were confronted with economic hardship to a greater extent than they were in 1991.

In addition, we found a higher level of depressive morbidity among single people in 2005 than in 1991, as well as among the unemployed and among people with lower education levels. Putting all of these observations together, it seems that in 2005, compared with 1991, the risk of depression had increased among people most exposed to social risks according to sociodemographic categories, and that the shift in age classes in people reporting depression parallels the changing economic status of different age groups in the area.

The total number of people consulting medical professionals for help has not increased over the study period. Indeed, GP consultation rates have actually decreased, and the number of respondents consulting psychiatrists has not changed, irrespective of the severity of depression. In contrast, psychologists now play a more important role in the management of all forms of depression including the most severe ones. The

emergence of nonmedical specialists in the management of mental health problems in France is similar to what has been reported in the United States, Canada, and in several European countries such as the Netherlands.[2] In France, this change corresponds to an increase in the volume of service provision by psychologists, whereas access to medical professions has remained stable. In addition, psychologists appear to have gained access to sectors of people who previously managed depression outside the formal health service. These sectors include lesser-educated people and middle-aged patients with more severe depression. This expansion of clientele for mental health services is consistent with findings from another study on attitudes toward mental health care, in which demand for psychotherapy rather than psychotropic drugs was observed to have increased, irrespective of education level.[15]

The use of psychotropic drugs by people with severe depression has not changed over the study period, whereas it has decreased in people with moderate depression. These trends may be related, because GPs prescribed most psychotropic medications in France. The observation that the role of GPs in the management of mental health problems has decreased over the study period could explain the concomitant decrease in psychotropic drug use. In parallel, an increase in consultation of psychologists may also drive the decrease in psychotropic drug use, particularly for patients with less severe depressive disorders. It should be noted that owing to methodological limitations in the conduct of the 2 studies, it was not possible to analyze changes in the use of the different classes of psychotropic drugs (notably antidepressants and anxiolytics).

Conclusion

Although people are now more open about talking about their depression, no increase in the prevalence of MDEs was observed between 1991 and 2005 in the Parisian region. However, the relative importance of those groups at most risk for depression has changed. For example, elderly people are no longer a prominent high-risk group, whereas risk associated with single people and the unemployed has increased, especially more highly qualified people.

The profile of people providing care for depression has changed, with GPs playing a less important role, the role of psychiatrists being unchanged and, notably, the role of psychologists, who were largely absent from the 1991 survey, increased dramatically by 2005, notably for the less educated and the most severely depressed. In parallel, use of psychotropic drugs for depression seems to have decreased.

These changes can largely be explained by changes in the availability of different health care providers. If this evolution is maintained, these health care changes are likely to be amplified with a decrease in the availability of psychiatrists owing to retirement of psychiatrists of the baby boom generation[10] and a concomitant growth in the role of psychologists in the management of psychiatric disorders, as is happening in neighbouring European countries.

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[1]Research Unit Director, Université Paris Descartes (Equipe d'Accueil 4096), Fondation Mutuelle Générale de l'Éducation Nationale pour la Santé Publique, Paris, France.
[2]Research Associate, Centre de recherche psychotropes santé mentale, Centre national de la recherche scientifique, Unite Mixte de Recherche 8136; Institut Nationale de la Santé et de la Recherche Médicale, U611; Université Paris Descartes, Paris, France.
[3]Statistician, Université Paris Descartes (EA 4096), Fondation MGEN pour la Santé Publique, Paris, France.
Address for correspondence: Pr V Kovess-Masfety, EA 4069 Université Paris Descartes, 15 rue de l'école de Médecine, 75270 Paris cedex 06 France; fsp@mgen.fr.

Résumé : Prévalence, facteurs de risque et utilisation des soins de santé dans la dépression : une enquête dans une vaste région de France, entre 1991 et 2005

Objectif : Comparer la prévalence, les facteurs de risque, et l'utilisation des soins de santé pour la dépression entre 2 périodes, en ce qui concerne les changements des facteurs sociaux et de la prestation des soins de santé.

Méthode : Nous avons comparé les données de 2 enquêtes menées dans une vaste région française urbanisée (Île-de-France) à 15 ans d'intervalle (1991, n = 1192; 2005, n = 5308), à l'aide de méthodologie et d'instruments comparables.

Résultats : La prévalence générale de la dépression a augmenté légèrement durant cette période. Par contre, la tendance des gens qui disent se sentir déprimés a augmenté radicalement. Les populations à risque ont aussi changé durant cette période. La proportion des personnes qui consultent un psychiatre n'a pas changé, alors que les consultations d'omnipraticiens (OP) ont diminué et que les consultations des psychologues ont augmenté du triple. L'utilisation des psychotropes par les personnes qui sont déprimées a diminué significativement.

Conclusion : La tendance à la hausse des symptômes dépressifs ne correspond pas à une augmentation des troubles dépressifs. Dans une région française urbanisée bien dotée en personnel, les psychologues jouent un rôle grandissant dans la prise en charge de la dépression aux dépens des OP, tandis que l'utilisation des psychiatres demeure inchangée. L'utilisation en baisse des psychotropes peut en être une conséquence.