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Editorial

The Prevalence of Psychiatric Morbidity

OPCS Survey of Psychiatric Morbidity in Great Britain

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Mass population surveys of psychiatric morbidity in adults are uncommon. For example, over the past 15 years, in the United States, 18 571 people were interviewed in the National Institute of Mental Health Epidemiologic Catchment Area Program (ECA; Regier *et al*, 1988), and 8098 were interviewed in the National Comorbidity survey (NCS; Kessler *et al*, 1994). Information on the prevalence of psychiatric morbidity, from such studies, can be used to provide a framework for the formulation of effective mental health policy. In Great Britain, the Department of Health has commissioned the Office of Population Censuses and Surveys (OPCS) to provide detailed information on the prevalence of psychiatric problems, and the social disabilities and service use associated with mental illness, among adults (Jenkins & Melzer, 1995). The first publication reports on the prevalence of psychiatric morbidity among adults living in private households (OPCS, 1994). The main focus is on neurotic symptoms and disorders, but the prevalence of psychotic disorders, and drug and alcohol dependence is also considered.

Survey design

Over 18 000 addresses in England, Scotland and Wales were selected to identify private households with at least one person aged 16 to 64 years. The postcode address file was used as a sampling frame: 10 108 adults cooperated with the study and participated in an interview with an OPCS interviewer between April and September 1993.

Neurotic psychopathology

The Clinical Interview Schedule – Revised (CIS–R) (Lewis & Pelosi, 1990), a standardised interview schedule, was used to elicit any of 14 neurotic symptoms (fatigue, sleep problems, irritability, worry, depression, depressive ideas, anxiety, obsessions, concentration and forgetfulness, somatic symptoms, compulsions, phobias, worry about physical health, and panic). A score for each symptom was derived following a more detailed assessment of the frequency and severity of the symptom in the last week. Each symptom score ranged from 0 to 4 (with the exception of depressive ideas which ranged from 0 to 5) and a sum score from all 14 symptoms (range 0 to 57) was obtained for each participant. An overall threshold score for significant psychiatric morbidity was set at a cut off score of 12 and individual symptoms were regarded as severe when the score was 2 or more. ICD–10 (WHO, 1993) diagnoses of neurotic disorders were made using algorithms based on CIS–R responses.

Psychotic psychopathology

The Psychosis Screening Questionnaire (Bebbington & Nayani, 1995) was used to screen for psychosis. Respondents who screened positive for psychosis, together with those reporting a psychotic illness, or taking neuroleptics, were interviewed using the Schedules for Clinical Assessment in Neuropsychiatry (SCAN) (WHO, 1992). Diagnoses of schizophrenia and other functional psychoses were derived from SCAN interviews by clinicians. A diagnosis of 'psychosis unspecified' was given to those subjects refusing to participate in a SCAN interview, based on information from the questionnaires completed by the OPCS interviewers.

Alcohol and drug dependence

A measure of alcohol dependence was created by adding up positive responses to 12 questions focusing on the 3 components of dependence: loss of control, symptomatic behaviour, and binge drinking. A score of 3 or more was defined as indicating alcohol dependence.

Five questions in the survey measured drug dependence: frequent drug use, stated dependence, inability to cut down, need for larger amounts, and withdrawal symptoms. A positive response to any statement was used to indicate drug dependence.

Results

The results of the survey can be summarised and are displayed in Box 1.

Box 1. The prevalence of psychiatric morbidity among adults aged 16–64, living in private households, in Great Britain.

- 14% of adults had a neurotic health problem (score of 12 or more on the CIS–R). Women were far more likely to suffer this type of problem than men.
- The most common neurotic symptoms were fatigue (27%), sleep problems (25%), irritability (22%), and worry (20%).
- The most prevalent neurotic disorder (ICD–10) was mixed anxiety and depressive disorder (7.7%), followed by generalised anxiety disorder (3.1%). The prevalence of all neurotic disorder was higher among women than men.
- Functional psychosis had a prevalence of 0.4% in the past year.
- The overall rate of alcohol and drug dependence was 4.7% and 2.2% respectively (both in the past year). Men were three times more likely than women to have alcohol dependence and twice as likely to be drug dependent. Alcohol and drug dependence were most prevalent among young adults, particularly young men aged 16–24.

Discussion

Neurotic psychopathology

The main finding, that 14% of adults have a neurotic health problem, resembles findings from previous, smaller scale studies on the prevalence of minor psychiatric disorder in community samples. Most find a prevalence ranging from 10 to 30% depending on the threshold used for case definition (Goldberg & Huxley, 1980; Cox *et al*, 1987). However, the precision of the prevalence figures in this survey needs to be questioned, since 21% (2633/12 730) of the adults selected for interview refused to cooperate. This is a problem which continues to compromise epidemiological research. It is worth noting that the refusal rates were similar for the ECA (21–32%; Regier *et al*, 1988) and for the NCS (17.4%; Kessler *et al*, 1994). The measures of neurotic symptoms were based on an instrument with reported reliability and validity (Lewis & Williams, 1989; Lewis *et al*, 1992), but interpreting the significance of severe neurotic symptoms (score of 2 or more) is difficult given the ubiquity, transience and fluctuating nature of neurotic symptoms. A week may be a short time in psychiatry, and the results may not reflect enduring neurotic symptoms.

The algorithms used to generate ICD–10 diagnoses have face validity, but comparisons of these prevalence rates with existing prevalence studies may prove complex given differences in study designs. In particular, diagnostic criteria differ between studies as do the time periods by which prevalence is defined. However, the prevalence rates and age/sex distribution described for each disorder conform to expected rates (Gelder *et al*, 1989) and are broadly similar to DSM–III rates reported in the ECA study, and to DSM–III–R rates reported in the NCS. It is notable, however, that the annual prevalence of major depression in the NCS was much higher (10.3%) than the weekly prevalence reported here (2.1%) and the monthly prevalence reported in the ECA study (range 1.5–2.6). This is likely to be due to different sensitivities of the interview schedules used (Composite International Diagnostic Interview (WHO, 1990) used in the NCS, and Diagnostic Interview Schedule (Robins *et al*, 1981) used in the ECA study). The rate of mixed anxiety and depressive disorder seems high (7.7%) and may reflect the fact that this category represents a 'catch-all' for those respondents above the CIS–R threshold of 12, but who do not meet the specific ICD–10 criteria for anything else.

Psychotic psychopathology

The 0.4% annual prevalence rate of psychotic disorders in the community is in keeping with European studies (Jablensky, 1986). However, the accuracy of this figure is questionable given that 37% of those screened positive for psychosis (276/749) refused a SCAN interview. It is not clear if any of these subjects were included in the prevalence figures, and it is not possible to take account of false negatives on the screen.

Alcohol and drug dependence

The annual prevalence rates of alcohol and drug dependence are remarkably similar to the 6-month prevalence rates for alcohol/drug abuse and dependence found in the ECA study. The excess of alcohol abuse in males is less marked than that found in the ECA study (Myers *et al*, 1984), but the excess of drug dependence in males is of a similar proportion. The excess of alcohol and drug dependence in young adults was also demonstrated in the ECA study.

Future publications

Three reports will give further information on this sample including the prevalence rates in different

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socio-demographic groups, co-morbidity amongst psychiatric disorders, characteristics of people with psychiatric disorders, service use, and aspects of social disability. Another series of bulletins and reports will describe three more samples to provide additional information on people suffering from psychotic disorders, and to provide prevalence rates for psychiatric morbidity in institutions and among homeless people.

These publications will provide new information on the mental health needs of the population of Great Britain and will hopefully assist in the development of mental health services. Epidemiological attention should now turn to children and adolescents, people who are older, have learning disabilities, show offending behaviour, or suffer from physical illness.

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