**Liverpool
Public Health
Observatory**

Merseyside Mental Health Needs Assessment

Populations at risk of mental health problems amongst working age adults

Janet Ubido and Alex Scott-Samuel

PROVIDING INTELLIGENCE FOR THE PUBLIC HEALTH

Merseyside Mental Health Needs Assessment

Populations at risk of mental health problems amongst working age adults

Liverpool Public Health Observatory
Observatory report series number 86
August 2011

Authors:
Janet Ubido and Alex Scott-Samuel, Liverpool Public Health Observatory

With input from the Steering Group:
Annette James, Public Health Strategic Lead, Liverpool PCT
Erica Crisp, Senior Commissioning Manager (Mental Health), NHS Halton & St Helens
Barbara Edwards, Programme Manager, Mental Health Systems Management, NHS Wirral
Antoinette Egan, Senior Insight and Social Marketing Executive, Liverpool PCT
Julie Graham, Senior Health Improvement Advisor, NHS Wirral
Richard Holford, Public Health Development Manager, NHS Knowsley / Knowsley MBC
Pat Nicholl, Deputy Head of Health Improvement, NHS Sefton

Contact: j.ubido@liv.ac.uk

Contents

Figure 1 – Area covered by the mental health needs assessment

Merseyside Local Authority Boundaries

Sefton

St. Helens

Liverpool

Knowsley

Wirral

Halton

Produced by Colin Wilson
Liverpool Public Health Intelligence Team

This map is reproduced from Ordnance Survey material with the permission
of Ordnance Survey on behalf of the controller of Her Majesty's Stationery Office,
may contain National Statistics © Crown copyright and database rights 2011 Ordnance Survey 100050548.
Unauthorised reproduction infringes Crown copyright and may lead to prosecution or civil proceedings.

Summary

This mental health needs assessment uses a population approach to identify at-risk groups and areas of need in Merseyside. In the new NHS structure, commissioning will be undertaken by GP/clinical commissioning groups and local authorities, with advice and support from public health. The NHS commissioning board will also be involved, especially where local commissioning groups are not ready to take on this role. The needs assessment presented here will be a tool for these bodies, with a much wider scope than just providing information for specialist mental health commissioning.

The 2011 government mental health strategy '*No health without mental health'* places a firm emphasis on early intervention to stop serious mental health issues developing, and on tackling inequalities. The new strategy recognises the importance of addressing the social determinants of mental health, for example with measures such as providing face-to-face debt advice.

The focus of the needs assessment is on a preventive/population approach. This involves:
- identifying the strength of protective factors for mental health within communities, so that action can be taken to build on these
- identifying risk factors for mental health within communities, so that interventions can be geared towards addressing these
- analysis of social factors at super output area level within local authorities, or of vulnerable groups, to identify small areas or populations within a given local authority that are likely to experience particular health problems, and may therefore be targeted by intervention programmes.

There will be gaps in the needs assessment- what is presented is for areas where data is available, and what is possible within the time limits of the project.

Protective factors for mental health
Wellbeing: Factors seen as key to maintaining wellbeing include self-esteem, confidence, resilience, social networks and sense of control. Each Merseyside PCT, with the exception of Halton & St.Helens, had lower mental wellbeing scores than the North West average. The most deprived areas were most likely to have low mental wellbeing.

Employment: On balance, any adverse effects of work on mental health appear to be outweighed by the beneficial effects of work on well-being and by the likely adverse effects of (long-term) sickness absence or unemployment (see 'unemployment' in section on risk factors below). Amongst those receiving secondary mental health services in Merseyside PCTs, the proportion in settled employment is lower than the North West average in Liverpool, Sefton and Wirral PCTs.

Education: It has been noted that there are substantial returns to education in term of improved mental health, with one study finding the biggest impact on individuals who gain GCSEs. On Merseyside, numbers with five or more GCSEs are significantly below the

national average in Halton, St.Helens, Liverpool and Knowsley - especially in Knowsley, where only 1 in 3 (33.5%) of children at key stage 3 have 5 or more GCSEs. Across Merseyside, all local authorities, with the exception of Sefton, have significantly more young people who are 'not in education or training' (NEET) than the England average. In Liverpool and Knowsley, more than 1 in 4 young people are NEET.

Physical activity: Exercise has been shown to improve the mental and physical health of people with a range of mental health problems. In Merseyside, each local authority has levels of physical activity below the national average of just over 11%, although none were significantly lower. The lowest levels were found in Knowsley and St.Helens.

Access to green space: There is increasing evidence for the links between access to and use of green spaces and mental health. Data available for Liverpool shows that green infrastructure is not equally distributed across the city, with 22% of the areas having 80% of the total accessible green infrastructure. Some areas have no accessible green infrastructure. The most affluent areas of the city have 18% more green infrastructure than the most deprived. Low levels of green infrastructure occur in areas of the city with a higher incidence of coronary heart disease, poor mental health and poor air quality

Settled accommodation: Proportions of those receiving secondary mental health services who are in settled accommodation in Halton & St.Helens, Wirral and Knowsley, are higher than the national average of 59.1%. In Halton & St.Helens, more than three-quarters of people receiving such care are in settled accommodation. This contrasts with Sefton, where only around 1 in 10 are settled, and Liverpool, where the proportion is 1 in 5.

Other protective factors in communities include opportunities for individuals to develop coping skills such as an increased sense of self-esteem; and the existence of social support, such as. self-help groups or someone to talk to. Due to time limitations, these were not covered in the needs assessment.

Risk factors for mental health
Factors such as poor quality housing, unemployment and deprivation can contribute to mental ill health or can make an episode of mental distress more difficult to manage.

Deprivation: Living in more deprived communities is strongly associated with lower levels of mental wellbeing. All the local authorities in Merseyside have deprivation levels significantly above the national average. In Halton, they are more than twice as high, and in Liverpool and Knowsley, more than three times as high.

Within local authorities, in Liverpool, there are several wards across the north, plus Speke-Garston in the south, with deprivation levels in the top fifth on Merseyside. Levels are also high in the north of Knowsley, south west Sefton, central Halton and mid-east Wirral. In St.Helens, there are only two wards in the centre of the borough with areas of high deprivation. There are large areas in Wirral, Sefton and St.Helens with very low levels of deprivation.

Social stratification: Evaluations have shown that the type of neighbourhood can be a better predictor of certain behaviours than any personal or household level indicator such as

income, social class, or age. Across the North West, on the whole, there were higher levels of hospital admissions for mental health in the least affluent areas. In geodemographic analysis, the most deprived group is the 'urban challenged', found in the centre of Liverpool and also on the Runcorn side of Halton.

Unemployment: In recent years parts of Merseyside have enjoyed rapid growth. However, the economic downturn is being felt, for example in Liverpool, where employment was down 1.4% over 2008-9. In the short term this can be expected to increase demands on mental health services

The proportion of the Merseyside population claiming Job Seekers Allowance is higher than nationally in each local authority – more than twice as high in Liverpool. Super output area analysis on Merseyside shows the distribution of claimants is similar to the distribution of deprivation on Merseyside

Housing type: Social housing is often associated with poor quality buildings, high levels of unemployment and crime and poor access to local services. The relationship between housing and mental health works two ways, with mental health problems making it more difficult for people to access good housing and with poor housing contributing to mental health problems.

Proportions of rented housing are higher than the North West and national averages in Liverpool, Knowsley, Halton and St.Helens. Nearly half of all households in Liverpool are either social housing or privately rented, compared to only around a quarter in Sefton. The distribution of social housing within local authorities across Merseyside follows a similar pattern to that of deprivation.

Poor physical health: People with poor physical health are at a higher risk of experiencing common mental health problems. The converse is also true, with people having mental health problems being more likely to have poor physical health.

In Merseyside, the percentage of the population with a limiting long-term illness ranged from just over 1 in 5 in Halton to around 1 in 4 in Knowsley and Liverpool. In all Merseyside PCTs, proportions were significantly higher than for Cheshire & Merseyside Strategic Health Authority and the North West.

Alcohol: There is a great deal of overlap between alcohol and mental illness, for example suicide is eight times more likely to occur in the presence of alcohol misuse or dependency. In Liverpool and Halton, around 1 in 4 adults are binge drinkers, which is significantly more than the England average of 1 in 5. In Sefton and Knowsley, levels of binge drinking are less than the national average.

Crime: Fear of crime and feeling your neighbourhood is unsafe/ violent can have a negative effect on mental health. Knowledge of actual violent crime levels in the area will contribute to fear of crime and feeling unsafe. In Merseyside, crime levels are significantly higher than the national average in Liverpool and Halton.

Being a victim of crime can lead to mental health problems, such as in domestic abuse (see below). People with mental health problems are significantly more likely than the general population to be the victims of crime. In addition, people with mental health problems are said to also 'face barriers at every stage of getting a crime brought to justice'.

Vulnerable groups at risk (including those with 'protected characteristics')
Vulnerable groups that may be at high risk of developing mental health problems include some black and minority ethnic groups, travellers, asylum seekers, people who are homeless, people with disabilities, carers, people who are lesbian/gay/bisexual and those recently released from prison. Such people have an increased risk of developing mental health problems due to factors such as discrimination, cultural misunderstandings, limited access to services and to employment, poverty and deprivation.

Estimates of the numbers of people in Merseyside from some of the more vulnerable groups are presented in the needs assessment. Within these groups, numbers of those who are likely to experience mental health problems were estimated as follows:

Estimates of numbers at risk of having mental health conditions amongst some of the vulnerable groups in Merseyside

	% at risk of mental health problems	Estimated number with mental health problems
Asylum seekers & refugees	50%	858
Gypsies and travellers	35%	122
People who are lesbian, gay or bi-sexual	39.4%	21,593
People with a learning disability	25%	5,572
Those with severe or profound hearing impairment	33.3%	885
Marital status: separated	23.3%	7,083
Marital status: divorced	27.1%	27,182
Looked after children	45%	1,118
Adult survivors of childhood sexual abuse*	*12.4%	*13,152
Released prisoners	90%	1450
Carers**	**18%	**30,723

N.B. General population prevalence of common mental disorder in the past week is 16%
* with more severe mental health problems, in receipt of psychiatric treatment.
No studies were found estimating those with more common mental health problems – (note: three-quarters of adults with a common mental disorder are not in receipt of medication or counselling)
** with significant levels of neurotic symptoms.
Estimates do not take account of local variations in age, sex, deprivation etc.

Prevalence of mental disorders
Across Merseyside in 2010, there were an estimated 147,950 people (16.2%) with a common mental disorder. For each local authority, estimates range from nearly 48,000 in Liverpool, to around 12,000 in Halton.

There were an estimated 3,678 (0.4%) with a psychotic disorder on Merseyside in 2010, ranging from 1,186 in Liverpool, to 300 in Halton.

In Merseyside, predicted numbers of people with two or more psychiatric disorders ranged from 21,350 in Liverpool, to 5,360 in Halton, with 65,900 in Merseyside as a whole.

On Merseyside, it is estimated that there are just over 4,000 people with borderline personality disorder and just over 3,000 with antisocial personality disorder

Incapacity benefit for mental illness can be used as a proxy measure of levels of severe mental illness in the community. Data will indicate where improvements are necessary in the provision of services to help mentally ill people find work and reduce social exclusion. Across Merseyside, in each local authority, rates of claims for incapacity benefit for mental illness are significantly higher than the national average – twice as high in Liverpool and Knowsley, where more than 1 in 20 people of working age claim, compared to 1 in 36 nationally. In Liverpool, **almost 1 in 10 of the population aged 55-59 claim incapacity benefit for mental illness**.

At super output area level, the distribution of incapacity benefit claimants for mental health conditions is very similar to that for the hospitalised prevalence of mental health conditions and incidence of self-harm. In each, there are high levels in the following areas:
- to the North West of Liverpool, (and a patch within the far east side of Speke-Garston for incapacity benefit claimants and self-harm – although hospitalised self-harm is relatively low in Liverpool compared to the rest of Merseyside)
- across the north and the centre of Knowsley (although hospitalised self-harm is relatively low in Knowsley compared to the rest of Merseyside)
- to the east of Wirral (for self-harm, high levels were more widespread, across the north east of the borough)
- in the centre of St.Helens
- in the centre of Halton, especially on the Runcorn side
- in the far North West and far south west of Sefton

Suicide and self-harm:
There were an estimated 83 suicides on Merseyside in 2010 amongst those aged 18-64. Numbers are highest in Liverpool, with 26.

There were 13,937 hospital admissions for self harm in Merseyside in the period 2003/04 to 2007/08. On Wirral, the standardised ratio of 223.53 was significantly higher than the rest of Merseyside and more than twice that for England (100). In Wirral, the highest ratios occurred across the north east side of the borough. Wirral, Halton and St.Helens each had levels above the North West average of 129.91.

Allocation of resources
Of the money spent on mental health in the North West, only 0.2% is spent on prevention or helping people stay mentally well (2008). Across Merseyside, there is variation in spending

on mental health, ranging from £218 per head in Sefton to £165 in St.Helens. Only Knowsley and St.Helens spent less than the North West average of £195 per head (2011).

There is even greater variation in the amount being spent on the process of commissioning mental health services. Spending in Liverpool was £1.36 per head, which was three times as high as spending in Sefton at £0.38 per head (2008).

Conclusion
What has been learned?
The needs assessment presented here has focussed on the needs of those who do not necessarily have a diagnosed illness, but for a range of reasons are at high risk of falling into poor mental and physical health.

In Merseyside, vulnerable groups that may be at high risk of developing mental health problems have been identified. Local authorities and areas within local authorities have been highlighted as having high levels of factors associated with poor mental health such as deprivation, unemployment, or young people 'not in education or training'.

Limitations of the needs assessment
There are gaps in the needs assessment - what is presented is for areas where data is available, and what is possible within the time limits of the project. It was not possible to carry out a full assessment of user engagement in the commissioning process. Other areas not covered that could be considered in future needs assessments include the mental health needs of: women during pregnancy, peri-natal and post-natal periods; teenage mothers; lone parents; people with eating disorders; those with post-traumatic stress disorder; the workforce; service and ex-service personnel; people who are transgender and people with other types of disability, including visual impairment and physical disability.

How the needs assessment can inform commissioning
This document can be used to inform commissioning, through the identification of geographical areas and groups most at risk that need to be targeted with preventive measures and service provision.

It is suggested that mental health interventions need to focus on a whole range of factors that influence a person's ability to live healthy and well, including welfare (housing advice and homelessness, debt advice etc.), community development, measures to reduce social isolation, work/learning, self care and healthy lifestyles. Interagency working is a key recommendation, for example recognising the important effects that planning decisions on the design of neighbourhoods and green space initiatives can have on mental health.

There needs to be a more preventive focus in the mental health commissioning process, with contracts specifying outcomes relating to vulnerable groups and areas, such as measuring the number of people with mental health problems returning to work.

Summary of recommendations
Recommendations relating to most topic areas are presented throughout the document and brought together at the end. They are summarised as follows:

1. *Promote wellbeing*
   - Promote the Five Ways to Wellbeing messages.
   - Use the NW Wellbeing survey findings to inform effective targeting of resources.

2. *Maximise protective factors*
   - Build community capacity with measures such as debt advice and reducing social isolation.
   - Develop a more preventive focus in the mental health commissioning process, with contracts specifying outcomes such as measuring the number of people with mental health problems returning to work.
   - Encourage interagency working to ensure that mental health is a consideration in all aspects of public policy.
   - Use a lifecourse approach to promote early interventions for positive mental wellbeing targeted at children and young people.

3. *Meet the needs of vulnerable/minority groups*
   - Meet basic needs for food and safe shelter as a first priority.
   - Provide appropriate training for mental health staff of the needs of vulnerable groups.
   - Improve awareness of mental health issues amongst staff in various sectors relating to vulnerable groups, for example housing sector staff and frontline staff in primary care.
   - Provide accessible support, enabling easy access to services by vulnerable minorities, including use of signposting.
   - Ensure support is culturally appropriate.
   - Encourage inter-agency working, for example making it a requirement that social landlords recognise and refer tenants with mental health problems.
   - Provide vocational support for people from vulnerable groups, for example assistance to people such as carers to remain in work or find employment.
   - Provide vocational rehabilitation for people with long-term mental health problems to help to overcome barriers to work.
   - Target preventive interventions such as those for suicide and self-harm at those groups most at risk.

4. *Consider age, sex and small areas*
   - Develop an awareness of the needs of sub-groups of the population and apparent pockets of need within local authority boundaries.

5. *Consult and develop partnership working with populations at risk and service users*
   - Consult, involve and engage service users and those from vulnerable groups at risk, so that their views are represented in the commissioning process.
   - Ensure that future mental health needs assessments include a focus on gathering the views of those from populations at risk and users of mental health services.

The Full Recommendations are listed at the end of the report.
Note – since this report was produced, the APHO profiles for 2011 have been released. Profile data in this report is based on 2010 data)

Introduction

In December 2010, Liverpool Public Health Observatory was commissioned by the five Merseyside PCTs (Halton & St.Helens, Knowsley, Liverpool, Sefton and Wirral) to undertake a mental health needs assessment. Results will help to inform the commissioning process in its efforts to support adult mental health and well-being in each PCT. Figure 1 on page 3 shows the geographical area covered by the needs assessment.

The emphasis of the mental health needs assessment is on a population approach of identifying at-risk groups and areas of need in Merseyside. In the new NHS structure, commissioning will be undertaken by GP/clinical commissioning groups and local authorities, with advice and support from public health. The NHS commissioning board will also be involved, especially where local commissioning groups are not ready to take on this role. The needs assessment presented here will be a tool for these bodies, with a much wider scope than just providing information for specialist mental health commissioning.

Aims
The initial aim of the project was to collate current data and intelligence, firstly with regard to mental health needs and determinants across specified target groups in the Mersey population, and secondly with regard to the utilisation of resource to meet those needs. Thirdly it was to offer some projections with regard to changes in mental health needs over the next ten years.

Objectives
The project set out to:

1. Describe and quantify the prevalence of common and serious mental health disorders in the adult (over 18years) population.
2. Highlight and evidence mental health inequalities with particular reference to the demography of the local population and those groups most at risk of poor mental health by reason of their socio-economic status, sex, age, ethnicity, sexual orientation, gender identity, disability, and religion/beliefs, caring responsibilities, dual diagnosis.
3. Describe patterns of access to primary and secondary care services.
4. Provide a critique of the allocation of resource & investment in services in comparison with need and strategic health priorities.
5. Highlight areas of unmet need and gaps in provision.
6. Highlight the limitations in available data and intelligence and expose gaps in understanding.

A project group was established, which included membership from both public health and commissioning, from each Merseyside PCT. The first meeting was 16/12/10 at which it was agreed that the main aim would be to support mental health care commissioning.

Due to limitations of time, it was recognised that for a researcher working two days a week for six months, it would not be possible to provide full details on each of the objectives. It was noted that the two recent Merseyside Mental Health Equity Audits in 2004 and 2008

(also carried out by Liverpool Public Health Observatory) had identified inequities in access to primary and secondary services. Rather than repeat this exercise, it was decided that the current needs assessment would focus on prevalence and the identification of areas/groups most at risk of poor mental health (as in Objectives 1 and 2 above).

It was also noted that any analysis involving service provision would be difficult due to the fact that there is a great deal of change in service provision at the present time. This is due to NHS reorganisation and the economic climate. Subsequent meetings of the project group confirmed that the focus of the needs assessment would be on a population approach of identifying at-risk groups and areas of need, including the prevalence of mental health problems.

The focus is on a preventive/population approach. This involves:
- identifying the strength of protective factors for mental health within communities, so that action can be taken to build on these
- identifying risk factors for mental health within communities, so that interventions can be geared towards addressing these
- analysis of social factors at super output area level within local authorities, or of vulnerable groups, to identify small areas or populations within a given local authority that are likely to experience particular health problems, and may therefore be targeted by intervention programmes.

Vulnerable groups that may be at high risk include some black and minority ethnic groups, travellers, asylum seekers, people who are homeless, people with disabilities, carers, people who are lesbian/gay/transgender and, those recently released from prison.

Gaps:
There will be gaps in the needs assessment. What is presented is for areas where data is available, and what is possible within the time limits of the project. It was not possible to carry out a full assessment of user engagement in the commissioning process. Other areas not covered that could be considered in future needs assessments include the mental health needs of:
- Women during pregnancy, peri-natal and post-natal periods;
- Teenage mothers;
- Lone parents;
- People with eating disorders;
- Those with post-traumatic stress disorder;
- The workforce;
- Service and ex-service personnel;
- People who are transgender;
- People with other types of disability, including visual impairment and physical disability.

Time constraints also meant that the needs assessment would focus on relevant readily available health statistics and demographic data and would not involve wider consultation and literature searches.

(Note – since this report was produced, the APHO profiles for 2011 have been released. Profile data in this report is based on 2010 data)

Health needs assessment

Health needs assessment has been defined as follows:
> *'a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities' (NICE, 2005).*

Health needs assessment is used to inform the planning process, so that resources are used in a way that raises most effectively the health status of the whole population, taking full account of its known health problems and particular health needs.

Background

'Mental health' and 'mental wellbeing' are terms that have been used interchangeably (Coggins et al, 2007). The World Health Organisation defined mental health as follows;
> *"mental health is a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community"* (WHO, 2001).

An emphasis on measures to ensure the population maximises its mental health, rather than focusing only on treating or preventing mental illness, will have the overall effect of reducing levels of mental illness amongst the population. The key determinants for mental health include a combination of hereditary, material, socio-economic, environmental and psycho-social factors (Coggins et al, 2007).

National policy

The new government mental health strategy '*No health without mental health'* supersedes the *'New Horizons: a shared vision for mental health'* guidance from late 2009, placing a much firmer emphasis on early intervention to stop serious mental health issues developing, particularly among children (DH 2011a and DH, 2011b). The Coalition Programme document makes some reference to commitments relating to mental health (HM Government 2010). However, strategies are being produced at a time of unprecedented financial challenges. Over the past three years, there has been no increase in NHS funding and this is expected to continue for the foreseeable future (Kings Fund, 2011).

Social determinants of mental health:
The new strategy recognises the importance of social determinants of mental health and that socio-economic deprivation and social isolation can both contribute to the development of mental health problems and result from them. (DH 2011a and DH, 2011b). There is an impact on all areas of people's lives and that of their community. People with mental health problems are more likely than the rest of the population to:
- have fewer qualifications,

- find it harder to both obtain and stay in work,
- have a household income of less than £200 per week,
- they are almost three times as likely to have debt problems,
- one in four tenants with mental health problems is in serious rent arrears and is at risk of losing their home,
- more than four times as likely to have experience sexual abuse,
- twice as likely to report a lack of social support,
- are more likely to be homeless or insecurely housed,
- are more likely to live in areas of high social deprivation,
- they are also more likely to have poor physical health. This is due in part to higher rates of health risk behaviours, such as smoking, and alcohol and substance misuse. Some people with mental health problems have poor diets, may not be physically active and may be overweight, though the reasons for this are complex

(DH 2011a and 2011b; Mental Health Foundation, 2007).

Amongst those with a psychotic disorder, the differences are much starker. Compared to the general population, people with a psychotic disorder are:
- almost three times as likely to be living alone,
- five times more likely to report a lack of social support,
- more than fifteen times as likely to have experienced sexual abuse.

(Mental Health Foundation, 2007 - *based on a social and economic analysis of the 2000 Psychiatric Morbidity Survey by Meltzer et al, 2002*)

Figure 2 illustrates the links between socioeconomic stress, resulting from material deprivation and poor mental health (Liverpool PCT, 2009a)

Figure 2
Socio-economic stress and its impacts on health
(taken from the Joint Strategic Framework for Public Mental Health 2009-2012: Liverpool PCT, 2009a)
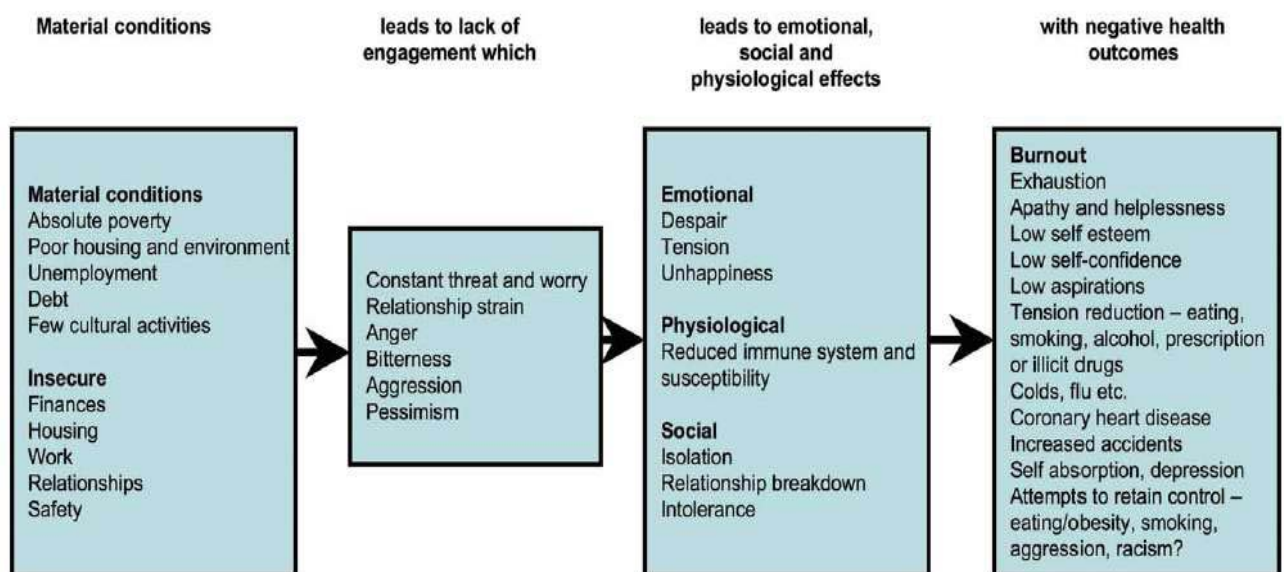
Source: Liverpool PCT, 2009a

The new mental health strategy recognises how these relationships deepen health inequalities and add to trans-generational patterns of poor health.

Benefits of targeting mental illness
The mental health strategy (DH, 2011a) notes that improved mental health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. These include improved physical health and life expectancy, better educational achievement, increased skills, reduced health risk behaviours such as smoking and alcohol misuse, reduced risk of mental health problems and suicide, improved employment rates and productivity, reduced anti-social behaviour and criminality, and higher levels of social interaction and participation. Early interventions can improve health and reduce costs (DH, 2011a).

Tackling health inequalities
The Marmot Review into health inequalities in England, '*Fair Society, Healthy Lives',* was published in 2010. It proposed an evidence based strategy to address the social determinants of health, the conditions in which people are born, grow, live, work and age and which can lead to health inequalities (Marmot, 2010).

One year on from Marmot, the London Health Observatory and the Marmot Review Team have produced baseline figures for some key indicators of the social determinants of health, health outcomes and social inequality that correspond, as closely as is currently possible, to the indicators proposed in the Marmot Review (LHO, 2011)

The figures show that addressing health inequalities is as important as ever. Men in England's richest areas live 9 years longer than men in the poorest areas; women in the most affluent areas live 6 years longer women in the poorest areas. And almost half of all children entering school do not exhibit a 'good level of development'. Health inequalities cost the economy up to £33 billion of lost productivity every year. The review team conclude that 'we cannot afford not to tackle this'. They have produced data tables for each local authority so that health inequalities can be monitored. The indicators at local authority level are: life expectancy at birth; children reaching a good level of development at age five; young people not in employment, education or training (NEET); and, percentage of people in households receiving means tested benefits (LHO, 2011).

Life course perspective:
Giving every child the best start in life was the highest priority recommendation in Marmot. Marmot noted that disadvantage starts before birth and accumulates throughout life. The review stated that action to reduce health inequalities must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken (Marmot, 2010).

The new mental health strategy *'No health without mental health'* (DH, 2011a&b) recognises the three aspects involved in reducing mental health inequality:
- tackling the inequalities that lead to poor mental health;
- tackling the inequalities that result from poor mental health – such as lower employment rates, and poorer housing, education and physical health; and
- tackling the inequalities in service provision – in access, experience and outcomes.

The Government has taken action to tackle public attitudes towards mental illness - one of the key objectives of the new strategy. One of the cornerstones of tackling inequalities in service provision is delivering a truly personalised approach that identifies the specific needs of each individual and their family and carers, so that they have more control over the support they receive.

The 2011 strategy notes how the public health White Paper *Healthy Lives, Healthy People* gave an overview of the determinants of ill health and reduced wellbeing, and outlined key approaches across the life course to address these. It committed Public Health England to support local authorities to make public mental health part of public health.

Positive mental health and wellbeing
The white paper emphasised health as a positive sense of well-being and not merely the absence of illness (DH, 2010a). There will be increased emphasis on promoting both physical and mental wellbeing as part of healthy lifestyles. Factors seen as key to maintaining wellbeing include self-esteem, confidence, resilience, social networks and sense of control.

Increasing control was also a priority within the 2010 Marmot Review on health inequalities, which stressed that for individuals to be able to take control of their own lives, the right conditions have to be created, through individual and community empowerment.

Interventions will focus on a whole range of factors that influence a person's ability to live healthy and well, including welfare (housing advice and homelessness, debt advice etc.), community development, work/learning, self care and healthy lifestyles (Hussey and Stansfield, 2011).

The 2011 strategy broadens the approach taken to tackle the wider social determinants and consequences of reduced wellbeing and mental health problems. One example of this approach is providing face-to-face debt advice. Evidence suggests that this can be cost-beneficial within five years. The upfront cost of debt advice is more than offset by savings to the NHS, savings in legal aid, and gains in terms of employment productivity, even before taking into account savings for creditors.

Resilience
Resilience is the capacity of individuals and communities to deal with stress and adversity. A report by the Joseph Rowntree Foundation noted that the term 'resilience' *'seems to imply more than succeeding to keep one's head above water – it suggests the ability to withstand repeated setbacks, or even the capacity for certain individuals to use the difficulties faced as an impetus to take positive steps forward in their lives'* (Batty and Cole, 2010, p.8). Wellbeing, resilience and the prevention of mental health problems are thus distinct but linked, and many of the successful interventions affect all three (DH 2011b).

The needs assessment will focus on the social and environmental factors relating to mental health and wellbeing, identifying those groups most at risk of reduced mental wellbeing and mental ill health.

Current climate and mental health service provision

The commissioners and providers of mental health care in Merseyside have plans to reduce the hospitalisation of working age people with mental health problems, with a shift in emphasis to community care. More specialised community mental health services will need to be developed. The Joint Strategic Needs Assessment (JSNA) report for Liverpool noted that in Mersey Care NHS Trust, which serves north Mersey, mental health admissions are planned to fall between 20-40% over the next seven years (Liverpool PCT 2009b).

However, the incidence of mental health problems – including in young people – can increase in times of economic and employment uncertainty, as can the rate of suicide (DH, 2011a). Since Mersey Care plans for bed reductions were outlined in 2008, the economic downturn has hit Merseyside. Unemployment has risen, and economic activity is down. In these circumstances, more demand for mental health services and negative impacts on other health measures can be expected (Liverpool PCT, 2009b).

1. Demography

Liverpool has the largest population on Merseyside, followed by Wirral and Sefton (Table 1.1). Projected population changes suggest that by 2020, there will be an overall decline in population in each Merseyside local authority – especially in Sefton and Wirral where there will be a 7% decline by 2020. This is in contrast to the national picture, where the population is expected to increase by 3% by 2020, and regionally, where there is a smaller decline of 1%. The population of Liverpool has declined considerably recently, but has now stabilised, with no change expected over the next ten years.

Table 1.1
Merseyside population estimates ages 18-64, 2010

	Population estimates, ages 18-64	% projected change	
		2015	2020
Halton	74,400	-3%	-5%
St.Helens	108,600	-2%	-3%
Knowsley	92,600	0%	-2%
Liverpool	296,300	0%	0%
Sefton	161,100	-4%	-7%
Wirral	181,200	-4%	-7%
North West		0%	-1%
England		2%	3%

Data source: http://www.poppi.org.uk/PANSI%20v%204.1%20User%20Guide.pdf
PANSI = Projecting Adult Needs and Service Information System

There are slightly more females than males in each PCT (Figure 1.1).

Figure 1.1
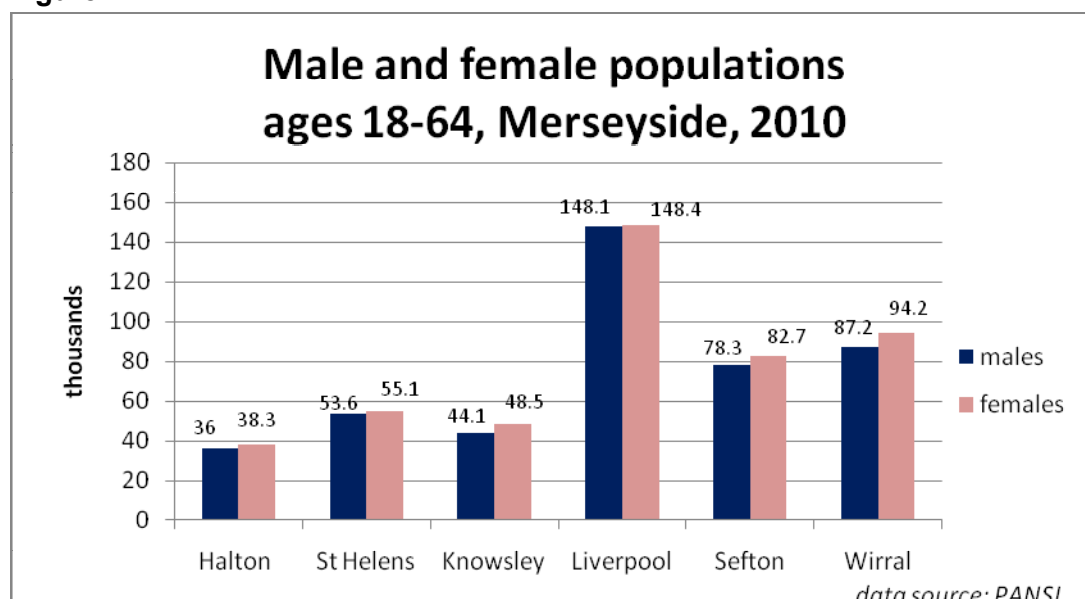
Liverpool has the largest proportion of people from black and ethnic minority groups amongst the population (8.5%). This is less than the national average of 11.7%. In the other Merseyside local authorities, proportions in each are only 2–3% (Table 1.2).

Table 1.2
Ethnic composition of Merseyside population, by local authority

%	Halton	St. Helens	Knowsley	Liverpool	Sefton	Wirral	England
White	97.8	97.8	97.1	91.5	97.2	97.1	88.2
Mixed	0.8	0.7	1.1	2	0.8	0.9	1.7
Asian or Asian British	0.6	0.8	0.7	2.3	0.9	0.9	5.7
Black or Black British	0.3	0.3	0.5	1.9	0.4	0.4	2.8
Chinese or Other Ethnic Group	0.4	0.5	0.6	2.3	0.6	0.7	1.5
Total black & ethnic minority	2.1	2.3	2.9	8.5	2.7	2.9	11.7

Data source: neighbourhood.statistics.gov.uk

2. Protective factors, risk factors and populations at risk

There are factors that promote and protect mental health and wellbeing and factors that are associated with a risk of poor mental health. Protective (or resilience) factors and risk factors can be influenced by aspects of social identity, such as gender, ethnicity, sexual orientation, age and disability (Myers et al, 2005).

Protective factors have been summarised as follows:

> 1. Psycho-social, life and coping skills of individuals, e.g. increasing a sense of self-esteem and autonomy.

> 2. Social support as a buffer against adverse life events, e.g. self-help groups, someone to talk to.

> 3. Access to resources and services which protect mental well-being, e.g. increasing benefit uptake and increasing opportunities for physical, creative and learning activities.

> (Myers et al, 2005)

Risk factors will increase the likelihood of experiencing poor mental health and are linked with less favourable outcomes for those who have mental health problems. They have been summarised as follows:

> 1. The incidence or the impact of negative life events and experiences for individuals, e.g. abuse, relationship breakdown, long term illness or disability.

> 2. Social isolation and exclusion.

> 3. The impact of deprivation and structural inequalities in health.

> (Myers et al, 2005)

2.1 Protective factors for mental health

Other protective factors in communities include opportunities for individuals to develop coping skills such as an increased sense of self-esteem; and the existence of social support, such as. self-help groups or someone to talk to. Due to time limitations, these were not covered in the needs assessment.

Wellbeing

'Mental health' and 'mental wellbeing' are terms that have been used interchangeably (as mentioned in the 'Background' section above) (Coggins et al, 2007). Wellbeing has been defined as *'more than just happiness. As well as feeling satisfied and happy, wellbeing means developing as a person, being fulfilled and making a contribution to the community'* (New Economics Foundation 2006).

People with a mental illness may have an absence of mental health, but it is possible to have both mental ill-health and still have moderate or even flourishing levels of mental health and wellbeing. On the other hand, it is possible to be free from mental illness, but with low levels of mental health (Coggins et al, 2007).

Although there may be exceptions, on the whole, populations with high levels of wellbeing are more likely to be protected from mental illness than populations with low levels. An emphasis on measures to ensure the population maximises its mental health using a lifecourse approach, rather than focusing only on treating or preventing mental illness, will have the overall effect of reducing levels of mental illness amongst the population.

Five ways to wellbeing
The 2008 Foresight Report on Mental Capital and Wellbeing emphasised the importance of promoting positive mental health for the general population. It proposed that achieving a small change in the average level of wellbeing across the population would produce a large decrease in the percentage with mental disorder, and also in the percentage who have 'sub-clinical disorder' (those "languishing") (Government Office for Science, 2008).

The Foresight project commissioned work to identify the wellbeing equivalent of "five fruit and vegetables a day". Based on an extensive review of the evidence, they suggested steps for individual action. The *five ways to wellbeing* are:

- *Connect with people around you*
- *Be active: go for a walk; cycle; run; play a game*
- *Give/ do something nice for a friend or stranger*
- *Take notice – be aware of the world around you*
- *Keep learning – try something new*

Deacon et al (2010a) note that tackling behaviour change cannot be done in isolation from improving wellbeing. They recommend that the individual wellbeing messages such as 'Five ways to wellbeing' are used alongside other behaviour change programmes as, well as being considered in bespoke wellbeing programmes.

The first step in 'stepped care': A stepped care recovery model seeks to treat service users at the lowest appropriate service tier in the first instance, only 'stepping up' to intensive/specialist services as clinically required. It aims to provide the most effective but least intrusive treatment appropriate to an individual's needs (CPFT, 2008). Wellbeing services would be part of Step 1.

Targeting of resources

The Marmot Review (2010) noted that focusing solely on the most disadvantaged will not reduce health inequalities sufficiently, as it will only tackle a small part of the problem. Marmot recommended that to reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. Marmot called this proportionate universalism, where greater intensity of action is likely to be needed for those with greater social and economic disadvantage.

Thirty years of social science research has found that people in more equal societies live longer, a smaller proportion die in infancy and self-rated health is better. People in more equal societies are far less likely to experience mental illness (Wilkinson and Pickett, 2009).

North West Wellbeing Survey

The North West Mental Wellbeing Survey was undertaken in 2009 and has provided a better understanding about the positive wellbeing of people in the region, so that resources can be targeted more efficiently and effectively to improve the wellbeing of the population. The survey included a validated measure of mental wellbeing, providing a baseline at local level to support outcome based commissioning. It will assist in the identification of population groups with lower and higher levels of wellbeing (Deacon et al 2010a).

The North West Wellbeing survey results relating to Merseyside PCTs have been summarised here, with overall wellbeing scores for each PCT and selected data on gender, age, deprivation, ethnicity, physical activity and anxiety/depression. Results are from the North West survey report (Deacon et al, 2010a) and the separate individually commissioned PCT reports. Box 1 takes ethnicity as an example, showing the range of individual questions that make up an overall wellbeing score.

Further analysis of the survey has recently been undertaken by the North West Public Health Observatory, but there was not time to include results here:
(*see*: http://www.nwph.net/nwpho/Publications/Forms/AllItems.html).

Overall wellbeing

Measurements of wellbeing were carried out using the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS). The five Merseyside PCTs had large enough sample sizes to compare against each other (at least 500). Data was weighted by gender, age group, and deprivation level so that the sample survey in each PCT was representative of the PCT as a whole.

Each Merseyside PCT, with the exception of Halton & St.Helens, had lower mental wellbeing scores than the North West average. Liverpool had the lowest average mental wellbeing score (Figure 2.1) and the smallest proportion of the population reporting high levels of mental wellbeing (Figure 2.2).

Figure WB1

Mean mental wellbeing scores for Merseyside PCTs

data source: Deacon et al, 2010
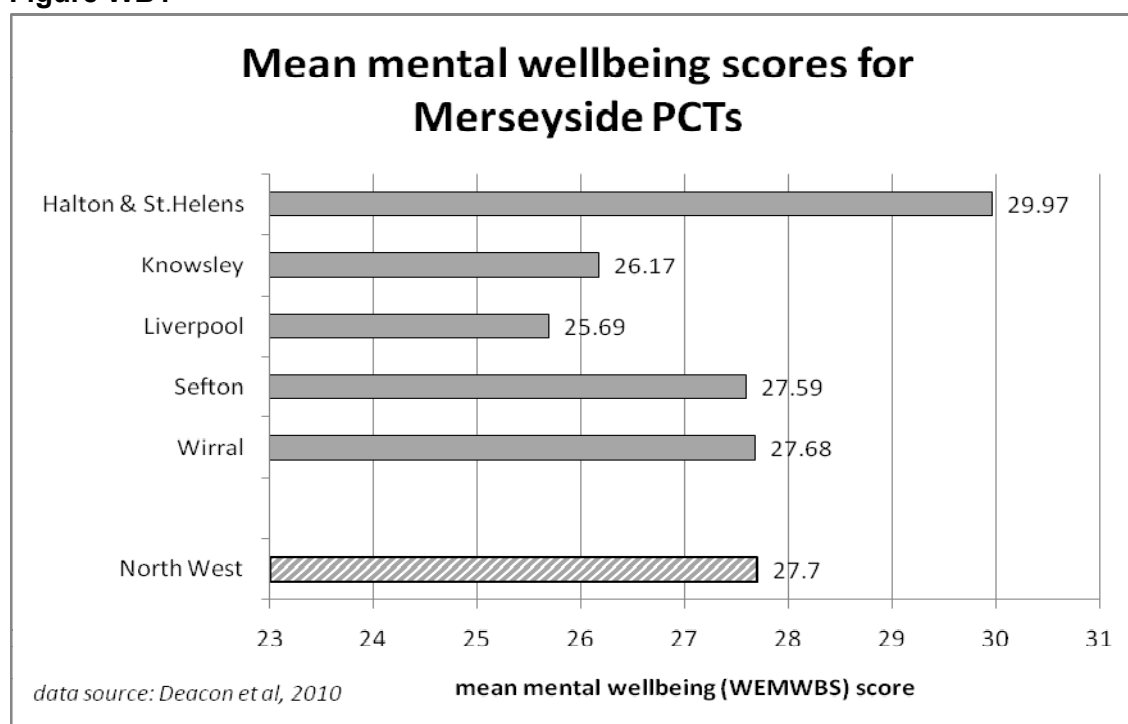
People in Liverpool were significantly more likely than people across the North West to have low mental wellbeing. Compared to the North West average of 16.8%, only Liverpool had a greater proportion reporting low levels of wellbeing – the remaining PCTs each had either the same or lower levels. Almost 1 in 3 (30.3%) Liverpool respondents reported low levels of mental wellbeing – the highest proportion amongst all North West PCTs. In contrast, in Halton & St. Helens, just over 1 in 3 reported high mental wellbeing (35.4%) (Figure 2.2). It is possible that high well-being scores could be a reflection of low expectations.

Figure 2.2

Level of mental wellbeing of respondents in Merseyside PCTs

data source: Deacon et al, 2010
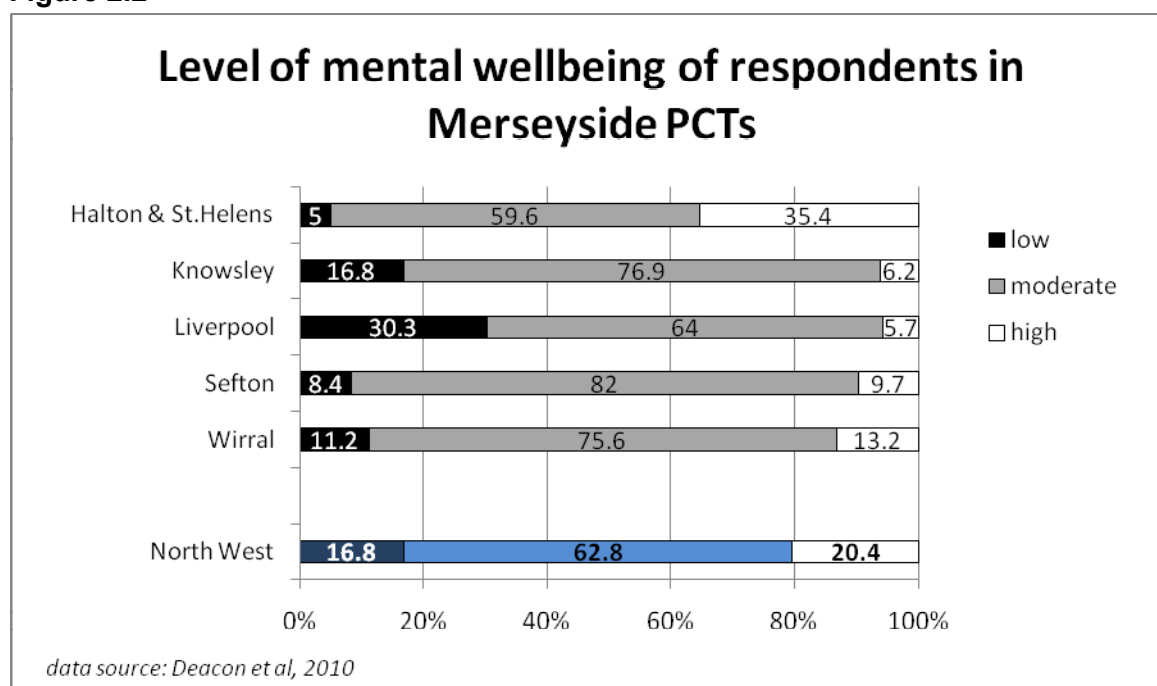
In Sefton, although the mean score was close to the North West average (Figure 2.1), significantly fewer people in Sefton than across the region had high and low levels of mental wellbeing, while significantly more had moderate levels (Figure 2.2) (Harrison et al, 2010a).

Gender & wellbeing
In Liverpool, Halton & St.Helens Knowsley and Wirral, there were no significant differences by gender.

In Sefton, men were significantly more likely than women to have a high level of mental wellbeing (Harrison et al, 2010a). In Knowsley, there was a slightly higher proportion of low mental wellbeing amongst males (20%) compared to females (15.5%) (Barker, 2010).

Age & wellbeing
The North West survey found a dip in levels of wellbeing around middle age (40-54 years) (Deacon et al, 2010a). Deacon et al found this trend to be supported by the wider literature and suggest further analysis to indicate where interventions could be targeted.

In each Merseyside PCT, there were no significant differences between the age groups in overall mental wellbeing. However, in Liverpool and Sefton, from age 25, the proportion of adults with high levels of mental wellbeing generally decreased as age increased. In Halton & St.Helens, it was reported that there did appear to be a dip in the proportion of people with high mental wellbeing between the ages of 40 and 54 years (Mason et al, 2011).

Looking at low mental wellbeing, in Wirral, people aged 55-64 years were the most likely to have low mental wellbeing when compared to other age groups (22.5%, although this proportion was only significantly higher than for those aged 16-24 years [3.0%]) (Harrison et al, 2010b).

Deprivation & wellbeing
The regional survey found that living in more deprived communities is strongly associated with lower levels of mental wellbeing. Poor mental wellbeing can be viewed as both a cause and consequence of inequalities. Disadvantaged communities not only receive less economic wealth but they also live in environments which reduce their wellbeing further. Living in an unsafe or deprived area is detrimental to life satisfaction and mental health (quoted in Deacon et al, 2010a).

Adults living in the most deprived areas were most likely to have low mental wellbeing (20.2%), while adults living in the least deprived areas were least likely to (11.4%).

In the regional North West report and subsequent supplements, there was no more detail about deprivation by PCT. The Wirral and Knowsley survey reports explored further the links with deprivation. In Wirral, those from the most deprived areas were significantly more likely to have low mental wellbeing (15.4%) than people from Wirral's second most deprived areas (7.9%) (Harrison et al, 2010b).

In Knowsley, people from the most deprived and third most deprived areas were more likely to have low mental wellbeing scores (both around 20%) (Barker, 2010).

Ethnicity & wellbeing
Across the Region, non-White adults were significantly more likely to have above average mental wellbeing (26.5% compared to 20% amongst White adults). Knowsley PCT carried out further analysis of results. They found that amongst non-White people in Knowsley, there was a higher proportion of 'high' mental wellbeing. The non-white group attained a higher mean WEMWBS score than the white group, (28.33 compared to 26.12, respectively). Due to sample size limitations it was not possible to undertake analysis of specific questions by ethnic category (Barker, 2010).

Box 1 shows the scores relating to ethnicity for the individual questions that made up the overall wellbeing scores. It was noted that comparisons between White and non- White groups need further analysis by geographical area, given potential variations between ethnic groups that make up the non-White category (Deacon et al, 2010a).

A recent supplement to the North West Wellbeing Survey has examined further the factors relating to wellbeing and ethnicity (Knuckey et al, 2011).

Other protected characteristics
Apart from age, sex and ethnic group, there was no detailed analysis by other protected characteristics as listed in the Equality Act 2010. 'Protected characteristics' or groups are those against which the Act prohibits discrimination; they are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation (DH 2011b).

Mental wellbeing data on the protected groups needs to be more robust to allow effective analysis. As services respond to the requirements of the Equality Act more accurate information on the wellbeing of these groups should become available

Anxiety/depression & wellbeing
People with low mental wellbeing were more than three times as likely as those with higher levels of mental wellbeing to be moderately anxious or depressed, and were significantly more likely to feel extremely anxious or depressed than those with average or high levels of mental wellbeing. However, six out of ten people with low mental wellbeing said that they were not anxious or depressed. Anxiety and depression were more common in women than men, among people aged 40-54 years, and among White adults. Anxiety and depression also increased as deprivation increased. People aged 16-24 years were most likely to say that they were not anxious or depressed (Deacon et al, 2010a).

Levels of anxiety and depression in PCTs
Table 2.1 shows levels of anxiety and depression in each PCT, as reported in the wellbeing survey. Across the North West, 15% of respondents reported moderate anxiety or depression. This is just slightly less than the prevalence of common mental disorder of 16.2% reported in the recent National Morbidity Survey (McManus et al, 2009 and see Table 3.1 in Section 3).

Levels of reported moderate and extreme anxiety and depression were higher than the North West average in Liverpool, Halton and St.Helens and in Wirral. In Liverpool, levels of moderate anxiety and depression were higher than in the other Merseyside PCTs, with 1 in 5

(20.4%) reporting that they were moderately anxious or depressed, compared to only 6% in Knowsley. Levels of extreme anxiety and depression were highest in Halton and St.Helens, at 6.3% of respondents, compared with less than 1% in Knowsley.

Table 2.1
North West Wellbeing Survey – Levels of anxiety and depression
in Merseyside PCTs, 2009.

	% Moderately anxious or depressed	% Extremely anxious or depressed
Halton & St.Helens	18.1	6.3
Knowsley	6	<1
Liverpool	20.4	5.7
Sefton	7.8	2.5
Wirral	17.8	4.9
North West	15	3.5

Data source: PCT wellbeing survey reports

Links between anxiety and wellbeing in PCTs
In Halton and St.Helens, adults with a below average level of mental wellbeing were over twice as likely as those with average levels and twelve times as likely as those with above average mental wellbeing to report being moderately anxious or depressed (54.5% compared with 22.8% and 4.4% respectively), and these differences were significant (Mason et al, 2011).

In Knowsley, those with high levels of mental wellbeing were more likely to report not being anxious or depressed. Anxiety and depression were more common in females and in the older age groups (65+ years) (Barker, 2010).

Adults in Liverpool with below average levels of mental wellbeing were twice as likely to say they were moderately anxious or depressed when compared to people with average mental wellbeing (32.2% compared with 16.0%, a significant difference) (Deacon et al, 2010b).

Similarly in Sefton, people with below average mental wellbeing were significantly more likely than those with average mental wellbeing to say they were moderately anxious or depressed (22.5% compared with 6.5%) (Harrison et al, 2010a).

In Wirral, those with below average levels of mental wellbeing were significantly more likely to feel extremely anxious or depressed (23.2%) than those than those with average (2.1%) and above average (3.1%) levels of mental wellbeing (Harrison et al, 2010b).

Physical activity
The Government's physical activity guideline recommends 30 minutes of moderate activity on five days a week. The wellbeing survey found that the across the North West, the likelihood of meeting recommended activity levels significantly increased as mental

wellbeing increased. Of those with an above average level of mental wellbeing, 44.9% were meeting the physical activity target, compared to only 19.1% of those with a below average level of mental wellbeing (Deacon et al, 2010a). At individual PCT level, there were no such significant differences in Wirral or Knowsley.

Box 1
Example of breakdown of wellbeing in the North West: ethnic group

Non-White adults were significantly more likely to say they feared personal attack (3.7%) or burglary (3.2%) compared with White adults (1.0% and 0.7% respectively).

The proportion of non-White adults who felt able to ask for help if in financial difficulty was significantly higher (80.1%) than the proportion of White adults (74.7%).

White adults were significantly more likely to have some problems walking about (19.8%) compared with non-White adults (11.4%).

Non-White adults were significantly more likely to have no pain or discomfort (77.7%) compared with White adults (69.1%).

White adults were more likely to report feeling moderately (15.0%) and extremely (3.7%) anxious or depressed than non-White adults (12.7% and 1.8% respectively).

There were differences between ethnic groups relating to numbers experiencing various significant life events in the last 12 months.

Non-White adults were significantly less likely (18.0%) to be meeting the physical activity target than White adults (31.3%).

White adults were significantly less likely to spend 2 hours or less on a typical day sitting or reclining (22.0%) compared with non-White adults (24.3%) and were significantly more likely to be sedentary for 8 hours or more (7.2%).

White individuals were significantly more likely (63.7%) than non-White individuals (39.0%) to have lived in their local area for 10 years or more.

Non-White individuals were significantly more likely (10.8%) than White individuals (8.4%) to live in supported housing.

Non-White adults were significantly more likely than White adults to live in employed status households (77.5% compared with 57.5%), and were more than twice as likely as White adults to be living in full-time education status households (4.5% compared with 1.2%). White adults were more than four times as likely as non-White adults to live in retired status households (27.0% compared with 5.9%) and were also significantly more likely to live in households which were classified as inactive due to sickness (2.5% compared with 1.6%).

Non-White adults were significantly more likely to live in multi adult and small or large family households compared with White individuals.

Deacon et al, 2010a

Employment

Work can have both positive and negative effects on mental health and well-being. The North West Wellbeing survey found that adults with higher mental wellbeing were significantly more likely to be in full time or part time work than those with lower levels of mental wellbeing (see section 2.1 above) (Deacon et al, 2010a). Work has a key effect on resilience. It is an important determinant of self-esteem and identity and can provide a sense of fulfilment and opportunities for social interaction. For most people, work provides their main source of income (NICE, 2009).

Work can also have negative effects on mental health, particularly in the form of stress. NICE note that mental wellbeing at work is determined by the interaction between the working environment, the nature of the work and the individual. The NICE guidance *'Promoting mental wellbeing at work'* focuses on interventions to promote mental wellbeing through productive and healthy working conditions. The five NICE recommendations cover: strategy; assessing opportunities for promoting mental wellbeing and managing risk; flexible working; the role of line managers; and supporting micro, small and medium-sized businesses. The NICE guidance could be used as a basis for training in local businesses about mental wellbeing.

On balance, any adverse effects of work on mental health appear to be outweighed by the beneficial effects of work on well-being and by the likely adverse effects of (long-term) sickness absence or unemployment (Waddell and Burton, 2006). Waddell and Burton reviewed the scientific evidence on the relationship of work and health. They concluded that the general consensus of research is that work is important in promoting mental health and recovery from mental health problems and that loss of a job is detrimental to mental health.

Unemployment is covered in section 2.2 below.

Employment amongst those receiving secondary mental health services

Amongst those receiving secondary mental health services in Merseyside PCTs, the distribution of those in settled employment is very similar to that of settled accommodation, with higher levels in Halton & St.Helens, Knowsley and Wirral (Figure 2.3). Levels in Halton & St.Helens and Knowsley are higher than the North West average. As shown in Figure 3.3 (in prevalence section), Halton also has the second lowest rate of incapacity benefit claimants for mental illness on Merseyside (although still higher than the national average).

The proportions of those in settled employment in Liverpool are the lowest on Merseyside (Figure 2.3). Liverpool also has the highest rate of those on incapacity benefit for mental illness (see Figure 3.3 in prevalence section).

Figure 2.3

Of those receiving secondary mental health services,
% in settled employment, 2009/10

PCT
Halton & St.Helens 10.6
Knowsley 8.2
Liverpool 1.6
Sefton 1.7
Wirral 6
England 7.9

0   5   10   15

%

Data source: Health & Social Care Information Centre,
Mental Health Minimum Dataset
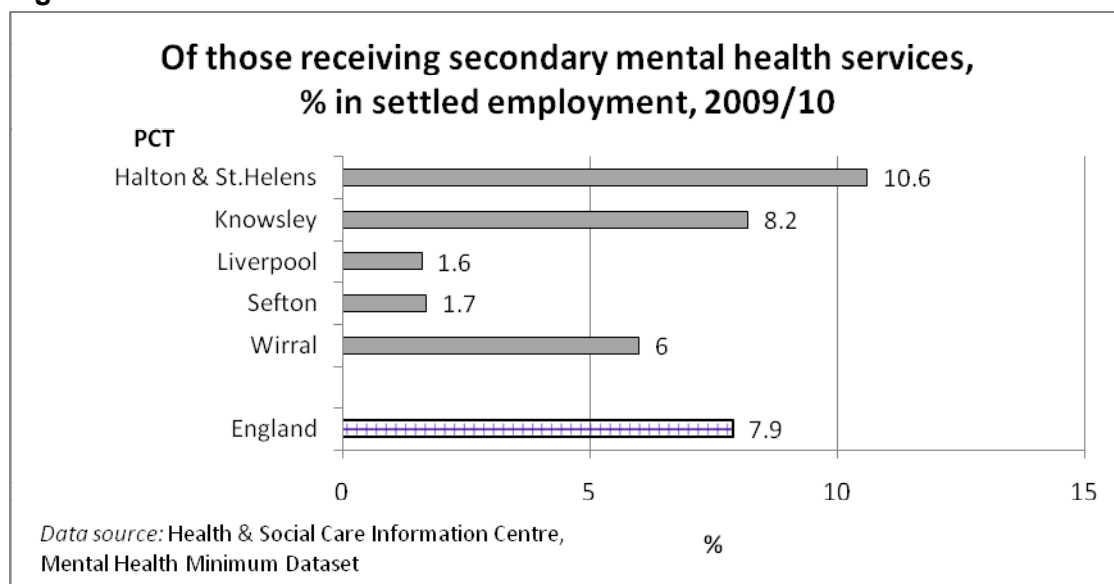
Note: NI150 Refers to those aged 18 to 69 who are receiving secondary mental health services, who are on the Care Programme Approach and have an employment status recorded as 'Employed'. Employed refers to those who are either employed for a company or self-employed. It should also include those who are in supported employment (including government-supported training and employment programmes), those in permitted work (i.e. those who are in paid work and also receiving Incapacity Benefit) and those who are unpaid family workers (i.e. those who do unpaid work for business they own or for a business a relative owns).
http://www.ic.nhs.uk/webfiles/publications/009_Social_Care/socmhi09-
10/Mental_Health_Indicators_NI_149_and_NI_150_PCT_2009-10.xls
(Note – since this report was produced, the APHO profiles for 2011 have been released. All profile data in this report is based on 2010 data)

A recent supplement to the North West Wellbeing Survey analyses the relationship between mental wellbeing and employment and resilience in more detail (Carlin et al, 2011).

Recommendations:
In a Scottish resource document on mental health and inequalities, Myers et al (2005) argue for a focus on mental health in areas of public policy that relate to employment and employability. For those with mental health problems, there are large human and financial costs in economic inactivity.

To improve population mental health, investment is required in employment opportunities and workplace pay and conditions. To promote and protect mental health, the following measures are recommended:

- Enhance job satisfaction and job control
- Support re-entry into the labour market for those who are unemployed
- Promote job retention to minimise absence and job loss through ill-health
- Support efforts to improve pay, working conditions and job security, notably for the most vulnerable workers
- Make the business case for improving job control, social support and effort/reward imbalance

- Early referral to workplace based support for employees experiencing psychiatric symptoms or personal crises to avert employment breakdown

(Myers et al, 2005 and Liverpool PCT, 2009b)

Education

In a lifecourse approach, the impact of education is crucial, with huge implications for future health, economics and employment. It has been noted that the significant effects of education on several health outcomes have been estimated in academic literature, but that mental health has mostly been ignored (Chevalier and Feinstein, 2006). Research carried out by Chevalier and Feinstein concluded that there are substantial returns to education in term of improved mental health. The positive impact of qualifications on mental health is biggest for individuals who gain GCSEs, for example, having GCSEs reduces the risk of depression at the age of 42 by five percentage points.

Education can directly affect health outcomes by making individuals more health conscious, by shortening time before help is sought or by following the therapy more accurately. The authors note that the effect of education on health may also be indirect through income, employment, working conditions or family relations (Chevalier and Feinstein, 2006).

The North West Wellbeing survey found that people with low levels of mental wellbeing were more likely to have no qualifications than those with high mental wellbeing. Those with low mental wellbeing were far less likely to have qualifications at degree level (Deacon et al, 2010a).

The National Psychiatric Morbidity Survey found that, compared to those with no disorder, those with neurotic or psychotic disorders were more likely to have no formal educational qualifications (Singleton et al, 2001).

Figure 2.4 shows that across Merseyside, significantly more children in Sefton and Wirral have 5 or more GCSEs when compared to the average for England of 1 in 2 (50.9%). Levels in Halton, St.Helens, Knowsley and Liverpool were significantly below the national average – especially in Knowsley, where only 1 in 3 (33.5%) of children at key stage 3 have 5 or more GCSEs.

Figure2.4

5 GCSE grades, 2008/09
(A*-C, including English & Maths)

LA

Halton — 44.6 (n=687)
St.Helens — 47.4 (n=1023)
Knowsley — 33.5 (n=551)
Liverpool — 44.3 (n=2371)
Sefton — 53.2 (n=1882)
Wirral — 53.8 (n=2151)

England — 50.9

% with 5 GCSEs at key stage 4, 2008/09

black = significantly worse than England average
white = significantly better than England average

data source: APHO health profiles 2010
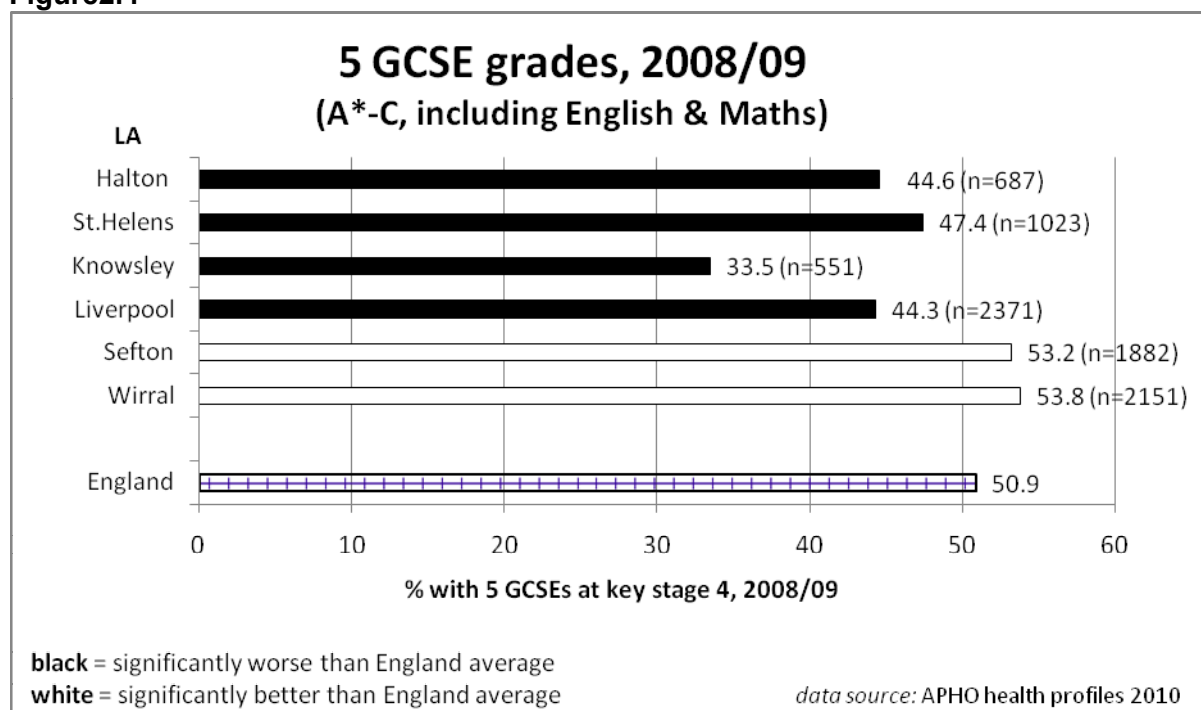
The Marmot Review Team selected a small set of key indicators of the social determinants of health, health outcomes and social inequality (LHO, 2011). One of these is the number of young people who are not in employment, education and training, or 'NEET'. Across Merseyside, all local authorities, with the exception of Sefton, have significantly more young people who are NEET than the England average. In Liverpool and Knowsley, more than 1 in 4 young people are NEET (Figure 2.5).

Figure 2.5

% Young people aged 16-19 not in employment,
education or training (NEET) 2009/10

Halton — 11.4
St. Helens — 8.1
Knowsley — 28.2
Liverpool — 29.2
Sefton — 7.2
Wirral — 9.6
NW — 7.8
England — 7

%

black=significantly more than England average

data source: LHO Marmot Indicators
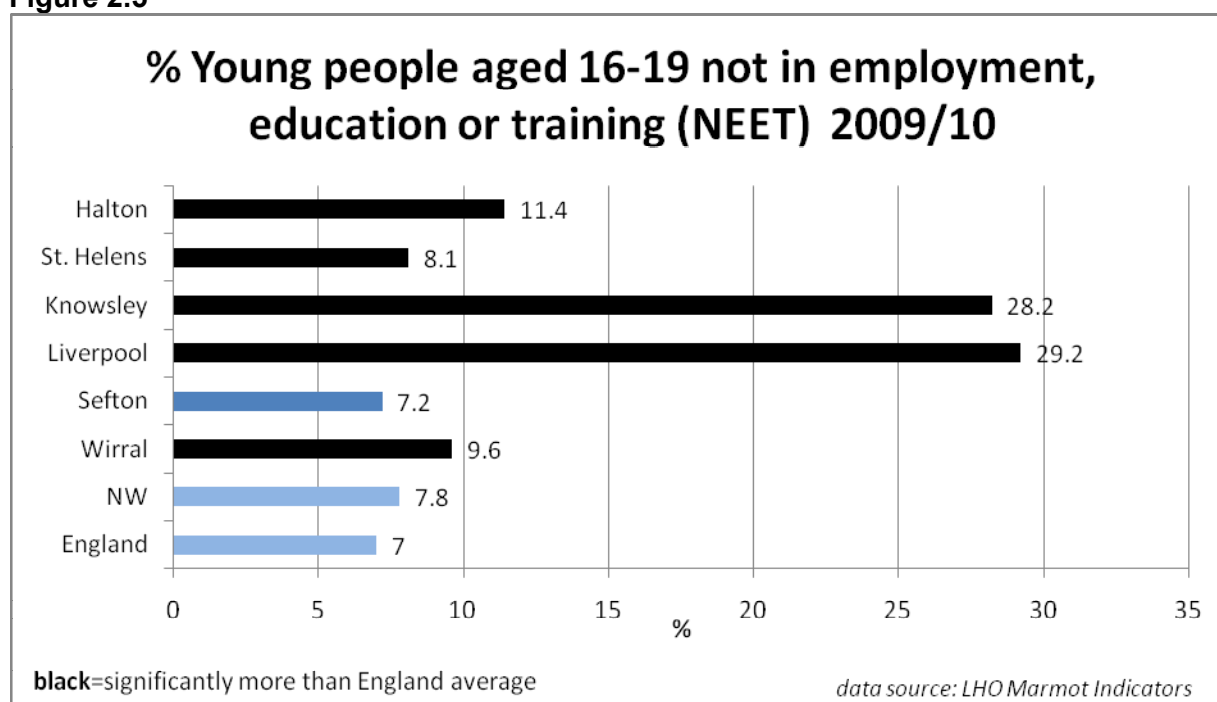
Recommendations:
- Maximise educational attainment, recognising that this is a protective factor for mental health.
- Ensure that educational establishments are in a position to influence mental health awareness in early years/education so that young people have the tools to self manage common mental health problems. Mental health agencies need to work with partners in education to include mental health awareness in the school curriculum.

Physical activity

The Mental Health Foundation note that exercise has been shown to improve the mental and physical health of people with a range of mental health problems, including psychotic disorders, depression and anxiety. Taking part in social activities, sport and exercise is associated with higher levels of life satisfaction (Mental Health Foundation, 2007). This is supported by the results of the North West Well Being survey. The Government's physical activity guideline recommends 30 minutes of moderate activity on five days a week. The wellbeing survey found that the across the North West, the likelihood of meeting recommended activity levels significantly increased as mental wellbeing increased (see 'wellbeing' above).

A modelled estimate based on Health Survey for England showed that in Merseyside, each local authority has levels of physical activity below the national average of just over 11%, although none were significantly lower (Figure 2.6). The highest levels were found in Halton (10.7%), and the lowest levels in Knowsley and St.Helens. The North West Wellbeing Survey gave percentages meeting the physical activity target and showed that Knowsley and Wirral had levels higher than the North West average. Their survey was based on a sample of around 500 in each PCT (Deacon et al 2010a).

Figure 2.6
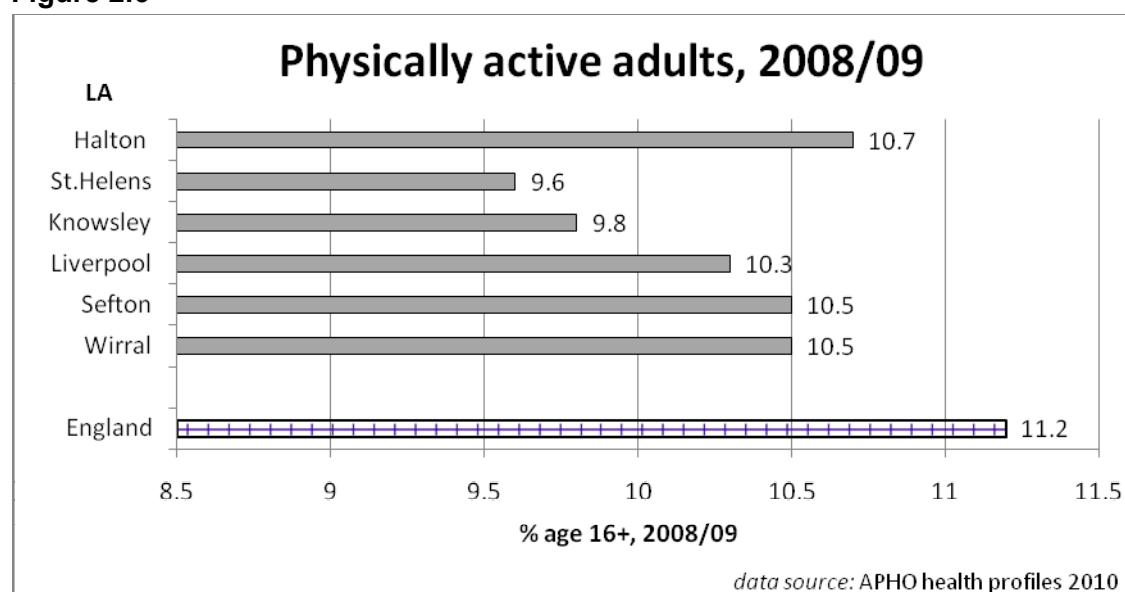
Modelled estimate based on Health Survey for England 2006-08 (with a sample of 14,400 households)   http://www.ic.nhs.uk/webfiles/publications/HSE06/HSE06_Summary.pdf

Access to green spaces

The importance of access to green space to mental health is becoming more widely recognised. Sefton's Green Space Strategy and Liverpool's Green Infrastructure Strategy aim to improve access to and quality of green space, recognising the positive effect this can have on mental health (Sefton Council, 2009, Liverpool City Council, 2010).

The Liverpool Green Infrastructure Technical Report presents the evidence for the links between green space and mental health, including:
- Access to and use of green spaces can have a positive effect on mental wellbeing and cognitive function
- Views of the natural environment have been found to have a positive effect on stress levels, promoting a reduction in blood pressure and possibly encouraging faster healing in patients following postsurgical intervention
- Using green space leads to greater social contact and community cohesion

(evidence presented in 'Liverpool City Council, 2010')

The Liverpool report found that green infrastructure is not equally distributed across the city, with 22% of the areas having 80% of the total accessible green infrastructure. Some areas have no accessible green infrastructure. The most affluent areas of the city have 18% more green infrastructure than the most deprived. Low levels of green infrastructure occur in areas of the city with a higher incidence of coronary heart disease, poor mental health and poor air quality.

The Liverpool report included a graph showing the relationship between the percentage of accessible green infrastructure and the level of hospitalised mental health (Figure 2.7). There were lower levels of hospital admission in areas with a high percentage of green space. However, this relationship is complicated by other factors that determine mental health, such as deprivation and the fact that there will be more people in areas with less green space.

The report also presented a map of Liverpool, showing where green infrastructure is lowest and the incidence of mental health hospital admissions is highest. The aim was to identify areas to focus activity, although it was recognised that a general city-wide improvement will support an overall improvement in community mental health.

Recommendations
- Increase multi-agency working, recognising the important effects that planning decisions in the design of neighbourhoods and green space initiatives can have on mental health.

- Carry out mapping throughout Merseyside to identify wards/super output areas where green infrastructure is lowest and the incidence of mental health hospital admissions is highest.

- Increase green infrastructure in areas of high levels of mental illness but low levels of green infrastructure.

- Provide opportunities for walkable communities, encouraging communities to be more active.

Figure 2.7
Hospitalised prevalence of mental health conditions and percentage green infrastructure cover in Liverpool
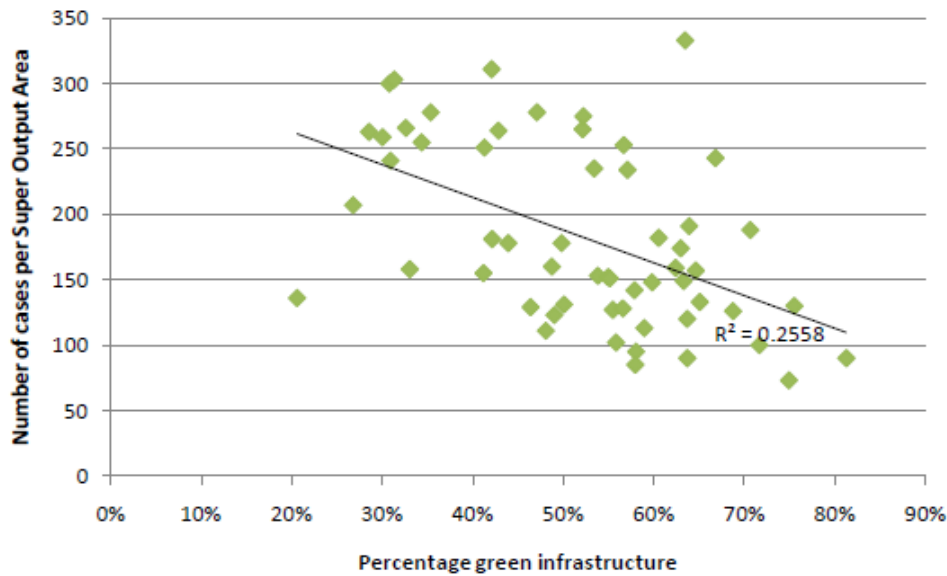
Source: Liverpool City Council, 2010

Settled accommodation
for those receiving secondary mental health services

Figure 2.8 shows the proportions of those receiving secondary mental health services who are in settled accommodation. In Halton & St.Helens, Wirral and Knowsley, proportions are higher than the national average of 59.1%. In Halton & St.Helens, more than three-quarters of people receiving such care are in settled accommodation. This contrasts with Sefton, where only around 1 in 10 are settled, and Liverpool, where the proportion is 1 in 5.

The differences could be partly explained by discrepancies in data collection between different trusts. The two PCTs with the lowest levels of settled accommodation are those served by Merseycare NHS Trust alone. Knowsley is served by 5 Boroughs Trust as well as Merseycare; Halton & St.Helens by 5 Boroughs; and Wirral by Cheshire and Wirral NHS Trust. NHS

Wirral recently did a data check and found the employment field was being missed by care co-ordinators. Following a check of all notes the number in employment improved significantly

Figure 2.8

Of those receiving secondary mental health services, % in settled accomodation, 2009/10

data source: Health & Social Care Information Centre, Mental Health Minimum Dataset
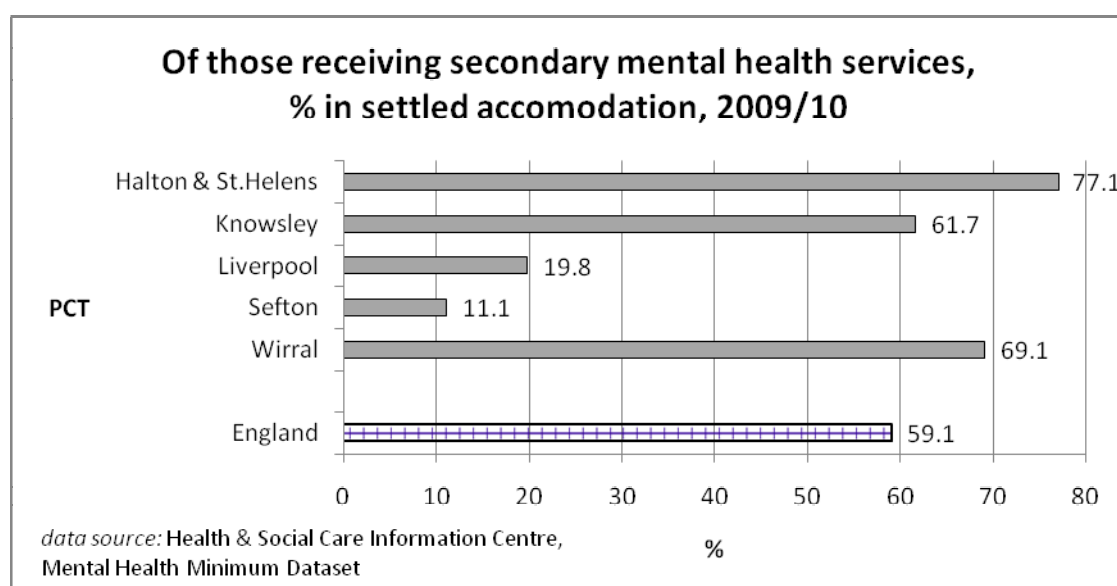
Note: NI149 Refers to those aged 18 to 69 who are receiving secondary mental health services, who are on the Care Programme Approach and have a settled accommodation indicator recorded as 'Settled'. Settled Accommodation is defined as secure, medium to long term accommodation where the occupier, or head of household, has security of tenure / residence in their usual accommodation.
http://www.ic.nhs.uk/webfiles/publications/009_Social_Care/socmhi09-10/Mental_Health_Indicators_NI_149_and_NI_150_PCT_2009-10.xls

Protective factors not covered: Other protective factors in communities include opportunities for individuals to develop coping skills such as an increased sense of self-esteem; and the existence of social support, such as. self-help groups or someone to talk to (Myers et al, 2005). Due to time limitations, these were not covered in the needs assessment.

2.2 Risk factors for mental health

Deprivation

As mentioned in section 2.1 above, the North West Wellbeing survey found that living in more deprived communities is strongly associated with lower levels of mental wellbeing (Deacon et al, 2010a). There has been much written about the links between mental health and social deprivation, with theories of downward drift or alternatively social causation being put forward as explanations (Moser 2001; Wilkinson and Marmot, 2003; Pickett and Wilkinson, 2006).

The poorest fifth of adults are at double the risk of experiencing a mental health problem as those on average incomes (Mental Health Foundation, 2007). The 2007 Psychiatric Morbidity Survey (McManus et al, 2009) found that, for common mental disorders, this pattern is more marked for men than women. Men in the lowest household income group

were three times more likely to have a common mental disorder than those in the highest income households (23.5% and 8.8% respectively).

The existence of a current post traumatic stress disorder (PTSD) was found to be around three times more likely in lowest income households (6.2% of men and 4.1% of women) compared to those in the highest income quintile (2% of men and 1.7% of women) (McManus et al, 2009).

For psychotic disorders, the differences between the income groups are even more significant, with a 0.9% prevalence rate amongst those with the lowest incomes, compared to 0.1% amongst those in the highest income group (McManus et al, 2009). The trend was more prominent amongst men than women.

In areas defined as 'deprived', it has been found that admission rates to psychiatric hospitals are up to three times higher than the national average (Hatloy 2002, Harwood and Nzuobontane 2002). The associations are complex. High admission rates may indicate high overall levels of need. They may also suggest a lack of capacity in primary and community based mental health services to manage and contain mental health problems in the community. They may also be related to ease of access to services, and to variations in the diagnosis of mental illness (Pidd and Newbigging 2002). Soomro suggested the importance of variations in clinical practice (Soomro et al 2002). Ostler et al (2001) noted that it seems there may be an effect of living in a deprived area that may have an influence over and above that of individual deprivation. There is also the possibility that simply being aware of income inequalities may have adverse consequences for mental health (Weich et al 1998).

Merseyside
The 2008 Mental Health Equity Profile for Mersey Care NHS Trust looked at the associations between various mental health indicators and deprivation. There were significant positive correlations between deprivation and all but two of the twelve indicators, with high levels of deprivation associated with high rates. Correlations were especially strong with hospitalised mental health conditions (r=0.99, p<0.01 in Kirkby), hospitalised self-harm (r=0.94, p<0.0001 in Sefton), A&E attendances for self-harm (r=0.86, p<0.01, Sefton and Kirkby) and non-attendance at outpatients (r=0.73, p<0.01) (Ubido and Lewis, 2008).

Similarly, the NWPHO report on inequalities in the north-west (NWPHO, 2006) found strong links between deprivation and hospital rates of admission for mental health problems. The prevalence rate was 2.75 times higher for the most deprived quintile of the population in the North West region than that for the most affluent.

There was a similar pattern with hospitalised self-harm incidence rates, where the rate of admissions for the most deprived quintile of the population was 3.4 times that for the least deprived quintile.

All the local authorities in Merseyside have deprivation levels significantly above the national average (Figure 2.9). In Halton, they are more than twice as high, and in Liverpool and Knowsley, more than three times as high.

Figure 2.9
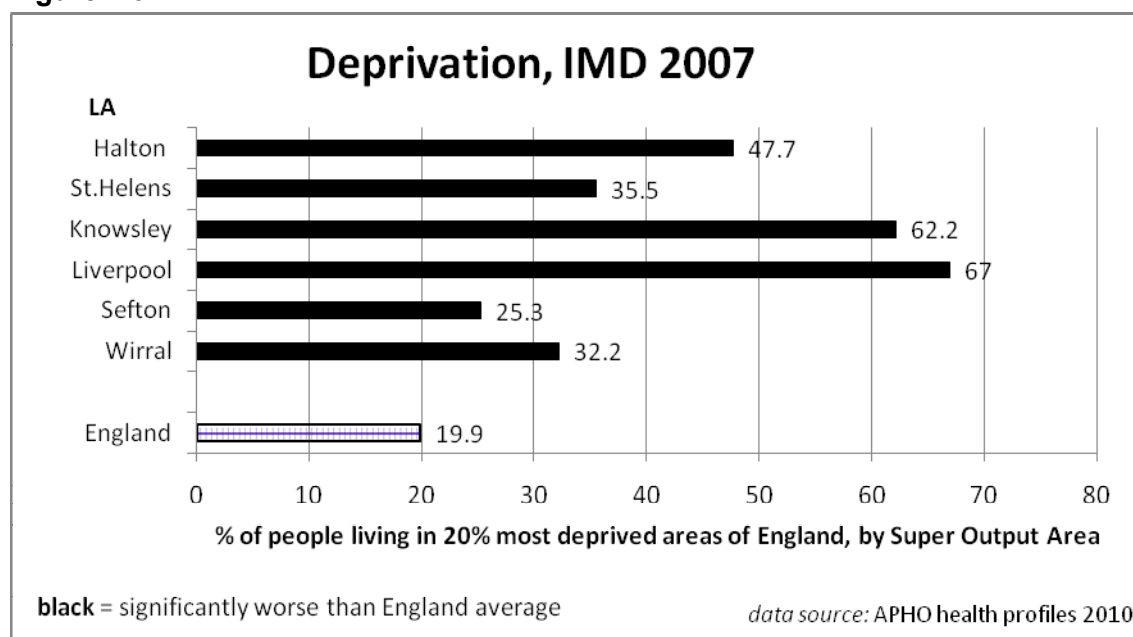
Map 1 in Appendix 1 shows deprivation levels by lower layer super output area in Merseyside, with ward boundaries overlaid. The 2010 index of multiple deprivation scores have been sorted into quintiles[1]. In Liverpool, there are several wards across the north, plus Speke-Garston in the south, with deprivation levels in the top fifth on Merseyside. Levels are also high in the north of Knowsley, south west Sefton, central Halton and mid-east Wirral. In St.Helens, there are only 2 wards in the centre of the borough with areas of high deprivation. There are large areas in Wirral, Sefton and St.Helens with very low levels of deprivation.

Map 2 in Appendix 1 shows the proportion of households in fuel poverty by lower layer super output area. Patterns are similar to those of deprivation. There are some exceptions, including Cambridge ward in Sefton, Northwood and Kirkby central in Knowsley, Bold in St.Helens and especially Clatterbridge in Wirral, where there are higher levels of fuel poverty in relation to deprivation levels. It is possible that there may be more elderly people in these areas, which could explain the differences.

Map 3 in the Appendix shows general levels of poverty by mid-layer super output area. Patterns are similar to those for deprivation, with one of the main differences being that a larger part of the north of Knowsley has levels in the top fifth for Merseyside.

---

[1] *The index of multiple deprivation (IMD) was devised specifically to indicate deprivation at a small geographical level. It comprises 7 separate domains of deprivation, based on 38 indicators. Most of the indicators can be updated regularly, for example 'unemployment claimant counts', so forming a dynamic index. The 7 domains are: Income, Employment, Health and Disability, Education Skills and Training, Barriers to Housing and Other Services, Crime and Living Environment (Communities and Local Government, 2011)*

Social stratification:

Geodemographic classification systems aim to classify small geographic areas according to the 'type' of people who live there, or to classify people according to the type of neighbourhood in which they live. Evaluations have shown that the type of neighbourhood can be a better predictor of certain behaviours than any personal or household level indicator such as income, social class, or age (Dedman et al, 2006). As with analysis of other social factors, this kind of analysis can be used to identify small areas within a given Local Authority that are likely to experience particular health problems, and may therefore be targeted by intervention programmes (Dedman et al, 2006).

The NWPHO report on inequalities in the north-west used the 'People and Places' geodemographic lifestyle groupings to examine relationships between 'wealth and health' (NWPHO, 2006). More details on the construction of these groupings can be found in Appendix 2 of the NWPHO report. For the report, the 'People and Places' categories were re-ordered by a national poverty index based on the IMD 2004 income domain score, as shown in Table 2.2.

Table 2.2
People and Places categories, ordered by poverty index

People & Places Code	People & Places Classification	Poverty (National)
A	Mature Oaks	3.80%
C	Blossoming Families	4.60%
B	Country Orchards	5.30%
D	Rooted Households	6.70%
F	Senior Neighbourhoods	8.10%
E	Qualified Metropolitans	9.30%
G	Suburban Stability	12.30%
H	New Starters	19.10%
J	Urban Producers	23.70%
K	Weathered Communities	26.30%
I	Multicultural Centres	34.80%
L	Disadvantaged Households	42.00%
M	Urban Challenge	45.00%
U	Unclassified	16.90%

(source: NWPHO, 2006)

Map L shows the distribution of lifestyle groups in Merseyside. The most deprived group is the 'urban challenged', found in the centre of Liverpool and also on the Runcorn side of Halton. The most affluent 'mature oaks' are found mostly in West Wirral, just below the north end of Sefton, to the north of St.Helens and the south east of Knowsley.

Map L
Geodemographic classifications for Merseyside.
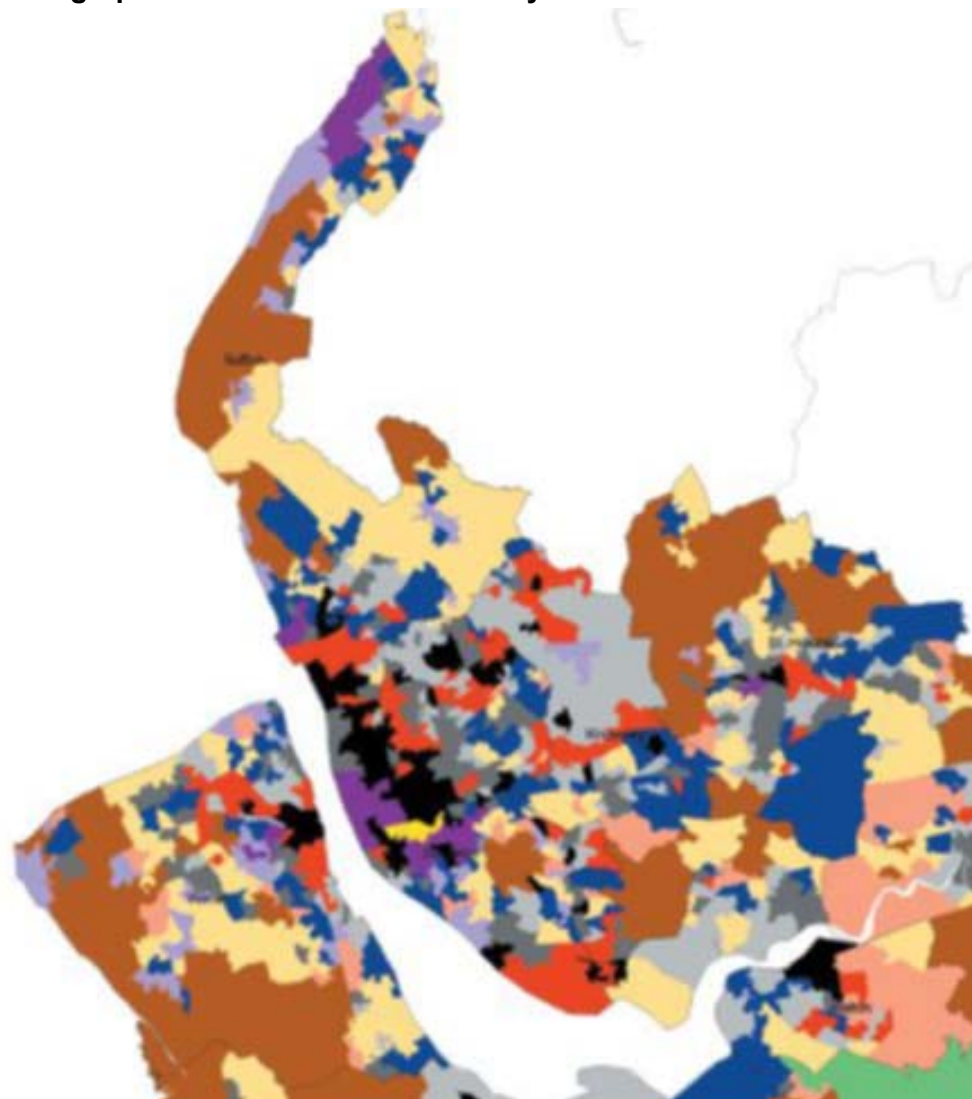
Geodemographics (People & Places)
Percentage of population within group

- mature oaks (12.7%)
- country orchards (6.5%)
- blossoming families (8.3%)
- rooted households (13%)
- qualified metropolitans (5%)
- senior neighbourhoods (5.2%)
- suburban stability (12.4%)
- new starters (4.6%)
- multicultural centres (6.4%)
- urban producers (9.4%)
- weathered communities (6.1%)
- disadvantaged households (6.4%)
- urban challenge (2.9%)
- unclassified (1.3%)

Source: NWPHO, 2006

The links between lifestyle and mental health were explored in the NWPHO report. On the whole, there were higher levels of hospital admissions for mental health in the least affluent areas (Figure 2.10). The exception was the 'New Starters' grouping, where there were higher levels of mental illness prevalence than other similar lifestyle groupings.

A similar relationship is seen for self-harm incidence levels (Figure 2.11), although 'Qualified Metropolitans' and 'Multicultural Centres' lifestyle groups show lower levels of admission than neighbouring groups.

More details on the hospitalised prevalence of mental health and on hospital incidence of self harm can be found in Section 3.2 below.

Figure 2.10
Hospitalised Prevalence for Mental Health Conditions by Geodemographic Lifestyle Group
North West residents: HES 1998-2002 (NWPHO, 2006)
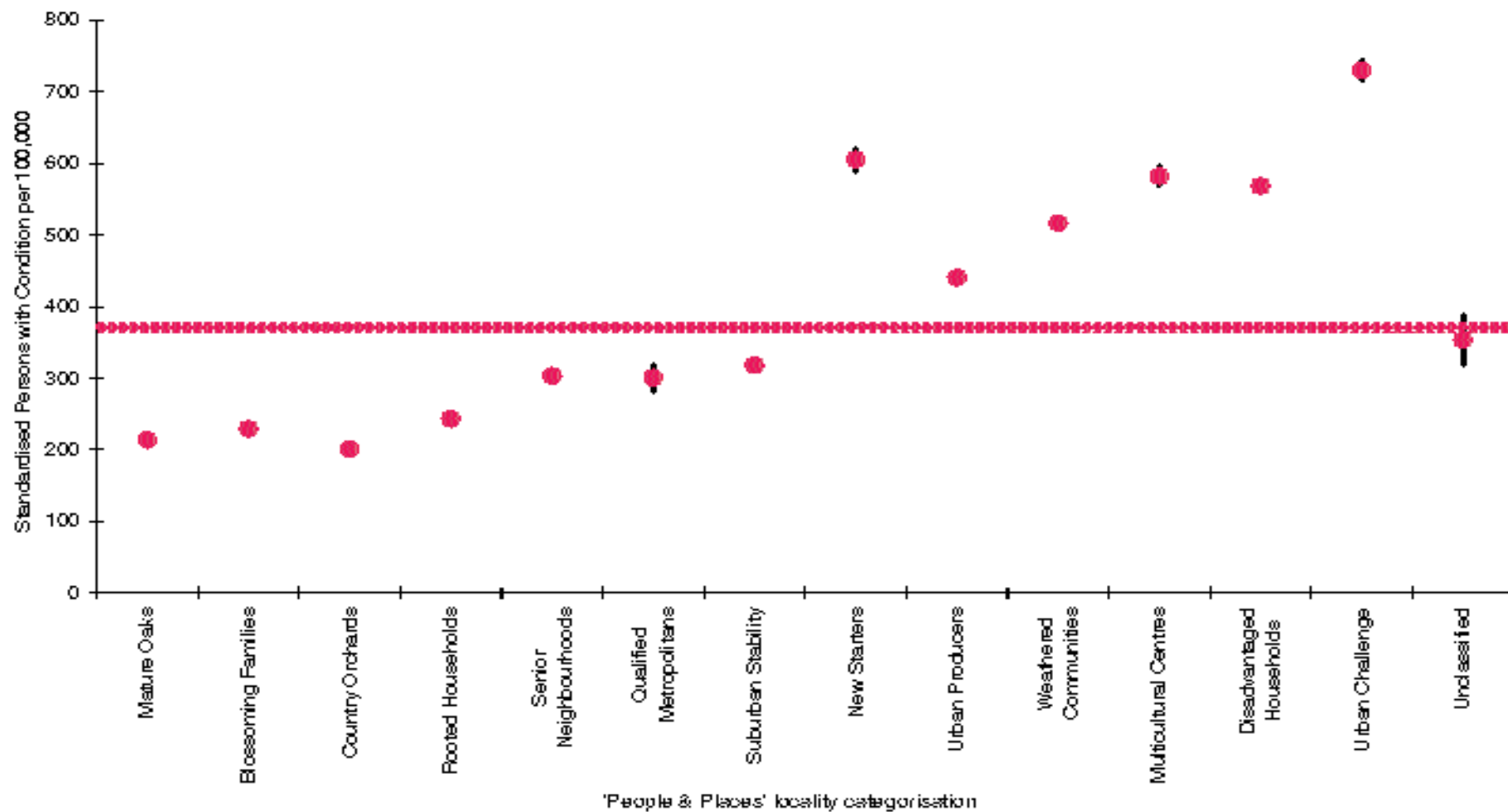
Reproduced from NWPHO, 2006

Figure 2.11
Hospitalised Emergency Incidence for Self Harm by Geodemographic Lifestyle Group
North West residents: HES 1998-2002 (NWPHO, 2006)
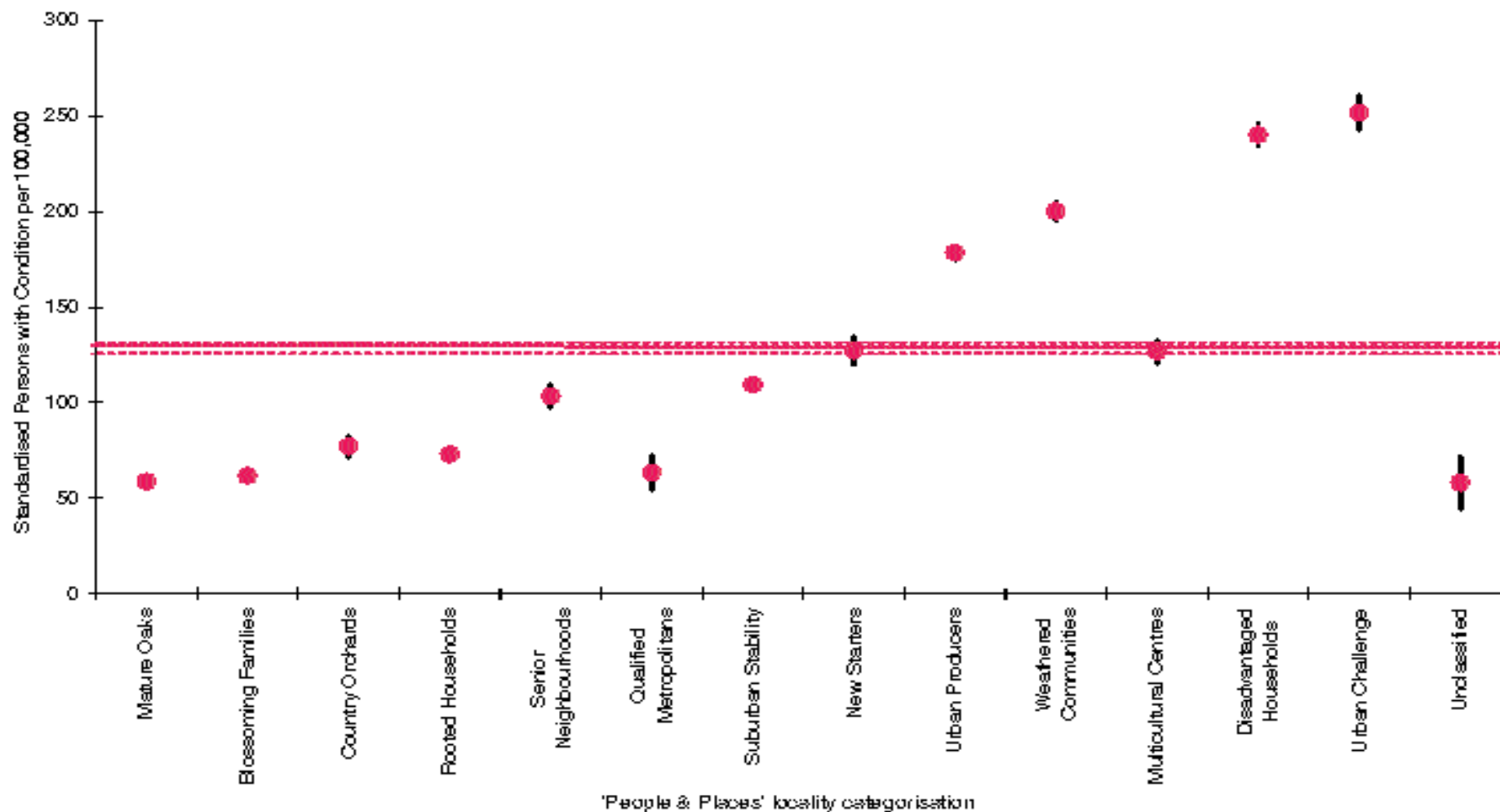
Reproduced from NWPHO, 2006

Unemployment

Being unemployed and economically inactive (i.e. unemployed and not seeking work) is associated with an increased risk of mental health problems (Meltzer et al, 2002). Unemployed people are twice as likely to have depression as people in work (NSF, 1999)

In 2001, the psychiatric morbidity survey found that compared to those with no neurotic disorder, those with neurotic disorder were more likely to be economically inactive. Compared to those with no psychosis, those with a psychosis were more than twice as likely to be economically inactive (Singleton et al, 2001).

The proportion of the Merseyside population claiming Job Seekers Allowance is higher than nationally in each local authority – more than twice as high in Liverpool, where the indirect standardised ratio was 218 (Figure 2.12). (Ratios are standardised against the population of England, where the ratio is 100).

Figure 2.12
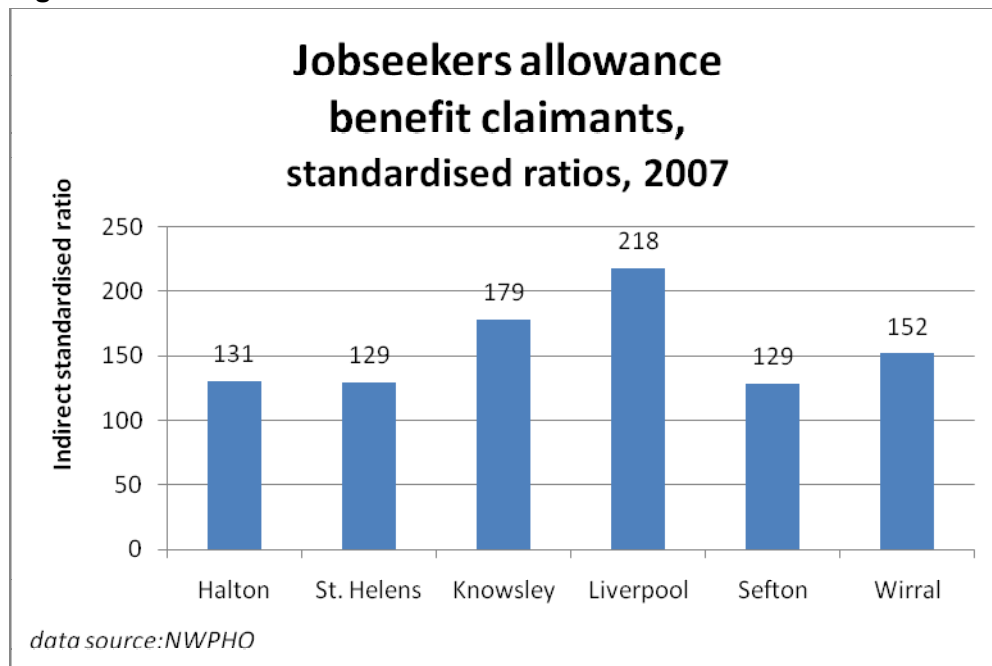
Map 4 in Appendix 1 shows jobseekers allowance claimants by lower layer super output area on Merseyside. As would be expected, the distribution of claimants is similar to the distribution of deprivation on Merseyside (see deprivation section above).

The Economy: In recent years parts of Merseyside have enjoyed rapid growth. However, the economic downturn is being felt, for example in Liverpool, where employment was down 1.4% over 2008-9. In the short term this can be expected to increase demands on mental health services (Liverpool PCT, 2009b).

Housing type

Good-quality, affordable, safe housing is seen as essential to our wellbeing. Poor housing or homelessness can contribute to mental ill health or can make an episode of mental distress more difficult to manage (MIND 2007a).

Shelter have reported that there is a shortage of good quality housing and that social housing is often associated with poor quality buildings, high levels of unemployment and crime and poor access to local services (Shelter report from 2007 quoted in MIND 2007a).

Social housing is also associated with overcrowding. A survey carried out by Shelter found that children growing up in social housing have, on average, seven square metres less space in which to play and develop, than the national average (Shelter, 2005).

The relationship between housing and mental health works two ways, with mental health problems making it more difficult for people to access good housing and with poor housing contributing to mental health problems. Studies have revealed the following links between housing and mental health:

- People with mental health problems are under-represented in owner-occupied accommodation, which is generally seen as the most socially valued and secure housing in the UK today.*
- Compared to those with no neurotic disorder, those with neurotic disorder were more likely to be tenants of the local authority or a housing association. Those with a psychosis were more than twice as likely as those with no psychosis to be tenants of the local authority or housing association.***.
- There are links between overcrowded family housing and depression, anxiety, sleep problems and strained relationships. In the Shelter survey, of families that are severely overcrowded, 93% said that their living conditions caused depression, anxiety or stress.****
- Children living in social sector housing are at greater risk of developing mental health problems**
- Compared with the general population, people with mental health problems are twice as likely to be unhappy with their housing and four times as likely to say that it makes their health worse.*.
- Mental ill health is frequently cited as a reason for tenancy breakdown. Of tenants with mental health problems, one in four are in serious rent arrears and at risk of losing their home. Consideration should be given to making it a requirement that social landlords recognise & refer tenants with mental health problems.
- Housing problems are frequently cited as a reason for a person being admitted or re-admitted to inpatient mental health care*.
- Housing sector staff (for example, Local Authority Homeless Persons Units) often lack awareness of mental health issues. Equally, some mental health support staff would benefit from greater awareness of housing issues*.

*(*MIND, 2007a, **Mental Health Foundation, 2007, ***Singleton et al, 2001, ****Shelter, 2005).*

Proportions of rented housing are higher than the North West and national averages in Liverpool, Knowsley, Halton and St.Helens. Nearly half of all households in Liverpool are either social housing or privately rented, compared to only around a quarter in Sefton (Figure 2.13).

Figure 2.13
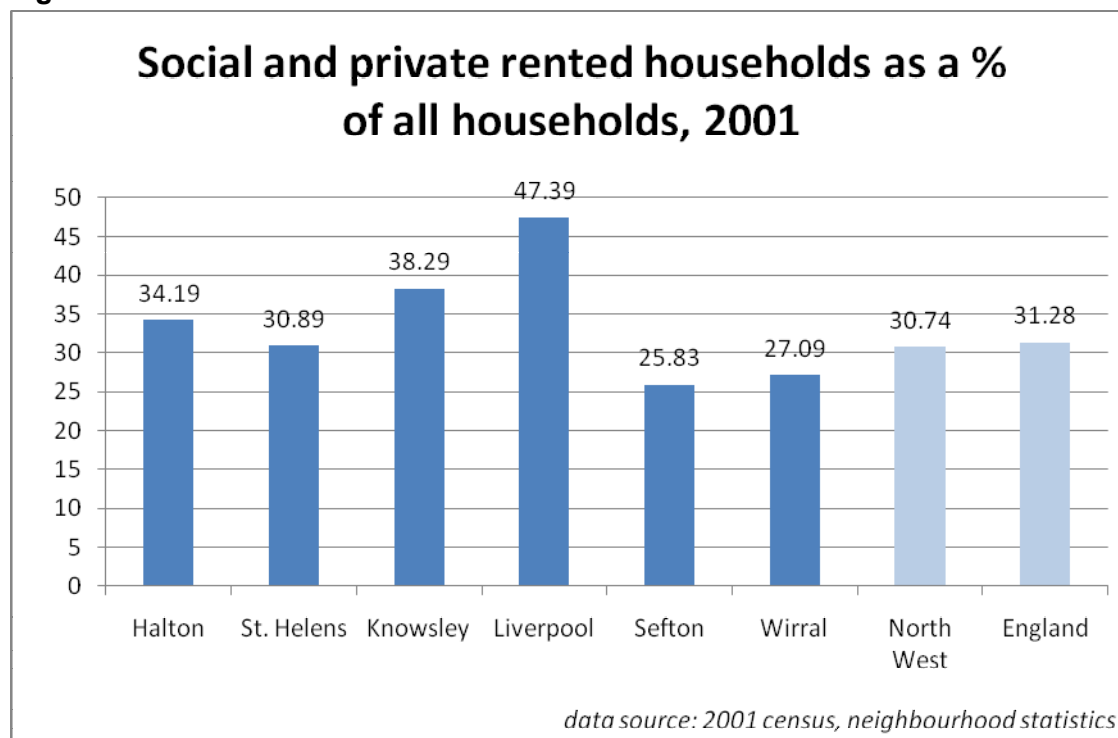
Map 5 (see Appendix 1) shows that the distribution of social housing within local authorities across Merseyside follows a similar pattern to that of deprivation (Map 1 in Appendix 1). There are high proportions of socially and privately rented housing in North West and south Liverpool. Levels are high in most areas within the north half of Knowsley and in south Sefton and the west of Wirral. In St.Helens, most social housing is in the town centre area and to the south of the town centre in Thatto Heath. In Halton, Castlefields and some of its surrounding areas have the highest levels of social housing

Recommendations
Recommendations include:
- Give consideration to making it a requirement that social landlords recognise & refer tenants with mental health problems.
- Encourage housing and health agencies to work together, recognising that housing problems are frequently cited as a reason for a person being admitted or re-admitted to inpatient mental health care.
- Ensure housing sector staff (for example, Local Authority Homeless Persons Units) have awareness of mental health issues. Conversely, ensure mental health support staff have greater awareness of housing issues.

Homeless people as minority group at risk of mental health problems are covered in Section 2.2 above.

Poor physical health

People with poor physical health are at a higher risk of experiencing common mental health problems. The converse is also true, with people having mental health problems being more likely to have poor physical health.

In 2001, compared to those with no disorder, those with neurotic or psychotic disorders were more likely to have a long-term limiting illness. It has been noted that those with schizophrenia will live an average of 10 years less than someone without a mental health problem. Depression affects 27% of people with diabetes, 31% of those who have had a stroke, 33% of cancer patients and 44% of those with HIV/AIDS (Mental Health Foundation, 2007).

In Merseyside, the percentage of the population with a limiting long-term illness ranged from just over 1 in 5 in Halton to around 1 in 4 in Knowsley and Liverpool (Figure 2.14). In all Merseyside PCTs, proportions were significantly higher than for Cheshire & Merseyside Strategic Health Authority and the North West.

Figure 2.14
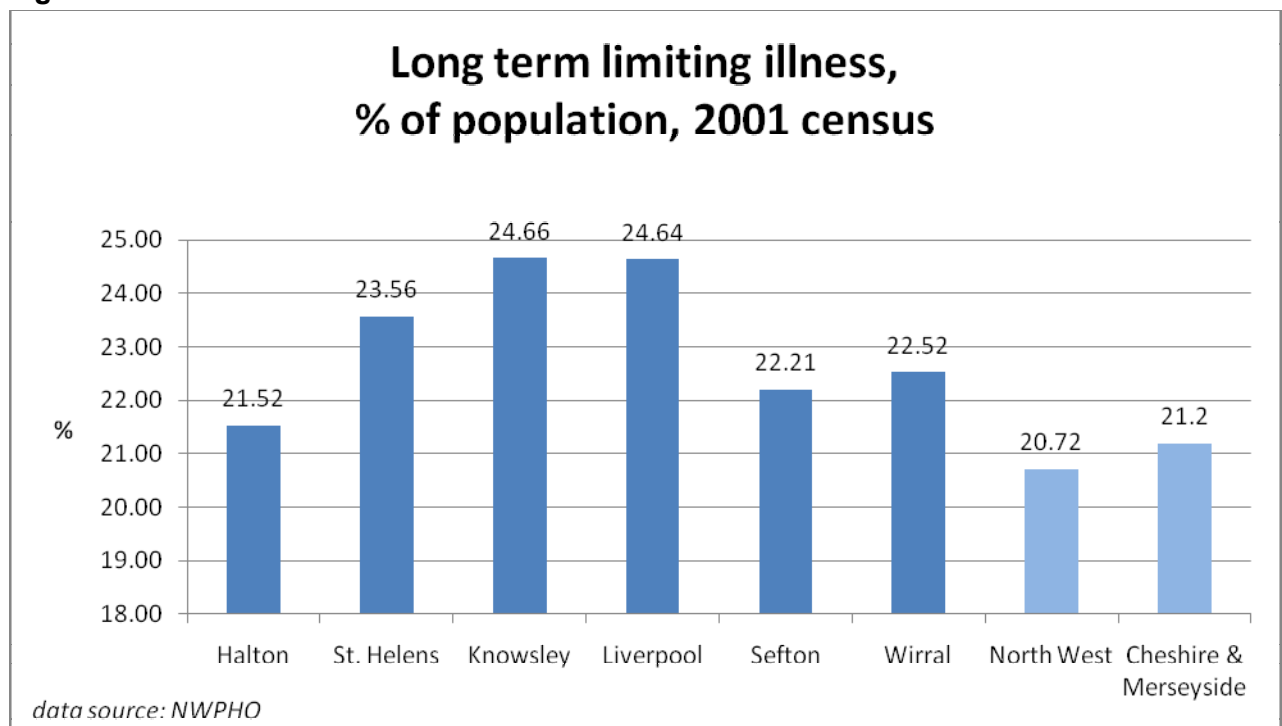
Map 6 shows the distribution of people with long term limiting illness across Merseyside, showing patterns within local authorities. Levels across almost the whole of Knowsley are amongst those in the top fifth on Merseyside.

Section 2.3 includes a consideration of the mental health problems of people with disabilities.

Alcohol

Problem or harmful drinking has obvious implications for physical health. There is also a great deal of overlap between alcohol and mental illness (NEPHO, 2008). For example:

- Suicide is eight times more likely to occur in the presence of alcohol misuse or dependency. As many as 65% of suicides have been linked to excessive drinking (Mental Health Foundation, 2006)
- At least two-thirds of people entering treatment for alcohol dependency have depressive or similar symptoms (Mental Health Foundation, 2006)
- Personality disorder and schizophrenia may give people a pre-disposition to alcohol dependency (Mental Health Foundation, 2006)
- People with drug and alcohol problems have higher rates of other mental health problems (NSF, 1999).

Children who regularly see their parents drink are twice as likely to binge on alcohol themselves, according to a recent survey by the Joseph Rowntree Foundation, (Bremner et al, 2011). There is a need to take a life course approach to education around alcohol issues, in an effort to help prevent alcohol problems developing.

Alcohol and domestic violence:
There are also strong links between alcohol and domestic violence, which in turn can lead to mental health problems. Although alcohol does not cause domestic violence, there is evidence that where the domestic violence exists, alcohol is often present (Galvani, 2010). Domestic violence is considered further under the next heading of 'crime'.

Binge drinking on Merseyside
On Merseyside, Figure 2.15 shows that in Liverpool and Halton, around 1 in 4 adults are binge drinkers, which is significantly more than the England average of 1 in 5. In Sefton and Knowsley, levels of binge drinking are less than the national average.

Figure 2.15
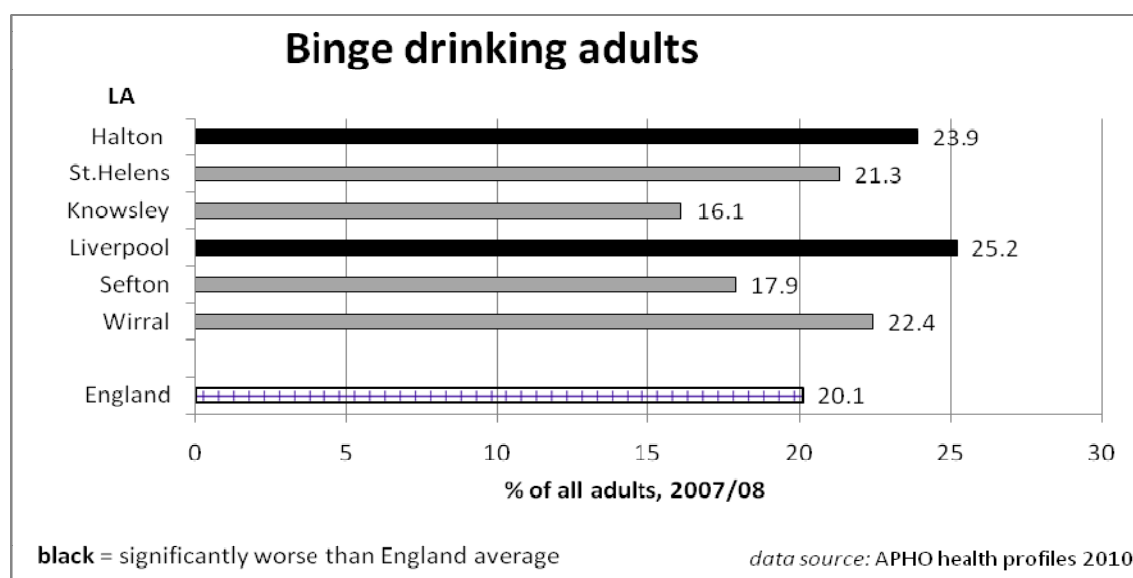
Recommendations

The Mental Health Foundation report, *'Understanding the relationship between alcohol and mental health'* made the following recommendations:

- All alcohol-related public health materials, training and teaching should cover mental health aspects of alcohol misuse/use.
- Government should invest more in treatment services, especially specialist services for people with dual diagnosis and generally in services treating alcohol dependency. The latter should have clearly defined pathways to mental health services for support and treatment.
- Psychology treatment centres should have staff trained in delivering CBT to people with alcohol dependency and concurrent anxiety or depression.
- Government should consider the mental health consequences of policies surrounding alcohol as part of the impact assessment process.
- Health warnings should be introduced on alcohol packaging and include the warning "Excessive use of alcohol can damage your mental health."
- Government should target people with mental health problems with health promotion advice and active support in managing issues such as alcohol use.
- In primary care settings, identified individuals who are using alcohol to 'treat' underlying problems such as stress, depression or anxiety should be able to benefit from alternative approaches to managing mental health problems. These include talking therapies, exercise, diet, self-help groups and spirituality.
- Increased education about the association between alcohol use and mental health in schools should be used to alert people to the potential risks of using alcohol to self-medicate. Education about the complex reasons for alcohol use and misuse is also vital.

(Mental Health Foundation, 2006)

- School education and public health training and teaching materials should also raise awareness of the links between drinking behaviour, levels of domestic violence and associated mental health problems.

Crime

Crime in the neighbourhood and effects on mental health

Fear of crime in neighbourhoods does not always accurately reflect actual crime levels. It can also be derived from secondary information about crime levels (for example via media reports), observable evidence of disorder, and prejudices. Knowledge of actual violent crime levels in the area will contribute to fear of crime and feeling unsafe (Skogan, 1986). Figure 2.16 shows levels of violent crime across Merseyside, with levels significantly higher than the national average in Liverpool and Halton.

Figure 2.16
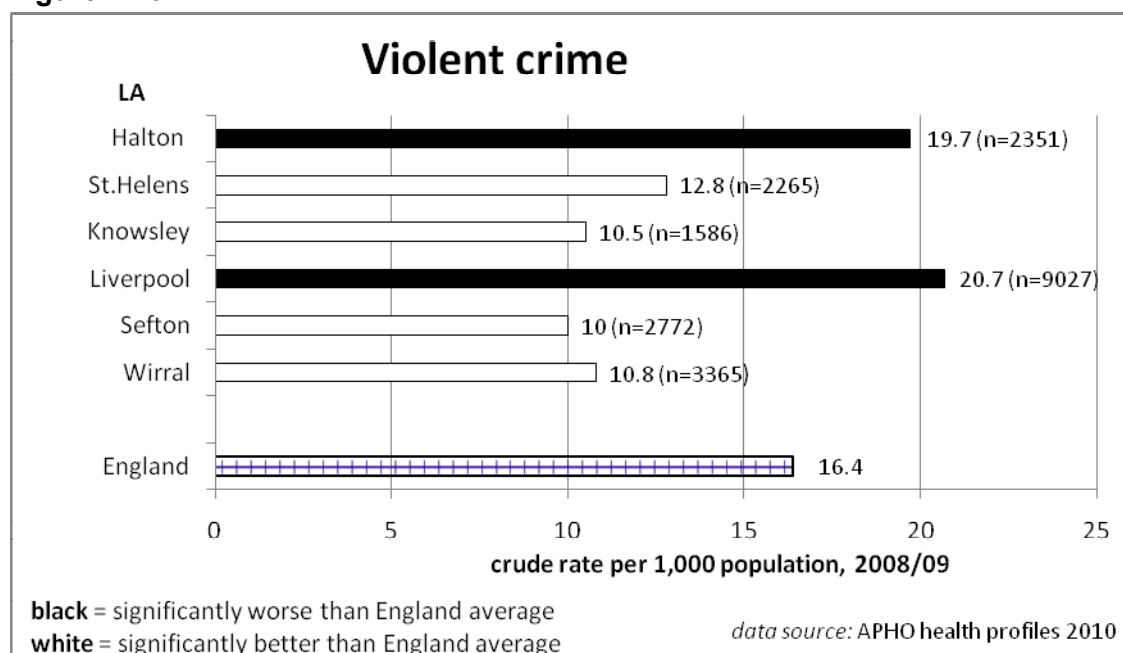
Violent crime

LA

	crude rate per 1,000 population, 2008/09
Halton	19.7 (n=2351)
St.Helens	12.8 (n=2265)
Knowsley	10.5 (n=1586)
Liverpool	20.7 (n=9027)
Sefton	10 (n=2772)
Wirral	10.8 (n=3365)
England	16.4

black = significantly worse than England average
white = significantly better than England average

data source: APHO health profiles 2010

Fear of crime and feeling your neighbourhood is unsafe/ violent can have a negative effect on mental health. A UK study by Stafford et al (2007) found that people with high levels of fear of crime were 50% more likely to exhibit symptoms of common mental disorder and more than 90% more likely to exhibit symptoms of depression than were those with the lowest levels. They found that fear of crime may be a barrier to participation in health-promoting physical and social activities, such as exercise and seeing friends. The authors note that the direction of the relationship remains unclear, so that although fear of crime could lead to poorer health, it is equally possible that physical health limitations and poor mental health could increase a person's sense of vulnerability and fear of the effect of crime.

Recommendations:
Stafford et al concluded that public health practitioners should support fear-reduction initiatives. They noted that reduction of actual crime rates may not be sufficient to reduce the fear of crime (and its subsequent effect on health). Initiatives addressing factors such as environmental design, including clear sight lines, good street lighting, and mixed land use, can be used to reduce opportunities for crime and fear of crime. They also suggest that police and government should provide information on the true (rather than perceived) risk and crime rate, educate about self-protection, and involve communities in crime prevention.

Being a victim of crime as a cause of mental health problems.

Being a victim of crime can lead to mental health problems, such as in domestic abuse. People who have been abused or been victims of domestic violence have higher rates of mental health problems (NSF, 1999). Women's Aid noted that it is now well accepted that abuse (both in childhood and in adult life) is often the main factor in the development of depression, anxiety and other mental health disorders, and may lead to sleep disturbances,

self-harm, suicide and attempted suicide, eating disorders and substance misuse (references listed: Women's Aid, 2011). They gathered the following statistics:

- •Abused women are at least three times more likely to experience depression or anxiety disorders than other women.
- •One-third of all female suicide attempts and half of those by black and ethnic minority women can be attributed to past or current experiences of domestic violence.
- •Women who use mental health services are much more likely to have experienced domestic violence than women in the general population.
- •70% of women psychiatric in-patients and 80% of those in secure settings have histories of physical or sexual abuse.
- •Children who live with domestic violence are at increased risk of behavioural problems and emotional trauma, and mental health difficulties in adult life.

(Women's Aid, 2011)

Victims of domestic abuse may feel unable to disclose the abuse to their GP, so that the reasons for their depression or other difficulties may be ignored.

Recommendation
Victims of crimes such as domestic abuse need to be offered the opportunity to talk about what is happening, rather than simply being given medication (Women's Aid, 2011).

People with mental health problems as victims of crime.

People with mental health problems are significantly more likely than the general population to be the victims of crime. In a recent Mind survey, 71% of respondents with mental health problems had been the victim of a crime in the last two years, compared to 24% in the general population. Just 19% of respondents felt safe all of the time in their own homes (Mind, 2007b).

In addition, people with mental health problems are said to also 'face barriers at every stage of getting a crime brought to justice' (Farmer, 2009). MIND noted that victims and witnesses with mental distress can be denied access to justice, because their evidence is deemed 'unreliable' due to their mental health problem. Mind describe their new toolkit for prosecutors and advocates, which they say seeks to address this barrier to justice and tackle discrimination within the criminal justice system. They believe that the toolkit will help legal professionals to handle mental health evidence sensitively and appropriately; provide the right support to ensure victims and witnesses can give their best evidence; and challenge unacceptable use of psychiatric evidence by defence lawyers or other witnesses (MIND, 2011).

Recommendations:
- In primary care and other settings, ensure that opportunities to talk are presented to people who may have been the victims of crime.

- Offer support appropriate to the needs of the individual, including referral to mutual support groups, more formal counselling, or psychotherapy.

2.3 Vulnerable groups at risk, including those with 'protected characteristics'

The new mental health strategy asks for data collection across all outcomes and indicators in relation to protected characteristics. 'Protected characteristics' or groups are those against which the equality Act 2010 prohibits discrimination; they are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation (DH 2011b).

The strategy notes that improving access is an important first step in improving mental health care for everybody, but particularly for those at higher risk, including some black and minority ethnic groups, homeless people, people with low skills, asylum seekers and those in the criminal justice system. Improving access is about finding innovative ways of meeting the needs of those who may for example find the standard general practice systems difficult to use. Simple steps for improving access include offering variable lengths of appointment times or an outreach approach, such as holding sessions in community centres or hostels (DH 2011b).

Minority ethnic groups

The ethnic composition of the Merseyside population has been presented in Section 1, Table 1.2, above.

The new government mental health strategy noted that the evidence on the incidence of mental health problems in black and minority ethnic groups (BME groups) is complex (DH, 2011a). This is due to the fact that the term BME covers many different groups with very different cultural backgrounds, socio-economic status and experiences in wider society.

As mentioned in Section 2.1 above, in the North West wellbeing survey, across the Region, non-White adults were significantly more likely to have above average mental wellbeing (26.5%) (Deacon et al, 2010a).

The prevalence of psychotic disorder is higher among black men. The most recent National Psychiatric Morbidity Survey found a significantly higher prevalence of psychosis amongst black men (3.1%) than men from other ethnic groups (0.2% of white men, no cases observed among men in the South Asian or 'other' ethnic group). There was no significant variation by ethnicity among women (McManus et al, 2009).

As mentioned on p.61, women are more likely than men to suffer from common mental disorders. The differences between the sexes are most marked amongst South Asian adults,

with a 34.3% rate for South Asian women, compared to 10.3% of South Asian men (McManus et al, 2009).

Although rates of mental health problems are thought to be higher in minority ethnic groups in the UK than in the white population, they are less likely to have their mental health problems detected by a GP (Mental Health Foundation, 2007). The Mersey Care Mental Health Profile found that black people were much more likely to score highly on most mental health indicators, for example they were more than twice as likely as white people to be on the Trust's mental health caseload, four times as likely to receive crisis resolution, twice as likely to have outpatient attendances, more than three times as likely to miss an outpatient appointment, five times as likely to be an inpatient, four times as likely to have their hospital discharge delayed, and seven times more likely to be detained under section of the mental health act (Ubido and Lewis, 2008).

The Mersey Care Profile found that crisis resolution visits and detentions under section were also high amongst the Asian population – especially in Sefton, where Asian people had four times as many detentions under section as the white population. These are both indicators that suggest that Asian people, as with black people, are less likely to seek community care, and/or face problems with access to such care. They are then more likely to develop acute mental health problems (Ubido and Lewis, 2008).

It has been recognised that black people are less likely than white people to be offered psychotherapy, counselling and other non-medical interventions. They are more likely to be given physical treatments such as medication and ECT (Mental Health Foundation, 2007).

The five year government plan 'Delivering race equality in mental health care' has been reviewed (Wilson, 2010). The review noted that future improvements will rely on:
- local collection and monitoring of information on ethnicity and culture;
- better use of these data to inform commissioning and provision in health and social care;
- a focus on outcomes that work for individuals and communities;
- monitoring and evaluating effectiveness of service delivery, especially around equality needs; and
- establishing mechanisms that allow local user groups to engage with providers and commissioners, and that empower and support them so that they can engage effectively.

Asylum seekers and refugees

Definition: In the UK an asylum seeker is someone who has submitted a claim for refugee status to the UK Border Agency, and is awaiting a decision or appealing against a refusal. Those with Refugee status may remain in the UK for four years, and then apply for settled status. They may bring one spouse and any children under 18 years (Hutchinson, 2008).

In December 2009, of the 29,150 asylum seekers in the UK (including dependants), 23,845 were being supported in dispersed accommodation, 4,670 were receiving subsistence only

support and 635 were supported in initial accommodation (including those in induction centres) (Home Office, 2010).

Numbers of asylum seekers supported in accommodation in the UK have fallen from 34,150 in 2007 to 23,845 in 2009. However, proportions of the UK total being dispersed to the North West have increased over the same period, from 15% in 2007, to just over 1 in 4 (27.20%) of all asylum seekers in the UK in 2009. Of the 6,485 based in the North West in 2009, 1 in 5 (21.20%) were in Liverpool (there were none recorded elsewhere in Merseyside). Numbers of asylum seekers in supported accommodation in Liverpool have increased from 1,010 in 2007 to 1,375 in 2009 (Table 2.3a).

Table 2.3a
Asylum seekers supported in accommodation as at the end of December 2007, 2008 and 2009. Number of applicants (including dependants)

	2007	**2008**	**2009**
Liverpool	1,010	1,205	1,375
(% of NW total)	(15.04%)	(19.56%)	(21.20%)
North West total	6,715	6,160	6,485
(% of UK total)	(19.66%)	(24.50%)	(27.20%)
United Kingdom Total	34,150	25,145	23,845

Data source: http://rds.homeoffice.gov.uk/rds/immigration-asylum-stats.html

Numbers of asylum seekers in receipt of subsistence only, without accommodation, has reduced by half nationally in recent years, from 8,900 in 2007 to 4,670 in 2009. More than half of such asylum seekers were based in London, with 6% (265) in the North West (2009 data). Of those in the North West, 15.09% were in Merseyside – with 25 in Liverpool and 15 in Sefton (Home Office 2010, and see Table A1 in Appendix 2). This group will be especially vulnerable.
(N.B. There may have been other asylum seekers on subsistence only benefit in the rest of Merseyside, but Home Office figures only count areas where there are 15 or more).

There is another group of asylum seekers and refugees who do not appear in official statistics, these are the destitute asylum seekers who may be working illegally in poor conditions, such as in prostitution, or may have become involved in crime. They have no benefits or housing, and no permission to work. Such people are even more likely to have mental health needs. It has been estimated that there may be as many as 300 people each year who become destitute in Liverpool (ICCM, 2008).

Mental health problems
The new government mental health strategy noted that the rates of mental health problems in particular migrant groups, and subsequent generations, can be higher than in the general population. For example, migrant groups and their children are at two to eight times greater risk of psychosis. More recent arrivals, such as some asylum seekers and refugees, may

also require mental health support following their experiences in their home countries (DH, 2011a).

MIND have similarly acknowledged that refugees and asylum-seekers experience a higher incidence of mental distress than the wider population. The most common diagnoses are trauma-related psychological distress, depression and anxiety (MIND, 2009). It should be noted that although symptoms of psychological distress are common, they do not necessarily signify mental illness (Burnett and Peel, 2001). It is also possible that mental distress could be a result of difficult living circumstances experienced in the UK (MIND 2009). According to guidelines produced by the World Health Organisation, it is established that an average of more than 50% of refugees present mental health problems ranging from chronic mental disorders to trauma, distress and great deal of suffering (WHO).

A recent study by Asylum Link found that 12% of the asylum seeker population had been sectioned under the Mental Health Act, compared to 1% of the general population (cited in Hutchinson, 2008). Hutchinson noted that this highlights some of the differences in treatment that asylum seekers are receiving. As the majority of mental health needs services are accessed through the GP this leads to difficulty when there are a high number (40%) of asylum seekers in the UK who have not registered with a practice (Hutchinson, 2008).

Merseyside: Based on the figures in Table 2.3a and the WHO guidelines, it could be estimated that in one year there are around 851 asylum seekers and refugees in Liverpool and 7 in Sefton who may have mental health problems (Table 2.3b). This is likely to be an underestimate, as the 300 destitute asylum seekers whose basic human needs are not being met are more likely than other asylum seekers to suffer from mental health problems.

Table 2.3b
Asylum seekers on Merseyside: Estimate of numbers with mental health problems

	Number of asylum seekers in Merseyside, 2009	Estimated number with mental health problems***
In supported accommodation*	1375 (Liverpool)	688
With subsistence only*	40 (25 in Liverpool, 15 in Sefton)	20 (13 in Liverpool, 7 in Sefton)
Estimated destitute asylum seekers**	300	150
All asylum seekers	1715	858

*Home Office : http://rds.homeoffice.gov.uk/rds/immigration-asylum-stats.html
** ICCM, 2008
*** 50% - based on WHO guidelines
Note: These estimates of levels of mental health problems do not take account of variations in the age and sex structure of local populations, or variations in related factors such as deprivation, which may be higher in local populations and may therefore mean that levels of mental health problems are likely to be underestimated.

For asylum seekers and refugees who have mental health problems, their basic needs for food and shelter have to be dealt with first, and only then will it be possible to begin to tackle any mental health needs. This would involve various agencies working together – local authority, housing, benefits agencies and health.

Recommendations:
- Ensure mental health professionals can work together with housing and other agencies to ensure basic human needs for food and shelter are being met.
- Provide training and education for frontline staff in primary care to assist asylum seekers in registering at practices and feeling welcome
- Base health services within the community where they are easily accessible to asylum seekers, including a 24/7 crisis service enabling immediate access to care.
- Improve signposting to what services there are currently on offer to asylum seekers within NHS health care, the voluntary sector, within faith based organisation etc.
- Give more information to asylum seekers in their own language around accessing services and explaining their illnesses and medication side-effects etc. Assist them in defining specifically what their mental health needs are and how these can be treated.

Taken from the Asylum Seeker Scoping Report by Liverpool PCT (Hutchinson, 2008) and ICCM (2008).

Gypsies and Travellers

There are five authorised traveller sites across Merseyside, with two in Halton and one each in Liverpool, Sefton and St.Helens, housing 174 caravans in total. There are no sites in Knowsley or Wirral. The vast majority of caravans are on authorised sites. Of the 174 caravans in Merseyside, nearly half are in Halton, and nearly one-third in St.Helens (Table 2.4).

A study of the health status of Gypsy Travellers in Sheffield found that the proportion reporting any problems with 'nerves' or 'feeling fed up' was significantly greater than a matched comparison group of urban deprived residents (35% compared to 19%) (Van Cleemput and Parry, 2001). Van Cleemput and Parry used this terminology rather than 'anxiety and depression' which they found may have been unfamiliar to some of the gypsy and traveller community.

Table 2.5 shows the results of Van Cleemput and Parry's study applied to the statistics on numbers of caravans in Merseyside presented in table 2.4 above. It was predicted that there would be average of two working age adults for each caravan. Based on these estimates, in July 2009 there were potentially 122 working age adults amongst the gypsy and traveller communities in Merseyside who had anxiety or depression. Of these, there would be 54 in Halton, 37 in St.Helens, 18 in Sefton and 13 in Liverpool. These numbers are likely to fluctuate as groups of travellers move around.

Table 2.4
Count of gypsy and traveller caravans, 16th July 2009

	Authorised sites (with planning permission)	Unauthorised sites (without planning permission)		Total all caravans	% of Merseyside total
	No. of Caravans	No. of Caravans			
		"Tolerated"	"Not tolerated"		
North West	**1164**	**58**	**193**	**1415**	
Halton (2 sites)	73	0	4	77	44.25%
Knowsley	0	0	0	0	0%
Liverpool	19	0	0	19	10.92%
Sefton	25	0	0	25	14.37%
St Helens	45	8	0	53	30.46%
Wirral	0	0	0	0	0%
Merseyside total	**162**	**8**	**4**	**174**	

Data source:
http://webarchive.nationalarchives.gov.uk/+/http://www.communities.gov.uk/housing/housingmanagementcare/gypsiesandtravellers/gypsyandtravellersitedataandstat/
Note: These estimates of levels of mental health problems do not take account of variations in the age and sex structure of local populations, or variations in related factors such as deprivation, which may be higher in local populations and may therefore mean that levels of mental health problems are likely to be underestimated.

Table 2.5
Numbers of gypsies & travellers potentially at risk of mental health problems, July 2009

	Number of caravans	Estimated number of working age adults (2 per caravan)	Potential number with anxiety or depression (35%)
North West	**1415**	**2830**	**991**
Halton (2 sites)	77	154	54
Knowsley	0	0	0
Liverpool	19	38	13
Sefton	25	50	18
St Helens	53	106	37
Wirral	0	0	0
Merseyside total	**174**	**348**	**122**

Table based on Van Cleemput and Parry (2001) and table 2.4 above

Recommendations:
Apart from the Sheffield study, it has been noted that the mental health of travellers has been largely ignored except for very general references to the negative impact on travellers of discriminatory behaviour by the wider society (Doyal et al, 2002). Minority groups are more vulnerable to inappropriate services if they only represent a tiny proportion of the local population. The House of Commons health committee report into the provision of mental health services reported that '*what is needed is the planning of fair access with culturally appropriate mental health services for travellers, in close liaison with local authorities, through health and social care partnership arrangements*' (House of Commons, 2000).

Lesbian, gay and bi-sexual populations

A recent ONS survey estimates that 1.5% of the population is lesbian, gay or bi-sexual (LGB). Regional variations were found in the proportion of adults identifying as LGB, ranging from the highest at 2.2% in London, to the lowest at 0.9% in Northern Ireland. In the North West, the proportion was the same as the UK average (1.5%) (Joloza et al, 2010). The survey's statistics are considered experimental, in a testing phase, as they have not yet been assessed by the UK Statistics Authority.

This estimate has been criticised on the grounds that the methodology was very likely to deter people from stating that they were LGB, leading to underreporting the LGB population. The preferred estimate up until now has been that provided by the DTI of an LGB population of between 5 to 7%, as provided in the Final Regulatory Impact Assessment: Civil Partnership Act 2004 (DTI, 2004).

Mental health: A Mind report on the mental health and social wellbeing of gay men, lesbians and bisexuals in England and Wales noted that there is substantial research from the USA showing that lesbians, gay men and bisexual suffer discrimination and appear to have higher rates of anxiety, depression and suicidal behaviour. LGB service users can face the same discrimination within the mental health service, as they do in wider society (King and McKeown, 2003).

King and McKeown's survey suggested that the situation may be similar in Britain. They found that despite having similar levels of social support and physical health, there was more psychological distress reported amongst gay men and lesbians compared to heterosexuals (Table 2.6). Their main findings for these comparisons were similar to those reported in US studies.

Table 2.6
Common mental disorder, by sexuality and gender

	Heterosexual	Gay/lesbian	Bisexual
Male **CIS-R mean score**	10.09	12.23	14.92
Female **CIS-R mean score**	10.34	12.67	12.52

Data source: King and McKeown, 2003
N.B. The revised Clinical Interview Schedule (CIS-R) specifically assesses common mental disorders in community settings in the UK

A US literature review of the prevalence of mental disorder amongst LGB populations found that, compared with heterosexuals, gay men and lesbians are about 2.5 times more likely to have had a mental disorder at any point in their lifetime (odds ratio = 2.41) (odds ratios for current disorders were similar, and the odds ratio for anxiety on its own was very similar, at 2.43) (Meyer, 2003).

Transgender populations have not been considered here, as no data is collected by ONS surveys relating to this group of people. Also, King and McKeown's study did not include transgender people.

Mental health service use: The survey by King and McKeown (2003) also looked at use of mental health services, and found that gay men and lesbians were more likely than heterosexuals to have consulted a mental health professional in the past, regardless of current mental state. Up to a third of gay men, one quarter of bisexual men and over 40 per cent of lesbians recounted negative or mixed reactions from mental health professionals when being open about their sexuality. Bisexual women were less likely than lesbians to report having received a positive reaction from a mental health professional when declaring their sexuality. One in five gay men and lesbians and a third of bisexual men recounted that a mental health professional made a causal link between their sexuality and their mental health problem (King and McKeown, 2003).

Merseyside
Based on the DTI (2004) estimate, around 6% of the population on Merseyside are likely to be LGB. Table 2.7 gives estimates of the LGB population aged 18-64 in each local authority in Merseyside.

If the prevalence of common mental disorder in the general population is 16.2% (see table 3.1, Section 3), and people who are LGB are around 2.43 times more likely to suffer from anxiety (see three paragraphs above), then the prevalence of anxiety amongst the LGB population would be expected to be 39.4% (16.2 x 2.43).

These estimates have been applied to the populations of the Merseyside local authorities, as shown in Table 2.7. There likely to be around 54,852 people who are LGB in Merseyside, of whom 21,593 are likely to have mental health problems.

Table 2.7

Sexual identity and mental health problems amongst working age adults on Merseyside

	Estimated LGB population aged 18-64 (6%)*	People who are LGB estimated to have anxiety/ common mental disorder (39.4%)**
Halton	4464	1757
St.Helens	6516	2565
Knowsley	5556	2187
Liverpool	17778	6998
Sefton	9666	3805
Wirral	10872	4280
Merseyside	54852	21593

*Based on the DTI (2004) estimate of an LGB working age population of between 5 to 7%. **This may be an over-estimate, as it is much higher than the ONS (Joloza et al, 2010) estimate of 1.5%, which is awaiting testing by the UK Statistics Authority.**
** Based on general population CMD prevalence of 16.2% (McManus et al, 2009), and odds ratio for lesbian/gay anxiety of 2.43 times that for heterosexuals (Meyer, 2003)

Note: These estimates of levels of mental health problems do not take account of variations in the age and sex structure of local populations, or variations in related factors such as deprivation, which may be higher in local populations and may therefore mean that levels of mental health problems are likely to be underestimated.

Also, ideally, the odds ratio would have been applied to the prevalence of CMD in the heterosexual population, not the general population – which would have given higher prevalences of CMD amongst LGBs

Recommendations

King and McKeown's MIND report (2003) made several recommendations for improving the mental health and social wellbeing of people who are LGB, including:

- Ensure that training for health and social service professionals covers the relationship between sexuality and mental wellbeing; the increased risk of self harm and suicide in LGB people; how to respond appropriately to LGB people in a mental health setting.
- Monitor the experiences of LGB people as users of services, and respond appropriately to feedback.
- Ensure those working with children and young people are aware of all the issues around sexuality, developing policies where appropriate to tackle issues such as bullying.

People with disabilities

People with a disability are more likely to have mental health problems. For example in a survey carried out for the Equality Commission for NI, while 34% of those who were not disabled had experienced *'quite a lot or a great deal of stress in the last 12 months'*, the percentage rose to 52% for disabled people (reported in McWhirter ed, 2004). Mental health problems amongst disabled people can be due to the resulting social barriers, rather than the disability itself. For example a study of people with spinal injuries found no relationship between the degree of physical impairment and depression, concluding that the depression is associated with the restrictions in the social role of the individual (Fuhrer, 1993, discussed in Morris, 2004).

The relationship between disability and mental health can work in the opposite direction, with mental health problems leading to disability. For example stress can suppress the body's immune system, reducing resistance to disease and increasing the risk of coronary heart disease (Morris, 2004). Morris points out that in some cases, people's experiences of the mental health system itself may mean they acquire physical impairments, for example related to the side effects of medication.

The links between disability and mental health will vary depending on the type of disability, for example some disabilities will be more socially isolating than others. For the purposes of this needs assessment, the focus is on two types of disability – learning disability, where there is often an overlap with mental health, and hearing impairment, which is very isolating, and strongly linked to anxiety and depression. Future needs assessments could expand this to include other areas, such as visual impairment and physical disability.

Learning disability

Figure 2.17 shows the numbers of people in Merseyside predicted to have a learning disability which is mild, moderate or severe. Numbers in each local authority are expected to fall slightly by 2020.

Figure 2.17
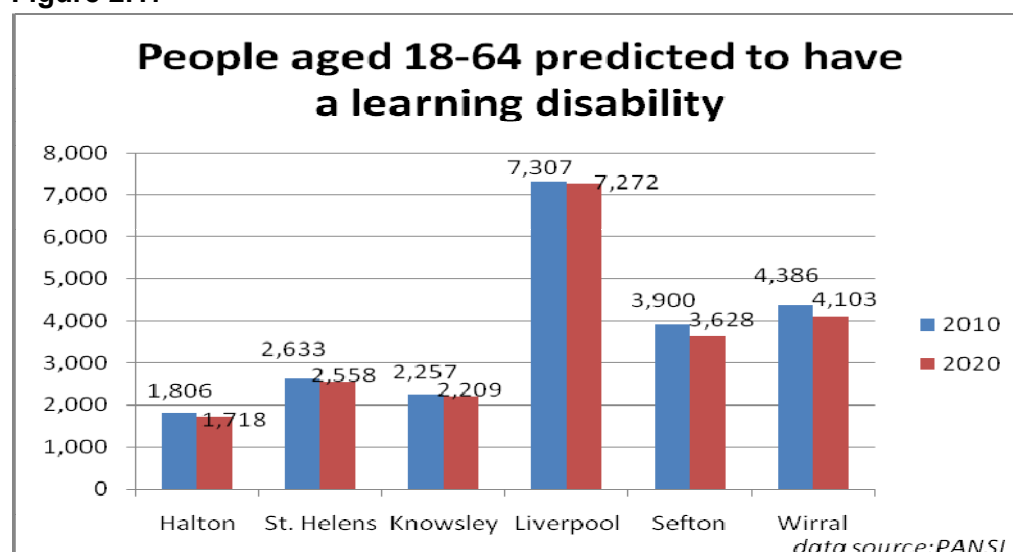
The prevalence of anxiety and depression in people with learning disabilities is the same as the general population, (though higher in people with Down's syndrome). Prevalence of schizophrenia is 3% (three times greater than for the general population), with higher rates for people of South Asian origin (Giraud-Saunders, 2011). It has been estimated that 25-40% of people with learning disabilities experience risk factors associated with mental health problems (Social Exclusion Unit, 2004). Variations are due to differences in the population sampled and the definitions used. Using the lowest estimate of 25%, there could be at least 5,572 working age people with learning disabilities in Merseyside at risk of having a mental health problem (table 2.8).

A recent paper from the Foundation for People with Learning Disabilities notes that according to people with learning disabilities and their families, if a mental health problem presents, for whatever reason, it is more likely to be attributed to their learning disability or classed as challenging behaviour (Giraud-Saunders, 2011).
Giraud-Saunders points out that access to the full range of mental health interventions for those with learning disabilities is often limited and, that assumptions are often made that they will not benefit from such treatments as 'talking therapies', although she notes that research and guidance is available on the applicability of CBT and Mindfulness.

Table 2.8
Numbers of those with learning disability with risk factors
for mental health problems, ages 18-64, 2010.

	Numbers predicted to have learning disability	Numbers at risk of mental health problem (25%)
Halton	1,806	452
St. Helens	2,633	658
Knowsley	2,257	564
Liverpool	7,307	1,827
Sefton	3,900	975
Wirral	4,386	1,097
Merseyside	**22,289**	**5,572**

Data source: PANSI

Note: These estimates of levels of mental health problems do not take account of variations in the age and sex structure of local populations, or variations in related factors such as deprivation, which may be higher in local populations and may therefore mean that levels of mental health problems are likely to be underestimated.

'Boundary problems', were also noted, with people with mild to moderate learning disabilities being at particular risk of falling between the gap of learning disability services and mental health services, as there is often disagreement about which specialist should treat them, with both services denying that the individual meets eligibility criteria.

The government has identified that people with learning disabilities are at an increased risk of mental health problems and that services must address this need (in the Government's 'Valuing People Now' and 'No Health Without Mental Health' policies). Giraud-Saunders recommends that the following issues be addressed:

- There is little attention to promoting mental health amongst people with learning disabilities, their families and frontline staff.
- There is insufficient attention to identifying early warning signs of common mental health problems.
- A minority of people with learning disabilities get an annual health check in primary care (42% in 2009/10) - of those who do, it is not known how well mental health issues are covered. If people with learning disabilities, their families and staff are not alert to mental health problems, this may affect the detection rate via health checks.
- 'Boundary' problems between secondary mental health and learning disability services persist.

(Giraud-Saunders, 2011)

Hearing impairment

Hearing loss is the second most common disability (Davis, 1991). In the UK, it is estimated that 8.95 million adults suffer hearing loss – around 1 in 5 of the adult population. Around three-quarters of these are over 60 years old (RNID 2006).

Of people with hearing impairment using British Sign Language, around 30% have mental health problems, mainly anxiety and depression (Social Exclusion Unit, 2004). People using British Sign Language are generally born with deafness. Earlier research has suggested that there are similar proportions of mental health problems amongst people who become deaf later in life. A study by Cowie found that over a third of those with profound hearing loss acquired in adult life reported being depressed often (Cowie and Douglas-Cowie 1987). This is a large proportion compared, for example, to the estimated 3.5% of registered blind people who have mental health problems (Social Exclusion Unit, 2004). Several other studies have pointed to links between deafness and mental health problems (Kitson & Fry 1990, McEntee 1993, Chisholm et al. 1998). There is a lack of recent research on this topic.

Estimates of mental health problems amongst those who are deaf can be calculated by applying the above estimates of the numbers of deaf people with mental health problems to national deaf population estimates. This would give a figure of 885 people in Merseyside with severe or profound deafness who are also suffering from depression or anxiety. The majority (287) would be in Liverpool (Table 2.9). This is an underestimate of mental health problems amongst those with hearing loss, because there would also be a significant proportion of the less severely deaf population who have depression or anxiety.

Table 2.9

Estimates of depression and anxiety amongst people who are severely or profoundly deaf in Merseyside, ages 16-60, 2005

Numbers	Deaf & hard of hearing population	Severely or profoundly deaf population	Severely or profoundly deaf with depression or anxiety
Halton and St Helens	12144	530	177
Knowsley	6244	273	91
Liverpool	19760	863	287
Sefton	10710	468	156
Wirral	12041	526	175
Merseyside total	60899	2658	885

Based on ONS 2005 population estimates. Population base used was ages 15-59.
Source of deaf population data: RNID (2006)
Mental health estimates based on Cowie and Douglas-Cowie (1987) (33.3%)
Merseyside totals may be different due to rounding.
See Appendix Tables A21 and A3 for more details

Note: These estimates of levels of mental health problems do not take account of variations in the age and sex structure of local populations, or variations in related factors such as deprivation, which may be higher in local populations and may therefore mean that levels of mental health problems are likely to be underestimated.

Social exclusion amongst people who are deaf affects both their mental health and their access to appropriate mental health services (DH 2002b). It is recognised that people who are deaf who have health problems are a 'hard to reach' group, as they are often reluctant to seek help, mainly because of the communication difficulties they face. The same could be true for people with other kinds of disabilities. It is important for mental health services to consider the particular needs people with hearing impairment. There is no routine data on numbers of disabled people accessing mental health services or treatment. Special surveys would help to highlight inequalities faced by disabled people (e.g. Ubido et al 2002).

Age and Sex

Gender

As mentioned in Section 2.1, the North West survey on wellbeing found little difference between men and women, except in Sefton, where women were significantly less likely than men to have a high level of mental wellbeing (Harrison et al, 2010a).

Women are more likely to have been treated for a mental health problem than men (Mental Health Foundation, 2007). The 2008 Mersey Care Mental Health Equity Profile found that females were more likely than males to be referred by their GP for mental health problems, to be on the hospital trust mental health caseload, to receive crisis resolution home

treatment, and to attend mental health outpatient departments. For example, analysis of GP referrals to adult mental health services in Liverpool during 2005-2008 revealed that there were 24 per thousand population amongst females, compared to only 18 per thousand amongst males (Ubido and Lewis, 2008).

The overall prevalence of mental illness does not appear to differ significantly between women and men. For specific disorders however, clear gender differences emerge:

- Anxiety, depression and eating disorders are up to one and a half to two times more common in women (DH 2002a, Deacon et al 2010a). In the 2007 psychiatric morbidity survey, prevalence rates of common mental disorders amongst women were significantly higher than amongst men (19.7% of women, 12.5% of men) (McManus et al, 2009).
- Substance misuse and anti-social personality disorders are more common in men (DH 2002a).

Poverty, social isolation, employment inequalities, caring responsibilities, child sexual abuse and domestic violence have all been identified as contributing to the mental ill health of women (DH 2002a; and see relevant sections elsewhere in this report). Suicidal thoughts are more prevalent amongst women than men, as is self-harm, especially amongst female prisoners. Women make up just 6% of the prison population and yet in 2003, they accounted for 46% of all reported self-harm incidents (see self harm section below).

It would appear that males are less likely to approach services for help (Ubido and Lewis, 2008), and that GPs can find it more difficult to detect depression and anxiety in males (Kessler et al, 1999). Kessler suggested this could be due to the increased tendency of males to 'normalise' or play down the significance of any psychological symptoms. For some, this will lead to the development of more severe, acute mental health problems. Males are much more likely than females to commit suicide – seven times more likely in Knowsley. They are also more likely to be detained under section of the Mental Health Act (Ubido et al, 2004; Ubido and Lewis, 2008). The new mental health strategy similarly noted the specific problems presented by men - that three-quarters of people who commit suicide are men; men are three times more likely than women to be dependent on alcohol and more than twice as many men in psychiatric units are compulsorily detained. It is recommended that services should be sensitive to the ways in which men present mental health problems (para 6.33, DH 2011a).

Recommendations:

In a Scottish resource document on mental health and inequalities, Myers et al (2005) recommended that approaches to mental health and well-being need to be gender-sensitive. In programmes and initiatives for improving mental health and well-being, they listed issues to consider which include:

- What does mental health/illness mean for women and for men? What is well-being?
- Given the different employment patterns of men and women, what are the implications for mental health at work?
- To what extent are initiatives for tackling suicide and self harm gender sensitive?
- What does building community capacity mean for men and women?
- How can initiatives improve the mental health of younger men and women, and older men and women?

- How gender sensitive are mental health improvement programmes for children and young people?
- How do measures for improving infant mental health impact on mothers or on fathers?
- How is stigma and discrimination experienced by men and by women with mental health problems?
- What does recovery mean for women and for men with mental health problems?

Mental health service provision also needs to be gender-sensitive. To achieve this, Myers et al (2005) recommend various considerations, including:
- The need for women-only or men-only services.
- Workforce development to ensure gender sensitivity.
- Issues of equality of access to responsive gender sensitive services including in terms of the times as which clinics are held, availability of child care or care for dependants, enabling people, as far as practicable/appropriate to have a clinician or carer of the same gender.
- The needs of specific groups of men and women with mental health problems such as: Women from different black and minority ethnic communities; Men from different black and minority ethnic communities; Women with children or other caring responsibilities; Women who have experienced violence or sexual abuse; Men who have experienced violence or sexual abuse.

Age

The prevalence of common mental disorders was found to be highest amongst those aged 45-54 (McManus et al, 2009). As mentioned in the wellbeing section above, the North West wellbeing survey found a corresponding dip in levels of wellbeing around middle age (40-54 years) (Deacon et al, 2010a).

Deacon et al found this trend to be supported by the wider literature and suggest further analysis to indicate where interventions could be targeted. They note that:

> *'this would involve identifying whether there are particular subgroups who are more susceptible to poor wellbeing (for example, by work, relationship status and health behaviours). This may indicate where interventions could be targeted. For example, it was noted that some initial investigations suggest that while the 40-54 year age group are more likely to have a full-time job or to be self-employed, their higher levels of economic activity are less likely to be associated with higher levels of mental wellbeing. In particular, compared with those in other age groups, people who are in full-time employment or are self employed in this age group are less likely to report satisfaction with their personal relationships, are more likely to have had a recent divorce or become separated, and are less likely to meet with or talk to people from outside their own household' (Deacon et al, 2010a).*

Families and households at risk/ marital status

Family structure can influence the risk of developing mental health problems. The Mental Health Foundation (2007) noted that children of single-parent families are twice as likely to have mental health problems compared to children of two-parent families (16%, compared to 8%).

Children from large families, children of poor and poorly educated parents and those living in social sector housing were also at higher risk. Children in poor households are three times as likely to have mental health problems as children in well-of households (Mental Health Foundation, 2007, quoting NSF, 1999). *(Note – there were no percentages included – so it was not possible to calculate estimates).*

In Merseyside in 2007, each local authority (with the exception of Sefton) had levels of child poverty significantly worse than the national average. In Liverpool, as many as 41.2% of children were living in poverty (Figure 2.18).

In light of the coming cuts and growing cost of living, there is a risk of child poverty deteriorating greatly in the years ahead. A contraction in the employment market is also a key risk factor (CPAG 2011).

Figure 2.18

Children in poverty

LA

Halton	29.95 (n=7230)
St.Helens	25.3 (n=8833)
Knowsley	36.9 (n=11784)
Liverpool	41.2 (n=32695)
Sefton	21.5 (n=11373)
Wirral	26.5 (n=16187)
England	22.4

% of children living in families receiving means-tested benefits, 2007

black = significantly worse than England average
white = significantly better than England average

data source: APHO health profiles 2010
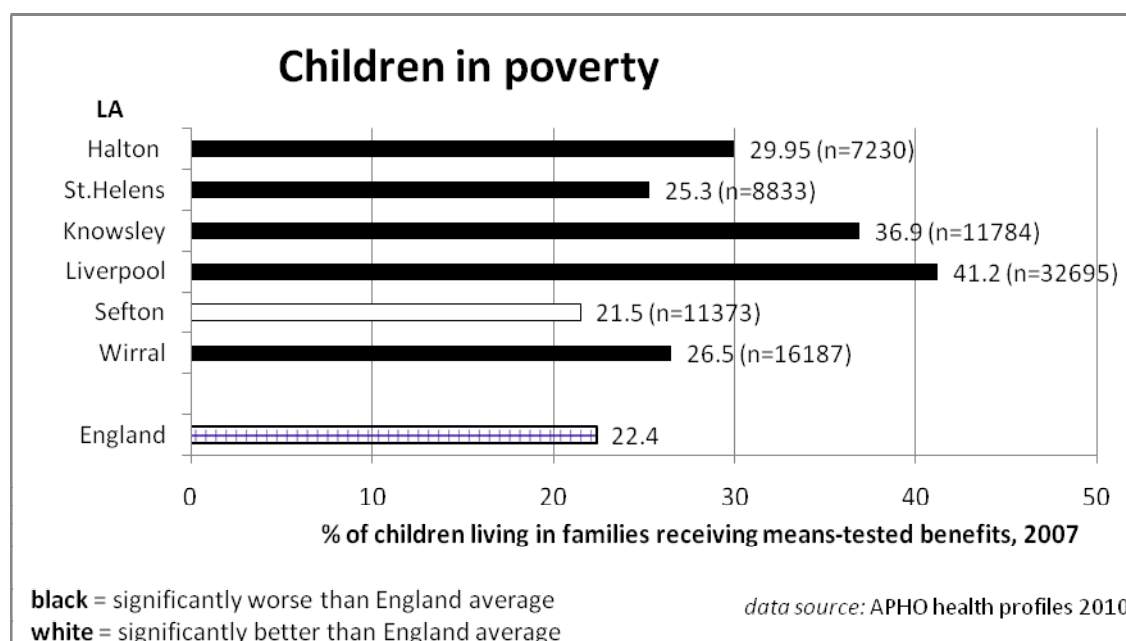
Marital status: Amongst adults, the 2007 Psychiatric Morbidity Survey found that amongst men, those who were divorced had the greatest likelihood of having a common mental disorder (CMD). More than 1 in 4 divorced men (27.7%) had a common mental disorder, compared to 1 in 10 (10.1%) of men who were married (McManus et al, 2009). Amongst women, rates were similarly high for those who were divorced (26.6%), but even higher (33%) for those who were separated. For men who were separated, rates were similar to those for married men (10.5%).

For men and women combined, rates of common mental disorder were 23.3% amongst those who were separated and 27.1% of those who were divorced.

The 2000 Psychiatric Morbidity Survey found that, compared to those with no neurotic disorder (i.e. CMD), those with neurotic disorder were more likely to:
- be living as a lone parent family unit (more than twice as likely - 9% compared with 4%)
- come from a lower social class

(the 2007 survey report – McManus et al, 2009 - did not include these variables for analysis).

Those with a probable psychosis are even more likely than those with neurosis to have many of the characteristics associated with vulnerable family structure, being three times more likely to be separated or divorced; and three times more likely to be living as a lone-parent family unit (Singleton et al, 2001).

In Merseyside, only Knowsley (3.12%) and Liverpool (3.07%) had higher proportions of people who were separated when compared to the national average 0f 2.4% (Figure 2.19). Proportions of divorced people in Merseyside were higher than the national average of 8.2% in each local authority except in Knowsley (8.1%) and St.Helens (8.2%). Highest rates were found in Wirral, where 9.2% of people aged 16 or over were divorced (Figure 2.20).

Figure 2.19
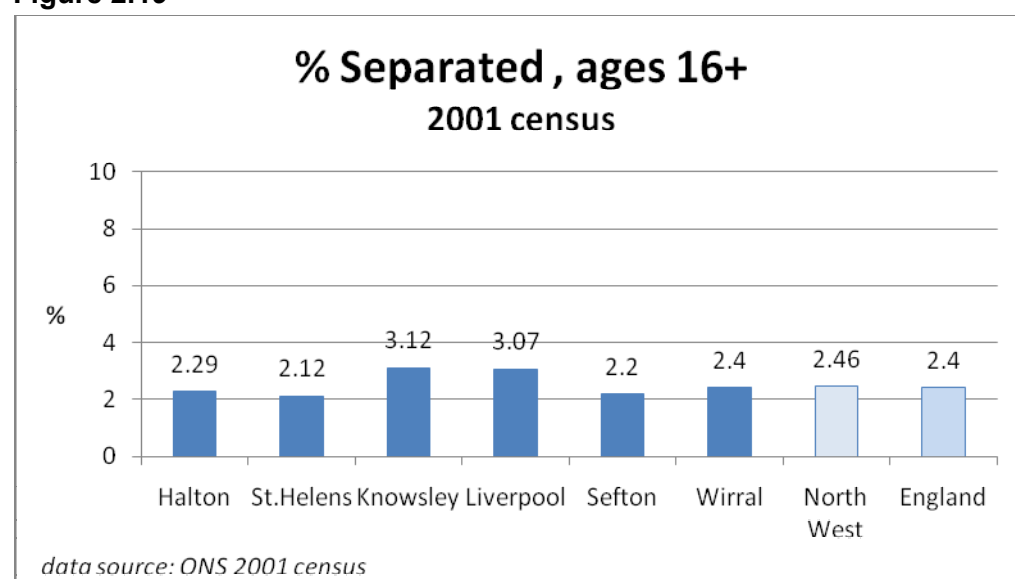
Table 2.10 gives the actual numbers of separated and divorced people in each local authority on Merseyside, with a total of 30,399 separated and 100,303 divorced. If the results of the 2007 National Morbidity Survey are applied to the Merseyside population, there would be an estimated 7,083 (23.3%) separated and 27,182 (27.1%) divorced people in Merseyside with a common mental disorder (Table 2.10). Predicted numbers for each local authority are shown in the table.

Figure 2.20

% Divorced, ages 16+,
2001 census

	Halton	St.Helens	Knowsley	Liverpool	Sefton	Wirral	North West	England
%	8.9	8.2	8.1	8.5	8.3	9.2	8.6	8.2

data source: ONS 2001 census
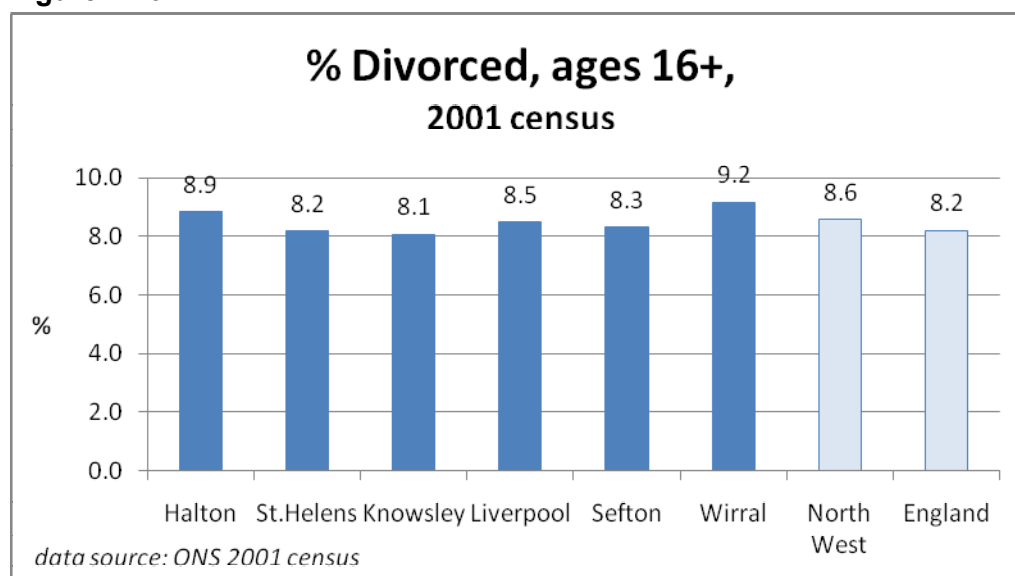
Table 2.10
Numbers of separated and divorced people in Merseyside,
of whom numbers estimated to have a common mental disorder

		Halton	St.Helens	Knowsley	Liverpool	Sefton	Wirral	Merseyside
Numbers of separated and divorced people*	Separated	2121	2976	3619	10769	4961	5953	30399
	Divorced	8188	11485	9357	29764	18789	22720	100303
Numbers estimated to have a common mental disorder**	Separated (23.3%)	494	693	843	2509	1156	1387	7083
	Divorced (27.1%)	2219	3112	2536	8066	5092	6157	27182

*based on 2001 census
**based on National Psychiatric Morbidity Survey 2007 (McManus et al, 2009)
Note: These estimates of levels of mental health problems do not take account of variations in the age and sex structure of local populations, or variations in related factors such as deprivation, which may be higher in local populations and may therefore mean that levels of mental health problems are likely to be underestimated.

Children at risk

Looked after children

The Department of Health's *'No health without mental health'* (DH, 2011b) notes that in England, 0.5% of all under-18-year-olds are looked after, with 72% living in foster placements. These children and young people have a five-fold increased risk of mental disorders, a six- to seven-fold increased risk of conduct disorder and a four- to five-fold increased risk of attempting suicide in adulthood.

Around 45% of looked after children have a mental health disorder, rising to 72% for those in residential care (DH, 2011b). The Department of Health state that timely and effective health assessments, involving the use of screening tools, are crucial to the speedy identification of problems and referral to support services. *(p.16 in DH 2011b includes an example of a package of care that has led to improved outcomes).*

In Merseyside, there were 2,485 looked after children in 2009 (as at 31st March 2009). Table 2.11 shows that rates across Merseyside were higher than the national average in each local authority in 2009. All except Halton and Sefton were higher than the North West average, with the highest rates found in Liverpool (99) and Wirral (93).

Table 2.11
Children who were Looked After, 31st March 2009

Local authority	Numbers	Rate per 10,000 children aged under 18 years	Estimate of numbers with a mental health problem (45%)
Halton	160	57	72
St.Helens	325	84	146
Knowsley	305	88	137
Liverpool	860	99	387
Sefton	365	64	164
Wirral	630	93	284
Merseyside	2,645		1,190
North West	10,600	71	
England	60,900	55	

Data source: http://www.dcsf.gov.uk/rsgateway/DB/SFR/s000873/FINALAdditionalTables1to13.xls

Applying the DH estimate above, there could be around 1,190 looked after children in Merseyside with a mental health problem (45% of 2,645), with the highest numbers in Liverpool (430) and in Wirral (315) (Table 2.11). As they reach adulthood, they will be requiring support from the adult mental health services across Merseyside.

Note: These estimates of levels of mental health problems do not take account of variations in the age and sex structure of local populations, or variations in related factors such as deprivation, which may

be higher in local populations and may therefore mean that levels of mental health problems are likely to be underestimated.

Feeling safe, bullying and emotional health amongst children
The national Tellus2 survey (2007) revealed that the numbers of children who said they felt unsafe at home from being hurt by others ranged from as many as 1 in 12 in St.Helens to 1 in 27 in Liverpool (see table A4 in Appendix 2).

Severe school bullying was reported to be worst in Knowsley, where 1 in 14 said they had been bullied most days in the last 4 weeks (see table A4 in Appendix 2).

Based on the Tellus4 survey (2010), compared with the rest of the country, children in Liverpool, Knowsley and St.Helens are amongst those with the best levels of emotional health. Children in Wirral and Sefton also have higher than national average levels of emotional health.
See Ubido and Winters 2010, p.31 for more details:
N.B. 'Tellus4' did not cover 'unsafe at home' or bullying.

Adult survivors of childhood sexual abuse

Figure 2.21 shows the estimated numbers of people in the adult population in Merseyside aged 18-64 who report having been sexually abused during their childhood, projected to 2020. Numbers are taken from PANSI data[2], based on a report of a study by the NSPCC in which 11% of respondents reported having been abused in childhood against their wishes or when they were 12 years old or younger, the prevalence being 7% for males and 16% for females (Cawson et al, 2000).

Numbers of adults who are survivors of sexual; abuse in childhood range from 34,111 in Liverpool to 8,648 in Halton (Figure 2.21). Numbers are expected to fall slightly in each local authority between 2010 and 2020.

A significant proportion of these adults would be expected to have some form of mental health problem. Research shows that both male and female victims of abuse have significantly higher rates of psychiatric problems than the general population. For example a study by Spataro et al (2004) found that survivors of sexual abuse were more than three times as likely to have received psychiatric treatment than general population controls (12.4% compared to 3.6% over a nine year period). Rates were higher for personality disorders, anxiety disorders and major affective disorders, but not for schizophrenia.

---

[2] Projecting Adult Needs and Service Information System

Figure 2.21
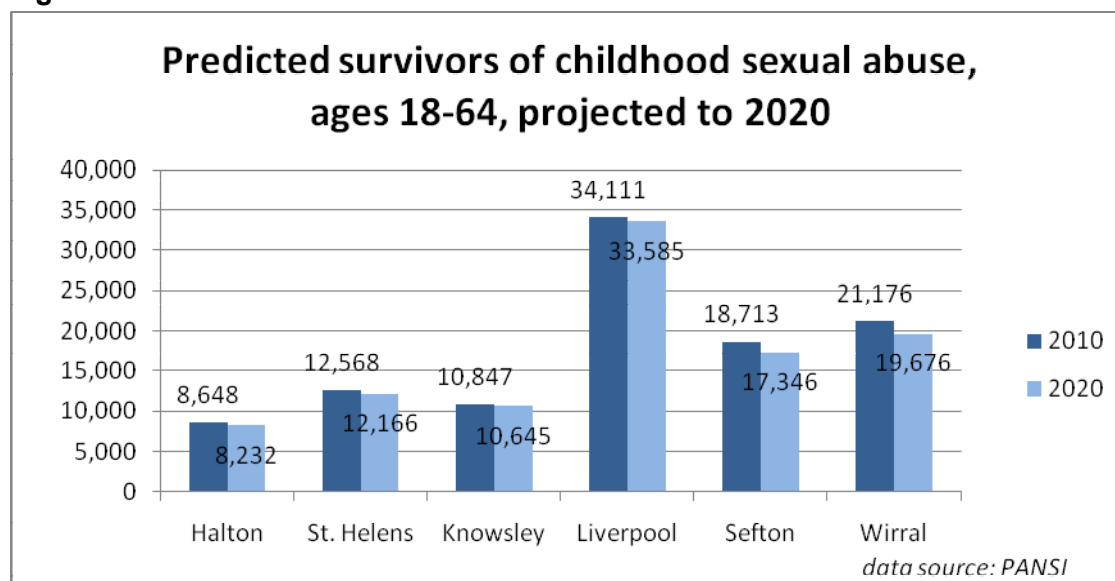
Predicted survivors of childhood sexual abuse, ages 18-64, projected to 2020

Source: http://www.poppi.org.uk/PANSI%20v%204.1%20User%20Guide.pdf

A social and economic analysis of the 2000 Psychiatric Morbidity Survey found that people with mental health problems are more than four times as likely to have experienced sexual abuse than the rest of the population (Meltzer et al, 2002). There will be effects both ways, with sexual abuse potentially leading to mental health problems in adult life, and also the increased vulnerability of children and adults with mental health problems making them more likely to become targets for sexual abuse.

Applying the results of the Spataro et al study (2004) to Merseyside statistics would suggest that there could be an estimated 13,152 adult survivors of childhood sexual abuse who have received psychiatric treatment, ranging from 4,230 in Liverpool to 1,072 in Halton (Table 2.12).

Table 2.12
Estimated numbers with mental health problems amongst those aged 18-64 predicted to be survivors of childhood sexual abuse, 2010

	Predicted survivors*	Number estimated to be in receipt of psychiatric treatment**
Halton	8,648	1072
St. Helens	12,568	1558
Knowsley	10,847	1345
Liverpool	34,111	4230
Sefton	18,713	2320
Wirral	21,176	2626
Merseyside total	**106,063**	**13152**

data source: PANSI

**12.4%, based on Spataro et al (2006)*

Note: These estimates of levels of mental health problems do not take account of variations in the age and sex structure of local populations, or variations in related factors such as deprivation, which may be higher in local populations and may therefore mean that levels of mental health problems are likely to be underestimated.

Homeless people

Homelessness is associated with severe poverty and is a social determinant of health. Statutorily homeless households contain some of the most vulnerable members of society. Statistics suggest that 62% of officially accepted homeless households include dependent children or an expectant mother. Statutorily homeless statistics are an underestimate of homelessness, as rough sleepers are not included – there are likely to be many people with mental illness amongst this group who, with a few exceptions, will not be accessing mainstream mental health services (APHO, 2010 and National Mental Health Development Unit, 2010).

The Mental Health Foundation (2007) compiled the following facts:
- 30-50% of homeless rough sleepers experience mental health problems
- 1 in 4 homeless people will die by suicide
- homeless children living in temporary accommodation are more likely to have behavioural problems
- homeless mothers and children have significantly more mental health problems
- between 1900 and 2006, the numbers of homeless people experiencing mental illness more than doubled to 7,340 in the UK
- homeless people are 40 times less likely to be registered with a GP (DH, 2011a)

In Merseyside in 2008/09, Knowsley had the highest rate of statutory homeless households, at almost 5 per 1,000 households (Figure 2.22). The rate in Knowsley was twice the national average. Rates in Halton & St.Helens were also significantly higher than the national average. Rates in Sefton and Wirral were significantly lower than the national average.

Official statistics on numbers of rough sleepers estimate that there were 13 on Merseyside at any one point in time in 2010 (Table 2.13). Liverpool, Sefton and Wirral each had 3 - there were none in Knowsley. Numbers in Liverpool show a sharp fall from previous years, when there were 9 in 2009 and 13 in 2008.

These numbers are underestimates, as rough sleepers will not always be visible. A study by Cisis, the national charity for single homeless people, found that hidden homelessness is highly prevalent, with many sleeping rough, in squats, staying with friends, or in other homeless situations. The study noted that by its very nature, it is extremely difficult to accurately estimate the size of the homeless population. Crisis conclude that the most accurate statement is to say that 'there are countless thousands of hidden homeless people throughout Britain' (Reeve and Batty, 2011).

Figure 2.22

Statutory homelessness

LA

Halton	3.34 (n=166)
St.Helens	3.75 (n=280)
Knowsley	4.97 (n=312)
Liverpool	2.62 (n=505)
Sefton	0.82 (n=97)
Wirral	1.45 (n=197)
England	2.48

crude rate of homeless households per 1,000 households, 2008/09

black = significantly worse than England average
white = significantly better than England average

data source: APHO health profiles 2010
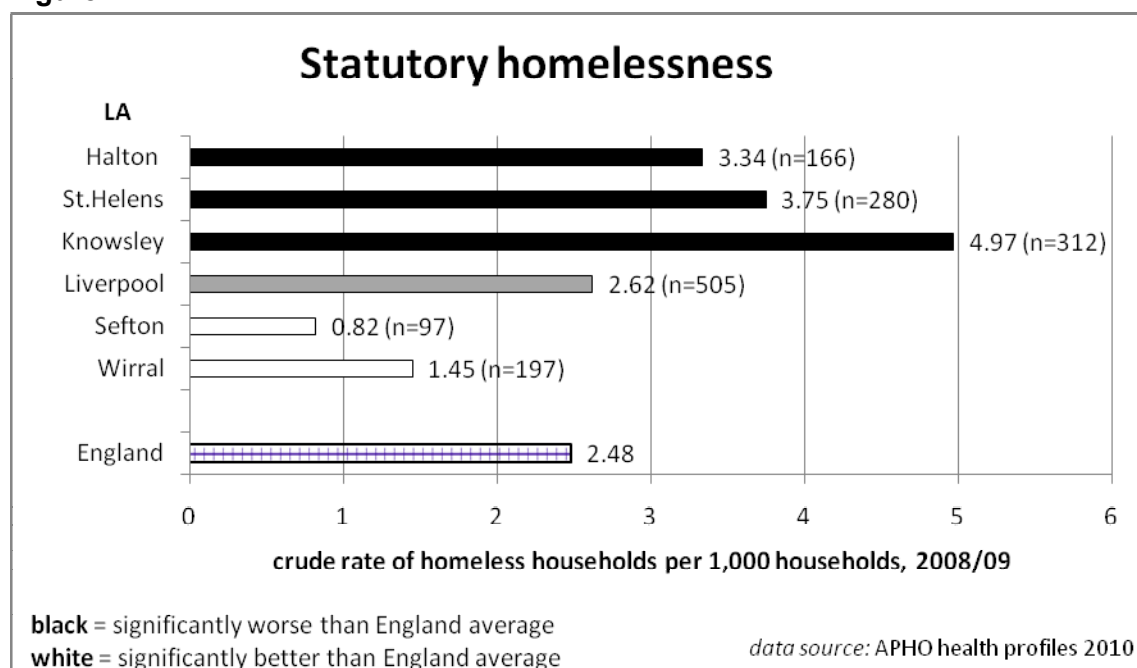
Note: "non-statutory   homeless are, those to whom no duty is owed either because they are deemed intentionally homeless, or are not in a priority need categories (APHO, 2010).

Table 2.13
Rough sleepers, street counts, 2010

	Number of rough sleepers
Halton	2*
St Helens	2*
Knowsley	0*
Liverpool	3**
Sefton	3*
Wirral	3*
Merseyside	**13**

*= estimate, June 2010
**=actual count, 25/03/10
Data source: Department for Communities and Local Government
http://www.communities.gov.uk/publications/corporate/statistics/roughsleepingcount2010

Recommendations from the National Mental Health Development Unit (2010) include:
- Tackling homelessness effectively will require agencies to integrate accommodation with psychologically informed health and support services
- Train and support staff to recognise and work with behavioural and other issues common in people who have experienced complex trauma, such as homeless people
- Ensure multi-agency risk management follows risk assessment so that homeless people are not excluded from accommodation or other support services

- Work with the presenting behaviour of the homeless person, rather than restricting access to services until behaviour changes (e.g. alcohol abuse).
- Target outreach support at squatters and other hidden homeless (Reeve and Batty, 2011)

'No Health Without Mental Health' noted that it is essential that access to and take-up of mental health services among homeless people is improved and that they include an outreach element. Recognising the complex causes of homelessness, homeless outreach teams need the involvement of mental health teams and drug and alcohol services to help them offer effective support (DH, 2011a).

Housing type as a risk factor in mental health was covered in an earlier section (in 'Housing type', Section 2.2)

Offenders

Prisoners

Amongst the prison population, there are significantly more people with mental disorders compared to the general population:

- up to 90% of prisoners have some kind of mental disorder and/or substance abuse problem
- the most common are personality disorders, which are prevalent in 64% of males and 50% of female prisoners. Neurotic disorders such as anxiety and depression are prevalent in 40% male and 64% female prisoners
- The prevalence of functional psychoses is well above the general population average of 0.4%. 7% of male and 14% of female prisoners had suffered from functional psychoses in the past year. In addition, up to three-quarters of prisoners with 'severe' mental illness are not identified in their prison reception health check
- as many as 12-15% of all prisoners have **four** concurrent mental disorders
- the incidence of mental disorders is higher for prisoners who are women, older people and ethnic minority groups
- 30% of all prisoners have a history of self-harm. Women make up just 6% of the prison population and yet in 2003, they accounted for 46% of all reported self-harm incidents
- the suicide rate for men in prison is five times that of men in the community. For those leaving prison, the incidence of death is considerably higher in the first few months in the community than in the months and years following. This is most commonly attributed to drug overdoses so it is not always clear whether another factor such as suicide was intended.

(Dodd, 2010, Mental Health Foundation, 2007, Singleton et al 1998)

Liverpool PCT carried out an Offender Health Needs Assessment in 2009 (Dodd 2010). Table 2.14 shows the prevalence of mental health problems amongst the 1,359 prisoners at HMP Liverpool. Of these, 319 were on remand and 1,040 were sentenced.

Table 2.14

Estimated prevalence of mental health problems amongst remand and sentenced prisoners at HMP Liverpool (males - as at 29th September 2009)   (Dodd 2010)

Health problem	Remand Prevalence	Expected Number (total on remand = 319)	Sentenced Prevalence	Expected Number (total sentenced = 1040)
Psychosis and personality disorder				
Personality disorder	78%	**249**	64%	**666**
Functional psychoses	10%	**32**	7%	**72**
Neurotic disorder (in past week)				
Post-traumatic disorder	5%	**16**	3%	**31**
Mixed anxiety and depression	26%	**83**	19%	**198**
Generalised anxiety disorder	11%	**35**	8%	**83**
Depressive episodes	17%	**54**	8%	**83**
Phobias	10%	**32**	6%	**62**
Obsessive-compulsive disorder	10%	**32**	7%	**72**
Panic disorder	6%	**19**	3%	**31**
Any neurotic disorder	59%	**188**	40%	**416**
Self-harm & Suicide				
Suicide attempts (in past week)	2%	**6**	0%	**0**
Suicide thoughts (in past week)	12%	**38**	4%	**41**
Non-suicidal self-harm	5%	**16**	7%	**72**

Source: Dodd (2010), based on Marshall et al (2000)
N.B. prisoners can be counted more than once if they have more than one diagnosis

As many as 1 in 10 of those on remand suffered from a functional psychosis (compared to only 0.3% of males in the general population – see table 3.1, Section 3).

For each type of problem, (with the exception of non-suicidal self-harm), prevalence is greater amongst remand prisoners when compared to sentenced prisoners. As many as 12% of remand prisoners had suicidal thoughts in the previous week – three times as many as sentenced prisoners. Twice as many remand prisoners had depressive episodes or panic disorders in the past week, compared to sentenced prisoners.

There are no female or young offender prisons in Merseyside. This has implications for the mental health of female prisoners, who may suffer as a result of being far away from their families in Merseyside

Released prisoners
From April 2010 to March 2011, there were 1,614 prisoners released from prisons around the UK who commenced licence in Merseyside. Numbers varied from 112 to 176 per month. Offenders who spend more than 12 months in prison are released on licence (Lewis, 2011). Based on these statistics, it is estimated that up to 1,450 prisoners with mental health problems and/or substance abuse problems are released on licence to addresses in Merseyside each year (based on the estimate that up to 90% of prisoners have some kind of mental disorder and/or substance abuse problem in Singleton et al, 1998 and DH 2011).

Note: These estimates of levels of mental health problems do not take account of variations in the age and sex structure of local populations, or variations in related factors such as deprivation, which may be higher in local populations and may therefore mean that levels of mental health problems are likely to be underestimated.

An offender health needs assessment for Merseyside is currently being carried out by Liverpool Public Health Observatory, with a report to be published early 2012.

Carers

Prevalence of caring
The 2001 census found that around 1 in 10 of the total population provide unpaid care to family, friends or neighbours with long-term physical or mental health problems (Figure 2.23). A study by Carers UK found that carers who provide high levels of unpaid care are more than twice as likely to suffer from poor health compared to people without caring responsibilities. Working age carers with the highest weekly hours of caring have the poorest levels of health (Carers UK, 2006).

A survey into the mental health of carers in the UK found that:
- in 2000, one in six people aged 16 or over (16%) was caring for a sick, disabled or elderly person and one in five households (21%) contained a carer. These figures represent around 6.8 million adult carers in 5 million households
- about a third of carers (5% of adults) were looking after someone living with them and two-thirds (11% of adults) were caring for someone living elsewhere

- nearly one in ten adults (9%) were the main support for the person they were looking after and nearly one in twenty (4%) were spending 20 or more hours per week on caring tasks

(Singleton et al, 2002).

A study of young carers found that of the 175,000 young carers in the UK, 29% are looking after people with mental health problems (Dearden and Becker, 2004).

The mental health charity Rethink carried out a survey of those who care for people with mental health problems, and found that as many as one in four (27%) said that they had been denied access to help during the past three years. Over half of all carers (56%) cited an access related issue as the most frustrating aspect of dealing with mental health services (Rethink, 2003).

Mental health of carers: The survey of the mental health of carers found that 18% of carers had significant levels of neurotic symptoms. Female carers were more likely to have neurotic symptoms than male carers (21% of female carers, compared to 12% of males). Female carers were 23% more likely to have neurotic symptoms than women in the general population. Those who spend 20 or more hours caring each week were twice as likely to suffer from neuroses as those spending less time caring (Singleton et al, 2002).

In Merseyside, there are an estimated 170,685 people providing unpaid care to family, friends or neighbours with long-term physical or mental health problems (Table 2.15). In each local authority on Merseyside, the proportion of the population who are carers is greater than the national average of 1 in 10 (9.9%) (Figure 2.23). In St.Helens and Wirral, nearly 1 in 8 of the population are carers.

There are an estimated 44,664 people in Merseyside who provide care for 50 hours or more each week. The proportion providing such levels of care in Merseyside is higher than the national average. In Knowsley, nearly 1 in 3 of all carers (30.6%) provide care for 50 hours per week or more – compared to only 1 in 5 (20.5%) nationally.

Of the carers on Merseyside, as many as 30,723 could have significant neurotic symptoms (based on the estimate of 18% in Singleton et al, 2002). Estimates for each local authority are given in Table 2.15.

Figure 2.23

% of total population providing unpaid care,
of which % providing care for 50 hours or more per week,
2001 census
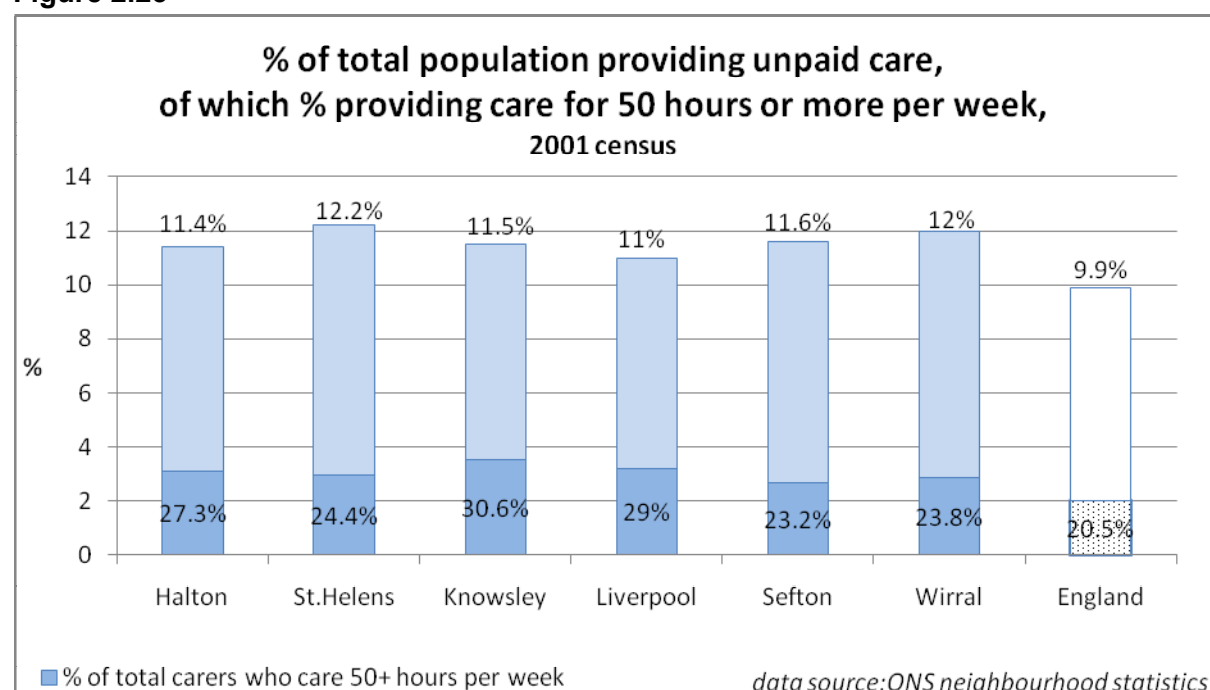
From the 2001 census, which asked people whether they were providing unpaid care to family, friends or neighbours with long-term physical or mental health problems.

Table 2.15
Numbers of people providing care, and proportions likely to have significant neurotic symptoms, (based on 2001 census)

	Halton	St.Helens	Knowsley	Liverpool	Sefton	Wirral	Merseyside
Number of people providing unpaid care	13528	21519	17360	48123	32701	37454	170685
...of which, number providing care for 50 or more hours per week	3699	5256	5306	13937	7570	8896	44664
*Of all carers, numbers likely to have significant neurotic symptoms	2435	3873	3125	8662	5886	6742	30723

Data source: 2001 census, which asked people whether they were providing unpaid care to family, friends or neighbours with long-term physical or mental health problems.
http://neighbourhood.statistics.gov.uk/dissemination/LeadHome.do;jessionid=ac1f930c30d8543c0be0467042c78619cb8012692216?m=0&s=1271257626939&enc=1&nsjs=true&nsck=true&nssvg=false&nswid=1260
*based on estimates in Singleton et al (2002)

Note: These estimates of levels of mental health problems do not take account of variations in the age and sex structure of local populations, or variations in related factors such as deprivation, which may

be higher in local populations and may therefore mean that levels of mental health problems are likely to be underestimated.

The government's National Carers' Strategy (DH, 2008) states that by 2018 every carer should be: recognised and supported as an expert care partner; enjoying a life outside caring; not financially disadvantaged; mentally and physically well; treated with dignity; and that: children will be thriving, protected from inappropriate caring roles. Long-term plans on how these outcomes are to be achieved are detailed in 'Recognised, Valued and Supported: Next Steps for the Carers' Strategy' (DH, 2010b). Six key areas have been identified as priority commissioning needs for carers:

- *A life outside caring*: including the need for respite breaks and support to remain in or to find employment
- *Health and wellbeing*: including the need for GP services to be flexible and to understand the needs of carers
- *Access to information*: in accessible format and location
- *Consultation with carers*: in planning, commissioning and evaluating services
- *Partnership with carers*: including involving carers in the assessment process and developing a programme of carer awareness training events for a range of staff who work with carers
- *Supporting young carers*: through their transition into adulthood, ensuring access to appropriate information and advice.

(O'Connor, 2010, Knowsley JSNA)

For young carers, Barnados runs 15 projects across the UK which work to support them and their families as follows:

- Helping the family to find the support they need, and are entitled to, from local services, so that a child's caring responsibilities can be reduced.
- Supporting young carers to use local services such as sports clubs, support groups, and health centres.
- Providing advice and emotional support through counselling and drop-in sessions.
- Liaising with schools so that teachers can better support their students.
- Providing opportunities for young carers to take a break from their caring responsibilities spend time with other young carers and share experiences.
- Providing opportunities for young carers to learn more about their parent's illness or disability.

(Barnados, 2011)

3. Populations suffering ill health

Prevalence of mental disorders

Table 3.1 shows the prevalence of different types of mental disorder, as found in the most recent psychiatric morbidity survey (McManus et al, 2009). The vast majority of psychiatric disorders are for common mental health problems such as anxiety and depression (12.5% of men and 19.7% of women). There is also a substantial proportion of people who have a dual diagnosis, meeting the diagnostic criteria for two or more psychiatric disorders (6.9% of men and 7.5% of women) (McManus et al, 2009).

Table 3.1

Prevalence of mental disorders, males and females, ages 16+,
by type of disorder, 2007

	% males	% females	% all persons
Common mental disorder (past week)	12.5	19.7	16.2
Current post traumatic stress disorder	2.6	3.3	3.0
Suicidal thoughts (past year)	3.4	5.2	4.3
Suicide attempts (past year)	0.5	0.9	0.7
Psychotic disorder (past year)	0.3	0.5	0.4
Borderline personality disorder (past year)	0.3	0.6	0.4
Antisocial personality disorder (past year)	0.6	0.1	0.3
Two or more psychiatric disorders	6.9	7.5	7.2

Source: McManus et al, 2009

3.1 Prevalence of Common Mental Disorders

Common mental disorders, also known as neurotic disorders, cause marked emotional distress and interfere with daily function. They comprise different types of depression and anxiety and can often remain undiagnosed.

The National Morbidity surveys, undertaken in 1993, 2000 and 2007, provide the best estimates of the prevalence of these disorders (McManus et al [eds], 2009). The 2007 survey categorised common mental disorders as follows:

• Generalised anxiety disorder;
• Mixed anxiety and depressive disorder;
• Depressive episode (including mild, moderate and severe);
• Phobias;
• Obsessive-compulsive disorder; and
• Panic disorder.

In the 2007 survey, the national prevalence of common mental disorders was found to be 16.2% amongst adults (McManus et al, 2009). More than half of these people had a mixed anxiety and depressive disorder (9% of the total sample).

Figure 3.1 shows the estimated numbers of people with a common mental disorder for each local authority on Merseyside. The Merseyside total was 147,950 in 2010. Numbers range from nearly 48,000 in Liverpool, to around 12,000 in Halton. Numbers are predicted to fall slightly over the next 10 years in each local authority on Merseyside.

Figure 3.1

Common mental disorder, predicted numbers aged 18-64, 2010 and 2020, Merseyside
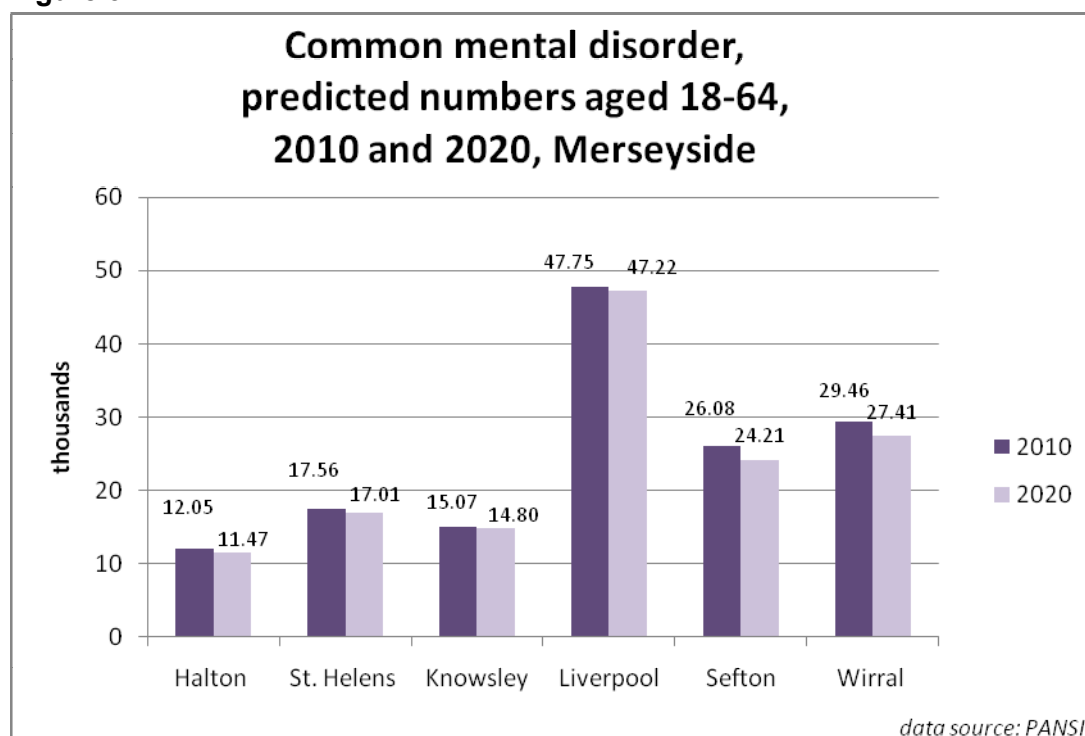
Gender

Women were more likely than men to have a common mental disorder (CMD). One woman in five had a CMD during the week before interview (19.7%) compared with one man in eight (12.5%). There were significantly higher rates in females for all categories except panic disorders and obsessive compulsive disorder (McManus et al, 2009). Levels in the North West were higher than the national average for both sexes (Table 3.2).

Table 3.2
Common mental disorder in past week by region and sex, ages 16+, 2007.

	North West %	National %
Men	14.7	12.5
Women	20.3	19.7
All persons		16.2

Data source: Adult psychiatric morbidity survey, McManus et al (2009)

Age

Overall, the prevalence of common mental disorders was found to be highest amongst those aged 45-54 and lowest in those aged 75 plus. The rate among women peaked in the 45-54 age group, with a quarter (25.2%) meeting the criteria for at least one CMD. Among men, the rate was highest in 25-54 year olds (14.6%of 25-34 year olds, 15.0% of 35-44 year olds, 14.5% of 45-54 year olds) (McManus et al, 2009).

Trends
Prevalence of common mental disorders increased between 1993 and 2000, especially amongst women aged 45-64, where the rate rose by around one-fifth. There was no change in prevalence between 2000 and 2007.

Social factors:
Social factors make highly significant contributions to the onset and outcomes of particular disorders, such as common mental disorders, addictions and personality disorders. Poverty and unemployment tend to increase the duration of episodes of common mental disorders, but it is not clear whether or not they cause the onset of an episode (McManus et al, 2009). Depression and anxiety can be associated with debt and financial strain, but the direction of the association remains unclear. Other associations with common mental disorders include:

- being female;
- stress at work;
- social isolation;
- poor housing;
- negative life events;
- poor physical health;
- a family history of depression;
- poor interpersonal and family relationships;
- a partner in poor health; and
- problems with alcohol

(McManus et al, 2009).

Around 1 in 5 GP consultations are for common mental disorders. Anxiety and depression has been estimated to cause 1 in 5 of days lost from work in Britain, with 40 million days lost each year due to stress-related disorders (McManus et al, 2009).

Those with a neurotic or psychotic disorder are more likely than those with no disorder to have many of the characteristics associated with deprivation, such as economic inactivity, social housing tenancy, no educational qualifications, poor physical health.

Treatment and service use
The 2007 psychiatric morbidity survey found evidence that many people with common mental disorders do not receive treatment, even when their disorders are severe and disabling. Overall, three-quarters of adults with a common mental disorder were not in receipt of medication or counselling – including two-thirds of those who were assessed as having a level of neurotic symptoms sufficient to warrant treatment (McManus et al, 2009).
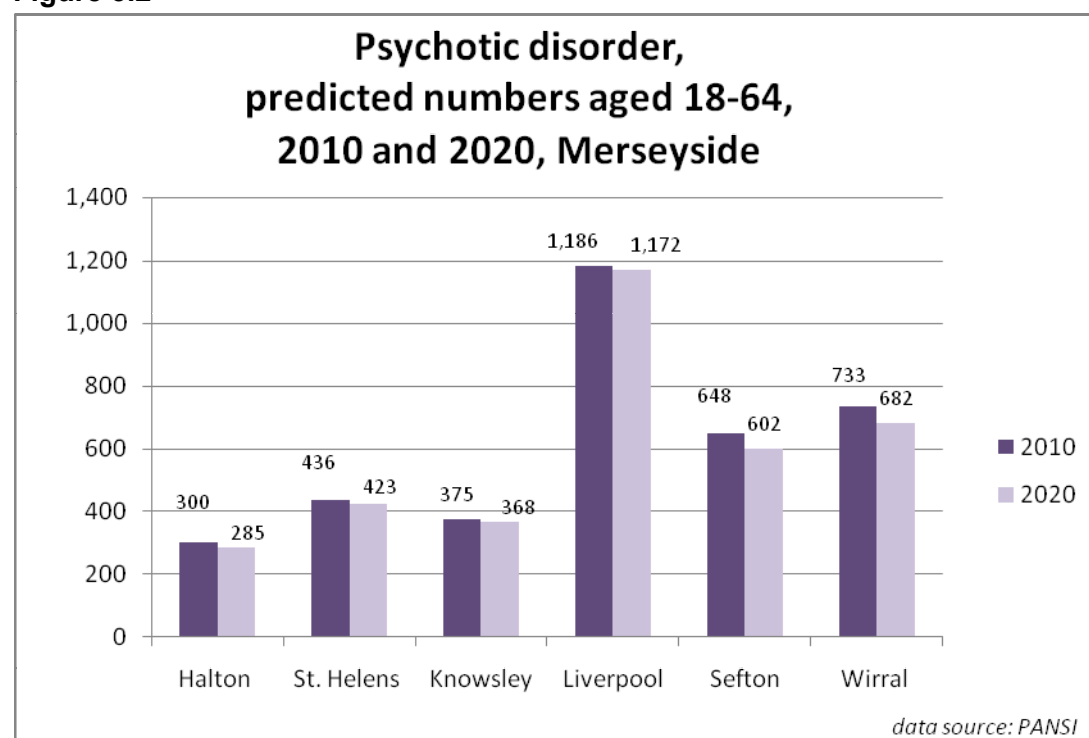
3.2 Prevalence of more severe mental health conditions

Although relatively uncommon, more severe mental health conditions such as psychotic disorders result in high costs to the NHS and society. People with such conditions are known to have low rates of employment and when employed, are often in poorly paid and less secure jobs (McManus et al, 2009). Psychoses are disorders that produce disturbances in thinking and perception severe enough to distort perception of reality. The main types are schizophrenia and affective psychosis, such as bi-polar disorder (McManus et al, 2009).

The latest psychiatric morbidity survey carried out in 2007 found that nationally, the overall prevalence of psychotic disorder was found to be 0.4% (0.3% of men, 0.5% of women). In both men and women the highest prevalence was observed in those aged 35 to 44 years (0.7% and 1.1% respectively). The age standardised prevalence of psychotic disorder was significantly higher among black men (3.1%) than men from other ethnic groups (0.2% of white men, no cases observed among men in the South Asian or 'other' ethnic group). There was no significant variation by ethnicity among women (McManus et al, 2009).

In Merseyside, Figure 3.2 shows that numbers of people with a psychotic disorder are expected to fall slightly by 2020 in each local authority. Estimated numbers of people with a psychotic disorder in 2010 range from 1,186 in Liverpool, to 300 in Halton.

Figure 3.2

Treatment and service use

The 2007 psychiatric morbidity survey found that two-thirds of adults with a psychotic disorder in the past year were receiving some form of medication and/or counselling. Just over half were receiving medication (56%) and half (48%) were in counselling or therapy (some had both).

It has been suggested that population based surveys such as the national psychiatric morbidity surveys do not identify sufficiently large numbers of cases to enable estimates of the prevalence of more severe mental health conditions such as psychoses (CPMH, 2002). IMD scores, which are regulary updated, can be used as a proxy for more severe mental health need (see section 2.2 on deprivation above). Other proxy indicators are data on claims for incapacity benefit for mental illness and hospitalised prevalence for mental health conditions..

Incapacity benefit for mental illness

Claims for incapacity benefit for mental illness can be used a proxy measure of levels of severe mental illness in the community. This provides a direct measure of socio-economic disadvantage in those 'not in work' because of mental illness (APHO, 2010).

People with long term psychiatric disabilities are less likely to be in employment than those with long term physical disabilities, despite indications that most people with severe mental illness would like to work. Data on incapacity benefit claims for mental illness will indicate where improvements are necessary in the provision of services to help mentally ill people find work and reduce social exclusion (APHO, 2010).

Unemployment rates are high amongst people with severe mental illness, with rates of 60–100% reported in the UK (APHO, 2010). The APHO (2010) point out that these high rates reflect the disability caused by severe mental illness, but they also reflect discrimination (unemployment rates are higher than in other disabled group) and the low priority given to employment by psychiatric services.

The APHO (2010) note that people with long-term psychiatric disabilities are even less likely to be in employment than those with long-term physical disabilities. Despite high unemployment rates amongst the severely mentally ill, surveys

---

Box 2
Impact of benefit cuts

The impact of the currently proposed welfare benefit cuts will hit hard on Merseyside, as stated in a recent 'Guardian' article:

'over 20% of working-age residents in Liverpool and Knowsley are claiming out of work benefits, the highest level in England......... Cuts to the payments of £197 a head by 2015 will damage local small business, from taxi firms to hairdressers. This may also derail the fragile progress made in recent years in tackling the city's deep-rooted social and health problems. Liverpool has the third-lowest life expectancy in England, as well as high levels of mental illness, smoking, alcohol abuse, obesity and teenage pregnancy. Housing conditions there are among the poorest in the country......'
(Butler P and Carter H, 2011)

---

have consistently shown that most want to work. These low rates of employment should be considered against the facts that at least 30-40% of people who are significantly disabled by enduring mental illness are capable of holding down a job.

According to the APHO (2010), more than 900,000 adults in England claim sickness and disability benefits for mental health conditions. This group is now larger than the total number of unemployed people claiming Jobseeker's Allowance in England. Between 1995 and 2004, the numbers of people claiming incapacity benefit for mental health problems almost doubled and makes up more than 40% of the total number of claimants. (Mental Health Foundation, 2007). However, the Mental Health Foundation noted that almost half of the people in contact with community mental health teams do not receive the full amount of welfare benefits to which they are entitled.

The APHO refer to evidence that suggests vocational rehabilitation services can help mentally ill people find work (Crowther et al, 2001).
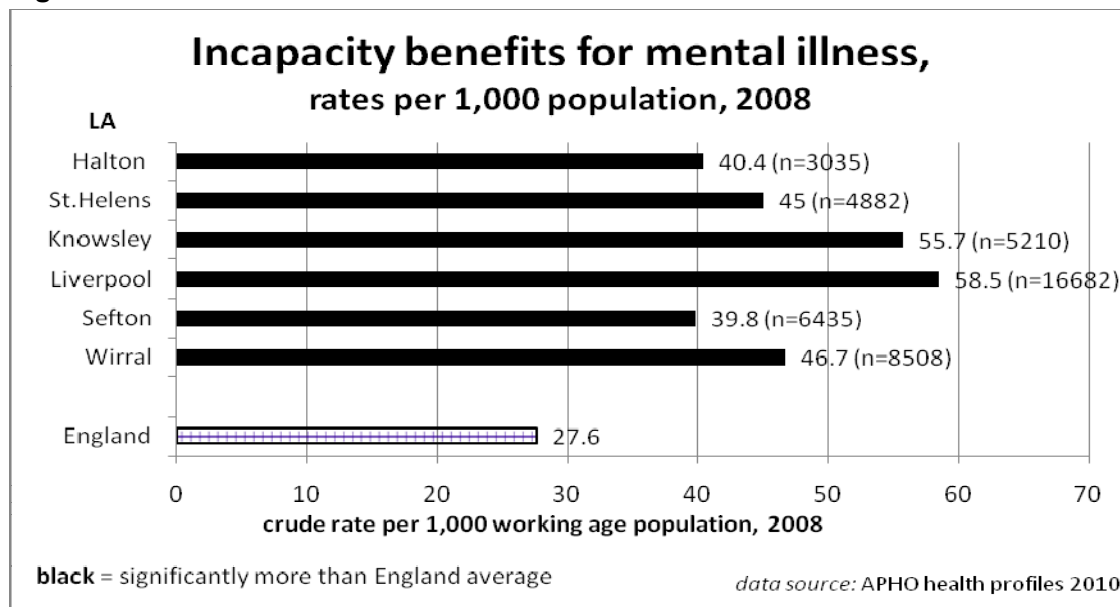(from APHO, 2010)

Barriers to returning to work may include:
- There may be a lack of available jobs in the current economic climate. In addition many of those who have been out of the job market for a considerable period will require some retraining: they will commonly lack both confidence and appropriate skills for the contemporary labour market.
- The welfare system has built in disincentives to returning to work—the "benefits trap".
- The disadvantages faced by people with a history of mental illness in the open employment market. These include stigma, a reluctance to employ them, the risk of failure faced by them and the "benefits trap".
- There may be a tendency for mental health professionals and others to underestimate the capacities and skills of their clients and to possibly overestimate the risk to employers. The vast majority of individuals who leave the labour market due to mental health problems do so before they have any contact with mental health services.
- The dominance of a model of mental illness that emphasizes episodes and "cure" as opposed to one that focuses on overcoming the disabilities of people with long-term mental illness.
- Lack of expertise in business development among mental health professionals

(RCP, 2005)

Incapacity benefit claims for mental illness on Merseyside, 2008 & 2010
Figure 3.3 shows that in all Merseyside local authorities, the rate of incapacity benefit claimants for mental illness is significantly higher than the national average. The highest rates are found in Liverpool and Knowsley, where rates are twice as high as the national average (also see Box 2). In Liverpool, 16,682 people claimed incapacity benefit for mental illness during 2008, which is as many as 1 in 17 of the working age population, compared to 1 in 36 nationally.

Figure 3.3

Incapacity benefits for mental illness,
rates per 1,000 population, 2008

LA

Halton	40.4 (n=3035)
St.Helens	45 (n=4882)
Knowsley	55.7 (n=5210)
Liverpool	58.5 (n=16682)
Sefton	39.8 (n=6435)
Wirral	46.7 (n=8508)
England	27.6

crude rate per 1,000 working age population, 2008

black = significantly more than England average

data source: APHO health profiles 2010

Note: the APHO ready-made data has been used here, even though this is for 2008 (2010 is available by numbers - presented below) - because the APHO have included significance levels

Trends:

Although nationally, numbers of claimants almost doubled between 1995 and 2004, more recently there has been a decline in numbers. In each Merseyside local authority, numbers of claimants have declined between 2004 and 2010, especially in Wirral, Liverpool and Sefton, where there was a 20% fall in numbers of claimants during this period (Figure 3.4 and see Table A5 in Appendix for actual numbers).

Figure 3.4

Incapacity benefits for mental illness
number of claimants, 2004-2010

Legend: Halton, St. Helens, Knowsley, Liverpool, Sefton, Wirral

data source: Department of Work & Pensions

Age:

In each local authority, numbers of claimants are highest in the 35-44 age group, with for example 3,700 claiming in Liverpool in 2010. Rates per thousand population reveal that those aged 55-59 and 50-54 are most likely to be claimants. Liverpool has the highest rates, where almost 1 in 10 of the population aged 55-59 (94.14 per thousand) claim incapacity benefits for mental illness (Figure 3.5 and see Appendix Table A6 for actual numbers). Sefton has the lowest rates on Merseyside for this age group, but rates are still high, with just over 1 in 20 people aged 55-59 claiming benefit (51.14 per thousand).

Figure 3.5
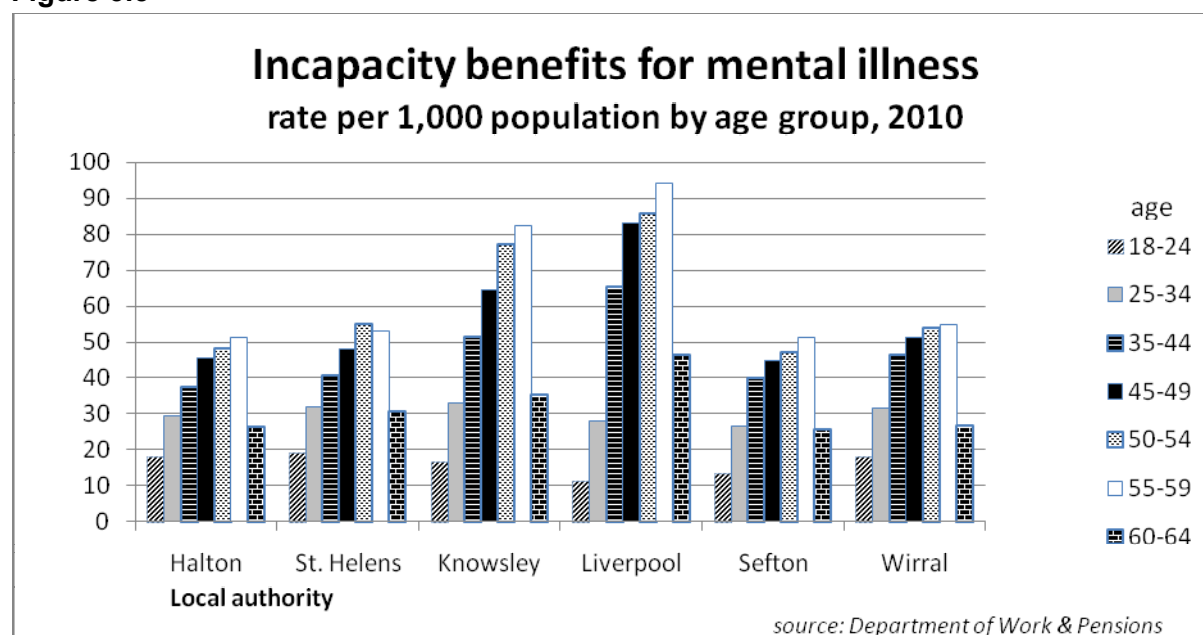
(actual numbers in Table A6 in Appendix)
N.B. rate for 18-24 claimants based on pop for ages 20-24, as 18-24 not available – so rates are higher than they should be for this age group
Source of benefits data: https://www.nomisweb.co.uk/Default.asp
Source of population data: ONS, http://www.statistics.gov.uk/statbase/product.asp?vlnk=15106

Sex:

Males are more likely to claim incapacity benefit for mental illness than females. In Merseyside, the difference between the sexes was most marked in Wirral, where the rate per thousand population was 49.64 for males compared to 37.10 for females in 2010 (Figure 3.6). Amongst males, the highest rate was found in Liverpool (57.07 per thousand). The highest female rate was in Knowsley (46.52).

A closer analysis of age and sex data reveals that the high rate in Liverpool for the 55-59 age group (94.14 per thousand) is due to a very high rate amongst females of 101.63 claimants per thousand population (i.e. just over 1 in 10). Amongst females in each local authority, the highest rates are in the age group 55-59. For males, the picture is more varied – in Liverpool, it is the 45-49 age group that has the highest rates. For males in Sefton, where rates are generally lower than other local authorities, the 35-44 age group has the

highest rates compared to other age groups. (see Appendix tables A7 and A8 for age plus sex breakdown).

Figure 3.6
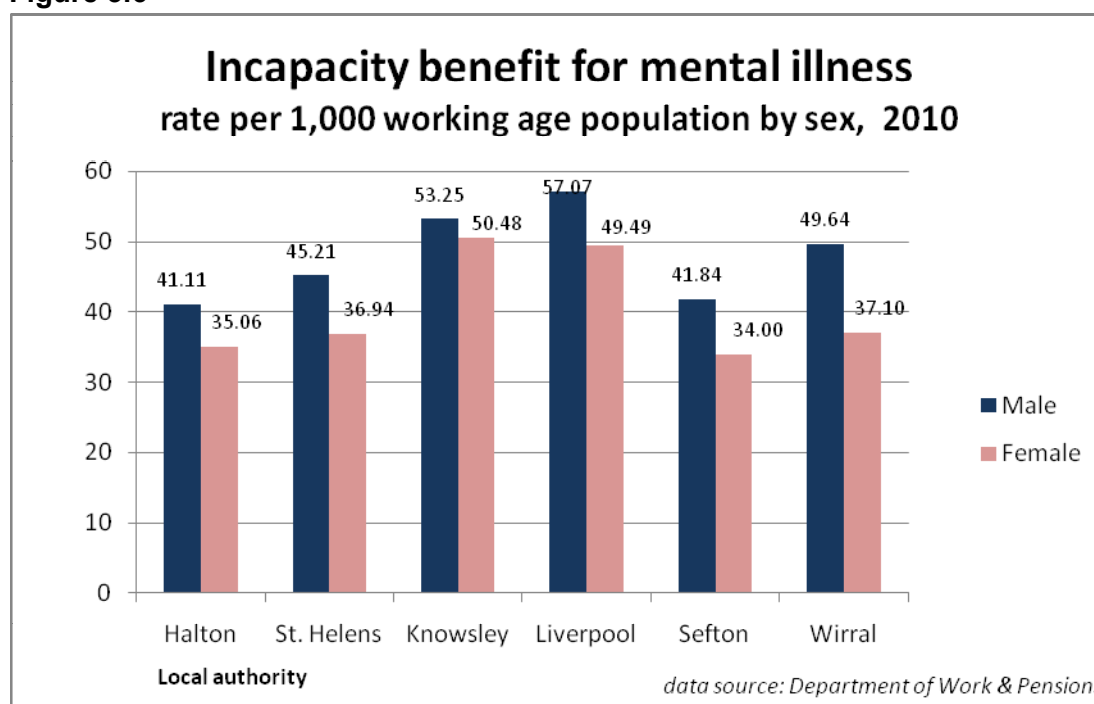
N.B. rate for 18-64 claimants based on pop for ages 20-64, as 18-64 not available
Source of benefits data: https://www.nomisweb.co.uk/Default.asp
Source of population data: ONS, http://www.statistics.gov.uk/statbase/product.asp?vlnk=15106

Map 7 (see Appendix) shows the distribution of standardised ratios of claimants within each local authority on Merseyside, with the darkest patches indicating super output areas with levels in the top fifth for Merseyside. In Liverpool, there are high levels of claimants in areas within a cluster of wards to the North West of the City (including all of Kirkdale, Everton and Kensington & Fairfield) and also most of Princess Park and the far south east side of Speke-Garston (the same patch that has higher levels of self harm).

Across the north of Knowsley, there are areas with high ratios of claimants, including most of Northwood and parts of Cherryfileld and Whitefield. Across the centre of Knowsley, there are high ratios in most of St.Gabriels, around the borders of Page Moss, St.Bartholomews, Longview and St.Michaels and across a strip in the south of Prescot West.

There is a cluster of wards along the north east side of the Wirral with high ratios of claimants, including most of Seacombe and Birkenhead & Tranmere and parts of Liscard and Rock Ferry. High levels are also found in an area stretching back through most of Bidston and St.James, and parts of Leasowe & Moreton East, together with an area in the south of Upton.

In St.Helens, high levels of claimants are concentrated in the whole of Parr and most of the Town Centre.

In Halton, there are high levels of claimants on the Runcorn side, in most of Castlefields and Windmill Hill.

In the far north of Sefton, there are high ratios of claimants in most of Cambridge ward. To the south of the borough, high levels can be found in most of Linacre and in the south part of Church ward.

Summary of incapacity benefit and hospitalised prevalence and incidence data:
The distribution of incapacity benefit claimants for mental health conditions is very similar to that for the hospitalised prevalence of mental health conditions and incidence of self-harm (see relevant sections above). In each, there are high levels in the following areas:
- to the North West of Liverpool, (and a patch within the far east side of Speke-Garston for incapacity benefit claimants and self-harm – although hospitalised self-harm is relatively low in Liverpool compared to the rest of Merseyside)
- across the north and the centre of Knowsley (hospitalised self-harm is relatively low in Knowsley compared to the rest of Merseyside)
- to the east of Wirral (for self-harm, high levels were more widespread, across the north east of the borough)
- in the centre of St.Helens
- in the centre of Halton, especially on the Runcorn side
- in the far North West and far south west of Sefton

Hospitalised prevalence of mental health conditions

The commissioners and providers of mental health care in Merseyside have plans to reduce the hospitalisation of working age people with mental health problems, with a shift in emphasis to community care. More specialised community mental health services will need to be developed. The Joint Strategic Needs Assessment (JSNA) report for Liverpool noted that in Mersey Care NHS Trust, which serves north Mersey, mental health admissions are planned to fall between 20-40% over the next seven years (Liverpool PCT 2009b).

However, the incidence of mental health problems – including in young people – can increase in times of economic and employment uncertainty, as can the rate of suicide (DH, 2011). Since Mersey Care plans for bed reductions were outlined in 2008, the economic downturn has hit Merseyside. Unemployment has risen, and economic activity is down. In these circumstances, more demand for mental health services and negative impacts on other health measures can be expected (Liverpool PCT, 2009b).

Hospital admissions for all mental health conditions

Data on standardised ratios for the hospitalised prevalence of mental health conditions are available on the North West Public Health Observatory website (http://www.nwph.net/healthprofiler/selectindex.aspx).

Figure 3.7 shows that in each local authority on Merseyside, ratios are well above the England average of 100. All but Sefton have ratios above the North West average of 141.80. In Liverpool, the ratio is twice the national average (202.98), which is significantly higher than anywhere else on Merseyside. The ratio in Halton of 190.17 is also significantly higher than in the remaining Merseyside local authorities. Sefton has a significantly lower ratio than the other Merseyside local authorities (128.84).

Figure 3.7
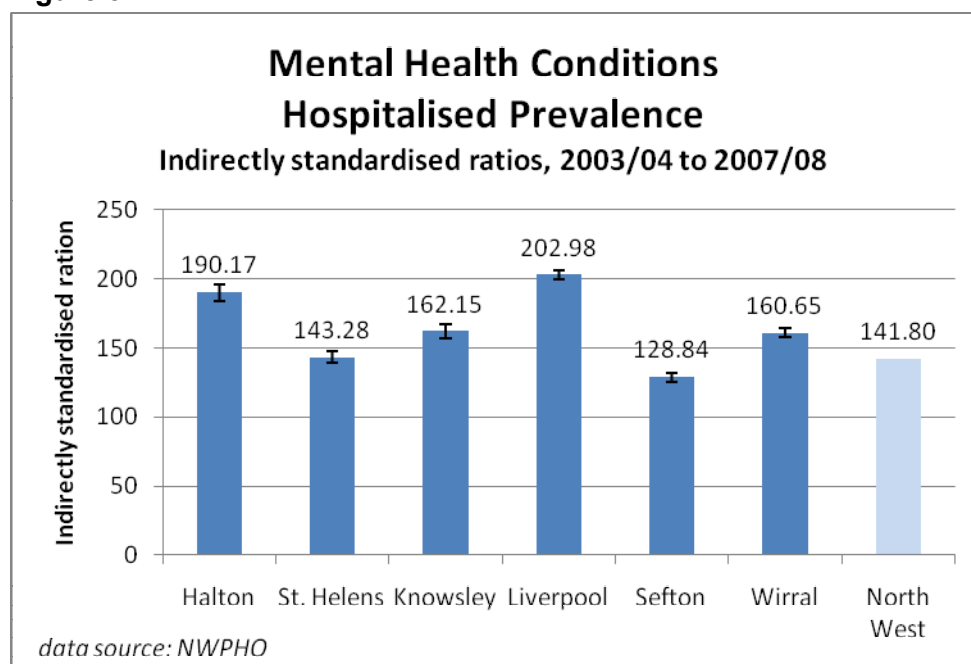
*Note: the reference population is England with a value of 100. Values of more than 100 mean that hospitalised prevalence is **more than expected** in the local population after adjusting for differences in age and sex.*

Map 8 in the Appendix shows the variation in prevalence ratios within the Merseyside local authorities. To enable analysis at small area level, the NWPHO combined data for a four year period (2003/04 to 2007/08). For the map, ratios have been sorted into quintiles (see maps in Appendix).

Within Liverpool, there is a cluster of wards in the North West of the city with super output areas having ratios in the top fifth on Merseyside – including most of Kirkdale and Everton, and Kensington & Fairfield. Ratios are also high in most of Picton and Princess Park, and to the east of Riverside. High ratios are also found in most of Yew Tree ward, in the east of the city; the east end of Riverside; the south side of St.Michaels; in the far south end of Cressington ward, merging into the far north of Speke-Garston ward;and also in west Belle Vale.

In Halton, on the Widnes side of the river, there are high ratios in Riverside, south Appleton and south Kingsway. Over in Runcorn, the whole of Castlefields and Halton Lea have super output areas with ratios in the top fifth on Merseyside. High ratios are also found in patches within other wards, including to the west of Windmill Hill and to the east of Grange.

In Knowsley, there is an area across the middle of the borough with high ratios. This area includes the whole of Stockbridge, most of Longview, north of Page Moss and the far south east area of Prescot West.

On the north east side of Wirral, there is a group of wards with high ratios. These include most of Birkenhead & Tranmere ward; south east of Leasowe & Moreton East; north of Bidston & St.James and Rock Ferry; to the east of New Brighton, Liscard and Seacombe; and around the boundary of Claughton and Oxton.

In St.Helens, there is only one ward (Town Centre) which has super output areas with ratios in the top fifth on Merseyside.

Sefton has the lowest overall hospitalised prevalence ratio for mental health conditions (128.84) – the only local authority with a ratio lower than the North West average (see Figure 3.7 above). However, there are areas within Sefton with very high ratios – most of the super output areas in Cambridge ward have ratios in the top fifth on Merseyside. Elsewhere in Sefton, there are high ratios to the far north of Duke's ward, on the west side of Ford and to the south of Church and Linacre.

Hospital admissions by diagnosis, 2006.

The above data on hospital admissions for all mental health conditions is routinely provided by the NWPHO. Up until 2006, the Mental Health Observatory (MHO, based within the North East Public Health Observatory) provided hospital admissions data by diagnosis, and by sex. Funding for the MHO ceased in 2006. The MHO data for 2006 is presented here. (Data is available for each year starting from 2001)
(source: Mental Health Observatory: http://www.nepho.org.uk/mho/diagnosis)

Psychoses (excluding affective disorders)
Liverpool had significantly higher rates of hospital admissions for psychoses (excluding affective disorders) than the other local authorities on Merseyside, for both males and females in 2006. Amongst males, the rate of 8.04 per 100,000 in Liverpool was the highest in the North West. Rates in Sefton were also high – significantly higher than in Wirral, Knowsley, Halton and St.Helens (Figure 3.8). St.Helens had the lowest male rate, at 2.65 per 100,000.

Rates were significantly lower amongst females compared to males. Amongst females, the rate in Liverpool of 3.25 per 100,000 was fourth highest of the 22 local authorities in the North West and significantly higher than other local authorities on Merseyside. The rates for females in Halton and St.Helens were significantly lower than the rest of Merseyside. The rate in St.Helens was the lowest in the North West, and the rate in Halton was the third lowest.

N.B. the rate of 0.0 for females in St.Helens was not typical – in previous years, the rates were 3.07 in 2005, 2.97 in 2004 and 2.55 in 2003

Figure 3.8

Psychosis (excluding affective disorders) –
Hospital admissions, ages 18-64, 2006
Merseyside local authorities, by sex, directly standardised rates
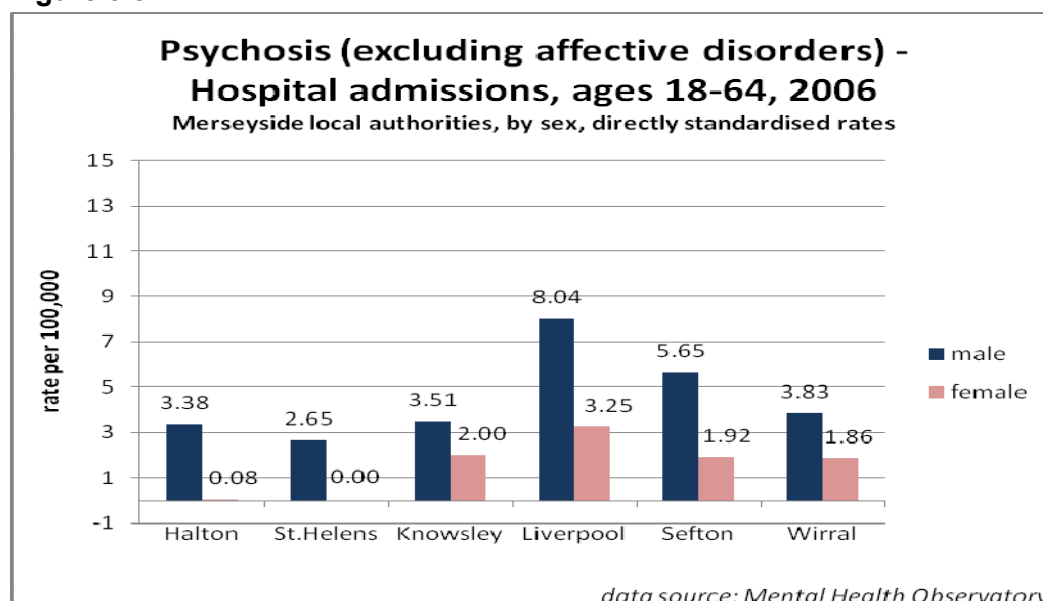
Affective disorders

Halton and Liverpool had significantly higher rates of affective disorder in males and females compared to the other local authorities on Merseyside in 2006 (Figure 3.9). Although still significant, the difference in rates in Liverpool compared to the rest of Merseyside (excluding Halton) is not quite as dramatic as it was with other psychoses (Figure 3.8).

As with other psychoses (Figure 3.8), rates of affective disorder were lowest in St.Helens, for both sexes (Figure 3.9). For males, the rate in St.Helens was the third lowest in the North West. Amongst females, the rate of 1.02 per 100,000 in St.Helens was the lowest in the North West.

Apart from in St.Helens, rates were lower amongst males than females.

Figure 3.9

Affective disorders –
Hospital admissions, ages 18-64, 2006
Merseyside local authorities, by sex, directly standardised rates
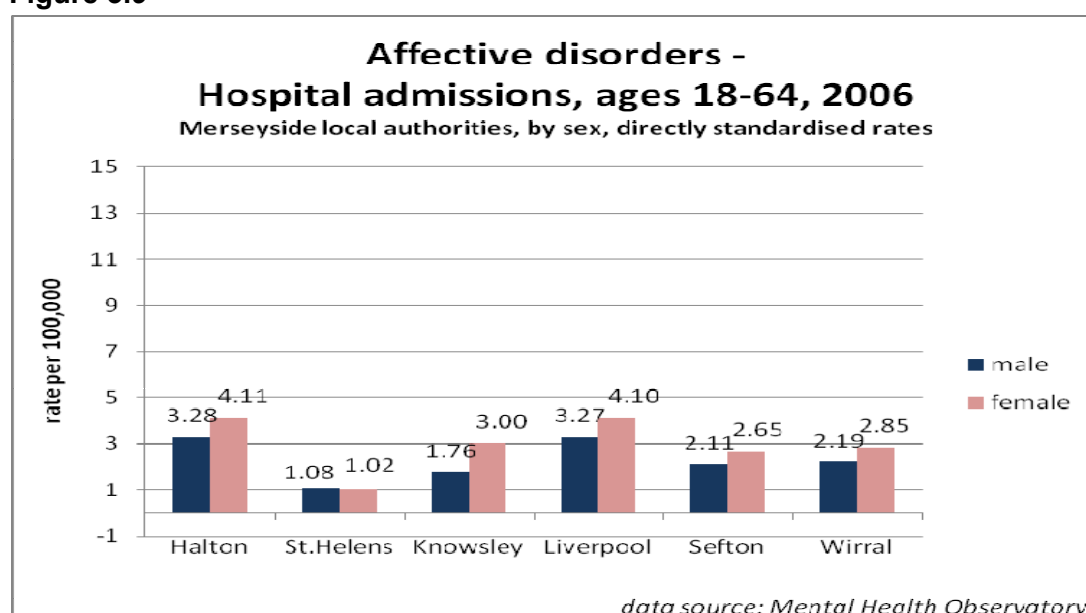
Other mental health disorders

In the MHO data, there are two further categories of hospitalised prevalence. These are: *'Other mental health disorders'* and *'Other mental behavioural disorders, plus 'no diagnosis'.'* It would appear that there may be discrepancies between local authorities in allocating admissions to these categories (see Appendix Table A9) – for example amongst males in Liverpool, prevalence for the first of these two categories was very high, and for the second was very low. In St.Helens, the situation was reversed (see Appendix A9 for full tables). To overcome the possibility of discrepancies in coding, the two categories were combined into one category of 'other mental health conditions' for this needs assessment.

The hospitalised prevalence of 'other mental health conditions' was greater than for either affective disorders or other psychoses. Amongst males on Merseyside, rates were again highest in Liverpool (13.14 per 100,000), closely followed by Knowsley (12.10 per 100,000). The rate in Liverpool was three times higher than in Sefton (4.37). Halton also had a low rate (4.77).

Rates were lower in females than males. The highest female rates were in Knowsley (10.79) and Liverpool (7.99). As with males, Sefton and Halton had the lowest rates.

Figure 3.9
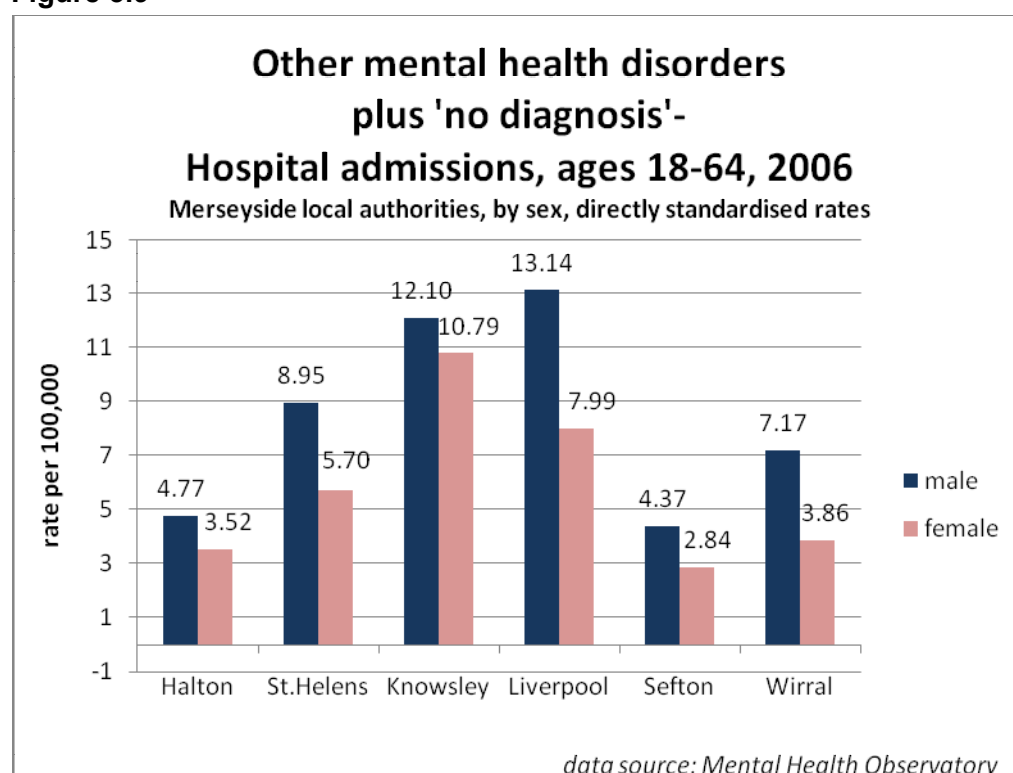
Hospitalised prevalence summary

Data from the NWPHO on the overall hospitalised prevalence of mental health conditions, and from the MHO by diagnosis and sex is presented above. For overall mental health

conditions, levels are significantly higher in Liverpool and Halton and significantly lower in Sefton, compared to the rest of Merseyside. When analysed by sex and diagnosis, different patterns emerge. Liverpool still has significantly high rates in most categories and in Halton, rates for affective disorders are still high. Knowsley has the highest level of 'other' mental health conditions amongst females on Merseyside and the second highest levels of psychoses amongst females and 'other' mental health conditions.

In Sefton, rates are still low for most categories, except for psychoses amongst males, where rates are the second highest on Merseyside and significantly higher than in Halton, St.Helens, Knowsley and Wirral. *(note – Sefton also has the second lowest levels of self-harm on Merseyside – with a ratio of 104.23 - similar to the England average).*

St.Helens has consistently low rates, both in the overall prevalence ratios, which are the second lowest on Merseyside, and in the analysis by diagnosis and sex for affective disorders and other psychoses, where levels are the lowest on Merseyside for both sexes. For 'other' mental health conditions, rates in St.Helens were the third highest of the six local authorities on Merseyside, for both sexes.

Analysis by super output area (SOA) similarly reveals pockets of need within local authorities. Map 8 shows that there can be areas with very high ratios within local authorities that have low overall ratios – e.g. in Sefton, the overall ratio is lower than the North West average, and is significantly the lowest on Merseyside. However, there are several wards in Sefton with SOAs in the highest fifth for levels of hospitalised prevalence of mental health conditions on Merseyside.

Suicide and self harm

Suicide
Previous government targets on suicide reduction have been withdrawn and a new cross-government suicide prevention strategy is to be published this year (DH 2011a).

Risk factors:
Socioeconomic factors such as educational and social disadvantage are related to suicidal behaviour. Unemployment is a known risk factor, as is low household income.

The 2007 Psychiatric Morbidity Survey supported previous research which found that being divorced or separated is associated with suicidal thoughts and attempts (McManus et al, 2009). The authors note that this highlights the need for preventive interventions to be targeted at people experiencing such events.

Those bereaved by suicide are at an increased risk of suicide themselves. For every suicide it is claimed that on average six people suffer intense grief, with those affected including parents, partners, children, siblings, friends, colleagues at work, and also clinicians (Hawton and Simkin, 2003). Counselling and self-help groups such as Survivors of Bereavement by Suicide (previously known as SOBs) provide invaluable 'postvention' support. Hawton and Simkin note that other factors which might help reduce distress include specialised training

for professionals who have contact with people bereaved by suicide, modifications to those aspects of coroners' inquest procedures that the bereaved report finding most stressful, and more sensitive media coverage of suicides.

Media reporting of suicide is very influential, with sensitive reporting having the potential to save lives. The greater the amount of coverage of suicide in the media, the greater the increase in suicide rate (Stack, 2003).It can be very dangerous to provide specific details of a suicide method, as this can provide a suicidal person with the knowledge they need to take their own life. There is a Press Complaints Commission Code of Practice on this matter, which all media should endeavour to follow (Vose, 2011). Other considerations include limiting the amount of coverage, avoiding sensationalism in coverage, and avoiding positive definitions of the deceased (Stack, 2003).

There are sites, often bridges, which become well-known as places for suicide. Media reports of newsworthy suicides from these sites appear to encourage imitative behaviour. Prevention strategies have focused upon limiting suicides from such sites by surveillance, barriers, muted media reporting, and signage offering help and telephone hotlines. A small number of studies provides evidence that installing barriers at popular jumping sites reduces suicides from those sites (Beautrais, 2007). An Australian study found that preventing vehicular access to a suicide jumping hotspot was an effective means of suicide prevention at the site, with was no evidence of substitution to other jumping sites (Skegg and Herbison, 2009).

Trends:
Rates and numbers of suicides have fallen during the period 1997-2007. In 1997, the rate in England and Wales was 11.94 per 100,000 and fell to 9.21 in 2007. (University of Manchester, 2010).

Age:
Across England and Wales, rates have fallen in all age groups, particularly in those aged under 25 and 25-44 (University of Manchester, 2010).

Sex:
In the UK, men are three times more likely than women to die by suicide. This is especially true of young men, where for example men aged 25-34 are four times as likely to kill themselves as women of this age group (Mental Health Foundation, 2007). In the North West, the male suicide rate per 100,000 decreased from 21.7 in 2000 to 19.8 in 2009. The female suicide rate also decreased, from 6.4 to 5.9 (ONS, 2011).

Since 2000, suicide rates for males in England have tended to be highest in the northern regions and lowest in the East of England and London. In 2009 male rates were highest in the North West, at 19.8 per 100,000. The region with the lowest male rate was London at 13.6 (ONS, 2011).

There was no clear pattern in regional suicide rates among women. In 2009 female rates were highest in the North West at 5.9 per 100,000, and lowest in Yorkshire at 3.6. (ONS, 2011).

Overall in the North West, there was a 23% decrease in rates from the period 1997-99 to 2005-07 (University of Manchester, 2010).

Services need to be sensitive to the ways in which men present mental health problems, as recommended in the mental health strategy (para 6.33, DH 2011a).

Patient deaths:
During 1997-2007, just over 1 in 4 (26%) of people who took their own lives had been in contact with mental health services in the 12 months prior to death. The rate of such 'patient suicides' decreased significantly between 2004-07 (University of Manchester, 2010).

Data:
Suicide monitoring should become 'real time' by public health in the same way that public health monitors infectious disease. Currently all PCT suicide data is based on coroners' reports that are eighteen months after an event. Should a change in the suicide rate occur or a cluster develop, there are no mechanisms to spot this happening. There are models in place worldwide to do this, with a track record of reducing rates, which could be adopted in Merseyside (Vose, 2011).

Suicidal thoughts and attempts: As would be expected, the prevalence of suicidal thoughts and suicide attempts is far greater than actual suicides. The 2007 National Psychiatric Morbidity Survey found a prevalence of 4.3% for suicidal thoughts and 0.7% for suicide attempts in the past year (Table 3.3) (McManus et al, 2009). In each, there was a greater prevalence amongst females. This is in contrast to actual suicides, which are three times more likely in males compared to females, (see previous page).

Table 3.3
Prevalence of suicidal thoughts and attempts in the past year, males and females aged 16+

	% males	% females	% all persons
Suicidal thoughts (past year)	3.4	5.2	4.3
Suicide attempts (past year)	0.5	0.9	0.7

Source: National Psychiatric Morbidity Survey, McManus et al, 2009

Merseyside Local Authorities:
Suicides: Predicted numbers of suicides in Merseyside amongst those aged 18-64 for 2010 were 83 (66 male, 15 female). Numbers were highest in Liverpool, with 26 in 2010. This number is expected to increase by one in 2020. Numbers are expected to either stay the same or fall by one in the remaining Merseyside local authorities (Figure 3.10).

Figure 3.10

Suicide: predicted numbers in 2010 and 2020, ages 18-64, Merseyside

data source: PANSI
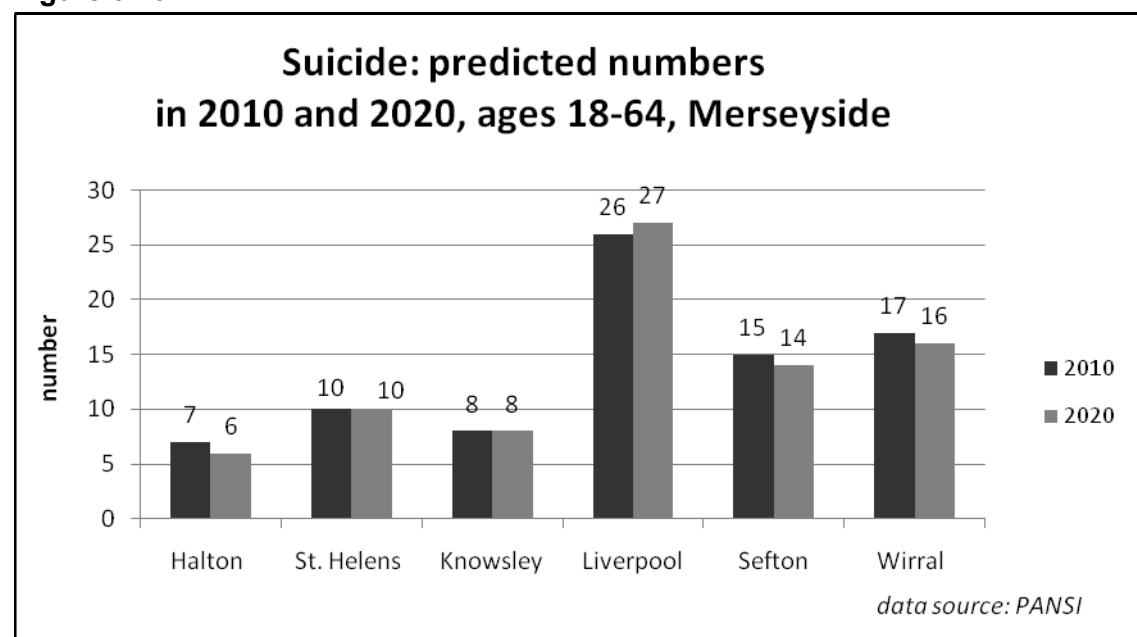
Suicidal thoughts and attempts in Merseyside: If the results of the National Psychiatric Morbidity Survey reported above are applied to the local population, it can be estimated that amongst those aged 16 plus, there would be 51,630 people on Merseyside with suicidal thoughts in the past year and 8,405 people who had attempted suicide in the past year. Table 3.4 gives estimated numbers for each local authority.

Table 3.4
Estimated prevalence of suicidal thoughts and attempts in the past year, ages 16+, 2009

	Ages 16+ mid 2009 population (thousands)	Estimate of numbers with suicidal thoughts (4.3%)	Estimate of numbers of suicide attempts (0.7%)
Halton	94.7	4072	663
St. Helens	144.1	6196	1009
Knowsley	119.5	5139	837
Liverpool	367.4	15798	2572
Sefton	225.4	9692	1578
Wirral	249.6	10733	1747
Merseyside	1200.7	51630	8405

Data source: ONS population data. Estimates of suicidal thoughts and attempts from National Psychiatric Morbidity Survey (McManus et al, 2009)

Note: These estimates do not take account of variations in the age and sex structure of local populations, or variations in related factors such as deprivation, which may be higher in local

populations and may therefore mean that levels of mental health problems are likely to be underestimated.

CALM (the campaign against living miserably) was set up in 2000 response to the high suicide rate among young men, and offers practical, anonymous, confidential help from professionals. CALM report that the numbers of suicides on Merseyside among young men has fallen by 55% over the past 10 years, bringing it below the average for young men in the North West and the rest of England & Wales, according to 2011 figures by the Office of National Statistics (ONS). Merseyside has made more progress on reducing suicides amongst young men than most other areas of the country. Merseyside CALM believe this is driven by the existence of the support they offer.

Recommendations
- Target preventive interventions around suicide hotspots such as bridges, waterways, and railways.
- Continue to support initiatives such as CALM.
- Target preventive interventions at people experiencing events such as divorce or separation.
- Provide support to 'Survivors of Bereavement by Suicide' self help groups, Also ensure specialised training for professionals who have contact with people bereaved by suicide and modifications to those aspects of coroners' inquest procedures that the bereaved say they find most stressful.
- Ensure more sensitive media coverage of suicides, especially avoiding details of methods used.
- Although the focus is on males with their high suicide rate, there should also be a consideration of the needs of women, who have a high prevalence of suicidal thoughts and attempts compared to men.
- Develop models to monitor suicide deaths as they happen, rather than the current situation of eighteen months after the event.

Self harm
Deliberate self-harm ranges from destructive behaviours with no suicidal intent, but which relieve tension or communicate distress, through to attempted suicide (Mental Health Foundation, 2007). It is recognised that most of those who attend A&E after self-harming would meet the criteria for one or more psychiatric diagnoses. More than two-thirds would be classed as depressed. People who have self-harmed are at significant risk of suicide (Mental Health Foundation, 2007).

The 2007 National Psychiatric Morbidity Survey found that 4.9% of people had engaged in self-harm at some point in their life (Table 3.5). As with suicides, self-harm was found to vary by marital status, with those who were single most at risk (McManus et al, 2009).

Table 3.5
Self-harm lifetime prevalence (from 2007 National Psychiatric Morbidity Survey)

	% men	% women	% all persons
Self-harm	4.4	5.4	4.9

Source: McManus et al, 2009

Merseyside
There were 13,937 hospital admissions for self harm in Merseyside in the period 2003/04 to 2007/08 (Table 3.6). On Wirral, the standardised ratio of 223.53 was significantly higher than the rest of Merseyside and more than twice that for England (100) (Figure 3.11). Wirral, Halton and St.Helens had levels above the North West average of 129.91.

In Liverpool, although numbers hospitalised for self-harm were second highest (table 3.6), the ratio of 72.70 was significantly lower than elsewhere on Merseyside and was well below the England average of 100 (Figure 3.11). Map 9 shows that in Liverpool, there were no super output areas with ratios in the top fifth for Merseyside (see Appendix). In Wirral, the highest ratios occurred across the north east side of the borough. High ratios were also found across the centre of St.Helens, down the centre of the Runcorn side of Halton (south of the river), around the centre of the Widnes side of Halton (north of the river) and in a narrow strip across the centre of Knowsley (to the south side of Longview and Prescot West). In Sefton, Cambridge in the north and parts of Linacre in the south had high ratios. (Source: http://www.nwph.net/healthprofiler/selectindex.aspx).

Figure 3.11
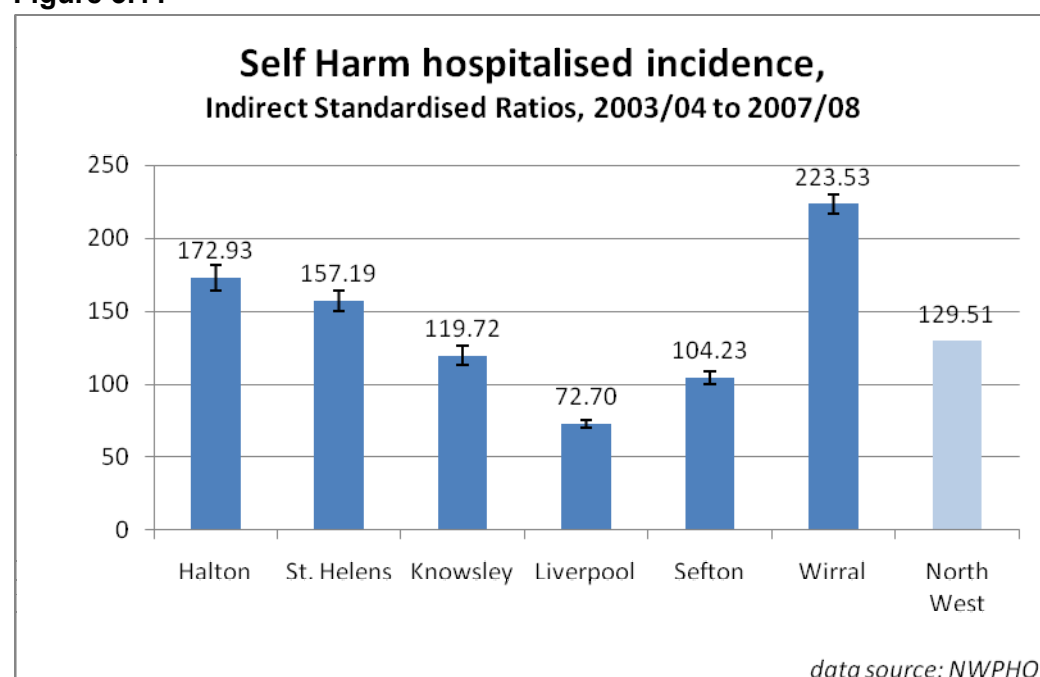
Table 3.6
Self harm hospitalised incidence, numbers and
indirect standardised ratios, Merseyside, 2003/04 to 2007/08

Local authority	Number	Standardised Ratio
Halton	1488	172.93
St. Helens	1955	157.19
Knowsley	1317	119.72
Liverpool	2448	72.70
Sefton	1976	104.23
Wirral	4753	223.53
Total	Merseyside 13937	North West 129.51

Data source: NWPHO

In addition to hospitalised self-harm, the Trauma and Injury Intelligence Group (TIIG) at Liverpool JMU collected data on emergency department attendances for self-harm and ambulance suicide or psychiatric call-outs by Merseyside residents.
TIIG data for 2006 to 2009 shows a 3% increase in hospital admissions for self harm amongst Merseyside residents – especially in St.Helens, where there was a 20% increase (Halton was not included). In Sefton, there was a 21% reduction in numbers admitted (TIIG, 2010). Numbers of admissions were highest amongst Wirral residents.

Over the same 3 year period up to 2009, the number of emergency department attendances by Merseyside residents decreased by 23%. Decreases were most pronounced in Liverpool (46%) and Wirral (35%). Attendances by St.Helens residents increased by 21%.

Ambulance call-outs for suicide/psychiatric conditions increased by 18% on Merseyside over a 3 year period up to the end of 2009. Increases were most pronounced in Knowsley (39%) and St.Helens (32%).

Deprivation: Links were found between the Index of Multiple Deprivation and both self-harm hospital admissions and ambulance call-outs. The super output areas in the most deprived quintiles had significantly higher rates of admission and ambulance call outs than those in the least deprived quintiles.

Ambulance call outs for males aged 15-34
An earlier TIIG report included data on ambulance call-outs for psychiatric and suicide attempts. Figure 3.12 illustrates patterns across Merseyside (excluding St.Helens and Halton). The MSOA of E02001331 (Kirkby Central/Northwood/Cherryfield) had the highest rate of self-harm ambulance call outs for males aged 15 to 34 years in Merseyside, at a rate of 244 per 10,000 population, over a nine month period. The second highest was in Birkenhead. South west Sefton and North West Liverpool also had high rates (TIIG, 2007).
N.B. actual numbers may be small

Figure 3.12: Ambulance call outs: male psychiatric & suicide attempts, Middle Super
Output Area of residence, ages15 to 34, Merseyside, average annual crude rate per 10,000
population, January to September 2006 (Populations, MSOA mid Year 2004).
Note: Map does not include St.Helens or Halton.   ***Reproduced from: TIIG (2007).***

**Crude rate of ambulance calls
out per 10,000 population**

0 – 19

20 - 39

40 - 59

60 - 79

80 - 99

100+
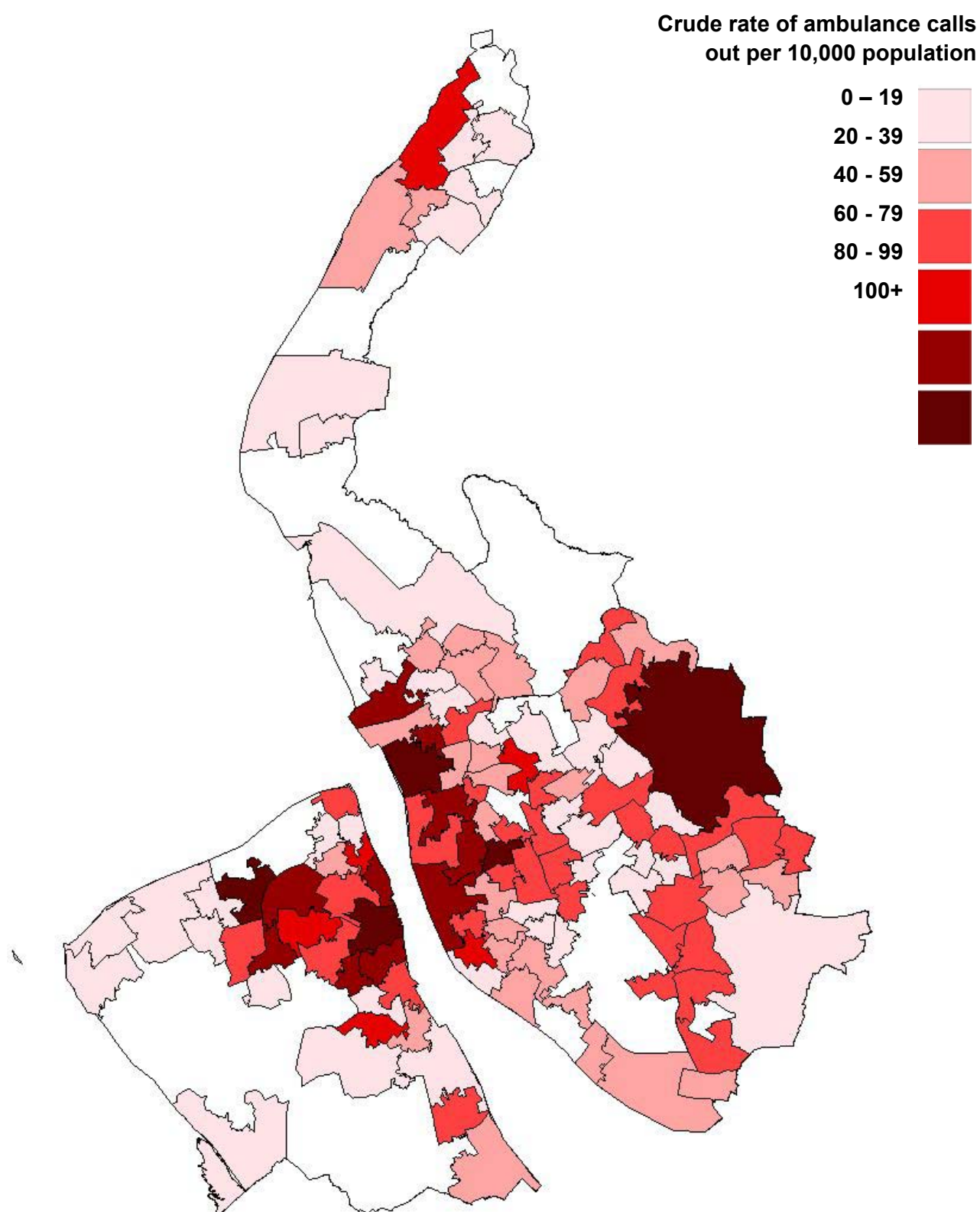
****Psychiatric and suicide attempts

Personality disorder

Personality disorders are associated with low educational attainment, unemployment, unstable housing and inconsistency in relationships. Interventions in childhood have been identified as a priority in preventing the development of full adult personality disorder (McManus et al, 2009).

McManus et al describe antisocial personality disorder (ASPD) as being characterised by disregard for and violation of the rights of others. People with ASPD have a pattern of aggressive and irresponsible behaviour which emerges in childhood or early adolescence. They account for a disproportionately large proportion of crime and violence committed. Personality disorders have been identified in as many as 63% of male remand prisoners and 49% of male sentenced prisoners. A disproportionate amount of crimes and violent offences are committed by people with personality disorders (quoted by McManus et al, p.106, 2009).

Borderline personality disorder (BPD) is characterised by high levels of personal and emotional instability associated with significant impairment.

The most recent National Psychiatric Morbidity Survey included estimates of the one year prevalence of personality disorders. As shown in table 3.1 above, ASPD was present in 0.3% of adults aged 18 or over (0.6%of men and 0.1%of women). 1.7% of men aged 18-34 had ASPD, while no cases were identified in men aged 55 or over. Amongst women, 0.4% aged 16-34 had ASPD, while no cases were identified in those aged 35 or over.
The overall prevalence of BPD was similar to that of ASPD, at 0.4%of adults aged 16 or over (0.3% of men, 0.6% of women).

On Merseyside, it is estimated that there are just over 4,000 people with borderline personality disorder and just over 3,000 with antisocial personality disorder. Numbers in each PCT are shown in Table 3.7.

Table 3.7
Numbers with borderline or antisocial personality disorder, ages 18-64, Merseyside PCTs, 2010.

	Borderline personality disorder	Antisocial personality disorder
Halton	338	254
St.Helens	491	377
Knowsley	423	313
Liverpool	1,335	1,037
Sefton	731	553
Wirral	827	617
Merseyside	4145	3151

Source:PANSI

Dual diagnosis/ Comorbidity

Psychiatric comorbidity involves an individual meeting the diagnostic criteria for two or more psychiatric disorders. It is known to be associated with increased severity of symptoms, longer duration, greater functional disability and increased use of health services. The 2007 psychiatric morbidity survey analysed comorbidity, and included individuals with two or more of the following:

- the most common mental disorders (namely anxiety and depressive disorders) as well as:
- psychotic disorder;
- antisocial and borderline personality disorders;
- eating disorder; posttraumatic stress disorder (PTSD);
- attention deficit hyperactivity disorder (ADHD);
- alcohol and drug dependency; and
- problem behaviours such as problem gambling and suicide attempts.

Just under a quarter of adults (23.0%) met the criteria or screened positive for at least one of the psychiatric conditions under study. Of those with at least one condition 19.1% met the criteria for two conditions and 12.2% met the criteria for three or more conditions (68.7% had only one condition). Numbers of identified conditions were not significantly different for men and women (McManus et al, 2009).

In Merseyside, Figure 3.13 shows that numbers of people with two or more psychiatric disorders ranged from 21,350 in Liverpool, to 5,360 in Halton. Numbers are expected to decline in each local authority by 2020.

Figure 3.13
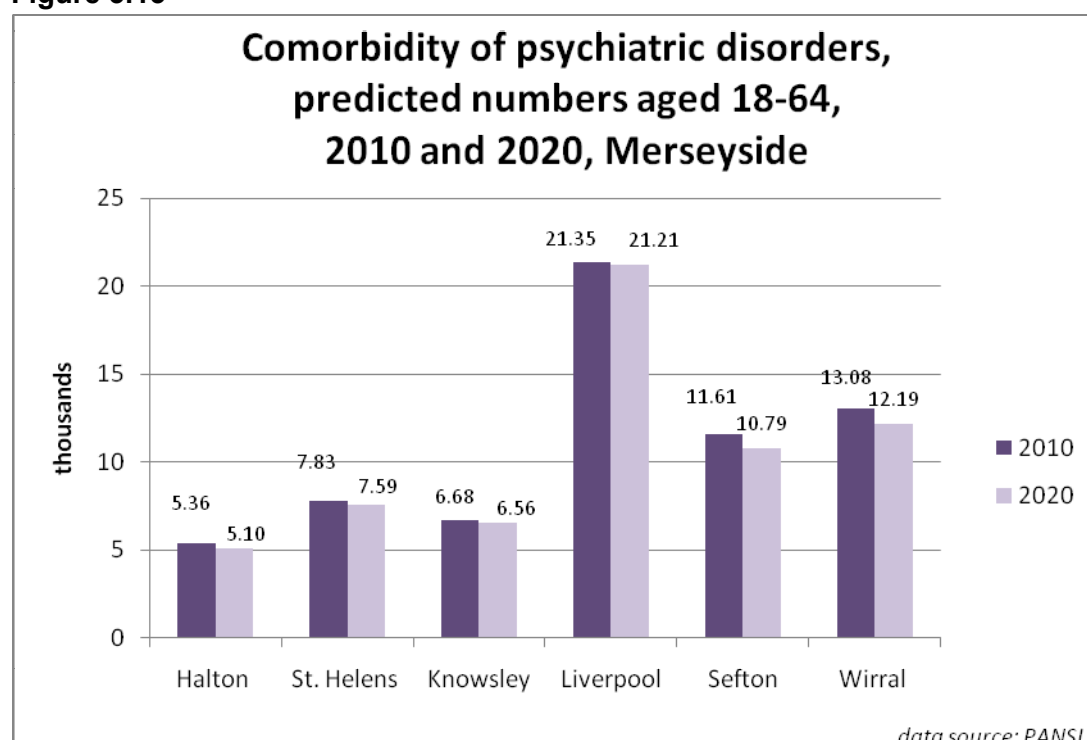
4. Allocation of resources and investment in services

Spending on mental health services

A report by the NHS North West Commission on mental health services in 2008 found that in the North West, almost three quarters (73.3%) of the money spent on mental health goes to secondary mental health services, helping people who are ill to get better (NHS North West, 2008). As shown in Figure 4.1, relatively little is spent on primary care and even less (0.2%) is spent on prevention or helping people to stay mentally well.

The Commission's report emphasised that helping those who become ill to achieve a full recovery and stay well remains under resourced – at 2.6% of total mental health spending.

The report also noted the need to improve user engagement – which only takes up 0.2% of total spending. They recommended the creation of a cross-agency programme to support improvements in user engagement in mental health.
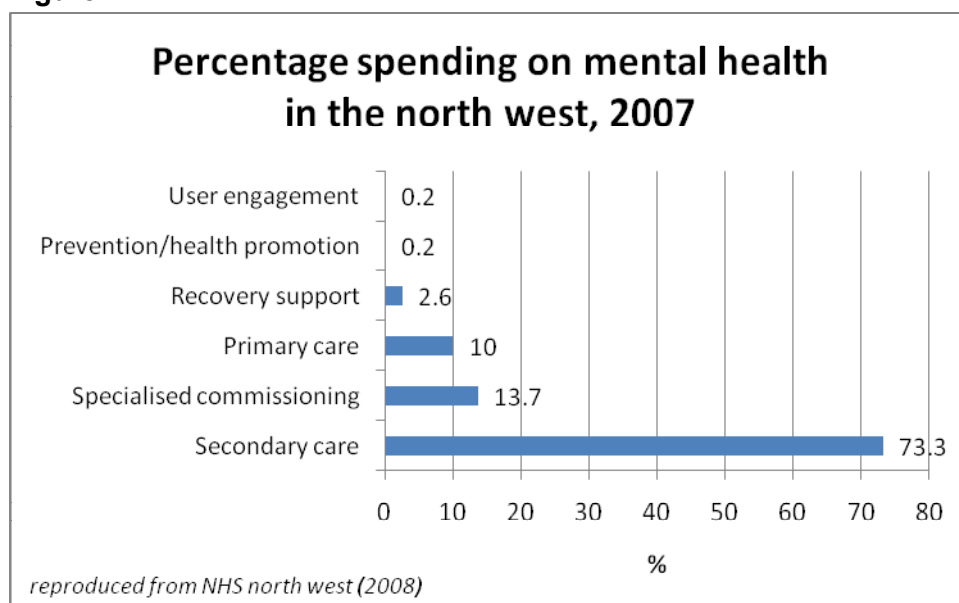
Figure 4.1

Figure 4.2 shows the variation in investment in mental health per head across Merseyside, as reported by Mental Health Strategies (2011). Spending ranged from £218 per head in Sefton to £165 in St.Helens. Only Knowsley and St.Helens spent less than the North West average of £195 per head.

Figure 4.2

LIT weighted mental health investment per head population, 2010/11

	£
Halton	202
St.Helens	165
Knowsley	175
Liverpool	208
Sefton	218
Wirral	199
North west	195

source: Mental Health Strategies (2011)
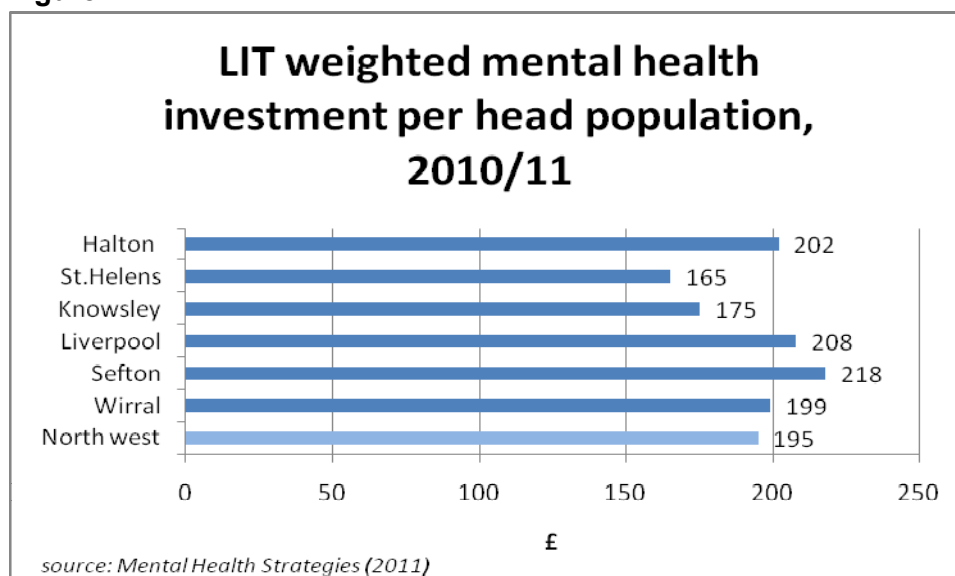
LIT=Local Implementation Team

Spending on commissioning mental health services

The NHS North West Commission report found great variation in the amount being spent on the process of commissioning mental health services, with some PCTs spending up to eight times as much as others in 2007. On Merseyside, spending in Liverpool at £1.36 per head was the second highest in the North West, and more than three times as high as spending in Sefton, at £0.38 per head (Figure 4.3). Spending in Liverpool and in Halton & St.Helens was higher than the North West average of £0.66 per head (NHS North West, 2008).

The commission report noted that contracts tended to be too simple and limited in detail, with a focus on service inputs. They recommended that in future, there should be more of a focus on preventive outcomes and positive mental health, such as measuring the number of people with mental health problems returning to paid work.

Figure 4.3

PCTs mental health commissioning spend per head, 2007

	£
Halton & St.Helens	1.05
Knowsley	0.58
Liverpool	1.36
Sefton	0.38
Wirral	0.63
North west	0.66

reproduced from NHS north west (2008)
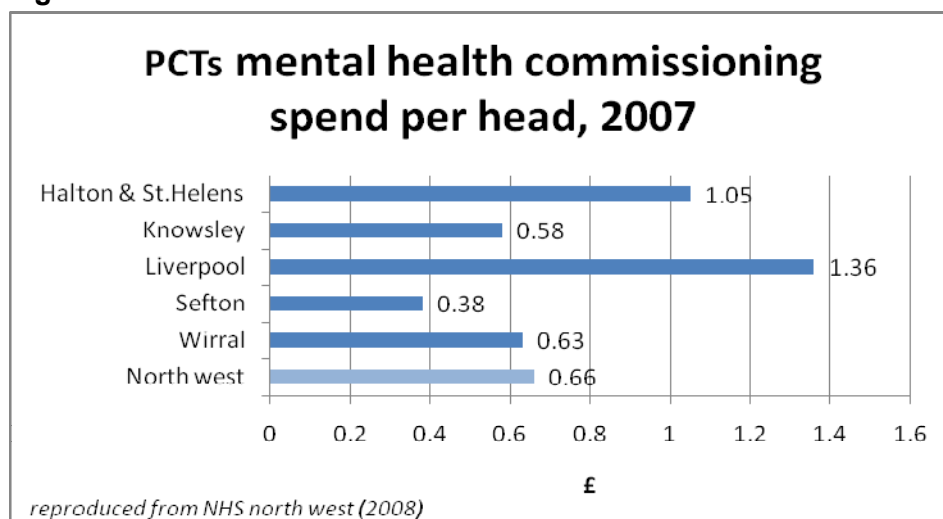
Discussion and Recommendations

Discussion

What has been learned?
In addition to strategies for improving the health of those identified as having mental health problems in Merseyside, consideration should be given to the needs of those who do not necessarily have a diagnosed illness, but for a range of reasons are at high risk of falling into poor mental and physical health (Liverpool PCT, 2009a). The needs assessment presented here, with its focus on vulnerable groups and areas, will assist in this process.

Vulnerable groups that may be at high risk include some black and minority ethnic groups, travellers, asylum seekers, people who are homeless, people with disabilities, carers, people who are lesbian/gay/transgender, survivors of childhood sexual abuse, disabled people, those separated or divorced and those recently released from prison.

In Merseyside, local authorities and areas within local authorities have been identified as having high levels of factors associated with poor mental health - including deprivation, unemployment, social housing, child poverty, young people 'not in education or training', people with long term limiting illness, alcohol use, violent crime, and physical inactivity.

Limitations of the needs assessment
There are gaps in the needs assessment - what is presented is for areas where data is available, and what is possible within the time limits of the project. It was not possible to carry out a full assessment of user engagement in the commissioning process within the timescale of the project. Other areas not covered that could be considered in future needs assessments include the mental health needs of: women during pregnancy, peri-natal and post-natal periods; teenage mothers; lone parents; people with eating disorders; those with post-traumatic stress disorder; the workforce; service and ex-service personnel; people who are transgender; and people with other types of disability, including visual impairment and physical disability.

Time constraints also meant that the needs assessment would focus on relevant readily available health statistics and demographic data and would not involve wider consultation and literature searches

How the needs assessment can inform commissioning
This document can be used to inform commissioning, through the identification of geographical areas and groups most at risk that need to be targeted with preventive measures and service provision.

Measures that help to promote equality will be most effective in improving mental health and wellbeing. There is a need to tackle the inequalities that both lead to poor mental health, and result from poor mental health, such as lower employment rates, and poorer housing, education and physical health. Mental health interventions need to focus on a whole range of factors that influence a person's ability to live healthy and well, including welfare (housing

advice and homelessness, debt advice etc.), community development, measures to reduce social isolation, work/learning, self care and healthy lifestyles (Hussey and Stansfield, 2011). Mental wellbeing should be seen as 'everybody's business' (DH, 2011a) with interagency working ensuring that mental health is a consideration in all aspects of public policy, for example including leisure services, planning (green space initiatives), housing, employment, education, as well as health service provision. Mental wellbeing impact assessment is a useful tool to enable this to happen (Coggins et al, 2007).

There needs to be a more preventive focus in the mental health commissioning process, with contracts specifying outcomes relating to vulnerable groups and areas, such as measuring the number of people with mental health problems returning to work. Improving access to support services is an important first step in improving mental health care for everybody, but particularly for those vulnerable groups at higher risk. Improving access is about finding innovative ways of meeting the needs of such hard to reach groups (DH, 2011b).

Recommendations

A summary of recommendations is presented here. More detailed recommendations for most areas of the needs assessment can be found throughout the document, at the end of most sections.

1. Promoting wellbeing
- Convey positive mental wellbeing as an essential public health message, promoting the Five Ways to Wellbeing as protective and enhancing measures.

- Use the NW Wellbeing survey findings to inform effective targeting of resources in line with the proportionate universalism recommended by Marmot.

- Ensure that there are improvements in data collection relating to the mental wellbeing of protected groups (as detailed in the Equality Act 2010) to enable more effective analysis.

2. Maximising protective factors
- Build capacity for mental health in communities by focussing interventions on factors such as welfare (housing advice and homelessness, debt advice etc.), community development, measures to reduce social isolation, increase resilience, encourage work/learning, self care and healthy lifestyles.

- Develop a more preventive focus in the mental health commissioning process, with contracts specifying outcomes such as measuring the number of people with mental health problems returning to work.

- Encourage interagency working to ensure that mental health is a consideration in all aspects of public policy, for example including leisure services, planning (green

space initiatives), housing, employment, education (both improving educational attainment, and ensuring mental health awareness is on the school curriculum), as well as health service provision.

- Use mental wellbeing impact assessment to ensure that this takes place.

- Starting early, using a lifecourse approach, promote early interventions and support for positive mental wellbeing targeted at children and young people, to reduce the number of adults likely to need mental health services in future. This would include education to raise awareness of the links between mental health and alcohol, physical activity and educational achievement.

3. Meeting the needs of vulnerable/minority groups
Meet basic needs as a first priority:
- Ensure that mental health professionals work together with housing and other agencies to ensure basic human needs for food and safe shelter are being met (especially relevant when dealing with homeless people, asylum seekers, ex-offenders and some travellers).

- Integrate any accommodation provided with psychologically informed health and support services.

- Once basic needs have been met, introduce measures to minimise social isolation which will also help to promote mental wellbeing.

Provide adequate training for staff
- Improve awareness of some mental health support staff around housing and other issues relating to vulnerable groups.

- Improve awareness of mental health issues amongst staff in various sectors relating to vulnerable groups, for example:

    o housing sector staff (in e.g. Local Authority Homeless Persons Units).
    o frontline staff in primary care, who need training and education in how to assist those from more vulnerable groups in the community in registering at practices and feeling welcome. For example homeless people, or people who are deaf (who are often reluctant to seek help, mainly because of the communication difficulties they face).

- Provide training and support where appropriate for staff in various agencies to recognise and work with behavioural and other issues common in people who have had traumatic experiences in their childhood or adult life, such as in some people who are homeless or asylum seekers.

- Encourage GPs to offer alternatives to medication, for example using social prescribing; offering victims of crime/domestic abuse opportunities to talk; or referral for counselling or to local IAPT services (under the '*Improving Access to Psychological Therapies*' programme).

- Use the Department of Health's '*Creating Capable Teams Approach'* to support *'New Ways of Working'*, to provide the ability to influence higher education and training programmes by being clear about the capabilities required.

Provide accessible support

- Base health services within the community where they are easily accessible to vulnerable minorities, such as asylum seekers, including a 24/7 crisis service enabling immediate access to care.

- Improve access for those who may find the standard general practice systems difficult to use. For example: offer variable lengths of appointment times or an outreach approach, such as holding sessions in community centres or hostels; offer carers flexible arrangements to fit in with their caring responsibilities.

Use signposting

- Improve signposting to what services there are currently on offer to minority groups within NHS health care, the voluntary sector, within faith based organisations etc.

Ensure support is culturally appropriate

- Ensure staff are trained in cultural awareness, so they can give more information in culturally appropriate form, for example to asylum seekers in their own language or to travellers avoiding jargon.

- Assist individuals in defining specifically what their mental health needs are and how these can be treated.

- Support should be offered to all recently arrived asylum seekers and refugees, recognising that around 50% are likely to require mental health support following their experiences both in their home countries and on arrival in the UK.

- Work with the presenting behaviour of the individual, rather than restricting access to services until behaviour changes (e.g. homeless people with alcohol abuse).

Encourage inter-agency working

- For example ensure homeless outreach teams have the involvement of mental health teams and drug and alcohol services to help them offer effective support.

- Consider making it a requirement that social landlords recognise and refer tenants with mental health problems.

- Ensure that mental health and substance misuse services work closely to deliver an integrated response to the needs of people with dual diagnosis problems.

Provide vocational support for people from vulnerable groups

- Provide assistance to people such as carers to remain in work or find employment.

Provide vocational rehabilitation for people with long-term mental health problems
- Introduce vocational rehabilitation services to help to overcome barriers to work, including:
  - retraining (developing skills and confidence);
  - dealing with stigma;
  - training mental health professionals and others not to underestimate the capabilities of their clients or overestimate the risks to employers;
  - less of a focus on 'cure' and more on coping with long-term mental illness.

Use targeted prevention
- Ensure that annual health checks are offered to and taken up by people with learning disabilities, and that they include attention to mental health issues.
- Target other preventive interventions to those groups most at risk. For example people experiencing divorce or separation may need to be targeted and signposted to sources of help to prevent mental health problems developing.

Improve suicide prevention
- Target suicide hotspots, such as bridges, with prevention interventions
- Continue to support CALM and Survivors of Bereavement by Suicide
- Target other 'at risk' groups, such as those separated or divorced, unemployed, homeless, prisoners, looked after children or women with suicidal thoughts
- Ensure more sensitive media coverage of suicides, avoiding details of methods used

4. Consideration of age, sex and small areas
- Develop awareness of the needs of sub-groups of the population, so that strategies can be developed and targeted at specific areas/groups, for example
  - in Sefton, where analysis by diagnosis and sex reveals high levels of admissions for psychoses amongst males
  - amongst those aged 40-54, for whom there appears to be a dip in levels of wellbeing.

- Further analyse factors behind apparent pockets of need within local authority boundaries, for example inequalities such as:
  - the relatively high levels of self-harm and self-harm ambulance call-outs in Kirkby, (despite low levels in Knowsley as a whole), especially in the more deprived areas, and in the more deprived parts of Sefton and Liverpool. Such analysis would include examining the links between A&E attendance and access to GPs.
  - in Sefton, the overall ratio for hospitalised prevalence of mental health conditions is lower than the North West average, and is significantly the lowest on Merseyside. However, there are several wards in Sefton with SOAs

in the highest fifth for levels of hospitalised prevalence of mental health conditions on Merseyside.

5. Consultation and partnership working with populations at risk and service users

- Using a cross-agency programme, consult, involve and engage service users and those from vulnerable groups at risk, so that their views are represented in the commissioning process.

- Ensure that future mental health needs assessments include a focus on gathering the views of those from populations at risk and users of mental health services.

6. Data

- Develop models to monitor suicide deaths as they happen.

References

APHO (2010) *The Indicator Guide, Health Profiles 2010*. Association of Public Health Observatories and Department of Health.
http://www.apho.org.uk/resource/view.aspx?RID=50204

Barker A (2010) *Mental Wellbeing in Knowsley 2010*. Knowsley PCT.

Barnados (2011) Young Carers. Website last accessed 29/9/11
http://www.barnardos.org.uk/what_we_do/our_projects/young_carers.htm

Batty E, Cole I (2010) *Resilience and the recession in six deprived communities: Preparing for worse to come?* Sheffield Hallam University, for the Joseph Rowntree Foundation, July 2010
http://www.jrf.org.uk/publications/resilience-and-recession

Beautrais A (2007) Suicide by Jumping: A Review of Research and Prevention Strategies. *Crisis;.* 28(Suppl. 1):58–63
http://www.psycontent.com/index/V44U442Q65LM6344.pdf

Bremner P, Burnett J, Nunney F, Ravat M, Mistral W (2011) *Young people, alcohol and influences: A study of young people and their relationship with alcohol.* Joseph Rowntree Foundation, June.
http://www.jrf.org.uk/sites/files/jrf/young-people-alcohol-full.pdf

Burnett A and Peel M (2001) Asylum seekers and refugees in Britain. *BMJ 322, p.544*
http://www.bmj.com.ezproxy.liv.ac.uk/content/322/7285/544.full?ijkey=bb65497283daa767e9e3925b02d3a2df53dd9447&keytype2=tf_ipsecsha

Butler P, Carter H (2011) Liverpool to bear brunt of cuts as Merseyside councils slash services. *Guardian*, 27th February 2011.
http://www.guardian.co.uk/society/2011/feb/27/liverpool-faces-toughest-budget-ever/print

Carers UK (2006) Working Carers: Evidence from the 2001 Census. A report for Carers UK by Sheffield Hallam University.
http://www.carersnet.org.uk/documents/who.pdf

Carlin H, Chambers S, Knuckey S, Perkins C, Bellis M (2011) *North West Wellbeing Survey: Employment and Resilience.* North West Public Health Observatory.
http://www.nwph.net/nwpho/Publications/NWMWS_Employment.pdf

Cawson P, Wattam C, Brooker S and Kelly G (2000) *Child Maltreatment in the United Kingdom*, NSPCC.
http://www.nspcc.org.uk/inform/research/findings/childmaltreatmentintheunitedkingdom_wda48252.html

Chevalier A and Feinstein L (2006) *Sheepskin or Prozac: The Causal Effect of Education on Mental Health*. Institute for the study of Labour (IZA) Discussion Paper No. 2231.
http://ssrn.com/abstract=923530

Chisholm D, Corker M, Kyle J & McCleland R (1998) *Mental Health Services for Deaf People: Are They Appropriate?* Sign, Beaconsfield.

Coggins T, Cooke A, Friedli L, Nicholls J, Scott-Samuel A, Stansfield J (2007) *Mental Well-being Impact Assessment: A Toolkit. 'A Living and Working Document'*. Care Services Improvement Partnership (CSIP), North West Development Centre.
http://www.liv.ac.uk/ihia/IMPACT%20Reports/mwia-toolit1.pdf

Communities and Local Government (2011) *The English Indeces of Deprivation 2010.* Department for Communities and Local Government, London.
http://www.communities.gov.uk/publications/corporate/statistics/indices2010

Cowie R and Douglas-Cowie E (1987) *Acquired deafness: the deadly game of hit and miss.* British Association for the Advancement of Science, Annual Meeting 24-28 August.

CPAG (2011) *End Child Poverty. Child Poverty Map of the UK. Part 1: England.* Child Poverty Action Group, March.
http://endchildpoverty.org.uk/files/child-poverty-map-of-the-uk-part-one.pdf

CPFT (2008) *Stepped care mental health model.* Cambridgeshire and Peterborough NHS Foundation Trust
http://www.clinicom.cpft.nhs.uk/Carepathways/Steppedcarementalhealthmodel/tabid/249/Default.aspx

CPMH (2002) *Profile of mental health need, service provision and activity in Darlington PCT*. Centre for Mental Health, University of Durham, May
www.dur.ac.uk/mental.health/serviceMapping/Darlington.doc

Reeve K & Batty E (2011) The hidden truth about homelessness: Experiences of single homelessness in England. Crisis and CRESR (The Centre for Regional Economic and Social Research).
http://www.crisis.org.uk/data/files/publications/HiddenTruthAboutHomelessness_web.pdf

Crowther R, Marshall M, Bond G, Huxley P (2001) Vocational rehabilitation for people with severe mental illness. *Cochrane Database of Systematic Reviews 2001*, Issue 2. Art. No.: CD003080. DOI: 10.1002/14651858.CD003080

Davies A C (1991) Epidemiological profile of hearing impairments. *Acta Otolaryngologica (Stockh)*, Suppl., 476: 23-31.

Deacon L, Carlin H, Spalding J, Giles S, Stansfield J, Hughes S, Perkins C, Bellis M (2010a) *North West Mental Wellbeing Survey 2009*. North West Public Health Observatory.
http://www.nwph.net/nwpho/NorthWestMentalWellbeingSurvey.pdf

Deacon L, Harrison R, Mason J, Carlin H, Giles S, Stansfield J, Perkins C, Bellis M (2010b) *Liverpool Mental Wellbeing Survey 2009*. North West Public Health Observatory.

Dearden C and Becker S (2004) *Young Carers in the UK: The 2004 Report.* The Children's Society.
http://www.lboro.ac.uk/departments/ss/centres/YCRG/youngCarersDownload/YCReport2004%5B1%5D.pdf

Dedman D, Hennell T, Hooper J, Tocque K (2006) *Using Geodemographics to Illustrate Health Inequalities*. North West Public Health Observatory, Centre for Public Health, Liverpool John Moores University
http://www.nwpho.org.uk/inequalities/Geodem_Inequalities_dr4.pdf

Dodd S (2010) *Offender Health Needs Assessment at HMP Liverpool*. Liverpool PCT.

Doyal L, Cameron A, Cemlyn S,Nandy, Shaw M (2002) *The health of Travellers in the South West region: a review of data sources and a strategy for change*. South West Public Health Observatory
http://www.swpho.nhs.uk/resource/item.aspx?RID=9043

DH (2002a) *Women's Mental Health: Into the Mainstream. Strategic development of mental health care for women*. London. Department of Health.

DH (2002b) *A Sign of the Times. Modernising mental health services for people who are deaf.* London.Department of Health
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Consultations/Closedconsultations/DH_4016951

DH (2008) *Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own.* Strategy document. Department of Health
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085345

DH (2010a) *Healthy lives, healthy people* White Paper: Our strategy for public health in England. Department of Health, November.
http://www.dh.gov.uk/en/Publichealth/Healthyliveshealthypeople/index.htm

DH (2010b) *Recognised, valued and supported: next steps for the Carers Strategy*. Department of Health.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122077

DH (2011a) *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages.* Department of Health.
www.dh.gov.uk/mentalhealthstrategy

DH (2011b) *No Health Without Mental Health: Delivering better mental health outcomes for people of all ages*. Department of Health.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124057.pdf

DTI (2004) Final Regulatory Impact Assessment: Civil Partnership Act 2004
http://webarchive.nationalarchives.gov.uk/+/http://www.berr.gov.uk/files/file24232.pdf

Farmer P (2009) MIND Chief Executive. Quoted in Hursch A (2009) Police and prosecutors apologise to disabled victims of crime. *Guardian*, Sunday 10 May 2009
http://www.guardian.co.uk/politics/2009/may/10/police-disabled-victims-apology

Fuhrer MJ, Rintala DH, Hart KA, Clearman R and Young M (1993) Depressive symptomology in persons with spinal cord injury who reside in the community. *Archives of Physical Medicine and Rehabilitation*, 74, 255–60.

Galvani S (2010) *Grasping the nettle: alcohol and domestic violence.* Revised edition. Alcohol Concern Factsheet, June.
http://www.alcoholconcern.org.uk/assets/files/Publications/Grasping%20the%20nettle%20factsheet%20revised%20June%202010.pdf

Giraud-Saunders A (2011) *Mental health in people with learning disabilities*. Foundation for people with learning disabilities.
http://www.mentalhealth.org.uk/content/assets/PDF/policy-archive/Mental_health_in_people_with_learning_disabilities.pdf

Government Office for Science (2008) *Mental Capital and Wellbeing: Making the most of ourselves in the 21st century.* Foresight Mental Capital and Wellbeing Project. Final Project report – Executive summary. The Government Office for Science, London.
http://www.bis.gov.uk/assets/biscore/corporate/migratedD/ec_group/116-08-FO_b

Harrison R, Deacon L, Spalding J, Carlin H, Giles S, Stanfield J, Perkins C, Bellis M (2010a) *Sefton Mental Wellbeing Survey 2009*. North West Public Health Observatory
http://www.seftonpct.nhs.uk/Library/healthy_lifestyles/Public_Health_Intelligence/Lifestyle_Surveys/Sefton%20Mental%20Wellbeing%20Survey%202009.pdf

Harrison R, Deacon L, Carlin H, Giles S, Stanfield J, McManus M, Perkins C, Bellis M (2010b) *Wirral Mental Wellbeing Survey 2009*. North West Public Health Observatory

Harwood C, Nzuobontane D (2002) *Wirral Mental Health Equity Audit*, Birkenhead and Wallasey PCT.

Hatloy I (2002) *The social context of mental distress,* MIND Factsheets: Mental Health Statistics 6, April.

Hawton K and Simkin S (2003) Helping people bereaved by suicide. *British Medical Journal*, 327, 177 (Published 24 July 2003)
http://www.bmj.com/content/327/7408/177.full

HM Government (2010) *The Coalition: our programme for government: Freedom Fairness Responsibility.* Cabinet Office.
http://www.cabinetoffice.gov.uk/sites/default/files/resources/coalition_programme_for_government.pdf

Home Office (2010) *Control of Immigration Statistics: United Kingdom 2009*. Home Office Statistical Bulletin.
http://rds.homeoffice.gov.uk/rds/pdfs10/hosb1510.pdf

House of Commons (2000) *Health Committee Fourth Report. Provision of NHS mental health services*. London. The Stationery Office.
http://www.publications.parliament.uk/pa/cm199900/cmselect/cmhealth/373/37307.htm

Hussey R, Stansfield J (2011) Drawing new life from the 'well'. *Health Service Journal*, 121, 20-22.

Hutchinson H (2008) *Scoping of Asylum Seeker Services within Liverpool*. Liverpool PCT, September.

ICCM (2008) *Inequalities and Cultural Needs in Mental Health Service Provision for Black and Minority Ethnic communities in Liverpool.* Asylum Link Merseyside, Merseyside Chinese Community Development Association, Irish Community Care Merseyside (ICCM). Managed by ICCM, supported by UCLAN.
http://help.northwest.nhs.uk/storage/library/community_engagement_ALM_MCCDA_ICCM.pdf

Joloza T, Evans J, O'Brien R (2010) *Measuring Sexual Identity: An Evaluation Report*. Integrated Household Survey, Office for National Statistics, September 2010
http://www.ons.gov.uk/ons/rel/ethnicity/measuring-sexual-identity---evaluation-report/2010/index.html

Kessler D, Lloyd K, Lewis G, Pereira-Gray D (1999) Cross-sectional study of symptom attribution and recognition of depression and anxiety in primary care. *British Medical Journal*, 318, 18, 436-440.

King M, McKeown E (2003) *Mental health and social wellbeing of gay men, lesbians and bisexuals in England and Wales*. Mind.
http://www.pcsproud.org.uk/SummaryfindingsofLGBreport.pdf

Kings Fund (2001) *Mental Health and the Productivity Challenge : the need to integrate mental and physical health care more closely*. Mental Health Symposium.
http://blog.lighthouse-healthcare.co.uk/?p=64

Kitson N & Fry R (1990) Prelingual deafness and psychiatry.*British Journal of Hospital Medicine* 44, 353–355

Knuckey S, Carlin H, Perkins C, Bellis M (2011) *North West Wellbeing Survey: Focus on Ethnicity.* North West Public Health Observatory.
http://www.nwph.net/nwpho/Publications/NWMWS_Ethnicity.PDF

Lewis C (2011) Offender health needs assessment – initial findings, including data from Merseyside Probation Service. Full report expected early 2012. Liverpool Public Health Observatory

LHO (2011) *Marmot Indicators for Local Authorities in England*. London Public Health Observatory. Website last accessed 21/6/11
http://www.lho.org.uk/LHO_Topics/national_lead_areas/marmot/marmotindicators.aspx

Liverpool City Council (2010??) *Liverpool Green Infrastructure Strategy. Technical Document, Version 1.0.* Liverpool City Council Planning Service.
http://www.greeninfrastructurenw.co.uk/liverpool/Technical_Document.pdf

Liverpool PCT (2009a) *Joint Strategic Framework for Public Mental Health 2009-2012*:
http://www.liverpoolpct.nhs.uk/Library/Your_PCT/Publications/JSFMH.pdf

Liverpool PCT (2009b) *Joint Strategic Needs Assessment*. Liverpool PCT and Liverpool City Council.
http://www.liverpoolpct.nhs.uk/Library/Your_PCT/Publications/Joint%20Health%20Unit.pdf

LHO (2011) *Marmot Indicators for Local Authorities in England*. London Public Health Observatory and Marmot Review Team.
http://www.lho.org.uk/LHO_Topics/national_lead_areas/marmot/marmotindicators.aspx

Marmot M (2010) *Fair Society, Healthy Lives*. Strategic review of health inequalities in England post-2010.
http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLivesExecSummary.pdf

Marshall T, Simpson S, Stevens A (2000) *Toolkit for health care needs assessment in Prisons.* Department of Public health & Epidemiology, University of Birmingham. February.

Mason J, Deacon L, Carlin H, Giles S, Stansfield J, Perkins C, Bellis M (2011) *Halton and St.Helens Mental Wellbeing Survey 2009*. North West Public Health Observatory.
http://www.haltonandsthelenspct.nhs.uk/library/documents/HTSHhaltonandsthelensmentalwellbeings urvey2009.pdf

McEntee M.K (1993) Accessibility of mental health services and crisis intervention to the deaf. *American Annals of the Deaf* 138 (1), 26–30.

McManus S, Meltzer H, Brugha T, Bebbington P, Jenkins R (eds) (2009) *Adult psychiatric morbidity in England, 2007. Results of a household survey.* NHS Information Centre for health and social care, National Centre for Social Research and the Department of Health Sciences, University of Leicester.
http://www.ic.nhs.uk/webfiles/publications/mental%20health/other%20mental%20health%20publicatio ns/Adult%20psychiatric%20morbidity%202007/APMS%202007%20%28FINAL%29%20Standard.pdf

McWhirter L ed (2004) *Equality and inequalities in health and social care in Northern Ireland: A statistical overview*. Northern Ireland Statistics and Research Agency. Department of Health, Social Services and Public Safety.
http://www.dhsspsni.gov.uk/equality_inequalities.pdf

Meltzer H, Singleton N, Lee A, Bebington P, Brugha T, Jenkins R (2002) *The Social and Economic Circumstances of Adults with Mental Disorders.* National Statistics. London, The Stationery Office.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh _4060765.pdf

Mental Health Foundation (2006) *Cheers? Understanding the relationship between alcohol and mental health.*
http://www.mentalhealth.org.uk/content/assets/PDF/publications/cheers_report.pdf

Mental Health Foundation (2007) *Fundamental facts. The latest facts and figures on mental health.*
http://www.mentalhealth.org.uk/publications/fundamental-facts/

Mental Health Strategies (2011) *Finance Mapping of mental health services for working age adults and older people, 2010/11*. Series of LIT Reports.

Meyer IH (2003) Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin,* 129(5), 674-697
http://web.ebscohost.com.ezproxy.liv.ac.uk/ehost/pdfviewer/pdfviewer?sid=649ee91d-76ac-43cf-9a98-c8622d5eea2f%40sessionmgr110&vid=2&hid=112

MIND (2007a) *Housing and mental health*.
http://www.mind.org.uk/help/social_factors/housing_and_mental_health#mentalhealth

Mind (2007b) Another assault: Mind's campaign for equal access to justice for people with mental health problems. Mind.
http://www.mind.org.uk/assets/0000/4014/Anotherassault.pdf

MIND (2009) *A civilised society: Mental health provision for refugees and asylum-seekers in England and Wales.*
http://www.mind.org.uk/assets/0000/5695/refugee_report_2.pdf

MIND (2011) *Improving people's court experiences*.
http://www.mind.org.uk/campaigns_and_issues/current_campaigns/another_assault/improving_peoples_court_experiences

Morris J (2004) *People with physical impairments and mental health support needs*. Joseph Rowntree Foundation.
http://www.jrf.org.uk/sites/files/jrf/1859352103.pdf

Moser K (2001) Inequalities in treated heart disease and mental illness in England and Wales, 1994-98. *British Journal of General Practice*, 51, 438-444.

Myers F, McCollam A, Woodhouse A (2005) Resource document on mental health and inequalities in Scotland. Scottish Development Centre for Mental Health
http://www.scotland.gov.uk/Publications/2005/11/04145113/51135

National Mental Health Development Unit (2010) *Mental Health Good Practice Guide. Meeting the psychological and emotional needs of homeless people*. National Mental Health Development Unit and Department for Communities and Local Government. May.
http://www.nmhdu.org.uk/complextrauma

New Economics Foundation (2006).
www.neweconomics.org/gen/well_being_top.aspx?page=1038&folder=174

NHS North West (2008) A better future in mind: Mental health services in the North West
http://www.northwest.nhs.uk/document_uploads/Mental_Health_in_the_North_West/FinalMHC_active_inks_oct08.pdf

NICE (2005) *Health needs assessment: A practical guide*. National Institute for Health and Clinical Excellence.
http://www.nice.org.uk/aboutnice/whoweare/aboutthehda/hdapublications/health_needs_assessment_a_practical_guide.jsp

NICE (2009) *Promoting mental wellbeing at work, NICE public health guidance 22*. National Institute for Health and Clinical Excellence.
http://www.nice.org.uk/newsroom/nicenewslettersandalerts/intopractice-newsletterforimplementers/niceguidanceandyourworkplace.jsp

NEPHO (2008) *Community Mental Health Profiles*. North East Public Health Observatory. Website last accessed January 2011.
http://www.nepho.org.uk/mho/Community

NSF (1999) *National Health Service: National Service Frameworks*. London.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4077209.pdf

NWPHO (2006) *Where Wealth means Health: Illustrating Inequality in the North West*. North West Public Health Observatory. January 2006. ISBN: 1-902051-77-7

http://www.nwpho.org.uk/inequalities/

O'Connor (2010) Knowsley JSNA: Carers. Knowsley PCT. 26/11/10.

ONS (2011) *Statistical Bulletin: Suicide rates in the United Kingdom, 2000–2009*.Office for National Statistics, January 27th.
http://www.statistics.gov.uk/pdfdir/sui0111.pdf

Ostler K, Thompson C, Kinmoth ALK, Peveler RC, Stevens L, Stevens A (2001) Influence of socio-economic deprivation on the prevalence and outcome of depression in primary care. *British Journal of Psychiatry*, 178, 12-17.

Pickett K, James O, & Wilkinson R (2006) Income inequality and the prevalence of mental illness: a preliminary international analysis. *Journal of Epidemiology and Community Health, 60,* 646-647.
http://jech.bmj.com/content/60/7/646.extract

Pidd F, Newbigging K (2002) *Mental Health: Public Health Information Report*, North West Public Health Observatory, December 2002.

RCP (2005) Royal College of Psychiatrists Memorandum to Select Committee on Work and Pensions available at:
http://www.publications.parliament.uk/pa/cm200506/cmselect/cmworpen/616/6022719.htm

Rethink (2003) *Who cares? The experiences of mental health carers accessing services and information.* Rethink (National Schizophrenia Fellowship).
http://www.mentalhealthshop.org/applications/site_search/mhs_search.rm?term=who+cares&submit.x=0&submit.y=0

RNID (2006) Facts and figures on deafness and tinnitus. The Royal National Institute for Deaf People

Sefton Council (2009) *Green Space Strategy for Sefton.*
http://www.sefton.gov.uk/pdf/PERD%20Green_Space_Strategy_FINAL_FOR_WEB.pdf

Shelter (2005) Full house? How overcrowded housing affects families
http://england.shelter.org.uk/professional_resources/policy_library/policy_library_folder/?a=39532

Singleton N et al (1998) *Psychiatric morbidity among prisoners in England and Wales.* Government Statistical Service. June 1998. ONS.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4007132

Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H (2001) *Psychiatric Morbidity among adults living in private households, 2000*. London: The Stationery Office.
http://www.statistics.gov.uk/downloads/theme_health/psychmorb.pdf

Singleton N, Aye Maung N, Cowie A, Sparks J, Bumpstead R, Meltzer H (2002) *Mental Health of Carers*. National Statistics. London, The Stationery Office.
http://www.statistics.gov.uk/downloads/theme_health/Mental_Health_of_Carers_June02.pdf

Skegg K and Herbison P (2009) Effect of restricting access to a suicide jumping site. *Australian and New Zealand Journal of Psychiatry*, 43:498502
http://informahealthcare.com/doi/pdf/10.1080/00048670902873698

Skogan W (1986) Fear of crime and neighbourhood change. In Reiss A & Tonry M (eds) (1986) Communities and crime. University of Chicago Press, Chicago and London.
http://heinonline.org/HOL/Page?handle=hein.journals/cjrr8&div=10&g_sent=1&collection=journals

Social Exclusion Unit (2004) *Mental Health and Social Exclusion*. Social Exclusion Unit Report. London, Office of the Deputy Prime Minister.
http://www.socialinclusion.org.uk/publications/SEU.pdf

Stafford M, Chandola T, Marmot M (2007) Association Between Fear of Crime and Mental Health and Physical Functioning. *American Journal of Public Health*. November 2007, Vol 97, No. 11, 2076-2081
http://ajph.aphapublications.org/cgi/content/abstract/97/11/2076

Soomro G, Burns T, Majeed A (2002) Socio-economic deprivation and psychiatric referral and admission rates – an ecological study in one London borough. *Psychiatric Bulletin,* 26, 175-178.

Spataro J, Mullen P, Burgess P, Wells D, Moss S (2004) Impact of child sexual abuse on mental health: Prospective study in males and females. *The British Journal of Psychiatry*, 184, 416-421.
http://bjp.rcpsych.org/cgi/content/abstract/184/5/416

Stack S (2003) Media coverage as a risk factor in suicide. *J Epidemiol Community Health*;57:238-240
http://jech.bmj.com/content/57/4/238.full

Tellus (2007) *Tellus survey – staying safe.* 1/1/07
http://yhpho.york.ac.uk/IADataServer//metadata.asp?DBElementType=dataset&DBElementID=324&DateID=2007-01-01&Period=Year&GeographyTypeID=26

Tellus4 (2010). *Tellus 4 survey for 2009. Summary*. National Foundation for Educational Research (NFER), 11th Feb.
http://www.nfer.ac.uk/emie/detail.asp?id_content=717&id_category=277&id_Ref=7490&level=1&detail=news

TIIG (2007) *Self harm in young males across Merseyside*. Report for CALM, May 2007.

TIIG (2010) *Self-harm in Merseyside: an analysis of emergency department, hospital admissions and ambulance data.* Trauma and Injury Intelligence Group, Liverpool JMU, September.
http://www.tiig.info/writedir/86adSelf%20harm%20report%20Merseyside%20Sept%202010.pdf

Ubido J, Huntington J, Warburton D (2002) Inequalities in access to healthcare faced by women who are deaf. *Health & Social Care in the Community*, 10, 247–253 2002
http://onlinelibrary.wiley.com/doi/10.1046/j.1365-2524.2002.00365.x/citedby

Ubido J, Church E, Michel E (2004) *Merseyside Mental Health Equity Audit: Equity in access to and provision of services.* A report for the Directors of Public Health, Merseyside PCTs. Liverpool Public Health Observatory Report Series, report number 59, December 2004
http://www.liv.ac.uk/PublicHealth/obs/publications/report/mhea_full.pdf

Ubido J, Lewis C (2008) *Mental Health Equity Profile for the Mersey Care NHS Trust catchment area.* Liverpool Public Health Observatory Report series No.69, September 2008
http://www.liv.ac.uk/PublicHealth/obs/publications/report/Mental%20Health%20Equity%20Profile%20-%20full%20report.pdf

Ubido J & Winters L (2010) *Healthcare needs assessment: Specialist intervention in safeguarding children across Merseyside.* Liverpool Public Health Observatory report series number 75
http://www.liv.ac.uk/PublicHealth/obs/publications/report/safeguarding_needs_assessment_FINAL_REPORT_01.pdf

University of Manchester (2010) *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report: England and Wales*. July.
http://www.medicine.manchester.ac.uk/psychiatry/research/suicide/prevention/nci/inquiryannualreports/AnnualReportJuly2010.pdf

Van Cleemput PV and Parry G (2001) Health Status of Gypsy Travellers. *Journal of Public Health Medicine*, 23, 2, 129-134.
http://jpubhealth.oxfordjournals.org/content/23/2/129.full.pdf+html

Vose C (2011) NHS Knowsley and Chair of Merseyside and Cheshire Suicide Reduction Group. Personal correspondence 4/8/11.

Waddell G and Burton A (2006) Is work good for your wellbeing? London, The Stationery Office
http://www.dwp.gov.uk/docs/hwwb-is-work-good-for-you.pdf

Wilkinson R, Marmot M (2003) *Social Determinants of Health: The Solid Facts*. 2nd edition. World Health Organisation.
http://www.euro.who.int/__data/assets/pdf_file/0005/98438/e81384.pdf

Wilkinson R, Pickett K (2009) The Spirit Level: Why More Equal Societies Almost Always Do Better. Penguin Books, London.

Weich S, Lewis G (1998) Poverty, unemployment and common mental disorders: population based cohort study. *British Medical Journal*, 317, 115-119.

WHO (2001) *The World Health Report 2001. Mental Health: New Understanding, New Hope.* World Health Organisation, Geneva, 2001.

WHO**.** *Mental health of refugees, internally displaced persons and other populations affected by conflict.* Guidelines for public health topics in crises. World Health Organisation**.**
Website last accessed 24/3/11
http://www.who.int/hac/techguidance/pht/mental_health_refugees/en/

Wilson M (2010) *Delivering race equality action plan: a five year review*. Department of Health, London.
http://www.nmhdu.org.uk/silo/files/race-equality-action-plan-a-five-year-review.pdf

Women's Aid (2011) *The Survivor's Handbook.* Women's Aid Federation of England. Website last accessed 25/7/11
http://www.womensaid.org.uk/domestic-violence-survivors-handbook.asp?section=0001000100080001003600002

Appendices

Appendix 1:

Maps by super output area

KEY for maps

Knowsley Electoral Wards

1	Cherryfield
2	Park
3	Shevington
4	Northwood
5	Whitefield
6	Kirkby Central
7	Prescot West
8	Stockbridge
9	Page Moss
10	Swanside
11	St. Bartholomews
12	Longview
13	St. Michaels
14	Prescot East
15	Whiston North
16	Whiston South
17	St. Gabriels
18	Roby
19	Halewood North
20	Halewood West
21	Halewood South

Liverpool Electoral Wards

1	Kirkdale
2	County
3	Warbreck
4	Fazakerley
5	Croxteth
6	Yew Tree
7	West Derby
8	Norris Green
9	Clubmoor
10	Anfield
11	Everton
12	Central
13	Kensington & Fairfield
14	Tuebrook & Stoneycroft
15	Knotty Ash
16	Old Swan
17	Childwall
18	Wavertree
19	Picton
20	Princes Park
21	Riverside
22	St Michael's
23	Greenbank
24	Church
25	Woolton
26	Belle Vale
27	Allerton & Hunts Cross
28	Cressington
29	Mossley Hill
30	Speke-Garston

Sefton Electoral Wards

1	Cambridge
2	Meols
3	Norwood
4	Duke's
5	Kew
6	Birkdale
7	Ainsdale
8	Harington
9	Ravenmeols
10	Manor
11	Blundellsands
12	Park
13	Sudell
14	Molyneux
15	St. Oswald
16	Netherton & Orrell
17	Ford
18	Victoria
19	Church
20	Linacre
21	Litherland
22	Derby

Wirral Electoral Wards

1	Hoylake & Meols
2	Moreton West & Saughall Massie
3	Leasowe & Moreton East
4	Wallasey
5	New Brighton
6	Liscard
7	Seacombe
8	Bidston & St James
9	Birkenhead & Tranmere
10	Claughton
11	Upton
12	Greasby, Frankby & Irby
13	West Kirby & Thurstaston
14	Heswall
15	Pensby & Thingwall
16	Prenton
17	Oxton
18	Rock Ferry
19	Bebington
20	Clatterbridge
21	Bromborough
22	Eastham

St. Helens Electoral Wards

1	Rainford
2	Billinge & Seneley Green
3	Haydock
4	Earlestown
5	Newton
6	Blackbrook
7	Parr
8	Town Centre
9	Moss Bank
10	Windle
11	Eccleston
12	West Park
13	Thatto Heath
14	Sutton
15	Bold
16	Rainhill

Halton Electoral Wards

1	Hough Green
2	Birchfield
3	Farnworth
4	Halton View
5	Appleton
6	Riverside
7	Kingsway
8	Broadheath
9	Ditton
10	Mersey
11	Castlefields
12	Daresbury
13	Norton North
14	Windmill Hill
15	Norton South
16	Halton Lea
17	Halton Brook
18	Grange
19	Beechwood
20	Heath
21	Hale

Map 1   **see 1st page of Appendix 1 for map KEY**

Index of Multiple Deprivation 2010 by Lower Layer Super Output Area

Index of Multiple Deprivation 2010 Score

- 56.3 to 83.1
- 38.4 to 56.3
- 22.8 to 38.4
- 12.8 to 22.8
- 2.9 to 12.8

Electoral Ward Boundaries (see table for labels)

Note: The higher the Score, the more deprived an area is.

Data Source: Department for Communities & Local Government.

Produced by Colin Wilson
Liverpool Public Health Intelligence Team

This map is reproduced from Ordnance Survey material with the permission
of Ordnance Survey on behalf of the controller of Her Majesty's Stationery Office,
may contain National Statistics © Crown copyright and database rights 2011 Ordnance Survey 100050548.
Unauthorised reproduction infringes Crown copyright and may lead to prosecution or civil proceedings.

Map 2   **see 1st page of Appendix 1 for map KEY**

Estimated Percentage of Households in Fuel Poverty by Lower Layer Super Output Area: 2008

Percentage of Households

- 22.4% to 38.5%
- 19.2% to 22.4%
- 16.5% to 19.2%
- 14.0% to 16.5%
- 4.2% to 14.0%

Electoral Ward Boundaries (see table for labels)

Data Source: Department of Energy and Climate Change

Produced by Colin Wilson
Liverpool Public Health Intelligence Team

This map is reproduced from Ordnance Survey material with the permission of Ordnance Survey on behalf of the controller of Her Majesty's Stationery Office, may contain National Statistics © Crown copyright and database rights 2011 Ordnance Survey 100050548. Unauthorised reproduction infringes Crown copyright and may lead to prosecution or civil proceedings.

Percentage of Households in Poverty by Mid Layer Super Output Area: April 2007 to March 2008

Percentage of Households

- 29.3% to 42.0%
- 25.1% to 29.3%
- 20.6% to 25.1%
- 17.4% to 20.6%
- 8.5% to 17.4%

Electoral Ward Boundaries (see table for labels)

Note: Poverty defined as; household below 60% of the median income (after housing costs).

Data Source: Office for National Statistics

Produced by Colin Wilson
Liverpool Public Health Intelligence Team
This map is reproduced from Ordnance Survey material with the permission of Ordnance Survey on behalf of the controller of Her Majesty's Stationery Office, may contain National Statistics © Crown copyright and database rights 2011 Ordnance Survey 100050548. Unauthorised reproduction infringes Crown copyright and may lead to prosecution or civil proceedings.

Map 4   **see 1ˢᵗ page of Appendix 1 for map KEY**

Estimated Percentage of Working Age Population Claiming Jobseekers Allowance by Lower Layer Super Output Area: August 2009

Percentage of Working Age Population

- 9.1% to 18.8%
- 6.5% to 9.1%
- 4.4% to 6.5%
- 3.2% to 4.4%
- 0.5% to 3.2%

Electoral Ward Boundaries (see table for labels)

Note: Working age is 16-64 years for males and 16-59 for females.

Data Sources: Office for National Statistics and Department for Work & Pensions

Produced by Colin Wilson
Liverpool Public Health Intelligence Team

This map is reproduced from Ordnance Survey material with the permission of Ordnance Survey on behalf of the controller of Her Majesty's Stationery Office, may contain National Statistics © Crown copyright and database rights 2011 Ordnance Survey 100050548. Unauthorised reproduction infringes Crown copyright and may lead to prosecution or civil proceedings.

Percentage of Households that are Social Housing Rented by Lower Layer Super Output Area: 2001 Census

Map 6   see 1st page of Appendix 1 for map KEY

Percentage of Population with Long Term Illness by Mid Layer Super Output Area: 2001 Census

Produced by Colin Wilson
Liverpool Public Health Intelligence Team

This map is reproduced from Ordnance Survey material with the permission
of Ordnance Survey on behalf of the controller of Her Majesty's Stationery Office,
may contain National Statistics © Crown copyright and database rights 2011 Ordnance Survey 100050548.
Unauthorised reproduction infringes Crown copyright and may lead to prosecution or civil proceedings.

Mental Health Specific Incapacity Benefit/Severe Disablement Allowance Claimants by Mid Layer Super Output Area: August 2007

Benefit Claimants
(Indirectly Standardised Ratio)

- 263.6 to 539.6
- 202.9 to 263.6
- 137.5 to 202.9
- 82.2 to 137.5
- 31.5 to 82.2

Electoral Ward Boundaries (see table for labels)

Data Sources: Office for National Statistics and North West Public Health Observatory

Produced by Colin Wilson
Liverpool Public Health Intelligence Team

This map is reproduced from Ordnance Survey material with the permission of Ordnance Survey on behalf of the controller of Her Majesty's Stationery Office, may contain National Statistics © Crown copyright and database rights 2011 Ordnance Survey 100050548. Unauthorised reproduction infringes Crown copyright and may lead to prosecution or civil proceedings.

Map 8   **see 1ˢᵗ page of Appendix 1 for map KEY**

Hospitalised due to Mental Health Conditions Prevalence by Mid Layer Super Output Area: April 2003 to March 2008 Pooled

Mental Health Conditions Prevalence (Indirectly Standardised Ratio)

- 232.0 to 424.6
- 177.3 to 232.0
- 139.3 to 177.3
- 101.7 to 139.3
- 53.2 to 101.7

Electoral Ward Boundaries (see table for labels)

Data Sources: Hospital Episode Statistics, Office for National Statistics and North West Public Health Observatory

Produced by Colin Wilson
Liverpool Public Health Intelligence Team

This map is reproduced from Ordnance Survey material with the permission of Ordnance Survey on behalf of the controller of Her Majesty's Stationery Office, may contain National Statistics © Crown copyright and database rights 2011 Ordnance Survey 100050548. Unauthorised reproduction infringes Crown copyright and may lead to prosecution or civil proceedings.

Map 9   **see 1ˢᵗ page of Appendix 1 for map KEY**

Hospitalised due to Self Harm Incidence by Mid Layer Super Output Area: April 2003 to March 2008 Pooled
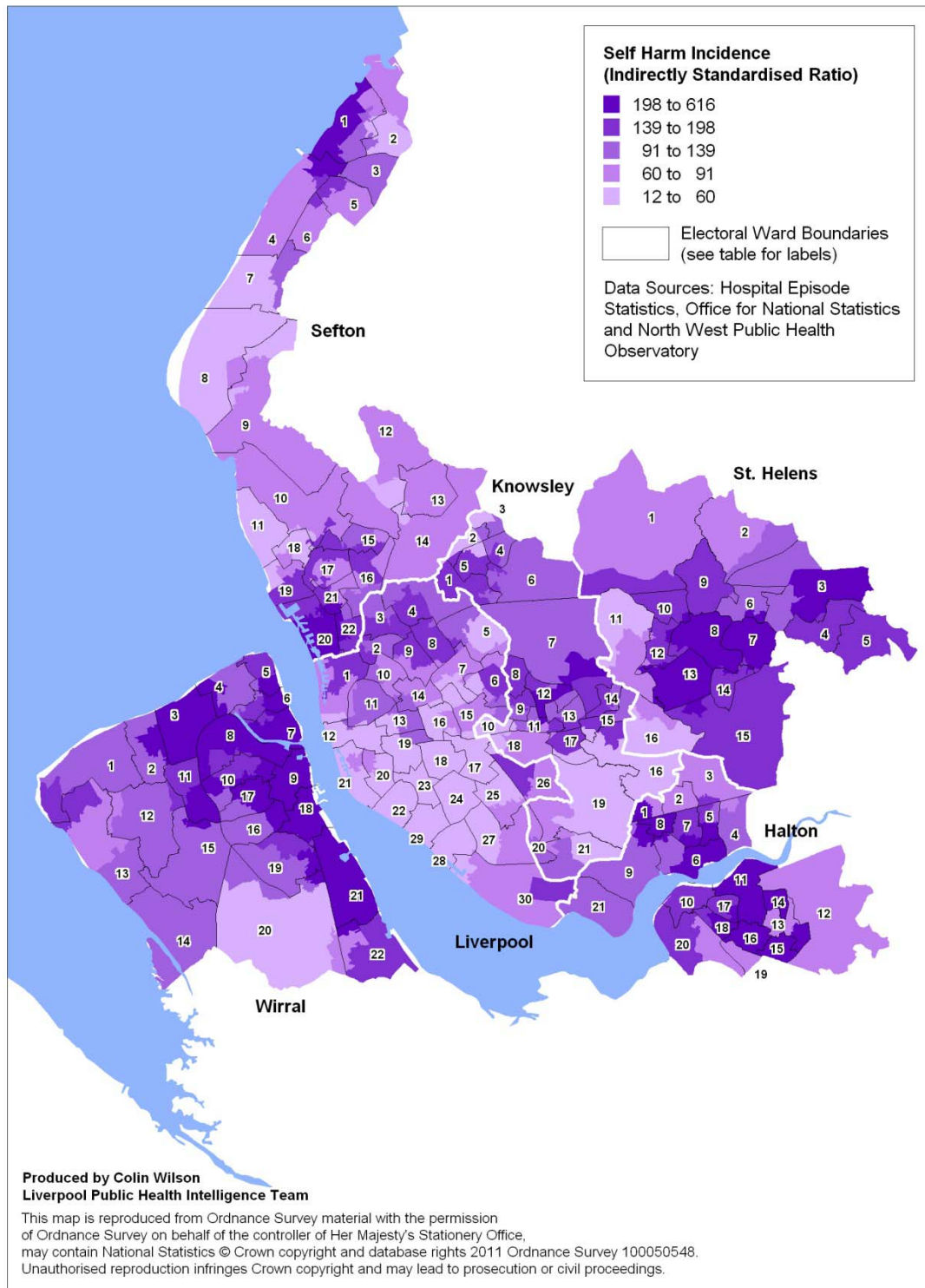
Appendix 2:

Supplementary tables and figures

Table A1

Asylum seekers in receipt of subsistence only support (1)(2)(3), by Local Authority and UK Government Office Region as at the end of December 2007, 2008 & 2009

	Local Authority (4)	2007	% of NW total	2008	% of NW total	2009	% of NW total
	Liverpool	80	14.29	40	10.39	25	9.43
	Sefton	-	-	15	-	15	5.66
							15.09
			% of UK total		% of UK total		% of UK total
North West	Total	560	(6)	385	(6)	265	(6)
TOTAL (UNITED KINGDOM)		8,900	(100)	6,195	(100)	4,670	(100)

N.B. 68% were London

(1)   Figures (other than percentages) rounded to the nearest 5 (- = 0, * = 1 or 2) and may not sum to the totals shown because of independent rounding.

(2)   Excludes unaccompanied asylum seeking children supported by Local Authorities, estimated around 4,600 in December 2009.

(3)   From Q2 2009 any cases with an invalid application status are excluded.

(4)   Local Authorities with fewer than 15 cases, when rounded, are grouped by region as "Other".

Previously published in Control of Immigration: Quarterly Statistical Summary, United Kingdom, Q4 2009, Table 6

Data Source: http://rds.homeoffice.gov.uk/rds/immigration-asylum-stats.html

Table A2

Proportions of UK population with different degrees of hearing impairment 2005 (thousands)

age	UK population	deaf & hard of hearing population	%of total population deaf & hard of hearing	mild/moderate deafness	severe/profound deafness	% of total population with severe/profound deafness
16-60	35895.9	2474	6.892152	2366	108	0.30087
60+	12754.8	6471	50.733841	5891	580	4.547308
tot 16+	48650.7	8945	18.386169	8257	688	1.414163

Source: ONS and RNID (2006)

Table A3

Estimates of depression and anxiety amongst people who are severely or profoundly deaf in Merseyside, ages 16-60, 2005

2005	Population aged 15-59	deaf & hard of hearing aged 16-60	severe/profound deafness ages 16-60	mental health problems amongst those who are severely/profoundly deaf
Halton and St Helens	176200	12144	530	177
Knowsley	90600	6244	273	91
Liverpool	286700	19760	863	287
Sefton	155400	10710	468	156
Wirral	174700	12041	526	175
Merseyside	883600	60899	2658	885

Based on ONS 2005 population estimates. Population base used was ages 15-59.
Source of deaf population data: RNID (2006)
Mental health estimates based on Cowie and Douglas-Cowie (1987)
Merseyside totals may be different due to rounding

Table A4

'Tellus' survey : Staying safe. School age children, Merseyside local authorities, 2007

	Local authority					England (n=111,325)
	Knowsley (n=634)	Liverpool (n=1,252)	Sefton (n=874)	St Helens (n=415)	Wirral (n=1,004)	
	%	%	%	%	%	%
1.*Around the local area I feel A bit/very unsafe from being hurt by other people	28.7	26.2	25.2	22.1	29.2	25
2.Around the local area I feel Very/quite safe from being hurt by other people	69.8	72.5	72.9	76.7	69.6	74
3.*At home I feel A bit/very unsafe from being hurt by other people	5.8	3.7	4.1	8.1	7.2	4
4.At home I feel Very/quite safe from being hurt by other people	93.5	95.7	94.9	91.5	92	95
5.*Going to and from school I feel A bit/very unsafe from being hurt by other people	17.3	12.7	11.1	11.5	14.7	13
6.Going to and from school I feel Very/quite safe from being hurt by other people	81	86.1	86.9	86.4	84.5	85
7.*Have been bullied in school at least a couple of times in the last four weeks	23.7	20.3	27.1	32.4	27.8	17
8.*Have been bullied in school most days in the last four weeks	7	3	5.3	4.2	4.7	5
9.*Have been bullied somewhere else at least a couple of times in the last four weeks	69.8	72.5	72.9	76.7	69.6	n/a
10.*In school I feel A bit/very unsafe from being hurt by other people	11.2	10.7	13.3	5.4	9.9	14
11. In school I feel Very/quite safe from being hurt by other people	87.1	88.2	85.5	94	89.4	85
12.*My school deals with bullying not very/not at all well	26	25.1	25.6	10.5	29.2	30
13.My school deals with bullying very/quite well	54.7	55.9	61.6	81.3	55.8	57

* = not safe.
Data source:YHPHO ChiMat dataset
http://yhpho.york.ac.uk/IADataServer//metadata.asp?DBElementType=dataset&DBElementID=324&DateID=200
7-01-01&Period=Year&GeographyTypeID=26
These details are not available in the more recent 'Tellus' surveys

Table A5

Benefit payments - incapacity benefit / severe disablement – number of claimants

	Halton	St. Helens	Knowsley	Liverpool	Sefton	Wirral
2004	2,950	4,680	5,270	17,870	6,970	9,110
2005	2,980	4,910	5,310	17,700	7,000	8,820
2006	2,960	4,970	5,370	17,380	6,870	8,710
2007	3,050	5,000	5,360	17,040	6,610	8,660
2008	3,110	4,970	5,270	16,820	6,520	8,640
2009	2,800	4,550	4,820	15,820	6,100	8,060
2010	2,600	4,120	4,400	14,390	5,640	7,240
% decrease, 2004 to 2010	11.86%	11.97%	16.51%	19.47%	19.08%	20.53%

Data source: https://www.nomisweb.co.uk/Default.asp

Table A6
Benefit payments - incapacity benefit / severe disablement, 2010

Age	Halton			St. Helens			Knowsley		
	number	pop (thousands)	rate per thousand	number	pop (thousands)	rate per thousand	number	pop (thousands)	rate per thousand
18-24	140	7.8	17.95	200	10.6	18.87	180	11.0	16.36
25-34	420	14.2	29.58	640	20.1	31.84	560	17.0	32.94
35-44	620	16.6	37.35	1,050	25.9	40.54	1,100	21.5	51.16
45-49	400	8.8	45.45	620	12.9	48.06	750	11.6	64.66
50-54	390	8.1	48.15	630	11.5	54.78	780	10.1	77.23
55-59	410	8.0	51.25	600	11.3	53.10	710	8.6	82.56
60-64	200	7.6	26.32	360	11.8	30.51	270	7.7	35.06
65 and over	20	17.0	1.18	40	30.1	1.33	50	23.3	2.15
tot working age	2,580	71	36.29	4,100	104	39.39	4,350	88	49.71

Age	Liverpool			Sefton			Wirral		
	number	pop (thousands)	rate per thousand	number	pop (thousands)	rate per thousand	number	pop (thousands)	rate per thousand
18-24	580	51.7	11.22	220	16.5	13.33	330	18.6	17.74
25-34	1,820	65.0	28.00	690	25.8	26.74	990	31.2	31.73
35-44	3,700	56.6	65.37	1,430	36.0	39.72	1,910	41.1	46.47
45-49	2,520	30.3	83.17	960	21.4	44.86	1,160	22.7	51.10
50-54	2,350	27.4	85.77	900	19.2	46.88	1,120	20.8	53.85
55-59	2,250	23.9	94.14	900	17.6	51.14	1,100	20.0	55.00
60-64	1,020	22.1	46.15	460	17.9	25.70	550	20.6	26.70
65 and over	150	63.3	2.37	80	55.9	1.43	70	58.6	1.19
tot working age	14,240	277	51.41	5,560	154	36.01	7,160	175	40.91

N.B. rate for 18-24 claimants based on pop for ages 20-24, as 18-24 not available – so rates are higher than they should be for this age group

Figure A7

Incapacity benefits for mental illness
Male rate per 1,000 population
by age group, 2010
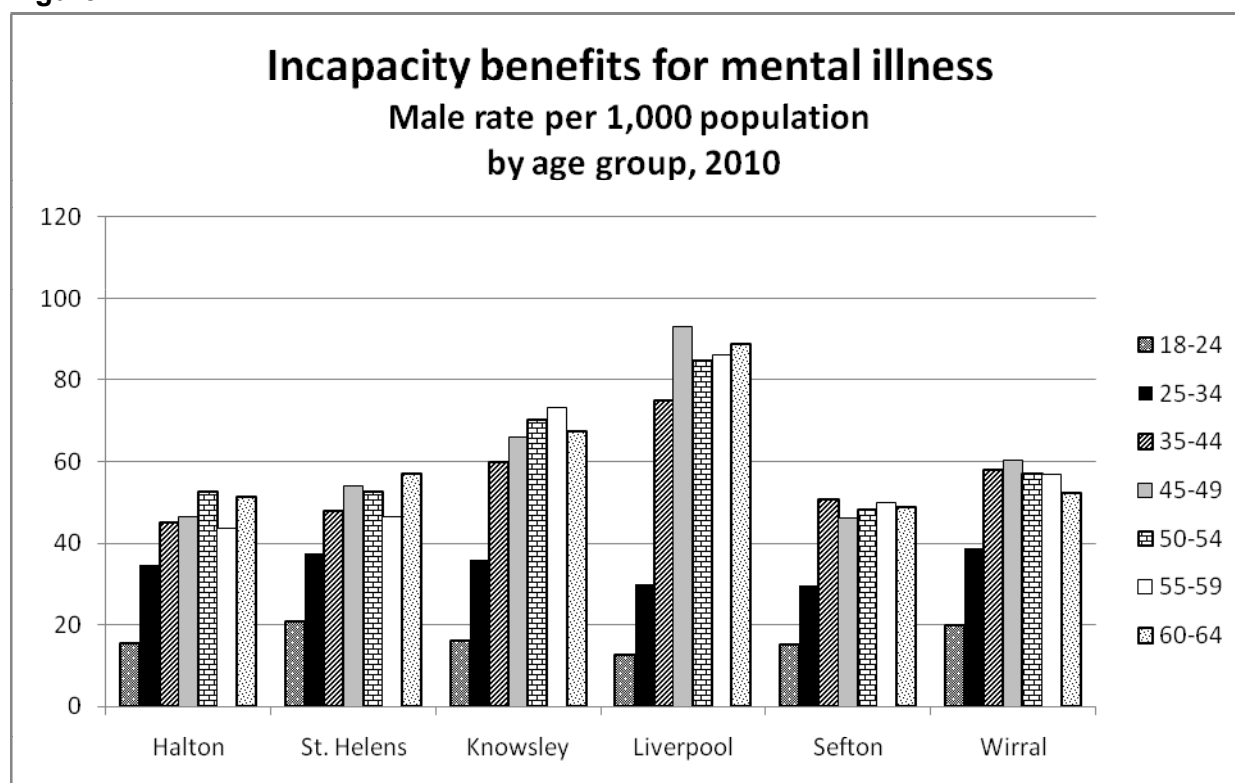
MALES Rate per thousand by age						
Age	Halton	St. Helens	Knowsley	Liverpool	Sefton	Wirral
18-24	15.38	20.75	16.07	12.74	15.29	20.00
25-34	34.78	37.37	35.80	29.88	29.77	38.82
35-44	45.00	48.00	60.00	74.91	50.90	58.12
45-49	46.34	53.97	66.04	93.06	46.08	60.38
50-54	52.63	52.63	70.21	84.73	48.35	57.14
55-59	43.59	46.43	73.17	86.21	50.00	56.70
60-64	51.35	56.90	67.57	88.89	48.84	52.48

Data source: Department of Work & Pensions

Figure A8

Incapacity benefits for mental illness
Female rate per 1,000 population
by age group, 2010

FEMALES Rate per thousand by age						
Age	Halton	St. Helens	Knowsley	Liverpool	Sefton	Wirral
18-24	20.51	18.87	16.67	9.69	11.25	15.38
25-34	23.29	25.49	30.34	25.96	23.62	25.63
35-44	31.40	33.58	43.48	56.18	30.05	36.82
45-49	45.65	40.91	63.49	74.68	43.75	42.98
50-54	44.19	55.17	83.33	86.71	45.54	50.91
55-59	56.10	58.62	91.11	101.63	52.22	52.88
60-64	2.63	5.00	5.00	5.31	4.30	2.86

Data source: Department of Work & Pensions

Table A9

**Directly standardised rates for hospital admissions,
ages 18-64, by diagnosis and sex, 2006.** Rates per 100,000

	Other mental health disorders		Other mental behavioural disorders, plus 'no diagnosis'	
	male	female	male	female
Halton	1.58	1.59	3.20	1.93
St.Helens	2.86	1.38	6.09	4.32
Knowsley	5.35	2.97	6.75	7.82
Liverpool	11.97	7.29	1.16	0.70
Sefton	4.11	2.65	0.26	0.19
Wirral	4.89	2.09	2.28	1.77

Data Source: NEPHO MHO
http://www.nepho.org.uk/mho/diagnosis

Acknowledgements

Liverpool Public Health Observatory

Department of Public Health and Policy
Whelan Building
Quadrangle
University of Liverpool
Liverpool L69 3GB

Tel: 0151 794 5570/81
Fax: 0151 794 5588
E-mail: obs@liv.ac.uk
WWW: http://www.liv.ac.uk/PublicHealth/obs

UNIVERSITY OF
LIVERPOOL