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Understanding depression and suicide rates in the UK in comparison to Pakistan

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ABSTRACT

This review compares depression and suicide rates in the UK and Pakistan, highlighting disparities and challenges in mental health care. While depression affects one in six individuals in the UK, limited resources, stigma, and funding constraints in Pakistan result in a shortage of mental health professionals, particularly in rural areas. The complex relationship between depression and suicide is explored, emphasizing the need for multifaceted intervention strategies. Disparities in suicide rates underscore socio-cultural and healthcare system differences. While the UK implements comprehensive prevention strategies, Pakistan struggles with underreporting, stigma, and limited access to care. Notably, Thar Desert Region in Pakistan has seen a surge in suicides, reflecting socio-economic challenges. Globally, the World Health Organization's (WHO) mental health gap action program aims to address treatment gaps, yet disparities persist. Collaborative efforts are needed to invest in mental health infrastructure, reduce stigma, and increase awareness, promoting mental well-being globally.

Keywords: mental health, WHO, depression, suicide, mortality

INTRODUCTION

Depression is a widespread and complex mental health condition that affects millions of individuals worldwide, transcending age, gender, and socio-economic boundaries. According to the World Health Organization (WHO), depression is a leading cause of disability globally, affecting an estimated 5.0% of adults worldwide, contributing significantly to the overall burden of disease [1]. This corresponds to over 280 million people who suffer from depression worldwide. In addition to affecting adults, depression also significantly affects the elderly; 5.7% of adults over 60 suffer from the illness [2].

As a multi-faceted phenomenon, depression has garnered attention from various health organizations, researchers, and policymakers aiming to unravel its intricate nature and provide effective interventions.

WHO, a specialized agency of the United Nations concerned with global health, characterizes depression as a common mental disorder that affects people of all ages, from all walks of life. Their fact sheet on depression emphasizes its widespread prevalence and its impact on individuals, families, and communities. Depression is more than just feeling sad; it is a persistent state of low mood, affecting an individual's ability to perform daily activities and engage with world [1].

The extensive nature of depression in different demographic groups, including children, should not be overlooked. The significance of addressing depression in early stages of life, recognizing the long-term consequences if left unattended.

WHO has stressed how urgently mental health care must change on a worldwide scale. Their extensive review highlights several key issues, including the large number of people affected by mental disorders, the significant impact of mental health conditions on disability and mortality, and the global structural threats to mental health like social and economic inequalities, public health emergencies, war, and climate crises. According to the survey, there were 14.0% of adolescents worldwide and around a billion individuals dealing with mental disorders in 2019 [3].

The COVID-19 pandemic has made this worse, with increases in anxiety and depression of over 25.0% in just the first year [3]. The research also notes widespread discrimination, stigma, and human rights abuses directed towards those with mental health disorders. It also draws attention to the differences in access to mental health care, particularly in low-income nations, where a negligible percentage of the population in need has access to efficient, reasonably priced, and high-quality care.

Burden of Depression & Associated Mortality Globally

The burden of depression varies globally. Global burden of disease study 2019 spanning from 1990 to 2019 across 204 countries and territories noted that the incidence of depressive disorders has been decreasing globally [4]. However, the incidence rate is still increasing in regions with high socio-demographic indices (SDI), especially among younger generations. The study also found that certain populations require more psychological support, such as individuals born after the 1950s in high SDI regions and males in middle SDI regions.

Notably, the nations with the greatest incidence of depressive illnesses in 2023 were Greece and Greenland, which can be attributed to past traumas, economic crises, and hard living conditions. Depression affects over 86 million individuals in Southeast Asia, while the number varies significantly between countries. With an estimated 5.0% of the population affected by depression and a sizable lack of access to appropriate therapy, Latin America and the Caribbean likewise face obstacles in treating depression. These results highlight the prevalence of depression around the world and the demand for all-encompassing mental health interventions.

Depression in the United Kingdom & Pakistan

With 67 million people living there as of mid-2021, the UK is regarded as a high-income nation [5]. Its advanced economy, which is supported by a robust industrial and technical basis and notable contributions from the services sector (banking, insurance, and real estate), is responsible for this status.

As of early 2024, Pakistan has a population of over 243 million, making it one of the most populous nations [6]. Pakistan, a nation with a sizable population, is regarded as low-income and has several economic difficulties. These issues, which together impede the nation's economic growth and residents' well-being, include a high poverty rate, restricted access to high-quality healthcare and education, and inadequate infrastructure.

Depression can affect one in six individuals in the UK with studies showing that women experience depression twice as likely in comparison to men [7]. However, less men have been found to receive treatment for depression and often males and females can go undiagnosed. The prevalence of depression in the UK adults is estimated to be 4.5% [8]. Mild depression accounts for 70.0% of all cases. Moderate depression accounts for 20.0% and severe depression, 10.0% of all cases [9].

Depression is a prevalent mental health condition in Pakistan, with estimates suggesting that up to 34.0% of the population may suffer from depression at some point in their lives. More than 4.0% of all diseases in Pakistan are mental disorders, with women bearing a disproportionately heavy burden of mental health issues.

In Pakistan, there are thought to be 24 million people who require mental health care. Unfortunately, the funding allotted for mental health condition screening and treatment is insufficient to satisfy the growing demand. Pakistan has one of the lowest rates of psychiatrists in WHO Eastern Mediterranean Region and the entire world, with only 0.2 per 100,000 people, according to WHO data [10].

Link Between Suicide & Depression

There is a complex and well-researched relationship between depression and suicide. Studies have demonstrated a robust association between suicidal ideation and depression, underscoring the significance of emotional regulatory mechanisms in this connection [11]. Understanding these emotional regulating processes, particularly in various groups such as never-suicidal individuals (never entertained the idea of suicide or carried out any suicidal acts), suicidal idolators (those who idolize or overly adore the idea of suicide), and suicide attempters (those who have made conscious attempts to take their own lives but were unsuccessful), was the focus of a study conducted by the University of St Andrews and others.

One finding of the study was that brooding, a type of ruminative thinking, was a common trait among all three of the groups mentioned above and was strongly associated with a depressed mood at the time. For those who attempted suicide, their mood had stronger connections with brooding, aggression, and vague personal memories than the never-suicidal group. Meanwhile, those with suicidal thoughts had more ties to neuroticism and impulsivity, yet these traits had less impact on their mood [11].

Subsequent research endeavors may aim to delve deeper into these conjectures or examine the diversity among individuals who try or consider suicide.

A meta-analysis of longitudinal studies evaluated the potential consequences of depression and hopelessness on suicidal ideation, attempts, and fatalities [12]. The purpose of the investigation was to determine how well depression and hopelessness predicted future outcomes related to suicide. Strict inclusion criteria and an extensive literature search were part of the study's methodology, which made sure the analysis was founded on high-caliber, peer-reviewed papers. To ascertain how these methodological problems would affect the impact of depression and hopelessness on suicide, the meta-analysis considered several variables, including sample severity, sample age, and research follow-up length. This work is essential for identifying the specificity of impacts on discrete suicide-relevant outcomes, which will guide research and therapeutic practice.

The meta-analysis found that while despair and depression are risk factors for suicide thoughts and actions, their predictive ability was not as strong as anticipated. The overall estimates of prediction did not go above an odds ratio of 2.0 for any outcome, with the most minimal effects observed in the prediction of suicide fatalities [12].

These findings highlight how complicated the connection is between depression and suicide. They emphasize the need of considering a variety of risk factors, such as hopelessness and depression, in suicide prevention and treatment initiatives, as well as the necessity of developing an in-depth knowledge of emotional and cognitive processes in various suicidal groups.

Suicide Rates in the United Kingdom vs. Pakistan

There are notable disparities between suicide rates and preventive tactics in Pakistan and the UK, which are mostly caused by social, cultural, and medical system variables.

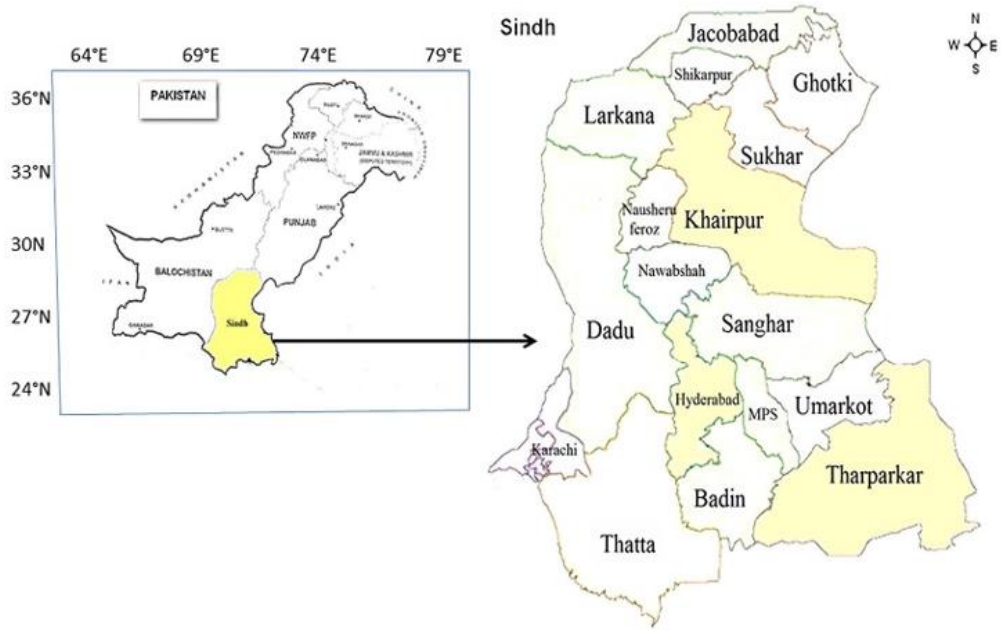

Figure 1. Map of Pakistan highlighting the Sindh Region, where Tharparkar is situated [18]

The latest data in the UK reveals differences in suicide rates between genders and regions. The UK's total suicide rate in 2018 was 11.2 fatalities per 100,000 people, a significant rise from the year before [13]. The suicide rate was much greater in men than in women. The rate of suicide deaths among men was 17.2 per 100,000, whereas the rate among women was 5.4 per 100,000. The total suicide rate in England in 2022 was 10.5 per 100,000, with 16.1 suicides per 100,000 males and 5.3 suicides per 100,000 females [14].

According to the most recent data available, Pakistan's suicide rate poses a complicated and worrisome public health problem. Although WHO does not always receive official suicide death figures, central estimate of 7.5 per 100,000 people [15]. As of 2015, the global average rate was 9.5 per 100,000 persons, which is considerably lower than this figure [16]. Nonetheless, the social shame and legal complications associated with suicide in Pakistan may mean that these numbers are underreported. For example, even if an amendment decriminalized attempted suicide in 2022, suicide is still a crime in the nation and is punished by jail time and fines [17].

There has been a noticeable rise in suicides in Pakistan's Thar Desert area. During a five-year period ending in 2020, the District of Tharparkar (**Figure 1**) reported the greatest number of suicide cases, despite having a lower population of 1.65 million people in comparison to other regions of Sindh, where there are more than two million residents [18, 19].

According to police statistics, the district had 112 and 113 suicides in 2020 alone–the highest yearly totals ever reported in the area [20]. This is a rate of 7.0 suicides per 100,000 people.

The data indicates a noteworthy increase in suicide cases when compared to prior years. Nevertheless, the existing sources do not offer extensive statistical trend analysis over a longer period or year-by-year precise information. Numerous socioeconomic causes, including poverty, unemployment, health problems, and various societal pressures, are contributing to this surge.

MENTAL HEALTH IN PAKISTAN

Whilst in the UK, there are services available for those dealing with mental health concerns, and suicide prevention is often approached in a more systematic and integrated manner within the healthcare system, these aspects of care are not so well established in Pakistan.

The economic burden of mental illness in Pakistan is substantial, and the allocation of government funding is a crucial aspect of addressing this issue. As of 2020, the economic burden of mental illness in Pakistan was estimated to be around 616.9 billion Pakistani rupees (1.73 billion GBP). In contrast, only a small fraction of the total health budget, about 2.4 billion PKR (6.8 million GBP) (0.4% of the total health budget), was allocated to mental health. This amount covers less than 2.0% of the total economic burden of mental illnesses [21].

This situation adds to the difficulties in dealing with and preventing suicide. Public health initiatives are required to increase public awareness, destigmatize suicide, limit access to common suicide methods, enhance monitoring, and improve mental health services. For the early detection, care, and assistance of those who are in danger, training for schools, law enforcement, and healthcare professionals is also essential.

In Pakistan, there is a notable gender bias in suicide rates, with variations in prevalence and methods between men and women. A study analyzing suicides in Pakistan between 2019 and 2020 reported that about 61.9% of suicides were committed by men and 38.1% by women [22]. This disparity is significant and reflects broader socio-cultural dynamics within the country. Numerous sociocultural variables also have an impact on the gender variations in suicidal behavior in Pakistan.

For instance, research on nonfatal suicidal behavior in Karachi found that women were more likely to be married and typically younger than males when it came to suicide attempts

[23]. Gender differences also existed in the techniques of suicide, whereas both sexes frequently used benzodiazepine self-poisoning, women were more likely to utilize organophosphate pesticides [23].

Given the enormous obstacles to successful suicide prevention posed by cultural attitudes and budget constraints, Pakistan must prioritize the improvement of mental health services and raising public awareness.

Mental Health Gap: WHO's Perspective Regarding Current Situation in the United Kingdom & Pakistan

WHO's mental health gap action program aims to scale up care for mental, neurological, and substance (MNS) use disorders, particularly in low- and middle-income countries [24]. Its main objectives include closing the treatment gap, increasing capacity, and integrating mental health services into primary healthcare settings. The effort provides evidence-based recommendations, resources, and training for healthcare practitioners to detect and manage mental health disorders effectively. The objective is to overcome the notable gaps in mental health treatment by expanding access to high-quality mental health services on a worldwide scale.

There is a glaring difference in mental health care between Pakistan and the UK. Access to mental health services is typically greater in the UK, where a strong healthcare system offers a variety of treatments, such as psychological therapy and drugs. On the other hand, Pakistan confronts serious difficulties in providing mental health treatment because of its weak healthcare infrastructure, lack of finances, and stigma associated with mental illness in the society [25]. This discrepancy supports WHO's concern that more than 75.0% of MNS use condition sufferers in low- and middle-income nations do not have access to essential medical care.

MANAGEMENT OF DEPRESSION GLOBALLY: DISPARITIES IN SERVICE AVAILABILITY & STIGMA

In Europe, pharmacotherapy (such as antidepressants), psychotherapy (such as cognitive behavioral treatment and interpersonal therapy), lifestyle adjustments, and support groups are just a few of the choices available for managing depression [1]. While access to mental health treatments differs from nation to nation, comprehensive care is the goal of many European healthcare systems. The European approach to treating depression also emphasizes the need for community-based assistance, specialized psychiatric services, and the integration of mental health services into primary care.

Depression prevalence and management vary widely, influenced by factors such as healthcare systems, cultural attitudes towards mental health, and socioeconomic conditions [25, 26]. European countries generally have more resources and established healthcare systems for mental health care compared to many regions such as those in the Middle East, potentially leading to better diagnosis and treatment rates. However, stigma and access to care can still be significant issues in various parts of Europe, affecting the overall management and understanding of depression.

In comparison, depression and anxiety disorders are highly prevalent in the Middle East, with studies indicating significant portions of populations in countries like Lebanon, Iraq, and Saudi Arabia suffering from these conditions [26]. Despite the high rates of mental illness, mental health care receives limited attention and funding from governments in the region, leading to challenges in diagnosis and treatment.

Depression management in Asia is influenced by a variety of factors including cultural perceptions, availability of healthcare services, and societal attitudes towards mental health. In many Asian countries, there is a strong cultural stigma associated with mental health issues, which can lead to underreporting and a reluctance to seek help [4]. Traditional beliefs and practices such as acupuncture often play a significant role in how mental health is understood and treated.

The stigma associated with mental health is a worldwide issue, defined by institutional, social, and self-imposed attitudes towards mental disease. This causes prejudice, social exclusion, and a reluctance on the part of individuals impacted to ask for assistance. The problem is made worse by structural obstacles in healthcare and other sectors, and unfavorable stereotypes propagated by the media frequently contribute to the general misinformation and stigma associated with mental health disorders.

UNITED KINGDOM & PAKISTAN: A COMPARATIVE CASE STUDY

A cross-sector approach is the main emphasis of the UK government's suicide prevention strategy for England (2023-2028), which aims to lower the suicide rate and aid individuals who are impacted by suicide and self-harm [27]. The NHS long term plan, which has been crucial in helping to create regional suicide prevention strategies and bereavement services, is funding this initiative with £57 million [28]. Enhancing data and evidence, addressing common risk factors, offering customized support to high-risk groups, encouraging online safety and responsible media content, offering efficient crisis support, limiting access to suicide means and methods, and guaranteeing efficient bereavement support are some of the strategy's key components. The plan lists more than 100 activities that should be done and highlights that everyone has a duty to prevent suicide.

There is still work to be done in the UK to lessen the stigma associated with mental illness and suicide. Even if there has been an improvement in public knowledge and acceptance, people still encounter social and personal obstacles when talking about mental health concerns or asking for assistance. Suicide is frequently stigmatized, which might discourage people from seeking help and add to a general lack of knowledge and understanding among the public. The government of the UK, together with many organizations, is persistently striving to de-stigmatize mental health and suicide, foster candid conversations, and motivate people to pursue assistance.

Similarly, in Pakistan, a significant challenge is the stigma associated with mental health problems, which keeps many people from getting treatment because they fear social rejection. In addition, the public does not comprehend or have sufficient knowledge of mental health concerns.

The lack of specialist mental health facilities and practitioners is another major issue facing the nation. Pakistan has a population of over 216 million, but only around 450 psychiatrists [10]. This means that access to mental health treatment is especially challenging in rural regions, where there is only one psychiatrist for every million people. Most of the mental health budget is utilized in hospital psychiatric units, which are primarily located in urban areas and are often overburdened. Additionally, the public health sector in Pakistan has yet to fully recognize psychology as a profession, contributing to a limited number of psychology and psychiatry professionals in the country.

A limited budget for mental health care is one of the other problems that exacerbates the treatment gap, as mentioned previously. Healthcare professionals require more mental health training, particularly those in the child protection and psychosocial support sectors, where there is frequently a lack of formal mental health education.

To effectively assist people with mental health disorders, there is an urgent need for more financing and awareness of mental health services on a global scale. Increased funding for mental health services is essential for increasing patient access to high-quality care, lowering stigma, and making sure that patients get the all-encompassing assistance they need. Increasing awareness is crucial because it may improve knowledge of mental health concerns, motivate individuals to get treatment, and create a more accepting community, where physical and mental health are valued equally. When combined, these initiatives have the potential to greatly enhance the lives of persons impacted by mental health issues and promote global health in communities.

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Data sharing statement: Data supporting the findings and conclusions are available upon request from the corresponding author.

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