The Problem of Mental Health, Suicide and Depression in SA; A Clinical Overview

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Content

State of Mental Health in South Africa

SADAG Helpline

Dissecting Suicide

Depression is a Medical Disease

Doctors > Burnout > Suicide

South African face considerable mental health challenges …..

Lifetime prevalence any mental health condition in South Africa was 30.3%
- Anxiety disorders were the most prevalent form of 'disorder'
- Substance abuse and 'mood disorders' were the next most prevalent conditions in South Africa

Smaller South African studies:
- Attempted suicide rates of 7.8%
- Rates of suicidal ideation of 19% among high school students
- Prevalence rate of PTSD among South African school children 22%
- Post-partum depression rates as high as 34.7% have been documented
- Rates as high as 37% for depression

South African Stress and Health (SASH) study 2003 and 2004
WHO's World Mental Health Survey Initiative

Mental disorders are referred to as: “disturbances of thought, emotion, behaviour, and/or relationships with others that lead to significant suffering and functional impairment in one or more major life activities, as identified in the major classification systems such as the WHO International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM).”

The WHO considers mental health a human right

World Health Organization

Report of the National Investigative Hearing Into the Status of Mental Health Care in South Africa - The South African Human Rights Commission, March 2019

Identified 12 Key Findings

‘Throughout the investigation, lack of resourcing, lack of technical capacity and possibly even lack of concern for the welfare of people with intellectual and psychosocial disabilities have arisen as root causes for system-wide failures to protect and promote the rights of this group’.

‘There is considerable under-investment in mental health by the South African Government’.

‘Comprehensive implementation of the National Mental Health Policy Framework and Strategic Plan (2013 - 2020) has not yet occurred’.

‘Services for children and adolescents are neglected’

south african human rights commission

Population
55 291 225 people

8 million people on
medical aids

100 000 people:
16.56 psychiatric beds
4.33 general hospital
psychiatric beds

Total mental health
expenditure per person
(upper middle income group)
R99.47 per person

WHO Mental Health Profile of South Africa

WHO Mental Health Profile of South Africa

- Suicide mortality rate (per 100 000 population) 11,6
- Mental Health Workforce (rate per 100 000 population)
  - Psychiarists 1,52
  - Child Psychiatrists 0,08
  - None other professionals reported
- No existence of a suicide prevention strategy (as a standalone document or as an integrated element of the national policy/ plan adopted by government)

UN World Population Prospectus 2015
World Bank Income Groups 2016
WHO Global Health Estimates 2018

World Health Organization

Mental Health Budget

- 3% of the total health budget is allocated to Mental Health
- Not every province has a mental health budget/plan/report
- Only 4 of the 9 provinces submitted budget reports
- Half a billion rand is spent on Mental Health services
- 45% budget allocated for psychiatric hospitals
- 9% budget allocated for primary healthcare

State of Mental Health in SA

- Youngest suicide was 6 years old
- 23 completed suicides every day in the country
- For every 1 suicide, there are 20 attempted suicides (estimated 460 attempted suicides every 24 hours)
- 1 in 3 South Africans will or do have a mental illness at some point of their lifetime
- Only 25% of people with a mental illness access/have access to treatment
- Leaving 75% of people with a mental illness NOT getting treatment or care

THE SOUTH AFRICAN DEPRESSION AND ANXIETY GROUP

State of Mental Health in SA

- More than 60% tertiary hospital beds allocated to forensic patients
- Men are 5 times more likely to commit suicide
- Doctors are 2.5 times more likely to commit suicide than others
- 1% of hospital beds allocated to children
- 1 in 4 people in the workplace have been diagnosed with Depression

SADAG – Celebrating 25 years

SADAG Call Centre Statistics

- ± 600 calls per day
- 22 toll free Helplines
- Hundreds of emails, sms's & whatsapp's everyday
- Only Suicide Crisis Helpline in South Africa
- Over 600 000 hits on our website every month
- Calls for Depression, Anxiety, Trauma, Bipolar , Substance Abuse, Panic, Post-Natal depression, Schizophrenia, Suicide, etc

Trends in Suicide Among Youth Aged 10 to 19 Years in the United States, 1975 to 2016

Ruch DA, Sheftall AH, Schlagbaum P et al *JAMA Network Open.* 17 May 2019;2(5)

- Suicide is a leading cause of death among youth aged 10 to 19 years in the US, with rates traditionally higher in male than in female youth
- From 1975 to 2016 identified 85 051 youth suicide deaths in the US 68 085 male [80.1%] and 16 966 female [19.9%]
- Core finding of this study is that the ratio of male to female suicide rates for children and adolescents has declined over the past 40 years
- A growing proportion of female youth are choosing this more violent and lethal method of suicide (hanging or suffocation)
- Trends from the 2007 to 2017 national Youth Risk Behaviour Survey19 revealed a significantly larger percentage increase in female youth who seriously considered attempting suicide (18.7%to 22.1%) compared with male youth (10.3%to 11.9%)
- The percentage of female youth who made a suicide plan also increased significantly from 13.4%to 17.1%,
- The Youth Risk Behaviour Survey19 found that the percentage of female youth who experienced persistent feelings of sadness or hopelessness increased significantly between 2007 and 2017 (from 35.8% to 41.1%)

Death by Suicide and Psychiatric Diagnosis

Psychological autopsy studies done in various countries from over almost 50 years report the same outcomes.

- 90% of people who die by suicide are suffering from one or more psychiatric disorders:

  - Major Depressive Disorder
  - Bipolar Disorder, Depressive Phase
  - Alcohol or Substance Abuse
  - Schizophrenia
  - Personality Disorders such as Borderline Personality Disorder

Clayton, J. *Suicide Prevention: Saving Lives One Community at a Time.* American Foundation for Suicide Prevention. http://www.afsp.org/files/Misc_//standardizedpresentation.ppt

Warning Signs of Suicide

- Threatening to hurt or kill oneself or talking about wanting to hurt or kill oneself
- Looking for ways to kill oneself by seeking access to firearms, pills, or other means
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person
- Feeling hopeless
- Feeling rage or uncontrolled anger or seeking revenge
- Acting reckless or engaging in risk activities – seemingly without thinking

National Suicide Prevention Lifeline. *What are the warning signs for suicide?* http://www.suicidepreventionlifeline.org/GetHelp/SuicideWarningSigns.aspx

Warning Signs of Suicide (Cont.)

- Feeling trapped – like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family, and society
- Feeling anxious, agitated or unable to sleep or sleeping all the time
- Experiencing dramatic mood swings
- Seeing no reason for living or having no purpose in life.

National Suicide Prevention Lifeline. *What are the warning signs for suicide?* http://www.suicidepreventionlifeline.org/GetHelp/SuicideWarningSigns.aspx

SUICIDE: A MULTI-FACTORIAL EVENT

The epidemiology of major depression in South Africa

S Afr Med J. 2009; 99: 367-373

METHODS:

A nationally representative household survey was conducted between 2002 and 2004 using the World Health Organization Composite International Diagnostic Interview (CIDI) to establish a diagnosis of depression. The dataset analysed included 4351 adult South Africans of all racial groups.

RESULTS:

The prevalence of major depression was 9.7% for lifetime and 4.9% for the 12 months prior to the interview. The prevalence of depression was significantly higher among females than among males. The prevalence was also higher among those with a low level of education. Over 90% of all respondents with depression reported global role impairment.

Depression = ‘whole body illness’

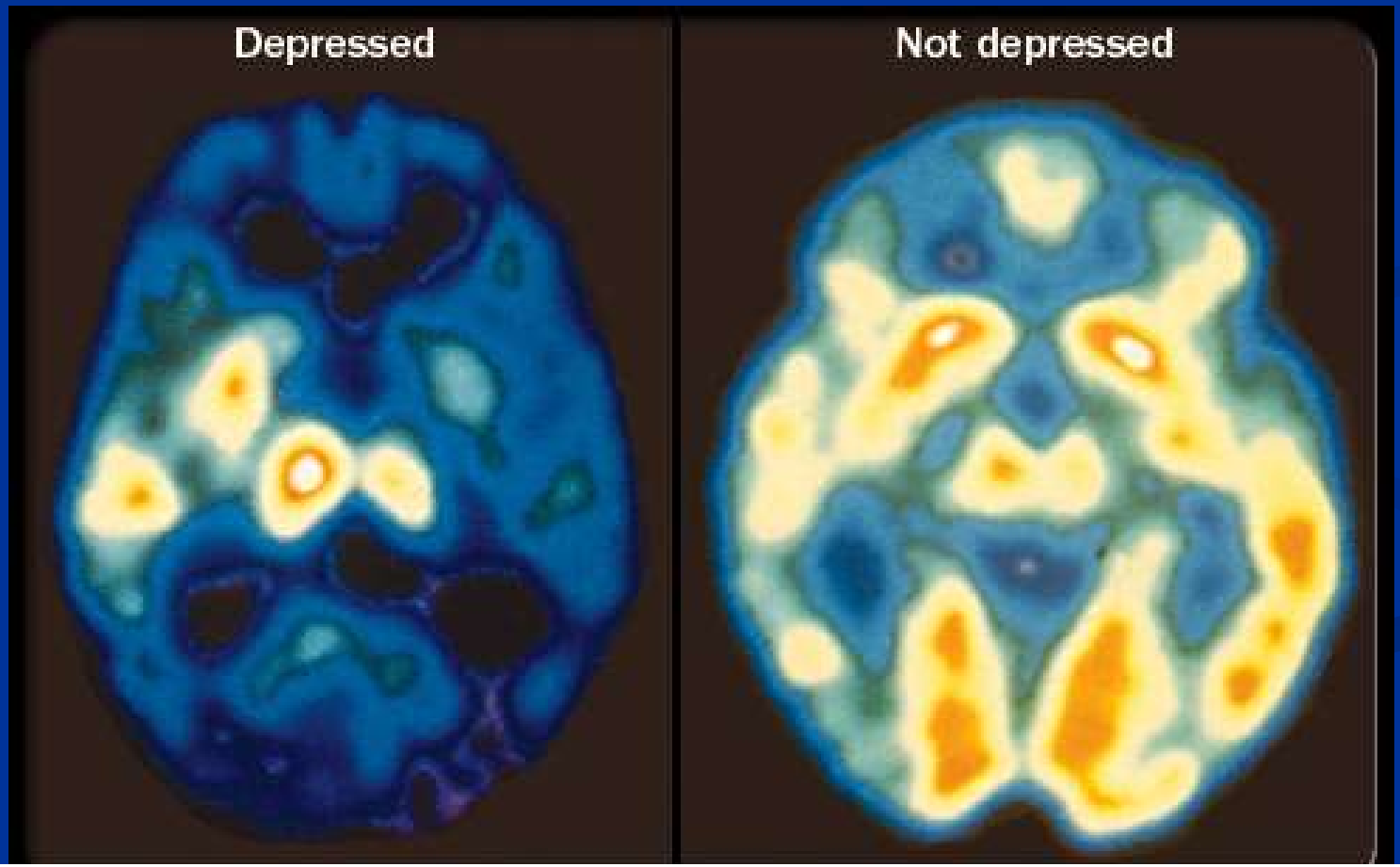
Biological/physical = sleep disturbance, fatigue, constipation, changes in appetite, generalized aches and pains;

Psychological = depressed/sad and /or irritable mood, low motivation, reduced sexual desire, feelings of guilt and worthlessness, suicidal thoughts;

Social = social withdrawal, reduced interest in hobbies and acitivities, poor performance at work/studies

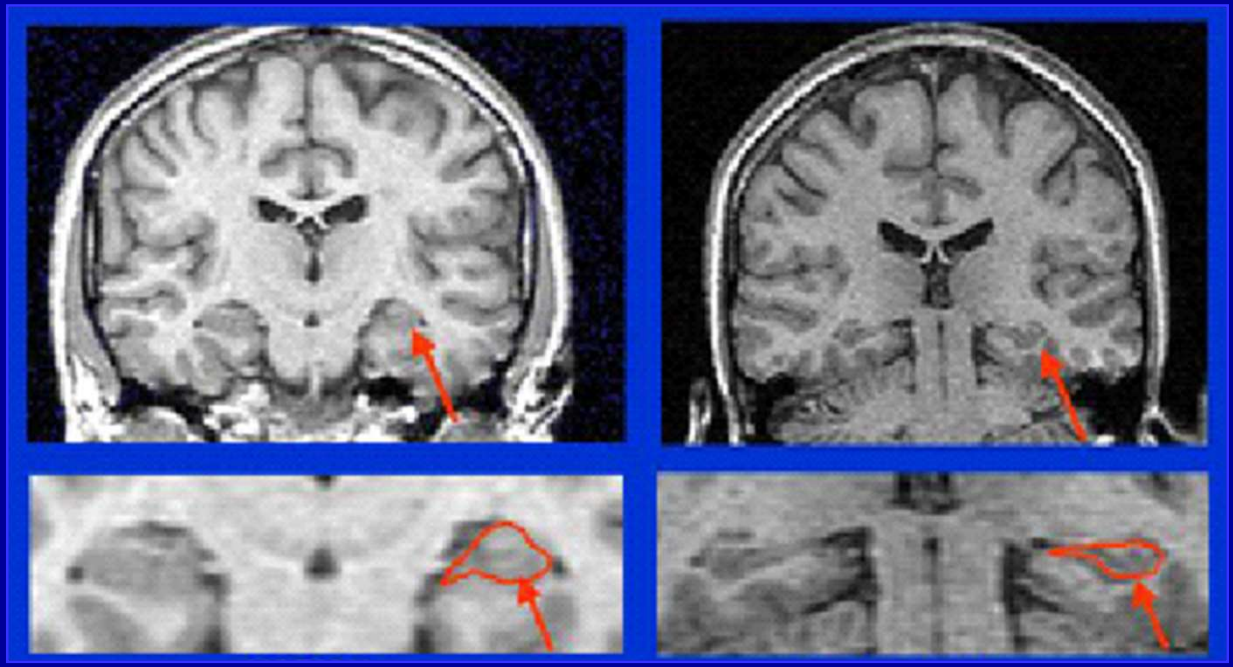
THE DEPRESSED BRAIN

Decreased brain activity with depression



Brain atrophy in depression?

Atrophy of the Hippocampus in Depression

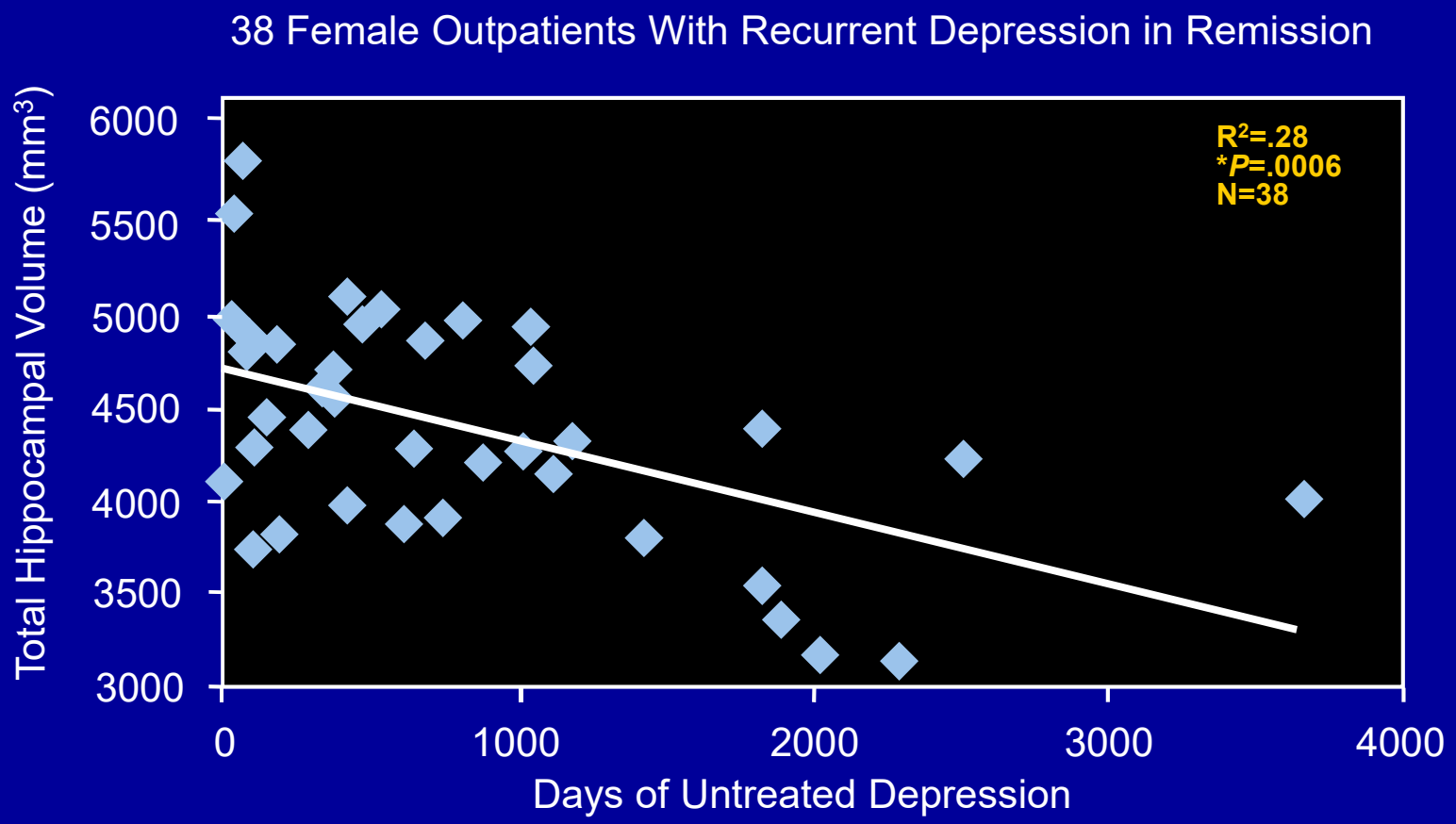


Normal

Depression

Bremner JD, et al. *Am J Psychiatry*. 2000;157(1):115-118.

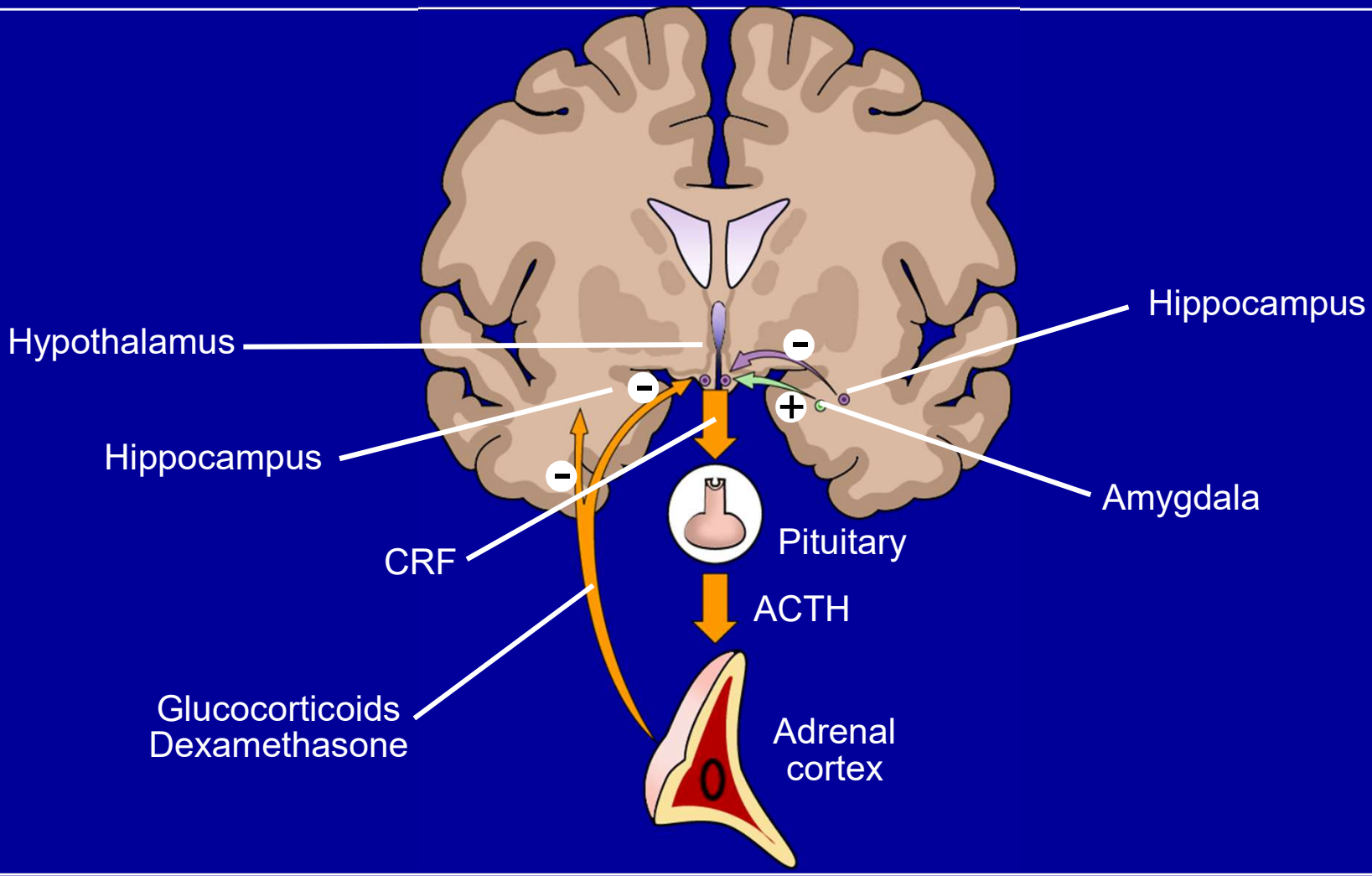
Correlation between hippocampal volume and duration of untreated depression*



***Significant inverse relationship between total hippocampal volume and the length of time depression went untreated.**

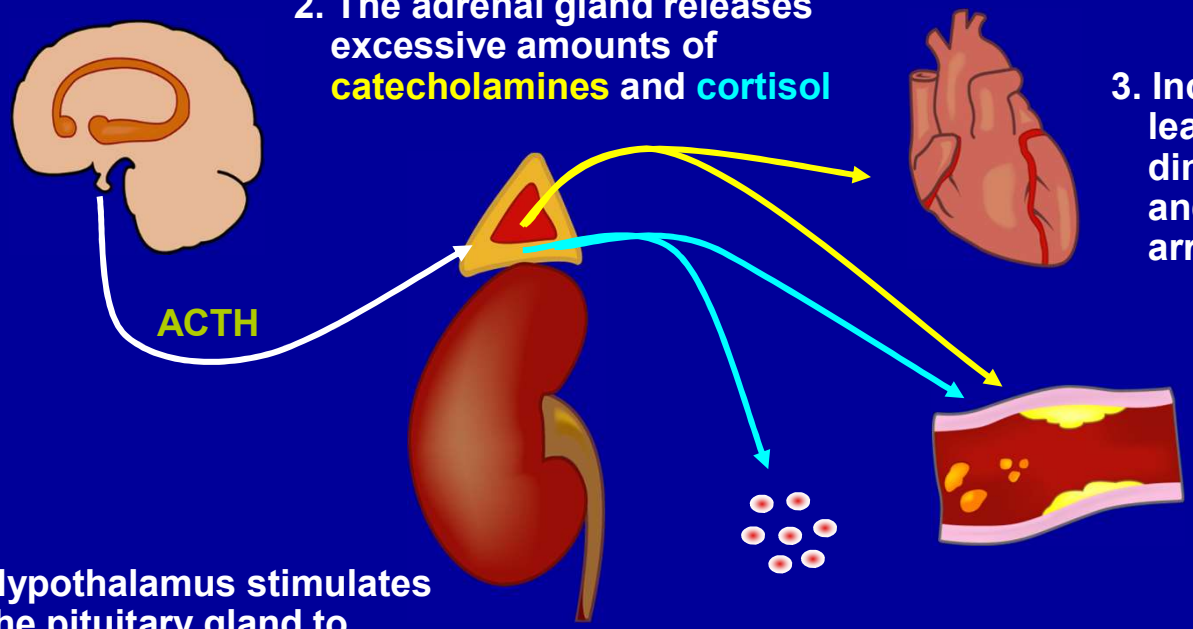
Sheline YI, et al. *Am J Psychiatry*. 2003;160(8):1516-1518.

Hippocampal dysfunction contributes to neuroendocrine dysregulation



Nestler EJ, et al. *Neuron.* 2002;34(1):13-25.

Major depressive disorder may have systemic consequences



2. The adrenal gland releases excessive amounts of catecholamines and cortisol

3. Increase in catecholamines can lead to myocardial ischemia, diminished heart rate variability, and can contribute to ventricular arrhythmias

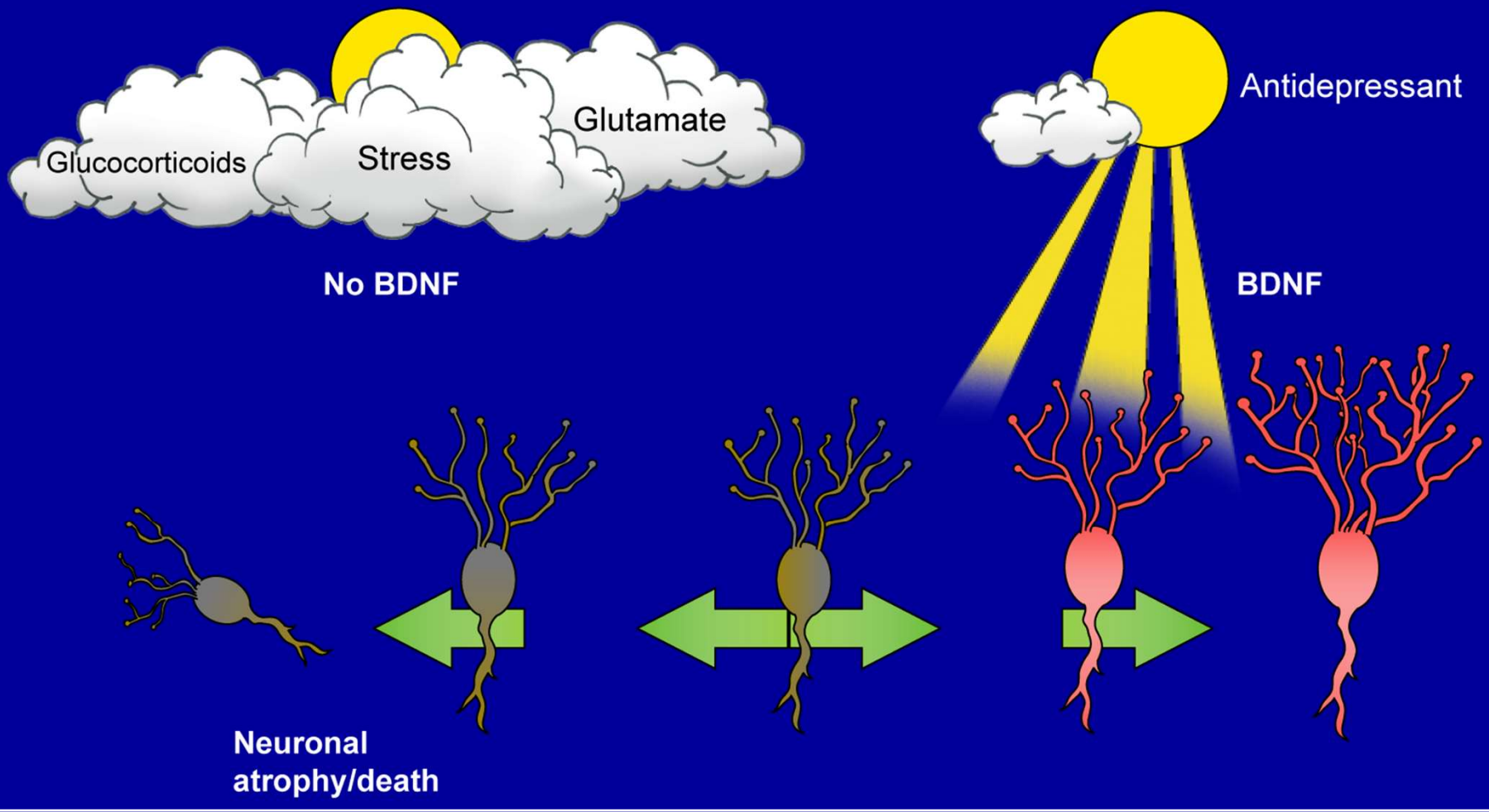
4. Increase in catecholamines causes platelet activation; increase in cytokines and interleukins may also contribute to atherosclerosis and eventual hypertension

1. Hypothalamus stimulates the pituitary gland to release excessive ACTH, continuously driving the adrenal gland

5. Cortisol antagonizes insulin and contributes to dyslipidemia, type 2 diabetes, and obesity; increases in cortisol also suppress the immune system

Adapted from: Musselman DL, et al. *Arch Gen Psychiatry.* 1998;55(7):580-592.

The monoamine hypothesis of gene action: The impact of stress on BDNF



Adapted from: Stahl SM. *Essential Psychopharmacology: Neuroscientific Basis and Practical Applications*; 2000:187.

Doctors & Suicide

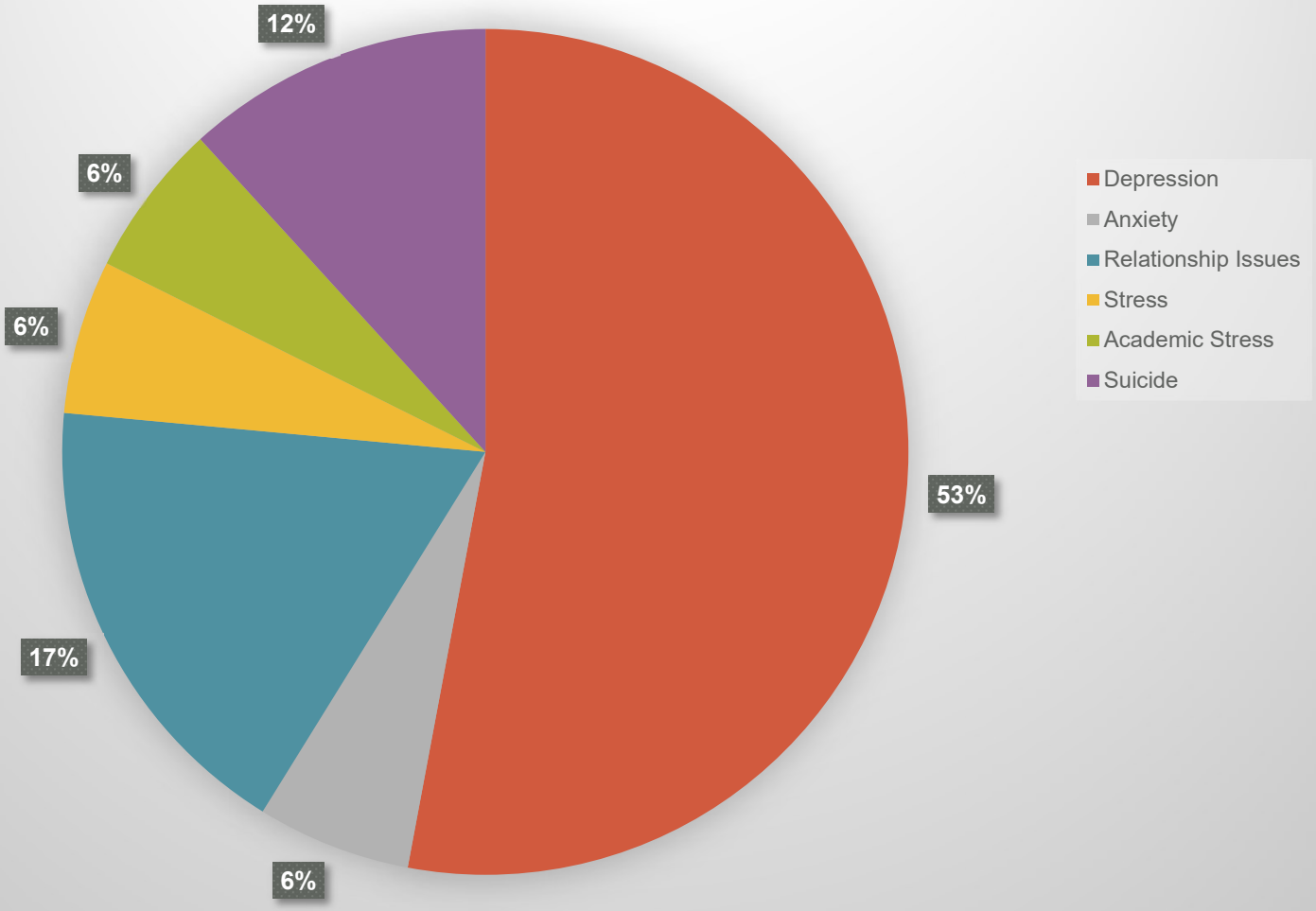
- No South African data…yet!
- Doctors have the highest rate of suicide in the world
- One Doctor suicide per day
- US Doctors suicide rate twice the general average population
- New SASA Research (April 2019) :
- - 22% of practitioners in the private sector
- - 48% in the public sector experienced emotional exhaustion


Discovery
THE SOUTH AFRICAN DEPRESSION AND ANXIETY GROUP
DISCOVERY
MEDICAL
STUDENT'S HELPLINE

SADAG Helpline Calls

Month	October 2018	November 2018	December 2018	January 2019	February 2019	March 2019
Number of Calls	189	315	279	289	280	230

Reasons for Calling March 2019



The American Foundation for Suicide Prevention (AFSP) 2018 www.afsp.org

Physicians have *higher rates* of burnout, depressive symptoms, and suicide risk than the general population

Physicians and trainees can experience high degrees of mental health distress and are *less likely* than other members of the public to seek mental health treatment.

Physicians report several *barriers* to seeking mental health care, including time constraints, hesitancy to draw attention to self-perceived weakness, and concerns about reputation and confidentiality.

An estimated 300-400 physicians die by *suicide* in the US per year

The *suicide rate* among male physicians is 1.41 times higher than the general male population.

Among female physicians the relative risk is even more pronounced – 2.27 times greater than the general female population

Physicians who took their lives were less likely to be *receiving mental health treatment* compared with nonphysicians who took their lives even though depression was found to be a significant risk factor at approximately the same rate in both groups

28% of residents experience a major depressive episode during training versus 7%-8% of similarly aged individuals

Among physicians, *risk for suicide increases* when mental health conditions go unaddressed, and *self-medication* occurs as a way to address anxiety, insomnia or other distressing symptoms

In one study 23% of interns had suicidal thoughts

Unaddressed mental health conditions, in the long run, are more likely to have a negative impact on a physician's professional reputation and practice than reaching out for help early

Personality and Burnout Among Primary Care Physicians: An International Study

Brown PA, Slater M & Lofters A.
Psychology Research and Behaviour Management 2019:12 169–177

- Burnout is a syndrome comprised of three major dimensions:
  - emotional exhaustion
  - depersonalization
  - reduced personal accomplishment
- Aetiology appears to be multifactorial, involving work-related and personal factors including personality traits
- Burnout was a common problem among primary care physicians.
- Personality, particularly neuroticism, agreeableness, and conscientiousness, impacts physician burnout.
- Strategies that modulate the impact of personality on burnout may be beneficial for optimal health care delivery.

Symptoms of Burnout

Feeling of lack of control over commitments

Loss of purpose

Loss of motivation

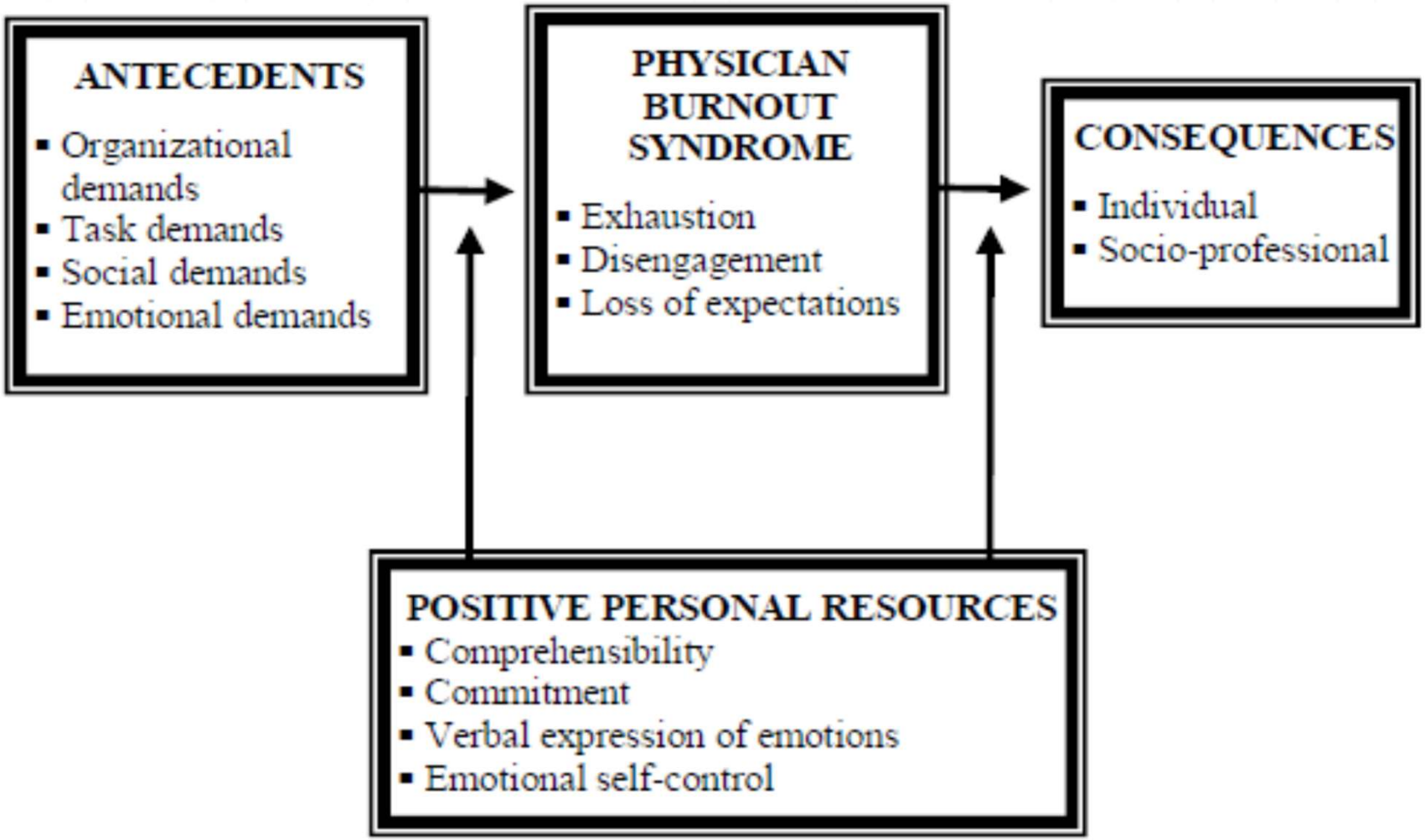
Detachment from relationships

Feeling tired and lethargic

Feeling that you are accomplishing less

Increased tendency to think negatively

Theoretical Model of the Physician Burnout Process



Physician Burnout Questionnaire (PhBQ)

1) Physician Burnout Syndrome Scale (PhBSS) = assessing cognitive components, behavioral and emotional syndromes
2) Physician Burnout Antecedents Scale (PhBAS) = analyzing issues related to physicians' work and social and organizational climate (social deterioration of the profession, time pressure, social pressure, relationship and supervision with management, contact with pain and death, and difficult interaction with patients)
3) Physician Burnout Consequences Scale (PhBCS) = considering the personal (physical and emotional) and organizational consequences, such as professional isolation and intentions to quit
4) Positive Personal Resources Scale (PPRS) = including four individual moderators of the process of burnout: verbal emotional expression, commitment, comprehensibility, and emotional self-regulation.

How can you avoid burnout?

Make sure that you are still enjoying what you are doing
Repeat to yourself, often: I have a right to fun, pleasure and relaxation
Get plenty of a restful sleep, relaxation and recreation
Learn and practice stress management techniques
Learn to say ‘no’
Constantly re-evaluate your goals and decide what is important and essential to your enjoyment and appreciation of life
Reduce your commitments
Follow a healthy diet
Use the correct food supplements to support your body and your mind
Learn to delegate
If others drain your energy, step back and avoid them for a while
Exercise moderately, but regularly, and choose something you enjoy

Mental illness in the Western Cape Province, South Africa: A review of the burden of disease and healthcare interventions

N Jacob & D Coetzee *S Afr Med J* March 2018;108(3):176-180

‘Neuropsychiatric disorders were ranked third as contributors to disability-adjusted life-years in South Africa (SA). Despite this high morbidity, mental health is often overlooked on the public health agenda’.

‘Available evidence supports the need for improved integration of mental health services in primary healthcare and strengthening of community services. Challenges include a lack of capacity due to staff shortages and inadequate availability and allocation of resources’.

Barriers to integration of mental health services into Primary Health Care

- High burden of disease
- Pressured PHC services where staff have multiple tasks, high patient loads, limited supervision and poor referral networks
- Lack of political will, particularly the absence of mental health on the public health priority agenda
- Lack of public mental health leadership
- The stigma of mental illness, viewed as a sign of weakness and disgrace
- Lack of knowledge regarding the prevalence and nature of mental illnesses
- Under-resourced health facilities in terms of staff, infrastructure and medication
- Poorly trained nursing staff
- Lack of appropriate screening tools
- Insufficient skilled counsellors, psychologists and psychiatrists

Jacob N & Coetzee D Mental illness in the Western Cape Province, South Africa: A review of the burden of disease and healthcare interventions *S Afr Med J* 2018;108(3):176-180

Thank You

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