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Report based on the analysis of the ONS Survey of Psychiatric Morbidity among Adults in Great Britain carried out in 2000 for the Department of Health, the Scottish Executive Health Department and the National Assembly for Wales

Adults with a psychotic disorder living in private households, 2000

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1 Tables showing percentages

The row or column percentages may add to 99% or 101% because of rounding.

The varying positions of the percentage signs and bases in the tables denote the presentation of different types of information. Where there is a percentage sign at the head of a column and the base at the foot, the whole distribution is presented and the individual percentages add to between 99% and 101%. Where there is no percentage sign in the table and a note above the figures, the figures refer to the proportion of people who had the attribute being discussed, and the complementary proportion, to add to 100%, is not shown in the table.

The following conventions have been used within tables:

- \- no cases
- 0 values less than 0.5%
- .. data not available

A percentage may be quoted in the text for a single category that is identifiable in the tables only by summing two or more component percentages. In order to avoid rounding errors, the percentage has been recalculated for the single category and therefore may differ by one percentage point from the sum of the percentages derived from the tables.

2 Statistical significance

Because of the low prevalence of psychotic disorders and the severity and nature of these conditions, it is difficult to obtain a sufficiently large and fully representative sample of people with psychotic disorder from the general population for detailed analysis. Therefore, the percentages presented in this report are indicators of prevalence only within this particular sample, and should not be taken as estimates for the total population of people with a psychotic disorder. However, the sample is likely to be typical of many of the people with psychotic disorders within the household population and to represent people across the range of severity of disorder. Differences in service use and other circumstances have been investigated by means of multi-variate analysis. Where an association is said to be statistically significant this refers to comparisons within this sample group only and does not indicate that the same association would be found to be significant within the whole population of people with psychotic disorder.

3 Small bases

Very small bases have been avoided wherever possible because of the relatively high sampling errors that attach to small numbers. In general, percentage distributions are shown if the base is 30 or more. Where the base is lower, actual numbers are shown in square brackets.

Authors' Acknowledgements

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Ms T Jones, National Assembly for Wales
Dr J Loudon, Scottish Executive
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Summary of key findings

Background, aims and method (Chapter 1)

- The data covered in this report come from two sources: a survey which was carried out in 2000 and is a repeat of an earlier survey of adults living in private households, and a supplementary sample of people with psychosis identified through GP records held on the General Practice Research Database.
- The analysis is based on information obtained from 60 people identified as probably having a psychotic disorder in the 2000 survey of adults living in private households and 140 people identified from GP records as having at some time been given a diagnosis of psychotic illness or prescribed medication for treating such conditions.
- The aim of the report is to investigate the circumstances of adults with a psychotic disorder, and to identify characteristics associated with their functioning, circumstances and use of services.
- The severity, nature and comparative rarity of psychotic illness makes it difficult to obtain a representative sample of people with psychotic disorder living in the community of sufficient size for detailed analysis. Therefore, the results presented in this report and tests for the significance of associations relate only to this particular sample and may not be true for the total population of people with a psychotic disorder. However, the sample is likely to be typical of many of the people with psychotic disorders within the household population and to represent people with a range of severity of disorder.

Medication and service use (Chapter 2)

- Overall, 91% of this sample of people with a psychotic illness were receiving some form of treatment, either medication or some form of counselling or therapy.
- Just over four-fifths (82%) of respondents were receiving one or more psychoactive medications. The majority of these, 63% of the sample as a whole, were taking drugs used in the treatment of psychoses, over a third of the sample (37%) were taking antidepressant medication, and just over a fifth (22%) were taking hypnotics or anxiolytics.
- In this sample, 10% of people who were using antipsychotic medication were receiving them as depot injections (injections administered at regular intervals, for example weekly or monthly). This is substantially fewer than was found in the sample from a similar survey in 1993, when a quarter of the sample living in private households were receiving antipsychotic depot injections.
- Although similar proportions of people aged under 45 and 45 and over were receiving medication, younger respondents were more likely to be receiving psychological therapy or counselling. Over a third (39%) of those aged under 45 were receiving counselling or therapy, either alone or with medication, compared with just over a fifth (22%) of those aged 45 and over.

- The most common group of non-medicinal therapy reported was psychotherapy and psychoanalysis – reported by almost half (49%) of those receiving counselling or therapy, while over two-fifths (42%) were receiving counselling, and 14% were being treated through behavioural or cognitive therapy.

- In the year before the interview, three-fifths (62%) of respondents had consulted their general practitioner about a mental or emotional problem and 10% had done so in the previous two weeks. Younger people and those with higher levels of neurotic symptoms were more likely to have spoken to their GP in the previous 12 months.

- Overall, 3% of the sample reported an in-patient stay in the last quarter relating to a mental health problem and over a fifth of the sample (22%) reported one or more out-patient visits. Younger respondents were almost twice as likely as those aged 45 and over to have attended an out-patient department in the three months before interview in connection with a mental health problem (30% compared with 17%).

- Two-fifths (40%) of the adults in this sample of people with a psychotic disorder had had contact with community care services during the previous quarter. People living alone and those who were economically inactive had increased odds of receiving such services.

- More than a quarter (27%) of informants had used one or more day activity services (such as a community mental health centre, day activity centre or sheltered workshop) in the previous year, and 20% in the three months before interview. Men were twice as likely as women to have used a day activity service in the past year: 38% had done so, compared with 17% of women. People living alone, in particular, and those in manual social classes were more likely to have used these services once other factors were taken into account.

Activities of daily living (Chapter 3)

- Over half of this sample of people with psychotic disorder (56%) reported difficulties with one or more activities of daily living (ADL). Most of these (49% of the whole sample) said that they needed help to overcome at least one of these difficulties.

- People were most likely to have difficulty with practical activities (35%), dealing with paperwork (32%) and household activities (26%) and least likely to report having difficulty with medical care (7%) or personal care (12%).

- Respondents with high levels of neurotic symptoms (those with CIS-R scores of twelve or more) had significantly increased odds of having difficulties with all aspects of ADL, except for practical activities.

- Those who were economically inactive also had increased odds of having difficulties with using transport, managing money, household activities and practical activities, but not personal care, medical care or dealing with paperwork.

- People who reported having a long-standing physical complaint had greater odds of reporting difficulties with personal care and practical activities only.

- Not surprisingly, the level of educational qualifications obtained was inversely associated with the need for help with paperwork – people with qualifications at A level or above had lower odds of having difficulties dealing with paperwork than those with lower levels of qualifications.

- The majority of those who needed help with one or more activities were receiving help with at least one ADL for which help was needed. However, of those who needed help, 4% received none for any ADL for which they needed it and 11% had at least one difficulty for which they had an unmet need for help.

- Family and friends were the most common providers of help for activities of daily living. Forty-one per cent of those needing help received it from their spouse or partner, 36% from another relative, and in 32% of cases from a friend. Health or social care workers provided help for 19% of informants who needed help, while nearly a quarter of those needing help (23%) received help from others including, for example, paid domestic help and solicitors.

Economic activity and finances (Chapter 4)

- In this sample of people with a psychotic disorder, a very high proportion of people, 70%, were economically inactive. Just over a quarter (27%) were in paid employment, half of them full time and half part time.

- The majority (62%) of those who were economically inactive were not seeking work because they were long-term sick or disabled, another fifth (20%) were retired and 12% were looking after their family or home.

- Four variables were found to be independently associated with being unable to work due to long term illness or disability. The strongest association was with CIS-R score: having a high CIS-R score more than quadrupled the odds of not being able to work due to illness or disability. Living in rented accommodation trebled the odds, while being male and living alone also both independently increased the odds.

- Among the adults in our sample who were in paid employment at the time of interview, almost half (47%) said that they had taken time off in the past year because of their health or the way they were feeling.

- Among those who were not currently working but had previously had a job, the majority, 59%, said they were not working because the way they had been feeling made it impossible for them to do any kind of job. Eighteen per cent were not working because of a physical health problem, 5% had been unable to find a suitable job and 12% said they did not want or need a job.

- Overall, at the time of interview, 79% of respondents were receiving some form of state benefit or allowance. Twenty-eight per cent of informants were in receipt of income support, family credit or working families tax credit. Over a half of informants, 52%, were in receipt of a benefit relating to a disability.

- Apart from benefits, over half of the sample (54%) had no other sources of income, and three respondents (2%) said they had neither state benefits nor other sources of income. Nearly a quarter (24%) of respondents had some earned income, including 8% of those who received benefits. Overall 14% had a pension from a former employer.

- Almost half of this sample (45%) had a gross weekly income of under £100. For those on state benefits and without other sources of income, this rose to 61%, compared with 29% for those in receipt of state benefits but who had other sources of income, and 21% of those with other income and no state benefits.

- Overall, 17% of respondents reported that, in the past 12 months, there had been times when they had been seriously behind in paying bills. Almost a tenth (9%) of the sample had been disconnected from one or more of the utilities (water, gas, electricity, telephone) in the previous twelve months.

Social networks and perceived social support (Chapter 5)

- Among this sample of people with a psychotic illness, a fifth (20%) reported feeling close to fewer than four people. In comparison, in the survey of adults living in private households in 2000 only 5% had a small primary support group (less than four people).

- Just over one fifth (21%) of this sample of people with psychotic illnesses were classified as having a severe lack of perceived social support, while 25% had a moderate lack and 54% had no lack of social support.

- Sex and age were both associated with having a severe lack of social support. Twenty-eight per cent of men, compared with 15% of women, were classified as having a severe lack of social support, as were 31% of people aged under 45 compared with 14% of those aged 45 and over.

Tobacco, alcohol and drugs (Chapter 6)

- A large proportion of this sample of people with a psychotic illness were, or had been, smokers: 44% were smokers, a fifth (20%) were ex-smokers and just over a third (36%) had never been a regular smoker. The 2000 General Household Survey found that, amongst the general adult population aged 16 to 74 years, 29% smoked, 22% were ex-smokers and half (50%) had never smoked.

- As well as having a high prevalence of smoking, a large proportion of people in the sample reported smoking heavily (20 or more cigarettes a day). Just over a quarter (27%) of the sample of people with psychotic illness were heavy smokers while only one in twelve (9%) of the general population in the same age group did so.

- Age group and tenure were independently associated with both smoking and heavy smoking in this sample of people with a psychotic disorder. Younger people and those who rented their homes had greater odds of both smoking and being a heavy smoker. High levels of neurotic symptoms were also associated with greater odds of being a heavy smoker.

- Among this sample, 27% of respondents had an AUDIT score of 8 or more – that is, they were found to have a hazardous level of drinking in the year before interview – including 14% who were classified as alcohol dependent. In the survey of adults living in private households in 2000 25% of people were assessed as having hazardous drinking patterns.

- Men were more likely than women in this sample to have a hazardous pattern of alcohol consumption, and younger people were more likely than older people to do so. This is similar to the pattern seen in the general population.

- Overall, 30% reported ever using one or more illicit drugs, and 8% reported having done so within the last twelve months. These figures are similar to the rates found in the household survey.

Stressful life events, suicidal thoughts and behaviours (Chapter 7)

- Over two-thirds (70%) of this sample of people with a psychotic illness had thought about suicide at some time in their lives and 45% had attempted suicide. In addition, 21% had harmed themselves without intending to commit suicide. These rates are far higher than those found in the general household population in which the corresponding figures are 13% reporting suicidal thoughts, 4% attempted suicide and 2% deliberate self-harm at sometime in their lives.

- Almost everyone in the sample (97%) had experienced one of the stressful life events in the group concerning relationship problems, illness and bereavement. Compared with the general household population, this sample reported experiencing particularly high rates of serious illness or assault to themselves, 63% compared with 26% in the general population, and divorce or separation, 47% compared with 22%. They were also more than twice as likely to report a serious problem with a close friend or relative, 30% did so.

- Stressful events relating to employment and finances were also far more common in this sample than in the general household population. They were also much more likely to report having had a problem with the police involving a court appearance – 22% reported having done so. Men in the sample were more likely than women to report almost all of this group of stressful events.

- A very high proportion of people in this sample reported experiencing one of the types of victimisation covered in the survey. Over a fifth (21%) reported sexual abuse and the rate was markedly higher among women and younger people (31% in each case). About a quarter of the sample said they had experienced violence in the home (25%) and being homeless (23%), while 41% said they had suffered bullying.

- Over half of the sample, 57%, had experienced six or more stressful life events and 17% reported ten or more of them.

- The proportion of people in this sample who reported suicidal thoughts and, in particular, self-harm with or without suicidal intent, increased with the number of stressful life events they reported. Those who reported eight or more events had particularly high rates: over 80% reporting suicidal thoughts and over 60% attempting suicide at some time in their lives.

- Among those who reported a serious problem with a close friend or relative, 66% said they had attempted suicide at sometime in their life (compared with 44% of the sample as a whole). A similar proportion of those who had experienced violence in the home had attempted suicide (67%) as had 71% of those who had been homeless and 74% of those who had experienced sexual abuse.

- The presence of significant levels of neurotic symptoms, as shown by a CIS-R score of 12 or over, was associated with a four-fold increase in the odds of reporting suicidal thoughts at some time. In contrast having a long-standing physical health problem was associated with a decreased likelihood of reporting suicidal thoughts once other factors had been taken into account. High levels of neurotic symptoms were also associated with suicide attempts and in this case the number of stressful life event also showed a very strong association.

1 Background, aims and method

1.1 Focus of the report

Mental illness was identified as one of the key areas for action in *The Health of the Nation*, a White Paper published by the Department of Health in July 1992 (Department of Health, 1992) and subsequently in *Our Healthier Nation* (Department of Health, 1999a) and *Our National Health: a plan for action, a plan for change* (Scottish Executive, 2000). Frameworks for action have been set out in the *Health of the Nation Mental Illness Key Area Handbook* (Department of Health, 1994), *The Spectrum of Care* (Department of Health, 1996), *A Framework for Mental Health Services in Scotland* (Scottish Executive, 1997) and most recently in the *National Service Framework for Mental Health* (Department of Health, 1999b).

To provide information to support and monitor these initiatives, a series of national surveys of psychiatric morbidity have been carried out by ONS (formerly OPCS) over the past decade, which were commissioned by the Department of Health, the Scottish Executive Health Department and the National Assembly for Wales. These surveys covered a wide range of different population groups. They included:

- adults aged 16–64 living in private households (Meltzer *et al*, 1995a, b, c);
- residents of institutions specifically catering for people with mental health problems: hospitals, nursing homes, residential care homes, hostels, group homes and supported accommodation (Meltzer *et al*, 1996a, b, c);
- homeless adults living in hostels, nightshelters, private sector leased accommodation or roofless people using day centres (Gill *et al*, 1996);
- adults known by services to have a psychotic disorder (Foster *et al*, 1996);
- prisoners (Singleton *et al*, 1998); and
- children and adolescents (Meltzer *et al*, 2000).

The data covered in this report come from two sources: a survey which was carried out in 2000 and is a repeat of the first survey of adults living in private households, and a supplementary sample of people with psychosis identified through GP records. The 2000 survey was a repeat of the 1993 survey of adults in private households but included a number of developments, which are described in more detail in the main survey report (Singleton *et al*, 2001). Most notably, there was a slight increase in the age range, so that it covered people aged 16 up to 74 years, and measures of personality disorder and intellectual functioning were included.

The *National Service Framework for Mental Health* (Department of Health, 1999b) laid down a number of objectives for the improvement of services to those with serious mental illness. These included assessment of service users for antipsychotic medication, access to education, training, occupational and social care support. This report presents information relating to these areas collected from two groups of adults aged 16–74 living in private households who have a psychotic illness.

Bringing together data obtained from people with psychotic disorders identified in the main survey, and from those located through a supplementary sample obtained through general practice records provides a sample of large enough size for separate analysis. The main survey was conducted throughout Great Britain so the sample of people with psychotic disorder will include some people resident in Scotland or Wales. However, the supplementary survey only covered practices in England, so no Scottish or Welsh residents are included in that sample. Hence, the results presented in this report largely relate to residents of England.

The aim of the report is to investigate the circumstances of adults with a psychotic disorder, and to identify characteristics associated with their functioning, circumstances and use of services. The report considers:

- medical treatment including use of psychoactive medication, non-compliance with medication regimes, and use of other forms of treatment;

- use of services, including GP consultations, in-patient stays and outpatient visits, community care services and use of day activity facilities;
- difficulties with activities of daily living, and assistance required and received with these activities;
- social networks and perceived social support;
- economic activity, income and financial difficulties;
- substance misuse: smoking, alcohol consumption and illicit drug use; and
- stressful life events and suicidal thoughts and behaviour.

The current survey is intended to update the information reported in *Adults with a psychotic disorder living in the community* (Foster *et al*, 1996). However, there are important differences between the data presented here and those in that earlier report:

(i) The age range has been extended to include people aged 65–74, who were excluded from the earlier survey.
(ii) The supplementary sample for the 1993 survey was obtained by different methods, discussed in more detail below.
(iii) The 1996 report included a sample of people with a psychotic illness who were identified in a separate survey of people living in communal establishments carried out in 1994, which has not been repeated. This group comprised people living in establishments, such as supported lodgings or small group homes, which met the standard ONS definition of a household. A few people living in this type of accommodation may be in the sample obtained in the 2000 survey or the supplementary sample but no attempt was made to specifically sample this type of accommodation.
(iv) There were some differences in the way in which psychotic disorder was assessed in the 1993 and 2000 surveys of adults living in private households.

1.2 The samples used in this report

The prevalence of psychotic disorder in the general population is about 0.5%, so very large sample sizes would be required to yield sufficient numbers of people with these disorders for detailed analysis.

The main survey identified only 60 people suffering from psychotic illness and it was therefore necessary to identify a supplementary sample of people with psychosis to allow analysis of service use and social and economic functioning among this group. The difficulties associated with obtaining representative samples of people with psychotic disorder in surveys are discussed in more detail in Appendix A.

The supplementary sample aimed to provide a representative sample of people living in the community and known to have a psychotic or other severe mental disorder. Information was collected on the same topics as those covered in the main survey (see below).

Ethical approval for the supplementary survey was obtained from the London Multi-centre Research Ethics Committee and the Local Research Ethics Committees in all areas where the survey was likely to take place.

1.2.1 The supplementary sample

The sample design of the earlier supplementary survey in 1993 involved trying to identify all people with psychosis in the 200 postal sectors selected for the private household sample. Approaches were made to managers of Mental Health Units asking them to identify, with their teams, all individuals who had a psychotic illness living in these postal sectors. GPs with patients in the selected areas were identified by Family Health Service Authorities and were also asked to identify their patients who may have had psychosis and were **not** in contact with secondary services. The people identified in these ways were then approached by the person making the referral, and asked if they would take part in the survey.

However, many Mental Health Care Teams and GPs, especially those without computerised record systems refused to take part, and some details were obtained from only 90 out of the 200 postal sectors. No information was available on the number of people excluded as a result of non-response, nor on their age, sex or condition. Therefore, as well as being extremely time-consuming and expensive, this method provided data from which it was impossible to generalise to the whole population or even to estimate the potential bias in the results.

To try and overcome these problems a different approach was taken in 2000. The sample was obtained from records held by the General Practice Research Database (GPRD). The GPRD is currently owned by the Department of Health and managed by the Medicines Control Agency. However the Office for National Statistics managed the database between 1994 and 1999 and during this time a system of periodic audit of data quality was established, enabling the selection of research quality data. Practices were recruited on a volunteer basis and the population covered is broadly representative of the population of England and Wales.

Participating practices follow agreed guidelines for the recording of clinical data and submit anonymised, patient-based clinical records on a regular basis to the database. The records consist of information that is normally required for general practitioners (GPs) to perform their clinical and contractual responsibilities. As well as recording information on consultations and prescriptions issued by the GP, they will also include detail of referrals to out-patients and the outcome of these and details of, for example, discharge letters received. Diagnostic and treatment data in the GPRD are based on the clinical judgements made by the GPs themselves, or on information given by hospitals or other medical personnel. The GPs contributing to the database are not required to record the reason for every consultation; however they, are required to record all significant morbidity events including date of onset of chronic conditions, prescriptions and the reason for prescribing in certain instances (there is a requirement to specify a reason at the first issue of a repeat prescription and then subsequently only if there is a change to the medication), and referrals.

The quality of data is continually assessed to ensure maintenance of research standards. Data from each practice are routinely examined after each data collection (normally every six weeks) to monitor whether the research recording agreement has been followed. Practices which fail the quality assessment criteria are informed of the areas in which they have failed so that they may improve their recording procedures and/or correct the records as appropriate. Research studies only use data from practices that met quality standards during the time period covered by the study.

It was envisaged that use of the GPRD would overcome some of the problems of the lack of generalisability encountered in the 1994 study. Even if response was still poor, the GPRD would provide some statistical information about the sample which would allow comparisons between subjects who were withdrawn from the survey by their GPs, those who refused on their own behalf and those who responded to the survey.

One hundred and seventy two English GPRD practices were identified as being suitable for inclusion in the sample in that they were active contributors of research quality data to the database at the start of 1998. Initially, practices were ordered by geographical area and size of practice and one in two practices selected alternately from a random start point. The intention was to use the remaining practices as replacements for those who refused to take part.

Ten practices of varying sizes and geographical locations were selected to test the procedures being used. Introductory letters were sent to practices from the GPRD giving a brief description of the survey and seeking practice participation. Five practices were unable or unwilling to participate and were replaced with previously unselected practices. From this pilot phase, agreement was obtained from 7 practices, approximately half of those invited. *(Table 1.1.)*

Once agreement to participate was received from practices, GPRD staff then identified all patients within these practices fulfilling one or more of the following conditions:

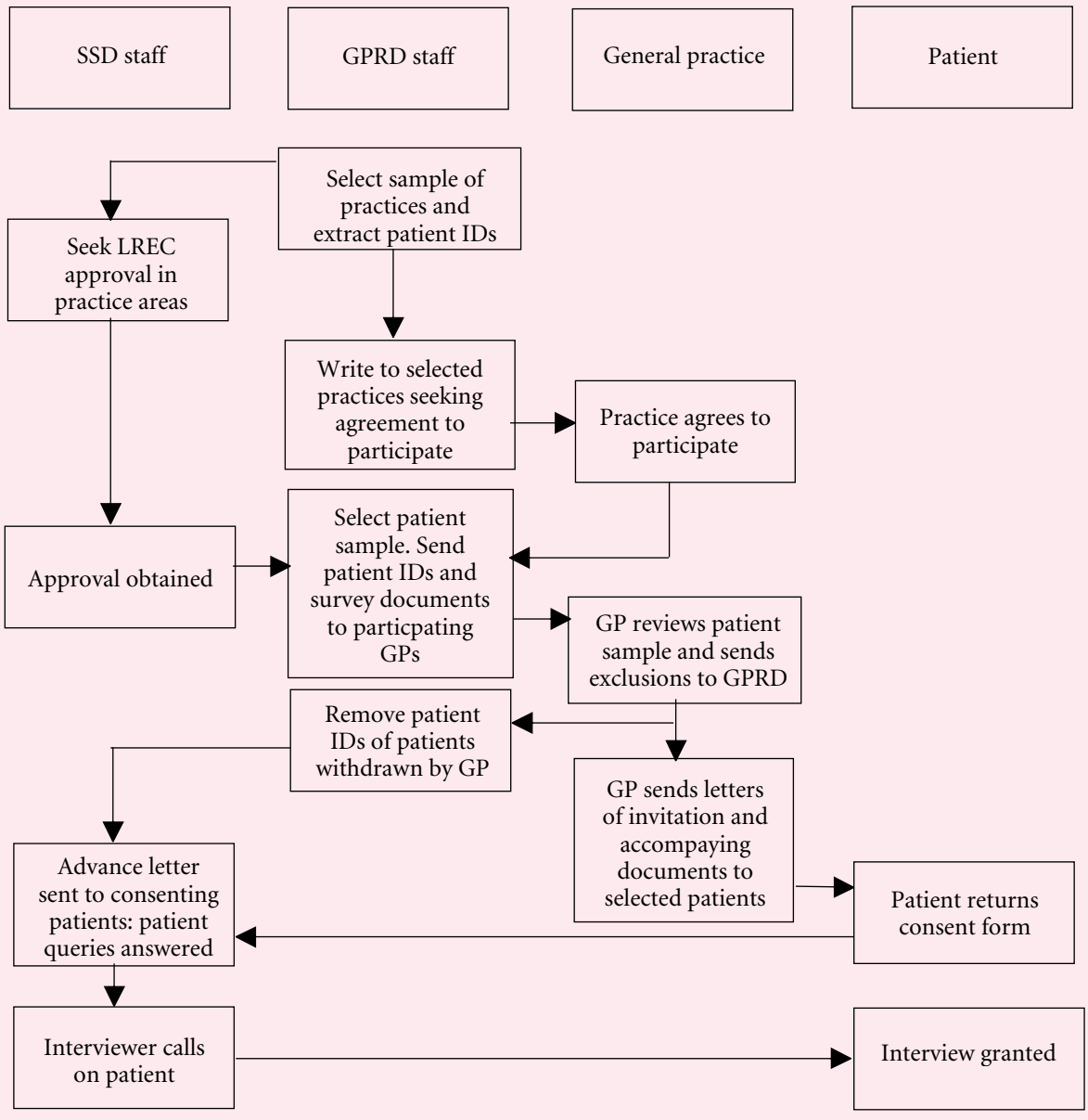
- they had been diagnosed with schizophrenia, either currently or in the past;
- they had been diagnosed with bipolar disorder (manic depression), either currently or in the past; and
- they had been prescribed drugs normally used to treat one of the above disorders, either currently or in the past. People aged 60 and over who were receiving anti-psychotic drugs that are frequently used to treat elderly people suffering from other conditions, such as agitation or restlessness associated with dementia (thioridazine, sulpiride, risperidone, olanzapine and promazine hydrochloride), were excluded from the sample because of the high probability that they were not suffering from a psychotic disorder.

GPRD staff extracted the patient IDs and some basic demographic information for all patients meeting these conditions. The sample of patients for the survey was then randomly selected taking 1 in 2 diagnosed patients and 1 in 20 patients who had received anti-psychotic medication but where no diagnosis of psychotic illness was indicated.

Participating practices were then sent copies of letters of invitation, information leaflets, consent forms and reply-paid envelopes. Patient IDs of those patients included in the sample from their practice were included with this material.

Participating GPs checked that patients on the list were still registered with the practice, and established whether it was appropriate for them to be asked to take part in the survey. They then sent out invitations to their patients asking if they wished to take part in the survey. Patients who were willing to participate returned the informed consent form to SSD (Social Survey Division) in reply-paid envelopes. Because names and addresses were only obtained when people agreed to take part, it was not possible to send reminders to non-responding patients.

Figure 1.1 Flow chart of survey procedures for obtaining the supplementary sample



Shortly before interviewers were due to call, an advance letter was sent to those who had agreed to take part informing them that an interviewer would call (the usual procedure on ONS surveys). This allowed sampled individuals a further opportunity to cancel their participation by telephoning ONS before the interviewer arrived. An overview of the procedures used to obtain the sample for interview is shown in the flow chart in Figure 1.1.

Table 1.2 shows the response from patients within the pilot practices. Just over a quarter (27%) of the respondents were ineligible for the survey, 8% were excluded on health grounds and the remaining 65% were sent invitations. Of those invited in the pilot phase, 18% returned reply slips indicating agreement to participate.

Pilot practices were asked to comment on the procedures used and amendments made as appropriate. Once procedures were finalised, a further 76 practices were approached. The response rates at both practice and patient level at this stage (main stage 1) are shown in Tables 1.1 and 1.2. Because response was lower than we had anticipated, and the rate of ineligibility and exclusions higher, it was decided to contact all remaining unselected practices fitting the criteria agreed with GPRD. It was also clear by this stage that GPs were more likely to exclude patients in the treatment-only group on the grounds of ineligibility, and that response was generally lower among this group. It was therefore decided to include all diagnosed patients in the lists sent to general practices in main stage 2, and to exclude those in the treatment-only group. Overall, response from practices was 37%, while for patients it was 11% of the sample as a whole and 17% of those invited. Response rates of this level are to be expected when patients are asked to opt-in and no reminders are possible since names and addresses are not available to the survey team. *(Tables 1.1–1.3)*

Just over a third (34%) of the patients selected in these responding practices were excluded by GPs, either because they were ineligible or for health reasons. Table 1.4 shows reasons given by GPs for excluding selected patients from the sample. In almost half the cases (48%), the patient was either no longer with the practice or had died. A further one in five (19%) were not suffering from a psychotic illness (many of these had been selected on the basis of prescription only). Eight per cent were not resident in private households, and a similar proportion were excluded for a range of other reasons. Seventeen per cent of those excluded (7% of the sample as a whole) were eligible for the survey, but were felt by their GP to be too ill to participate. *(Table 1.4)*

1.2.2 The private household survey sample

The procedures for identifying people with a psychotic disorder in the main survey are described in some detail in the survey report (Singleton *et al*, 2001) and are summarised below. In the main survey a two-stage approach was adopted to assess the presence of psychotic disorder in the year before interview. In the initial lay interview the following criteria were considered indicative of possible psychotic disorder:

- Self-report, at questions about long-standing illness or reasons for consulting a GP, of symptoms suggestive of psychotic disorder, eg mood swings, or having been given a diagnosis of psychotic disorder, such as schizophrenia or manic depression.
- Taking anti-psychotic medication.
- A history of admission to a mental hospital or ward.
- A positive response to question 5a of the Psychosis Screening Questionnaire (Bebbington and Nayani, 1994) which asks about auditory hallucinations.

A positive response on any one of these criteria led to selection for a second stage interview using the Schedule for Clinical Assessment in Neuropsychiatry (SCAN) (World Health Organisation, 1999). A sample of people who screened negative were also interviewed at the second stage to investigate the likely extent of false negatives: some whom sifted positive for personality disorder and others who screened negative for both types of disorder.

Not all those people who were selected for a second stage interview took part in this stage of the survey, either because they refused a further interview or could not be contacted during the field work period. To obtain an estimate of the prevalence of psychotic disorder based on the whole sample who had undertaken an initial interview, an assessment of probable psychotic disorder was applied to these

people using an algorithm that was first used in the survey of psychiatric morbidity among prisoners (Singleton *et al*, 1998). In the survey of prisoners, data collected from people who had both an initial interview and a second stage SCAN interview were used to identify factors associated with an increased likelihood of receiving a SCAN assessment of psychotic disorder. This found that the presence of any two of the criteria used for the initial screening for SCAN interview as described above, was indicative of a probable psychotic disorder.

Therefore, in the current survey, an assessment of probable psychosis was given to those who screened positive for psychosis and were either assessed as having a psychotic disorder at SCAN interview or, if no SCAN interview had been conducted, who reported two or more of the above criteria at initial interview. People who screened negative for psychosis were designated unlikely to have psychotic disorder. For more details about the assessment of psychotic disorder in the survey and the rationale for this approach see Appendix A of this report and also the report of the 2000 survey (Singleton *et al*, 2001).

1.3 Representativeness of the supplementary sample

Response to the survey was low, so care must be taken in interpreting the results presented in this report. It is possible to get an idea of the extent to which the people interviewed in the supplementary sample were representative of all people with psychotic disorders registered with GPs in England in two ways. Firstly, by considering the representativeness of the practices that contribute to the GPRD and secondly, by comparing those who took part in the survey with those who did not.

Practices that contribute to the GPRD must be computerised and prepared to maintain their records to strict quality standards. Therefore, they may not be representative of all GP practices. Practice size ranges from single handed to six or more partners, with a slightly larger proportion of GPRD practices having four or more partners than is the case nationally and correspondingly fewer single-handed GPs. However a comparison of the 1998 GPRD population by age and sex with the population of England and Wales shows the age distributions to be broadly similar.

There is some variation in coverage between NHS Regional Office areas from 1.4% in North Thames to 3.6% in West Midlands (Office for National Statistics, 2000). This publication also describes GPRD distribution by ONS area classification and deprivation categories. Despite these factors, a study carried out in 1994 (Hollowell, 1997) comparing GPRD data with MSGP4 (Morbidity Statistics from General Practice: Fourth National Study 1991–2) data found good agreement in, for example, rates for treated asthma. The database has been widely used in epidemiological research studies.

To allow sampling for the survey, some basic anonymised data were obtained for all patients meeting our sampling criteria for psychotic disorder in those practices eligible to take part in the survey. The data for practices that agreed to participate in the survey and those that did not were compared to check for any possible non-response bias arising as a result of refusals at the practice level. In practices which refused to take part there were slightly more older people meeting our sampling criteria and a slightly smaller proportion with no diagnosis but selected on the basis of prescription only. However, the differences were small and unlikely to be important. *(Table 1.5)*

Non-response among patients in participating practices, either through exclusions by GPs or from non-response by invited patients is another possible source of non-response bias. In order to identify the likely extent of any such bias the characteristics of people who took part in the survey were compared with those that did not for different reasons. This revealed a few differences between those who agreed to interview and those who were not interviewed because of refusal, ineligibility or because the GP felt that they were unsuitable for interview on health grounds. These are shown in Table 1.6. It can be seen that patients who were withdrawn by their GP on health grounds were more likely to be aged under 25 or 55 and over. There was also slightly higher proportion of people with a diagnosis of schizophrenia and smaller proportion with bi-polar disorder among those withdrawn on health grounds. There was a higher proportion of people with bi-polar disorder in the group who agreed to interview compared with those who refused, and a correspondingly higher proportion of people who were receiving

anti-manic medication. However, there were no other notable differences between the two groups. *(Table 1.6)*

Exclusion of people on health grounds may have led to some of the more severe cases being excluded from the sample, although the health problems may have been related to disorders to other than psychotic disorders, for example, dementia among elderly respondents. The high rate of exclusions and non-response means that the sample is not directly representative of all people with psychotic disorders living in private households and care must be taken in interpreting the results presented in this report. However, it is likely that the circumstances and experiences described are similar to those of a large proportion of that population and the broad picture obtained is fairly typical.

1.4 Characteristics of supplementary sample and main sample respondents

Table 1.7 compares some of the characteristics of the main and supplementary samples of people with psychosis. There appear to be a number of differences between the two samples but, because the numbers are small, the only difference that is statistically significant is in defacto marital status: the proportion of divorced and separated people is higher in the main survey group (37%) compared with the supplementary sample (18%) and that of married and cohabiting people is lower (28% compared with 49%). *(Table 1.7)*

1.5 The questionnaire

The same questionnaire was used for people in the supplementary sample obtained from the GPRD as in the main survey of psychiatric morbidity among adults living in private households. Details of the interviewing procedures and the questionnaire used for the main survey can be found in the Technical Report of the survey (Singleton *et al*, 2002) available on the National Statistics website (www.statistics.gov.uk).

The topics covered in the survey are shown below:

(a) Assessments of mental health problems
- Neurotic symptoms and disorders – using the Clinical Interview Schedule, revised version (CIS-R).
- Psychotic symptoms.
- Personality disorder.
- Suicidal thoughts and attempts.
- Alcohol misuse and dependence.
- Drug misuse and dependence.

(b) Other topics covered by the survey
Questions to gather information on a range of factors that might be related to mental disorder were also included in the survey questionnaire. The topics covered were:

- General health and service use:
  - self-perceived health status: the SF-12 and long-standing illness;
  - medication and service use – GP, in-patient, out-patient, day care and community care; and
  - lifetime experience of treatment in mental hospitals/wards.
- Socio-demographic data:
  - personal characteristics: eg age, marital status, ethnicity.
- Education and employment.
- Finances – income and debt.
- Accommodation – tenure, stability, quality.
- Stressful life events experienced.
- Social networks and social support.
- Activities of daily living and need for informal care.
- Intellectual functioning
  - New Adult Reading Test (NART); and
  - TICS-m and animal naming test (adults aged 60 and over).

1.6 Analysis methods

The sample used in this report has been drawn from two surveys, involving differing methods and probabilities of selection. For such a small sample, re-weighting in an attempt to produce population estimates would be unlikely to render accurate results, and it has not been attempted. Percentages presented in this report are therefore indicators of prevalence only within this particular sample, and should not be taken as estimates for the total population of people with a psychotic disorder. However, as mentioned earlier, the sample is likely to be typical of many of the people with psychotic disorders within the household population and to represent people across the whole range of severity of disorder.

The sample is useful in allowing us to investigate whether different characteristics are associated with different behaviours or circumstances of people with psychosis and provides a rough guide to the possible levels of service use and social and economic circumstances of people with psychotic disorder living in private households. Differences in service use and other circumstances have been investigated by means of multi-variate analysis. This can be used to indicate groups with different probabilities of the event under investigation, although odds ratios from the sample models should not be seen as estimates for the whole population. Where an association is said to be statistically significant this refers to comparisons within this sample only and does not indicate that the same association would be found to be significant within the whole population of people with psychotic disorder.

The main method of analysis used throughout this report is multiple logistic regression. This method identifies which of a set of independent variables, or characteristics of people in the sample, are associated with a dichotomous dependent variable. The dependent variables were set up to indicate the presence or absence of a particular behaviour or state, for example, respondent was on prescribed medication versus not on medication, or informant was a heavy smoker versus not a heavy smoker. The analysis identifies which of the independent variables included in the analysis are most strongly associated with the dependent measure, after controlling for the effect of the other variables in the model. A forward stepwise method of analysis was used. All models used the following set of independent variables which included a variety of sociodemographic variables and indicators of the person's physical health and level of neurotic symptoms such as anxiety and depression (CIS-R score):

- Sex — male; female
- Age — under 45; 45–74
- Marital status — married or cohabiting; single; widowed, divorced, separated
- Educational qualifications — 'A' levels and over; Other; None
- Economic status — economically active; economically inactive
- Social class — I,II,IIINM; IIM, IV, V; other, not known
- Tenure — owner; renter
- Household size — 1; 2; 3 and over
- CIS-R score — below 12; 12 and over
- Long standing physical illness — none; one or more
- Sample group — supplementary sample; main survey sample

As described in section 1.4, there were some possible differences between the sample of people obtained from the main survey and those from the supplementary sample. However, the small number of people, particularly in the main survey group means that these differences were generally not statistically significant and also makes it inappropriate to present results for the two groups separately as apparently large differences may well occur by chance. However, a variable indicating the sample group from which the case came was included in all the logistic regression analyses to identify any areas in which the two samples differed from each other.

Tables showing the results of the logistic regression analyses list only those characteristics that were significantly associated with the dependent variable, although all variables shown above were included in the analysis. An example of the results obtained from these analyses is shown in Table 2.10 (page 22). In this case, in the first column of results, the dependent variable is whether the respondent had talked to a GP in the past year about a mental or emotional problem. Two variables, age group and level of neurotic symptoms (CIS-R score), were included in the final model. This showed that each of these factors was, after allowing for the effects of the other, significantly associated with the probability of consulting a GP. For each variable in the model, the logistic regression produces an estimate of the odds of the event occurring for an individual in each category. The tables in this report show the odds ratio for each category of the independent variables included in the final models.

This is derived by dividing the odds for that category by the odds for a defined reference category. Where more than one independent variable is included in the model, the odds and odds ratios are adjusted for the effects of the other variables in the model. In Table 2.10 the adjusted odds ratio for people with a CIS-R score of 12 and over is 2.72. Thus the odds of having consulted a GP were almost three times higher for this group than for people with lower levels of neurotic symptoms and a CIS-R score below 12. Odds ratios that are significantly different from those of the reference category for that variable are indicated with asterisks in the tables. More information on logistic regression analysis and the interpretation of odds ratios can be found in Appendix B.

Table 1.1 Response at different stages of the survey – general practices

	Practices approached Number	Practices responding Number	Percentage of practices approached
Pilot	15	7	47
Main stage 1	76	29	38
Main stage 2	81	27	33
Total	172	63	37

Table 1.2 Patient outcome by basis for selection

	Basis for selection		
	Diagnosis	Prescription only	Total
	%	%	%
Outcome			
Cooperating	12	5	11
Non-cooperating	56	49	55
Excluded on health grounds	7	7	7
Ineligible	25	39	27
Base (all sampled)	*1244*	*152*	*1396*

Table 1.3 Response at different stages of the survey – patients

	Pilot	Main stage 1	Main stage 2	Total
	%	%	%	%
Invitation sent	65	66	67	66
Excluded on health grounds	8	7	7	7
Ineligible	27	27	26	27
Base (patients sampled)	*78*	*589*	*729*	*1396*
	Percentage of patients invited			
Patients consenting	18	15	18	17
Base (patients invited)	*51*	*389*	*489*	*929*

Table 1.4 Reasons for patients being withdrawn from the sample

Reason given for excluding patient	%
Patient is no longer registered with practice	43
Patient does not have a psychotic illness	19
Current health of patient makes him/her unsuitable for inclusion	17
Patient is not resident in a private household	8
Patient has died	5
Other reason	8
Base	*553*

Table 1.5 Characteristics of patients in co-operating and non-co-operating practices

	Practice outcome		
	Agreed to participate	Refused to participate	All practices
	%	%	%
Sex			
Male	51	53	52
Female	49	47	48
Age			
16–24	2	1	1
25–34	13	11	12
35–44	20	20	20
45–54	24	23	23
55–64	20	23	22
65–74	20	22	21
Diagnosis			
Schizophrenia	55	58	57
Bi-polar disorder	28	26	27
Both	6	8	7
No diagnosis	11	7	9
Grounds for patient selection			
Diagnosis only	17	20	19
Prescription only	11	7	9
Diagnosis and prescription	72	72	72
	Percentage who had received each medication		
Prescriptions			
Anti-psychotic medication	79	76	77
Anti-manic medication	24	21	22
Base	*1396*	*2051*	*3447*

Table 1.6 Characteristics of co-operating and non-co-operating patients – supplementary sample

	Patient outcome				
	Agreed to interview	Refused interview	Withdrawn on health grounds	Ineligible	All
	%	%	%	%	%
Sex					
Male	49	51	49	53	51
Female	51	49	51	47	49
Age					
16–24	-	1	5	2	2
25–34	11	12	9	18	13
35–44	23	21	20	19	20
45–54	28	26	16	21	24
55–64	21	22	23	16	20
65–74	17	19	27	24	20
Diagnosis					
Schizophrenia	49	55	60	55	55
Bi-polar disorder	42	28	20	25	28
Both	4	8	9	4	6
No diagnosis	6	9	11	16	11
Grounds for patient selection					
Diagnosis only	15	17	15	19	17
Prescription only	6	9	11	16	11
Diagnosis and prescription	79	74	74	65	72
			Percentage who had received each type of medication		
Prescriptions					
Anti-psychotic medication	76	80	81	76	79
Anti-manic medication	33	24	19	20	24
*Base**	*140*	*790*	*373*	*93*	*1396*

* Patients from cooperating practices only.

Table 1.7 Characteristics of main sample and supplementary sample

	Main survey sample	Supplementary sample	All
	%	%	%
Sex			
Male	50	48	48
Female	50	52	52
Age			
16–24	3	1	2
25–34	18	9	12
35–44	30	25	26
45–54	25	28	27
55–64	13	22	20
65–74	10	15	14
Marital status			
Married/cohabiting	28	49	43
Divorced/separated	37	18	24
Widowed	5	6	6
Single	30	26	28
Employment status			
Working full time	7	16	13
Working part time	14	14	14
Unemployed	2	4	3
Economically inactive	77	67	70
Social class			
I,II	18	26	24
IIINM	18	28	25
IIIM	17	13	14
IV	17	21	20
V	18	10	12
Not known	12	2	5
Base	*60*	*140*	*200*

2 Medication, treatment and use of services

2.1 Introduction

This chapter looks at the extent to which people with a psychotic illness had used medication, other forms of treatment and accessed a range of services. It also examines whether those on treatment reported compliance with the treatment regimes, whether treatment had been offered and refused and, if so, why this decision was made.

The survey collected information about medication used in the treatment of psychiatric disorders prescribed to informants at the time of interview. The medicines were coded according to the British National Formulary (British National Formulary 2000). The categories considered were:

- drugs used for the treatment of psychotic illness, including antipsychotic drugs, antipsychotic depot injections and antimanic drugs (for simplicity this whole group of drugs may sometimes be referred to as antipsychotic medication in this chapter);
- antidepressants; and
- hypnotics and anxiolytics.

Other forms of treatment fall into two broad categories: psychological therapy and counselling. These included psychotherapy, behavioural or cognitive therapy, art music or drama therapy, social skills training, marital or family therapy, sex therapy and counselling.

The section on service utilisation covers: GP consultations, in-patient episodes, out-patient or day-patient visits, community care services and day activity services.

2.2 Treatment

Overall, 91% of respondents were receiving some form of treatment. When considering the proportion receiving treatment, it should be remembered that, in the main survey, one of the four criteria used to identify people likely to have psychosis was the receipt of drugs used for treating psychotic illnesses. Also the receipt of such drugs at some time was one way in which people were identified from the GPRD for inclusion in the supplementary sample. This might tend to inflate the proportion of people receiving treatment in the sample. However, antipsychotic medication alone was not sufficient to provide an assessment of disorder, and a history of a diagnosis or treatment of disorder rather than current treatment was used as a criteria for selection from the GPRD, specifically so people who had slipped out of treatment or may have recovered would also be included in the sample.

There were no differences in the proportions receiving any type of treatment in terms of sex and age. However, those aged 45 and over, were more likely than younger respondents to be receiving medication only (68% compared with 55%). Among the younger respondents, 6% were receiving a psychological therapy or counselling only, compared with 1% of those aged 45 and over. Although similar proportions of each age group were receiving medication, among the younger respondents over a third (39%) were receiving counselling or other psychological therapy, either alone or with medication, compared with just over a fifth (22%) of those aged 45 and over. *(Table 2.1)*

2.2.1 Medication use

Just over four-fifths (82%) of respondents were receiving one or more of the medications considered in this section. The majority of these, 63% of the sample as a whole, were taking drugs used in the treatment of psychoses, over a third of the sample (37%) were taking antidepressant medication, and just over a fifth (22%) were taking hypnotics or anxiolytics.

Men were more likely than women to be taking medication used for treating psychotic disorders – 71% compared with 55%. Younger informants, those under 45, were more likely to report that they were receiving antidepressant medication; 48% of this group reported taking antidepressants, compared with 30% of those aged 45 and over. *(Table 2.2)*

Logistic regression was used to investigate which characteristics were most strongly associated with being on drugs used to treat psychoses and antidepressant medication. Further information on this method of analysis and the variables used in the analysis is given in Chapter 1 and Appendix B. As shown in Table 2.3, four variables were independently associated with being on medication used for the treatment of psychoses: sex, employment status, whether the informant had a long-standing physical illness and CIS-R score. The association was strongest for employment status and CIS-R score. The odds of those with significant levels of neurotic symptoms, as shown by CIS-R scores of 12 and over, being in receipt of antipsychotic medication were less than one third of those with scores below 12. The medication being prescribed, however, by controlling symptoms may have an effect on CIS-R scores. Those who were economically inactive had odds over three times greater than those who were economically active of being prescribed drugs used to treat psychoses. It should be remembered that no causal relationship or direction is implied by these odds, and in the case of employment status, it is likely that the severity of illness affects both the likelihood of being on antipsychotic medication and being unable to work. This survey did not include any estimation of the severity of the psychotic illness.

Of the variables included in the analysis, only age and CIS-R score were associated with being on antidepressant medication once the effects of the other variables in the model are controlled for. Again, the strongest association was with CIS-R score but in this case those with higher levels of neurotic symptoms were more likely to be on medication. For antidepressant medication, the odds that those with scores of 12 and over were having antidepressant medication were almost three times greater than those of people with scores below 12. *(Table 2.3)*

2.2.2 Depot injections

Antipsychotic medication may be administered by injections at regular intervals. These are often termed depot injections. Respondents were asked whether they were receiving any medication by injection and, if so, what. In this sample, 10% of people who were using antipsychotic medication were receiving them as depot injections. This is substantially fewer than was found in the sample from the 1993 surveys, when a quarter of the sample living in private households were receiving antipsychotic depot injections (Foster *et al*, 1996).

People aged under 45 were less likely to be receiving their antipsychotic medication in the form of depot injections than older people, 2% were receiving depot injections compared with 14% of those aged 45 and over. Logistic regression analysis showed only age group to be significantly and independently associated with receiving antipsychotic medication in the form of depot injections. *(Tables 2.4 and 2.5)*

2.2.3 Compliance with medication

Informants were asked whether they sometimes did not take medication which had been prescribed for their condition even though they should, or whether they ever took more than had been prescribed. Just under a third of respondents who were taking psychoactive medication (32%) had sometimes not taken their medication when they should have, and 20% reported that they had taken more of the medication than the prescribed dose.

Those under 45 were more likely to report non-compliance with medication than were older respondents. Forty eight percent of the younger informants reported that they sometimes did not take medication when they should, compared with 21% of those aged 45 and over. Younger respondents were also more likely to report taking more than the stated dose of medication, although this difference did not achieve statistical significance. *(Table 2.6)*

Two variables were independently associated with not taking psychoactive medication: age and social class. Those under 45 had odds over three times those of older informants of sometimes not taking their medication, while those in manual social classes (which included those who had never worked) also had increased odds of not always taking their medication. The only variable independently associated with taking more than the prescribed dose of medication was CIS-R score. *(Table 2.7)*

2.2.4 Psychological therapy or counselling

Respondents were shown a card listing different types of psychological therapy and asked if they were currently receiving any of these or similar treatments. As mentioned at the start of section 2.2, 29% of the people in this sample said they were receiving some form of psychological therapy or counselling either alone or as well as psychoactive medication. This is somewhat lower than reported for the small group of people with psychotic disorder from the main survey sample alone (40%) (Singleton *et al*, 2001, Table 5.13), suggesting some difference between the two groups included in this report with respect to these types of treatment. This should be borne in mind when considering the results presented here. Table 2.8 shows the different types of therapy reported by those who were having these types of treatment. The most frequently mentioned group was psychotherapy or psychoanalysis, reported by almost half (49%) of those receiving counselling or other psychological therapy. Over two-fifths (42%) of informants having one of these types of treatment were receiving counselling, and 14% were being treated through behavioural or cognitive therapy. Other types of therapy were relatively rare. *(Table 2.8)*

2.3 Contact with health and other services

The analysis in this section covers four categories of services: GP consultations, in-patient episodes and day- or out-patient visits, community care services and the use of day activity facilities. It is probable that the use of some of these services will vary according to the characteristics of informants, such as their age and living arrangements. As in other sections, logistic regression was used to identify which of the characteristics recorded by the survey were independently associated with service usage.

We would also expect that use of services might be related to the severity and time since onset of a person's condition. However, as we do not have information on these factors for the whole survey sample, the analysis cannot control for these factors and the interpretation of results should take account of possible relationships of this type.

2.3.1 GP consultations

Informants were asked whether they had consulted a GP in the last year, or in the last two weeks for either a physical, or a mental, nervous or emotional problem. Consultations included those made in person or by telephone. This analysis concentrates on consultations for mental health problems.
In the year before the interview, three-fifths (62%) of respondents had consulted their general practitioner about a mental or emotional problem and 10% had done so in the past two weeks. However, there was significant variation with age. Three quarters (75%) of those under 45 had consulted their GP in the past year, compared with only just over half (54%) of respondents aged 45 and over. Younger respondents were also more likely to have consulted their GP in the two weeks before interview. Overall, one in ten patients had done so, but among younger respondents almost one in six (16%) had consulted the GP in the last two weeks, compared with only 6% of those aged 45 and over. There were no significant differences between men and women in the proportion consulting the GP. *(Table 2.9)*

Logistic regression analysis showed that the characteristics independently associated with having talked to the GP in the previous twelve months about mental or emotional problems were age and CIS-R score. The odds of those aged over 45 having spoken to the GP were less than half those of informants under 45. The odds of those with CIS-R scores of twelve or more having spoken to the GP in the previous twelve months about a mental or emotional problem were almost three times greater than those for people with lower scores. *(Table 2.10)*

2.3.2 In-patient stays and out-patient or day-patient visits

Overall, 3% of the sample reported an in-patient stay in the last quarter relating to a mental health problem. Because of the small proportion of respondents reporting in-patient stays it is difficult to examine the relationship between in-patient stays and other factors. *(Table 2.9)*

Out-patient or day-patient visits were reported more frequently than in-patient stays. Over a fifth of the sample (22%) reported one or more such visits in the past quarter. Younger respondents were almost twice as likely as those aged 45 and over to do so (30% compared with 17%). *(Table 2.9)*

Logistic regression analysis was carried out to identify factors independently associated with attending an out-patient department because of a mental or emotional problem. Only age was associated with outpatient attendance in connection with a mental or emotional problem in the past three months in this group of people with a psychotic disorder: the odds of older people attending outpatients being half that of younger people. *(Table 2.10)*

2.3.3 Community health and support services

Informants were asked whether they had used any of a range of community health and support services in the three months before interview. They were asked to exclude contacts with professionals that they had already mentioned in connection with in-patient stays or out-patient visits. The services listed were:

- psychiatrist;
- psychologist;
- community psychiatric nurse;
- community learning difficulties nurse;
- other nursing services;
- self-help or support group;
- social worker;
- home help or care worker; and
- outreach worker or family support.

Overall, two-fifths (40%) of the adults in this sample of people with a psychotic disorder had had some contact with one or more of these services during the previous quarter. There were no differences by sex or age in the proportions of people who had used any of the community services. *(Tables 2.11)*

Receipt of any community care services in the past twelve months was independently associated with living alone and economic inactivity. People living alone had almost two and a half times greater odds of receiving these services than those who were living with others, while those who were economically inactive had twice the odds of the economically active of receiving such services. These associations were even stronger when the analysis was limited to visits from a community psychiatric nurse. *(Table 2.12)*

2.4 Day activity services

Respondents were asked whether they had used any of a range of day activity services in the previous twelve months. The services were:

- A community mental health centre.
- A day activity centre.
- A sheltered workshop.

Respondents who reported use of any of these services were then asked whether they had used them during the last quarter.

Overall, over a quarter (27%) of informants had used one or more day activity services in the previous year, and 20% in the three months before interview. Men were twice as likely than women to have used a day activity service in the past year, 38% had done so, compared with 17% of women. *(Table 2.13)*

Logistic regression analysis showed that use of day activity services was independently associated with sex, household size and social class. Women had odds only a quarter of those of men of having used any day activity services in the year before interview. The association with household size was also very strong. People living alone had more than three times greater odds of using day activity services than those living with other people. The association with social class was less strong, but still significant. People in manual social classes were more likely than those in non-manual classes to have used a day activity service once the other factors were taken into account. *(Table 2.14)*

Separate analyses of factors associated with the use of community mental health centres and day centres (the two main types of day activity services used) found that sex, household size and sample group were independently associated with using community mental health centres. Men, people living alone and those in the main survey sample

had greater odds of having attended a community mental health centre. Sex and employment status were associated with day centre use: Men and people who were economically inactive having greater odds of attending. *(Table 2.14)*

A count of the number of services received by each individual is shown in Table 2.14 to provide an indication of the extent to which people accessed the full range of services possible. The services included in the count were:

- consultations with a GP in the past year for a mental problem;
- inpatient stays for a mental or emotional problems in the past quarter;
- out- or day-patient visits for mental or emotional problems in the past quarter;
- community care service receipt in the past quarter; and
- day activity service use in the past quarter.

Just under a quarter of the sample (24%) had not received any of these services and slightly more than a third (36%) had received only one. About half of the remainder (22% of the sample as a whole) reported having received three or more of the types of services covered. Men in the sample were a little more likely than the women to have received two or more services, while older people were less likely to report receiving any of the services and also less likely to be receiving two or more. *(Table 2.15)*

2.5 Help not sought and services turned down

Everyone taking part in the survey was asked if there were any times in the past year when they had not sought help from a doctor or other professional when they or others thought they should have done so, or when they had been offered such help but had turned it down. Overall, 16% of this group of people with a psychotic disorder said they had decided not to see a doctor or other health professional when perhaps they should have but only 8% said they had refused help that was offered. The main reasons given for not seeking help were that they did not think anyone could help and that they were afraid of possible treatment or tests. People with high levels of neurotic symptoms as shown by CIS-R scores of 12 and over had increased odds of not seeking help once other factors were taken into account. The type of help most often mentioned as offered but refused was counselling. *(Tables 2.16 and 2.17)*

Table 2.1 Treatment received by adults with a psychotic illness

by sex and age

	Sex		Age		
	Male	Female	Under 45	45 and over	All
	%	%	%	%	%
Current treatment					
None	9	9	6	11	9
Medication only	64	61	55	68	62
Counselling or therapy only	2	4	6	1	3
Medication and counselling/therapy	25	26	33	21	26
Base	*97*	*103*	*80*	*120*	*200*

Table 2.2 Medication prescribed

by sex and age

	Sex		Age		
	Male	Female	Under 45	45 and over	All
	Percentage using the medication				
Drugs used in psychoses etc.	71	55	59	66	63
Antidepressants	31	43	48	30	37
Any antipsychotic or antidepressant medication	**82**	**79**	**81**	**80**	**80**
Hypnotics and anxiolytics	26	17	21	22	22
Any psychoactive medication	**86**	**80**	**82**	**82**	**82**
Base	*97*	*103*	*80*	*120*	*200*

Table 2.3 Odds ratios for characteristics associated with treatment with different types of medication

	Drugs used in psychoses etc	Antidepressant medication
	Adjusted odds ratios	
Sex		
Female	1.00	
Male	2.14*	
Age group		
Under 45		1.00
45 and over		0.54*
Employment status		
Economically active	1.00	
Economically inactive	3.45**	
CIS-R score		
Below 12	1.00	1.00
12 and over	0.28***	2.74**
Long standing physical complaints		
Absent	1.00	
Present	0.47*	
Other factors entered in the models but not significantly associated with any dependent variable	Marital status, social class, educational qualifications, 1 person household, tenure, sample group	

*p<0.05 **p<0.01 ***p<0.001

Table 2.4 Mode of administration of antipsychotic medication by sex and age

	Sex		Age		
	Male	Female	Under 45	45 and over	All
	%	%	%	%	%
Depot injections	13	5	2	14	10
Oral medication only	87	95	98	86	90
Base	*69*	*57*	*47*	*79*	*126*

Table 2.5 Odds ratios for characteristics associated with receipt of antipsychotic medication by depot injection

	Antipsychotic medication by depot injection
	Adjusted odds ratios
Sex	
Female	1.00
Male	3.80
Age group	
Under 45	1.00
45 and over	9.82*
Other factors entered in the model but not significantly associated with the dependent variable	Marital status, social class, educational qualifications, 1 person household, tenure, long-standing physical complaint, CIS-R score, employment status, sample group

*p<0.05 **p<0.01 ***p<0.001

Table 2.6 Non-compliance with medication dosage by sex and age

	Sex		Age		
	Male	Female	Under 45	45 and over	All
	Percentage reporting non-compliance with dosage				
Sometimes does not take medication	36	28	48	21	32
Sometimes takes more than the stated dose	22	18	24	17	20
*Base**	*83*	*82*	*66*	*99*	*165*

* All people on antipsychotic, antidepressant, hypnotic or anxiolytic medication, orally or by injection.

Table 2.7 Odds ratios for characteristics associated with non-compliance with dosage of psychoactive medication

	Sometimes did not take psychoactive medication	Sometimes took more than prescribed
	Adjusted odds ratios	
Social class		
Manual	2.09*	
Non-manual	1.00	
Age group		
Under 45	1.00	
45 and over	0.28***	
CIS-R score		
0–11		1.00
12 and over		2.61*
Other factors entered in the models but not significantly associated with any dependent variable	Sex, marital status, educational qualifications, 1 person household, tenure, long-standing physical complaint, CIS-R score, employment status, sample group	

"*=p<0.05, **=p<0.01, ***=p<0.001"

Table 2.8 Types of therapy or counselling being undertaken

by those receiving such treatment

	Percentage reporting each type of therapy
Psychotherapy or psychoanalysis	49
Counselling	42
Behavioural or cognitive therapy	14
Art, music or drama therapy	7
Social skills training	5
Marital or family therapy	2
Other therapy	9
Base (all having therapy)	*57*

Table 2.9 Health care services used for mental and emotional problems

by sex and age

	Sex		Age		
	Male	Female	Under 45	45 and over	All
	Percentage reporting using each service				
GP consultations					
... in last year	64	61	75	54	62
... in past 2 weeks	9	11	16	6	10
Inpatient stay in past quarter	5	1	1	4	3
Outpatient visit in past quarter	26	18	30	17	22
Base	*97*	*103*	*80*	*120*	*200*

Table 2.10 Odds ratios for characteristics associated with use of health care services

	Talked to GP about mental problem in past year	Visited out-patients in past quarter
	Adjusted odds ratio	
Age group		
Under 45	1.00	1.00
45 and over	0.44*	0.47*
CIS-R score		
Below 12	1.00	
12 and over	2.72**	
Other factors entered in the models but not significantly associated with any dependent variable	Sex, marital status, social class, educational qualifications, 1 person household, tenure, long-standing physical complaint, employment status, sample group	

*p<0.05 **p<0.01 ***p<0.001

Table 2.11 Use of community health services in the last quarter by sex and age

	Sex		Age		
	Male	Female	Under 45	45 and over	All
	Percentage using each service				
Community care services used					
Community psychiatric nurse	29	17	21	24	23
Psychiatrist	21	17	20	18	18
Social worker	14	6	15	7	10
Self-help or support group	9	5	5	8	7
Home help/care worker	5	4	5	4	4
Psychologist	3	2	4	2	2
Other nursing services	1	3	5	-	2
Outreach worker/family support	3	1	4	1	2
Any community care used in the last quarter	**43**	**37**	**44**	**38**	**40**
Base	*97*	*103*	*80*	*120*	*200*

Table 2.12 Odds ratios for characteristics associated with use of community care services in the past quarter

	Visited by CPN in the community	Any community care services used
	Adjusted odds ratios	
One person household		
No	1.00	1.00
Yes	3.72***	2.54**
Employment status		
Economically active	1.00	1.00
Economically inactive	4.35**	2.23*
Other factors entered in the models but not significantly associated with any dependent variable	Sex,age group, marital status, social class, educational qualifications, tenure, long-standing physical complaint, CIS-R score, sample group	

*p<0.05 **p<0.01 ***p<0.001

Table 2.13 Use of day activity services by sex and age

	Sex		Age		
	Male	Female	Under 45	45 and over	All
			Percentage using each service		
In the last year used					
... a community mental health centre	24	11	24	12	17
... a day activity centre	19	7	14	12	12
... a sheltered workshop	4	-	4	1	2
... other day activity service	1	1	-	2	1
Any day activity service used in the last year	**38**	**17**	**32**	**23**	**27**
In the last quarter used					
... a community mental health centre	12	8	12	8	10
... a day activity centre	13	6	10	9	10
... a sheltered workshop	3	-	2	1	2
... other day activity service	-	1	-	1	0
Any day activity service used in the last quarter	**26**	**14**	**21**	**18**	**20**
Base	*97*	*103*	*80*	*120*	*200*

Table 2.14 Odds ratios for characteristics associated with use of day activity services in the past year

	Use of mental health centre in the past year	Use of day centre in the past year	Use of day activity services in the past year
	Adjusted odds ratio		
Sex			
Female	1.00	1.00	1.00
Male	2.38*	3.08*	2.50*
One person household			
No	1.00		1.00
Yes	2.43*		3.32**
Social class			
Non-manual			1.00
Manual			2.20*
Employment status			
Economically active		1.00	
Economically inactive		11.41*	
Sample group			
Supplementary sample	1.00		
Main survey sample	3.02**		
Other factors entered in the models but not significantly associated with any dependent variable		Age group, marital status, educational qualifications, tenure, long-standing physical complaint, CIS-R score	

*p<0.05 **p<0.01 ***p<0.001

Table 2.15 Count of number of services received by sex and age

	Sex		Age		
	Male	Female	Under 45	45 and over	All
			Percentage using each service		
Number of services used					
None	23	24	14	30	24
1	28	45	36	37	36
2	24	14	24	15	18
3	15	12	19	10	14
4	9	5	6	8	7
5	1	1	1	1	1
Base	*97*	*103*	*80*	*120*	*200*

Table 2.16 Help turned down or not sought in the past year by sex and age

	Sex		Age group		
	Male	Female	Under 45	45 and over	All
	Percentage reporting in the past year				
Offered help/services which have been turned down	5	10	9	7	8
Decided not to see a doctor	11	20	24	11	16
Base	*96*	*103*	*80*	*119*	*199*

Table 2.17 Odds ratios for characteristics associated with not consulting a doctor in the past year

	Decided not to see a doctor
	Adjusted odds ratio
CIS-R score	
Under 12	1.00
12 and over	6.94***
One person household	
No	1.00
Yes	0.41
Other factors entered in the model but not significantly associated with the dependent variable	Sex,age group, marital status, social class, employment status, educational qualifications, tenure, long-standing physical complaint, sample group

*p<0.05 **p<0.01 ***p<0.001

3 Activities of daily living

3.1 Introduction

A set of questions asked respondents whether they had any difficulties with a list of activities of daily living. The questions covered the types of activities listed below.

- Personal care, such as dressing, washing, bathing, using the toilet.
- Using transport to get out and about.
- Medical care, taking medicines and pills, having injections or changing dressings.
- Household activities, such as preparing meals, shopping, laundry and housework.
- Practical activities, like gardening, decorating and doing household repairs.
- Dealing with paperwork, for example, writing letters, sending cards or filling in forms.
- Managing money – budgeting for food and paying bills.

Respondents who reported difficulty with any of these activities were asked whether they needed help with the activities, and if so, who provided it.

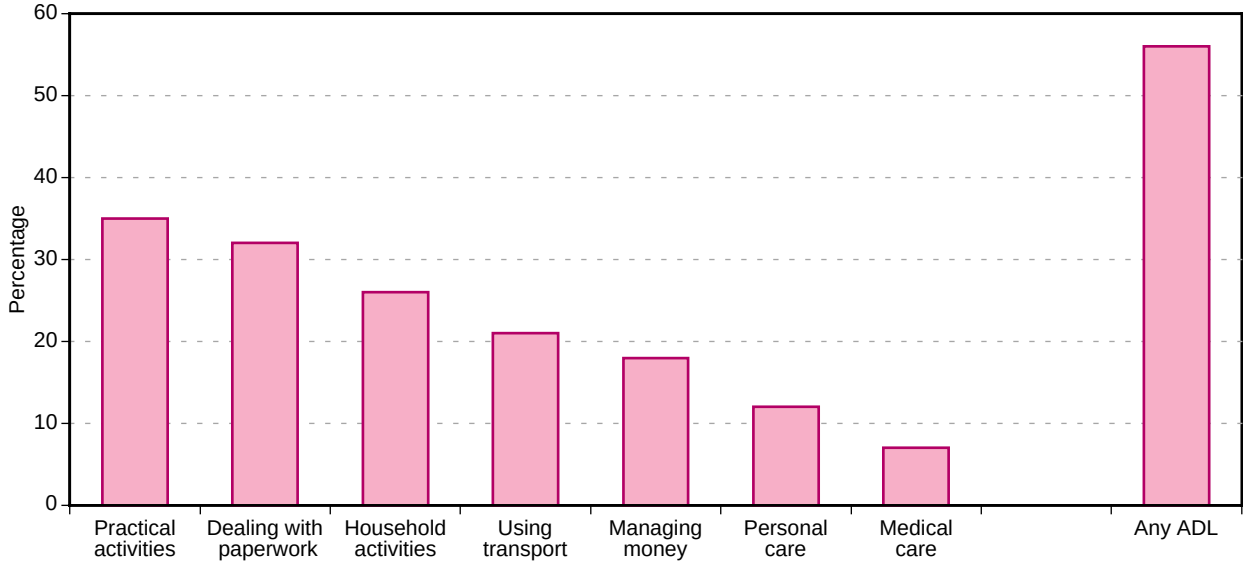
This chapter first considers which characteristics of this sample of people with a psychotic illness were associated with having difficulties with each activity of daily living. The extent to which the same people reported problems with more than one activity is then considered together with the factors associated with having four or more difficulties. Finally, section 3.4 looks briefly at the extent to which informants who needed help with activities received it and whether help was provided by health professionals or voluntary workers.

3.2 Difficulties with activities of daily living

Over half of this sample of people with psychotic disorder (56%) reported difficulties with activities of daily living (ADL) in one or more of the areas listed above. Most of these (49% of the whole sample) said that they needed help to overcome at least one of these difficulties. People were most likely to have difficulty with practical activities (35%), dealing with paperwork (32%) and household activities (26%) and least likely to report having difficulty with medical care (7%) or personal care (12%). *(Table 3.1 and Figure 3.1)*

Overall, there were no significant differences between men and women or between older and younger adults in the likelihood of reporting difficulties with activities of daily living. *(Table 3.2)*

Figure 3.1 Proportion of the sample having difficulty with different activities of daily living



Factors which were independently associated with difficulties with different aspects of daily living were examined using logistic regression, and the results are shown in Table 3.3. Respondents with high levels of neurotic symptoms (those with CIS-R scores of twelve or more) had significantly increased odds of having difficulties with all aspects of ADL, except for practical activities. Those who were economically inactive had increased odds of having difficulties with using transport, managing money, household activities and practical activities, but not personal care, medical care or dealing with paperwork. Compared with those who were employed in non-manual occupations, those from manual occupations had lower odds of having difficulty with household activities. It might be expected that those who had long standing physical complaints would have difficulties with a number of activities of daily living. However, this analysis shows that having a long standing physical complaint was independently associated only with difficulties with personal care and practical activities. Not surprisingly, the level of educational qualifications obtained was strongly associated with the need for help with paperwork – people with qualifications at A level or above had lower odds of having difficulties dealing with paperwork than those with lower levels of qualifications. *(Table 3.3)*

3.3 Number of difficulties experienced

Among this sample of adults with a psychotic illness, over a third (39%) had difficulties with two or more of the specified activities, and just under a sixth (15%) had difficulties with four or more of the activities. *(Table 3.4)*

Only three characteristics were independently associated with having difficulties with four or more ADLs. Single people had significantly lower odds of having difficulties with four or more ADLs than others (OR 0.16). Those with CIS-R scores of twelve and over both had significantly increased odds of having difficulties with four or more ADLs. Having a CIS-R score of 12 or more increased these odds nearly nine-fold (OR 8.92). *(Table 3.5)*

3.4 Help with activities of daily living

While people may find difficulty with ADLs, if these difficulties are not too great they may be able to manage without help. Further questions were therefore asked to identify how many people had difficulties severe enough to require help to overcome them, and from what sources they obtained this help. Overall, almost half of this sample of people with psychotic disorder (49%) reported that they needed help with one or more of the specified activities of daily living. There were no significant differences in the proportions of people reporting they needed help with any activities between men and women and older and younger people in this sample. *(Table 3.6)*

The majority of those who needed help with one or more activities were receiving help with at least one of the activities for which they needed it. However, of those who needed help, 4% received none for any activity of daily living for which they needed it and 11% had at least one difficulty for which they had an unmet need for help.

Table 3.7 shows that, family and friends were the most common providers of help for activities of daily living. Forty one per cent of those needing help received it from their spouse or partner, 36% from another relative and in 32% of cases, help was provided by a friend. Health or social care workers provided help for 19% of informants who needed help, while nearly a quarter of those needing help (23%) received help from others including, for example, paid domestic help and solicitors. *(Table 3.7)*

Table 3.1 Difficulties with activities of daily living

	Has difficulty with the activity	Needs help with the activity
	Percentage reporting each problem	
Has difficulty with...		
practical activities	35	30
dealing with paperwork	32	27
household activities	26	22
using transport	21	16
managing money	18	16
personal care	12	7
medical care	7	6
Any of the above	**56**	**49**
Base	*197*	*197*

Table 3.2 Difficulties with activities of daily living by sex and age

	Sex		Age		All
	Male	Female	Under 45	45 and over	
			Percentage with each difficulty		
Has difficulty with...					
practical activities	32	38	28	40	35
dealing with paperwork	35	29	34	31	32
household activities	24	28	24	27	26
using transport	21	21	19	22	21
managing money	21	16	24	15	18
personal care	10	14	8	15	12
medical care	6	8	9	6	7
Any of the above	**59**	**52**	**52**	**58**	**56**
Base	*96*	*101*	*80*	*117*	*197*

Table 3.3 Odds ratios for characteristics associated with difficulties with different activities of daily living

	Personal care	Using transport	Medical care	Managing money	Household activities	Practical activities	Dealing with paperwork
				Adjusted odds ratios			
Social class							
Non-manual					1.00		
Manual					0.40*		
Employment status							
Economically active		1.00		1.00	1.00	1.00	
Economically inactive		4.05*		16.31**	6.19**	2.70**	
Educational qualifications							
A level and over							1.00
Other qualifications							4.92**
No qualifications							6.73***
CIS-R score							
Below 12	1.00	1.00	1.00	1.00	1.00		1.00
12 and over	4.12**	5.40***	17.89**	4.89***	6.61***		2.70**
Long standing physical complaints							
Absent	1.00					1.00	
Present	3.16*					2.02*	

*p<0.05; **p<0.01; ***p<0.001

Marital status, age, sex, tenure, household size and sample group were also included in the regression analyses but were not significant for any of the dependent variables

Table 3.4 Number of activities of daily living respondent had difficulties with by sex and age

	Sex		Age		All
	Male	Female	Under 45	45 and over	
	%	%	%	%	%
Number of ADLs					
None	41	48	48	42	44
One	21	13	16	17	17
Two	14	17	14	16	15
Three	9	9	10	9	9
Four or more	16	14	12	16	15
Base	*96*	*101*	*80*	*117*	*197*

Table 3.5 Odds ratios for characteristics associated with difficulties with 4 or more ADL

	Has difficulty with 4 or more ADLs
	Adjusted odds ratios
Marital status	
Married	1.00
Single	0.16*
Widowed/divorced/separated	1.12
Employment status	
Economically active	1.00
Economically inactive	4.76
CIS-R Score	
Under 12	1.00
12 and over	8.92***

*p<0.05; **p<0.01; ***p<0.001

Table 3.6 Need for help with activities of daily living by sex and age

	Sex		Age		All
	Male	Female	Under 45	45 and over	
	Percentage needing help				
Needs help with...					
practical activities	27	34	25	34	30
dealing with paperwork	30	25	34	23	27
household activities	21	24	22	22	22
managing money	18	14	20	13	16
using transport	19	14	16	16	16
personal care	4	10	4	9	7
medical care	3	8	6	5	6
Any of the above	**51**	**48**	**50**	**49**	**49**
Base	*96*	*101*	*80*	*117*	*197*

Table 3.7 Sources of help with activities of daily living by sex and age

	Sex		Age		All
	Male	Female	Under 45	45 and over	
	Percentage receiving help from each source				
Help provided by...					
Spouse/cohabitee	35	48	32	47	41
Other relative	35	38	40	33	36
Friend	37	27	28	35	32
Health or social care worker	24	12	25	14	19
Other	22	23	15	28	23
Does not receive help for at least one difficulty for which help is needed	**8**	**15**	**12**	**11**	**11**
Does not receive help for any of the difficulties for which help is needed	**2**	**6**	**8**	**2**	**4**
Base (all needing help)	*49*	*48*	*40*	*57*	*97*

4 Economic activity and finances

4.1 Introduction

This chapter examines variation in economic activity and income among this sample of people with psychotic illness. It looks at characteristics associated with categories of economic activity – working full time, working part time, unemployed or economically inactive. It considers the circumstances of people in these categories and the extent to which mental health problems may have influenced their economic activity and financial position.

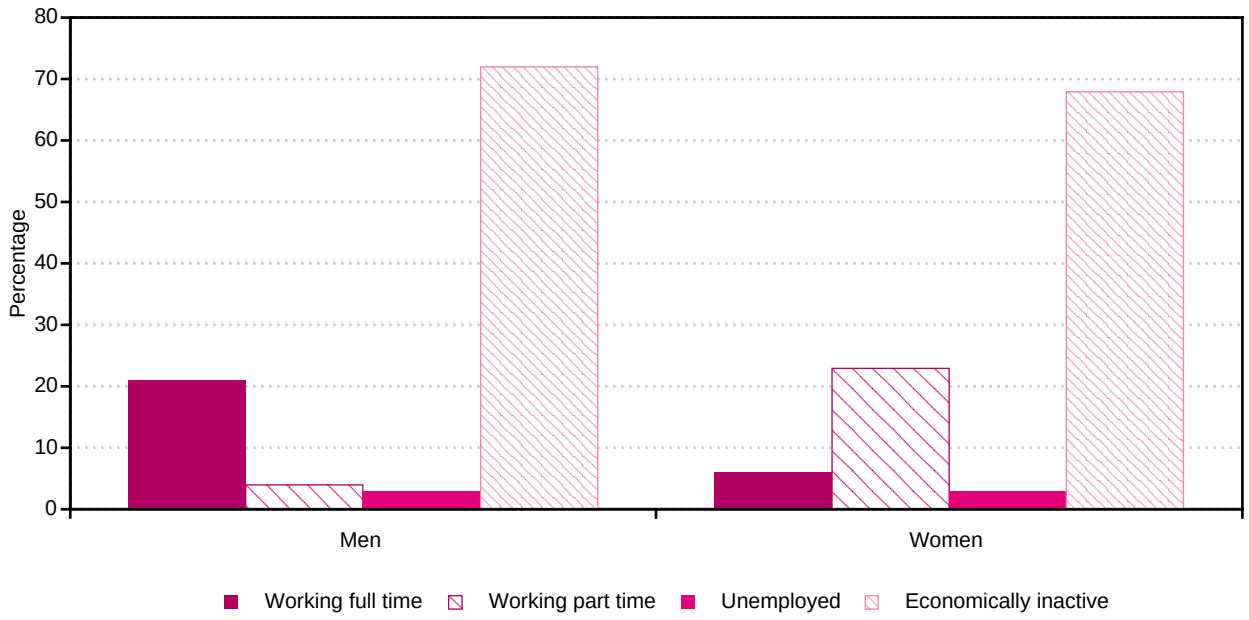
4.2 Economic activity and employment

Numerous studies have shown that being unemployed and economically inactive (i.e. unemployed and not seeking work) is associated with an increased risk of mental health problems (Fryers *et al*, 2002). In the report by Meltzer *et al* (2002) *The social and economic circumstances of adults with mental disorders* based on the main survey of psychiatric morbidity among adults in 2000, it was clear that, despite the small number in the sample with psychotic disorder, they were particularly likely to be unemployed or economically inactive.

In the population as a whole in the spring quarter of 2000, 60% of people aged 16 and over were in employment, 4% were unemployed and 36% were economically inactive (Office for National Statistics, 2002). In this sample of people with a psychotic disorder, a markedly higher proportion of people, 70%, were economically inactive. Just over a quarter (27%) were in paid employment, half of them full time and half part time. There was no association between levels of economic activity and age, with the under 45s as likely to be economically inactive as those over 45. There was also no difference between the sexes in the proportion of economically inactive respondents. However, among men, 21% worked in full time employment and 4% in part time employment, whereas among women, 6% worked in full time employment and 23% in part time employment. *(Table 4.1 and Figure 4.1)*

The majority (62%) of those who were economically inactive were not seeking work because they were long-term sick or disabled (62%), a fifth (20%) were retired and 12% were looking after their family or home. Just over four-fifths (81%) of economically inactive men said they were long-term sick or disabled, compared with

Figure 4.1 Economic activity status by sex



less than half (43%) of the women. Women were more likely to say they were looking after the family or home than men, 20% compared with 4%. There were also differences between the younger and older age groups. Nearly four-fifths (79%) of those under 45 said they were long-term sick or disabled, compared to half (51%) of those over 45. A third of those aged 45 and over (34%) said that they were retired. *(Table 4.2)*

Table 4.3 shows the results of logistic regression analyses to identify factors associated with economic activity in this group of people with psychotic disorder. Four variables were found to be independently associated with being in paid work. The strongest associations were with marital status and tenure; the odds of being in work if a person was widowed, divorced or separated were a quarter of those for people who were married, and those for people living in rented accommodation were a third those of owner occupiers. There were also significant associations with social class and CIS-R score. Those from a manual social class and those with CIS-R scores of 12 and over also had lower odds of being in work compared with those in a non-manual social class and those with lower levels of neurotic symptoms.

There was a very strong association between being economically inactive and tenure; those living in rented accommodation had an odds ratio more than 4 times higher than owner-occupiers. The level of neurotic symptoms was also independently associated, those with CIS-R scores of 12 and over were more likely to be economically inactive than those with lower scores.

Four variables were found to be independently associated with being unable to work due to long term illness or disability. The strongest association was with CIS-R score, having a high CIS-R score more than quadrupled the odds of not being able to work due to illness or disability. Living in rented accommodation trebled the odds while being male and living alone both independently increased the odds. *(Table 4.3)*

As well as asking about current employment status, the survey included specific questions about the extent to which mental health problems had directly affected the respondent's employment status and ability to do work. Among the adults in our sample who were in paid employment at the time of interview, almost half (47%) said that they had taken time off in the past year because of their health or the way they were feeling. The median number of days taken off (including time taken off for physical illness) was 14 days, while the mean was 70 days because of a small number of people having 5 months or more off because of ill-health. *(Table 4.4)*

Among those who were not currently working but had previously had a job, the majority, 59%, said this was because the way they had been feeling made it impossible for them to do any kind of job. Eighteen per cent were not working because of a physical health problem, 5% had been unable to find a suitable job and 12% said they did not want or need a job. Five per cent gave other reasons. Excluding those who did not wish to work, two-thirds (67%) of those not currently working felt that it would be impossible for them to do work, but just over a fifth (23%) felt that they could do sheltered work and one in six (17%) that they could do a part time job. *(Table 4.5)*

4.3 Finances

Survey respondents were asked some questions about their finances – about receipt of state benefits, income from other sources, their gross income and financial difficulties they had experienced.

4.3.1 State Benefits and income

Overall, at the time of interview 79% of respondents were receiving some form of state benefit or allowance. Receipt of particular allowances is shown in Table 4.6.

Twenty-eight per cent of informants were in receipt of one or more income-related benefits (income support, family credit or working families tax credit). The proportion was much higher among those aged under 45 (45%) than among those aged 45 and over (16%). *(Table 4.7)*

Over a half of informants, 52%, were in receipt of a benefit relating to a disability, i.e. Incapacity Benefit, Disability Living Allowance, Severe Disablement Allowance, Invalid Care Allowance, Disability Working Allowance, Attendance

Allowance, Statutory Sick Pay or Industrial Injury Disablement Benefit. Among men, this proportion was 66%, compared with 38% among women. *(Table 4.7)*

Table 4.8 shows the results of logistic regression analysis on receipt of benefits related to disability. Four variables were independently associated with receipt of benefits related to disability; sex, tenure, CIS-R score and whether the person lives alone. Men, those renting their accommodation, those with CIS-R scores of 12 and over and those living alone had increased odds of being in receipt of benefits related to a disability. As might be expected, these are the same factors that were found to be associated with being economically inactive due to being long-tem sick and disabled. *(Table 4.8)*

Apart from these benefits, over half of the sample (54%) had no other sources of income, and three respondents (2%) said they had neither state benefits nor other sources of income. Nearly a quarter (24%) of respondents had some earned income, including 8% of those who received benefits. Overall 14% had a pension from a former employer. *(Table 4.9)*

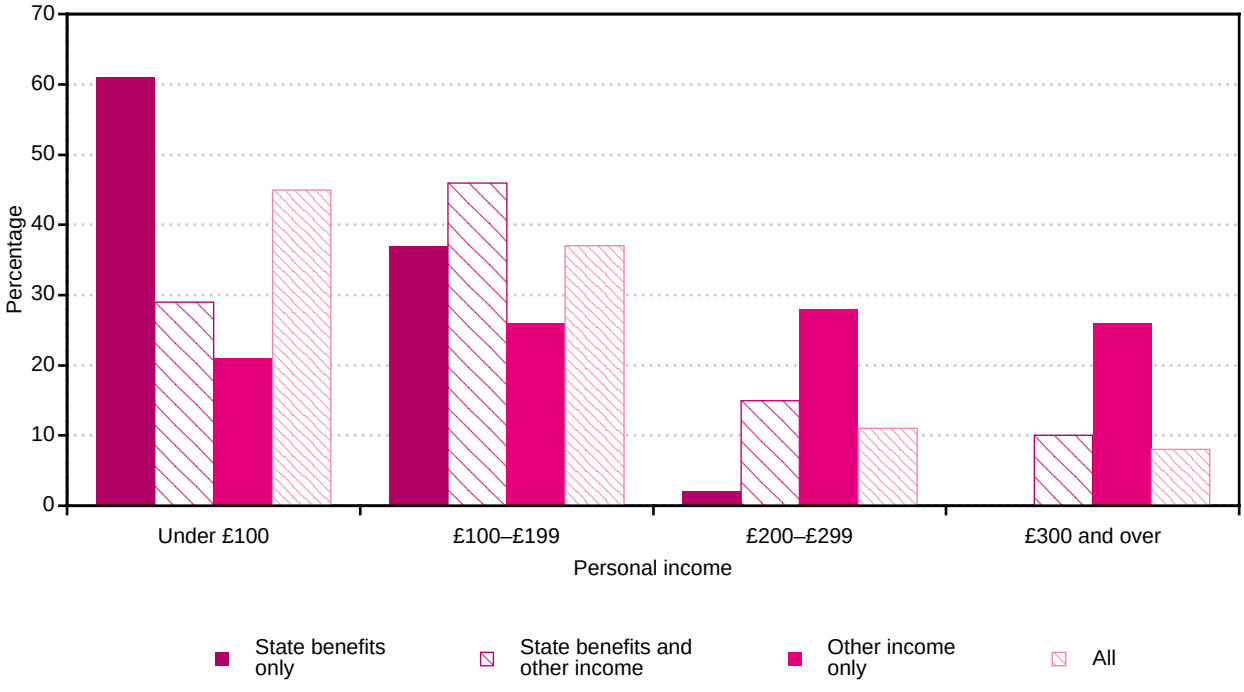
Almost half of this sample (45%) had a gross weekly income of under £100. For those on state benefits and without other sources of income, this rose to 61%, compared with 29% for those in receipt of state benefits but who had other sources of income, and 21% of those with other income and no state benefits. Only 2% of respondents on state benefits alone had gross weekly incomes of £200 or greater, compared with 25% of those on state benefits and with other sources of income, and 54% of those whose entire income came from other sources. *(Table 4.10 and Figure 4.2)*

4.3.2 Financial difficulties

Informants where asked whether, in the past 12 months, there had been times when they had been seriously behind in paying within the time allowed for a range of items.[1] Seventeen per cent answered that they had been. Among respondents with income other than state benefits, 6% had been in debt in the previous twelve months, whilst amongst those whose only source of income was state benefits, or who had no source of income, over a quarter (27%) had experienced debt in the twelve months before interview. *(Table 4.11)*

Almost a tenth (9%) of this sample had been disconnected from one or more of the utilities (water, gas, electricity, telephone) in the previous twelve months. The rate was higher (14%) among those whose only source of income was from state benefits than among those with other sources of

Figure 4.2 Level of income by source of income



income (2%). Eighteen per cent of the sample reported using less of at least one of these utilities because they were unable to afford it. Among those on benefits alone, over a quarter (29%) had used less than they needed, compared with 7% of those with income from other sources. *(Table 4.12)*

Finally, informants were asked whether there had been times during the past year when they had borrowed money from pawnbrokers, money-lenders, friends or relations in order to pay for their day-to-day needs. A fifth (20%) said that they had. Most often this was from family (11%) and friends (10%), but 4% had borrowed money from a money-lender and 1% from a pawnbroker. Borrowing for day-to-day needs was higher among those with no income other than benefits, of whom 30% had borrowed money, compared with 10% of those with other sources of income. *(Table 4.13)*

Note

1 Items asked about were rent, gas, electricity, water, hire purchase repayments, mortgage repayments, council tax, credit card repayments, mail order catalogue repayments, telephone, TV licence, road tax, DSS Social Fund loan, and other loan repayments.

Table 4.1 Employment status

by sex and age

	Sex		Age		All
	Male	Female	Under 45	45 and over	
	%	%	%	%	%
Employment status					
Working full time	21	6	11	15	13
Working part time	4	23	14	14	14
Unemployed	3	3	5	2	3
Economically inactive	72	68	70	70	70
Base	*96*	*101*	*80*	*117*	*197*

Table 4.2 Reason for economic inactivity

by sex and age

	Sex		Age		All
	Male	Female	Under 45	45 and over	
	%	%	%	%	%
Reason for not seeking work					
Long-term sick or disabled	81	43	79	51	62
Retired from paid work	13	28	-	34	20
Looking after the family/home	4	20	16	10	12
Student	1	1	2	1	1
Temporarily sick or injured	-	3	2	1	1
Other	-	4	2	2	2
Base = economically inactive	*69*	*69*	*56*	*82*	*138*

Table 4.3 Odds ratios for characteristics associated with economic activity†

	Working	Economically inactive	Not working as sick or disabled
	Adjusted odds ratios		
Sex			
Female			1.00
Male			2.50*
Marital status			
Married/cohabitting	1.00		
Single	0.51		
Widowed/divorced/separated	0.23**		
Household size			
Lives with others			1.00
Lives alone			2.43*
Social class			
Non-manual	1.00		
Manual/not known	0.44*		
Tenure			
Owner	1.00	1.00	1.00
Renter	0.32**	4.44***	3.15**
CIS-R score			
Below 12	1.00	1.00	1.00
12 and over	0.40*	2.11*	4.68***
Other factors entered in the model but not significantly associated with any dependent variable	Age, educational qualifications, source of sample, long-standing physical illness		

*p<0.05; **p<0.01; ***p<0.001
† The number of people classified as unemployed was too small to allow analysis.

Table 4.4 Time off work in the past year due to ill-health

	%
Had time off work...	
Yes	47
No	53
*Base**	*58*
Median number of days off**	**14**
Mean number. of days off**	**70**

* People who had worked in past year.
** People who had taken time off for ill-health only.

Table 4.5 Reason for not currently working and type of employment possible for those who have previously had a job

	%
Reason not currently working	
Way they feel makes it impossible	59
Physical health problem	18
Unable to find suitable job	5
Do not want or need a job	12
Other reasons	5
Base	*116*
	Percentage giving each answer
Type of employment possible	
Could do sheltered work	23
Could do part-time work	17
Impossible to do work	67
*Base**	*96*

* Those who wanted/needed work only.

Table 4.6 State Benefits received

	% receiving benefit
Benefit	
Disability-related benefits	
Incapacity Benefit	31
Care component of Disability Living Allowance	14
Disability Living Allowance nes	14
Mobility Allowance of Disability Living Allowance	12
Severe Disablement Allowance	9
Attendance Allowance	2
Industrial Injury Disablement Benefit	2
Invalid Care Allowance	2
Disability Working Allowance	1
Statutory Sick pay	1
Any disability related benefit	**52**
Income-related benefits	
Income Support	27
Family Credit/Working Families Tax Credit	2
Any income-related benefits	**28**
Other benefits	
Retirement Pension	16
Child Benefit	11
One Parent Benefit	2
Widows Pension or Allowance	1
Jobseekers Allowance	1
Any other benefits	**30**
Householder receiving Housing Benefit	38
Any benefit received	**79**
No benefits received	**21**
Base	*196*

Table 4.7 Benefits received by sex and age

	Sex		Age		All
	Male	Female	Under 45	45 and over	
			% receiving benefit		
Benefit received					
Benefit related to a disability	66	38	56	48	52
Householder receiving Housing benefit	48	30	49	31	38
Other benefit	12	46	25	32	30
Income-related benefit	33	22	45	16	28
Any benefit	**80**	**77**	**80**	**78**	**79**
Base	*97*	*103*	*80*	*120*	*200*

Table 4.8 Odds ratios for characteristics associated with receipt of benefits related to a disability

	Receiving benefit related to a disability
	Adjusted odds ratios
Sex	
Female	1.00
Male	2.99**
Household size	
Lives with others	1.00
Lives alone	2.46*
Tenure	
Owned	1.00
Rented	2.39*
CIS-R score	
Below 12	1.00
12 and over	3.54***
Other factors entered in the model but not significantly associated with the dependent variable	Age, marital status, social class, educational qualifications, source of sample, physical complaint

*p<0.05; **p<0.01; ***p<0.001

Table 4.9 Sources of income other than benefits by whether or not benefits were received

	Receiving state benefits		
	Yes	No	All
	Percentage with income from each source		
Source of income			
Earnings from employment	8	81	24
Interest from savings	16	36	20
Pension from former employer	15	10	14
Other income	8	5	8
None of these	66	7	54
Base	*154*	*42*	*196*

Table 4.10 Income

by source of income

	Source of income			
	State benefits only	State benefits and other income	Other income only	All*
	%	%	%	%
Level of income				
Under £100	61	29	21	45
£100–£199	37	46	26	37
£200–£299	2	15	28	11
£300 and over	-	10	26	8
Base	*100*	*52*	*39*	*194*

* 3 respondents who said they had no income are included in 'All'.

Table 4.11 Financial debts

by source of income

	Income source		
	State benefits only or no income	Other income source	All
	Percentage experiencing each problem		
Respondent has been behind in payments for...			
Water	8	1	5
Telephone	9	1	5
Rent	7	0	4
Council Tax	6	2	4
Mail order catalogue	5	2	4
TV licence	6	1	4
Gas	5	0	3
Electricity	4	0	2
Other loans	3	1	2
Goods on hire purchase	1	1	1
Mortgage repayments	2	0	1
Credit Card payments	0	1	1
Road Tax	0	1	1
DSS Social Fund Loan	1	0	1
None of these	73	94	83
Base	*105*	*91*	*196*

Table 4.12 Financial difficulties

by source of income

	Source of income		
	State benefits only or no incoe	Other income source	All
	Percentage experiencing each problem		
Respondent has been disconnected from...			
Telephone	11	1	7
Electricity supply	3	0	2
Water supply	2	0	1
Gas supply	1	1	1
Any of these	**14**	**2**	**9**
Respondent has used less...			
Electricity supply	15	5	11
Gas supply	15	3	10
Telephone	13	2	8
Water supply	2	0	1
Any of these	**29**	**7**	**18**
Respondent has borrowed from...			
Family	16	5	11
Friend(s)	14	4	10
Moneylender	7	1	4
Pawnbroker	1	0	1
Any of these	**30**	**10**	**20**
Base	*105*	*91*	*196*

5 Social networks and perceived social support

5.1 Introduction

The psychiatric morbidity surveys examined two aspects of social functioning:

- extent of social networks; and
- self perceived social support.

This chapter considers each of these aspects of social functioning within this sample of people with a psychotic illness.

5.2 Extent of social networks

Information on social networks was obtained through questions about the numbers of friends and relatives informants felt close to:

- adults who lived with respondents and to whom they felt close;
- relatives living elsewhere to whom they felt close; and
- friends or acquaintances living elsewhere who informants would describe as close or good friends.

People in the three categories above were defined as the respondent's 'primary support group'. These questions were used in earlier surveys of psychiatric morbidity carried out by ONS including the 2000 survey of psychiatric morbidity among adults living in private households. Research suggests that adults whose total primary support group numbers three or fewer adults are at greatest risk of psychiatric illness. (Brugha *et al*, 1987; Brugha *et al*, 1993)

For the purposes of this report, the people were grouped into three categories based on the size of their primary support group: 0–3, 4–8 and 9 and over. In the survey of adults living in private households in 2000 only 5% had a small primary support group (less than four people) but the small group of people with probable psychotic disorder stood out as the group most likely to have a small primary support group (Meltzer *et al*, 2002b). Among the sample of people with a psychotic illness covered in the current report (which includes people from that general household survey), a fifth (20%) reported feeling close to fewer than four people, while just over two-fifths (42%) had a primary support group of between four and eight people and 39% had nine or more people to whom they felt close or described as good friends.

There were no differences between men and women in the size of their primary support groups. People aged 45 and over, however, were more likely than those aged under 45 to have primary support groups of 9 people or more, 46% compared with 29%. *(Table 5.1)*

5.3 Perceived social support

Perceived social support was derived from respondents answers to seven questions originally fielded in the 1987 Health and Lifestyle survey (Breeze *et al*, 1994) and also included in other ONS surveys of psychiatric morbidity. The seven questions take the form of statements that individuals could say were not true, partly true or certainly true for them:

There are people I know – amongst my family or friends:

- who do things to make me happy;
- who make me feel loved;
- who can be relied upon no matter what happens;
- who would see that I am taken care of if I needed to be;
- who accept me just as I am;
- who make me feel an important part of their lives; and
- who give me support and encouragement.

Responses to each statement were scored 1 for not true, 2 for partly true and 3 for certainly true. Overall scores, therefore, could range from 7, if all answers were not true, to 21 if all answers were certainly true. The scores were categorised into three groups, following the conventions used in earlier surveys in this series:

- score of 21 – no lack of social support;
- score of 18–20 – moderate lack of social support; and
- score of 17 or less – severe lack of social support.

Just over one-fifth (21%) of this sample of people with psychotic illnesses were classified as having a severe lack of perceived social support, while 25% had a moderate lack and 54% had no lack of social support.

Sex and age were both associated significantly with having a severe lack of social support. Twenty-nine per cent of men, compared with 15% of women, were classified as having a severe lack of social support, as were 31% of people aged under 45 compared with 14% of those aged 45 and over. *(Table 5.2)*

Figure 5.1 illustrates that a clear relationship exists between the size of an informant's primary support group and perceived social support. The proportion of respondents with a perceived severe lack of social support was only 8% among those with primary support groups of nine or more people, rising to 24% of those with primary support groups of between 4 and 8, and 41% among those with a small primary support group of 3 or fewer people. *(Figure 5.1 and Table 5.3)*

Table 5.4 shows the results from multiple logistic regression to identify factors independently associated with perceived social support levels and size of primary support group. The odds of perceiving a severe lack of social support were lower for women than for men, and for those aged 45 and over than for those under 45. Informants who were single, widowed or divorced had odds more than double those of married informants of perceiving a severe lack of social support. Those with CIS-R scores of twelve or more were more likely than those with scores below 12 to perceive a severe lack of social support.

The only characteristic independently associated with having a primary support group of three or fewer people was CIS-R score – those with scores of 12 or more had odds four and a half times greater than those with lower scores of having a support group of three or fewer people. *(Table 5.4)*

Fig 5.1 Perceived social support by size of primary support group

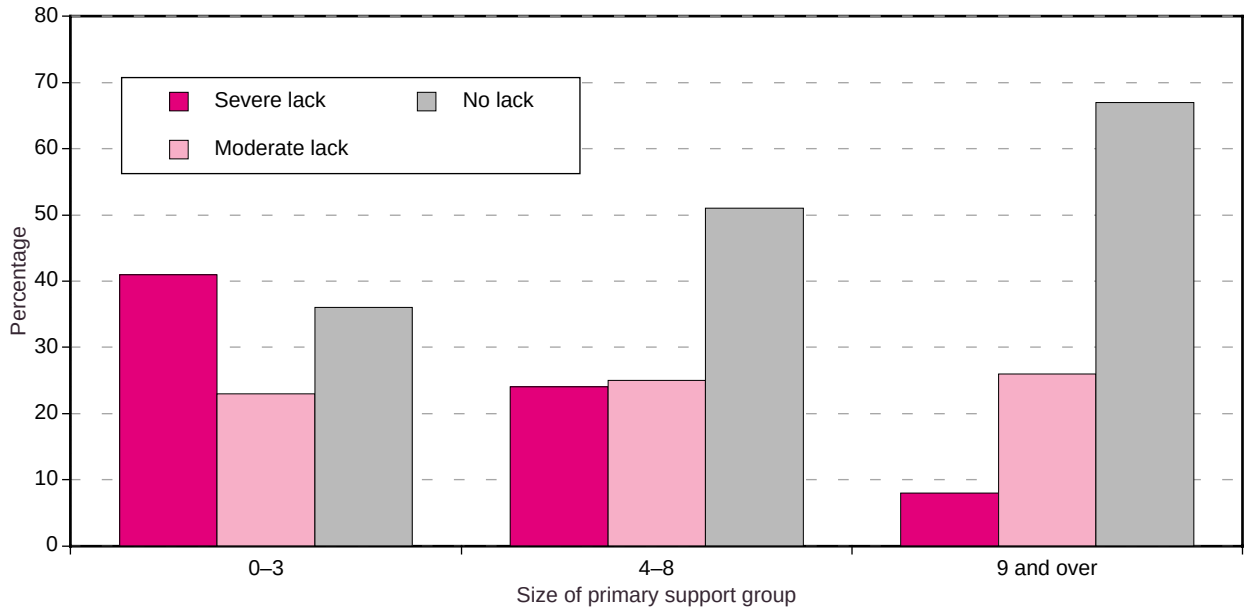


Table 5.1 Size of primary support group
by sex and age

	Sex		Age		All
	Male	Female	Under 45	45 and over	
	%	%	%	%	%
Size of primary support group					
0–3	20	19	28	14	20
4–8	41	42	44	40	42
9 and over	39	39	29	46	39
Base	*97*	*103*	*80*	*120*	*200*

Table 5.2 Perceived social support
by sex and age

	Sex		Age		All
	Male	Female	Under 45	45 and over	
	%	%	%	%	%
Perceived social support					
Severe lack of support	28	15	31	14	21
Moderate lack of support	24	26	24	26	25
No lack of support	48	59	45	60	54
Base	*97*	*103*	*80*	*120*	*200*

Table 5.3 Peceived social support
by size of primary support group

	Size of primary support group			
	0–3	4–8	9 and over	All
	%	%	%	%
Perceived social support				
Severe lack of support	41	24	8	21
Moderate lack of support	23	25	26	25
No lack of support	36	51	67	54
Base	*39*	*83*	*78*	*200*

Table 5.4 Odds ratios for characteristics associated with severe lack of social support and primary support group of fewer than 3 people

	Has severe lack of social support	Has primary support group of three or fewer people
	Adjusted odds ratios	
Sex		
Male	1.00	
Female	*0.46	
Age group		
Under 45	1.00	
45 and over	*0.42	
Marital status		
Married	1.00	
Single, widowed, divorced	*2.23	
CIS-R score		
Below 12	1.00	1.00
12 and over	*2.52	***4.63

*p<0.05; **p<0.01; ***p<0.001

Other variables not significantly associated: Social class, tenure, physical complaint, educational qualifications, household size, source of sample.

6 Tobacco, alcohol and drugs

6.1 Introduction

Measures of cigarette smoking, alcohol use and drug misuse were collected for all respondents. Everyone was asked a series of questions about their use of tobacco, alcohol and illegal drugs. Those who drank alcohol or used drugs such as cannabis, heroin or cocaine were asked further questions to assess their consumption and possible dependence. Computer-Assisted Self-Interviewing (CASI), in which respondents enter their own answers into the computer, was used for the sections on alcohol dependence and drug use to encourage honest answers to these potentially sensitive questions. This chapter first describes levels of smoking, then the extent of hazardous drinking and alcohol dependence, before examining drug dependence.

6.2 Cigarette smoking

Informants were asked whether they had ever smoked cigarettes, and if so, whether they smoked nowadays. Smokers were asked how many cigarettes a day they smoked separately for weekdays and weekends. Daily consumption was computed as a mean of these figures. For analysis, adults were grouped into the following classifications:

- those who never have been a regular smoker;
- ex-smokers;
- those currently smoking below 10 cigarettes daily;
- those currently smoking 10 or more a day but fewer than 20; and
- those currently smoking 20 or more cigarettes a day.

A large proportion of adults in this sample of people with a psychotic illness were, or had been, smokers: 44% were smokers, a fifth (20%) were ex-smokers and just over a third (36%) had never been a regular smoker. In comparison, the 2000 General Household Survey found that amongst the general population aged 16 to 74 years 29% smoked, 22% were ex-smokers and half (50%) had never smoked. As well as having a high prevalence of smoking, a large proportion of people with psychotic illness reported smoking heavily (i.e. 20 or more cigarettes a day). Just over a quarter (27%) of the sample of people with psychotic illness were heavy smokers while only one in twelve (9%) of the general population in the same age group smoked heavily.

In this sample, as in the general population, women were generally less likely to smoke than men and also smoked less. For example, 43% of women had never smoked compared with 27% of men. Conversely almost a third (32%) of men were heavy smokers (smoking 20 or more cigarettes a day) compared with just under a quarter (24%) of women. The proportions of people under and over 45 years old who had never smoked were similar, however over a quarter (28%) of those aged 45 and over were ex-smokers compared to only 9% of those aged under 45. *(Table 6.1)*

Logistic regression analysis was carried out to establish which characteristics were independently associated with cigarette smoking and with heavy cigarette smoking (20 or more cigarettes daily) in this sample of people with a psychotic disorder. The analysis showed that age group and tenure were associated with both smoking and heavy smoking. For those in the youngest age group (16 to 34) the odds of being a smoker were five times those for the oldest age group (55 to 74) and the odds of being a heavy smoker were more than four times higher. Those aged 35 to 44 and 45 to 54 were also more likely to smoke than those aged 55 to 74. Those who rented their home had odds of being a smoker two and a half times greater than those who owned their home, and three times greater of being heavy smokers. High CIS-R scores were also independently associated with being a heavy smoker. The odds of being a heavy smoker were three times higher for those with CIS-R scores of 12 and over than for those with lower CIS-R scores. *(Table 6.2)*

6.3 Alcohol consumption

Two instruments were used to assess alcohol misuse – the Alcohol Use Disorders Identification Test (AUDIT) and the Severity of Alcohol Dependence questionnaire (SAD-Q). The AUDIT was developed from a six-country WHO collaborative project and has been shown to be a good indicator of hazardous alcohol use (Saunders *et al,* 1993). It defines hazardous drinking as an established pattern of drinking, which brings the risk of physical and psychological harm now or in the future. The year before interview is used as a reference period. Answers to all questions are scored from 0 to 4 and then summed to provide a total score ranging from 0 to 40. A total score of 8 and over is the threshold used to provide an assessment of hazardous drinking.

The prevalence of alcohol dependence in the six months before interview was assessed using the Severity of Alcohol Dependence questionnaire (SAD-Q) (Stockwell *et al*, 1983). The SAD-Q was asked of all respondents who had an AUDIT score of 10 and over. A total SAD-Q score of 3 or less indicates no dependence, while a score of four or above suggests some alcohol dependence. Mild dependence is indicated by a score of between 4 and 19, moderate dependence by a score of 20–34, and severe dependence by a SAD-Q score of 35–60.

For the current analysis we have used a classification based on both measures. The categories are:

- No hazardous drinking – those with an AUDIT score of less than 8.
- Hazardous level of drinking but no dependence – those with an AUDIT score of 8 or more, but a SAD-Q score of between 0 and 3.
- Alcohol dependence – those with an AUDIT score of 8 or more and a SAD-Q score of 4 or more.

Among this sample, 27% of respondents had an AUDIT score of 8 or more – that is, they were found to have a hazardous level of drinking in the year before interview. This is a similar level of hazardous drinking to that found in the household sample, at 25% (Singleton *et al*, 2001). Thirteen per cent were found to have hazardous levels of drinking without alcohol dependence, and 14% were classified as alcohol dependent. Men and women showed different patterns of alcohol consumption. Among men, 37% were drinking alcohol at hazardous levels, and 21% showed evidence of alcohol dependence. Among women, 18% had hazardous levels of alcohol consumption, while 8% were alcohol dependent. In the general population younger people tend to drink more heavily than older adults and the same was true in this sample: those aged under 45 years were twice as likely as those aged 45 and over to show signs of alcohol dependence – 22% compared with 9%. *(Table 6.3)*

Logistic regression analysis was carried out to establish characteristics independently associated with alcohol dependence in this sample of people with a psychotic illness. Those with CIS-R scores of twelve and over had odds of being alcohol dependent over five times greater than those without evidence of neurotic illness. Women and informants with a long standing physical complaint both had significantly lower odds than men and those with no long standing physical complaint of being alcohol dependent. *(Table 6.4)*

6.4 Illicit drug use

Informants were asked about their illicit use of drugs, including sedatives, tranquillisers, cannabis, amphetamines, cocaine, heroin, hallucinogens, ecstasy and solvents. Illicit use of drugs was established by presenting informants with a list of drugs and asking them whether they had used any of the drugs without a prescription from the doctor. Overall, 30% reported ever using one or more of the specified drugs, and 8% reported having done so within the last 12 months. These levels are similar to those found in the household survey. *(Table 6.5)*

Further information about drug use in the year preceding interview was collected about six drugs: cannabis, amphetamines, crack, cocaine, ecstasy, tranquillisers and opiates. Included in the questions about drug use in the past year and month were five questions to measure drug dependence. The topics covered by these questions were:

- Frequency of drug use: used drug every day for two weeks or more.
- Stated dependence: felt they needed it or were dependent on it.
- Inability to cut down: tried to cut down but could not.
- Need for larger amounts: needed more to get an effect.
- Withdrawal symptoms: feeling sick because stopped or cut down.

A positive response to any of the five questions was used to indicate drug dependence. For the purposes of analysis informants were grouped into those who were dependent on cannabis only, those who were dependent on another drug (with or without associated dependence on cannabis), and those with no drug dependence. It should be noted that the threshold for dependence used here is quite low. People who are frequent users (i.e. daily users for a fortnight or more) or who have developed some tolerance for the drug, so require more to get the same affect, will be assessed as dependent. A large proportion of those assessed as dependent on cannabis and ecstasy had only scored one on the dependence questions. This threshold was used to provide comparability with the 1993 survey but may overestimate dependence on some drugs.

Among this sample, 1% were classified as dependent on cannabis, and 2% on drugs other than cannabis (with or without cannabis dependence). There were no statistically significant differences between men and women, or between age groups. *(Table 6.6)*

Table 6.1 Cigarette smoking by sex and age

	Sex		Age		All	General population (GHS 2000)*
	Male	Female	Under 45	45 and over		
	%	%	%	%	%	%
Daily cigarette consumption						
Never smoked	27	43	34	37	36	50
Ex-smoker	24	17	9	28	20	22
1–9 cigarettes per day	7	3	9	3	5	8
10–19 cigarettes per day	9	14	16	9	12	12
20 and over cigarettes per day	32	24	32	24	27	9
Base	*96*	*102*	*80*	*118*	*198*	*12814*

*Source: General Household Survey, 2000, Office for National Statistics, people aged 16 to 74 only

Table 6.2 Odds ratios for characteristics associated with smoking and heavy smoking

	Smoking	Heavy smoking
	Adjusted odds ratios	
Age group		
16–34	5.04**	4.36*
35–44	3.28**	1.36
45–54	3.50**	3.49*
55–74	1.00	1.00
Tenure		
Owns home	1.00	1.00
Rents home	2.60**	3.01**
CIS-R score		
Below 12		1.00
12 and over		2.98**
Other variables included in the models but not significant for either of the dependent variables:	Marital status, sex, household size, employment status, educational qualifications, social class, long-standing physical complaint and sample group	

*p<0.05; **p<0.01; ***p<0.001

Table 6.3 Level of alcohol consumption by sex and age

	Sex		Age		All
	Male	Female	Under 45	45 and over	
	%	%	%	%	%
Level of alcohol consumption					
No hazardous drinking[1]	63	82	67	77	73
Hazardous drinking but no dependence[2]	16	10	11	14	13
Alcohol dependence[3]	21	8	22	9	14
Base	*96*	*102*	*80*	*118*	*198*

1 AUDIT score <8.
2 AUDIT score ≥8 but SAD-Q score 0–3.
3 AUDIT score ≥8 and SAD-Q score 4 and over.

Table 6.4 Odds ratios for characteristics associated with alcohol dependence

	Alcohol dependence
	Adjusted odds ratios
Sex	
Male	1.00
Female	0.32*
CIS-R score	
Below 12	1.00
12 and above	5.16***
Long standing physical complaint	
Absent	1.00
Present	0.29**
Other variables included in the regression model but not significant for the dependent variable	Marital status, age group, household size, employment status, educational qualifications, social class, tenure and sample group

*p<0.05; **p<0.01; ***p<0.001

Table 6.5 Illicit drug use

by sex and age

	Sex		Age		All
	Male	Female	Under 45	45 and over	
			Percentage reporting use		
Illicit drug use					
Ever used an illicit drug	39	22	45	19	30
Used an illicit drug in last year	10	5	12	4	8
Base	*96*	*102*	*80*	*118*	*198*

Table 6.6 Drug dependence

by sex and age

	Sex		Age		All
	Male	Female	Under 45	45 and over	
	%	*%*	*%*	*%*	*%*
Drug dependence					
None	96	98	94	99	97
Dependent on cannabis only	2	-	1	1	1
Dependent on other drug with or without cannabis	2	2	5	-	2
Base	*96*	*102*	*80*	*118*	*198*

7 Stressful life events, suicidal thoughts and behaviours

7.1 Introduction

People with psychotic illness are known to be at particularly high risk of suicide (Westermeyer *et al*, 1991; Harris and Barraclough, 1998; Inskip *et al*, 1998; Department of Health, 2001). In this survey a series of questions was asked looking at suicidal thoughts and non-fatal suicidal behaviour as well as deliberate self-harm without suicidal intent. Four questions were included to assess self-harm with suicidal intent, based on the work of Paykel *et al* (1974) and Salmons and Harrington (1984).

1. Have you ever thought that life was not worth living?
   (If YES, in the last week, last year, or at another time)
2. Have you ever wished that you were dead?
   (If YES, in the last week, last year, or at another time)
3. Have you ever thought of taking your life, even though you would not actually do it?
   (If YES, in the last week, last year, or at another time)
4. Have you ever made an attempt to take your life, by taking an overdose of tablets or in some other way?
   (If YES, in the last week, last year, or at another time)

Responses to question 3 were used to assess suicidal thoughts and those to question 4 for non-fatal suicidal behaviour.

To measure deliberate self-harm without the intention of suicide, respondents were asked an additional question.

5. Have you deliberately harmed yourself in any way but not with the intention of killing yourself?

Respondents who answered yes to this question were then asked a series of questions about how they had harmed themselves and for what reasons. All information about non-fatal suicidal behaviour was obtained from these interviews. No records were assessed.

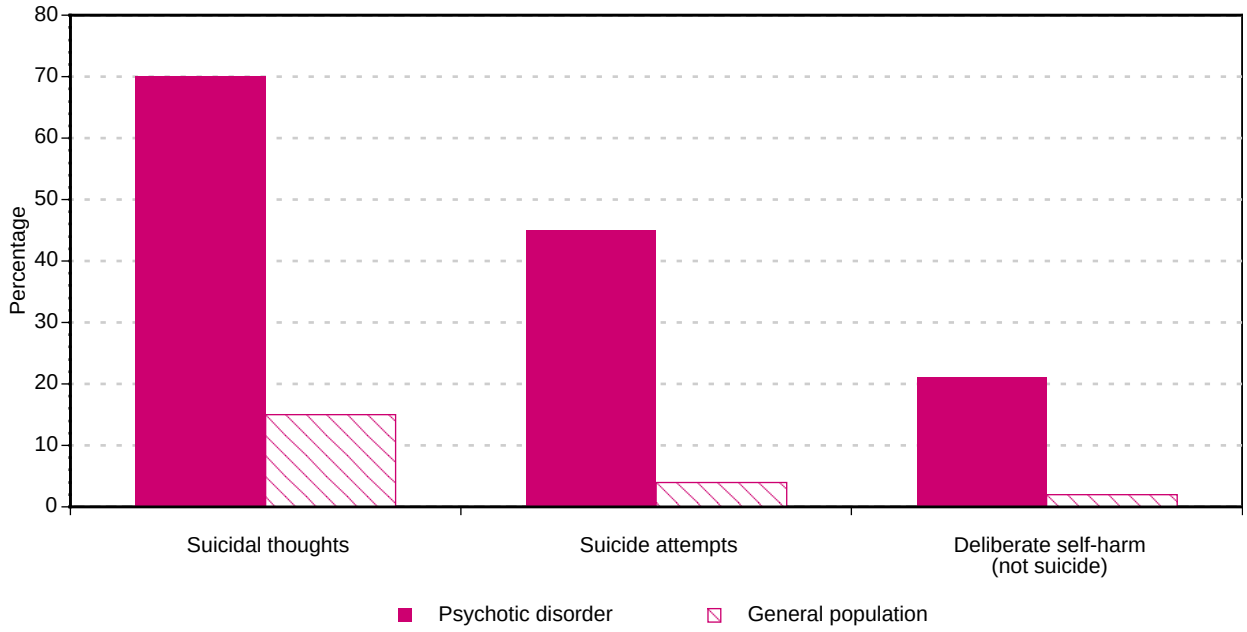
An earlier report, based only on the main survey of psychiatric morbidity among adults living in private households in 2000, considered factors associated with non-fatal suicidal thoughts and behaviours among the general population (Meltzer *et al*, 2002). This found the strongest correlates of non-fatal suicidal behaviour to be the number of stressful life events experienced, age, psychotic disorder, depression and mixed anxiety and depression and dependence on drugs other than cannabis. However, the number of people with psychotic disorder in the main survey sample was very small. This chapter looks at the prevalence of suicidal thoughts and self-harm with and without suicidal intent among the larger group of people with psychotic disorder covered by this report. It also considers the extent of stressful life events experienced by this group and the association between these and suicidal thoughts and behaviours.

7.2 Prevalence of suicidal thoughts and deliberate self-harm

Over two-thirds (70%) of this sample of people with a psychotic illness had had suicidal thoughts at some time in their lives and 45% had attempted suicide, while 21% had harmed themselves without intending to commit suicide. These rates are far higher than those found in the general household population aged 16 to 74, in which the corresponding figures were 13% reporting suicidal thoughts, 4% attempted suicide and 2% deliberate self-harm at sometime in their lives. *(Table 7.1 and Figure 7.1)*

In the general population women and younger people were more likely to report suicidal thoughts, and suicide attempts and other deliberate self-harm was also more common among younger people (Meltzer *et al*, 2002). However, in this group of people with a psychotic illness there was no difference between men and women in the prevalence of suicidal thoughts, nor for self-harm with or without suicidal intent. Younger people in the sample were more likely to report all of these behaviours than those aged 45 or over. *(Table 7.1)*

Figure 7.1 Lifetime prevalence of non-fatal suicidal behaviour: people with psychotic disorder compared with the general population



7.3 Stressful life events

Meltzer *et al* (2002) found a very strong relationship between the number of stressful life events a person had experienced and their likelihood of reporting suicidal thoughts and attempts and other types of self-harm. Everyone in our sample of people with psychotic disorders was asked the same series of questions about their experience of a range of stressful life events.

All respondents were shown three sets of cards that listed a range of stressful life events (18 in total) and were asked to say which, if any, they had suffered at any time of their life. They covered relationship problems, illness and bereavement; employment and financial crises; and victimisation experiences. All are events which might have an adverse effect on a person's mental health. They were also used in the ONS survey of psychiatric morbidity among prisoners (Singleton *et al*, 1998).

However, the lists did not include all common stressful events, excluding for example, moving house and having a baby. Previous research has shown that events such as these are unlikely to significantly increase risk for psychiatric disorders. (Brugha *et al*, 1985). In addition, when looking at the number of events experienced, it should be remembered that the events may not carry equal weight in terms of their psychological impact, and that some events are likely to be found in combination with others; for example running away from home and homelessness. If an event was reported in the lifetime of the individual, a further question established whether this was within the past six months.

The proportion of people reporting experiencing stressful life events was far higher in this sample of people with psychotic illness than in the general household population aged 16 to 74. Almost everyone in the sample (97%) had experienced one of the events in the group concerning relationship problems, illness and bereavement. Compared with the general household population, this sample reported experiencing particularly high rates of serious illness or assault to themselves, 63% compared with 26% in the general population, but this may reflect the fact that psychotic disorder would be classified as a severe illness by most people. Rates of divorce or separation were also much higher than in the general population, 47% compared with 22%. They were also more than twice as likely to report a serious problem with a close friend or relative, 30% did so compared with 12% of people in the main household survey. *(Table 7.2)*

Given the low rate of employment and the low incomes experienced by this group of people with a psychotic illness that are described in chapter 4 of

this report, it is not surprising that stressful events relating to employment and finances were also far more common in this sample than in the general household population. They were also much more likely to report having had a problem with the police involving a court appearance – 22% reporting having done so compared with only 9% in the general population. Men in the sample were more likely than women to report all of this group of stressful events, except having something they valued lost or stolen, but there were no differences between the age groups. *(Table 7.2)*

A very high proportion of people in this sample reported experiencing one of the types of victimisation covered in the survey. Over a fifth (21%) reported sexual abuse and the rate was significantly higher among women and younger people (31% in each case). About a quarter of the sample said they had experienced violence in the home (25%) and being homeless (23%), while 41% said they had suffered bullying. As well as reporting a higher rate of sexual abuse, younger people were more likely to report bullying, running away from home and being expelled from school. *(Table 7.2)*

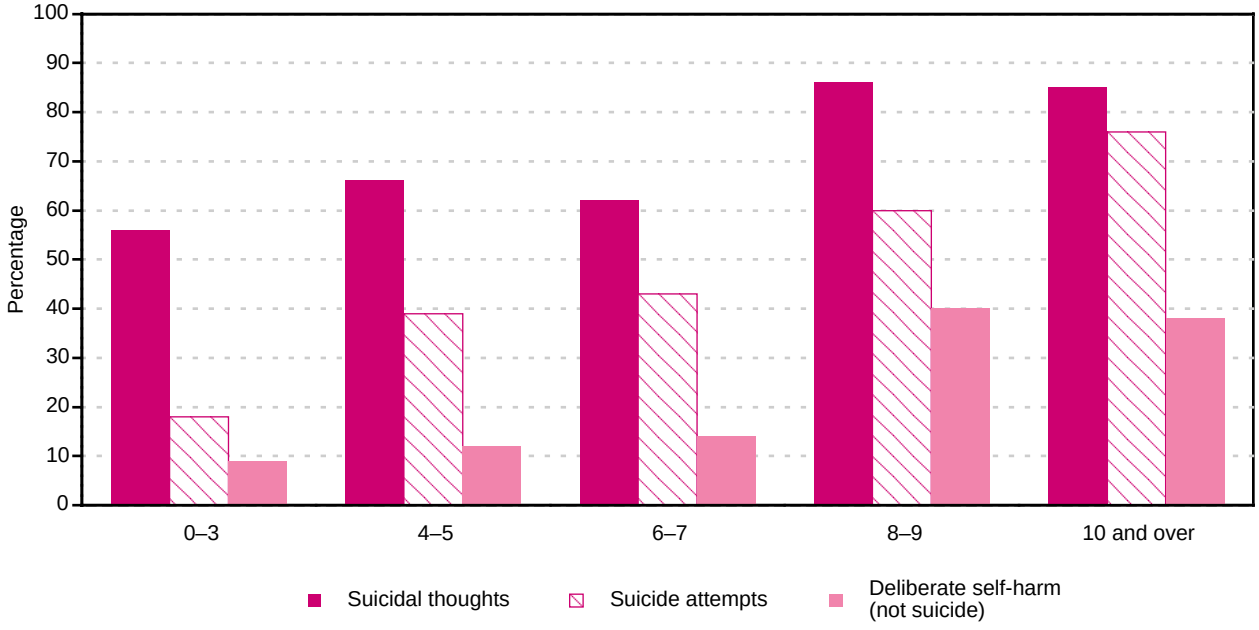
Meltzer *et al* (2002) found that the number of stressful life events was a more important predictor of suicidal thoughts and behaviours than the individual events experienced. In the survey of psychiatric morbidity among adults living in private households 17% of the sample reported 6 or more of the stressful events and this group had markedly increased odds of suicidal thoughts and self-harm with or without suicidal intent compared with people who had not experienced any of the events. In this sample of people with a psychotic illness over half, 57%, had experienced six or more events and 17% reported ten or more of them. *(Table 7.3)*

7.4 Factors associated with suicidal thoughts and behaviours

As was the case in the general household population (Meltzer *et al*, 2002), the proportion of people in this sample who reported suicidal thoughts and, in particular, self-harm with or without suicidal intent increased with the number of stressful life events they reported. Those who reported eight or more events had particularly high rates; over 80% reporting suicidal thoughts and over 60% attempting suicide at some time in their lives. *(Table 7.4, Figure 7.2)*

When the relationship between non-fatal suicidal behaviours and individual events are considered, a few events stand out as being associated with particularly high rates of suicide attempts at some time. Among those who reported a serious problem with a close friend or relative, 66% said they had attempted suicide at sometime in their life (compared with 44% of the sample as a whole). A similar proportion of those who had experienced violence in the home had attempted suicide (67%)

Figure 7.2 Lifetime prevalence of non-fatal suicidal behaviours by number of stressful life events



as had 71% of those who had been homeless and 74% of those who had experienced sexual abuse. (Tables 7.5 to 7.7)

Logistic regression analysis was carried out to identify those factors independently associated with non-fatal suicidal thoughts and behaviours in this sample of people with probable psychotic disorder. As well as the factors listed in chapter 1 and considered throughout this report in these analyses, the number of stressful life events was also included in the modelling procedures. The presence of significant levels of neurotic symptoms, as shown by a CIS-R score of 12 and over, was associated with a four-fold increase in the odds of reporting suicidal thoughts at some time in one's life. In contrast having a longstanding physical health problem was associated with a decreased likelihood of reporting suicidal thoughts once other factors had been taken into account. High levels of neurotic symptoms were also significantly associated with suicide attempts and in this case the number of stressful life events also showed a very strong association. The odds ratio for those reporting 10 or more stressful life events compared to those reporting 0 to 3 was 12.2. The two factors independently associated with deliberate self-harm without suicidal intent were the number of stressful life events and younger age. *(Table 7.8)*

Table 7.1 Prevalence of non-fatal suicidal behaviour by sex and age

	Sex		Age		All	Household population*
	Male	Female	Under 45	45 and over		
	Cumulative percentage of population					
Suicidal thoughts						
Past week	4	7	10	2	6	0
Past year	22	23	31	17	22	4
Lifetime	69	70	78	64	70	13
Never	31	30	22	36	30	87
Suicide attempts						
Past week	-	-	-	-	-	0
Past year	5	9	10	5	7	1
Lifetime	45	45	53	40	45	4
Never	55	55	47	60	55	96
Deliberate self-harm without suicidal intent	22	21	33	13	21	2
Base	*97*	*103*	*80*	*120*	*200*	*8572*

* Adults aged 16 to 74 living in private households (Meltzer *et al*, 2002; Table 3.1).

Table 7.2 Stressful life events by sex and age

	Sex		Age		All	General population*
	Male	Female	Under 45	45 and over		
	Percentage reporting experiencing each event					
Relationship problems, illness and bereavement						
Death of close friend/other relative	70	73	70	73	72	64
Death of close relative	76	77	51	94	77	54
Serious illness or assault	64	62	60	65	63	26
Serious illness or assault to close relative	24	38	32	30	31	24
Separation or divorce	41	52	46	47	47	22
Serious problem with close friend/relative	31	29	36	26	30	12
None of these	3	2	5	1	3	10
Employment and financial crises						
Made redundant or sacked	61	34	41	51	47	30
Looking for work for 1 month and over	59	27	46	40	43	23
Something valued lost or stolen	36	41	40	38	39	22
Major financial crisis	34	14	20	26	24	11
Problem with police and court appearance	32	12	21	22	22	9
None of these	15	32	25	22	23	46
Vicitimisation experiences						
Bullying	41	41	52	32	41	18
Violence in the home	18	32	32	20	25	7
Running away from home	15	22	30	10	18	5
Violence at work	12	7	9	10	10	4
Being homeless	23	23	29	19	23	4
Sexual abuse	11	31	31	15	21	3
Being expelled from school	5	3	9	1	4	2
None of these	39	37	29	44	38	71
Base	*96*	*101*	*80*	*117*	*197*	*8515*

* Adults aged 16 to 74 living in private households (Meltzer *et al*, 2002, Table 5.7)

Table 7.3 Number of stressful life events by sex and age

	Sex		Age		All
	Male	Female	Under 45	45 and over	
	%	%	%	%	%
Number of stressful life events					
3 or less	20	25	21	23	22
4 or 5	19	22	20	21	20
6 or 7	26	19	19	25	22
8 or 9	19	17	20	16	18
10 and over	18	17	20	15	17
Base	*97*	*103*	*80*	*120*	*200*

Table 7.4 Prevalence of non-fatal suicidal behaviour by number of stressful life events

	Number of stressful life events					
	0–3	4–5	6–7	8–9	10 and over	All
	Cumulative percentage of population					
Suicidal thoughts						
Past week	2	5	2	11	9	6
Past year	16	22	13	40	26	22
Lifetime	56	66	62	86	85	70
Never	44	34	38	14	15	30
Suicide attempts						
Past week	-	-	-	-	-	-
Past year	-	2	7	20	9	7
Lifetime	18	39	43	60	76	45
Never	82	61	57	40	24	55
Deliberate self-harm without suicidal intent	9	12	14	40	38	21
Base	*45*	*41*	*44*	*35*	*34*	*199*

Table 7.5 Prevalence of non-fatal suicidal behaviour by relationship problems

	Relationship problem, illness or bereavement							
	Death of close friend\other relative	Death of close relative	Serious illness or assault	Serious illness or assault to close relative	Separation or divorce	Serious problem with close friend\relative	None of these	All
	Cumulative percentage of population							
Suicidal thoughts								
Past week	7	4	6	5	6	13	-	6
Past year	20	20	27	25	30	26	-	22
Lifetime	66	68	75	76	76	79	[2]	69
Never	34	32	25	24	24	21	[3]	31
Suicide attempts								
Past week	-	-	-	-	-	-	-	-
Past year	6	5	10	12	9	13	-	7
Lifetime	44	44	52	47	57	66	-	44
Never	56	56	48	53	43	34	[5]	56
Deliberate self-harm without suicidal intent	20	21	27	25	25	37	-	21
Base	*108*	*151*	*124*	*59*	*65*	*38*	*[5]*	*196*

Table 7.6 Prevalence of non-fatal suicidal behaviour by employment and financial crises

	Employment and financial crises						
	Made redundant or sacked	Looking for work for 1 month and over	Something valued lost or stolen	Major financial crisis	Problem with police and court appearance	None of these	All
	Cumulative percentage of population						
Suicidal thoughts							
Past week	5	4	7	2	9	9	6
Past year	24	21	25	17	23	20	22
Lifetime	76	74	67	81	74	61	69
Never	24	26	33	19	26	39	31
Suicide attempts							
Past week	-	-	-	-	-	-	-
Past year	10	10	11	6	9	2	7
Lifetime	58	53	44	60	58	35	44
Never	42	47	56	40	42	65	56
Deliberate self-harm without suicidal intent	23	29	23	26	29	15	21
Base	*93*	*83*	*75*	*47*	*43*	*46*	*196*

Table 7.7 Prevalence of non-fatal suicidal behaviour by vicitimisation experience

	Vicitimisation experience								
	Bullying	Violence in the home	Running away from home	Violence at work	Being homeless	Sexual abuse	Being expelled from school	None of these	All
	Cumulative percentage of population								
Suicidal thoughts									
Past week	8	14	17	-	13	17	[1]	1	6
Past year	26	35	33	[6]	40	38	[3]	12	22
Lifetime	76	84	83	[15]	84	86	[8]	59	69
Never	24	16	17	[4]	16	14	-	41	31
Suicide attempts									
Past week	-	-	-	-	-	-	-	-	-
Past year	9	12	14	[1]	11	17	[1]	-	7
Lifetime	57	67	75	[9]	71	74	[8]	24	44
Never	43	33	25	[10]	29	26	-	76	56
Deliberate self-harm without suicidal intent	30	35	42	[7]	36	38	[4]	4	21
Base	*80*	*49*	*36*	*[19]*	*45*	*42*	*[8]*	*74*	*197*

Table 7.8 Odds ratios for characteristics associated with non-fatal suicidal behaviour

	Lifetime suicidal thoughts	Lifetime suicidal attempts	Deliberate self-harm
CIS-R score			
Below 12	1.00	1.00	
12 and over	4.11***	3.61***	
Long standing physical complaint			
Absent	1.00	1.00	
Present	0.41**	0.52	
Number of stressful life time events			
0 – 3		1.00	1.00
4 or 5		2.58	1.47
6 or 7		3.78*	1.90
8 or 9		4.70**	6.53**
10 and over		12.20***	5.67**
Age group			
16 – 34			4.68*
35 – 44			4.76**
45 – 54			2.07
55 – 74			1.00
Other factors entered in the model but not significantly associated with any dependent variable	Sex, employment status, household size, social class, tenure, educational qualifications, sample group		

* = p<0.05; ** = p<0.01; *** = p<0.001

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Appendix A

Assessment of psychosis

A.1 Introduction

The assessment of psychosis requires a more detailed assessment process not normally used in health surveys. We have brought together in this appendix information to help people unfamiliar with the concepts and procedures involved. The aim of this appendix is to help the reader understand the nature of these disorders and some of the difficulties of obtaining samples of adequate size to allow accurate assessment of the prevalence of disorder and the experiences and circumstances of those with disorder.

A.2 Definitions of mental disorder

In this survey report the term mental disorder is used. This terminology can cause concern. The assessment methods used in this survey were based on the World Health Organisation International Classification of Diseases chapter on Mental and Behavioural Disorders (ICD-10) Diagnostic Criteria for Research (DCR). In this report the definition of mental disorder in ICD-10 is used.[1]

The disorder discussed in this report is psychotic disorder, which consists mainly of two types:

- Schizophrenia; and
- affective psychosis, such as bi-polar disorder.

According to ICD-10 the schizophrenic disorders are characterised in general by fundamental and characteristic distortions of thinking and perception. The disturbance involves the most basic mental functions that give the person a feeling of individuality, uniqueness, and self-direction. The most intimate thoughts, feelings, and acts are often felt to be known to, or shared by others. False explanatory beliefs may develop, which are termed delusions. These may include the false belief that natural or supernatural forces are at work to influence the afflicted person, their individual thoughts or actions, which may lead to unusual behaviour by the sufferer. The person may believe they are at the centre of all that happens. Hearing voices or other sounds when there is no one there, termed auditory hallucinations, is common. Perception may also be disturbed in other ways. However memory and consciousness are usually not specifically affected. It will often be apparent from conversation that the sufferer, uncharacteristically, is not thinking logically or fluently. Mood may be shallow or inappropriate to the circumstances. The sufferer may not realise that their feelings and ideas are mistaken, which makes it difficult to collect good and accurate information in a survey about such symptoms. Many sufferers are very disabled by the disorder and the individual's relative inactivity and lack of attention to self-care and personal appearance, although not unique to this disorder, will be regarded by carers and professionals as an important indicator of the course of the condition. The level of disability may make it impossible for the individual to take part in any survey.

The other most common form of psychosis is affective psychosis. This can occur with extreme elation, termed mania, or depression. Disturbances in perception and thinking will typically be related to the mood, either grandiose or extremely hopeless and negative. Heightened mood may be accompanied by rapid speech, over-activity, and reduced sleep. Severely depressed mood may be accompanied by extreme withdrawal from others, total loss of appetite for food and fluids, self-neglect and even stupor. Affective psychosis tends to occur with distinct episodes and recurrences and can respond very well to medical treatment. Once again there is typically severe loss of insight.

A.3 Methods of assessing mental disorders

Diagnostic instruments

For most mental and physical health problems there is no clear dividing line between health and illness. However, it is easier to describe the health of a population and answer important questions about disorders when those with significant health problems can be reliably distinguished using survey interviews. Two approaches for identifying those with significant health problems have been developed. It is conventional to describe these as diagnostic instruments although, in fact, a medical diagnosis is not actually made. The two approaches are termed fully structured and semi-structured.

The first approach comprises of a series of clearly worded questions requiring simple replies such as 'yes', 'no' or 'don't know'. An example would be the question: has your health been good in the past month? The advantage of this fully structured method is that it can be administered by a lay interviewer who does not need any specialised knowledge of health and disease. Therefore the fully structured interview method can be used in very large surveys at an acceptable cost. The disadvantage of the method is that it relies on the knowledge, understanding and insight of the survey respondent. In the case of some complex mental disorders the fully structured method may not be sufficiently accurate.[2]

Making assessments of psychotic disorders is particularly problematic for lay interviewers. A structured questionnaire is too restrictive. A second interviewing approach, sometimes used in surveys, the semi-structured questionnaire, requires the use of clinical judgements. The use of pre-worded fully structured questions with fixed replies, such as yes, or no, or not known will often be inadequate for the purpose and, given the nature of psychotic disorder, would not be suitable for collecting information on symptoms of the kind defined above. An important disadvantage of the semi-structured method is that the interviewer needs special training and clinical experience. Because interviewers use judgement, standardisation is more difficult and more supervision and quality control is therefore desirable. These additional features of semi-structured interviews greatly increase the costs of such surveys and limit the use of the semi-structured method to the more detailed study of selected groups of respondents. The method is often used in two stage surveys, described below.

The Schedules for Clinical Assessment in Neuropsychiatry

One such semi-structured clinical assessment tool designed for use in epidemiological surveys is SCAN (Schedules for Clinical Assessment in Neuropsychiatry[3]). With SCAN the examiner needs to adopt a more flexible approach to respondents than would be appropriate in a fully structured interview. The examiner, who should be a clinically experienced interviewer, makes judgements, using strict guidelines, as to which symptoms are and which are not clearly present. This is not a task for which lay interviewers have the necessary training or experience. The SCAN interview begins with a series of open ended questions in which the respondent is asked to describe their physical and mental health problems using their own words. The SCAN is divided up into separate sections in which specific kinds of symptoms are then enquired about, including mood disturbance and anxiety, hallucinations, delusions, memory problems and problems due to alcohol and drug taking. Every symptom in SCAN is defined in a glossary. The interviewer must decide for each example whether the definition in the glossary matches what the respondent says when asked about that symptom. Thus the method is partially rather than fully structured and is often termed a semi-structured interview. Once the symptoms present have been rated by the clinically experienced interviewer trained in SCAN, the rules for making diagnoses in ICD-10 are used to determine which psychotic disorders are present, i.e. schizophrenia, affective psychoses such as bi-polar disorder. This allocation of a diagnostic category is made by a computer programme in order to ensure total reliability. Thus it is not a medical diagnosis but it does employ rules developed to mimic the clinical diagnostic process.

One versus two stage designs

We pointed out earlier that semi-structured clinical interviews are highly costly but necessary in order to identify correctly survey respondents with significant complex disorders such as psychotic

disorder. To reduce cost, ways have been developed to select those more likely to have such disorders, for whom the more complex assessment is required. In the present example, psychotic disorder, it has been found that survey respondents are more likely to have such a disorder if they are receiving medication for psychosis or if they have previously had a psychiatric admission. In a two stage (or two phase) design the fully structured lay interview is used to ask all survey respondents about their current medication and their history of being in hospital. This is known as sifting or (analogous to screening) for possible cases of psychosis. Those who say yes to such questions are then asked to agree to a second interview, hence the second stage. The second interview, for example with SCAN, is then used to confirm whether or not they really do have psychosis. Because the sift is not perfect some true cases may be missed. Therefore a random sample of those who replied no to the sift questions may also be interviewed in the second stage. However to check for missed cases accurately many 'sift negative' persons need to be assessed with the full semi-structured interview, which also adds to the costs involved. Judgements need to be made about the relative merits of these choices taking account of the costs involved and the benefits in terms of good health survey information.

Making prevalence estimates from 2-stage designs

A two-stage approach was adopted to provide an assessment of psychotic disorder in the household survey. In the first stage interviews, carried out by ONS interviewers, screening questions were included to identify people who might have a psychotic disorder. The factors used to identify people who might have a psychotic disorder had been found in the 1993 survey of psychiatric morbidity among private households and the 1997 survey of psychiatric morbidity among prisoners to be the best predictors of the likelihood of receiving an assessment of psychotic disorder at a second stage semi-structured clinical interview. These were:

- a self-reported diagnosis or symptoms (such as mood swings or hearing voices) indicative of psychotic disorder;
- receipt of anti-psychotic medication;
- a history of admission to a mental hospital; and
- a positive answer to question 5a in the Psychosis Screening Questionnaire which refers to auditory hallucinations.

The presence of any one of these criteria was sufficient for a person to screen positive for psychosis. Then a sub-sample of people were selected to take part in a second stage interview carried out by psychologists employed and supervised by the University of Leicester, who received training and clinical experience with the SCAN interview extending over a month. The people included in the sub-sample can be divided into 3 groups that were selected using different sampling fractions as follows:

- all those who screened positive for psychotic disorder;
- half of those who screened positive for antisocial or borderline personality disorder but not psychosis; and
- 1 in 14 of those who screened positive for other types of personality disorder or screened negative for both disorders.

The second stage interviews used the SCAN v2.1 (Schedules for Clinical Interviews in Neuropsychiatry[4]), a semi-structured interview which provides ICD-10 diagnoses of psychotic disorder.

An assessment of the prevalence of psychotic disorder could be obtained by simply weighting the results from the sub-sample who had a second stage SCAN interviews to take account of varying sampling fractions and non-response. However, there are problems with this approach:

1. The second stage sample design included a SCAN assessment of people who screened negative for psychosis in the first stage interview which allows some assessment of the prevalence of psychotic disorder among this group who are likely to be cases that are unknown to services. However, the bulk of the positive cases are likely to be in the screen positive group and logistic regression analysis showed that the most important predictor of a positive SCAN assessment among the stage 2 sample was the presence of one or more of the screening criteria, and that the odds of a positive assessment increased dramatically the more criteria were

present. However, there were some positive cases among those who screened negative and because of the different sampling fractions used, these cases get a much higher weight than the majority of cases which occurred among the screen positives. The effect of the wide range of weights is to produce an estimate with a high coefficient of variation (the sampling error as a proportion of the estimate itself) with a very wide confidence interval around it, which is shown (estimate 1) in Table A1. Thus for all adults the prevalence estimate is 1.1% with a 95% confidence interval ranging from 0.5% to 1.7% while for women the prevalence estimate is 1.6% with a 95% confidence interval ranging from 0.4% to 2.7%. Estimates which cover such a wide possible range are very difficult to use for policy purposes, eg for predicting the numbers of people who might require services, or for monitoring trends over time.

2. The comparatively small size of the sub-sample which completed a second stage interview limits the amount of additional analysis, such as co-occurrence of disorders and social and economic factors associated with disorders, which can be done using this second-stage sample only. Therefore there is a requirement for some measure of probable/possible disorder for the sample as a whole to be used for these types of analysis and for the consideration of variations in prevalence of disorder among different sub-groups.

The results obtained from the second stage interviews can be viewed as belonging to two groups for whom the prevalence of psychotic disorder can be obtained with different degrees of precision. The first group is people who screen positive for psychotic disorder from which we have SCAN assessments for all who agreed to a second interview. The prevalence of disorder is comparatively high amongst this group and a high proportion were interviewed, so the confidence interval is relatively narrow as is shown in Table A1. The prevalence estimate for this group is 13.3% (95% CI 8.1%–18.6%) and the coefficient of variation (CV) is 20%.

The second group are those who screened negative for psychotic disorder. Among this group psychotic disorder is likely to be extremely rare and, since only a small proportion could be included in the second stage of the survey, any estimate of the prevalence among this group will be extremely imprecise. The sample of screen negatives taken was small and alternative random samples of screen negatives would quite possibly have given very different estimates. The prevalence estimate obtained for this group is 0.6% (95% CI 0.0%–1.2%), which is very much lower than in the screen positive group but is much less precise having a CV of 47%, double that of the screen positive estimate. In this sample all the false negatives on the psychosis screen were found among women – a fact which is reflected in the wide confidence intervals around the estimate for women shown in estimate 1 in Table A1. This might be due to true differences in prevalence between men and women, differences in responses to the screening questions, differences in the way the SCAN interviewers interpreted symptoms between men and women or a chance finding resulting from the sampling for the second stage. There was no difference between men and women in the proportion screening positive for psychosis. However, women were more likely than men to receive a positive SCAN assessment when other factors, such as the presence of different screening criteria, were controlled for and it appeared that the psychosis screen worked better for men than for women. Comparison between the detailed responses in the SCAN interviews for the false negative cases and other positive cases showed no apparent differences, except that the screen negatives were not receiving services and did not show evidence of significant disability or distress. It may be that men with psychotic disorder are more likely than women to be known to services and receiving treatment, but the difference between the men and women shown in estimate 1 is not statistically significant indicating that it could just be an artefact of the particular sample selected in the survey.

The finding of some screen negatives does suggest that a prevalence rate based solely on screen positives (estimate 2) is likely to be an underestimate. However, in view of the wide confidence interval, it is also quite possible that estimate 1, which includes the screen negatives,

may be itself a substantial overestimate. Therefore, it was decided that it would not be useful to use the prevalence estimate which includes the SCAN data from screen negatives in the report because of the imprecision and uncertainty associated with it. It is recognised that any estimate that does not take account of false negatives on the screen will be an underestimate, but the extent of that underestimate and the importance of it is uncertain. However, the estimate adopted is more stable and therefore more use for policy analysis and monitoring trends. The problem of obtaining an assessment of psychotic disorder for those people who sifted positive for psychosis but did not have a SCAN interview because they refused a second interview or could not be contacted at that time was dealt with slightly differently in the earlier 1993 survey of adults in private households and the 1997 survey of prisoners. In both cases the relationship between the initial interview data and the SCAN assessment data for those who completed both stages was considered to identify factors indicative of likely psychotic disorder. In 1993, those taking antipsychotic medication and who reported that they had a psychotic illness or that their doctor told them they had such an illness were considered as having a functional psychosis. In the survey of prisoners there was some additional information available and it was found that the presence of any two of the sift criteria described above was a better indicator of probable psychosis. In this survey data, there continued to be a good relationship between the screening criteria and the likelihood of a positive SCAN assessment and it was decided to use the same approach as adopted in the 1997 prison survey for providing an assessment of probable psychosis for those people who sifted positive for psychosis but did not complete a SCAN interview. In summary, the assessment of probable psychosis used in this survey was obtained for individual respondents as follows:

- For those who sifted positive for psychosis and undertook a SCAN interview, the SCAN assessment was used.
- For those who sifted positive for psychosis but did not complete a SCAN interview, an assessment based on whether or not they reported two or more of the screening criteria at the initial interview was applied.
- All those who screened negative for psychosis at the initial interview were designated psychosis negative regardless of whether or not they had undertaken a SCAN interview.

The prevalence estimates obtained in this way are shown in Table A1 and in relation to some basic classificatory variables in the main survey report.[5]

Obtaining samples of people with psychotic disorders for separate analysis

Because psychosis is quite rare in the general population even in a large survey very few cases will be identified. Large samples are needed to study these individuals and describe their characteristics reliably. Another source for such persons needs to be considered. It is important that the source chosen is typical and thus represents the general population. Because these disorders are severe and disruptive the majority of sufferers are thought to come to the attention of medical services such as the general practitioner. Therefore a sample could be obtained from general practices. However there needs to be some way of identifying such persons within the practice records in order to draw a random and thus representative sample. We used records held by the General Practice Research Database (GPRD). There are problems with such approaches. One is relying on the accuracy of a register database that must to be kept up to date by often very busy general practitioners. Secondly, because of the vulnerability of such patients, doctors and research ethics committees may feel that it is necessary to screen potential cases and identify those who might be harmed by the survey interview. This in turn means having to rely on the help, effort and co-operation of the general practitioner and also means that the final sample obtained may not be representative. In addition, the requirement for maintaining confidentiality of medical records means that such patients must be approached by their GPs or other medical staff and asked to opt-in to the survey or give permission for their details to be released to the organisation conducting the research. This also reduces the response rate as reminders cannot be issued and the opportunity to provide additional information to help people make a decision on whether or not

to participate is usually lost. For all of these reasons it is not possible to obtain the level of co-operation and the response rate that surveyors have been accustomed to when approaching the general public in a general household survey.

A.4 The approach used in this report

The main purpose of this report is to describe the characteristics and living circumstances of people with psychotic disorder and to provide information on the services and treatment they receive. The main household survey only identified 60 people with a psychotic disorder, which limits the power of any analysis. Therefore the analysis in this report brings together people with psychotic disorders identified in the main household survey, and those located through a supplementary sample. This sample was obtained from records held by the General Practice Research Database (GPRD). Selection was on the basis of a diagnosis indicating schizophrenia, affective psychoses such as bi-polar disorder, or a prescription for anti-psychotic drugs. The details of the selection procedures and the response obtained is given in Chapter 1.

References

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3 Wing J K, Babor T, Brugha T, Burke J, Cooper J E, Giel R, Jablensky A, Regier D and Sartorius N (1990) SCAN: Schedules for Clinical Assessment in Neuropsychiatry. *Archives of General Psychiatry* **47**, 589–593.

4 World Health Organisation Division of Mental Health (1999) *SCAN Schedules for Clinical Assessment in Neuropsychiatry Version 2.*1, World Health Organisation: Geneva.

5 Singleton N, Bumpstead R, O'Brien M, Lee A and Meltzer H (2001) *Psychiatric Morbidity Among Adults Living in Private Households,* TSO: London.

Table A1 Alternative estimates of psychosis prevalence

Assessment based on ...	Sample size	Prevalence Estimate (percentage)	95% CI* LL	95% CI* UL	Sampling Error	CV**
1. SCAN interviews only – including screen negatives						
Men	272	0.65	0.32	0.98	0.17	26%
Women	351	1.57	0.41	2.73	0.59	37%
All adults	623	1.11	0.52	1.70	0.30	27%
People who screened positive	203	13.31	8.06	18.56	2.68	20%
People who screened negative	420	0.63	0.04	1.22	0.30	47%
2. SCAN or prisons algorithm for screen positives (screen negatives assumed negative)						
Men	3,852	0.57	0.35	0.79	0.11	19%
Women	4,728	0.49	0.31	0.67	0.09	20%
All adults	8,580	0.53	0.37	0.69	0.08	15%

*95% confidence interval; LL=lower limit, UL=upper limit.
**Coefficient of Variation = Sampling Error/Estimate.

Appendix B

Multiple logistic regression and odds ratios

Logistic regression analysis has been used in the analysis of the survey data to provide a measure of the effect of, for example, various characteristics on the receipt of medication among this sample of people with psychotic disorder. Unlike the cross tabulations presented elsewhere in the report, multiple logistic regression (MLR) estimates the effect of any variable while controlling for the confounding effect of other variables in the analysis.

Logistic regression produces an estimate of the probability of an event occurring when an individual is in a particular category compared to a reference category. This effect is measured in terms of odds. For example, Table 2.10 shows that having a CIS-R score of 12 and over increases the odds of having consulted a GP in the past year compared to the reference category of CIS-R score below 12. The amount by which the odds are actually increased is shown by the Adjusted Odds Ratio (OR). In this case the OR is 2.72 indicating that if someone has a CIS-R score of 12 and over the odds that they will consult their GP are almost trebled, controlling for the possible confounding effects of the other variables in the statistical model. To determine whether this increase is due to chance rather than to the effect of the variable one must consult the associated 95% confidence interval and p values. In tables showing adjusted odds ratios, ORs which are statistically significant at the 95% level are indicated by a single asterisk * and ORs which are statistically significant at the 99% level are indicated by double asterisks **.

Odds ratios and how to use them multiplicatively

The odds ratios presented in the tables show the adjusted odds due solely to membership of one particular category – for example having a CIS-R score on or above the threshold of 12 compared with those with a score below the threshold. However, odds for more than one category can be combined, by multiplying them together. This provides an estimate of the increased odds of having high levels of neurotic symptoms due to being a member of more than one category at once. For example, being someone aged 45 and over and having a high CIS-R score. In Table 2.10 having a high CIS-R score increases the odds of consulting a GP in the year before interview (OR=2.72), while being aged 45 and over (compared to those aged under 45) independently decreases the odds (OR=0.44). The odds for people aged 45 or over and having high CIS-R scores compared with younger people with low scores is therefore the product of the two independent odds ratios, 1.20.

Glossary

Glossary of survey definitions and terms

Adults

In this survey adults were defined as persons aged 16 and over and less than 75.

Alcohol dependence

Alcohol misuse was measured using two different instruments. First the Alcohol Use Disorders Identification Test (AUDIT) was used to assess hazardous drinking (see below). Those who scored 10 and over on the AUDIT were also asked the Severity of Alcohol Dependence Questionnaire (SAD-Q). People who scored 4 and over on the SAD-Q were considered to be dependent on alcohol.

Analgesic, hypnotic and anxiolytic medication

Analgesics are drugs for relieving pain, while hypnotics and anxiolytics are drugs used for treating sleep problems and for reducing anxiety.

CIS-R (Clinical Interview Schedule – revised version)

The CIS-R is an instrument designed to measure neurotic symptoms and disorders, such as anxiety and depression. It comprises 14 sections each covering a particular type of neurotic symptoms. Scores are obtained for each symptom based on frequency, duration and severity in the past week. Individual symptom scores can be summed to provide an overall score for the level of neurotic symptoms. A score of 12 and over indicates the presence of significant levels of neurotic symptoms while a score of 18 and over indicates symptoms of a level likely to require treatment. If required, diagnoses of 6 specific neurotic disorders can be obtained by looking at answers to the various sections of the CIS-R and applying algorithms based on the ICD-10 diagnostic criteria for research.

Depot injections

When antipsychotic medication is given by injections on, for example, a monthly basis, these are sometimes termed depot injections.

Drug dependence

In the year prior to interview drug dependence was measured by asking all those who had used drugs in the past year a series of five questions. These covered: daily use of the drug for two weeks or more; feelings of dependence; inability to cut down; need for increasing quantities; withdrawal symptoms. For a person to be considered dependent, a positive response to any one of these questions was required.

Drugs used in psychoses etc

Drugs used in psychoses and related conditions include antipsychotic drugs, including depot injections. These are also known as 'neuroleptics'. In the short term they are used to quieten disturbed patients whatever the underlying psychopathology (see depot injections). Also included in this group are antimanic drugs which are used in mania to control acute attacks and prevent their recurrence.

Economic activity

Economically active persons are those over the minimum school-leaving age who were working or unemployed in the week before the week of interview. These persons constitute the labour force.

Working persons

This category includes persons aged 16 and over who, in the week before the week of interview, worked for wages, salary or other form of cash payment such as commission or tips, for any number of hours. It covers persons absent from work in the reference week because of holiday, sickness, strike or temporary lay-off, provided they had a job to return to with the same employer. It also includes persons attending an educational establishment during the specified week if they were paid by their employer while attending it, people who worked in Government training schemes and unpaid family workers.

Persons are excluded if they have worked in a voluntary capacity for expenses only, or only for payment in kind, unless they worked for a business, firm or professional practice owned by a relative.

Full-time students are classified as 'working', 'unemployed' or 'inactive' according to their own reports of what they were doing during the reference week.

Unemployed persons

This survey used the International Labour Organisation (ILO) definition of unemployment. This classifies anyone as unemployed if he or she was out of work in the four weeks before interview, or would have been but for temporary sickness or injury, and was available to start work in the two weeks after the interview. Otherwise, anyone out of work is classified as economically inactive.

The treatment of all categories on this survey is in line with that used in the Labour Force Survey (LFS).

For most of the analyses in the report a variable which divided the sample into economically active (working or unemployed) or economically inactive (everyone else) was used.

Educational level

Educational level was based on the highest educational qualification obtained and was initially grouped as follows:

1. Degree or higher degree
   NVQ Level 5

2. Teaching qualification
   HNC/HND
   BRC/TEC Higher
   BTEC/SCOTVEC Higher
   City and Guilds
   Full Technological Certificate
   Nursing Qualifications (SRN, SCM, RGN, RM, RHV, Midwife)
   NVQ Level 4

3. GCE A levels and AS levels
   SCE Higher
   ONC/OND/BTEC/TEC/BTEC not higher
   City and Guilds Advanced/Final Level
   GNVQ (Advanced Level)
   NVQ Level 3

4. GCE O level passes (Grade A–C if after 1975)
   GCSE (Grades A–C)
   CSE Grade 1
   SCE Ordinary (Bands A–C)
   Standard Grade (Level 1–3)
   School Certificate or Matric
   City and Guilds Craft/Ordinary Level
   GNVQ (Intermediate level)
   NVQ Level 2

5. CSE Grades 2–5
   GCE O level Grades D and E after 1975
   GCSE (Grades D,E,F,G)
   SCE Ordinary (Bands D and E)
   Standard Grade (Level 4,5)
   Clerical or Commercial qualifications
   Apprenticeships
   NVQ Level 1 and GNVQ (Foundation Level)
   CSE ungraded

6. No formal qualifications

For most of the analyses in this report these groupings were collapsed into three categories: 'A' levels or above which covers the first three groups, Other qualifications which includes all other groups except the last one, and None which equates to the 'No formal qualifications' group above.

Ethnicity

Household members were classified into nine groups by the person selected for interview. For analysis purpose these nine groups were subsumed under 4 headings: White, Black, South Asian and Other.

White	White
Black – Caribbean	Black
Black – African	
Black – Other	
Indian	South Asian
Pakistani	
Bangladeshi	
Chinese	Other
Other	

Hazardous alcohol use

Hazardous alcohol use is a pattern of drinking carrying with it a high risk of damage to health in the future. The prevalence of alcohol misuse in the previous year was assessed using the Alcohol Use Disorders Identification Test (AUDIT) at the initial interview. An AUDIT score of eight or above indicates hazardous alcohol use.

Household

The standard definition used in most surveys carried out by ONS Social Survey Division, and comparable with the 1991 Census definition of a household, was used in this survey. A household is defined as single person or group of people who have the accommodation as their only or main residence and who either share one meal a day or share the living accommodation. (See E McCrossan *A Handbook for interviewers*. HMSO: London 1991)

Household size

Basic information (age, sex, ethnicity and relationship to others in the household) was collected from the informant about all people living in the household. This was used to produce a variable for the number of people living in the household.

Intellectual functioning

Three tests were included in the survey to measure different aspects of intellectual functioning. All participants completed the National Adult Reading Test (NART), a measure of crystallised intelligence, reflecting the extent of intellectual development by adulthood. Scores on the NART have then been translated into estimated verbal IQ scores on the WAIS-R using the algorithm recommended by the developers of the NART.

Those aged 60 and over also completed two tests likely to be sensitive to cognitive decline associated with ageing or dementia. The modified Telephone Interview for Cognitive Screening (TICS-m) was developed as a brief screening test for dementia. Those scoring below a cut-point have a high probability of significant cognitive impairment, and of meeting criteria for a clinical diagnosis of dementia. The animal naming test assesses verbal fluency, in this case the number of different animals a participant can name in one minute.

Long-standing physical illness

All respondents were asked if they had any long-standing illness, disability or infirmity, that is any thing that had troubled them over a period of time or was likely to affect them over a period of time. If they had any such conditions they were then asked what they were. Anyone who mentioned a physical health problem at this question was classified as having a long-standing physical illness or health problem.

Marital Status

Informants were categorised according to their own perception of marital status. Married and cohabiting took priority over other categories. Cohabiting included anyone living together with their partner as a couple.

Neurotic disorders, depression or anxiety disorders

These are characterised by a variety of symptoms such as fatigue and sleep problems, forgetfulness and concentration difficulties, irritability, worry, panic, hopelessness, and obsessions and compulsions, which are present to such a degree that they cause problems with daily activities and distress. The prevalence of neurotic symptoms in the week prior to interview was assessed using the revised version of the Clinical Interview Schedule (CIS-R) (see above). A score of 12 and over indicates the presence of significant neurotic symptoms while a score of 18 and over indicates symptoms of a level likely to require treatment.

Psychiatric Morbidity

The expression psychiatric morbidity refers to the degree or extent of the prevalence of mental health problems within a defined area.

Psychoses

These are disorders that produce disturbances in thinking and perception that are severe enough to distort the person's perception of the world and the relationship of events within it. Psychoses are normally divided into two groups: organic psychoses, such as dementia and Alzheimer's disease, and functional psychoses, which mainly cover schizophrenia and manic depression.

Region

When the survey was carried out there were 8 NHS Regional Office Areas in England. These were the basis for stratified sampling and have been retained for purposes of analysis. Scotland and Wales were treated as two distinct areas.

Social Class

Based on the Registrars general's 1991 *Standard Occupational Classification,* Volume 3 OPCS, HMSO: London social class was ascribed on the basis of the informants own occupation. If the informant was unemployed or economically inactive at the time of interview but had previously worked, social class was based on the most recent previous occupation.

The classification used in the tables are as follows:

Descriptive Definition	Social Class	
Professional	I	Non-manual
Intermediate occupations	II	
Skilled occupations – non-manual	III NM	
Skilled occupation – manual	III M	Manual
Partly-skilled	IV	
Unskilled occupations	V	
Armed Forces		

Social class was not determined where the subject had never worked, or if the subject was a full-time student or where occupation was inadequately described.

Tenure

Four tenure categories were created:

'Owned outright' means bought without a mortgage or loan or with a mortgage or loan which has been paid off.

'Owned with mortgage' includes co-ownership and shared ownership schemes.

'Rent from LA/HA' means rented from local authorities, New Town corporations or commissions or Scottish Homes, and housing associations which include co-operatives and property owned by charitable trusts.

'Rent from other source' includes rent from organisations (property company, employer or other organisation) and from individuals (relative, friend, employer or other individual).

For the analyses in this report these were then grouped into two groups: owners (including those who owned their home outright and those purchasing their homes with a mortgage) and renters (those renting from any source).

national STATISTICS

Report based on the analysis of the ONS Survey of Psychiatric Morbidity among Adults in Great Britain carried out in 2000 for the Department of Health, the Scottish Executive Health Department and the National Assembly for Wales

Non-fatal suicidal behaviour among adults aged 16 to 74 in Great Britain

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This report has been produced by the Social Survey Division of the Office for National Statistics in accordance with the Official Statistics Code of Practice.

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Notes to tables

1 Tables showing percentages

The row or column percentages may add to 99% or 101% because of rounding.

The varying positions of the percentage signs and bases in the tables denote the presentation of different types of information. Where there is a percentage sign at the head of a column and the base at the foot, the whole distribution is presented and the individual percentages add to between 99% and 101%. Where there is no percentage sign in the table and a note above the figures, the figures refer to the proportion of people who had the attribute being discussed, and the complementary proportion, to add to 100%, is not shown in the table.

The following conventions have been used within tables:

-	no cases
0	values less than 0.5%
..	data not available

2 Statistical significance

Unless otherwise stated, differences mentioned in the text have been found to be statistically significant at the 95% confidence level. Standard errors that reflect the complex sampling design and weighting procedures used in the survey have been calculated and used in tests of statistical significance. Tables giving the standard errors for key estimates are shown in Appendix A.

3 Small bases

Very small bases have been avoided wherever possible because of the relatively high sampling errors that attach to small numbers. In general, percentage distributions are shown if the base is 30 or more. Where the base is lower, actual numbers are shown in square brackets.

Acknowledgements

We would like to thank everybody who contributed to the survey and the production of this report. We were supported by our specialist colleagues in ONS who carried out the sampling, field work and computing elements for the survey.

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Dr D Jones, Department of Health
Ms T Jones, National Assembly for Wales
Dr J Loudon, Scottish Executive
Mr G Russell, Scottish Executive
Mr J Sweeney, National Assembly for Wales

Most importantly, we would like to thank all the participants in the survey for their time and co-operation.

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Summary of key findings

Background and purpose

- This report presents the analysis of the data on suicidal thoughts and attempts collected in the 2000 ONS survey of psychiatric morbidity among adults in Great Britain (Singleton *et al*, 2001).
- Data are presented on the relationship between non-fatal suicidal behaviour (suicidal ideation, suicide attempts and deliberate self-harm without suicidal intent) in the past week, past year and lifetime and socio-demographic, socio-economic, psychiatric and social functioning characteristics and places them in the context of the existing literature.
- The four questions used to assess self-harm with suicidal intent were – Have you ever thought that life was not worth living? Have you ever wished that you were dead? Have you ever thought of taking your life, even though you would not actually do it? Have you ever made an attempt to take your life, by taking an overdose of tablets or in some other way? Any positive response led to a follow up question on timing: in the last week, last year, or at another time.
- The additional question to assess self-harm without suicidal intent was: Have you deliberately harmed yourself in any way but not with the intention of killing yourself?

Characteristics of the sample

- Slightly more than half (55%) of all survey respondents were women but there was no difference between the sexes in their age distribution.
- About one in fifteen (7%) of all respondents were from ethnic groups other than 'White'.
- Overall, men and women were equally likely to be married or cohabiting (56%), but men were more likely than women to be single (33% and 26% respectively), whereas women were more likely than men to be widowed or divorced: 15% of women compared with 9% of men.
- Two thirds of the sample were living as a couple, just over a third with children (35%) and nearly a third (31%) without children. About one in six of the respondents (16%) lived in a one-person family unit, and a further 1 in 10 lived with one parent.
- Over a quarter of the sample (27%) had no formal educational qualifications; men were less likely than women to be in this position (25% compared with 30%).
- Although about two-thirds (67%) of all respondents were in paid employment, men were more likely than women to be doing paid work (74% compared with 61%). Only 4% of men and 2% of women were unemployed; the remainder was classed as economically inactive.

Summary – continued

- The largest group of respondents were in Social Class II (29%), a quarter were in IIINM, and a fifth (19%) were in Social Class IIIM. A further 16% were in Social Class IV, and the remainder in Social Classes V (6%) and I (5%).

- Overall, a third (33%) of the sample were not currently in employment (27% of men and 39% of women). About 1 in 10 were in each of the managers/administration (11%) or the clerical/ secretarial (10%) groups.

- Nearly three quarters of the sample owned their own property: 24% owned outright and 49% owned with a mortgage. A further 17% rented from a Local Authority or Housing Association, and the remaining 10% rented privately.

Socio-demographic correlates of suicidal behaviour

Suicidal thoughts

- Overall, 14.9% of survey respondents said they had considered suicide at some point in their life, 3.9% in the past year and 0.4% had done so in the past week.

- Women were more likely than men to have ever considered suicide (17% and 13% respectively). This sex difference can be seen across all of the age groups.

- Suicidal ideation was more prevalent among young people than among older people: about 17% of those aged 16 to 44 said they had had suicidal thoughts in their lifetime, compared with only 6% of those aged 65 to 74.

- White respondents, both men and women, were about twice as likely to have had suicidal thoughts compared with the sample of Black or South Asian origin: 15% compared with 8%.

- 28% of divorced women and 25% of divorced men said they had ever had suicidal thoughts compared with 13% of married women and 9% of married men

- Among men, lone parents and men living on their own were the most likely to have had suicidal thoughts (about 20% each) compared with only 9% of men in couples without children.

- Among women, lone parents and those living with their parents were the most likely to have ever thought about suicide: 28% and 26% respectively had ever considered suicide, compared with only 14% of women in couples with or without children.

- 27% of unemployed women said they had thought at one time about ending their life, compared with 16% of women presently in full or part time employment.

- 20% of men and 25% of women who rent from a Local Authority or Housing Association had thought about suicide in their lifetime, compared with 8% of men and 12% of women who owned their property outright.

Suicide attempts

- 4.4% of respondents said they had ever attempted suicide, and 0.5% had attempted suicide in the past year.

Summary – continued

- Similar to suicidal ideation, younger people were more likely to have attempted suicide: about 5% of 16- to 24-year-olds and 6% of 25- to 34-year-olds had ever attempted suicide, compared with 2% of those aged 65 to 74.

- There was no statistically significant variation in the percentage of respondents in different ethnic groups who had ever attempted suicide.

- About 10% of divorced respondents (9% of divorced men and 11% of divorced women) had attempted suicide in their lifetime, compared with 3% of married respondents (2% of married men and 3% of married women)

- Lone parents, both men and women, were the most likely to have attempted suicide in their lifetime: 8% and 11% respectively, compared with, for example, only 2% of men living as a couple without children.

- Unemployed women were more likely to have ever attempted suicide (16% compared with 4% of those in employment)

- 8% of men and 10% of women in Social Class V had attempted suicide in their lifetime compared with 1% of men and 3% of women in Social Class I.

Deliberate self-harm (without suicidal intent)

- All respondents were asked if they had ever deliberately harmed themselves without suicidal intent, and 2% said that they had (2% of men and 3% of women).

- The percentage of both men and women who had ever deliberately harmed themselves decreased with age, from 5% of the youngest age group to 0.2% of those aged 65 to 74.

- There was no statistically significant variation in the percentage of respondents in different ethnic groups who had ever deliberately harmed themselves.

- Single respondents (particularly single women) were the most likely to have deliberately harmed themselves, followed by separated and divorced women.

- Unemployed women were more likely to have deliberately harmed themselves at some time (9% compared with 2% of those in full time employment).

Psychiatric disorders and suicidal behaviour

Suicidal thoughts

- At least 40% of respondents with panic, phobic symptoms, depressive ideas, obsessions and compulsions had lifetime suicidal thoughts. The corresponding proportion in relation to the symptom-free group was 5%.

- The lifetime prevalence of suicidal thoughts among those scoring 0–5 on the CIS-R was 7%. This rose to 33% of those with scores in the range 12–17 and further increased to 49% among those who scored 18 and over.

Summary – continued

- Compared with the non-disorder group (which had a 10% prevalence of lifetime suicidal thoughts) the rate for those with depressive episode was 52%.
- The highest rates of suicidal thoughts were found among the group with OCD, a 64% lifetime prevalence, reflecting the clinical experience that people with obsessions tend to be preoccupied with death.
- The lifetime prevalence of suicidal thoughts increased from 1 in 10 of the no-disorder group to a third of those with one neurotic disorder, a half of the group with two disorders and around three-quarters of those with three or more neurotic disorders.
- Among the non-alcohol dependent group, about 14% had ever thought about suicide, this proportion nearly doubled among those moderately dependent, 27%, and the rate doubled again among the severely dependent group, 57%.

Suicide attempts

- Around 20% of respondents assessed as having significant symptom levels of panic, phobias and depressive ideas, in the week prior to interview, stated that they had ever made a suicide attempt. In contrast, just less than 1% of the sample who reported no neurotic symptoms mentioned that they had ever attempted suicide.
- The lifetime prevalence of suicide attempts rose with increasing CIS-R scores: 1% of those scoring 0–5; 10% of those with scores in the range 12–17 and 22% among those who scored 18 or more.
- 25% of respondents assessed as having a depressive episode in the week prior to interview had at one time attempted suicide compared with 2% of the group without a neurotic disorder.
- The lifetime prevalence of suicide attempts increased from 2% of the no-disorder group to 14% of those with one neurotic disorder, 21% of the group with 2 disorders and 40% of those with three or more neurotic disorders.
- Among the 60 respondents assessed by the survey to have possible psychotic disorder, just over two-thirds had thought about suicide, and just over a half had attempted it.
- 4% of the non-alcohol dependent group had at one time, thought about suicide. This proportion increased to 9% among those moderately dependent and rose to 27% of the severely alcohol dependent group.
- Those who were dependent on drugs other than cannabis were around five times more likely than the non-dependent group to have ever attempted suicide, 20% compared with 4%.

Deliberate self-harm (without suicidal intent)

- Among the group with panic and phobic symptoms, the proportions who reported they had deliberately tried to harm themselves (without suicidal intent) were 16% and 13% respectively, compared with less than 1% of those with no neurotic symptoms.
- Twenty-three per cent of the survey sample assessed as having a phobic disorder had at one time self-harmed themselves.

Summary – continued

- A lifetime rate of 30% for deliberate self-harm was found among those with three or more neurotic disorders.
- About a quarter of those assessed with possible psychotic disorder had deliberately harmed themselves (without suicidal intent).
- The rates for deliberate self-harm (without suicidal intent) were 2%, 7% and 22% for the non-dependent, moderately dependent and severely alcohol dependent groups respectively.
- 11% of those dependent on drugs other than cannabis had deliberately self-harmed themselves compared with 2% of those not dependent on drugs.

Social functioning and suicidal behaviour

Suicidal thoughts

- Among the group who reported not having experienced any of the stressful events, only 5% had had suicidal thoughts. As the number of life events rose, so did the proportion experiencing suicidal thoughts. Of the group who had suffered the highest number of events, six or more, a third had had suicidal thoughts.
- Suicidal thoughts were relatively common among those who had experienced a serious problem with a close friend or relative, with more than a quarter of such people having had suicidal thoughts at some point in their lifetime.
- Events for which the prevalence of suicidal thoughts was particularly high include having a major financial crisis (29%), having a problem with the police or a court appearance (27%) and having looked for work for one month or over (23%).
- Higher rates of lifetime suicidal thoughts were found among groups who reported ever having been homeless (48%), running away from home (45%), experiencing violence in the home (44%) and being expelled from school (41%).
- Over half of those who reported experience of sexual abuse also reported having had suicidal thoughts during their lifetime.
- The prevalence of suicidal thoughts among men with a severe lack of social support was double that of those with no lack (22% compared with 11%) and for women the difference was even greater (35% of those with a severe lack compared with 14% of those with no lack).
- Those reporting a primary support group of three or less people were almost three times more likely than those with a group of nine or more to report having had suicidal thoughts during their lifetime (30% compared with 12%).

Suicide attempts

- 12% of those who had had a problem with the police or a court appearance, 10% of those who had experienced a major financial crisis and 8% of those who had looked for work for one month or more had attempted suicide at some time in their life.

Summary – continued

- Around a quarter of people who reported running away from home, being homeless, having experienced sexual abuse and having experienced violence in the home had attempted suicide at some time in their life (between 22% and 26%).

- Women with a severe lack of social support were over five times more likely than those with no lack to have attempted suicide in their lifetime (16% compared with 3%) and twice as likely to have attempted suicide than men (8%).

- 12% of all respondents with a primary support group of three or less had attempted suicide in their lifetime, compared with only 3% with a social group of nine or more people.

Deliberate self-harm (without suicidal intent)

- The rate of deliberate self-harm rose from less than 1% among those who had not experienced a life event to 2% for those who had four stressful life events to 6% among those experiencing six or more events.

- The prevalence of self-harm was particularly high for the groups reporting that they had run away from home (14%), had experience of sexual abuse (14%), had been expelled from school (13%) and had been homeless (12%).

- Respondents with a severe lack of support were over three times more likely than those with no lack to have deliberately harmed or hurt themselves (7% compared with 2%).

- 9% of women with a support group of three or less people had deliberately harmed or hurt themselves in their lifetime compared with only 1% of those with nine or more in their support group.

Correlates of non-fatal suicidal behaviour: logistic regression analysis

Suicidal thoughts

- The odds of respondents with psychosis (compared with the rest of the survey sample) of having lifetime suicidal thoughts was 3.73. The corresponding figures for the six neurotic disorders ranged from 2.24 for phobia to 2.91 for obsessive-compulsive disorder.

- Those with alcohol and drug dependence were also more likely to have had lifetime suicidal thoughts (OR= 2.12 and 1.56) compared with the non-dependent groups.

- Compared with the group who had never experienced a stressful life event, those who reported three or more events had over three times the odds of having had suicidal thoughts and the odds ratio increased to 9.75 among the group who had experienced six or more events.

Suicide attempts

- The two factors which seemed to have the greatest influence on suicide attempts were number of stressful life events and psychosis. The odds ratio for six or more versus no stressful events was 13.64 and for psychosis compared with no psychosis, the odds ratio was 6.07.

Summary – continued

Deliberate self-harm (without suicidal intent)

- The main variables in the logistic regression model associated with deliberate self-harm without the intention of suicide were number of stressful like events (OR= 17.74) age (OR=10.89 for 16- to 24-year-olds compared with 65- to 74-year-olds) psychosis (OR=4.96), depression and mixed anxiety and depression (ORs = 2.68 and 2.86) and drug dependence, specifically to drugs other than cannabis (OR=2.37).

Help seeking behaviour

Suicide attempts

- 52% of respondents who had ever attempted suicide, said they had sought some help: 30% had seen a specialist medical service, such as a psychiatrist or counsellor or someone at the local hospital, 25% had sought help from their GP or family doctor, and 25% had asked friends or family for help.

Deliberate self-harm (without suicidal intent)

- 50% of respondents who had deliberately self-harmed sought help. Just over a third (36%) had received medical attention, and a similar percentage (37%) had seen a psychiatrist.

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1 Background and aims of the report

1.1 Background to the report

Mental illness was identified as one of the key areas for action in *The Health of the Nation*, a White Paper published by the Department of Health in July 1992 (Department of Health, 1992) and subsequently in *Our Healthier Nation* (Department of Health, 1999a) and *Our National Health*: T*he Health Plan for Scotland* (Scottish Executive, 2000). Frameworks for action have been set out in the *Health of the Nation Mental Illness Key area handbook* (Department of Health, 1994), *The Spectrum of Care* (Department of Health, 1996), *Framework for Mental Health services in Scotland* (Scottish Executive, 1997) and most recently in the *National Service Framework for Mental Health* (Department of Health, 1999b).

In all these documents, and in the consultation paper, *National Framework for the Prevention of Suicide and Deliberate Self-Harm in Scotland*, there is an expressed desire to decrease the rate of suicide among the population of Great Britain and targets are set to this end. To provide information to support and monitor this initiative, inter alia, a series of national surveys of psychiatric morbidity have been carried out by ONS (formerly OPCS) over the past decade, which were commissioned by the Department of Health, the Scottish Executive Health Department and the National Assembly for Wales. These surveys covered a wide range of different population groups. They included:

- adults aged 16 to 64 living in private households (Meltzer *et al*, 1995a, b, c);
- residents of institutions specifically catering for people with mental health problems: hospitals, nursing homes, residential care homes, hostels, group homes and supported accommodation (Meltzer *et al*, 1996a, b, c);
- homeless adults living in hostels, nightshelters, private sector leased accommodation or roofless people using day centres (Gill *et al*, 1996);
- adults known by services to have a psychotic disorder (Foster *et al*, 1996);
- prisoners (Singleton *et al*, 1998); and
- children and adolescents (Meltzer *et al*, 2000).

The survey covered in this report was carried out in 2000 and is a repeat of the 1993 survey of adults living in private households. However, the 2000 survey included a number of developments: there was a slight increase in the age range, so that it covered people aged 16 up to 74 years, and measures of personality disorder and intellectual functioning were included.

Most notably, there was a change in the sample who were asked the questions on non-fatal suicidal behaviour. In the 1993 survey the questions were only asked of those who reported at least one significant symptom of depression in the past four weeks. In the 2000 survey, questions on suicidal thoughts, suicidal attempts and deliberate self-harm without the intention of committing suicide were asked of everyone.

However, the main report covering the prevalence of mental disorders, published in December 2001, did include comparisons of rates of neurotic and psychotic disorders in the GB population between 1993 and 2000. (Singleton *et al*, 2001)

1.2 Assessment of non-fatal suicidal behaviour

The concept of non-fatal suicidal behaviour

In his review of suicide and suicidal behaviour among adolescents, Diekstra *et al* (1995) refers to the work of Kreitman (1977) who originally proposed the term, parasuicide to encompass a whole range of behaviour, from suicidal gestures to manipulative attempts to serious but unsuccessful attempts to kill oneself. However there is no international agreement on the precise definition of parasuicide. Many American authors, for example, Spirito (1989) use the term, "attempted suicide" which includes the element of suicidal intention.

In their introduction to the WHO multicentre study, Bille-Brahe *et al* (1994) quotes an earlier reference to Kreitman relating to the definitional problems with the term, "parasuicide" (Kreitman *et al*, 1969):

> The problem of nomenclature in so called studies of attempted suicide has certain affinities with migraine: both are recurrent, are associated with headaches and induce difficulties in focusing clearly. The only point on which everyone seems to be agreed is that the existing term, attempted suicide, is unsatisfactory, for the excellent reason that the great majority of patients so designated are not in fact attempting suicide.

Measuring non-fatal suicidal behaviour

To overcome many of these definitional problems, the ONS survey of psychiatric morbidity included four questions to assess self-harm with suicidal intent, based on the work of Paykel *et al* (1974) and Salmons and Harrington (1984).

1. Have you ever thought that life was not worth living?
   (If YES, in the last week, last year, or at another time)

2. Have you ever wished that you were dead?
   (If YES, in the last week, last year, or at another time)

3. Have you ever thought of taking your life, even though you would not actually do it?
   (If YES, in the last week, last year, or at another time)

4. Have you ever made an attempt to take your life, by taking an overdose of tablets or in some other way?
   (If YES, in the last week, last year, or at another time)

Responses to question 3 were used to assess suicidal ideation and those to question 4 for suicide attempts.

To measure deliberate self-harm without the intention of suicide, respondents were asked an additional question.

5 Have you deliberately harmed yourself in anyway but not with the intention of killing yourself?

Respondents who answered yes to this question were then asked a series of questions about how they had harmed themselves and for what reasons.

All information about non-fatal suicidal behaviour was obtained from these interviews. No records were assessed.

Definitions of all mental disorders assessed in the survey and the instruments used to measure them can be found in the report of the main survey (Singleton *et al*, 2001)

1.3 Review of previous research

Prevalence studies

As part of the National Comorbidity Study in the US, Kessler and his colleagues looked at the prevalence of non-fatal suicidal behaviour among a nationally representative sample of 5,877 adults aged 15 to 54 years based on data collected between 1990 and 1992. (Kessler, Borges and Walters, 1999). Among the survey respondents, 13.5% reported lifetime suicidal thoughts (suicidal ideation) and 4.6% overall had made a suicidal attempt. Therefore, about 30% of respondents who had ever thought about suicide had, at one time, made a suicide attempt.

In Denmark, as part of the 1994 Danish National Health Interview Survey, 1,362 individuals were asked questions regarding their suicidal behaviour. In this survey 6.9% reported having suicidal thoughts within the past year. In terms of suicidal attempts, the lifetime prevalence was 3.4% with a one-year rate of 0.5% (Kjoller and Helweg-Larson, 2000)

Prevalence of suicidal ideation and suicide attempts were also derived from the Australian National Survey of Mental Health and Wellbeing (Pirkis, Burgess and Dunt, 2000). For 10,641 respondents, the lifetime and 12 month rates for suicidal ideation were 16.0% and 3.4% respectively, and for suicidal attempts, the corresponding rates were 3.6% and 0.4%.

Two recently published articles have examined variations in rates of suicidal ideation and suicide attempts across several countries. In the first, Weissman *et al* (1999) report results from nine independently conducted, epidemiological studies. Suicidal ideation and attempts were assessed on the Diagnostic Interview Schedule in over 4,000 respondents from the US, Canada, Puerto Rico,

France, West Germany, Lebanon, Taiwan, Korea and New Zealand. Lifetime prevalence rates for suicidal ideation ranged from 2.1% (Beirut) to 18.5% (Christchurch). Lifetime suicidal attempts ranged from 0.7% (Beirut) to 5.9% (Puerto Rico). Although rates of suicidal ideation varied widely, the rates of suicide attempts among most countries were more consistent.

In a review of 20 published studies from 1970 to 2000, Welch (2001) reports that the lifetime rates of parasuicide, defined as suicide attempts and deliberate self harm, ranged from 0.7% to 5.9%, with annual rates between 0.02 to 1.1%.

Risk factors

In November 1993, a specialist conference on attempted suicide was held in the Netherlands with representatives from Europe, USA and Canada. The papers from this conference were collated into a publication entitled *Attempted Suicide in Europe: Findings from the Multicentre Study on Parasuicide by the WHO Regional Offices for Europe* (Kerkhof *et al*, 1994). A paper by Schmidtke *et al* (1994) summarised the socio-demographic characteristics of suicide attempters in Europe – suicide attempters were predominantly men, aged 25 to 34, single, with poor educational attainment and in the lowest social class. The most frequent psychiatric disorders among men who attempt suicide were adjustment disorders followed by substance and alcohol disorders. For women, the most common mental disorder was also adjustment disorder, followed by personality disorder without neurotic depression and then neurotic depression.

More recently, the increased prevalence of suicidal attempts among adults with particular psychiatric disorders have been described:

- Anxiety disorders, affective disorders and substance misuse disorders (Pirkis, Burgess and Dunt 2000).
- Alcohol, inhalants and heroin (Borges, Walters and Kessler, 2000).
- Cannabis abuse and dependence (Beautrais, Joyce and Mulder, 1999).
- Personality disorder (Suominen, Isometsa, Henriksson, Ostamo and Lonquist, 2000).
- Eating disorders among women (Hawton, Harris, Simkin, Fagg, Bale and Bond, 1997).

Similar socio-demographic and psychiatric factors emerged from the analysis of the data from the national survey of psychiatric morbidity among prisoners carried out in 1997 in England and Wales. (Meltzer *et al*, 1999). Prisoners who attempted suicide tended to be young, white, single, born in the UK and to have left school early and be poorly educated. Personality Disorder, psychosis, neurotic disorders and alcohol abuse were all found to be more prevalent among prisoners who had attempted suicide than in those who had not. Suicide attempters were more likely to have very small primary support groups and to have a severe lack of social support. They were also much more likely to have experienced a variety of adverse life events, both in the last six months and particularly over the course of their lifetime, notably violence or sexual abuse.

1.4 Coverage of the report

After the description of the sample, presented in chapter 2, the report goes on to examine the relationship between non-fatal suicidal behaviour and socio-demographic characteristics (Chapter 3), psychiatric factors (Chapter 4) and social functioning (Chapter 5). In Chapter 6, the data from the previous chapters are brought together, by means of logistic regression analysis, to find out which of the factors are the most significant, independent correlates of suicidal behaviour. The last chapter focuses on the use of services of those who have attempted suicide.

1.5 Focus of the analysis

The three chapters in this report which examine the relationship between non-fatal suicidal behaviour and socio-demographic, psychiatric and social functioning characteristics follow a similar analysis plan.

In the first part of the chapter, the analysis focuses on the prevalence of suicidal thoughts, suicidal attempts and deliberate self-harm by the characteristics of interest in the respective chapters. The data presented in these tables are cumulative percentages, for example, showing the prevalence of suicidal attempts in the past week, the past year (including the past week) and lifetime rates (including past week and past year). These data are

shown as percentages to one decimal point reflecting the standard practice of presenting prevalence data in psychiatric epidemiology.

In the second part of these three chapters, suicidal thoughts or attempts within the lifetime of the respondent become the independent variables and we examine what are the key factors which can distinguish those who have attempted suicide and those who have not in the last year.

In Chapter 6 all the significant factors which have emerged from the previous three chapters are put into a logistic regression model.

1.6 Access to survey data

Anonymised data from the survey will be lodged with the Data Archive, University of Essex, within 3 months of the publication of this report. Independent researchers who wish to carry out their own analyses should apply to the Archive for access. For further information about archived data, please contact:

ESRC Data Archive
University of Essex
Wivenhoe Park
Colchester
Essex CO4 3SQ
Tel: (UK) 01206 872323
FAX: (UK) 01206 872003
Email: archive@essex.ac.uk.

1.7 Sampling and interviewing procedures

The survey was carried out between March and September 2000. A two-stage approach to the assessment of mental disorders was used. The first stage interviews were carried out by ONS interviewers and included structured assessment and screening instruments for measuring mental disorders, as well as covering a range of other topics, such as service use, risk factors for disorder and background socio-demographic factors. A sub-sample of people were then selected to take part in a second stage interview to assess psychosis and personality disorder, the assessment of which requires a more detailed interview than was possible at the first stage and some clinical judgement. These interviews were carried out by specially trained psychologists employed by the University of Leicester. More details of the assessment instruments used in the two stages are given in Chapter 4.

The small users postcode address file (PAF) was used as the sampling frame for the survey because of its good coverage of private households in Great Britain. In the PAF, the postcode sectors were stratified on the basis of socio-economic group within NHS Region. A postal sector contains on average 2,550 delivery points.

Initially, 438 postal sectors (the primary sampling units) were selected with a probability proportional to size (number of delivery points). This included 370 sectors in England, 22 in Wales and 46 in Scotland. Within each of these sectors, 36 delivery points were selected (with the exception of one sector which was accidentally sampled twice), yielding a sample of 15,804 delivery points.

Interviewers visited the 15,804 addresses to identify private households with at least one person aged 16 to 74 years. The Kish grid method was used to select systematically one person in each household. (Kish, 1965) More details of sampling procedures can be found in the Technical Report.

Overall, 10% of sampled addresses were ineligible because they contained no private households. Of the remaining addresses, 11% contained no-one within the eligible age range, which left an eligible sample of 12,792 addresses.

Just under 70% of those approached agreed to take part in an interview and despite the length of the interview, 95% completed the full interview, i.e. 8,450 respondents.

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2 Characteristics of the sample

The purpose of this chapter is to describe the socio-demographic characteristics of the sample, showing their distribution by age and sex.

Age

Slightly more than half (55%) of all respondents were women but there was no difference between the sexes in their age distribution. *(Table 2.1)*

Ethnicity

There were no differences between the sexes in distributions of ethnic origin. Only about one in fifteen (7%) of all respondents were from ethnic groups other than 'White'. The representation of non-white ethnic groups decreased with age among both men and women. About one in eight (12%) of the youngest respondents (aged 16 to 24) said they were from an ethnic group other than white compared with just one in fifty (2%) of the oldest respondents (aged 65 to 74). *(Table 2.2)*

Marital status

Overall, men and women were equally likely to be married or cohabiting (56%), but men were more likely than women to be single (33% and 26% respectively), whereas women were more likely than men to be widowed or divorced: 15% of women compared with 9% of men.

As might be expected, the distribution of marital status varied with age, and by sex within age groups. The youngest respondents (aged 16 to 24 years) were less likely than those in all other age groups to be married or cohabiting. The oldest women (those aged 65 to 74) were more likely than any other group to be widowed or divorced, and more than twice as likely as men of their age (32% compared with 16%). *(Table 2.3)*

Family unit type

Each informant's family unit was classified into one of six family unit types. 'Couple no children' included married or cohabiting couples without children. 'Couple with child' comprised a married or cohabiting couple living with at least one child from their current or a previous relationship. 'Lone parent' describes a man or woman living with at least one child. The child need not be under eighteen and could be an adult who had never married and has no children. 'One person' does not necessarily imply that the respondent lives alone. It includes those who live alone, but it also includes adults living with a sibling, or grandparents living with their children and their family, as well as those living with unrelated people in shared households. The category 'adult living with parents' would contain the same members as a 'couple with child', except in this case it is the adult son or daughter who is the respondent. Similarly, 'adult living with one parent' covers a similar type of family unit, except that only one parent is present.

Two-thirds of the sample were living as a couple, just over a third with children (35%) and nearly a third (31%) without children. About one in six of the respondents (16%) lived as a one-person family unit, and a further 1 in 10 lived with one parent. Women were more likely to be a lone parent with children (9% compared with only 2% of men) and men were more likely to be living with a parent (16% of men and 10% of women lived with one or more parent).

These distributions also varied greatly by age and by sex within the age groups: older men were more likely to be living as a couple without children whereas older women were more likely to be living as a couple without children or to be living in a one-person family unit. Not surprisingly, people in the youngest age group (16 to 24) were the most likely to be living with their parent(s), and those in the mid-age groups were the most likely to be living as a couple with children. *(Table 2.4)*

Educational qualifications

Over a quarter of the sample (27%) had no formal educational qualifications; men were less likely than women to be in this position (25% compared with 30%).

Over a third (37%) of the sample's highest qualification was GCSE (or equivalent) and a further 15% had reached A-level. Overall, 15% of respondents had a qualification at degree level or above, and men were more likely than women to have achieved this level (17% compared with 12%).

These sex differences did not apply to the youngest age group but were progressively more pronounced across the higher age groups. In both sexes, younger respondents tended to be better qualified than older respondents. The proportion of respondents with no formal qualifications increased from 15% of 16- to 24-year-olds to 59% of those aged 65 to 74 years. *(Table 2.5)*

Economic activity

Table 2.6 gives a breakdown of economic activity by age and by sex. Although about two thirds (67%) of all respondents were in paid employment, men were more likely than women to be doing paid work (74% compared with 61%). Only 4% of men and 2% of women were unemployed; the remainder were classed as economically inactive, i.e. not seeking work.

Not surprisingly, respondents aged 65 to 74 years were less likely than those in any other age group to be in paid employment – 10% compared with 82% of respondents aged 25 to 34 years. Those in the youngest age group (16 to 24) were the most likely to be unemployed:10% compared with 3% or 4% of other age groups. *(Table 2.6)*

Social class

The largest group of respondents were in Social Class II (29%), a quarter were in IIINM, and a fifth (19%) were in Social Class IIIM. A further 16% were in Social Class IV, and the remainder in Social Classes V (6%) and I (5%).

There were differences both by sex and by age in the distributions of respondents by social class. In particular, men were more likely than women to be in Social Classes I and IIIM and less likely to be in IIINM. Among both men and women, respondents aged 16 to 24 were the most likely to be in Social Class IIINM, and the least likely to be in Social Class II. There was no clear pattern among the other social classes. *(Table 2.7)*

Occupational group

The distribution of respondents' occupational group by age and sex is shown in table 2.8. Overall, a third (33%) of the sample were not currently in employment (27% of men and 39% of women). About 1 in 10 were in each of the managers/ administration (11%) or the clerical/secretarial (10%) groups, but not surprisingly, these percentages varied greatly by age among men and women and by sex within age group. *(Table 2.8)*

Tenure

Table 2.9 shows the distribution of tenure by age and sex. Nearly three quarters of the sample owned their own property: 24% owned outright and 49% owned with a mortgage. A further 17% rented from a Local Authority or Housing Association, and the remaining 10% rented privately.

Overall, there were no significant differences between men and women, but there were sex differences in some of the age groups. For example, among those aged 16 to 24, men were more likely than women to live in a property that was owned outright (15% and 10% respectively), whereas women were more likely to rent from an LA or HA (23% compared with 16% of men). These percentages may reflect the finding that young men are more likely than young women to be living with one or more parent and it is the parent that owns the property not the respondent.

The percentage of both men and women who own their property outright steadily increased from 7% of those aged 25 to 44 to 69% of those aged 65 to 74, and those who own with a mortgage increased to a peak of 70% among ages 35 to 44 and then fell again to 8% of those in the oldest age group. These findings may reflect both the increase in owner-occupation over the last half-century, and the housing market situation for different age cohorts. *(Table 2.9)*

Table 2.1 Age of respondents
by sex

	Men	Women	All
Age	%	%	%
16–24	15	15	15
25–34	21	20	20
35–44	21	20	21
45–54	18	18	18
55–64	14	14	14
65–74	11	12	11
Base	*3852*	*4728*	*8580*

Table 2.2 Ethnicity of respondents
by age and sex

	Age						
	16–24	25–34	35–44	45–54	55–64	65–74	All
	%	%	%	%	%	%	%
Men							
White	88	92	91	95	95	97	93
Black	3	3	4	2	2	1	3
South Asian	6	3	3	2	1	1	3
Other	2	2	2	2	1	1	2
Base	*385*	*711*	*824*	*747*	*646*	*539*	*3852*
Women							
White	88	91	94	96	97	99	94
Black	3	3	1	1	1	0	2
South Asian	6	3	3	2	1	-	3
Other	3	3	2	1	1	0	2
Base	*409*	*972*	*1024*	*798*	*796*	*729*	*4728*
All							
White	88	91	92	96	96	98	93
Black	3	3	3	2	2	1	2
South Asian	6	3	3	2	1	0	3
Other	3	2	2	1	1	1	2
Base	*794*	*1683*	*1848*	*1545*	*1442*	*1268*	*8580*

Table 2.3 Marital status of respondents by age and sex

	Age						
	16–24	25–34	35–44	45–54	55–64	65–74	All
	%	%	%	%	%	%	%
Men							
Married/cohabiting	1	40	66	76	77	78	56
Separated	-	2	4	3	2	1	2
Single	98	55	19	8	6	5	33
Divorced	1	4	10	12	11	5	7
Widowed	-	0	0	0	4	11	2
Base	*385*	*711*	*824*	*747*	*646*	*539*	*3852*
Women							
Married/cohabiting	6	52	66	74	72	61	56
Separated	2	5	5	3	3	2	3
Single	91	37	14	5	3	6	26
Divorced	1	6	13	14	11	5	9
Widowed	-	0	1	4	10	27	6
Base	*409*	*972*	*1024*	*798*	*796*	*729*	*4728*
All							
Married/cohabiting	4	46	66	75	75	69	56
Separated	1	3	5	3	2	2	3
Single	95	46	17	7	5	5	30
Divorced	0	5	12	13	11	5	8
Widowed	-	0	1	2	7	19	4
Base	*794*	*1683*	*1848*	*1545*	*1442*	*1268*	*8580*

Table 2.4 Family type of respondents by age and sex

	Age						
	16–24	25–34	35–44	45–54	55–64	65–74	All
	%	%	%	%	%	%	%
Men							
Couple, no child(ren)	5	28	16	29	58	72	31
Couple with child(ren)	3	36	62	54	23	8	35
Lone parent with child(ren)	-	0	3	2	2	1	2
One person only	17	21	15	12	17	18	17
Adult with parents	22	2	1	0	0	-	4
Adult with one parent	54	12	3	2	1	0	12
Base	*385*	*711*	*824*	*747*	*646*	*539*	*3852*
Women							
Couple, no dependent child	13	25	11	36	58	54	31
Couple with dependent child	9	45	65	43	17	7	35
Lone parent with dependent child	5	13	13	9	4	3	9
One person only	19	12	9	10	20	36	16
Adult with parents	11	1	0	-	-	-	2
Adult with one parent	42	5	2	1	0	0	8
Base	*409*	*972*	*1024*	*798*	*796*	*729*	*4728*
All							
Couple, no dependent child	9	26	13	33	58	62	31
Couple with dependent child	6	40	64	48	20	7	35
Lone parent with dependent child	3	7	8	6	3	2	5
One person only	18	16	12	11	19	28	16
Adult with parents	17	2	1	0	0	-	3
Adult with one parent	48	9	3	2	1	0	10
Base	*794*	*1683*	*1848*	*1545*	*1442*	*1268*	*8580*

Table 2.5 Highest level of educational qualifications of respondents by age and sex

	Age						
	16–24	25–34	35–44	45–54	55–64	65–74	All
	%	%	%	%	%	%	%
Men							
Degree	8	24	20	21	12	9	17
Teaching, HND, nursing	6	8	8	7	6	6	7
A Level or equivalent	26	17	18	15	12	7	16
GCSE A–C grades or equivalent	38	29	27	21	16	10	24
GCSE D–F grades or equivalent	8	10	10	10	11	13	10
No qualifications	15	12	17	26	44	54	25
Base	*385*	*711*	*824*	*747*	*646*	*539*	*3852*
Women							
Degree	12	20	16	13	5	3	12
Teaching, HND, nursing	6	8	7	9	7	6	7
A Level or equivalent	23	19	14	9	5	4	13
GCSE A–C grades or equivalent	35	33	32	24	18	8	26
GCSE D–F grades or equivalent	9	9	12	10	13	16	11
No qualifications	15	11	20	34	51	62	30
Base	*409*	*972*	*1024*	*798*	*796*	*729*	*4728*
All							
Degree	10	22	18	17	8	6	15
Teaching, HND, nursing	6	8	7	8	6	6	7
A Level or equivalent	24	18	16	12	8	6	15
GCSE A–C grades or equivalent	37	31	30	22	17	9	26
GCSE D–F grades or equivalent	8	10	11	10	12	14	11
No qualifications	15	12	18	30	48	59	27
Base	*794*	*1683*	*1848*	*1545*	*1442*	*1268*	*8580*

Table 2.6 Economic activity of respondents by age and sex

	Age						
	16–24	25–34	35–44	45–54	55–64	65–74	All
	%	%	%	%	%	%	%
Men							
Employed full time	45	85	87	80	50	3	65
Employed part time	26	5	3	4	10	9	9
Unemployed	10	3	3	4	3	0	4
Economically inactive	20	7	7	12	38	88	23
Base	*385*	*711*	*824*	*747*	*646*	*539*	*3852*
Women							
Employed full time	40	49	37	39	18	1	33
Employed part time	29	24	37	36	25	6	28
Unemployed	5	2	3	2	1	0	2
Economically inactive	26	25	24	23	55	93	37
Base	*409*	*972*	*1024*	*798*	*796*	*729*	*4728*
All							
Employed full time	42	68	62	59	34	2	49
Employed part time	27	14	20	20	18	8	18
Unemployed	7	2	3	2	2	0	3
Economically inactive	23	16	15	18	46	90	30
Base	*794*	*1683*	*1848*	*1545*	*1442*	*1268*	*8580*

Table 2.7 Social class of respondents by age and sex

	Age						
	16–24	25–34	35–44	45–54	55–64	65–74	All
	%	%	%	%	%	%	%
Men							
I	3	10	7	9	8	7	8
II	15	31	35	38	28	31	31
IIINM	31	12	10	9	7	10	12
IIIM	24	28	31	29	35	34	30
IV	17	15	13	12	18	12	14
V	8	3	4	3	4	5	4
Armed forces	0	1	1	0	-	0	0
Base	*385*	*711*	*824*	*747*	*646*	*539*	*3852*
Women							
I	2	5	3	2	0	0	2
II	15	30	32	33	25	23	27
IIINM	48	36	32	34	38	36	37
IIIM	6	9	8	8	8	10	8
IV	25	16	18	16	18	19	18
V	5	4	6	7	10	12	7
Base	*409*	*972*	*1024*	*798*	*796*	*729*	*4728*
All							
I	2	8	5	6	4	4	5
II	15	30	34	35	26	27	29
IIINM	40	23	21	22	23	24	25
IIIM	15	19	20	18	21	21	19
IV	21	15	15	14	18	16	16
V	7	4	5	5	7	8	6
Armed Forces	0	0	0	0	-	0	0
Base	*794*	*1683*	*1848*	*1545*	*1442*	*1268*	*8580*

Table 2.8 Occupational group of respondents by age and sex

	Age						
	16–24	25–34	35–44	45–54	55–64	65–74	All
	%	%	%	%	%	%	%
Men							
Managers and admin	5	17	22	22	10	3	15
Professional occupations	3	12	9	11	7	1	8
Associate professional and technical	5	10	9	9	6	1	7
Clerical, secretarial	9	9	6	5	3	0	6
Craft and related	12	17	17	14	12	2	13
Personal, protective	8	4	6	5	2	1	5
Sales occupations	14	4	3	3	3	0	5
Plant and machine operators	6	11	13	12	11	2	10
Other occupations	9	5	5	2	6	1	5
Not employed	30	10	10	16	40	88	27
Base	*385*	*711*	*824*	*747*	*646*	*539*	*3852*
Women							
Managers and admin	4	10	11	11	5	1	8
Professional occupations	4	9	7	9	4	0	6
Associate professional and technical	4	9	10	8	5	1	7
Clerical, secretarial	17	17	18	19	10	1	15
Craft and related	1	1	2	2	1	-	1
Personal, protective	12	11	12	9	8	1	9
Sales occupations	17	8	7	7	5	1	8
Plant and machine operators	3	3	2	3	1	-	2
Other occupations	6	4	6	6	5	2	5
Not employed	31	27	26	25	56	93	39
Base	*409*	*972*	*1024*	*798*	*796*	*729*	*4728*
All							
Managers and admin	5	14	16	17	7	2	11
Professional occupations	4	10	8	10	6	1	7
Associate professional and technical	5	10	9	9	5	1	7
Clerical, secretarial	13	13	12	12	7	1	10
Craft and related	6	9	9	8	6	1	7
Personal, protective	10	8	9	7	5	1	7
Sales occupations	15	6	5	5	4	1	6
Plant and machine operators	5	7	8	7	6	1	6
Other occupations	7	5	5	4	5	1	5
Not employed	30	18	18	20	48	91	33
Base	*794*	*1683*	*1848*	*1545*	*1442*	*1268*	*8580*

Table 2.9 Tenure of respondents by age and sex

	Age						
	16–24	25–34	35–44	45–54	55–64	65–74	All
	%	%	%	%	%	%	%
Men							
Owns–outright	15	8	6	21	47	74	23
Owns–mortgage	46	54	71	62	35	8	50
Rents–LA/HA	16	20	16	13	14	16	16
Rents–privately	23	18	8	4	4	3	11
Base	*385*	*711*	*824*	*747*	*646*	*539*	*3852*
Women							
Owns–outright	10	6	8	24	53	65	24
Owns–mortgage	44	60	69	56	28	9	48
Rents–LA/HA	23	19	16	16	15	23	18
Rents–privately	23	15	7	4	4	3	9
Base	*409*	*972*	*1024*	*798*	*796*	*729*	*4728*
All							
Owns–outright	13	7	7	23	50	69	24
Owns–mortgage	45	57	70	59	31	8	49
Rents–LA/HA	19	19	16	15	15	20	17
Rents–privately	23	17	7	4	4	3	10
Base	*794*	*1683*	*1848*	*1545*	*1442*	*1268*	*8580*

3 Socio-demographic correlates of suicidal behaviour

3.1 Introduction

This chapter is divided into three sections. Section 3.2 looks at the responses to questions on suicidal ideation and attempts, and deliberate self-harm without suicidal intent and presents prevalence rates by socio-demographic factors. The following part of the chapter (Section 3.3) looks at respondents' socio-demographic characteristics by whether or not the respondent had ever thought about or attempted suicide or deliberately harmed themselves. Section 3.4 looks at deliberate self-harm without suicidal intent in more detail.

All respondents were asked if they had ever considered suicide, and if so, when was this. The tables presented show the cumulative percentage of respondents who had had suicidal thoughts, so, for example, the percentage who had had lifetime thoughts about suicide includes all those who reported that they had suicidal thoughts in the past week, past year or ever.

Respondents who said that they had considered suicide in the past, were asked if they had ever attempted suicide and if so, when this was. Those who had not considered suicide have been included in the table with the group of people who said they had never attempted suicide. Again, the tables show cumulative percentages.

3.2 Prevalence of non-fatal suicidal behaviour

Age and sex

Overall, 14.9% of survey respondents said they had considered suicide at some point in their life, 3.9% in the past year and 0.4% had done so in the past week. This lifetime prevalence rate, 14.9%, is similar to that found in national surveys in the United States (US) – 13.5% (Kessler, Borges and Walters, 1999) and in Australia – 16.0% (Pirkis, Burgess and Dunt, 2000) despite different instrumentation and a slightly different upper age limit. However, in both Great Britain and the US the proportion of those who had ever thought about suicide and subsequently went on to attempt suicide was exactly the same, 30%.

Women were more likely than men to have ever considered suicide (17% and 13% respectively). This sex difference can be seen across all of the age groups. This fits in with the pattern found in other countries. Weissman *et al* (1999) concluded that females as compared to males had only marginal higher rates of suicidal ideation in most countries.

Focussing now on suicide attempts, 4.4% of respondents said they had ever attempted suicide, and 0.5% had attempted suicide in the past year. The percentages were similar for men and women. The equivalent lifetime prevalence figures for the US, Australia and Denmark were 4.6%, 3.6% 3.4% (Kessler, Borges and Walters, 1999; Pirkis, Burgess and Dunt, 2000; Kjoller and Helweg-Larsen, 2000). In all countries the rate for suicide attempts in the past year was around 0.5%.

Adding the more recent figures from the US, Great Britain and Australia to the nine countries covered by Weissman *et al* (1999), excluding Taiwan and Lebanon which have unusually low rates, the lifetime prevalence of suicidal ideation and suicide attempts in descending order are:

Lifetime prevalence (%)

	Suicidal ideation	Suicide attempts
Christchurch, New Zealand (1989)	18.5	4.4
United States (1989 NCS)	16.5	4.8
Korea (1990)	16.5	4.8
Australia (2000)	16.0	3.6
West Germany (1992)	15.6	3.4
Great Britain (2000)	14.9	4.4
Savigny, France (1989)	14.2	4.9
United States (1990/2)	13.5	4.6
Edmonton, Alberta (1988)	11.2	3.8
United States: (1980s ECA)	11.2	3.1
Puerto Rico (1987)	9.5	5.9

In Great Britain, suicidal ideation was more prevalent among young people than among older people: about 17% of those aged 16 to 44 said they had had suicidal thoughts in their lifetime, compared with only 6% of those aged 65 to 74.

National surveys in Denmark (Kjoller and Helweg-Larsen, 2000) and Australia (Pirkis, Burgess and Dunt, 2000) demonstrated the same relationship between suicidal ideation and age. In Great Britain, the age gradient was evident for both men and women. *(Table 3.1, Figure 3.1)*

Similar to suicidal ideation, younger people were more likely to have attempted suicide: about 5% of 16- to 24-year-olds and 6% of 25- to 34-year-olds had ever attempted suicide, compared with 2% of those aged 65 to 74. This age difference was found for both men and women with the group reporting the highest rates being women aged 16 to 24 who had a lifetime prevalence rate of 8% for suicide attempts, 2% overall in the past year *(Table 3.1, Figure 3.2)*

Finally, all respondents were asked if they had ever deliberately harmed themselves without the intention of committing suicide, and 2% said that they had (2% of men and 3% of women).

The percentage of both men and women who had ever deliberately harmed themselves decreased with age, from 5% of the youngest age group to 0.2% of those aged 65 to 74. *(Table 3.1, Figure 3.3)*

Figure 3.1 Percentage of respondents who had ever had suicidal thoughts by age and sex

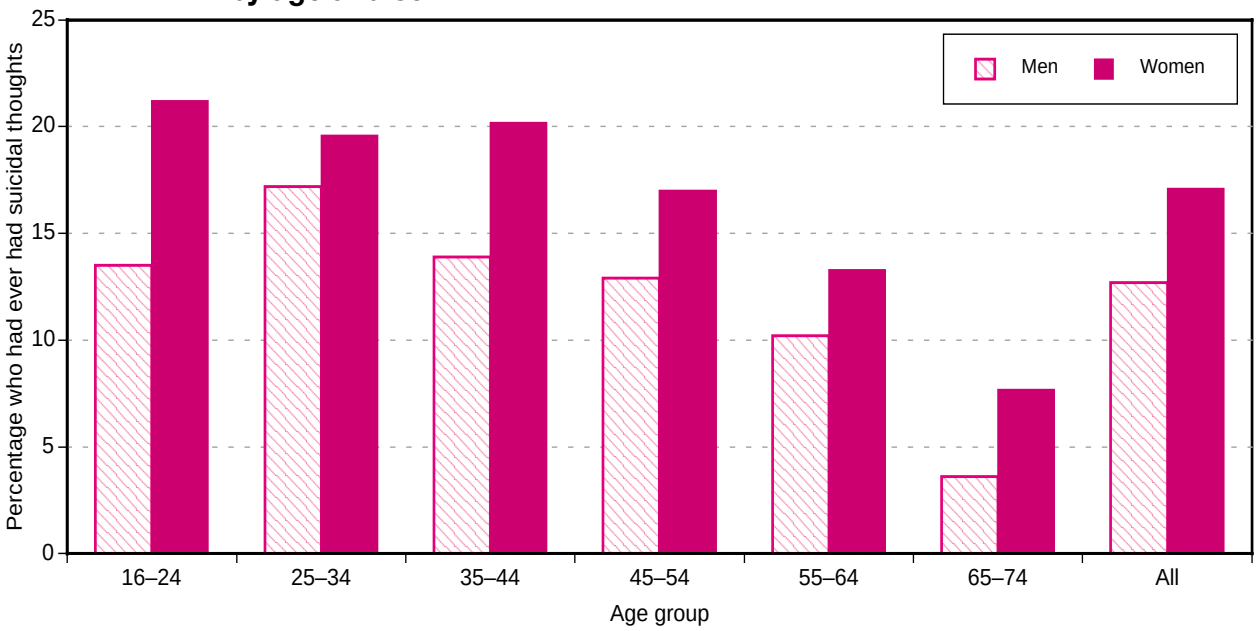


Figure 3.2 Percentage of respondents who had ever attempted suicide by age and sex

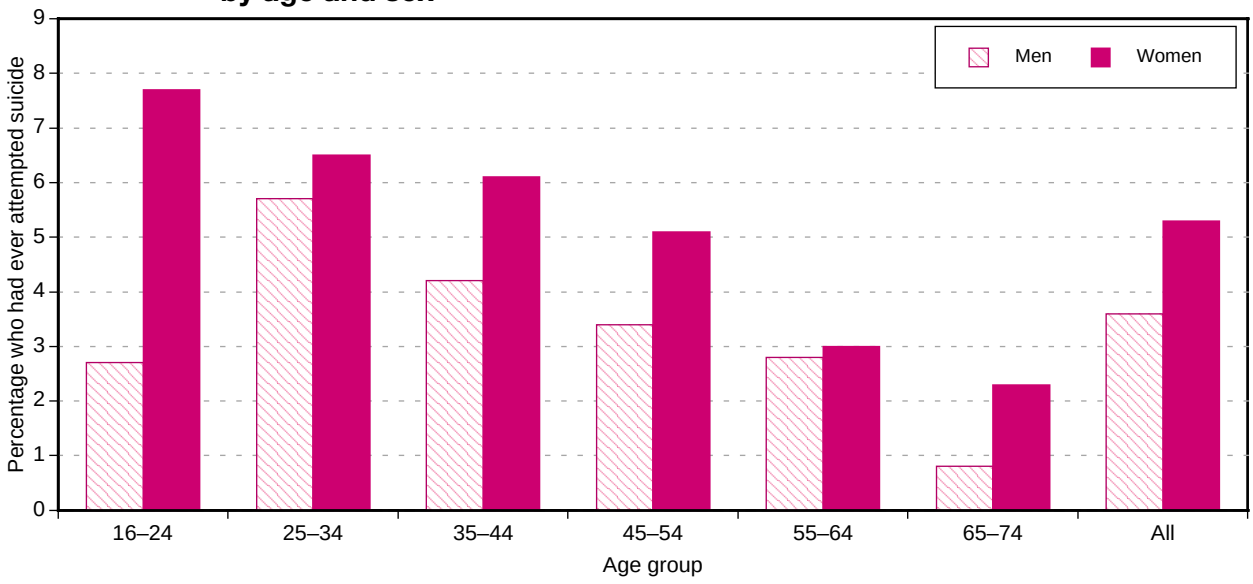
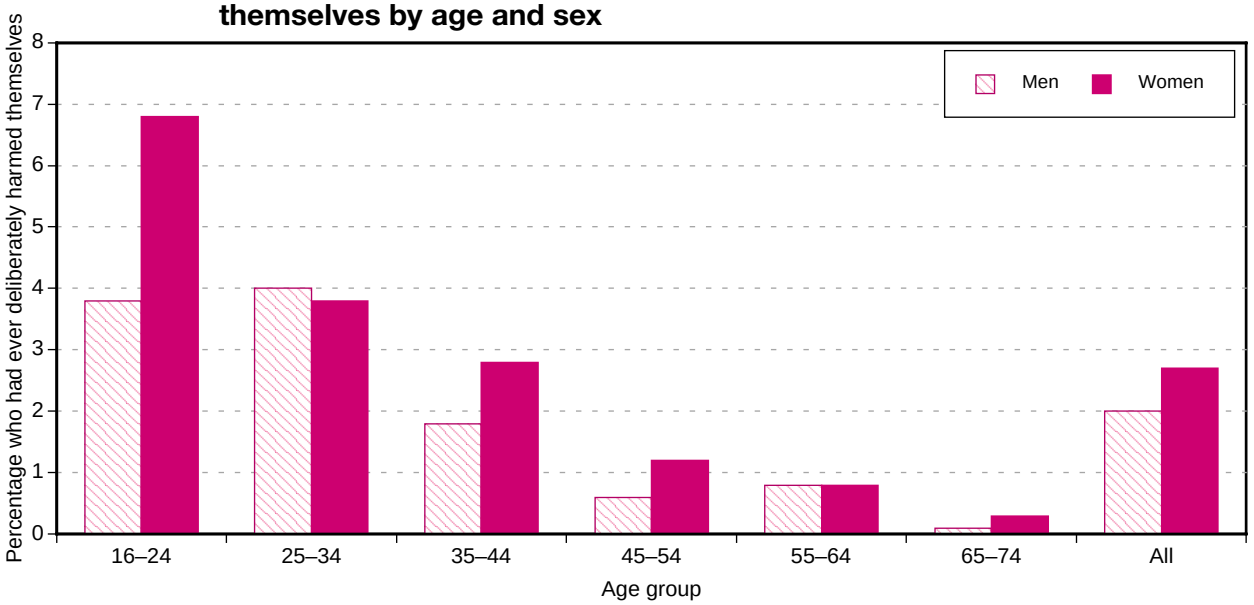


Figure 3.3 Percentage of respondents who had ever deliberately harmed themselves by age and sex



Ethnicity

White respondents, both men and women, were about twice as likely to have had suicidal thoughts compared with the sample of Black or South Asian origin: 15% compared with 8%. There was no statistically significant variation in the percentage of respondents in different ethnic groups who had ever attempted suicide or deliberately harmed themselves. *(Table 3.2)*

Marital status and family unit type

Among both men and women, separated and divorced respondents were the most likely to have ever had suicidal thoughts, and married and widowed respondents the least likely. For example, 28% of divorced women (25% of divorced men) said they had ever had suicidal thoughts compared with only 13% of married women (9% of married men).

Similarly, separated or divorced men and women tended to be more likely to have attempted suicide than their married or widowed counterparts. About 10% of divorced respondents (9% of divorced men and 11% of divorced women) had attempted suicide in their lifetime, compared with only 3% of married respondents (2% of married men and 3% of married women).

These findings replicate those from several other countries. In the comparative analysis among nine countries carried out by Weissman *et al* (1999) they concluded that in most countries suicidal ideation and attempts were associated with being currently divorced/separated as compared to currently married.

It has been argued that non-married individuals abuse alcohol more than married people and that this may contribute to the relationship between marital status and suicide attempts. However, a study by Stack and Wasserman (1995) using logistic regression analysis on the ECA survey data found that marital status affects the odds of attempting suicide independent of alcohol abuse.

A slightly different pattern was seen when deliberate self-harm without suicidal intent was looked at. Single respondents (particularly single women) were the most likely to have deliberately harmed themselves, followed by separated and divorced women. *(Table 3.3)*

This relationship between marital status and deliberate self harm is identified in the review by Welch who looked at 20 population studies on parasuicide between 1970 and 2000. (Welch, 2001). She defined parasuicide as suicide attempts and deliberate self-harm inflicted with no attempt to die. Among the risk factors she identified was being single or divorced. The results from this survey highlight the importance of distinguishing suicidal attempts, with and without the intention of suicide, for analytical purposes.

Table 3.4 shows that the relationship between suicidal thoughts and family type was slightly different among men and women. Among men, lone parents and men living in a family unit on their own were the most likely to have had suicidal thoughts (about 20% each) compared with only 9% of men in couples without children. Among women, however, lone parents and those living with their parents were twice as likely to have ever thought about suicide: 28% and 26% respectively had ever considered suicide, compared with only 14% of women in couples with or without children.

Both men and women lone parents were the most likely to have attempted suicide in their lifetime: 8% and 11% respectively, compared with, for example, only 2% of men living as a couple without children.

Similarly, men and women living with one or both parents, were more likely to have ever deliberately harmed themselves but this is probably a reflection of the relatively younger age of the sample in these groups. *(Table 3.4)*

Educational factors

There was no clear association between educational qualifications and suicidal ideation, suicide attempts or self-harm. *(Table 3.5)*

Socio-economic factors

All the studies reviewed so far indicate that being unemployed is a risk factor for suicidal behaviour. This was also found to be the case in Great Britain. Table 3.6 shows that both unemployed men and women were more likely than their employed or economically inactive counterparts to have had suicidal thoughts in the past year. For example, 27% of unemployed women said they had thought at one time about ending their life, compared with 16% of women in full or part time employment.

Unemployed women were more likely to have ever attempted suicide (16% compared with 4% of those in employment) or deliberately harmed themselves (9% compared with 2% of those in full time employment). The relationship among men was less evident though following a similar trend.

As for marital status, it has been argued that the relationship between unemployment and suicidal attempts is not straightforward. A study in New Zealand on the relationship between unemployment and serious suicide attempts (Beautrais, Joyce and Mulder, 1998) concluded that the relationship is non-causal. They believe it reflects common or correlated factors that contribute to both risks of both unemployment and suicidal behaviour. Any remaining association between unemployment and suicide risk appears to arise from the correlation that exists between unemployment and psychiatric disorder. In the present study, this contention is examined in Chapter 6.

There was very little variation in the prevalence of suicidal thoughts between people from different social classes. However, when suicidal behaviours are considered, respondents from manual social classes were more likely than those from non-manual, social classes to have ever attempted suicide. For example 8% of men in Social Class V (10% of women) had attempted suicide in their lifetime compared with 1% of men in Social Class I (3% of women). *(Table 3.7)*

The pattern of deliberate self-harm was much less clear: among men there were no significant differences between the different social classes, whereas among women, those in Social Classes I and IV were more likely than others to have deliberately harmed themselves. *(Table 3.7)*

There were a few significant differences in suicidal thoughts and behaviour between respondents from different occupational groups but no clear pattern. Interestingly people in jobs traditionally occupied by the other sex seemed more likely to have had suicidal thoughts or to have attempted suicide. For example, men in clerical and secretarial jobs were the most likely to have ever thought about (18%) and ever attempted suicide (6%). Similarly, women in craft-related jobs were the most likely to have thought about suicide (31%) or have attempted suicide (9%). *(Table 3.8)*

Tenure

Table 3.9 shows that men and women who rent their accommodation, were more likely than owners to have suicidal thoughts. For example,

20% of men and 25% of women who rent from a Local Authority or Housing Association had thought about suicide in their lifetime, compared with 8% of men and 12% of women who owned their property outright. LA/HA renters were also the most likely to have attempted suicide.

Among women, private renters were the most likely to have deliberately harmed themselves (7% compared with only 1% of outright owners, and 2% of women who own their property with a mortgage). *(Table 3.9)*

3.3 Distribution of socio-demographic characteristics by suicidal thoughts and behaviour

Whereas the previous section looked at the prevalence rates of suicidal thoughts and behaviour by various different socio-demographic characteristics, this section looks at those who have thought about or attempted suicide or tried to harm themselves and those who have not, and compares these two groups in terms of their socio-demographic characteristics.

Table 3.10 shows the different characteristics of respondents who said that they had had suicidal thoughts in their lifetime and those who had not ever had suicidal thoughts.

Among the respondents who had thought about suicide, 43% were men, 66% were aged 44 or under, 37% were single, 14% were divorced and 22% lived in a one-person family unit. In contrast, among those who had not ever thought about suicide, 51% were men, 54% were aged 44 or under, 28% were single, 7% were divorced and 15% lived in a one-person family unit.

There were also differences when other socio-economic characteristics were considered: those who had had suicidal thoughts were more likely to be economically inactive (33% compared with 29% of those who had never had suicidal thoughts), in lower social classes and renting accommodation.

Table 3.11 shows the distribution of socio-demographic and socio-economic characteristics for respondents who had made a suicide attempt and those who had not.

Respondents who had ever attempted suicide were more likely than those who had never attempted suicide to be:

- women;
- younger;
- single or divorced;
- living in a one-person family unit;
- economically inactive;
- in lower social classes; and
- renting accommodation from the Local Authority or a Housing Association.

Respondents who had deliberately tried to harm themselves were more likely than those who had not tried to self-harm to be women, aged 16 to 34, single, living alone or with one parent, in Social Class IV or not employed, and renting accommodation. *(Table 3.12)*

3.4 Reasons for deliberate self-harm and methods used

It was shown above (Table 3.1) that 2% of respondents said that they had ever tried to harm themselves deliberately, without suicidal intent. These respondents were then asked what they did to harm themselves, why they did it and about any medical attention or help they had received as a consequence of their self-harm.

Nearly two-thirds (63%) of self-harmers said they had cut themselves, 14% had swallowed an object and 6% had burnt themselves. Nearly a third (32%) said they had harmed themselves in some other way.

Three-quarters of self-harmers had done so in anger and over half (56%) had done so to draw attention to themselves. Stanley *et al* (2001) confirms that self-mutilators perceived their suicide attempts as less lethal, with a greater likelihood of rescue and with less certainty of death. However, they also tend to underestimate how lethal their behaviour could be.

None of the apparent differences between men and women were statistically significant due to the small number of people who said they had harmed themselves. *(Table 3.13)*

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Table 3.1 Prevalence of non-fatal suicidal behaviour by age and sex

	Age						
	16–24	25–34	35–44	45–54	55–64	65–74	All
	Cumulative percentage of population						
Men							
Suicidal thoughts							
Past week	0.2	0.1	0.4	0.7	0.2	0.2	0.3
Past year	5.2	4.3	3.7	4.3	2.1	0.5	3.6
Lifetime	13.5	17.2	13.9	12.9	10.2	3.6	12.7
Never	86.5	82.8	86.1	87.1	89.8	96.4	87.3
Suicide attempts							
Past week	-	0.1	-	-	-	-	0.0
Past year	0.8	1.2	0.3	0.2	-	0.2	0.5
Lifetime	2.7	5.7	4.2	3.4	2.8	0.8	3.6
Never	97.3	94.3	95.8	96.6	97.2	99.2	96.4
Deliberate self-harm without suicidal intent	3.8	4.0	1.8	0.6	0.8	0.1	2.0
Base	*384*	*710*	*822*	*747*	*646*	*539*	*3848*
Women							
Suicidal thoughts							
Past week	0.9	0.6	0.9	0.1	0.5	0.1	0.5
Past year	8.3	4.4	5.0	3.0	1.8	1.4	4.1
Lifetime	21.2	19.6	20.2	17.0	13.3	7.7	17.1
Never	78.8	80.4	79.8	83.0	86.7	92.3	82.9
Suicide attempts							
Past week	-	0.1	-	-	-	-	0.0
Past year	1.5	0.8	0.5	0.1	0.2	0.1	0.5
Lifetime	7.7	6.5	6.1	5.1	3.0	2.3	5.3
Never	92.3	93.5	93.9	94.9	97.0	97.7	94.7
Deliberate self-harm without suicidal intent	6.8	3.8	2.8	1.2	0.8	0.3	2.7
Base	*409*	*970*	*1023*	*798*	*796*	*728*	*4724*
All							
Suicidal thoughts							
Past week	0.5	0.3	0.7	0.4	0.3	0.1	0.4
Past year	6.7	4.3	4.4	3.7	1.9	1.0	3.9
Lifetime	17.3	18.4	17.0	15.0	11.7	5.8	14.9
Never	82.7	81.6	83.0	85.0	88.3	94.2	85.1
Suicide attempts							
Past week	-	0.1	-	-	-	-	0.0
Past year	1.1	1.0	0.4	0.1	0.1	0.1	0.5
Lifetime	5.1	6.1	5.1	4.3	2.9	1.6	4.4
Never	94.9	93.9	94.9	95.7	97.1	98.4	95.6
Deliberate self-harm without suicidal intent	5.3	3.9	2.3	0.9	0.8	0.2	2.4
Base	*793*	*1680*	*1845*	*1545*	*1442*	*1267*	*8572*

Table 3.2 Prevalence of non-fatal suicidal behaviour by ethnicity and sex

	Ethnicity				
	White	Black	South Asian	Other	All*
	Cumulative percentage of population				
Men					
Suicidal thoughts					
Past week	0.3	-	-	-	0.3
Past year	3.9	0.6	0.6	-	3.6
Lifetime	13.1	4.1	4.4	16.2	12.7
Never	86.9	95.9	95.6	83.8	87.3
Suicide attempts					
Past week	0.0	-	-	-	0.0
Past year	0.5	-	0.6	-	0.5
Lifetime	3.6	1.8	0.6	10.0	3.6
Never	96.4	98.2	99.4	90.0	96.4
Deliberate self-harm without suicidal intent	2.1	0.7	-	2.9	2.0
Base	*3572*	*95*	*77*	*69*	*3848*
Women					
Suicidal thoughts					
Past week	0.6	0.7	-	-	0.5
Past year	4.1	3.1	3.1	3.8	4.1
Lifetime	17.4	12.7	12.3	14.5	17.1
Never	82.6	87.3	87.7	85.5	82.9
Suicide attempts					
Past week	0.0	-	-	-	0.0
Past year	0.5	-	-	2.4	0.5
Lifetime	5.3	3.7	5.8	4.9	5.3
Never	94.7	96.3	94.2	95.1	94.7
Deliberate self-harm without suicidal intent	2.7	3.4	3.2	-	2.7
Base	*4455*	*89*	*81*	*100*	*4724*
All					
Suicidal thoughts					
Past week	0.4	0.3	-	-	0.4
Past year	4.0	1.6	1.8	1.8	3.9
Lifetime	15.3	7.5	8.2	15.4	14.9
Never	84.7	92.5	91.8	84.6	85.1
Suicide attempts					
Past week	0.0	-	-	-	0.0
Past year	0.5	-	0.3	1.1	0.5
Lifetime	4.5	2.6	3.1	7.6	4.4
Never	95.5	97.4	96.9	92.4	95.6
Deliberate self-harm without suicidal intent	2.4	1.8	1.5	1.6	2.4
Base	*8027*	*184*	*158*	*139*	*8572*

* Includes those with no answer at ethnic origin.

Table 3.3 Prevalence of non-fatal suicidal behaviour by marital status and sex

	Marital Status					
	Married	Single	Separated	Divorced	Widowed	All
	Cumulative percentage of population					
Men						
Suicidal thoughts						
Past week	0.2	0.2	-	1.6	-	0.3
Past year	2.3	5.0	9.4	5.7	2.7	3.6
Lifetime	8.8	16.3	21.7	24.8	9.3	12.7
Never	91.2	83.7	78.3	75.2	90.7	87.3
Suicide attempts						
Past week	-	0.0	-	-	-	0.0
Past year	0.2	0.8	0.7	1.1	-	0.5
Lifetime	2.4	4.2	7.6	9.1	2.7	3.6
Never	97.6	95.8	92.4	90.9	97.3	96.4
Deliberate self-harm without suicidal intent	1.1	3.7	1.2	2.3	-	2.0
Base	*2010*	*1171*	*123*	*409*	*135*	*3848*
Women						
Suicidal thoughts						
Past week	0.4	0.8	0.8	0.6	0.5	0.5
Past year	2.2	7.0	8.7	4.9	5.6	4.1
Lifetime	13.2	21.7	27.4	27.6	13.1	17.1
Never	86.8	78.3	72.6	72.4	86.9	82.9
Suicide attempts						
Past week	-	0.1	-	-	-	0.0
Past year	0.2	1.2	1.2	1.1	0.2	0.5
Lifetime	3.3	7.5	10.1	11.4	3.2	5.3
Never	96.7	92.4	89.9	88.6	96.8	94.7
Deliberate self-harm without suicidal intent	1.4	5.7	3.7	3.0	0.6	2.7
Base	*2370*	*1104*	*237*	*572*	*441*	*4728*
All						
Suicidal thoughts						
Past week	0.3	0.5	0.5	1.0	0.4	0.4
Past year	2.3	5.9	9.0	5.3	4.9	3.9
Lifetime	11.0	18.7	25.2	26.3	12.2	14.9
Never	89.0	81.3	74.8	73.7	87.8	85.1
Suicide attempts						
Past week	-	0.1	-	-	-	0.0
Past year	0.2	1.0	1.0	1.1	0.1	0.5
Lifetime	2.8	5.7	9.2	10.4	3.1	4.4
Never	97.2	94.3	90.8	89.6	96.9	95.6
Deliberate self-harm without suicidal intent	1.3	4.6	2.8	2.7	0.4	2.4
Base	*4380*	*2275*	*360*	*981*	*576*	*8580*

Table 3.4 Prevalence of non-fatal suicidal behaviour by family type and sex

	Family Type						
	Couple, no child	Couple and child(ren)	Lone parent and child(ren)	One person only	Adult with parents	Adult with one parent	All
	Cumulative percentage of population						
Men							
Suicidal thoughts							
Past week	0.1	0.3	2.4	0.7	-	0.2	0.3
Past year	1.9	3.2	6.5	6.1	6.9	4.5	3.6
Lifetime	9.1	12.1	19.7	20.5	11.7	12.7	12.7
Never	90.9	87.9	80.3	79.5	88.3	87.3	87.3
Suicide attempts							
Past week	-	-	-	0.1	-	-	0.0
Past year	0.2	0.3	-	1.0	1.1	1.1	0.5
Lifetime	2.0	3.5	7.5	6.9	3.9	2.8	3.6
Never	98.0	96.5	92.5	93.1	96.1	97.2	96.4
Deliberate self-harm without suicidal intent	0.7	1.9	1.7	3.5	2.2	3.7	2.0
Base	*1242*	*1109*	*73*	*1029*	*82*	*313*	*3848*
Women							
Suicidal thoughts							
Past week	0.6	0.3	1.2	0.9	-	0.3	0.5
Past year	2.5	2.5	8.7	6.0	16.4	5.6	4.1
Lifetime	14.5	14.3	27.9	20.9	26.2	18.4	17.1
Never	85.5	85.7	72.1	79.1	73.8	81.6	82.9
Suicide attempts							
Past week	0.1	-	-	-	-	-	0.0
Past year	0.3	0.2	1.6	0.6	-	2.1	0.5
Lifetime	4.5	3.1	11.1	7.6	5.5	7.4	5.3
Never	95.5	96.9	88.9	92.4	94.5	92.6	94.7
Deliberate self-harm without suicidal intent	2.1	1.5	5.0	3.4	7.5	5.3	2.7
Base	*1430*	*1308*	*590*	*1153*	*38*	*205*	*4724*
All							
Suicidal thoughts							
Past week	0.3	0.3	1.4	0.8	-	0.3	0.4
Past year	2.2	2.8	8.4	6.0	9.8	4.9	3.9
Lifetime	11.8	13.2	26.7	20.7	16.2	14.9	14.9
Never	88.2	86.8	73.3	79.3	83.8	85.1	85.1
Suicide attempts							
Past week	0.0	-	-	0.0	-	-	0.0
Past year	0.2	0.2	1.3	0.8	0.8	1.5	0.5
Lifetime	3.2	3.3	10.6	7.2	4.4	4.6	4.4
Never	96.8	96.7	89.4	92.8	95.6	95.4	95.6
Deliberate self-harm without suicidal intent	1.4	1.7	4.5	3.5	3.9	4.4	2.4
Base	*2672*	*2417*	*663*	*2182*	*120*	*518*	*8580*

Table 3.5 Prevalence of non-fatal suicidal behaviour by educational qualifications and sex

	Educational qualifications						
	Degree	Teaching, HND, Nursing	A Level	GCSE A–C grades or equivalent	GCSE D–F grades or equivalent	No qualifications	All
	Cumulative percentage of population						
Men							
Suicidal thoughts							
Past week	0.4	0.3	-	0.1	0.3	0.6	0.3
Past year	3.8	1.7	3.9	4.4	2.5	3.4	3.6
Lifetime	12.8	10.8	15.8	13.8	11.5	10.6	12.7
Never	87.2	89.2	84.2	86.2	88.5	89.4	87.3
Suicide attempts							
Past week	-	-	-	-	-	0.1	0.0
Past year	0.4	0.3	0.2	0.4	0.5	0.9	0.5
Lifetime	2.9	0.7	3.4	3.7	4.5	4.4	3.6
Never	97.1	99.3	96.6	96.3	95.5	95.6	96.4
Deliberate self-harm without suicidal intent	1.6	1.5	2.2	2.0	3.3	1.8	2.0
Base	*661*	*271*	*585*	*855*	*393*	*1046*	*3848*
Women							
Suicidal thoughts							
Past week	0.6	-	0.3	0.5	0.6	0.7	0.5
Past year	3.5	2.3	4.4	3.8	4.6	4.8	4.1
Lifetime	19.1	15.4	17.5	18.5	16.9	15.4	17.1
Never	80.9	84.6	82.5	81.5	83.1	84.6	82.9
Suicide attempts							
Past week	0.2	-	-	-	-	-	0.0
Past year	0.3	0.2	0.3	0.4	1.4	0.6	0.5
Lifetime	3.2	3.8	4.2	6.3	6.7	5.6	5.3
Never	96.8	96.2	95.8	93.7	93.3	94.4	94.7
Deliberate self-harm without suicidal intent	2.6	1.7	2.1	3.1	2.5	3.0	2.7
Base	*577*	*343*	*543*	*1170*	*546*	*1518*	*4724*
All							
Suicidal thoughts							
Past week	0.5	0.1	0.1	0.3	0.5	0.7	0.4
Past year	3.7	2.0	4.1	4.1	3.7	4.2	3.9
Lifetime	15.5	13.1	16.5	16.2	14.4	13.2	14.9
Never	84.5	86.9	83.5	83.8	85.6	86.8	85.1
Suicide attempts							
Past week	0.1	-	-	-	-	0.0	0.0
Past year	0.3	0.2	0.3	0.4	1.0	0.7	0.5
Lifetime	3.0	2.3	3.8	5.1	5.7	5.1	4.4
Never	97.0	97.7	96.2	94.9	94.3	94.9	95.6
Deliberate self-harm without suicidal intent	2.1	1.6	2.1	2.6	2.9	2.4	2.4
Base	*1238*	*614*	*1128*	*2025*	*939*	*2564*	*8580*

Table 3.6 Prevalence of non-fatal suicidal behaviour by economic activity and sex

	Economic activity				
	Employed full time	Employed part time	Unemployed	Inactive	All
	Cumulative percentage of population				
Men					
Suicidal thoughts					
Past week	0.1	-	-	0.9	0.3
Past year	2.9	4.3	4.2	5.3	3.6
Lifetime	11.9	14.9	21.2	12.9	12.7
Never	88.1	85.1	78.8	87.1	87.3
Suicide attempts					
Past week	-	-	-	0.1	0.0
Past year	0.2	0.2	0.4	1.3	0.5
Lifetime	2.8	3.7	5.5	5.3	3.6
Never	97.2	96.3	94.5	94.7	96.4
Deliberate self-harm without suicidal intent	1.8	2.4	3.0	2.4	2.0
Base	*2352*	*285*	*145*	*1030*	*3848*
Women					
Suicidal thoughts					
Past week	0.4	0.2	2.3	0.8	0.5
Past year	3.1	4.3	10.6	4.5	4.1
Lifetime	15.8	15.9	27.3	18.6	17.1
Never	84.2	84.1	72.7	81.4	82.9
Suicide attempts					
Past week	-	0.1	-	-	0.0
Past year	0.2	0.9	1.1	0.6	0.5
Lifetime	4.3	4.2	15.9	6.4	5.3
Never	95.7	95.8	84.1	93.6	94.7
Deliberate self-harm without suicidal intent	1.9	2.9	9.2	2.9	2.7
Base	*1462*	*1168*	*114*	*1953*	*4724*
All					
Suicidal thoughts					
Past week	0.0	0.0	0.9	0.8	0.4
Past year	2.9	4.3	6.6	4.8	3.9
Lifetime	13.2	15.7	23.4	16.4	14.9
Never	86.8	84.3	76.6	83.6	85.1
Suicide attempts					
Past week	-	0.1	-	0.0	0.0
Past year	0.2	0.7	0.7	0.9	0.5
Lifetime	3.3	4.1	9.3	6.0	4.4
Never	96.7	95.9	90.7	94.0	95.6
Deliberate self-harm without suicidal intent	1.8	2.8	5.3	2.7	2.4
Base	*3814*	*1453*	*259*	*2983*	*8580*

Table 3.7 Prevalence of non-fatal suicidal behaviour by social class and sex

	Social Class						
	I	II	IIINM	IIIM	IV	V	All*
	Cumulative percentage of population						
Men							
Suicidal thoughts							
Past week	0.3	0.3	-	0.2	0.5	0.7	0.3
Past year	4.0	2.4	5.0	3.0	5.5	5.4	3.6
Lifetime	12.5	11.4	15.3	11.9	14.9	16.2	12.7
Never	87.5	88.6	84.7	88.1	85.1	83.8	87.3
Suicide attempts							
Past week	-	-	-	-	0.1	-	0.0
Past year	-	0.1	-	0.4	1.1	2.4	0.5
Lifetime	0.8	2.3	4.3	4.0	5.1	8.4	3.6
Never	99.2	97.7	95.7	96.0	94.9	91.6	96.4
Deliberate self-harm without suicidal intent	1.1	1.4	2.6	1.4	3.4	4.2	2.0
Base	*304*	*1157*	*409*	*1116*	*533*	*165*	*3848*
Women							
Suicidal thoughts							
Past week	0.8	0.4	0.3	0.1	1.2	0.5	0.5
Past year	1.2	2.5	4.6	2.9	5.4	5.8	4.0
Lifetime	17.8	15.6	16.8	17.0	18.9	19.2	17.1
Never	82.2	84.4	83.2	83.0	81.1	80.8	82.9
Suicide attempts							
Past week	0.0	0.1	-	-	-	-	0.0
Past year	0.4	0.2	0.5	0.8	0.6	1.7	0.5
Lifetime	3.0	3.6	4.5	7.5	6.4	10.2	5.2
Never	97.0	96.4	95.5	92.5	93.6	89.8	94.8
Deliberate self-harm without suicidal intent	5.6	1.5	2.4	2.9	4.2	1.3	2.7
Base	*115*	*1279*	*1612*	*388*	*831*	*325*	*4724*
All							
Suicidal thoughts							
Past week	0.4	0.3	0.3	0.2	0.9	0.6	0.4
Past year	3.3	2.5	4.7	3.0	5.4	5.7	3.9
Lifetime	13.8	13.4	16.4	13.0	17.1	18.1	14.9
Never	86.2	86.6	83.6	87.0	82.9	81.9	85.1
Suicide attempts							
Past week	-	0.0	-	-	0.1	-	0.0
Past year	0.1	0.2	0.4	0.4	0.8	1.9	0.5
Lifetime	1.3	2.9	4.5	4.7	5.9	9.5	4.4
Never	98.7	97.1	95.5	95.3	94.1	90.5	95.6
Deliberate self-harm without suicidal intent	2.2	1.5	2.4	1.8	3.9	2.4	2.4
Base	*419*	*2436*	*2021*	*1504*	*1364*	*490*	*8580*

* Includes Armed Forces/No answer.

Table 3.8 Prevalence of non-fatal suicidal behaviour by occupational group and sex

	Occupational group										
	Managers and Administrators	Professional Occupation	Associate professional and Technical	Clerical, secretarial	Craft related	Personal, protective	Sales Occupation	Plant and Machine operators	Other Occupations	Not employed	All
	Cumulative percentage of population										
Men											
Suicidal thoughts											
Past week	0.1	0.3	0.4	-	-	-	-	-	0.3	0.8	0.3
Past year	2.4	2.5	3.3	4.3	1.5	4.3	5.2	3.5	4.1	5.1	3.6
Lifetime	12.8	10.7	13.2	17.6	11.1	11.5	11.4	11.7	10.7	14.1	12.7
Never	87.2	89.3	86.8	82.4	88.9	88.5	88.6	88.3	89.3	85.9	87.3
Suicide attempts											
Past week	-	-	-	-	-	-	-	-	-	0.1	0.0
Past year	-	-	-	-	-	0.3	-	0.9	1.2	1.2	0.5
Lifetime	2.5	0.9	2.7	6.0	2.4	2.5	3.0	4.1	3.5	5.4	3.6
Never	97.5	99.1	97.3	94.0	97.6	97.5	97.0	95.9	96.5	94.6	96.4
Deliberate self-harm without suicidal intent	1.2	1.0	2.6	3.9	2.0	3.4	1.9	1.2	1.0	2.5	2.0
Base	*544*	*317*	*272*	*193*	*488*	*160*	*145*	*352*	*165*	*1175*	*3848*
Women											
Suicidal thoughts											
Past week	0.1	0.8	0.2	0.2	2.4	0.3	-	1.2	0.2	0.9	0.5
Past year	3.0	1.5	1.8	4.8	6.0	3.7	5.5	2.5	3.1	4.8	4.1
Lifetime	15.9	16.7	13.8	16.3	31.1	13.5	17.5	20.8	12.5	19.1	17.1
Never	84.1	83.3	86.2	83.7	68.9	86.5	82.5	79.2	87.5	80.9	82.9
Suicide attempts											
Past week	-	0.4	-	-	-	-	-	-	-	-	0.0
Past year	-	0.8	0.2	0.7	-	0.3	0.5	-	1.3	0.6	0.5
Lifetime	3.1	4.1	2.6	3.2	9.2	4.5	5.9	6.4	6.6	6.9	5.3
Never	96.9	95.9	97.4	96.8	90.8	95.5	94.1	93.6	93.4	93.1	94.7
Deliberate self-harm without suicidal intent	1.9	2.6	1.1	2.0	3.4	3.9	3.0	2.3	1.8	3.2	2.7
Base	*359*	*281*	*314*	*628*	*43*	*400*	*303*	*93*	*209*	*2067*	*4724*
All											
Suicidal thoughts											
Past week	0.1	0.5	0.3	0.2	0.2	0.2	-	0.2	0.3	0.8	0.4
Past year	2.6	2.1	2.6	4.7	1.8	3.9	5.4	3.3	3.6	4.9	3.9
Lifetime	13.9	13.3	13.5	16.7	12.6	12.8	15.2	13.4	11.6	17.1	14.9
Never	86.1	86.7	86.5	83.3	87.4	87.2	84.8	86.6	88.4	82.9	85.1
Suicide attempts											
Past week	-	0.2	-	-	-	-	-	-	-	0.0	0.0
Past year	-	0.3	0.1	0.5	-	0.3	0.3	0.8	1.3	0.9	0.5
Lifetime	2.7	2.2	2.7	4.0	2.9	3.8	4.8	4.5	5.0	6.3	4.4
Never	97.3	97.8	97.3	96.0	97.1	96.2	95.2	95.5	95.0	93.7	95.6
Deliberate self-harm without suicidal intent	1.4	1.7	1.9	2.5	2.1	3.7	2.6	1.4	1.4	2.9	2.4
Base	*903*	*598*	*586*	*821*	*531*	*560*	*448*	*445*	*374*	*3242*	*8580*

Table 3.9 Prevalence of non-fatal suicidal behaviour by tenure and sex

	Tenure				
	Owned outright	Owned with mortgage	Rented from LA or HA	Rented from other source	Total
	Cumulative percentage of population				
Men					
Suicidal thoughts					
Past week	-	0.3	0.7	0.3	0.3
Past year	1.1	3.4	6.8	5.6	3.6
Lifetime	7.7	11.7	20.5	17.0	12.7
Never	92.3	88.3	79.5	83.0	87.3
Suicide attempts					
Past week	-	-	0.1	-	0.0
Past year	0.2	0.3	1.7	0.2	0.5
Lifetime	2.0	2.6	9.2	3.2	3.6
Never	98.0	97.4	90.8	96.8	96.4
Deliberate self-harm without suicidal intent	0.8	1.6	3.9	3.9	2.0
Base	*964*	*1812*	*655*	*371*	*3848*
Women					
Suicidal thoughts					
Past week	0.3	0.4	1.1	0.9	0.5
Past year	2.2	3.9	6.3	5.9	4.1
Lifetime	11.9	15.8	24.9	22.7	17.1
Never	88.1	84.2	75.1	77.3	82.9
Suicide attempts					
Past week	-	-	-	0.3	0.0
Past year	0.1	0.4	1.5	0.3	0.5
Lifetime	2.3	3.8	12.1	7.4	5.3
Never	97.7	96.2	87.9	92.6	94.7
Deliberate self-harm without suicidal intent	1.0	2.2	4.2	7.1	2.7
Base	*1238*	*2045*	*1000*	*407*	*4724*
All					
Suicidal thoughts					
Past week	0.2	0.4	0.9	0.6	0.4
Past year	1.7	3.6	6.5	5.7	3.9
Lifetime	9.8	13.7	22.9	19.7	14.9
Never	90.2	86.3	77.1	80.3	85.1
Suicide attempts					
Past week	-	-	0.0	0.1	0.0
Past year	0.2	0.4	1.6	0.2	0.5
Lifetime	2.1	3.2	10.8	5.2	4.4
Never	97.9	96.8	89.2	94.8	95.6
Deliberate self-harm without suicidal intent	0.9	1.9	4.0	5.4	2.4
Base	*2202*	*3857*	*1655*	*778*	*8580*

Table 3.10 Socio-demographic and socio-economic characteristics

by lifetime suicidal thoughts

	Suicidal thoughts in lifetime		
	Yes	No	All
	%	%	%
Sex			
Male	43	51	50
Female	57	49	50
Age			
16–24	17	14	15
25–34	25	20	20
35–44	24	20	21
45–54	18	18	18
55–64	11	15	14
65–74	4	13	11
Ethnicity			
White	96	93	93
West Indian or African	1	2	2
Asian or Oriental	2	3	3
Other	2	2	2
Marital status			
Married/cohabiting	41	59	56
Separated	5	2	3
Single	37	28	30
Divorced	14	7	8
Widowed	3	4	4
Family type			
Couple, no dependent child	24	32	31
Couple with dependent child	31	36	35
Lone parent with dependent child	9	4	5
One person only	22	15	16
Adult with parents	3	3	3
Adult with one parent	10	10	10
Highest level of educational qualifications			
Degree	15	14	15
Teaching, HND, nursing	6	7	7
A Level	16	14	15
GCSE A–C grades or equivalent	28	25	25
GCSE D–F grades or equivalent	10	11	11
No qualifications	24	28	27
Economic activity			
Employed full time	43	50	49
Employed part time	19	18	18
Unemployed	5	3	3
Inactive	33	29	30
Social Class			
I	5	5	5
II	26	30	29
IIINM	27	24	25
IIIM	17	20	19
IV	19	16	16
V	7	5	6
Armed forces	-	0	0
Occupational group			
Managers and administrators	10	11	11
Professional occupations	6	7	7
Associate professional and technical	6	7	7
Clerical, secretarial	12	10	10
Craft and related	6	7	7
Personal, protective	6	7	7
Sales occupations	6	6	6
Plant and machine operators	6	6	6
Other occupations	4	5	5
Not employed	38	32	33
Tenure			
Owns–outright	16	25	24
Owns–mortgage	45	50	49
Rents–LA/HA	26	16	17
Rents–privately	13	9	10
Base	*1380*	*7192*	*8572*

Table 3.11 Socio-demographic and socio-economic characteristics

by lifetime suicide attempts

	Suicide attempt in lifetime		
	Yes	No	All
	%	%	%
Sex			
Male	40	50	50
Female	60	50	50
Age			
16–24	17	15	15
25–34	28	20	20
35–44	24	21	21
45–54	18	18	18
55–64	9	14	14
65–74	4	12	11
Ethnicity			
White	94	93	93
West Indian or African	1	2	2
Asian or Oriental	2	3	3
Other	3	2	2
Marital status			
Married/cohabiting	36	57	56
Separated	6	3	3
Single	38	29	30
Divorced	19	8	8
Widowed	3	4	4
Family type			
Couple, no dependent child	22	31	31
Couple with dependent child	26	35	35
Lone parent with dependent child	12	5	5
One person only	26	16	16
Adult with parents	3	3	3
Adult with one parent	10	10	10
Highest level of educational qualifications			
Degree	10	15	15
Teaching, HND, nursing	4	7	7
A Level	12	15	15
GCSE A–C grades or equivalent	29	25	25
GCSE D–F grades or equivalent	14	11	11
No qualifications	31	27	27
Economic activity			
Employed full time	36	50	49
Employed part time	17	18	18
Unemployed	6	3	3
Inactive	40	30	30
Social Class			
I	2	5	5
II	19	30	29
IIINM	25	25	25
IIIM	20	19	19
IV	22	16	16
V	12	5	6
Armed forces	–	0	0
Occupational group			
Managers and administrator	7	11	11
Professional occupations	4	7	7
Associate professional and technical	4	7	7
Clerical, secretarial	9	10	10
Craft and related	5	7	7
Personal, protective	6	7	7
Sales occupations	7	6	6
Plant and machine operators	6	6	6
Other occupations	6	5	5
Not employed	47	32	33
Tenure			
Owns–outright	11	24	24
Owns–mortgage	36	50	49
Rents–LA/HA	42	16	17
Rents–privately	12	10	10
Base	*430*	*8141*	*8572*

Table 3.12 Socio-demographic and socio-economic characteristics

by lifetime deliberate self-harm

	Deliberate self harm in lifetime		
	Yes	No	All
	%	%	%
Sex			
Male	43	50	50
Female	57	50	50
Age			
16–24	33	14	15
25–34	34	20	20
35–44	20	21	21
45–54	7	18	18
55–64	5	14	14
65–74	1	12	11
Ethnicity			
White	95	93	93
West Indian or African	2	2	2
Asian or Oriental	2	3	3
Other	1	2	2
Marital status			
Married/cohabiting	30	57	56
Separated	3	3	3
Single	57	29	30
Divorced	9	8	8
Widowed	1	4	4
Family type			
Couple, no dependent child	18	31	31
Couple with dependent child	25	35	35
Lone parent with dependent child	10	5	5
One person only	24	16	16
Adult with parents	5	3	3
Adult with one parent	18	10	10
Highest level of educational qualifications			
Degree	13	15	15
Teaching, HND, nursing	5	7	7
A Level	13	15	15
GCSE A–C grades or equivalent	28	25	25
GCSE D–F grades or equivalent	13	11	11
No qualifications	28	27	27
Economic activity			
Employed full time	38	49	49
Employed part time	22	18	18
Unemployed	7	3	3
Inactive	34	30	30
Social Class			
I	5	5	5
II	19	29	29
IIINM	27	25	25
IIIM	15	19	19
IV	28	16	16
V	6	6	6
Armed forces	–	0	0
Occupational group			
Managers and administrators	7	11	11
Professional occupations	5	7	7
Associate professional and technical	6	7	7
Clerical, secretarial	11	10	10
Craft and related	6	7	7
Personal, protective	11	7	7
Sales occupations	7	6	6
Plant and machine operators	4	6	6
Other occupations	3	5	5
Not employed	41	33	33
Tenure			
Owns–outright	9	24	24
Owns–mortgage	39	49	49
Rents–LA/HA	29	17	17
Rents–privately	23	10	10
Base	*200*	*8375*	*8572*

Table 3 .13 Type and resaons for deliberate self-harm

by sex

	Men	Women	All
	Percentage		
How harmed self*			
Cut self	59	66	63
Swallowed object	12	15	14
Burnt self	4	8	6
Harmed self in other way	38	28	32
Reason for self-harm*			
To draw attention	58	54	56
Because of anger	68	80	75
Base	*71*	*122*	*193*

* Respondents could give more than one answer.

4 Psychiatric disorders and suicidal behaviour

4.1 Concepts and methods of assessment

In this chapter, two questions are addressed:

- To what extent does non-fatal suicidal behaviour differ by the presence or absence of mental disorders?

- What are the psychiatric characteristics of those who have had lifetime experience of suicidal thoughts, suicidal attempts and deliberate self-harm compared with those who have not?

The answer to the first question is given by presenting prevalence statistics on suicidal thoughts, behaviour and deliberate self-harm by the prevalence or severity of neurotic disorders, psychotic disorders, alcohol and drug dependence, (Section 4.2).

The second question is answered by using the same data as above but reversing the roles of the dependent and independent variables. Thus, we compare the distributions of the psychiatric characteristics of those who had lifetime experiences of suicidal thoughts, behaviour and deliberate self-harm with those who had not.

Range of mental disorders

The content of the 2000 survey governed the range of psychiatric disorders covered in this report. Therefore, the first part of this chapter shows the presence of non-fatal suicidal behaviour by (a) neurotic symptoms and disorders, (b) psychotic disorder, (c) alcohol use and dependence, and (d) drug dependence. A brief summary of how these disorders were assessed is given below. A fuller explanation can be found in the main report (Singleton *et al* 2001). Although Personality Disorder was covered in the original survey, a separate report focussing on this topic will be produced and is not covered here.

Neurotic symptoms and disorders

Neurotic symptoms and disorders in the week preceding interview were assessed in the 2000 ONS survey using the revised version of the Clinical Interview Schedule, CIS-R (Lewis and Pelosi 1990, Lewis *et al* 1992). Data are presented on the prevalence of non-fatal suicidal behaviour by 14 neurotic symptoms, the distribution of total CIS-R scores, which give an indication of severity of symptoms , six neurotic disorders and the number of neurotic disorders.

The CIS-R comprises 14 sections, each covering a particular area of neurotic symptoms as follows:

- Somatic symptoms.
- Fatigue.
- Concentration and forgetfulness.
- Sleep problems.
- Irritability.
- Worry about physical health.
- Depression.
- Depressive ideas.
- Worry.
- Anxiety.
- Phobias.
- Panic.
- Compulsions.
- Obsessions.

Each section begins with a number of mandatory filter questions. They establish the existence of a particular neurotic symptom in the past month. A positive response leads to a more detailed assessment of the symptom in the past week: frequency, duration, severity, and time since onset. Answers to these questions determine the informant's score on each section. Possible scores range from zero to 4 on each section (except the section on depressive ideas, which has a maximum score of 5).

Specific neurotic disorders were assessed by looking at the answers to various sections of the CIS-R and applying algorithms based on the ICD-10 diagnostic criteria for research (World Health Organisation 1992).

Six diagnostic categories can be obtained from the CIS-R:

- Generalised Anxiety Disorder.
- Depressive episode.
- Phobias.
- Obsessive Compulsive Disorder.
- Panic disorder.
- Mixed anxiety and depressive disorder.

Because an individual may appear in more than one category of neurotic disorder, it is possible to assign to each respondent a score indicating how many of the diagnostic algorithms correspond to the report of their symptoms.

Psychotic disorder

Making assessments of psychotic rather than neurotic disorders is more problematic for lay interviewers. Neurotic symptoms were assessed by fully structured questions. These rely on the understanding of the questions by the respondent and on their insight and willingness to acknowledge these kinds of mental health problems. A structured questionnaire is too restrictive for assessing psychotic symptoms which, by definition, involve some element of departure from reality and psychological insight.

Thus the person with a neurotic symptom typically is aware that they should not have some disagreeable feelings and thoughts but has difficulty in over coming them.

In contrast, among people with psychosis, the unusual thoughts and experiences described seem real to the sufferer who may even act inappropriately because of this. Accurately assessing this required a process of questioning and clinical judgement by an interviewer. The approach used involved a semi-structured interview by a clinically experienced interviewer who decided which symptoms were present. Each symptom is defined in a glossary of definitions and is rated according to defined thresholds of severity.

A two-stage approach was therefore adopted to assess the presence of psychotic disorder. The criteria from the initial lay interview which were considered indicative of possible psychotic disorder were:

- Self-report, at questions about long-standing illness or reasons for consulting a GP, of symptoms suggestive of psychotic disorder, eg mood swings, or having been given a diagnosis of psychotic disorder, such as schizophrenia or manic depression.
- Taking anti-psychotic medication.
- A history of admission to a mental hospital or ward.
- A positive response to question 5a of the psychosis screening questionnaire which asks about hearing voices.

A positive response on any one of these criteria led to selection for a second stage interview using the Schedule for Clinical Assessment in Neuropsychiatry, SCAN (Wing *et al* 1990, World Health Organisation, 1999). A sample of people who screened negative were also interviewed at the second stage, either because they sifted positive for personality disorder or because they were selected from the group who screened negative for both types of disorder.

Therefore, in the current survey, an assessment of probable psychosis was given to those who screened positive for psychosis and were either assessed as having a psychotic disorder at SCAN interview or, if no SCAN interview had been conducted, who reported two or more of the above criteria at initial interview. People who screened negative for psychosis were designated unlikely to have psychotic disorder

Alcohol problems and dependence

The principal instrument used to assess alcohol problems was the Alcohol Use Disorders Identification Test, AUDIT (Babor *et al* 1992). This measure was developed from a six-country WHO collaborative project and has been shown to be a good indicator of hazardous drinking (Saunders *et al* 1993). It defines hazardous alcohol use as an established pattern of drinking which brings the risk of physical and psychological harm. Taking the year before interview as a reference period, the AUDIT

consists of 10 questions covering the following topics:

- Hazardous alcohol consumption:
  - frequency of drinking;
  - typical quantity; and
  - frequency of heavy drinking.
- Dependence symptoms:
  - impaired control over drinking;
  - increased salience of drinking; and
  - morning drinking.
- Harmful alcohol consumption:
  - feeling of guilt or remorse after drinking;
  - blackouts;
  - alcohol-related injury; and
  - other concerns about drinking.

Answers to all questions are scored from zero to 4 and then summed to provide a total score ranging from zero to 40. A total score of 8 is indicative of hazardous alcohol use.

The prevalence of alcohol dependence was assessed using the Severity of Alcohol Dependence questionnaire, SAD-Q. (Stockwell *et al*, 1983). The SAD-Q was asked of all respondents who had an AUDIT score of 10 or more. It consists of 20 questions, covering a range of symptoms of dependence, and possible scores range from 0 to 3 on each question. Adding up the scores from all questions gives a total SAD score of between zero and 60 indicating different levels of alcohol dependence. A total SAD score of 3 or less indicates no dependence, while a score of four or above suggests some alcohol dependence. Mild dependence is indicated by a score of between 4 and 19, moderate dependence by a score of 20 to 34, and severe dependence by a SAD score of 35 to 60. The reference period for alcohol dependence was the 6 months prior to interview.

Drug dependence

A number of questions designed to measure drug use were contained in the questionnaire. Information was first collected on all the types of drugs respondents had ever used, and then about drugs used in the previous year. Further information about drug use in the year, and month, preceding interview was collected about six drugs: cannabis, amphetamines, crack, cocaine, ecstasy, tranquillisers and opiates. Included in the questions about drug use in the past year and month were five questions to measure drug dependence. The topics covered by these questions are:

- Frequency of drug use: used drug every day for two weeks or more.
- Stated dependence: felt they needed it or were dependent on it.
- Inability to cut down: tried to cut down but could not.
- Need for larger amounts: needed more to get an effect.
- Withdrawal symptoms: feeling sick because stopped or cut down.

A positive response to any of the five questions was used to indicate drug dependence. Because people could be dependent on more than one drug, they were further grouped into those who were:

- dependent on cannabis only;
- dependent on another drug (including those also dependent on cannabis); and
- not drug dependent.

4.2 Prevalence of non-fatal suicidal behaviour and deliberate self-harm

Neurotic symptoms and disorders

The prevalence of lifetime suicidal thoughts, attempts and deliberate self-harm is vastly increased among those with any neuropsychopathology compared with those with no neurotic symptoms even though the assessment of significant neurotic symptoms related to the seven days before interview.

For example, just less than 1% of the sample who reported no neurotic symptoms also mentioned that they had attempted suicide some time in their life. In contrast around 20% of respondents assessed as having significant symptom levels of panic, phobias and depressive ideas, just in the week prior to interview, stated that they had made a suicide attempt. The corresponding proportions in relation to lifetime suicidal thoughts were 5%

among the symptom-free group and at least 40% of those with panic, phobic symptoms, depressive ideas, obsessions and compulsions. These huge differences in proportions also occurred for the answers to the questions about deliberate self harm (without suicidal intent). Among the group with no neurotic symptoms, less than 1% said that they had deliberately tried to harm themselves whereas among the group with panic and phobic symptoms, the proportions rose to 16% and 13% respectively. The nature and magnitude of these differences were evident for both men and women. *(Table 4.1)*

One way of examining the relationship between suicidal thoughts and behaviour and all the 14 neurotic symptoms is to compare lifetime prevalence of non-fatal suicidal behaviour by the total CIS-R score. This shows very clearly that the likelihood of suicidal thoughts, attempts and self-harm increases dramatically with the number of significant symptoms. Looking at the extremes of the distributions of the total CIS-R score shows that the lifetime prevalence of suicidal attempts and of thoughts among those scoring 0–5 on the CIS-R was 1% and 7%. These rose to 10% and 33% of those with scores in the range 12–17 and further increased to 22% and 49% among those who scored 18 and over. *(Figure 4.1)*

Among women scoring 18 and over on the CIS-R, about a quarter had at one time made a suicide attempt compared with a fifth of the men, and in this group at least 1 in 10 men and women had tried to harm themselves at some time, without suicidal intent. *(Table 4.2)*

One might have expected that the sample with depressive episode would have shown the highest rates of non-fatal suicidal behaviour, as thoughts of death are included among the symptoms of major depression. Compared with the non-disorder group (which had a 10% prevalence of lifetime suicidal thoughts and 2% of suicidal attempts) the rates for those with depressive episode were indeed higher, 52% and 25%. However the highest rates of suicidal thoughts were found among the group with OCD, a 64% lifetime prevalence, reflecting the clinical experience that people with obsessions tend to be preoccupied with death. Between 25 and 30 per cent of those with phobia, OCD and depressive disorder had attempted to kill themselves in their lifetime including 5–6% in the past year. *(Figure 4.2)*

Kessler *et al* (1999) also found that every one of the DSM-III-R disorders was a significant risk factor for a lifetime suicide attempt

The one mental disorder that stands out from the rest in terms of its relationship with deliberate self harm is phobia. Twenty-three per cent of the survey sample with an imputed diagnosis of phobia had at one time self-harmed. A similar proportion was found for men and women. Among the group

Figure 4.1 Non-fatal suicidal behaviour by CIS-R score

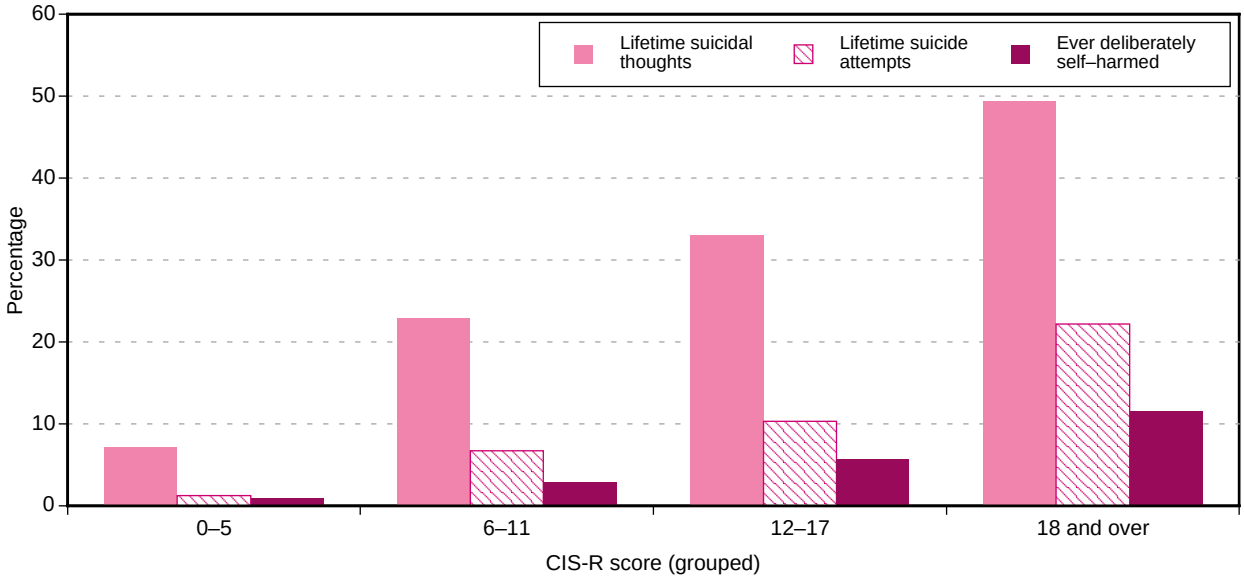
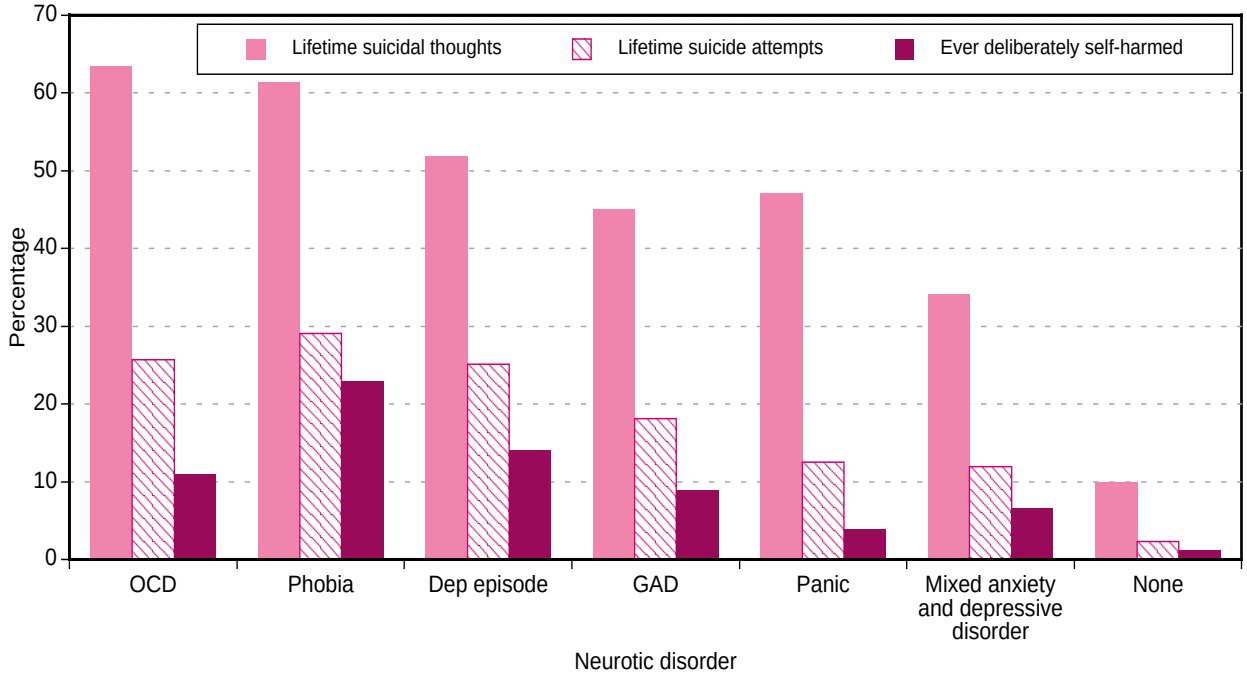


Figure 4.2 Non-fatal suicidal behaviour by type of neurotic disorder



without any of the neurotic disorders, the rate was 1%. *(Table 4.3)*

The co-occurrence of neurotic disorders has a very marked effect on suicidal behaviour. Although the group who have more than one neurotic disorder represent a small proportion of the total population, about one and a half percent of the survey sample, they have significantly higher rates of non-fatal suicidal behaviour. Focussing on the lifetime prevalence of suicidal thoughts, the rate increased from 1 in 10 of the no-disorder group to a third of those with one disorder, half of the group with 2 disorders and around three-quarters of the small sample with three or more neurotic disorders. The corresponding rates for lifetime suicidal attempts were 2%,14%, 21% and 40%. A similar trend was evident for deliberate self harm without suicidal intent, with the highest lifetime rate of 30% found among those with three or more neurotic disorders. *(Table 4.4)*

Psychosis

The increased rate of suicide attempts among patients with psychosis has been well documented. Dyck *et al* (1988) found that patients with schizophrenia to have the highest relative risk of attempted suicide among groups with different mental disorders. More recently, Walsh *et al* (1999) conducted a study to estimate the prevalence and risk factors for parasuicide in a large community based sample of patients with chronic psychosis. They found a two year prevalence of parasuicide of 19%. Those who attempted suicide were significantly more likely to be younger, of white ethnic origin, to have a diagnosis of affective disorder, to be currently depressed, to have experienced more auditory hallucinations and to have received treatment with anti-psychotic drugs for a longer period.

Among the 60 respondents given an assessment in the current survey as possibly having a psychotic disorder, just over two-thirds had thought about suicide, and just over a half had attempted it. In addition about a quarter of this group had deliberately harmed themselves with no suicidal intent.

Although women who are likely to have a psychotic disorder seemed to have more prevalent non-fatal suicidal behaviour than their male counterparts, the number of cases in each group, 30, makes it difficult to know if this is a real difference.

The lifetime prevalence of just over 50% for suicidal attempts for people with psychosis is far higher than that for any of the neurotic disorders; those with phobia and OCD had equivalent rates of just less than 30%. *(Table 4.5)*

Alcohol problems and dependence

Minor levels of alcohol problems increase suicidal behaviour a little for women, but the real impact comes with severe alcohol problems for both sexes. There is a three to four-fold increase in the likelihood of exhibiting non-fatal suicidal behaviour among those who have major alcohol problems (AUDIT score = 16–40) compared to those who do not (AUDIT score = 0–7). In this group, about a third had at some time thought about suicide, about 1 in 8 had actually attempted it and around 1 in 12 had deliberately self-harmed. *(Table 4.6)*

There was a clear pattern to the results for alcohol dependence. The impact of alcohol dependence on non-fatal suicidal behaviour was most clearly seen when comparing those with moderate or severe dependence with the sample rated as non- or mildly dependent. For example, among the non-alcohol dependent group, about 14% had ever thought about suicide, this proportion nearly doubled among those who were moderately dependent, 27%, and the rate doubled again among the severely dependent group, 57%. The corresponding figures for lifetime suicide attempts were 4%, 9% and 24%, and for deliberate self-harm, 2%, 7% and 22%. *(Table 4.7)*

Looking at hazardous use and alcohol dependence together, it is alcohol dependence rather than hazardous drinking that has the most pronounced effect on the prevalence of suicidal thoughts and behaviour. *(Table 4.8)*

Drug dependence

The picture for drug dependence in relation to non-fatal suicidal behaviour is similar to that for neurosis, psychosis and alcohol dependence. Those who were dependent on drugs other than cannabis were around five times more likely than the non-dependent group to have ever attempted suicide, 20% compared with 4%, and to have deliberately harmed themselves, 11% compared with 2%. *(Table 4.9)*

4.3 Psychiatric characteristics of those with lifetime suicidal experiences

Lifetime suicidal thoughts

The sample of respondents who reported ever having had suicidal thoughts were more likely than the rest of the sample to have reported neurotic symptoms, even though these were just assessed in the week before interview. They were at least twice as likely to have a score of two or more for all of the 14 neurotic symptoms and four times more likely to have a CIS-R score at or above the threshold score of 12 (41% compared with 10%)

Whereas 1% or less of the group who had never thought about suicide had depressive episodes, phobias, OCD and panic disorder, in the group where such thoughts existed, the rate for depression was 9%, phobia 7% and OCD, 5%. In this latter group, 10% were assessed as having more than one neurotic disorder compared with 1% of the former group. *(Table 4.10)*

The respondents who had thought about suicide compared with those who had not were far more likely to have been assessed as being alcohol dependent, 14% compared with 6%, and drug dependent, 10% compared with 3%. *(Table 4.11)*

Lifetime suicidal attempts

The differences in psychiatric morbidity according to whether or not suicide had ever been attempted were even more marked than for suicidal thoughts. Among those who had ever attempted suicide, 56% were categorised as having a neurotic disorder, 6% probably had a psychotic disorder, 17% were alcohol dependent and 14% were drug dependent. Of those who had never attempted suicide, the prevalence of any neurotic disorder was 15%, less than half a percent had psychosis, 7% were alcohol dependent and 3% drug dependent. *(Tables 4.12 and 4.13)*

Lifetime deliberate self-harm

The psychiatric characteristics of those who had tried to harm themselves without suicidal intent were remarkably similar to those who had attempted

suicide: 57% had a neurotic disorder, 6% were categorised as psychotic, 24% as alcohol dependent and 16% as drug dependent. *(Tables 4.14 and 4.15)*

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Table 4.1 Prevalence of non-fatal suicidal behaviour by neurotic symptoms and sex

	Neurotic Symptoms															
	Panic	Phobias	Depressive ideas	Compulsions	Obsessions	Concentration forgetfulness	Anxiety	Depression	Worry/ physical health	Worry	Irritability	Somatic symptoms	Fatigue	Sleep problems	No Neurotic symptoms	All
	Cumulative percentage of population															
Men																
Suicidal thoughts																
Past week	4.1	2.6	3.7	1.7	4.4	1.5	2.4	2.6	2.5	1.5	1.4	2.1	1.1	1.0	-	0.3
Past year	27.9	22.9	24.6	16.7	22.9	16.0	16.9	15.9	13.1	12.6	12.7	14.7	10.1	10.0	0.2	3.6
Lifetime	58.7	47.1	44.3	32.4	38.7	34.5	37.7	33.3	28.4	30.5	30.6	31.4	27.5	25.4	4.5	12.7
Never	41.3	52.9	55.7	67.6	61.3	65.5	62.3	66.7	71.6	69.5	69.4	68.6	72.5	74.6	95.5	87.3
Suicide attempts																
Past week	0.8	0.5	0.2	-	-	-	-	0.2	-	-	0.1	0.3	0.1	-	-	0.0
Past year	4.1	4.4	3.2	0.5	3.8	1.9	2.0	1.4	1.6	1.7	2.0	2.0	1.8	1.4	-	0.5
Lifetime	19.3	18.4	16.4	11.7	12.8	14.0	14.8	11.9	10.0	10.3	10.5	9.3	10.5	8.7	0.9	3.6
Never	80.7	81.6	83.6	88.3	87.2	86.0	85.2	88.1	90.0	89.7	89.5	90.7	89.5	91.3	99.1	96.4
Deliberate self-harm without suicidal intent	17.5	13.0	7.2	4.4	7.8	6.9	7.7	5.9	5.9	4.3	5.5	5.2	5.3	4.8	0.8	2.0
Base	*80*	*137*	*311*	*98*	*166*	*364*	*313*	*420*	*281*	*646*	*670*	*214*	*893*	*935*	*1989*	*3848*
Women																
Suicidal thoughts																
Past week	6.8	3.3	4.2	3.8	4.7	3.6	2.9	3.9	3.2	2.3	2.2	1.9	1.5	1.2	-	0.5
Past year	27.7	16.9	19.7	18.8	17.1	14.1	14.1	18.1	12.0	10.7	10.9	10.4	8.9	7.5	0.7	4.1
Lifetime	55.2	40.4	44.7	46.3	45.2	38.7	37.1	37.0	33.9	32.5	32.8	34.6	29.7	26.2	6.5	17.1
Never	44.8	59.6	55.3	53.7	54.8	61.3	62.9	63.0	66.1	67.5	67.2	65.4	70.3	73.8	93.5	82.9
Suicide attempts																
Past week	-	0.4	0.2	-	0.4	-	0.3	0.2	0.3	0.1	0.1	0.3	0.1	-	-	0.0
Past year	3.9	3.2	3.4	2.7	2.4	2.2	2.1	3.2	2.1	1.7	1.8	1.6	1.4	0.9	-	0.5
Lifetime	24.7	18.6	19.9	20.9	18.2	16.5	15.7	17.0	14.8	12.7	12.1	11.9	11.0	10.1	1.0	5.3
Never	75.3	81.4	80.1	79.1	81.8	83.5	84.3	83.0	85.2	87.3	87.9	88.1	89.0	89.9	99.0	94.7
Deliberate self-harm without suicidal intent	14.7	13.5	10.5	10.7	9.5	9.2	8.0	8.3	7.6	6.7	6.8	5.9	5.8	4.9	0.5	2.7
Base	*119*	*292*	*551*	*189*	*349*	*526*	*477*	*580*	*352*	*1014*	*1006*	*417*	*1544*	*1671*	*1818*	*4724*
All																
Suicidal thoughts																
Past week	5.5	3.0	4.0	2.9	4.6	2.6	2.7	3.3	2.8	1.9	1.8	2.0	1.3	1.1	-	0.4
Past year	27.8	19.1	21.7	18.0	19.3	15.0	15.4	17.1	12.5	11.5	11.7	12.1	9.4	8.5	0.4	3.9
Lifetime	56.9	42.9	44.5	40.8	42.8	36.8	37.4	35.3	31.3	31.6	31.8	33.3	28.8	25.8	5.3	14.9
Never	43.1	57.1	55.5	59.2	57.2	63.2	62.6	64.7	68.7	68.4	68.2	66.7	71.2	74.2	94.7	85.1
Suicide attempts																
Past week	0.4	0.4	0.2	-	0.2	-	0.1	0.2	0.2	0.1	0.1	0.3	0.1	-	-	0.0
Past year	4.0	3.6	3.3	1.8	2.9	2.0	2.0	2.3	1.8	1.7	1.9	1.7	1.6	1.1	-	0.5
Lifetime	22.1	18.5	18.4	17.2	16.2	15.4	15.3	14.6	12.5	11.7	11.4	10.9	10.8	9.5	0.9	4.4
Never	77.9	81.5	81.6	82.8	83.8	84.6	84.7	85.4	87.5	88.3	88.6	89.1	89.2	90.5	99.1	95.6
Deliberate self-harm without suicidal intent	16.0	13.3	9.1	8.2	8.8	8.1	7.9	7.1	6.8	5.7	6.2	5.6	5.6	4.8	0.7	2.4
Base	*199*	*429*	*862*	*287*	*515*	*890*	*790*	*1000*	*633*	*1660*	*1676*	*631*	*2437*	*2606*	*3807*	*8572*

Table 4.2 Prevalence of non-fatal suicidal behaviour by grouped CIS-R score and sex

	CIS-R Score				
	0–5	6–11	12–17	18 and over	All
	Cumulative percentage of population				
Men					
Suicidal thoughts					
Past week	-	-	1.0	3.9	0.3
Past year	0.6	5.7	10.8	27.8	3.6
Lifetime	6.2	21.7	32.4	49.4	12.7
Never	93.8	78.3	67.6	50.6	87.3
Suicide attempts					
Past week	-	-	-	0.3	0.0
Past year	-	1.0	2.0	3.6	0.5
Lifetime	1.2	6.6	8.8	19.8	3.6
Never	98.8	93.4	91.2	80.2	96.4
Deliberate self-harm without suicidal intent	1.0	2.3	5.6	10.3	2.0
Base	*2790*	*555*	*255*	*248*	*3848*
Women					
Suicidal thoughts					
Past week	0.0	0.2	0.1	5.5	0.5
Past year	1.1	3.8	8.9	21.6	4.1
Lifetime	8.2	23.8	33.3	49.4	17.1
Never	91.8	76.2	66.7	50.6	82.9
Suicide attempts					
Past week	-	-	-	0.3	-
Past year	0.1	0.4	1.3	3.1	0.5
Lifetime	1.4	6.8	11.3	23.9	5.3
Never	98.6	93.2	88.7	76.1	94.7
Deliberate self-harm without suicidal intent	0.8	3.1	5.7	12.5	2.7
Base	*2930*	*900*	*447*	*447*	*4724*
All					
Suicidal thoughts					
Past week	0.0	0.1	0.5	4.8	0.4
Past year	0.8	4.6	9.7	24.2	3.9
Lifetime	7.1	22.9	33.0	49.4	14.9
Never	92.9	77.1	67.0	50.6	85.1
Suicide attempts					
Past week	-	-	-	0.3	0.0
Past year	0.1	0.7	1.6	3.3	0.5
Lifetime	1.3	6.7	10.3	22.2	4.4
Never	98.7	93.3	89.7	77.8	95.6
Deliberate self-harm without suicidal intent	0.9	2.8	5.7	11.6	2.4
Base	*5720*	*1455*	*702*	*695*	*8572*

Table 4.3 Prevalence of non-fatal suicidal behaviour by type of neurotic disorder and sex

	Neurotic Disorder							
	Any phobia	Obsessive Compulsive Disorder	Depressive episode	Generalised Anxiety Disorder	Panic disorder	Mixed anxiety/ Depressive disorder	No neurotic disorder	All
	Cumulative percentage of population							
Men								
Suicidal thoughts								
Past week	5.7	6.0	7.8	3.5	-	1.8	-	0.3
Past year	39.2	46.5	29.5	22.2	12.8	15.9	1.3	3.6
Lifetime	65.6	66.0	52.2	47.7	46.8	35.6	8.3	12.7
Never	34.4	34.0	47.8	52.3	53.2	64.4	91.7	87.3
Suicide attempts								
Past week	1.2	-	-	-	-	-	-	0.0
Past year	6.8	3.5	4.3	3	-	2.9	0.1	0.5
Lifetime	30.4	20.3	25.1	20.1	11.6	10.3	2.0	3.6
Never	69.6	79.7	74.9	79.9	88.4	89.7	98.0	96.4
Deliberate self-harm without suicidal intent	22.6	8.4	10.7	9.1	4.5	7.4	1.2	2.0
Base	*58*	*39*	*99*	*180*	*29*	*269*	*3300*	*3848*
Women								
Suicidal thoughts								
Past week	8.8	14.5	11.2	2.6	1.7	0.5	0.1	0.5
Past year	32.8	30.0	26.0	17.4	18.0	9.9	1.7	4.1
Lifetime	58.9	61.9	51.6	42.8	47.5	33.2	11.8	17.1
Never	41.1	38.1	48.4	57.2	52.5	66.8	88.2	82.9
Suicide attempts								
Past week	1.1	-	0.9	-	-	-	-	0.0
Past year	5.6	5.7	5.3	2.0	-	1.3	0.2	0.5
Lifetime	28.3	29.2	25.1	16.2	13.5	12.9	2.7	5.3
Never	71.7	70.8	74.9	83.8	86.5	87.1	97.3	94.7
Deliberate self harm without suicidal intent	23.2	12.7	17.0	8.8	3.4	6.2	1.3	2.7
Base	*117*	*73*	*154*	*249*	*40*	*499*	*3766*	*4724*
All								
Suicidal thoughts								
Past week	7.6	11.2	9.7	3.0	0.8	1.0	0.0	0.4
Past year	35.2	36.4	27.6	19.7	15.4	12.2	1.5	3.9
Lifetime	61.4	63.5	51.9	45.1	47.2	34.1	10.0	14.9
Never	38.6	36.5	48.1	54.9	52.8	65.9	90.0	85.1
Suicide attempts								
Past week	1.2	-	0.5	-	-	-	-	0.0
Past year	6.0	4.9	4.9	2.5	-	1.9	0.2	0.5
Lifetime	29.1	25.7	25.1	18.1	12.5	11.9	2.3	4.4
Never	70.9	74.3	74.9	81.9	87.5	88.1	97.7	95.6
Deliberate self-harm without suicidal intent	23.0	11.0	14.1	8.9	3.9	6.7	1.2	2.4
Base	*175*	*112*	*253*	*429*	*69*	*768*	*7066*	*8572*

Table 4.4 Prevalence of non-fatal suicidal behaviour by number of neurotic disorders and sex

	Number of neurotic disorders				
	0	1	2	3 and over	All
	Cumulative Percentage				
Men					
Suicidal thoughts					
Past week	-	1.3	3.9	18.1	0.3
Past year	1.3	15.0	25.5	65.3	3.6
Lifetime	8.3	37.2	52.1	87.0	12.7
Never	91.7	62.8	47.9	13.0	87.3
Suicide attempts					
Past week	-	0.1	-	-	0
Past year	0.1	2.1	2.7	13.1	0.5
Lifetime	2.0	10.8	24.3	45.2	3.6
Never	98.0	89.2	75.7	54.8	96.4
Deliberate self-harm without suicidal intent	1.2	6.5	6.9	32.4	2.0
Base	*3300*	*455*	*66*	*27*	*3848*
Women					
Suicidal thoughts					
Past week	0.1	1.5	6.2	19.9	0.5
Past year	1.7	11.5	26.4	49.4	4.1
Lifetime	11.8	37.0	52.9	67.9	17.1
Never	88.2	63.0	47.1	32.1	82.9
Suicide attempts					
Past week	-	-	1.6	-	0
Past year	0.2	1.7	2.3	10.0	0.5
Lifetime	2.7	15.3	18.3	36.1	5.3
Never	97.3	84.7	81.7	63.9	94.7
Deliberate self-harm without suicidal intent	1.3	7.1	14.6	27.4	2.7
Base	*3766*	*828*	*91*	*39*	*4724*
All					
Suicidal thoughts					
Past week	0.0	1.4	5.1	19.1	0.4
Past year	1.5	12.9	26.0	56.7	3.9
Lifetime	10.0	37.1	52.5	76.7	14.9
Never	90.0	62.9	47.5	23.3	85.1
Suicide attempts					
Past week	-	0.1	0.8	-	0
Past year	0.2	1.9	2.5	11.4	0.5
Lifetime	2.3	13.5	21.3	40.3	4.4
Never	97.7	86.5	78.7	59.7	95.6
Deliberate self-harm without suicidal intent	1.2	6.9	10.8	29.7	2.4
Base	*7066*	*1283*	*157*	*66*	*8572*

Table 4.5 Prevalence of non-fatal suicidal behaviour by probable psychosis and sex

	Probable Psychosis		
	No psychosis	Probable psychosis	All
	Cumulative Percentage		
Men			
Suicidal thoughts			
Past week	0.3	2.1	0.3
Past year	3.5	24.9	3.6
Lifetime	12.5	56.3	12.7
Never	87.5	43.7	87.3
Suicide attempts			
Past week	0.0	-	0.0
Past year	0.5	2.2	0.5
Lifetime	3.4	37.7	3.6
Never	96.6	62.3	96.4
Deliberate self-harm without suicidal intent	1.9	17.7	2.0
Base	*3818*	*30*	*3848*
Women			
Suicidal thoughts			
Past week	0.5	14.9	0.5
Past year	3.9	47.6	4.1
Lifetime	16.8	83.3	17.1
Never	83.2	16.7	82.9
Suicide attempts			
Past week	0.0	-	0.0
Past year	0.4	20.6	0.5
Lifetime	5.0	69.3	5.3
Never	95.0	30.7	94.7
Deliberate self-harm without suicidal intent	2.5	39.4	2.7
Base	*4694*	*30*	*4724*
All			
Suicidal thoughts			
Past week	0.4	8.1	0.4
Past year	3.7	35.5	3.9
Lifetime	14.6	68.8	14.9
Never	85.4	31.2	85.1
Suicide attempts			
Past week	0.0	-	0.0
Past year	0.5	10.8	0.5
Lifetime	4.2	52.4	4.4
Never	95.8	47.6	95.6
Deliberate self-harm without suicidal intent	2.2	27.8	2.4
Base	*8512*	*60*	*8572*

Table 4.6 Prevalence of non-fatal suicidal behaviour by grouped AUDIT score and sex

	AUDIT Score			
	Score 0–7	Score 8–15	Score 16–40	All
	Cumulative Percentage			
Men				
Suicidal thoughts				
Past week	0.3	0.3	0.7	0.3
Past year	3.3	2.9	10.6	3.6
Lifetime	11.3	11.7	34.0	12.7
Never	88.7	88.3	66.0	87.3
Suicide attempts				
Past week	-	-	0.3	0.0
Past year	0.4	0.2	2.6	0.5
Lifetime	3.2	2.9	11.2	3.5
Never	96.8	97.1	88.8	96.5
Deliberate self-harm without suicidal intent	1.7	2.1	5.4	2.0
Base	*2450*	*1176*	*204*	*3830*
Women				
Suicidal thoughts				
Past week	0.5	0.5	2.8	0.5
Past year	3.6	5.9	14.4	4.1
Lifetime	15.4	24.6	44.3	17.1
Never	84.6	75.4	55.7	82.9
Suicide attempts				
Past week	-	0.2	-	0.0
Past year	0.3	1.6	1.9	0.5
Lifetime	4.3	9.5	20.4	5.3
Never	95.7	90.5	79.6	94.7
Deliberate self-harm without suicidal intent	2.0	5.1	19.3	2.7
Base	*4008*	*621*	*73*	*4702*
All				
Suicidal thoughts				
Past week	0.4	0.4	1.1	0.4
Past year	3.5	3.8	11.4	3.9
Lifetime	13.7	15.6	36.2	14.9
Never	86.3	84.4	63.8	85.1
Suicide attempts				
Past week	-	0.1	0.2	0.0
Past year	0.4	0.6	2.4	0.5
Lifetime	3.8	4.9	13.1	4.4
Never	96.2	95.1	86.9	95.6
Deliberate self-harm without suicidal intent	1.9	3.0	8.3	2.4
Base	*6458*	*1797*	*277*	*8532*

Table 4.7 Prevalence of non-fatal suicidal behaviour by severity of alcohol dependence and sex

	Alcohol Dependence			
	No alcohol dependence	Mild alcohol dependence	Moderate or severe dependence	All
	Cumulative Percentage			
Men				
Suicidal thoughts				
Past week	0.2	0.7	3.5	0.3
Past year	3.0	6.2	34.5	3.6
Lifetime	11.0	23.0	58.6	12.7
Never	89.0	77.0	41.4	87.3
Suicide attempts				
Past week	-	0.1	-	0.0
Past year	0.3	1.2	9.7	0.5
Lifetime	3.0	6.1	23.4	3.5
Never	97.0	93.9	76.6	96.5
Deliberate self-harm without suicidal intent	1.5	4.9	23.4	2.0
Base	*3406*	*388*	*34*	*3828*
Women				
Suicidal thoughts				
Past week	0.5	2.1	-	0.5
Past year	3.8	12.5	[1]	4.1
Lifetime	16.4	41.5	[3]	17.1
Never	83.6	58.5	[5]	82.9
Suicide attempts				
Past week	-	0.9	-	0.0
Past year	0.4	3.4	[1]	0.5
Lifetime	4.8	19.6	[2]	5.3
Never	95.2	80.4	[6]	94.7
Deliberate self-harm without suicidal intent	2.4	13.3	[1]	2.7
Base	*4558*	*136*	*8*	*4702*
All				
Suicidal thoughts				
Past week	0.4	1.0	3.1	0.4
Past year	3.4	7.5	32.4	3.9
Lifetime	13.8	26.8	56.8	14.9
Never	86.2	73.2	43.2	85.1
Suicide attempts				
Past week	-	0.3	-	0.0
Past year	0.4	1.6	10.3	0.5
Lifetime	4.0	8.8	23.9	4.4
Never	96.0	91.2	76.1	95.6
Deliberate self-harm without suicidal intent	1.9	6.6	22.5	2.4
Base	*7964*	*524*	*42*	*8530*

Table 4.8 Prevalence of non-fatal suicidal behaviour by combined AUDIT and SAD ratings and sex

	No hazardous alcohol use	Hazardous use but no dependence	Alcohol dependence	All
	Cumulative Percentage			
Men				
Suicidal thoughts				
Past week	0.3	0.1	0.9	0.3
Past year	3.3	2.2	8.1	3.6
Lifetime	11.3	10.2	25.4	12.7
Never	88.7	89.8	74.6	87.3
Suicide attempts				
Past week	-	-	0.1	0.0
Past year	0.4	-	1.7	0.5
Lifetime	3.2	2.7	7.3	3.5
Never	96.8	97.3	92.7	96.5
Deliberate self-harm without suicidal intent	1.7	0.9	6.1	2.0
Base	*2450*	*957*	*422*	*3829*
Women				
Suicidal thoughts				
Past week	0.5	0.4	2.1	0.5
Past year	3.6	5.4	12.6	4.1
Lifetime	15.4	23.0	41.5	17.1
Never	84.6	77.0	58.5	82.9
Suicide attempts				
Past week	-	-	0.9	0.0
Past year	0.3	1.1	3.7	0.5
Lifetime	4.3	8.5	19.9	5.3
Never	95.7	91.5	80.1	94.7
Deliberate self-harm without suicidal intent	2.0	5.0	13.3	2.7
Base	*4009*	*551*	*144*	*4704*
All				
Suicidal thoughts				
Past week	0.4	0.2	1.1	0.4
Past year	3.5	3.3	9.0	3.9
Lifetime	13.7	14.4	28.6	14.9
Never	86.3	85.6	71.4	85.1
Suicide attempts				
Past week	-	-	0.3	0.0
Past year	0.4	0.4	2.1	0.5
Lifetime	3.8	4.6	9.8	4.4
Never	96.2	95.4	90.2	95.6
Deliberate self-harm without suicidal intent	1.9	2.3	7.5	2.4
Base	*6459*	*1508*	*566*	*8533*

Table 4.9 Prevalence of non-fatal suicidal behaviour by drug dependence and sex

	Drug dependence			
	No dependence	Dependent on cannabis only	Dependent on drug other than cannabis	All
	Cumulative Percentage			
Men				
Suicidal thoughts				
Past week	0.3	-	1.0	0.3
Past year	3.1	11.7	14.2	3.6
Lifetime	11.5	32.1	40.0	12.7
Never	88.5	67.9	60.0	87.3
Suicide attempts				
Past week	-	0.4	-	0.0
Past year	0.5	0.4	-	0.5
Lifetime	3.1	12.0	11.7	3.6
Never	96.9	88.0	88.3	96.4
Deliberate self-harm without suicidal intent	1.7	7.5	5.5	2.0
Base	*3667*	*118*	*50*	*3835*
Women				
Suicidal thoughts				
Past week	0.5	1.9	2.0	0.5
Past year	3.7	17.8	25.3	4.1
Lifetime	16.5	38.9	64.7	17.1
Never	83.5	61.1	35.3	82.9
Suicide attempts				
Past week	0.0	-	-	0.0
Past year	0.5	3.9	4.4	0.5
Lifetime	4.9	16.5	38.2	5.3
Never	95.1	83.5	61.8	94.7
Deliberate self-harm without suicidal intent	2.4	13.3	24.7	2.7
Base	*4610*	*55*	*35*	*4700*
All				
Suicidal thoughts				
Past week	0.4	0.5	1.3	0.4
Past year	3.4	13.3	17.6	3.9
Lifetime	14.0	33.9	47.5	14.9
Never	86.0	66.1	52.5	85.1
Suicide attempts				
Past week	-	0.3	-	0.0
Past year	0.5	1.4	1.3	0.5
Lifetime	4.0	13.2	19.8	4.4
Never	96.0	86.8	80.2	95.6
Deliberate self-harm without suicidal intent	2.1	9.1	11.4	2.4
Base	*8277*	*173*	*85*	*8535*

Table 4. 10 Neurotic symptoms and disorders by lifetime suicidal thoughts

	Suicidal thoughts in lifetime		
	Yes	No	All
	%	%	%
Neurotic Symptoms			
Sleep problems	50	25	29
Fatigue	53	23	27
Irritability	43	16	20
Worry	40	15	19
Depression	26	8	11
Depressive ideas	28	6	10
Concentration and forgetfulness	24	7	10
Anxiety	21	6	9
Somatic symptoms	15	5	7
Worry/physical health	15	6	7
Obsessions	16	4	6
Phobias	13	3	5
Panic	8	1	2
Compulsions	8	2	3
No neurotic symptoms	16	50	45
Base	*1380*	*7192*	*8572*
CIS-R Score in 4 groups			
0–5	32	74	68
6–11	26	15	17
12–17	17	6	8
18 and over	24	4	7
Base	*1380*	*7192*	*8572*
Neurotic Disorders			
Mixed anxiety/depressive disorder	20	7	9
Generalised anxiety disorder	13	3	4
Depressive episode	9	1	3
Any phobia	7	1	2
Obsessive compulsive disorder	5	1	1
Panic disorder	2	0	1
No neurotic disorder	56	88	84
Base	*1380*	*7192*	*8572*
Number of Neurotic Disorders			
0	55	88	84
1	35	11	14
2	6	1	2
3 and over	4	0	1
Base	*1380*	*7192*	*8572*

Table 4. 11 Probable psychosis and alcohol and drug dependence by lifetime suicidal thoughts

	Suicidal thoughts in lifetime		
	Yes	No	All
	%	%	%
Probable Psychosis			
No psychosis	98	100	100
Probable psychosis	2	0	0
Base	*1380*	*7192*	*8572*
Grouped Audit Scores			
Score 0–7	67	75	74
Score 8–15	24	23	23
Score 16–40	9	3	4
Base	*1372*	*7160*	*8532*
Grouped score on severity of alcohol dependence			
No dependence	86	94	93
Mild dependence	12	6	7
Moderate dependence	1	0	0
Severe dependence	0	0	0
Base	*1370*	*7160*	*8530*
Drug dependence			
No dependence	90	97	96
Dependent on cannabis only	6	2	2
Dependent on other drug with or without cannabis	4	1	1
Base	*1373*	*7162*	*8535*

Table 4. 12 Neurotic symptoms and disorders by lifetime suicide attempts

	Suicide attempts in lifetime		
	Yes	No	All
	%	%	%
Neurotic Symptoms			
Sleep problems	62	27	29
Fatigue	66	26	27
Irritability	52	19	20
Worry	50	18	19
Depression	36	10	11
Depressive ideas	40	8	10
Concentration and forgetfulness	34	9	10
Anxiety	29	8	9
Somatic symptoms	17	6	7
Worry/physical health	20	6	7
Obsessions	20	5	6
Phobias	19	4	5
Compulsions	12	3	3
Panic	10	2	2
No neurotic symptoms	10	47	45
Base	*430*	*8141*	*8571*
CIS-R Score in 4 groups			
0–5	20	70	68
6–11	26	16	17
12–17	18	7	8
18 and over	37	6	7
Base	*430*	*8141*	*8571*
Neurotic Disorders			
Mixed anxiety/depressive disorder	24	8	9
Generalised anxiety disorder	18	4	4
Depressive episode	15	2	3
Any phobia	12	1	2
Obsessive compulsive disorder	6	1	1
Panic disorder	2	1	1
No neurotic disorder	44	85	84
Base	*430*	*8141*	*8571*
Number of Neurotic Disorders			
0	44	85	84
1	43	13	14
2	7	1	2
3 and over	6	0	1
Base	*430*	*8141*	*8571*

Table 4. 13 Probable psychosis and alcohol and drug dependence by lifetime suicide attempts

	Suicide attempts in lifetime		
	Yes	No	All
	%	%	%
Probable Psychosis			
No psychosis	94	100	100
Probable psychosis	6	0	0
Base	*430*	*8141*	*8571*
Grouped Audit Scores			
Score 0–7	64	74	74
Score 8–15	26	23	23
Score 16–40	11	3	4
Base	*423*	*8108*	*8531*
Grouped score on severity of alcohol dependence			
No dependence	84	93	93
Mild dependence	14	7	7
Moderate dependence	2	0	0
Severe dependence	1	0	0
Base	*423*	*8106*	*8529*
Drug dependence			
No dependence	87	97	96
Dependent on cannabis only	8	2	2
Dependent on other drug with or without cannabis	6	1	1
Base	*425*	*8109*	*8534*

Table 4. 14 Neurotic symptoms and disorders by lifetime deliberate self-harm

	Deliberate self-harm in lifetime		
	Yes	No	All
	%	%	%
Neurotic Symptoms			
Sleep problems	59	28	29
Fatigue	64	26	27
Irritability	53	19	20
Worry	46	18	19
Depression	33	10	11
Depressive ideas	37	9	10
Concentration and forgetfulness	34	9	10
Anxiety	28	8	9
Somatic symptoms	16	7	7
Worry/physical health	20	7	7
Obsessions	21	5	6
Phobias	26	4	5
Compulsions	10	3	3
Panic	13	2	2
No neurotic symptoms	13	46	45
Base	*200*	*8375*	*8575*
CIS-R Score in 4 groups			
0–5	25	69	68
6–11	20	17	17
12–17	19	8	8
18 and over	36	7	7
Base	*200*	*8375*	*8575*
Neurotic Disorders			
Mixed anxiety/depressive disorder	25	8	9
Generalised anxiety disorder	17	4	4
Depressive episode	15	2	3
Any phobia	17	1	2
Obsessive compulsive disorder	5	1	1
Panic disorder	1	1	1
No neurotic disorder	43	84	84
Base	*200*	*8375*	*8575*
Number of Neurotic Disorders			
0	43	84	84
1	42	14	14
2	7	1	2
3 and over	8	1	1
Base	*200*	*8375*	*8575*

Table 4. 15 Probable psychosis, alcohol and drug dependence by lifetime deliberate self-harm

	Deliberate self-harm in lifetime		
	Yes	No	All
	%	%	%
Probable Psychosis			
No psychosis	94	100	100
Probable psychosis	6	0	0
Base	*200*	*8375*	*8575*
Grouped Audit Scores			
Score 0–7	58	74	74
Score 8–15	29	23	23
Score 16–40	13	3	4
Base	*197*	*8338*	*8635*
Grouped score on severity of alcohol dependence			
No dependence	76	93	93
Mild dependence	19	7	7
Moderate dependence	4	0	0
Severe dependence	1	0	0
Base	*197*	*8336*	*8533*
Drug dependence			
No dependence	84	96	96
Dependent on cannabis only	10	2	2
Dependent on other drug with or without cannabis	6	1	1
Base	*197*	*8341*	*8538*

5 Social functioning and suicidal behaviour

5.1 Stressful life events

Assessment and choice of events

All respondents were shown three sets of cards which listed a range of stressful life events (18 in total) and were asked to say which, if any, they had suffered at any time. They covered relationship problems, illness and bereavement; employment and financial crises; and victimisation experiences, i.e. events which might have an adverse effect on a person's mental health. They were used in the ONS survey of psychiatric morbidity among prisoners (Singleton *et al* 1998).

However, the lists did not include all common stressful events, excluding for example, moving house and having a baby. Previous research has shown that events such as these are unlikely to significantly increase risk for psychiatric disorders. (Brugha *et al* 1985). In addition, when looking at the number of events experienced, it should be remembered that the events may not carry equal weight in terms of their psychological impact, and that some events are likely to be found in combination with others; for example running away from home and homelessness. If an event was reported in the lifetime of the individual, a further question established whether this was within the past six months.

Number of stressful events

Respondents in the sample who had experience of stressful events showed a much greater prevalence of suicidal thoughts and behaviour than those who did not. Among the group who reported not having experienced any of the stressful events, only 5% had had suicidal thoughts and 2% had attempted suicide in their lifetime. Of the group who had suffered the highest number of events (six or more), a third had had suicidal thoughts and 14% had attempted suicide. These findings endorse the conclusion from Vilhjalmsson *et al* (1998) that 'financial hardship, legal stress, family difficulties, stress perceptions and low material support are significantly correlated to thoughts of committing suicide'.

The Samaritans (on their website in 2002) refer to several social functioning characteristics which have been found to be antecedents to suicide attempts: serious argument with a partner, disturbed family relationships, social isolation, history of physical and sexual abuse.

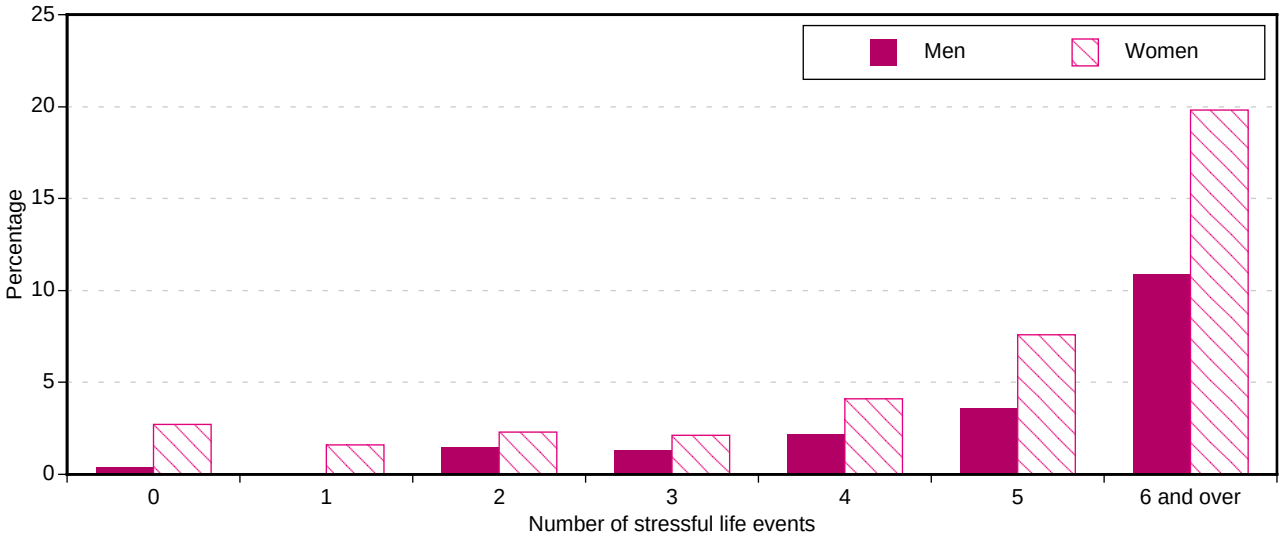
In this study, the prevalence of suicidal thoughts rose steadily by the number of stressful events experienced. This pattern was evident for both for men and women. *(Table 5.1)*

Thus, it appears that the number of events is more important than the actual type of event and that they act cumulatively to increase the likelihood of suicidal behaviour. As problems emerge in each domain of life (family, health, employment, finances etc) the opportunities to find relief in another domain diminish and there is an increased likelihood of contemplating suicide.

The prevalence of suicidal thoughts and behaviour was much higher for women than for men irrespective of number of events and is most marked among those who had suffered six or more stressful events: 43% of women in this group had suicidal thoughts at some time compared with 27% of men in the same group. With regard to suicidal behaviour, women in all groups were more likely to have attempted suicide than men; from four times as likely in the no stressful events group, to twice as likely in the six or more events group. *(Figure 5.1)*

The prevalence of deliberate self-harm followed a similar pattern. Overall, the rate rose from less than 1% among those who had not experienced a life event to 2% for those who had four stressful life events to 6% among those experiencing six or more events. The highest rate of deliberate self-harm, 9%, was found among women who had experienced six or more stressful events in their lives.

Figure 5.1 Lifetime suicide attempts by number of stressful life events and sex



5.2 Type of stressful events

Relationship problems, illness or bereavement

Table 5.2 shows the prevalence rates of suicidal thoughts and behaviours by events related to relationship problems, illness or bereavement. These include: separation or divorce, serious illness, injury or assault, serious problem with a close friend or relative, serious illness, injury or assault to a close friend or relative, death of a close relative and death of a close friend or other relative.

The prevalence of suicidal thoughts was greatly increased among those who had experienced one or more of these events compared with those who had not. For example, just 8% of those who had not experienced any of these stressful events also reported having had suicidal thoughts at some point during their lifetime. Those who had experienced one or more of these events were between two and three times more likely to report that they had had suicidal thoughts in their lifetime (between 14% and 26%).

Suicidal thoughts were most common among those who had experienced a serious problem with a close friend or relative, with more than a quarter of such people having had suicidal thoughts at some point in their lifetime. Other traumas linked to a high prevalence of suicidal thoughts were separation or divorce (25%), serious illness, injury or assault (22%) and serious illness, injury or assault to a close relative (20%).

The prevalence of suicidal thoughts for men was highest among those who had had a serious problem with a close friend or relative (26%). For women, the prevalence of suicidal thoughts was equally high for those who had been separated or divorced, had experienced a serious illness, injury or assault or who had had a serious problem with a close friend or relative (27%).

The experience of one or more of these stressful events also seemed to show a marked association with the prevalence of suicidal attempts. Of those who had not experienced any of the stressful events, only 1% had attempted suicide during their lifetime, compared with between 4% and 9% of those who reported that they had experienced such an event. Not unexpectedly, the stressful events for which prevalence of suicidal attempts was most marked were the same as those associated with suicidal thoughts; separation or divorce, serious illness, injury or assault and a serious problem with a close friend or relative (9% each).

As with suicidal thoughts and behaviour, there was a greater prevalence of deliberate self-harm among those who had experienced one of the stressful events than those who had not (between 2% and 5% of those who had experienced one or more of the stressful events compared with less than one percent of those who had not). Again, deliberate self-harm was particularly prevalent among those who had had a serious problem with a close friend or relative (5%), a serious illness, injury or assault

(4%), separation or divorce (4%) or had had a close friend or relative suffering from a serious illness, injury or assault (4%).

The association between bereavement and deliberate self-harm was much more apparent in men than in women; death of a close relative and death of a close friend or other relative were the only two stressful events for which the prevalence of deliberate self-harm was greater for men. Four per cent of men who had experienced the death of a close relative had deliberately harmed or hurt themselves during their lifetime which is double the rate for women who had experienced such a bereavement. For other events, the prevalence of deliberate self-harm was greater in women than in men. *(Table 5.2)*

Employment and financial crises

Table 5.3 shows the prevalence of suicidal thoughts and behaviours by the events listed on the second card shown to respondents. These included: problems with the police or a court appearance, major financial crisis, having looked for work for one month and over; something valued being lost or stolen and being made redundant or sacked.

The prevalence of suicidal thoughts was higher among those who had experienced one of these events than among those who had not. Of those who had not experienced any of the events on this card, only 10% had had suicidal thoughts during their lifetime. This compares with a prevalence of between 19% and 29% of respondents who had experienced one or more of the traumas listed on the show card.

Events for which the prevalence of suicidal thoughts was particularly high include having a major financial crisis (29%), having a problem with the police or a court appearance (27%) and having looked for work for one month or over (23%). This was true for both men and women, though the prevalence of suicidal thoughts was much higher for women than it was for men for all three of these events.

The most striking difference between the genders regarding experience of this set of events is with regard to having had a problem with the police or a court appearance. The prevalence of suicidal thoughts among women was almost double that of men (40% compared with 24%).

The prevalence of suicidal attempts among respondents who had experienced an employment or financial crisis, was between four and six times higher than among those who had not experienced any of these events. For example, 12% of those who had had a problem with the police or a court appearance, 10% of those who had experienced a major financial crisis and 8% of those who had looked for work for one month or more had attempted suicide at some time in their life. This compares with just 2% of those who had not experienced any of the stressful events on the card. *(Table 5.3)*

Victimisation experiences

Stressful events that respondents were shown on the third card included running away from home, sexual abuse, violence in the home, ever having been homeless; violence at work and being bullied.

Suicidal thoughts and behaviour were most prevalent among respondents who had experienced traumas in this group, probably because the events included here carry much more weight in terms of psychological impact. The gravity of this can be seen when looking at the difference between those who had not experienced any of the events and those who had (see table 5.4). Only 9% of those who had not experienced any of the events had had suicidal thoughts during their lifetime, compared with between 27% and 55% in all the other groups. *(Table 5.4)*

Overall, the greatest prevalence of suicidal thoughts was found in those who had reported sexual abuse. Over half of those who reported experience of sexual abuse also reported having had suicidal thoughts during their lifetime. With a similarly high prevalence were being homeless (48%), running away from home (45%), violence in the home (44%) and being expelled from school (41%).

The events for which suicidal thoughts were most prevalent differed between men and women. Almost two-thirds (59%) of women who reported sexual abuse also reported having suicidal thoughts in their lifetime, compared with 40% of men. For

men, the prevalence of suicidal thoughts was highest among those who reported experience of violence in the home (44%), a prevalence which was matched in women, followed closely by being homeless and sexual abuse (both 40%).

Suicide attempts were also more prevalent among respondents who reported victimisation experiences. Less than 2% of those who had not experienced any of these events had attempted suicide in their lifetime, compared with between 10% and 26% among those who had experienced one or more of the events (see figure 5.2). In particular, around a quarter of people who reported running away from home, being homeless, having experienced sexual abuse and having experienced violence in the home had attempted suicide at some time in their life (between 22% and 26%).

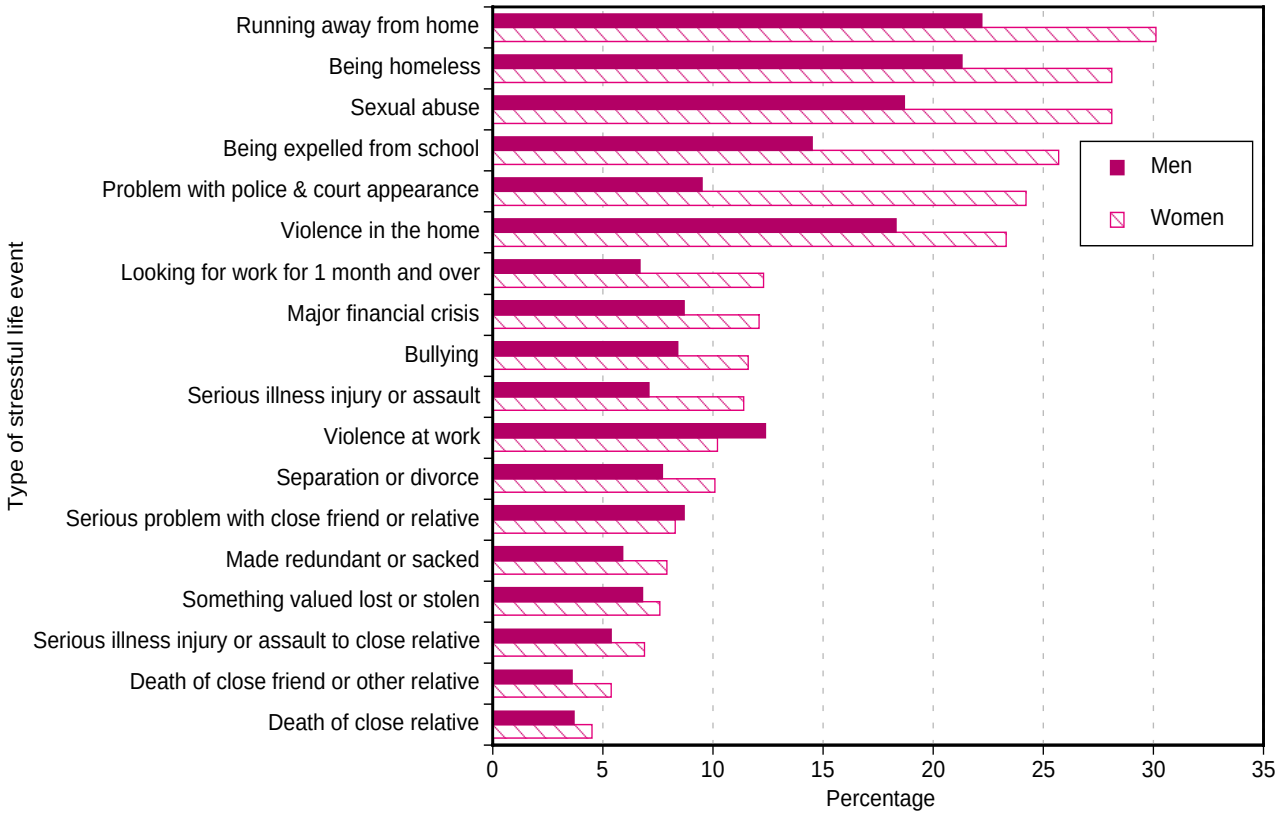
Perhaps the most marked difference in suicidal behaviour between the sexes is in relation to being expelled from school; Women who reported this experience were almost twice as likely as men to have attempted suicide in their lives (26% of women compared with 14% of men).

Less than 1% of the group who had not had any victimisation experiences reported deliberately harming or hurting themselves in their lifetime without the intention of committing suicide. This compares with between 5% and 14% of those who had experienced one or more of the events. The prevalence of self-harm was particularly high for the groups reporting that they had run away from home (14%), had experience of sexual abuse (14%), had been expelled from school (13%) and had been homeless (12%).

For men, the prevalence of deliberate self-harm was significantly higher for the group who had experienced sexual abuse than any other group (17% compared with between 5% and 11%). Respondents with experience of homelessness or running away from home were the next most likely to report having deliberately harmed or hurt themselves, followed by violence in the home (9%).

For women, being expelled from school showed a high prevalence of deliberate self-harm with more than a quarter (26%) in this group reporting that they had harmed or hurt themselves during their life. This is about three times the prevalence of

Figure 5.2 Lifetime suicide attempts by type of stressful life event



deliberate self-harm for men reporting the same experience (8%).

This finding is particularly interesting as women who had experienced sexual abuse had significantly higher prevalence of both suicidal thoughts and attempts and this indicates that suicidal thoughts and behaviours and deliberate self-harm have very different triggers.

5.3 Perceived social support

Assessment of perceived social support

Perceived social support was assessed from respondents' answers to seven questions which were originally used in the 1987 Health and Lifestyle survey, and were also included in the 1992 Health Survey for England (Breeze *et al* 1994) and the ONS (OPCS) surveys of psychiatric morbidity among adults in private households and in institutions catering for people with mental disorder. (Meltzer *et al* 1995; Meltzer *et al* 1996)

The seven questions take the form of statements that individuals could say were not true, partly true or certainly true for them:

There are people I know among my family and friends:
- who do things to make me happy;
- who make me feel loved;
- who can be relied on no matter what happens;
- who would see that I am taken care of if I needed to be;
- who accept me just as I am;
- who make me feel an important part of their lives; and
- who give me support and encouragement.

Scores of 1–3 were obtained for each question and overall scores ranged from 7 to 21. The maximum score of 21 indicated no lack of perceived social support; scores of 18 to 20 indicated a moderate lack, and scores of 17 and below showed that individuals perceived a severe lack of social support.

Suicidal thoughts and behaviour seem to be directly linked to perception of social support. The prevalence of suicidal thoughts of those whose perceived social support was categorised as being severely lacking was almost double that of the group perceiving no lack (27% compared with 15%). This pattern was the same for both men and women, with the prevalence of lifetime suicidal thoughts decreasing as the perceived social support score increased.

The prevalence of suicidal thoughts among men perceiving a severe lack of social support was double that of those with no lack (22% compared with 11%) and for women the difference was even greater (35% of those with a severe lack compared with 14% of those with no lack).

Lifetime suicidal attempts followed the same pattern that again was more exaggerated in women. Women who perceived a severe lack of social support were over four times more likely than those with no lack to have attempted suicide in their lifetimes (16% compared with 3%) and more than twice as likely to attempt suicide than men in the same group (8%).

The prevalence of respondents deliberately harming or hurting themselves decreased dramatically with increased perceived social support. Respondents with a severe lack of support were over three times more likely than those with no lack to have deliberately harmed themselves (7% compared with 2%). However, for deliberate self-harm, most of the difference can be seen between the severe lack and moderate lack groups, with little difference occurring between those with no lack of social support and those with only a moderate lack.

This was a similar pattern for men and women, although among women the prevalence of self-harm without suicidal intent was higher in the group reporting a severe lack of social support. They were four times more likely to have deliberately harmed themselves than those with a moderate lack (12% compared with 3%). *(Table 5.5)*

5.4 Primary support group

Calculating the size of a person's primary support group

Another group of questions assessed the extent of respondents' social networks. These were also adapted from questions used in the other ONS (OPCS) surveys of psychiatric morbidity and

focused on the numbers of people (aged 16 and over) that respondents felt close to. Here again the frame of reference was broadened to include everyone the individual was acquainted with, rather than just friends and relatives.

Information was collected about three groups of people:

- adults living inside the household that respondents felt close to;
- relatives, aged 16 or over, living outside the household that respondents felt close to; and
- friends or acquaintances living outside the household that would be described as close or good friends.

Close friends and relatives form an individual's 'primary support group'. Previous research has suggested that adults with a primary support group of 3 people or fewer are at greatest risk of psychiatric morbidity. (Brugha *et al* 1987; Brugha *et al* 1993)

A similar relationship can be found between an individual's 'primary support group' and their suicidal thoughts and behaviours, with prevalence of suicidal thoughts decreasing with the increase in size of the primary support group. Those reporting a primary support group of three or less people were almost three times more likely as those with a group of nine or more to report having had suicidal thoughts during their lifetime (30% compared with 12%).

This pattern was found for both men and women, with the prevalence of suicidal thoughts in men more than doubling between the large primary support group and the small primary support group (11% of men with a social support group of nine or more people, compared with 23% of men with 3 or less). The prevalence in women with a small support group was three times that found in the large support group (39% compared with 13%).

Suicidal attempts followed the same pattern with 12% of all respondents with a primary support group of three or less having attempted suicide in their lifetime, compared with only 3% with a support group of nine or more people. For both men and women also, the prevalence of suicidal attempts among those with the smallest social support group was four times that in the largest primary support group.

The prevalence of deliberate self-harm decreased with the increase in size of the primary support group. For women in particular, this increase was quite marked, with 9% of women with a support group of three or less people having deliberately harmed or hurt themselves in their lifetime, compared with only 1% of those with nine or more in their support group. *(Table 5.6)*

5.5 Characteristics of those with lifetime suicidal thoughts and experiences

Lifetime Suicidal Thoughts

Respondents who reported having had suicidal thoughts at some time in their life were more likely to have experienced a greater number of stressful events and to report a severe lack of social support.

While only 2% of respondents who had thought about suicide had not experienced any stressful life events, 38% of this group had experienced six or more of the events listed. In comparison among those who had not thought about suicide, 14% reported experiencing six or more events.

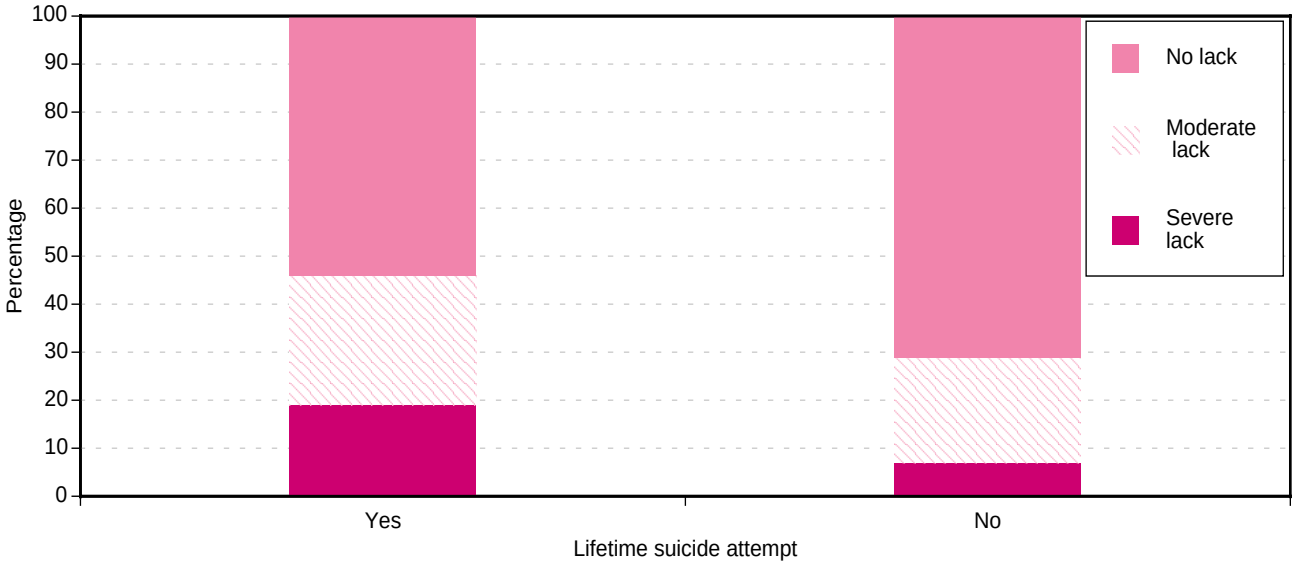
Respondents who had thought about suicide, compared with those who had not, were far more likely to perceive a severe lack of social support (14% compared with 7%) and to have a support group of three or less people (10% compared with 4%). *(Table 5.7)*

Lifetime Suicidal Attempts

The difference between those who had and had not attempted suicide, in terms of lifetime experience of stressful events, were even more marked than for suicidal thoughts.

Of those who had never attempted suicide, only 16% had suffered six or more events, while 71% perceived no lack in social support and 67% had a social support group of size of nine or more. Respondents who had attempted suicide were much more likely to have experienced six or more stressful events (56%), to have a severe lack in social support (19%) and to have a support group of three or less people (14%) *(Table 5.7 and Figure 5.3)*.

Figure 5.3 Perceived social support by lifetime suicide attempts



Deliberate self-harm without suicidal intent

Of the sample of respondents who had deliberately harmed themselves in their lifetime, only 1% had never experienced any of the stressful events whereas 48% had experienced six or more.

However, perceived social support and size of primary support group were much less significant in the reporting of deliberate self-harm, with 22% of those who had harmed themselves having a severe lack of social support whereas 53% had no lack of social support. Of those who had never deliberately harmed themselves, 17% had experienced six or more stressful events, 8% had a severe lack of social support (whereas 71% had no lack) and 67% had a support group of nine or more people. *(Table 5.9)*

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Table 5.1 Prevalence of non-fatal suicidal behaviour by number of stressful life events and sex

	Number of stressful life events							
	0	1	2	3	4	5	6 and over	All
Men	*Cumulative percentage of population*							
Suicidal thoughts								
Past week	-	-	0.1	0.1	0.2	0.3	0.9	0.3
Past year	0.8	1.6	2.0	2.6	3.2	4.8	7.3	3.6
Lifetime	2.8	3.9	7.6	9.8	10.6	16.4	26.7	12.7
Never	97.2	96.1	92.4	90.2	89.4	83.6	73.3	87.3
Suicide attempts								
Past week	-	-	-	-	-	0.1	-	0.0
Past year	-	-	0.6	-	0.1	0.4	1.5	0.5
Lifetime	0.4	-	1.5	1.3	2.2	3.6	10.9	3.6
Never	99.6	100.0	98.5	98.7	97.8	96.4	89.1	96.4
Deliberate self-harm without suicidal intent	0.6	1.0	1.2	1.4	1.9	1	4.8	2.0
Base	*180*	*397*	*627*	*668*	*653*	*433*	*890*	*3848*
Women								
Suicidal thoughts								
Past week	-	0.1	0.3	0.4	0.1	0.7	2.2	0.5
Past year	0.9	1.7	3.1	2.6	3.3	6.6	10.7	4.1
Lifetime	6.6	8.4	9.7	13.0	16.3	26.1	43	17.1
Never	93.4	91.6	90.3	87.0	83.7	73.9	57	82.9
Suicide attempts								
Past week	-	-	-	-	0.2	-	-	0.0
Past year	-	-	0.1	0.2	0.6	0.4	2.8	0.5
Lifetime	2.7	1.6	2.3	2.1	4.1	7.6	19.8	5.3
Never	97.3	98.4	97.7	97.9	95.9	92.4	80.2	94.7
Deliberate self-harm without suicidal intent	0.6	0.4	1.4	1.7	2.2	4.2	9.1	2.7
Base	*190*	*588*	*952*	*1023*	*727*	*495*	*748*	*4723*
All								
Suicidal thoughts								
Past week	-	0.0	0.2	0.3	0.1	0.5	1.4	0.4
Past year	0.8	1.6	2.6	2.6	3.3	5.7	8.7	3.9
Lifetime	4.6	6.4	8.7	11.6	13.3	21.0	33.0	14.9
Never	95.4	93.6	91.3	88.4	86.7	79.0	67.0	85.1
Suicide attempts								
Past week	-	-	-	-	0.1	0.1	-	0.0
Past year	-	-	0.3	0.1	0.3	0.4	2.0	0.5
Lifetime	1.5	0.9	2.0	1.7	3.1	5.5	14.4	4.4
Never	98.5	99.1	98.0	98.3	96.9	94.5	95.6	95.6
Deliberate self-harm without suicidal intent	0.6	0.7	1.3	1.5	2	2.5	6.5	2.4
Base	*370*	*985*	*1579*	*1691*	*1380*	*928*	*1639*	*8572*

Table 5.2 Prevalence of non-fatal suicidal behaviour by relationship problems, illness or bereavement and sex

	Relationship problem, illness or bereavement							
	Separation or divorce	Serious illness injury or assault	Serious problem with close friend or relative	illness injury or asssult to close relative	Death of close friend or other relative	Death of close relative	None of these	All
Men	*Cumulative percentage of population*							
Suicidal thoughts								
Past week	0.7	0.7	1.1	0.5	0.3	0.5	-	0.3
Past year	6.4	5.9	5.5	4.7	3.8	3.1	2.2	3.6
Lifetime	22.0	18.4	25.8	17.5	12.8	11.9	6.6	12.7
Never	78.0	81.6	74.2	82.5	87.2	88.1	93.4	87.3
Suicide attempts								
Past week	-	0.1	-	-	-	-	-	0
Past year	0.8	1.2	1.1	0.9	0.4	0.3	-	0.5
Lifetime	7.7	7.1	8.7	5.4	3.6	3.7	0.3	3.6
Never	92.3	92.9	91.3	94.6	96.4	96.3	99.7	96.4
Deliberate self-harm without suicidal intent	1.6	2.6	4.0	2.0	3.3	4.3	0.6	2.0
Base	*887*	*1210*	*434*	*912*	*2328*	*2186*	*323*	*3817*
Women								
Suicidal thoughts								
Past week	1.0	0.8	0.9	0.7	0.6	0.5	-	0.5
Past year	7.0	6.3	6.4	5.6	4.0	3.6	1.9	4.1
Lifetime	26.9	26.8	26.9	22.5	17.2	15.7	10.4	17.1
Never	73.1	73.2	73.1	77.5	82.8	84.3	89.6	82.9
Suicide attempts								
Past week	-	0.1	-	0.1	0.0	-	-	0.0
Past year	1.4	1.7	1.4	0.6	0.4	0.3	-	0.5
Lifetime	10.1	11.4	8.3	6.9	5.4	4.5	1.9	5.3
Never	89.9	88.6	91.7	93.1	94.6	95.5	98.1	94.7
Deliberate self-harm without suicidal intent	4.4	4.9	5.0	4.6	3.1	1.7	0.7	2.7
Base	*1265*	*1161*	*580*	*1259*	*3117*	*2844*	*284*	*4698*
All								
Suicidal thoughts								
Past week	0.9	0.8	1.0	0.6	0.5	0.5	-	0.4
Past year	6.7	6.1	6.0	5.1	3.9	3.4	2.1	3.8
Lifetime	24.6	22.0	26.4	20.1	15.1	13.9	8.2	14.9
Never	75.4	78.0	73.6	79.9	84.9	86.1	91.8	85.1
Suicide attempts								
Past week	-	0.1	-	0.1	0.0	-	-	0.0
Past year	1.1	1.4	1.3	0.8	0.4	0.3	-	0.5
Lifetime	9.0	8.9	8.5	6.2	4.5	4.1	1.0	4.4
Never	91.0	91.1	91.5	93.8	95.5	95.9	99.0	95.6
Deliberate self-harm without suicidal intent	3.9	4.4	4.7	3.6	2.6	1.7	0.6	2.4
Base	*2152*	*2371*	*1014*	*2171*	*5445*	*5030*	*607*	*8515*

Table 5.3 Prevalence of non-fatal suicidal behaviour by employment and financial crises and sex

	Employment and financial crisis						
	Problem with police and court appearance	Major financial crisis	Looking for work for 1 month and over	Something valued lost or stolen	Made redundant or sacked	None of these	All
Men	*Cumulative percentage of population*						
Suicidal thoughts							
Past week	1.0	1.1	0.2	0.6	0.4	0.1	0.3
Past year	6.8	7.3	4.7	5.4	4.9	3.6	3.6
Lifetime	24.0	26.5	19.4	19.7	17.1	12.7	12.7
Never	76.0	73.5	80.6	80.3	82.9	87.3	87.3
Suicide attempts							
Past week	-	-	0.1	0.1	0.0	-	0.0
Past year	1.5	0.6	1.0	0.9	0.9	0.2	0.5
Lifetime	9.5	8.7	6.7	6.8	5.9	1.0	3.6
Never	90.5	91.3	93.3	93.2	94.1	99.0	96.4
Deliberate self-harm without suicidal intent	4.4	4.2	2.9	2.5	2.5	1.5	2.0
Base	*582*	*586*	*1256*	*938*	*1600*	*1316*	*3816*
Women							
Suicidal thoughts							
Past week	1.7	0.9	1.6	0.8	0.9	0.3	0.5
Past year	8.4	5.9	8.9	4.7	4.1	2.9	4.1
Lifetime	39.6	34.0	31.9	21.9	22.4	12.4	17.1
Never	60.4	66.0	68.1	78.1	77.6	87.7	82.9
Suicide attempts							
Past week	-	-	-	-	-	0.0	0.0
Past year	2.8	0.8	1.6	1.1	0.4	0.2	0.5
Lifetime	24.2	12.1	12.3	7.6	7.9	3.3	5.3
Never	75.8	87.9	87.7	92.4	92.1	96.7	94.7
Deliberate self-harm without suicidal intent	7.8	5.5	6.6	3.2	3.1	2.1	2.7
Base	*167*	*421*	*678*	*992*	*945*	*2577*	*4699*
All							
Suicidal thoughts							
Past week	1.1	1.0	0.6	0.7	0.5	0.2	0.4
Past year	7.1	6.8	6.0	5.1	4.6	2.6	3.9
Lifetime	26.8	29.2	23.2	20.7	18.8	10.1	14.9
Never	73.2	70.8	76.8	79.3	81.2	89.9	85.1
Suicide attempts							
Past week	-	-	0.0	0.0	0.0	0.0	0.0
Past year	1.7	0.7	1.2	1.0	0.7	0.2	0.5
Lifetime	12.2	9.9	8.4	7.1	6.6	2.4	4.4
Never	87.8	90.1	91.6	92.9	93.4	97.6	95.6
Deliberate self-harm without suicidal intent	5.0	4.7	4.0	2.8	2.7	1.9	2.4
Base	*749*	*1007*	*1934*	*1930*	*2545*	*3893*	*8515*

Table 5.4 Prevalence of non-fatal suicidal behaviour by victimisation experiences and sex

	Victimisation Experience								
	Running away from home	Sexual abuse	Violence in the home	Being homeless	Being expelled from school	Violence at work	Bullying	None of these	All
Men	*Cumulative percentage of population*								
Suicidal thoughts									
Past week	1.8	1.7	1.9	2.1	1.9	0.7	0.5	0.2	0.3
Past year	12.8	15.1	16.5	11.2	9.8	8.4	7.8	1.9	3.6
Lifetime	37.9	40.3	44.4	40.4	34.9	26.9	25.9	7.4	12.7
Never	62.1	59.7	55.6	59.6	65.1	73.1	74.1	92.6	87.3
Suicide attempts									
Past week	-	-	0.4	-	-	-	-	-	0.0
Past year	3.3	3.5	2.7	3.3	-	1.5	1.5	0.1	0.5
Lifetime	22.2	18.7	18.3	21.3	14.5	12.4	8.4	1.3	3.6
Never	77.8	81.3	81.7	78.7	85.5	87.6	91.6	98.7	96.4
Deliberate self-harm without suicidal intent	11.1	17.4	8.7	10.6	7.6	4.9	4.6	0.8	2.0
Base	*188*	*71*	*175*	*179*	*87*	*227*	*733*	*2695*	*3816*
Women									
Suicidal thoughts									
Past week	4.9	3.1	1.9	2.7	4.5	0.9	1.5	0.2	0.5
Past year	16.6	17.4	10.9	13.5	28.3	5.8	9.2	2.4	4.1
Lifetime	51.4	58.8	44.2	56.0	52.5	26.4	31.5	10.8	17.1
Never	48.6	41.2	55.8	44.0	47.5	73.6	68.5	89.2	82.9
Suicide attempts									
Past week	0.5	-	-	-	-	-	-	-	0.0
Past year	4.7	3.9	2.7	2.7	8.2	1.2	1.8	0.1	0.5
Lifetime	30.1	28.1	23.3	28.1	25.7	10.2	11.6	2.3	5.3
Never	69.9	71.9	76.7	71.9	74.3	89.8	88.4	97.7	94.7
Deliberate self-harm without suicidal intent	16.2	13.2	10.4	13.4	25.7	4.3	7.8	0.9	2.7
Base	*267*	*275*	*539*	*190*	*54*	*96*	*746*	*3342*	*4698*
All									
Suicidal thoughts									
Past week	3.4	2.7	1.9	2.4	2.7	0.8	1.0	0.2	0.4
Past year	14.8	16.9	12.6	12.3	15.6	7.8	8.4	2.1	3.9
Lifetime	44.9	54.5	44.3	47.5	40.5	26.7	28.5	9.1	14.9
Never	55.1	45.5	55.7	52.5	59.5	73.3	71.5	90.9	85.1
Suicide attempts									
Past week	0.2	-	0.1	-	-	-	-	-	0.0
Past year	4.0	3.8	2.7	3.0	2.6	1.4	1.7	0.1	0.5
Lifetime	26.3	25.9	21.8	24.4	18.1	11.8	9.9	1.8	4.4
Never	73.7	74.1	78.2	75.6	81.9	88.2	90.1	98.2	95.6
Deliberate self-harm without suicidal intent	13.8	14.2	9.9	11.9	13.3	4.8	6.1	0.9	2.4
Base	*455*	*346*	*714*	*369*	*141*	*323*	*1479*	*6037*	*8514*

Table 5.5 Prevalence of non-fatal suicidal behaviour by perceived social support and sex

	Perceived social support			
	Severe lack	Moderate lack	No lack	All
Men		*Cumulative percentage of population*		
Suicidal thoughts				
Past week	1.1	0.5	0.1	0.3
Past year	8.2	3.1	3.1	3.6
Lifetime	22.0	14.0	10.8	12.8
Never	78.0	86.0	87.2	87.2
Suicide attempts				
Past week	-	-	0.0	0.0
Past year	1.5	0.5	0.3	0.5
Lifetime	7.6	4.1	2.7	3.6
Never	92.4	95.9	97.3	96.4
Deliberate self-harm without suicidal intent	3.6	2.8	1.5	2.0
Base	*429*	*973*	*2395*	*3797*
Women				
Suicidal thoughts				
Past week	2.2	0.9	0.3	0.5
Past year	15.9	6.1	2.7	4.1
Lifetime	35.3	23.3	14.3	17.1
Never	64.7	76.7	85.7	82.9
Suicide attempts				
Past week	-	-	0.0	0.0
Past year	3.0	1.1	0.3	0.6
Lifetime	16.1	7.2	3.4	5.3
Never	83.9	92.8	96.6	94.7
Deliberate self-harm without suicidal intent	11.8	2.7	2.0	2.7
Base	*290*	*867*	*3532*	*4689*
All				
Suicidal thoughts				
Past week	1.5	0.7	0.2	0.4
Past year	10.9	4.3	3.9	3.9
Lifetime	26.7	17.9	14.9	14.9
Never	73.3	82.1	85.1	85.1
Suicide attempts				
Past week	-	-	0.0	0.0
Past year	2.0	0.7	0.3	0.5
Lifetime	10.6	5.4	3.4	4.4
Never	89.4	94.6	96.6	95.6
Deliberate self-harm without suicidal intent	6.5	2.8	1.8	2.4
Base	*719*	*1840*	*5927*	*8486*

Table 5.6 Prevalence of non-fatal suicidal behaviour by size of primary support group and sex

	Size of primary support group			
	3 and under	4 – 8	9 and over	All
Men	*Cumulative percentage of population*			
Suicidal thoughts				
Past week	1.8	0.4	0.1	0.3
Past year	10.4	4.7	2.6	3.6
Lifetime	23.2	15.6	10.7	12.7
Never	76.8	84.4	89.3	87.3
Suicide attempts				
Past week	0.3	-	-	0.0
Past year	2.6	0.4	0.3	0.5
Lifetime	10.0	4.6	2.6	3.6
Never	90.0	95.4	97.4	96.4
Deliberate self-harm without suicidal intent	5.6	2.8	1.4	2.0
Base	*277*	*1027*	*2499*	*3803*
Women				
Suicidal thoughts				
Past week	3.6	1.0	0.1	0.5
Past year	14.2	6.8	2.1	4.1
Lifetime	38.6	22.6	13.1	17.1
Never	61.4	77.4	86.9	82.9
Suicide attempts				
Past week	-	0.1	-	0.0
Past year	3.6	1.0	0.1	0.6
Lifetime	15.5	7.7	3.5	5.3
Never	84.5	92.3	96.5	94.7
Deliberate self-harm without suicidal intent	9.4	4.6	1.4	2.7
Base	*239*	*1490*	*2960*	*4689*
All				
Suicidal thoughts				
Past week	2.6	0.7	0.1	0.4
Past year	12.0	5.8	2.4	3.9
Lifetime	29.8	19.4	11.8	14.9
Never	70.2	80.6	88.2	85.1
Suicide attempts				
Past week	0.2	0.0	-	0.0
Past year	3.0	0.7	0.2	0.5
Lifetime	12.3	6.3	3.0	4.4
Never	87.7	93.7	97.0	95.6
Deliberate self-harm without suicidal intent	7.2	3.8	1.4	2.4
Base	*516*	*2517*	*5459*	*8492*

Table 5.7 Social functioning characterstics by lifetime suicidal thoughts

	Had suicidal thoughts in lifetime		
	Yes	No	All
	%	%	%
Relationship problems, illness and bereavement			
Death of close friend/other relative	65	64	64
Death of close relative	50	54	54
Serious illness injury or assault	38	23	26
Serious illness injury or assault to close relative	33	23	24
Separation or divorce	36	20	22
Serious problem with close friend/relative	21	10	12
None of these	5	10	10
Base	*1367*	*7148*	*8515*
Employment and financial crises			
Made redundant or sacked	37	28	30
Looking for work for 1 month and over	36	21	23
Something valued lost or stolen	31	21	22
Major financial crisis	22	9	11
Problem with police and court appearance	16	8	9
None of these	31	49	46
Base	*1368*	*7147*	*8515*
Victimisation experiences			
Bullying	34	15	18
Violence in the home	20	4	7
Running away from home	16	3	5
Violence at work	7	3	4
Being homeless	12	2	4
Sexual abuse	12	2	3
Being expelled from school	5	1	2
None of these	44	76	71
Base	*1367*	*7147*	*8514*
Number of stressful life events			
0	2	6	5
1	6	15	14
2	11	20	19
3	15	20	19
4	14	16	16
5	15	10	10
6 and over	38	14	17
Base	*1380*	*7192*	*8572*
Perceived Social Support			
Severe lack	14	7	8
Moderate lack	26	21	22
No lack	60	72	70
Base	*1365*	*7121*	*8486*
Size of primary support group			
3 and under	10	4	5
4 – 8	37	27	29
9 and over	53	69	66
Base	*1365*	*7127*	*8492*

Table 5.8 Social functioning characteristics by lifetime suicide attempts

	Had suicide attempts in lifetime		
	Yes	No	All
	%	%	%
Relationship problems, illness and bereavement			
Death of close friend/other relative	65	64	64
Death of close relative	49	53	53
Serious illness injury or assault	52	23	26
Serious illness injury or assault to close relative	33	23	24
Separation or divorce	44	21	22
Serious problem with close friend/relative	21	11	12
None of these	2	10	9
Base	*425*	*8089*	*8514*
Employment and financial crises			
Made redundant or sacked	44	29	30
Looking for work for 1 month and over	44	22	23
Something valued lost or stolen	36	22	22
Major financial crisis	25	11	11
Problem with police and court appearance	25	8	9
None of these	25	47	46
Base	*425*	*8089*	*8514*
Victimisation experiences			
Bullying	40	17	18
Violence in the home	34	6	7
Running away from home	31	4	5
Violence at work	21	3	4
Being homeless	11	4	4
Sexual abuse	20	3	3
Being expelled from school	7	2	2
None of these	29	73	71
Base	*424*	*8089*	*8513*
Number of stressful life events			
0	2	5	5
1	3	14	14
2	8	19	19
3	8	20	19
4	11	16	16
5	13	10	10
6 and under	56	16	17
Base	*430*	*8141*	*8571*
Perceived Social Support			
Severe lack	19	7	8
Moderate lack	27	22	22
No lack	54	71	70
Base	*424*	*8061*	*8485*
Size of primary support group			
3 and under	14	5	5
4 –8	41	28	29
9 and over	45	67	66
Base	*424*	*8067*	*8491*

Table 5.9 Social functioning characteristics by lifetime deliberate self-harm

	Lifetime deliberate self-harm		
	Yes	No	All
	%	%	%
Relationship problems, illness and bereavement			
Death of close friend/other relative	70	64	64
Death of close relative	37	53	53
Serious illness injury or assault	47	23	26
Serious illness injury or assault to close relative	33	23	24
Separation or divorce	36	22	22
Serious problem with close friend/relative	21	12	12
None of these	2	9	9
Base	*197*	*8321*	*8518*
Employment and financial crises			
Made redundant or sacked	33	29	30
Looking for work for 1 month and over	40	23	23
Something valued lost or stolen	26	22	22
Major financial crisis	23	11	11
Problem with police and court appearance	19	9	9
None of these	36	46	46
Base	*197*	*8321*	*8518*
Victimisation experiences			
Bullying	46	17	18
Violence in the home	29	6	7
Running away from home	30	5	5
Violence at work	19	3	4
Being homeless	8	4	4
Sexual abuse	21	3	3
Being expelled from school	10	2	2
None of these	26	72	71
Base	*196*	*8321*	*8517*
Number of stressful life events			
0	1	5	5
1	4	14	14
2	10	19	19
3	13	19	19
4	13	16	16
5	11	10	10
6 and under	48	17	17
Base	*200*	*8375*	*8575*
Perceived Social Support			
Severe lack	22	8	8
Moderate lack	26	22	22
No lack	53	71	70
Base	*197*	*8292*	*8489*
Size of primary support group			
3 and under	16	5	5
4 – 8	46	28	29
9 and over	39	67	66
Base	*197*	*8298*	*8495*

6 Correlates of suicidal behaviour: logistic regression analysis

6.1 Multiple logistic regression and Odds Ratios

Logistic regression analysis has been used to provide a measure of the independent association between socio-demographic, psychiatric and social functioning variables and non-fatal suicidal behaviour. Unlike the crosstabulations presented in the previous three chapters, logistic regression estimates the effect of one variable while controlling for the confounding effect of other variables in the analysis.

Logistic regression produces an estimate of the probability of an event (eg a suicide attempt) occurring to individuals in a given category compared with a reference category for that variable (eg having a neurotic disorder compared with not having one, or in the age range 16 to 24 compared with 65- to 74-year-olds). This effect is measured in terms of odds.

The amount by which the odds actually increases is shown by the Adjusted Odds Ratio (OR). For example, an OR of 1.90 indicates that women (compared with men) have nearly double the odds of a lifetime suicide attempt, controlling for the possible confounding effects of the other variables in the statistical model. To determine whether this increase is due to chance rather than to the effect of the variable, one must consult the associated 95% confidence interval.

Confidence intervals around an Odds Ratio

The confidence intervals around odds ratios can best be described by an example. Table 6.1, shows an odds ratio of 1.70 for the association between sex and suicidal thoughts, with a confidence interval from 1.44 to 2.00, indicating that the 'true' (i.e., population) OR is likely to lie between these two values. If the confidence interval does not include 1.00 then the OR is likely to be significant – that is, the association between the variable and the odds of a particular suicidal behaviour is unlikely to be due to chance. If the interval includes 1.00, then it is possible that the 'true' OR is actually 1.00, that is, no increase in odds can be attributed to the variable.

Odds ratios and how to use them multiplicatively

The odds ratios presented in the tables show the adjusted odds due solely to membership of one particularly category – for example, being female rather than male. However, multiplying them together can combine odds for more than one category. This provides an estimate of the increased odds of suicidal behaviour due to being a member of more than one category at once – for example, being a woman and having a psychotic disorder. For example, in Table 6.1 being female rather than male increases the odds of a lifetime suicidal attempt (OR=1.70), while in Table 6.3, having a psychotic disorder (compared with not having psychosis) also independently increases the odds (OR=3.73). The increased odds for women with psychosis compared with men without psychosis is therefore the product of the two independent odds ratios, 6.34.

The reference group chosen for a variable was that with the lowest prevalence. With ordinal or interval variables, eg educational qualifications or age, the group with the lower prevalence of the two extremes of the range was chosen, i.e. the oldest age group.

6.2 Correlates of suicidal thoughts

The socio-demographic, socio-economic, psychiatric and social functioning variables were all entered into the logistic regression analysis together. Not surprisingly, all the psychiatric disorders were independently and significantly associated with lifetime suicide thoughts.

The odds of respondents with psychosis (compared with the rest of the survey sample) of having lifetime suicidal thoughts was 3.73. The corresponding figures for the six neurotic disorders ranged from 2.24 for phobia to 2.91 for

obsessive-compulsive disorder. Those with alcohol and drug dependence were also more likely to have had lifetime suicidal thoughts (OR= 2.12 and 1.56) compared with the non-dependent groups.

However, the most marked association with ever having thought about suicide was the number of stressful life events. Compared with the group who had never experienced a stressful life event, those who reported three or more events had over three times the odds of having had suicidal thoughts and the odds ratio increased to 9.75 among the group who had experienced six or more events. The other two social functioning variables were also significantly associated with lifetime suicidal thoughts: those with a severe lack of social support (compared with no lack) were 75% more likely to have ever had suicidal thoughts and then those with a small primary support group (3 or less) were about 50% more likely than respondents with a primary support group of 9 or more to have had such thoughts.

Of the nine socio-demographic and socio-economic variables entered into the analysis only age, sex and ethnicity produced significant associations. Suicidal thoughts were more prevalent among the younger age groups, women and those who reported their ethnicity as White. This confirms the suggestions made by other authors (see Chapter 4) that marital status, economic activity, social class and tenure do not have a direct causal relationship with suicidal ideation and that they are confounded with psychiatric and social functioning characteristics. *(Tables 6.1 to 6.4)*

6.3 Correlates of suicide attempts

The number of factors independently associated with lifetime, suicide attempts were less than with suicidal thoughts. The two factors which seemed to have the greatest influence were number of stressful life events and psychosis. The odds ratio for six or more versus no stressful events was 13.64 and for psychosis compared with no psychosis the odds ratio was 6.07. Focusing on the neurotic disorders, those with anxiety, depression or mixed anxiety and depression were about twice as likely to have made suicide attempts, controlling for other confounding variables. This is in contrast to the ORs for suicidal thoughts, where the two most significant neurotic disorders were OCD and phobia. However, the relationship between age, sex and suicide attempts were similar to those for suicidal thoughts, being far more likely to occur among women and 16- to 34-year-olds. *(Tables 6.1 to 6.4)*

An additional analysis was carried out just among those who had suicidal thoughts to investigate the factors which distinguished between those in this group who went on to attempt suicide and those who did not. Two factors emerged. Those with psychosis among the group with suicidal thoughts were over four times more likely to have made a suicide attempt (OR=4.38) and people living in housing association or local authority rented accommodation (compared with owner occupiers) were two and a quarter times more likely to follow up their wishes.

6.4 Correlates of deliberate self-harm

The main variables in the logistic regression model associated with deliberate self-harm, shown in Tables 6.1 to 6.4 were:

- number of stressful like events (OR= 17.74 for 6 or more events compared to none);
- age (OR=10.89 for 16- to 24-year-olds compared with 65- to 74-year-olds);
- psychosis (OR=4.96);
- depression and mixed anxiety and depression (ORs = 2.68 and 2.86); and
- drug dependence, specifically those other than cannabis (OR=2.37).

Table 6.1 Socio-demographic correlates of non-fatal suicidal behaviour

	Lifetime suicidal thoughts		Lifetime suicide attempts		Deliberate self-harm	
Variable	Adjusted Odds ratio	95% C.I.	Adjusted Odds ratio	95% C.I.	Adjusted Odds ratio	95% C.I.
Age						
65–74	1.00	-	1.00	-	1.00	-
55–64	1.87***	1.38 - 2.54	1.71	0.99 - 2.95	1.73	0.53 - 5.66
45–54	2.23***	1.60 - 3.10	2.22**	1.25 - 3.92	1.69	0.50 - 5.66
35–44	2.90***	2.04 - 4.13	2.95***	1.61 - 5.40	3.76*	1.13 - 12.44
25–34	3.43***	2.38 - 4.94	4.30***	2.30 - 8.02	8.12***	2.44 - 26.98
16–24	3.80***	2.42 - 5.95	4.67***	2.22 - 9.82	10.89***	3.02 - 39.30
Sex						
Men	1.00	-	1.00	-	1.00	-
Women	1.70***	1.44 - 2.00	1.90***	1.43 - 2.51	1.60*	1.07 - 2.40
Marital Status						
Married	1.00	-	1.00	-	1.00	-
Separated	1.36	0.94 - 1.97	1.32	0.73 - 2.37	0.50	0.19 - 1.29
Single	1.11	0.85 - 1.46	0.83	0.52 - 1.32	0.91	0.50 - 1.69
Divorced	1.37*	1.04 - 1.82	1.33	0.83 - 2.22	0.74	0.36 - 1.52
Widowed	1.10	0.75 - 1.64	0.95	0.48 - 1.88	0.51	0.13 - 1.98
Family type						
Couple, no children	1.00	-	1.00	-	1.00	-
Couple and (child)ren	0.96	0.78 - 1.18	0.74	0.51-1.08	1.12	0.64 -1.89
Lone parent and (child)ren	0.97	0.70 - 1.34	0.91	0.54 - 1.52	1.21	0.58 -2.50
One person only	1.21	0.93- 1.56	1.28	0.82 - 1.98	1.22	0.66 - 2.26
Adult with parents	1.52	0.82 - 2.83	1.54	0.50 -4.79	1.66	0.44 - 6.22
Adult with one parent	0.98	0.66 -1.44	0.93	0.47 - 1.84	1.56	0.70 - 3.50
Ethnic origin						
White	1.00	-	1.00	-	1.00	-
Black	0.38***	0.21 - 0.61	0.36*	0.14 - 0.94	0.83	0.30 - 2.33
South Asian	0.22***	0.01 - 0.51	0.57	0.17 - 1.96	0.84	0.20 - 3.63
Other	0.72	0.43 - 1.20	1.08	0.52 - 2.25	0.42	0.10 - 1.78

*** p<0.001, ** p<0.01, * p<0.05

Table 6.2 Socio-economic correlates of non-fatal suicidal behaviour

Variable	Lifetime suicidal thoughts		Lifetime suicide attempts		Deliberate self-harm	
	Adjusted Odds ratio	95% C.I.	Adjusted Odds ratio	95% C.I.	Adjusted Odds ratio	95% C.I.
Educational qualifications						
No qualifications	1.00	-	1.00	-	1.00	-
GCSE level	1.11	0.92 - 1.34	1.01	0.76 -1.36	0.68	0.44 - 1.06
A levels or above	1.32	1.07 - 1.63	0.81	0.57 - 1.16	0.72	0.43 = 1.12
Employment status						
Working full time	1.00	-	1.00	-	1.00	-
Working part time	1.10	0.90 - 1.35	0.94	0.65 - 1.35	1.32	0.81 - 2.16
Unemployed	1.09	0.76 - 1.55	1.02	0.61 -1.74	1.55	0.77 - 3.13
Economically inactive	1.15	0.94 - 1.40	1.14	0.83 - 1.58	1.16	0.72 - 1.88
Social Class						
I	1.00	-	1.00	-	1.00	-
II	0.75	0.54 - 1.04	1.21	0.56 - 2.60	0.40*	0.19 - 0.87
III Non-manual	0.83	0.59 - 1.18	1.31	0.59 - 2.90	0.46	0.20 -1.02
III Manual	0.69*	0.48 - 0.99	1.44	0.65 - 3.20	0.34*	0.15 - 0.80
IV	0.74	0.51 - 1.06	1.31	0.58 - 2.93	0.57	0.25 - 1.30
V	0.75	0.49 - 1.16	1.80	0.76 - 4.24	0.39	0.15 - 1.06
Tenure						
Owned outright	1.00	-	1.00	-	1.00	-
Owned with mortgage	0.95	0.77 - 1.17	1.08	0.72 - 1.62	1.20	0.61 - 2.35
Rented from LA or HA	1.21	0.96 - 1.53	2.24	1.50 - 3.35	1.44	0.72 - 2.91
Rented from other source	1.06	0.80 - 1.41	1.17	0.71 - 1.93	2.24*	1.08 - 4.67

*** p<0.001, ** p<0.01, * p<0.05

Table 6.3 Psychiatric correlates of non-fatal suicidal behaviour

Variable	Lifetime suicidal thoughts		Lifetime suicide attempts		Deliberate self-harm	
	Adjusted Odds ratio	95% C.I.	Adjusted Odds ratio	95% C.I.	Adjusted Odds ratio	95% C.I.
Probable psychosis						
No	1.00	-	1.00	-	1.00	-
Yes	3.73***	(1.79 - 7.80)	6.07***	(2.98 - 12.38)	4.96***	(2.06 - 11.90)
Obsessive Compulsive Disorder						
No	1.00	-	1.00	-	1.00	-
Yes	2.91***	1.77 - 4.80	1.20	0.65 - 2.23	0.85	0.38 - 1.91
Mixed Anxiety and Depressive Disorder						
No	1.00	-	1.00	-	1.00	-
Yes	2.86***	2.37 - 3.44	2.60***	1.95 - 3.48	2.86***	1.89 - 4.33
General Anxiety Disorder						
No	1.00	-	1.00	-	1.00	-
Yes	2.58***	2.00 - 3.32	2.02***	1.41 - 2.89	1.97**	1.18 - 3.30
Panic						
No	1.00	-	1.00	-	1.00	-
Yes	2.69***	1.53 - 4.71	1.72	0.80 - 3.70	1.13	0.31 - 4.12
Depression						
No	1.00	-	1.00	-	1.00	-
Yes	2.25***	1.61 - 3.14	2.13***	1.41 - 3.23	2.68***	1.52 - 4.73
Phobia						
No	1.00	-	1.00	-	1.00	-
Yes	2.24***	1.49 - 3.37	1.78*	1.10 - 2.90	3.08	1.68 - 5.65
Drug dependence						
Not dependent	1.00	-	1.00	-	1.00	-
Cannabis only	1.59*	1.09 - 2.33	1.55	0.92 - 2.62	1.21	0.77 - 1.89
Other drugs +/- cannabis	2.12**	1.24 - 3.63	1.80	0.92 - 3.55	2.37***	1.50 - 3.77
Alcohol dependence						
No hazardous alcohol use	1.00	-	1.00	-	1.00	-
Hazardous use, not dependent	1.06	0.89 - 1.28	1.34	0.99 - 1.81	1.42	0.74 - 2.69
Alcohol dependence	1.56***	1.56 -1.22	1.61*	1.11 -2.33	1.19	0.51 - 2.76

*** p<0.001, ** p<0.01, * p<0.05

Table 6.4 Social functioning correlates of non-fatal suicidal behaviour

Variable	Lifetime suicidal thoughts		Lifetime suicide attempts		Deliberate self-harm	
	Adjusted Odds ratio	95% C.I.	Adjusted Odds ratio	95% C.I.	Adjusted Odds ratio	95% C.I.
No. of stressful life events						
None	1.00	-	1.00	-	1.00	-
1	1.81	0.93 - 3.53	1.53	0.33 - 7.06	2.00	0.22 - 17.46
2	2.38**	1.25 - 4.53	2.71	0.64 - 11.51	3.98	0.51 - 31.01
3	3.39***	1.79 - 6.41	2.62	0.62 - 11.14	6.21	0.81 - 47.48
4	4.21***	2.22 - 7.98	4.09	0.97 - 17.23	9.77*	1.28 - 74.32
5	6.35***	3.34 - 12.07	6.33*	1.51 - 26.57	9.94*	1.30 - 76.47
6 and over	9.75***	5.18 - 18.35	13.64***	3.31 - 56.16	17.74**	2.37 - 132.60
Perceived social support						
No lack	1.00	-	1.00	-	1.00	-
Moderate lack	1.35***	1.15 - 1.59	1.27	0.97 - 1.66	0.95	0.62 - 1.44
Severe lack	1.71***	1.36 - 2.16	1.48*	1.04 - 2.08	1.86**	1.16 - 2.96
Primary support group						
9 and over	1.00	-	1.00	-	1.00	-
4 – 8	1.37***	1.18 - 1.58	1.34*	1.04 - 1.73	1.72**	1.19 - 2.45
3 and under	1.48***	1.14 - 1.93	1.44	0.98 - 2.12	1.48	0.84 - 2.60

*** p<0.001, ** p<0.01, * p<0.05

7 Help seeking behaviour following suicide attempts

About half (52%) of respondents who had ever attempted suicide, said they had sought some help. Three in ten (30%) had seen a specialist medical service, such as a psychiatrist or counsellor or someone at the local hospital, a quarter (25%) had sought help from their GP or family doctor, and a quarter (25%) had asked friends or family for help.

Although it appeared that women were more likely than men to seek help, the difference was not statistically significant probably due to the low number of respondents in the subgroups. *(Table 7.1)*

Table 7.2 shows that respondents of different ages who had ever tried to commit suicide tended to seek help from different groups of people. Those in the youngest age group (16 to 24) were more likely to seek help from their friends and family, whereas older respondents were more likely to have been referred to a specialist service such as a counsellor or psychiatrist. *(Table 7.2)*

A similar percentage of respondents who had deliberately self-harmed sought help (50%). Just over a third (36%) had received medical attention, and a similar percentage (37%) had seen a psychiatrist. *(Table 7.3)*

Table 7.1 Sources of help following suicide attempts

by sex

	Sex		
	Men	Women	Total
	Percentage		
Source of help*			
Friend/family/neighbours	22	27	25
GP	26	25	25
Specialist medical service	25	33	30
Voluntary service	3	2	2
Someone else	3	1	2
Received help	48	54	52
Did not receive help	52	46	48
Base (= Respondents who had attempted suicide)	*156*	*273*	*429*

* Percentages sum to more than the 'Received help' total as respondents could give more then one answer.

Table 7.2 Sources of help following suicide attempts

by age

	Age				
	16–24	25–44	45–64	65–74	Total
	%	%	%		%
Source of help*					
Friend/family/neighbours	40	22	20	[5]	25
GP	21	26	28	[5]	25
Specialist medical service	18	33	28	[13]	30
Voluntary service	-	3	3	[0]	2
Someone else	1	3	-	[0]	2
Received help	51	52	52	[14]	52
Did not receive help	49	48	48	[10]	48
Base (= Respondents who had attempted suicide)	*48*	*231*	*126*	*24*	*429*

* Percentages sum to more than the 'Received help' total as respondents could give more then one answer.

Table 7.3 Sources of help following deliberate self-harm

by sex

	Sex		
	Men	Women	Total
		Percentage	
Source of help*			
Received medical attention	28	41	36
Seen a psychiatrist	28	45	37
Received help	40	58	50
Did not receive help	60	42	50
Base (=Respondents who had deliberately self-harmed themselves)	*71*	*122*	*193*

* Percentages sum to more than the 'Received help' total as respondents could give more then one answer.

To navigate throughout the Glossary either use its Bookmarks or Select the HAND tool, position it over the list below and when an Arrow appears on the hand click the mouse button once to enlarge the text. Continue clicking the arrowed hand tool to advance throughout the list.

Glossary of survey definitions and terms

Adults

In this survey adults were defined as persons aged 16 or over and less than 75.

Alcohol dependence

Alcohol misuse was measured using two different instruments. First the Alcohol Use Disorders Identification Test (AUDIT) was used to assess hazardous drinking (see below). Those who scored 10 or above on the AUDIT were also asked the Severity of Alcohol Dependence Questionnaire (SAD-Q). People who scored 4 or more on the SAD-Q were considered to be dependent on alcohol.

Drug dependence

In the year prior to interview drug dependence was measured by asking all those who had used drugs in the past year a series of five questions. These covered: daily use of the drug for two weeks or more; feelings of dependence; inability to cut down; need for increasing quantities; withdrawal symptoms. For a person to be considered cannabis dependent, positive responses to at least two of these questions were required. For the other drugs (heroin, methadone, amphetamines, crack and cocaine powder) one positive response was taken to indicate a measure of dependence.

Drugs used in psychoses etc

Drugs used in psychoses and related conditions include antipsychotic drugs, including depot injections. These are also known as 'neuroleptics'. In the short term they are used to quieten disturbed patients whatever the underlying psychopathology. See depot injections. Also included in this group are antimanic drugs which are used in mania to control acute attacks and prevent their recurrence.

Economic activity

Economically active persons are those over the minimum school-leaving age who were working or unemployed in the week before the week of interview. These persons constitute the labour force.

Working persons
This category includes persons aged 16 and over who, in the week before the week of interview, worked for wages, salary or other form of cash payment such as commission or tips, for any number of hours. It covers persons absent from work in the reference week because of holiday, sickness, strike or temporary lay-off, provided they had a job to return with the same employer. It also includes persons attending an educational establishment during the specified week if they were paid by their employer while attending it, people who worked in Government training schemes and unpaid family workers.

Persons are excluded if they have worked in a voluntary capacity for expenses only, or only for payment in kind, unless they worked for a business, firm or professional practice owned by a relative.

Full-time students are classified as 'working', 'unemployed' or 'inactive' according to their own reports of what they were doing during the reference week.

Unemployed persons
This survey used the International Labour Organisation (ILO) definition of unemployment. This classifies anyone as unemployed if he or she was out of work in the four weeks before interview, or would have but for temporary sickness or injury, and was available to start work in the two weeks after the interview. Otherwise, anyone out of work is classified as economically inactive.

The treatment of all categories on this survey is in line with that used in the Labour Force Survey (LFS)

Educational level

Educational level was based on the highest educational qualification obtained and was grouped as follows:

Degree or higher degree
NVQ Level 5

Teaching qualification
HNC/HND
BRC/TEC Higher
BTEC/SCOTVEC Higher
City and Guilds
Full Technological Certificate
Nursing Qualifications (SRN, SCM, RGN, RM, RHV, Midwife)
NVQ Level 4

GCE A levels and AS levels
SCE Higher
ONC/OND/BTEC/TEC/BTEC not higher
City and Guilds Advanced/Final Level
GNVQ (Advanced Level)
NVQ Level 3

GCE O level passes (Grade A–C if after 1975)
GCSE (Grades A–C)
CSE Grade 1
SCE Ordinary (Bands A–C)
Standard Grade (Level 1–3)
School Certificate or Matric
City and Guilds Craft/Ordinary Level
GNVQ (Intermediate level)
NVQ Level 2

CSE Grades 2-5
GCE O level Grades D and E after 1975
GCSE (Grades D,E,F,G)
SCE Ordinary (Bands D and E)
Standard Grade (Level 4,5)
Clerical or Commercial qualifications
Apprenticeships
NVQ Level 1 and GNVQ (Foundation Level)

CSE ungraded
No formal qualifications

Ethnicity

Household members were classified into nine groups by the person selected for interview. For analysis purpose these nine groups were subsumed under 4 headings: White, Black, South Asian and Other.

White	White
Black–Caribbean Black–African Black–Other	Black
Indian Pakistani Bangladeshi	South Asian
Chinese Other	Other

Family Unit

In order to classify the relationships of the subject to other members of the households, the household members were divided into family units.

Subjects were assigned to a family unit depending on whether they were or had ever been married, and whether they (or their partners) had any children living with them.

A 'child' was defined for family unit purposes as an adult who lives with one or two parents, provided he or she has never been married and has no child of his or her own in the household.

For example, a household containing three women, a grandmother, a mother and a child would contain two family units with the mother and child being in one unit, and the grandmother being in another. Hence family units can consist of:

- A married or cohabiting couple or a lone parent with their children
- Other married or cohabiting couples
- An adult who has previously been married. If the adult is now living with parents, the parents are treated as being in a separate family unit.
- An adult who does not live with either a spouse, partner, child or parent. This can include adults who live with siblings or with other unrelated people, eg flatmates.

Family unit type

Each informant's family unit was classified into one of six family unit types:

'Couple no children' included a married cohabiting couple without children.

'Couple with child' comprised a married or cohabiting couple with at least one child from their liaison or any previous relationship.

'Lone parent' describes both men and women (who may be single, widowed, divorced or separated) living with at least one child. The subject in this case could be a divorced man looking after his 12-year-old son or a 55-year-old widow looking after a 35-year-old daughter who had never married and had no children of her own.

'One person' describes the family unit type and does not necessarily mean living alone. It includes people living alone but includes one person living with a sister, or the grandmother who is living with her daughter and her family. It also includes adults living with unrelated people in shared houses, eg flatmates.

'Adult living with parents' describes a family unit which has the same members as 'couple with child' but in this case it is the adult son or daughter who is the subject. It includes a 20 year old unmarried student living at home with married or cohabiting parents, and a 62-year-old single woman caring for her elderly parents.

'Adult living with lone parent' covers the same situations as above except there is one and not two parents in the household.

Hazardous alcohol use

Hazardous alcohol use is a pattern of drinking carrying with it a high risk of damage to health in the future. The prevalence of alcohol misuse in the previous year was assessed using the Alcohol Use Disorders Identification Test (AUDIT) at the initial interview. An AUDIT score of eight or above indicates likely hazardous alcohol use.

Household

The standard definition used in most surveys carried out by ONS Social Survey Division, and comparable with the 1991 Census definition of a household, was used in this survey. A household is defined as single person or group of people who have the accommodation as their only or main residence and who either share one meal a day or share the living accommodation. (See E McCrossan *A Handbook for interviewers*. HMSO: London 1991)

Marital Status

Informants were categorised to their own perception of marital status. Married and cohabiting took priority over other categories. Cohabiting included anyone living together with their partner as a couple.

Neurotic disorders, depression or anxiety disorders

These are characterised by a variety of symptoms such as fatigue and sleep problems, forgetfulness and concentration difficulties, irritability, worry, panic, hopelessness, and obsessions and compulsions, which are present to such a degree that they cause problems with daily activities and distress. The prevalence of neurotic symptoms in the week prior to interview was assessed using the revised version of the Clinical Interview Schedule (CIS-R). A score of 12 or more indicates the presence of significant neurotic symptoms while a score of 18 or more indicates symptoms of a level likely to require treatment.

Psychiatric Morbidity

The expression psychiatric morbidity refers to the degree or extent of the prevalence of mental health problems within a defined area.

Psychoses

These are disorders that produce disturbances in thinking and perception that are severe enough to distort the person's perception of the world and the relationship of events within it. Psychoses are normally divided into two groups: organic psychoses, such as dementia and Alzheimer's disease, and functional psychoses, which mainly cover schizophrenia and manic depression.

Region

When the survey was carried out there were 8 NHS Regional Office Areas in England. These were the basis for stratified sampling and have been retained for purposes of analysis. Scotland and Wales were treated as two distinct areas.

Social Class

Based on the Registrars General's 1991 *Standard Occupational Classification*, Volume 3 OPCS, HMSO: London social class was ascribed on the basis of the informants own occupation. If the informant was unemployed or economically inactive at the time of interview but had previously worked, social class was based on the most recent previous occupation.

The classification used in the tables are as follows:

Descriptive Definition	Social Class
Professional	I
Intermediate occupations	II
Skilled occupations – non-manual	III NM
Skilled occupation – manual	III M
Partly-skilled	IV
Unskilled occupations	V
Armed Forces	

Social class was not determined where the subject had never worked, or if the subject was a full-time student or where occupation was inadequately described.

Tenure

Four tenure categories were created:
'Owned outright' means bought without a mortgage or loan or with a mortgage or loan which has been paid off.

'Owned with mortgage' includes co-ownership and shared ownership schemes.

'Rent from LA/HA' means rented from local authorities, New Town corporations or commissions or Scottish Homes, and housing associations which include co-operatives and property owned by charitable trusts.

'Rent from other source' includes rent from organisations (property company, employer or other organisation) and from individuals (relative, friend, employer or other individual).

national STATISTICS

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Report based on the analysis of the ONS Survey of Psychiatric Morbidity among Adults in Great Britain carried out in 2000 for the Department of Health, the Scottish Executive Health Department and the National Assembly for Wales

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This report has been produced by the Social Survey Division of the Office for National Statistics in accordance with the Official Statistics Code of Practice.

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Notes to tables

1 Tables showing percentages

The row or column percentages may add to 99% or 101% because of rounding.

The varying positions of the percentage signs and bases in the tables denote the presentation of different types of information. Where there is a percentage sign at the head of a column and the base at the foot, the whole distribution is presented and the individual percentages add to between 99% and 101%. Where there is no percentage sign in the table and a note above the figures, the figures refer to the proportion of people who had the attribute being discussed, and the complementary proportion, to add to 100%, is not shown in the table.

The following conventions have been used within tables:

- \- no cases
- 0 values less than 0.5%
- .. data not available

2 Statistical significance

Unless otherwise stated, differences mentioned in the text have been found to be statistically significant at the 95% confidence level. Standard errors that reflect the complex sampling design and weighting procedures used in the survey have been calculated and used in tests of statistical significance.

3 Small bases

Very small bases have been avoided wherever possible because of the relatively high sampling errors that attach to small numbers. In general, percentage distributions are shown if the base is 30 or more. Where the base is lower, actual numbers are shown in square brackets.

Authors' Acknowledgements

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Mr G Russell, Scottish Executive
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Summary of key findings

1 Background and focus of the report

- This report is one of several topic reports looking at data from the survey carried out by ONS on the psychiatric morbidity of adults aged 16 to 74 living in private households in Great Britain. This report focuses mainly on the economic and social functioning of adults with mental disorders.

- This survey was commissioned by the Department of Health, the Scottish Executive Health Department and the National Assembly for Wales.

- The survey covered in this report was carried out in 2000 and is a repeat of the 1993 survey of adults living in private households. However, in 2000 there was a slight increase in the age range, so that it covered people aged 16 up to 74 years compared with 16 to 64 years in the 1993 survey.

- There was also an expansion of some of the topics covered, most notably, in the realm of economic and social functioning. For example, there were new sections on days off work due to sickness, the extent of debt, and satisfaction and stability of accommodation. The 2000 survey also included an assessment of Personality Disorder.

- The report is divided into five substantive chapters:

  - the economic circumstances of people with mental disorders;
  - their accommodation and living arrangements;
  - disability associated with mental health problems measured by difficulties with activities of daily living;
  - stressful life events and social networks, in particular; and
  - changes in the characteristics of people with neurotic disorders between 1993 and 2000.

- The content of the 2000 survey governed the range of psychiatric disorders covered in this report: (a) neurotic symptoms and disorders, (b) psychotic disorder, (c) alcohol use and dependence, and (d) drug dependence. Personality Disorder was also included in the 2000 survey but will be the subject of a separate report.

2 Education, employment and financial characteristics

- Compared with all other groups, those with a psychotic disorder were more likely to have left school before reaching sixteen years old and with no qualifications. The alcohol and drug dependent groups included the highest proportion of students, i.e. those who had not yet finished their full time education.

- Across the whole sample, about a third (33%) were unemployed or economically inactive whereas among those rated as having psychosis, the rate was more than double (72%).

- The proportion of the sample in the manual social classes among the non-disorder group was 39% in contrast to 44% of those with a current neurotic disorder, 52% and 54% of those with alcohol and drug dependence and rising to 61% of those with a psychotic disorder.

- The mean number of days off work in the past 12 months for a health problem was 19 for those with a neurotic disorder compared with a total sample average of 7 days.

- About 60% of the sample assessed as having a psychotic disorder were in a household with an income less than £300 a week compared with 37% of those with a current neurotic disorder and 28% of the sample with no mental disorder.

- Overall, 12% of the total sample of respondents said they had incurred some sort of debt in the past year. However, among the group with any of the four mental disorders covered in the survey, 24% had been behind with their payments.

- The bills that tended to be unpaid or paid late covered a wide spectrum but at least 5% had problems with paying their council tax, telephone bill, rent, gas bill, water rates and credit card payments.

- In terms of cutting down on the use of the telephone, gas, electricity and water, the rate of 6% for those with no disorder was doubled for the alcohol dependent group (12%), and at least tripled for those with drug dependence or neurotic disorders (18% and 21%) and rose to 33% among those with a psychotic disorder.

- Ten per cent of the no disorder group had borrowed money in the past 12 months. Among the group with any disorder just over a quarter had borrowed money and among the drug dependent group the proportion was 50%. The two primary sources of funds were from family and friends.

3 Family, household and housing characteristics

- Those with a disorder were more likely to be single, divorced or separated and less likely to be married. The groups rated as being alcohol and drug dependent had the highest proportions of single people: 58% and 77% respectively compared with 30% of the whole sample. Those with a psychotic disorder had the highest percentages of divorced and separated people: 26% and 7% respectively compared with the sample average of 8% and 3%.

- Among the sample assessed as currently having a neurotic disorder, 9% were lone parents compared with 4% in the no-disorder group. In the group with a probable psychotic disorder, 43% were living in a one-person family unit, almost three times the proportion of those with no mental disorder, 15%.

- Those with a mental disorder were far more likely than those with no disorder to be living in rented accommodation (38% compared with 24%). Among those with a psychotic disorder about half were living in accommodation rented from a housing association or local authority. The drug dependent group included the highest proportion in privately rented housing: 30%.

- Those with a disorder were slightly more negative than the no-disorder group in their assessment of the standard of their accommodation: 11% and 5% respectively said they were fairly or very dissatisfied. Similarly, the sample with any of the four types of mental disorder were twice as likely as those without a mental disorder to describe the state of repair of their home as poor: 9% compared with 4%.

- The most frequent complaint was lack of space – mentioned by 20% of all survey respondents, but by about 30% of those with a neurotic disorder, alcohol and drug dependence.

- Overall, 6% had doubts about the security of their present accommodation. This overall figure included 12% of those with neurosis, psychosis and alcohol dependence and 15% of the drug dependent group who were concerned about their security. The five main reasons respondents gave for their feelings of insecurity were: financial problems (20%), lease or contract was running out (18%) illness (14%), domestic problems (8%) and problems with landlord or agent (7%).

4 Activities of daily living (ADL)

- The seven areas of activity limitation considered in this survey were:

  - Personal care such as dressing, bathing, washing or using the toilet.
  - Using transport to get out and about.
  - Medical care such as taking medicines or pills, having injections or changes of dressing.
  - Household activities such as preparing meals, shopping, laundry and housework.
  - Practical activities such as gardening, decorating, or doing household repairs.
  - Dealing with paperwork such as writing letters, sending cards, or filling in forms.
  - Managing money such as budgeting for food or paying bills.

- Twenty-one per cent of the whole sample had difficulty with at least one ADL, comprising 16% of the no disorder group and 37% of those with any of the four specified mental disorders (neurosis, psychosis, alcohol and drug dependence).

- Among the groups with each type of disorder, there were marked variations in the proportions having difficulty with at least one ADL, ranging from 28% and 34% of the alcohol and drug dependent group to 45% of those with a current neurotic disorder and rising to 60% of those with a psychotic disorder.

- Among the whole sample, difficulties with practical activities had the highest prevalence at 12%, followed by dealing with paperwork (8%), household activities (6%) and using transport and managing money, both at 5%. Difficulties with personal care and medical care had rates of 4% and 1% respectively across the whole sample.

- Those with neurosis or psychosis were far more likely than the no-disorder group to have problems with every activity. Comparing the three groups, no disorder, neurosis and psychosis, the rates of difficulty with practical activities were: 9%, 26% and 30%; dealing with paperwork: 6%, 18% and 38%; household activities: 4%, 18% and 26%; and using transport: 3%, 16% and 20%.

- Those with alcohol and drug dependence were only markedly different from the no disorder group on one ADL: managing money. Here the rate among the group without a mental disorder was 2% compared with 16% and 26% among those with alcohol and drug dependence respectively.

5 Social context

- Over the course of their lives, just over half of survey respondents (53%) had experienced the death of a close relative and just over two-thirds (70%) the death of a close friend or other relative. About a quarter of the sample also reported separation or divorce (27%), serious illness, being a victim of assault or injury (26%) and serious illness, assault or injury to someone close (24%).

- Three of these six specified life events were twice as likely to have been experienced by those with a mental disorder compared with those with no mental disorder: separation or divorce (44% compared with 23%), serious injury, illness or assault (40% compared with 22%), and having a serious problem with a close friend or relative (27% compared with 13%).

- The prevalence of each lifetime experience was nearly always highest among the group with psychosis: 75% reported death of close friend or other relative; 72% mentioned the death of a close relative, 64% had a serious illness or injury, 55% were separated or divorced, and 33% had a serious problem with a close friend or relative.

- During their lifetime, 30% of respondents had been made redundant, 23% had been searching for work for a month or more, 22% had something of value lost or stolen, 11% had a major financial crisis and 9% had been in trouble involving a court appearance.

- Two of these five events showed significant differences in their frequency of reporting between those with and without a mental disorder: major financial crisis (22% compared with 9%) and being in trouble with the police necessitating a court appearance (14% compared with 7%). A quarter of those with psychosis had had a major financial crisis; a third of the drug dependent group and a quarter of the alcohol dependent group had been in trouble with the police involving a court appearance.

- Overall, 18% of survey respondents reported having been bullied, 7% experienced violence in the home and 5% had run away from home. Those with mental disorders were far more likely to have experienced any of the victimisation events than the no disorder group. For example, 3% of the group with no disorder said they had run away from home. The equivalent percentages among the currently neurotic group and those with alcohol dependence was 12%; the rate was 24% among those with drug dependence, and 34% among those with psychosis. (Figure 5.3)

- The lifetime prevalence of each victimisation experience was nearly always highest among the group with psychosis: 47% said they had been bullied, 37% had been subject to violence in the home, 34% had run away from home, 31% cited sexual abuse, 28% had been homeless, and 11% had experienced violence at work.

- Although being expelled from school had a prevalence rate of 1% among the no disorder group the percentages among the alcohol and drug dependent groups were 6% and 12% respectively.

- Only 2% of all survey respondents had been in local authority care or in a borstal or young offenders unit whereas among the group with psychosis 17% had been in local authority care and 4% in borstal.

- Overall, 8% of survey respondents were assessed as having a severe lack of perceived social support. Among the group with none of the four mental disorders covered in the survey the rate was 6% but among the groups with neurosis, alcohol and drug dependence, it was double that of the non-disorder group, 12–13%, and rose to 30% among the group with a psychotic disorder.

- Those with a mental disorder were about twice as likely to have a small primary support group, i.e. less than four people – 9% compared with 4%. However, the group with a psychotic disorder stood out from the rest with 32% of them having a primary support group of three or fewer people.

6 Comparison of the economic and social characteristics of people with mental disorders, 1993 and 2000

- Changes in the educational profile between the groups with neurotic disorders in 1993 and 2000 were: an increase of 4% of those with degrees (from 10 to 14%); an increase of 4% of those with A levels (from 11% to 15%) and a decrease of 5% of those with no qualifications (from 34% to 29%).

- Among the groups with neurotic disorders there was an increase in the proportion economically inactive, i.e. unemployed and not seeking work, which rose from 31% to 35% but there was also an increase in those working full time from 38% to 43%, still markedly less than the 55% employment rate of the non-disordered group. The big drop was in the unemployment rate from 14% in 1993 to 4% in 2000.

- In terms of social class the main movement between 1993 and 2000 was in the proportion of all respondents in Social Class III Manual (IIIM) – a fall of 10% and in Social Class III Non-Manual (IIINM) – a rise of 9%. This change was reflected in the groups with neurotic disorders: a decrease of 11% in IIIM and an increase of 8% in IIINM.

- The main change in the legal marital status of survey respondents between 1993 and 2000 was a decrease in the proportions who were married or cohabiting and a corresponding increase of being single (which includes cohabiting couples). Among those with neurotic disorders the proportions married fell by 12% with the single status group increasing by 7% and the divorce rate up by 4%.

- In the first survey, 33% of those with a neurotic disorder mentioned at least one ADL difficulty but this proportion rose to 41% in 2000. These increases were evident across all activities, the largest increases were found for practical activities (up 6%), managing money (up 5%) and dealing with paperwork (up 4%).

- There was a slight improvement between the social support profile of all survey respondents between 1993 and 2000 both among those with a neurotic disorder and those with no psychiatric disorder: a 6% increase among those who said they did not lack social support.

- Similarly, in terms of the size of the primary support group, there was a slight decrease, about 2% among both groups in terms of those who said they had 3 or less close family members or friends.

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1 Background and focus of the report

1.1 Background to the report

This report is one of several topic reports looking at data from the survey carried out by ONS on the psychiatric morbidity of adults aged 16 to 74 years living in private households in Great Britain. This survey was commissioned by the Department of Health, the Scottish Executive Health Department and the National Assembly for Wales. This report focuses mainly on the economic and social functioning of adults with mental disorders.

The survey covered in this report was carried out in 2000 and is a repeat of the 1993 survey of adults living in private households. However, the 2000 survey included a number of developments. There was a slight increase in the age range, so that it covered people aged 16 up to 74 years compared with 16 to 64 years in the 1993 survey, and measures of Personality Disorder and intellectual functioning were included. (Singleton *et al* 2001)

Most notably, there was an expansion of the topics covered in the realm of economic and social functioning. For example, there were new sections on days off work due to sickness, the extent of debt, and satisfaction and stability of accommodation.

Although the main report did cover some social and economic functioning characteristics of people as characteristics of the sample, the full range of topics included in the survey are covered here. To put the results presented here in a wider context, the main prevalence tables from the main report (Singleton *et al* 2001) are reproduced here in Appendix A.

There is a vast amount of research which has looked at the social and economic functioning of people with mental disorders over the past 20 years. A review of this body of work has recently been put together in a series of three reports under the overall title: *Social Inequalities and the Distribution of the Common Mental Disorders* (Fryers *et al,* 2002, Melzer *et al,* 2002, Shah, 2002)

1.2 Coverage of the report

The report is divided into four substantive chapters. Chapter 2 focuses on the economic circumstances of people with mental disorders and covers:

- Educational attainment and age left full time education.
- Economic activity and social class.
- Income and receipt of benefits.
- Debt.

Chapter 3 is concerned with accommodation and living arrangements, a topic not covered in the 1993 national survey. The topics included here are:

- Marital status and family composition.
- Tenure.
- Accommodation stability (number of moves in past 2 years).
- Satisfaction with accommodation.
- Condition of accommodation.
- Perceived security of tenure.

In Chapter 4, the topic of interest is disability associated with mental health problems. In this context, disability is measured by difficulties with activities of daily living.

The final part of the report, Chapter 5, covers stressful life events social networks, in particular:

- Size of primary support group.
- Perceived level of social support.
- Contact with friends.

1.3 Range of mental disorders

The content of the 2000 survey governed the range of psychiatric disorders covered in this report: (a) neurotic symptoms and disorders, (b) psychotic disorder, (c) alcohol use and dependence, and (d) drug dependence. A brief summary of how these

disorders were assessed is given below. A fuller explanation can be found in the main report (Singleton *et al,* 2001). Although Personality Disorder and cognitive decline were covered in the original survey, a separate report focussing on each of these topics will be produced and they are not covered here.

Neurotic symptoms and disorders

Neurotic symptoms and disorders in the week preceding interviews were assessed in the 2000 ONS survey using the revised version of the Clinical Interview Schedule, CIS-R (Lewis and Pelosi 1990, Lewis *et al* 1992). Data are presented on the prevalence of non-fatal suicidal behaviour by 14 neurotic symptoms, the distribution of total CIS-R scores, which give an indication of severity of symptoms, six neurotic disorders and the number of neurotic disorders.

The CIS-R comprises 14 sections, each covering a particular area of neurotic symptoms as follows:

- Somatic symptoms.
- Fatigue.
- Concentration and forgetfulness.
- Sleep problems.
- Irritability.
- Worry about physical health.
- Depression.
- Depressive ideas.
- Worry.
- Anxiety.
- Phobias.
- Panic.
- Compulsions.
- Obsessions.

Each section begins with a number of mandatory filter questions. They establish the existence of a particular neurotic symptom in the past month. A positive response leads to a more detailed assessment of the symptom in the past week: frequency, duration, severity, and time since onset. Answers to these questions determine the informant's score on each section. Possible scores range from 0 to 4 on each section (except the section on depressive ideas, which has a maximum score of 5).

Specific neurotic disorders were assessed by looking at the answers to various sections of the CIS-R and applying algorithms based on the ICD-10 diagnostic criteria for research (World Health Organisation 1992).

Six diagnostic categories can be obtained from the CIS-R:

- Generalised Anxiety Disorder.
- Depressive episode.
- Phobias.
- Obsessive Compulsive Disorder.
- Panic disorder.
- Mixed anxiety and depressive disorder.

Because an individual may appear in more than one category of neurotic disorder, it is possible to assign to each respondent a score indicating how many of the diagnostic algorithms correspond to the report and the pattern of their symptoms.

Psychotic disorder

Making assessments of psychotic rather than neurotic disorders is more problematic for lay interviewers. Neurotic symptoms were assessed by fully structured questions. These rely on the understanding of the questions by the respondent and on their insight and willingness to acknowledge these kinds of mental health problems. A structured questionnaire is too restrictive for assessing psychotic symptoms which, by definition, may involve some element of departure from reality and psychological insight.

Thus, the person with a neurotic symptom typically is aware that they should not have some disagreeable feelings and thoughts but has difficulty in overcoming them.

In contrast, among people with psychosis, the unusual thoughts and experiences described seem real to the sufferer who may even act inappropriately because of this. An accurate assessment requires a process of questioning and clinical judgement by an interviewer. The approach used involved a semi-structured interview by a clinically experienced interviewer who decided

which symptoms were present. Each symptom was defined in a glossary of definitions and was rated according to defined thresholds of severity.

A two-stage approach was therefore adopted to assess the presence of psychotic disorder. The criteria from the initial lay interview which were considered indicative of possible psychotic disorder were:

- Self-report, at questions about long-standing illness or reasons for consulting a GP, of symptoms suggestive of psychotic disorder, eg mood swings, or having been given a diagnosis of psychotic disorder, such as schizophrenia or manic depression.
- Taking anti-psychotic medication.
- A history of admission to a mental hospital or ward.
- A positive response to question 5a of the psychosis screening questionnaire which asks about hearing voices.

A positive response on any one of these criteria led to selection for a second stage interview using the Schedule for Clinical Assessment in Neuropsychiatry, (SCAN) (Wing *et al*, 1990, World Health Organisation, 1999). A sample of people who screened negative were also interviewed at the second stage, either because they sifted positive for personality disorder or because they were selected from the group who screened negative for both types of disorder.

Therefore, in the current survey, an assessment of probable psychosis was given to those who screened positive for psychosis and were either assessed as having a psychotic disorder at the SCAN interview or, if no SCAN interview had been conducted, who reported two or more of the above criteria at the initial interview. People who screened negative for psychosis were designated unlikely to have psychotic disorder.

Alcohol problems and dependence

The principal instrument used to assess alcohol problems was the Alcohol Use Disorders Identification Test, (AUDIT) (Babor *et al*, 1992). This measure was developed from a six-country WHO collaborative project and has been shown to be a good indicator of hazardous drinking (Saunders *et al*, 1993). It defines hazardous alcohol use as an established pattern of drinking which brings the risk of physical and psychological harm. Taking the year before interview as a reference period, the AUDIT consists of 10 questions covering the following topics:

- Hazardous alcohol consumption
  - frequency of drinking;
  - typical quantity; and
  - frequency of heavy drinking.

- Dependence symptoms
  - impaired control over drinking;
  - increased salience of drinking; and
  - morning drinking.

- Harmful alcohol consumption
  - feeling of guilt or remorse after drinking;
  - blackouts;
  - alcohol-related injury; and
  - other concerns about drinking.

Answers to all questions are scored from 0 to 4 and then summed to provide a total score ranging from 0 to 40. A total score of 8 is indicative of hazardous alcohol use.

The prevalence of alcohol dependence was assessed using the Severity of Alcohol Dependence questionnaire, (SAD-Q). (Stockwell *et al*, 1983). The SAD-Q was asked of all respondents who had an AUDIT score of 10 or more. It consists of 20 questions, covering a range of symptoms of dependence, and possible scores range from 0 to 3 on each question. Adding up the scores from all questions gives a total SAD score of between 0 and 60 indicating different levels of alcohol dependence. A total SAD score of 3 or less indicates no dependence, while a score of four or above suggests some alcohol dependence. Mild dependence is indicated by a score of between 4 and 19, moderate dependence by a score of 20 to 34, and severe dependence by a SAD score of 35 to 60. The reference period for alcohol dependence was the 6 months prior to interview.

Drug dependence

A number of questions designed to measure drug use were contained in the questionnaire. Information was first collected on all the types of drugs respondents had ever used, and then about drugs used in the previous year. Further information about drug use in the year, and month, preceding interview was collected about six drugs: cannabis, amphetamines, crack, cocaine, ecstasy, tranquillisers and opiates. Included in the questions about drug use in the past year and month were five questions to measure drug dependence. The topics covered by these questions are

- Frequency of drug use: used drug every day for two weeks or more.
- Stated dependence: felt they needed it or were dependent on it.
- Inability to cut down: tried to cut down but could not.
- Need for larger amounts: needed more to get an effect.
- Withdrawal symptoms: feeling sick because stopped or cut down.

A positive response to any of the five questions was used to indicate drug dependence. Because people could be dependent on more than one drug, they were further grouped into those who were:

- dependent on cannabis only;
- dependent on another drug (including those also dependent on cannabis); and
- not drug dependent.

1.4 Sampling and interviewing procedures

The survey was carried out between March and September 2000. A two-stage approach to the assessment of mental disorders was used. The first stage interviews were carried out by ONS interviewers and included structured assessment and screening instruments for measuring mental disorders, as well as covering a range of other topics, such as service use, risk factors for disorder and background socio-demographic factors. A sub-sample of people were then selected to take part in a second stage interview to assess psychosis and personality disorder, the assessment of which requires a more detailed interview than was possible at the first stage and some clinical judgement. These interviews were carried out by specially trained psychologists employed by the University of Leicester.

The small users postcode address file (PAF) was used as the sampling frame for the survey because of its good coverage of private households in Great Britain. In the PAF, the postcode sectors were stratified on the basis of socio-economic group within NHS Region. A postal sector contains on average 2,550 delivery points.

Initially, 438 postal sectors (the primary sampling units) were selected with a probability proportional to size (number of delivery points). This included 370 sectors in England, 22 in Wales and 46 in Scotland. Within each of these sectors, 36 delivery points were selected (with the exception of one sector which was accidentally sampled twice), yielding a sample of 15,804 delivery points.

Interviewers visited the 15,804 addresses to identify private households with at least one person aged 16 to 74 years. The Kish grid method was used to select systematically one person in each household, (Kish, 1965). More details of sampling procedures can be found in the Technical Report.

Overall, 10% of sampled addresses were ineligible because they contained no private households. Of the remaining addresses, 11% contained no-one within the eligible age range, which left an eligible sample of 12,792 addresses.

Just under 70% of those approached agreed to take part in an interview and despite the length of the interview, 95% completed the full interview, i.e. 8,450 respondents.

1.5 Access to survey data

Anonymised data from the survey will be lodged with the Data Archive, University of Essex, within 3 months of the publication of this report. Independent researchers who wish to carry out their own analyses should apply to the Archive for access. For further information about archived data, please contact:

ESRC Data Archive
University of Essex
Wivenhoe Park
Colchester
Essex CO4 3SQ
Tel: (UK) 01206 872323
FAX: (UK) 01206 872003
Email: **archive@essex.ac.uk.**

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2 Education, employment and financial characteristics

2.1 Introduction

This chapter is divided into three sections: education, employment and financial circumstances. As social class was measured by the informant's own occupation, this topic is included in the section on employment. Throughout, the chapter, we examine the distribution of all these characteristics among the samples with different types of mental disorder and compare them with the no disorder group.

2.2 Educational attainment

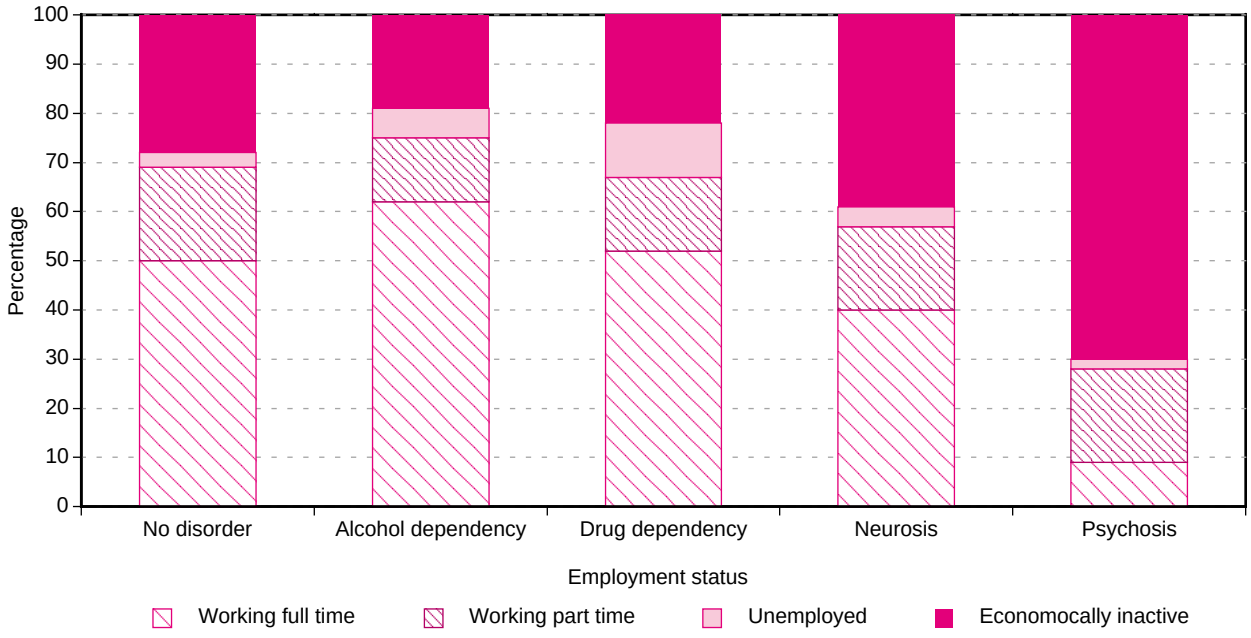
Two measures of educational status were included in the survey: age left full time education and highest qualifications attained. Compared with all other groups, those with a psychotic disorder were more likely to have left school before reaching sixteen years old and with no qualifications. The alcohol and drug dependent groups included the highest proportion of students, i.e. those who had not yet finished their full time education. *(Table 2.1)*

2.3 Employment

All the studies reviewed by Fryers *et al* (2002) indicate that being unemployed and economically inactive (i.e. unemployed and not seeking work) is associated with an increased risk of mental heath problems. Table 2.2 shows that this is particularly evident for those with a high probability of having a psychotic disorder. Across the whole sample, about a third (33%) were unemployed or economically inactive whereas among those rated as having psychosis, the rate was more than double (72%). *(Table 2.2 and Figure 2.1)*

Overall, the social class distributions of those with a mental disorder compared with those with none of the four mental disorders were shifted more to the manual classes (III Manual, IV and V) compared with (I, II and III Non-manual). If the informant was unemployed or economically inactive at the time of interview but had previously worked, social class was based on the most recent previous occupation. The proportion of the sample

Figure 2.1 Employment status by type of mental disorder



in the manual social classes among the non-disorder group was 39% in contrast to 44% of those with a current neurotic disorder, 52% and 54% of those with alcohol and drug dependence and rising to 61% of those with a psychotic disorder. *(Table 2.2)*

Among all those in employment, the alcohol and drug-dependent groups had the highest proportions (17% and 13% respectively) of those working in craft and related occupations skilled construction, skilled engineering, metal-working, textile, vehicle, garment, agricultural trades etc. *(Table 2.2)*

Nevertheless, alcohol and drug dependence did not seem to have a great effect on time off work. Respondents in both of these groups were close to the total sample average of 7 days in the past year. The mean number of days off work in the past 12 months for a health problem was 19 for those with a neurotic disorder. There is not a reliable comparable statistic for those with a psychotic disorder as so few were currently employed: 13 out of 60. Nevertheless, for the few that were in employment, there is strong indication that their health problems do cause them to take a great deal of time off work.*(Table 2.3)*

There are many factors which influence working status; some are extraneous to the individual, such as employment opportunities in the area where one lives. Others relate to personal circumstances: age, sex, ethnicity, family composition and physical health. Logistic regression analysis was carried out to examine the independent association of mental disorders with not working controlling for these other personal characteristics. Each of the six neurotic mental disorders assessed in the survey, psychosis, alcohol and drug dependence were entered in the model as well as the five personal characteristics described above. As expected, there was increased odds of not working for women compared with men (OR=1.92), for lone parents compared with couples with no children (OR=2.46), and for those with a physical complaint compared with those who reported no physical health problem (OR=1.99). No doubt, these odds ratios are influenced by the fact that the group, not working, includes the unemployed and those not actively seeking work because they want to, or have to, look after families or are permanently disabled.

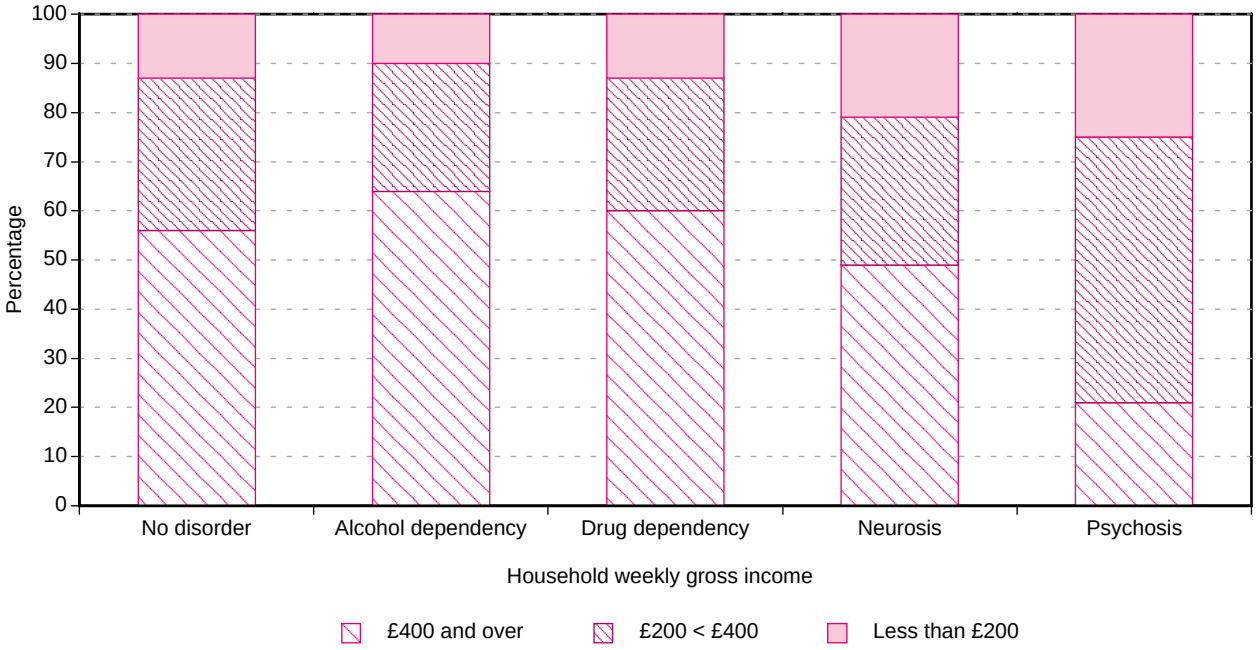
Having controlled for these personal factors, the odds of respondents with a psychotic disorder not working were nearly four times that of the rest of the sample (OR= 3.88). The equivalent significant odds ratios for the other mental disorders were: moderate or severe alcohol dependence (2.08), depressive episode (2.07), phobia (1.97), dependent on drugs other than cannabis (1.83) and Generalised Anxiety Disorder (1.79). Depression and phobias were equally as likely as a physical complaint (OR = 1.99) to be correlated with not working. *(Table 2.4)*

2.4 Financial circumstances

The most marked differences in income distribution across the sample occurs between the group with a psychotic disorder and all other groups. The measure used in the top half of Table 2.5 is gross weekly household income. About 60% of the sample assessed as having a psychotic disorder were in a household with an income less than £300 a week compared with 37% of those with a current neurotic disorder and 28% of the sample with no mental disorder. The corresponding proportions with an income less than £200 a week were 25%, 21% and 13%. This may be explained by the findings in the bottom half of the same table which show that about two-thirds of the group with psychosis were receiving a State Benefit (either Income Support or Incapacity Benefit) compared with just less than a third of those with a neurotic disorder and just 10% of those with none of the four mental disorders. *(Table 2.5 and Figure 2.2)*

Logistic regression analysis shows however that when the psychiatric and socio-demographic variables were entered into a model to predict the likelihood of earning less than £200 a week, the biggest odds ratios were for lone parent and child compared to couples with no children (OR=4.57) or being in a Black or South Asian ethnic group compared to the White group (ORs=2.38 and 2.42). Even though psychosis, alcohol and drug dependence did not emerge as significant, independent factors, five of the six neurotic disorders were associated with having greater odds of earning less than £200 a week: panic disorder (OR=2.25), depression (OR=2.13), phobia (OR=1.87), Generalised Anxiety Disorder (OR=1.71) and mixed anxiety and depressive disorder (OR=1.47). *(Table 2.6)*

Figure 2.2 Household weekly gross income by type of mental disorder



One of the new set of questions included in the 2000 survey, i.e. not included in 1993 was on the subject of debt. The four elements covered were:

- Whether in debt and type of debt.
- Whether any utilities (telephone, gas, electricity, water) had been disconnected.
- Whether efforts had been made to cut down on the use of utilities.
- Whether money had been borrowed and if so from whom.

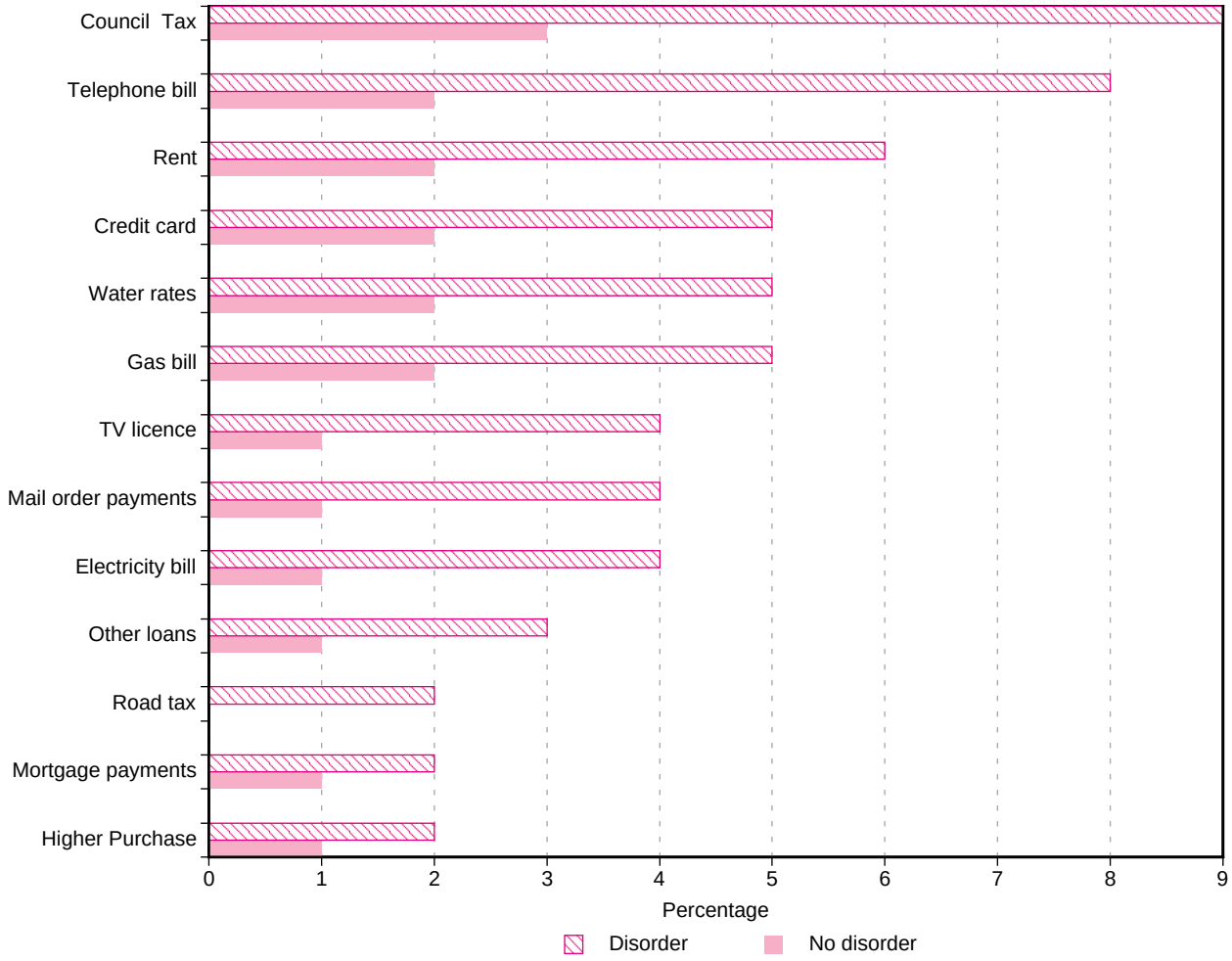
Overall, 12% of the total sample of respondents said they had incurred some sort of debt in the past year. However, among the group with any of the four mental disorders covered in the survey, 24% had been behind with their payments. The bills that tended to be unpaid or paid late covered a wide spectrum but at least 5% had problems with paying their council tax, telephone bill, rent, gas bill, water rates and credit card payments.

Taking account of the debt problem, it is not surprising that those with a mental disorder were at least three times as likely to have had their telephone, gas, electricity or water disconnected compared with the no disorder group: 10% compared with 3%. The rate among those dependent on drugs was nearly 20%. In all cases, the vast majority had had their telephone disconnected, only 2% or less had had any of the other three utilities cut off. *(Table 2.7 and Figure 2.3)*

In terms of cutting down on the use of the telephone, gas, electricity and water, the rate of 6% for those with no disorder was doubled for the alcohol dependent group (12%), and at least tripled for those with drug dependence or neurotic disorders (18% and 21%) and rose to 33% among those with a psychotic disorder. The data also indicate that many of the people who did cut down did so on several utilities, eg, gas and electricity and water.

How did the people in debt find the money to pay off their debts, or even if not in debt did they borrow money to pay for their day to day needs? Ten percent of the no disorder group had borrowed money in the past 12 months. Among the group with any disorder just over a quarter had borrowed money and among the drug dependent group the proportion was 50%. The two primary sources of funds were from family and friends. *(Table 2.7)*

Figure 2.3 Type of debt by whether or not had mental disorder



Logistic regression was used to show the factors which were independently associated with being in debt. The odds of being in debt as opposed to not were significantly higher for lone parents and Black respondents and lower for women and those in older age groups. All those with mental disorders (except phobia) had increased odds of being in debt compared with the no disorder group: dependent on cannabis only (OR=2.87), dependent on other drugs (2.84) moderate or severe alcohol dependence (2.61) panic disorder (2.44) GAD (2.20), depressive episode (1.93) mixed anxiety and depression (1.88), OCD (1.76) and psychosis (1.50). *(Table 2.8)*

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Table 2.1 Educational characteristics

by type of mental disorder

	Current neurotic disorder	Probable psychotic disorder	Alcohol dependent	Drug dependent (any drug)	Any of the four types of mental disorder	None of the four types of mental disorder	All
	%	%	%	%	%	%	%
Age left full-time education							
14 and under	6	3	3	3	5	7	7
15	26	39	17	11	23	20	20
16	29	32	34	37	31	29	29
17	10	8	10	9	10	10	10
18	10	5	11	12	10	10	10
19 and over	15	10	16	16	15	18	17
Not yet finished	4	3	10	13	6	6	6
Never went to school	0	-	0	1	0	0	0
Highest educational qualifications obtained							
A level or above	34	16	39	41	36	37	36
GCSE level	35	44	39	42	37	36	36
No qualifications	31	40	22	17	28	27	27
Base	*1509*	*60*	*567*	*258*	*2012*	*6533*	*8580*

Table 2.2 Employment characteristics

by type of mental disorder

	Current neurotic disorder	Probable psychotic disorder	Alcohol dependent	Drug dependent (any drug)	Any of the four types of mental disorder	None of the four types of mental disorder	All
	%	%	%	%	%	%	%
Employment status							
Working full time	40	9	62	52	47	50	49
Working part time	17	19	13	15	16	19	18
Unemployed	4	2	6	11	5	2	3
Economically inactive	39	70	19	22	32	29	30
Social class based on occupation of respondent							
I	3	1	5	3	4	6	5
II	28	18	24	22	26	30	29
III Non-manual	26	21	17	22	22	25	25
III Manual	19	21	32	27	24	18	19
IV	18	21	15	19	18	16	16
V	7	19	5	8	7	5	6
Armed forces	0	-	0	-	0	0	0
Occupational grouping of respondent							
Managers and administration	11	8	12	10	11	12	12
Professional occupations	6	1	6	4	6	8	7
Associate profession and technical	7	3	8	7	7	8	7
Clerical, secretarial	11	-	10	8	10	11	11
Craft and related	5	4	17	13	9	7	8
Personal, protective	7	3	5	7	7	8	7
Sales occupations	7	5	5	8	6	6	6
Plant/machine operators	3	-	10	8	6	7	6
Other occupations	4	6	6	7	4	5	5
Not employed	40	70	21	27	34	29	30
Base	*1509*	*60*	*567*	*258*	*2012*	*6533*	*8580*

Table 2.3 Employment disruption

by type of mental disorder

	Current neurotic disorder	Probable psychotic disorder	Alcohol dependent	Drug dependent (any drug)	Any of the four types of mental disorder	None of the four types of mental disorder	All
	%	%	%	%	%	%	%
Health caused you to take time off work							
Yes	48	[8]	37	37	43	26	30
No	52	[5]	63	63	57	74	70
Mean number of days off work in past year	**19**	**67**	**8**	**7**	**14**	**5**	**7**
Base (=All respondents currently employed or employed in last year)	*856*	*13*	*437*	*193*	*1257*	*4380*	*5637*

Table 2.4 Psychiatric risk factor correlates of not working (compared with working)

Psychiatric variables	Adjusted Odds Ratio	95% C.I.
Depressive episode		
No	1.00	———
Yes	2.07***	1.49 - 2.87
OCD		
No	1.00	———
Yes	1.15	0.71 - 1.87
GAD		
No	1.00	———
Yes	1.79***	1.39 - 2.30
Phobia		
No	1.00	———
Yes	1.97**	1.33 - 2.92
Panic Disorder		
No	1.00	———
Yes	1.62	0.92 - 2.86
Mixed anxiety/depression		
No	1.00	———
Yes	1.25*	1.02 - 1.64
Probable Psychosis		
No	1.00	———
Yes	3.88***	1.86 - 8.13
Alcohol dependence		
None	1.00	———
Mild	0.91	0.72 - 1.14
Moderate/severe	2.08*	1.00 - 4.30
Drug dependence		
No dependence	1.00	———
Cannabis only	1.32	0.95 - 1.84
Drugs other than cannabis	1.83*	1.16 - 2.89

Other Variables	Adjusted Odds Ratio	95% C.I.
Sex		
Male	1.00	———
Female	1.92***	1.71 - 2.15
Age#		
16–24	1.00	———
25–44	0.50***	0.40 - 0.60
45–64	1.07	0.87 - 1.32
Ethnicity		
White	1.00	———
Black	1.44*	1.06 - 2.10
South Asian	1.85***	1.34 - 2.53
Other	1.42	0.99 - 2.05
Family type		
Couple no children	1.00	———
Couple and children	0.92	0.79 - 1.06
Lone parent and child	2.46***	1.94 - 3.11
One person	1.57***	1.31 - 1.87
Adult with parents	0.84	0.58 - 1.23
Adult with one parent	1.29*	1.02 - 1.64
Physical complaint		
No	1.00	———
Yes	1.99***	1.78 - 2.24

*** p<0.001, ** p<0.01, * p<0.05"
# Analysis limited to those aged 16–64

*** p<0.001, ** p<0.01, * p<0.05"

Table 2.5 Amount and source of income by type of mental disorder

	Current neurotic disorder	Probable psychotic disorder	Alcohol dependent	Drug dependent (any drug)	Any of the four types of mental disorder	None of the four types of mental disorder	All
	%	%	%	%	%	%	%
Household grouped weekly gross income							
Under £100	3	4	1	2	2	2	2
£100 but under £200	18	21	10	11	15	11	12
£200 but under £300	16	36	10	6	14	15	14
£300 but under £400	14	19	16	21	15	16	15
£400 but under £500	11	12	13	15	11	12	12
£500 and over	39	9	51	44	43	46	45
			Percentage receiving each type of benefit				
Benefits received							
Income Support	13	30	7	7	11	4	5
Incapacity Benefit	12	44	6	5	10	2	4
Family credit	3	-	3	1	3	2	2
Jobseekers Allowance	2	-	3	6	3	1	2
Statutary sick pay	1	-	1	1	1	1	1
Industrial Injury Benefit	1	-	0	0	1	1	1
Any of the above benefits	**29**	**64**	**18**	**18**	**25**	**10**	**14**
Base	*1509*	*60*	*567*	*258*	*2012*	*6533*	*8580*

Table 2.6 Psychiatric risk factor correlates of gross household income less than £200 per week (compared with £200 and over per week)

Psychiatric variables	Adjusted Odds Ratio	95% C.I.
Depressive episode		
No	1.00	———
Yes	2.13**	1.35 - 3.37
OCD		
No	1.00	———
Yes	0.81	0.36 - 1.81
GAD		
No	1.00	———
Yes	1.71**	1.18 - 2.48
Phobia		
No	1.00	———
Yes	1.87*	1.06 - 3.30
Panic Disorder		
No	1.00	———
Yes	2.25*	1.01 - 5.01
Mixed anxiety/depression		
No	1.00	———
Yes	1.47**	1.11 - 1.94
Probable Psychosis		
No	1.00	———
Yes	1.26	0.40 - 3.87
Alcohol dependence		
None	1.00	———
Mild	0.72	0.48 - 1.09
Moderate/severe	2.02	0.65 - 6.22
Drug dependence		
No dependence	1.00	———
Cannabis only	1.23	0.72 - 2.10
Drugs other than cannabis	1.34	0.60 - 2.99

Other Variables	Adjusted Odds Ratio	95% C.I.
Sex		
Male	1.00	———
Female	1.04	0.87 - 1.25
Age#		
16–24	1.00	———
25–44	0.68*	0.48 - 0.97
45–64	1.53*	1.05 - 2.20
Ethnicity		
White	1.00	———
Black	2.38***	1,47 - 3.83
South Asian	2.42***	1.56 - 3.76
Other	1.83*	1.05 - 3.17
Family type		
Couple no children	1.00	———
Couple and children	0.80*	0.64 - 0.98
Lone parent and child	4.57***	3.12 - 6.70
One person	1.31	0.83 - 2.07
Adult with parents	0.85	0.46 - 1.57
Adult with one parent	1.21	0.82 - 1.80
Physical complaint		
No	1.00	———
Yes	1.35**	1.12 - 1.62

*** p<0.001, ** p<0.01, * p<0.05
# Analysis limited to those aged 16–64

*** p<0.001, ** p<0.01, * p<0.05

Table 2.7 Financial hardship

by type of mental disorder

	Current neurotic disorder	Probable psychotic disorder	Alcohol dependent	Drug dependent (any drug)	Any of the four types of mental disorder	None of the four types of mental disorder	All
	%	%	%	%	%	%	%
Type of debt							
Council Tax	9	12	9	12	9	3	4
Telephone bill	8	9	9	18	8	2	4
Rent	6	10	7	10	6	2	3
Gas bill	6	4	6	8	5	2	2
Water rates	6	10	3	8	5	2	2
Credit card payments	5	2	5	8	5	2	2
Electricity bill	5	2	5	9	4	1	2
Mail order catalogue payments	4	7	4	6	4	1	1
TV licence	4	5	4	9	4	1	1
Other loans	4	5	2	4	3	1	1
Goods on Hire Purchase	2	3	2	4	2	1	1
Mortgage repayments	2	1	1	1	2	1	1
Road Tax	2	1	2	3	2	0	1
DSS Social Fund	1	-	1	2	1	0	0
Child Support or Maintenance	0	-	0	0	0	0	0
Any type of debt	***24***	***33***	***25***	***38***	***24***	***9***	***12***
Utilities disconnected							
Telephone	9	10	9	17	8	2	4
Electricity	1	1	1	2	1	0	0
Gas	2	2	2	1	2	1	1
Water	1	2	1	-	1	0	0
Any utility disconnected	***11***	***14***	***10***	***19***	***10***	***3***	***5***
Utilities cut down on							
Telephone	12	17	6	9	10	3	5
Electricity	13	17	7	12	10	3	5
Gas	12	18	6	11	10	3	5
Water	3	1	1	1	2	1	1
Any utility cut down on	***21***	***33***	***12***	***18***	***18***	***6***	***9***
Where borrowed money							
Family	22	18	26	41	23	8	11
Friends	10	17	17	28	11	2	4
Money lender	4	7	3	4	3	1	2
Pawnbroker	2	-	2	4	2	0	1
Any source	***27***	***34***	***32***	***50***	***28***	***10***	***14***
Base	*1509*	*60*	*567*	*258*	*2012*	*6533*	*8580*

Table 2.8 Psychiatric risk factor correlates of being in debt (compared with not in debt)

Psychiatric variables	Adjusted Odds Ratio	95% C.I.
Depressive episode		
No	1.00	———
Yes	1.93***	1.35 - 2.78
OCD		
No	1.00	———
Yes	1.76*	1.06 - 2.92
GAD		
No	1.00	———
Yes	2.20***	1.64 - 2.93
Phobia		
No	1.00	———
Yes	1.48	0.95 - 2.31
Panic Disorder		
No	1.00	———
Yes	2.44**	1.29 - 4.61
Mixed anxiety/depression		
No	1.00	———
Yes	1.88***	1.51 - 2.33
Probable Psychosis		
No	1.00	———
Yes	1.50	0.71 - 3.14
Alcohol dependence		
None	1.00	———
Mild	1.53***	1.21 - 1.93
Moderate/severe	2.61*	1.23 - 5.55
Drug dependence		
No dependence	1.00	———
Cannabis only	2.87***	2.09 - 3.96
Drugs other than cannabis	2.84***	1.80 - 4.48

*** p<0.001, ** p<0.01, * p<0.05

Other Variables	Adjusted Odds Ratio	95% C.I.
Sex		
Male	1.00	———
Female	0.77**	0.66 - 0.89
Age		
16–24	1.00	———
25–44	0.48***	0.38 - 0.60
45–64	0.18***	0.14 - 0.24
65–74	0.08***	0.05 - 0.14
Ethnicity		
White	1.00	———
Black	2.61***	1.84 - 3.71
South Asian	1.21	0.80 - 1.81
Other	1.77**	1.18 - 2.65
Family type		
Couple no children	1.00	———
Couple and children	1.56***	1.27 - 1.92
Lone parent and child	4.03***	3.01 - 5.39
Lone parent only	2.10***	1.67 - 2.64
Adult with parents	0.34***	0.20 - 0.58
Adult with one parent	0.48***	0.34 - 0.67
Physical complaint		
No	1.00	———
Yes	1.25**	1.08 - 1.46

*** p<0.001, ** p<0.01, * p<0.05

3 Family, household and housing characteristics

3.1 Introduction

Although this chapter begins with a brief look at the family and household characteristics of the survey respondents, it is mainly concerned with the respondents' housing characteristics: what sort of place they live in, satisfaction with where they live and problems with their accommodation. As in the previous chapter, the analysis focuses on the distribution of these characteristics by presence and type of mental disorder.

3.2 Family and household characteristics

The distribution of three family and household characteristics: marital status, family unit type and household size, by mental disorder is presented in Table 3.1. Those with a disorder were more likely to be single, divorced or separated and less likely to be married. The groups rated as being alcohol and drug dependent had the highest proportions of single people: 58% and 77% respectively compared with 30% of the whole sample. This is what would be expected as these two groups are predominantly in the younger age groups. Those with a psychotic disorder had the highest percentages of divorced and separated people: 26% and 7% respectively compared with the sample average of 8% and 3%. *(Table 3.1)*

Each informant's family unit was classified into one of six family unit types. 'Couple no children' included married or cohabiting couples without children. 'Couple with child' comprised a married or cohabiting couple living with at least one child from their current or a previous relationship. 'Lone parent' describes a man or woman living with at least one child. The child need not be under eighteen and could be an adult who had never married and has no children. 'One person' does not necessarily imply that the respondent lives alone. It includes those who live alone, but it also includes adults living with a sibling, or grandparents living with their children and their family, as well as those living with unrelated people in shared households. The category 'adult living with parents' would contain the same members as a 'couple with child', except in this case it is the adult son or daughter who is the respondent. Similarly, 'adult living with one parent' covers a similar type of family unit, except that only one parent is present.

Among the sample assessed as currently having a neurotic disorder, 9% were lone parents compared with 4% in the no-disorder group. In the group with a probable psychotic disorder, 43% were living in a one-person family unit, almost three times the proportion of those with no mental disorder, 15%. About a quarter of the alcohol group and around a third of the drug dependent group were living with one or both parents, compared with 12% of the sample without a mental disorder. *(Table 3.1)*

Overall 12% of survey respondents lived by themselves, 35% were in a household of two persons, and 53% lived in a household of three or more people. People with a psychotic disorder were far more likely to live alone, 38%.

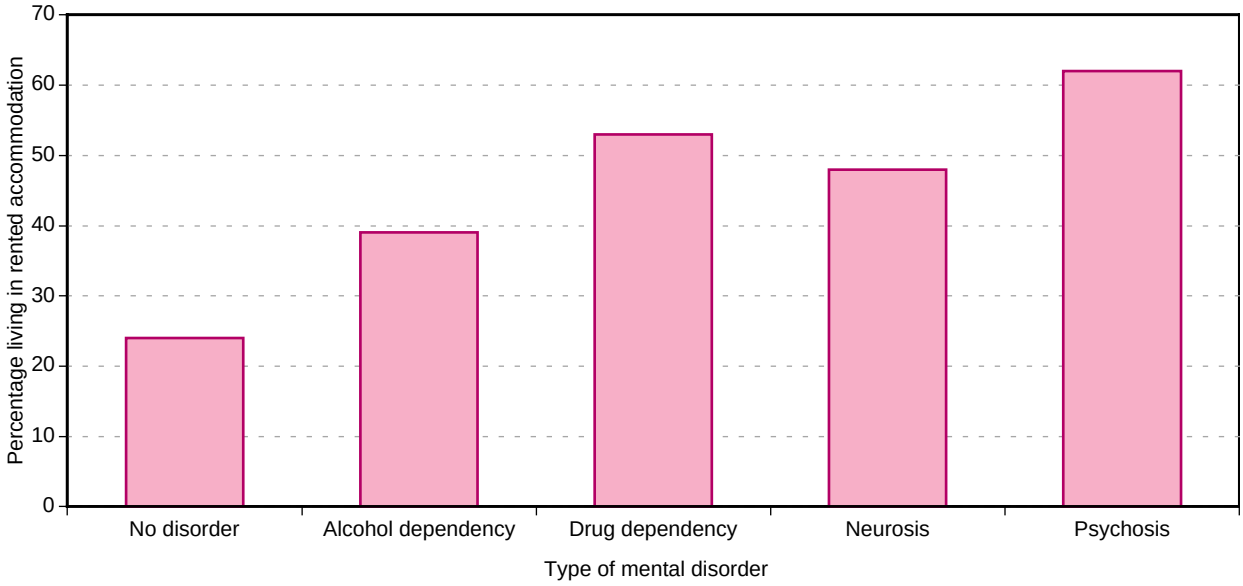
3.3 Housing characteristics

Tenure

Across the sampled population, a quarter owned their accommodation outright, a half were owner-occupiers with a mortgage and the remaining quarter were in rented accommodation. Those with a mental disorder were far more likely than those with no disorder to be living in rented accommodation (38% compared with 24%). Among those with a psychotic disorder about half were living in accommodation rented from a Housing Association or Local Authority. The drug dependent group included the highest proportion in privately rented housing: 30%. *(Table 3.2 and Figure 3.1))*

About a quarter of those with a neurotic or psychotic disorder had been living in their present accommodation for two years or less. The proportion rose to a third for the groups with alcohol or drug dependence. All the four disorder groups who had been in their accommodation for two years or less had an average of 2 moves in that time. *(Table 3.2).*

Figure 3.1 Proportion of respondents living in rented accommodation by type of mental disorder



Attitudes towards accommodation

Those with a disorder were slightly more negative than the no-disorder group in their assessment of the standard of their accommodation: 11% and 5% respectively said they were fairly or very dissatisfied. Similarly, the sample with any of the four types of mental disorder were twice as likely as those without a mental disorder to describe the state of repair of their home as poor: 9% compared with 4%. However, when asked about specific accommodation problems, both groups were more forthcoming – about a half of the group with a disorder and a third of the group with none of four mental disorders covered in the survey mentioned at least one type of problem. The most frequent complaint was lack of space – mentioned by 20% of all survey respondents, but by about 30% of those with a neurotic disorder, alcohol and drug dependence. The next two frequently mentioned problems, with a rate of 7% overall, were rotten window frames and floors, and damp walls, floors or foundations. These accommodation problems were twice as likely to be reported by those with a mental disorder than the rest of the sample. Although the remaining accommodation problems, (no place to sit outside, inadequate heating and lighting, mould, leaky roof) were mentioned by 5% or less of all respondents, they were considerably more likely to be mentioned by those with any of the four mental disorders. Eight per cent of the sample assessed as having a mental disorder felt that their health was made worse by their accommodation compared with 2% of the no disorder group *(Table 3.3 and Figure 3.2)*

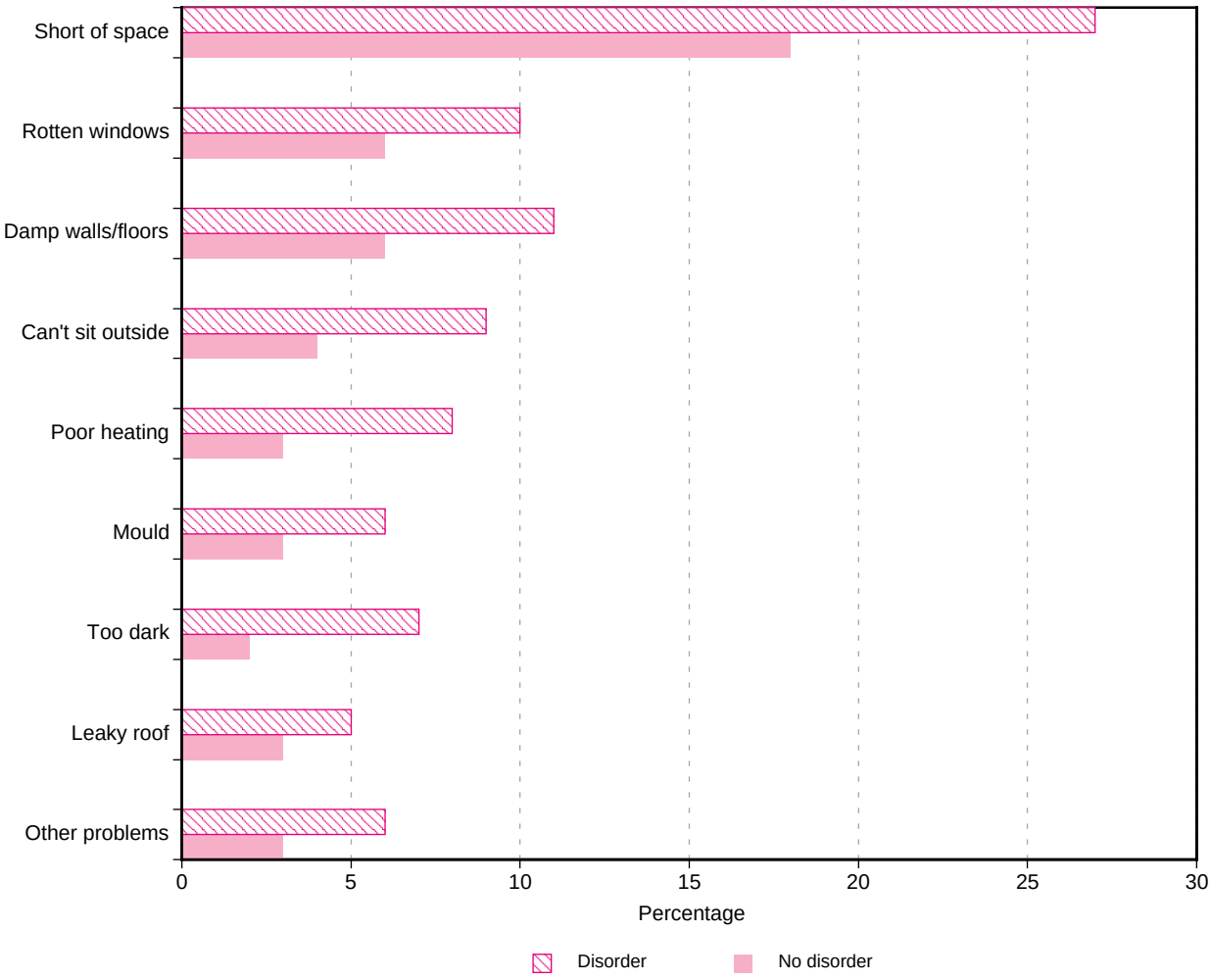
People with mental disorders may express greater dissatisfaction or problems with their accommodation than those with no disorder because their standard of housing is worse. Table 3.2 has shown that they are more likely to live in rented accommodation which may be in poorer condition than accommodation owned by respondents. Larger families may complain more of lack of space and young people may be more tolerant of poor housing. Hence, logistic regression analysis was carried out to examine the independent association of mental disorders with three attitudes to accommodation: general dissatisfaction, any accommodation problem such as lack of space or damp, and accommodation making health worse, taking account of family and household characteristics.

In all three logistic regression analyses, the family and household characteristics entered in the model, showed consistent associations in the expected direction.

The odds of having negative attitudes towards ones accommodation:

- Decreased with age.
- Was higher among Black than White survey respondents.

Figure 3.2 Accommodation problems by whether or not had mental disorder



- Was lower among young adults living with parent(s) compared with a married couple.
- Was markedly higher among those living in rented rather than owner occupier housing.
- Was lower among those who had lived in their accommodation for 2 years or less.

However, the mental disorders which were significantly associated with negative attitudes varied according to the attitude being measured. Looking first at dissatisfaction with accommodation, with the group that did not have the disorder as the reference group, there were increased odds for moderate or severe alcohol dependence (OR=3.23), GAD (OR=2.38), dependence on cannabis (OR=1.88) and mixed anxiety and depressive disorder (OR=1.56). *(Table 3.4)*

The mental disorders associated with increased odds ratios for any accommodation problem were phobia (OR=2.15), panic disorder (OR=1.77) and mixed anxiety and depressive disorder (1.56). *(Table 3.5)*

The four mental disorders significantly associated with the feeling that accommodation made health worse were panic disorder (OR=4.09), depressive episode (OR=3.62), mixed anxiety and depressive disorder (OR=3.30) and Generalised Anxiety Disorder (OR=1.82) (Table 3.6)

Security of accommodation

All survey respondents were asked whether they could stay in their accommodation as long as they like or whether they may have to move before they would like. Overall, 6% had doubts about the security of their present accommodation. This overall figure included 12% of those with neurosis, psychosis and alcohol dependence who were concerned about the security and 15% of the drug dependent group. The five main reasons respondents gave for their feelings of insecurity

were: financial problems (20%), lease or contract was running out (18%) illness (14%), domestic problems (8%) and problems with landlord or agent (7%). There was minimal variation in these percentages among those with and without mental disorders. *(Table 3.7)*

Overall, 113 of the 8,545 respondents in the survey reported lack of security with their accommodation owing to financial problems. When asked to specify the type of financial problem, 38% said other debts or responsibilities, 30% gave unemployment as a reason, 14% mentioned increases in mortgage payments and 10% increases in rent. The even smaller number of the total sample, 35, who gave problems with landlord as one of the reasons why they may have to leave their accommodation were also asked to describe the type of problem. Between a quarter and a third mentioned conflict about repairs, unpleasant or difficult landlord, or the landlord wanted to evict the tenant or sell the property. *(Table 3.7)*

The final set of questions in the housing section of the questionnaire were concerned with whether or not there was a disabled person living in the household who required specially adapted accommodation and whether or not the accommodation was suitable for that person. Among the group without any of the four specified disorders, 3% said their household contained a disabled person who needed special adaptations to the home. This proportion rose to 8–9% of those with a neurotic or psychotic disorder. However, it is not known whether they were referring to themselves or some other person in the household. Overall, three quarters of respondents who said their accommodation needed adaptations were content that the accommodation was suitable. *(Table 3.8)*

Table 3.1 Family and household characteristics by type of mental disorder

	Current neurotic disorder	Probable psychotic disorder	Alcohol dependent	Drug dependent (any drug)	Any of the four types of mental disorder	None of the four types of mental disorder	All
	%	%	%	%	%	%	%
Marital status							
Married	50	28	27	14	42	60	56
Separated	4	7	3	2	4	2	3
Single	29	36	58	77	39	27	30
Divorced	12	26	10	7	11	7	8
Widowed	4	3	1	1	3	4	4
Family unit type							
Couple, no children	28	22	20	17	25	33	31
Couple and child(ren)	34	17	25	17	31	36	35
Lone parent and child(ren)	9	7	4	4	7	4	5
One person only	20	43	24	28	21	15	16
Adult with parents	1	5	7	10	4	3	3
Adult with one parent	8	6	19	25	12	9	10
Household size							
1	15	38	16	12	15	11	12
2	32	30	26	23	30	36	35
3	22	23	25	26	23	21	21
4 and over	30	9	34	39	32	32	32
Base	*1509*	*60*	*567*	*258*	*2012*	*6533*	*8580*

Table 3.2 Tenure and change of accommodation by type of mental disorder

	Current neurotic disorder	Probable psychotic disorder	Alcohol dependent	Drug dependent (any drug)	Any of the four types of mental disorder	None of the four types of mental disorder	All
	%	%	%	%	%	%	%
Tenure							
Owned outright	15	10	12	7	15	27	24
Owned with mortgage	47	28	49	39	47	50	49
Rented from HA or LA	26	49	22	23	24	15	17
Rented from other source	12	13	17	30	14	9	10
Length of time in present accommodation							
More than 2 years	75	75	68	64	73	82	80
2 years or less	25	25	32	36	27	18	20
Base (= all respondents)	*1509*	*60*	*567*	*258*	*2012*	*6533*	*8580*
Mean number of times moved accommodation in past 2 years	2.1	2.7	2.1	2.4	2.0	1.5	1.7
Base (= respondents who had been in their present accommodation for less than 2 years)	*379*	*13*	*189*	*96*	*534*	*1200*	*1734*

Table 3.3 Attitudes towards present accommodation by type of mental disorder

	Current neurotic disorder	Probable psychotic disorder	Alcohol dependent	Drug dependent (any drug)	Any of the four types of mental disorder	None of the four types of mental disorder	All
	%	%	%	%	%	%	%
Satisfaction with accommodation							
Very satisfied	50	46	55	45	52	65	62
Fairly satisfied	33	41	29	32	32	27	28
Neither satisfied/dissatisfied	5	2	6	7	5	3	4
Fairly dissatisfied	6	-	6	8	6	3	4
Very dissatisfied	5	11	4	9	5	2	3
State of repair of home							
Good	64	52	66	62	66	76	74
Adequate	26	29	25	24	25	20	21
Poor	9	19	9	14	9	4	5
			Percentage having each type of accommodation problem				
Accommodation problems							
Shortage of space	28	23	28	31	27	18	20
Rotten window frames/floors	10	12	12	11	10	6	7
Damp wall, floor, foundations	11	20	13	17	11	6	7
No place to sit outside	8	14	10	16	9	4	5
Lack adequate heating	8	12	8	12	8	3	4
Mould	6	10	6	10	6	3	4
Too dark, not enough light	7	12	7	11	7	2	4
Leaky roof	4	6	7	7	5	3	3
Other problems	6	4	7	8	6	3	4
Any of the above problems	***49***	***49***	***51***	***54***	***48***	***33***	***37***
Health made worse by accommodation	%	%	%	%	%	%	%
Yes	10	14	6	10	8	2	4
No	90	86	94	90	92	98	96
Base	*1509*	*60*	*567*	*258*	*2012*	*6533*	*8580*

Table 3.4 Psychiatric risk factor correlates of dissatisfaction with accommodation

Psychiatric variables	Adjusted Odds Ratio	95% C.I.
Depressive episode		
No	1.00	———
Yes	1.26	0.80 - 2.00
OCD		
No	1.00	———
Yes	0.54	0.24 - 1.18
GAD		
No	1.00	———
Yes	2.38 ***	1.67 - 3.38
Phobia		
No	1.00	———
Yes	1.94 *	1.15 - 3.26
Panic Disorder		
No	1.00	———
Yes	1.72	0.78 - 3.80
Mixed anxiety/depression		
No	1.00	———
Yes	1.56**	1.18 - 2.05
Probable Psychosis		
No	1.00	———
Yes	0.68	0.24 - 1.92
Alcohol dependence		
None	1.00	———
Mild	1.02	0.74 - 1.42
Moderate/severe	3.23**	1.38 - 7.55
Drug dependence		
No dependence	1.00	———
Cannabis only	1.88**	1.25 - 2.84
Drugs other than cannabis	1.51	0.84 - 2.70

*** p<0.001, ** p<0.01, * p<0.05

Other Variables	Adjusted Odds Ratio	95% C.I.
Sex		
Male	1.00	———
Female	1.03	0.85 - 1.26
Age		
16–24	1.00	———
25–44	0.55***	0.41 - 0.74
45–64	0.21***	0.21 - 0.44
65–74	0.16***	0.16 - 0.43
Ethnicity		
White	1.00	———
Black	2.12***	1.40 - 3.20
South Asian	0.87	0.50 - 1.52
Other	1.06	0.61 - 1.86
Family unit type		
Couple, no children	1.00	———
Couple and child(ren)	1.13	0.87 - 1.46
Lone parent and child(ren)	1.10	0.75 - 1.62
One person only	1.02	1.02 - 1.36
Adult with parents	0.16***	0.06 - 0.41
Adult with one parent	0.62*	0.41 - 0.93
Tenure		
Owned outright	1.00	———
Owned with mortgage	1.01	
Rented from HA or LA	3.84***	
Rented from other source	3.46***	
Length of time in present accommodation		
More than 2 years	1.00	———
2 years or less	0.65**	0.51 - 0.83

*** p<0.001, ** p<0.01, * p<0.05

Table 3.5 Psychiatric risk factor correlates of accommodation problems

Psychiatric variables	Adjusted Odds Ratio	95% C.I.
Depressive episode		
No	1.00	———
Yes	1.07	0.78 - 1.47
OCD		
No	1.00	———
Yes	1.06	0.67 - 1.68
GAD		
No	1.00	———
Yes	1.15	0.91 - 1.46
Phobia		
No	1.00	———
Yes	2.15***	1.46 - 3.16
Panic Disorder		
No	1.00	———
Yes	1.77*	1.02 - 3.08
Mixed anxiety/depression		
No	1.00	———
Yes	1.56***	1.33 - 1.84
Probable Psychosis		
No	1.00	———
Yes	0.73	0.38 - 1.42
Alcohol dependence		
None	1.00	———
Mild	1.43***	1.19 - 1.73
Moderate/severe	1.56	0.77 - 3.19
Drug dependence		
No dependence	1.00	———
Cannabis only	1.40*	1.04 - 1.90
Drugs other than cannabis	1.26	0.82 - 1.96

*** p<0.001, ** p<0.01, * p<0.05

Other Variables	Adjusted Odds Ratio	95% C.I.
Sex		
Male	1.00	———
Female	1.01	0.92 - 1.11
Age		
16–24	1.00	———
25–44	0.95	0.79 - 1.14
45–64	0.46***	0.37 - 0.56
65–74	0.29***	0.22 - 0.38
Ethnicity		
White	1.00	———
Black	1.80***	1.32 - 2.46
South Asian	0.98	0.73 - 1.31
Other	1.08	0.78 - 1.50
Family unit type		
Couple, no children	1.00	———
Couple and child(ren)	1.20**	1.06 - 1.36
Lone parent and child(ren)	1.05	0.83 - 1.32
One person only	1.18*	1.02 - 1.38
Adult with parents	0.49***	0.35 - 0.68
Adult with one parent	0.46***	0.37 - 0.58
Tenure		
Owned outright	1.00	———
Owned with mortgage	1.13	0.98 - 1.30
Rented from HA or LA	2.79***	2.38 - 3.28
Rented from other source	2.28***	1.86 - 2.80
Length of time in present accommodation		
More than 2 years	1.00	———
2 years or less	0.77***	0.68 - 0.88

*** p<0.001, ** p<0.01, * p<0.05

Table 3.6 Psychiatric risk factor correlates of feeling present accommodation makes health worse

Psychiatric variables	Adjusted Odds Ratio	95% C.I.
Depressive episode		
No	1.00	———
Yes	3.62***	2.25 - 5.81
OCD		
No	1.00	———
Yes	1.38	0.67 - 2.84
GAD		
No	1.00	———
Yes	1.82*	1.14 - 2.90
Phobia		
No	1.00	———
Yes	1.63	0.87 - 3.03
Panic Disorder		
No	1.00	———
Yes	4.09***	1.87 - 8.95
Mixed anxiety/depression		
No	1.00	———
Yes	3.30***	2.42 - 4.50
Probable Psychosis		
No	1.00	———
Yes	0.94	0.34 - 2.58
Alcohol dependence		
None	1.00	———
Mild	0.94	0.60 - 1.48
Moderate/severe	1.29	0.43 - 3.89
Drug dependence		
No dependence	1.00	———
Cannabis only	1.68	0.98 - 2.90
Drugs other than cannabis	1.80	0.89 - 3.66

*** p<0.001, ** p<0.01, * p<0.05

Other Variables	Adjusted Odds Ratio	95% C.I.
Sex		
Male	1.00	———
Female	1.44**	1.10 - 1.88
Age		
16–24	1.00	———
25–44	0.94	0.63 - 1.39
45–64	0.53*	0.33 - 0.87
65–74	0.57	0.31 - 1.04
Ethnicity		
White	1.00	———
Black	2.05**	1.21 - 3.50
South Asian	1.48	0.78 - 2.81
Other	1.35	0.69 - 2.67
Family unit type		
Couple, no children	1.00	———
Couple and child(ren)	0.70	0.49 - 1.00
Lone parent and child(ren)	0.71	0.44 - 1.16
One person only	0.83	0.58 - 1.19
Adult with parents	0.36	0.12 - 1.09
Adult with one parent	0.77	0.45 - 1.31
Tenure		
Owned outright	1.00	———
Owned with mortgage	0.66	0.40 - 1.06
Rented from HA or LA	5.31***	3.45 - 8.16
Rented from other source	3.15***	1.88 - 5.29
Length of time in present accommodation		
More than 2 years	1.00	———
2 years or less	0.90	0.65 - 1.23

*** p<0.001, ** p<0.01, * p<0.05

Table 3.7 Security of accommodation by type of mental disorder

	Current neurotic disorder	Probable psychotic disorder	Alcohol dependent	Drug dependent (any drug)	Any of the four types of mental disorder	None of the four types of mental disorder	All
	%	%	%	%	%	%	%
Security of accommodation							
Will be able to stay as long as one likes	88	88	89	85	89	95	94
Might have to leave before one wants to	12	12	11	15	11	5	6
Base (= all respondents)	*1509*	*60*	*567*	*258*	*2012*	*6533*	*8580*
Reasons why one might have to leave before one wants to	*Percentage of respondents who gave each reason*						
Financial problems	26	[1]	24	29	24	17	20
Lease/contract is running out	9	-	21	27	15	20	18
Illness	18	[2]	8	1	15	14	14
Domestic problems	13	-	3	6	10	6	8
Problems with landlord agent	6	[2]	5	11	7	7	7
Problem with neigbours	7	[2]	4	1	6	4	5
Other reasons	38	[1]	44	42	40	42	41
Base (= those with insecure accommodation)	*190*	*6*	*56*	*38*	*230*	*310*	*540*
Type of financial problem	*Percentage of respondents who mentioned each problem*						
Other debts or responsibilities	51	[1]	[5]	[4]	44	32	38
Unemployment	35	-	[5]	[3]	32	27	30
Increase in mortgage payment	22	-	[1]	[1]	18	10	14
Increase in rent	13	-	[2]	[1]	10	10	10
Problems with Housing Benefit	12	-	-	[1]	10	4	7
Working fewer hours/less overtime	14	-	[2]	[1]	11	2	7
other reasons	11	-	[2]	[1]	21	28	24
Base (= those who gave financial reasons why might have to leave accommodation)	*52*	*1*	*11*	*8*	*57*	*56*	*113*

Table 3.8 Adaptations to accommodation owing to disabled person in household by type of mental disorder

	Current neurotic disorder	Probable psychotic disorder	Alcohol dependent	Drug dependent (any drug)	Any of the four types of mental disorder	None of the four types of mental disorder	All
	%	%	%	%	%	%	%
Is there a disabled person in household that makes it necessary to have specially adapted accommodation?							
Yes	8	9	2	3	6	3	4
No	92	91	98	97	94	97	96
Base (=all respondents)	*1509*	*60*	*567*	*258*	*2012*	*6533*	*8580*
Is the accommodation suitable for the disabled person?							
Yes	69	[5]	[4]	[4]	65	74	71
No	31	-	[7]	[3]	35	26	29
Base (all who felt it necessary to have adpted accommodation)	*130*	*5*	*11*	*7*	*141*	*227*	*368*

4 Activities of daily living

4.1 Introduction

All adults interviewed in the survey were asked about any difficulty they had with particular activities of daily living (ADL). The selection of activities was influenced by the topics covered in the MRC Needs for Care Assessment (Brewin and Wing, 1989) and the OPCS Surveys of Disability (Martin, White and Meltzer, 1989). The seven areas of functioning chosen for this survey were the same as those included in the previous, 1993, ONS survey (Meltzer, Gill, Petticrew and Hinds, 1995):

- **Personal care** such as dressing, bathing, washing or using the toilet.
- **Using transport** to get out and about
- **Medical care** such as taking medicines or pills, having injections or changes of dressing.
- **Household activities** such as preparing meals, shopping, laundry and housework.
- **Practical activities** such as gardening, decorating, or doing household repairs.
- **Dealing with paperwork** such as writing letters, sending cards, or filling in forms.
- **Managing money** such as budgeting for food or paying bills.

If respondents said they had any difficulty with any activity, they were asked whether they needed help and who provided it.

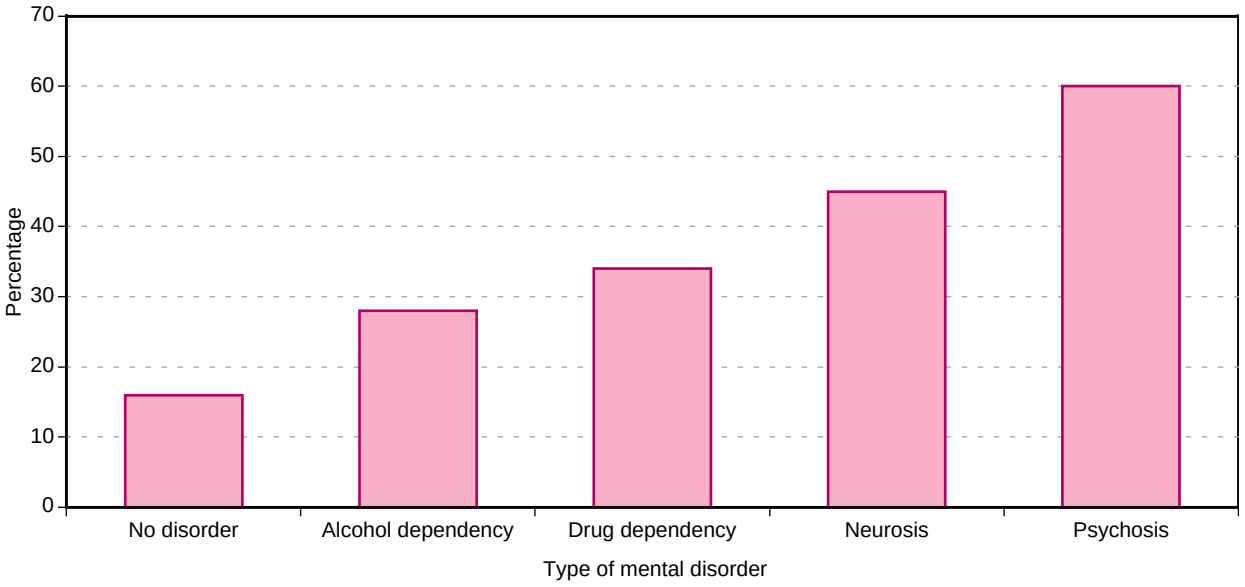
4.2 Number and type of ADL difficulties

Number of ADL difficulties

Across the whole sample the proportion of 16- to 74-year-olds who had difficulty with at least one ADL was 21%, made up of 16% of the no disorder group and 37% of those with any of the four specified mental disorders (neurosis, psychosis, alcohol and drug dependence). However, among the groups with each type of disorder, there were marked variations in the proportions having difficulty with at least one ADL, ranging from 28% and 34% of the alcohol and drug dependent group, to 45% of those with a current neurotic disorder and rising to 60% of those with a psychotic disorder. *(Figure 4.1)*

One way of summarising the distribution of number of ADL difficulties in each group is to examine the mean values. The mean number of

Figure 4.1 Proportion of respondents with any ADL difficulty by type of mental disorder



ADL difficulties for the group without any of the four disorders was 0.3. The mean values for the alcohol and drug dependent groups were 0.5 and 0.6. Among the group with a current neurotic disorder, it was 1.1 and the highest value was shown for those with a psychotic disorder at 1.6. *(Table 4.1)*

Type of ADL difficulties

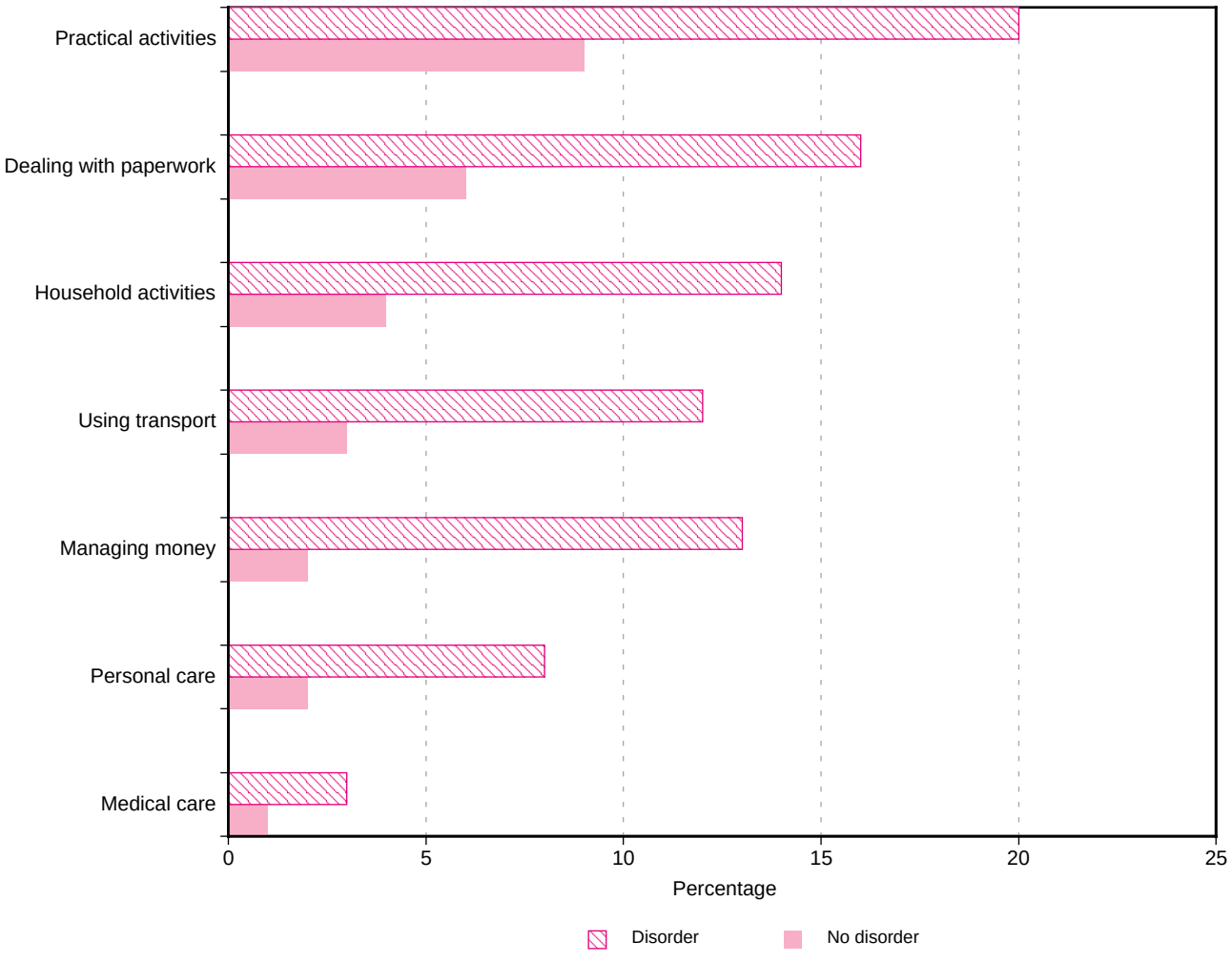
Among the whole sample, difficulties with practical activities had the highest prevalence at 12%, followed by dealing with paperwork (8%), household activities (6%) and using transport and managing money, both at 5%. Difficulties with personal care and medical care had rates of 4% and 1% respectively across the whole sample.

The pattern of difficulties with the seven activities of daily living was different for those with a neurotic or psychotic disorder compared with the alcohol and drug dependent groups. Those with neurosis or psychosis were far more likely than the no-disorder group to have problems with every activity. Comparing the three groups, no disorder, neurosis and psychosis, the rates of difficulty with practical activities were 9%, 26% and 30%, dealing with paperwork: 6%, 18% and 38%, household activities: 4%, 18% and 26% , and using transport: 3%, 16% and 20%. Those with alcohol and drug dependence were only markedly different from the no disorder group on one ADL: managing money. Here the rate among the group without a mental disorder was 2% compared with 16% and 26% among those with alcohol and drug dependence respectively. *(Table 4.2 and Figure 4.2)*

4.3 Help required and source of help received

Tables 4.3 to 4.9 focus on those who had difficulty with each of the seven ADL covered in the survey looking at whether respondents felt they needed help and who provided the assistance. Since the

Figure 4.2 Difficulties with ADL by whether or not had mental disorder



base numbers for calculating percentages are relatively small, comments will be restricted to those with a current neurotic disorder.

At least 4 out of 5 adults who currently had a neurotic disorder and had difficulties with practical activities, dealing with paperwork and household activities said they needed help with these activities, and nearly all, at least 94%, got help. In most cases, help came from close family members (spouse, son/daughter, brother/sister, parent) and in about 20% of cases help came from friends. *(Tables 4.3, 4.4, 4.5)*

About two-thirds of the group with a neurotic disorder reported needing help with using transport, personal care and medical care and for at least 94% of those in need, it was provided. For all three activities, family members were the most cited sources of help. Nevertheless, friends made a significant contribution in the use of transport - 31% mentioned help from friends. *(Tables 4.6, 4.8, 4.9)*

Help in managing money had a slightly different profile from the other six activities. First, only a half of those with a neurotic disorder said they needed help. Second, although families were the main source of help, parents made a marked contribution with 22% helping those who needed it. *(Table 4.7)*

4.4 Association between mental disorders and particular ADL

In order to examine the independent association of mental disorders with particular activities of daily living, logistic regression was used. The independent variables, the ADL, were dichotomised into whether or not people had difficulty with each task. In terms of the explanatory variables it is appreciated that physical illness is of great importance. Other factors entered into the model were four sociodemographic characteristics – sex, age, ethnicity and family type. Sex was chosen because certain activities of daily living are traditionally carried out more by one sex than the other. Similarly, family type can have an effect because certain tasks can be delegated to other family members. Age is an important factor as it is highly correlated with physical disability. Finally, ethnicity was chosen as there may be different cultural traditions in the performance of certain activities of daily living. Each of these four sociodemographic variables and physical illness entered in the model showed significant odds ratios for some activities of daily living. However, our interest is in the independent association between having a mental disorder and the performance of activities of daily living, i.e. controlling for sex, age, physical illness etc.

There are eight logistic regression tables. The first, Table 4.10, shows the psychiatric risk factors associated with difficulties with any activity of daily living. The subsequent seven tables concentrate on the relationship between mental disorders and each ADL.

The increase in the odds of having difficulty with any ADL for the groups with mental disorders compared with the non-case reference group is striking: depressive episode (OR=3.64), phobia (OR=3.21), mixed anxiety and depressive disorder (OR=3.05), dependence on drugs other than cannabis (2.74), GAD (OR=2.57), OCD (OR=2.17), panic disorder (1.94). The odds ratio for psychosis was also high, 2.09 but just failed to reach statistical significance. *(Table 4.10)*

Three of the six neurotic disorders showed significant increases in odds ratios associated with difficulties for all seven activities of daily living: depressive disorder, generalised anxiety disorder and mixed depressive and anxiety disorder. In contrast OCD only showed significant increases in odds ratios for difficulties with personal care and managing money. Psychosis also showed just two significant odds ratios – difficulties with medical care and dealing with paperwork. Alcohol and drug dependence only emerged as significant psychiatric risk factor correlates for difficulties in managing money. *(Tables 4.11 to 4.17)*

References

Brewin C R and Wing J K (1989) *MRC Needs for Care assessment*, MRC Social Psychiatry Unit, Institute of Psychiatry: London

Martin J, White A and Meltzer H (1989) *The OPCS Surveys of disability in Great Britain, Report 4, Disabled Adults: Services, Transport and Employment*, HMSO: London.

Meltzer H, Gill B, Pethcrew M and HInds K (1995) O*PCS Surveys of Psychiatry Morbidity in Great Britain Report 3, Economic Activity and Social Functioning of adults with psychiatric disorders*. HMSO: London.

Table 4.1 Number of ADL difficulties

by type of mental disorder

Number of ADL difficulties	Current neurotic disorder	Probable psychotic disorder	Alcohol dependent	Drug dependent (any drug)	Any of the four types of mental disorder	None of the four types of mental disorder	All
	%	%	%	%	%	%	%
0	56	40	72	66	63	84	79
1	18	28	18	22	17	10	11
2	8	10	5	7	6	3	4
3	8	7	3	3	6	2	2
4	5	1	1	1	4	1	2
5	6	15	1	1	4	1	2
Any ADL difficulty	***45***	***60***	***28***	***34***	***37***	***16***	***21***
Mean number of ADL difficulties	***1.1***	***1.6***	***0.5***	***0.6***	***0.9***	***0.3***	***0.4***
Base (= all respondents)	*1509*	*60*	*567*	*258*	*2012*	*6533*	*8545*

Table 4.2 Type of ADL difficulties

by type of mental disorder

	Current neurotic disorder	Probable psychotic disorder	Alcohol dependent	Drug dependent (any drug)	Any of the four types of mental disorder	None of the four types of mental disorder	All
	%	%	%	%	%	%	%
Practical Activities	26	30	8	6	20	9	12
Dealing with paperwork	18	38	11	11	16	6	8
Household activities	18	26	5	5	14	4	6
Using transport	16	20	4	4	12	3	5
Managing Money	14	22	16	26	13	2	5
Personal Care	10	12	3	1	8	2	4
Medical care	4	10	2	3	3	1	1
Any type of difficulty	***45***	***60***	***28***	***34***	***37***	***16***	***21***
Base	*1509*	*60*	*567*	*258*	*2012*	*6533*	*8545*

Table 4.3 Help required for practical activities by type of mental disorder

	Current neurotic disorder	Probable psychotic disorder	Alcohol dependent	Drug dependent (any drug)	Any of the four types of mental disorder	None of the four types of mental disorder	All
Whether help is needed	%	%	%	%	%	%	%
Yes	87	[76]	84	[79]	86	84	85
No	13	[24]	16	[21]	14	16	15
Base (= respondents who had difficulties with practical activities)	*447*	*20*	*62*	*20*	*479*	*741*	*1220*
			Percentage reporting each source of help				
Source of help received							
Spouse/cohabitee	49	[4]	35	[5]	48	51	49
Son/daughter	32	[2]	28	[1]	33	33	33
Brother/sister	12	[3]	17	-	12	10	11
Parent	7	[1]	11	[1]	8	6	7
Grandchild	1	-	-	-	1	3	2
Grandparent	1	-	-	-	1	0	1
Other relative	5	-	9	-	6	4	5
Boyfriend/girlfriend	3	[1]	10	[1]	4	1	2
Friend	20	[3]	32	[5]	21	14	17
Paid domestic help	4	[1]	10	[2]	6	9	8
Landlord/landlady	1	-	3	-	1	1	1
Home care worker or home help	0	-	1	-	-	2	1
CPN/Nurse	-	-	-	-	-	0	0
Paid nurse	-	-	-	-	-	-	-
Social worker	-	-	-	-	-	0	0
Occupational Therapist							
Voluntary worker	-	-	-	-	-	-	0
Bank manager	-	-	-	-	-	-	-
Solicitor	-	-	-	-	-	-	-
Other person	10	[3]	10	[5]	10	12	11
No-one	6	[3]	10	[2]	6	6	3
Base (= respondents who need help with practical activities)	*391*	*15*	*54*	*17*	*416*	*623*	*1039*

Table 4.4 Help required for dealing with paperwork by type of mental disorder

	Current neurotic disorder	Probable psychotic disorder	Alcohol dependent	Drug dependent (any drug)	Any of the four types of mental disorder	None of the four types of mental disorder	All
Whether help is needed	%	%	%	%	%	%	%
Yes	82	[89]	75	80	84	86	84
No	18	[11]	25	20	16	14	16
Base (= respondents who had difficulties with paperwork)	*304*	*24*	*79*	*33*	*359*	*409*	*768*
			Percentage reporting each source of help				
Source of help received							
Spouse/cohabitee	54	[5]	44	[11]	52	63	58
Son/daughter	21	[4]	10	[2]	19	19	19
Brother/sister	9	-	11	[2]	9	8	8
Parent	9	-	21	[7]	12	13	12
Grandchild	1	-	-	[1]	1	0	1
Grandparent	1	-	1	[2]	1	1	1
Other relative	4	-	3	[2]	3	4	4
Boyfriend/girlfriend	4	[1]	7	[5]	4	2	3
Friend	13	[6]	21	[5]	16	9	12
Paid domestic help	-	-	-	-	-	0	0
Landlord/landlady							
Home care worker or home help	0	[1]	-	-	0	1	1
CPN/Nurse	1	[3]	-	[1]	1	-	1
Paid nurse	-	-	1	-	0	-	0
Social worker	2	[4]	5	[2]	2	1	1
Occupational Therapist							
Voluntary worker	2	-	2	-	2	0	1
Bank manager	1	-	1	-	1	0	0
Solicitor	1	[1]	1	-	1	0	1
Other person	5	[1]	7	[2]	6	5	5
No-one	2	-	-	[1]	2	1	1
Base (= respondents who need help with paperwork)	*256*	*20*	*59*	*26*	*294*	*347*	*641*

Table 4.5 Help required for household activities by type of mental disorder

	Current neurotic disorder	Probable psychotic disorder	Alcohol dependent	Drug dependent (any drug)	Any of the four types of mental disorder	None of the four types of mental disorder	All
Whether help is needed	%	%	%	%	%	%	%
Yes	82	[84]	79	[83]	81	82	82
No	18	[16]	21	[17]	19	18	18
Base (= respondents who had difficulties with household activities)	*314*	*18*	*38*	*17*	*327*	*285*	*612*
			Percentage reporting each source of help				
Source of help received							
Spouse/cohabitee	60	[4]	[11]	[7]	59	63	61
Son/daughter	34	[3]	[6]	[2]	35	27	31
Brother/sister	8	-	[2]	[3]	8	8	8
Parent	9	[1]	[2]	[2]	9	9	9
Grandchild	1	-	-	-	1	4	2
Grandparent	0	-	-	-	0	-	0
Other relative	3	-	[1]	-	3	2	2
Boyfriend/girlfriend	4	[2]	[3]	[1]	4	1	2
Friend	17	[5]	[6]	[3]	17	8	12
Paid domestic help	2	-	-	-	2	5	4
Landlord/landlady	0	-	-	-	0	-	0
Home care worker or home help	4	[2]	[4]	[2]	4	6	5
CPN/Nurse							
Paid nurse	-	-	[1]	-	0	-	0
Social worker	1	[1]	[1]	-	1	-	0
Occupational Therapist	0	-	-	-	0	-	0
Voluntary worker	0	-	-	-	0	-	0
Bank manager							
Solicitor	1	-	-	[1]	1	-	0
Other person	2	-	[1]	-	2	1	1
No-one	4	[1]	[1]	[1]	3	2	3
Base (= respondents who need help with household activities)	*247*	*14*	*29*	*13*	*259*	*236*	*495*

Table 4.6 Help required for using transport by type of mental disorder

	Current neurotic disorder	Probable psychotic disorder	Alcohol dependent	Drug dependent (any drug)	Any of the four types of mental disorder	None of the four types of mental disorder	All
Whether help is needed	%	%	%	%	%	%	%
Yes	68	[84]	[74]	[55]	67	65	66
No	32	[16]	[26]	[45]	33	35	34
Base (= respondents who had difficulties with transport)	*275*	*14*	*29*	*14*	*284*	*261*	*545*
			Percentage reporting each source of help				
Source of help received							
Spouse/cohabitee	56	[3]	[7]	[4]	56	63	59
Son/daughter	38	[1]	[5]	[5]	37	38	38
Brother/sister	18	[1]	[3]	[4]	18	8	13
Parent	7	[1]	-	[2]	7	7	7
Grandchild	3	[1]	-	[1]	3	5	4
Grandparent	-	-	-	-	-	0	0
Other relative	6	-	[3]	[2]	6	6	6
Boyfriend/girlfriend	2	[1]	[2]	[2]	3	1	2
Friend	31	[5]	[9]	[4]	31	24	28
Paid domestic help	-	-	-	-	-	0	0
Landlord/landlady	1	-	[1]	-	1	-	1
Home care worker or home help	1	-	[2]	-	1	2	2
CPN/Nurse	-	-	-	-	-	0	0
Paid nurse	-	-	-	-	-	-	-
Social worker	2	[1]	[1]	-	2	-	1
Occupational Therapist							
Voluntary worker	1	[1]	[2]	-	1	3	2
Bank manager							
Solicitor	1	[1]	-	-	1	-	0
Other person	5	[3]	[2]	[2]	5	10	8
No-one	6	[1]	[1]	-	6	2	4
Base (= respondents who need help with transport)	*186*	*11*	*22*	*8*	*191*	*160*	*351*

Table 4.7 Help required for managing money by type of mental disorder

	Current neurotic disorder	Probable psychotic disorder	Alcohol dependent	Drug dependent (any drug)	Any of the four types of mental disorder	None of the four types of mental disorder	All
Whether help is needed	%	%	%	%	%	%	%
Yes	56	[69]	38	40	51	57	53
No	44	[31]	62	60	49	43	47
Base (= respondents who had difficulties with managing money)	*195*	*13*	*76*	*54*	*240*	*158*	*398*
			Percentage reporting each source of help				
Source of help received							
Spouse/cohabitee	56	[3]	52	[7]	56	60	58
Son/daughter	9	[1]	1	[1]	8	7	8
Brother/sister	7	-	-	[3]	6	1	4
Parent	22	[1]	26	[7]	22	17	20
Grandchild							
Grandparent	2	-	2	[1]	1	-	1
Other relative	1	-	-	-	1	1	1
Boyfriend/girlfriend	6	[1]	7	[5]	6	2	5
Friend	3	[2]	2	[1]	3	2	2
Paid domestic help							
Landlord/landlady							
Home care worker or home help	1	[1]	-	-	1	2	1
CPN/Nurse	1	[1]	-	-	0	-	0
Paid nurse							
Social worker							
Occupational Therapist	-	-	-	-	-	1	0
Voluntary worker	1	-	-	-	1	-	0
Bank manager	1	-	-	-	1	4	2
Solicitor	0	-	-	-	0	-	0
Other person	2	-	6	-	2	6	3
No-one	9	[1]	14	[2]	10	5	8
Base (= respondents who need help with managing money)	*104*	*10*	*31*	*21*	*119*	*79*	*198*

Table 4.8 Help required for personal care by type of mental disorder

	Current neurotic disorder	Probable psychotic disorder	Alcohol dependent	Drug dependent (any drug)	Any of the four types of mental disorder	None of the four types of mental disorder	All
Whether help is needed	%	%	%	%	%	%	%
Yes	71	[68]	[60]	[45]	71	66	68
No	29	[32]	[40]	[55]	29	34	32
Base (= respondents who had difficulties with personal care)	*176*	*8*	*17*	*5*	*183*	*176*	*359*
			Percentage reporting each source of help				
Source of help received							
Spouse/cohabitee	75	[2]	[4]	[2]	74	75	74
Son/daughter	20	[1]	[3]	-	24	17	20
Brother/sister	5	-	-	-	5	6	5
Parent	2	-	-	-	2	9	5
Grandchild	-	-	-	-	-	4	2
Grandparent							
Other relative	3	-	-	-	2	1	2
Boyfriend/girlfriend	3	-	-	-	2	-	1
Friend	8	[2]	-	-	7	1	4
Paid domestic help	0	-	-	-	0	-	0
Landlord/landlady	0	-	-	-	0	-	0
Home care worker or home help	2	-	[1]	-	2	9	6
CPN/Nurse	-	-	-	-	-	0	0
Paid nurse	0	-	-	-	0	-	0
Social worker	-	-	-	-	-	-	-
Occupational Therapist	-	-	-	-	-	-	-
Voluntary worker	-	-	-	-	-	-	-
Bank manager	-	-	-	-	-	-	-
Solicitor	-	-	-	-	-	-	-
Other person	4	-	-	-	4	1	2
No-one	5	-	-	-	5	3	4
Base (= respondents who need help with personal care)	*117*	*5*	*7*	*2*	*120*	*104*	*224*

Table 4.9 Help required for medical care

by type of mental disorder

	Current neurotic disorder	Probable psychotic disorder	Alcohol dependent	Drug dependent (any drug)	Any of the four types of mental disorder	None of the four types of mental disorder	All
Whether help is needed	%	%	%	%	%	%	%
Yes	65	[73]	[15]	[28]	71	56	61
No	35	[27]	[85]	[72]	29	44	39
Base (= respondents who had difficulties with medical care)	*48*	*5*	*7*	*6*	*51*	*39*	*90*
			Percentage reporting each source of help				
Source of help received							
Spouse/cohabitee	80	[2]	[1]	[1]	79	[15]	77
Son/daughter	18	[1]	-	-	18	[4]	17
Brother/sister	4	-	-	-	4	-	3
Parent	2	-	-	-	2	-	2
Grandchild	-	-	-	-	-	-	-
Grandparent	-	-	-	-	-	-	-
Other relative	2	-	-	-	2	-	2
Boyfriend/girlfriend	-	[1]	[1]	[1]	2	-	1
Friend	10	[1]	[1]	[1]	11	-	7
Paid domestic help							
Landlord/landlady							
Home care worker or home help	1	-	-	-	1	[1]	2
CPN/Nurse	8	-		-	8	[4]	11
Paid nurse	-	-	-	-	-	-	-
Social worker	-	-	-	-	-	-	-
Occupational Therapist	-	-	-	-	-	-	-
Voluntary worker	2	-	-	-	2	-	2
Bank manager	-	-	-	-	-	-	-
Solicitor	-	-	-	-	-	-	-
Other person	2	-	-	-	2	-	2
No-one	-	-	-	-	-	-	-
Base (= respondents who need help with medical care)	*35*	*4*	*2*	*2*	*36*	*22*	*58*

Table 4.10 Psychiatric risk factor correlates of any ADL difficulty

Psychiatric variables	Adjusted Odds Ratio	95% C.I.
Depressive episode		
No	1.00	———
Yes	3.64***	2.61 - 5.08
OCD		
No	1.00	———
Yes	2.17**	1.31 - 3.58
GAD		
No	1.00	———
Yes	2.57***	1.99 - 3.31
Phobia		
No	1.00	———
Yes	3.21***	2.13 - 4.82
Panic Disorder		
No	1.00	———
Yes	1.94*	1.10 - 3.41
Mixed anxiety/depression		
No	1.00	———
Yes	3.05***	2.56 - 3.63
Probable Psychosis		
No	1.00	———
Yes	2.09	0.99 - 4.39
Alcohol dependence		
None	1.00	———
Mild	1.60***	1.28 - 2.00
Moderate/severe	1.85	0.82 - 4.15
Drug dependence		
No dependence	1.00	———
Cannabis only	2.18***	1.55 - 3.06
Drugs other than cannabis	2.74***	1.70 - 4.41

*** p<0.001, ** p<0.01, * p<0.05

Other Variables	Adjusted Odds Ratio	95% C.I.
Sex		
Male	1.00	———
Female	1.08	0.96 - 1.22
Age		
16–24	1.00	———
25–44	1.16	0.90 - 1.50
45–64	1.94***	1.49 - 2.53
65–74	4.31***	3.23 - 5.76
Ethnicity		
White	1.00	———
Black	1.24	0.83 - 1.86
South Asian	1.10	0.73 - 1.66
Other	1.27	0.83 - 1.93
Family type		
Couple no children	1.00	———
Couple and children	0.99	0.84 - 1.15
Lone parent and child	1.47**	1.12 - 1.92
Lone parent only	1.30**	1.10 - 1.54
Adult with parents	1.58 *	1.02 - 2.43
Adult with one parent	1.32	0.99 - 1.76
Physical complaint		
No	1.00	———
Yes	3.48***	3.07 - 3.94

*** p<0.001, ** p<0.01, * p<0.05

Table 4.11 Psychiatric risk factor correlates of difficulty with practical activities

Psychiatric variables	Adjusted Odds Ratio	95% C.I.
Depressive episode		
No	1.00	———
Yes	3.91***	2.68 - 5.72
OCD		
No	1.00	———
Yes	1.39	0.77 - 2.50
GAD		
No	1.00	———
Yes	2.40***	1.78 - 3.24
Phobia		
No	1.00	———
Yes	2.08**	1.31 - 3.30
Panic Disorder		
No	1.00	———
Yes	1.50	0.76 - 2.97
Mixed anxiety/depression		
No	1.00	———
Yes	2.95***	2.38 - 3.67
Probable Psychosis		
No	1.00	———
Yes	1.10	0.48 - 2.48
Alcohol dependence		
None	1.00	———
Mild	0.86	0.60 - 1.26
Moderate/severe	2.13	0.84 - 5.44
Drug dependence		
No dependence	1.00	———
Cannabis only	0.59	0.28 - 1.24
Drugs other than cannabis	1.01	0.42 - 2.43

*** p<0.001, ** p<0.01, * p<0.05

Other Variables	Adjusted Odds Ratio	95% C.I.
Sex		
Male	1.00	———
Female	1.67***	1.42 - 1.95
Age		
16–24	1.00	———
25–44	4.14***	2.45 - 7.02
45–64	9.09***	5.32 - 15.52
65–74	20.24***	11.66 - 35.12
Ethnicity		
White	1.00	———
Black	0.84	0.45 - 1.57
South Asian	1.70	0.98 - 2.96
Other	1.20	0.66 - 2.17
Family type		
Couple no children	1.00	———
Couple and children	0.97	0.79 - 1.18
Lone parent and child	1.28	0.91 - 1.80
Lone parent only	1.49	1.22 - 1.84
Adult with parents	1.05	0.36 - 3.06
Adult with one parent	1.39	0.86 - 2.26
Physical complaint		
No	1.00	———
Yes	9.20***	7.49 - 11.30

*** p<0.001, ** p<0.01, * p<0.05

Table 4.12 Psychiatric risk factor correlates of difficulty with dealing with paperwork

Psychiatric variables	Adjusted Odds Ratio	95% C.I.
Depressive episode		
No	1.00	———
Yes	3.54***	2.48 - 5.07
OCD		
No	1.00	———
Yes	1.03	0.56 - 1.88
GAD		
No	1.00	———
Yes	2.07***	1.52 - 2.82
Phobia		
No	1.00	———
Yes	2.12***	1.34 - 3.34
Panic Disorder		
No	1.00	———
Yes	2.80***	1.50 - 5.25
Mixed anxiety/depression		
No	1.00	———
Yes	2.49***	1.97 - 3.14
Probable Psychosis		
No	1.00	———
Yes	2.72**	1.32 - 5.60
Alcohol dependence		
None	1.00	———
Mild	1.24	0.91 - 1.68
Moderate/severe	2.00	0.84 - 4.79
Drug dependence		
No dependence	1.00	———
Cannabis only	1.76*	1.12 - 2.70
Drugs other than cannabis	0.57	0.24 - 1.34

*** p<0.001, ** p<0.01, * p<0.05

Other Variables	Adjusted Odds Ratio	95% C.I.
Sex		
Male	1.00	———
Female	0.68***	0.57 - 0.80
Age		
16–24	1.00	———
25–44	0.89	0.61 - 1.26
45–64	1.54*	1.07 - 2.23
65–74	2.51	1.68 - 3.75
Ethnicity		
White	1.00	———
Black	1.98**	1.26 - 3.10
South Asian	0.56	0.28 - 1.15
Other	1.02	0.56 - 1.84
Family type		
Couple no children	1.00	———
Couple and children	1.11	0.90 - 1.38
Lone parent and child	1.60**	1.12 - 2.29
Lone parent only	1.24	0.99 - 1.56
Adult with parents	1.26	0.69 - 2.33
Adult with one parent	0.86	0.56 - 1.30
Physical complaint		
No	1.00	———
Yes	1.90***	1.60 - 2.25

*** p<0.001, ** p<0.01, * p<0.05

Table 4.13 Psychiatric risk factor correlates of difficulty with household activities

Psychiatric variables	Adjusted Odds Ratio	95% C.I.
Depressive episode		
No	1.00	———
Yes	5.72***	3.83 - 8.56
OCD		
No	1.00	———
Yes	1.23	0.64 - 2.39
GAD		
No	1.00	———
Yes	3.01***	2.14 - 4.23
Phobia		
No	1.00	———
Yes	3.73***	2.32 - 6.14
Panic Disorder		
No	1.00	———
Yes	2.38*	1.14 - 4.97
Mixed anxiety/depression		
No	1.00	———
Yes	3.85***	2.98 - 4.97
Probable Psychosis		
No	1.00	———
Yes	1.04	0.41 - 2.61
Alcohol dependence		
None	1.00	———
Mild	0.95	0.60 - 1.51
Moderate/severe	0.89	0.28 - 2.83
Drug dependence		
No dependence	1.00	———
Cannabis only	1.26	0.62 - 2.54
Drugs other than cannabis	0.80	0.26 - 2.44

*** p<0.001, ** p<0.01, * p<0.05

Other Variables	Adjusted Odds Ratio	95% C.I.
Sex		
Male	1.00	———
Female	1.46***	1.19 - 1.79
Age		
16–24	1.00	———
25–44	2.65***	1.46 - 4.80
45–64	5.64***	3.07 - 10.35
65–74	8.75***	4.65 - 16.47
Ethnicity		
White	1.00	———
Black	0.89	0.40 - 1.99
South Asian	0.59	0.22 - 1.58
Other	1.08	0.50 - 2.34
Family type		
Couple no children	1.00	———
Couple and children	0.89	0.68 - 1.16
Lone parent and child	1.04	0.66 - 1.62
Lone parent only	1.28	0.98 - 1.67
Adult with parents	1.85	0.61 - 5.61
Adult with one parent	1.88*	1.08 - 3.30
Physical complaint		
No	1.00	———
Yes	11.67***	8.44 - 16.16

*** p<0.001, ** p<0.01, * p<0.05

Table 4.14 Psychiatric risk factor correlates of difficulty with using transport

Psychiatric variables	Adjusted Odds Ratio	95% C.I.
Depressive episode		
No	1.00	———
Yes	3.24***	2.08 - 5.07
OCD		
No	1.00	———
Yes	1.10	0.55 - 2.20
GAD		
No	1.00	———
Yes	2.91***	2.03 - 4.17
Phobia		
No	1.00	———
Yes	5.72***	3.50 - 9.38
Panic Disorder		
No	1.00	———
Yes	2.47*	1.11 - 5.50
Mixed anxiety/depression		
No	1.00	———
Yes	4.42***	3.38 - 5.78
Probable Psychosis		
No	1.00	———
Yes	0.84	0.32 - 2.24
Alcohol dependence		
None	1.00	———
Mild	0.69	0.40 - 1.20
Moderate/severe	0.87	0.27 - 2.74
Drug dependence		
No dependence	1.00	———
Cannabis only	0.78	0.31 - 1.98
Drugs other than cannabis	1.41	0.50 - 4.04

*** p<0.001, ** p<0.01, * p<0.05

Other Variables	Adjusted Odds Ratio	95% C.I.
Sex		
Male	1.00	———
Female	1.28*	1.03 - 1.59
Age		
16–24	1.00	———
25–44	4.64***	2.06 - 10.42
45–64	10.33***	4.55 - 23.46
65–74	19.17***	8.29 - 44.34
Ethnicity		
White	1.00	———
Black	1.25	0.58 - 2.71
South Asian	1.62	0.75 - 3.50
Other	0.78	0.31 - 1.95
Family type		
Couple no children	1.00	———
Couple and children	0.80	0.60 - 1.06
Lone parent and child	1.08	0.68 - 1.72
Lone parent only	1.39*	1.06 - 1.82
Adult with parents	0.81	0.15 - 4.39
Adult with one parent	1.69	0.88 - 3.24
Physical complaint		
No	1.00	———
Yes	11.08***	7.78 - 15.78

*** p<0.001, ** p<0.01, * p<0.05

Table 4.15 Psychiatric risk factor correlates of difficulty with managing money

Psychiatric variables	Adjusted Odds Ratio	95% C.I.
Depressive episode		
No	1.00	———
Yes	3.34***	2.18 - 5.12
OCD		
No	1.00	———
Yes	2.32**	1.29 - 4.16
GAD		
No	1.00	———
Yes	3.26***	2.27 - 4.67
Phobia		
No	1.00	———
Yes	1.78*	1.05 - 3.03
Panic Disorder		
No	1.00	———
Yes	4.74***	2.39 - 9.39
Mixed anxiety/depression		
No	1.00	———
Yes	3.56***	2.68 - 4.74
Probable Psychosis		
No	1.00	———
Yes	1.53	0.63 - 3.69
Alcohol dependence		
None	1.00	———
Mild	2.47***	1.84 - 3.32
Moderate/severe	1.50	0.61 - 3.68
Drug dependence		
No dependence	1.00	———
Cannabis only	4.48***	3.07 - 6.52
Drugs other than cannabis	4.94***	2.98 - 8.24

*** p<0.001, ** p<0.01, * p<0.05

Other Variables	Adjusted Odds Ratio	95% C.I.
Sex		
Male	1.00	———
Female	0.77**	0.66 - 0.89
Age		
16–24	1.00	———
25–44	0.93	0.64 - 1.34
45–64	0.76	0.49 - 1.16
65–74	0.74**	0.58 - 0.93
Ethnicity		
White	1.00	———
Black	1.61	0.88 - 2.94
South Asian	1.26	0.66 - 2.40
Other	1.33	0.69 - 2.58
Family type		
Couple no children	1.00	———
Couple and children	0.87	0.64 - 1.17
Lone parent and child	1.32	0.83 - 2.12
Lone parent only	0.94	0.68 - 1.32
Adult with parents	1.12	0.59 - 2.15
Adult with one parent	1.32	0.86 - 2.04
Physical complaint		
No	1.00	———
Yes	1.22	0.97 - 1.54

*** p<0.001, ** p<0.01, * p<0.05

Table 4.16 Psychiatric risk factor correlates of difficulty with personal care

Psychiatric variables	Adjusted Odds Ratio	95% C.I.
Depressive episode		
No	1.00	———
Yes	2.68***	1.61 - 4.48
OCD		
No	1.00	———
Yes	2.44*	1.20 - 4.96
GAD		
No	1.00	———
Yes	2.26***	1.49 - 3.44
Phobia		
No	1.00	———
Yes	2.81***	1.54 - 5.13
Panic Disorder		
No	1.00	———
Yes	3.55**	1.59 - 7.94
Mixed anxiety/depression		
No	1.00	———
Yes	3.59***	2.64 - 4.89
Probable Psychosis		
No	1.00	———
Yes	1.00	0.33 - 3.04
Alcohol dependence		
None	1.00	———
Mild	0.78	0.42 - 1.46
Moderate/severe	1.66	0.43 - 6.33
Drug dependence		
No dependence	1.00	———
Cannabis only	0.24	0.04 - 1.39
Drugs other than cannabis	0.72	0.16 - 3.35

*** p<0.001, ** p<0.01, * p<0.05

Other Variables	Adjusted Odds Ratio	95% C.I.
Sex		
Male	1.00	———
Female	0.95	0.74 - 1.22
Age		
16–24	1.00	———
25–44	5.12***	1.41 - 18.59
45–64	11.83***	3.24 - 43.13
65–74	18.23***	4.92 - 67.56
Ethnicity		
White	1.00	———
Black	0.90	0.34 - 2.43
South Asian	1.57	0.63 - 3.90
Other	0.70	0.23 - 2.15
Family type		
Couple no children	1.00	———
Couple and children	0.93	0.68 - 1.28
Lone parent and child	1.14	0.67 - 1.94
Lone parent only	0.90	0.65 - 1.26
Adult with parents	..	..
Adult with one parent	1.00	0.40 - 2.48
Physical complaint		
No	1.00	———
Yes	29.99***	15.58 - 57.73

*** p<0.001, ** p<0.01, * p<0.05

Table 4.17 Psychiatric risk factor correlates of difficulty with medical care

Psychiatric variables	Adjusted Odds Ratio	95% C.I.
Depressive episode		
No	1.00	———
Yes	2.34**	1.05 - 5.24
OCD		
No	1.00	———
Yes	2.46	0.89 - 6.79
GAD		
No	1.00	———
Yes	3.07***	1.57 - 6.00
Phobia		
No	1.00	———
Yes	1.69	0.64 - 4.49
Panic Disorder		
No	1.00	———
Yes	5.58***	2.01 - 15.48
Mixed anxiety/depression		
No	1.00	———
Yes	3.05***	1.76 - 5.28
Probable Psychosis		
No	1.00	———
Yes	3.38*	1.02 - 11.22
Alcohol dependence		
None	1.00	———
Mild	0.98	0.44 - 2.20
Moderate/severe	0.69	0.09 - 5.18
Drug dependence		
No dependence	1.00	———
Cannabis only	3.05*	1.23 - 7.53
Drugs other than cannabis	1.91	0.40 - 9.26

*** p<0.001, ** p<0.01, * p<0.05

Other Variables	Adjusted Odds Ratio	95% C.I.
Sex		
Male	1.00	———
Female	0.87	0.56 - 1.36
Age		
16–24	1.00	———
25–44	0.47	0.19 - 1.15
45–64	0.49	0.19 - 1.23
65–74	0.85	0.32 - 2.29
Ethnicity		
White	1.00	———
Black	0.52	0.06 - 4.24
South Asian	2.72	0.96 - 7.74
Other	0.72	0.11 - 4.59
Family type		
Couple no children	1.00	———
Couple and children	0.74	0.43 - 1.28
Lone parent and child	0.59	0.22 - 1.62
Lone parent only	0.37**	0.18 - 0.76
Adult with parents	1.01	0.27 - 3.74
Adult with one parent	0.32	0.10 - 1.02
Physical complaint		
No	1.00	———
Yes	7.17***	3.87 - 13.28

*** p<0.001, ** p<0.01, * p<0.05

5 Social context

5.1 Introduction

This chapter is concerned with the social context of survey respondents and whether or not they had one of the four studied mental disorders: neurosis, psychosis, alcohol and drug dependence. The term, social context, is used to cover the experience of stressful events, perceived social support, the size of the primary support group, and number of friends seen in the previous week.

5.2 Stressful life events

Assessment and choice of events

All respondents were shown three sets of cards which listed a range of stressful life events (18 in total) and were asked to say which, if any, they had suffered at any time of their life. They covered relationship problems, illness and bereavement; employment and financial crises; and victimisation experiences, i.e. events which might have an adverse effect on a person's mental health. They were used in the ONS survey of psychiatric morbidity among prisoners (Singleton *et al,* 1998). However, the lists did not include all common stressful events, excluding for example, moving house and having a baby. Previous research has shown that events such as these are unlikely to significantly increase risk for psychiatric disorders. (Brugha *et al,* 1985). In addition, when looking at the number of events experienced, it should be remembered that the events may not carry equal weight in terms of their psychological impact, and that some events are likely to be found in combination with others; for example running away from home and homelessness. If an event was reported in the lifetime of the individual, a further question established whether this was within the past 6 months.

Number of stressful events

Ninety-five per cent of respondents reported at least one of the eighteen stressful events in their lifetime. However, looking at the mean number of lifetime events shows considerable differences between groups with and without mental disorders. Across the whole sample, the mean number was 3.5. However the lowest figure was 3.2 among the group with none of the four specified mental disorders, and rose to twice this number, 6.5 for those assessed as having a psychotic disorder. The mean number of lifetime events was 5.0 among the drug dependent group. A similar pattern was found for stressful life events experienced in the past six months with a mean of 0.3 overall compared with 0.5 to 0.7 among the four groups with mental disorders. *(Table 5.1)*

Type of stressful events

Relationship problems, illness or bereavement

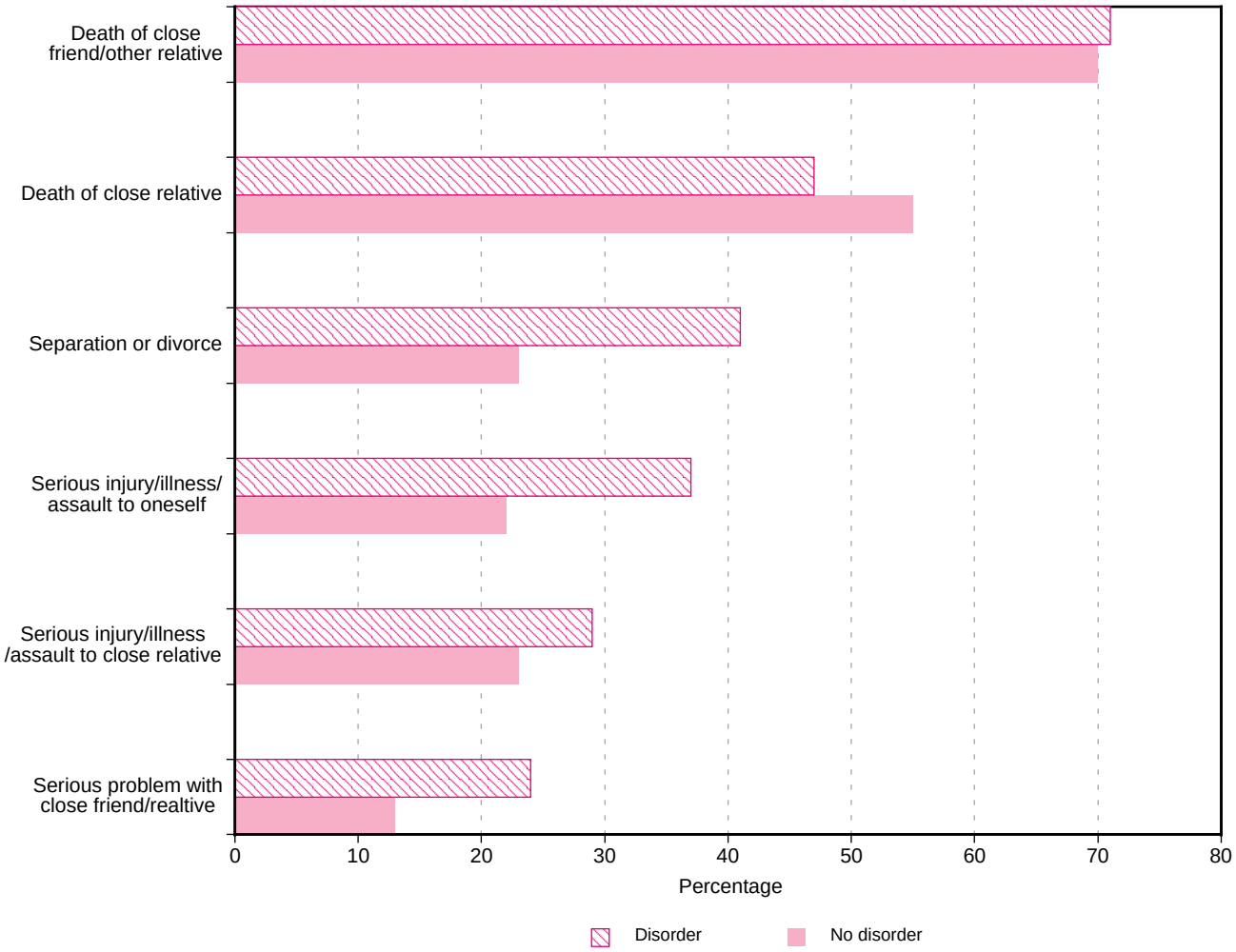
To what extent did survey respondents experience relationship problems, illness or bereavement in their lifetime and in the past six months? The specific events enquired about were: separation or divorce; serious illness, injury or assault; serious problem with a close friend or relative; serious illness; injury or assault to a close friend or relative; and death of a close relative.

Over the course of their lives just over half of survey respondents (53%) had experienced the death of a close relative and just over two-thirds (70%) the death of a close friend or other relative. This is not surprising considering the age distribution of the survey was 16 to 74 years. About a quarter of the sample also reported separation or divorce (27%), serious illness, being a victim of assault or injury (26%), and serious illness, assault or injury to someone close (24%).

Three of the six specified life events were twice as likely to be experienced by those with a mental disorder compared with those with no mental disorder: separation or divorce (44% compared with 23%), serious injury, illness or assault (40% compared with 22%), and having a serious problem with a close friend or relative (27% compared with 13%). *(Table 5.1)*

The prevalence of each lifetime experience was nearly always highest among the group with psychosis: 75% reported death of close friend or

Figure 5.1 Lifetime experience of illness, bereavement or relationship problems by whether or not had a mental disorder



other relative; 72% mentioned the death of a close relative, 64% had a serious illness or injury, 55% were separated or divorced, and 33% had a serious problem with a close friend or relative.

Even within the past six months, all events were much more frequent in the groups with mental disorders. Particularly high at 12% was the prevalence of death of a close friend or other relative within the past six months among the drug-dependent group. *(Table 5.2)*

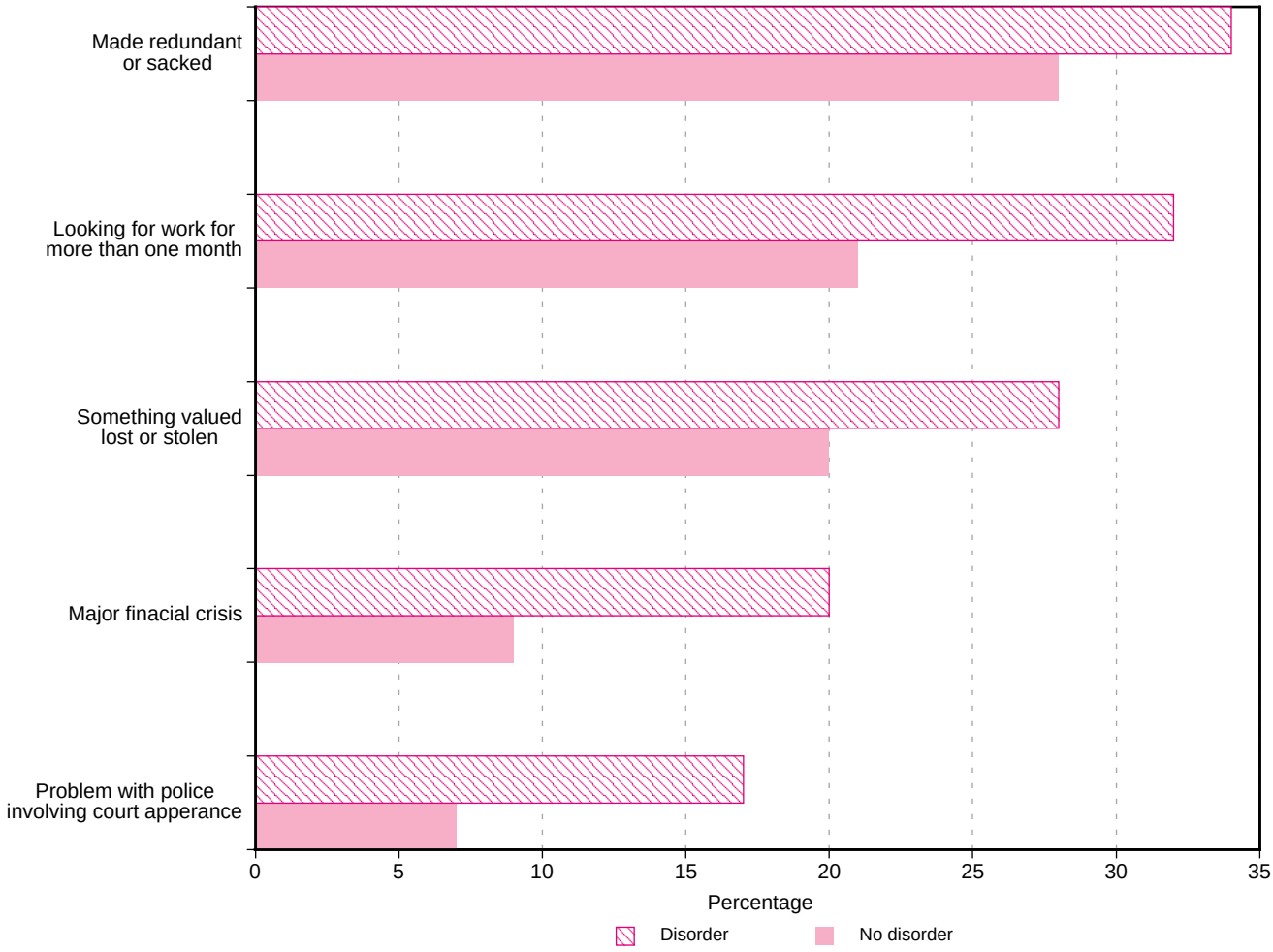
Employment and financial crises

Five events were subsumed under the heading employment and financial crises: problems with the police involving a court appearance, major financial crisis, having looked for work for one month and over, something valued being lost or stolen, and being made redundant or sacked.

During their lifetime 30% of respondents had been made redundant, 23% had been searching for work for a month or more, 22% had something of value lost or stolen, 11% had a major financial crisis and 9% had been in trouble involving a court appearance. Two of these five events showed significant differences in their frequency of reporting between those with and without a mental disorder: major financial crisis (22% compared with 9%) and being in trouble with the police necessitating a court appearance (14% compared with 7%). A quarter of those with psychosis had had a major financial crisis; a third of the drug dependent group and a quarter of the alcohol dependent group had been in trouble with the police involving a court appearance. *(Figure 5.2)*

The profile of survey respondents with mental disorders in terms of their employment and financial crises in the past six months show that the highest prevalence rates of looking for work for a month or more and something valued lost or stolen was found among the group with drug dependence (12% and 11% respectively). *(Table 5.3)*

Figure 5.2 Lifetime experience of employment or financial crisis by whether or not had mental disorder



Victimisation experiences

Stressful events that respondents were shown on the third card included running away from home, sexual abuse, violence in the home, ever having been homeless, violence at work and being bullied. Only three of these events achieved a prevalence rate of 5% or greater: 18% of survey respondents reported having been bullied, 7% experienced violence in the home and 5% had run away from home. Those with mental disorders were far more likely to have experienced any of the victimisation events than the no disorder group. For example, 3% of the group with no disorder said they had run away from home. The equivalent per centages among the currently neurotic group and those with alcohol dependence was 12%; the rate was 24% among those with drug dependence, and 34% among those with psychosis. *(Figure 5.3)*

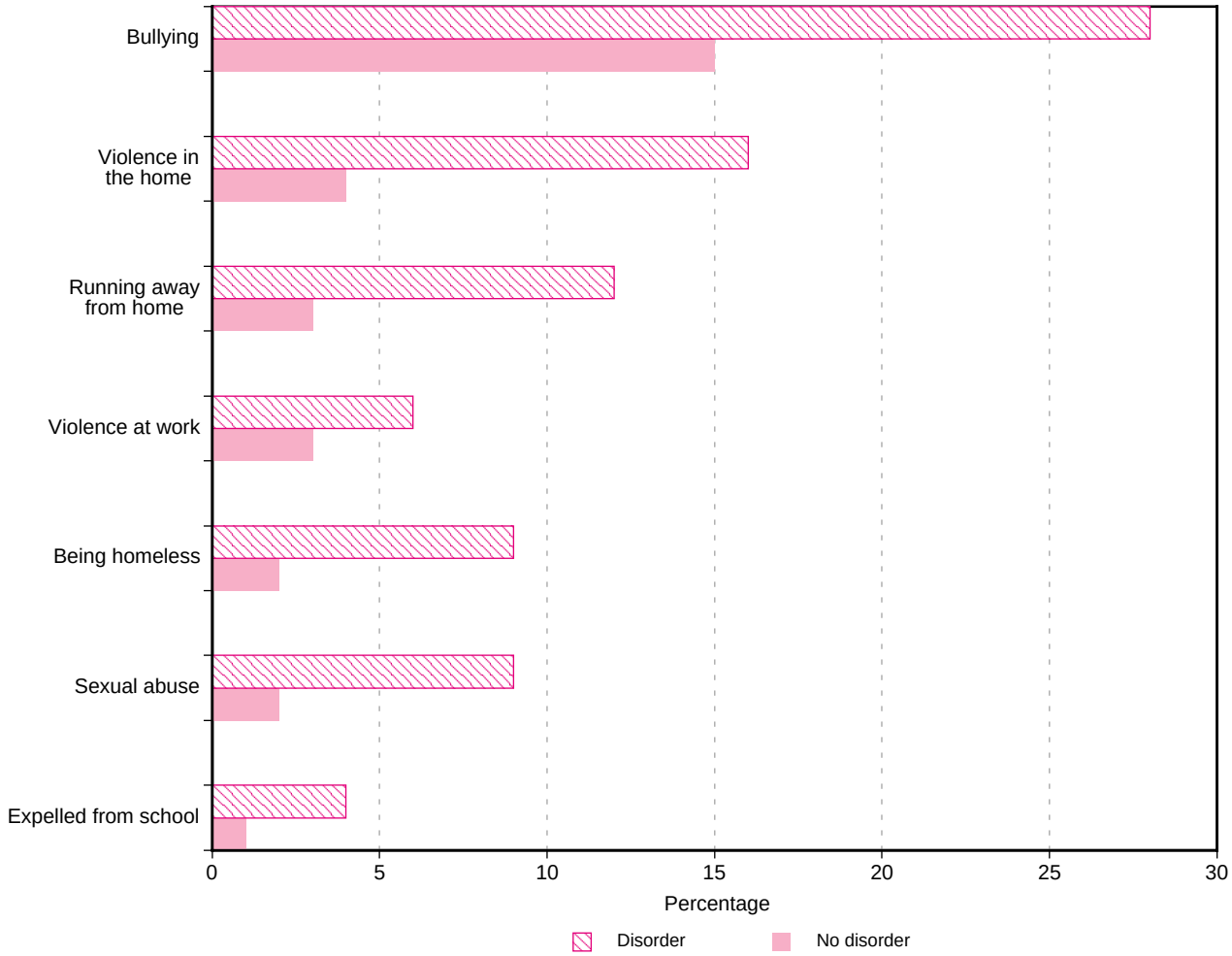
The prevalence of each lifetime, victimisation experience was nearly always highest among the group with psychosis: 47% said they had been bullied, 37% had been subject to violence in the home, 34% had run away from home, 31% cited sexual abuse, 28% had been homeless, and 11% had experienced violence at work.

Although being expelled from school had a prevalence rate of 1% among the no disorder group the percentages among the alcohol and drug dependent groups were 6% and 12% respectively. *(Table 5.4)*

Institutional care

In addition to asking about the eighteen life events, two additional questions were asked relating to institutional care in childhood: spent time in local authority care, or in a borstal or young offenders unit. Only 2% of all survey respondents had been in either of these institutions whereas among the group with psychosis 17% had been in local authority care and 4% in borstal. *(Table 5.5)*

Figure 5.3 Lifetime victimisation experience by whether or not had a mental disorder



Help sought to cope with stressful life events

All respondents who had experienced each stressful life event in the past six months were asked a series of questions about help sought after experiencing the event:

- Was there anyone among family or friends who understood what it was like?
- If Yes, were you able to talk about it openly to get support and understanding?
- Did you get professional help?
- If Yes, what sort of help?
- If No, did you try to get professional help?
- If No, why did you not try to get professional help?

The responses to all these questions are shown for 14 events in Tables 5.6 to 5.8. The four victimisation events omitted from Table 5.8 are excluded because the number of cases is too small. To illustrate the responses to these questions two examples are presented for each of the three main type of event.

Example 1: Death of a close relative

Two hundred and eighty four respondents mentioned the death of a close relative in the past six months. 95% of this group said they got help and understanding from their family and friends and nearly all, 96% of these, said they were able to talk about it with family and friends. Ten per cent of all respondents said they received professional help to cope with their bereavement. For the vast majority, this professional help comprised talking things over. 94% of those who did not get professional help did not want any help. *(Table 5.6)*

Example 2: Divorce or separation

In the six months prior to interview, 198 survey respondents said they divorced or separated. 78% of them said they felt that friends or family understood what they were going through and most, 96% were able to talk things over with them. Seventeen per cent of all respondents who had divorced or separated in the past six months had sought

professional help, two-thirds wanted to talk things over and a third wanted practical advice. Only ten per cent of those who did not get professional help said they would have liked it. *(Table 5.6)*

Example 3: Made redundant

One hundred and seventy respondents had been sacked or made redundant in the past six months. About three-quarters, 73%, said that family and friends had understood and the majority of them, 96% were supportive. Overall, 9% got professional help, mostly practical help. Most of those who did not get practical help did not want it. *(Table 5.7)*

Example 4: Major financial crisis

About one and a half of all survey respondents, 120 overall, said they had a major financial crisis in the past 6 months. Only two-thirds said that family and friends appreciated their situation, but those that did were supportive. Fifteen per cent overall sought professional help, 71% of them wanted practical help and 29% just needed to talk things over. Of the 100 respondents who had a financial crisis and did not get professional help, 13% did try to get help. *(Table 5.8)*

Example 5: Violence at work

Fifty-six respondents reported violence at work in the six months prior to interview. A relatively high proportion, 40%, felt that family and friends did not understand what was happening to them. Twenty per cent received help and an additional 6% of the remainder sought help. *(Table 5.8)*

Example 6: Violence in the home

Fifty respondents mentioned violence at home as one of the stressful life events that they had suffered over the past six months. A majority, 62% felt that family and friends did not understand what it was like. Only a quarter received professional help. Of those who did not seek or get help, only two-thirds said they did not need it, 15% did not know where to go to get help.

Logistic regression was applied to the data to look at the psychiatric risk factor correlates with experiencing at least one stressful life event in the past six months. The non-psychiatric factors entered into the analysis were sex, age, ethnicity, family type and physical complaint. Controlling for these factors, the odds of having a stressful life event in the past six months increased for those with depressive episode (OR=2.12), mixed anxiety and depression (OR=1.87), panic disorder (OR=1.76) and GAD (OR=1.42). Those dependent on drugs other than cannabis were also 84% more likely to have experienced a stressful event in the past 6 months compared with the non dependent group. *(Table 5.9)*

5.3 Social support and social isolation

Perceived social support

Assessment of perceived social support

Perceived social support was assessed from respondents' answers to seven questions which were originally used in the 1987 Health and Lifestyle survey, and were also included in the 1992 Health Survey for England (Breeze *et al,* 1994) and the ONS (OPCS) surveys of psychiatric morbidity among adults in private households and in institutions catering for people with mental disorder. (Meltzer *et al,* 1995; Meltzer *et al,* 1996) The seven questions take the form of statements that individuals could say were not true, partly true or certainly true for them:

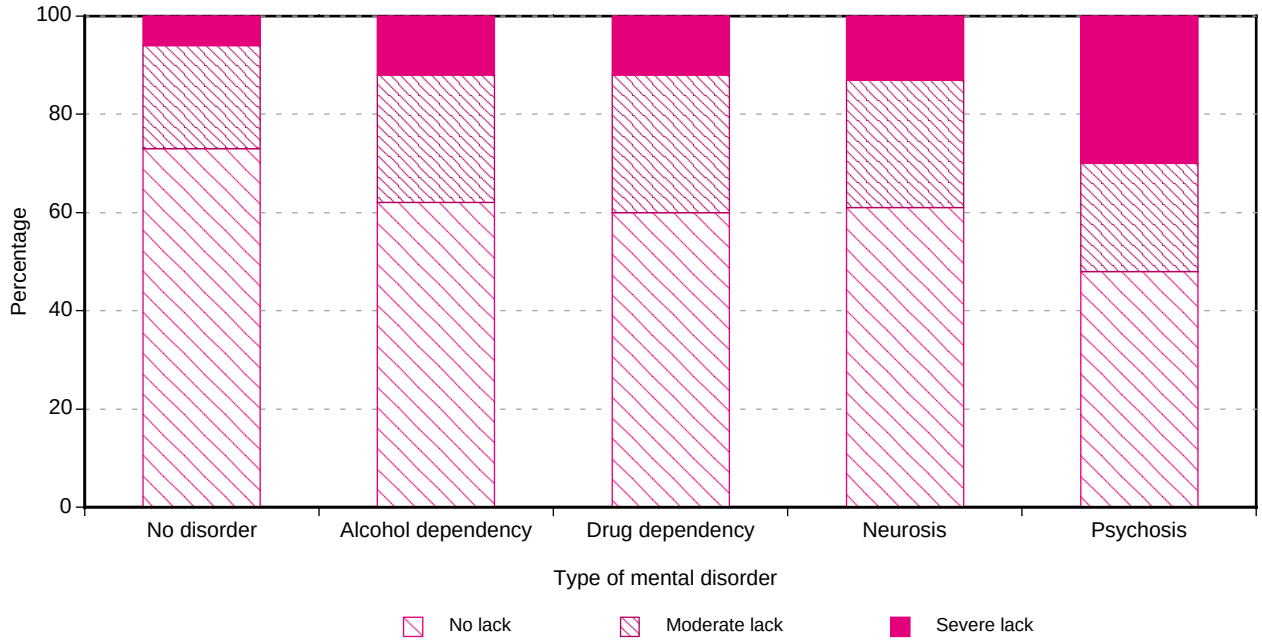
There are people I know among my family and friends:

- who do things to make me happy;
- who make me feel loved;
- who can be relied on no matter what happens;
- who would see that I am taken care of if I needed to be;
- who accept me just as I am;
- who make me feel an important part of their lives; and
- who give me support and encouragement.

Scores of 1–3 were obtained for each question and overall scores ranged from 7 to 21. The maximum score of 21 indicated no lack of perceived social support; scores of 18 to 20 indicated a moderate lack, and scores of 17 and below showed that individuals perceived a severe lack of social support.

Overall, 8% of survey respondents were assessed as having a severe lack of social support. Among the group with none of the four mental disorders covered in the survey the rate was 6%. The prevalence of severe lack of social support among

Figure 5.4 Perceived social support by type of mental disorder



the groups with neurosis, alcohol and drug dependence was double that of the non-disorder group, 12–13%, and rose to 30% among the group with a psychotic disorder. *(Table 5.10 and Figure 5.4)*

Primary support group

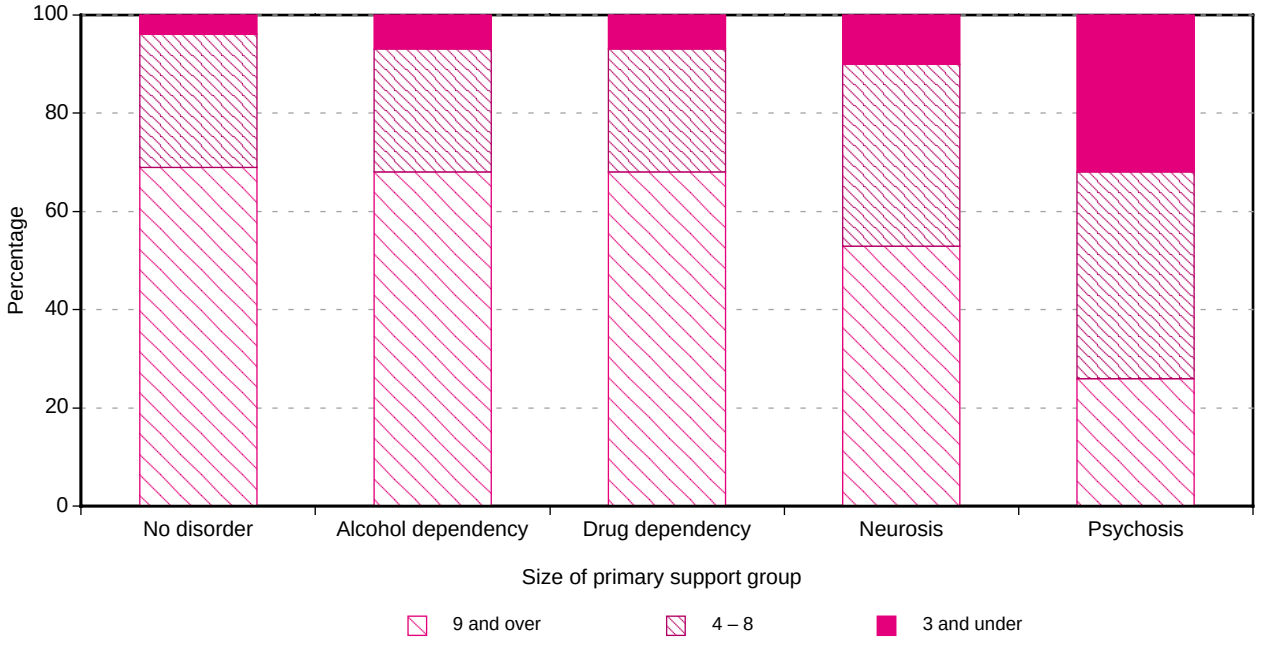
Calculating the size of a person's primary support group

Another group of questions assessed the extent of respondents' social networks. These were also adapted from questions used in the other ONS (OPCS) surveys of psychiatric morbidity and focused on the numbers of people (aged 16 and over) that respondents felt close to. Here again the frame of reference was broadened to include everyone the individual was acquainted with, rather than just friends and relatives.

Information was collected about three groups of people:

- adults living inside the household that respondents felt close to;
- relatives, aged 16 or over, living outside the household that respondents felt close to; and

Figure 5.5 Size of primary support group by type of mental disorder



- friends or acquaintances living outside the household that would be described as close or good friends.

Close friends and relatives form an individual's 'primary support group'. Previous research has suggested that adults with a primary support group of 3 people or fewer are at greatest risk of psychiatric morbidity (Brugha *et al*, 1987; Brugha *et al,* 1993)

Those with a mental disorder were about twice as likely to have a small primary support group, i.e. less than four people – 9% compared with 4%. However, the group with a psychotic disorder stood out from the rest with 32% of them having a primary support group of three or fewer people. *(Table 5.10 and Figure 5.5)*

Social isolation

Respondents were asked how many friends they had seen the past week and from their responses three size bands were constructed: none, one or two and three or more friends. Again, it was the group with psychosis who had a different profile from all others: 10% had seen no friends in the past week, compared with a total sample rate of 4%, and 45% had only seen one or two friends compared with an overall rate of 18%. *(Table 5.10)*

Tables 5.11 to 5.13 show the results of the logistic regression analysis to look at the psychiatric correlates of having a severe lack of social support, a small primary support group and having seen no friends in the past week. Controlling for sex, age, ethnicity, family type and physical complaints, there were increased odds of a lack of social support and social isolation among many of the groups with mental disorders.

Looking at a severe lack of social support compared with the reference group of no lack or a moderate lack, increased odds of having a severe lack were found for those with moderate or severe alcohol dependence (OR=2.68), phobia (OR=2.19), mixed anxiety and depressive disorder (OR=1.89) and GAD (OR=1.78). *(Table 5.11)*

The logistic regression analysis applied to having a small primary support group also indicated increased odds for four mental disorders, three of the them were the same as for severe lack of social support: GAD (OR=2.41), phobia (OR=2.38) and mixed anxiety and depressive disorder (OR=1.47). However, the greatest increase in odds were found for psychosis (OR=3.40).*(Table 5.12)*

The adjusted odds ratio of having seen no friends in the past week compared with seeing at least one friend were significantly increased for those with moderate or severe alcohol dependence (OR=3.03), phobia (OR=2.18) and mixed anxiety and depressive disorder (OR=1.42).*(Table 5.13)*

The presence of phobia as a significant correlate of all three measures of poor social functioning may be explained by some having a social phobia.

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Table 5.1 Number of stressful life events in lifetime and past six months by type of mental disorder

	Current neurotic disorder	Probable psychotic disorder	Alcohol dependent	Drug dependent (any drug)	Any of the four types of mental disorder	None of the four types of mental disorder	All
Number of stressful life events in lifetime	%	%	%	%	%	%	%
0	2	3	4	2	3	6	5
1	6	2	12	11	8	15	14
2	14	8	16	12	14	20	19
3	16	5	13	12	16	20	19
4	15	8	13	11	15	16	16
5	12	12	12	12	12	10	10
6	8	8	8	10	9	6	6
7	8	11	6	9	7	4	4
8	7	12	6	6	6	2	3
9	4	14	2	2	4	1	2
10	4	5	2	4	3	1	1
11–17	4	12	6	9	4	0	1
Any lifetime stressful event	***98***	***97***	***96***	***98***	***97***	***94***	***95***
Mean number of lifetime stressful events	***4.8***	***6.5***	***4.4***	***5.0***	***4.6***	***3.2***	***3.5***
Base (= all respondents)	*1509*	*60*	*567*	*258*	*2012*	*6533*	*8545*
Number stressful life events in past 6 months	%	%	%	%	%	%	%
0	61	60	64	56	62	78	74
1	27	31	24	25	26	18	20
2	8	8	7	10	8	3	4
3	2	1	3	6	2	1	1
4 and over	2	1	1	3	2	0	1
Any stressful event in past 6 months	***39***	***40***	***36***	***44***	***38***	***23***	***26***
Mean number of stressful events in past 6 month	***0.6***	***0.5***	***0.5***	***0.7***	***0.5***	***0.3***	***0.3***
Base (= all respondents)	*1509*	*60*	*567*	*258*	*2012*	*6533*	*8545*

Table 5.2 Illness, bereavement and relationship problems in lifetime and past six months by type of mental disorder

	Current neurotic disorder	Probable psychotic disorder	Alcohol dependent	Drug dependent (any drug)	Any of the four types of mental disorder	None of the four types of mental disorder	All
Lifetime	*Percentage experiencing each type of event*						
Death of close friend/other relative	72	75	66	70	71	70	70
Death of close relative	54	72	35	22	47	55	53
Separation or divorce	44	55	40	42	41	23	27
Serious injury/illness/assualt to you	40	64	35	30	37	22	26
Serious injury/illness/assualt to close relative	32	28	26	25	29	23	24
Serious problem with close friend/relative	27	33	20	31	24	13	15
Base	*1509*	*60*	*567*	*258*	*2012*	*6533*	*8545*
Part six months	*Percentage experiencing each type of event*						
Death of close friend/other relative	9	9	7	12	9	8	8
Death of close relative	5	2	2	1	4	3	3
Separation or divorce	4	3	3	5	4	2	2
Serious injury/illness/assualt to you	5	6	1	3	4	1	2
Serious injury/illness/assualt to close relative	5	4	4	3	4	2	3
Serious problem with close friend/relative	7	9	5	7	6	2	3
Base	*1509*	*60*	*567*	*258*	*2012*	*6533*	*8545*

Table 5.3 Employment and financial crises in lifetime and in past six months by type of mental disorder

	Current neurotic disorder	Probable psychotic disorder	Alcohol dependent	Drug dependent (any drug)	Any of the four types of mental disorder	None of the four types of mental disorder	All
Lifetime	*Percentage experiencing each type of event*						
Made redundant or sacked	33	42	39	40	34	28	30
Looking for work for more than one month	30	41	36	48	32	21	23
Something valued lost or stolen	27	46	32	38	28	20	22
Major financial crisis	22	24	18	22	20	9	11
Problem with police involving court appearance	14	19	25	35	17	7	9
Base	*1509*	*60*	*567*	*258*	*2012*	*6533*	*8545*
Part six months	*Percentage experiencing each type of event*						
Made redundant or sacked	3	-	6	8	4	2	2
Looking for work for more than one month	5	3	8	12	5	3	3
Something valued lost or stolen	4	6	6	11	5	2	3
Major financial crisis	4	-	3	4	3	1	1
Problem with police involving court appearance	2	3	3	5	2	0	1
Base	*1509*	*60*	*567*	*258*	*2012*	*6533*	*8545*

Table 5.4 Victimisation experiences in lifetime and in past six months

by type of mental disorder

	Current neurotic disorder	Probable psychotic disorder	Alcohol dependent	Drug dependent (any drug)	Any of the four types of mental disorder	None of the four types of mental disorder	All
Lifetime			*Percentage experiencing each type of event*				
Bullying	31	47	23	29	28	15	18
Violence in the home	20	37	12	20	16	4	7
Running away from home	13	34	12	24	12	3	5
Violence at work	6	11	9	9	6	3	4
Being homeless	9	28	10	15	9	2	4
Sexual abuse	12	31	4	6	9	2	3
Being expelled from school	4	1	6	12	4	1	2
Base	*1,509*	*60*	*567*	*258*	*2,012*	*6,533*	*8,545*
Part six months			*Percentage experiencing each type of event*				
Bullying	2	-	1	0	2	0	0
Violence in the home	2	3	1	3	2	0	1
Running away from home	0	3	-	-	0	-	0
Violence at work	1	-	1	1	1	1	1
Being homeless	1	1	1	1	1	0	0
Sexual abuse	0	2	0	0	0	0	0
Being expelled from school	-	-	-	-	-	0	0
Base	*1,509*	*60*	*567*	*258*	*2,012*	*6,533*	*8,545*

Table 5.5 Institutional care in childhood

by type of mental disorder

	Current neurotic disorder	Probable psychotic disorder	Alcohol dependent	Drug dependent (any drug)	Any of the four types of mental disorder	None of the four types of mental disorder	All
			Percentage attending each type of institution				
Spent time in a children's institution such as children's home, borstal or young offenders unit before 16	5	20	6	4	5	2	2
Taken into local authority care up to the age of 16	5	17	4	4	4	2	2
Home Office Approved School or borstal	1	4	1	0	1	0	0
Base	*1,509*	*60*	*567*	*258*	*2,012*	*6,533*	*8,545*

Table 5.6 Help sought for illness, bereavement and relationship problems in past six months

	Serious injury to oneself	Serious injury to a close relative	Death of close relative	Dealth of a close family friend	Divorce or separation	Serious problem with close friend/relative
	%	%	%	%	%	%
Was there anyone among family and friends who understood what it was like?						
Yes	79	91	96	92	78	84
No	21	9	4	8	22	16
Base (=Those who experienced each event)	*172*	*245*	*284*	*731*	*198*	*268*
Were you able to talk about it openly and get support and understanding?						
Yes	98	95	95	97	96	95
No	2	5	5	3	4	5
Base (=Respondents who said family/friends understood)	*134*	*219*	*271*	*673*	*153*	*219*
Did you get any professional help for it?						
Yes	56	15	10	3	17	14
No	44	85	90	97	83	86
Base (=Those who experienced each event)	*173*	*248*	*285*	*734*	*199*	*269*
Did you try to get professional help?						
Yes	9	3	-	0	3	4
No	91	97	100	100	97	96
Base (= Respondents with no professional help)	*70*	*209*	*251*	*709*	*158*	*229*
What sort of professional help?						
Practical things	47	26	10	19	11	43
Talk things over	27	48	70	80	67	42
Practical things and talk things over	26	26	20	1	22	15
Base (= Respondents tried professional help)	*112*	*48*	*45*	*37*	*53*	*52*
Why not tried to get professional help						
Did not know where to go	3	1	4	1	5	2
Did not need help	92	97	94	98	90	92
Other answer	5	2	2	1	5	6
Base (= Respondent not tried professional help)	*63*	*202*	*250*	*707*	*152*	*222*

Table 5.7 Help sought for employment and financial crises in past six months

	Made redundant or sacked	No success in looking for work for 1 month	Major finanacial crisis	Problem with police with court appearance	Something valued being stolen
	%	%	%	%	%
Was there anyone among family and friends who understood what it was like?					
Yes	73	77	67	56	80
No	27	23	33	44	20
Base (=Those who experienced each event)	*170*	*248*	*120*	*69*	*216*
Were you able to talk about it openly and get support and understanding?					
Yes	96	96	93	92	95
No	4	4	7	8	5
Base (=Respondents who said family/friends understood)	*121*	*191*	*81*	*44*	*174*
Did you get any professional help for it?					
Yes	9	18	15	26	6
No	91	82	85	74	94
Base (=Those who experienced each event)	*171*	*250*	*120*	*69*	*216*
Did you try to get professional help?					
Yes	3	5	13	1	3
No	97	95	87	99	97
Base (= Respondents with no professional help)	*150*	*204*	*100*	*45*	*200*
What sort of professional help?					
Practical things	62	52	54	[10]	[16]
Talk things over	18	27	29	[11]	[6]
Practical things and talk things over	20	22	17	[8]	-
Base (= Respondents tried professional help)	*34*	*74*	*42*	*29*	*22*
Why not tried to get professional help					
Did not know where to go	4	8	7	7	0
Did not need help	93	90	84	82	98
Other answer	3	2	9	11	2
Base (= Respondent not tried professional help)	*143*	*193*	*86*	*44*	*195*

Table 5.8 Help sought for victimisation experiences in past six months

	Bullying	Violence at work	Violence in the home
	%	%	%
Was there anyone among family and friends who understood what it was like?			
Yes	70	60	38
No	30	40	62
Base (=Those who experienced each event)	*43*	*56*	*50*
Were you able to talk about it openly and get support and understanding?			
Yes	67	96	[21]
No	33	4	[3]
Base (=Respondents who said family/ friends understood)	*31*	*34*	*24*
Did you get any professional help for it?			
Yes	27	20	24
No	73	80	76
Base (=Those who experienced each event)	*43*	*58*	*50*
Did you try to get professional help?			
Yes	2	6	4
No	98	94	96
Base (= Respondents with no professional help)	*32*	*45*	*38*
What sort of professional help?			
Practical things	[3]	[1]	[2]
Talk things over	[11]	[9]	[13]
Practical things and talk things over	[3]	[6]	[6]
Base (= Respondents tried professional help)	*17*	*16*	*21*
Why not tried to get professional help			
Did not know where to go	16	6	15
Did not need help	75	92	66
Other answer	9	2	19
Base (= Respondent not tried professional help)	*31*	*42*	*36*

Table 5.9 Psychiatric risk factor correlates of at least one stressful life event in past six months

Psychiatric variables	Adjusted Odds Ratio	95% C.I.
Depressive episode		
No	1.00	———
Yes	2.12***	1.56 - 2.86
OCD		
No	1.00	———
Yes	1.45	0.92 - 2.27
GAD		
No	1.00	———
Yes	1.42**	1.12 - 1.80
Phobia		
No	1.00	———
Yes	1.40	0.97 - 2.02
Panic Disorder		
No	1.00	———
Yes	1.76*	1.03 - 3.00
Mixed anxiety/depression		
No	1.00	———
Yes	1.87***	1.59 - 2.20
Probable Psychosis		
No	1.00	———
Yes	1.05	0.55 - 2.02
Alcohol dependence		
None	1.00	———
Mild	1.17	0.97 - 1.42
Moderate/severe	1.29	0.64 - 2.59
Drug dependence		
No dependence	1.00	———
Cannabis only	1.40	1.05 - 1.88
Drugs other than cannabis	1.84**	1.22 - 2.77

*** p<0.001, ** p<0.01, * p<0.05

Other Variables	Adjusted Odds Ratio	95% C.I.
Sex		
Male	1.00	———
Female	0.91	0.82 - 1.01
Age		
16–24	1.00	———
25–44	0.74***	0.61 - 0.88
45–64	0.69***	0.56 - 0.84
65–74	0.62***	0.49 - 0.79
Ethnicity		
White	1.00	———
Black	1.01	0.80 - 1.52
South Asian	0.80	0.598 - 1.11
Other	1.43*	1.03 - 1.98
Family type		
Couple no children	1.00	———
Couple and children	0.96	0.84 - 1.09
Lone parent and child	1.52***	1.21 - 1.92
Lone parent only	1.25**	1.07 - 1.46
Adult with parents	1.32	0.97 - 1.81
Adult with one parent	1.31*	1.06 - 1.62
Physical complaint		
No	1.00	———
Yes	1.20***	1.08 - 1.33

*** p<0.001, ** p<0.01, * p<0.05

Table 5.10 Social functioning characteristics by type of mental disorder

	Current neurotic disorder	Probable psychotic disorder	Alcohol dependent	Drug dependent (any drug)	Any of the four types of mental disorder	None of the four types of mental disorder	All
	%	%	%	%	%	%	%
Perceived social support							
Severe lack	13	30	12	12	12	6	8
Moderate lack	26	22	26	28	26	21	22
No lack	61	49	61	60	62	73	70
Primary Support Group							
Three and under	10	32	7	7	9	4	5
4–8	37	42	28	28	33	27	29
9 and over	53	26	65	65	58	69	66
Number of friends seen in past week							
None	6	10	5	4	5	4	4
One or two	27	45	22	20	25	18	20
Three and over	67	45	73	77	70	78	76
Base	*1509*	*60*	*567*	*258*	*2012*	*6533*	*8545*

Table 5.11 Psychiatric risk factor correlates of severe lack of social support

Psychiatric variables	Adjusted Odds Ratio	95% C.I.
Depressive episode		
No	1.00	———
Yes	1.45	0.94 - 2.25
OCD		
No	1.00	———
Yes	0.71	0.35 - 1.40
GAD		
No	1.00	———
Yes	1.78***	1.27 - 2.50
Phobia		
No	1.00	———
Yes	2.19***	1.35 - 3.53
Panic Disorder		
No	1.00	———
Yes	0.62	0.21 - 1.82
Mixed anxiety/depression		
No	1.00	———
Yes	1.89***	1.47 - 2.43
Probable Psychosis		
No	1.00	———
Yes	2.14	1.00 - 4.58
Alcohol dependence		
None	1.00	———
Mild	1.12	0.84 - 1.49
Moderate/severe	2.68**	1.25 - 5.74
Drug dependence		
No dependence	1.00	———
Cannabis only	1.11	0,70 - 1.75
Drugs other than cannabis	0.91	0.47 - 1.77

*** p<0.001, ** p<0.01, * p<0.05

Other Variables	Adjusted Odds Ratio	95% C.I.
Sex		
Male	1.00	———
Female	0.47**	0.39 - 0.56
Age		
16–24	1.00	———
25–44	1.03	0.76 - 1.41
45–64	1.17	0.83 - 1.63
65–74	1.08	0.72 - 1.62
Ethnicity		
White	1.00	———
Black	1.67*	1.08 - 2.59
South Asian	2.59***	1.76 - 3.80
Other	1.19	0.70 - 2.04
Family type		
Couple no children	1.00	———
Couple and children	1.58***	1.24 - 2.00
Lone parent and child	3.24***	2.25 - 4.67
Lone parent only	3.08***	2.41 - 3.94
Adult with parents	2.32***	1.39 - 3.86
Adult with one parent	1.45	0.99 - 2.16
Physical complaint		
No	1.00	———
Yes	1.14	0.96 - 1.36

*** p<0.001, ** p<0.01, * p<0.05

Table 5.12 Psychiatric risk factor correlates of small primary support group

Psychiatric variables	Adjusted Odds Ratio	95% C.I.	Other Variables	Adjusted Odds Ratio	95% C.I.
Depressive episode			**Sex**		
No	1.00	———	Male	1.00	———
Yes	1.48	0.93 - 2.35	Female	0.64***	0.52 - 0.79
OCD			**Age**		
No	1.00	———	16–24	1.00	———
Yes	1.47	0.78 - 2.77	25–44	1.07	0.73 - 1.57
			45–64	1.01	0.67 - 1.53
GAD			65–74	0.90	0.54 - 1.51
No	1.00	———			
Yes	2.41***	1.70 - 3.43	**Ethnicity**		
			White	1.00	———
Phobia			Black	0.86	0.44 - 1.67
No	1.00	———	South Asian	1.74*	1.04 - 2.91
Yes	2.38***	1.45 - 3.92	Other	1.10	0.57 - 2.15
Panic Disorder			**Family type**		
No	1.00	———	Couple no children	1.00	———
Yes	1.13	0.42 - 3.02	Couple and children	1.55***	1.16 - 1.06
			Lone parent and child	3.04***	2.02 - 4.58
Mixed anxiety/depression			Lone parent only	2.22***	1.64 - 3.01
No	1.00	———	Adult with parents	0.32	0.10 - 1.03
Yes	1.47 *	1.07 - 2.03	Adult with one parent	1.39	0.87 - 2.21
Probable Psychosis			**Physical complaint**		
No	1.00	———	No	1.00	———
Yes	3.40***	1.62 - 7.15	Yes	1.17	0.95 - 1.44
Alcohol dependence					
None	1.00	———			
Mild	1.04	0.72 - 1.51			
Moderate/severe	1.74	0.68 - 4.45			
Drug dependence					
No dependence	1.00	———			
Cannabis only	1.01	0.56 - 1.80			
Drugs other than cannabis	0.86	0.36 - 2.03			

*** p<0.001, ** p<0.01, * p<0.05

*** p<0.001, ** p<0.01, * p<0.05

Table 5.13 Psychiatric risk factor correlates of having seen no friends in past week

Psychiatric variables	Adjusted Odds Ratio	95% C.I.
Depressive episode		
No	1.00	———
Yes	1.22	0.66 - 2.26
OCD		
No	1.00	———
Yes	1.50	0.67 - 3.36
GAD		
No	1.00	———
Yes	1.11	0.66 - 1.79
Phobia		
No	1.00	———
Yes	2.18*	1.10 - 4.29
Panic Disorder		
No	1.00	———
Yes	2.24	0.91 - 5.50
Mixed anxiety/depression		
No	1.00	———
Yes	1.42*	1.01 - 2.00
Probable Psychosis		
No	1.00	———
Yes	1.18	0.37 - 3.77
Alcohol dependence		
None	1.00	———
Mild	0.88	0.57 - 1.37
Moderate/severe	3.03*	1.15 - 8.03
Drug dependence		
No dependence	1.00	———
Cannabis only	0.80	0.37 - 1.74
Drugs other than cannabis	0.94	0.36 - 2.49

*** p<0.001, ** p<0.01, * p<0.05

Other Variables	Adjusted Odds Ratio	95% C.I.
Sex		
Male	1.00	———
Female	0.56***	0.45 - 0.70
Age		
16–24	1.00	———
25–44	1.30	0.80 - 2.12
45–64	1.17	0.70 - 1.96
65–74	1.19	0.66 - 2.14
Ethnicity		
White	1.00	———
Black	1.47	0.80 - 2.72
South Asian	1.99	1.17 - 3.41
Other	0.96	0.44 - 2.07
Family type		
Couple no children	1.00	———
Couple and children	0.99	0.76 - 1.28
Lone parent and child	0.62	0.34 - 1.14
Lone parent only	0.66	0.46 - 0.93
Adult with parents	0.81	0.38 - 1.70
Adult with one parent	0.36**	0.20 - 0.68
Physical complaint		
No	1.00	———
Yes	1.05	0.84 - 1.32

*** p<0.001, ** p<0.01, * p<0.05

6 Comparison of the economic and social characteristics of adults with neurotic disorders, 1993 and 2000

6.1 Introduction

This chapter looks at differences in the profiles of people with neurotic disorders (sometimes called common mental disorders) and those without these disorders between 1993 and 2000. The 2000 psychiatric morbidity survey was a repeat of the survey carried out in 1993.

Both surveys were conducted among adults living in private households in Great Britain and used a similar sampling approach and covered a similar range of disorders. However, there were some changes in survey methods and coverage between the two. In 2000, the upper age limit for respondents was extended from 64 to 74. Therefore, to permit comparison, only data relating to those adults aged 16 to 64 in the 2000 survey are considered in this chapter. In the 2000 survey, computer assisted interviewing replaced the paper and pencil questionnaires used in 1993. Hence, mode effects and other possible effects arising from developments in survey methodology between 1993 and 2000 may have had an influence on results.

Although data were collected for other disorders in both surveys, functional psychoses, and drug and alcohol dependence, this chapter only considers those with neurotic disorders because there were significant differences in the way the other disorders were assessed between 1993 and 2000 and the numbers of people with these disorders are too small for robust comparisons to be made. Personality disorder was covered in the 2000 survey but not in the original 1993 survey.

Assessing changes in the circumstances of people with disorder between 1993 and 2000 needs to take account of general changes in the characteristics of interest in society as a whole. For example, if there has been an increase in the proportion of women in employment over the period then any increase among people with neurotic disorders needs to take this into account. The changes in profiles of those without neurotic disorders are therefore also presented in order to provide an indication of the significance of any marked changes among those with neurotic disorders in the two surveys.

6.2 Educational, employment and social class characteristics

Among those with no psychiatric disorder there was an improvement in their overall educational level between 1993 and 2000, measured by the highest educational qualification obtained. The proportions with a degree rose from 11% to 16% and the same increase (from 11% to 16%) was shown for those having A levels as their highest qualification. Conversely, there was a decrease of 5% of those with no qualifications and a reduction of 5% of those with teaching, HND and nursing qualifications as their highest qualification.

The magnitude and direction of the changes between the groups with neurotic disorders in 1993 and 2000 was very similar to the non-disorder group: an increase of 4% of those with degrees (from 10 to 14%); an increase in 4% of those with A levels (from 11% to 15%) and a decrease of 5% of those with no qualifications (from 34% to 29%). *(Table 6.1)*

The employment situation of the respondents to the two surveys also improved from 1993 to 2000. Among the control group, i.e. those without a neurotic disorder, the proportion working full time rose from 54% to 57%, part time work increased by 3% from 17% to 20%, those unemployed and seeking work fell from 8% to 3% and the proportion not seeking work stayed relatively constant at about 22%. These differences follow the trend shown in the Labour Force Survey. (http://statbase/downloads/theme-labour/LMS-FR-HS/Table01.xls)

The biggest change in employment status for the group with neurotic disorder was in the unemployment rate which fell from 14% in 1993 to 4% in 2000. In contrast, there was an increase in the proportion economically inactive, i.e. unemployed and not seeking work, which rose

from 31% to 35% but there was also an increase in those working full time from 38% to 43%, still markedly less than the 57% employment rate of the non-disordered group. *(Table 6.2)*

In terms of social class the main movement between 1993 and 2000 was in the proportion of all respondents in Social Class III Manual (IIIM) – a fall of 10% and in Social Class III Non-Manual (IIIM) – a rise of 9%. This change was reflected in the groups with neurotic disorders: a decrease of 11% in IIIM and an increase of 8% in IIINM. *(Table 6.3)*

6.3 Family and household characteristics

The main change in the legal marital status of survey respondents between 1993 and 2000 was a decrease the proportions who were married – a reduction of 13% – with a corresponding increase of being single (up by 9%) and divorced (up by 3%). This change, which probably reflects the increase in the proportion of people who are cohabiting without marrying and of separations, was also evident in the groups with neurotic disorders where the proportions married fell by 12% with the single status group increasing by 7% and the divorce rate up by 4%. *(Table 6.4)*

The family unit typology used in both surveys (see Glossary) showed similar changes in those with a neurotic disorder and those with no disorder. Overall, survey respondents who lived with both parents fell by 8% and those who lived with one parent rose by 8%. *(Table 6.5)*

There was very little difference in the tenure profile of respondents between 1993 and 2000 among those with a neurotic disorder and among those with no disorder. *(Table 6.6)*

6.4 Activity of Daily Living (ADL) profile

In 1993, 12% of survey respondents with no neurotic disorder reported a difficulty with one or more of seven activities of daily living and there was hardly any change in 2000. In the first survey, 33% of those with a neurotic disorder mentioned at least one ADL difficulty but this proportion rose to 41% in 2000. *(Table 6.7)*

Table 6.8 shows that these increases were evident across all activities, the largest increases were found for practical activities (up 6%), managing money (up 5%) and dealing with paperwork (up 4%). *(Table 6.8)*

6.5 Social support and social networks

There was a slight improvement between the social support profile of all survey respondents between 1993 and 2000 both among those with a neurotic disorder and those with no disorder: a 6% increase among those who did not perceive a lack social support. *(Table 6.9)*

Similarly, in terms of the size of the primary support group, there was a slight decrease in terms of those who said they had 3 or less close family members or friends, about 2% among both groups. *(Table 6.10)*

Table 6.1 Highest educational qualifications by type of mental disorder, 1993 and 2000

Respondents aged 16–64

	Current neurotic disorder			No neurotic disorder			Total survey sample		
	1993	2000	Difference	1993	2000	Difference	1993	2000	Difference
	%	%	%	%	%	%	%	%	%
Degree	10	14	4	12	16	4	11	16	5
Teaching, HND, nursing	9	7	-2	12	7	-5	12	7	-5
A levels	11	15	4	11	16	5	11	16	5
GCSE or equivalent	36	35	-1	38	38	0	38	38	0
No qualifications	34	29	-5	27	22	-5	28	23	-5
Base	*1701*	*1364*		*8055*	*5883*		*9756*	*7247*	

Table 6 2 Employment status

by type of mental disorder, 1993 and 2000

Respondents aged 16–64

	Current neurotic disorder			No neurotic disorder			Total survey sample		
	1993	2000	Difference	1993	2000	Difference	1993	2000	Difference
	%	%	%	%	%	%	%	%	%
Working full time	38	43	5	54	57	3	51	55	4
Working part time	17	18	1	17	20	3	17	20	3
Unemployed	14	4	-10	8	3	-5	9	3	-6
Economically inactive	31	35	4	21	20	-1	23	22	-1
Base	*1713*	*1364*		*8117*	*5884*		*9830*	*7248*	

Table 6.3 Social class

by type of mental disorder, 1993 and 2000

Respondents aged 16–64

	Current neurotic disorder			No neurotic disorder			Total survey sample		
	1993	2000	Difference	1993	2000	Difference	1993	2000	Difference
	%	%	%	%	%	%	%	%	%
I	4	4	0	7	6	-1	7	5	-2
II	24	28	4	27	30	3	27	29	2
III Non manual	18	26	8	15	24	9	16	25	9
III Manual	29	18	-11	29	19	-10	29	19	-10
IV	18	17	-1	15	16	1	16	16	0
V	6	7	1	5	5	0	5	5	1
Armed forces	1	0	-1	1	0	-1	1	0	-1
Base	*1682*	*1323*		*7985*	*5690*		*9667*	*7013*	

Table 6.4 Legal marital status

by type of mental disorder, 1993 and 2000

Respondents aged 16–64

	Current neurotic disorder			No neurotic disorder			Total survey sample		
	1993	2000	Difference	1993	2000	Difference	1993	2000	Difference
	%	%	%	%	%	%	%	%	%
Married	53	49	-4	61	55	-6	60	54	-6
Separated	3	4	1	2	3	1	2	3	1
Single	32	31	-1	31	33	2	31	33	2
Divorced	8	12	4	5	8	3	5	8	3
Widowed	4	3	-1	2	2	0	2	2	0
Base	*1707*	*1376*		*8076*	*5917*		*9783*	*7293*	

Table 6.5 Family unit type

by type of mental disorder, 1993 and 2000

Respondents aged 16–64

	Current neurotic disorder			No neurotic disorder			Total survey sample		
	1993	2000	Difference	1993	2000	Difference	1993	2000	Difference
	%	%	%	%	%	%	%	%	%
Couple, no child	22	25	3	27	27	0	26	27	1
Couple and child(ren)	39	36	-3	40	39	-1	40	38	-2
Lone parent and child(ren)	10	10	0	5	5	0	6	6	0
One person only	18	19	1	13	14	1	14	15	1
Adult with parents	8	1	-7	12	4	-8	11	3	-8
Adult with one parent	3	8	5	3	12	9	3	11	8
Base	*1713*	*1376*		*8117*	*5917*		*9830*	*7293*	

Table 6.6 Tenure of accommodation

by type of mental disorder, 1993 and 2000

Respondents aged 16–64

	Current neurotic disorder			No neurotic disorder			Total survey sample		
	1993	2000	Difference	1993	2000	Difference	1993	2000	Difference
	%	%	%	%	%	%	%	%	%
Owned outright	13	12	-1	17	19	2	16	18	2
Owned with mortgage	48	50	2	58	55	-3	56	54	-2
Rented from LA or HA	28	25	-3	16	15	-1	18	17	-1
Rented from other source	11	13	2	9	10	1	9	11	2
Base	*1713*	*1360*		*8117*	*5871*		*9830*	*7231*	

Table 6.7 Number of ADL difficulties

by type of mental disorder, 1993 and 2000

Respondents aged 16–64

	Current neurotic disorder			No neurotic disorder			Total survey sample		
	1993	2000	Difference	1993	2000	Difference	1993	2000	Difference
	%	%	%	%	%	%	%	%	%
0	67	59	-8	88	87	-1	84	82	-2
1	14	17	3	8	9	1	9	10	1
2	7	7	0	2	2	0	3	3	0
3	5	7	2	1	1	0	2	2	0
4	3	4	1	1	1	0	1	1	0
5 or more	3	5	2	0	0	0	1	1	0
Base	*1713*	*1376*		*8117*	*5917*		*9830*	*7293*	

Table 6.8 Type of ADL difficulties

by type of mental disorder, 1993 and 2000

Respondents aged 16–64

	Current neurotic disorder			No neurotic disorder			Total survey sample		
	1993	2000	Difference	1993	2000	Difference	1993	2000	Difference
	Percentage having difficulty with each activity								
Difficulty with...									
... personal care	7	9	2	1	2	1	2	3	1
... using transport	11	14	3	2	2	0	4	4	0
... medical care	2	3	1	1	1	0	1	1	0
... household activities	13	16	3	2	3	1	4	5	1
... practical activities	18	24	6	5	6	1	7	9	2
... dealing with paperwork	13	17	4	5	6	1	6	8	2
... managing money	10	15	5	3	3	0	4	5	1
Base	*1712*	*1376*		*8104*	*5917*		*9816*	*7293*	

Table 6.9 Perceived social support

by type of mental disorder, 1993 and 2000

Respondents aged 16–64

	Current neurotic disorder			No neurotic disorder			Total survey sample		
	1993	2000	Difference	1993	2000	Difference	1993	2000	Difference
	%	%	%	%	%	%	%	%	%
Severe lack	17	14	-3	8	7	-1	10	8	-2
Moderate lack	28	26	-2	26	21	-5	26	22	-4
No lack	55	61	6	66	72	6	64	70	6
Base	*1686*	*1362*		*8022*	*5874*		*9708*	*7236*	

Table 6.10 Size of primary support group

by type of mental disorder, 1993 and 2000

Respondents aged 16–64

	Current neurotic disorder			No neurotic disorder			Total survey sample		
	1993	2000	Difference	1993	2000	Difference	1993	2000	Difference
	%	%	%	%	%	%	%	%	%
0 – 3	13	11	-2	6	4	-2	7	5	-2
4 – 8	40	37	-3	31	28	-3	32	29	-3
9 and over	47	52	5	64	68	4	61	66	5
Base	*1713*	*1364*		*8117*	*5874*		*9830*	*7238*	

Appendix A
Tables A1–A12

Table AI Prevalence of mental disorders by sex

	Sex		
	Men	Women	All
	Percentage with each psychiatric characteristic		
CIS-R Score in 4 groups			
0– 5	73	62	68
6–11	14	19	17
12–17	6	10	8
18 and over	6	9	7
Neurotic Disorders			
Mixed anxiety/depressive disorder	7	11	9
Generalised anxiety disorder	4	5	4
Depressive episode	2	3	3
Any phobia	1	2	2
Obsessive compulsive disorder	1	1	1
Panic disorder	1	1	1
Number of Neurotic Disorders			
0	87	81	84
1	11	17	14
2	2	2	2
3 and over	1	1	1
Probable Psychosis			
No psychosis	99	100	100
Probable psychosis	1	1	1
Alcohol dependence			
No hazardous alcohol use	62	84	73
Hazardous use, no dependence	26	13	19
Alcohol dependence	12	3	7
Drug dependence with cannabis			
No dependence	95	98	96
Dependent on cannabis only	4	1	2
Dependent on other drug with or without cannabis	2	1	1
Base	*3852*	*4728*	*8580*

Table A2 Prevalence of mental disorders by age

	Age												
	16–19	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69	70–74	All
	Percentage with each psychiatric characteristic												
CIS–R Score in 4 groups													
0–5	68	67	64	66	66	64	66	64	70	72	78	78	68
6–11	19	17	19	18	17	18	17	18	16	14	13	14	17
12–17	6	9	10	8	8	9	9	10	7	6	5	6	8
18 and over	7	6	8	8	9	9	8	9	7	7	4	3	7
Neurotic Disorders													
Mixed anxiety/depressive disorder	8	9	11	9	9	11	9	9	7	8	6	6	9
Generalised anxiety disorder	1	2	4	4	5	6	7	7	5	4	3	2	4
Depressive episode	2	2	2	2	4	3	4	3	3	2	1	1	3
Any phobia	1	2	2	2	3	2	2	2	1	2	1	1	2
Obsessive compulsive disorder	1	2	1	1	1	1	1	1	2	1	0	0	1
Panic disorder	1	0	1	1	1	1	1	1	1	0	0	1	1
Number of Neurotic Disorders													
0	87	84	82	83	83	81	80	80	84	85	90	91	84
1	13	15	16	15	13	17	16	17	12	12	10	9	14
2	1	1	1	1	3	2	2	2	2	2	0	0	2
3 and over	–	0	1	1	1	1	1	1	1	1	–	–	1
Probable Psychosis													
No psychosis	100	100	100	99	99	99	100	99	100	100	100	100	100
Probable psychosis	0	0	0	1	1	1	1	1	1	0	0	0	1
Alcohol dependence													
No hazardous alcohol use	61	55	62	72	72	75	76	79	80	86	85	90	74
Hazardous use, no dependence	25	29	24	21	18	18	20	17	16	12	13	8	19
Alcohol dependence	14	15	14	7	10	7	4	4	4	2	2	1	7
Drug dependence with cannabis													
No dependence	90	86	91	96	98	99	98	99	100	100	100	100	96
Dependent on cannabis only	5	10	6	3	2	1	2	0	0	0	–	–	2
Dependent on other drug with or without cannabis	4	4	3	0	1	1	0	0	0	0	0	–	1
Base	*334*	*460*	*730*	*953*	*1006*	*842*	*723*	*822*	*703*	*739*	*668*	*600*	*8580*

Table A3 Prevalence of mental disorders by ethnicity

	Ethnicity				
	White	Black	South Asian	Other	All
	Percentage with each psychiatric characteristic				
CIS-R Score in 4 groups					
0–5	68	70	68	58	68
6–11	17	17	13	23	17
12–17	8	5	10	9	8
18 and over	7	9	10	10	7
Neurotic Disorders					
Mixed anxiety/depressive disorder	9	7	10	14	9
Generalised anxiety disorder	4	4	4	4	4
Depressive episode	2	3	4	4	3
Any phobia	2	2	2	1	2
Obsessive compulsive disorder	1	2	4	-	1
Panic disorder	1	1	-	2	1
Number of Neurotic Disorders					
0	84	85	81	80	84
1	14	12	16	18	14
2	2	1	3	3	2
3 and over	1	2	1	-	1
Probable Psychosis					
No psychosis	100	98	100	100	100
Probable psychosis	1	2	-	-	1
Alcohol dependence					
No hazardous alcohol use	73	82	92	80	74
Hazardous use, no dependence	20	12	5	12	19
Alcohol dependence	8	6	2	8	7
Drug dependence with cannabis					
No dependence	96	97	98	94	96
Dependent on cannabis only	2	2	1	4	2
Dependent on other drug with or without cannabis	1	1	1	2	1
Base	*8031*	*185*	*142*	*156*	*8514*

Table A4 Prevalence of mental disorders by marital status

	Legal maritial status of respondent					
	Married	Seperated	Single	Divorced	Widowed	Total
	Percentage with each psychiatric characteristic					
CIS-R Score in 4 groups						
0–5	70	56	68	58	69	68
6–11	17	20	17	18	14	17
12–17	7	12	9	10	8	8
18 and over	6	13	7	14	9	7
Neurotic Disorders						
Mixed anxiety/depressive disorder	8	13	9	10	9	9
Generalised anxiety disorder	4	9	3	10	4	4
Depressive episode	2	5	3	6	4	3
Any phobia	1	5	2	3	2	2
Obsessive compulsive disorder	1	2	1	2	3	1
Panic disorder	1	1	1	1	1	1
Number of Neurotic Disorders						
0	85	74	84	75	82	84
1	13	19	14	20	15	14
2	1	4	1	4	2	2
3 and over	1	2	1	1	1	1
Probable Psychosis						
No psychosis	100	98	100	99	100	100
Probable psychosis	0	2	0	1	1	1
Alcohol dependence						
No hazardous alcohol use	80	78	60	71	87	74
Hazardous use, no dependence	16	13	26	19	11	19
Alcohol dependence	4	9	14	10	3	7
Drug dependence with cannabis						
No dependence	99	97	90	97	100	96
Dependent on cannabis only	1	2	6	3	0	3
Dependent on other drug with or without cannabis	0	1	3	1	1	1
Base	*4383*	*360*	*2279*	*982*	*576*	*8580*

Table A5 Prevalence of mental disorders by family unit type

	Family unit type						
	Couple, no child	Couple and child(ren)	Lone parent and child(ren)	One person only	Adult with parents	Adult with one parent	Total
	Percentage with each psychiatric characteristic						
CIS-R Score in 4 groups							
0–5	71	67	54	64	79	72	68
6–11	16	18	17	17	14	16	17
12–17	7	8	13	9	4	7	8
18 and over	7	7	16	10	3	6	7
Neurotic Disorders							
Mixed anxiety/depressive disorder	8	9	14	9	3	8	9
Generalised anxiety disorder	4	4	10	6	1	2	4
Depressive episode	2	2	6	4	1	1	3
Any phobia	1	1	4	3	2	2	2
Obsessive compulsive disorder	1	1	2	3	2	0	1
Panic disorder	1	1	1	1	0	0	1
Number of Neurotic Disorders							
0	85	84	71	80	93	87	84
1	13	14	24	16	6	12	14
2	1	1	4	3	0	0	2
3 and over	1	0	1	1	1	0	1
Probable Psychosis							
No psychosis	100	100	99	99	99	100	100
Probable psychosis	0	0	1	1	1	0	1
Alcohol dependence							
No hazardous alcohol use	78	77	82	67	54	60	74
Hazardous use, no dependence	18	18	12	22	28	26	19
Alcohol dependence	5	5	6	11	18	14	7
Drug dependence with cannabis							
No dependence	98	98	97	94	88	91	96
Dependent on cannabis only	1	1	2	4	7	7	3
Dependent on other drug with or without cannabis	1	0	1	3	5	3	1
Base	*2673*	*2419*	*664*	*2186*	*120*	*518*	*8580*

Table A6 Prevalence of mental disorders by age left full time education

	Age left full time education							
	<14	15	16	17	18	19	Not yet finished	All
	Percentage with each psychiatric characteristic							
CIS-R Score in 4 groups								
0–5	72	64	67	69	67	70	71	68
6–11	14	17	17	17	18	17	17	17
12–17	6	9	7	8	8	8	8	8
18 and over	8	10	8	6	7	5	4	7
Neurotic Disorders								
Mixed anxiety/depressive disorder	8	9	9	9	9	9	7	9
Generalised anxiety disorder	5	7	4	4	3	4	1	4
Depressive episode	2	4	3	3	2	2	1	3
Any phobia	2	2	2	2	1	1	2	2
Obsessive compulsive disorder	1	1	1	1	1	1	1	1
Panic disorder	1	1	1	1	1	0	0	1
Number of Neurotic Disorders								
0	85	79	84	84	84	85	89	84
1	13	17	14	14	15	13	11	14
2	1	3	1	2	0	2	0	2
3 and over	1	1	1	1	1	0	0	1
Probable Psychosis								
No psychosis	100	99	99	100	100	100	100	100
Probable psychosis	0	1	1	0	0	0	0	0
Alcohol dependence								
No hazardous alcohol use	87	77	71	72	73	73	64	74
Hazardous use, no dependence	10	17	20	21	19	20	24	19
Alcohol dependence	3	6	9	7	8	7	12	7
Drug dependence with cannabis								
No dependence	98	98	95	97	96	97	92	96
Dependent on cannabis only	1	1	3	2	3	3	5	3
Dependent on other drug with or without cannabis	1	1	2	2	2	1	3	1
Base	*732*	*1896*	*2484*	*830*	*825*	*1448*	*292*	*8580*

Table A7 Prevalence of mental disorders by educational qualifications

	Highest educational qualifications obtained			
	A level or above or above	GCSE level	No qualifications	All
	Percentage with each psychiatric characteristic			
CIS-R Score in 4 groups				
0–5	69	68	66	68
6–11	17	17	17	17
12–17	8	8	8	8
18 and over	6	7	9	7
Neurotic Disorders				
Mixed anxiety/depressive disorder	9	9	8	9
Generalised anxiety disorder	4	4	6	4
Depressive episode	2	3	4	3
Any phobia	2	1	3	2
Obsessive compulsive disorder	1	1	1	1
Panic disorder	1	1	1	1
Number of Neurotic Disorders				
0	85	84	81	84
1	14	14	15	14
2	1	1	2	2
3 and over	0	1	1	1
Probable Psychosis				
No psychosis	100	99	99	100
Probable psychosis	0	1	1	1
Alcohol dependence				
No hazardous alcohol use	71	73	78	74
Hazardous use, no dependence	21	20	16	19
Alcohol dependence	8	8	6	7
Drug dependence with cannabis				
No dependence	96	96	98	96
Dependent on cannabis only	3	3	1	3
Dependent on other drug with or without cannabis	1	1	1	1
Base	*2982*	*2968*	*2565*	*8515*

Table A8 Prevalence of mental disorders by employment status

	Employment Status				
	Full Time	Part Time	Unemployed	Economically Inactive	All
	Percentage with each psychiatric characteristic				
CIS-R Score in 4 groups					
0–5	75	74	67	67	73
6–11	14	17	19	14	15
12–17	6	4	5	7	6
18 and over	4	5	9	12	6
Neurotic Disorders					
Mixed anxiety/depressive disorder	8	8	10	10	9
Generalised anxiety disorder	3	4	5	7	4
Depressive episode	2	2	4	5	3
Any phobia	1	2	2	3	2
Obsessive compulsive disorder	1	1	2	2	1
Panic disorder	1	1	1	1	1
Number of Neurotic Disorders					
0	86	90	86	79	87
1	13	9	9	15	11
2	1	1	4	4	2
3 and over	0	0	1	2	1
Probable Psychosis					
No psychosis	100	100	100	99	100
Probable psychosis	0	1	0	1	1
Alcohol dependence					
No hazardous alcohol use	66	79	64	84	74
Hazardous use, no dependence	25	15	21	11	19
Alcohol dependence	9	5	15	5	7
Drug dependence with cannabis					
No dependence	96	97	86	97	96
Dependent on cannabis only	3	2	9	2	3
Dependent on other drug with or without cannabis	1	1	4	1	1
Base	*3817*	*1453*	*260*	*2986*	*8516*

Table A9 Prevalence of mental disorders by Social Class

	Social Class						
	I	II	IIINM	IIIM	IV	V	Total
	Percentage with each psychiatric characteristic						
CIS-R Score in 4 groups							
0–5	78	68	65	70	66	63	68
6–11	13	18	18	15	18	18	17
12–17	7	8	9	8	8	9	8
18 and over	2	7	8	7	9	11	7
Neurotic Disorders							
Mixed anxiety/depressive disorder	8	9	10	8	8	11	9
Generalised anxiety disorder	3	5	3	5	6	5	5
Depressive episode	1	2	2	3	3	5	3
Any phobia	1	2	1	1	3	3	2
Obsessive compulsive disorder	1	1	2	1	1	1	1
Panic disorder	0	1	1	1	1	1	1
Number of Neurotic Disorders							
0	89	84	83	84	82	79	83
1	10	14	16	14	15	18	14
2	0	1	1	2	2	3	2
3 and over	0	0	0	1	1	1	1
Probable Psychosis							
No psychosis	100	100	100	100	99	98	100
Probable psychosis	0	0	0	1	1	2	1
Alcohol dependence							
No hazardous alcohol use	71	74	80	65	73	74	74
Hazardous use, no dependence	22	20	15	22	20	19	19
Alcohol dependence	7	6	5	13	7	7	7
Drug dependence with cannabis							
No dependence	98	97	97	95	96	95	96
Dependent on cannabis only	1	2	2	4	3	2	3
Dependent on other drug with or without cannabis	1	1	1	1	1	3	1
Base	*419*	*2431*	*2018*	*1498*	*1359*	*486*	*8224*

Table A10 Prevalence of mental disorders by grouped weekly household income

	Weekly Income						
	Under 100	£100–200	£200–300	£300–400	£400–500	£500 and over	Total
	Percentage with each psychiatric characteristic						
CIS-R Score in 4 groups							
0–5	57	59	68	67	69	71	68
6–11	25	19	15	21	18	16	17
12–17	7	10	8	7	7	8	8
18 and over	11	13	9	5	6	5	7
Neurotic Disorders							
Mixed anxiety/depressive disorder	9	11	9	7	8	8	9
Generalised anxiety disorder	7	7	6	4	3	3	4
Depressive episode	3	5	3	2	2	2	3
Any phobia	3	4	2	1	2	1	2
Obsessive compulsive disorder	1	1	1	1	1	1	1
Panic disorder	0	1	1	1	1	0	1
Number of Neurotic Disorders							
0	79	76	82	86	86	86	84
1	20	19	15	13	13	13	14
2	1	4	2	1	1	1	2
3 and over	1	1	1	0	1	0	1
Probable Psychosis							
No psychosis	99	99	99	100	100	100	100
Probable psychosis	1	1	1	1	0	0	1
Alcohol dependence							
No hazardous alcohol use	88	82	81	74	72	70	74
Hazardous use, no dependence	9	12	14	19	20	22	19
Alcohol dependence	3	6	5	7	8	8	7
Drug dependence with cannabis							
No dependence	96	97	99	95	96	97	96
Dependent on cannabis only	4	2	1	2	3	3	3
Dependent on other drug with or without cannabis	0	1	0	3	1	1	1
Base	*104*	*667*	*789*	*805*	*598*	*2146*	*8580*

Table A11 Prevalence of mental disorders by tenure

	Tenure of accomodation				
	Owned outright	Owned with mortgage	Rented from LA or HA	Rented from other source	Total
	Percentage with each psychiatric characteristic				
CIS-R Score in 4 groups					
0–5	76	69	57	62	68
6–11	15	17	20	19	17
12–17	5	8	10	10	8
18 and over	4	7	14	9	7
Neurotic Disorders					
Mixed anxiety/depressive disorder	6	9	12	10	9
Generalised anxiety disorder	3	4	7	4	4
Depressive episode	1	2	5	4	3
Any phobia	1	1	4	3	2
Obsessive compulsive disorder	0	1	2	3	1
Panic disorder	0	1	1	1	1
Number of Neurotic Disorders					
0	90	84	75	80	84
1	10	14	20	17	14
2	1	1	3	2	2
3 and over	0	0	2	1	1
Probable Psychosis					
No psychosis	100	100	99	99	100
Probable psychosis	0	0	2	1	1
Alcohol dependence					
No hazardous alcohol use	81	72	76	61	74
Hazardous use, no dependence	16	21	15	26	19
Alcohol dependence	4	7	9	13	7
Drug dependence with cannabis					
No dependence	99	97	95	89	96
Dependent on cannabis only	1	2	3	7	3
Dependent on other drug with or without cannabis	0	1	2	4	1
Base	*2196*	*3853*	*1650*	*777*	*8476*

Table A12 Prevalence of mental disorders by NHS Regional Office

	NHS Regional Office										
	Northern and Yorkshire	Trent	West Midlands	North West	Eastern	London	South East	South West	Scotland	Wales	All
	Percentage with each psychiatric characteristic										
CIS-R Score in 4 groups											
0–5	66	70	69	64	68	67	68	69	72	67	68
6–11	19	17	18	17	16	16	19	15	15	15	17
12–17	8	6	8	11	8	8	8	8	6	8	8
18 and over	8	7	5	9	8	9	5	7	6	10	7
Neurotic Disorders											
Mixed anxiety/depressive disorder	9	8	9	11	10	8	8	9	7	10	9
Generalised anxiety disorder	5	4	4	6	4	5	4	4	4	5	4
Depressive episode	3	2	2	3	3	4	2	1	2	4	3
Any phobia	2	1	1	3	2	2	1	2	1	2	2
Obsessive compulsive disorder	1	1	1	2	1	2	1	1	1	2	1
Panic disorder	1	1	0	0	1	1	1	1	1	1	1
Number of Neurotic Disorders											
0	83	86	85	80	83	82	86	83	86	81	84
1	14	13	13	17	15	15	13	15	12	16	14
2	2	1	1	2	1	2	1	1	2	2	2
3 and over	1	0	1	1	1	1	1	0	0	1	1
Probable Psychosis											
No psychosis	99	99	100	99	100	100	99	100	100	100	100
Probable psychosis	1	1	0	1	0	0	1	0	1	1	1
Alcohol dependence											
No hazardous alcohol use	69	74	73	68	80	75	77	76	72	70	74
Hazardous use, no dependence	23	20	20	23	15	17	16	19	19	21	19
Alcohol dependence	8	6	7	9	6	8	8	5	8	9	7
Drug dependence with cannabis											
No dependence	97	98	98	95	97	95	96	97	94	98	96
Dependent on cannabis only	2	1	1	3	2	4	3	2	4	2	2
Dependent on other drug with or without cannabis	1	1	1	2	2	1	1	1	2	0	1
Base	*963*	*751*	*739*	*991*	*829*	*881*	*1302*	*791*	*921*	*412*	*8580*

Glossary of survey definitions and terms

Adults

In this survey adults were defined as persons aged 16 and over and less than 75.

Alcohol dependence

Alcohol problems was measured using two different instruments. First the Alcohol Use Disorders Identification Test (AUDIT) was used to assess hazardous drinking (see below). Those who scored 10 or above on the AUDIT were also asked the Severity of Alcohol Dependence Questionnaire (SAD-Q). People who scored 4 and over on the SAD-Q were considered to be dependent on alcohol.

Drug dependence

In the year prior to interview drug dependence was measured by asking all those who had used drugs in the past year a series of five questions. These covered: daily use of the drug for two weeks or more; feelings of dependence; inability to cut down; need for increasing quantities; withdrawal symptoms. For a person to be considered cannabis dependent, positive responses to at least two of these questions were required. For the other drugs (heroin, methadone, amphetamines, crack and cocaine powder) one positive response was taken to indicate a measure of dependence.

Drugs used in psychoses

Drugs used in psychoses and related conditions include antipsychotic drugs, including depot injections. These are also known as 'neuroleptics'. In the short term they are used to quieten disturbed patients whatever the underlying psychopathology. See depot injections. Also included in this group are antimanic drugs which are used in mania to control acute attacks and prevent their recurrence.

Economic activity

Economically active persons are those over the minimum school-leaving age who were working or unemployed in the week before the week of interview. These persons constitute the labour force.

Working persons

This category includes persons aged 16 and over who, in the week before the week of interview, worked for wages, salary or other forms of cash payment such as commission or tips, for any number of hours. It covers persons absent from work in the reference week because of holiday, sickness, strike or temporary lay-off, provided they had a job to return to with the same employer. It also includes persons attending an educational establishment during the specified week if they were paid by their employer while attending it, people who worked in Government training schemes and unpaid family workers.

Persons are excluded if they have worked in a voluntary capacity for expenses only, or only for payment in kind, unless they worked for a business, firm or professional practice owned by a relative.

Full-time students are classified as 'working', 'unemployed' or 'inactive' according to their own reports of what they were doing during the reference week.

Unemployed persons

This survey used the International Labour Organisation (ILO) definition of unemployment. This classifies anyone as unemployed if he or she was out of work in the four weeks before interview and looking for work, or would have but for temporary sickness or injury, and was available to start work in the two weeks after the interview. Otherwise, anyone out of work is classified as economically inactive.

The treatment of all categories on this survey is in line with that used in the Labour Force Survey (LFS).

Educational level

Educational level was based on the highest educational qualification obtained and was grouped as follows:

Degree or higher degree
NVQ Level 5
Teaching qualification
HNC/HND
BRC/TEC Higher
BTEC/SCOTVEC Higher
City and Guilds
Full Technological Certificate
Nursing Qualifications (SRN, SCM, RGN, RM, RHV, Midwife)
NVQ Level 4
GCE A levels and AS levels
SCE Higher
ONC/OND/BTEC/TEC/BTEC not higher
City and Guilds Advanced/Final Level
GNVQ (Advanced Level)
NVQ Level 3
GCE O level passes (Grade A–C if after 1975)
GCSE (Grades A–C)
CSE Grade 1
SCE Ordinary (Bands A–C)
Standard Grade (Level 1–3)
School Certificate or Matric
City and Guilds Craft/Ordinary Level
GNVQ (Intermediate level)
NVQ Level 2
CSE Grades 2–5
GCE O level Grades D and E after 1975
GCSE (Grades D,E,F,G)
SCE Ordinary (Bands D and E)
Standard Grade (Level 4,5)
Clerical or Commercial qualifications
Apprenticeships
NVQ Level 1 and GNVQ (Foundation Level)
CSE ungraded
No formal qualifications

Ethnicity

Household members were classified into nine groups by the person selected for interview. For analysis purpose these nine groups were subsumed under 4 headings: White, Black, South Asian and Other.

White	White
Black – Caribbean	Black
Black – African	
Black – Other	
Indian	South Asian
Pakistani	
Bangladeshi	
Chinese	Other
Other	

Family Unit

In order to classify the relationships of the subject to other members of the households, the household members were divided into family units.

Subjects were assigned to a family unit depending on whether they were or had ever been married, and whether they (or their partners) had any children living with them.

A 'child' was defined for family unit purposes as an adult who lives with one or two parents, provided he or she has never been married and has no child of his or her own in the household.

For example, a household containing three women, a grandmother, a mother and a child would contain two family units with the mother and child being in one unit, and the grandmother being in another. Hence family units can consist of:

- A married or cohabiting couple or a lone parent with their children.
- Other married or cohabiting couples.
- An adult who has previously been married. If the adult is now living with parents, the parents are treated as being in a separate family unit.
- An adult who does not live with either a spouse, partner, child or parent. This can include adults who live with siblings or with other unrelated people, eg flatmates.

Family unit type

Each informant's family unit was classified into one of six family unit types:

- 'Couple no children' included a married cohabiting couple without children.
- 'Couple with child' comprised a married or cohabiting couple with at least one child from their liaison or any previous relationship.
- 'Lone parent' describes both men and women (who may be single, widowed, divorced or separated) living with at least one child. The subject in this case could be a divorced man looking after his 12-year-old son or a 55-year-old widow looking after a 35-year-old daughter who had never married and had no children of her own.
- 'One person' describes the family unit type and does not necessarily mean living alone. It includes people living alone but includes one person living with a sister, or the grandmother who is living with her daughter and her family. It also includes adults living with unrelated people in shared houses, eg flatmates.
- 'Adult living with parents' describes a family unit which has the same members as 'couple with child' but in this case it is the adult son or daughter who is the subject. It includes a 20 year old unmarried student living at home with married or cohabiting parents, and a 62 year old single woman caring for her elderly parents.
- 'Adult living with lone parent' covers the same situations as above except there is one and not two parents in the household.

Hazardous alcohol use

Hazardous alcohol use is a pattern of drinking carrying with it a high risk of damage to health in the future. The prevalence of alcohol problems in the previous year was assessed using the Alcohol Use Disorders Identification Test (AUDIT) at the initial interview. An AUDIT score of eight or above indicates likely hazardous alcohol use.

Household

The standard definition used in most surveys carried out by ONS Social Survey Division, and comparable with the 1991 Census definition of a household, was used in this survey. A household is defined as single person or group of people who have the accommodation as their only or main residence and who either share one meal a day or share the living accommodation (see E McCrossan (1991) *A Handbook for interviewers*, HMSO: London)

Marital Status

Informants were categorised to their own perception of marital status. Married and cohabiting took priority over other categories. Cohabiting included anyone living together with their partner as a couple.

Neurotic disorders, depression or anxiety disorders

These are characterised by a variety of symptoms such as fatigue and sleep problems, forgetfulness and concentration difficulties, irritability, worry, panic, hopelessness, and obsessions and compulsions, which are present to such a degree that they cause problems with daily activities and distress. The prevalence of neurotic symptoms in the week prior to interview was assessed using the revised version of the Clinical Interview Schedule (CIS-R). A score of 12 and over indicates the presence of significant neurotic symptoms while a score of 18 and over indicates symptoms of a level likely to require treatment.

Psychiatric Morbidity

The expression psychiatric morbidity refers to the degree or extent of the prevalence of mental health problems within a defined area.

Psychoses

These are disorders that produce disturbances in thinking and perception that are severe enough to distort the person's perception of the world and the relationship of events within it. Psychoses are normally divided into two groups: organic psychoses, such as dementia and Alzheimer's disease, and functional psychoses, which mainly cover schizophrenia and manic depression.

Region

When the survey was carried out there were 8 NHS Regional Office Areas in England. These were the basis for stratified sampling and have been retained for purposes of analysis. Scotland and Wales were treated as two distinct areas.

Social Class

Based on the Registrars general's 1991 *Standard Occupational Classification*, Volume 3 OPCS, (HMSO: London), social class was ascribed on the basis of the informants own occupation. If the informant was unemployed or economically inactive at the time of interview but had previously worked, social class was based on the most recent previous occupation.

The classification used in the tables are as follows:

Descriptive Definition	Social Class
Professional	I
Intermediate occupations	II
Skilled occupations – non-manual	III NM
Skilled occupation – manual	III M
Partly-skilled	IV
Unskilled occupations	V
Armed Forces	

Social class was not determined where the subject had never worked, or if the subject was a full-time student or where occupation was inadequately described.

Tenure

Four tenure categories were created:

- 'Owned outright' means bought without a mortgage or loan or with a mortgage or loan which has been paid off.
- 'Owned with mortgage' includes co-ownership and shared ownership schemes.
- 'Rent from LA/HA' means rented from local authorities, New Town corporations or commissions or Scottish Homes, and housing associations which include co-operatives and property owned by charitable trusts.
- 'Rent from other source' includes rent from organisations (property company, employer or other organisation) and from individuals (relative, friend, employer or other individual).