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EDITORIAL

The British Mental Health Survey Programme: achievements and latest findings

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Introduction

The British National Psychiatric Morbidity Survey Programme (http://www.mentalhealthsurveys.co.uk/) started in 1993, and it seems timely now, with the publication of the most recent survey [39], to take stock of its impact on our understanding of mental disorders and of what the next steps should be.

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The survey programme was designed to improve knowledge and understanding of mental illness, its causes and consequences, in order to inform governmental objectives for mental health [18]. These comprised prevention, treatment and rehabilitation of mental disorders; improvement of quality of life; prevention of mortality; provision of services and interventions; mental health promotion; tackling fear, ignorance and stigma around mental illness; and continued research into the causes, consequences and care of specific mental disorders, together with their contribution to social exclusion. The survey programme has provided a key source of continuous information to government, commissioners and researchers. Most recently it has informed the Foresight Report on Mental Capital and Wellbeing (www.foresight.gov.uk, [8]).

Strategy and methods

The approach linked the survey methodology of the Office for National Statistics (ONS, formerly OPCS), and more recently, the National Centre for Social Research (NatCen), with the expertise of psychiatric epidemiologists in academic departments of psychiatry. There was additional input from policy advisors from various governmental departments.

A population-based approach was taken, with a series of surveys of particular groups and subgroups, based on a model of probability sampling. While our survey methods have evolved over time, the emphasis has been on using a core of similar instruments to allow comparison between different population subgroups and periods. For each target group, the survey has been designed to assess:

- The prevalence of specific mental disorders in the population, including levels of drug and alcohol misuse;

Table 1 Components of the British mental health survey programme

Baseline surveys	
Adults living in private households 1993	Meltzer et al. [40, 41]
Residents of institutions catering for people with mental disorders 1994	Meltzer et al. [42]
Homeless people including those sleeping rough 1994	Gill et al. [24]
Prisoners 1997	Singleton et al. [48]
Children and adolescents 1998	Meltzer et al. [43]
Children and adolescents looked after by local authorities 2001	Meltzer et al. [45]
People providing informal care 2001	Singleton et al. [49]
Repeat surveys	
Adults living in private households 2000	Singleton et al. [50]
Adults living in private households 2007	McManus et al. [38]
Children and adolescents 2004	Green et al. [27]
Longitudinal surveys	
Adults living in private households 2002	Singleton and Lewis [51]
Children and adolescents 2002	Meltzer et al. [46]

- The prevalence of risk factors and associated disabilities (physical illness, financial strain, smoking, social disabilities, sickness absence);
- Service utilisation by people with mental disorders, covering specialist mental health services and general medical, local authority and non-statutory services;
- The degree to which health and social care needs are being met.

The programme comprised three types of survey: summarised in Table 1 and Fig. 1;

- An *initial survey* for each specified population to provide baseline data;
- A *follow up survey* of respondents from the baseline survey to monitor clinical and non-clinical outcomes;
- *Repeat surveys* after 5–7 years to assess the change in population prevalence rates.

Besides monitoring changes in prevalence rates, service use and unmet need, surveys with a longitudinal element provide us with unique opportunities to test aetiological hypotheses. However, there have been as yet no repeat or longitudinal surveys of prisoners, homeless people, carers or children looked after by local authorities.

The British adult survey programme has used the revised Clinical Interview Schedule (CIS-R) [36] administered by lay interviewers in a first phase interview to cover anxiety and depressive symptoms. CIS-R assessments are related to the last 7 days, and the instrument was chosen because this minimises recall bias: it is likely to be more accurate than lifetime and 12 month assessments. A second phase involved clinical assessments of a subset of respondents using SCAN, and SCID-II to cover psychosis, personality disorders and other conditions requiring clinical assessment [23, 56]. The survey also allows dimensional analyses, examples of which include those of [39] on disability and of [34] on the distribution of psychotic symptoms based on the Psychosis Screening Questionnaire (PSQ) [1].

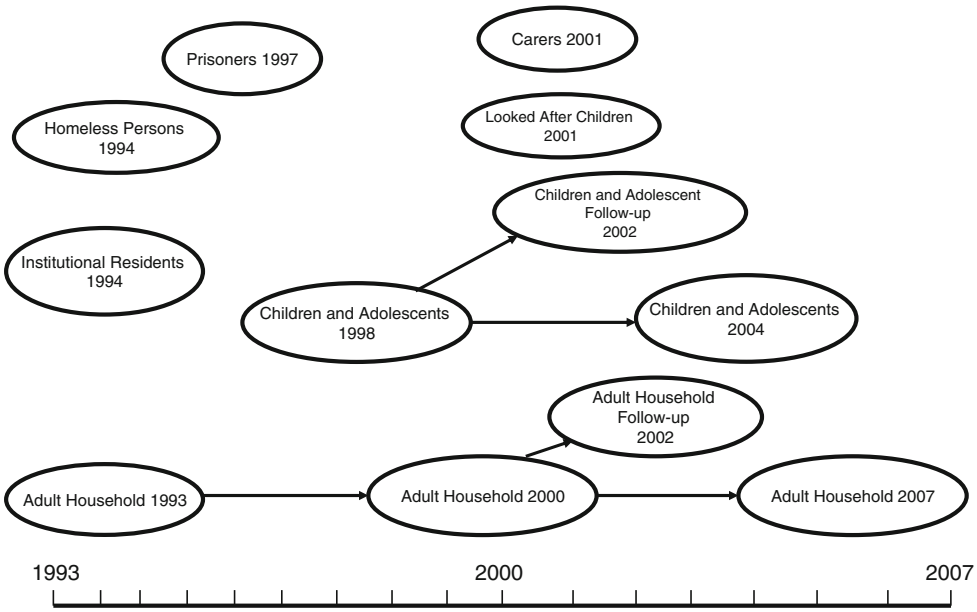

Fig. 1 The British psychiatric morbidity survey programme

In the children's surveys, the initial assessment involved the Strengths and Difficulties Questionnaire (SDQ) [25] and the Development and Well-Being Assessment (DAWBA) [26] followed by a clinical assessment of qualitative and quantitative data from three collateral sources.

Repeat surveys included an invariant core of questions to measure factors associated with disorders such as socio-demographic characteristics, activities of daily living [9, 37], recent stressful life events [10], social support networks [11] and the use of services and treatments.

Achievements of the survey programme and latest findings

The surveys have delineated the scale of psychiatric morbidity and of accompanying disability in the general population and particular subgroups [3, 29–31]. They have also enhanced our understanding of relatively under-investigated conditions such as developmental disorders [27].

The 2007 survey introduced for the first time screening for certain conditions as a way of profiling the associated traits in the population [38]. This included the first assessments of the adult population for features of post traumatic stress disorder (PTSD), attention deficit hyperactivity disorder (ADHD), eating disorders, and problematic and pathological gambling.

A third of adults reported having experienced a traumatic event of some kind after the age of 16, although overall only 3.0% of people screened positive for current PTSD; rates declined with increasing age.

A total of 8.2% of adults screened positive for ADHD, as indicated by a score of four and above on a 6-item self-report scale; 2.3% reported five characteristics and 0.6% all six characteristics. Only a fifth of screen positive participants were receiving psychiatric treatment of any kind.

A total of 6.4% of adults screened positive for an eating disorder, of whom a fifth were receiving treatment, and 1.6% of adults screened positive *and* reported that the eating problems had a significant negative impact on their life.

While two-thirds of adults had spent money on gambling in the last year, only 3.2% met one or more of the criteria for problem gambling, 0.7% met three or more criteria and 0.3% met the threshold of five or more criteria taken to indicate pathological gambling. A quarter of the latter were receiving some kind of treatment for a mental or emotional problem.

Other conditions, including common mental disorder, psychosis, alcohol and drug abuse and personality disorder, have been assessed throughout the survey programme, allowing comparisons over time. Prevalences can be traced for England across all three surveys. Between 1993 and 2000 there was a significant increase in the population aged 16–64 in the prevalence of CMD, from 15.5% to 17.5%, but no further increase by 2007 (17.6%).

The prevalence of alcohol dependence was 5.9% in 2007, having fallen somewhat in men since 2000. The prevalence of hazardous drinking among 16–74 year olds was also reduced, from 28.1% in 2000 down to 25.5% in 2007. The prevalence of drug dependence was 3.4% in 2007, similar to 2000, but still higher than in 1993.

Suicidal thoughts at some point in people's lives are relatively common: in the 2007 survey 16.7% had thought about committing suicide, 5.6% had attempted suicide and 4.9% had harmed themselves without suicidal intent. In England, the proportion of women reporting suicidal thoughts in the last year, and of people reporting self harm, increased between 2000 and 2007.

The overall prevalence of probable psychosis was 0.5% (unchanged from previous years).

Antisocial personality disorder was assessed in the 2000 and 2007 surveys. In 2007, it was identified in 0.3% of adults (0.6% men, 0.1% women), mostly in the younger age groups, while borderline personality disorder was identified in 0.4% of adults (0.3% men, 0.6% women). Rates were similar in 2000. Comorbidity was common, especially between antisocial personality disorder and psychosis.

In addition, the survey programme has increased our understanding of the links between mental illness and substance abuse, including nicotine (e.g. [17, 19–21]); physical illness and PD, [47]; mental disorders and PD (e.g. [54]); and mental disorder and violence (e.g. [14, 15]).

The surveys also examined the extent to which people with disorders accessed services and treatment [4, 5, 13, 22, 53]. Only a quarter of people with CMD were receiving some kind of treatment in 2007, unchanged from 2000. Strikingly, the use of psychotropic medication for CMD doubled between 1993 and 2000, although use of talking therapies did not significantly increase [13]. Few people with drug and alcohol misuse were receiving treatment [22]. In contrast, most people with psychosis were in touch with health and social care, the majority receiving some form of treatment (85% in 2000 and 80% in 2007).

Secondary analyses of these datasets have greatly enriched our understanding of risk factors for mental disorders. Our investigations have covered such topics as age and gender differences, lone mothers, parenting, debt and the role of primary support groups [2, 12, 16, 33, 52, 55]. Other studies have established the links between victimisation experiences and psychosis [6], and the factors leading to suicidal behaviour [7, 28, 32, 44].

The factors associated with higher rates of mental disorder among adults include *sociodemographic factors* (being female, aged between 35 and 54, social class V, tenants of Local Authorities and Housing Associations);

characteristics of the family (separation or divorce, living as a one person family unit, or as a lone parent) and *personal characteristics* (a predicted verbal IQ of 70–85, impaired personal functioning, no formal educational qualification, one or more physical complaints).

New episodes of psychiatric illness were twice as common in adults living in rented accommodation, and three times as common in women reporting six or more stressful life events. Onsets were also more common in men who were unemployed, and in men with low income.

People with common mental disorders are more likely to have experienced several stressful life events in the last 6 months, and to have smaller social networks than those with no disorder. These features are even more marked in people in prison, homeless people and informal carers than in the population as a whole. Life events are clearly important risk factors for common mental disorders. The strongest associations between CMD and life events related to recent threats to health, recent interpersonal problems and lifetime stressors (including sexual abuse and expulsion from school). The strength of association between recent life events and CMD increased steadily up to the 45–54 age group, declining thereafter. In the 65–74 year age range, CMD was significantly associated with lifetime stressors, but not with recent life events. The lifetime stressors included bullying, sexual abuse, running away from home and institutional care in childhood [35].

Attributes associated with higher rates of mental disorder among children include *characteristics of the child* (physical health problems and having special educational needs); *characteristics of the family* (lone parenthood, reconstituted families, poor educational levels, lack of employment and low income); *family functioning characteristics* (psychological distress among mothers and family discord); *stressful life events* (separation of parents, parents in trouble with the police) and *neighbourhood characteristics* (deprivation and lack of social cohesion).

Conclusions

The British National Mental Health Surveys have had considerable impact on policy, and on cross-governmental preparations for the future delivery of health, education, social welfare and criminal justice (www.foresight.gov.uk) [8]. Local services, public health advisors, economists and national governments depend on such information. We feel the approaches and methods developed and used in this programme of surveys have provided a cost-effective balance of information: on dimensions and categories, determinants and consequences, health and social service use and other behaviours. Future surveys should incorporate interdisciplinary components, for example by including biological sampling. Repeat surveys and follow-up surveys greatly add to the potential of the survey programme, and should in future become a standard requirement.

The 2007 survey report can be found at:
www.ic.nhs.uk/pubs/psychiatricmorbidity07

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