9.0 Mental Health

This chapter outlines the Mental Health priorities and needs of the Wirral population. The key driver is 'No Health without Mental Health' which provides our local framework for ongoing development of Mental Health services to meet local need.

Since the first edition of the Mental Health Section of the JSNA and the introduction of NHS Wirral's Strategic Plan there are numerous service developments that have been commissioned as a result of the identification of local need and gaps.
Download Summary for Mental Health Services

Chapter Summary

- The Department of Health Mental Health Strategy, 'No Health without Mental Health' states that access to Psychological Therapies, such as counselling should increase to 60% by 2015.
- NHS Wirral is working in partnership with local Clinical Commissioning Groups (CCG's) to increase access to Psychological Therapies. A procurement process took place in 2011 to commission Wirral IAPT compliant services that ensure priority access to Military Veterans and Perinatal women.
- Attention deficit hyperactivity disorder (ADHD) has an estimated prevalence of 2.5% in adults. In 2008, a Wirral pilot service for Adults with ADHD found high levels of co-morbidity with substance misuse.
- National data suggests that people with a mental health problem are more likely to be on a lower income, be on welfare benefits, and live in debt. Mental health is also the most commonly reported reason for claiming incapacity benefits, both nationally and locally.
- In Wirral it is estimated that there is a higher prevalence of severe mental illness compared with the North West and England average (QOF, 2010/11)
- Hospital admissions data for mental health indicates a strong association between deprivation and increased admissions. Admissions for self harm and prevalence of a common mental illness show a similar pattern. This indicates a greater need for mental health interventions in areas with higher levels of deprivation
- NHS Wirral is eighth highest of the 27 PCTs in the North West for antidepressant prescribing rates but sixth lowest in terms of prescribing costs. This demonstrates that cost effective options for treatment are being used locally.
- Dementia is a key priority for Wirral. In 2011, 4443 people aged 65 and over were estimated to be living with Dementia with the expectation that by 2020, this figure would rise to 5282 and further rise to 6892 by 2030. (www.poppi.org.uk)
- Wirral suicides/open verdicts between 2009 and 2010 have reduced, with 25 deaths recorded from January 2009 to December 2009 representing a 17% decrease. In Wirral the number of suicides have been reducing year on year.
- However, between 2006 and 2007 a two-fold increase was observed in this area with no significant explanation for the rise. In relation to the total number of deaths in Wirral overall suicides are relatively small. This makes it difficult to identify any commonalties or apply any seasonal trends.

9.1 What is Mental Health?

Mental health is fundamental to good health, wellbeing and quality of life. It impacts on how we think, feel, communicate and understand. It enables us to manage our lives successfully and live to our full potential. We all have mental health needs irrespective of any diagnosis associated with mental health

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).

No other health condition matches mental ill health in terms of prevalence, persistence and breadth of social and economic impact. According to the World Health Organisation 2001, nearly a quarter of all years of life lost due to ill-health, disability or early death are the result of mental disorder (cancer and cardiovascular illness account for significantly less; a sixth each).The economic burden is also significant. Costs to society have been estimated at £105 billion.

9.1.1 Mental health is everybody's business

Key Messages

- Mental health is everybody's business
- There is no health without mental health
- Mental health cuts across all areas of life
- Focus on mental well-being - the majority of mental health needs are met within primary care services or the community generally
- Foundations for good mental health and well-being are laid in childhood.
- Span across whole life age range – what happens to children has a major impact on their mental health throughout life. In this respect experience of trauma including violence and sexual abuse is highly significant.
- Specialist services are crucial for people who have long-term mental illness– they are few in number but high in complexity.

9.1.2 National Strategy

The Coalition government mental health strategy '*No health without mental health' (2011)* places a strong emphasis on early intervention to stop serious mental health issues developing, particularly among children. The strategy states, 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.

9.1.3 Social determinants of mental health

'No health without mental health' *(DH, 2011)* 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. There is an impact on all areas of people's lives and that of their community.

The report suggests that 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 2011, No health without mental health**).**

9.1.4 Measuring Mental Health

Measuring mental health is complex. A wide variety of data sources are needed to illustrate all the relevant experiences of people and populations. Each additional analysis adds to the richness of the picture.

There is a wide range of determinants of both mental illness and mental well-being. Mental illness and mental well-being are not opposite ends of the same spectrum. The absence of a psychiatric diagnosis does not imply the presence of well-being.

Some determinants of mental illness and mental health relate to the individual, such as their psychological skills and personal resources, whilst others relate to the wider social, political, and economic circumstances of people's lives. These determinants can be risk factors for poor mental health or mental illness, or can be protective factors, enabling people to cope with stress or adverse events. Many determinants of mental health and well-being are interrelated and so tend to cluster in individuals and populations. Some people experience many risk factors which have a cumulative effect on their short and long term mental health, and a wider impact on the mental health of their families, particularly their children. Early life experiences are particularly influential on longer term psychological well-being and future health behaviours.

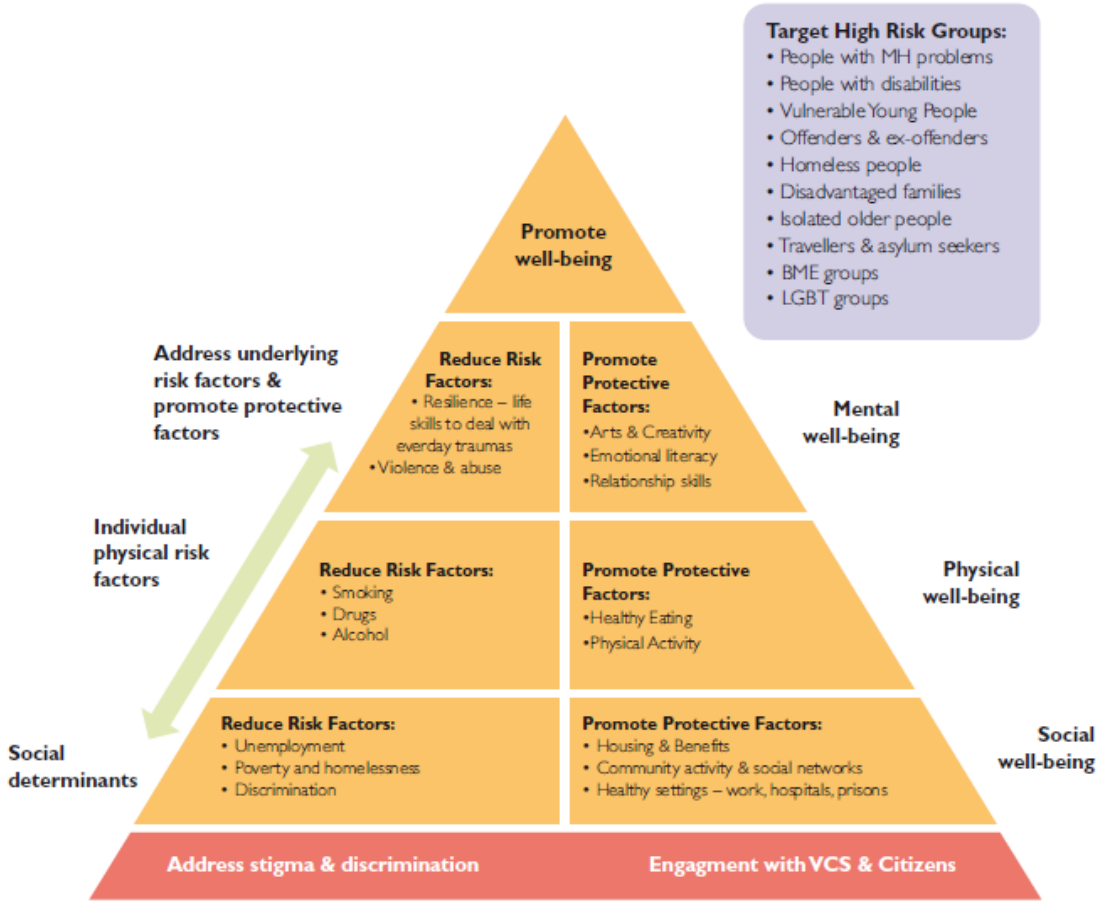
There is strong and growing research literature on mental illness and mental well-being. This report attempts to include a wide range of background contextual information to help with the interpretation of the data. Any one determinant of mental illness or mental well-being may not appear particularly significant until considered in this wider context, when the clustering of disadvantage in certain localities may become evident.

In addition, interpretation of the data requires local experience and intelligence as it is not always possible to measure what is important. As with all population data, the average experience of a locality may not be true for all individuals living therein. Relatively affluent areas may be home to very disadvantaged people.

9.2 Mental Wellbeing

Mental well-being is influenced by many factors, including genetic inheritance, childhood experiences, life events, individual ability to cope and levels of social support, as well as factors like adequate housing, employment, financial security and access to appropriate health care. Gender has a significant impact on mental health and vulnerability to mental illness. Racism, homophobia and other forms of discrimination also affect mental health and can be an underlying cause of mental illness. (Mental health inequalities: Measuring what counts Sainsbury Centre for Mental Health)

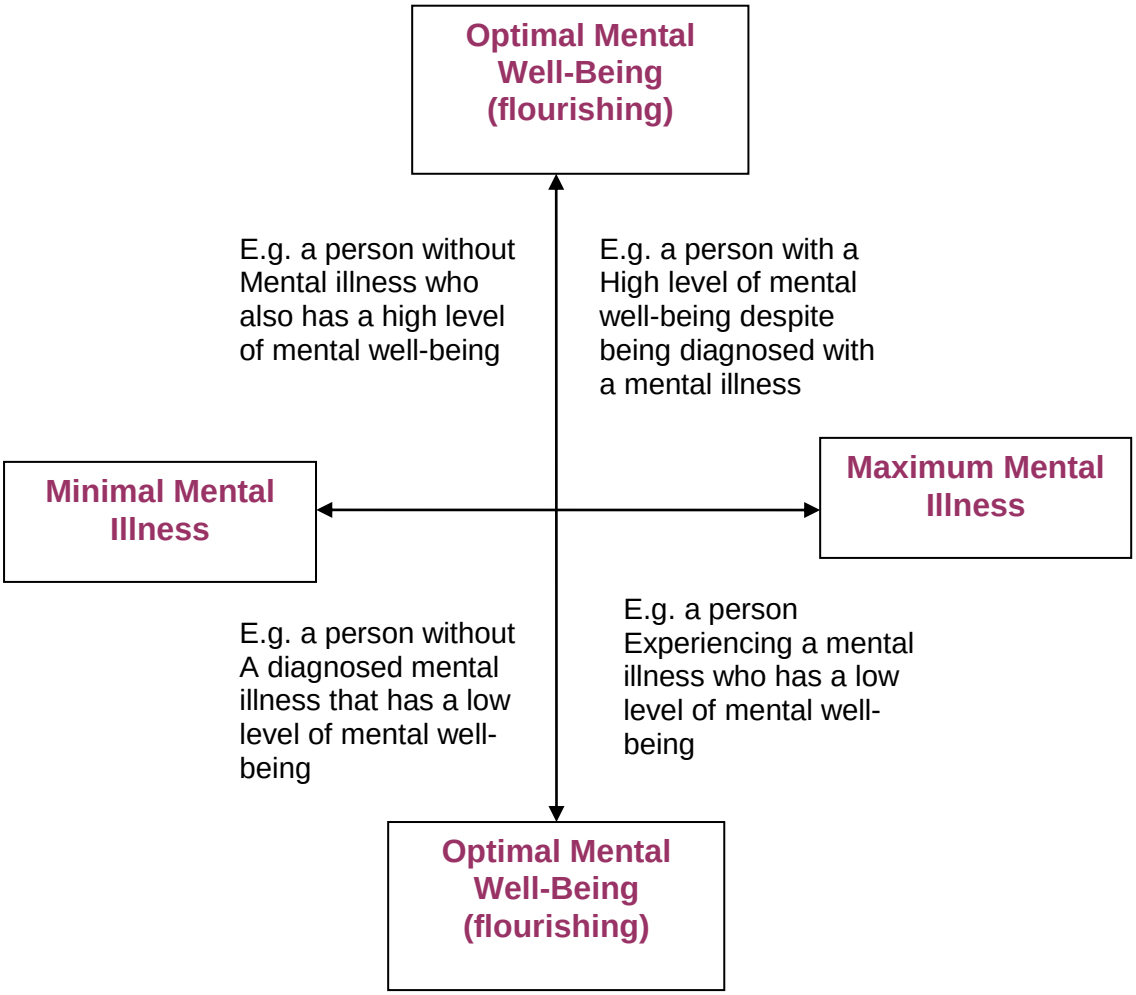
Figure 9.2.1 Integrated well-being model – Nurse and Campion 2008



There are many definitions of well-being: a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities, and the wider environment.

Although mental illness and mental well-being are related, they are not opposite ends of a spectrum. They form distinct axes, where the presence or absence of mental illness can be unrelated to the presence or absence of mental health or well-being.

Only a small proportion of individuals who do not have a common mental illness are mentally healthy or flourishing, confirming that the absence of mental illness is not the presence of mental well-being. Any state of mental health less than 'flourishing' is associated with increased impairment and burden to self and society.



Source: Corey Keyes Model

9.2.1 Wellbeing and Recovery are Integral to each other

Recovery is about individuals being able to build and manage a meaningful and productive life regardless of whether or not symptoms and problems persist or recur. One definition of recovery is: "a set of values about a person's right to build a meaningful life for themselves, with or without the continuing presence of mental health symptoms. Recovery is based on ideas of self-determination and self-management. It emphasises the importance of 'hope' in sustaining motivation and supporting expectations of an individually fulfilled life."

It is important therefore that people feel able to have meaningful and satisfying roles in society with access to mainstream services such as housing, education and leisure. Inevitably this is dependent on local circumstances – the availability of work, especially in an economic downturn, and being part of e.g. social networks, support groups and day services. People who experience mental illness need support to take control of their own care and support, and to recover on their own terms, including, where appropriate, help to get back into meaningful and productive employment. Evidence to support recovery comes from individuals themselves: "I have taken ownership of my illness and I take responsibility for what I do and do not do. I don't let it control me… it's not the whole of my life, it's just a part of my life now"…

9.3 Socio Demographics

9.3.1 Prevalence Common Mental Health Problems

According to data taken form Wirral GP clinical systems 34,748 patients on GP Registers have had mental health problems recorded on clinical systems, with 10,511 being recorded in the last three years 2009/2011.

Table 9.3.1a Prevalence of common mental health problems recorded between 2009/2011 by age group and gender

Age Group	Female		Male		All	
	Number	Rate per 1000	Number	Rate per 1000	Number	Rate per 1000
0 - 14	48	1.8	29	1.0	77	1.4
15 - 19	202	21.2	64	6.1	266	13.3
20 - 34	1,826	62.2	979	33.1	2,805	47.6
35 - 49	2,180	62.9	1,193	34.8	3,373	49.0
50 - 64	1,666	50.5	873	26.6	2,539	38.6
65+	1,064	30.3	387	14.1	1,451	23.2
Total	**6,986**		**3,525**		**10,511**	

Source: Wirral PCT (2011) GP Clinical Systems, Registered Population

- The highest rate recorded in the last three years is for those aged 35 – 49 followed by age group 20- 34.

Table 9.3.1b below illustrates the number of mental health recorded in GP Clinical systems by Diagnosis and Read Code.

Table 9.3.1b Number and percentage of common mental problems recorded in last 3 years and ever recorded by diagnosis group 2011

Read Code	Diagnosis	Mental Health recorded in the last 3 years 2009 - 2011		Mental Health diagnosis recorded ever	
		Number	Percent	Number	Percent
E2003	Anxiety with depression	4,702	45%	14,205	41%
E2001	Panic disorder	1,400	13%	5,022	14%
E290%	Brief depressive reaction	930	9%	4,117	12%
E202%	Phobic Anxiety	872	8%	2,800	8%
Eu321	Moderate depressive episode	461	4%	1,394	4%
Eu411%	Generalized anxiety disorder	414	4%	1,047	3%
Eu32	Depressive episode	381	4%	2,084	6%
Eu412	Mixed anxiety and depressive disorder	321	3%	886	3%
Eu40%	Phobic anxiety disorders	224	2%	690	2%
Eu431	Post - traumatic stress disorder	209	2%	582	2%
Eu45%	Somatoform disorders	177	2%	413	1%
Eu322	Severe depressive episode without psychotic symptoms	132	1%	341	1%
Eu324	Mild depression	106	1%	319	1%
Eu320	Mild depressive episode	92	1%	538	2%
Eu410-2	Panic disorder [episodic paroxysmal anxiety]	68	1%	232	1%
Eu44%	Dissociative [conversion] disorders	15	0%	56	0%
Eu43	Reaction to severe stress, and adjustment disorders	7	0%	22	0%
Total Number		**10,511**		**34,748**	

Source: Wirral PCT (2011) GP Clinical Systems, Registered Population

- Anxiety and depression was the most common individual diagnosis both in the last 3 years and ever recorded.

There is a strong relationship between prevalence of recorded common mental health problems and deprivation of usual residence of patients. Table 9.3.1c indicates that people from the most deprived quintile are more likely to be diagnosed with common mental health problems.

Table 9.3.1c Prevalence of common mental health problems recorded in the last 3 years (2009 - 2011) and ever recorded by deprivation quintile

Deprivation quintile	Mental Health Diagnosis recorded in the last 3 years (2009-2011)		Mental health diagnosis recorded ever	
	Number	Percent	Number	Percent
1 Most Deprived	3,824	36%	12,620	36%
2	2,031	19%	6,385	18%
3	1,127	11%	4,431	13%
4	2,026	19%	5,986	17%
5 Least Deprived	1,503	14%	5,326	15%
	10,511		**34,748**	

Source: Wirral PCT (2011) GP Clinical Systems, Registered Population

Table 9.3.1d Prevalence of common mental problems recorded in the last three years 2009-2011 and ever recorded by Consortium

Clinical Commissioning Group	Mental Health diagnosis recorded in the last 3 years		Mental Health Diagnosis recorded ever	
	Number	Rate per 1000	Number	Rate per 1000
Wirral GP Commissioning Consortium	4,802	37.8	14,759	116.1
Wirral Health Commissioning Consortium	4,622	28.1	15,596	94.8
Wirral NHS Alliance	1,087	27.2	4,393	109.8
Wirral	**10,511**	**31.7**	**34,748**	**104.8**

Source: Wirral PCT (2011) GP Clinical Systems, Registered Population

Note: All of this information is for patients who are recorded in GP practice clinical systems. Any patients not recorded in practices systems will be excluded from these figures.

9.3.2 Estimated prevalence

This table is based on the report Adult psychiatric morbidity in England, 2007: Results of a household survey, published by the Health and Social Care Information Centre in 2009.

Table 9.3.2a Estimated prevalence of mental health disorders 2011 – 2030 for Wirral

Mental health Disorder	2011	2015	2020	2025	2030
People aged 18-64 predicted to have a common mental disorder (CMD)	29,275	28,327	27,409	26,591	25,696
People aged 18-64 predicted to have a borderline personality disorder (BPD)	821	795	769	745	719
People aged 18-64 predicted to have an antisocial personality disorder (ASPD)	615	596	579	567	553
People aged 18-64 predicted to have psychotic disorder	728	704	682	661	639
People aged 18-64 predicted to have two or more psychiatric disorders	13,008	12,589	12,191	11,847	11,468

Source: www.pansi.org.uk 2012

Mental health Disorder	% males	% females
Common mental disorder	12.5	19.7
Borderline personality disorder	0.3	0.6
Antisocial personality disorder	0.6	0.1
Psychotic disorder	0.3	0.5
Two or more psychiatric disorders	6.9	7.5

Source: www.pansi.org.uk 2012

Common mental disorders (CMDs) are mental conditions that cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. They comprise different types of depression and anxiety, and include obsessive compulsive disorder. The report found that 19.7% of women and 12.5% of men surveyed met the diagnostic criteria for at least one CMD.

Personality disorders are longstanding, ingrained distortions of personality that interfere with the ability to make and sustain relationships. Antisocial personality disorder (ASPD) and borderline personality disorder (BPD) are two types with particular public and mental health policy relevance.

ASPD is 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. ASPD was present in 0.3% of adults aged 18 or over (0.6% of men and 0.1% of women).

BPD is characterised by high levels of personal and emotional instability associated with significant impairment. People with BPD have severe difficulties with sustaining relationships, and self-harm and suicidal behaviour is common.

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).

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. 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.

Psychiatric comorbidity – (or meeting the diagnostic criteria for two or more psychiatric disorders) - is known to be associated with increased severity of symptoms, longer duration, greater functional disability and increased use of health services.

Disorders included the most common mental disorders as follows:

- anxiety and depressive disorders
- psychotic disorder;
- antisocial and borderline personality disorders;
- eating disorder;
- posttraumatic stress disorder (PTSD);
- attention deficit hyperactivity disorder (ADHD);
- alcohol and drug dependency;
- 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: 68.7% met the criteria for only one condition, 19.1% met the criteria for two conditions and 12.2% met the criteria for three or more conditions.

Numbers of identified conditions were not significantly different for men and women.

9.3.3 Early Onset Dementia

There are a relatively small number of younger people (under 65) who have developed dementia, but they present particular issues for services traditionally designed for older people, with adult services not necessarily containing the skills or knowledge to provide for people with dementia. Younger people developing dementia are often psychically fitter than older counterparts, and therefore present particular issues for carers.

Table 9.3.3a Males aged 30-64 predicted to have early onset dementia, by age, projected to 2030

Male Age Group	2011	2015	2020	2025	2030
Males aged 30-39	1	1	1	1	1
Males aged 40-49	4	4	3	3	4
Males aged 50-59	23	24	24	22	19
Males aged 60-64	20	17	18	19	18
Total males aged 30-64	**48**	**46**	**46**	**45**	**41**

Source: www.pansi.org.uk, 2012

Table 9.3.3b Females aged 30-64 predicted to have early onset dementia, by age, projected to 2030

Females Age Group	2011	2015	2020	2025	2030
Females aged 30-39	2	2	2	2	2
Females aged 40-49	6	5	4	4	4
Females aged 50-59	16	17	18	16	13
Females aged 60-64	13	12	12	13	13
Total females aged 30-64	**36**	**35**	**36**	**35**	**31**

Source: www.pansi.org.uk, 2012

Age Group	Per 100,000 males	Per 100,000 females
30-34	8.9	9.5
35-39	6.3	9.3
40-44	8.1	19.6
45-49	31.8	27.3
50-54	62.7	55.1
55-59	179.5	97.1
60-64	198.9	118

Source: www.pansi.org.uk, 2012

As at 31 March 2010, there was a known cohort of people living in Wirral aged under 65 who had a diagnosis of Early Onset Dementia.

In 2009, a pilot project was undertaken with Age UK, Wirral to provide day care for people with Early Onset Dementia. Based on the outcome of the pilot the service was mainstreamed from April 2010. There are 16 day care places available for people assessed as suitable for the service by the Adult Cognitive Assessment Team. As a consequence of specific needs of carers for this client group, carer support activities are provided by Age UK, Wirral.

9.3.4 Prevalence of Dementia

Approximately, 750,000 people in the UK have dementia – and this number is expected to double in the next thirty years. The Coalition Government is committed to improving the care and experience of people with dementia and their carers by transforming dementia services to achieve better awareness, early diagnosis and high quality treatment at every stage and in every setting, with a greater focus on local delivery of quality outcomes and local accountability for achieving them. (Department of health - Dementia)
http://www.dh.gov.uk/health/category/policy-areas/social-care/dementia/

At a regional level by 2030, the North West is predicted to have 136,000 people with Dementia. As at 2011, there are nearly 81,500 people living with Dementia in the North West (POPPI). Currently only 45% of the estimated number of people with Dementia is on a GP register, obtaining the care needed. (Pickles et al Sept 2011)

Dementia is identified as a key priority within the current local NHS Operating Framework 2011/12, the focus for dementia and the implementation of the national strategy identified priority areas:

- Improving the care of people with Dementia in Care Homes
- Improving the care of people with Dementia in hospitals
- Access to early diagnosis and treatment
- Reducing antipsychotic prescribing

9.3.5 Summary of the whole system modelling project for Dementia

The drive to improve dementia services in Wirral can be traced back to before the National Dementia Strategy (NDS). Initially, The Alzheimer's Society in Wirral worked on dementia pathways, which was subsequently picked up in work with the Care Services Efficiency and Delivery Team (CSED) and then developed by local partners.

Early priorities and challenges were identified as being in the areas of dementia diagnosis and a general over-dependence in the local care economy on care home admissions. Early work on the dementia pathway has also been consolidated and follows the pattern of awareness raising; prevention; diagnosis; support; case management; safety and end of life care.

Features to date have included the close working with voluntary sector, development of hospital liaison, and the commissioning of the Memory Assessment Service. The next stage in this project involves Wirral partners working with Whole System Partnership to review and update the pathways and provide a computer simulation model to identify where future progress is still to be made.

9.3.6 National Dementia Strategy and Thinking 'whole system'

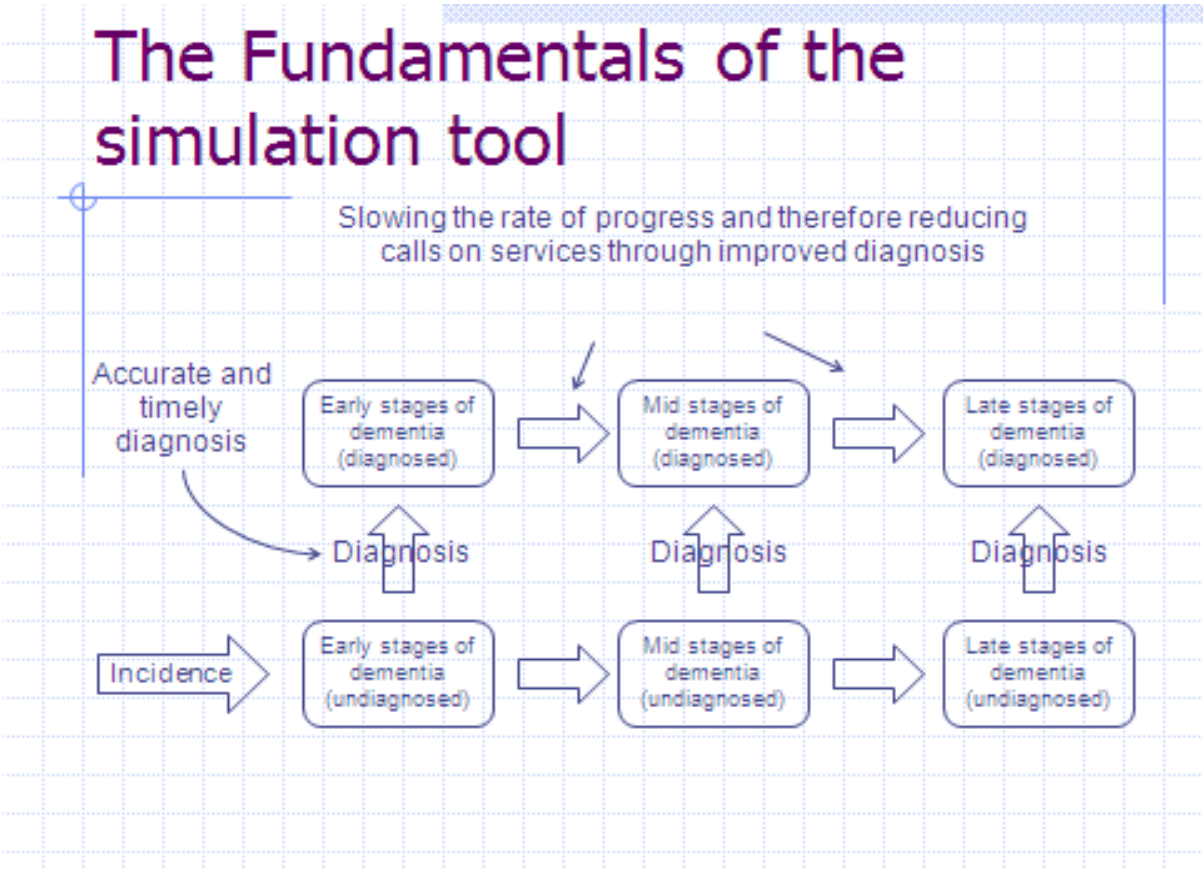
The National Dementia Strategy reflects an integrated and whole system strategy with different parts of that system being inter-locking and inter-dependant. The underlying demographic trends also need to be factored in, as is the case with the simulation tool being used. This tool reflects the dynamic nature of the whole system in the following ways:

- ***Good quality early diagnosis and support in the community for all*** – the simulation tool uses incidence and prevalence data, together with local levels of diagnosis, to simulate the overall population needs and the impact of earlier diagnosis on health and social care support in the community.
- ***Improved quality of care in general hospitals*** – the simulation tool measures the impact of liaison psychiatry on a general hospital in terms of capacity whilst also linking this to the consequence in specialist MH and community services.
- ***Living well with dementia in care homes*** – the simulation tool explores the impact of such care on hospital admissions and the rate at which people in care homes progress to needing specialist EMI support/funding.
- ***Reduced use of antipsychotic medication*** – the simulation tool considers the benefits in terms of reduced risk factors to people's physical health and the financial benefit when antipsychotic medication is regularly reviewed.

Locally, the priorities also include:

- ***Investigating the impact of a shared care approach for dementia patients*** – between specialist and primary care services.
- ***Estimating the cost of NICE guidance changes*** – resulting in increasing prescribing levels for mild to moderate dementia patients.

One of the assumptions of this model is that earlier diagnosis of dementia delays the progression from mild to moderate and moderate to severe dementia and therefore improving the quality of life whilst reducing the cost to health and social care services (see diagram, The Fundamental of the simulation tool).



The results of the project will be completed in April 2012, with an aim of annually reviewing progress against the recommendations and the National Dementia Strategy.

9.4 Deprivation

9.4.1 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).

The mental health strategy *'No health without mental health'* (DH, 2011) recognises the following three aspects involved in reducing mental health inequality:

- inequalities that lead to poor mental health;
- inequalities that result from poor mental health – such as lower employment rates, and poorer housing, education and physical health; and
- Inequalities in service provision – in access, experience, and outcomes.

The government is taking action to tackle public attitudes towards mental illness which is one of the key objectives of the new strategy. One of the cornerstones of tackling inequalities in service provision is delivering a 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* (HM Government, 2010) provides 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.

The white paper emphasised health as a positive sense of well-being and not merely the absence of illness (HM Government, 2010). There will be increased emphasis on tackling both physical and mental health 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. It 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).

'No health without mental health 'aims to broaden the approach taken to tackle the wider social determinants and consequences of 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.

9.4.2 Employment

Work can have both positive and negative effects on mental health and well-being. 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.

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 (Deacon et al, 2010).

The number of patients active on the Care Programme Approach varies by employment status table 9.4.2a

Table 9.4.2a: Number of people under Care Programme Approach with Cheshire Wirral Partnership (NHS) Trust by employment status aged 18 – 69 who have received secondary mental health services in the financial year as at February 2012

Employment Status	Feb-12
Unemployed and Seeking Work	837
Long term sick or disabled and in receipt of benefit	232
Not known	60
Retired	60
Unpaid Voluntary Work and Not Working and Not actively seeking work	47
Employed	42
Student in full or part time education/training and who are not working or actively seeking work	19
Other include Education/Training	15
Homemaker and Not Working and Not actively seeking work	11
Not applicable	4
Not receiving Benefits and Not Working and Not actively seeking work.	4
Not disclosed	3
Grand Total	**1334**
NI150 as at February 2012	**3.15%**

Source: Cheshire and Wirral Partnership (NHS) Trust, February 2012

The above table refers to the population aged 18 to 69 who are receiving secondary mental health services, who are on the Care Programme Approach with Cheshire and Wirral Partnership (NHS) Trust and have an employment status recorded as 'Employed' at as at February 2012.

This excludes the population who are not registered with the Care Programme Approach with Cheshire Wirral Partnership. The status “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).

"Adults 'in contact with secondary mental health services' are defined as those aged 18 to 69 who are receiving secondary mental health services and who are on the Care Programme Approach (CPA). However, it is recognised that this existing definition may limit the scope of the measure, potentially excluding individuals who have been supported to maintain paid employment but are not on the CPA. This aspect is subject to review and development work in 2011/12 with a view to agreeing a revised definition for 'in contact with secondary mental health services'." (DH Adult Social Care Outcomes Framework: Nov 11)

A report produced by MIND (2011) states that Mental ill health is a real and present issue for all employers, with one in six employees experiencing stress, anxiety or depression at some time at an estimated cost to the UK economy of £26bn pa. Mental ill health costs employers when employees are off work sick as well as those who come into work when unwell (an estimated £15bn pa).

9.4.3 Income

A report produced by MIND (2007) states that poverty can be both a determinant and consequence of mental illness:

- People with a mental health problem are more likely to live on lower than average incomes;
- Over 75% are reliant on welfare benefits;
- 1 in 4 people with a mental health problem also report being in debt compared to 1 in 11 of the general population;
- Unemployment rates could be as high as 75%.

Mental health problems are estimated to cost the country over £77 billion a year through the costs of care, economic losses and premature death. Early intervention to keep people in work and maintain social contacts can significantly reduce these costs. Once a person has reached crisis point, it is much more difficult and costly to restore their employment and social status (Social Exclusion Unit, 2004).

Cheshire and Wirral Partnership Trust (CWP) have provided raw data which requires further analysis. Further work is required to ensure that the data meets the definitions outlined for this employment National Indicator.

The majority of people accessing the service do not have their employment status recorded, so the percentage employed does not necessarily provide a reliable figure about the employment status of this population group.

Mental health incapacity benefit claimants

Mental health is the most commonly reported reason for claiming incapacity benefit, both nationally and locally, in Wirral nearly half of all claimants (45%) are unable to work due to mental health reasons. Table 9.4.3a shows claimants by Wirral ward.

Table 9.4.3a: Mental health incapacity benefit claimants, by Wirral ward (November 2010)

2003 CAS ward	Total IB/ESA claimants	ESA - disease – Mental Health	IB/SDA disease – Mental Health	Total IB/ESA - Disease Mental Health	% of all IB/ESA claimants
Bebington	570	45	195	240	42.1
Bidston	1,225	120	420	540	44.1
Birkenhead	1,955	255	790	1,045	53.5
Bromborough	920	80	320	400	43.5
Clatterbridge	540	45	160	205	38.0
Claughton	915	105	330	435	47.5
Eastham	560	45	175	220	39.3
Egerton	1,135	130	435	565	49.8
Heswall	325	15	115	130	40.0
Hoylake	455	50	175	225	49.5
Leasowe	1,110	100	400	500	45.0
Liscard	1,020	100	380	480	47.1
Moreton	675	40	230	270	40.0
New Brighton	1,075	100	455	555	51.6
Oxton	780	85	315	400	51.3
Prenton	745	65	265	330	44.3
Royden	465	35	155	190	40.9
Seacombe	1,490	200	545	745	50.0
Thurstaston	475	30	140	170	35.8
Tranmere	1,415	170	545	715	50.5
Upton	915	80	285	365	39.9
Wallasey	550	60	195	255	46.4
Wirral Total	**19,315**	**1,955**	**7,025**	**8,980**	**46.5**

Source: www.nomisweb.co.uk Benefit Claimants, 2011

- A greater proportion of the adult working population from Birkenhead, Seacombe and Tranmere are on incapacity benefits and are claiming for mental health reasons; this is particularly high in Birkenhead.
- The lowest numbers of claimants are in Heswall.

Fewer than four in ten employers say that they would consider employing someone with a history of mental health problems (compared with 6 out of 10 for someone with a physical disability). Most companies don't have effective policies to deal with employee's mental health and do not know enough about their legal position (Future Foundation, 2008).

9.4.4 Housing

People with mental health problems, particularly those with severe and enduring mental health problems are a key group at risk of social exclusion. Improving settled

accommodation outcomes for adults with mental health problems is an important strategy to reduce the risk of social exclusion; this is part of the new National Indicator (NI) dataset: Adults in contact with secondary mental health services in settled accommodation (NI 149).

Cheshire and Wirral Partnership (NHS) Trust have provided raw data which requires further analysis. Further work is required to ensure that the data meets the definitions outlined for this housing NI. The data needs to be cross referenced with the data held by the Department of Adult Social Services for the number of people with a mental health problem accessing supported living.

Table 9.4.4a Number of people under Care Programme Approach with Cheshire Wirral Partnership (NHS) Trust in Settled Accommodation, aged 18 – 69 who have received secondary mental health services in the financial year as at February 2012

Settled Accommodation	**Feb-12**
Owner occupier	212
Tenant - private landlord	199
Tenant - Housing Association	142
Supported accommodation	136
Tenant - Local Authority	90
Settled mainstream housing	85
Other MH accommodation	34
Supported group home	33
Other mainstream housing	29
Other sheltered housing	8
Sheltered housing for older persons	6
Supported lodgings	5
Non MH Accommodation with care	2
Shared ownership scheme	1
Extra care sheltered housing	0
Bail/Probation hostel	0
Total	**982**
NI149 as at February 2012	**73.61%**

Source: Cheshire and Wirral Partnership (NHS) Trust. 2012

Non settled accommodation refers to accommodation arrangements that are precarious, or where the person has no or low security of tenure/residence in their usual accommodation and so may be required to leave at very short notice (NI 149 definition).

“Adults ‘in contact with secondary mental health services’ are defined as those aged 18 to 69 who are receiving secondary mental health services and who are on the Care Programme Approach (CPA). However, it is recognised that this existing definition may limit the scope of the measure, potentially excluding individuals who have been supported to maintain paid employment but are not on the CPA. This

aspect is subject to review and development work in 2011/12 with a view to agreeing a revised definition for 'in contact with secondary mental health services'." (DH Adult Social Care Outcomes Framework: Nov 11)

In accordance with Wirral Council, Department of Adult Social Services the following people were known to the local authority with mental health problems in residential care and those in receipt of supported living. (DASS 2012)

- There are 92 people recorded known to Wirral Local Authority with mental health problems with supported living
- There are 487 people known to Wirral Local Authority with mental health problems in residential care.

9.4.5 Mortality

Wirral has a lower suicide/undetermined injury directly standardised rate (DSR) than the North West and England (DSR takes account of variations between areas and over time in the age/sex structure of the population). See table 5.4.5a.

Table 9.4.5a: Mortality from suicide and undetermined injury Wirral Local Authority, 1995-97 to 2008-10

Year	Total Number of Deaths	Directly Standardised Rate	95% Confidence Interval	
			Lower Limit	Upper Limit
1995-97	126	12.8	10.5	15.1
1996-98	144	14.6	12.1	17.0
1997-99	133	13.3	11	15.6
1998-00	134	13.2	10.9	15.5
1999-01	126	12.9	10.7	15.4
2000-02	123	12.8	10.6	15.3
2001-03	121	12.9	10.6	15.3
2002-04	113	12.3	10.1	14.8
2003-05	106	11.5	9.3	13.8
2004-06	108	11.6	9.3	13.8
2005-07	112	11.8	9.5	14.0
2007-09	88	9.5	7.4	11.5
2008-10	63	6.8	5.1	8.6

Source: NHS Information Centre, 2012

The 2008-10 rate for Wirral is lower than the England and North West average.

- Wirral: 6.8 per 100,000
- North West: 9.07 per 100,000
- England: 7.92 per 100,000

There is a national target to reduce the rate of suicide/underdetermined injury deaths by 20% by 2010 (baseline is 1995-97). In order to meet this target the North West rate needs to average 8.28/100,000 by 2009-11.

- The 2009 Suicide Audit for Wirral released in May 2011 reviewed all cases of suicide and those recorded as 'open' verdicts brought to conclusion in the Wirral Coroner's Court in January to December 2009

- Since 2008 the criteria for how a suicide verdict is recorded has changed. Verdicts are now either reported as 'open' or 'other', hence the number of cases for 2009 reported as zero. This can prove problematic as it is considered not all open verdicts are potential suicides. However for audit purposes and for the purpose of this document, all open verdicts have been included in the analysis.

A report produced by the Public Health Intelligence team shows that in 2009 deaths recorded as suicides and open verdicts have shown:

- Higher proportion of males.
- Suicides were highest among males aged between 31 – 60 years. The lowest was seen in those aged between 21 – 30 years and 71 years and over. Nationally in 2009 men aged 45 – 74 saw the highest suicide rates and for women this was also the same.
- Individuals are most likely to be single or divorced and live alone.
- Those who are unemployed or retired are significantly more likely to commit suicide than those who are in employment, thus meaning employment appears to provide some form of protection.
- Ethnicity is not routinely recorded; the only information that may contribute to this is place/country of birth.
- There does not appear to be any seasonal variation with suicide however the summer months appears to show a slight increase and statistics of episodes of self-harm show increase presentations at A&E during July August and December.
- The most likely method of suicide amongst males is hanging/strangulation. There does not appear to be any common form for females however, previous data has shown overdose as the most chosen method.
- The majority of deaths occurred at home this can make prevention strategies problematic.
- At present a large proportion of deaths reported to the coroner were unascertainable, resulting in an open verdict. A number of these may not be relevant for audit purposes but since 2008 all verdicts have been recorded as 'open'
- Only a small proportion (12%) had a previous history of self harm
- Two fifths (40%) had problems with alcohol/drugs or both. In previous years this figure had been higher. Reporting of these issues is either due to GP reporting or anecdotal evidence presented by those attending the inquest
- Similarly, reporting of mental health issues may also be anecdotal dependant on those attending the inquest

- Almost a third of people visited their GP within 4 weeks of their death for a variety of reasons.
- Potential contributory factors include; depression; relationship breakdown/row; bereavement; financial problems; previous familial suicide; redundancy; ill health or ill health of partner.

9.5 Primary Care Mental Health Needs, Services and Treatment

9.5.1 Improving Access to Psychological Therapies (IAPT)

The NHS is expected to continue expanding access to psychological therapy services in 2011/12. This is part of overall commitment to full roll-out of the programme by 2014/15.

The four year plan is to extend access to:

- Children and young people
- Older people
- People with severe and enduring mental health problems
- People with co-morbid and physical health long term conditions.
- Military and veterans health

In light of the Murrison report (Fighting fit-A mental health plan for service men and veterans), there is a programme to improve mental health services for veterans. (DOH 2011/12 Operating Framework)

According to Advancing Quality Alliance (AQUA) Observatory (2011) data, it is estimated that nearly 940,000 adults have below average wellbeing, over 500,000 have nervous trouble/depression, and nearly 200,000 have extreme anxiety/depression. A total of over a million (nearly one in five) adults have some level of anxiety or depression. It is also possible that nearly 150,000 people never speak to neighbours and some 33,000 never meet with friends or relatives.

The Improving Access to Psychological Therapies (IAPT) Programme supports the implementation of National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders.

It was created to offer patients a realistic and routine first-line treatment, combined where appropriate with medication which traditionally had been the only treatment available. The programme was first targeted at people of working age but in 2010 was opened to adults of all ages.

Click here for Wirral Primary care Mental Health Services Page 1 - 7

9.5.2 Antidepressant prescribing

Antidepressant prescribing

Table 9.5.2a: Actual numbers of antidepressant items and cost prescribed between April 2011 and March 2012

	Total Items	Total Cost
Wirral GPCC	140,787	£592,532
Wirral HCC	176,638	£735,544
Wirral NHS Alliance	40,258	£190,101
All Wirral Practices	357,683	**£1,518,177**
North West	7,815,910	£38,025,217
England	47,405,843	£232,975,432

Source: ePACT Prescription Services, 2012

- In 2011/12 £1.5 million pounds were spent on antidepressant prescribing across the Wirral, representing 2.8% of total drug expenditure.

Table 9.5.2b: Standardised values of antidepressant items and cost prescribed between April 2011 and March 2012.

Prescriber Name	Items/1000 APUs*	Cost/1000 APU's
Wirral GP Consortia	90.08	£760
Wirral Health Consortia	81.71	£687
Wirral NHS Alliance	77.91	£740
All Wirral Practices	84.32	£720
North West	89.45	£869
England	73.07	£718

Source: ePACT Prescription Services, 2012

Note: Prescribing costs and frequencies have been weighted using appropriate cost and prescription item-based prescribing units as patient denominators to enable prescribing costs and frequencies to be compared.

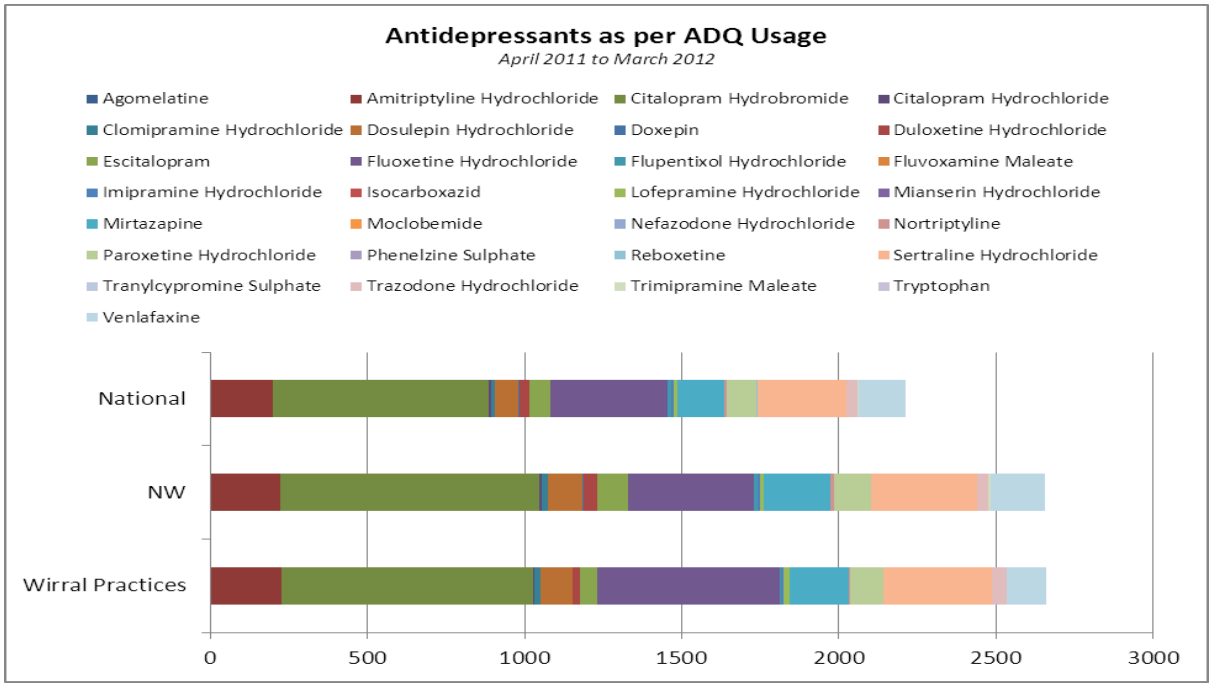
*** APU = Astro Prescribing Unit**, is designed to weight individual practice populations for age, sex and temporary residents rather than just the patients aged 65 and over for further information see http://www.nhsbsa.nhs.uk/PrescriptionServices/1962.aspx

- Items per 1000 APU is higher for all consortia than the national average. Cost per 1000/APU for all Wirral practices is similar to national indicating that Wirral GPs are making cost effective choices. Costs for WHCC are much lower than national reported figures.

- **Wirral PCT is 11th lowest of the 24 North West PCTs for antidepressant prescribing rates.**

- See Figures 9.5.2c and 9.5.2d below

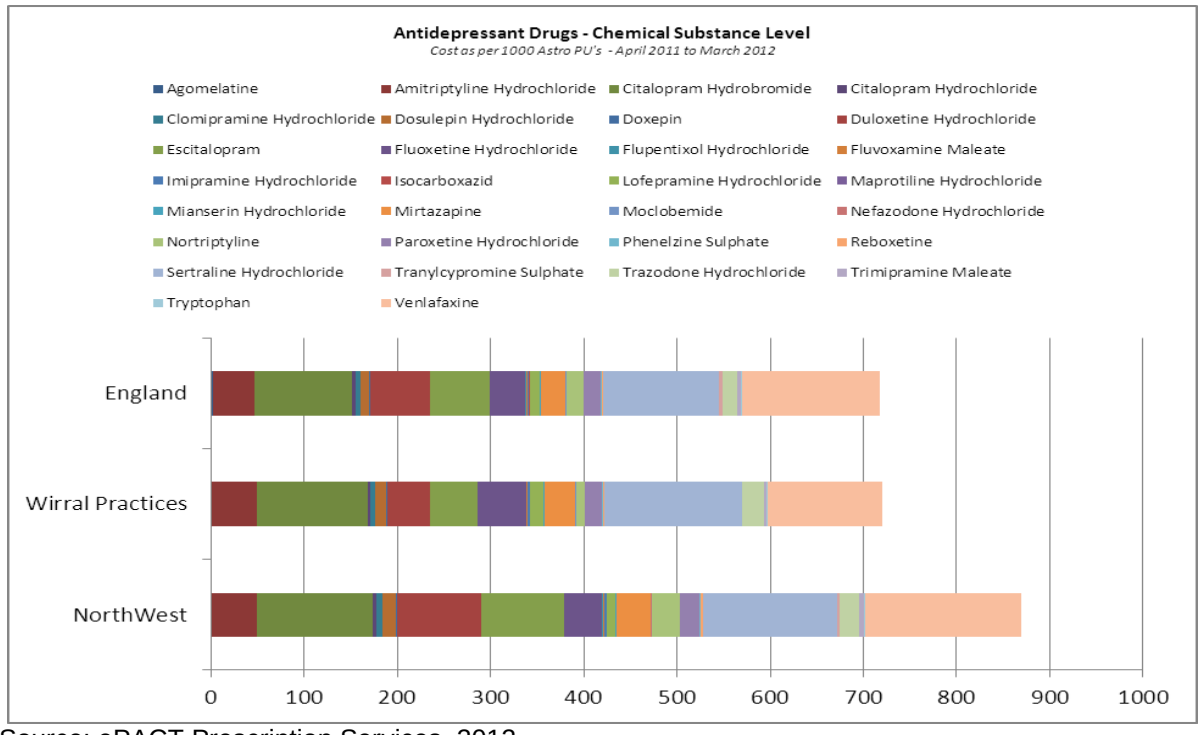
Figure 9.5.2c: Standardised prescribing frequency (items) across Wirral, North West and National: April 2011 – March 2012



Source: ePACT Prescription Services, 2012

***Note: ADQ is 'average daily quantity'.**

Figure 9.5.2d: Standardised prescribing cost (£s) across Wirral, North West and National: April 2011 – March 2012



Source: ePACT Prescription Services, 2012

The number of items prescribed and actual cost to Wirral PCT since 2006 are outlined below in Table 9.5.2e.

Table 9.5.2e.Actual items and costs of antidepressant prescribing within Wirral PCT over the last six years

Financial Year	Actual Items	Actual Costs
Financial 2006/2007	268,212	£1,949,439
Financial 2007/2008	281,209	£1,785,720
Financial 2008/2009	293,490	£1,535,021
Financial 2009/2010	317,537	£1,406,130
Financial 2010/2011	337,917	£1,436,109
Financial 2011/2012	357,683	£1,518,177

Source: ePACT Prescription Services, 2012

- The number of items prescribed has increased year on year but with the overall expenditure reducing in the same period.

Antipsychotic prescribing

Antipsychotic prescribing expenditure accounted for approximately £2 million across the Wirral, equivalent to 3.6% of total drug expenditure across the Wirral, see table 9.5.2f

Table 9.5.2f Actual and standardised numbers of antipsychotic items and cost prescribed between April 2011 and March 2012

	Total Antipsychotic Items	Total Antipsychotic Cost	Standardised Items/1000 Astro-PUs	Standardised cost/1000 Astro-PUs £
Wirral GPCC	22,095	£812,395	14.14	£1,042
Wirral HCC	25,709	£928,052	11.89	£867
Wirral NHS Alliance	6,330	£234,109	12.25	£911
All Wirral Practices	54,134	£1,974,556	12.76	£937
North West			15.18	£961
England	-	-	11.60	£748

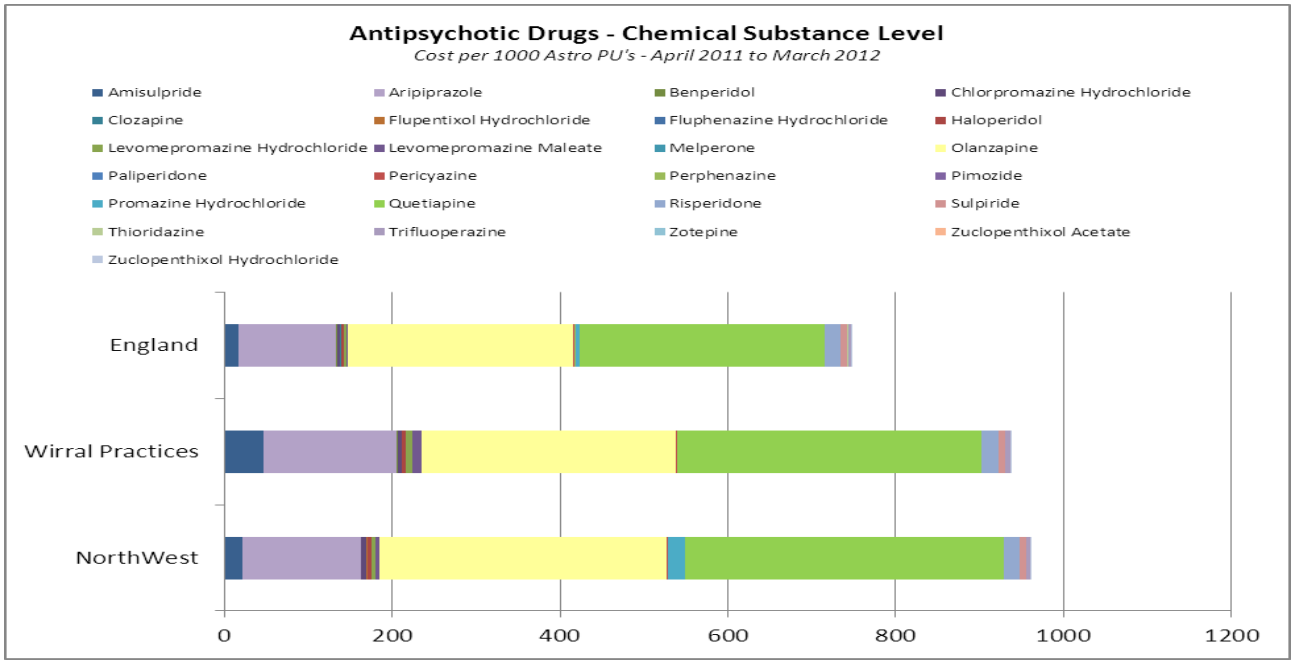
Source: ePACT Prescription Services, 2012

- Prescribing rates for the Wirral are higher than the national average, which reflect local deprivation rates.

- **General practice prescribing of these drugs in Wirral is 10th lowest across the North West region.**

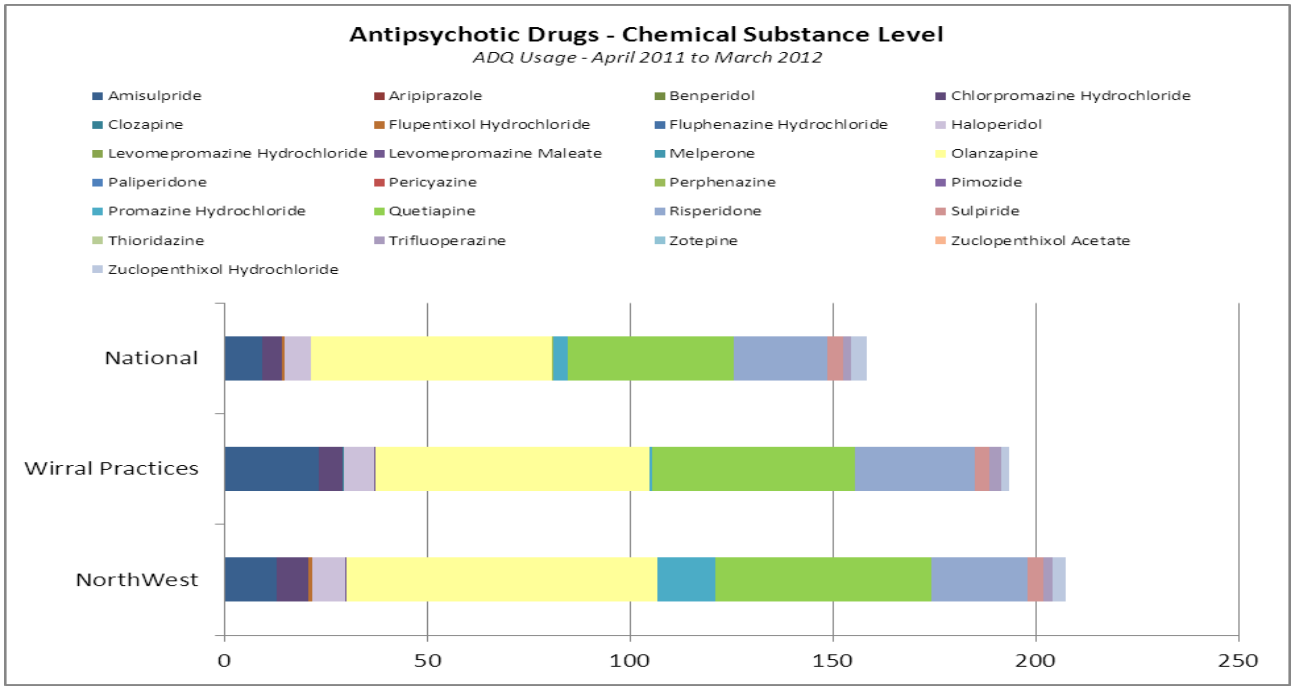
- See Figures 9.5.2g and 9.5.2h below

Figure 9.5.2g **Standardised** prescribing cost (£s) of antipsychotics across Wirral, North West and England



Source: ePACT Prescription Services, 2012

Figure 9.5.2h: Standardised prescribing '**ADQ'** (items) of antipsychotics across Wirral, North West and England



Source: ePACT Prescription Services, 2012

***Note: ADQ is 'average daily quantity'.**

9.6 The needs of people with Severe and Long Term Mental Health Issues

9.6.1 Recovery

Recovery is the ultimate aim for all Wirral residents with long term mental health problems. The Wellness Recovery Action Planning (WRAP) is a self-management and recovery system developed in the US by people with mental health difficulties. People are supported to create their own wellness recovery action plan, setting out their goals, what help they need to get there, what helps keep them well, and what puts their mental health at risk. WRAP aims to:

- increase the person's sense of control over their mental health problems
- increase personal empowerment
- improve quality of life
- Assist people in achieving their own life goals and dreams.

A WRAP will also state how the person wants others to respond when symptoms have made it impossible for them to continue to make decisions safely for themselves and take care of themselves.

Local integrated services promote WRAP within in-patient and community mental health services, with staff training in WRAP a core training function.

A number of service users in Wirral have developed a Recovery website to support the recovery process. Further details available on (http://www.recoverywirral.com)

Recovery Star is a further tool for people using services to enable them to measure their own recovery progress, with the help of mental health workers or others. The 'star' contains ten areas covering the main aspects of people's lives, including living skills, relationships, work and identity and self-esteem. Service users set their personal goals within each area and measure over time how far they are progressing towards these goals. This can help them identify their goals and what support they need to reach them, and ensure they are making progress, however gradual, which itself can encourage hope. (Mental Health Foundation)

9.6.2 Service User Support

People who have used Mental Health Services have grasped the concept of recovery which promotes overall health and wellbeing and social inclusion.

There are a number of local service user led support groups across Wirral, which include;

- Positive mental health groups
- Women's group
- Apex Running group
- Eating Disorder group
- Wirral Bi-polar support group
- Wirral Mind
- Wirral Pathfinders

- BME Women's group
- 'Feel better with a book' Reading group

9.6.3 Severe and enduring mental illness: prevalence

Severe and enduring mental health problems include psychotic disorders (schizophrenia and bipolar affective disorder, also known as manic depression) (SEU, 2004).

There are a number of estimates for prevalence of severe mental illness in Wirral. Whilst there is a degree of variance between these estimates, all of them indicate that in Wirral there is a higher prevalence of severe mental illness than both the North West and England.

According to deprivation weighted data based on Key Health Statistics from General Practice (1998), rates for schizophrenia in Wirral are considerably higher than for England, particularly for males:

- 650 men estimated to be treated for schizophrenia which is 6% higher than England.
- 566 women estimated to be treated for schizophrenia which is 4.7% higher than England.

Practice population data (2010/11) for people with severe and enduring mental illness (defined as schizophrenia, bipolar affective disorder or other psychoses) as recorded through the Quality Outcomes Framework (QOF) gives a GP practice prevalence of:

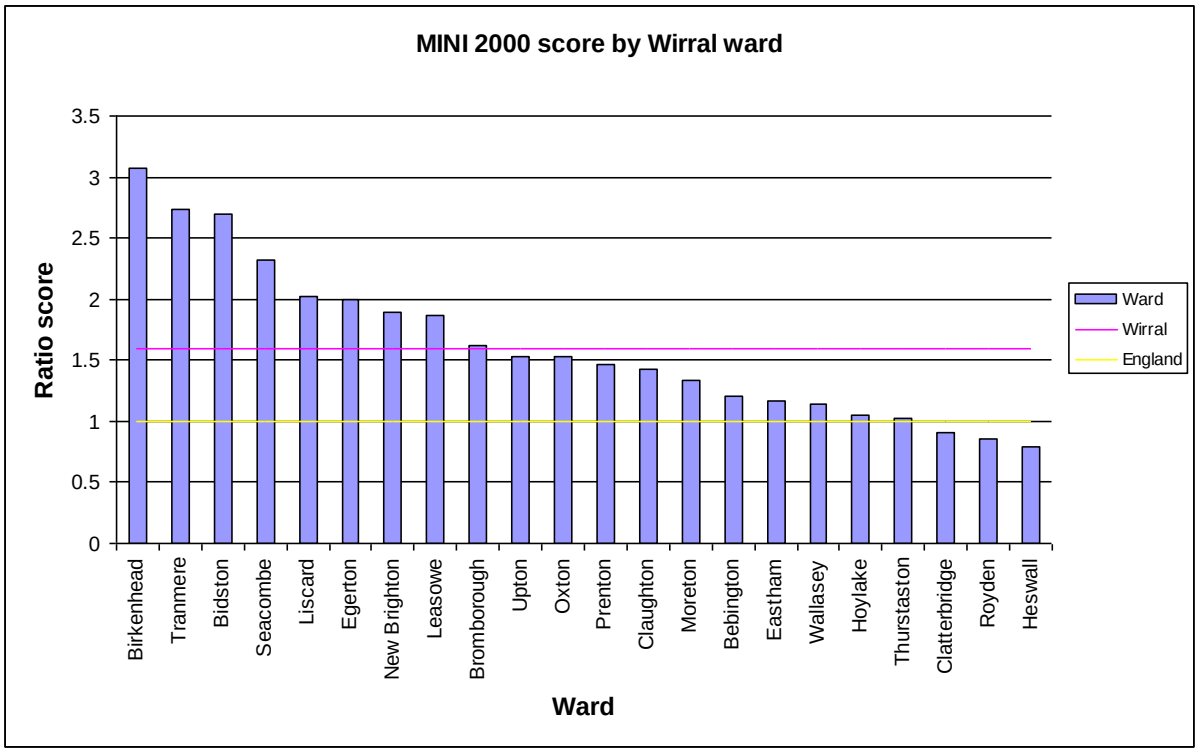
- 0.9% for Wirral
- 0.8 for England
- 2979 people were recorded on Wirral's register
- Wirral ranks 40th highest out of 151 PCTs in England

Source: Information Centre

9.7 Mental Illness Needs Index (MINI 2000)

This data supports estimated data from the Mental Illness Needs Index (MINI 2000), which predicts the rate of psychiatric admissions to acute care. It uses a range of social and economic factors that are associated with high rates of admission to acute care. The MINI 2000 score is a ratio against the England average, see figure 9.7.1.

Figure 9.7.1: MINI score by Wirral ward



Source: Calculated using University of Durham's MINI 2000 trial ready reckoner, 2007

- Wirral's score is 1.6 which means that Wirral is predicted to have 1.6 times the admission rate of England.

- The MINI scores for Wirral wards range considerably from 0.79 in Heswall to 3.07 in Birkenhead.

9.8 Community Mental Health Services

9.8.1 Early Intervention in Psychosis

Adolescence and emerging adulthood are a high-risk time for developing mental disorders; In England 7,500 young people develop an emerging psychosis each year. The early phase of psychosis is a critical period affecting long-term outcomes. Failure to intervene early often has huge significant personal costs in terms of an individual having reduced capacity to reach their social, emotional and vocational potential, as well as wider social and economic costs. (Mental Health NHS Confederation, May 2011)

According to the World Health Organization's *World Health Report 2001*, schizophrenia and other forms of psychoses that affect young people represent a major public health problem. Worldwide, they rank as the third most disabling condition (following quadriplegia) and pose an enormous burden in terms of human suffering. The economic and social cost of mental ill health has been estimated to be £105.2 billion in the UK.

Birchwood (1999) completed research that indicated that following the onset of psychosis the efficacy of treatment and interventions that would be provided within

the first 3 years would have an impact on the individual's prognosis. This period has become known as the "critical period". The early intervention caseload over a three year period as at January 2012 was 196, for further information click here for Wirral Early Intervention Team data Page 7 to 9.

9.8.2 Community Mental Health Teams (CMHT's)

The Community Mental Health Team performs functions for two groups of people:

1. Most patients treated by the CMHT will have time limited disorders and be referred back to their GPs after a period of weeks or months (an average of 5–6 contacts) (Burns et al, 1993) when their condition has improved.

2. A substantial minority, however, will remain with the team for ongoing treatment, care and monitoring for periods of several years. They will include people needing ongoing specialist care for:

    - Severe and persistent mental disorders associated with significant disability, predominantly psychoses such as schizophrenia and bipolar disorder.
    - Longer term disorders of lesser severity but which are characterised by poor treatment adherence requiring proactive follow up.
    - Any disorder where there is significant risk of self harm or harm to others (e.g. acute depression) or where the level of support required exceeds that which a primary care team could offer (e.g. chronic anorexia nervosa).
    - Disorders requiring skilled or intensive treatments (e.g. Cognitive Behavioural Therapy, vocational rehabilitation, medication maintenance requiring blood tests) not available in primary care.
    - Complex problems of management and engagement such as presented by patients requiring interventions under the Mental Health Act (1983)
    - Severe disorders of personality where these can be shown to benefit by continued contact and support
    - CMHT's in Wirral also provide an Assertive Outreach function

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_085652.pdf

For Wirral Community Mental Health team data click here pages 8-10

9.8.3 Personality Disorder

Personality disorders relate to permanent characteristics of an individual's personality that cause problems with how they interact with people and react emotionally. Personality disorders take many forms, all having particular characteristics, sometimes including psychosis.

Research from the Office of National Statistics (2000 psychiatric morbidity survey) states that as many as 5.4% of men have a personality disorder, and for women, it is 3.4%. Personality disorders are found more in younger age groups (25-44 year age group) and are equally common between males and females.

Two types of personality disorder which are of particular concern are antisocial personality disorder (ASPD) and borderline personality disorder (BPD).

Personality disorders are common and often disabling conditions. Many people with personality disorder are able to negotiate the tasks of daily living without too much distress or difficulty. Individuals with a severe condition can suffer a great deal of distress, and can place a heavy burden on family, friends and those who provide care for them. As with all forms of mental illness, the majority of people with a personality disorder who require treatment will be cared for within primary care. Only individuals who suffer the most significant distress or difficulty will be referred to specialist services.

People with antisocial personality disorder have a pattern of aggressive and irresponsible behaviour which emerges in childhood or early adolescence, they account for a disproportionally large proportion of crime and violence committed.

People with borderline personality disorder

Although borderline personality disorder is a condition that is thought to occur globally (Pinto *et al.*, 2000), there has been little epidemiological research into the disorder outside the western world. Only three methodologically rigorous surveys have examined the community prevalence of borderline personality disorder. Coid and colleagues (2006) reported that the weighted prevalence of borderline personality in a random sample of 626 British householders was 0.7%.

People with borderline personality disorder have severe difficulties with sustaining relationships and self-harm and suicidal behaviour is common. The Adult Psychiatric Morbidity Survey 2007 survey indicate that there are 0.3% of adults aged 18+ with antisocial personality disorder and 0.4% of adults aged 16+ with borderline personality disorder.

Click here for personality disorder service data page 11 and 12

9.8.4 Crisis Resolution and Home Treatment

Crisis Resolution Home Treatment (CRHT) provides intensive home treatment for adults of working age suffering from severe and enduring mental illness, offering an alternative to hospital admission. Support is also provided to carers and families.

CRHT works closely with Inpatient Services, Community Mental Health Teams, A&E staff, Psychiatric Liaison, and Early Intervention Teams. When a referral has been made to the team, an assessment time is agreed with the referrer, and a practitioner from CRHT will assess the service user's needs. If Home Treatment is deemed to be an appropriate intervention, a care plan will be collaboratively agreed between the CRHT practitioner, the service user and, if appropriate, the carer.

Most referrals received by the team are already known to secondary mental health services. However, the team also accepts referrals that are new to mental health services, which have already been assessed by a mental health practitioner based within the Accident & Emergency Department.

Click here for resolution home treatment data page 12 and 13

9.9 Older Peoples Mental Health

Good mental health and well-being are as important for older people as for any other age group. The link between positive mental health and good psychical health, may have added benefits, notably in relation to reduced risk of cardiovascular disease. Mental well-being also protects against stroke, with sustained low mood and depression increasing the risk of stroke. The foundations for good psychical and mental health in older people are laid down in childhood and throughout adulthood, but much can be done to promote and maintain good mental health and well-being in older age including opportunities for social involvement and activity, good relationships and a sense of being valued. Risk factors for older people include loneliness, social isolation, and fear of crime, loss of independence, lack of transport, poverty and debt, anxiety over meeting winter fuel bills.

The Wirral population is more prominent in relation to older age groups, with a lower proportion of younger adults. However a higher proportion of older people aged 65+ with the Wirral average being a 43% increase from 2008 – 2033.

For further information see JSNA Population chapter here:
http://info.wirral.nhs.uk/ourjsna/wirral2009-10/wirralpopulation/

Click here for Wirral hospital inpatient, admissions data and anti-psychotic prescribing pages 14 - 16

9.9.1 Wirral People aged 65 and over predicted to have dementia, by age and gender, projected to 2030

	2011	2015	2020	2025	2030
Aged 65-69	206	242	216	225	243
Aged 70-74	378	401	492	443	467
Aged 75-79	696	717	768	943	865
Aged 80-84	1,125	1,132	1,210	1,324	1,657
Aged 85-89	1,139	1,233	1,344	1,517	1,672
Aged 90 and over	899	1,047	1,253	1,577	1,990
Total Age 65+	**4,443**	**4,773**	**5,282**	**6,028**	**6,892**

Source: POPPI, 2012

As a consequence of the national strategy, NHS Wirral and Department of Adult Social Services developed a local strategy for Older People with Mental Health Needs (NHS Wirral and Wirral DASS) which is linked to NHS Wirral Strategic Plan. The local strategy built on the development and implementation of a locally agreed dementia pathway. Both the pathway and local strategy identified the need for people to receive care and treatment in the community for as long as possible and reduce the need for unplanned hospital admissions.

It is estimated that there are approximately 4443 people living with dementia in Wirral. However, quality outcomes framework (QOF) data as at 31 March 2011 reports that 1902 people in Wirral have a formal diagnosis which equates to 43% of expected prevalence. This is in line with the Regional rates.

In addition, NHS Wirral has undertaken a detailed analysis of the numbers of people with a diagnosis of dementia either attending and or being admitted to Wirral University Teaching Hospital.

In the period 2009/10, a total number of 2517 people either attended and or were admitted to hospital. In 2010/11, the figure increased to 2575. As a percentage of the total activity; 71% related to emergency admissions via A&E (2010) the percentage for 2011 was 69% (Performance and Public Health Intelligence Team 2012)

9.9.2 Depression and Older People

Depression is the most common mental illness in older people and the second commonest singe underlying cause for all GP consultations. Between 10% and 15% of older people (65 years and over) are likely to have depression. Risk factors include loneliness and social isolation, increasing frailty and psychical ill health and reduced independence. It is important that primary care staff are fully aware of the risk factors and in addition to treatment options are able to point older people to befriending schemes, local support groups, leisure and social activities. Primary care may have an important signposting role here, working with local social care and voluntary organisations. Social networks and opportunities for learning, volunteering, mentoring, peer support and leisure activities are known to be of benefit to people with depression.

Between 13% and 16% of older people will have depression that is sufficiently severe to require some form of treatment. Older people with psychical health needs have higher rates of depression.

The Quality Outcomes Framework 2010/11 Wirral's prevalence rate was 0.11 with national prevalence rates being slightly lower at 0.87.

Wirral's population for people aged 65+ is projected to grow from 58,100 in 2008 to 83,300 in 2033. This represents an increase of 43%.

9.9.3 Vulnerable groups

The new mental health strategy specifies 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. This is particularly relevant 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.

9.9.4 Mental health and ethnicity

There are ethnic as well as socioeconomic dimensions to the prevalence of mental ill-health. Members of black and minority ethnic communities are disproportionately represented in hospital statistics, with Black African, Black Caribbean and Black/White mixed groups of adults three times more likely to be admitted to hospital than the population as a whole. They are also up to 44 per cent more likely to be sectioned; (that is, detained without their consent).

Black and minority ethnic groups (7.9 per cent of population) have a three-fold increased risk of psychosis, with a seven-fold increased risk in black African-Caribbean groups and a two- to three-fold increased suicide risk. Yet Black people are 40 per cent more likely to be turned away than White people when they asked for help from mental health services. Black African Caribbean and South Asian patients are less likely to have their mental health problems detected by a GP. At the same time, and paradoxically, they are more likely to have other problems wrongly attributed to mental health.

Black Caribbean, Black African and White/Black Caribbean mixed groups are 40 to 60 per cent more likely than average to be admitted to hospital from a criminal justice referral which means their mental health problems are often only detected when they come into contact with law enforcement agencies. Black men are also almost twice

as likely as white men to be detained in police custody under Section 136 of the Mental Health Act.

Given these population trends, there is a high level of fear associated with mental health treatment. Specifically they will receive inappropriate and poor treatment (e.g. excessive restraint and medication) and be discriminated against. The problems in mental health care seem to be amplified for ethnic groups and for the disadvantaged, with the inverse care law applying. That is, those who are in most need of support are the least likely to access the services which provide this support. The provision of good medical care tends to vary inversely with the need for it in the population served. (The Centre for Social Justice Mental Health Feb, 2011)

Ongoing statutory duties and requirements exist in relation to:

- Delivering Race Equality in Mental Health

The five year government plan 'Delivering race equality in mental health care' has been reviewed (Wilson, 2009). 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.
- Independent Mental Health Advocacy

9.9.5 Military Veterans

There are no definitive figures on the total number of veterans in the UK at the present time. However, the office for national statistics in conjunction with Royal British Legion in 2007 estimated that 26,061 veterans in Wirral.

The number of ex-armed forces recorded and receiving and armed forces pension is 1,285 for wirral. This is likely to be an underestimation as only those who complete two years or more service would be eligible to receive pension.

http://info.wirral.nhs.uk/document_uploads/angela-denny/Armed%20Services%20Personnel%20Estimate%20NW%20Oct%202011.pdf

Whilst we have limited information, there is a need for further detailed analysis to understand the total set of social circumstances and their location, in order to determine how best to meet their mental health needs.

In the North West and as part of the North West IAPT programme, Wirral patients have access to a dedicated Military Veteran Service provided by Pennine Care. This service became operational in November 2011.

9.9.6 Offenders (Prisoners)

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

9.9.7 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 Northern Ireland, 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 (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.

9.9.8 Adults with Attention Deficit Hyperactive Disorder

The National Institute for Health and Clinical Excellence (NICE) recognises that signs of Attention Deficit Hyperactivity Disorder (ADHD) may persist into adulthood with associated emotional and social problems. Adults with untreated ADHD symptoms present an increasing pressure on primary care resources. In addition, this cohort of patients often have poor employment records, have more motor vehicle accidents and present with high degree of co-morbid psychiatric disorders and substance misuse. It is also known that a high number of this cohort of patients become involved with the Criminal Justice Services. (ADHD in Practice, 2009. v1)

Unlike many other health disorders that affect the mind, ADHD starts in childhood and its onset will not occur in adulthood. Up to 60% of children with ADHD will keep showing symptoms into adulthood, and it is estimated that between 2 - 4% of adults in the UK have ADHD. The majority of these cases are likely to be undiagnosed.

Whilst adults are less likely to have an intense degree of hyperactivity, they are frequently likely to:

- feel restless
- be on edge most of the time
- Be prone to fidgeting and have great difficulties in relaxing.

Added to this, many problems may arise from undiagnosed childhood ADHD leading to severe problems with low self-esteem, self-belief and a very low sense of self-worth in adulthood. All of these problems can lead to profound problems with depression and other psychological illnesses, and in many cases ADHD adults can take refuge in alcohol, drugs or substance abuse.

Click here for Wirral Adult ADHD service data P17

9.9.9 Alcohol Related Brain Disease (ARBD)

In 2008, work was undertaken to understand the local levels of need for people with Alcohol Related Brain Disease, and has drawn upon three studies undertaken in Scotland. Using upper and lower estimates of 0.038% and 0.14% of the population; between 127 and 466 cause of alcohol related brain disease (ARBD) would be predicted for Wirral. Therefore, there is a potential wide variation in the range of prevalence. (Dementia Services Development Centre, University of Stirling, 2008)

Click here for Wirral ARBD data page 18

9.9.10 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 (1987) 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 methods. 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 9.13.10a). 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 9.9.10a Estimates of depression and anxiety amongst people who are severely or profoundly deaf in Merseyside, ages 16-60, 2005

PCT	Deaf & hard of hearing population	Severely or profoundly deaf population	Severely or profoundly deaf with depression or anxiety
Liverpool	19,760	863	287
Halton and St Helens	12,144	530	177
Wirral	12,041	526	175
Sefton	10,710	468	156
Knowsley	6,244	273	91
Merseyside Total	**60,899**	**2,660**	**886**

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).

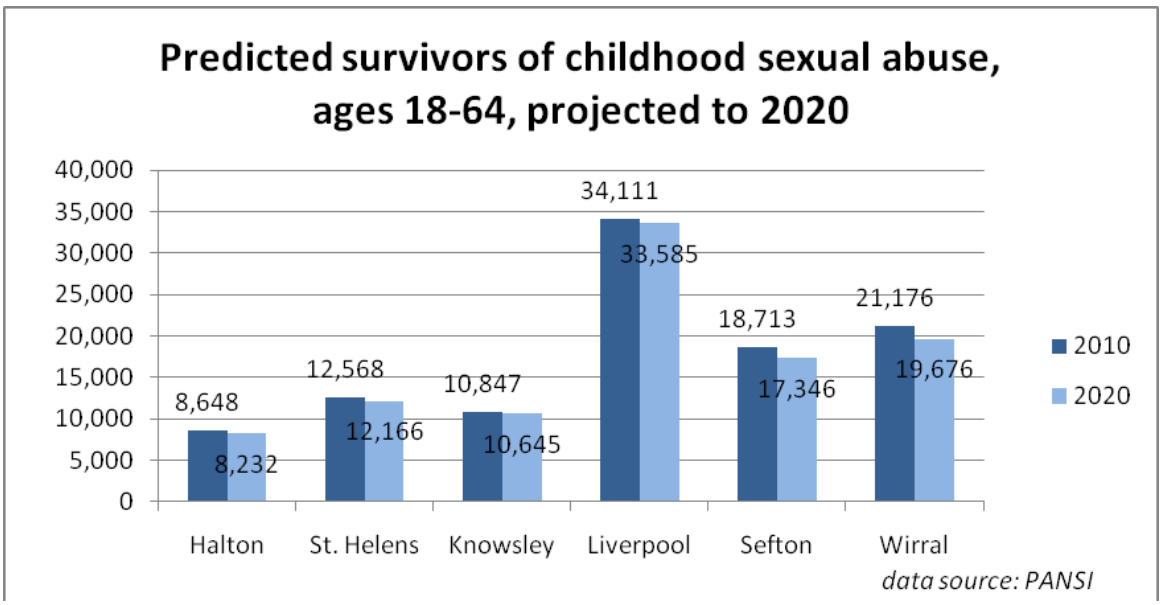
9.9.11 Adult survivors of childhood sexual abuse

Figure 9.9.11a 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 Protecting Adult needs and Service Information (PANSI data, based on a report of a study by the National society for the prevention of cruelty to children (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). (Merseyside Mental Health Needs Assessment. Liverpool Public Health Observatory 2011)

The numbers of adults who are survivors of sexual abuse in childhood range from 34,111 in Liverpool to 8,648 in Halton. 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.

Figure 9.9.11a Predicted survivors of childhood sexual abuse age 18-64



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 more 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 9.9.11b).

Table 9.9.11b: Estimated numbers with mental health problems amongst those aged 18-64 predicted to be survivors of childhood sexual abuse, 2010

PCT	Predicted Survivors*	Number estimated to be in receipt of psychiatric treatment **
Liverpool	34,111	4,230
Wirral	21,176	2,626
Sefton	18,713	2,320
St. Helens	12,568	1,558
Knowsley	10,847	1,345
Halton	8,648	1,072
Merseyside Total	**106,063**	**13,152**

*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.

9.9.12 Homeless People

For more information please visit Housing and Homeless JSNA

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.

Table 9.9.12a Rough sleepers, street counts, 2010

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

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

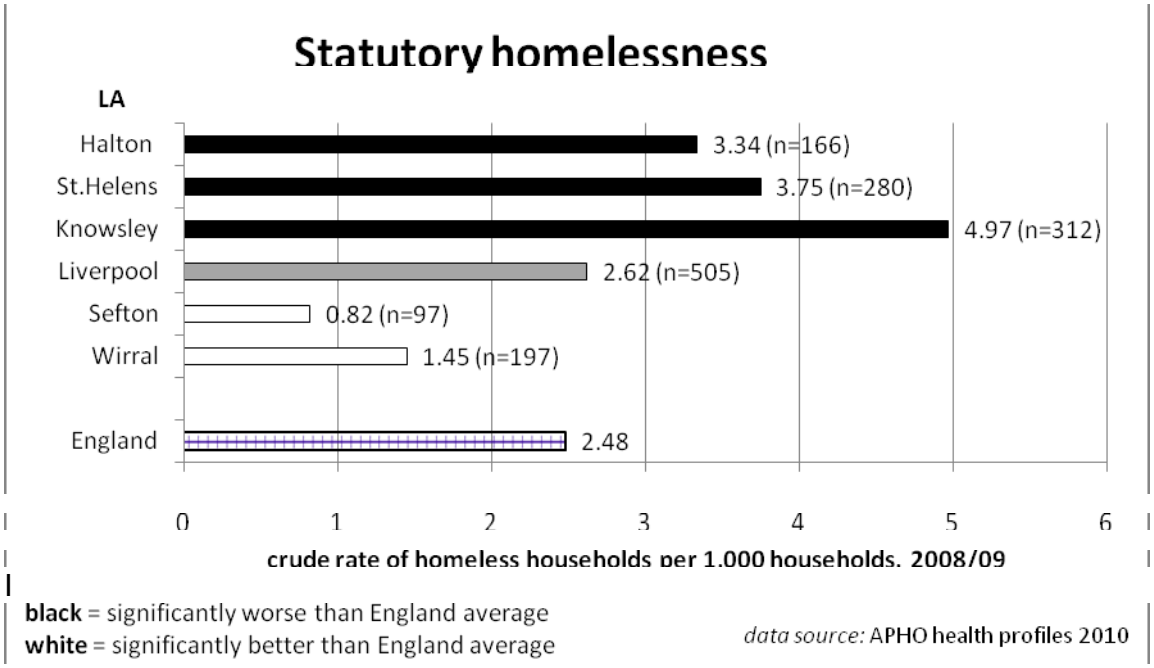
An offender health needs assessment for Merseyside is currently being carried out by Liverpool Public Health Observatory, with a report to be published early 2012.

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)

Crisis, 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).



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).

Date source: Merseyside Mental Health Needs Assessment, 2011

9.9.13 Carers

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).

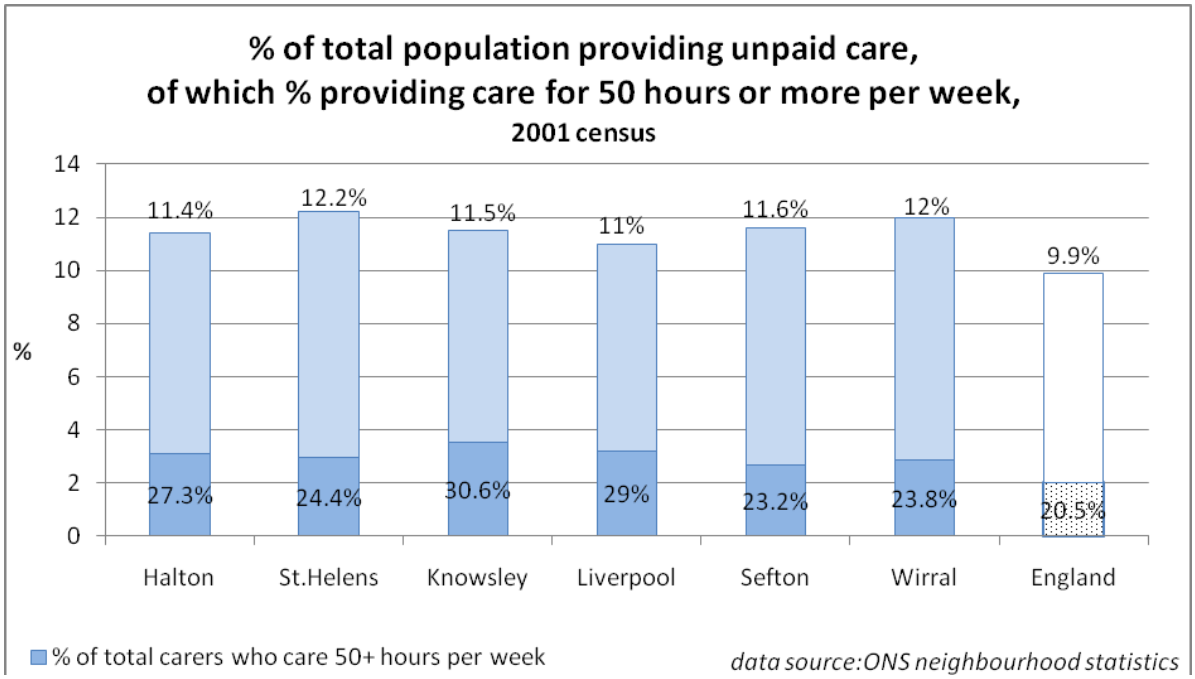
In Merseyside, there are an estimated 170,685 people providing unpaid care to family, friends or neighbours with long-term physical or mental health problems (Table 9.9.13a). In each local authority on Merseyside, the proportion of the population who are carers is greater than the national average of 1 in 10 (9.9%) v= [-0 (Figure 9.9.13b). In St.Helens and Wirral, nearly 1 in 8 of the population are carers.

Table 9.9.13a The number of People providing unpaid care

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

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.
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)

Figure 9.9.13b Percentage of total population providing unpaid care and those providing care for 50 hours or more per week.



Source: 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.
http://www.liv.ac.uk/PublicHealth/obs/publications/report/86_Merseyside_mental_health_needs_assessment_WEB_VERSION.pdf

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 9.11.13a

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