Mental Health and Illness in Greater Glasgow
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SUMMARY

MEASURING MENTAL HEALTH AND ILLNESS IN GREATER GLASGOW

- A comprehensive description of mental health and illness requires information from several different sources.
- This report combines community surveys, estimates of general practice work, psychiatric and general hospital admissions and suicide rates to describe mental health in the Greater Glasgow area.
- Its aim is to give a broad overview of mental health problems rather than a detailed study of particular conditions.
- Measures of use of existing services cannot indicate where unmet needs lie.

MENTAL HEALTH PROBLEMS IN GREATER GLASGOW

There is a serious lack of accurate measures of the number of people with particular mental health problems living in Greater Glasgow. There are, however, some clear patterns.

- Women report mental ill-health in the community more than men.
- Neurotic disorders are about 40 times more common than psychotic disorders.
- Most types of serious mental health problems are more common in the most deprived parts of Greater Glasgow.
- Problems relating to alcohol and drug misuse are widespread and becoming more common.
- Suicide rates among younger men have been rising slowly in recent years.
- There is an apparently rising prevalence of mental health problems in children and adolescents. This suggests a need for both increased health services and collaborative action with education and social services.
- People with learning disabilities have particular needs for physical and mental health services - current provision of services and their use by this group needs to be better understood.

MENTAL ILLNESS IN THE COMMUNITY, THE HEALTH CENTRE AND THE HOSPITAL

- Among people living in the community neurotic disorders (anxiety, depression, panic attacks, etc.) are about 40 times more common than psychotic disorders (schizophrenia, manic depression, etc) - 160 per thousand versus 4 per thousand.
- Among people attending GPs, neurotic disorders are about 25 times more common than psychotic disorders. Depression and anxiety account for an estimated 73% of all consultations for mental health problems in general practice in Greater Glasgow. General practice consultations for most mental illnesses are much more common in women. Consultations for depression, anxiety and schizophrenia are much more frequently made by people living in the most deprived areas.
- Reflecting their greater severity, psychotic disorders are about twice as commonly the reason for admission to psychiatric hospital in Greater Glasgow than neurotic disorders.
Mental Health and Illness In Greater Glasgow

MENTAL ILLNESS & GENDER

Overall psychiatric hospital admission rates in Greater Glasgow are identical for males and females. However, more women than men are admitted for self-poisoning, depression or dementia. Men have much higher rates of admission for schizophrenia and drug and alcohol related emergencies and they are 3.5 times more likely to commit suicide.

MENTAL ILLNESS AND AGE

Each form of mental illness has its own distinctive age profile which may be different for men and women. The peak ages in Greater Glasgow for a range of important conditions are shown here. There is no clear peak age for severe depression.

MENTAL HEALTH AND DEPRIVATION

For most mental health problems in Greater Glasgow there is a strong link with deprivation. Compared with people living in the most affluent areas, people living in the most deprived areas are 2.7 times more likely to be admitted for depression, 3 times more likely to commit suicide, 4.5 times more likely to be admitted for self-poisoning, 6 times more likely to be admitted with schizophrenia, 10 times more likely to be admitted for an alcohol related problem and 33 times more likely to be admitted for a drug misuse related problem. Dementia is the main exception, where no link is apparent.

NOT ONE PROBLEM BUT MANY

In Greater Glasgow, there is considerable overlap between mental illness and drug misuse and dependence. A high proportion of people in prison or who are homeless are mentally ill or have drug problems, or both.
DRUG MISUSE AND DEPENDENCE IN GREATER GLASGOW

- Drug misuse and dependence have a major influence on mental health in Greater Glasgow.

- In the Greater Glasgow area there are an estimated 210,000 smokers, 33,000 people drinking more than twice the recommended upper limit and 7-10,000 poly-drug users.

- Similar numbers of men and women smoke, but heavy drinking and drug injecting are more common among men.

- Smoking is now much more common in the most deprived areas of Greater Glasgow than the most affluent. Dependence on nicotine is a key factor in preventing many people from stopping smoking.

- Rates of hospital admission for alcohol or drug misuse related problems are 10 times and 33 times more common respectively among people living in the most deprived parts of Greater Glasgow compared with the most affluent.

- Many people with mental illness misuse alcohol or other drugs which may further increase their difficulties.

- Problem drinking and polydrug misuse are a frequent cause of severe mental distress, not only for the user but for his or her family and the wider community.

HOMELESSNESS AND MENTAL HEALTH

A national survey of homeless people revealed high levels of mental illness and alcohol and drug dependence. Accurate figures on the mental health of homeless people in Greater Glasgow are lacking, pointing to the need for a systematic assessment of need in this especially vulnerable group.

HEAD INJURY AND MENTAL HEALTH

A recent survey has been conducted of 3,000 people who had sustained a head injury in Greater Glasgow over one year. It was found that, even among those with a relatively mild injury, disabling mental health problems were still common one year after the injury. Few had sought or obtained help from health or social services for these problems.

MENTAL HEALTH NEEDS OF ETHNIC MINORITY COMMUNITIES

Around 3.3% of people in Greater Glasgow originate in the Indian-subcontinent or China. Smaller numbers of residents originate in other parts of the world and students come from many countries. There are no reliable data to indicate whether or not mental health problems are more common among ethnic minorities than the general population in Greater Glasgow. A recent survey of a sample of users and carers from the Pakistani, Chinese and Indian communities revealed large differences in perceptions of mental illness. Differences in communication with service providers because of language and cultural differences were frequently reported.

MENTALLY DISORDERED OFFENDERS

Compared with the general population, a high proportion of people charged or convicted of criminal offences have mental illness, learning disability or drug or alcohol dependence. A prevalence of psychosis of 7-14% was found in a recent survey of prisoners in England and Wales. At least 30% of prisoners in many Scottish prisons have a current or past history of drug injecting. Greater Glasgow Health Board is now implementing a comprehensive strategy designed substantially to improve the treatment of mentally disordered offenders whilst ensuring public safety.
POST-NATAL DEPRESSION
A study of post-natal depression among women giving birth in Greater Glasgow in 1997 has recently been reported. Of the 1100 women assessed, 26% had evidence of post-natal depression. Higher rates of depression were found among women with a previous history of depression, those who had had at least three previous births and current smokers. Further work is required to assess the effectiveness of the service response.

SEXUAL, PSYCHOLOGICAL AND PHYSICAL ABUSE
Abuse in a variety of forms can have important adverse effects on the mental health of both children and adults. The consequences will vary according to the nature, circumstances and duration of the abuse. It is estimated that about 47,000 women and 27,000 men living in Greater Glasgow may have experienced sexual abuse as a child. It is also estimated that around 30,000 women in Greater Glasgow may have experienced domestic violence from a male partner in the past year.

TREATMENT AND CARE
The need for treatment and care of people with mental disorders varies enormously according to each individual’s problems and circumstances. Important factors include the type, severity and duration of the mental health problem and its effects on the individual and his or her family. Factors which are often important in causing or worsening the mental health problem, or impeding recovery, include marital breakdown, unemployment, poor accommodation, physical illness, physical or sexual abuse and financial or legal difficulties. This section summarises the types of health service treatment available and underlines the importance of addressing social problems. A notable change in the last five years has been the large increase in the prescription of antidepressants and the steady decline in the use of tranquillisers. Treating drug or alcohol dependence often involves lengthy and repeated interventions, with relapse being frequent. Well organised services can however, achieve very worthwhile improvements.

THE WAY FORWARD
Given the links between poor mental health and social deprivation, substantial improvements in mental health would seem unlikely without addressing social inequalities and improving the standards of housing, education and employment in deprived areas. The need for close cooperation between a wide variety of agencies is of paramount importance. The growing impact of drug misuse on mental health is an inescapable aspect of life in Greater Glasgow today.

This report has identified a number of areas of unmet need. However, our understanding of mental health in Glasgow remains incomplete and, for many aspects, uncertain. More research is required to ascertain the number of people with particular mental health problems and their needs, and to assess the effectiveness of existing services.
1. WHY IS MENTAL HEALTH IMPORTANT?

1.1 Mental health is precious. Without it, the happiness we all seek is difficult or impossible to achieve. Feeling content with the present and optimistic about the future; being able to think clearly and remember important things; being free from fear, anxiety or irrational thoughts; sleeping well: these are some of the basic elements of good mental health. As we all know, such a state can be difficult to achieve and all too easy to lose. It depends on many factors including family background, past experiences, physical health, current surroundings, employment and income and relationships with others. Good mental health can suddenly be wrecked by an accident, an assault or a bereavement; it can be gradually washed away by years of heavy drinking; or it can vanish inexplicably as a serious illness such as severe depression, schizophrenia or dementia develops. When this happens, life can literally fall apart, resulting in misery not only for the individual but also usually for his or her family and friends and sometimes for the wider community. Finding a way back is often difficult and may feel impossible alone. The help of loved ones and of skilled professional and other carers at the right time and in the right measure can make all the difference between continued despair and recovery. Getting a job, overcoming financial problems or moving to a new area may often be part of the solution.

1.2 Promoting and protecting good mental health and treating mental illness when it occurs are top priorities for the Scottish Health Service and for Greater Glasgow Health Board. The Government has reaffirmed its commitment to improving mental health in its recently published White Paper, “Towards a Healthier Scotland”. This important report recognises the way in which an individual’s life circumstances and behaviour can interact to the detriment of their physical and mental health. In the “Framework for Mental Health Services in Scotland”, published in 1997, the Government has provided a clear structure within which local services can be developed, with a particular emphasis upon helping people with severe and enduring mental illness. Within Greater Glasgow, a Mental Health Framework Steering Group has been established involving the Health Board, the Primary Care Trust and representatives of each of the six local authorities within Greater Glasgow. The aim of the Steering Group is to oversee a coordinated improvement of mental health services in the area. The Government’s White Paper on renewing the NHS in Scotland, “Designed to Care”, describes how health services will be organised in future and how mental health services in particular will fit into the new arrangements.

1.3 In its Health Improvement Programme, the Health Board has explained in some detail how it intends to work towards improving the health of the people of Greater Glasgow and making the best use of the resources available to it. The Health Board recognises that achieving and maintaining good mental health is not simply a matter of providing good health
services. Working with others to diminish environmental, economic and social problems is crucial. National and local government and the business sector have key roles in creating employment and wealth and enabling it to be used for the wellbeing of the community as a whole. The criminal justice system is essential in ensuring our security and protecting our rights, without which anarchy would reign. Education helps us to understand the world, to communicate and develop skills. Religious bodies can invest life with greater meaning and purpose. The arts and media enrich and inform. The transport system takes us where we want to be. These are some of the essential ingredients of a peaceful society that can support families and friendships and enable its members to fulfill their hopes and dreams. There is much to be done!

1.4 Against this backdrop of major change and development, this report examines what we know and what we don’t know about mental illness and other mental health problems in Greater Glasgow. What are the main problems? How much mental illness is there? Who are most likely to be affected? Why might they be affected? What are the main gaps in our knowledge? What can be done to treat mental health problems and help those affected by it? It then looks ahead and considers what might be done better to protect mental health and care for people with mental health illness.
2. MEASURING MENTAL HEALTH PROBLEMS IN GREATER GLASGOW

ASSEMBLING A PICTURE OF MENTAL HEALTH PROBLEMS

2.1 There is no single measure of the mental health of an individual nor of a population. Much like a jigsaw puzzle, the picture of mental health in Greater Glasgow must be assembled from a many small pieces. Although several are missing, when all the available pieces are put in place we should get a good idea of the whole picture.

In this report, several similar terms are used. They are defined here and, as far as possible, are used consistently throughout.

Mental health  an individual’s overall state of mental functioning, sense of wellbeing and capacity for learning and development

Mental illness  a condition resulting in a definite change to an individual’s mental health compared with their previous mental state, to which a medical diagnosis eg. depression or schizophrenia can usually be applied.

Mental health disorder  includes mental illness and other behavioural or emotional states that are clearly abnormal or distressing to the individual eg. personality disorder or substance intoxication, and which may be either long-standing or short-lived.

Mental health problems  encompasses all problems that have a negative effect on an individual’s mental health including eg. bereavement, post-traumatic stress, sexual dysfunction or financial worries.

A number of medical terms are used to describe mental illness and disorders. The six main types of disorder are:

Psychosis, neurosis, dementia, personality disorder, addiction and learning disability.

Psychoses  are conditions that seriously affect mental functioning and may result in hallucinations, delusions and irrational thoughts, for example about being controlled or persecuted. The most common are schizophrenia and manic depression.

Neuroses  include anxiety, sleep disturbance, depression, phobias, panic attacks, obsessions and compulsions and reactions to severe stress. They are generally less severe and disabling than psychoses.

In dementia  there is a serious loss of mental functioning including memory, language and judgement due to the death of brain cells. It is usually progressive and irreversible and mainly affects older people. The commonest form is Alzheimer’s disease.

Personality disorder  is a pattern of behaviour or experience resulting from a person’s particular personality characteristics leading to distress or suffering to that person or others.
Addiction or dependence is a persistent uncontrorollable desire to take a drug or other substance (or engage in a particular behaviour), usually accompanied by unpleasant symptoms if the substance or behaviour is discontinued.

Learning disability, previously known as mental handicap, is an impairment of mental ability since birth or infancy.

Organic disorders are those where there is evidence of brain damage usually caused by external agents.

Functional disorders are those where there is no evidence of brain damage.

Affective disorders are those leading to an alteration in mood e.g. depression or mania.

**Sources Of Information**

2.2 Our description of mental health in the Greater Glasgow area is built up from several sources, including people’s self-reported symptoms, information from GP consultations, hospital activity and death certificates. From these data, several important conditions have been chosen to represent the major mental health problems. It is appreciated that many areas of special need are included within broad diagnostic groupings but the aim of this report is to provide an overview of mental health, not to displace experts’ local understanding of specific problems.

All measures of mental health that involve the use of mental health services - for instance, numbers of people who are admitted to psychiatric hospitals - are inextricably linked to the provision of services themselves. They are thus subject to the limitation that they may measure only those problems that have been recognised. This may not reflect the true extent of problems as experienced by the population or allow an accurate comparison with the situation in other areas.

**Mental Health in the Community**

2.3 Ideally, the state of mental wellbeing in the community should be established as a baseline for all other measures of mental health. However, overall wellbeing is not easy to measure and such information does not exist for the Greater Glasgow population. Instead, inferences must be drawn from indicators of levels of distress and illness. This report uses three measures of mental health in the community: suicide rates, self-poisoning (“parasuicide”) rates and results from the Office of Population Censuses and Surveys (OPCS) Survey of Psychiatric Morbidity.

2.4 Suicide occurs more often in people suffering from mental illness, particularly depression and schizophrenia, and in those who are dependent on drugs or alcohol. It is more common among people who are unemployed or in other disadvantaged circumstances. Many people who die by suicide have not been formally diagnosed as mentally ill. Suicide is thus often considered to be a measure of the level of distress in society. Details of suicide deaths were obtained from General Register Office (GRO) death certificates.
2.5 Self-poisoning is among the most common reasons for emergency admission to hospital in the United Kingdom. The term “parasuicide” is sometimes used to describe self-poisoning and other forms of serious self-harm where death may have been intended. However, there are important differences between suicide and self-poisoning, and for this reason the term “self-poisoning” is preferred. The proportion of self-poisoners who have a diagnosis of mental illness is relatively small and deliberate self-poisoning can usually be seen as a cry for help or a means of escaping an intolerable personal or domestic situation. Perhaps to an even greater extent than suicide, self-poisoning rates indicate the level of distress and unhappiness experienced in the population. It is important to note that around 2% of people who are admitted to hospital with self-poisoning in Scotland will go on to die by suicide within a year and thus they should not be considered to have a trivial problem. Information on self-poisoning was obtained from Scottish Morbidity Record 1 (SMR1) returns from hospitals in the Greater Glasgow area. All patients discharged from Scottish NHS hospitals have an SMR1 form completed, describing their main conditions, and the information is collected by the Information Services Division of the NHS in Scotland (ISD).

2.6 The Office of Population Censuses and Surveys (OPCS) [recently renamed the Office for National Statistics (ONS)] interviewed 10,108 people aged 16-64 years across the United Kingdom (excluding the Scottish Highlands and Islands) between 1993 and 1994. The main aim of the survey was to find out the prevalence of both serious and less serious mental health problems in the general population. People were asked about a number of psychiatric complaints that they had had over the previous week and year. Surveys of the general population have the advantage of picking up many problems about which people never see a doctor. On the other hand, they have the disadvantage of relying to some extent upon individuals’ self-diagnoses of conditions such as “depression”, “anxiety” and “phobias”. Different people tend to consider the same symptoms in different ways and their use of psychiatric terms may not be the same as that of health professionals. In addition, women and men are likely to differ in the way in which they report certain symptoms and people from ethnic minorities may interpret psychiatric terms differently from the rest of the population.

2.7 Tobacco, alcohol and other drugs of dependence and misuse. Information about drug misuse was obtained from a number of sources. The Scottish Health Survey was carried out in 1995 and involved interviews with 7929 adults including 1245 from Greater Glasgow. Respondents were asked about smoking and drinking among other things. The Research Unit in Health and Behaviour Change at the University of Edinburgh carried out computer assisted telephone interviews (CATI) with 26 673 adults living in Greater Glasgow during the period 1988-95. Respondents were asked about smoking, drinking, physical activity and diet. The Health Promotion
Department at GGHB commissioned surveys of alcohol and drug use among 1089 16-19 year olds in 1995 and 1151 12-25 year olds in 1996. Finally, information on the damaging effects of alcohol and other drug misuse was obtained from Scottish Morbidity Record (SMR1) returns on discharges from general hospitals in Greater Glasgow following an emergency admission for which a diagnosis of alcohol or drug related dependence or misuse (excluding "self-poisoning") was recorded.

**PRIMARY CARE ACTIVITY**

2.8 "Primary care" in the United Kingdom includes general practitioners (GPs), practice nurses, health visitors, community pharmacists, practice dieticians and others. For most people with mental health problems, primary care is the only health service used.

2.9 General practitioners do not routinely record details of all their consultations in a way that allows researchers readily to assess how many patients have, for instance, symptoms of anxiety or schizophrenia. However, a sample of 52 practices throughout Scotland are currently collecting data on all the main health problems of their research. This is called the Continuous Morbidity Record (CMR). Complete CMR data for 1997 from 42 of the 52 participating practices has been provided by the Information Services Division. By adjusting these all-Scotland results to take into account the age, sex and levels of affluence and deprivation in Greater Glasgow, estimates can be made of the situation in Greater Glasgow. The estimates obtained from the Scottish CMR data are very similar to those found in a survey of general practitioners’ case-notes in England and Wales.

2.10 **Drug prescribing for the treatment of mental illness.** One of the main ways of treating various forms of mental illness is the prescription of certain drugs. Information was obtained from the Pharmacy Practice Division on all NHS prescriptions issued by GPs in the Greater Glasgow area during the period 1992-96 for the following types of drugs: antidepressants; anxiolytics (tranquillisers) and hypnotics (sleeping medicine); and anti-psychotics (for the treatment of schizophrenia and other related forms of severe mental illness). As with many of the other sources of information used in this report, these data should be interpreted with caution as they reflect the prescribing practices of GPs at least as much as the actual problems of their patients. However, they are a valuable indicator of the primary care response to mental illness in the community.

**HOSPITAL ADMISSIONS**

2.11 Only a small proportion of all people with mental illness need admission to a psychiatric hospital for treatment. In 1980, Goldberg and Huxley estimated that about 1 out of every 100 people in the community with psychiatric illness would need hospital admission in any given year. Recent changes in the provision of health services for more severely mentally ill people have meant that mental health resource centres and other forms of community care have replaced many hospital beds. Admissions to psychiatric hospitals therefore have to be regarded in the light of such changes.
Table 2.1  The Greater Glasgow Health Board Area by Deprivation Category

<table>
<thead>
<tr>
<th>Deprivation Category</th>
<th>Population</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>86,660</td>
<td>9.4</td>
</tr>
<tr>
<td>2</td>
<td>71,909</td>
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<td>4</td>
<td>127,225</td>
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<tr>
<td>5</td>
<td>84,816</td>
<td>9.2</td>
</tr>
<tr>
<td>6</td>
<td>210,198</td>
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<tr>
<td>7</td>
<td>271,045</td>
<td>29.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>921,923</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Whenever a patient is admitted to and discharged from a Scottish psychiatric hospital, an SMR4 (Scottish Morbidity Record 4) form is completed. The SMR4 describes the patient’s diagnosis and other details. SMR4 data should therefore record all psychiatric admission and discharge diagnoses in Scotland.

**Mental Health Among Prisoners and the Homeless**

2.12 Data were obtained from surveys in prisons in Scotland, England and Wales to give an indicator of the likely mental health needs of Greater Glasgow residents who are imprisoned. Data were also obtained from a recent survey of homeless people living in hostels or sleeping rough throughout the United Kingdom.

2.13 Mental health resource centre data should in future help to fill in the missing information on current services for people with more severe mental illness who would previously have been treated in psychiatric hospitals. However, at present these data are far from complete and thus cannot be used to give an accurate picture across Greater Glasgow.

**Deprivation Categories**

2.14 The deprivation category (Depcat) is a way of describing how well off an area is. There are many social and economic features of an area that determine whether it is deprived, such as the level of unemployment, how well paid employed people are, the quality of housing, access to public transport and leisure facilities and so on. It has been shown that the level of deprivation of an area has a strong bearing on the health of the people who live in it. It is therefore important to know how affluent or deprived an area is when investigating the nature and extent of mental illness within its population. The Depcat score developed by Vera Carstairs and Russell Morris uses four measures of socio-economic circumstances - overcrowding, unemployment, proportion
of residents in social classes IV and V and car ownership. These are then used to rate the area on a scale of 1 to 7, with 1 being the most affluent and 7 the most deprived. The Greater Glasgow Depcat scores were calculated using data from the 1991 census for each of the 144 postcode sectors that make up the whole area. The proportion of the population in each deprivation category is shown in Table 2.1. This shows that more than 50% of the population live in areas defined as the most deprived, Depcats 6 and 7. As will be seen, this has a very large bearing on the amount of mental health problems in the Greater Glasgow area.

Figure 2.1 shows that most of the more deprived areas are in the north and east of the city, along the River Clyde and in four peripheral housing estates.

2.15 In order to examine the relationships between mental health and deprivation, we have compared the rates of occurrence of particular conditions, GP consultations or hospital admissions among people living in each of the deprivation category areas. This is expressed as a "relative risk", where the of a condition in each of the other areas is compared to that in the most affluent. Thus, if the relative risk of a condition in Depcat 7 is four that means it occurs four times more often in a given number of people living in Depcat 7 compared with the same number living in Depcat 1.

Other Sources of Information

2.16 In compiling this report, we also drew on a number of other information sources. These included:


2. A one year follow-up study of 3000 people with head injuries in Greater Glasgow.

3. A report on mental health problems for the ethnic minorities in Greater Glasgow prepared by the Glasgow Association for Mental Health and published in 1997.

Deprivation in Greater Glasgow - A post-code sector map

Based on 1991 Census data analysed using the method of Carstairs & Morris\textsuperscript{15}
3. MENTAL ILLNESS IN GREATER GLASGOW

3.1 The OPCS Survey of Psychiatric Morbidity involved interviews with over 10,000 people aged between 15 and 64 living throughout the United Kingdom (except the Scottish Highlands). The interviews were carried out between April 1993 and August 1994. People were interviewed in their own homes and therefore the survey excludes people in hospital, nursing homes or prison or who are homeless. Consequently, it is likely to under-estimate the proportion of people with mental health problems and particularly those who have serious mental illness. The OPCS Survey found that women were more likely than men to report most neurotic symptoms such as sleep problems, worry, anxiety and obsessions. People who were unemployed or who were economically inactive, particularly men, were on average more than twice as likely to experience these symptoms than people in work. Higher rates were also more likely among people living alone or as a single parent with one child or more. There was no relationship between these symptoms and ethnic origin when other factors were taken into account. Symptoms were also more frequent among people living in rented accommodation than among owner-occupiers and in urban as opposed to semi-rural or rural areas. Overall, about 20% of women and 12% of men had had symptoms of a neurotic disorder in the week before the interview, with mixed anxiety and depression being the most common. Around 2% of women and 7.5% of men were found to be alcohol dependent and 1.5% of women and 3% of men were drug dependent. In contrast, only 0.4% of both men and women had evidence of having a psychotic disorder. As with the neurotic disorders, psychosis was more common among people who were unemployed or economically inactive or who lived in rented accommodation.

3.2 These findings are important because they give a good idea of the relative frequency of the main types of mental health problems. Thus, neurotic disorders were experienced about forty times more often than psychotic ones, with alcohol and drug dependence being about twelve and five times more common respectively than psychosis.

3.3 Although the OPCS Survey was carried out to a high scientific standard, it is not possible reliably to extrapolate these figures to the Greater Glasgow population in order to give a good idea of the number of people with each condition. This is mainly because the OPCS sample was taken from across the United Kingdom and included much lower proportions of people who were unemployed or lived in rented accommodation than is the case in Greater Glasgow. As these two factors are related to high levels of many mental disorders, the OPCS figures are very likely seriously to under-estimate the problems in Greater Glasgow. In addition, the OPCS Survey does not include people living in institutions such as nursing homes, hostels for the homeless and prisons. Other work has shown clearly
that mental health disorders are much more common among people in these circumstances than in the general population. Their omission also leads to a major under-estimate of the actual number of problems.

3.4 This unsatisfactory situation could only be rectified by carrying out a detailed survey within Greater Glasgow or establishing accurate registers of people with particular conditions. Careful consideration should be given to the practicalities of achieving this.

**SUICIDE**

3.5 Suicide is a relatively rare event but can to some extent be used as a barometer of mental distress in the community. Over the five years 1991-95, there were a total of 418 recorded suicides among males and 131 among females in Greater Glasgow. That represents about 1 in 1000 men and 3 in 10,000 women over a five year period.

3.6 Men are thus over three times as likely to die by suicide compared to women (Figure 3.1). The difference between the sexes is
Fig 3.3  Suicide rates in adults (25-44 years old) per 100,000 population in Scotland and Greater Glasgow 1985-95

largest in 15-24 year olds, among whom men are over six times likelier than women to die by suicide.

3.7 Suicide rates change with age. In men there is a peak at 35-44 years and in women at 25-34 years plus a rise in later life - although because fewer people survive to old age, the largest number of deaths from suicide occurs between 25 and 34 years old in both men and women.

3.8 Figures 3.2 - 3.3 show suicide rates in men and women between 1985 and 1995. Suicide rates in adults (15+ years old) have changed little overall in the past decade in Scotland, with men having higher rates than women at all ages. Small increases and decreases over time are apparent, but these fluctuations probably reflect the small numbers of individuals involved. However, Greater Glasgow mirrors Scottish and UK trends in seeing an increase in suicide rates in men aged 15-24 between 1990 and 1994, with a lower figure in 1995. Because death by suicide is frequently confirmed only after investigation of the circumstances of death, complete records take some time to be assembled. When completed returns of death certificates for subsequent years are available it will be possible to see whether there is a continuing increase in suicide in young men.

Fig 3.4  Relative risk of Suicide in Greater Glasgow 1991 to 1995 by Depcat (n=546)

<table>
<thead>
<tr>
<th>Depcat</th>
<th>1</th>
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<td>7</td>
<td>5</td>
<td>19</td>
<td>9</td>
<td>25</td>
<td>47</td>
</tr>
</tbody>
</table>

Average annual number of suicides by Depcat 1991 - 1995
Fig 3.5  Admission rates for self poisoning in Greater Glasgow in 1995 \((n=2445)\)

3.9 There are likely to be differences in patterns of suicide in different ethnic groups. Scottish Morbidity Records and death certificate records do not contain sufficient details of ethnicity, but clearly this is an important area that requires further investigation.

3.10 Figure 3.4 shows that people from the poorest areas in Greater Glasgow are almost three times more likely to die by suicide than those from the most affluent areas. A recently published analysis of the links between deprivation on health has shown the same trend is found throughout Scotland.\(^6\) This, combined with the fact that just over 50% of the population of Greater Glasgow live in such areas means that 85% of suicides involved people who live in deprivation categories 6 and 7. It is increasingly recognised that a substantial proportion of people who commit suicide have serious drug or alcohol problems. Most of the individuals who have committed suicide in Barlinnie or Corntonvale women's prison in recent years have been drug addicts.

**Self Harm Other Than Suicide**

3.11 The most common type of deliberate self harm in the United Kingdom is self-poisoning. There are no reliable data on other types of self-harm such as wrist-slaying or
Fig 3.7  Relative Risk for Admissions for Self Poisoning in 1995 in Greater Glasgow by Depcat (n=2445)

![Graph showing relative risk for admissions for self poisoning in Greater Glasgow by Depcat](image)

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<thead>
<tr>
<th>Depcat</th>
<th>Actual number of parasuicides by Depcat in 1995</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>70</td>
</tr>
<tr>
<td>2</td>
<td>95</td>
</tr>
<tr>
<td>3</td>
<td>107</td>
</tr>
<tr>
<td>4</td>
<td>239</td>
</tr>
<tr>
<td>5</td>
<td>242</td>
</tr>
<tr>
<td>6</td>
<td>680</td>
</tr>
<tr>
<td>7</td>
<td>1012</td>
</tr>
</tbody>
</table>

self-mutilation. Self-poisoning is more common in young women, people from more deprived areas, in cities compared to rural areas, and in the unemployed. Patterns of admission to hospital for self-poisoning in Greater Glasgow are consistent with these trends: a peak rate occurs in the 15-24 year age-group in women, where the ratio of female to male admissions is 3:2 (Figure 3.5); the peak rate in men is between 25 and 34 years. Rates fall with increasing age thereafter. The apparent rise among males aged over 85 probably reflects the very small numbers involved.

3.12 The number of admissions for self-poisoning for Greater Glasgow has risen steadily since 1989 after several years of stability (Figure 3.6). It is not clear why this is. It has become one of the most common reasons for emergency medical admission to hospital, with an average of seven cases in the Greater Glasgow area every day. This represents two major problems: the serious level of mental distress in the population; and the heavy use of NHS resources as a result of self-harm.

3.13 The pattern of self-poisoning by deprivation category shows a clear and significant trend of increased rates with increasing deprivation (Figure 3.7). People from the most deprived areas are 4.5 times more likely to be admitted to hospital for self-poisoning compared to those from the most affluent areas. Almost 70% of all admissions for self-poisoning were of individuals living in deprivation category areas 6 and 7.

3.14 Recent analysis of Scottish patterns of self-poisoning suggests that the majority of patients take paracetamol. Paracetamol is often mistakenly assumed to be a relatively safe drug. However, in doses as little as 10-15g (20-30 tablets) it can cause rapidly progressive liver damage leading to death within a few days of the overdose. Unless treatment with an antidote is started quickly, liver transplantation is the only option, if a suitable donor can be found.
CHILD AND ADOLESCENT
MENTAL HEALTH

3.15 A description of local need has been developed from a recent report on the Commissioning of Child and Adolescent Mental Health Services in Greater Glasgow and a national report, Together We Stand: The Commissioning, Role and Management of Child and Adolescent Mental Health Services. More evidence of need is provided in the Children’s Services Plan of Glasgow City Council.

3.16 Mental health problems in children and adolescents include difficulties or disabilities arising in a number of areas of psychological and emotional development, and include a wide range of emotional and behavioural problems.

3.17 There are around 200,000 people under the age of 18 living in Greater Glasgow. There have been no systematic surveys to establish a picture of the prevalence of mental health disorder in this young population.

Table 3.1 Risk groups for child and adolescent mental health problems.

<table>
<thead>
<tr>
<th>Physical Illness</th>
<th>Family Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic illness; terminal illness</td>
<td>Mentally ill parent; children acting as carers.</td>
</tr>
<tr>
<td></td>
<td>Parent involved in crime; parent with alcohol or drug problem; violent families.</td>
</tr>
<tr>
<td></td>
<td>Children from divorced, separated or reconstituted families.</td>
</tr>
<tr>
<td>Others</td>
<td>Children who abuse other children.</td>
</tr>
<tr>
<td></td>
<td>Children who misuse alcohol or other drugs.</td>
</tr>
<tr>
<td></td>
<td>Children who have been traumatised.</td>
</tr>
<tr>
<td></td>
<td>Children from ethnic minorities who have been racially harassed.</td>
</tr>
<tr>
<td></td>
<td>Children from refugee families.</td>
</tr>
<tr>
<td></td>
<td>Homeless children and young people.</td>
</tr>
</tbody>
</table>

Source: A report on the Commissioning of Child and Adolescent Mental Health Services, Greater Glasgow Health Board, 1996.

Table 3.2 Numbers of children in Greater Glasgow at high risk of mental health disorder due to social or personal factors

<table>
<thead>
<tr>
<th>Abuse</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children currently registered as being at risk of physical abuse</td>
<td>186</td>
</tr>
<tr>
<td>Children currently registered as being at risk of physical neglect</td>
<td>148</td>
</tr>
<tr>
<td>Children currently registered as being at risk of sexual abuse</td>
<td>96</td>
</tr>
<tr>
<td>Total number of children on children protection register in Greater Glasgow</td>
<td>439</td>
</tr>
</tbody>
</table>

"Looked after" children

| Residential schools; secure units | 601 |
| Children in alternative care; fostering and community parents | 486 |

Special needs

| Physical sensory | 350 |
| Pre-school | 1600 |
| Special educational need | 3000 |
| Generalised learning disabilities | 2000 |

Source: A report on the commissioning of child and adolescent mental health services, Greater Glasgow Health Board, 1996.
Table 3.3 Mental health disorders among children and adolescents, their features and likely numbers in Greater Glasgow area

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Features</th>
<th>&lt;12yrs</th>
<th>13-17yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major depressive disorder</td>
<td>Low mood, poor sleep, school failure</td>
<td>1000</td>
<td>3000</td>
</tr>
<tr>
<td>Eating disorder</td>
<td>Anorexia: self starvation, overactivity</td>
<td></td>
<td>600</td>
</tr>
<tr>
<td></td>
<td>Bulimia: bingeing, vomiting</td>
<td></td>
<td>1500</td>
</tr>
<tr>
<td>Psychotic disorder</td>
<td>Schizophrenia, manic depressive illness</td>
<td></td>
<td>600</td>
</tr>
<tr>
<td>Hyperkinetic disorders</td>
<td>Poor concentration</td>
<td>1000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>+ overactivity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autistic spectrum disorders</td>
<td>Speech/language delay, autism</td>
<td>1800</td>
<td></td>
</tr>
<tr>
<td>Obsessive compulsive disorder</td>
<td>Problem thoughts and/or rituals</td>
<td>1000</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>3800</td>
<td>6700</td>
</tr>
</tbody>
</table>

population. However, it is clear that mental health problems are much more likely to occur in children or adolescents exposed to certain stresses or disadvantages, summarised in Table 3.1. These are not mutually exclusive, as children may be exposed to more than one risk factor, thereby increasing their vulnerability. If a pattern of disturbed behaviour is established in early years, this is often followed by poor performance at school and a higher risk of earlier use of tobacco, alcohol and other drugs, further compounding the problems.

3.18 Table 3.2 shows the approximate number of children in Greater Glasgow registered as being at high risk of abuse, being looked after or with special needs. Particularly in the case of abuse, these figures are likely to under-estimate the true numbers.

3.19 In a recent interview survey of 463 adult drug injectors in Greater Glasgow, 60% had at least one child, with the group having a total of 490 children between them. (Scottish Centre for Infection and Environmental Health, unpublished data). Given current estimates of 7,000 to 10,000 injectors in Greater Glasgow, this would suggest that there are also around 7,000 to 10,000 children of whom at least one parent has a serious drug problem. A high proportion of these children are likely to experience neglect, separation and other physical or mental trauma with important consequences for their mental health. Based on comparisons of the numbers of young adults admitted for serious drug or alcohol problems, it is likely that at least as many children have one or more parents with a serious alcohol problem.

3.20 Using prevalence estimates developed by the NHS health advisory service and others.18 Table 3.3 gives a very rough indication of the numbers of children in the Greater Glasgow area suffering from particular disorders. It should be noted that serious mental health disorders are
much more common in adolescence than younger children. Further insights into the mental health of young people in Greater Glasgow have been provided by surveys of a group of 1,000 young people who were interviewed when aged 15, 18 and 21 years old.\textsuperscript{20} Using a standard survey method, the general health questionnaire (GHQ), they found that the proportion of males with evidence of significant psychological problems rose sharply from 11\% to 33\% between 15 and 18 years and from 19\% to 42\% among females aged 15 and 18. These figures all point to worryingly high levels of mental distress among adolescents in Greater Glasgow. There is considerable evidence that depression is especially common and often goes undetected. Adolescents generally do not seek help from general practitioners or other health or social services and therefore the vast majority of these young people would not be receiving specific help. Tobacco, alcohol and other drug misuse among young people in Greater Glasgow are considered in Section 4. All show very worrying trends.

3.21 Whilst milder forms of eating disorders are common, a small number of adolescents and young adults, mostly female, suffer from potentially life threatening anorexia nervosa. This may require long periods of intensive residential treatment for which the NHS in Greater Glasgow currently has no facilities.

**Learning Disabilities**

3.22 There are an estimated 2,765 individuals with severe learning disabilities in the Greater Glasgow area, calculated using previously published national prevalence. (Table 3.4)\textsuperscript{21}

<table>
<thead>
<tr>
<th>Age Group (Years)</th>
<th>Estimated No. in GGHB Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>150</td>
</tr>
<tr>
<td>5-9</td>
<td>172</td>
</tr>
<tr>
<td>10-14</td>
<td>216</td>
</tr>
<tr>
<td>15-19</td>
<td>270</td>
</tr>
<tr>
<td>20-24</td>
<td>401</td>
</tr>
<tr>
<td>25-29</td>
<td>361</td>
</tr>
<tr>
<td>30-34</td>
<td>287</td>
</tr>
<tr>
<td>35-39</td>
<td>208</td>
</tr>
<tr>
<td>40-44</td>
<td>171</td>
</tr>
<tr>
<td>45-54</td>
<td>246</td>
</tr>
<tr>
<td>55-64</td>
<td>200</td>
</tr>
<tr>
<td>64-74</td>
<td>83</td>
</tr>
<tr>
<td>75 and over</td>
<td>very few</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>2,765</strong></td>
</tr>
</tbody>
</table>
3.23 At the end of April 1998, there were around 315 long stay learning disabled residents living on the Lennox Castle site. There are a further 218 GGHB-funded residents in other learning disability hospitals including the Royal Scottish National Hospital, Kirklands, Birkwood, Merchiston, Lynebank and Strathmartine.

3.24 It is unclear how well services care for the larger proportion of individuals with learning disabilities who are not in institutional care. In a recent paper, Espie and Brown provided evidence that their general health and access to health care is often very poor. In particular, there is a lack of basic health promotion and identification of ill-health. Both the knowledge and attitudes of health professionals and communication and behavioural difficulties experienced by many people with learning disabilities can be barriers to the effective delivery of health care. Specialist community learning disability staff have a role in supporting and advising primary care teams.

3.25 Referring to the Scottish Health Advisory Service (SHAS) reports, Espie and Brown underline the need to recognise an apparent increase in the prevalence of physical and mental illnesses among people with learning disability. More work should be done to determine their true extent and to ensure that current services are equipped to address them. This should include consideration of additional training for staff and carers.

### Table 3.5 Estimated total annual general practice consultations for various mental health disorders in Greater Glasgow. New and return consultations are shown, with percentages of all mental health related consultations in general practice

<table>
<thead>
<tr>
<th>Disorder</th>
<th>New consultations (% of all)</th>
<th>Return consultations (% of all)</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>46477 (17%)</td>
<td>54651 (20%)</td>
<td>101128</td>
</tr>
<tr>
<td>Alcohol problems</td>
<td>42766 (16%)</td>
<td>56552 (21%)</td>
<td>99318</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>1520 (0.6%)</td>
<td>3311 (1.2%)</td>
<td>4831</td>
</tr>
<tr>
<td>Other psychoses</td>
<td>546 (0.2%)</td>
<td>1561 (0.6%)</td>
<td>2107</td>
</tr>
<tr>
<td>Other</td>
<td>2210 (0.8%)</td>
<td>3144 (1.1%)</td>
<td>5354</td>
</tr>
<tr>
<td>Dementia</td>
<td>16145 (5.9%)</td>
<td>19220 (7.0%)</td>
<td>35365</td>
</tr>
<tr>
<td>TOTAL</td>
<td>121216 (44.7%)</td>
<td>153304 (56.3%)</td>
<td>274520</td>
</tr>
</tbody>
</table>
Fig 3.8 Non-psychotic depression. New and return consultations in primary care by sex and deprivation category, 1997

Mental Illness in Primary Care

3.26 Data from the Continuous Morbidity Record (CMR) give a good indication of the workload generated by mental illness in general practice in the Greater Glasgow area. Table 3.5 gives the estimated numbers of consultations each year in general practice in Greater Glasgow for various mental disorders. This shows that depression and anxiety account for 73% of all mental health consultations in general practice and are much more common than schizophrenia or dementia.

Figures 3.8-3.11 show first-time consultations and repeat consultations combined for each of the four conditions.

Mental health problems accounted for 7.3% of all general practice consultations. It should not be forgotten that large numbers of people, particularly those with anxiety or depression or problems with drink or drugs may never seek the help of their GP or, having done so, may continue to suffer in silence at home.

3.27 The commonest mental health problem encountered in general practice is depression. Women consult their general practitioners around two and a half times more commonly than men (Figure 3.8). Consultations are about twice as common among individuals from the most deprived areas compared with the most

Fig 3.9 New and return consultations for anxiety in primary care. Rates per 100,000 population by sex and Depcat.
affluent, although there is not a consistent relationship between Depcat and consultation rate.

3.28 The second commonest mental health problem encountered in general practice is anxiety (Figure 3.9). As with non-psychotic depression, women consult their GPs with symptoms of anxiety more than twice as commonly as men. Although there is not a consistent relationship between deprivation category of residence and rate of consultation for anxiety, there are much higher consultation rates in people who live in Depcat 7 areas. In women, both new consultations for anxiety and repeat attendances are around twice as common in Depcat 7 compared with other areas.

3.29 Although a severe and usually disabling illness, schizophrenia contributes much smaller numbers of GP consultations than either anxiety or depression (Figure 3.10). Consultation rates are slightly higher in men overall. The relationship between consultations for schizophrenia and area of deprivation has similarities with anxiety and non-psychotic depression. While there is not a clear relationship between deprivation and schizophrenia in patients from Depcats 1-6, there are
Fig. 3.12  Psychiatric admissions in Greater Glasgow in 1993-95 by age and sex, per 100,000 population.

substantially higher consultation rates in patients from Devecat 6 areas. This means that individuals from the most deprived areas are over six times likelier to consult their GP with schizophrenia than those in the most affluent areas. Overall there are approximately 25 times more consultations for anxiety and depression than for psychotic conditions.

3.30 Consultations in general practice for dementia are highest in people living in Devecat 7 areas (Figure 3.11). Among men but not women, rates of consultation are much higher in Devecat 7 compared to other areas. Low consultation rates in patients from Devecat 6 areas are found in both men and women, and for both new and repeat consultations: it is not clear why this is the case.

PSYCHIATRIC HOSPITAL ACTIVITY

3.31 Evidence of changing admissions to psychiatric hospitals was presented in Glasgow’s Health: Women Count in 1994.22 It showed that rates of admission for all psychiatric disorders were falling in women but rising in men, although at that time rates of admission for women were still higher.

Fig. 3.13  Relative risk of mental health hospital admission of Greater Glasgow residents in 1993-95 by deprivation category of residence \(n=15644\)
3.32 More recent data, shown in Figure 3.12, suggest that these trends have continued, such that in the period 1993-95, admissions for men were slightly higher at most ages. The much higher rate of admissions in women over 64 means that the all-age admission rates to psychiatric hospitals in the Glasgow area are similar in men and women.

3.33 It is not clear what has caused these changes. The pathway to receiving inpatient psychiatric care is a complex one and does not just depend upon the severity of an individual’s condition. The availability and proximity of hospital beds, availability of alternatives to hospital admission (for example, a mental health resource centre) and doctors’ own preferences for the type of treatment all influence how hospitals are used.

3.34 The area in which patients live makes a considerable difference to their likelihood of being admitted to hospital with a psychiatric illness (Figure 3.13).

3.35 Patients from the most deprived areas are almost three times as likely to be admitted to a psychiatric hospital in the Greater Glasgow area as those from the most affluent areas. There is a fairly consistent relationship between area of residence and chances of admission to a psychiatric hospital, with the exception of people from Depcat 2 areas who have a relatively high admission rate: it is not clear why Depcat 2 stands out in this way.

3.36 Mental illness, as with most kinds of illness, results in more admissions of people from deprived areas compared to those from more affluent areas. Part of this may be because of different referral patterns to hospital by GPs from different areas. However, evidence from the OPCS Survey of Psychiatric Morbidity confirms that mental illness is more common in people from lower socio-economic groups. The reasons for this have been briefly discussed already. Mental illness may result from a wide

Table 3.6 Mental health admissions in Greater Glasgow, by diagnostic group, 1993-95

<table>
<thead>
<tr>
<th>Diagnostic Group</th>
<th>GGHB TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia</td>
<td>3069 (20%)</td>
</tr>
<tr>
<td>Depression - non psychotic</td>
<td>2287 (15%)</td>
</tr>
<tr>
<td>Alcoholic psychosis/dependence syndrome</td>
<td>2062 (13%)</td>
</tr>
<tr>
<td>Affective psychoses</td>
<td>2125 (14%)</td>
</tr>
<tr>
<td>Schizophrenic psychoses</td>
<td>2087 (13%)</td>
</tr>
<tr>
<td>Other psychoses</td>
<td>1205 (8%)</td>
</tr>
<tr>
<td>Other conditions</td>
<td>678 (4%)</td>
</tr>
<tr>
<td>Drug abuse</td>
<td>614 (4%)</td>
</tr>
<tr>
<td>Personality disorders</td>
<td>506 (3%)</td>
</tr>
<tr>
<td>Mental handicap</td>
<td>478 (3%)</td>
</tr>
<tr>
<td>Neurotic disorders</td>
<td>448 (3%)</td>
</tr>
<tr>
<td>Disorders of childhood</td>
<td>32 (&lt;1%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>15591</td>
</tr>
</tbody>
</table>
variety of factors experienced by people living in more deprived areas. In addition, people may end up living in worse circumstances as a result of mental illness. It is likely that a combination of these factors is responsible for the observed patterns of psychiatric admissions.

**Reasons for Admission to Psychiatric Hospitals**

3.37 Taken together, psychotic illnesses form the commonest reason for admission to a psychiatric hospital in the Greater Glasgow area, and account for just over a third of all psychiatric admissions. (Table 3.6) The dementias account for around a fifth of all admissions to hospital, and alcohol-related psychiatric illness and non-psychotic depression each account for about one in seven admissions.

3.38 Figure 3.14 shows that dementia and schizophrenia account for a disproportionate percentage of bed days because average lengths of stay are relatively long.

3.39 We have examined in more detail hospital admission rates for four kinds of mental

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**Fig. 3.15 Admissions for schizophrenia in Greater Glasgow per 100,000 population by age and sex, 1993-95. (n=2087)**
Fig 3.16  Relative risk of admission for schizophrenia in Greater Glasgow, by Depeat, 1993-95 (n=2087)

There is a peak admission rate between the ages of 25-34 and this gradually declines with age. Men have just over twice the rate of admission to hospital for schizophrenia compared to women.

3.42 The association between socio-economic status and schizophrenia is shown in Figure 3.16. In the GGHB area, patients who are admitted to hospital with schizophrenia are just over six times more likely to come from the most deprived areas compared to the most affluent. The trends for Scotland as a whole or similar.

SCHIZOPHRENIA

3.40 The average age of onset of schizophrenia is in the mid to late 20s. Men tend to develop it at a slightly younger age than women and do less well in the longer term.

3.41 GGHB inpatient statistics, provided in Figure 3.15, bear out these general trends.

Fig. 3.17  Admissions for affective psychoses in Greater Glasgow in 1993-95 per 100,000 population (n=2125)
**Depression and Affective Psychoses**

3.43 Hospital admission rates for both non-psychotic depression and affective psychoses are 1.7 times higher in women compared to men (Figures 3.17 & 3.18). There is little obvious pattern with age over 24 years in admissions in both sexes. The high rate in admissions in men over 84 years old for non-psychotic depression is largely a consequence of very small numbers (16 admissions in a two-year period for the GGHB area). Above 74 years old, the pattern of female to male admissions changes in non-psychotic depression, with little difference in 75-84 year olds, and a higher rate of admissions in men above 85 years; again these features may be because of the small numbers involved.

3.44 While admission rates for both groups of affective disorders are lower for individuals from Depcat 1 in contrast with other Depcats, there is no clear gradient between Depcats 2-7 (Figures 3.19 & 3.20).
Mental Health Problems Of Older People

3.45 Older people with mental health problems comprise:

- those who develop a functional mental illness, such as depression, schizophrenia or another psychosis late in life.

- people with dementia or allied brain diseases.

- older people who have had a mental health problem since early or middle age.

- relatives or friends who care for someone in these groups.

A significant number of older people will have a combination of these - for example dementia and depression.

3.46 Anxiety and depression among the elderly are also common reasons for consulting a general practitioner. Problem drinking and misuse of or dependence upon tranquillisers or sleeping pills may continue with advancing years. Rates of suicide among the over 65s show similar patterns to those of younger people, with a suicide rate being only slightly lower among the elderly. For many elderly people, life is characterised by loneliness and isolation, boredom and inactivity, relative poverty and increasing physical disability and discomfort. It is not surprising, therefore, that anxiety and depression should be particularly prevalent among older people.

3.47 For a population of 900,000 there will be about 144,000 people over the age of 65 years, of whom about:

- 12,000-19,000 have a moderate depressive illness.

- 4,200 have a major depressive illness.

- 14,000 have significant anxiety levels.

- 2,200 have a psychotic illness (eg. schizophrenia)

- 3,600 have moderate or severe dementia and 7,200 have mild dementia.
3.48 Old age psychiatry services have responsibility for people with dementia, and for older people who develop a severe mental health problem later in life. Those with enduring mental health problems who have been under the care of a general psychiatrist within the adult service remain there unless their needs change and warrant a transfer to the old age specialist team.

3.49 Older people with mental health problems may present with a physical illness or disability. Services for older people with mental health problems should therefore incorporate ways of meeting physical health needs as well as mental health, social and practical needs.

3.50 Figures 3.17 and 3.18 show admission rates for psychotic and non-psychotic depression are as high or higher among the over 65's as they are in younger age groups.

**DEMENTIA**

3.51 Dementia is a disease of the brain that usually begins slowly, often with loss of memory. As it progresses other functions of the brain deteriorate, so skills, the personality, and ultimately bodily functions fail. Although there is no cure for dementia at present, there is much research aimed at finding causes and developing drugs to slow down the disease. Dementia is difficult to diagnose in the early stages, although an early diagnosis can be very useful. An accurate diagnosis is most important, in order to distinguish dementia from treatable conditions such as depression, and to identify other co-existing mental and physical illnesses which may be treatable.

3.52 Early diagnosis is also crucial to allow individuals to make decisions about their legal and financial affairs whilst they still can, and to plan for the future with their family and friends. Without a diagnosis, people with dementia are left in the dark.

<table>
<thead>
<tr>
<th></th>
<th>30-59</th>
<th>60-64</th>
<th>65-69</th>
<th>70-74</th>
<th>75-79</th>
<th>80-84</th>
<th>85-89</th>
<th>90+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>Male</td>
<td>269</td>
<td>342</td>
<td>418</td>
<td>733</td>
<td>457</td>
<td>702</td>
<td>404</td>
<td>207</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>162</td>
<td>119</td>
<td>269</td>
<td>898</td>
<td>1082</td>
<td>1771</td>
<td>1614</td>
<td>978</td>
</tr>
<tr>
<td></td>
<td>All</td>
<td>431</td>
<td>461</td>
<td>688</td>
<td>1631</td>
<td>1538</td>
<td>2473</td>
<td>2019</td>
<td>1158</td>
</tr>
<tr>
<td>2006</td>
<td>Male</td>
<td>278</td>
<td>309</td>
<td>364</td>
<td>660</td>
<td>540</td>
<td>759</td>
<td>465</td>
<td>309</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>166</td>
<td>100</td>
<td>224</td>
<td>736</td>
<td>1099</td>
<td>1638</td>
<td>1557</td>
<td>1356</td>
</tr>
<tr>
<td></td>
<td>All</td>
<td>445</td>
<td>408</td>
<td>588</td>
<td>1396</td>
<td>1639</td>
<td>2396</td>
<td>2022</td>
<td>1665</td>
</tr>
</tbody>
</table>
and may become increasingly anxious and withdrawn as control over their lives dwindles.

3.53 Table 3.7 gives estimates of the numbers of people with dementia in the Greater Glasgow area in 1994 and 2006. The prevalence increases with age, and the rise is particularly marked in those aged 80 years and over. Because the age group 75-85 years is the fastest growing segment of the population, growth in the number of people with dementia is largely in the over 75 age group. Before the age of 70 there are more men with dementia illness than women, whereas in the 75 and over age group women with dementia far outnumber men, simply because many more women live long enough to develop dementia.

3.54 Dementia affects 10-11,000 people in Greater Glasgow today. The number will rise about 10% by the year 2011 and by another 10% by 2021.

3.55 Of all people with dementia 20-25% live at home alone, 30-35% live at home with others, 12-15% live in residential care, about 10% live in a nursing home and about 20% live in hospital continuing care. About 40-45% of people with dementia therefore live in long-stay care. Many would prefer to be cared for at home if adequate support was available for themselves and their carers.

3.56 Area of residence, described by Depcat, does not appear to be significantly related to admission to hospital for dementia (Figure 3.21). This may be because the causes of dementia are less related to underlying socio-economic and other life circumstances than are those of other mental disorders. However, over the age of 65, area of residence has an increasingly weak relationship with all types of illness. One hypothesis for this is that those people who survive to older age have generally better health, and are more evenly distributed between areas of affluence and areas of deprivation.

Table 3.21 Relative risk of admission for dementia in Greater Glasgow, by Depcat, 1993-95 (n=1770)

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<th>Depcat</th>
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<tr>
<td>Average annual number of admissions for dementia by Depcat 1993-1995</td>
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<td></td>
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<tr>
<td>23</td>
<td>98</td>
<td>56</td>
<td>64</td>
<td>85</td>
<td>115</td>
<td>149</td>
<td></td>
</tr>
</tbody>
</table>
3.57 Scottish studies show that of people with dementia known to services, more than 56% need help at least once a day with personal care but such help is available to less than half of those who need it. Half of those living in the community are not known to services.

3.58 People with dementia and their carers need timely information, emotional support and practical help from the point of diagnosis through to the terminal stages of the illness, which may not come until after many years.

3.59 There is good evidence that comprehensive support including advice and information to individual carers and families, and attendance at carers' support groups, reduce the need for spouses of patients with dementia to place their husbands or wives in institutional care. However, the time may come when admission to long-term care is in the best interests of patients and/or carers and simply regarding admission as an unsuccessful outcome is inappropriate.

3.60 It is estimated that 34% of carers of people with dementia need one hour a day or more of help with supervision, 20% need one hour or more a day of help with housework and 10% need similar levels of help with personal care. There is a need to develop innovative domiciliary support services: in particular, services to assist carers to keep the person with dementia occupied and supervised.

**EARLY ONSET DEMENTIAS**

3.61 Whilst most people with dementia are aged over 60 (see Section 3.55) the condition can sometimes develop at a younger age. The most common types among younger people are also the most common in later life i.e. Alzheimer's disease, vascular dementia and alcohol-related dementia. Rare but important causes include Creutzfeldt-Jakob disease, Huntington’s disease, tumour, hydrocephalus and HIV infection. In a small proportion of cases e.g. HIV infection, there maybe a good response to treatment. Correct diagnosis is therefore vital. Whilst the rate the disease progresses may be no more rapid than for older people, the effect of the illness on affected individuals and their families may be very different than for older people. A rough estimate of the number of people with the different types of early onset dementia in Greater Glasgow is given in Table 3.8.
Table 3.8  Estimated prevalence of cases of early onset dementia among persons aged under 65 in Greater Glasgow

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer's disease</td>
<td>70</td>
</tr>
<tr>
<td>Huntington’s disease</td>
<td>90</td>
</tr>
<tr>
<td>Other degenerative dementias (CJD, frontal dementias, HIV, etc)</td>
<td>60</td>
</tr>
<tr>
<td>Alcohol-related brain damage (excluding Korsakoff's Syndrome)</td>
<td>45</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>265</strong></td>
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</table>

*Source: NHS Health Advisory Service, Heading for Better Care, 1996*

**Conclusions**

3.62 Patterns of mental illness vary between men and women, between young and old and between the affluent and the disadvantaged. The information presented here demonstrates that there is an enormous variation in the proportion of people who experience mental health problems according to their social and economic circumstances. If the mental health of the people in Greater Glasgow is to be improved by both prevention and treatment and care, it is essential that these major differences are recognised and acted upon. There is a fuller discussion of these issues in Section 11 and 12.
4. DRUG MISUSE AND DEPENDENCE IN GREATER GLASGOW

INTRODUCTION

4.1 Drugs that affect the way we feel, think or behave are used by almost everyone at one time or another and by many on a frequent basis. The most commonly used drugs of this type are alcohol and tobacco. A wide range of others, most of which are illegal, are also used by many, generally younger, people. These include cannabis, ecstasy, tranquillisers, amphetamines, LSD, heroin and cocaine. Our usual aim in taking any mind-altering drug is to feel better: to steady the nerves, to overcome inhibitions, to feel more energetic, to get to sleep, etc. In this respect, drugs often do the trick - at least to begin with. The almost universal use of alcohol is testament to its ability to improve our sense of well-being - up to a point. If we are to understand better the huge popularity of drug taking, we need to recognise that a great many people and especially adolescents and young adults are convinced they are beneficial.

4.2 Unfortunately, most drugs can also have serious adverse effects on both mental and physical health if too much is taken or too often. One of the main problems is dependence or addiction. By far the most common but perhaps the least acknowledged dependence today is on the nicotine in tobacco. This dependence largely explains why so many people find it difficult to stop smoking even when they know it is damaging their health and costing a fortune. The dependent smoker finds that going without a cigarette leads to increasing feelings of anxiety, agitation, headaches and general discomfort. Many people find this is a huge obstacle to giving up. Taking another cigarette is so much easier! Although the vast majority of people who drink regularly are not dependent on alcohol, a small proportion are, and require to drink throughout the day to feel comfortable. In severe cases of alcohol dependence, to suddenly stop drinking can lead to life-threatening illness. Other potentially addictive drugs include the tranquillisers known as benzodiazepines, the best known of which are temezepam and diazepam (Valium). Heroin and other opiate drugs, and cocaine are also highly addictive.

4.3 Many drugs also have serious effects on the function of the brain, either in the short-term, e.g. loss of co-ordination, self-control or consciousness, or in the long-term e.g. permanent brain damage leading to memory loss or depression. The effects of drugs can be particularly unpredictable if more than one are taken simultaneously. The misuse of drugs by individuals who already have mental health problems can lead to a vicious cycle of disordered behaviour and dependence which can be extremely difficult to unravel and greatly complicate the efforts of others to help.

4.4 Over the past 15 to 20 years, there has been a huge increase in the number of young people in Greater Glasgow using drugs other than tobacco or alcohol. Many thousands of people in the area
have become addicted to heroin and other similar drugs. Typically, the heroin is injected or smoked several times a day and is often used together with other drugs such as the benzodiazepines tranquillisers. Drug taking becomes the dominant influence on the life of the addict, poisoning relationships with family and friends, requiring theft or prostitution to finance the purchase of drugs, and threatening both mental and physical health on a daily basis. It is hard to overestimate the damage to the wellbeing of the addict, his or her family and the wider community caused by heroin dependence.

4.5 Paradoxically, many heroin addicts in Greater Glasgow today have slid into drug misuse and dependence in an attempt to escape the unhappiness or emptiness of their lives. The great majority have been brought up in the most deprived parts of the area. Many have had a difficult childhood, with problems at home and at school. Long-term parental unemployment or heavy drinking is common; physical or sexual abuse in childhood is frequently reported, particularly by female addicts. Drug taking will typically have started in primary or early secondary school with cigarettes, solvents and alcohol leading on to cannabis and other illegal drugs. The difficulty that many addicts have in overcoming their dependence on drugs is increased by the long-standing nature of their problems and the perceived lack of a better alternative.

4.6 The use of drugs is therefore inextricably bound up with mental health today. Properly used, both prescribed and non-prescribed drugs can improve mental health. Improperly used, they are a source of enormous harm to both mental and physical health. In the rest of this section, the extent of non-prescribed drug use in Greater Glasgow and the mental health problems this causes are briefly reviewed.

TOBACCO

4.7 In the Scottish Health Survey in 1995, 38% of men and 41% of women living in Greater Glasgow said they were current smokers. These are higher proportions than anywhere else in Scotland. In a telephone survey of 5156 residents of Greater Glasgow aged 18 to 60 years in 1994-95, 32% of men and 35% of women were current smokers and 24% and 20% respectively were ex-smokers. The percentages of smokers, ex-smokers and non-smokers in each of the age and sex groups are summarised in Figure 4.1. If smokers aged under 18 and over 60 are included, these surveys indicate that there are at least 100,000 male and 110,000 female smokers in the Greater Glasgow area.

4.8 In the telephone survey, respondents were classified according to occupational group, ranging from I (professional) to VI (unskilled). Figure 4.2 shows that the percentage of current smokers varied enormously from 13% (I) to 47% (VI) in men and from 13% (I) to 57% (VI) in women. A very similar picture was found in the Scottish Health Survey.

4.9 Using data from surveys carried out each year from 1988 to 1995, there were
significant declines in the percentage of smokers from 36% to 32.7% in men and 38.4% to 34.1% in women. A declining trend was seen in all occupational groups among both men and women but there was no evidence of a narrowing of the wide gaps between the occupational groups over the eight years. The average number of cigarettes smoked per year changed little over the eight years, being around 7,000 for men and 6,200 for women. This costs about £1000 per person per year or about £200 million for the whole of Greater Glasgow.

**Attempts To Give Up Smoking**

4.10 In the month before interview, about 20% of both male and female current smokers had tried unsuccessfully to stop smoking. This represents over 40,000 people in Greater Glasgow - a huge number. The fact that so many are wanting to stop but so few succeed is a testament to the addictiveness of smoking. Among males, the proportion trying to stop smoking decreased with age, from 31% among 18 to 23 year olds to 14% among 40 to 50 year olds.

**Smoking Among 12 To 15 Year Olds**

4.11 In a survey of 1151 12 to 15 year olds living in Greater Glasgow carried out in 1995-96, the proportion who said they were current smokers increased from 6% among 12 year olds to 19% among 15 year olds. There was little difference between affluent and deprived areas in the proportion of 12 year olds who smoked but, by 15 smoking was twice as common among those from the more deprived areas. More girls than boys are now smoking and the proportion of girls who smoke has been increasing recently. The smokers were more likely than the non-smokers to have drunk over the recommended alcohol limit, taken other drugs or had sexual intercourse. This relationship between early smoking, drinking and misuse of other drugs has been found in other major surveys in the United Kingdom.
4.12 There are thus a huge number of people in Greater Glasgow who are dependent on cigarettes. Smoking is now much more common in deprived areas. Many people are becoming addicted as teenagers, particularly women. A growing number of smokers have successfully stopped, but many others are trying to do so and failing. Substantial numbers of smokers will go on to develop serious health problems such as lung cancer, heart disease, chronic bronchitis and circulation problems. The pain and distress these conditions cause to not only the individual concerned but his or her family and carers should not be underestimated.

4.13 Because of the long-term consequences of smoking for physical and mental health, the tenacity of the addiction to nicotine, and the link between smoking and other forms of drug misuse and high risk behaviour among young people, helping non-smokers to avoid becoming smokers and smokers to stop smoking must be among the Health Board’s top priorities. Smoking cessation interventions including the use of nicotine replacement therapy have been shown to be highly cost effective and should be more widely used.23

ALCOHOL

4.14 A more comprehensive strategic review of the health consequences of alcohol for Greater Glasgow is being prepared and is expected to be published in 1999. This present report provides a summary of the current picture.

4.15 The mental health consequences of heavy drinking and alcohol dependence are many and varied. Problems at work and marital or financial difficulties are common. Problem drinking may be a response to underlying depression or may itself precipitate depression. In a high proportion of cases of suicide, alcohol is a major factor. Heavy drinking also leads to untold misery for the families of the affected individual due to erratic or violent behaviour or financial ruin. Accidental or intentional injury or death, occurring whilst under the influence of alcohol due, for example, to drinking and driving or fighting can cause immense and long-lasting distress to both victims

Fig. 4.2 Percentage of current smokers in each occupational group in Greater Glasgow, 1994-95

![Graph showing percentage of current smokers in different occupational groups.](image-url)
and their families. A substantial proportion of thefts and other crimes are committed under the influence of alcohol, often causing lasting distress to the victims. Accurate data on these consequences of alcohol are not available but should not be underestimated. A high proportion of people who are homeless or in prison have severe alcohol problems. This is considered in more detail in Sections 5 and 8.

4.16 In the Scottish Health Survey of 1995,

1245 Greater Glasgow residents aged 16 to 64 years were questioned about their consumption of alcohol. 16% of men and 30% of women said they normally had less than one drink per week or did not drink at all. On the other hand, 37% of men and 14% of women said they normally drank more than the recommended weekly limit of 21 units of alcohol for men and 14 units for women, with 12% and 1% respectively drinking over twice the upper limit. If representative of Greater Glaswegians

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<tr>
<td>Average annual number of emergency alcohol-related admissions in Greater Glasgow by Depcat 1991-95</td>
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<td>70</td>
<td>106</td>
<td>147</td>
<td>340</td>
<td>265</td>
<td>975</td>
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generally, this indicates there are over 100,000 men and 40,000 women who regularly drink over the recommended limits in Greater Glasgow and over 30,000 and 3000 respectively drinking more than twice the upper limit. Men in Greater Glasgow drink more than men in other parts of Scotland, with current drinkers averaging 28 units per week, compared with 21 units in Scotland as a whole. Women in Glasgow drink an average of 7.7 units per week compared with 7 units for women in Scotland as a whole.

4.17 Men in Glasgow are also much more likely than women to take at least five drinks on the same occasion, with 12% of men doing so at least twice a week compared with only 2.3% of women. Frequent heavy drinking is commonest among men aged 18 to 23 and men in unskilled occupational groups. Over the period 1988-95, the proportion of respondents in Greater Glasgow reporting heavy drinking increased significantly for both men and women.6

4.18 In the Health Promotion Department’s surveys of 12 to 15 and 16 to 19 year olds in Greater Glasgow, the proportion of respondents who got drunk at least once a week rose steadily from less than 3% of 12 year olds to around 30% of 19 year olds. Heavy drinkers were much more likely than light or non-drinkers to also be current smokers, to have taken other drugs in the past year, to have been sexually active and to have low expectations of future employment prospects.

4.19 Figure 4.3 shows the annual number of emergency admissions to general hospitals in Greater Glasgow where the patient was recorded as being alcohol dependent, suffering from alcohol abuse or with evidence of long-term heavy drinking. The number of recorded admissions has been rising steadily since the mid-80’s. In over 60% cases occurring in 1995, the main reason for admission was a head injury or a fracture, strongly suggesting the patient had been drunk.

4.20 Figure 4.4 shows the relative risk of alcohol-related emergency admissions to general hospitals (1991-95) and psychiatric admissions (1995) in the Greater Glasgow area according to the deprivation category of area of residence standardised for age and sex. The alcohol-related emergency admission rates were more than ten times higher for residents living in the most deprived areas compared with the most affluent. During the period 1993-95, 13% of all admissions to mental hospitals in Glasgow were for a diagnosis of alcohol psychosis or dependence. The rates were nine times higher for people living in the most deprived areas compared with the most affluent (Figure 4.4). This is thus clear evidence that the patterns of drinking in the more deprived parts of Greater Glasgow are associated with much more harm than that in more affluent areas.

4.21 As alcohol dependence is now often treated in an out-patient or community setting, the number of admissions is likely to be a poor reflection of need. Reliable data on out-patient or community cases
are, however, not available. Alcohol-related problems are a frequent reason for seeing a GP. In a recent survey of GPs in Greater Glasgow, the average number of patients per GP said to have a serious drinking problem was 11. Assuming the sample is representative of all Greater Glasgow GPs, this implies they have a total of roughly 6900 patients with serious drinking problems. More than 50% of GPs reported that alcohol-related family or employment problems and teenage drinking problems had become more common in the past 5 years.

4.22 A rare but devastating form of alcohol-related brain damage is Korsakoff’s syndrome. This results in a largely permanent loss of the ability to memorise new information. Onset occurs typically in heavy drinkers in their 40s or 50s as a result of the combined effects of alcohol and a deficiency of the vitamin thiamine. Because affected individuals are unable to remember what has just happened or what they have just done, they are often unable to look after themselves properly and require long-term care. As it does not affect life expectancy, people with Korsakoff’s syndrome can spend many years in residential care. Recent data indicate that the incidence of Korsakoff’s syndrome in the East End of Glasgow has increased sharply in recent years and at 8 cases per 100,000 population in 1995 is among the highest reported anywhere in the world. This has serious implications for the provision of long-term care. Chronic heavy drinking can also lead to dementia and is addressed in Chapter 3.

ILLEGAL DRUGS

4.23 The misuse of and addiction to drugs other than tobacco and alcohol has increased greatly in the Greater Glasgow area over the past 15 years. Similar trends have been seen throughout the United Kingdom and in most other countries. A more detailed review of the drug problem in Greater Glasgow appears in “Tackling Drugs Together in Greater Glasgow”, the strategy of the Greater Glasgow Drug Action Team. In the present report, the main features of the problem will be summarised and its relationships with other aspects of mental health explored.

4.24 Cannabis is by far the most commonly misused drug after tobacco and alcohol. In recent surveys, 15% of 12 to 15 year olds and 31% of 16 to 19 year olds had tried cannabis at least once. Other drugs frequently used by young people in Greater Glasgow, particularly associated with the dance scene include amphetamines, ecstasy and LSD. Although cannabis dependency is a recognised condition, it is relatively rare. Cannabis use may precipitate a psychotic illness in those who are already predisposed. Habitual use of amphetamines can lead to depression and irrational feelings of persecution (paranoia). There is growing concern that the use of ecstasy may result in long-term depression and loss of memory. Thus, although the consequences for mental health of these drugs may be minor in the short-term for most users, long-term use may have serious implications for mental health.
4.25 Far more severe consequences for mental health in Greater Glasgow result from addiction to heroin and other opiates and to the benzodiazepines tranquillisers such as temazepam and diazepam. Over the past 15 to 20 years, there has been a rapid increase in multiple or “poly-drug” misuse where a wide variety of drugs are injected, smoked or swallowed. The most popular are heroin and temazepam or diazepam but many others are used if available. By 1990, it was estimated that there were around 7-10,000 drug injectors in the Greater Glasgow area, most living in the most deprived parts of the city. Figure 4.5 shows that people living in the most deprived areas were 33 times more likely to be admitted for a drug-related emergency than those living in the most affluent. This link between serious drug-related harm and deprivation is much stronger than for any other mental health problem.

4.26 Poly-drug use and drug injecting have done incalculable harm to the mental health and wellbeing of tens of thousands of Glaswegians. For the users themselves, there is the tyranny of the daily search for drugs and the money to buy them; the huge swings in mood and feelings as the effects of the drugs rise and fall; the panic attacks, sleeplessness, memory blanks, outbursts of violence and epileptic seizures that can result from benzodiazepine use or withdrawal; the damaging effects on relationships with family and friends; the impact of arrest, trial and imprisonment for drug-related offences; the permanent brain damage that can follow years of use; physical disfigurement from drug-related burns or other injuries; the death of friends or relatives from overdose. For the families of addicts, there is the pain and worry of seeing a loved one being ruined by drugs, the humiliation of their son or daughter being convicted; the grief for the many hundreds of families who have lost someone from a fatal overdose, AIDS or a drug-related murder. For many children of drug users there is often the worst possible start to life, full of uncertainty and disruption. For the wider community there are the countless victims of crime and the fear of crime. It is estimated that more than two million drug-related offences are committed in Greater Glasgow each year.

**DRUG MISUSE AND PSYCHIATRIC ILLNESS**

4.27 In recent years, it has become clear that drug or alcohol misuse or dependence increasingly coexists with other types of mental health disorder. This is often described as "co-morbidity" or "dual diagnosis". A high proportion of people with chronic mental illness smoke heavily. Alcohol or other drug misuse can often either precipitate and co-exist with depression or psychosis. People with schizophrenia or a personality disorder may resort to alcohol or drug misuse in an attempt to improve the way they feel. The drug misuse may worsen their symptoms or become an addiction with its own set of problems. In some cases, the drugs may unleash aggressive or paranoid thoughts that can lead to violence against relatives, staff or, rarely, members of the public. Self-medication by psychiatric patients is common. In a recent study of psychiatric
patients admitted to Gartnavel Royal Hospital. 49% were found on urine testing to have been using cannabis or other non-prescribed drugs in the period before admission. Studies elsewhere have confirmed the high frequency of drug misuse among psychiatric patients. Numerous reports from drug services, social work and housing departments indicate that there are many people with serious disorders of their behaviour or mood which do not seem to be explained by their drug misuse alone. This is clearly an area where further research is required to better clarify the nature and extent of the problem and identify ways of helping individuals who are often extremely disruptive and difficult to manage. All psychiatric services now need to be able to recognise and respond effectively to alcohol or other drug misuse in their patients.

4.28 Another group of people who are severely dependent on drugs are those who initially receive tranquillisers or sleeping pills for anxiety or sleeplessness but become unable to stop taking the drugs because of the severe “rebound” anxiety, sleeplessness and other symptoms they experience when they try to stop. Whilst prescribing of benzodiazepines in Greater Glasgow has declined somewhat in recent years, it is likely that several thousand people are still addicted to them.
5. HOMELESSNESS AND MENTAL HEALTH

5.1 Mental health problems including alcohol and drug misuse and dependence are common among homeless people. Schizophrenia, for example, is a major cause of homelessness and in turn homelessness may itself do much to worsen the underlying problem.

5.2 A survey of mental disorders among homeless people throughout the UK was published in 1996. Among 530 single homeless persons living in hostels and 260 homeless persons living in private rented accommodation, the prevalence of neurotic disorders was 38% and 35% and the prevalence of psychotic disorders was 8% and 2% respectively. Among homeless people attending night shelters and day centres about 6 in 10 had evidence of significant mental illness. Sixteen percent of hostel dwellers were defined as alcohol dependent compared with 44% and 50% of night shelter and day centre attenders. Dependence on drugs other than cannabis was 6% among hostel residents, 13% among those using day centres and 22% of those using night shelters. It is estimated that there are around 2,500 to 3,000 people in Greater Glasgow who are homeless. Most are single men and most live in hostels run by Glasgow City Council or a variety of other organisations. In a given year, several hundred people sleep rough in the city. In an extensive search on one night in September 1996, 54 rough sleepers were found in city centre locations.

5.3 In a recent survey of residents in Glasgow hostels for the single homeless, 10% of the 2028 residents were reported as having mental illness, 37% had an alcohol problem and 13% a drug problem. As the survey relied on interviews with the hostel managers rather than the residents themselves, it is uncertain how accurate these figures are and there is no information about the nature and severity of their problems.

5.4 In a survey of 110 young single homeless people in Glasgow, 42% were found to have evidence of significant mental distress and of these 53% admitted current misuse of drugs.

5.5 There is a dearth of accurate information about the proportion of homeless people in Greater Glasgow who have significant mental health problems, and the nature and severity of those problems. Without such information, rational planning of mental health services for the homeless is difficult. A major survey of the mental and physical health of a representative sample of homeless people in Greater Glasgow will be conducted by the Office of National Statistics in conjunction with a local multi-agency steering group during 1999, with the results expected to be published in Spring 2000.

5.6 It should also be noted that there are many people who are not homeless but whose mental health problems are compounded by their inadequate or inappropriate accommodation. This can create a vicious circle leading to tenancy breakdown or eviction, deterioration in health and possible admission to hospital. The inadequacy of the accommodation may then delay discharge or jeopardise any improvements in mental health that had been achieved in hospital.
6. HEAD INJURY AND MENTAL HEALTH

6.1 Head injury can result in long-term mental health problems. The scale of the problem has recently been demonstrated by a study by Professor Graham Teasdale and his colleagues. In the twelve months to 31st January 1996, they identified 3,005 head injured adults admitted to general hospitals in Greater Glasgow. Of these, around 90% had a mild injury, 5% a moderate and 3% a severe injury. All the severe and moderately severe cases and 20% of the mild cases were selected for the study and of these about 70% were followed up for one year. A good recovery at one year was achieved by 48%, 43% and 26% of the mild, moderate and severely injured patients respectively. Relatively few mental health problems were encountered among those who had made a good recovery. However, the majority of patients remained moderately or severely disabled and, among these, mental disturbance was common. The most frequent and disabling problems were anxiety, depression and unstable temper, poor memory, concentration and reduced ability to converse and make decisions. Most of the disabled patients also complained of tiredness, headache and difficulty sleeping. Problems with vision, hearing and balance and seizures were commonly reported. About a third of those with moderate disability and two-thirds of those with severe disability were described as not coping.

6.2 After one year, most patients had been in contact with their GP but this was usually infrequent. Fewer than one in three had had any input from rehabilitation or social work services. Although the main problems identified related to mental health, the most common form of treatment was physiotherapy.

6.3 The authors estimate that there will be between 1,000 and 1,500 newly disabled patients in Greater Glasgow each year as a result of head injury. Most are young men with many years of life ahead of them. This important study has thus demonstrated a substantial area of unmet need.
7. MENTAL HEALTH NEEDS OF ETHNIC MINORITY COMMUNITIES

7.1 There are around 30,000 people or 3.3% of the Greater Glasgow population with origins in the Indian subcontinent (India, Pakistan and Bangladesh) or China. In most cases, the first members of these families came to settle in Glasgow since the second world war. There are also significant numbers of people in Glasgow with Italian and Eastern European origins. There is a well-established Jewish community. There are relatively small numbers of people with African or Caribbean origin. With three universities in Glasgow, students from virtually every corner of the globe may spend some time here.

7.2 Differences in ethnic, cultural and religious background can have an important bearing on mental health. People subjected to racism can experience enormous anxiety, depression and anger. Where people from ethnic minorities also have poor housing conditions with high levels of unemployment and low income, these can create the same stress as experienced by people from the majority population in similar circumstances which can be heightened by greater isolation and language difficulties.

7.3 No reliable information is currently available to indicate whether people in Greater Glasgow with ethnic minority origins have a higher incidence of mental health problems than the general population in similar socio-economic circumstances. Nevertheless, members of the ethnic minorities may experience particular difficulties when mental illness does develop. This has been recently highlighted by the Ethnic Minority Project of the Glasgow Association for Mental Health which published a report in 1997: “Perceptions of mental health needs of Black and Ethnic Minority Communities in Glasgow”.

7.4 The report was based on extended interviews with 25 users or potential users of mental health services and 35 carers of people with mental health problems. About half of those interviewed were Pakistani in origin, a third Chinese and the remainder Indian. A number of significant points emerged from this study. There were important differences between the Pakistani/Indian and the Chinese responses about what they believe to be causes of mental health problems. The Pakistani/Indian respondents more often associated mental health problems with a range of social factors relating to immigration and living in a new country, whilst the Chinese focused on work and money related problems as the main contributory factors. Most respondents had poor knowledge about existing mental health services. Difficulties in communication with service providers because of language differences and a lack of understanding of the patient’s cultural background were seen as crucial obstacles to establishing a meaningful rapport with service providers and obtaining appropriate help. Many respondents also felt that the fear and confusion surrounding mental illness and the stigma attached to it were often strongly felt by members of their community and contributed to many potential clients not accessing services. These important points need to be addressed by service providers.
8. MENTALLY DISORDERED OFFENDERS

8.1 Where mental disorder or learning disability results in disturbed or anti-social behaviour, this can result in an offence or offences being committed and the individual being arrested. People under the influence of alcohol or other drugs are more likely to offend. Many drug addicts frequently commit property crime to acquire the money they need to buy drugs. In addition, people who are arrested and imprisoned may subsequently develop mental health problems such as anxiety or depression and in some cases may attempt or commit suicide. Consequently, the police, the courts, the prison service and the criminal justice sections of social work departments frequently come into contact with offenders who are mentally disordered or have a significant learning disability. Under the terms of the Mental Health (Scotland) Act, persons who are arrested, charged or convicted and who have a mental disorder as defined by the Act may be transferred to a psychiatric hospital or other place of treatment.40

8.2 The types of offences committed by mentally disordered offenders vary widely in nature and seriousness and largely relate to the type of underlying mental disorder. These range from minor disturbances of the peace to sexually offending, arson, assaults and murder. Problem drinking is typically associated with disturbance of the peace and assault. Drug misuse and dependence is usually the underlying reason for shoplifting, burglary, robbery, fraud and soliciting.

8.3 Much is already being done to address the needs of mentally disordered offenders. The State Hospital at Carstairs is a key national resource, specialising in the treatment of individuals in secure conditions. In recent years, its facilities and procedures have undergone immense improvement but are under great pressure because of insufficient provision of appropriate secure facilities at the local level. The Forensic Directorate in the Greater Glasgow Primary Care NHS Trust is the main specialist service for mentally disordered offenders in Greater Glasgow. It has close links with the prisons and the courts. Nevertheless, as the Health Board’s Strategy demonstrates, there is considerable room for improvement in services, both in the provision of secure in-patient treatment and in developing co-ordinated care and on-going support in the community and in conjunction with the police, the courts and the prisons. The Health Board is committed to achieving this over the next few years.

8.4 The many complex issues that relate to the provision of services for mentally disordered offenders are addressed in a comprehensive strategy agreed by Greater Glasgow Health Board in December 1997.41

8.5 We will limit our consideration of this highly complex area to a summary of the currently available evidence for the prevalence of mental ill health among people detained within the criminal justice system. In an analysis of arrestees detained at one of Glasgow’s busiest
police stations in the first six months of 1997, out of around 5000 individuals about 1000 were considered to have a significant health problem. Of these, 20% had a major drug problem, 38% were considered suicidal and 3% had a "mental disturbance". Many were drunk. Further work is needed to know more about the nature and severity of these mental health and substance misuse problems and to ascertain whether there are similar findings at other police stations.

8.6 A major survey of psychiatric morbidity among prisoners was published by the Office of National Statistics in 1998. A total of 3142 individuals from all prisons in England and Wales were interviewed, including both male and female and sentenced and unsentenced prisoners. In the 12 months before entering prison, 20% of male prisoners and 40% of female prisoners had been receiving help or treatment for a mental health problem. The prevalence of functional psychosis was found to be 7% for male sentenced prisoners, 10% for male remand prisoners and 14% for female prisoners. Personality disorder was extremely common, being found in 64% of male sentenced prisoners, 78% of male remand prisoners and 50% of female prisoners. A wide range of neurotic symptoms were reported by at least one in three of the sample, especially among female prisoners, of whom at least two-thirds reported sleep problems, worry, fatigue and depression. Suicidal thoughts and attempts were common especially among remand prisoners. Over half the males and almost 40% of the females reported hazardous drinking in the year before imprisonment. Over two-thirds of the male prisoners and female remand prisoners and over half the female sentenced prisoners had used illegal drugs in the past year. Opiate dependence was reported by 36% and 41% of male and female remand prisoners respectively and 18% and 23% of male and female sentenced prisoners. More than 80% of the sample had more than one of the main types of mental health disorders that were considered. This impressive survey thus shows that the levels of mental health problems among prisoners are far higher than in the general population.

8.7 There is much less reliable information about mental health problems among Scottish prisoners. In a survey of a 50% random sample of all untried prisoners in Scotland in 1993, a major psychiatric disorder was found in 2.3% of those interviewed. 22% of the prisoners had alcohol-related problems and 73% had used illicit drugs in the past, a third of them intravenously. These figures appear lower than those from the ONS study in England and Wales. An analysis was carried out on the information obtained during the medical admissions screening of all 906 men admitted to Barlinnie Prison during January 1998. Past or current mental illness was recorded for 11% of prisoners including 14% of remand prisoners and 9% of convicted prisoners. Specific diagnoses were not recorded and formal mental health assessments were not carried out. As a result, the true extent of mental illness is likely to be seriously under-estimated.
39% of prisoners said they had used drugs at sometime in the past with 23% reporting drug misuse in the past 4 weeks. This included 8% who were receiving prescribed methadone before admission. Over 7% gave a history of current problems with alcohol and 2% of alcohol problems in the past. A comparison of these data with the results of the ONS survey in England and Wales suggests the Barlinnie figures are a serious underestimate.

8.8 At present, there is a lack of accurate up-to-date comparable data on the extent of mental disturbance and mental illness among other prisons holding Greater Glasgow residents. It is clear, however, that over the past 15 years, there has been a huge increase in the proportion of prisoners with serious drug problems, many of whom are drug injectors dependent on heroin and benzodiazepines. It is currently estimated that at least 30% of Scottish prisoners have a recent history of drug injecting. "A high proportion of suicides in prison and a large number of deaths occurring after release from prison in recent years have involved drug misusers. It is also plain that many offenders have serious personality disorders which neither the prison service nor the mental health service are currently equipped to manage well. How we address drug misuse and personality disorder are two key issues facing those with responsibilities for work with offenders."
9. POST NATAL DEPRESSION

9.1 This section summarises the results of a study carried out by the Women’s Health Section of the Department of Public carried out in 1997. Its aim was to identify the number of women in Glasgow with evidence of post-natal depression; to determine the factors associated with depression; and examine the response of primary health care staff to women with depression.

9.2 All women resident in the Greater Glasgow area who gave birth during the first three months of 1997 were expected to be screened around twelve weeks after delivery. Screening was carried out by health visitors using the Edinburgh Postnatal Depression Scale (EPDS) which has been validated and widely used for this purpose. The EPDS yields a score of between 0 and 30. Women with scores above 12 are likely to suffer from post-natal depression and should be clinically assessed. Of the 2,540 women eligible for screening, assessment forms were received for 1,740 (67%). Of these, 1098 (43%) had been properly completed during the correct 10 to 14 week period after the birth. A further 17% had been properly completed but either too soon or too late. However, it is likely that the low response rate largely reflected the practice of the attending health visitors and that the women screened were broadly representative of all women giving birth in Greater Glasgow during the study period.

9.3 The study found that 26% of the 1098 women had an EPDS score of 12 or more suggesting post-natal depression. The main factors which were found to be strongly linked to post-natal depression were:

1. A history of previous depression.
2. Having had at least three previous births.
3. Smoking.

However, many women with high scores did not have any of these three factors which therefore could not be used alone to identify most women who had post-natal depression. Other factors which were found to be more commonly linked to high scores were: living in deprived areas; being unemployed or whose partner was unemployed; and bottle feeding compared with breast feeding. Women aged 15 to 19 and 35 to 39 were least likely to have a high score. The women's ethnic origin and fluency in English and the method of delivery, baby's sex and baby's condition were not significantly related to a high score.

9.4 As a consequence of the EPDS score, the health visitor took action in 92% of cases with a high score compared with 9% of cases with a low score. Action usually involved either revisiting the patient or referring her to another service. No information is available about what then happened nor about whether any of the action taken resulting in an improvement in the patients symptoms or other benefits. The incidence of post-natal depression in Greater Glasgow appears higher than that detected in other parts of the United Kingdom and other countries.
when using the same screening tool. It is unclear why this is. The study has confirmed that post-natal depression is an important problem in Greater Glasgow affecting around 2,500 women each year. Further work is required to assess the effectiveness of the service response, particularly for those women where the depression is severe. If undetected and untreated, post-natal depression can have adverse consequences on the social, emotion and intellectual development of the baby, on the mother's relationship with her partner and her own long-term mental wellbeing.
10. SEXUAL, PSYCHOLOGICAL AND PHYSICAL ABUSE

10.1 In recent years it has become clear that sexual, emotional, psychological and physical abuse may all have important adverse effects on the mental health of both children and adults. The forms this can take include child sexual abuse, domestic violence and rape or sexual assault. In most cases the abuse is perpetrated by males against females in a family or other domestic setting. There is also growing evidence of the extent of sexual abuse of both girls and boys in residential care homes. People who have been abused are more likely than those who have not to be depressed, to attempt suicide and to misuse or become dependent on drugs or alcohol. Some may suffer from post-traumatic stress disorder.

10.2 American studies have found that the proportion of people reporting childhood sexual abuse ranges from 12% to 38% among females and 6% to 13% among males. One of the few British studies found that 12% of females and 8% of males reported experiencing sexual abuse as a child. Extrapolated to the Greater Glasgow population, this suggests that about 47,000 women and 27,000 men living in the Greater Glasgow area may have experienced sexual abuse as a child. About three children per 1,000 are on the Child Abuse Register in the West of Scotland at any one time, of whom 16% to 20% are thought to have experienced sexual abuse. As the register only records reported cases, this is certainly a serious underestimate of the true extent of the problem.

10.3 There is a strong link between sexual victimisation and an increased risk for a wide range of mental health problems in adulthood. Between 25% and 75% of people experiencing sexual abuse report that it had had a damaging effect on their lives. Its impact will clearly vary according to the nature, circumstances and duration of the abuse. The prevalence of child sexual abuse among various samples of female psychiatric patients has been extensively studied. Around 30% of female patients attending psychiatric outpatient clinics report having been sexually abused in childhood. A disproportionately large number of women who are drug or alcohol dependent report having been sexually abused.

10.4 The causal connection between childhood sexual abuse and the development of mental illness is, however, less clear given the possible contribution of other factors in the survivor’s background such as disturbed family relationships. A report examining the links between child sexual abuse and its implications for Health Service provision is being produced by the Public Health Department for publication in 1999.

10.5 Accurate data on the true extent of sexual, emotional, psychological and physical abuse of adults are not available but it is undoubtedly common. The demands made on support groups and refuges in Greater Glasgow for women who are the victims of abuse is testament to this. Extrapolation from national government
estimates suggest that around 30,000 women in Greater Glasgow may have experienced domestic violence from a male partner in the past year and 100,000 at any time\textsuperscript{85}. Much more needs to be done to investigate the true extent of abuse and its consequences for mental health in Greater Glasgow, to provide more effective treatment and support for its victims and above all to prevent its occurrence. In this regard, the recent publication of a Scottish Office Action Plan on Preventing Violence Against Women is a very welcome development\textsuperscript{86}. 

11. TREATMENT AND CARE

11.1 The requirement for treatment and care of individuals with mental health problems will vary enormously according to the person’s problem and circumstances. A particular diagnosis of mental illness can give a strong indication of the need for treatment or care. However, in addition to the diagnosis, it is always necessary to consider in detail the severity and persistence of symptoms and behavioural problems and the individual’s social circumstances. Problems associated with mental illness include:

- Subjective symptoms such as hallucinations or irrational fears (phobias)
- Suicide and attempts at suicide
- Socially embarrassing or unacceptable behaviours
- Slowness, lack of motivation or poor self-care.
- Lack of insight into the nature of the problem
- Overall social disability and inability to cope.

Factors which may be involved in either causing or worsening the person’s problems include marital breakdown or family conflict, previous physical or sexual abuse, unemployment, job insecurity or boredom, poor accommodation or homelessness, financial difficulties or legal problems including arrest or imprisonment.

This brief consideration of treatment and care takes a Health Service perspective. It is not intended to suggest that social work and voluntary organisations, amongst others, have less important roles.

11.2 General practitioners and their staff have an important position in the care of patients who reach medical attention. They are able to provide some help for the great majority of individuals with mental health problems, most of which are anxiety and depression. General practitioners often have the advantage of knowing their patients and families for a long time, and can provide continuity if their patients require treatment by other health professionals. It is the general practitioner’s responsibility to determine whether a patient’s symptoms merit further treatment or referral. General practitioners will also often know other close family members who may themselves be affected by the patients’ illness, leading to mental health problems of their own. This may be especially true for the principal carers.

11.3 Broadly, there are three options open to the general practitioner: drug treatment, non-drug treatment (psychotherapy and counselling) or referral to other professionals. Drug treatments for mental illness in primary care are principally focused on antidepressants, anxiolytics (anxiety-reducing drugs or tranquillisers) and hypnotics (sleep-inducing drugs) with antipsychotic drugs being used less frequently. To some extent, GPs use psychotherapeutic and counselling
11.4 Access to specialised psychiatric services may be via a number of pathways. Generally, psychiatric services receive referrals from general practitioners, but hospital clinicians and social work may also request consultations and patients may self-refer. Mental health professionals include psychiatrists, psychotherapists, clinical psychologists, hospital nurses, occupational therapists, community psychiatric nurses (CPNs) and specialist social workers. Treatment may be given in the individuals’ own home, a mental health resource centre, an out-patient clinic, a day hospital or an in-patient hospital ward.

11.5 Specialist psychiatric treatment begins with a longer consultation than the general practitioner can usually accommodate. The initial aim is to explore and assess the patient’s symptoms and mental state, leading to a diagnosis and a plan of action. A number of different disciplines may then become involved in the care of an individual, and each brings its own contribution. Drug treatments and psychotherapy form the principle bases for treatment. Specialised treatment such as electro-convulsive therapy (ECT) for severe depression may also be used when appropriate. Admission to hospital will be recommended when this is considered necessary for the patient to be properly assessed and treated or when there are concerns about the safety of the patient or others. If the patient refuses to be admitted, procedures laid down in the Mental Health (Scotland) Act can be followed to enable the patient to be admitted and detained compulsorily.

11.6 Rarely, when the patient’s mental state is assessed as representing a serious danger to himself or others or when a serious offence has been committed, the patient may be confined to a locked ward or a secure unit. There are strict rules governing compulsory admissions to guard against infringements of civil liberties.

11.7 Over the past 10-15 years the organisation of care for people with mental health problems has undergone considerable change. There is now much greater emphasis on treating patients in the community rather than in hospital whenever safe and sensible to do so. There has also been greater recognition of the importance of addressing peoples’ problems in a more holistic way. Family conflict, inadequate accommodation, child care issues, unemployment and lack of leisure opportunities may all have a major bearing upon the patient’s ability to cope and recover. Involvement of social workers or appropriate voluntary organisations can often make an essential contribution to recovery. Successful care in the community may depend on the presence of a carer such as a partner or other family member. The pressures and stresses they can experience may lead to breakdown if sufficient professional help
is not available. Co-ordination of different services is thus often crucial to the success of care. Many of the well-publicised failures in recent years have resulted from poor communication between services or professionals. The tasks of co-ordination are clearly more complex when the individual is being treated in the community and not subject to constant supervision and particularly when his or her condition is severe and enduring. The burden upon family members and other informal carers is also inevitably increased. On the other hand, it is clear that most patients can be satisfactorily treated in the community, provided adequate support is provided.

**Prescribing for Mental Disorders**

11.8 One of the main forms of treatment for mental health disorders is the prescription of drugs. The main types used are hypnotics or anxiolytics which are used to help treat sleeplessness and anxiety respectively; anti-depressants; and anti-psychotics used to treat more serious psychotic illnesses such as schizophrenia. Figure 11.1. shows that over the past five years, the number of prescriptions by general practitioners for hypnotics and tranquillisers has fallen gradually in the Greater Glasgow area. This continues a trend over the last ten years or so, following the realisation that they are addictive and have become popular drugs of misuse. Nevertheless, there are still almost half a million prescriptions for these drugs written every year in Greater Glasgow. On the other hand, during the same period there has been a 70% increase in the number of prescriptions for anti-depressants. This results from the availability of a range of newer anti-depressants which are seen as being safer and more effective. There has also been a 36% increase in the number of prescriptions for anti-psychotics. This probably also results from the availability of a wider range of newer drugs which may be better tolerated by patients. Figure 11.2 shows the cost of these drugs to the Health Service. Although the most commonly prescribed, hypnotics and tranquillisers are relatively cheap. The newer anti-psychotic drugs are relatively more expensive explaining the doubling of expenditure on these. The most dramatic increase has been in the cost of anti-depressants, with expenditure in Greater Glasgow increasing by about £4 million during the five years 1993-97.

Although all these drugs have been shown to be effective in clinical trials, we have no information as to what benefits have resulted from their use in Greater Glasgow. This is an area where more research on the outcome of treatment, particularly with anti-depressants, would be very useful.

**The Treatment of Drug Dependence**

11.9 The treatment of drug dependence can be very challenging. The ultimate aim is normally to help the individual to stop taking the drug of addiction. For some people who are well motivated and whose addiction is relatively mild, this may successfully be achieved with a lot of encouragement and support. For many others, the dependence can be so well established, the withdrawal symptoms so
distressing and the hunger for the drug so persistent that coming off drugs in the short term may be impossible to achieve. The treatment of drug addiction therefore requires a variety of options that are tailored to meet the needs and capabilities of each individual. In many instances, whether the drug of addiction is nicotine, alcohol or heroin there may be many failed attempts at abstinence before success is achieved.

11.10 For certain types of addiction, regular prescription of the drug itself or a related drug can provide a very helpful degree of stabilisation and less harmful drug use and the possibility of gradual and controlled reduction. The two most successful approaches of this type have been using nicotine replacement for smokers and methadone replacement for heroin addicts.

11.11 A wide variety of forms of nicotine replacement including chewing gum, nasal spray and skin patches are available for purchase from pharmacies without prescription. If properly used, nicotine replacement can approximately double the success rate compared with willpower alone. Given the considerable benefits
to both physical and mental health that can result from stopping smoking and the large number of continuing smokers in Greater Glasgow who would like to give up, there is an extremely strong case for the use of nicotine replacement in a more systematic way. The recent government decision to make nicotine replacement available through the NHS under certain circumstances is extremely welcome.

11.12 Methadone is an opiate in the same family as heroin. It gives much less of a “high” than heroin and remains active in the body for much longer. Consequently, a single daily dose can be taken instead of several injections of heroin. Methadone is normally taken by mouth as a syrup. A great deal of research has been done on methadone, including a recent study in Greater Glasgow. This shows that if properly used, it can help many heroin addicts to greatly reduce and often stop injecting and using heroin altogether, with a consequent reduction in serious health problems, an improvement in their behaviour and huge reductions in the amount of drug-related crime they commit.32

11.13 The use of methadone in the treatment of heroin addiction in Greater Glasgow has increased greatly from between 200-300 patients in 1993 to almost 3,000 in 1999. In Greater Glasgow, methadone is mainly prescribed by general practitioners, with the daily dose usually being taken under the supervision of the pharmacist in the chemist shop.33 Achieving abstinence from heroin can be attempted by prescribing a gradually reducing dose of methadone or using other drugs to diminish the unpleasantness of the withdrawal symptoms. Realistically, this can be for many only a long term aim.

11.14 Many heroin addicts will require considerable psychological support to remain drug-free. The absence of employment or other meaningful activities can lead to boredom and disillusionment. Intrusive thoughts relating to past experiences, among which physical or sexual abuse is common, can be distressing and difficult to manage. Similar challenges are encountered in helping problem drinkers or people dependent on benzodiazepine tranquilisers. A fuller consideration of the treatment of drug dependence in Greater Glasgow is given in the Drug Action Team Strategy: “Tackling Drugs Together in Greater Glasgow”. The treatment of alcohol misuse and dependence will also be addressed in a forthcoming strategic report.
12. THE WAY FORWARD

12.1 The evidence presented in this report shows that mental health problems can occur at any time in life, regardless of age, gender and ethnic or cultural background. However, it is clear that people who live in the most disadvantaged circumstances are much more likely to suffer from mental ill health than those who live in the most affluent. There are undoubtedly many and complex reasons for this. Nevertheless, if we are to improve the mental health of people in Greater Glasgow and substantially reduce the burden of mental illness, it does seem likely that major efforts will be needed to reduce social inequalities and improve the environment and opportunities of people living in the most deprived parts of the area. Particularly welcome has been the Government’s recognition of the links between deprivation and ill-health and the need to regenerate depressed areas, improve the standards of housing, education and recreational facilities and increase opportunities for employment.\(^1\)

12.2 The report also demonstrates that the misuse of and dependence upon a wide variety of drugs, ranging from tobacco to heroin is a major mental health issue in Greater Glasgow. Many people take drugs to improve their sense of well-being but all too often the drugs themselves become a cause of distress and ill-health, not only for the drug takers but also for their families and the wider community. People with mental health problems are particularly likely to misuse or become dependent on drugs. The distinction that is sometimes made between mental illness and the mental health consequences of drug misuse has no basis in the reality of Greater Glasgow today.

12.3 The impact upon mental health of physical, psychological and sexual abuse has been receiving much greater attention in recent years. Much more needs to be done to prevent the abuse and provide genuine help for its victims.

12.4 Helping people who have mental health problems is often a very complex task. In the first place, they or their families need to recognise that they have a problem and then know where they can get help. A sense of shame or embarrassment, or simply a lack of energy may still prevent the individual from going for assistance. Many people also find it extremely difficult to talk about their problems and to put into words exactly what they feel. Effective help is then only likely to be given if the person’s problems are recognised and accurately assessed. Not only is it necessary to have an accurate diagnosis but it is also essential that other problems in the person’s life, for example, family conflict, financial problems and unemployment are recognised. Because many people who are mentally ill have many different problems, there is often a need for professionals and carers in different disciplines and agencies to work together. This requires the health service, social work, housing and the voluntary sector to work closely both at the planning level and for the benefit of individual patients. Close links between these
agencies and the police, the courts, and the prisons are also crucial in helping mentally disordered offenders.

12.5 The report has also highlighted several types of mental health problems where there is clearly substantial need but few, if any, locally based services. These include the long term mental health consequences of head injuries; eating disorders and alcohol-related brain damage and early onset dementia.

12.6 If treatment and care is to be as effective as possible, not only must the correct methods be used but efforts must also be taken to ensure that treatment is adhered to and achieves satisfactory results. With more and more treatment of mental illness now being provided in the community, systems of supervision and monitoring are often crucial, particularly for patients who may not be fully co-operative.

12.7 Much of the report is based on incomplete information and a number of major gaps in our understanding of mental health in Glasgow are now apparent. We do not have complete and accurate registers of people with severe and enduring mental illness. We therefore do not have a clear idea of the size of the problem or a means of being sure that all those in continuing need are receiving help. The recently introduced Care Programme Approach should help to improve this situation. Whilst various forms of treatment have been shown to be effective in carefully controlled clinical studies, we have virtually no information about how effective treatment in Greater Glasgow is in practice. These are thus some of the main areas which urgently require further research.
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