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SAMARITANS INFORMATION SHEET

Mental Health Problems and Suicide

Contents

This information sheet concerns certain conditions which come under the heading of mental illness or disorder. Substance abuse can be included under this heading but is not included in this briefing as it has been explored in 'Key Facts: Alcohol and Other Substance Abuse' [1].

There is a brief description of some of the terms mentioned in this information sheet at the end of the document.

For a more detailed review of depression, we have prepared a separate Information Sheet: Depression and Suicide

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1. Overview

- Mentally ill people are not an homogeneous group of the sick in a healthy society. [2]
- 4.4% of the UK population report symptoms suggesting a personality disorder, 3.4% of women and 5.4% of men. 0.6% of men and 0.5% of women reported symptoms which indicated probable psychotic disorder [3].
- There were no significant trends in the prevalence of symptoms of mental health problems in adults in the UK measured between 1993 and 2000. [3]
- Research shows that suicide risk is raised for virtually all mental health problems and substance abuse. Suicidal thoughts and behaviour, both past and present, increase the risk even further. [4]
- 90% of people who die by suicide are thought to have one or more diagnosable mental health problems at the time they kill themselves. [5]
- Major depression, anxiety states and schizophrenia and are most highly associated with suicide, with relative risks of 20, 8.5 and 6 times higher than that observed in the general population respectively. [4]
- It is very difficult to assess the risk of suicide in any one person, however a National Confidential Inquiry into suicide in those with mental illness throughout the UK found that 17% of suicides were preventable if better care and services had been available. [6]

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2. Descriptions and Definitions

- A useful definition of mental illness is: clinically recognisable patterns of psychological symptoms or behaviour causing short or long-term ill health, personal distress or distress to others. [2]

- Neurotic disorders (includes depression or anxiety disorders) – these are characterised by a variety of symptoms such as fatigue and sleep problems, forgetfulness and concentration difficulties, irritability, worry, panic, hopelessness, obsessions and compulsions. These are classified as neurotic disorders if they are at a level which causes problems with daily activities and distress. [3]

- Psychoses are disorders which produce disturbances in thinking and perception that are so severe that they distort the person's perception of the world and the relationship of events within it. Delusions and hallucinations are examples of this type of distortion. Psychoses are normally divided into two groups – organic, such as Alzheimer's disease and functional, such as schizophrenia and bipolar disorder (also called manic depression). [3]

- Hazardous alcohol use is a pattern of drinking carrying with it a high risk of damage to health in the future. [3] UK recommendations are that women should drink not more than 3 units of alcohol per day (with a weekly total not exceeding 14). The corresponding figures for men are 4 and 21. Is there anything to contextualise what this means to the person in the street – e.g. more than three units of alcohol each day or, regularly exceeding the recommended weekly limit?

- Schizophrenia involves the coherence of the personality. It can cause people to hallucinate, develop feelings of bewilderment and fear, and to believe that their deepest thoughts, feelings and acts may be known to, or controlled by others. [7]

- Affective or mood psychosis causes profound changes in mood, either to severe depression with reduction in levels of activity or elation with over activity (this includes bipolar affective disorder or manic depression). [7]

- Depressive disorder or depression is where symptoms such as low mood, loss of interest, reduced energy, suicidal ideas, sleep and appetite disturbance exceed 'normal' mood fluctuation. [7]

- Anxiety states include phobias and panic disorders where the symptoms of anxiety eg worry, tension, over-breathing, giddiness etc cause significant distress and/or disability. [7]

- Dementia leads to decline in intellectual functioning and memory caused by diseases of the brain such as Alzheimer's and Vascular (blood vessel) disease. [7]

- Eating disorders include anorexia nervosa, where severe weight loss occurs, and bulimia nervosa, both of which involve fear of fatness with under and over eating. [7]

- Personality disorders involve deeply ingrained and enduring behaviour patterns, appearing as

inflexible responses to a broad range of personal and social situations. They may be associated with distress and problems in social functioning. [7]

3. General Prevalence

- Mentally ill people are not an homogeneous group of the sick in a healthy society. Rather, mental ill-health can be thought of as a continuum ranging from minor distress to severe disorder of mind or behaviour, along which patterns of, even temporary, symptoms fit the definition of an 'illness'. [2]

- The most common disorder is mixed anxiety and depressive disorder (8.8%), followed by generalised anxiety disorder (4.4%) and then depressive episode, obsessive-compulsive disorder and panic disorders ranging from 2.6% to 0.8% of the population. [3]

- Approximately one quarter (24%) of people assessed as having a neurotic disorder were receiving treatment of some kind for a mental or emotional problem. 20% were taking medication; 9% were having counselling or psychotherapy and 4% were receiving both types of treatment. [3]. Neurotic Disorders is another name for Anxiety Disorders a category that includes specific conditions such as: Panic Disorder, Agoraphobia, Social Phobia, Acute Stress Disorder, Post Traumatic Stress Disorder and so on.

- 4.4% of the population in the UK? reported symptoms suggesting a personality disorder, 3.4% of women and 5.4% of men. [3]

- 0.6% of men and 0.5% of women reported symptoms which indicated probable psychotic disorder [3] in the UK

- 85% of those assessed as having a probable psychotic disorder were receiving treatment. [3]

- In addition, in 1994 about 33,200 adults aged 16 to 64 were permanently resident in accommodation for people with mental health problems in Great Britain. About two thirds suffered from schizophrenia and delusional disorders. [8]

- People with one mental health problem are at risk of developing another, eg schizophrenia is often linked with depression, and alcohol or drug abuse may be an individual's way of coping with the distress of severe anxiety or depression. [2]

- Levels of mental illness (depression, substance abuse, schizophrenia, etc) are particularly high in homeless people. [9]

4. Age and Sex Differences

- Women were more likely to report significant symptoms of neurotic disorder (18%) compared with men (12%). However, men were more likely to report hazardous levels of alcohol consumption (38%) and some level of alcohol dependence (11.9%) compared with 15% and 2.9% of women respectively [2]. Excessive drinking is thought by some to be a symptom of "masked" depression, particularly in men. [10]

- The lowest rates of any neurotic disorder were found among older people aged 65 to 69 (10.2%) and 70 to 74 (9.4%) [3]

- The highest rates of neurotic disorders were among those aged 40 to 54, at 20%. For men the highest rate was in the 45 to 49 age range (20.4%) and for women the peak was in the 50 to 54 year group (24.6%). [3]

- The prevalence of any type of personality disorder was 5.4% for men and 3.4% for women. [3]

- The prevalence of any psychotic disorder (mostly schizophrenia or bipolar disorder) was 0.5% in women and 0.6% in men. [3]

5. Trends

- There were no significant differences between prevalence of symptoms of mental health problems in adults in the UK measured between 1993 and 2000. The largest difference was been those reporting problems sleeping – 21% of men and 28% of women in 1993, compared with 24% in men and 34% in women in 2000. [3]

- There was, however, a slight but significant difference in neurotic disorder in men, at 12.6% in 1993 rising to 14.4% in 2000. [3]

- The overall prevalence of psychotic disorder remained the same between 1993 and 2000, at 0.4%. [3]

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6. Mental Health and children

- A national survey covering Great Britain in 1999 found that just under 10% of children aged between 5 and 15 had mental health problems. Boys were more likely than girls to have problems, both in the younger children aged 5 to 10 (10.4% of boys and 5.9% of girls) and the 11 to 15 age group (12.8% of boys and 9.6% of girls). [11]

- Nearly 10% of white children and 12% of black children were assessed as having a mental health problem whereas the prevalence rates among asian children were 8% of Pakistani and Bangladeshi and 4% of the Indian children surveyed. [11]

7. Mental Health and ethnicity

- A UK national survey of psychiatric morbidity in 2000 examined the prevalence of symptoms of mental health problems among ethnic groups, classifying them as white, black, south asian and 'other'. South Asian adults (19.2%) and those in the classified as "other" group (20.4%) appeared to have higher rates of prevalence for most neurotic disorders than their white counterparts (16.3%), while black adults appeared to have lower rates than both groups (14.1%) but the results were not statistically significant. [3]

- The only minority ethnic group among whom psychotic disorder was observed at all was the black group (1.8%). Compared to men who classified themselves as white, prevalence of functional psychosis (mainly schizophrenia or bipolar disorder) appeared to be three times greater (0.6% and 1.8% respectively). A similar pattern was found among women but the results were not statistically significant. [3]

- Among interviewees that stated that they were depressed, the Indian/African, Asian and Pakistani groups had similar rates of *suicidal thoughts* as the white group. This was true across gender and age groups. This is in contrast to other research studies which have found a high rate of *suicide* among young South Asian women. [12]

- Also among interviewees that stated that they were depressed, the Caribbean and white minority groups had the highest incidence of suicidal thought, with the Caribbean 16-24 year olds rate almost double the other Caribbean age groups and almost triple the white group in this age range. [12]

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8. Suicide Risk - General

- Research shows that suicide risk is raised for virtually all mental illnesses and substance abuse. Suicidal thoughts and behaviour, both past and present, increase the risk even further. [4]

- The association between mental health problems and suicide has been assessed by 'psychological autopsy' techniques, which have shown 90% of those dying by suicide to have one or more psychiatric disorders at the time they kill themselves. [5]

- People with severe mental health problems are less likely to be employed or married and the illness itself may cause social isolation. All these factors by themselves are associated with increased risk of suicide. [2]

- Another, somewhat circular, definition of people with mental disorder is those who have received psychiatric care - whether in-patient, involuntary commitment, long-stay, etc. Studies show that treatment within a psychiatric setting is consistently associated with high suicide risk - up to 39 times for those admitted involuntarily. Those recently discharged and recently admitted are at especially high risk. [4]

- A retrospective study of people who had died by suicide having been admitted to psychiatric care at some point in the previous five years, showed that communicating ideas of suicide was a very strong indicator of suicide risk. [13]

- People with mental health problems may remain at high risk of suicide for some time after they appear to be well. Care should be maintained for up to a year after a person at high risk of suicide is thought to have improved since this is the period when they are most in danger. [14]

- Suicide rates within the UK are reasonably similar in England, Wales and Northern Ireland but are higher in Scotland. Suicide rates in England are among the lowest in the European Union

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9. Suicide Risk - Specific Disorders

- Several studies show that **schizophrenia** is associated with a suicide risk which is 8.5 times higher than that observed in the general population. Suicide appears to be most common in those under 30 years of age, and the risk is highest in the first year following diagnosis. [4]

- The risk of those who have survived the initial phases of **schizophrenia** is lower, one study showed it to be 1.3 times the expected risk in contrast with 20.7 times for the acutely ill. [15]

- Studies show that **bipolar disorder** (or manic depression) incurs an average suicide risk which is 15 times that of the general population. The risk of suicide is increased by a past suicide attempt and alcohol abuse. [4] Lithium is a treatment which is shown to lower the risk of suicide. [16]

- Research involving people diagnosed with **major depression** shows that they have a 20-fold increased risk of suicide. The risk is highest in the first few weeks following discharge from hospital. [4]

- **Less severe forms of depression** show a reduced suicide risk. For people diagnosed with major depression, the lifetime risk of suicide may be as high as 6% [17], although this figure may be more applicable to those who have been admitted to hospital as a result of depression. For people seen as outpatients or treated by GPs, risks are much lower [18]

- Through retrospective examination of people who have killed themselves, 70% of recorded suicides are judged to have been by people experiencing **depression**. [19]

- **Older depressed** people may be at higher risk of suicide. One study found a risk which was 35 times higher, and which persisted over many years. [20]

- **Anxiety** states also show higher suicide risk. One study which looked at 'anxiety neurosis' showed a risk which was six times higher than the overall population, combining studies which have looked at anxiety, agoraphobia, obsessive-compulsive disorder and panic disorder shows that anxiety states in general have a 10-fold increased risk of suicide. [4]

- Studies on **personality disorders** showed that people who had received psychiatric in-patient treatment for this problem (therefore had a severe problem) were at seven times the expected risk of suicide. [4]

- **Personality disorders** have also been found to be common in people who have been seen at hospital for self-harm. [21]

- Studies on people referred to medical or psychiatric departments with **anorexia nervosa** show that they are at 23 times the risk of suicide in comparison to the overall population. 97% of those studied were women. Studies on bulimia nervosa have samples sizes too small to be statistically meaningful. [4]

- There have been few studies on suicide risk of people with **dementia**, usually Alzheimer's

disease. Those that do exist show that there have been no suicides amongst this group. There is the suggestion that people who have recently been diagnosed with dementia and still have some insight may have increased suicide risk, but there is no research to date to prove or disprove this theory. For those in later stages of the disease, impaired competence may be protective from suicidal thoughts. [4]

10. Learning Difficulties

- Learning difficulty is classified as a mental disorder under the International Classification of Diseases, although the Mental Health Foundation argues that in itself, a learning difficulty should not be regarded as a mental illness [1]. The category includes conditions such as Down's Syndrome. Studies show that there is no increase in suicide risk associated with learning difficulty. [4]

11. Care/support

- A study of people who were receiving treatment for mental illness found that reduction of care (including a reduction in supervision and a cut in drug dosage) was strongly related to risk of suicide, even when the reduction had been initiated by the patient, and the care profession had thought that the patient was improving. [14]

- The study found that only 34% had an identifiable key worker, which is an important factor in the Care Programme Approach, introduced in 1991 for vulnerable patients. However this proportion was also the same for those patients who did not go on to kill themselves, indicating how difficult it is to assess suicide risk in individuals. [14]

- It is very difficult to assess risk of suicide in individuals, however a National Confidential Inquiry into suicide in those with mental illness throughout the UK found that 17% of suicides were preventable if better care and services had been available. [22]

- From an earlier study in 1991, Appleby stated that "the feature which most strikingly distinguished suicides in people with mental illness was disturbed relationships with hospital staff resulting in premature discharge." [23]

- The National Confidential Inquiry [22] has recommended "Twelve Points to a Safer Service" to address policy and practice in mental health care; these points concern issues such as
    - staff training every three years;
    - targetting the most vulnerable (eg severe mental illness, or having a history of self-harm or violence);
    - maintaining contact with vulnerable people including follow-up after discharge; ensuring coordination between mental health and substance abuse services;
    - actions if a person fails to attend or does not take their medication;
    - prompt access to help in crisis for service users and their carers;
    - practical issues such as reducing the access to means of suicide for people in hospital and in the community;

- an audit or enquiry into any events such as self-harm or suicide to involve patients and families.

- Indicators of mental health and well-being (rates and types of mental health problems and rates and types of suicidal behaviours) show considerable differences between men and women. It is now being recognised that mental health services could have a part to play in addressing gender relations, for both users of services and for providers, although this has not yet been reflected to any large extent in national strategies. [24]

12. Government initiatives

- The White Paper, 'Saving lives: Our Healthier Nation', includes mental health as one of its 4 key areas. It sets out the action to be taken by health and social services to deliver their contribution to the target for mental health, which is a reduction in the suicide rate by at least one fifth by 2010. [25]

- In England, the Department of Health has published a national strategy to support the target set in the White Paper 'Saving lives: Our healthier Nation'. This is to be delivered by the National Institute for Mental Health in England (NIMHE). [26]

- The strategy identifies six goals which include a reduction of risk of suicide in key high risk groups, which include people who are currently, or have recently been, in contact with mental health services. It identifies that in England, there are on average 1,200 deaths by mental health service users per year, and a 20% reduction would mean 240 fewer deaths per year. [26]

- Other goals include the promotion of mental well-being in the wider population, reducing the access to means of suicide, improving reporting of suicidal behaviour in the media, promoting research and better monitoring of progress toward the target. [26]

- In 2002, the Scottish Executive published a national strategy to tackle the rising rate of suicide in Scotland. The strategy sets a target to reduce the Scottish suicide rate by 20% by 2013. This is a key part of its National Programme to Improve Mental Health and Well-Being. The National Programme's aims include
  - Increasing public awareness and understanding about the need for positive mental health and well-being
  - Taking action to address risk factors and 'at risk groups'
  - Working to eliminate stigma and discrimination against people with mental health problems.
  - Improving services by ensuring early identification of problems and early intervention and support.
  - This approach includes children and older people. [27]

- The government have produced a National Service Framework for Mental Health, which focusses on the mental health needs of adults of working age, up to 65. The framework has a number of guiding values and principles, including the involvement of service users and their carers in planning and delivery of care, the promotion of joint working between agencies that deliver care, including health and social care services as well as the voluntary sector, and ensuring that care is well-suited to service users' needs and non-discriminatory. [28]

- The framework sets out seven national standards for care provided by health and social services which cover five areas:
  - Mental health promotion
  - Primary care and access to services
  - Effective services for people with severe mental illness
  - Caring for carers
  - Prevention of suicide. [28]

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