However, we disagree with Stewart-Brown and colleagues' view that wellbeing interventions have been proven to reduce the prevalence of mental disorders.[2] To show the effectiveness of this theory, use of a wellbeing intervention would need to report a reduction in cases of people with mental disorders in the population offered the intervention. However, the evidence that Stewart-Brown and colleagues[2] invoke simply does not show this reduction. For example, they cited a systematic review of mindfulness interventions that assessed clinical populations of people with mental or physical disorders, and none of the studies reported a reduction in the prevalence of mental disorders.[4]

Population-based strategies to prevent mental health disorders that include wellbeing interventions are not the answer. New proposals must be judged against a background whereby clinical commissioning groups in England spend a small and decreasing proportion of their budgets on mental health,[5] despite between only a quarter and a third of people with common mental disorders receiving any treatment.[6]

Primary prevention of mental disorders is more likely to depend on equitable distribution of wealth, reforming the criminal justice system, and ensuring equal opportunities in education and employment than on wellbeing interventions.

NM is the editor-in-chief of the annual report of the Chief Medical Officer, 2013.[5] MHo, MHe, and SW declare no competing interests.

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## Methodology of the SEYLE trial on suicide prevention in schools

We congratulate Danuta Wasserman and colleagues for conducting the first multi-country, randomised controlled trial investigating school-based interventions for the prevention of suicidal behaviour in adolescents (April 18, p1536).[1] However, a few issues must be addressed.

Exclusion of pupils with a history of suicide attempt(s) omits a particularly vulnerable group because past suicide attempts have been shown to be the strongest predictors of future attempts.[2,3] Efficacy of intervention could be tested in this group, and it is not clear if any specific help was offered to the pupils who had previously attempted suicide. It is not clear why only pupils aged 14–16 years were studied, especially as adolescents (13–19 years old) have greater risk of suicide,[4] and such restrictive inclusion could limit the generalisability of the study.

Furthermore, no mention is made of pupils (if any) found to have substantial psychopathology, or taking psychotropic medications, during the study. No comment was made on substance use, which is another risk factor associated with adolescent suicide[5] and could have been included as a covariate during analysis.

Finally, more than half the potential study population (14 267 of 27 099 pupils, or their parents) declined to participate in the study, a major issue in school-based studies.[6] Even a brief exploration into the reasons for non-participation could help readers understand potential obstacles to these interventions.

We declare no competing interests.

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Over the past decade, UK Child and Adolescent Mental Health Services (CAMHS) have faced a rising tide of ever-increasing demand, coupled with diminishing funding. Cost-effective interventions to target suicide attempts in adolescents are needed urgently. In this bleak context, the SEYLE trial[1] could chart a course to safer waters.

The advantage of preventive intervention targeted to high-risk groups has long been debated against broader population-level approaches.[2] Results from the SEYLE trial support these wider-ranging methods. Although the outcome seems promising, patients were excluded from the trial if there was evidence of recent suicidal ideation. This exclusion reduces the general

application of an otherwise admirably pragmatic trial.

Furthermore, the study highlights the possible danger of extrapolating conclusions from self-report questionnaires. Results from the two trial groups show an illogical reduction in the number of "yes" responses to the question, "Have you ever made an attempt to take your own life?" at 12 months post intervention compared with the same participants at 3 months.

The Health and Social Care reforms of 2012 incentivised CAMHS to move toward reaction instead of prevention. Strategies to manage severe morbidity are prioritised over protective community measures. After proof of cost-effectiveness, integration of the Youth Aware of Mental Health tool into schools might help to redress this imbalance. However, further investigation into the value for recently suicidal young people and clarification of the reliability of SEYLE's outcome measures must be addressed before the ship sets sail.

We declare no competing interests.

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## Authors' reply

We thank Georgina Corbet Burcher, Rob McCutcheon, Ananya Mahapatra, and Rishi Gupta for their comments on our study.[1] The objective of the SEYLE study was to evaluate the primary preventive effects of school-based interventions, therefore only new cases of attempted suicide and severe suicidal ideation were analysed. We agree that the effect of treatment on pre-existing attempts and ideation are of interest. However, evaluation of treatment requires different methods than evaluation of primary preventive measures as used in the SEYLE study. In compliance with ethical treatment principles, individuals with pre-existing severe suicidal ideation or recent suicide attempts were immediately identified and treated according to the local availability of treatment options. We believe that a collaborative approach between primary prevention and treatment in public mental health and clinical practices is needed to reduce suicide rates.[2]

We are aware of the limitations of self-report for the measurement of suicidal ideation and attempts. However, prevention is primarily a population-based science and as such, researchers have to rely on self-reporting. Clinical interviews or observer-rated scales are not feasible with large samples, in this case more than 11 000 adolescents. Because self-report was used in the entire SEYLE population (interventions and control), the effect of any potential over-reporting or under-reporting is assumed to be randomly distributed.

Participation rates were mostly related to the complex procedures required by the ethics committees in different countries. Outside the strict experimental requirements of a randomised controlled trial, we believe participation rates would be much higher. For example, according to the follow-up questionnaires with instructors from all SEYLE countries, adolescents were very interested and engaged in the YAM programme.[3] The experimental design significantly affected the selection of the age group as well. It was necessary to ensure that recruited pupils were of comparable age between different school systems, and that each participant could be followed up in the same school for at least an entire year.

More than 20 scientific articles have been published based on the SEYLE data, and additional information about health risk behaviours and psychiatric symptoms can therefore be found elsewhere.[4–6]

We declare no competing interests.

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# Caring for patients with end-stage kidney disease

The renal issue of *The Lancet* emphasises worldwide inequalities in access to renal replacement therapy.[1,2] Innovative work in Tanzania supported by the International Society of Nephrology[3] was particularly interesting. In Malawi, two hospitals provide 15 haemodialysis stations, treating about 60 patients with end-stage kidney disease and with