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## Survey of Health and Well-Being Interviewers' Instructions

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## 1. Overview of the research programme on psychiatric morbidity

### 1.1 Background and purpose

The Department of Health has commissioned OPCS to carry out a national survey of psychiatric morbidity. At present, there is very little information on a national scale about the extent of mental illness in the population. Estimates of neurosis in the population vary from 10% to 20%. For psychosis the estimates vary even more widely but it appears that about 1 in 100 people are suffering from a psychotic illness.

The survey can be seen in the context of two government White Papers. About three years ago, "Care in the Community" was published. The emphasis was moving responsibility for the care of people with mental health problems to the local authorities. Indeed, over the past ten years there has been a policy of de-institutionalisation: the closure of large stay mental hospitals. Therefore, if local authorities are going to provide services and support for people with mental illness, they need to have some knowledge of the nature and extent of this task.

In July, last year, "The Health of the Nation" was launched. This White Paper highlighted five key areas where the government believed they could produce substantial improvements in Health Care. Mental illness was one of those key areas. Specific targets referred to reducing suicide rates and improving social disabilities.

The main purposes of the programme of research which OPCS is carrying out are to provide information on the prevalence of psychiatric morbidity, to look at the social disabilities of people with mental illness and to investigate their use of and need for services. We are also looking at the relationship between mental illness and stressful life events and the use of tobacco, alcohol and drugs. This should assist DH in their development of policies for mentally ill people. Currently, there is no national picture of the extent to which psychiatric illness limits daily activities and creates needs for various treatments and services.

The project is planned to cover the population aged from 16 to 64 living in private households and institutions in Great Britain.

These interviewers instructions cover the first of the four surveys which make up the OPCS programme of research on psychiatric morbidity:

- 1) a survey in private households (PAF sample)
- 2) a supplementary survey of people suffering from a psychotic illness who live in private households
- 3) a survey among residents of establishments catering for people with mental illness
- 4) a survey among homeless people (including people sleeping rough)

In September you will be sent the additional interviewers instructions for survey (2). There will be a new round of personal briefings for surveys (3) and (4) in April 1994.

## 1.2 Pilot surveys

We have carried out extensive feasibility and development work over the last two years: one pre-pilot and three pilot surveys.

This preliminary work was necessary to make sure we were picking up people we wanted to pick up. We also needed to find out whether we had sufficient information to establish diagnosis and need for services. There was never a problem with the acceptability of the survey.

## 2. Sample design

### 2.1 Sample size and distribution

A sample of private households has been taken from the small users Postcode Address File. We have selected 200 postal sectors in Great Britain, and 90 addresses from each postal sectors. Taking account of ineligible addresses, non-contacts and refusals we aim to achieve approximately 10,000 interviews. One quota is half a postal sector, ie 45 addresses, but all interviewers will be allocated two quotas with a break in between.

### 2.2 Sampling procedures

We wish to interview one person per household. In households with just one person aged 16 to 64, this is simple enough. For larger households, The procedure for selecting one person is detailed in section 3.1 .

Please note that, except in Scotland, at multi-household addresses all households are eligible for the survey.

In such instances, you should use the pink concealed multi-household sheets as usual to list the households at the address, but then ignore columns 3 and 4 as you will be approaching all households listed for interview. You should then record the outcome for each household in column 5. Hence, there is no limit on the number of extra households to be dealt with per quota. If you find your area has a large number of multi-household addresses and these rules mean the quota is substantially increased, do ring the Field Office for advice.

In Scotland, most multi-household addresses will be pre-sampled by SIU and you will receive pre-sampled multi-household sheets. At any addresses which turn out to be concealed multi-households, you should follow the procedures outlined above for England and Wales, ie. taking all households at the address.

At each address, all the households should be numbered. In a single-household address, the household number is always 1.

On all documents where you are required to stick a serial number label, there is a box marked "H'ld". You should always enter the household number, even for single-household address where the household number is always '1'.

### 2.3 Institutions

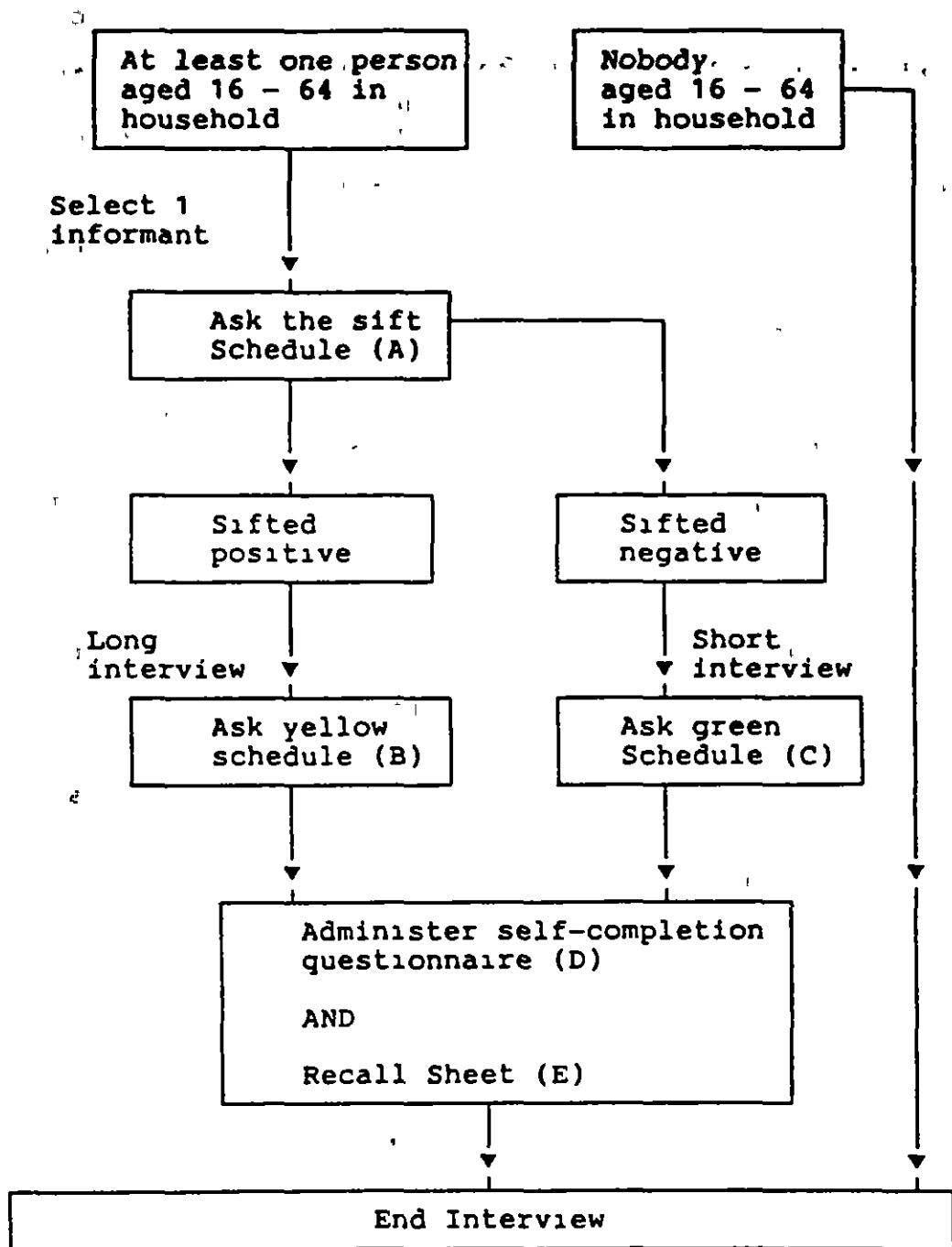
An institution is defined, as on the GHS, as 'any address at which four or more unrelated people sleep; while they may or may not eat communally, the establishment must be run or managed by a person (or persons) employed for this purpose by the owner'.

*A small institution which has less than four permanent residents should be treated as a private household.*

If an address has more than one part, you would include private households at all parts unless there was an instruction on your address list to interview at one part only or to exclude certain parts. For example, if the only address listed was 'Manor Hall Boarding school' but you found a 'Headmaster's cottage, Manor Hall Boarding school', you would include private households living at the headmasters cottage as well as any living at the school. If however, the address was marked 'DIVIDED ADDRESS' with 'Manor Hall Boarding School' as the sampled address and the 'Headmaster's cottage' also listed, you would not include private households living at the headmasters cottage.

### 3 Interviewing procedures

The interviewing procedures are shown in the flow chart below.



For proxy interviews, the self-completion questionnaire (D) and recall sheet (E) do not apply.

### **3.1 Introducing the survey**

When introducing the survey try and avoid terms such as "psychiatric morbidity" and "the mentally ill". The purpose leaflet may help here. In this leaflet, we have tried to be positive, referring to "health and well-being" and "coping with strains and stresses". The pilot surveys showed that the expression, strains and stresses of everyday life, was something most people could relate to.

The points which should be covered in the introduction of the survey are:

- (i) The survey is for the Department of Health, (in conjunction with the Scottish/Welsh Office)
- (ii) It is looking at how people are coping with the strains and stresses of everyday life
- (iii) They were selected from a random sample of addresses

### **3.2 Choosing the selected informant**

In households containing more than one eligible person, there is a procedure to help you select one person at random. This selection procedure is set out on the Calls and Outcomes sheet (Document H, lilac).

On page 2 of the Calls and Outcomes sheet, there is a doorstep selection box. You are asked to list everyone in the household starting with HOH. The procedure is similar to that of filling in a household box.

In column (e), you are asked to number the people aged 16 to 64 in age order, that is, eldest first.

For example: For address number 26

(a) Pers no.	(b) Relationship to HOH	(c) Sex	(d) Age	(e) Number adults 16 - 64 in age order
01	HOH	M	65	
02	Son	M	43	2
03	Daughter in law	F	45	1
04	Grandchild 1	F	15	
05	Grandchild 2	M	16	3

As there are 3 people in this household aged between 16 and 64, you are instructed to select one of these to go on to schedule A. You now need the pink cards, document I. The selection depends on the number of eligible persons in the household and the address number.

Looking at the column for 3 adults in the household aged 16 to 64 and at the row for address number 26, you are given the number 1 as your selection. You should therefore select person number 1 in column (e), that is, the wife. You should ring number 1 in column e, and then contact the wife as your selected informant to ask schedule A.

### 3.3 When to take a proxy interview

In certain circumstances it is permissible to take a proxy interview rather than lose information about the selected informant.

#### Conditions in which a proxy interview may be taken

- a. Where the informant is senile, mentally backward, or totally deaf.
- b. Where the informant is ill and will not be well enough to see you before the end of the field period. This includes illness due to a mental health problem.
- c. Where no contact can be made with an informant during the field period, eg where an informant is away or in hospital for the whole of the remaining field period.
- NB. If you are told by another member of the household that the informant is 'never in', you should still recall several times in the hope of seeing the informant in person before resorting to a proxy interview.
- d. Where an informant is 'too busy' or 'not interested in this sort of thing', provided the informant gives permission for the proxy to take place. You should always recall in order to explain the survey in person before accepting a proxy. In no circumstances should you take a proxy simply on the strength of another member of the household saying that the informant is 'too busy' or 'not interested in surveys'.
- e. Where an interpreter is used

There may be other circumstances in which it would be sensible to take a proxy. But, in such cases, ring the office for a ruling first. In all cases where a proxy is taken, we need a clear description from you on the Calls and Outcome Sheet as to why the proxy was necessary.

#### **Permission to take a proxy**

Wherever possible it is advisable to ask the informant for permission to do the proxy before interviewing another member of the household on his/her behalf. This is particularly true in the case of those who are 'too busy', 'not interested', or 'never in', because their excuse may simply be their way of saying that they don't want to be interviewed.

**NOTE -** If you never see the informant in person, ask another household member to obtain the informant's permission for you. (Obviously there are still some cases where one might do a proxy interview without permission - eg if the person in question is senile, or away until after the end of the field dates etc).

#### **Choice of proxy informant**

It is better to obtain proxy information from a close relative but because of the nature of the questions you should not choose anyone aged under 16.

In some cases it may not be possible to ask a close relative. In choosing your proxy informant you should use your judgement of good public relations, bearing confidentiality in mind. If you are in any doubt, ring the office for advice.

#### **3.4 Use of interpreters**

In some households there may be a language barrier, in which case you may have to use an interpreter in order to help you obtain all or part of the information. In these circumstances you should follow the rules for proxy interviewing.

Do not use an interpreter aged under 16

Follow directions on schedules for proxy interviews.

Remember to record on the Record of Calls and Outcome who acted as interpreter.

#### 4 List of survey documents

Document	Colour	Application
A Sift schedule	White	All selected informants (inc proxies)
B Yellow schedule	Yellow	All selected informants who are sifted positive by schedule A (inc proxies)
C Green	Green	All selected informants who are sifted negative by schedule A (inc proxies)
D Self-completion	Cream	All selected informants (but not proxies)
E Recall sheet	White	All selected informants (but not proxies)
F Check card	Buff	Attached to schedule A (but not for proxies)
G Purpose leaflet	White	All households (See G1 for Scotland, G2 for Wales)
H Calls and outcome	Lilac	All addresses
I Sampling cards	Pink	All households with 2 or more adults aged 16 to 64
J Prompt cards	Yellow cover	
K Reference cards	White	
L Interviewers instructions	White	
M Appendix to Interviewers instructions: Definitions	Pink	
N Advance letter	Headed paper	These will be posted by HQ
O Despatch Note	Grey	Despatch of schedules

## 5. Schedule A      The Sift Schedule

### 5.1 Applicability and content

#### Applicability

This schedule applies in all households where there is at least one adult aged 16 to 64 years. You should ask this of the selected informant (or proxy interviews can be taken for certain parts of this schedule).

The selected informant will, from now on, be referred to as the informant and as person number 01.

If the informant is different from the person who gave the household composition for the Calls and Outcomes sheet, you need to make arrangements to continue the interview with your informant. Having contacted your informant, it is worthwhile checking that his/her age meets with the survey criteria.

Content The schedule consists of the following parts:

- a) Household box and socio-demographic characteristics for subject and proxy interviews
- b) General health questions (including sift on medication and treatment, and long standing illness)
- c) Neurosis sift (CIS-R)
- d) Psychosis sift (PSQ)
- e) Proxy information (similar to (b))

#### Asterisked questions

Note that all questions starting from section A are opinion questions (there is just one asterisk at the head of each section). All questions must therefore be asked as printed and not reworded or explained in any way. For this reason, if you are not able to speak directly with your sampled informant, you must ask the proxy questions.

### 5.2 Household box and socio-demographic characteristics

#### Qn 1 Geographical area, page 1

The specialist mental health services that people use are to some extent dependent on what is available in their neighbourhood. Knowledge of geographical variation in the use of such services is a very important factor in policy development. We are therefore asking you to assess which of three types of area each address is in: urban, rural or semi-rural.

## **Qn 2 Household box, page 2**

Here, the first thing you are asked to do is fill in another household box, this time, relating it to your informant, who is always person number 01.

You should then list other members of the household, ringing the person numbers and describing relationship to the selected informant, and code sex, age, marital status, family type and racial or ethnic group as follows:

### **Relationship to selected informant**

Instead of asking about relationships the HOH, we require the relationship to the selected informant.

### **Sex**

This can be asked or recorded from the calls and outcome sheet.

### **Age now**

This can be asked or recorded from the calls and outcome sheet. Children less than one year old should be coded '00' and persons over 99 years old as '99'.

### **Marital status**

This survey, like the GHS has the additional category in the marital status box ( C - code 2) for people who are cohabiting.

You should ask as a running prompt, "Are you married, living together, single, widowed, divorced or separated ?". Code living together as code 2 (cohabiting). This has priority over the single, divorced and separated codes.

You are not expected to probe, "separated" but should an informant query the term, it covers any person whose spouse is living elsewhere because of estrangement (whether the separation is legal or not).

Marital status need not be asked if the informant makes reference to a 'husband' or 'wife'. In this case, simply ring code 1 (married) under marital status. Similarly, simply ring code 2 (cohabiting) in the Marital Status box without asking marital status if the informant has already referred to a 'common-law husband/wife' (or if cohabitation has been spontaneously mentioned, eg 'boyfriend/girlfriend' or 'he/she lives with me').

## **Family unit**

Figures collected by a number of government departments relate to families rather than households. Consequently, it is necessary to group household members into family units.

A family unit can be:

- \* a married or cohabiting couple
- \* a married or cohabiting couple/lone parent and their never married children providing these children have no children of their own;
- \* one person only, a divorced daughter without children

A brother or sister whose parents are not part of the household would form two separate family units.

Members of the informant's family unit should be numbers 1 in the family unit column, the next family unit 2 and so on, eg

Person number	Relationship to informant	Family unit
01	Informant	1
02	Husband	1
03	Son (never married)	1
04	Daughter (never married)	1
05	Mother	2

Person number	Relationship to informant	Family unit
01	Informant	1
02	Husband	1
03	Daughter (never married)	1
04	Sister (widow)	2
05	Brother (married to 06)	3
06	Sister-in-law (married to 05)	3
07	Niece (daughter of 04)	2

Note also:

- a. In general, family units cannot span more than 2 generations, ie grandparents and grandchildren cannot belong to the same family unit. The exception to this is where it is established that the grandparent has parental responsibility. In this case the grandmother as 'mother figure' would be in the same family unit.
- b. Adoptive and step children have the same family unit number as their adoptive step parents. As in the GHS, foster children are coded as being in their own family unit.

### Racial or ethnic group

The question about racial or ethnic group has been taken from the 1991 Census; it is also used on the Health survey. This question is printed at part (a) on page 2. Ask the question using the show card.

There are 8 categories; code 9 is for others. You do not need to specify the ethnic group at code 9. You should enter the code ( 1 to 9 ) in the last column of the household box. A refusal should be left as a blank in the coding column.

### Other household details:

Questions 4 to 8, pages 3 - 4.

We wish to collect some classificatory variables which relate to the household, eg tenure, car ownership.

#### Qn 6 Bedroom size

We require whatever the informant thinks of as a bedroom. Every household should have at least one bedroom, that is a room in which someone sleeps.

#### Qn 8 Availability of a car or van

The term 'Normally available' :

includes - vehicles used solely for driving to  
and from work  
vehicles on long term hire

excludes - vehicles used solely in the course of work  
- vehicles hired from time to time.

If a vehicle is not currently available for use because it has been dismantled or is in some way unfit for use, make a note as to whether it is repairable.

### **5.3 General health questions**

These questions serve two functions. Firstly, they establish at an early stage whether the informant has any physical health problems and should help them to start talking about themselves.

Secondly, they sift for informants who have a psychotic illness. This is done by asking about:

1. long-standing illness, disability or infirmity
2. Oral medication and injections
3. Consultations with a GP

#### **5.3.1 long-standing illness, disability or infirmity**

At question 11, page 6, you should record any such long-standing illness. You should try to obtain a medical diagnosis or establish the main symptoms.

Sometimes, people are suffering side-effects which arise from them taking medication for a different complaint. For example, an informant might be suffering from nausea because of treatment for schizophrenia. In such instances, you should write down the symptoms, and also the fact that they are side effects of treatment for schizophrenia. I.e. 'nausea - side effects of schizophrenia treatment'.

You should then check reference card A to see if any of the complaints given are listed. This is an alphabetic list of psychotic complaints, or words commonly used by people to describe psychotic complaints. Notice that depression is deliberately missing from this list. This is because the term depression can refer to a common neurotic complaint as well as a form of psychotic illness. At this stage we are only looking for people with psychotic complaints so the term 'depression' alone should be excluded.

#### **5.3.2 Oral medication and injections**

At questions 13 and 14 you should record the name of all medication or injections the informant is having.

Alternative and homeopathic medicines are to be included. Do not include creams, ointments or lotions.

You should then check reference card B. This is an alphabetic list of anti-psychotic medication (including injections).

Note two corrections to reference card B (please amend your card):

- (i) Sarine should say 'Sparine'.
- (ii) Cilest is a contraceptive pill which has erroneously appeared on this card !

When asking the name of any medication, you should, if necessary, ask to look at the bottle or box for clarification. (You should write down the name, strength and dosage at this point as you may need to know the second two points later in the interview).

If you cannot obtain a name for the medication, ask the informant to describe what it looks like and what it is for. Ie. describe shape and colour, whether there is anything written on the tablet and what medical condition or symptoms it is taken for. This will help us to identify it and whether it is anti-psychotic medication.

If the informant tells you that the medication is for a condition which is listed on reference card A, you should ring code 1 (and assume that, if the name of the medication were known, it would be listed on reference card B).

### 5.3.3 Consultations with a GP

At question 17, page 8, you should write down a medical diagnosis or describe main symptoms. The same rules apply as for recording long-standing illness (part 1). Again you should use reference card A to identify if any of these are a psychotic illness.

Notice that question 15 is a GHS question. It asks about all consultations in the past 2 weeks and includes consultations on behalf of other adults in the household. This question is included to give us comparable information to see if people with a mental, nervous or emotional problem consult their GP more often than others. Questions 16 and 17 are concerned only with consultations on an informant's own behalf.

## **5.4 Neurosis sift - Revised Clinical Interview Schedule**

### **Contents of this section:**

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### **5.4.1 Purpose of the CIS-R**

This part of the sift schedule consists of the Revised Clinical Interview Schedule (CIS-R) which has been developed by Dr Glyn Lewis and Dr Anthony Pelosi. The main purpose of the CIS-R is to identify the presence of neurosis, and where this occurs, to establish the nature and severity of neurotic symptoms, so that we can arrive at a specific diagnosis. The main body of the CIS-R contains 14 sections labelled A to N. Each section deals with a particular type of neurotic symptom. There is a 15th section, O which establishes the overall effect of these neurotic symptoms.

Because of the level of detail required, proxy interviews cannot be used for the CIS-R.

You will require some knowledge of neurotic symptoms in order to be able to carry out the CIS-R. Definitions and descriptions of these symptoms are given in the appendix to these instructions. It is important to spend some time familiarising yourself with these and learning the differences between them.

### **5.4.2 Content of the CIS-R**

- A Somatic symptoms
- B Fatigue
- C Concentration and forgetfulness
- D Sleep problems
- E Irritability
- F Worry about physical health
- G Depression
- H Depressive Ideas
- I Worry
- J Anxiety
- K Phobias
- L Panic
- M Compulsions
- N Obsessions
- O Overall effects

You will need to tag the check flap (document F, buff-coloured card) to the back of this schedule. You will also need to attach a serial number label and add the household number.

### 5.4.3 Key concepts in sections A to N

#### Existence and severity of neurotic symptoms

In each section, the first few questions establish the presence of a particular neurotic symptom in the past month. These questions finish with a line across the page.

For those informants who had such symptoms in the past month, you should ask the questions below the line. These questions ascertain the frequency, duration, severity and the time since onset of the symptoms.

It is the answers to these questions which determine the informant's score on each section. More frequent and more severe symptoms result in higher scores. The process of calculating a score is explained in section 5.4.5 of these instructions.

Note that all of the sections A to N have this structure except for section H 'Depressive ideas' which is really a continuation of section G 'Depression'.

#### Reference periods

Each section begins by asking whether the symptoms were present in the past month (except section H).

The past month refers to every day in the past month up to and including yesterday.

If informants reply that they 'felt the same as usual' or that the symptoms were present 'no more than usual' instead of saying the symptoms were present in the past month, you should treat this as if the symptoms were present. These replies could indicate 'chronic symptoms' which must not be ignored.

Those who had symptoms in the past month (or who may have chronic symptoms as just described) are asked the subsequent questions below the line which relate to the past week.

The past week refers to the past seven days, up to and including yesterday. This is often referred to as 'since last (DAY OF WEEK)'.

#### Frequency of symptoms

In each section where the symptoms were present in the past month, informants are asked how many days the symptoms were present in the past week.

If the informant replies that the symptom was present 'all the time', for example 'the worry is always there at the back of my mind' then you should prompt for an answer.

Similarly you should prompt for an answer if the informant does not know how often the symptom was present. If the informant is unsure e.g. whether the symptom was there on 3 or 4 days, you should ring the less frequent code, that is 3.

#### **Duration of symptoms**

In all sections except section H, the informant is asked about the duration of symptoms. This refers to how long the symptoms lasted on any day in the past week.

You may need to make it clear that this refers to the total number of hours the informant had the symptom. In other words, if the informant had three headaches in the day, they should estimate the total time headaches were experienced in that day.

However at sections L 'Panic' and N 'Obsessions', we are not interested in the total amount of time the symptoms lasted in a day, but in how long the 'panic attack' or the episode of having an obsessive thought lasted. This does not depend on how many times the person had an obsessive thought or panicked.

If the informant does not know the duration of symptoms, you should prompt for an answer. If the informant is unsure e.g. whether the headache lasted for 3 hours or more, you should assume that it did not.

#### **Onset of symptoms**

At the end of each section, all informants who reported symptoms in the past week are asked how long they have had the symptoms which they have described (except for at section H, 'Depressive Ideas').

For instance question A8 asks:

'How long have you had these problems which you have described with this ache or pain/discomfort ?'

The wording '...which you have described...' is important here because we are interested in knowing how long the person's problems have been as severe as they have been in the past week.

For example, if an informant had been suffering mild headaches caused by stress for a few months, but for the past 3 weeks the headaches had grown more severe, then the answers to questions A4 to A7 would reflect these severe headaches. Therefore at question A8 in asking how long the person has had the aches he/she has described we are referring to the 3 weeks he/she has had the more severe headaches.

Similarly, if an informant had been very depressed in the past month, but when asked about the past week, s/he reported much less severe depression, the question at G10 refers to how long s/he felt as depressed as s/he did in the past week. It may seem strange that we are overlooking perhaps many years of much worse depression. However, it is meaningless to ask about the onset of symptoms if we do not actually have information about those symptoms. Hence, since we only know about the symptoms of the past week, it makes sense to restrict our questioning to those symptoms.

#### 5.4.4 A guide to questions: sections A to N

##### Section A , Somatic symptoms

If the informant has several aches or pains, you should ask about the overall effect of any of these. If the informant has aches and also some discomfort you should refer to both of these in the subsequent questions.

When asking any questions relating to these symptoms it is important to remember that we are interested only in aches, pains or discomfort which are brought on, or made worse by feeling low, anxious or stressed. If the informant says that an ache is 'possibly' brought on or made worse by feeling this way, but that he/she does not know, you should treat this as a 'yes'.

It is important that the informant's own judgement of his/her aches, pains or discomfort is used for scoring.

##### Section B , Fatigue

At question B3 we want to know why the person is tired or lacking in energy. This is also a useful check that people who are tired from doing physical exercise and sports are not included in this section.

The duration of the feeling of tiredness does not include periods when the informant was asleep. If the informant says that they felt tired and fell asleep 10 minutes later, this only counts as 10 minutes of feeling tired.

##### Section C Concentration and forgetfulness

If the informant has both poor concentration and memory problems, questions C4 and C8 should refer to both of these symptoms.

## **Section D        Sleep problems**

For informants who had problems trying to get to sleep or getting back to sleep after waking up, we are interested in how long they spent trying to get to sleep (see question D5) rather than in the total amount of sleep lost. Note that informants are instructed to allow a quarter of an hour for informants to get back to sleep if they actually woke up.

For example: A mother reports that she went to bed at midnight and tried to get to sleep for an hour. Later in the night she had to get up to look after a child and she was up for half an hour. When she got back to bed she thinks she probably didn't fall asleep until another hour had passed.

In this example, we do not count the time she was awake looking after the child. The time taken trying to get to sleep is therefore 1 hour at midnight and another three-quarters of an hour trying to sleep after having been woken up. (Remember that the informant should allow a quarter of an hour to get back to sleep after being woken up).

For informants who did not properly wake up but were drifting in and out of sleep, the informant's own opinion of the time spent trying to get to sleep is required and you do not need to allow a quarter of an hour to return to sleep.

If the informant spent less than a quarter of an hour trying to get to sleep, or if he/she slept less than a quarter of an hour longer than usual, the informant is not regarded as having a sleep problem. In this case you are instructed to enter a zero score for this section, thus ignoring any score the informant may have obtained at question D3.

Note that there are 2 possible code 2's at questions D5 and D8. This is for reasons of signposting and also scoring.

## **Section E        Irritability**

At question E6, informants who felt like shouting are coded 1 regardless of whether they actually shouted or not.

## **Section F        Worry about physical health**

This section applies to all informants including those who are physically ill. Note that question F2 does not apply to people who reported having some problems with their physical health at the general health question, question 11a on page 6. This is important as we want to avoid possibly upsetting informants or causing them to worry.

Other than this, this section asks about the degree of worry about physical health irrespective of any health problems. In other words, we are interested in the amount a person worries whether or not they have much reason to be worried or not.

Worry about physical health also includes worry about a pregnancy. This should be clear from the schedule.

## Section G      Depression

At G1 and G2 you may find that informants have their own words for feeling sad, miserable or depressed. You should use them in all subsequent questions.

Informants are asked about

- a) feeling sad, miserable or depressed
- b) being unable to enjoy or take an interest in things.

Later, at G4 and G5, when asking about the presence of symptoms in the past week, we ask about (a) and (b) separately rather than as one combined question. This is because people who felt unable to enjoy or take an interest in things in the past week get a score of 1.

If informants have both of the symptoms described at (a) and (b) above, you should refer to both of them at questions G6 to G10.

At G6 (a), we are interested in the kinds of things which make someone feel depressed but at (b) we would like to know the main reason. For some informants there may be no single cause which makes them feel like this. In these cases (b) should be coded as 'Don't know/ no main thing'

## Section H      Depressive Ideas

This section is a continuation of the previous one (Depression) and it only applies to those who said they felt depressed in the past week.

Questions H1 to H6 ask about feelings of guilt, inadequacy and hopelessness, the times of day when they are most affected and the effect on their activities. If informants answers 'yes' to any of the questions about guilt, inadequacy or hopelessness, they are asked question H8 about whether they feel that life isn't worth living.

Finally, those informants who say 'yes' to H8 are asked if they have thought about killing themselves in the past week.

It is important to take your time over this section, to thank informants for answering the questions and to help them to orientate themselves back into the rest of the interview by explaining what the next few questions are about. This is all outlined in the schedule.

Note that questions H2, H8 and H9 are printed on prompt cards. These are available for you to use if you feel that the informant may find it embarrassing or difficult to answer in front of other people. At H9(a), H9(b) and H10 the wording in brackets which refers to thoughts of suicide should be used unless it is embarrassing or difficult to do so in front of other people.

#### Section I      Worry

This section is concerned with any worry the informant may have except worries about physical health. Worries about physical health should have been recorded at section F.

Question I3 is similar to G8.

At question I3 you may find that an informant mentions physical health as one of the things or the only thing he/she is worried about. In these instances, you are instructed to make a note on the Check flap so that, on completing section N, you can go back to section F and check that worry about physical health is recorded. If it is not recorded, you should ask the questions in section F again, starting with F1 and amending the score on the check flap if necessary.

If informants are worried about physical health alone, you should follow the instructions and then move on to the next section, 'Anxiety'.

If informants are worried about a number of things including physical health you should make it clear that, at this moment, we are only interested in worries about things other than physical health. Informants should try to answer with this in mind.

#### Section J      Anxiety

This questions below the line in this section are concerned with general anxiety only, that is some anxiety which cannot be explained by a phobia.

The first stage is to find out whether the informant felt anxious in the past month, questions J1 to J3. For those informants who have been feeling anxious, the second stage is to try to establish if this is always because of having a phobia, questions J3 and J5.

If the anxiety is always caused by a phobia, you should go on to the next section, K, which is specifically dealing with phobic anxiety.

If it is not clear at question J3 whether the informant's fear of something really constitutes a phobia, you should emphasise that there has to be no real danger so that the informant can decide.

Some people will have both phobic anxiety and general anxiety. The distinction should be explained if necessary to enable the informant to answer firstly about his/her general anxiety and then, at section K about his/her phobic anxiety.

## Section K Phobias

The questions below the line in this section apply to

- (i) informants who said that they felt anxiety resulting from a phobia, at section J

and

- (ii) those who said at question K2 that they avoided things in the past week because of having a phobia.

Informants are counted as avoiding the situation or thing which they have a phobia about if they deliberately didn't do something they wanted to do or used to do because of it. For instance, if someone had a phobia about eating in front of strangers, they might avoid doing so every lunchtime. On the other hand, someone who is scared of heights who deliberately moved into a bungalow two weeks ago cannot be counted as having avoided heights in the last week on this basis alone.

At K3a, informants who had phobic anxiety are asked to specify the situation or thing which makes him/her anxious. Those informants who have been avoiding things are asked to specify what they have been avoided the most.

You should refer to the answer at K3a at question K4.

You should select only one of the precodes at K3a and b. The informant must choose the most anxiety provoking situation or thing.

Because informants think that their phobia is so great that it can't be lumped into such huge categories, they will tend not to use the precodes when they ought to. Instead, they will specify their phobia as an 'other answer'. Please code this back to one of codes 1 to 5. Code 5 is a code that will fit a great many phobias.

You should use code 6 'other' only if you have difficulty deciding between precodes. For instance, if you can't decide between coding 1 or 3. In such cases, specify the informants answer so that it can be coded back in the office. Otherwise, you should use code 5 'any other specific cause'.

## **Section L        Panic**

This section applies to all informants who felt anxious, either generally or as a result of having a phobia.

At question L4 we are interested in the duration of the longest 'panic attack' not in the total time spent panicking on any one day.

## **Section M       Compulsions**

The informant has to decide whether acts which they repeat are unnecessary or whether they have good reason to repeat them.

The reason for asking what acts the person repeats unnecessarily is so that you can refer to these acts in subsequent questions.

At M6 the informant is asked to specify the most commonly repeated compulsion if there is more than one compulsive act mentioned at M3. This is so that you can ask how often this was repeated in the past week.

Be careful at M7. The question asks for the number of times something was repeated unnecessarily. You should be clear whether the informant answers with the number of times the act was repeated or with the total number of times the act was performed. An act which has been repeated 3 times has been performed a total of 4 times. The pre-codes should help you with this.

## **Section N       Obsessions**

An obsession is a repetitive unpleasant or distressing thought. It is unlike worry in that it is the same thought over and over again rather than worrying about something. Question N2 checks for this.

At N2, if it appears the informant is worrying and does not have an obsessive thought you should (as instructed) make a note on the Check flap, to go back and check that some worry was mentioned at section I, 'Worry'. If it is not recorded, you should go through section I again with the informant, starting at I1 and amending the score on the check flap if necessary.

At N3 those informants who report obsessive thoughts are asked what these are. The purpose of this is to help them to concentrate on these thoughts and when they had them. However, this may be upsetting for someone and so you are instructed not to probe and not to press the informant for an answer.

At N7, we are interested in how long an episode of having such thoughts lasted, not in the total time spent in a day having these thoughts.

## **Section O        Overall effects**

**This section applies to any informant who obtained a score of 2 or more on any of the preceding sections A to N.**

The quickest way to check whether this question applies is to look at the check card. If any box contains a score of 2,3,4 or 5, this section applies.

For example, an informant may have scored:

- 1 on Somatic Symptoms, section A
- 1 on Sleep Problems, section D
- 2 on Worry, section I
- and 0 on sections F and E.

Because the informant scored 2 on section I, section O now applies.

The question itself refers to the overall effects of any of the things which the informant told you about in sections A to N.

### 5.4.5 The scoring system

#### (i) Scoring at each section

You will see that some of the codes in the coding columns are in shaded boxes. When one of these codes is ringed it indicates that the frequency or severity of the informants symptoms are sufficiently great for the informant to be given a score. This will contribute to his/her overall score for the schedule.

Usually the score which might be obtained on any such question will be 1. For instance, an informant who had an ache or pain on five of the last seven days would get a score of 1 at question A4.

Some symptoms however are more severe than others so informants can sometimes get a score of 2 at one question. For example, if an informant slept for two hours more than usual in the past week and said this was a problem, a score of 2 would be obtained at question D8.

For each section where the informant had the associated symptoms in the past month, you will be asked to calculate the total score on that section. This is done by adding up all the scores which the informant obtained on that section.

The easiest way of doing this is to look for any codes in shaded boxes in that section which have been ringed and to add them up. You will find that an informant who says he/she did not have any such symptoms in the past week will get a score of zero.

The minimum score on each section is therefore 0, where the symptom was either not present in the past week or it was not too severe. The maximum score on each section is 4 ( except in section H, Depressive Ideas where the maximum score is 5 ). The score obtained on each section must be recorded at the end of each section in the box provided. Immediately after entering the score here, you should also enter it in the appropriate box on the check card, as instructed. You should do this even if the score for that section is zero. You should also check that the score is entered in the correct box on the check flap as this important information could easily be miscoded.

Note that a score is not calculated on a section where the informant did not have the symptoms in the past month. In these cases, you are instructed to move on to the next section and you do not need to total up a section score or add anything to the check card. The relevant box should be left blank.

**(ii) An example – Scoring at a section**

**Section D, Sleep problems**

**Description:** The informant has been having problems getting to sleep in the past month. He had this problem on the last 5 nights because he has been worrying about something. On the worst night he tried for 4 hours to get to sleep. He tried for more than 3 hours to get to sleep on three nights last week.

**Scoring:** In this scenario, you would code:

- 1 at D3 – involves ringing a shaded box
- 2 at D5 – involves ringing a shaded box
- 2 at D6 – this does not involve ringing a shaded box

Hence at D11, the total score would be 3 (1 + 2). This would be entered at D11 and in the box marked 'D Sleep problems' on the Check flap.

**(ii) Obtaining an overall score**

When you have completed all sections A to N, you will be instructed to sum the scores on the Check flap. Here, you will add all the section scores which have been entered at A to N. The result should be in the range 0 to 57. This should be entered in the box provided.

**(iii) An example – obtaining an overall score**

Imagine that you have now completed sections A to N and you are starting to complete the Check card. You find that you have entered the following scores in the boxes:

At section A, you have entered 0,  
at section C, you have entered 4,  
at section D, you have entered 3,  
at section G, you have entered 2,  
at section H, you have entered 2,  
and at section M, you have entered 0.

All other boxes have been left blank because the associated symptoms were not present in the past month.

In this case you add all the available scores to obtain a overall score of 11.

This is entered on the Check card in the box provided.

#### **5.4.6      The Check Card**

##### **(i)        Purposes of the Check Card**

The check card will provide us with important summary information about what sorts of symptoms people had and how severe their symptoms were.

For instance, one look at the check card will tell us, for each symptom:

- (a) symptom was present in the past week (score of 1 to 4/5),
- (b) symptom was present in the past month but not the past week (a score of 0 entered in the box),
- (c) symptoms were not present in the past month (a blank box).

However, from the interviewing point of view the Check card has 2 purposes:

The first is to provide a summary of scores obtained on each section so that they can be readily totalled.

Second, you may find that informants mention symptoms during the interview which should have been recorded at earlier sections. For instance, someone may mention a pain they have although they answered no at A1 when specifically asked whether they had any aches or pains. In this case you should make a note on the Check Card so that when you have completed section N, 'Obsessions' you can go back to complete such outstanding sections. In this example you would go through section A again beginning with question A1. On going through a section again, you may need to change the score on the Check Card. This is why it is important to complete any outstanding sections before totalling up the section scores.

You will find that there are specific instructions for you to go back and check sections F and I, at section I 'Worry' when informants mention that they are worried about their physical health and at section J 'Anxiety' if it appears that the informant is worried rather than anxious.

##### **(ii) Completing the Check Card**

1. Go back to check or ask the questions on any out-standing sections you have noted on the card and, if necessary, amend the score for that section on the card.
2. Total all the section scores and enter it in the box provided, noting whether it is above the threshold; score of 12 or more (the threshold is printed on the card).

## **5.5 Section P,      Psychosis sift - Psychosis Screening Questionnaire (PSQ)**

### **5.5.1      Purpose of the PSQ**

The purpose of the PSQ is to identify the possible presence of psychosis.

Unlike the CIS-R which is concerned with neurotic symptoms, this section does not attempt to establish the nature or the severity of any psychotic symptoms which are identified. It simply tries to establish the existence of such symptoms. Hence it is called a screening questionnaire. This is because detailed questions about psychotic symptoms require a great deal of probing which is best carried out by psychiatrists.

Having identified people who are screened positively, that is those who are possibly psychotic, psychiatrists will carry out follow-up interviews to obtain the detailed information about symptoms we require to get a specific diagnosis.

### **5.5.2      Applicability**

This section applies to all informants but it is not asked by proxy.

### **5.5.3      Content of the schedule**

The schedule consists of 5 main questions, P1 to P5 and their subsidiary questions (a) and (b), and an interviewer check, P6.

Each of the main questions finds out whether a particular behaviour, thought or feeling has been experienced in the past year. If it has, you are signposted on to a subsidiary question which establishes whether the behaviour, thought or feeling is severe enough to be regarded as a symptom of psychosis. If it is severe enough, the informant is described as being screened positive and there is no need to ask any more of the main questions. You are directed to the interviewer check, P6, where you should record whether the informant was screened positive or not.

Since the schedule does not contain detailed questions, its structure is relatively straightforward and it should be very quick to complete. However, the nature of the questions may elicit a humorous or quizzical reaction.

Whilst the majority of informants may be faintly amused we expect the informants in whom we are especially interested will treat the questions very seriously

On occasions informants may have difficulty interpreting the questions. In such cases you should simply repeat the question

#### **5.5.4 Reference period**

This schedule refers to the presence of symptoms over the past year (that is the past 12 months up to and including yesterday).

#### **5.6 Proxy Information, section Q**

This section is to be asked where it is not possible to interview the subject. The questions are similar to the general health questions (qns. 10 to 17) which are asked in all subject interviews.

Question Q2 asks whether the proxy informant is aware of any long-standing illness, disability or infirmity that the subject has. You should then list these in the grid below, trying to get a medical name if possible. Mainly we are interested in finding out if the subject has mental, nervous or emotional problems so you should get as much detail about any such problems which are mentioned. If the proxy informant does not know the details of the health problem, you should probe: 'Is it a mental, nervous or emotional problem?'.

As in the general health questions, you are asked to code whether the subject has a psychotic complaint, but we also want you to code whether the informant has some other mental health problem.

You should refer to reference card A to see if the complaint is a psychotic one. If not, you will have to decide if it is a mental health problem at all.

In such cases, you may have difficulty deciding whether the health problem described is mental or physical. If you are in any doubt, assume that it is a mental health problem. This means we do not risk losing information about the subject.

Note that mental handicap should not be included as mental health problems. Neurological problems should not be confused with 'nervous' problems. Common neurological problems are:

Epilepsy, Cerebral Palsy, Neuralgia, Myalgic Encephomyelitis (ME, Post Viral Syndrome), Muscular Dystrophy, Multiple Sclerosis and Motor Neurone Disease.

Such neurological problems should not be coded as mental health problems. Again, if you are unsure, you should code it as a mental health problem so that we do not risk losing information.

Q8 is comparable to question 18 of the General Health Questions, except that, like Q2, you need to use reference card A and possibly decide if the subject has a mental health problem. Again if the proxy informant does not know the details of the health problem, you should probe: 'Is it a mental, nervous or emotional problem?'.  
SMT is SMOOPO and short BINGIP

At Q4 and Q5 you are asked to check whether any medication and injections the informant has are listed on reference card B. As at question 13 and 14 of the General Health Questions, if the proxy informant cannot tell you the name of the subject's medication or injection, you should ask for a description and what medical condition or symptoms it is taken for. Then use reference card A to decide whether it is being taken for a psychotic condition. If it is, you should code 1 at (b), assuming that the medication or injection would be listed on reference card A if its name were known.

## 5.7 Interview outcome

### 5.7.1 Subject interviews

Having completed section P, you should code the outcome of the sift questionnaire on the front page.

Codes 01 to 04 are based on the outcome of the General Health Questions and code 05 is based on whether the informant screens positive on the Psychosis Screening Questionnaire, section P. If you ring any of these codes 01 to 05, it means that the informant is likely to have a psychotic illness.

Code 06 is ringed if the informant scored above threshold, scoring 12 or more, on the neurosis sift (CIS-R).

01 to 06 are multi-coded; code all that apply.

Informants coded 01 to 06 are eligible for a 'long' interview and are signposted to schedule B (Yellow).

The majority of informants will have neither psychotic nor neurotic problems. These 'others' should be coded 11. They are not eligible for the long interview and are signposted to schedule C (green).

### 5.7.2 Proxy interviews

You should code the outcome on the front page after completing section Q.

Codes 07 to 10 indicate whether the subject has a psychotic illness or any other mental health complaint. These are multi-coded; code all that apply. Informants who are coded 07 to 10 are eligible for the long interview and are signposted to schedule B.

Use code 12 for 'other' proxy interviews where the subject has no mental health problems, psychotic or neurotic. You are then signposted to schedule C, a short interview.

## **6 Schedule B The Yellow schedule**

### **6.1 Contents of the schedule**

The schedule consists of 9 sections, A to I:

- A Long-standing illness
- B Medication and treat
- C Health, social and voluntary care services
- D Practical activities and recent life events
- E Social life
- F Education and employment status
- G State benefits and income
- H Smoking
- I Drinking

### **6.2 Applicability**

This schedule applies to all informants who have been identified on Schedule A as having either neurotic symptoms with a score of 12 or more and/or psychotic symptoms and are thus eligible for the 'long' interview.

Proxy information can be collected for some of this schedule. You should record the reason for taking the proxy interview on the front page at the end of the interview.

Proxy information cannot be taken for parts of sections E, Social Life, F, Employment and the whole of sections H and I, smoking and drinking. This is indicated on the schedule

### **6.3 Section A Long-standing illness**

In Schedule A, you will already have recorded the medical diagnosis or main symptoms of any long-standing illness which the informant mentioned at question 11a, page 6 (or for proxies, question Q2a, page 46).

Also, at questions 17a, page 8 (or for proxies, question Q8a, page 48), you will have recorded the medical diagnosis or main symptoms of conditions for which the informant (or subject) consulted a GP in the past year.

At question A1 we would like to know a little more about these diagnoses or symptoms.

A1 is a composite question. You should start by transcribing the diagnoses or symptoms from the above mentioned parts of Schedule A at (a).

Transcribe all of these complaints, whether they are mental, nervous or emotional problems or physical problems.

You should enter each complaint in a separate column of the grid at (a), giving the medical diagnosis or a description of the main symptoms.

If the informant is aware that a complaint is a consequence of some other, underlying complaint, then you should record these as two separate complaints.

For example: An informant suffers from sleeplessness because of some medication he is having for schizophrenia, and also has a broken leg, you should record the following at (a):

Complaint 1: Schizophrenia  
Complaint 2: Sleeplessness - side effect of treatment  
for complaint at 1  
Complaint 3: Broken leg

If the informant has more than 8 complaints to record here, add pages from a spare schedule.

You should then take each complaint in turn and ask (b) to (d).

Note that at (c) you should enter the number of years the person has had the complaint at its present level of severity. If the informant has had the complaint for less than 1 year you should record the number of months.

## **6.4 Section B Medication and treatment**

This section is concerned with the use of:

- (a) pills, tablets or other oral medicine,
- (b) injections
- (c) counselling or therapy

We are not interested in creams, ointments or lotions.

Alternative and homeopathic medicines and treatments are to be included.

### **6.4.1 Question B1 - oral medication and injections**

Question B1 is concerned with oral medication and injections whether they are taken for physical or mental health reasons. It is a composite question extending over 3 pages which consists of the following parts:

About the medication or injection:

- (a) to (c): Name of medicine or injection, strength and dosage
- (d) : What medical condition they take the medicine for
- (e) : How long since informant started using it
- (f) to (h): Whether informant sometimes doesn't take medicine, and reasons
- (i) to (k): Whether informant sometimes takes more medicine than he/she should and reasons

About the medical condition (mentioned at (d)):

- (l) to (n): Whether informant tried any other medication or treatment, before this current medication for the same medical condition
- (o) to (r): Whether informant refused any other medication or treatment, before starting this current medication for the same medical condition

In Schedule A you will have already asked for the brand names (or descriptions) of any medication or injections which informants are taking. These will have been recorded at question 12a and 14a, page 7 (or for proxies, at Q4a and Q5a, page 47).

You are asked to transcribe these from Schedule A, entering them in the grid at (a), allowing one column per medicine or injection. Include all medicines and injections mentioned in schedule A.

Notice, for injections you should ring code '1'. This is inset in the coding column at (a). Without this we will not be able to tell whether it is an injection or oral medicine.

If the informant lists more than 8 medicines or injections, use pages from a spare schedule.

Then, for each medicine at (a), ask the subsequent questions, (b) to (r).

#### B1(b)

The strength of the oral medicine should be recorded eg. 75 mg. Since people who have injections are unlikely to know about the strength, you need not ask question (b) for injections. This point is not specified on the schedule.

B1(c) is about dosage, that is, how much medication the informant takes. Sometimes there is no fixed dosage; informants simply take medication when certain symptoms arise. In such cases, ring code 1 - 'Take as needed'.

People having injections should be asked about the number of injections per day or per month. We do not expect to know the volume injected.

At question B1(d), you should ask what condition the medication is for. Often, it is obvious to us, from the name of the medication that is taken for a certain illness. At other times, the underlying complaint is not so clear. For instance, sometimes the medication is taken to overcome side-effects of treatment for some other condition. In such cases, you will have to find out what the main complaint is.

For example:

At (a) we have recorded the following:

Medicine 1: Chlorpromazine  
Medicine 2: Ventolin  
Medicine 3: Temazepam

Later, at (d) you would record the medical diagnosis of the main condition, and describe the main symptoms.

For medicine 1: At (d) we establish it is for schizophrenia: hence at (d) we record 'schizophrenia'

For medicine 2: At (d) we establish it is for asthma. This is unrelated to the informant's schizophrenia: hence at (d) we record 'asthma - breathing problems'

For medicine 3: At (d) we establish it is for sleeping problems. These are side-effects of taking chlorpromazine (medicine 1). In this case, the underlying reason for taking Temazepam is schizophrenia. Hence, at (d) we record 'schizophrenia - sleeplessness caused by medication at column 1'

B1(f) - is concerned with informants not taking medication when they should. This includes taking less than the prescribed dosage. For informants who only take drugs 'as needed', only code them as not taking medication when they should if they have had the relevant symptoms but ignored them.

Similarly, question B1(i) is about informants taking more medication than they should. This includes informants who take medication 'as needed' but take it, either when they do not have the relevant symptoms, or more than the amount recommended by their doctor or on the packet.

For B1(m) to B1(r) there is a shift in emphasis. We are no longer interested in the current medication but in the underlying condition at (d) for which the medication is taken.

At (l), you are asked to ring the column number and transcribe the main condition from (d). Continuing with the previous example you would enter:

Column	Enter	Notes
1	'Schizophrenia'	
2	'Asthma'	
3	'Schizophrenia'	writing only the main condition

Clearly, once you have completed (b) to (r) for the medications in column 1 and 2, it would be unnecessary and annoying to ask questions (m) to (r) for the medication in column 3. This is because the questions about alternative treatments for schizophrenia were already asked in column 1.

This is why there is a check at (m) that you haven't already asked about this condition in a previous column.

In this example, you would ask (b) to (r) for columns 1 and 2, then, for column 3, ask (b) to (k), complete (l) and (m) and then go to question B2 (since there is no 4th item of medication to be asked about).

B1(m) to (r) ask about whether the informant has had some other medication or treatment in the past which they don't have now, or whether they were offered some which they refused.

Sometimes, informants will have tried several alternatives for the same condition in the past, or turned down a number. In such cases, take the last medication or treatment which the informant had ( or turned down ).

There are many complexities in dealing with this question; any difficulties can be addressed at the briefing.

#### 6.4.2 Question B2 – Counselling and therapy

B2 is similar to B1, but it is concerned with treatments, that is counselling or therapy. This includes dance therapy, psychotherapy, ECT and anything else the informant considers to be counselling or therapy. These can be for physical or mental health reasons.

It is a composite question extending over pages 10 and 11, which consists of the following parts:

About the counselling or therapy:

- (a) to (c): Description of the type of counselling or therapy, frequency of treatment, and how long since the treatment began
- (d) : What medical condition they have the treatment for
- (e) : If this condition, at (d), is not covered in the previous question, B1, go on to part (f)

About the medical condition (mentioned at (d)):

- (f) (DNA) : If this condition, at (d) is not covered in a previous column of this question, ask (f) to (k), otherwise, go to the next column or to C1
- (f) to (h): Whether informant tried any other treatment or medication, before this current treatment for the same medical condition
- (i) to (k): Whether informant refused any other treatment or medication, before starting this current treatment for the same medical condition

You should ask the question at (a) and record any counselling or therapy in the grid. If the informant has more than 3 types of counselling or therapy; use pages from spare schedules.

For each type of treatment received, you should try and get the medical name and enter it at (a). If this is not possible, describe what the treatment does. You should then ask the dependent questions for each treatment entered at (a).

At (d) you must establish the condition for which the informant has the counselling or therapy. As at question B1, you should write the main medical condition, giving a diagnosis and describing the main symptoms.

As in B1, the emphasis of the questioning now shifts to the underlying condition and whether the informant has had or refused any other treatment or medication for it.

At (e) there is an interviewer check that the informant is not having any medication for the same underlying condition. If s/he is, you do not need to ask the subsequent questions (f) to (k) as they will have been covered at B1. Otherwise, go to (f).

At (f), there is a further check. This ensures that, if the underlying condition is the same in column 1 and column 2, then questions (f) to (k) do not apply. This avoids repetition in the same way as the check at B1(m).

B2(f) to (k) ask about whether the informant has had some other treatment or medication in the past which they don't have now, or whether they were offered some which they refused.

Sometimes, informants will have tried several alternative for the same condition in the past, or turned down a number. In such cases, take the last medication or treatment which the informant had ( or turned down ).

## 6.5 Section C Health, social and voluntary care services

This section consists of the following parts:

- 6.5.1 GP consultations (C1)
- 6.5.2 In patient stays (C2-C4)
- 6.5.3 Out-patient episodes (C5-C6)
- 6.5.4 Home visits (C7-C8)
- 6.5.5 Refusal to accept treatment offered (C8)
- 6.5.6 Reasons for not seeking help from a GP (C9)

Again, many of these are composite questions.

At a number of questions in section C, informants are asked to specify which professional staff they have seen, either as out-patients, in-patients or at home. The titles of such staff are listed on cards. However, sometimes informants who see professional staff may have difficulty specifying the name of the professional or differentiating between those listed on the cards. In such instances, you should ask them about the professional they see and find out exactly what the professional does, recording this on the schedule and ringing the code for 'other'.

### 6.5.1 GP consultations

'Talking to a doctor' can mean seeing him/her (at home, at the surgery or health centre etc) or speaking to him/her on the telephone. This does not include social chats with a friend or relative who happens to be a doctor but it does include any chats with the informant's doctor.

Visits to a doctor at a district health authority clinic (e.g. family planning clinic) are included (unlike on the GHS). We do not want to include talking with a doctor at a hospital or special clinic as these talks will be covered later in part (c) 'out-patient visits'.

If the informant says that she went to the doctors to pick up a prescription or some medicine, you should only enter details if she actually talked to the doctor.

Ask for up to the 4 most recent consultations.

Often, people will consult their GP about physical symptoms when the underlying problem is a mental health one. At (b), we do not want you to probe out what the underlying problem is. Simply ask what the informant talked with their doctor about

### 6.5.2 In-patient stays

Question C4 asks detailed questions about in-patient stays in hospital. Ask for up to the 4 most recent in-patient stays.

Include- stays in private hospitals and clinics.

- dialysis patients required to stay in hospital overnight
- stays for sight or hearing problems

Exclude - stays for giving birth

An inpatient stay lasts from admission to discharge, so if an informant was sent home for the weekend during a spell as an inpatient, this just counts as one spell.

Record the number of nights actually spent in hospital on each stay in the last 12 months.

If a person interviewed by proxy is still in hospital, code the number of nights so far.

At (c), the questions are focused on those stays which were for a mental, nervous or emotional problem.

Also at (c), A and E stands for Accident and Emergency.

### **6.5.3 Out-patient episodes**

Questions C5 and C6 ask about out-patient visits. These are visits to a hospital or clinic for treatment or check-ups either on an appointment basis or just through turning up. These also include visits to day hospitals, private consulting rooms and casualty departments.

Note that some people may receive treatment or check-ups at day centres. These should be included, whereas visits to day centres for social and leisure activities are excluded. These are covered in Section E.

Day patients are defined as patients admitted to a hospital bed during the course of a day or to a day ward where a bed, couch or trolley is available for his/her use. They are admitted with the intention of receiving care or treatment which can be completed in a few hours so that they do not need to remain in hospital overnight. If a patient is admitted as a day patient but then stays overnight, they should be counted as an inpatient.

Include-dialysis patients if they are admitted only for the day and not required to stay overnight.

Exclude-dialysis patients required to stay overnight. They should be included as inpatients.

Ask for up to the 4 most recent out-patient visits.

### **6.5.4 Domiciliary services**

C7 is concerned with help received at home from the health, social and voluntary care services.

'Voluntary worker' mainly refers to someone from a voluntary or charitable organisation, the main ones being listed at C7(c). However, the voluntary worker may not be from any organisation. Ask about up to 2 voluntary workers.

Voluntary workers should be distinguished from volunteer workers who come from the social services.

### **6.5.5 Refusal to accept treatment**

This is a subject of major interest to those trying to provide services for people with mental health problems. One opinion which is commonly held among professional researchers in this field is that 50% of people not receiving certain forms of treatment have been offered it and refused it.

### **6.5.6 Reasons for not seeking help from a GP**

There are various reasons why people with mental health problems do not consult their GPs. Common reasons include not thinking there is a problem, or that the problem will get better on its own, being afraid of the consequences and the stigma of discussing these problems.

There are 12 precodes at C9a. You are asked to write down informants reasons verbatim and then code the answers. It will help to familiarise yourself with the codes. It is preferable to 'code' these answers during the interview rather than later on at home, as you may need to probe for more details from the informant.

### **6.6 Section D Practical activities and recent life events**

#### **6.6.1 Practical activities**

This section consists of 7 composite questions each dealing with a different activity of daily living and asks whether the informant has any difficulty or receives help.

The 7 aspects of daily living that are dealt with in this section are:

- (a) Personal care
- (b) Mobility and transport
- (c) Medical care
- (d) Household activities
- (e) Practical activities
- (f) Paperwork
- (g) Financial management

Some of the main questions (D1, D2, D3 etc) cover several different tasks subsumed under one general category. For example at D4, household activities covers preparing meals, laundry, shopping and housework. Difficulty with any of them should be coded 1 (yes).

If an informant says that he has no difficulty with some activity of daily living because he does not need to do it or want to do it, you should code this, as indicated on the schedule, as not having difficulty.

However, if informants can only do an activity with help, you should treat them as having some difficulty.

At (b), three boxes are provided for each activity to record the details about each helper. If there are more than 3 helpers, take the 3 who help the most in terms of the number of hours spent helping.

### **6.6.2 Recent life events**

These questions have been derived from the "Threatening Experiences Life Events Interview", developed by Dr T. S. Brugha from the Department of Psychiatry , University of Leicester.

This is really two composite questions. Each of the 11 main questions establish whether a particular stressful life event was experienced by the subject in the past 6 months.

Subsequent questions ask when the event happened, whether the informant felt supported and understood and whether they wanted or tried to get any professional help.

You should ask D8 to D13, and then parts (a) to (g) if applicable. Then you should turn over and ask D14 to D18 in the same way.

Sometimes you will find an informant who is clearly still affected by an event that occurred more than 6 months ago. For instance, an informant may still be grieving for someone who died a year ago. Nevertheless, the event did not occur within the 6 month period and so, for the purposes of these questions, you should not include this sort of case.

This may cause you some embarrassment in the interview, so you might like to ask the subsequent questions as a courtesy questions, but please do not enter anything in the grid.

The only exception to this 6 month rule is D8. A serious illness or injury which the informant has suffered in the past 6 months is included, even if it started earlier. In this case, at (a) you should observe the boxed instruction and code 6. You should not apply this example to any of the other questions D9 to D18.

Some of these main questions are difficult to answer when there are other people around. If you are not interviewing in private, use cards 19 and 20. These have the main questions printed on them and you will need to prompt for the answer to each.

## 6.7           Section E       Social life

This section is concerned with:

- (i) Social life - social activities and groups
- (ii) Social networks - whether there are people whom the informant feels close to.

### (i) Social life

E1 and E2: Ask the main question, ringing all the activities which the informant does. Then ask (a).

At E3, include anything which the informant regards as a social club.

E4 is concerned with Adult Education and Adult Training Centres. Descriptions of these can be found in the appendix.

### (ii) Social Networks

The questions on social networks cannot be asked by proxy as the information is likely to be unreliable.

Questions E6 to E10 are printed on cards which you can use if there is no privacy.

On the whole these questions are about people whom the informant feels close to. They are all opinion questions. Questions have been printed on cards which must be used when the interview is not being conducted in private. For instance, informants may answer that they do not feel close to anyone they live with, including their spouse. They may be discouraged from answering truthfully if the spouse is present, unless cards are provided.

For informants who live with other adults:

either use card 23 and prompt for answers to E6, E7 and E8,

or: -ask E6

-ask E7 (ignoring the preamble) and reading the parts in brackets to focus the informants mind on people who don't live with them

-ask E8 reading out the part in brackets as at E7

If E9 and E10 apply: read out the part in brackets or use the cards specified

**For informants who live with no other adults:**

either use card 24 for E7 and E8,

or: -ask E7, reading the preamble but not the parts in brackets as these are not relevant  
-ask E8, (ignoring the part in brackets as at E7

If E9 and E10 apply, omit the part in brackets or use cards

Friends or acquaintances may be professionals such as a home visitor or a counsellor, if the informant thinks of them in this way.

The informant can include people as living with them who are not by our definition in the same household.

#### **Question E10**

A to G are questions from the Health Survey. If there is no privacy, use cards 27a, b and c and prompt for the answers to each of the questions which are printed. Otherwise, use card 26 which shows the pre-coded answers only and ask the questions.

## 6.8 Section F Education and Employment Status

### 6.8.1 Education

F1 If you already know that your informant is currently still at secondary school, code 1 without asking the question. If informants tell you that they left school before reaching the minimum school leaving age (currently 16) because their birthday was in the holiday period between school years or terms, record them as having left at the minimum age.

F2 The qualifications shown on card 28 are grouped into 7 types. You should hand the informant the card and ask them to tell you the first one they come to that they have passed. You should then check that this is in fact their highest qualification as we only want the highest coded. Note that the qualifications are arranged in groups; we do not need the individual qualification coded, only the group in which it falls.

You may need to probe your informant's answer in order to establish which code to ring at F2. For example, if the informant mentions that s/he has a professional qualification and s/he does not know which of group 1 to 6 it should be coded under, you should code 7 and specify. This can then be recoded by PAB if appropriate.

### 6.8.2 Employment Status

The term, "Work" at F3 means any work for pay or profit done in the week ending last Sunday, even if it is for as little as one hour, including Saturday jobs and casual work (eg babysitting, running a mail order club).

Self-employed persons are considered to be working if they work in their own business, professional practice, or farm for the purpose of making a profit, or even if the enterprise is failing to make a profit or just being set up.

The unpaid 'family worker' (eg, a wife doing her husband's accounts or helping with the farm or business) is included as working if the work contributes directly to a business, farm or family practice owned or operated by a related member of the same household. (Although the individual concerned may receive no pay or profit, her contribution to the business profit counts as paid work at this question). Note that this applies when the business is owned or operated by a member of the same household.

Anyone on a Government scheme which is employer based should also be included as 'working last week'. For treatment of people on government training schemes, see the notes below relating to question F8.

At F3, code 05, include people who are intending to look for work but prevented by temporary ill-health, sickness or injury. This includes people who were prevented from looking because of an emotional reason.

Note that you should not exclude people on the basis of how long they have been prevented from looking for work (unlike the GHS which only includes those who have been prevented from looking for work for 28 days or less).

Code 06, "Going to school or college" can apply only to people who are under 50 years of age.

The category includes people following full time educational courses at school or at further education establishments (colleges, university etc). It includes all school children (16 years and over).

During vacations, students should still be coded as 'going to school or college'. If their return to college depends on passing a set of exams, you should code on the assumption that they will be passed. If however, they are having a break from full time education, ie. they are taking a year out, they should not be counted as being in full time education.

The following persons are excluded from code 06:

1. Students who say they are working or unemployed in the reference week (coded 01 at F3 or 03 to 05 at F3(a)(i))
2. Persons who are paid a wage or salary by an employer while attending school or college - they should have been counted 'in paid employment' at F3.

At Code 07, "Permanently unable to work" can only apply to those under state retirement age, ie to men aged 16 to 64 and women aged 16 to 59. Others must be coded at 08, 09 or 10.

Include any person whose inability to work is due to health or emotional problems or disablement. People who are permanently unable to work because of domestic responsibilities are not included here but should be coded 09.

At code 08, retired, the intention is to include only those who retired from their full-time occupation at approximately the retirement age for that occupation, and are not seeking further employment of any kind. Women who at a comparatively early age ceased work in order to become housewives are excluded from this category.

Note that a retired person who last week was ill or in hospital should be coded according to his/her normal status, that is retired.

Looking after the home or family, code 09, covers anyone who is mainly involved in domestic duties, provided this person has not already been coded in an earlier category. There can be more than one person in a household looking after the home or family.

People who are permanently unable to work because of domestic responsibilities are included here.

Note that a person looking after the home or family who last week was away on holiday or in hospital should be included in code 09.

Code 10 at F3, "Doing something else" include anyone for whom the earlier codes are inappropriate, eg full time students aged 50 or over who are not permanently unable to work, retired or looking after the home or family.

#### Question F8, page 36

Information at this question is used to code Socio-Economic Group and Industry. You should use the new classification system (1990) SOCC coding frames for Occupation and Industry coding on this survey.

We always need a detailed description of both occupation and industry. Please refer to the 'Handbook for Interviewers' for notes on questioning procedures. Please note that we need a job title, a full description of the work including the main activity, the level of skill and the level of responsibility.

#### *Self-employed/employee:*

In general accept the informant's answers except:

1 Where there is doubt you should try and find out how they are described for tax purposes, and for National Insurance purposes. If the informant does not pay tax or NI, accept the informant's answer, but note that working as mail order agents, pools agents, odd jobbing, baby sitting etc are usually classed as 'self employed'.

NB it is possible to be self-employed and work under contract to an employer (eg in the construction industry).

2 For all directors and managers who say initially that they are self-employed, check whether they work for a limited company. If they do, they are treated as employees for tax and NI purposes and should be coded 'employee' here.

**'Manager, Foremen/supervisor, other employee':**

The distinction at F8(a) between managers, foremen/supervisors, and other employees is important but sometimes difficult.

'Managers' are generally responsible for long-term planning and have overall control often through foremen or supervisors.

'Foremen' and 'supervisors' have day-to-day control of a group of workers who they supervise directly, sometimes themselves doing some of the work they supervise.

Ask or record the answer as appropriate remembering that job titles can often be misleading (eg a playground supervisor supervises children not employees, and so should not be coded as a supervisor; a 'stores manager' may be a store-keeper and not a manager).

**F9(c)      Sheltered employment**

Those in sheltered employment are likely to be aware of this so code "don't know" as "none of these". A definition is given in the appendix to the interviewers instructions.

**F10    Number of employees**

Exclude from the total number of employees:

- any relative who is a member of the informant's household
- any partners in a partnership (as they would also be self-employed).

Proxy interviews are not taken for questions F13 to F25 inclusive.

**F13 Sick absence**

We want to count sick absence due to any aspect of their health, physical or mental.

At (a), in calculating the number of days taken off work due to sickness, you should include weekends which fall within a period of sickness. You should check with your informant that s/he has made an allowance for this.

Two examples:

Informant was off sick on Thursday, Friday and Monday:  
count 5 days

Informant was off sick Thursday and Friday: count just 2 days.

## **6.9 Section G: State Benefits and other income**

### **Purpose of Section**

The main use of the Income Section is to provide a measure of overall income which is an important classificatory item used with data from all other sections of the questionnaire; and to give us information about the receipt of certain state benefits.

### **G1 and G2**

State benefits are divided between two questions (G1 and G2). We want to know which, if any, of these benefits are received. We do not need to know the amounts received.

If an informant is receiving a combined payment, record all of the benefits which are covered by that payment.

### **State Benefits (G1)**

#### **(a) Child benefit:**

- (i) Ask about one parent benefit separately, formerly called one parent increase. This is paid to one parent families in addition to the basic child benefit.
- (b) Family Credit (formerly called FIS): this benefit is paid to families with low earnings with at least one dependent child and with at least one earner working 24 hours a week or more. Family Credit replaces Family Income Supplement. Family Credit is paid for 26 weeks, unlike FIS which was paid for 52 weeks, after which time the family's situation is reviewed.

- (c) NI retirement pension: Retirement pension may have an earnings-related supplement. This is normally paid on the same order book as the basic pension, and should be included in the amount of pension recorded.

#### **(d) Income Support (formerly called supplementary benefit):**

Income Support replaced Supplementary Benefit. The rate of Income Support is assessed on the grounds of age and marital status with a flat-rate premium payable to claimants with children and special premiums payable to groups of claimants eg. lone parents, disabled people, pensioners (at two rates)

- (e) NI Sickness benefit: Exclude statutory sick pay paid by an employer. From April 5th. 1986, the only people claiming NI sickness benefit are those not entitled to Employer's Statutory Sick Pay.

- (f) **Unemployment benefit:** If the informant has never worked or has been unemployed for longer than one year, check that it is unemployment benefit (and not, for example, income support) that they are receiving.

Note ET allowances are paid through Unemployment Benefit Offices. The recipient receives their Unemployment/Income Support entitlement plus (usually) £10 on top. You should regard this as a top-up to the main benefit rather than as a separate benefit. Ie. simply code unemployment benefit or income support and ignore any ET allowance.

### **State benefits (G2)**

- (a) **Widows Pension or War Widow's Pension, and other widow's benefits**

Widow's pension is now paid immediately after bereavement rather than 6 months after bereavement. The ages at which the various rates of widow's pension are payable have been increased by 5 years. The lowest rate is now paid at age 45 instead of 40 and the full rate is paid at age 55 instead of 50 with all intervening age-related rates being similarly paid at a later age.

War Widow's pension is paid to widows (or widowers) or people who die as a result of service in the armed forces.

- (b) Other widow's benefits include widowed mother's allowance: widowed mother's allowance is now paid immediately after bereavement rather than 6 months after bereavement. The personal extension of widowed mother's allowance payable to women with children aged 16 to 19 who have left school but are still at home has been discontinued.

**PLEASE NOTE:** do not include Widow's Benefit at G2 as this is a single lump sum payment of £1000 which now replaces widow's allowance.

- (c) **War Disablement Pension** Payable to members of the armed forces disabled in the 1914-1918 war or after 2nd September 1939. Merchant seamen and civilians disabled in the 2nd World War are also eligible.

- (d) **Invalidity Pension, Invalidity Benefit, Invalidity Allowance**

Invalidity Benefit is made up of Invalidity Pension and Invalidity Allowance. Invalidity pension is paid when Sickness Benefit finishes if the person is still incapable of work. Invalidity allowance is paid as an addition to Invalidity pension if the illness began when the person was under 60 (men) or 55 (women).

- (e) **Severe disablement allowance** This is a weekly cash payment for people of working age who have not been able to work for at least 28 weeks but cannot get contributory Sickness or Invalidity Benefit because they have not paid enough NI contributions. Married women can get it if they are also unable to do normal household duties.

- (f) Industrial Disablement Benefit or Industrial Injuries Disablement Benefit. Payable to people who have become disabled as a result of an accident at work or an industrial disease.
- (h) Attendance allowance has been replaced by Disability Living Allowance for people who became disabled before the age of 65. Hence, we do not expect any of our informants to be receiving it.
- (i) Disability living allowance is a new benefit which was introduced in April 1992. It replaced mobility allowance and replaced and extended the help given by attendance allowance for people disabled before age 65. People aged under 65 who receive mobility allowance or attendance allowance will transfer automatically to disability living allowance in April. Attendance allowance will remain for people disabled after age 65! Hence, in this survey we do not expect to find anyone receiving mobility or attendance allowance.
- (j) Disability working allowance was introduced in April 1992 to help people with an illness or disability who have a disadvantage in getting a job. It is available to those who are starting work for 16 hours or more a week or who are already working 16 hours or more a week. This can be self employed work or work for an employer.

It is possible to claim disability working allowance as well as disability living allowance.

- (k) Invalid Care Allowance Weekly paid benefit for people of working age who give up working to look after an invalid or Attendance Allowance, Constant Attendance Allowance or who are covered by the top two rates of Disability Living Allowance (formerly attendance allowance).
- (l) Maternity allowance
- (m) Other types of benefit might include; guardian's allowance; industrial death benefit.

Exclude housing benefit.

### **G3 Other income**

Again we do not need to know the amounts of income from other sources, only whether some income is received or not.

#### **Occupational pensions from a former employer:**

Include

- all employer's pensions, not just retirement pension
- regular payments for early retirement (ie pension early)
- pension received from present employer (ie if informant is still working but is over the retirement age appropriate to the pension scheme).

Exclude -lump sum payments, private (personal) pensions and annuities.

#### **Private pensions or annuities:**

Include- pensions from Trade Union and Friendly Societies, and from private insurance schemes, annuities, and payments from a trust or covenant.

Exclude- pensions from a previous employer

### **G4 and G5 - Usual gross income from all sources**

Notice that G4 is for the individual whereas G5 is for the household.

Prompt card 33 is used for both questions. It shows gross income in bands at weekly and annual rates. Ask the informant to tell you which band their income or the household's income falls in.

## 6.10 An introduction to sections on smoking, drinking and drugs use

The Department of Health are interested in this because there is a correlation between smoking, alcohol use and drug taking and certain forms of mental illness, either as a cause or a consequence. For instance, as well as helping people to cope with stresses and strains in their lives, it is also thought that smoking alleviates some of the symptoms experienced by people with severe mental illness.

Because some of the questions are very sensitive, it is important that you introduce these sections telling the informant why we are interested to know about these topics. This is one suggestion:

'People react to stressful events in their lives in lots of different ways and they find different ways of coping. For instance, many people find that smoking, drinking alcohol or taking medication or other drugs helps. For others however, this leads to a variety of problems. This is an aspect of the people's health and well-being that the Department of Health are particularly interested in...'

## 6.11 Section H Smoking

Do not comment on the hazards of smoking or on your own feelings about smoking.

### General points

We are only interested in ordinary tobacco which is smoked. You should, therefore, ignore any reference to snuff, tobacco or tobacco products that are chewed or sucked or herbal tobaccos.

H1 By 'ever smoked a cigarette, a cigar or a pipe', we mean even just once in their life.

H2 and H13: Do not define 'nowadays', but ask informants to decide instead.

H3 and H4: Note that daily figures are required at both these questions. If any informant can only give the amount in ounces of tobacco or an overall weekly number of cigarettes, record these amounts as a last resort. Record       ounces of tobacco as a note beside the coding column.

H5 By 'filter-tipped' cigarettes we mean cigarettes manufactured with a tip on them. You should not include filtered cigarette-holders.

'Hand-rolled' cigarettes can be filter-tipped or plain, but it is the fact that they are hand-rolled and not manufactured that is important.

H6 The aim of this question is to categorise cigarette brands according to their tar level. There are a great many different brands; many with similar names are actually in different tar bands. Hence, there is a 3 page reference card headed 'BRAND CHECK LIST' (Reference card C) which shows the vast majority of cigarette brands which differentiate between tipped or plain cigarettes and their sizes; e.g. King Size, Luxury Length. You should use the Brand Check List to identify the exact brand and write the 3-digit brand code in the coding column. Your informant may help in sorting out the brand so please show him or her the card if necessary. When writing the brand, record full details as, for example Embassy No. 1 is in a different tar brand from Embassy No. 3. The Brand Check list is in alphabetical order to help you work out the correct code quickly.

If you do show this card to the informant, it is wisest to detach it from the other reference cards which list psychotic illnesses and anti-psychotic medication.

Occasionally someone may smoke a brand not on the check list-perhaps a new brand or cigarettes bought abroad-if so code 1 and give full details in the space for brand name etc.

Refer to the cigarette packet for details if possible.

If someone says that they really have no 'usual' brand of cigarettes, record details of the brand they are currently smoking.

H9 You may find that when you ask this question, not everyone will answer in terms of 'time after waking' and you will need to prompt. Remember to stress 'usually'.

H11 This question is now asked of all current and ex cigarette smokers. Someone who says in reply to H2 that they currently smoke cigarettes may not consider that they ever smoked cigarettes regularly. If they say this at H11, code 00.

## 6.12        Section I:        Drinking

This section is similar to the one used by the GHS. The main difference is that we do not have a self-completion version for 16 and 17 year-olds.

### The questions

#### I4A/B       Both questions ask for the MAIN reason

'Health reasons' (code 4) covers specific health problems whether or not they are drink related; e.g., because of medication which is not compatible with drinking; and general fears that drinking is bad for health.

I6-7 I6 collects information about frequency and I7 collects information about the amount usually consumed on any one day. There is no need to indicate which particular drink in the group the frequency or quantity relates to.

I6      Prompt each group of drinks on the list in relation to Card 34. Read out all drinks in each category, including what is in brackets.

Remember to include home-made or home-brewed drinks in the appropriate category (e.g. gooseberry wine should be coded as 'wine' and not entered as 'other alcoholic drink').

Be careful to include only alcoholic shandy. Cans of shandy should not be included because they have extremely low alcoholic content. Similarly all other non-alcoholic or low alcoholic drinks (e.g. low alcoholic wine) are also excluded.

Where drinks are grouped at this question, we are not interested in any one particular drink in a group of drinks as a whole. So, if someone says that they have a drink of whisky and a drink of gin each week, you should ask the question again, explaining that we just want to know how often (s)he has had a drink of any kind of spirits and liqueurs in the last 12 months.

I7      Shandy and beer/lager/stout/cider should be recorded as 'half pints' or large or small cans. Always record the total amount usually drunk on any one day

Notice that, unlike the GHS, we want the number of half-pints drunk. eg. if someone says 2½ pints, enter that as 5 half-pints;

Cans of beer, lager or cider are often measured in litres or fractions of a litre. We expect large cans to be approximately 440 ml. and small cans to be approximately 275 ml. (just under 1/2 pint). If the cans consumed were a different size we need to know, please record the size.

If bottles of beer, lager or cider have been drunk we need to know the size e.g. 1/2 pint, 350 mil, 3/4 pint, 75 cl., 1 litre etc.

Spirits should be recorded as singles, so that a 'double gin' should be entered as 2 singles. (In Scotland, singles are sometimes known as 'halves'.) If answers are given in terms of bottles, you should record the size e.g. miniature, 1/4 pint, litre etc.

Occasionally answers may be given as spoonfuls. In this case, establish and record whether it is a teaspoon or a tablespoon etc. 'Nips' or 'Tots' are acceptable answers to record for spirits.

Wine and sherry/martini etc. should usually be recorded as glasses. If answers are given in terms of bottles you will need to check the size i.e. 1/2 bottle, ordinary bottle or litre. Sherry may also be drunk in larger glasses known as 'schooners', and this should be recorded e.g. 2 schooners rather than 2 glasses.

At the 'anything else' category you will need to enter in each case the description of the quantity as well as the number e.g. 2 glasses, 1/2 bottle, 1 teaspoon etc.

If at any part of I7, the amount usually drunk on any one day varies so greatly that the respondent is unable to answer, you should probe for the amount most usually drunk on any one day during the past 12 months.

#### Drinking in the past year

Questions I8 to I10 ask about drinking over the past year to get a general picture. Here we switch to asking about units of alcohol. There are two facing picture cards, 35 and 36, to help you and your informant in converting quantities of alcohol to units. On the whole, they are the same as pub measures but a pint of beer is 2 units; a large glass of wine is 2 units.

We want to know how often the informant drank a certain amount of alcohol. At I8, how often did they drink 12 or more units of alcohol? At I9, how often did the person drink between 8 and 11 units of alcohol?

Note that at I9 we do not want to include those occasions when the informant drank 12 or more units. We are only interested in the times when the informant drank more than 8 units but stopped before drinking 12. The same reasoning applies to question I10.

Note that there is a signposting error at I9: codes 5 to 9 should go to I10.

Depending on the answers to I8, I9 and I10, you are directed to different parts of the self-completion questionnaire (Schedule D).

Essentially, light drinkers or teetotallers are asked part B of schedule D "only". This is concerned with drugs use and associated problems. This is why you are instructed to hand schedule D to the informant, already turned to page 6.

Other drinkers are asked to complete parts A and B of Schedule B. Part A covers drink problems. You should hand the schedule over, turned to page 2. They should then complete parts A and B of Schedule D.

While the informant is completing this, you should finish off this schedule by filling in the front page.

## 7.0 Schedule C      The Green schedule

This schedule applies to all informants who are eligible for a short (or shorter) interview. These are informants who were found not to have any mental health problems, or those who had problems which were not severe enough to be sifted as positive, by the sift schedule, A.

The purpose of asking schedule C of people who do not have mental health problems is to give us information to enable comparisons to be made between these people and those who do have a mental illness.

Essentially this is a shortened version of schedule B. The following sections have been extracted from schedule B to make up this schedule :

### Section    Topic

D	Practical activities and recent life events
E	Social Life
F	Education and employment (qns. F1 to F10, F26 only)
H	Smoking
I	Drinking

The sections occur in the same order as in Schedule B and the same comments apply. The same question numbers and prompt cards are used in schedules B and C.

For proxy interviews, the same directions apply as in schedule B: do not ask the questions on social networks (E5 to E10), smoking and drinking questions (sections H and I).

### Starting the schedule

It might help to give an introduction to schedule C. Since it starts with section D asking about difficulties with practical activities. One suggestion is:

'Many people find they have difficulty with doing practical activities, whether around the house or elsewhere and need help. I'd like to ask you about some of these activities even though they may not apply to you.'

### Ending the schedule

As with schedule B, answers to questions on drinking in the past year determine which parts of the self-completion questionnaire (schedule D) the informant should complete.

While the informant is completing the self-completion, you should fill in the front page of this schedule.

Proxy interviews end after section G. Then you should complete the front page.

## 8.0 Schedule D      Self-completion questionnaire

The questionnaire is designed for self-completion because of the sensitive nature of the questions. The questions however are fairly complicated and the issue of helping informants with them is discussed at 8.1.

You should point out that the questions are confidential and that an envelope is provided for them to seal their responses in if they wish. The reason for emphasising the confidentiality in this way is that these schedules are immediately followed by the Recall Sheet. We wish to make it clear that the decision to follow the interview up with another interviewer call has nothing to do with their answers to these questions.

For informants who have been identified as having a psychotic illness or symptoms at schedule A (coded 01 to 05 on the front page of schedule A), it is better to lose information on alcohol and drug use than to risk the informant disagreeing to recall.

### 8.1 Helping informants to fill in the questionnaire

Because of the layout of the questionnaire, some informants may find it hard to fill in. It is important that you acknowledge that some of the questions are difficult to handle and offer to help. This is especially so because you won't be able to check through these schedules because of their confidentiality.

On the whole there are two types of question;

questions like question 1 in part A, on page 2 where the informant has to ring 1 or 2 for yes or no.

questions like question 26 in part A, on page 4. Here the informant has to ring the code for yes or no at the main question (presented vertically like on a standard questionnaire) and then to identify the precodes which apply in an inset box, ringing the appropriate codes in the horizontal box. An example is given at 26a to help informants but you should be ready to help explain what to do.

However, if informants are happy to answer the questions rather than fill in the schedules, you should ask them.

In this case, all of the questions are to be treated as asterisked questions.

## **8.2 Part A      Alcohol related problems**

This part of schedule D is concerned with a number of alcohol related problems. It is taken from an American questionnaire devised by Cahalan and Room.

This part only applies to people who drink at least 5 to 7 units of alcohol more than once or twice in 6 months. This should be clear from the directions at I8 to I10 on schedules B and C. You should ensure that very light drinkers or teetotallers start this schedule at part B, page 6.

At question 26a, the informant should ring the numbers corresponding to all of the people who asked him/her to drink less or to act differently when drinking. Ie. it is a 'code all that apply' question. This is also true of 26c.

Once part A is finished, informants are directed to part B, page 6.

## **8.3 Part B      Use of drugs and associated problems**

The drugs (or types of drugs) that we are interested in are given in the box which is given on page 6 and following pages of schedule D. The list is arranged in such a way that people who take drugs like sleeping pills will quickly see that these questions might apply to them; they are not just concerned with illegal drugs.

We are interested in people who take drugs on the list either:

- on prescription but more than was prescribed for them
- to get high
- or without a prescription

The order in which we ask the questions A, B and C may seem strange when considering the illegal drugs on the list. For instance, for someone who uses ecstasy, question A is in effect assuming that it was prescribed for them. However, this is a necessary evil in this self-completion questionnaire as our prime aim is to ensure that people over-using drugs like sleeping pills are picked up.

Many of the informants will be taking tranquillisers like Valium or Librium. We are only interested if the informant takes more than they are prescribed or if they are obtaining them without prescription.

At all the questions in part B where we ask about which drugs were taken, we are only interested in the category of drugs as shown in the boxed list. We do not need to know the name of the drug. Informants should code all of the drug categories which apply to them at each such question.

If the informant is unsure about which category the drug they have taken belongs to, they should use the descriptions in the list to help them.

For example, if the effect of the drug is that it is an 'upper', code with other stimulants in category 4. Similarly, if the drug's effect is to cause hallucinations, code it with other hallucinogens in category 8.

#### 9.0 Ending the interview

Having finished schedule D, we would like to allow a breathing space before asking permission to recall. We leave it open to you to decide how this is best done bearing in mind that you may have already been there a long time and might not wish to bring up upsetting topics again from earlier in the interview. For example, you might ask the informant, 'Is there anything else you want to say?' or 'How did you find the interview?'. You may wish to record the answer, if so use the back of a schedule.

Generally though, please thank the informants for their help with the survey before introducing the recall sheet.

Proxy interviews will have already ended after section G on schedules B or C. At this point you should thank the proxy informants (and the subjects if they are present). There is no need to fill out a recall sheet.

## 10.0 Document E The recall sheet

### Why we are asking permission to recall

Nowadays, it is standard practice to ask informants for their permission to recall so that we can contact them again at a later time to collect further information about them, either for the same or another survey. Usually follow up interviews take place years after the main study, for instance, to see how people's circumstances have fared over time.

On this survey, we plan to follow up within a few days or weeks all informants who have been identified as having a psychotic illness or symptoms with an interview administered by a clinician. These informants will have been coded 01 to 05 on the front page of the sift schedule, A.

The follow up interview will give us a diagnostic assessment of the informant using an clinical interview called SCAN. Because of the clinical knowledge required to administer the interview, we have recruited senior psychiatric registrars as OPCS interviewers. The follow up will take place soon after the first interview, perhaps within weeks.

The recall sheet plays an important part in the procedure for quickly notifying the clinicians of whom to follow up.

### 10.2 The recall sheet

This is a single sheet of white card that should be completed for all informants except in the case of a proxy interview.

On this survey the recall sheet is being used as follows:

1. for informants who are thought to have a psychotic illness (coded 01 to 05 on front page of schedule A):

The completed recall sheet will be sent back to the office and, if the informant is willing, the sheet will be allocated to a clinician for a follow up interview.

2. For all other informants, including those who are identified as having a neurotic illness (coded 06 or 11)

The completed recall sheet will be sent back to the office and keyed but there are no immediate plans for any follow up study.

### 10.3 Completing the recall sheet:

Stick serial number label and add the household number

Ignore the box headed 'SCAN no:' ; this number will be added to the office as a case number for the clinicians.

You should write your name and the date of interview clearly so that the clinician when making contact with the informant can refer to you by name and mention when you visited.

1. Transcribe the outcome of the sift for psychosis and neurosis from the front page of schedule A into the boxes. You should ring all that apply. Codes 01 to 05 are in a separate box from codes 06 and 11 as these denote the interviews which are for immediate follow up and can be picked out quickly from all the other recall sheets at the office.

This information will be useful to the clinicians; it will tell them exactly how the informant came up positive on the various parts of the sift for psychosis and hence guide their questioning.

2. This is the standard recall question.

The question refers to the clinician as 'another interviewer on behalf of OPCS'. We do not want to alarm the informants by telling them the interviewer is a psychiatrist as this may raise fears of them being hospitalised. Likewise, the clinicians have been briefed to regard themselves as special OPCS interviewers. They have been briefed that they must not intervene professionally in any situations which they might come across while interviewing for us.

If the informant is eligible for an immediate follow up interview (coded 01 to 05 at 1) and wants to know more about the follow up you can tell him/her that an interviewer will be calling to do a similar interview but, this time, using a laptop computer. We want to compare the two procedures; using a paper and pen interview and the one on computer.

If the informant agrees to recall, you should indicate their likelihood of being followed up:

If any code 01 to 05 is ringed at 1., you should say that they will be receiving a letter from us shortly to tell them when someone will be coming to interview them.

Otherwise, if only 06 or 11 are ringed at 1., you should explain that this is something we ask on all surveys.

If the informant refuses to recall, you should code 2 for 'No (unconditional)' and give reasons.

If the informant agrees to recall, try and get a phone number at (a) as this will help the clinician to make an appointment. Enter the informants name at (b) and stick an address label at (c), adding any amendments to this address.

At (d), give any special instructions for recall which will help the clinician to find the address and make contact with the informant.

Remember that the recall sheet shows a name and address. This means that, for confidentiality, no personal information about the informant should appear on it (other than the coded outcome from the sift at question 1).

This is the end of the interview.

#### 10.4 Despatch of the recall sheet

For confidentiality, the recall sheet must be kept separate from any other completed survey documents because it carries a name and address.

Recall sheets should never be posted to HQ with the rest of your completed schedules, but should be despatched under separate cover.

To ensure allocations of follow-up interviews to clinicians done as quickly as possible, you should despatch all recall sheets to your region at least twice a week.

## 11. Field Instructions

### 11.1 Field Dates

Interviewers briefed in April:-

- A First quota (45 addresses) - from briefing to June 11th
- B Second quota (45 addresses) - July 26th to September 3rd

Interviewers briefed in May:-

- C First quota (45 addresses) - from briefing to July 9th
- D Second quota (45 addresses) - August 23rd to 1st October

### 11.2 Planning the work

The field periods for each quota are generous, so you should have no difficulties completing the work to time. Although there is no placing pattern, you should aim to provide a reasonably even work flow for any follow-up interviews that will need to be done on your quota.

Average interview length will be about 50 minutes for a "short" interview, and about 90 minutes with those informants who qualify for a "long" interview. Obviously, you will not know in advance which addresses are likely to produce long interviews, so you will need to allow enough time for the longer interview when spacing appointments. The number of interviews you are likely do in a day will also vary - while four or even five "short" interviews may be possible in a day, if you have two consecutive "long" emotionally draining interviews, that may be all you can handle on that day!

### 11.3 Calls and outcome sheet/doorstep selection

You will be returning a calls and outcome sheet for each address in your quota. Please note that the C&O sheet doubles as a doorstep selection document. At each address which contains a private household, you should be completing a household box on the calls and outcome sheet. In column e, you will be numbering any adults aged 16-64 in descending age order and using the pink sampling card I to select the right informant for that serial number when there are two or more eligible adults.

We still need the household composition recorded for ineligible households (ie those containing only persons aged 65 and over). Also please try to get household composition (or your best estimate) for those households which end up as refusals or non-contacts to give information about any non-response bias on the survey.

## **11.4 Despatch of work**

Completed schedules should be despatched weekly to your Region.  
Documents should be tagged as follows:-

### **Short interviews**

#### **Calls and outcome sheet**

- A sift schedule**
- F check card**
- C green schedule**
- D self-completion schedule**

### **Long interviews**

#### **Calls and outcome sheet**

- A sift schedule**
- F Check card**
- B yellow schedule**
- D self-completion schedule**

Any proxy interviews (short or long) will, of course, not include the F check card or the self-completion schedule.

(If you come across any multi-households, there should be a C&O sheet for each household. Please also enclose your listing of all households at the address on a pink multi-household form. Remember we are taking all households at a multi-household address, so ignore the column on the form which tells you which households to select).

Recall cards (E) should not be sent in with completed schedules, as they have identifying address information on them. Recall cards should therefore be sent in a separate envelope to your Region. They should also be despatched at least twice a week as we need to pass on any for follow-up interview quickly.

## 11.5 Claims

All work on the survey should be claimed under survey number 1361.  
Stage codes are as follows:

Quota A : code 01  
Quota B : code 02  
Quota C : code 03  
Quota D : code 04

Study time: 4 hours

Admin time: 5 hours per quota of 45 addresses for planning the quota, filling in calls and outcome sheets and despatching work.

Clerical time: 5 hours per quota for occ and ind coding, checking all documents have correct serial number, checking buff card F.

## 11.6 Contact with the office

Field	Anne Klepacz ext 2158
	Richard Whitehouse ext 2274
Research	Howard Meltzer ext 2192
	Baljit Gill ext 2288
Sampling	Dami Lawall ext 2352

## Survey of Health and Well-Being Appendix to Interviewers' Instructions

### Definitions and descriptions

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#### **Physical and mental health problems**

You may sometimes have difficulty deciding whether a health problem is mental or physical in nature.

Mental health problems do not include mental handicap. Similarly neurological problems are physical conditions and should not be confused with 'nervous' problems. Common neurological problems are:

Epilepsy, Cerebral Palsy, Neuralgia, Myalgic Encephomyelitis (ME, Post Viral Syndrome), Muscular Dystrophy, Multiple Sclerosis and Motor Neurone Disease.

Generally, if you are unsure whether a problem is mental or physical, you should assume it is mental so that we do not risk losing information about any mental health problems.

#### **Definitions and description of symptoms in sections A to N of schedule A**

##### **Somatic symptoms**

These symptoms can be any ache, pain or bodily discomfort which the informant attributes to feeling low, anxious or stressed. They also include any aches, pains or discomfort which are made worse by feeling low, anxious or stressed.

##### **Fatigue**

This refers to the feeling of tiredness, fatigue or loss of energy. It does not refer to the pleasant or muscular tiredness which can result from physical exertion.

##### **Concentration or forgetfulness**

These refer to the ability to fix one's mind and the tendency to forget things. Poor concentration and forgetfulness are relatively common symptoms. Naturally, there are problems with remembering whether one has forgotten something.

### **Sleep problems**

We are interested in people who could not sleep when they were trying to. People who did not get enough sleep simply because they stayed up too late or had to get up too early do not have a sleep problem.

We are also interested in people who feel they have been sleeping for too long and regard this as a problem.

Abnormal sleeping times are not necessarily regarded as a problem.

### **Irritability**

This refers to feeling short-tempered or 'snappy' towards people or feeling angry over things even if this does not show. Sometimes people feel that the anger they are experiencing is a justifiable result of provocation. Most will not regard this as feeling short-tempered or angry. Hence, people are asked whether they felt short-tempered or angry about things which seem trivial when they look back on them.

### **Depression**

This refers to feeling sad, miserable or depressed and whether people have been feeling able to enjoy themselves as much as usual (or at all). It involves feelings of guilt, inadequacy and hopelessness which are sometimes so overwhelming that the person feels suicidal.

### **Worry**

This is the complaint of repetitive and unpleasant preoccupation with something which is upsetting or anxiety provoking. The person is aware of what is making them upset or anxious. This is what distinguishes worry from anxiety (see below). People who say they are 'concerned about things' are not regarded as worrying.

### **Anxiety**

Anxiety is meant to refer to physical tension and mental nervousness where a person is not aware of the content of the anxiety provoking ideas in his/her mind. Anxiety and worry can be present at the same time.

Anxiety can be caused by a specific thing or situation, that is as a result of a phobia (phobic anxiety) or it may occur without an obvious precipitant ('general anxiety'). Again, both types of anxiety can be present at the same time.

### **Phobia**

This is the dread or uncontrollable fear of some thing or situation where the informant regards the fear as irrational i.e. there is no real danger. Hence, a person does not have a phobia if he has a fear of going out of the house at night and thinks that there is some real danger, or significant risk of danger, attached to this

Sometimes people deliberately avoid the things or situations which they have a phobia about. Consequently they do not report any anxiety caused by these things or situations within the reference period of the survey. To this end, specific questions about avoidance of such things or situations are asked

### **Panic**

This is the name given to extreme levels of anxiety accompanied by a variety of symptoms such as the heart racing or pounding, hands sweating or shaking, and feeling dizzy. Sometimes the panic is a result of phobic anxiety when a person encounters the thing or situation which he/she dreads.

### **Compulsions**

These are repetitive acts performed by a subject though they are regarded as unnecessary. These are most commonly checking that doors or windows are locked, that gas or electrical appliances are turned off. These compulsive acts may occur at work, for instance, in checking work over and over again. Sometimes people compulsively make sure they are clean by continually washing themselves.

People are aware that the thing which they are doing compulsively comes from an urge to do so from themselves and not because of some external reason. For instance, a person who checks the door is locked because she thinks the door has been opened since last checking is not counted as having a compulsion. However, the person who checks the door is locked who knows that the door has not been opened since he last checked it, does have a compulsion.

The subject has to decide whether he/she thinks the act which they have been repeating was done so unnecessarily or whether there was good reason.

## **Obsessions**

These are repetitive unpleasant or distressing thoughts. They are sometimes difficult to distinguish from worry. However, an obsession is the same single thought over and over again which is different from worrying about and around some anxiety provoking subject.

The difference between an obsession and a compulsion is that obsessions are repetitive thoughts while compulsions are repetitive acts. The two can be present at the same time.

## **Psychoses**

Psychoses produce disturbances in thinking and perception that can not be explained as responses to experience and are severe enough to distort the person's perception of the world and the relationship of events within it.

Psychoses are normally divided into two groups. organic psychoses and functional psychoses. Organic psychoses comprise illnesses such as dementia and Alzheimer's disease. These are not covered in this survey. We concentrate on functional psychoses which mainly cover schizophrenia and manic depression

## **Schizophrenia**

Schizophrenia is a most devastating mental illness. It is characterised by several distinctive alterations in mental experiences, modes of thinking and mood. The most characteristic disturbances occur during the active phase of the illness and take the form of hallucinations, delusions and altered behaviour towards others

Hallucinations and delusions are the most outstanding schizophrenic mental experiences. Auditory hallucinations are the most common. Thus, hearing ones thoughts aloud, or hearing voices commenting on one's every action or several voices engaged in conversation are most common. Normally the voices are being derogatory or giving praise and the person is talked about in the third person.

Commonly, schizophrenics have delusions about bodily control. The person feels that he is under the control of some outside force making him behave as a robot with no will of his own. He may feel hypnotised and feel forced to make particular movements, speak in a special voice, or walk in certain areas. The person feels that these thoughts come to him as penetrating waves from electronic or electrical equipment

Schizophrenics may experience changes in their thinking, particularly that their thoughts are disrupted by some outside agency, thoughts are withdrawn from their mind and other thoughts inserted into it.

Particularly noticeable in schizophrenics is their abnormal language. Characteristically they are difficult to understand. Their thinking is expressed in a vague or awkward fashion with words poorly chosen and ideas poorly related to one another. No effort is made to correct vagueness or lack of clarity in thought.

Another prominent disturbance is emotional expression. Schizophrenics may seem distant, unresponsive and cold. Often what is said is incongruous with the facial expression.

### **Manic-Depressive Psychosis**

The essential feature of manic depression is an excessive disturbance of mood and self-appraisal. Manic depression tends to be episodic with periods of elation (mania) or sadness (depression) interspersed with periods of apparent mental health varying in length from weeks to years.

During an attack of depression, the person complains of being miserable and unsure of himself. Evidence is given for this by means of a dejected appearance or by being restless or easily distracted. Not only is there feeling of sadness or misery but also low self-esteem: feeling inadequate, incompetent, worthless and blameworthy.

The most worrisome feature of the depressed person is inclination to suicide stemming from their attitudes of hopelessness and despair.

People with depression often suffer from disturbances in sleep, particularly waking early in the morning and being unable to return to sleep. Also they may have aches and pains, loss of appetite, constipation and weight loss.

Manic symptoms are almost the exact opposite of those seen during an attack of depression. People during an attack of mania say they are in excellent spirits, feel well, never felt better. They are active, restless, energetic and quick-witted; overbearing, over-confident and pompous. The restlessness and energy progress to hyperactivity. The person makes lots of plans, many of them implausible.

Manic people exhibit disturbed social behaviour. They have increased sexual interest and may become promiscuous. They tend to overspend and become reckless with money.

### **Neurotic Depression and Psychotic Depression**

In the private household survey you were told that depression is not a psychotic but a neurotic illness. Indeed, 98% of people who say they are depressed are suffering from neurotic depression. However, there are psychotic forms of depression which are much more severe (eg endogenous depression). Some of the people in this supplementary sample may have this form of psychotic illness.