

by emotional problems. More in-depth assessments are needed to collect such data. An argument consequently could be made that a probability sub-sample of respondents in omnibus health surveys should be administered in-depth follow-up psychiatric interviews to collect this additional information. The second-stage sub-samples would over-sample respondents with high K-6 scores so as to enrich the sample for cases, making this the third important way in which clinical interviews could be integrated with screening scales.

We are currently investigating the possibility of using this design in the USA. Rather than continue to replicate the National Comorbidity Survey (NCS) in point-in-time surveys each decade (Kessler *et al*, 1994, 2005), we would administer an NCS interview to a probability sample of omnibus survey respondents every month of every year, accumulating a sample of 12 000 cases over each decade. This approach has several advantages over the stand-alone survey method:

- increased statistical power to study respondents with mental illness by over-sampling those who are 'positive' according to the screening scales
- expansion of information on respondents from the omnibus survey
- fine-grained time trend information
- the ability to modify assessments quickly, rather than once a decade, when modifications would be useful.

Finally, as omnibus surveys are typically very large, we could target selection of follow-up sub-samples in ever-changing ways over time for purposes of refining causal analyses in a case-control framework. Respondent burden

would increase and further elaboration would be needed to launch longitudinal studies, but this general approach holds much promise to realise the greater potential of general-purpose psychiatric epidemiological surveys along the lines so rightly urged by Henderson and Andrews.

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ORIGINAL PAPER

A comment on the yield from national surveys of mental health

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Henderson and Andrews have written a timely paper to examine the yield from national surveys, and pose questions of value for money, survey methods, delineation of pathology by categorical boundaries rather than dimensions, and breadth of risk factors examined. We would like to address the points they raise, exemplified by the purposes (Jenkins *et al*, 1997) and yield of the British survey programme.

First, Henderson and Andrews ask whether national surveys give good value, when considered against the unmet need for services. The sheer scale of unmet need has in fact been delineated only by national surveys – without them we would not know the scale of need, and how far it is met and unmet by clinical services (Bebbington *et al*, 2000). Moreover, without the use of repeat surveys, we would not have known

about the considerable changes in Britain in the use of services and the delivery of treatment (Brugha *et al*, 2004).

Henderson and Andrews focus on surveys using the DSM diagnostic criteria, standardised lay interviews and data derived solely from self-report. However, the World Mental Health Survey (WMHS) includes a clinical component in some countries, although psychosis, developmental disorders and personality disorder are not covered throughout the WMHS. The British adult survey programme does use lay interviewers to administer the Clinical Interview Schedule – Revised (CIS-R) to cover anxiety and depressive symptoms, but it is augmented by clinical assessments using the Schedules for Clinical Assessment in Neuropsychiatry (SCAN) and the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II), in the case of adults (e.g. Brugha *et al*,

2005), and by clinical assessments of qualitative and quantitative data from three sources in the case of children (Goodman *et al*, 2000). Because CIS-R assessments are based on the last 7 days, they minimise recall bias and are likely to be more accurate than the Composite International Diagnostic Interview (CIDI) default lifetime and 12-month assessments, and are perhaps more helpful from the point of view of health policy in prospectively estimating incidence and persistence (Skapinakis *et al*, 2006). The CIS-R is half the length of the CIDI used in most of the other surveys referred to by Henderson and Andrews, and CIS-R surveys have therefore been able to include a range of assessments omitted from the CIDI-based surveys. In the British survey, over 20 classificatory variables have been used, quite apart from a wide range of questions on risk factors, protective factors and service use. The last have included measures of primary group size (e.g. Brugha *et al*, 2003) as well as far more service use and treatment data (e.g. Farrell *et al*, 2006).

The use of an instrument like the CIDI enables diagnosis but has not hitherto allowed a dimensional approach to psychiatric disorder, hence the recent decision to add further dimensional measures to the WMHS. In the British surveys, owing to the use of the CIS-R, and the Patient Satisfaction Questionnaire (PSQ), data collected are both dimensional (symptom scores) and categorical (symptoms present or absent, and diagnoses based on clusters of symptoms) (e.g. Melzer *et al*, 2003; Johns *et al*, 2004).

Arguably, a key limitation of the CIDI-based surveys is their relatively meagre information on determinants and use of care and services, because most of the survey interview time is taken up by the detailed coverage of a wide range of current and lifetime DSM and ICD categories, as conceived and perceived in specialist mental health service settings, which have relatively little relevance to primary care or to low-income countries. However, the WMHS exercise covers a uniquely wide range of countries (wide ranging in income and indeed in economic progress and stability), many of which never before had any information to influence national policy. It can therefore claim to be truly global and hence highly authoritative and, importantly, destigmatising.

Henderson and Andrews say 'Most surveys covered the age range 18–65, and only a minority included children or the elderly'. The British surveys have covered increasingly wider age ranges; indeed, the third household survey, currently in the field, includes a representative sample of the whole adult age range, there have been two surveys of children and a number of surveys of hard-to-reach populations, including people in institutions, people in prison, homeless people, carers and children in care. This spread of surveys provides synergy. (Interested readers can find the full list of British survey technical reports on <http://www.ons.gov.uk>, and of academic papers on <http://www.iop.kcl.ac.uk/departments/?locator=430>.)

Henderson and Andrews use 1-year prevalence figures to highlight the striking differences in prevalence estimates in different countries. Some of these differences may arise from the inaccuracy resulting from recall bias inherent in asking about time periods longer than the last few weeks, as well as from poor translation protocols, different methods of administration, quality of data-collection procedures, and sampling methods, some of which are now being addressed in the emerging WMHS results.

Henderson and Andrews argue that assessment of need should include appreciation of the disability 'that comes from mental illness'. In fact, the links between mental illness and disability are extremely complex and physical illness can contribute to both and be a consequence of both (e.g. Moran *et al*, 2007), which structured lay interviews may not be capable of disentangling.

Henderson and Andrews suggest that 'the scientific advance in understanding the causes of these mental disorders has been slight'. However, the additional material incorporated in the British surveys has enhanced understanding of likely risk factors, the aetiological significance of which can then be tested further in longitudinal studies. Examples of secondary analyses that have greatly enriched our understanding of risk factors include detailed work on the role of age, gender, primary support groups, lone mothers and parenting (e.g. Bebbington *et al*, 1998; Brugha *et al*, 2003; Targosz *et al*, 2003; Vostanis *et al*, 2006). The British survey programme has also illuminated our understanding of the links between: mental illness and substance misuse (including nicotine); physical illness and personality disorder; mental disorders and personality disorder; mental disorder and violence (e.g. Coid *et al*, 2006); and victimisation experiences and psychosis (Bebbington *et al*, 2004). It has also advanced our understanding of health service use and the factors leading to suicidal behaviour (e.g. Jenkins *et al*, 2005).

While Henderson and Andrews feel that it is tempting to compare prevalence rates between countries and to put differences in prevalence rates down to intrinsic attributes of the population, such as lifestyles or social cohesion, earlier cross-country comparisons would have been limited by differences in response rates, instruments used and respondent acknowledgement of symptoms, many of which are now addressed by the WMHS.

Henderson and Andrews argue that the justification for future surveys 'must be largely to keep mental health on the political agenda and to monitor changes in service use'. However, besides continuing to flag up unmet need, monitor service use and monitor changes in prevalence rates, surveys that contain a longitudinal element do provide us with unique opportunities to test aetiological hypotheses. Such information is crucial for developing prevention and promotion interventions. They inform governments' work on social exclusion. They help us understand vulnerable groups such as carers, homeless people and people in orphanages. They enhance our understanding of under-investigated conditions such as developmental disorders. Future surveys should continue to enhance their interdisciplinary collaborative components, for example by including biological sampling.

Thus, while acknowledging the urgency of what Henderson and Andrews say, we think that, because of design advantages and the continuing support of the Department of Health and the Scottish Executive, the British surveys of psychiatric morbidity have avoided many of the criticisms levelled by Henderson and Andrews, and that a programme of surveys jointly developed by scientists and policy makers will indeed address many of the issues they raise, so that national surveys provide immense value, both to governments and to scientists.

In conclusion, we feel from our collective various experiences of responsibility, both as researchers and as policy makers, that national mental health surveys have had a

considerable impact on both policy dialogue and policy making in health, education, social welfare and criminal justice (e.g. Layard, 2006). National governments, economists and public health advisors, as well as local services, depend on such information. It would be a shame for other countries if the UK were to remain the only country with the required precise and customised information available. We feel the British approaches and methods have been able to provide a cost-effective balance of information on dimensions and categories, determinants and consequences, health and social service use and other behaviours.

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SPECIAL PAPER

Perambulations of a President

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Previous Presidents wrote Council reports of their overseas visits and one wonders how wide an audience their reflections actually reached. What good fortune for me, then, that I can share my reflections in the pages of *International Psychiatry*. The title of this paper was given to me by a disgruntled senior member of the College working in England, who felt that I was paying far too much attention to international matters, and so I thought I should explain further why I consider the international role of the College to be so important.

The College has some 13 000 Members and Fellows, of whom about a fifth work overseas. Of those members working in the UK, about a quarter graduated from an overseas medical school and then came to the UK either for postgraduate studies in psychiatry or as an economic migrant, sometimes in direct response to active recruitment by UK governments. Many of those who came here after graduation have retained strong family and even professional links within their country of origin. Some 40% of members

have ongoing active links with another country, whether as residents or non-residents. This does not even include doctors in staff-grade posts, where the proportion of international medical graduates is even higher. For several years now, overseas members have been able to belong to an international division and the Board of International Affairs has been working hard to determine their needs.

When I became President I made a commitment to visit all the College's divisions. To my surprise, invitations have been more forthcoming from the College's international divisions than from the UK and Ireland. The College has agreed that I should try to time my visits to coincide with meetings of the officers and members of these divisions, and that the College should host a social event for all division members and friends, to facilitate networking. For financial reasons, such meetings need to 'piggy back' on to conferences in the appropriate region of the world, but even so it is often difficult for many of our members to join in such events. It is, of course, a privilege to visit another country and to hear about