
Mental health and wellbeing in the Lancashire sub-region

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Intelligence for Healthy Lancashire (JSNA)

NHS **NHS** **NHS** **NHS** **NHS**
Central Lancashire East Lancashire North Lancashire Blackburn with Darwen Blackpool



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Epidemiological profile of Lancashire

The previous sections have set out information relating to the determinants of mental health and to positive mental health, wellbeing, in Lancashire, and have outlined key issues for PCTs relating to improvement. The aim of this section is to set out the national context and local information on the extent of mental disorders, and to propose the types of mental health need which should be included in the remainder of the needs assessment project. It therefore:

- Discusses the drivers of future demand and highlights key concerns about unmet or inadequately met needs for people who experience mental disorders, based on national mental health policies, but likely to apply to in Lancashire
- Presents available information on the numbers of people in Lancashire who may be affected.

It should be noted that all projections are estimates, based on studies with differing findings, and a range of expert opinions. The further forward the projection, the greater the uncertainty also created by variations in demography. All these figures should therefore be taken as broad planning assumptions, rather than certain counts.

Future demand and currently unmet needs

Demand on mental health services the next five years will be driven by changes in the number who need services. In other words, there will be more people who need services because the population is increasing, not because mental illness is itself becoming more common. The King's Fund report 'Paying the Price' (2008) states that the 'increase in numbers simply reflects the increase in population. Prevalence rates for all mental disorders within all age groups are likely to remain broadly stable.'

The numbers of people who meet the diagnostic criteria for mental disorder is greater than the number who use services. Future demand is therefore not as simple as a linear projection. If more services are available, more people can be treated. In mental health, better access, diagnosis or case-finding can increase demand on services, for example the following may lead to greater use of services:

- Greater access to treatment for depression and anxiety
- Speedier response to crisis in severe mental illness

- More accessible and acceptable services may discover cases of previously unmet demand eg from people with untreated serious mental illness.
- Better diagnosis of disorders such as Adult Attention Deficit and Hyperactivity Disorder (ADHD).

However, more effective care pathways (such as management of serious mental illness in primary and community care) have the potential to manage demand by providing timely and preventative interventions. In January 2009, the results of the National Psychiatric Morbidity Survey (PMS 2007) were published. They confirm that:

- The proportion of people meeting the criteria for at least one common mental disorder (including anxiety and depression) did not increase between 2000 and 2007 (though it increased from 1993 to 2000).
- The prevalence of alcohol dependence did not increase since 2000 (it in fact reduced for men).
- The prevalence of drug dependence was higher in 2000 than in 1993 but has not increased since.
- There was no change in the prevalence of psychosis or personality disorder.

This confirms that prevalence rates for most disorders were stable. However:

- The number of people reporting self harm increased.
- The number of women reporting suicidal thoughts in the last year increased.
- The percentage of women aged between 16 and 64 years old with a common mental disorder rose from 19.1 per cent in 1993 to 21.5 per cent in 2007, with the highest rate in the age 45-54.

These increases highlight future needs which should be considered by commissioning strategies. The PMS 2007 also reported for the first time on problem gambling. In this context, its inclusion can be seen as 'horizon-scanning' for potential future mental real need.

Likely effect of austerity measures on demand for mental health services

A recent article in the British Medical Journal¹ notes that the very small real term increases in funding for the NHS announced in the Spending Review “*will not keep up with the rising demands of medical advances and the costs of an ageing population, with the latter adding perhaps 1 percentage point a year to demand*”.

The recession, and resulting austerity measures articulated in the Comprehensive Spending Review, are forecast by many experts to be likely to have an adverse effect on population health, and probably especially mental health, and to increased demand for mental health services in the future. Because of the link between mental health and physical health, any circumstances that have a deleterious effect on mental health will result in a deleterious effect on physical health and vice versa, so that demand for services other than those specific to mental health is also likely to increase.

As the article notes, as well as NHS funding, what happens to services that address the “wider determinants of health” - social care, housing, benefits and employment - also has a direct effect on demands on the NHS. The strong links between poor or insecure housing, low income and unemployment and poor mental health are well documented.

It has also been forecast by Marmot, the Institute for Fiscal Studies and others, that the austerity measures will be likely to disproportionately affect the most disadvantaged in society – the poor, sick and disabled - and so widen inequalities in health and the opportunities for good health (including good mental health) provided by a living income, decent housing and fulfilling employment².

Suicide

National picture

In England a person dies every 2 hours from suicide. Suicide is used as an alternative indicator for mental illness and therefore suicide reduction is a national target and a standard in the National Service Framework for Mental Health. The national (England) rate is 7.8 deaths per 100,000 population (2006-08) and the target is 7.3 for (2009-11). The national suicide prevention target has been calculated for there to be a reduction of at least a fifth by 2010 from the baseline of 1995-97. This 2006-08 rate shows that there has been a

¹ Timmins N (2010). Where do the cuts leave the NHS? British Medical Journal; 341:c6024

² Hunter DJ (2010). The impact of the spending review on health and social care. British Medical Journal; 341:c6024

reduction since the 2004-06 rate of 8.3. This is the lowest rate in England on record and one of the lowest in Europe (see table below). In the view of Mental Health Strategies, suicide rates at district level over short time periods cannot give reliable information about mental health service performance, and differences at that level cannot be distinguished from the effects of random variation. The following tables and charts have therefore been provided over a 3 or 5 year period wherever possible.

There is a large amount of research and evidence such as the *National Suicide Prevention Strategy* which suggests that suicide is strongly influenced by the makeup of the population and the communities that exist within it. Research consistently demonstrates that there are high rates in males, in urban areas rather than rural, in people who are single, in Protestants rather than Catholics, and in socially isolated rather than integrated communities. The 2008 annual report on progress towards the *National Suicide Prevention Strategy* cited the *Foresight Mental Capital and Wellbeing: Making the most of ourselves in the 21st Century* as highlighting the link between social factors and poor mental health. This has been brought to the attention of Chief Executives via the Department of Health in light of recent economic circumstances.

Of the countries where 2008 rates per 100,000 were available from WHO, for persons dying from suicide overall the rate differs significantly when looking at men and women separately. The rate (per 100,000) for men is consistently higher for all countries (see table 1 below) with it even rising to over 5 times the rate for women in Lithuania. The highest rates (per 100,000) are almost exclusively Eastern European countries where as the lowest rates are found in Greece, Turkey, Albania and Mexico. Table 3 looks at the local comparison between Male and Female suicide rates.

Table 1: Suicide rates by gender and country, 2008

Country	Male	Female	Persons
Lithuania	55.9	9.1	30.7
Hungary	37.1	8.6	21.5
Slovenia	32.1	7.9	19.8
Estonia	29.1	6.2	16.5
New Zealand	20.3	6.5	13.2
Czech Republic	20.2	4.2	11.8
Ireland	14.5	4.2	9.3
United Kingdom	17.7	5.4	9.2
People's Republic of China	19.7	8	6.6
Cyprus	7	1.7	4.3
Mexico	6.8	1.3	4
Albania	4.7	3.3	4
Turkey	5.36	2.5	3.94
Greece	4.8	1	2.8

Source: WHO - Suicide Rates 2008

The UK has a lower suicide rate than the average for the EU³; despite this, suicide is the greatest cause of death for men under the age of 35 in the UK⁴. The highest trends are almost exclusively Eastern European countries. The lowest rates are found in Greece, Malta, Portugal, and Spain. Suicide is strongly influenced by demography and societal makeup. Durkheim⁵ was the first to demonstrate convincingly that suicide is relatively stable within particular communities; there are high rates in males, in urban areas rather than rural, in people who are single, in Protestants rather than Catholics, and in socially isolated rather than integrated communities. A recent reproduction of his work reveals that mortality from suicide is increasing with social fragmentation score⁶.

Lancashire suicide audit

The tables below show the Directly Standardised Rates (DSRs) for Lancashire's neighbouring local authorities and the rates for the local authorities across Lancashire. Barrow-in-Furness has seen biggest reduction since the 1995-97 baselines. 81% (25) of the North West Local Authorities have seen a reduction since the baseline was set; Chorley has the seen the biggest rise from the 7 local authorities that have seen an increase in their Directly Standardised Mortality Rates (rates per 100,000).

Table 2: Directly standardised mortality rates (per 100,000) for suicide and injury undermined for other North West areas

Key	Area	95 - 97	98 - 00	01 - 03	04 - 06	2007	2008	07/08	Change between 95-97 & 07/08
1	Bolton MCD	11.55	10.00	8.19	8.13	11.95	15.10	13.53	1.98
2	Bury MCD	8.74	11.20	9.78	9.05	7.35	3.82	5.59	-3.16
3	Manchester MCD	16.02	16.83	11.99	11.57	7.89	12.59	10.24	-5.78
4	Oldham MCD	8.47	10.46	9.86	8.18	7.08	8.36	7.72	-0.75
5	Rochdale MCD	10.08	9.21	10.54	10.19	7.74	7.34	7.54	-2.54
6	Salford MCD	11.58	12.65	7.07	10.56	7.31	9.27	8.29	-3.29
7	Stockport MCD	9.01	9.68	7.79	7.74	8.20	8.95	8.58	-0.43
8	Tameside MCD	10.02	12.88	10.33	11.15	10.45	10.88	10.67	0.65
9	Trafford MCD	7.43	9.49	9.49	9.01	5.63	7.33	6.48	-0.95
10	Wigan MCD	7.46	11.04	9.29	9.92	12.77	8.63	10.70	3.24
11	Knowsley MCD	6.27	9.03	8.15	7.05	5.37	4.29	4.83	-1.44
12	Liverpool MCD	10.24	13.81	10.02	10.26	8.12	4.67	6.40	-3.85
13	St Helens MCD	7.07	7.34	7.53	6.63	8.82	9.82	9.32	2.25
14	Sefton MCD	7.51	7.92	11.00	9.76	4.56	5.56	5.06	-2.45
15	Wirral MCD	13.10	14.06	12.93	11.59	12.56	10.43	11.50	-1.61
16	Cheshire West and Chester	8.47	8.80	8.61	7.69	6.66	9.30	7.98	-0.49
17	Barrow-in-Furness CD	16.57	11.74	13.01	9.25	3.52	7.91	5.72	-10.86
18	Carlisle CD	11.60	15.24	10.93	16.27	15.28	6.06	10.67	-0.93

Source: Primary Care Informatics Unit

³ World Health Organisation Europe (2009) *European HFA Database*, WHO, Geneva.

⁴ Caley, M, and T. Fowler (2008) Suicide prevention: is more demographic information the answer? *Journal of Public Health (Advanced Access published December 3, 2008)* doi:10.1093 1-3.

⁵ Durkheim, E, (1970) *Suicide: A study in sociology*, Routledge, London.

⁶ Stevens, A. et al (2004) *Health Care Needs Assessment*, Radcliffe Publishing Ltd., Oxford, pg.181

Table 3: Directly standardised mortality rates (per 100,000) for suicide and injury undetermined for Lancashire

Key	Area	95 - 97	98 - 00	01 - 03	04 - 06	2007	2008	07/08	Change between 95-97 & 07/08
19	Blackburn with Darwen UA	13.54	12.39	13.54	11.35	13.46	8.38	10.92	-2.62
20	Blackpool UA	15.68	15.97	19.62	13.51	13.01	15.12	14.07	-1.61
21	Burnley CD	12.07	8.95	8.79	9.21	8.46	11.10	9.78	-2.29
22	Chorley CD	11.80	8.43	8.14	5.94	13.41	19.57	16.49	4.69
23	Fylde CD	9.87	9.95	7.35	6.98	4.65	8.86	6.76	-3.12
24	Hyndburn CD	11.15	16.23	9.75	7.59	14.76	7.11	10.94	-0.21
25	Lancaster CD	12.85	14.62	11.24	6.36	8.32	6.28	7.30	-5.55
26	Pendle CD	12.61	12.40	12.52	9.25	3.32	9.11	6.22	-6.40
27	Preston CD	13.93	13.84	9.44	10.10	17.44	9.72	13.58	-0.35
28	Ribble Valley CD	12.01	9.73	5.62	7.05	9.88	9.97	9.93	-2.09
29	Rossendale CD	9.36	11.79	5.76	10.82	16.11	11.47	13.79	4.43
30	South Ribble CD	9.90	8.73	8.14	10.14	7.37	7.08	7.23	-2.68
31	West Lancashire CD	8.64	9.20	5.05	6.98	6.65	11.28	8.97	0.32
32	Wyre CD	10.98	13.41	10.29	7.54	6.81	11.01	8.91	-2.07

Source: Primary Care Informatics Unit

The chart below shows in rank order local authorities grouped by those who have seen an increase and those who have seen a decrease since the setting of the baseline.

Figure 1: Change in suicide DSRs between 1995/07 and 2007/08

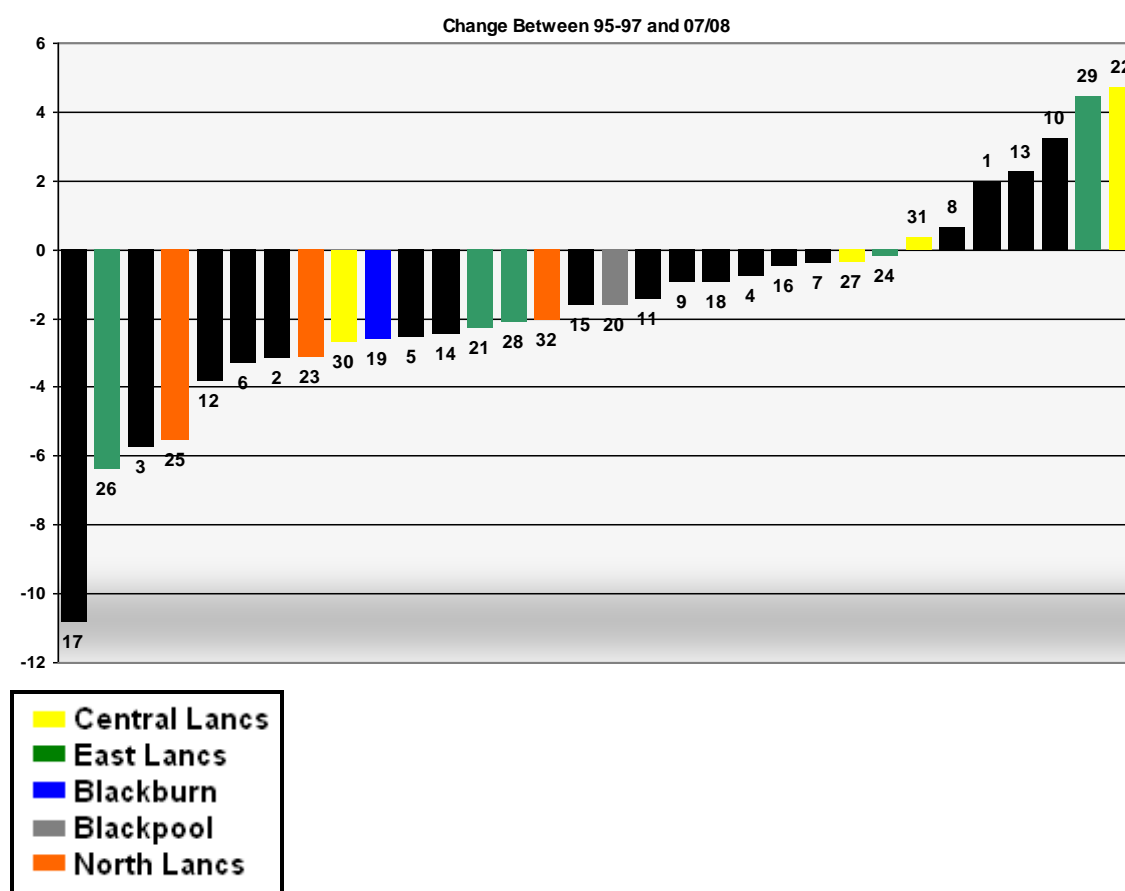
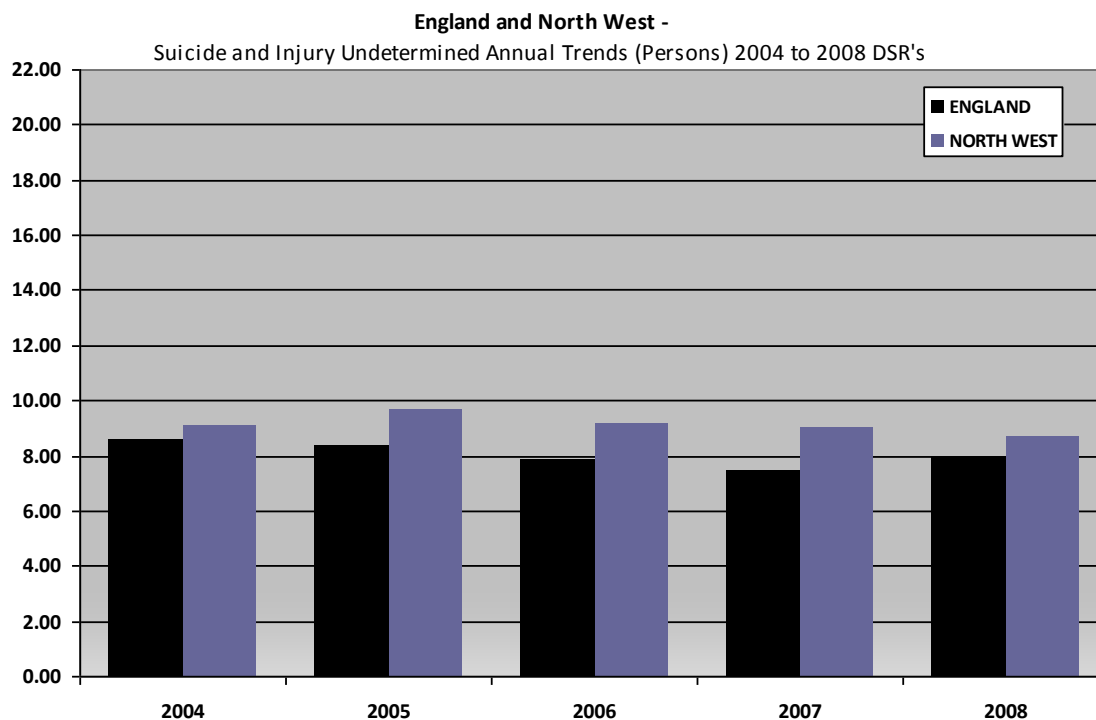


Figure 2: England and North West comparison of annual suicide DSRs



This chart shows the rates (per 100,000) for individual years for a 5 year period (2004 – 2008) for England and the North West. This demonstrates that as a whole the North West has had a consistently higher rate than the England average; this may also be true for other areas of varying deprivation.

The ONS states that there is only a moderate variation in suicide rates across Government office regions in England. Since the mid 1990's rates for males have always been higher in the north. Regional trends are reflected in national patterns of suicide rates

Gender

Suicide rates are higher for men than women of all age groups, and currently the national Mental Health Charity Mind states that men are almost three times more likely than women to die by suicide. This gender gap has widened considerably over the past few decades: in 1979 the female-to-male ratio for suicides was 2:3, but by 2005 it was about 1:3.

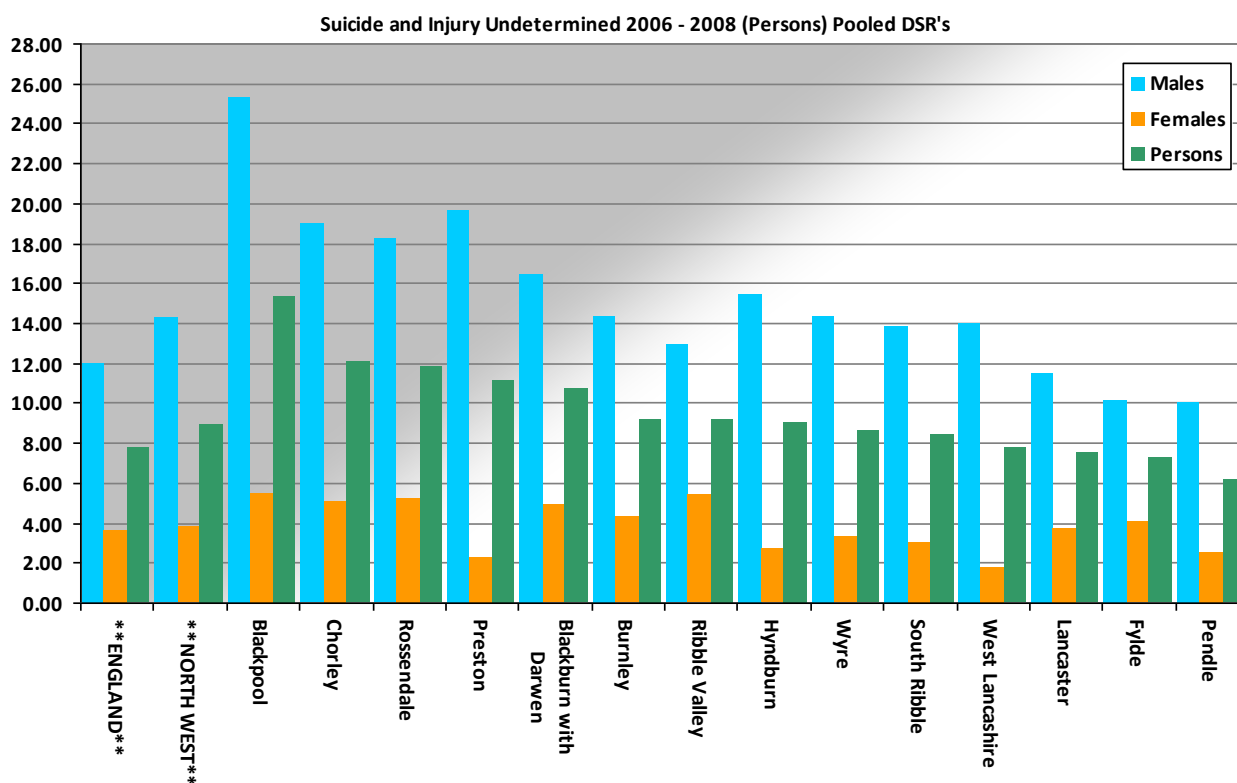
Suicide rates for both men and women have varied over the last 30 years, however. Between 1975 and 1990, the rate increased for men but decreased for women whereas between 1990 and 1997 rates decreased for both men and women. Between 1997 and 1999, there were some increases in overall numbers of suicides, and since 2000 the numbers have gone down for men but have remained fairly stable for women.

Three years pooled data has been shown below due the small numbers when looking at one year; 3 years also allows adjustment for any sharp increases and falls to give an average rate.

As an area Lancashire’s average DSRs (rates per 100,000) for all persons, males and females are all above the respective averages given for England and the North West as a whole. Lancashire averages – all persons: 9.82, males: 15.76 and females: 3.88

As with the majority of areas the boroughs across Lancashire have higher rates within the male population, and as can be seen below rates for Blackpool in particular along with Chorley, Preston and Rossendale are all significantly higher than other rates for males across the area. As a result these same 4 areas have higher overall rates.

Figure 3: Gender comparison of 2006-08 pooled DSRs by district



See appendix A for geographical maps of gender comparison of 2006-08 pooled DSRs.

Table 4: Gender comparison of 2006-08 pooled DSRs by district

	Males			Females			PERSONS			
	DSR	95% Confidence Intervals		DSR	95% Confidence Intervals		OBS	DSR	95% Confidence Intervals	
		LOW	UP		LOW	UP			LOW	UP
ENGLAND	12.01	11.76	12.25	3.65	3.52	3.78	12479	7.76	7.63	7.90
NORTH WEST	14.23	13.50	14.97	3.82	3.44	4.19	1890	8.95	8.54	9.36
Blackburn with	16.45	10.81	22.10	4.85	1.83	7.87	43	10.72	7.50	13.93
Blackpool	25.27	18.35	32.20	5.49	2.33	8.65	65	15.35	11.55	19.15
Burnley	14.30	7.61	20.98	4.31	0.99	7.63	25	9.18	5.51	12.85
Chorley	19.01	12.14	25.87	5.04	1.62	8.46	39	12.09	8.22	15.95
Fylde	10.15	4.05	16.25	4.03	0.41	7.65	16	7.22	3.58	10.86
Hyndburn	15.42	8.41	22.43	2.71	0.00	5.54	23	9.06	5.29	12.83
Lancaster	11.51	6.89	16.12	3.73	1.11	6.36	33	7.49	4.86	10.11
Pendle	10.05	4.66	15.43	2.50	0.00	5.35	17	6.17	3.15	9.19
Preston	19.69	13.47	25.90	2.30	0.04	4.57	43	11.12	7.77	14.47
Ribble Valley	12.89	5.18	20.60	5.41	1.00	9.81	18	9.18	4.71	13.65
Rossendale	18.21	9.44	26.98	5.24	1.22	9.25	24	11.77	6.95	16.59
South Ribble	13.83	7.94	19.73	3.06	0.52	5.59	28	8.42	5.21	11.62
West Lancashire	14.00	7.88	20.13	1.75	0.00	3.95	24	7.79	4.57	11.01
Wyre	14.37	8.07	20.67	3.32	0.26	6.37	26	8.63	5.20	12.06

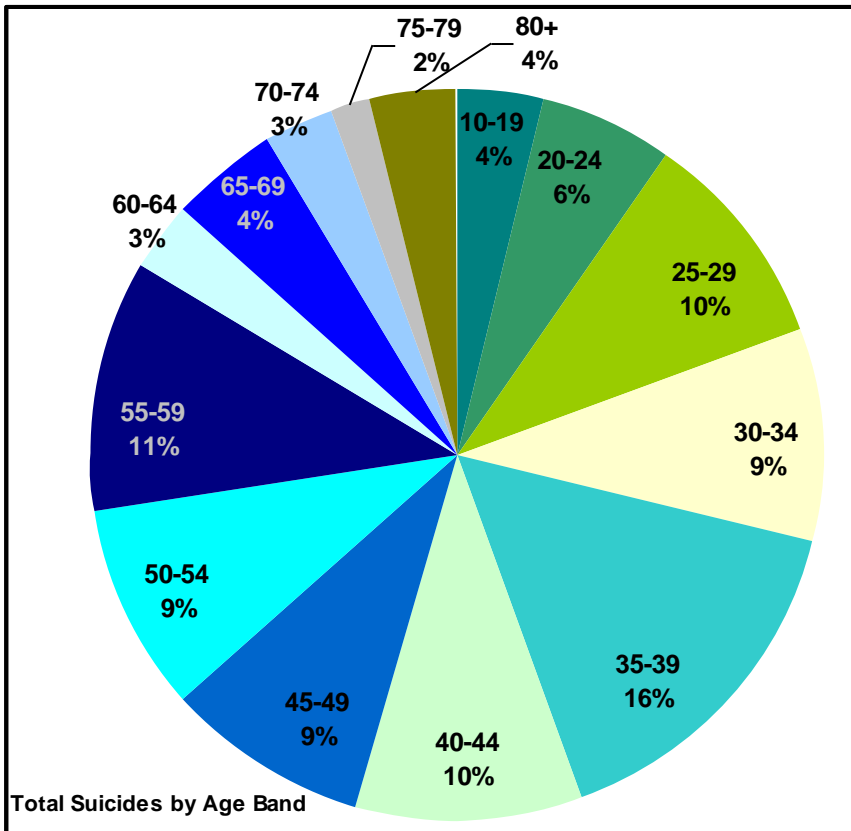
Although Blackpool has the highest number of suicides and the highest DSR due to the number of suicides for a population of its size, it is evident from these charts that a higher number of men in central Lancashire commit suicide and a higher proportion of women in East Lancashire commit suicide. Nationally the number of suicides by males is consistently higher than females; this is also reflected in local data.

Age

Between 1999 and 2008 in England as a whole the number of suicides fell by 12% in people aged over 15. When looking at 5 year age bands there is no particular age band that stands out (except perhaps 35 – 39) but it should be noted that over 50% of suicides occurred between the ages of 25 and 49.

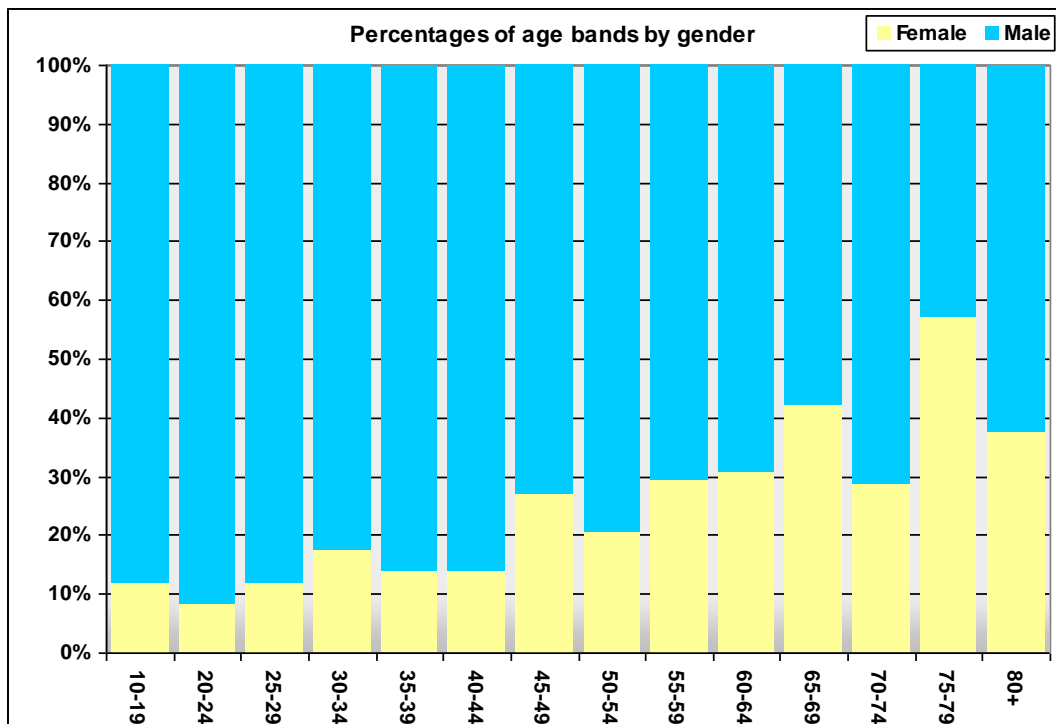
The Annual Report (2008) on progress against the National Suicide Prevention Strategy states that in the last 40 years suicide rates had fallen in older men and women but risen in young men. Over the last 10 years rates in young men have fallen but have remained high in comparison to those of the rest of the population. This is reflected in the Lancashire data which shows a higher proportion of males in age bands between 20 – 24 and 25 – 29.

Figure 4: total number of suicides by age band, 2006-08



The chart shows the differences in distribution across the age bands in relation to gender. It shows that as previously demonstrated there are consistently more men that commit suicide than women although this chart highlights that between 75 and 79 across Lancashire a higher proportion of women took their own life (and were registered) during 2006 – 2008. A steady increase in the proportion of women can be seen as the age bands increase.

Figure 5: Percentage of suicides in 5 year age bands by gender (Lancashire)



Ethnicity

No information is routinely collected around the ethnicity although there is a record of the place of birth. Looking at this information it shows that 92% of those who took their own life and were registered during 2006 – 2008 were born within the UK. There were a number of countries where only one person was born who then committed suicide in Lancashire and only a small number of countries where more than one person was born that committed suicide in Lancashire e.g. Pakistan and Poland; which reflects the ethnic diversity of Lancashire.

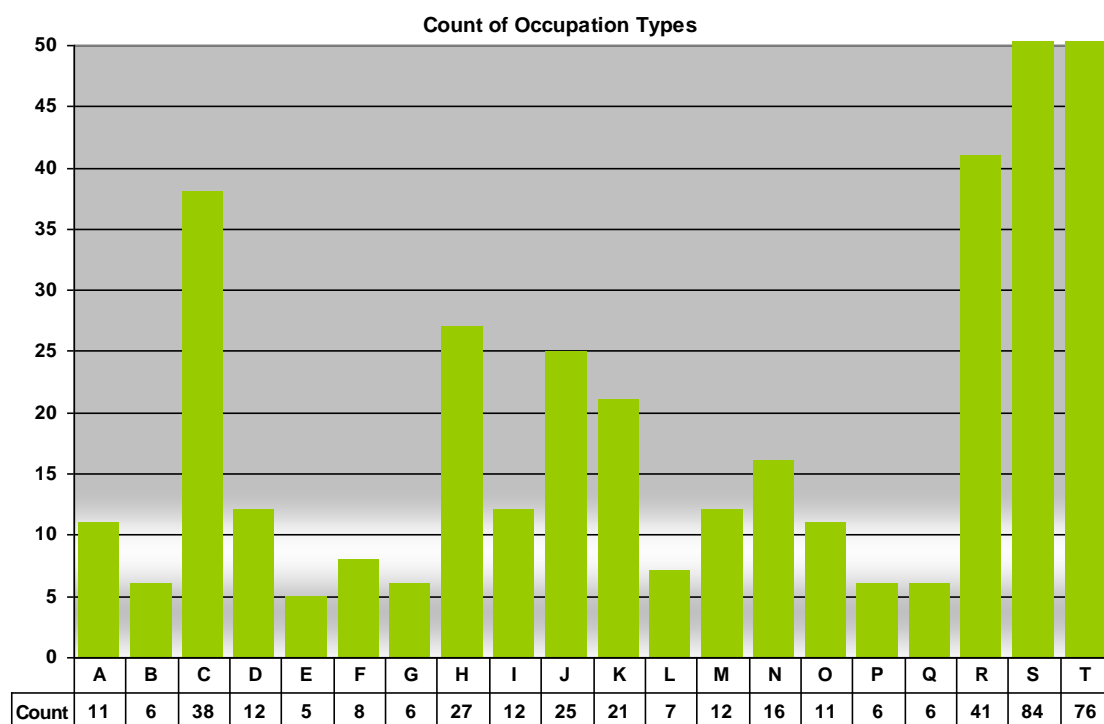
Occupation

Men in unskilled occupations are 4 times more likely to die by suicide than those with a professional occupation; however certain occupational groups are at higher risk – doctors, nurses, pharmacists, vets and farmers. (mind.org.uk) The table and chart below show the various occupations that were recorded, the most predominant being building/constructions and trades; which includes labourers, plasterers, electricians, plumbers etc. 18% of records did not have an occupation indicated and 20% were a mix of occupations that did not fit into the categories already stated (e.g. Baker, Priest, security guard etc). 59 (14%) of records were recorded as retired; when looking at the age of these individuals they were aged 45+. There were 69 people over 60 (who would be considered to be over the average retirement age) 67% of those over 60 were said to be retired. Although recorded the occupation does not always mean that the person was employed at the time of death so no link can be made between unemployment and suicide risk although the above data shows that the occupation of people who commit suicide in Lancashire is in line with national trends.

Table 5: Percentage of suicides by occupation (taken from ONS mortality files)

Key	Occupation	Total
A	Administration	2.6%
B	Armed Forces	1.4%
C	Building/Construction	9.0%
D	Care/Support Work	2.8%
E	Civil Servant	1.2%
F	Cleaner	1.9%
G	Directors/Senior Mgrs	1.4%
H	Driver	6.4%
I	Engineering	2.8%
J	Factory Work	5.9%
K	Hospitality	5.0%
L	IT	1.7%
M	Health/Police/Fire	2.8%
N	Retail	3.8%
O	Sales	2.6%
P	Student	1.4%
Q	Teacher	1.4%
R	Trades	9.7%
S	Other	19.8%
T	Unknown	17.9%
Total count		424

Figure 6: Number of suicides by occupation (taken from ONS mortality files)

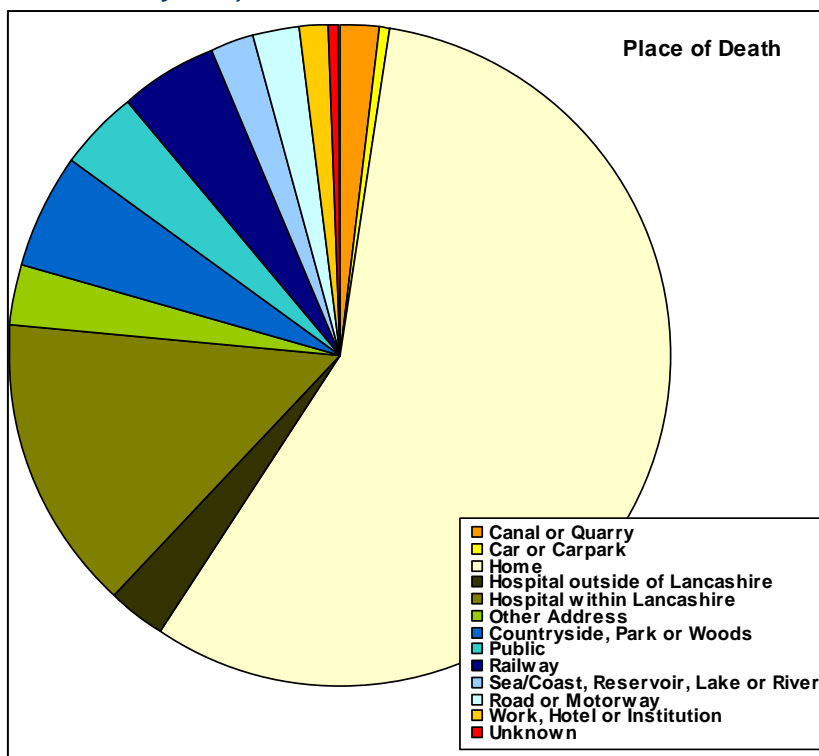


As the occupation type field recorded on the mortality files is not always completed or does not give enough detail the above occupation categories were defined manually using national classifications as guidance.

Suicide hotspots

In August 2009 the North West Public Health Observatory published a paper – Suicide in the North West: A review of non-residential and outdoor suicide locations. This study looked at those suicides and suicide attempts taking place in the North West between 2001 and 2006. In the North West only a small number of specific areas were identified as being habitually used for suicide; there were 49 locations highlighted where 2 or more successful (or attempted suicides) had taken place, the authors stated that it is up to local suicide partnerships to consider locally what constitutes as sufficient evidence for an intervention around a specific geographical hotspot.

Figure 7: Place of death recorded on deaths by suicide registered in Lancashire, 2006-08 (taken from ONS Mortality files)



A hotspot is loosely defined as a location where multiple occurrences have taken place or a collection of similar locations where multiple occurrences have taken place. It has been found that a high suicide rate does not correlate with geographical areas that include hotspots; in the North West Blackpool was identified as having a large number of high risk areas. An analysis of hotspots and high risk areas fall outside of this piece of analysis as it would need to be undertaken a local level with local data and knowledge.

High risk areas differ to hotspots in that they are not necessarily a hotspot (a place where multiple occurrences have taken place) but they are a potential preferred location of choice where people wanting to take their own life might choose. Whilst this high number of high risk areas does go alongside a high suicide rate there are areas such as Hyndburn, Pendle and Rossendale where their low number of high risk areas does not correlate to the suicide rates. Along with national

trends the majority of people committing suicide across Lancashire do so in their own home; this is believed to be a popular location due to the privacy and little opportunity for rescue.

As with other years between 2006 and 2008 there were a significant percentage of deaths by suicide that occurred in hospital (the chart differentiates between hospitals in and outside of Lancashire) this is not helpful in terms of identifying location trends as the hospital was not the location of the suicide it was only the place of death.

Methods used

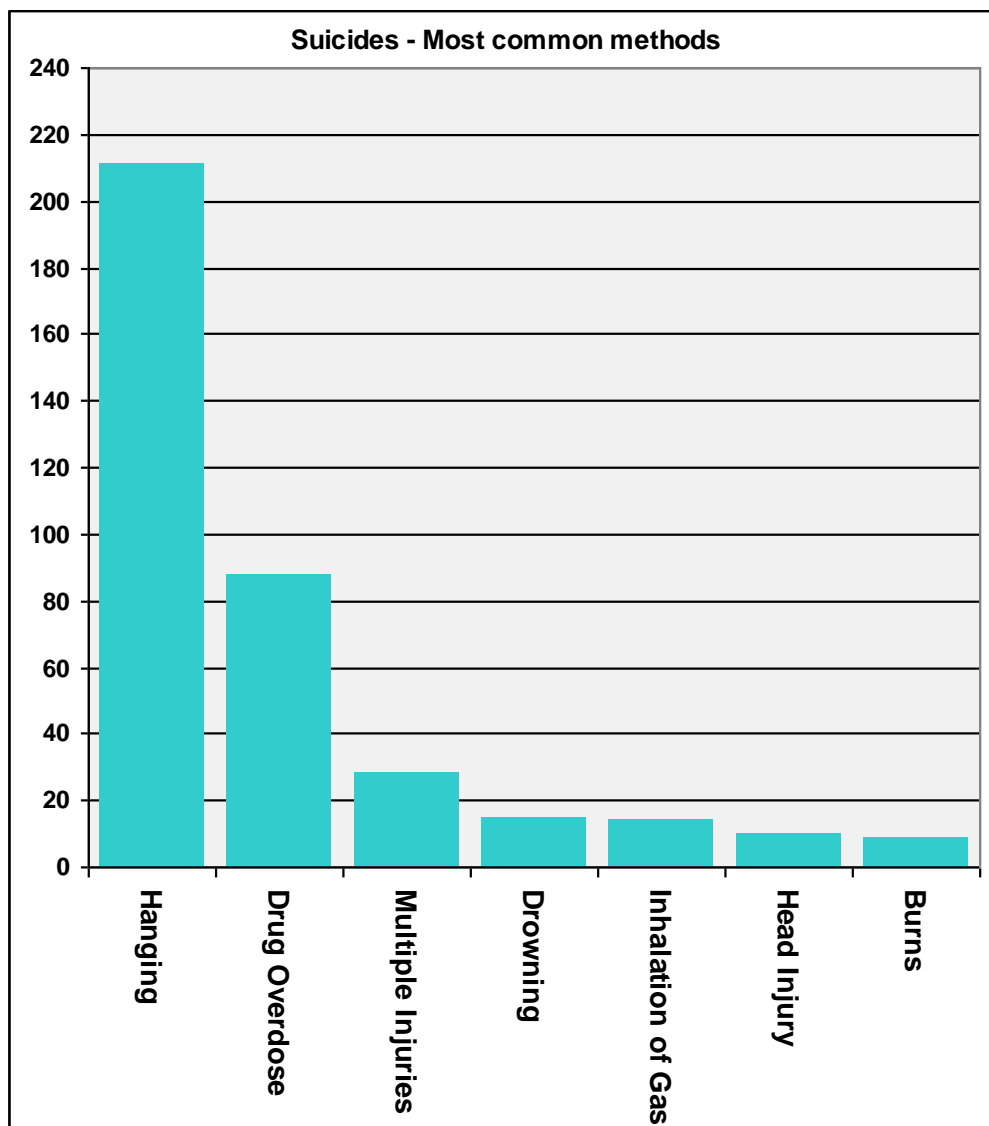
Nationally hanging accounts for half of the male suicides whereas drug related poisoning is the most common method among women. When looking at suicides in Lancashire 54% of male suicides were by hanging and 32% of female suicides were by drug overdose. 14% of suicides by drug overdose are using prescription medication (not defined as necessarily being own prescription).

Looking at a correlation of location and method the following is shown for suicides across Lancashire (2006-08):

- 25% of suicides at home are by drug overdose.
- 59% of suicides at home are by hanging.
- 34% of suicides resulting in deaths in hospital were caused by hanging.
- 19% of suicides resulting in deaths in hospital were caused by drug overdose.
- 43% of suicides by inhalation of gas (carbon monoxide) took place at home.
- 69% of suicides that took place at a household address other than address of residence were by hanging.
- All deaths by lacerations and stab wounds took place at home.

As you would expect 67% of suicide deaths at waterways (e.g. canal, reservoir etc) were by drowning although there were a significant number of hangings in these locations this (67%) accounted for the majority of deaths by drowning.

Figure 8: Most common methods of suicide in Lancashire 2006-08

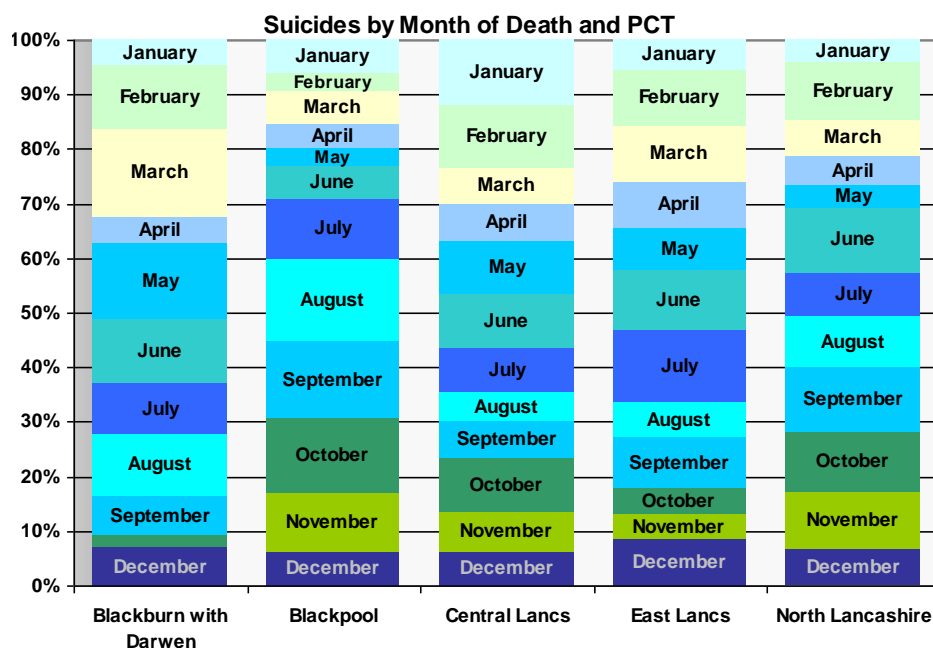


Seasonal patterns

Table 6: Percentage of suicide deaths by PCT and month of death

Month	Blackburn with Darwen	Blackpool	Central Lancs	East Lancs	North Lancs	Grand Total
January	4.65%	6.15%	11.94%	5.61%	4.00%	7.31%
February	11.63%	3.08%	11.19%	10.28%	10.67%	9.67%
March	16.28%	6.15%	6.72%	10.28%	6.67%	8.49%
April	4.65%	4.62%	6.72%	8.41%	5.33%	6.37%
May	13.95%	3.08%	9.70%	7.48%	4.00%	7.55%
June	11.63%	6.15%	9.70%	11.21%	12.00%	10.14%
July	9.30%	10.77%	8.21%	13.08%	8.00%	9.91%
August	11.63%	15.38%	5.22%	6.54%	9.33%	8.49%
September	6.98%	13.85%	6.72%	9.35%	12.00%	9.43%
October	2.33%	13.85%	9.70%	4.67%	10.67%	8.49%
November	0.00%	10.77%	7.46%	4.67%	10.67%	7.08%
December	6.98%	6.15%	5.97%	8.41%	6.67%	6.84%
Grand	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Figure 9: percentage of suicide deaths by PCT and month of death



There is little evidence available regarding patterns for month of death by suicide. There seems to be an anecdotal hypothesis that generally more suicides happen during the winter, although this is a generalisation as there are suggestions that in particular population groups, i.e. students, there is a trend of summer time occurrences. (<http://www.papyrus-uk.org/publications.html>). Further up to date research is needed nationally to establish any solid evidence of trends.

Looking at Lancashire data the highest percentage of suicides took place in June throughout 2006 to 2008; although overall there is not a large enough amount of variation to demonstrate a trend relating to month of death from suicide.

When broken down by PCT there would need to be more historical data to identify any definite trend but the following information can be demonstrated – Blackpool: 43% happened during August/September/October, Blackburn: 42% during February/March and May, Central Lancs: 22% during January and February, East Lancs: 21% spread across July and December and North Lancs: 23% spread across June and November.

Coroners Verdict

63% of suicides that took place between 2006 and 2008 across Lancashire took place in the year they were registered, the national target is based on the year of registration but it is useful to highlight the difference between this and the year of death as it can indicate delays in the date of death and the inquest. There was little difference in this percentage when looking at the individual years. 87% of suicides that were registered during PCT this 3 year period also occurred during this time.

The majority of open verdicts are recorded in cases of suicide where the intent of the deceased could not be proved; during the 3 year period 2006-08 an average of 16% of cases of suicide were recorded with an open verdict.

Self Harm

Self-harm is an important public and social health concern. This section attempts to provide an indication of the epidemiology of self-harm among residents of Lancashire. However, true prevalence of self-harm is difficult to estimate as it can go unreported, and potentially disproportionately underreported among certain sub-groups of the population.

In the Psychiatric Morbidity Survey in 2007, 5.6 per cent of people said they had attempted suicide at some point in their life and 4.9 per cent said they had engaged in self harm. These individuals did not necessarily come to the attention of services: less than two thirds of those who attempted suicide had sought help, and only about half of those who self-harmed. However,

- People diagnosed with mental illness (notably schizophrenia) are more likely to self harm.
- Those who survive a medically serious suicide attempt have a poorer outcome in terms of life expectancy.

The NICE guideline on self harm also notes that:

- 80 per cent of A & E attendances with self harm have taken an overdose of prescribed or over the counter medication.
- Self injury is more common than self poisoning in the population as a whole.
- Association with a physical illness as a precipitating factor.
- Two thirds of those attending A& E for self harm meet the criteria for depression at the time, but two thirds of these no longer meet the diagnostic criteria 1 -16 months later.
- Half those attending A& E due to self harm will have consumed alcohol.
- There are higher rates in young Asian women.

Analysis of emergency department, hospital admissions and ambulance data

The Trauma and Injury Intelligence Group (TIIG) has recently published an analysis of data on:

- Self-harm attendances by Lancashire residents to emergency departments (EDs) (2007-2009);
- Data on suicide / psychiatric call outs in Lancashire from the North West Ambulance Service (2007-09).
- Hospital admissions for self-harm by Lancashire residents (2006/07 to 2008/09).

The full report is available to download at <http://www.tiig.info/details.aspx?pid=52&id=454>, but to summarise:

- Over the 3 year period 2007-09, 5,323 Lancashire residents attended EDs as a result of self-harm. However, the trend in number of attendances over this 3 year period was downwards, except in the districts of West Lancashire and Wyre
- Over the same 3 year period there were a total of 10,870 ambulance suicide/psychiatric call outs in Lancashire. Year on year there was an increase which was most pronounced in Blackburn and Burnley.
- There were 10,010 self-harm hospital admissions for residents of Lancashire over the three financial years 2006/07 to 2008/09. The overall Lancashire number stayed fairly constant year on year although there were differences by district (e.g. there was an increase in Ribble Valley and a decrease in Burnley)
- Age and gender: there were more ED attendances and hospital admissions by females compared to males and the difference was more marked in the younger age groups.
- Location and type of self-harm: half of ED attendances for self-harm by Lancashire residents reported that the incident had occurred at home. Hospital admissions data show that the most common methods of self-harm drug overdose related.
- Time of ED attendances and ambulance call outs: the majority of ED attendances and ambulance call outs occurred at the weekends late at night or during the early hours of the morning
- Patient disposal: 40% of ED self-harm attendees were admitted to hospital, which gives an indication of the severity of the injuries sustained. This figure varied from district to district with more than $\frac{3}{4}$ of West Lancashire residents admitted. Younger males were least likely to be admitted.

- Area of residence of self-harm hospital admissions/location of ambulance call outs:
There was wide variation between areas with areas within Burnley, Hyndburn, Blackburn and Blackpool experiencing higher rates.
- Deprivation: Rates of ambulance call outs and admissions to hospital increased strongly with increasing deprivation.

Further data on hospitalised incidence of self-harm

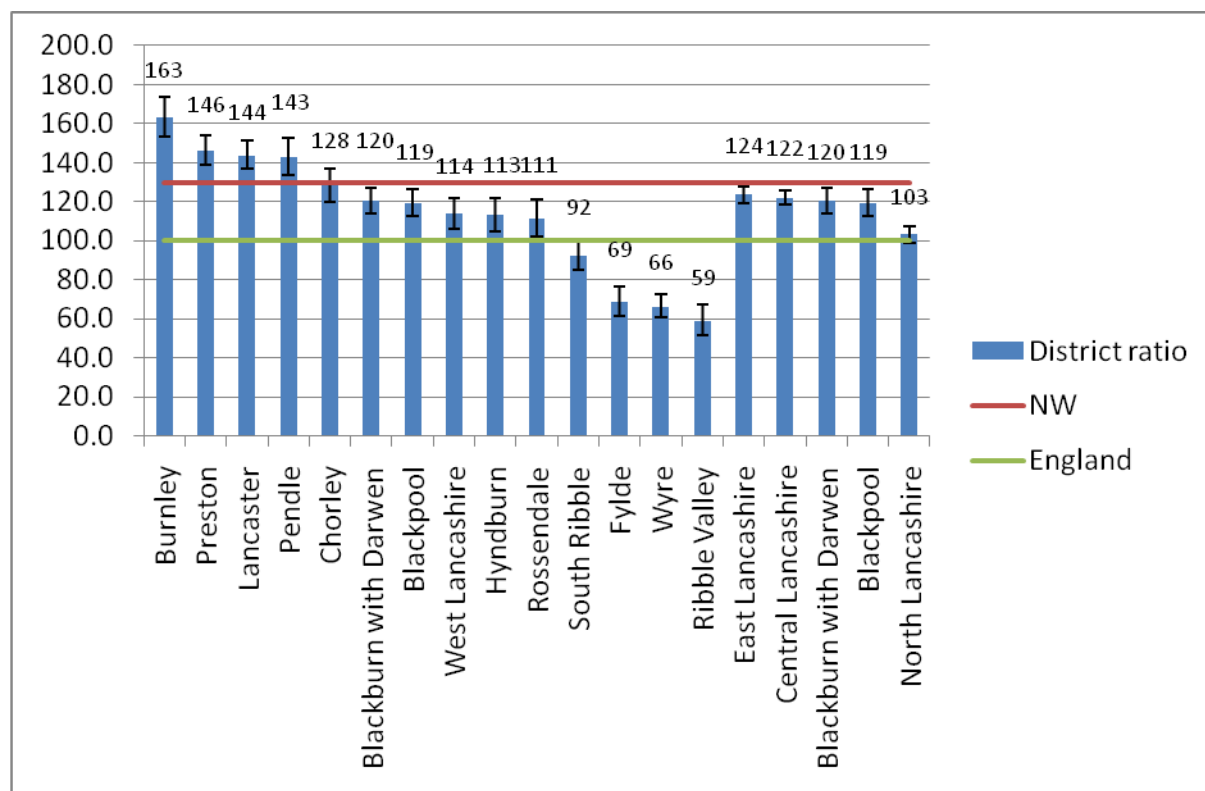
The North West Public Health Observatory has also collated information on people who were admitted to hospital as an emergency with a primary diagnosis of self-harm over the five year period 2003/04 to 2007/08 pooled. The indicator is produced at the level of Middle Layer Super Output Area (MSOA – average population 7,200), as well as for districts and PCTs. The indicator is a ratio indirectly standardised to the England average and so represents for an area the ratio of the number of admissions compared to the number that would be expected if that area experienced the same age specific admission rates as England. The England figure is set at 100, and so a figure of greater than 100 indicates more admissions than would be expected.

These data are broadly in line with the admissions data from the TIIG report described above, but to summarise:

Across the five year period there were 11,945 emergency admissions to hospital of residents of the Lancashire (14) sub-region where self-harm was recorded as the primary diagnosis (individuals who are admitted more than once during a year are counted only once). This represents an average of 2,389 per year. According to districts within Lancashire, the highest number of admissions was recorded in Lancaster district followed by Preston and Blackburn with Darwen, and the lowest number of admissions in Ribble Valley followed by Fylde and Wyre.

The chart below shows the hospitalised incidence ratio for Lancashire districts and PCTs compared to the North West and England. The 95% confidence interval bars indicate whether the ratio is significantly different from the comparators.

Figure 10: Hospitalised Incidence ratios for self-harm; Lancashire districts and PCTs compared to the North West and England; 2003/04 to 2007/08 pooled data



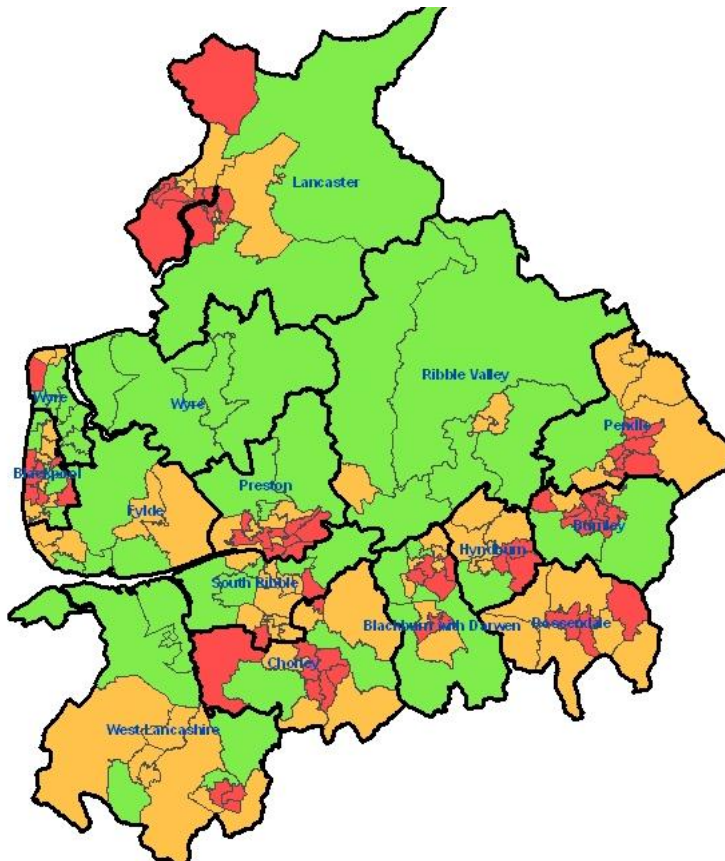
Source: North West Public Health Observatory – Health Profiler (www.nwpho.org.uk)

The Burnley district ratio of 163 indicates that in Burnley there were 63% more admissions than would be expected than if Burnley had experienced the same age specific admission rates as England. On the other hand, the Ribble Valley ratio of 59 indicates that residents of Ribble Valley experienced 41% fewer admission than would be expected. The confidence intervals around the district estimates indicate that 10 out of the 14 Lancashire districts are statistically significantly higher than the England figure. On a PCT basis, all of the Lancashire PCTs experience more admissions than would be expected compared to England (i.e. a ratio greater than 100), and all except North Lancashire are statistically significantly higher than the England figures.

There is wide variation in hospitalised incidence of self-harm between small areas within the Lancashire sub-region. The highest ratio of 326 occurs in a small area within Lancaster, and indicates just more than 3¼ times as many admissions as would be expected relative to England. At the other end of the spectrum, the lowest ratio (26) occurs in a small area of Blackburn district, indicating only around a quarter of the number of admissions that would be expected based on England age specific rates.

The map below shows the geographical distribution of hospitalised incidence ratios for self-harm throughout Lancashire. A key to ward names is given in appendix C.

Map 1: Distribution of hospitalised incidence of self-harm; MSOAs in Lancashire; 2003/03 to 2007/08 pooled data

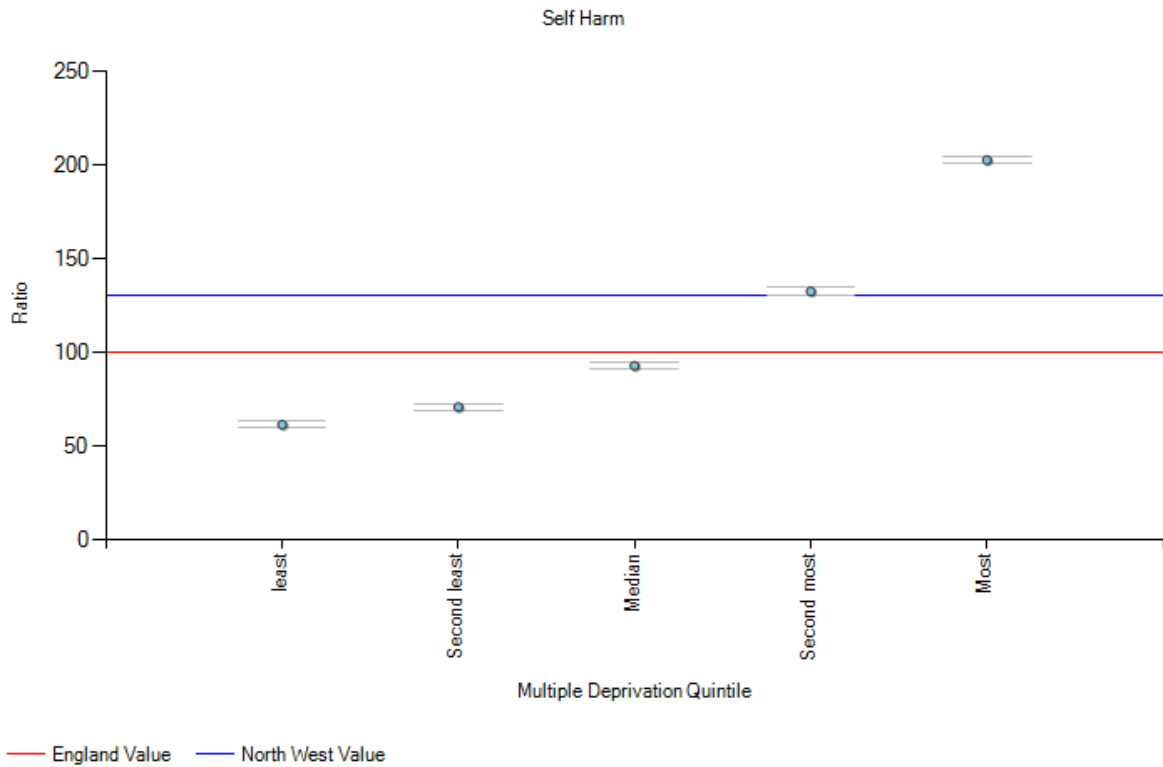


	Significantly higher than England average
	Not significantly difference from England average
	Significantly lower than England average

Source: North West Public Health Observatory Health Profiler (www.nwpho.org.uk)

The NWPHO also produce hospitalised incidence ratios of self-harm for deprivation quintiles within the North West. The chart below shows the strong social gradient for admission with self-harm, with ratios increasing steeply with increasing deprivation. In the most deprived fifth of areas within the North West, the ratio of around 200 indicates that there are twice as many admissions as would be expected relative to England.

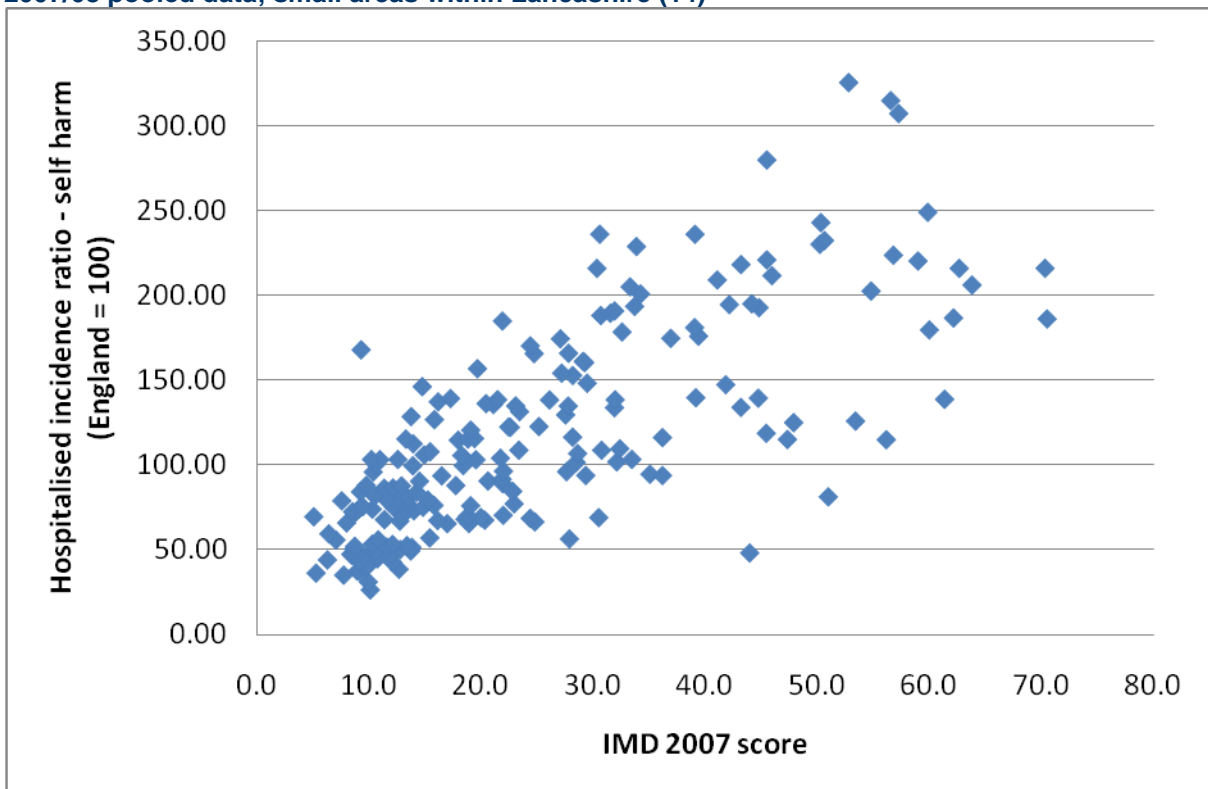
Figure 11: The social gradient in hospitalised incidence of self-harm in the North West; 2003/04 to 2007/08 pooled data



Source: North West Public Health Observatory health profiler

The scatter chart below shows the strong relationship between hospitalised incidence of self-harm and deprivation for small areas within Lancashire.

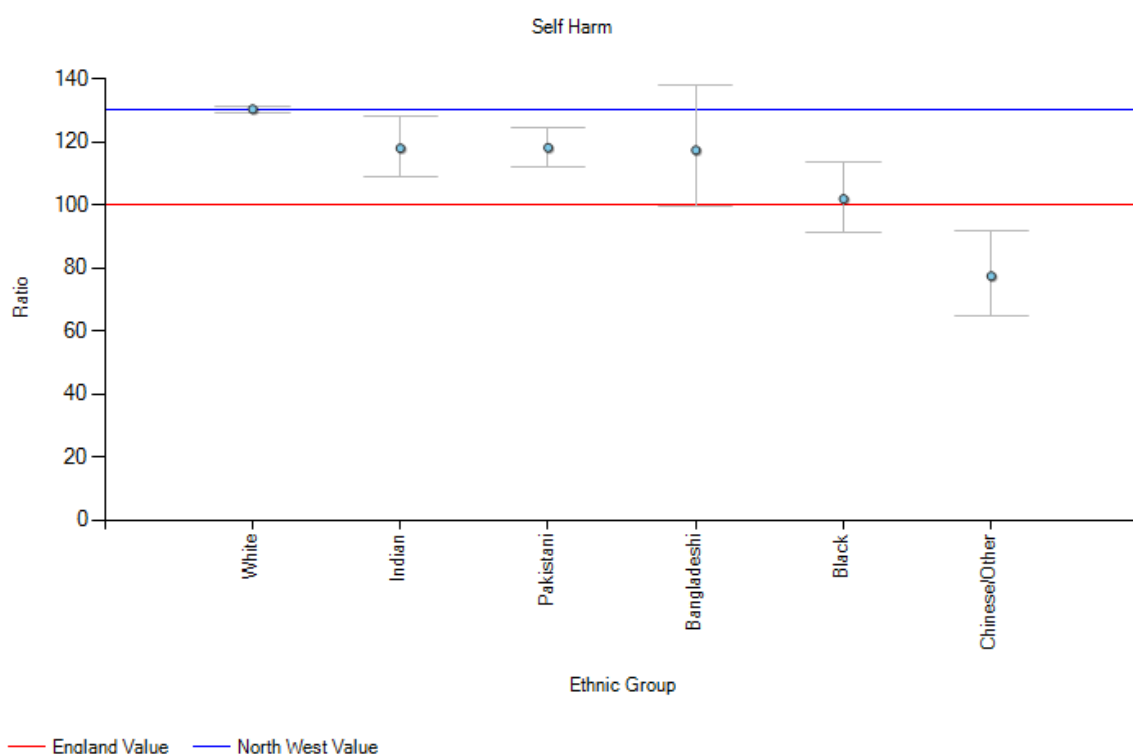
Figure 12: Relationship between hospitalised incidence of self-harm and deprivation; 2003/04 to 2007/08 pooled data; small areas within Lancashire (14)



Source: North West Public Health Observatory Health Profiler

The NWPHO also produce hospitalised incidence ratios of self-harm for different ethnic groups within the North West. The chart below shows that hospitalised incidence of self-harm in the Indian, Pakistani and Bangladeshi population is lower than that among the white population (although in the case of Bangladeshi populations this does not reach statistical significance). These South Asian groups have ratios lower than the North West average (although higher than the England average), whereas the ratio for white groups is similar to the North West average. Ratios among the black population are similar to the England average, and the Chinese lower; however, these groups are not strongly represented in Lancashire.

Figure 13: Hospitalised incidence of self-harm according to ethnic group; 2003/04 to 2007/08 pooled data for the North West



Source: North West Public Health Observatory health profiler

It should be noted that these data do not necessarily reflect true prevalence of self-harm, only cases that have resulted in an admission to hospital. People belonging to certain ethnic or social groups may be more or less likely to attend A&E or other services after self-harming.

Estimating “true” prevalence of self-harm in Lancashire

The Adult Psychiatric Morbidity Survey in 2007 (www.ic.nhs.uk/pubs/psychiatricmorbidity07), found that 6.7% of adults said that they had had suicidal thoughts at some point in their life, 5.6 per cent of people said they had attempted suicide at some point in their life and 4.9 per cent said they had engaged in self-harm. These estimates vary according to age and sex with prevalence among women high compared to men, and for both women and men higher prevalence in the younger age groups compared with older.

Time trend: prevalence of suicidal thoughts, suicide attempts, and self-harm among women have increased between 2000 and 2007. Among men prevalence of self-harm has increased over this time period, but prevalence of suicidal thought and suicide attempts in the past year have remained stable.

Ethnic group: age standardised prevalence of suicidal thoughts, suicide attempts and self-harm are substantially higher among the white compared to south Asian population. However, this could reflect cultural issues around disclosing this information rather than true prevalence.

Marital status: prevalence of suicidal thought, suicide attempts and self-harm tend to be lower among married or widowed people compared with single, divorced or separated people, and this difference is more marked among women compared to men.

Income: Prevalence of suicidal thought, suicide attempts and self-harm are all higher among those living in households with the lowest household income compared to the highest.

Region: The North West region tends to experience higher (but not always the highest) rates of suicidal thoughts, suicide attempts and self-harm relative to other regions.

As noted, individuals who self-harm or attempt suicide do not necessarily come to the attention of services: in this national survey less than two thirds of those who attempted suicide had sought help, and only about half of those who self-harmed. However,

- People diagnosed with mental illness (notably schizophrenia) are more likely to self-harm.
- Those who survive a medically serious suicide attempt have a poorer outcome in terms of life expectancy.

The NICE guideline on self-harm (<http://www.nice.org.uk/CG016>) also notes that:

- 80 per cent of A & E attendees with self-harm have taken an overdose of prescribed or over the counter medication
- Self-injury is more common than self-poisoning in the population as a whole
- Association with a physical illness as a precipitating factor
- Two thirds of those attending A& E for self-harm meet the criteria for depression at the time, but two thirds of these no longer meet the diagnostic criteria 1 -16 months later
- Half those attending A& E due to self-harm will have consumed alcohol

- There are higher rates in young Asian women
- The table below applies age and sex specific estimates of prevalence from the national Adult Psychiatric Morbidity Survey in 2007 to the age and sex structure of Lancashire districts in order to estimate the number of people locally who have had suicidal thoughts, attempted suicide and engaged in self-harm.

The tables below applies age and sex specific estimates of prevalence from the national Adult Psychiatric Morbidity Survey in 2007 to the age and sex structure of Lancashire districts in order to estimate the number of people locally who have had suicidal thoughts, attempted suicide and engaged in self-harm, where available either during the past year or during their lifetime. It should be noted that these are likely to provide a conservative estimate both in so far as people may not disclose this information and Lancashire, because of relatively high levels of deprivation and the observed positive relationship between deprivation and levels of self-harm, is likely to experience higher rates than the national average. Prevalence is also assumed to be uniform across Lancashire, which is not likely to be the case. However, these figures can provide a rough, likely conservative estimate of prevalence or need for services to prevent and treat self-harm.

Table 7: Estimated numbers experiencing suicidal thoughts (past year)

		Males	Females	Persons
00EX	BwD	1815	2869	4683
00EY	Blackpool	1833	2983	4816
30UD	Burnley CD	1102	1848	2950
30UE	Chorley CD	1422	2201	3623
30UF	Fylde CD	976	1578	2554
30UG	Hyndburn CD	1052	1700	2752
30UH	Lancaster CD	1896	3118	5014
30UJ	Pendle CD	1154	1882	3036
30UK	Preston CD	1948	3008	4956
30UL	Ribble Valley CD	728	1234	1962
30UM	Rosendale CD	859	1436	2295
30UN	South Ribble CD	1409	2320	3729
30UP	West Lancashire CD	1398	2428	3826
30UQ	Wyre CD	1387	2346	3733
	NHS Central Lancs.	6178	9957	16135
	NHS East Lancs	4895	8100	12995
	NHS North Lancs.	4259	7042	11301
	Lancashire (12)	15333	25098	40431
	Lancashire (14)	18980	30950	49930
Source: Adult Psychiatric Morbidity Survey, 2007 and ONS population estimates				

Table 8: Estimated numbers experiencing suicidal thoughts (lifetime)

		Males	Females	Persons
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00EX	BwD	7397	10498	17895
00EY	Blackpool	7506	10886	18392
30UD	Burnley CD	4491	6775	11266
30UE	Chorley CD	5954	8141	14095
30UF	Fylde CD	4046	5760	9807
30UG	Hyndburn CD	4311	6235	10546
30UH	Lancaster CD	7578	11338	18916
30UJ	Pendle CD	4756	6896	11652
30UK	Preston CD	7784	10895	18679
30UL	Ribble Valley CD	3026	4522	7548
30UM	Rossendale CD	3569	5277	8847
30UN	South Ribble CD	5845	8555	14400
30UP	West Lancashire CD	5736	8915	14651
30UQ	Wyre CD	5662	8604	14266
	NHS Central Lancs.	25318	36506	61824
	NHS East Lancs	20153	29705	49859
	NHS North Lancs.	17287	25703	42990
	Lancashire (12)	62758	91914	154672
	Lancashire (14)	77662	113298	190959
Source: Adult Psychiatric Morbidity Survey, 2007 and ONS population estimates				

Table 9: Estimated numbers attempting suicide (past year)

		Males	Females	Persons
00EX	BwD	249	500	749
00EY	Blackpool	243	491	733
30UD	Burnley CD	147	314	461
30UE	Chorley CD	189	363	552
30UF	Fylde CD	123	239	362
30UG	Hyndburn CD	143	287	430
30UH	Lancaster CD	251	548	799
30UJ	Pendle CD	153	317	470
30UK	Preston CD	262	552	814
30UL	Ribble Valley CD	98	197	295
30UM	Rossendale CD	117	240	358
30UN	South Ribble CD	186	383	569
30UP	West Lancashire CD	186	408	594
30UQ	Wyre CD	176	369	544
	NHS Central Lancs.	823	1707	2529
	NHS East Lancs	658	1355	2013
	NHS North Lancs.	549	1156	1706
	Lancashire (12)	2030	4218	6248
	Lancashire (14)	2521	5209	7730
Source: Adult Psychiatric Morbidity Survey, 2007 and ONS population estimates				

Table 10: Estimated numbers attempting suicide (lifetime)

		Males	Females	Persons
00EX	BwD	2288	3745	6033
00EY	Blackpool	2313	3865	6178
30UD	Burnley CD	1389	2417	3806
30UE	Chorley CD	1835	2898	4733
30UF	Fylde CD	1247	2036	3283
30UG	Hyndburn CD	1330	2221	3551
30UH	Lancaster CD	2350	4057	6408
30UJ	Pendle CD	1471	2459	3930
30UK	Preston CD	2418	3903	6321
30UL	Ribble Valley CD	928	1602	2530
30UM	Rosendale CD	1100	1881	2981
30UN	South Ribble CD	1801	3043	4843
30UP	West Lancashire CD	1765	3174	4940
30UQ	Wyre CD	1743	3048	4791
	NHS Central Lancs.	7819	13017	20837
	NHS East Lancs	6219	10579	16797
	NHS North Lancs.	5340	9142	14482
	Lancashire (12)	19378	32738	52116
	Lancashire (14)	23979	40348	64327
Source: Adult Psychiatric Morbidity Survey, 2007 and ONS population estimates				

Table 11: Estimated numbers engaging in self-harm (lifetime)

		Males	Females	Persons
00EX	BwD	2388	3096	5484
00EY	Blackpool	2256	2960	5216
30UD	Burnley CD	1391	1919	3311
30UE	Chorley CD	1796	2159	3955
30UF	Fylde CD	1156	1393	2549
30UG	Hyndburn CD	1337	1750	3087
30UH	Lancaster CD	2434	3433	5867
30UJ	Pendle CD	1460	1932	3392
30UK	Preston CD	2607	3519	6126
30UL	Ribble Valley CD	866	1140	2006
30UM	Rosendale CD	1078	1440	2518
30UN	South Ribble CD	1761	2289	4050
30UP	West Lancashire CD	1710	2449	4158
30UQ	Wyre CD	1641	2177	3819
	NHS Central Lancs.	7874	10416	18290
	NHS East Lancs	6132	8182	14314
	NHS North Lancs.	5231	7004	12234
	Lancashire (12)	19237	25601	44838
	Lancashire (14)	23880	31658	55538
Source: Adult Psychiatric Morbidity Survey, 2007 and ONS population estimates				

Serious mental illness

There is no universal definition of severe mental illness. However, the term usually refers to illnesses where psychosis occurs. Psychosis describes the loss of reality a person experiences so that they stop seeing and responding appropriately to the world they are used to. Schizophrenia and bipolar disorder are the two forms of severe mental illness considered in this section. However, this does not mean that other conditions are not regarded as serious - there are others such as schizo-affective disorder, severe clinical depression and personality disorders.

The exact causes of severe mental illness are not known. There may be a genetic vulnerability in some people that can be triggered by environmental and emotional factors such as bereavement, moving home, loss of a job or a breakdown in relationships.

Many people who experience severe mental illness can and do recover a meaningful and fulfilling quality of life. Treatments and support that address all the person's needs are need for the best chance of recovery. This includes medicines, talking therapies, appropriate housing, employment, social networks and financial independence.

Link between severe mental illness and physical health

It has been estimated that people with severe mental illness die 10 years younger than other people because of poor physical health.

People with schizophrenia and bipolar disease have higher risks of certain physical conditions than average, including cardiovascular diseases, respiratory diseases, diabetes, and infectious diseases such as Hepatitis C and HIV. This is likely to be due to a combination of factors such as an increased likelihood of engaging in risky lifestyle behaviours (e.g. smoking, drug use, unsafe drinking and unsafe sex) but also difficulty in accessing services and lack of confidence and empowerment. Social factors such as low income, poor housing and unemployment can disproportionately affect people with severe mental illness and these factors are known to have a deleterious effect on physical health. People with mental health problems have the highest levels of unemployment among any disabled group.

GP practice registers for severe mental illnesses

As part of the Quality and Outcomes Framework, GPs are required to hold a register of patients with certain key morbidities. Two of these registers relate to mental health: depression and severe mental illnesses (schizophrenia, bipolar disorder and other psychoses).

With respect to severe mental illnesses, across Lancashire (14) there were 13,332 patients included on registers as at end July 2010, representing an overall prevalence of 0.9%. The table

below gives the number and prevalence for the 5 PCTs in the Lancashire region compared to the North West and nationally.

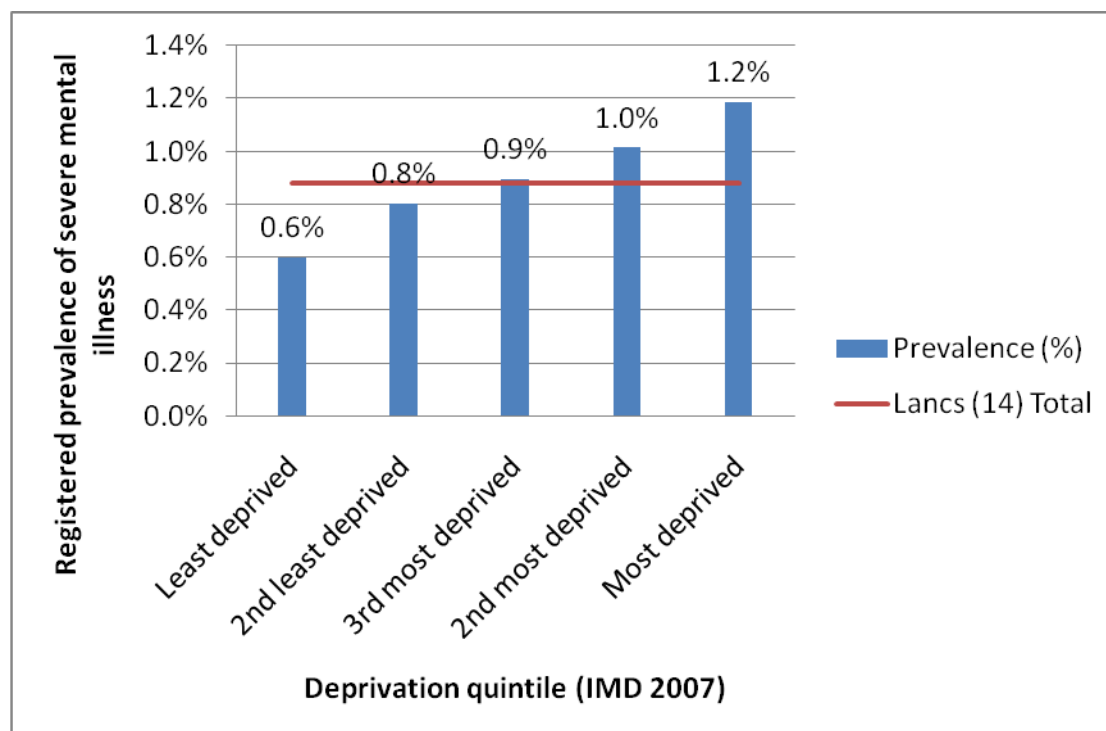
Table 12: Prevalence of patients on GP mental health registers (schizophrenia, bipolar disorder and other psychoses); PCTs in Lancashire compared to the North West and England; 2009/10

	Total registered population	No. on register	Prevalence
BwD PCT	166,999	1,774	1.1%
BLACKPOOL PCT	152,308	2,005	1.3%
CENTRAL LANCS PCT	467,250	3,425	0.7%
EAST LANCS PCT	388,267	3,408	0.9%
NORTH LANCS PCT	339,659	2,720	0.8%
LANCS (12) TOTAL	1,195,176	9,553	0.8%
LANCS (14) TOTAL	1,514,483	13,332	0.9%
NORTH WEST SHA	7,354,139	62,629	0.9%
ENGLAND	54,836,561	424,223	0.8%
Source: The Information Centre			

Registered prevalence is highest in Blackpool PCT and lowest in Central Lancs. There is wide variation between GP practices in Lancashire in the registered prevalence of severe mental illnesses, ranging from 0.1% in one Central Lancashire practice to 5.2% in one Blackpool practice.

There is a relationship between registered prevalence of severe mental health and deprivation. In the chart below, GP practices have been divided into fifths on the basis of their IMD 2007 score, and a registered prevalence of severe mental illness calculated for each quintile. There is a social gradient, with prevalence increasing with increasing deprivation; the registered prevalence in the most deprived fifth of practices is twice that of the least (1.2% and 0.6% respectively).

Table 13: GP registered prevalence of severe mental illness (schizophrenia, bipolar disorder and other psychoses) according to deprivation quintile of GP practices in Lancashire (14)



Source: The Information Centre (registered prevalence) and Office of the Deputy Prime Minister (IMD 2007)

Estimates of population prevalence of severe mental illness

GP registered prevalence of severe mental illness does not necessarily reflect “true” population prevalence as people can remain undiagnosed. Based on various surveys, including the Adult Psychiatric Morbidity Survey, The Kings Fund estimate the prevalence of schizophrenia and related disorders to be 5 per 1,000 among the adult population. Applying this to the population of Lancashire there would be an estimated 5,800 people with these conditions. It is estimated, however, that by 2026 this figure will have increased by approximately 16%. Tables showing the numbers of people estimated to have schizophrenia in 2011 and 2012 are shown in appendix A.

The number of people with bipolar disorder and related conditions is higher, but the total numbers are not expected to increase much over the next 20 years due to lower prevalence rates in older adults. Prevalence of bipolar disorder and related conditions is estimated from various surveys to be between 0.4% and 3.9% (i.e. between 4,700 and 45,560 people when applying this range of estimates to the Lancashire population).

The Adult Psychiatric Morbidity Survey estimates the prevalence of probable psychoses to be 0.5%. The age and sex specific estimates are applied to the Lancashire population in the table below, although it is noted that this estimate is based on a small sample.

Table 14: Estimated numbers with probable psychosis (16-74)

District	Numbers	Lower limit	Upper limit
BwD	189	281	470
Blackpool	186	294	481

Burnley CD	112	182	294
Chorley CD	149	228	378
Fylde CD	98	160	258
Hyndburn CD	109	169	278
Lancaster CD	188	288	475
Pendle CD	118	186	304
Preston CD	196	272	468
Ribble Valley CD	75	129	205
Rossendale CD	90	148	238
South Ribble CD	146	237	383
West Lancashire CD	142	243	385
Wyre CD	137	233	370
NHS Central Lancs.	633	981	1614
NHS East Lancs	503	815	1318
NHS North Lancs.	423	681	1103
Lancashire (12)	1560	2476	4036
Lancashire (14)	1934	3051	4986

Source: Adult Psychiatric Morbidity Survey; 2007

There is a social gradient in psychotic disorders with age standardised rates increasing from 0.1% of adults in the highest income quintile to 0.9% of adults in the lowest income quintile. This trend was more prominent among men than women.

Common mental health disorders

Links with physical health

The CSIP report 'Long term Conditions and Depression' (2006) highlights depression as a co-morbid condition of stroke, coronary heart disease and diabetes. It states that:

- The prevalence of post stroke depression may be as high as 61%
- People with heart disease are not likely to suffer from depression and people with depression are more likely to develop heart disease
- An estimated 24 per cent of people with diabetes suffer from depression.

Depression is associated with more symptoms and worse outcomes. It also is associated with adverse health risk behaviours such as smoking, diet, lack of exercise and poor compliance with self management regime. The report concludes that these factors lead to higher costs for the health care system.

Recorded Prevalence

This section will compare prevalence figures from QOF with modelled expected prevalence. This will allow us to identify unmet need in the population and provide an estimate of need on which to base commissioning decisions.

The first source to consider is the QOF disease registers in Lancashire relevant to mental health. For this JSNA; mental health, depression, and dementia registers are included.

Estimated prevalence

The National psychiatric morbidity survey provides estimates of the prevalence of common mental health disorders such as neurotic disorders, phobias, depressive episodes, generalised anxiety disorder and obsessive compulsive disorder. These are the sorts of conditions that may be appropriate for treatment using psychological therapies. Prevalence rates and expected numbers within the population in 2006 and 2016 are provided in appendix A.

Eating disorders in adults

According to the Mental Health Foundation, current estimates suggest that up to one per cent of women in the UK between the ages of 15 and 30 suffer from anorexia nervosa, and one to two per cent suffer from bulimia nervosa. As many cases of eating disorder are unreported or undiagnosed, the actual figures are likely to be higher⁷. The national Psychiatric Morbidity Survey in 2007 used an instrument to identify eating disorders that did not distinguish between anorexia, bulimia and other eating disorders. It showed that:

- 1.6 per cent of adults overall both met the threshold for clinical assessment for an eating disorder and reported a significant negative impact on their life.
- A quarter of the cases in the 16 to 24 year old age group which met the threshold for clinical assessment only were young men.

This instrument does not amount to a diagnosis but does indicate the potential need in the total population, including a greater potential need amongst young men than previously assumed. More conservative estimates were used by the King's Fund of 0.3 per cent (3 per 1,000) and one per cent (10 per 1,000) respectively. When estimating projecting prevalence, the broader estimates from the national Psychiatric Morbidity Survey are shown in the following table, from ONS population estimates 2007. The *2007 ONS National Psychiatric Morbidity Survey* found that 6.4%

⁷ "All about Anorexia Nervosa". Mental Health Foundation 1997; "All about Bulimia Nervosa" Mental Health Foundation 1997

of screened adults over 16 (using the SCOFF tool) have suffered an eating disorder in the last 12 months. This would mean that in Lancashire 57,824 people would be affected.

Men and women are affected differently and this report puts the prevalence for men at 3.5%, inferring that the prevalence of eating disorders in men is much higher than generally thought. Instead of the commonly accepted 1 in 10 of cases being men, the prevalence appears to be closer to 1 in 3. For women the estimated prevalence is higher at 9.2%. This rises to 20.3% in women aged 16-24.

Among those who screened positive for an eating disorder, the study found that a quarter (24.3%) also reported that their feelings about food significantly interfered with their ability to work, meet personal responsibilities and/or enjoy a social life. The tables below show district estimates of the numbers of people with an eating disorder.

Table 15: Estimated number of people with an eating disorder from national prevalence rates

Area	All persons
Blackburn with Darwen	6,413
Blackpool	7,058
Burnley	4,198
Chorley	5,233
Fylde	3,957
Hyndburn	3,884
Lancaster	7,239
Pendle	4,329
Preston	6,456
Ribble Valley	2,894
Rosendale	3,244
South Ribble	5,343
West Lancashire	5,395
Wyre	5,651
Central Lancs	22,428
East Lancs	18,549
North Lancs	16,848
Lancashire 12	57,824
Lancashire 14	71,295

Table 16: Estimated number of men and women with an eating disorder from national prevalence rates

Area	Males	Females
Blackburn with Darwen	1,720	4,697
Blackpool	1,882	5,198
Burnley	1,101	3,140
Chorley	1,432	3,759
Fylde	1,053	2,920
Hyndburn	1,033	2,868
Lancaster	1,918	5,364

Pendle	1,151	3,198
Preston	1,751	4,678
Ribble Valley	764	2,152
Rosendale	858	2,409
South Ribble	1,416	3,959
West Lancashire	1,405	4,062
Wyre	1,468	4,265
Central Lancs	6,004	16,458
East Lancs	4,906	13,768
North Lancs	4,440	12,549
Lancashire 12	15,350	42,775
Lancashire 14	18,952	52,670

Source: 2007 ONS National Psychiatric Morbidity Survey and 2008 Population Estimates

However, it is likely that many individuals with an eating disorder as defined in the PMS would not require treatment by secondary mental health services. The estimates for anorexia and bulimia nervosa used by the King's Fund are considerably lower, at 0.3 per cent for anorexia and 1 per cent for bulimia (females aged 10- 34).

Tables for anorexia and bulimia nervosa by district, including projection of future need are shown in appendix A.

Maternal mental health

Maternal mental health is an important challenge for commissioners, not least because psychiatric disorders are the leading cause of maternal deaths in the UK.

The most common form of postnatal disturbance is often referred to as the "baby blues" which is said to be experienced by at least half of western mothers. This usually lasts between 12-24 hours generally occurring between the third and fourth day after the birth but if untreated can last for months⁸. Depression and anxiety can be measured during pregnancy as well as postnatally. NICE guidance recommends psychological treatment or social support for pregnant women whose lives are significantly affected by sub-syndromal depression and anxiety, and the costing guideline estimates prevalence at 2.6 per cent. An incidence figure of 10 per cent of all new mothers is most often quoted for postnatal depression, although studies vary between 3 per cent and 22 per cent. However, it is argued that about half of these cases will never come to medical attention.

Puerperal psychosis (i.e. in the early postnatal period, up to three months after delivery) is a severe and relatively rare form of postnatal mental illness affecting between 0.1 and 0.2 percent of all new mothers. If 10 percent of new mothers experience post natal deprivation and 0.1 per cent of

new mothers experience psychosis, the current numbers per district would be as shown in the following table.

Table 17: Maternal mental health

Maternal mental health			
	Births 2008	Post natal depression	Puerperal psychosis
Lancashire	18,188	1,819	18
Blackburn with Darwen	2,392	239	2
Blackpool	1,761	176	2
Burnley	1,323	132	1
Chorley	1,248	125	1
Fylde	643	64	1
Hyndburn	1,165	117	1
Lancaster	1,493	149	1
Pendle	1,335	134	1
Preston	1,947	195	2
Ribble Valley	505	51	1
Rossendale	883	88	1
South Ribble	1,259	126	1
West Lancashire	1,251	125	1
Wyre	983	98	1
Source: ONS VS2			

Personality disorder and other mental disorders

According to ‘Personality disorder: No Longer a Diagnosis of Exclusion (DH/NIMHE 2003), ‘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, but there are others who because of the severity of their condition suffer a great deal of distress and can place a heavy burden on family, friends and those who provide care for them.’ Personality disorders are clustered into a number of different types, with varying estimates of the prevalence, many of which are high. However, the most recent PMS has focused on anti-social and borderline personality disorder, both of which are covered by NICE guidance issued in 2009.

The PMS 2007 survey contained prevalence information on disorders not included in the 2000 survey.

- 8.2 per cent of the adult population screened positive for **attention deficit hyperactivity disorder** (ADHD), with 2.3 per cent having five and 0.6 per cent having all six of the characteristics
- 0.7 per cent of adults met the threshold for **problem gambling**

⁸ “Postnatal depression” Royal College of Psych – March 2007

- ASPD was present in 0.3% of adults aged 18 or over (0.6% of men and 0.1% of women)
- 1.7% of men aged 18-34 had **anti-social personality disorder (ASPD)**, while no cases were identified in men aged 55 or over
- 0.4% of women aged 16-34 had **ASPD**, while no cases were identified in those aged over 35.
- The overall prevalence of **Borderline Personality Disorders (BPD)** was similar to that of ASPD, at 0.4% of adults aged 16 or over. While the association with sex was not significant, the observed pattern fits with the expected profile (0.3% of men, 0.6% of women).

The table below shows the numbers in Lancashire and the constituent districts with the disorders discussed above based on current population.

Table 18: Estimated numbers (aged 16 and over) with gambling problems, personality disorders and adult ADHD from national prevalence estimates

	Problem gambling	Borderline personality	Anti-social personality	ADHD screen positive	ADHD 5 of 6 characteristics
Blackburn with Darwen	701	401	301	8,216	2,305
Blackpool	772	441	331	9,043	2,536
Burnley	459	262	197	5,379	1,509
Chorley	572	327	245	6,705	1,881
Fylde	433	247	186	5,071	1,422
Hyndburn	425	243	182	4,976	1,396
Lancaster	792	452	339	9,276	2,602
Pendle	474	271	203	5,547	1,556
Preston	706	404	303	8,272	2,320
Ribble Valley	316	181	136	3,707	1,040
Rosendale	355	203	152	4,157	1,166
South Ribble	584	334	250	6,845	1,920
West Lancashire	590	337	253	6,913	1,939
Wyre	618	353	265	7,240	2,031
Central Lancs	2,453	1,402	1,051	28,736	8,060
East Lancs	2,029	1,159	869	23,766	6,666
North Lancs	1,843	1,053	790	21,586	6,055
Lancashire 12	6,325	3,614	2,711	74,087	20,781
Lancashire 14	7,798	4,456	3,342	91,346	25,621
Source: 2007 ONS National Psychiatric Morbidity Survey and 2008 Population Estimates					

Mental health needs of specific groups

Older People

Good mental health and emotional wellbeing is as important in older age as it is at any other time of life. For health and social care professionals, who often meet an older person for the first time during a crisis – when they are ill, or when other difficulties have become overwhelming – it can be hard to keep in mind the positive picture. Low expectations about the quality of life for older people are widespread among service providers, assessors and older people themselves ('What can you expect at your/my age?').

- Depression is the most common mental health problem in later life.
- Dementia is the next most common.
- Mental health problems are under-identified by professionals and older people themselves, and older people are often reluctant to seek help. So many older people experience delay before they are offered support.

The concentration of national effort has been targeted at adults, not older people. To an extent this was remedied by the publication of the National Service Framework for Older People where there was a separate chapter on the needs of older people with mental health problems. However, unlike the NSF for adults, there have been few national targets set for older people's mental health and social care services. Whilst many people see targets as taking the focus away from 'quality' they do have a positive aspect in that they maintain the focus on mental health generally to the benefit of all service users and carers. Although there are no national performance requirements the Revision to the Operating Framework for the NHS in England 2010/11 stated that:

NHS organisations should be working with partners on implementing the National Dementia Strategy. People with dementia and their families need information that helps them understand their local services, and the level of quality and outcomes that they can expect. PCTs and their partners should publish how they are implementing the National Dementia Strategy to increase local accountability for prioritisation.

Whilst older people's mental health services have indeed developed locally to provide some good services, older people have, nevertheless, been disadvantaged in that they have not previously

been able to access services such as Assertive Outreach, Crisis and Home Treatment, or psychology where there is good evidence of people's ability to benefit. Happily, this position is now changing but there is still some way to go in Bolton to provide as comprehensive a service for older people as adults.

The National Service Framework for Older People describes prevalence of mental illness for older people:

“At any one time, around 10-15% of the population aged 65 and over will have depression. More severe states of depression are less common, affecting 3-5% of older people”. Applying this to the population of Lancashire in 2009 suggests that between 20,500 and 30,800 older people will have depression at any one time, with between 6,100 and 10,300 affected by severe depression. As the older population increases over the next five years, these numbers can be expected to increase by approximately 14% over this period.

As mentioned in the demographic summary at the start of this review, the population of Lancashire is ageing in line with the national population. This means that in twenty years time we can expect there to be approximately 107,000 more people in Lancashire aged 65 and over.

Alzheimer's disease and other dementias

Alzheimer's disease and other dementias are characterized by a progressive decline in memory and other cognitive functions and is a major cause of late life disability. Aggressive or challenging behaviour can also be a feature. Informal carers, who provide the core of support, experience high rates of stress and depression.

More than one in twenty of the population aged 65 and over in England and Wales will suffer from a significant degree of dementia. Numbers of people in need of care over the coming decades are due to increase at an increased pace as the overall elderly population increases due to the disproportionate rise in the number of people aged 85 and over. The prevalence of dementia increases with age and is estimated at approximately 20% at 80 years of age. Furthermore, in a third of cases dementia is associated with other psychiatric symptoms such as depression, anxiety, and alcohol related problems.

In total the over-65 population of Lancashire is projected to increase by 58% over the next twenty years. This figure is in line with the national average (60%) but slightly above the regional (51%) projected increase. However, the over-85 population is estimated to grow considerably faster, with a 145% increase over the next twenty years. The Lancashire figure is above both the national (136%) and the regional (131%) projected increases.

Table 19: The over 65 population increase, 2010 to 2033

	2010	2017	2025	2033	Percentage increase 2010-2033
England	8,585,000	10,064,300	11,613,900	13,696,900	59.5%
North West	1,156,900	1,335,700	1,515,000	1,748,500	51.1%
Lancashire	210,500	249,300	287,000	333,200	58.3%
Burnley	14,200	16,300	18,500	21,000	47.9%
Chorley	17,500	22,200	26,000	30,300	73.1%
Fylde	18,500	21,800	25,300	29,700	60.5%
Hyndburn	12,900	14,700	16,500	19,100	48.1%
Lancaster	25,300	29,600	34,000	39,800	57.3%
Pendle	14,500	17,300	20,100	23,000	58.6%
Preston	19,100	21,400	23,900	27,400	43.5%
Ribble Valley	11,500	14,200	16,700	20,000	73.9%
Rossendale	10,200	12,200	14,400	17,100	67.6%
South Ribble	19,300	23,400	27,000	31,500	63.2%
West Lancashire	20,700	25,000	28,800	32,900	58.9%
Wyre	26,700	31,200	35,600	41,400	55.1%

Source: ONS 2008-based Subnational Population Projections

Table 20: The over 85 population increase, 2010 to 2033

	2010	2017	2025	2033	Percentage increase 2010-2033
England	1,193,000	1,469,900	1,975,900	2,820,200	136.4%
North West	148,400	180,100	244,400	342,500	130.8%
Lancashire	27,100	33,100	45,700	66,300	144.6%
Burnley	2,100	2,400	3,100	4,600	119.0%
Chorley	2,000	2,500	3,800	6,100	205.0%
Fylde	2,700	3,400	4,500	6,400	137.0%
Hyndburn	1,700	2,000	2,600	3,700	117.6%
Lancaster	3,600	4,300	5,700	8,100	125.0%
Pendle	2,000	2,400	3,100	4,400	120.0%
Preston	2,300	2,800	3,700	4,900	113.0%
Ribble Valley	1,400	1,800	2,600	3,900	178.6%
Rossendale	1,300	1,500	2,000	3,100	138.5%
South Ribble	2,300	2,900	4,100	6,100	165.2%
West Lancashire	2,300	3,000	4,700	6,800	195.7%
Wyre	3,400	4,200	5,800	8,100	138.2%

Source: ONS 2008-based Subnational Population Projections

The prevalence of dementia increases with age and can affect people of any age, but is most common in older people. One in five people over 80 and one in twenty people over 65 have a form of dementia. Both young onset and late onset dementia increases with age, doubling with every five-year increase across the age range.

Table 21: Consensus estimates of the population prevalence of late onset dementia

Age (years)	Male (%)	Female (%)	Total (%)	Estimated no. of people with dementia in Lancashire
65-69	1.5	1	1.3	735
70-74	3.1	2.4	2.9	1,415
75-79	5.1	6.5	5.9	2,354
80-84	10.2	13.3	12.2	3,550
85-89	16.7	22.2	20.3	3,492
90-94	27.5	29.6	28.6	2,475
95+	30	34.4	32.5	

Source: Dementia UK, Summary of Key Findings, 2007

- Alzheimer’s disease is considered to be the dominant subtype, particularly among older people, and in women.
- The report estimates that there are 11,392 people from black and minority ethnic groups with dementia. It is noteworthy that 6.1% of all people with dementia among black and minority ethnic (BME) groups are early-onset, compared with only 2.2% for the UK population as a whole, reflecting the younger age profile of BME communities.
- The prevalence of dementia among people in institutions varied little by age or gender, increasing from 55.6% among those aged 65–69 to 64.8% in those aged 95 and over.
- The consensus group also generated estimates of the prevalence of dementia among all those aged 65 years and over living in EMI (elderly mentally infirm) homes (79.9%), nursing homes (66.9%) and residential care homes (52.2%).
- The proportion of deaths attributable to dementia increases steadily from 2% at age 65 to a peak of 18% at age 85–89 in men, and from 1% at age 65 to a peak of 23% at age 85–89 in women. Overall, 10% of deaths in men over 65 years, and 15% of deaths in women over 65 years may be attributable to dementia.

The Mental Health Observatory estimates the number of future dementia sufferers to 2025 and suggests that the number of people over 65 in Lancashire with dementia will increase from 14,379 in 2010 to 21,385 in 2025; an increase of 49%. This is higher than the national increase of 43%. Projected increases at district level vary from 34% in Preston to 64% in Ribble Valley in line with projected population increases. Prevalence rates increase in line with national averages from 6.8% in 2010 to 7.3% in 2025 (the national increase is from 7.1% to 7.6%).

Table 22: Projected increase in number of dementia sufferers, 2010 to 2025

	2010	2015	2020	2025	% difference 2010-2025
England	607,249	671,656	755,951	866,297	42.7%
Lancashire	14,379	16,095	18,279	21,385	48.7%
Burnley	985	1,061	1,173	1,380	40.1%
Chorley	1,124	1,270	1,560	1,899	68.9%
Fylde	1,402	1,567	1,794	2,104	50.1%
Hyndburn	872	974	1,058	1,254	43.7%
Lancaster	1,823	2,009	2,269	2,594	42.3%
Pendle	1,016	1,115	1,211	1,399	37.6%
Preston	1,281	1,374	1,525	1,711	33.6%
Ribble Valley	741	854	1,002	1,213	63.8%
Rossendale	704	759	821	962	36.6%
South Ribble	1,262	1,446	1,675	1,939	53.6%
West Lancashire	1,298	1,493	1,732	2,050	57.9%
Wyre	1,868	2,174	2,458	2,879	54.1%

Source: Mental Health Observatory: Estimating the future numbers of cases of dementia, Gyles Glover, NEPHO, 2008

A register is a pre-requisite for the organisation of good primary care for a particular patient group. There is little evidence to support screening for dementia and it is expected that the diagnosis will largely be recorded from correspondence when patients are referred to secondary care with suspected dementia or as an additional diagnosis when a patient is seen in secondary care. However, it is also important to include patients where it is inappropriate or not possible to refer to a secondary care provider for a diagnosis and where the GP has made a diagnosis based on their clinical judgement and knowledge of the patient. There are currently 6,082 people on the dementia register in Lancashire for 2009/10. Diagnosed prevalence rates have remained constant at 0.5% and are comparable to national rates. At a district level prevalence varies from 0.4% to 0.7%.

Figure 14: Lancashire number of patients on the QOF dementia register, 2007/08 to 2009/10

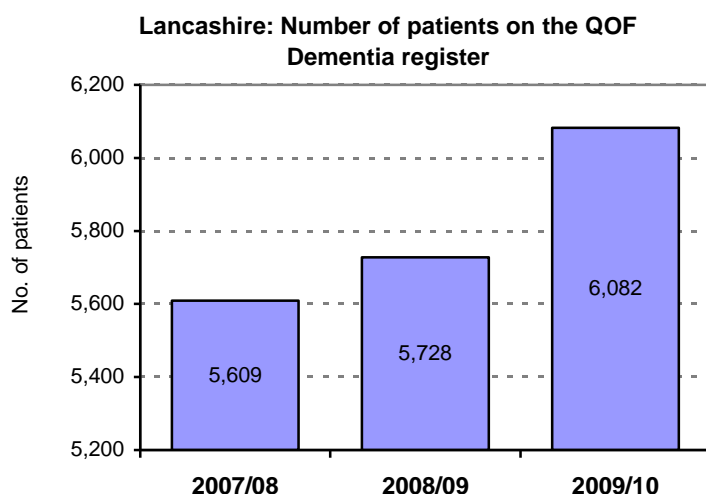


Table 23: Number and percent of patients on GP Dementia Registers, 2007/08 to 2009/10

	2007/08		2008/09		2009/10	
	No.	%	No.	%	No.	%
England	220,246	0.4%	232,430	0.4%	249,463	0.5%
Lancashire	5,609	0.5%	5,728	0.5%	6,082	0.5%
Burnley	360	0.4%	366	0.4%	414	0.4%
Chorley	400	0.4%	415	0.4%	450	0.5%
Fylde	515	0.7%	499	0.7%	483	0.7%
Hyndburn	391	0.5%	364	0.5%	383	0.5%
Lancaster	763	0.5%	851	0.6%	923	0.6%
Pendle	420	0.5%	412	0.5%	450	0.5%
Preston	538	0.4%	551	0.4%	565	0.4%
Ribble Valley	246	0.5%	246	0.5%	261	0.5%
Rosendale	357	0.5%	327	0.5%	340	0.5%
South Ribble	464	0.4%	474	0.4%	505	0.4%
West Lancashire	479	0.4%	517	0.5%	558	0.5%
Wyre	676	0.5%	706	0.6%	750	0.6%

Source: Quality & Outcomes Framework, Disease Prevalence
District figures calculated from GP Practices within the district

Alcohol dementia, sometimes linked with Korsakoff Syndrome, is a specific disorder of the brain associated with long-term heavy drinking and thiamine deficiency. It is thought that almost 10% of diagnoses of dementia are a result of extensive alcohol misuse. Furthermore, it is difficult to distinguish between dementia and Alzheimer's disease as there are very few qualitative differences between the two. Alcohol dementia can occur as young as thirty years of age, but usually occurs between the ages of fifty and seventy. The onset and severity of this specific type of dementia is directly linked to the levels of alcohol consumed by the individual⁹.

Alcohol misuse is a concern in Lancashire. From the DH Health Profile 2010 we know 23.5% of Lancashire's adults binge drink, which is significantly higher than the national average of 20.1%. Within the districts binge drinking is a particular problem in Burnley (25.8%), Chorley (26.2%), Ribble Valley (26.1%) and Rossendale (29.5%) which all have rates significantly higher than the national average. Figures compiled from the General Household Survey 2006 show the number of people over 65 drinking heavily is relatively low as a percentage - partly because the proportion who are teetotal is high. However, 15% of people aged 65+ drank every day in the week preceding the survey - a higher figure than for any other age group

Hospital stays for alcohol related harm are also high in Lancashire with 26,364 admissions in 2008/09. This equates to a rate of 1,900 per 100,000 population which is significantly higher than the national rate of 1,580. 15% of all alcohol specific admissions in Lancashire are in people aged 65 and over. Nationally, alcohol-related hospital admissions in the over-65's have increased by two thirds over the past four years and the increasing prevalence of alcohol misuse among the younger population can be expected to influence future dementia prevalence. Since the 1960's alcohol consumption has almost doubled. A contributing factor in this is that the price of alcohol relative to UK income has halved since the 1960's.

It is known that alcohol misuse in older people is currently underestimated and under diagnosed; and while Alzheimer's disease, vascular, and Lewy Body dementia continue to be the major causes of dementia, alcohol-related dementia is often overlooked or perceived as a co-morbidity. As alcohol levels amongst the younger and middle aged generations is twice that of the generations currently suffering dementia, we can expect alcohol-related dementia to increase in the future¹⁰.

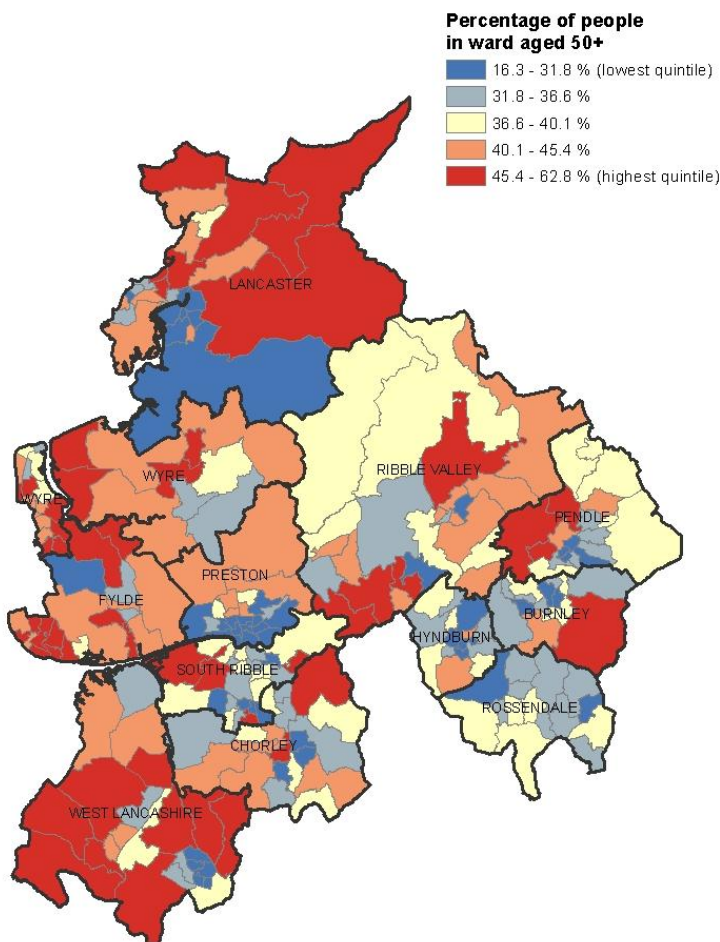
It is important to note that the elderly are not a homogenous group. As with any significant population group there has always been heterogeneity, but this is becoming increasingly more apparent as the group increases in size. There are inequalities between the older and the general

⁹ Lewis, C. (2009) *Horizon scanning for those aged 65 plus*, NWPHO, Liverpool.

¹⁰ Lewis, C. (2009) *Horizon scanning for those aged 65 plus*, NWPHO, Liverpool.

population, and within the older the population itself, and current trends show these social and economic inequalities are expected to increase. As the value of state pension relative to income declines, the circumstances of older people living on different sources of income are expected to diverge. It is known that health and social services can remarkably change the quality of life of older people and lessen health inequalities, especially for the most disadvantaged; however, as a population group they are spread widely across Lancashire.

Map 2: Population aged 50+ in Lancashire wards



Produced by the Corporate Research and Intelligence Team, Lancashire County Council 2011.
Source: Office for National Statistics, mid-2009 quinary population estimates for 2010 wards (experimental).

As a group the older population can be further dissected according to need. The National Service Framework for older people 2001 divided older people into three broad groups:

1. Entering old age: people who have come to the end of employment and parenting. These people may be as young as fifty and are active and independent. The goal of health and social

care for this group should be to promote and extend healthy active living and minimise morbidity;

2. Transitional phase: these people are in a transition between leading a healthy and active life and frailty. The goal of health and social care for this group should be to identify emerging problems with a view to preventing crisis and long-term dependence;
3. Frail old people: these people are vulnerable as a consequence of health problems such as stroke, dementia, etc. The goal of health and social care for this group should be to anticipate and respond to problems and recognise the complex interaction of physical, mental, and social care factors that compromise independence and quality of life.

The Framework also states that services should be culturally appropriate and recognise the higher prevalence of some conditions in certain groups, for example, the increased rate of diabetes among the South Asian population.

The Government strategy on dementia *Living Well with Dementia: A National Dementia Strategy* attempts to transform the care of sufferers and their families. The strategy promises “memory clinics” in every town offering assessment, support, information, and advice for those with memory difficulties. The Audit Commission report *Forget Me Not* promotes the improvement of mental health services for older people with particular emphasis on management at the early stages, access to specialist services, care for those who can no longer be cared for at home, and the development of services that can successfully respond to the complexity of needs as required. The report estimates that 11% of those with dementia need care at least once a week, almost 50% need care at least once daily, and that 34% need care or supervision continually or at brief irregular intervals each day. These rates suggest the following increases in Lancashire over the next five years:

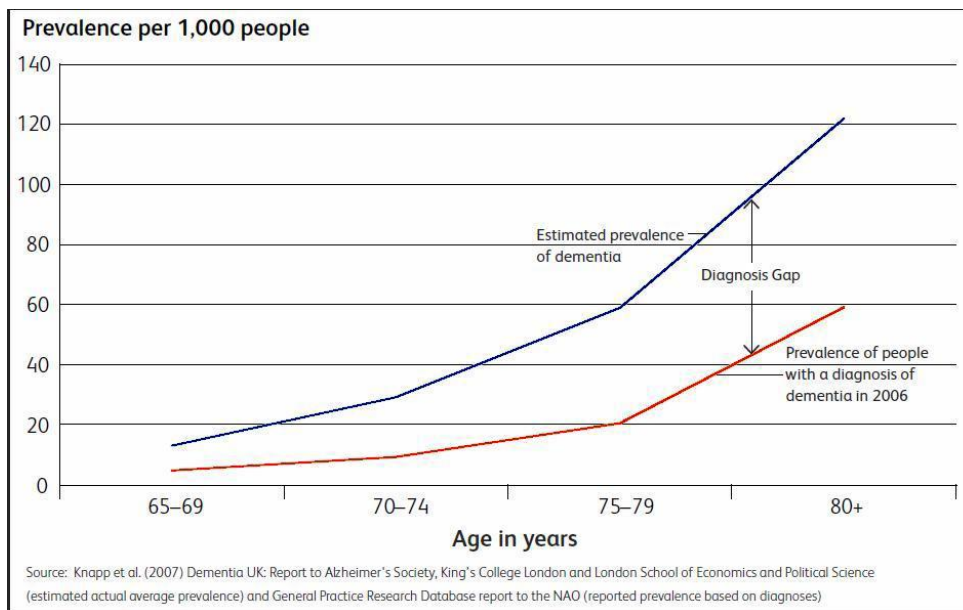
- 1,582 increasing to 1,770 people needing care at least once a week;
- 7,190 increasing to 8,048 people needing care at least once daily;
- 4,889 increasing to 5,472 people needing care or supervision continually or at brief irregular intervals each day.

An update report in 2007 argued that the current health and social care response to dementia is similar to the poor state of cancer care in the 1950s where cancer continued undiagnosed and there was little support in place to help sufferers and their carers. As a final figure the National Audit Office estimated that nationally only a third of people with dementia are currently diagnosed and found GPs attached a lack of urgency to diagnosing and addressing the disease. In

Lancashire data from GP disease registers suggest that approximately 40% of dementia cases are diagnosed.

The below graph is taken from the Alzheimer's Society report Dementia: what every commissioner needs to know and demonstrates the diagnosis gap for dementia. (The reported prevalence is based on levels of diagnosis within Primary Care Trusts for 2006, and the estimated actual prevalence has been calculated using data from the 2007 Dementia UK report in conjunction with population estimates from the Office for National Statistics).

Figure 15: Prevalence of dementia per 1,000 people



The following table shows Lancashire and the districts estimated prevalence of dementia in 2010 compared to numbers of people of dementia registered with a GP. Currently, only 42.3% of those estimated to have dementia in Lancashire are registered as such with a GP and this varies across the districts from 51% in Lancaster to 35% in Fylde and Ribble Valley.

Table 24: Difference in diagnosed and estimated dementia prevalence, 2010

	Estimated prevalence	Diagnosed prevalence	% difference
	No.	No.	
England	607,249	249,463	41.1%
Lancashire	14,379	6,082	42.3%
Burnley	985	414	42.0%
Chorley	1,124	450	40.0%
Fylde	1,402	483	34.5%
Hyndburn	872	383	43.9%
Lancaster	1,823	923	50.6%
Pendle	1,016	450	44.3%
Preston	1,281	565	44.1%
Ribble Valley	741	261	35.2%
Rosendale	704	340	48.3%
South Ribble	1,262	505	40.0%
West Lancashire	1,298	558	43.0%
Wyre	1,868	750	40.1%

Source: Mental Health Observatory: Estimating the future numbers of cases of dementia and QOF Disease Registers 2009/10

Having a care review among patients with dementia is vital to better assessing the specific care needs of individuals:

“The face to face dementia review should focus on support needs of patients and their carers. As the illness progresses, and more agencies are involved, the review should additionally focus on assessing the communication between health and social care and non-statutory sectors as appropriate, to ensure potentially complex needs are addressed. Communication and referral issues highlighted in the review need to be followed up as part of the review process”¹¹.

The following table shows data from QOF and represents patients on the dementia register who have had their care review recorded in the 15 months prior to the reference date. The denominator is all patients on the dementia register (excluding those who have been exception reported).

Table 25: Care review among patients with dementia: 2009/10

	No. reviewed	No. on register (exc exceptions)	% reviewed	% excepted
England	183,725	231,601	79.3%	7.1%
Lancashire	4,271	5,634	75.8%	7.4%
Burnley	289	389	74.3%	6.0%
Chorley	335	419	80.0%	6.9%
Fylde	356	446	79.8%	7.7%
Hyndburn	286	363	78.8%	5.2%
Lancaster	648	855	75.8%	7.4%
Pendle	272	400	68.0%	11.1%
Preston	375	522	71.8%	7.8%
Ribble Valley	168	239	70.3%	8.4%
Rosendale	251	319	78.7%	6.2%
South Ribble	347	460	75.4%	8.9%

¹¹ National Centre for Health Outcomes Development (2009) *Clinical and Health Outcomes Knowledge Base*, The IC, London.

West Lancashire	394	523	75.3%	6.3%
Wyre	550	699	78.7%	6.8%

Source: Quality & Outcomes Framework, Clinical domain
District figures calculated from GP Practices within the district

The percentage of patients on the dementia register who have had a care review is relatively consistent across England, Lancashire and the districts at around 75%-80%. However, dementia care overall is often criticised.

Considering efforts to meet the future increase in need, it is important to highlight that one in three people with dementia live in care homes and the quality of care has been found inadequate for people with dementia. A series of reports confirmed that services are struggling to deliver good quality dementia care. The Alzheimer's Society Home from home report found that people with dementia socially interact for just two minutes in an average six hour period in a care home¹². The Commission for Social Care Inspection report *See me, not just the dementia* concludes that over half of nursing homes fail to provide good dementia care¹³. Professor Sube Bannerjee's 2009 report *The use of antipsychotic medication for people with dementia: Time for Action* also estimates there are 180,000 people with dementia on antipsychotic drugs and in only about one third of these cases are the drugs having a beneficial effect; there are also 1,800 excess deaths per year as a result of their prescription. As a result of this report the NHS Information Centre was commissioned in 2010 to carry out an audit on the use of antipsychotic medication and to measure if there has been a change in the pattern of prescribing since the publication of the report. This work is underway and the initial results are expected soon.

The National Dementia Strategy for England outlines the Department of Health's vision for changing dementia services between April 2009 and March 2014. Importantly, the strategy has been developed after consultation with thousands of people with dementia, their carers, and health and social care professionals. The key transformations recommended for dementia services are grouped into four themes:

4. Raising awareness and understanding;
5. Early diagnosis and support;
6. Living well with dementia;
7. Making the change.

¹² Alzheimer's Society (2007) *Home from home*, Alzheimer's Society, London.

¹³ Commission for Social Care Inspection (2008) *See me, not just the dementia*, CSCI, Newcastle.

Efforts under the theme of raising awareness and understanding focus upon publicity campaigns to aid early diagnosis and reduce stigma.

Efforts under the theme of early diagnosis and support compose of the development of specialist memory assessment services, improving the information given following diagnosis, the development of a dementia care advisor role, and the development of peer support networks for people with dementia and their carers. These recommendations are based on some of the strongest messages from people with dementia and their carers that they need a single, local, named contact to offer advice about dementia and where to seek help. People with dementia and their carers also said they have so far drawn considerable benefit from meeting other people with dementia and meeting other carers to share practical advice about how to live with dementia.

Efforts under the theme of living with dementia consist of improvements to community personal support, implementing the *Carers' Strategy* for people with dementia, improving care in general hospitals, improving intermediate care for dementia, offering supportive housing and telecare, improving care home care, and improving end of life care.

Efforts under the making the change theme focus on issues of improving workforce education, joint planning, performance monitoring and evaluation (including inspection), dementia research, and effective national and regional support for implementation.

With the ageing population and the resultant increasing prevalence of dementia throughout the UK it is vital that services are transformed to adequately meet this need. The criticisms of the Alzheimer's Society, the Commission for Social Care Inspection, and the All Party Parliamentary Group on Dementia prove that current need is not always adequately met. In this light Levin lists ten key requirements for good dementia care¹⁴:

1. Early identification of dementia: health screening of patients over 75 years of age in general practice should include simple testing of cognitive function;
2. Integrated medico-social assessment: recognising the presence of cognitive impairment needs to be combined with an overall appraisal of the domestic situation;
3. Active medical treatment: medical and home nursing care may be required for concurrent physical illness as well as for behavioural problems. As a result district nurses must often deal with cognitive disorder in older people they visit, and so need both additional training and reduced caseloads to be able to cope adequately with the resulting problems;

¹⁴ Levin, E. (1997) *Carers: problems, strains, and services*, OUP, Oxford.

4. Timely referral: because of diagnostic and treatment problems, and for practical advice and help in management;
5. Information, advice, and counselling;
6. Continuing back-up and review: as episodes of NHS specialist care tend to be fairly brief, responsibility here often devolves to primary care professionals together with CPNs working in community mental health teams;
7. Regular help with household and personal care tasks: under the *Chronically Sick and Disabled Persons Act*, local authorities have a duty to assess disabilities and to provide aids and adaptations for the physically disabled, as well as support services such as meals on wheels and incontinence laundry. At the same time they often lack the resources to provide regular home help for the growing numbers of very elderly people who suffer from combined mental and physical impairment;
8. Regular breaks from caring;
9. Regular financial support: and the benefits advice appropriate;
10. Permanent residential care: families confronted with the prospect of long-term care may need support and guidance on a number of issues – to reach their decision that the time has come, to help them deal with any emotional conflicts, to know how to gauge the quality of care of a nursing home, and to take full advantage of any financial provisions made by the state.

The Alzheimer's Society report *Dementia: what every commissioner needs to know* concludes:

“Given the significant numbers of people with dementia using health and social care services, transforming services for people with dementia will be fundamental to achieving world class commissioning, personalisation, and the recommendations of the Darzi review”¹⁵.

Children and young people

The children and young people JSNA has various needs of children and young people. The emotional wellbeing and mental health needs of children and young people are as important as their physical health and is a vital safeguard to their future. Given this level of importance it is no surprise that emotional wellbeing is central to each of the five Every Child Matters Outcomes.

¹⁵ Alzheimer's Society (2009) *Dementia: what every commissioner needs to know*, Alzheimer's Society, London.

The emotional wellbeing and mental health of our children and young people is vital – to them as individuals and to all of us. Failing to tackle emotional problems and mental disorders as early as possible creates significant social and economic costs. The presence of mental illness during childhood has been shown to lead to costs which are up to ten times higher during adulthood.¹⁶

Emotional wellbeing and mental health problems in children are associated with educational failure, family disruption, disability, offending and anti-social behaviour, placing demands on social services, schools and the youth justice system. Untreated mental health problems create distress not only in the children and young people, but also for their families and carers, continuing into adult life and affecting the next generation.

Supporting children and young people with emotional wellbeing and mental health needs is not solely the responsibility of specialist CAMHS. In many cases, the intervention that makes a difference will come from another service. For example, a child presenting with behavioural problems may make better progress if his or her literacy problems are also addressed, in which case an input is required from education.¹⁷ Whilst it is a requirement to provide a comprehensive CAMHS and we should clearly be providing interventions and treatment for those children with mental health problems, the focus should be on early intervention and prevention for all the population and creating the conditions to support positive mental health and wellbeing.

There is strong consensus about what needs to be done, coming from many sources including the Marmot review of health inequalities, the CAMHS review, New Horizon and the Foresight report on mental capital and wellbeing. The recent publication by NHS North West "Living Well across Local Communities, prioritising wellbeing to reduce inequalities" further promotes the importance of positive mental health and asset based approaches. It represents a call to action and sets six statements of direction, one of which focuses on children and young people. Taken from the report:

Statement of direction 3: Children in all communities get the best start in life and young people are supported to become successful adults:

- This statement reflects the importance of early years and the transition to adulthood in achieving lifelong health and wellbeing (the Marmot review concludes this is the first

¹⁶ One year on, the first report from the National Advisory Council for Children's Mental Health and Psychosocial Wellbeing

¹⁷ National service framework for children, young people and maternity services, The Mental Health and Psychological Well-being of Children and Young People, 2004

national priority). The importance of strong intervention on early years at school, at home and in the community is echoed in other evidence too.

- It responds to the need to combat the cultural, social and environmental obstacles to health and wellbeing that particularly affect young people, including commercialism, peer pressure, poor transport systems, discrimination and exclusion, unemployment, low educational attainment, learning and development, family breakdown and unsafe environments. It also responds to the need to create intergenerational trust and reciprocal relationships.
- This statement also recognises the need to integrate strategic work affecting children and young people in broader policies affecting the whole of society by including them explicitly.

Emotional wellbeing and mental health risk factors

Child poverty increases the risk of emotional wellbeing and mental problems in children and young people. Evidence shows that children at the lowest parental income levels experience triple the risk of emotional wellbeing and mental health difficulties compared to children and young people at the higher end of income levels. Children and young people living with a single parent have twice the risk of an emotional wellbeing and mental health problem of those living with two parents.

Adverse childhood experiences are clearly associated with higher incidence of childhood emotional wellbeing and mental problems. Growing up in households where there is a parent mis-using alcohol or drugs, experiencing mental illness, domestic violence, committing sexual abuse, divorce and separation are all risk significant factors and the higher the numbers of adverse events, the stronger the risk.

Vulnerable population groups include:

- Children who are looked after;
- Children and young people who offend;
- Young homeless;
- Those with learning disabilities and special educational needs;
- Young carers;
- Young carers living with parents with mental health problems;

- Young carers living with parents with substance misuse problems;
- Young people who are abused
- Sexually inappropriate behaviours/young abusers
- Young people in transition to adult services.

In any locality there should be clarity about how the full range of users' needs are to be met, whether it be the provision of advice for minor problems or the arrangements for admitting a young person with serious mental illness to hospital.

Clear pathways should be set out to show how the range of emotional wellbeing and mental health needs of children and young people will be met, whether from within services whose prime purpose is to deliver mental health care or from other services with a different primary function, particularly those focused on early intervention and prevention.

Identifying the opportunities to promote positive mental health, particularly focused on the roles that children and young people, their families, communities and schools can take should also be clear in localities. Children's trusts are particularly well placed to identify and support these arrangements. Opportunities for young people to get involved in designing services and solutions and in supporting each other are desirable as this focuses on the promotion of positive mental health and moves away from the idea of services intervening to solve "problems".

It is important to understand that parents whose children have emotional wellbeing and mental health problems may seek help from a variety of professionals and often from more than one service. Teachers are most likely to be the first professionals approached, followed by primary care professionals, highlighting the importance and opportunities available to promote positive mental health within communities.

Professionals most commonly approached are:

- Teachers (40%)
- Primary health care professionals (30%)
- Specialist educational professionals, such as educational psychologists (25%)
- Specialist CAMHS (25%) who are seeing the most impaired young people (those with more than one diagnosis)
- Paediatrics (13%)
- Social Services (13%)

Positive events such as success at school (not necessarily academic) can increase self-efficiency, self-esteem and hence self-control over key life events, all of which promote resilience and personal wellbeing. Negative life events are risk factors for mental health and particular events

that could take place at school include bullying, social isolation, conflicts with staff and exclusion. Schools therefore represent a key setting to reduce the chances of negative life events and increase positive life events.

Positive mental health and wellbeing

The Child Wellbeing Index provides an attempt by Government to measure this important issue. The index measures indicators over the topics of material wellbeing, health and disability, education, crime, housing, environment and children in need to provide a holistic picture of wellbeing. Child wellbeing in Lancashire is strongly correlated with deprivation ($R^2 = 93.6\%$) as is highlighted by the fact that the most deprived districts of Burnley, Pendle and Preston, all feature in the bottom quintile nationally for child wellbeing whilst the Ribble Valley not only features in the top quintile nationally but is in fact ranked as having the 2nd highest child wellbeing of all authorities in the Country.

Table 26: Child Wellbeing Index ranks in Lancashire

District	Rank of average score	Percentile rank	Quintile
Burnley	323	91	Lowest 20% nationally
Chorley	132	37	2nd highest nationally
Fylde	49	14	Highest 20% nationally
Hyndburn	264	75	2nd lowest nationally
Lancaster	227	64	2nd lowest nationally
Pendle	300	85	Lowest 20% nationally
Preston	313	88	Lowest 20% nationally
Ribble Valley	2	1	Highest 20% nationally
Rossendale	193	55	Middle 20% nationally
South Ribble	133	38	2nd highest nationally
West Lancashire	225	64	2nd lowest nationally
Wyre	148	42	Middle 20% nationally

The Child Wellbeing Index provides a national rank for small areas. As a measure of poor wellbeing it is possible to consider the number of children in Lancashire who are resident in areas ranked as having wellbeing in the lowest 20% nationally. Across Lancashire 44,000 children, a fifth of all children aged 0 to 15 years in Lancashire, are living in such areas of low wellbeing. Children in Preston are the most affected as almost half live in areas with low levels of wellbeing. Burnley and Pendle are not far behind as more than 40% of children live in areas ranked as having some of the lowest levels of child wellbeing in the country.

Table 27: Numbers of children aged 0 to 15 living in areas ranked in the bottom quintile nationally for wellbeing

LA NAME	Children living in the areas of low wellbeing	Numbers of children aged 0-15	Proportion of children aged 0-15
Burnley	7,312	17,511	41.8%
Chorley	642	19,037	3.4%

Fylde	0	11,846	0.0%
Hyndburn	4,368	17,370	25.1%
Lancaster	3,978	23,649	16.8%
Pendle	7,696	18,284	42.1%
Preston	12,149	25,245	48.1%
Ribble Valley	0	10,632	0.0%
Rossendale	1,589	13,561	11.7%
South Ribble	635	19,671	3.2%
West Lancashire	3,962	20,455	19.4%
Wyre	2,076	18,114	11.5%
Lancashire	44,407	215,375	20.6%
Source: Child Wellbeing Index, Communities and Local Government			

To promote positive mental health and wellbeing in the school setting important issues to tackle are bullying and racism. Bullying can have strong negative impacts upon the lives of children and young people and the growth in the use of mobile phones, email and social networking websites have created a new outlet for bullying in the form of cyber bullying.

Analysis from the 2009/10 Lancashire Pupil Attitude Questionnaire highlights that those in younger years of school experience the most bullying with rates reducing as school year increases. Almost half of children in year 4 of primary school reported ever being bullied and 16% reported being bullied "often" or "most of the time". By year 11 only 30% of children reported ever being bullied and 6% reported being bullied "sometimes" or "a lot".

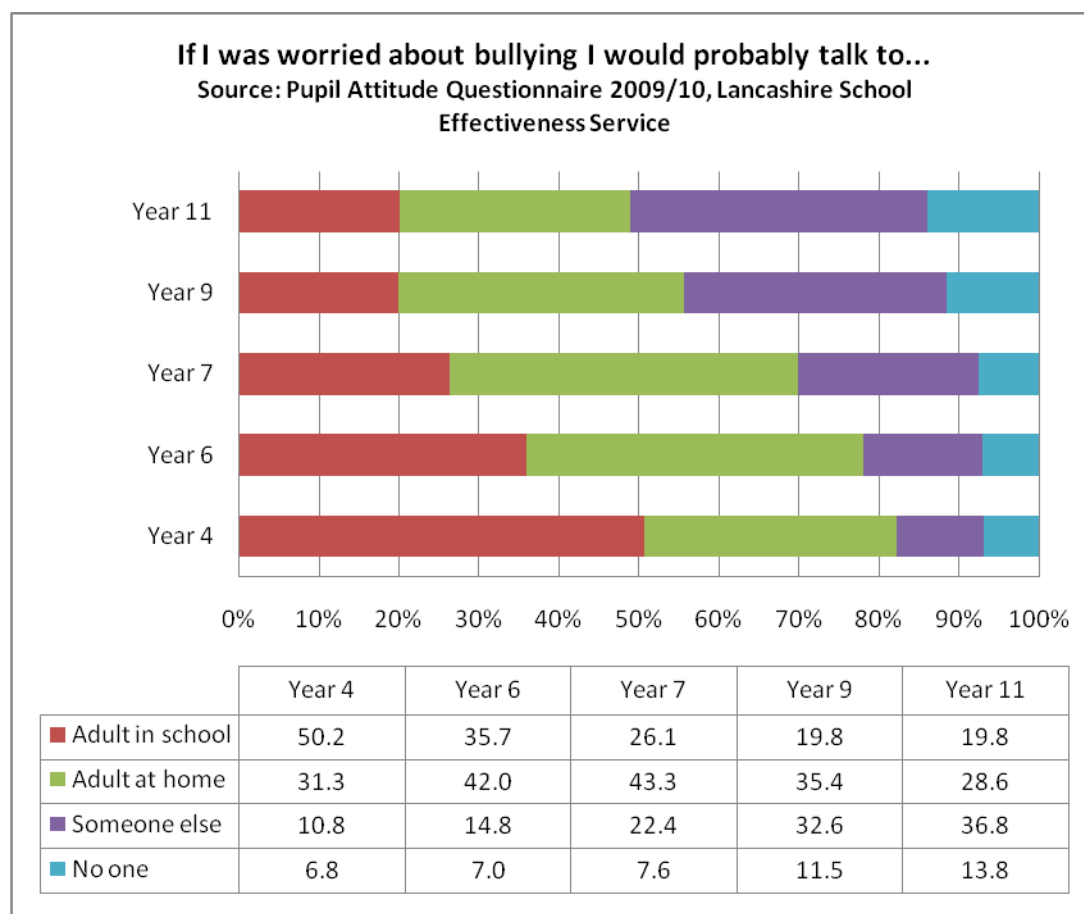
Bullying on the way to or from school is much less common than at school as 16% of year 4 and 18% of year 11 children reported ever being bullied on the way to or from school. Bullying on the way to or from school is most common in year 7 and year 9 children, which is likely to reflect the accompanied journey to school or young children.

Across all school years surveyed the children who partake in bullying are in the minority – between 20% and 25%. There is distinctly strong pattern with any age group more likely to bully than others, although year 7 appear least likely of all the age groups which may be due to their low status as newcomers to secondary school. The differences are small, however.

The experience of bullying is linked to the age of children, as is their response to it. There appears to be an increasing mistrust or reduction in confidence in adults as children age. This break down of intergenerational relations is reflective of a common theme in society as a whole. During year 4, more than 80% of children reported they would speak to an adult either at home or in school if they were concerned about bullying. This reduces to 77% in year 6, 69% in year 7, 55% in year 9 and fewer than half in year 11 who would confide in an adult. The majority of the shift is reflected in the numbers who report they would speak to someone else (the primary school children were given

the examples of siblings or friends). A worrying pattern is seen in the proportions who would not speak to anyone, which doubles from 7% of children in year 4 to 14% in year 11.

Figure 16: Who children would speak to if worried about bullying



Schools in Lancashire have a duty to report racist incidents and the tables below highlight the numbers of racist incidents are reducing. However, there were still 485 racist incidents reported during 2008/09. These incidents were equally split between primary and secondary schools, which is a changing pattern as racist incidents were more commonly reported by secondary schools during 2006/07.

Table 28: Racist incidents across Lancashire by schools

Racist incidents across Lancashire by schools			
	August 06-July 07	August 07-July 08	August 08-July 09
Nursery	2	5	0
Infant	3	4	0
Junior	5	6	8
Primary	261	229	191
Short Stay	21	9	25
Special	79	57	79
Secondary	322	228	182
Other	3	0	0
Totals	696	538	485

Source: Lancashire County Council, Schools Effectiveness Service

In general the reduction in racist incidents at the county level has been mirrored across the districts. Particular reductions in the reporting of racist incidents were experienced in Preston as they fell from 122 incidents during 2006/07 to 62 in 2008/09. Burnley is the noticeable exception to the general rule as there has been an increase in reported racist incidents between 2006/07 and 2008/09 (although with a reduced number of incidents in between).

Table 29: Racist incidents across Lancashire by education district

Racist incidents across Lancashire by education district			
	August 06-July 07	August 07-July 08	August 08-July 09
Lancaster & Morecambe	58	53	52
Wyre	38	36	26
Fylde	16	9	11
Preston	122	103	62
South Ribble	66	48	41
West Lancashire	46	27	40
Chorley	29	28	19
Hyndburn & Ribble Valley	94	54	63
Burnley	106	89	114
Pendle	75	63	43
Rossendale	37	21	14
Out County*	9	7	0
Totals	696	538	485

Source: Lancashire County Council, Schools Effectiveness Service

Measuring emotional wellbeing and mental health needs

The Child and Maternity Observatory, Chimat, offers a range of data to support CAMHS partnerships in assessing need. This prevalence data has been summarised here and further data tables are included in appendix A. It should be noted that the School Census provides measures of some overlapping conditions, particularly behavioural, emotional and social difficulties. These are presented in the section on Children with disabilities and learning difficulties and disabilities. The numbers there related to the Special Educational Needs Code of Practice and do not tally with the estimates provided here. It is therefore necessary for the reader to make a judgement about which statistics they place greater value upon.

Emotional Disorders

Emotional disorders are the most common emotional wellbeing and mental health problem in children and include anxieties, phobias and depression. Anxieties and phobias are related to fear, which can be generalised, or specific to a situation or object; for example school or separation from a parent. For a problem to be classified as a disorder, behaviour needs to present as an exaggeration of normal developmental trends.

The latest ONS survey provides prevalence of 4.3% for ages 5-16 (10% for girls aged 11 to 16 and 13% for boys). Estimates and projections for emotional disorders in children aged 5-16 years are in the table below.

Table 30: Estimates and projections of emotional disorders in children aged 5-16 years

AREA	2008	2009	2010	2011	2012	2013
Lancashire County	7184	7104	7053	7001	6946	6952
Central Lancashire	2755	2749	2741	2730	2717	2728
East Lancashire	2553	2503	2482	2451	2436	2439
North Lancashire	1879	1851	1834	1813	1786	1786
Burnley	562	552	547	538	534	537
Chorley	613	614	612	611	609	614
Fylde	409	397	396	394	390	388
Hyndburn	568	556	551	541	535	531
Lancaster	840	836	823	815	803	802
Pendle	594	582	579	571	568	570
Preston	809	816	820	818	814	817
Ribble Valley	377	371	369	367	363	363
Rosendale	452	442	436	434	437	438
South Ribble	643	637	632	629	627	628
West Lancashire	690	682	676	673	667	669
Wyre	630	617	616	604	593	596
Sources: ONS survey and 2008 mid-year population estimates and projections						

It is estimated that 1% of children and 3% of adolescents suffer from depression in any one year. Symptoms include sadness, irritability and loss of interest in activities. Associated features include changes in appetite; sleep disturbance and tiredness, difficulty concentrating, feelings of guilt, worthlessness and suicidal thoughts.

Conduct Disorders

Typical behaviour includes unusually frequent and severe temper tantrums beyond the age that this is normally seen, severe and persistent disobedience, defiant provocative behaviour, excessive levels of fighting and bullying, cruelty to others or animals, running away from home and some criminal behaviour.

These children and adolescents typically have low self-esteem, often showing marked misery and unhappiness as a result of a high incidence of depression. Some of these children lack the social skills to maintain friendships and may become isolated from peer groups.

Harsh and inconsistent parenting is the major cause of conduct disorder, but hyperactivity and a low IQ may also contribute. Family dysfunction, low income and parental mental illness are other factors which contribute to the risk of adult problems.

A conduct disorder can affect a child's development and interfere with their ability to lead a normal life. In children and young people with conduct disorders there is a high correlation with youth

offending, anti-social personality disorder and increased risk of abusing and becoming dependent on alcohol and to a lesser extent, illicit drugs.

The latest ONS estimates suggest that the prevalence of conduct disorders is 5.3% of people aged 5-16 years. Across Lancashire it is estimated there are more than 11,000 people age between five and 16 years with a conduct disorder.

Table 31: Estimates and projections of conduct disorders in children aged 5-16 years

AREA	2008	2009	2010	2011	2012	2013
Lancashire County	8854	8757	8693	8629	8562	8569
Central Lancashire	3396	3389	3378	3364	3349	3362
East Lancashire	3147	3085	3059	3021	3003	3006
North Lancashire	2316	2281	2261	2234	2202	2202
Burnley	692	681	674	663	658	661
Chorley	756	757	755	753	750	757
Fylde	505	490	488	485	480	478
Hyndburn	701	685	679	667	659	655
Lancaster	1036	1030	1014	1005	990	989
Pendle	732	718	713	704	700	703
Preston	997	1006	1011	1008	1004	1007
Ribble Valley	464	457	455	453	447	447
Rosendale	558	545	537	535	538	540
South Ribble	793	785	779	775	773	774
West Lancashire	850	841	833	829	822	825
Wyre	776	761	759	744	731	735

Sources: ONS survey and 2008 mid-year population estimates and projections

Attention Deficit Hyperactivity Disorder (ADHD)

Hyperkinetic disorder is the official term in the UK for describing children who are consistently over-active and inattentive. ADHD and Attention Deficit Disorder (ADD) are now more commonly used terms. ADHD is a neuro-biological disorder and there is more medical evidence for this than any other such disorder. It is primarily genetically inherited; however non-genetic factors have been linked to ADHD including exposure to lead, complications during pregnancy and delivery, premature birth, foetal exposure to alcohol or tobacco. The disorder is diagnosed many times more in boys than girls, however as differences in presentation may lead to referral bias, the existence in the overall difference of prevalence of ADHD in boys versus girls is debatable.

Children with hyperkinetic disorder may find it difficult to interact with other children and their inability to concentrate and restlessness at school impacts on their education and can be extremely disruptive to other pupils. Their behaviour can also put significant strains on family life. These problems can persist into adult life. Children with hyperkinetic disorder are at greater risk of

academic and occupational failure, self esteem issues, relationship problems, injury/accidents and substance abuse.

NICE guidelines (2008) demand that specialist ADHD teams for children and young people should develop age-appropriate training programmes for the diagnosis and management of ADHD for mental health, paediatric, social care, education, forensic and primary care providers; as well as for other professionals who have contact with people with ADHD. Parents or carers of pre-school children should be offered a referral to a parent training/education programme as the first line of treatment. School age children and young people with severe ADHD could be offered drug treatment. Such treatment should always form part of a comprehensive treatment plan to include psychological, behavioural and educational advice and intervention.

Medication such as methylphenidate can help treat hyperkinetic disorder, reducing the hyperactivity and improving concentration, although this is only a temporary effect. NICE (2006) guidelines state that medication should initially only be prescribed by a specialist after confirmed diagnosis. It can however be continued and monitored by a GP.

The latest ONS survey suggests hyperactivity prevalence of 1.4% of children aged 5-16 years. Applying this rate to population estimates suggest that more than 2,000 children are hyperactive in Lancashire.

Table 32: Estimates and projections of hyperactivity in children aged 5-16 years

AREA	2008	2009	2010	2011	2012	2013
Lancashire County	2339	2313	2296	2279	2262	2264
Central Lancashire	897	895	892	889	885	888
East Lancashire	831	815	808	798	793	794
North Lancashire	612	603	597	590	582	582
Burnley	183	180	178	175	174	175
Chorley	200	200	199	199	198	200
Fylde	133	129	129	128	127	126
Hyndburn	185	181	179	176	174	173
Lancaster	274	272	268	265	262	261
Pendle	193	190	188	186	185	186
Preston	263	266	267	266	265	266
Ribble Valley	123	121	120	120	118	118
Rossendale	147	144	142	141	142	143
South Ribble	209	207	206	205	204	204
West Lancashire	225	222	220	219	217	218
Wyre	205	201	200	197	193	194
Sources: ONS survey and 2008 mid-year population estimates and projections						

Self-harm and Suicide

Self-harm and suicide can be a symptom of underlying unhappiness or emotional disorder. Self-harm can include self-cutting, burning, hair-pulling or self-poisoning. It may be linked to suicidal thoughts and is a way of coping with problems, a means of taking control, or a form of release from painful feelings.

Depression, serious mental health problems and the misuse of drugs are all factors related to suicide attempts. Young people who have already tried to kill themselves, or know someone who has tried to kill themselves are also at greater risk of attempting suicide.

Suicide rates are very low in children, but start to increase from the age of 11. Boys and young men aged 15-24 are most at risk. A conservative estimate is that there are 24,000 cases of attempted suicide by adolescents (of 10-19 years) each year in England and Wales, which is one attempt every 20 minutes (Hawton et al, 1999). A Samaritans study found that four times more adolescent females self-harmed than adolescent males (Samaritans, 2003)

The most recent data from the Office for National Statistics (ONS) suggest a prevalence rate of 3.6 deaths per 100,000 population aged 15 to 19 years. If applied to the pan Lancashire population this equates to approximately four per year.

The following information is taken from Hawley and James:

- Common characteristics of adolescents who self harm are similar to the characteristics of those who commit suicide.
- Young South Asian females in the United Kingdom seem to have a raised risk of self harm. Intercultural stresses and consequent family conflicts may be relevant factors.
- As many as 30% of adolescents who self harm report previous episodes, many of which have not come to medical attention. At least 10% repeat self harm during the following year, with repeats being especially likely in the first two or three months.
- The risk of suicide after deliberate self harm varies between 0.24% and 4.30%. Our knowledge of risk factors is limited and can be used only as an adjunct to careful clinical assessment when making decisions about after care. However, the following factors seem to indicate a risk: being an older teenage male; violent method of self harm; multiple previous episodes of self harm; apathy, hopelessness, and insomnia; substance misuse; and previous admission to a psychiatric hospital.

Eating Disorders

These are more common in young women. Up to 1% of women are affected by anorexia nervosa, where the person eats very little, effectively starving themselves and between 1-2% bulimia nervosa which involves bingeing on food followed by induced vomiting or use of laxatives. The average age of onset of anorexia is 15 and of bulimia 18. Some eating disorders are associated with other underlying mental health conditions.

Alcohol and Substance Misuse

The use of alcohol and drugs can both exacerbate and trigger mental health problems: those with emotional wellbeing and mental health needs may be at greater risk of misusing drugs. For example, alcohol can be attractive to those suffering from depression because it increases confidence and may produce a feeling of wellbeing, drowning out problems in the short term. It is however, also a depressive and worsens the symptoms of depression, such as increasing the risk of suicidal thoughts.

Comprehensive CAMHS

The 1999 ONS survey on the mental health of children and adolescents in Britain (Meltzer et al 2000) reports high rates of service use amongst those with emotional wellbeing and mental health problems including health, education, social services and the police. However, only a small (unknown) proportion receive treatment from the CAMHS. In common with other countries, most children who need mental health services are not receiving specialised care.

To support children and young people with emotional wellbeing and mental health needs, however, a specialist service is not necessary or often appropriate. It is necessary that a full range of effective services are available including services for all groups of children and young people vulnerable to poor outcomes, ensuring the right balance between early intervention and more specialist services and agreeing complex pathways across many agencies. In short, there should be a graduated response to need where all services respond to emotional wellbeing issues meaning that only the children and young people with the higher end needs are accessing specialist services.

An appropriate model has three types of interventions focused on universal, targeted and specialist CAMHS:

- **Universal** services are focused on prevention, identification and early intervention of emotional wellbeing and mental health problems and are mainstreamed across health workers, local authority children's services, education and the voluntary sector.
- **Targeted services** are focused on those vulnerable children and young people and necessitate multi-agency working.
- **Specialist CAMHS** are focused on high level mental disorders and are delivered by staff with additional training and multidisciplinary CAMHS teams.

This is a comprehensive CAMHS and there is a national requirement for this to be in place in all areas by 2013. A key element of this model is the need for interventions in early years. The

National Standards Framework standard 9 states that the early years are fundamental and conditions during this time can lead to emotional and behavioural disorders. Particular support may be needed for parents who are ill (including mental illness) or who have a disability. Partnership working with adult social services, primary care services and early years support is therefore crucial. Being able to identify who is a parent is a crucial first step and it is uncertain whether this is currently recorded for all services (see young carers section for further discussion).

Lancashire has developed a Strategy for prevention and early intervention for children, young people and their families, which was published in April 2010. It identifies both:

- Preventative interventions, which focuses on reducing risk and promoting protective factors in the child as well as their cultural contexts (family, classroom, school, peer group, neighbourhood, etc), thereby promoting resilience. This activity should be delivered in universal services and settings.
- An early intervention approach which offers children, young people and families more than a solution to a specific problem; it offers them the skills to deal with a similar problem if it arises in the future. This is a targeted response to identified needs.

The Lancashire strategy aims to secure a county-wide approach providing a framework which enables all partners to co-ordinate their efforts, re-shape services and work together to utilise resources in a more integrated way to improve the resilience and outcomes for children, parents and families. The need for an early intervention and prevention strategy is made clear in the requirement for a comprehensive CAMHS. Early intervention and prevention will help reduce poor outcomes for children and young people. However, it also makes clear sense in economic terms as Backing the Future, a report by the New Economics Foundation and Action for Children, has estimated that for every £1 invested in early intervention, there is a financial benefit to society of between £7.60 and £9.20.

In November 2008 the National CAMHS Review, Children and Young People in Mind, made extensive recommendations for the on-going improvement of CAMHS services.

All parents, carers, children and young people throughout the country should have:

- A more positive understanding of mental health and psychological wellbeing as a result of national media activity;
- Up-to-date information, in a range of formats, about mental health and psychological wellbeing;
- Good telephone and web-based help and advice;
- Confidence that staff in the services they use every day:
 - Understand child development and mental health;
 - Actively promote strong mental health and psychological wellbeing;
 - Use language that they understand;

- Take them seriously;
- Can identify needs early;
- Can help their child and can draw on support from others to make sure needs are addressed.

Children and young people who need more specialised support and their parents and carers, should have:

- A high quality and purposeful assessment;
- A lead person to be their main point of contact;
- Clearly signposted routes to specialist help and timely access to this;
- Clear information about what to do if things don't go according to plan.

Children and young people and their families who are vulnerable should be confident that:

- Their mental health needs will be assessed alongside all their other needs;
- An individualised package of care will be available to them appropriate to their personal circumstances;
- For those experiencing complex, severe and on-going needs, these packages of care will be commissioned by the Children's Trust and delivered, where possible, in the local area

Young adults who are approaching 18 years of age and who are being supported by CAMHS should, along with their parents and carers:

- Know well in advance what the arrangements will be for transfer to adult services;
- Be able to access services that are based on best evidence of what works for young adults;
- Have a lead person who makes sure that the transition between services goes smoothly;
- Know what to do if things are not going according to plan;
- Have confidence that services will focus on need, rather than age and will be flexible.

Levels of need by Child and Adolescent Mental Health Services Tiers

The requirement for a Comprehensive CAMHS is a standard which highlights the need to improve service provision at all levels from universal services, promoting mental health and providing early interventions, to highly specialised services. This is the standard which all areas are achieve by 2013.

Over recent years a four tier model of provision has been used to guide the commissioning and planning of services:

- **Tier 1:** a primary level of care
- **Tier 2:** a service provided by specialist individual professionals relating to workers in primary care
- **Tier 3:** A specialised multi-disciplinary service for more severe, complex or persistent disorders
- **Tier 4:** Essential tertiary levels services such as day units, highly specialised out-patient teams and in-patient units.

This four tier model does not capture the range of prevention and early intervention activity which a comprehensive CAMHS provides. However, it is useful to consider this model as there has been research to identify numbers in need using it. The report 'Treating Children Well' (Z. Kurtz, Mental Health Foundation, 1996) provides an estimate of the number of children / young people who may experience emotional wellbeing and mental health problems appropriate to a response from CAMHS at Tiers 1, 2, 3 and 4. Applying these rates in Lancashire provides an estimate of the numbers in need, as provided in the table below. It should be possible to measure this against the numbers actually accessing services. This will enable an equity audit whereby we can check whether current services are being accessed equitably across the county.

Table 33: Children and young people aged 0 to 17 years experiencing mental health problems appropriate to a response from CAMHS tiers

AREA	Tier 1	Tier 2	Tier 3	Tier 4
Lancashire	37386	18693	4611	1171
Central Lancashire	14568	7284	1797	456
East Lancashire	13323	6662	1643	417
North Lancashire	9510	4755	1173	298
Burnley	3036	1518	374	95
Chorley	3246	1623	400	102
Fylde	2052	1026	253	64
Hyndburn	2967	1484	366	93
Lancaster	4284	2142	528	134
Pendle	3132	1566	386	98
Preston	4392	2196	542	138
Ribble Valley	1851	926	228	58
Rossendale	2337	1169	288	73
South Ribble	3351	1676	413	105
West Lancashire	3579	1790	441	112
Wyre	3174	1587	391	99

Source: 'Treating Children Well' and ONS 2008 mid-year population estimates

Understanding how these estimates of need relate to the numbers being supported by the CAMHS service will provide an audit of how equitably each stage is being resourced and whether access the districts of Lancashire is equitable.

Learning disabilities

Learning disability is defined as the presence of a significantly reduced ability to understand new or complex information, impaired intelligence, impaired social functioning, and has a lasting effect on development. The definition encompasses people with a wide range of disabilities but does not

include all people who have a 'learning difficulty'¹⁸. Learning disabilities can be subdivided into those conditions that arise at conception, during pregnancy, and after birth. The aetiology of causes fall into three main categories: genetic, infective, and environmental. However, no aetiological cause is found in approximately 30% of cases of severe learning disabilities.

It is difficult to provide an exact figure for learning disabilities for various reasons. The most significant of these are that the social construction of underlying concepts has changed over time, there is a wide spectrum of disorder, definitions are not standardised, and service utilisation research methodologies are common and so limit the population studied to those in touch with services¹⁹. Estimates and projections of the numbers of people with a learning disability (all people and those with a moderate to severe disability) are provided in appendix A.

Many risk factors for mental illnesses occur more frequently in people with learning disabilities. These include sensory impairment, communication difficulties, chronic ill health, stigma, low self-esteem, low levels of social support, and poor coping skills. As a result there is an increased prevalence of psychiatric and behavioural disorders over the general population. Determining exact figures is difficult because of poor detection, misdiagnosis, and methodological difficulties. All types of mental disorder are found, but rates of substance misuse and affective disorders are lower than the general population. Older people with learning disabilities have a higher prevalence of mental illness than both the general population and younger people with learning difficulties. This difference is largely accounted for by the increase in early onset dementia, particularly in people with Down's syndrome.

The Foundation for People with Learning Disabilities estimates 25- 40 per cent of people with learning disabilities experience mental health problems at some point in their lives. In the following table these prevalence rates have been applied to the estimates of the numbers of people with a learning disability in 2010 and projections for 2020. This suggests that between 6,700 and 10,700 people with a learning disability may also require support with a mental health need.

Table 34: People estimated to have learning disability and mental health need, Lancashire, 2010 and 2020

	2010		2020	
	25%	40%	25%	40%
Lancashire 14	6698	10717	6922	11075
Lancashire 12	5446	8713	5656	9049
Blackburn with Darwen	604	966	616	986
Blackpool	649	1038	650	1040
Burnley	387	619	377	603

¹⁸ National Centre for Health Outcomes Development (2009) *www.nchod.nhs.uk*

¹⁹ Stevens, A. et al (2004) *Health Care Needs Assessment*, Radcliffe Publishing Ltd., Oxford, pg.468

Chorley	491	786	518	829
Fylde	361	577	376	602
Hyndburn	363	580	369	590
Lancaster	680	1087	716	1145
Pendle	405	647	416	666
Preston	647	1035	667	1067
Ribble Valley	266	426	282	451
Rossendale	303	484	316	506
South Ribble	505	807	535	856
West Lancashire	514	822	525	839
Wyre	526	841	562	898

It may be the case that mental health need is greatest in those with a moderate to severe learning disability and therefore this should be the group of focus for commissioners. This is a decision to be taken by individual commissioners. The table below highlights the estimated numbers with a moderate to severe learning disability who may also have a mental health need. This suggests that there may be between 1,400 and 2,200 people with a moderate to severe learning disability in Lancashire who also have a mental health need.

Table 35: People estimated to have a moderate to severe learning disability and mental health need, Lancashire, 2010 and 2020

	2010		2020	
	25%	40%	25%	40%
Lancashire 14	1386	2218	1418	2268
Lancashire 12	1126	1801	1155	1848
Blackburn with Darwen	127	204	130	208
Blackpool	133	213	133	212
Burnley	80	128	77	123
Chorley	102	164	106	170
Fylde	72	116	74	118
Hyndburn	76	121	76	122
Lancaster	141	225	147	236
Pendle	84	134	86	137
Preston	136	218	141	225
Ribble Valley	55	88	57	91
Rossendale	64	102	66	105
South Ribble	105	167	109	175
West Lancashire	106	170	106	170
Wyre	106	169	111	177

Autism

There is a lot of cross over between those with autism and those who have learning disabilities as some people will have both and some parts of the autism spectrum may be considered a learning disability.

The National Autistic Society states that some very able people with ASD may never come to the attention of services as having special needs, because they have learned strategies to overcome any difficulties with communication and social interaction and found fulfilling employment that suits their particular talents. Other people with ASD may be able intellectually, but have need of support from services, because the degree of impairment they have of social interaction hampers their chances of employment and achieving independence. It is therefore very difficult to provide accurate figures. Tables of district estimates and projections for 2010 and 2020 of the numbers of people with autism are provided in appendix A.

The National Autistic Society of North Ireland estimates that more than 70% of children with autism have a mental health problem such as depression, obsessive compulsive disorder and anxiety disorder. They highlight that these problems are present despite the fact that many of them are preventable:

"Autism is a complex disability and so when mental health problems do develop in children with the condition they are much harder to recognise, diagnose and treat without appropriate knowledge. Tragically, they are often dismissed as an unfortunate, but unavoidable side effect of having autism."²⁰

The table below applies the suggested prevalence of mental health in those with a learning disability (25% to 40%) and the 70% prevalence rate suggested above to the estimates and projections of numbers of people with autism. This suggests that between 2,200 and 6,200 people with autism may also have a mental health need in Lancashire.

Table 36: People estimated with autism and a mental health need, Lancashire, 2010 and 2020

	2010			2020		
	25%	40%	70%	25%	40%	70%
Lancashire 14	2,217	3,547	6,208	2201	3522	6164
Lancashire 12	1,794	2,871	5,024	1782	2851	4989
Blackburn with Darwen	211	338	591	210	336	589
Blackpool	212	339	593	209	335	586
Burnley	127	203	356	117	187	327
Chorley	169	271	474	167	266	466
Fylde	113	180	315	109	174	305

²⁰ http://www.ni4kids.com/news/article.aspx?listing_id=68926643-bfc0-4e3d-b24c-689b5195a8ae, December 2010

Hyndburn	123	196	343	120	192	335
Lancaster	222	356	622	228	364	638
Pendle	136	217	380	133	212	372
Preston	227	363	636	234	374	655
Ribble Valley	85	136	238	85	135	237
Rosendale	102	164	286	102	162	284
South Ribble	166	266	466	168	269	470
West Lancashire	163	261	456	156	249	436
Wyre	160	256	447	164	262	458

Students

‘The mental health of students in higher education’ was the title of a report of the Royal College of Psychiatrists (2003). It notes that students have not been shown to be more likely than others of the same age to experience diagnosable mental disorders. However, the student population has increased, so that there are more students with mental health problems. They are very likely to experience disruption to their studies as a result of their mental health problems. The report states that university counselling services are in effect the primary mental health care option for students.

Its main emphasis is on commissioning strategies and policies for student mental health in order to facilitate access to services, local networks of best practice, agreement over funding responsibility, and relationships with secondary mental health care provision.

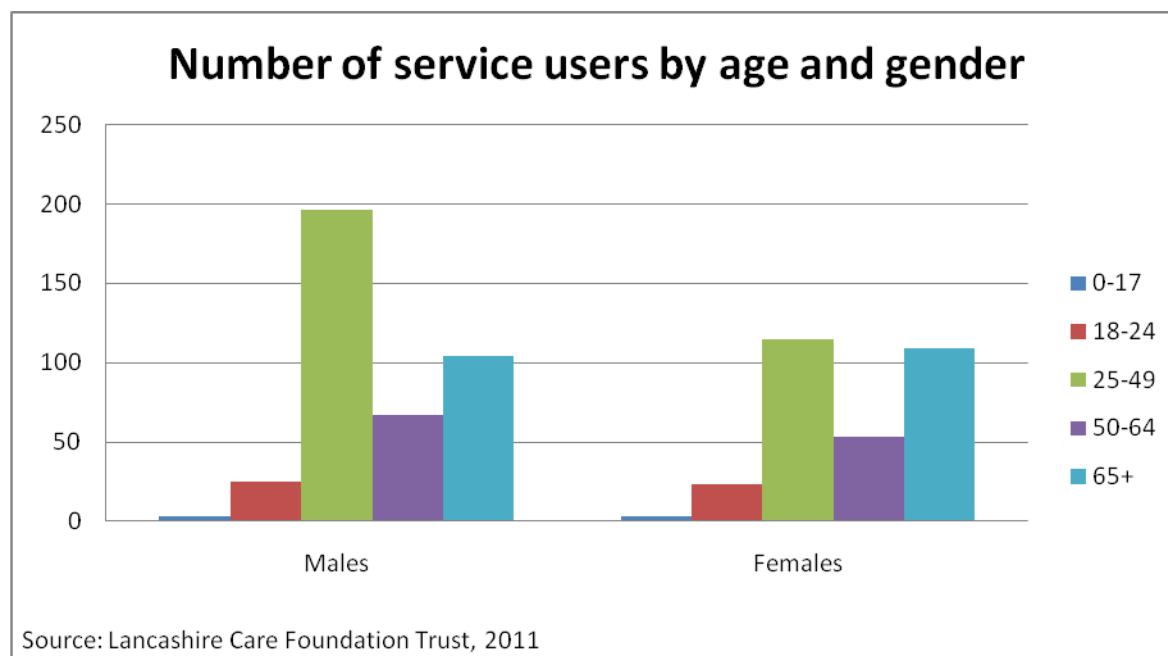
Geodemographic segmentation

Lancashire Care NHS Foundation Trust was established in April 2002 and authorised as a Foundation Trust on 1st December 2007. The Trust provides health and wellbeing services for a population of around 1.5million people. The services provided include community nursing, health visiting and a range of therapy services including physiotherapy, podiatry and speech & language. Wellbeing services provided include smoking cessation and healthy lifestyle services. The Trust specialises in inpatient and community mental health services. Lancashire Care NHS Foundation Trust covers the whole of the county and employs around 7,000 members of staff across more than 400 sites. You can find out more about LCFT by visiting: www.lancashirecare.nhs.uk

Lancashire Care Foundation Trust (LCFT) collects data about the age, gender ethnicity and other characteristics of their service users. These can be used to analyse the equity of access to their services. The following data was provided at the end of 2011.

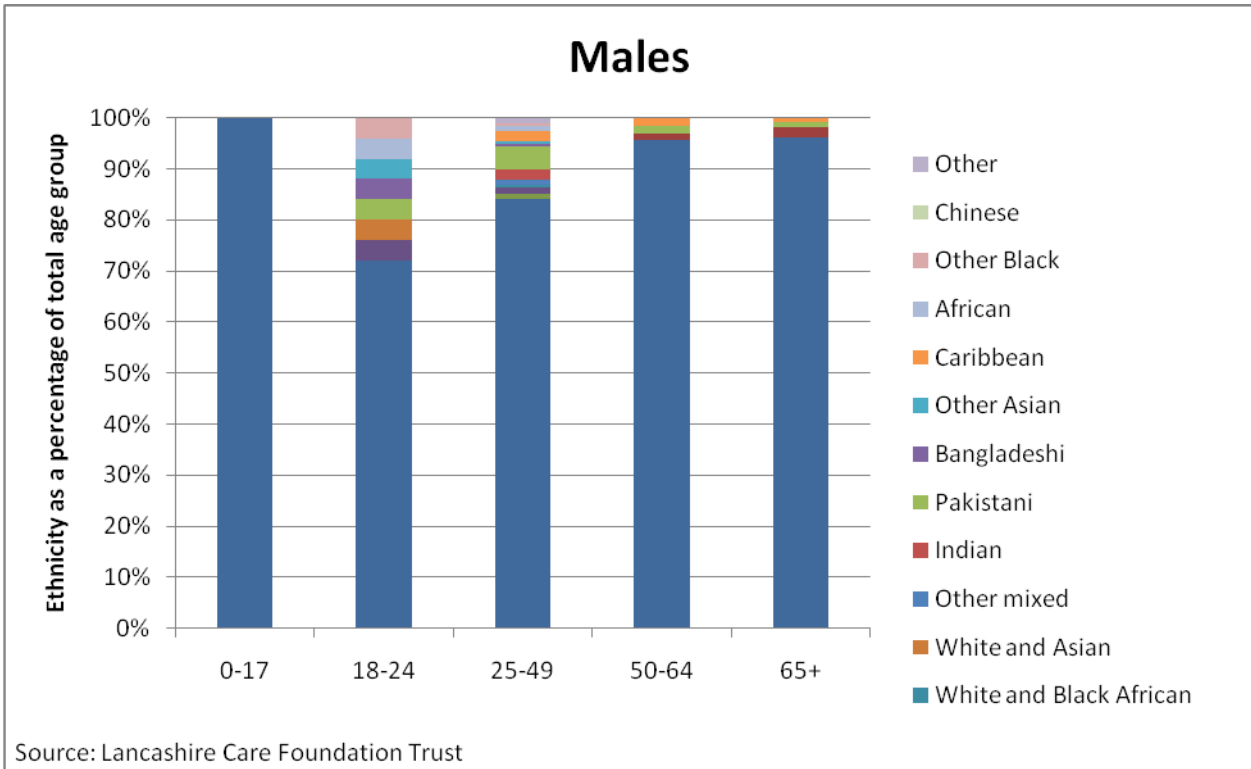
There are approximately 4 males for every three females accessing LCFT services. The majority of LCFT service users are males between the ages of 25 and 49. For most of the age bands the male/female split is fairly equal, except the 25-49 age group, where there are nearly twice as many males as there are females.

Figure 17: LCFT service users – age and gender



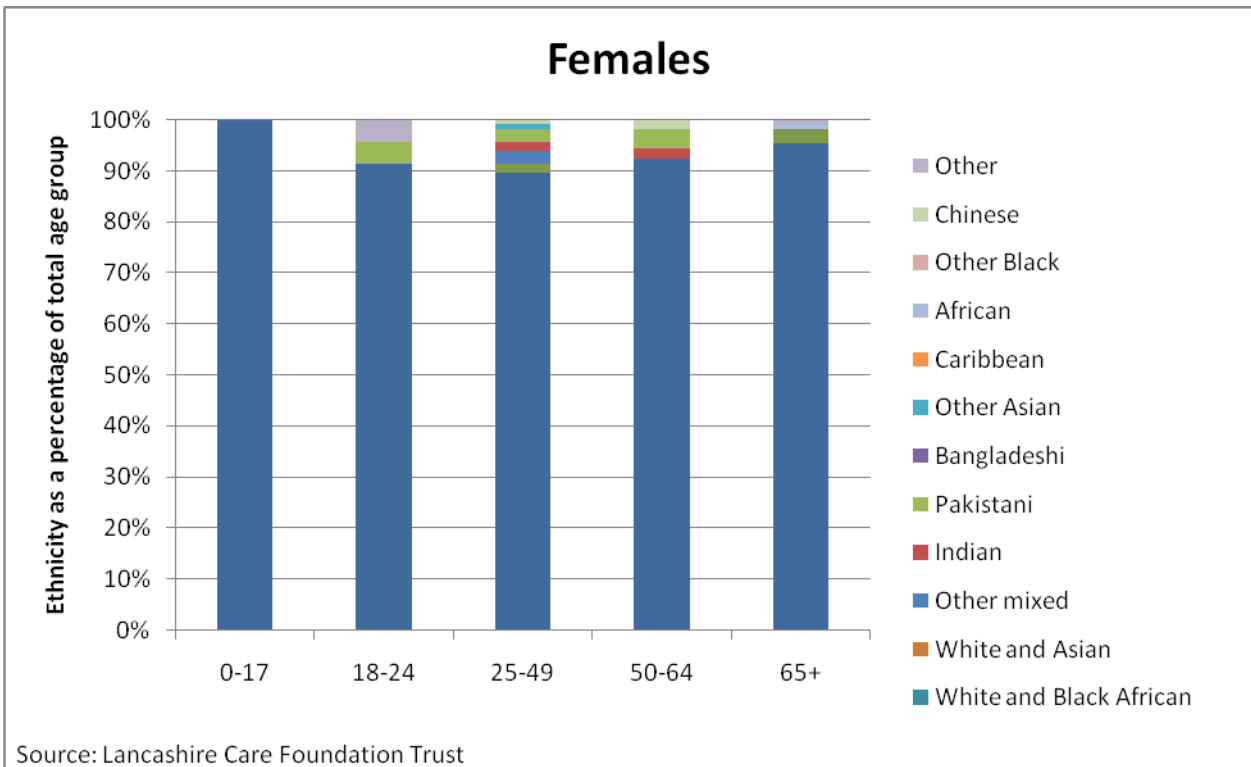
For males the 18 to 24 year old group of service users is the most ethnically diverse with 28% being from BME groups.

Figure 18: LCFT service users – males by age and ethnicity



For females the most ethnically diverse age group is the 25 to 49 year olds where just 10% are from BME groups.

Figure 19: LCFT service users – females by age and ethnicity



Mosaic Public Sector Profiler tool was used to identify the common characteristics of people accessing LCFT. This highlighted certain segments of Lancashire's population that are over or

underrepresented in terms of LCFT service use. The analysis below identifies the main overrepresented population segments.

Due to the fact that many segments were overrepresented to a greater or lesser degree, we have only listed those where with an index score of 150 or more (this means there are at least 50% more LCFT service users in a particular group than would be expected given the demographic structure of Lancashire).

We have also included saturation analysis showing the Mosaic types with the highest *number* of people accessing LCFT along with a brief description of the top three types.

Overrepresentation

The most overrepresented Mosaic groups include:

1. Group N – Young people renting flats in high density social housing;
2. Group G – Young, well-educated city dwellers;
3. Group O – Families in low-rise social housing with high levels of benefit need.

These are mapped in appendix B to show the percentage of households in each group across Lancashire.

Overrepresented Mosaic types include:

1. N60 – Tenants in social housing flats on estates at risk of serious social problems;
2. O68 – Families with varied structures living on low rise social housing estates;
3. G33 – Transient singles, poorly supported by family and neighbours;
4. M57 – Old people in flats subsisting on welfare payments;
5. G32 – Students and other transient singles in multi-let houses;
6. B08 – Mixed communities with many single people in the centres of small towns;
7. N61 – Childless tenants in social housing flats with modest social needs;
8. I40 – Multi-ethnic communities in newer suburbs away from the inner city;
9. K51 – Often indebted families living in low-rise estates;

10. O69 – Vulnerable young parents needing substantial state support.

Saturation

In descending order the Mosaic types with the largest number of LCFT service users are:

1. I44 – Low income families occupying poor quality older terraces;
2. I43 – Older town centres terraces with transient, single populations;
3. O69 – Vulnerable young parents needing substantial state support;
4. J45 – Low income communities reliant on low skill industrial jobs;
5. O67 – Older tenants on low rise social housing estates where jobs are scarce;
6. I42 – South Asian communities experiencing social deprivation;
7. K50 – Older families in low value housing in traditional industrial areas;
8. N61 – Childless tenants in social housing flats with modest social needs;
9. J46 - Residents in blue collar communities revitalised by commuters;
10. B05 - Better off empty nesters in low density estates on town fringes.

The top three of these Mosaic groups are described in more detail in appendix B.

Appendix A: Prevalence indicators

Suicide

Table 37: DSR mortality from suicide (all persons), 1993 to 2008

		1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
ENGLAND	DSR	9.61	9.17	9.46	9.07	8.96	9.93	9.80	9.26	8.84	8.60	8.51	8.57	8.35	7.84	7.47	7.98
	OBS	4810	4631	4748	4607	4521	5005	5006	4743	4563	4450	4452	4518	4421	4180	4006	4293
NORTH WEST	DSR	10.26	9.75	10.52	9.85	10.88	11.64	11.81	10.85	10.31	9.21	9.28	9.12	9.70	9.13	9.03	8.69
	OBS	715	679	733	682	745	805	812	745	717	641	645	641	680	640	636	614
Blackburn with Darwen	DSR	11.24	10.31	10.29	7.75	22.57	14.41	11.23	11.52	14.21	15.72	10.70	15.38	8.37	10.31	13.46	8.38
	OBS	16	15	14	10	31	18	16	16	18	21	15	21	11	14	18	11
Blackpool	DSR	14.37	10.87	16.03	13.44	17.56	18.13	15.16	14.62	22.55	19.40	16.91	3.70	18.92	17.91	13.01	15.12
	OBS	22	17	26	22	26	27	23	21	33	29	24	5	27	26	18	21
North Lancashire PCT	DSR	9.27	11.24	11.64	12.45	10.51	11.39	13.47	14.67	11.44	7.72	10.29	7.50	5.43	8.06	6.80	8.27
	OBS	30	34	35	37	33	37	42	47	35	26	34	27	18	26	22	27
Central Lancashire PCT	DSR	9.09	7.36	12.27	9.95	11.23	13.61	10.33	7.18	9.52	6.57	7.04	10.71	7.96	6.43	11.33	11.60
	OBS	40	34	54	44	50	62	44	33	44	32	32	49	39	30	51	53
East Lancashire Teaching PCT	DSR	10.99	8.69	12.85	10.79	11.12	12.86	12.54	9.95	10.48	9.12	7.04	10.16	9.63	6.91	10.19	9.60
	OBS	41	34	49	41	41	49	47	37	41	36	27	38	37	29	40	38
Lancashire	DSR	9.75	8.79	12.30	10.82	11.07	12.73	11.91	10.10	10.30	7.70	7.92	9.68	7.72	7.01	9.65	9.98
	OBS	111	102	138	122	124	148	133	117	120	94	93	114	94	85	113	118
Burnley CD	DSR	13.64	6.93	8.07	14.77	13.37	8.59	7.89	10.36	10.16	9.51	6.69	11.75	7.92	7.97	8.46	11.10
	OBS	12	8	7	14	12	8	7	9	9	9	6	11	7	8	7	10
Chorley CD	DSR	12.96	8.49	10.48	8.42	16.50	10.56	7.66	7.06	11.83	5.31	7.28	10.41	4.14	3.28	13.41	19.57
	OBS	13	9	10	8	16	11	7	7	13	6	8	10	5	4	14	21
Fylde CD	DSR	9.03	5.60	11.08	9.34	9.19	10.41	7.47	11.96	6.72	6.61	8.71	6.56	6.21	8.16	4.65	8.86
	OBS	7	4	8	6	7	9	6	10	5	5	6	7	5	6	3	7
Hyndburn CD	DSR	11.61	7.92	16.05	8.01	9.38	14.78	22.84	11.08	8.45	13.04	7.75	8.92	8.53	5.32	14.76	7.11
	OBS	9	7	13	6	7	11	17	9	7	11	6	7	7	5	12	6
Lancaster CD	DSR	9.22	12.17	12.25	17.15	9.15	8.97	15.70	19.18	15.67	6.94	11.11	6.92	4.30	7.86	8.32	6.28

Mental health and wellbeing in Lancashire

		1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
	OBS	13	15	16	23	13	13	21	26	21	10	16	11	6	12	12	9
Pendle CD	DSR	9.33	6.49	13.37	12.10	12.36	16.75	9.89	10.55	18.63	7.76	11.18	11.19	10.48	6.08	3.32	9.11
	OBS	8	5	13	10	11	15	10	9	17	7	10	9	10	5	3	9
Preston CD	DSR	9.78	7.01	18.99	14.45	8.34	22.03	12.46	7.02	13.11	10.59	4.62	13.71	10.38	6.22	17.44	9.72
	OBS	13	9	24	20	12	30	16	9	17	14	6	18	15	8	23	12
Ribble Valley CD	DSR	10.74	9.01	14.93	7.75	13.35	16.41	8.41	4.36	1.63	12.94	2.28	8.18	5.30	7.68	9.88	9.97
	OBS	6	5	7	5	7	8	4	2	1	7	2	5	3	5	7	6
Rossendale CD	DSR	8.35	14.79	13.82	8.54	5.73	9.34	13.57	12.46	9.99	2.83	4.45	9.59	15.15	7.73	16.11	11.47
	OBS	6	9	9	6	4	7	9	8	7	2	3	6	10	6	11	7
South Ribble CD	DSR	6.59	8.46	9.34	8.77	11.59	6.54	11.72	7.93	9.87	6.89	7.65	10.88	8.74	10.79	7.37	7.08
	OBS	7	9	9	9	12	7	12	9	11	8	9	12	11	12	7	9
West Lancashire CD	DSR	6.37	6.18	9.36	6.69	9.87	12.30	8.77	6.54	2.84	3.67	8.64	7.64	7.86	5.43	6.65	11.28
	OBS	7	7	11	7	10	14	9	8	3	4	9	9	8	6	7	11
Wyre CD	DSR	9.26	15.42	11.67	8.39	12.89	14.67	13.93	11.64	8.87	9.53	12.48	7.81	6.73	8.07	6.81	11.01
	OBS	10	15	11	8	13	15	15	11	9	11	12	9	7	8	7	11
Source: NCHOD																	

Table 38: DSR mortality from suicide (males), 1993 to 2008

		1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
ENGLAND	DSR	14.72	14.27	14.67	13.95	13.70	15.52	15.28	14.15	13.70	13.14	13.04	12.91	12.60	12.02	11.64	12.36
	OBS	3541	3459	3549	3421	3343	3788	3771	3511	3423	3303	3311	3300	3256	3131	3054	3266
NORTH WEST	DSR	16.02	15.05	16.27	15.40	16.32	18.46	18.40	17.03	15.99	13.80	13.86	14.15	15.32	14.38	14.48	13.84
	OBS	542	505	551	520	546	618	615	565	535	467	467	481	523	494	499	479
Blackburn with Darwen	DSR	13.05	15.33	11.90	13.73	35.16	25.54	19.35	16.74	20.57	18.22	17.24	23.67	10.35	11.86	20.84	16.66
	OBS	9	11	8	9	24	16	13	11	13	12	12	16	7	8	14	11
Blackpool	DSR	22.78	14.01	26.36	17.54	27.20	28.78	22.32	20.17	41.39	36.13	23.40	5.67	31.91	28.18	26.05	21.59
	OBS	16	10	21	14	19	21	16	14	29	26	16	4	22	20	18	15
North Lancashire PCT	DSR	12.34	16.76	18.06	21.92	16.77	16.77	20.61	23.42	16.99	12.51	14.55	12.36	6.72	13.24	8.65	14.06
	OBS	18	24	27	32	25	26	30	35	26	20	23	22	10	21	14	22

Mental health and wellbeing in Lancashire

		1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Central Lancashire PCT	DSR	15.89	12.97	19.98	15.23	15.88	21.42	18.20	10.84	13.69	8.91	10.86	17.93	14.09	10.59	19.38	19.73
	OBS	34	29	43	33	35	47	39	24	30	21	24	40	33	24	43	45
East Lancashire Teaching PCT	DSR	14.80	14.23	19.13	16.79	18.10	20.46	21.02	17.38	15.97	12.95	9.92	17.51	15.40	10.36	15.49	16.01
	OBS	27	26	35	31	33	37	38	32	30	25	18	32	29	20	29	31
Lancashire	DSR	14.39	14.21	19.17	17.40	16.94	19.83	19.82	16.46	15.23	11.25	11.48	16.35	12.27	11.24	15.11	16.88
	OBS	79	79	105	96	93	110	107	91	86	66	65	94	72	65	86	98
Burnley CD	DSR	16.42	12.70	2.48	18.06	26.96	13.65	13.98	18.77	8.82	15.56	10.17	20.30	13.73	8.69	17.02	17.18
	OBS	7	6	1	8	12	6	6	8	4	7	4	9	6	4	7	7
Chorley CD	DSR	21.61	13.70	19.04	16.34	22.81	18.50	10.93	13.77	17.68	8.92	12.81	16.25	8.50	4.93	21.07	31.02
	OBS	10	7	9	8	11	9	5	7	9	5	7	8	5	3	10	17
Fylde CD	DSR	8.99	5.94	11.43	17.95	15.62	14.41	11.96	18.24	10.99	12.29	9.30	9.01	8.78	10.90	6.07	13.47
	OBS	3	2	4	6	6	6	4	7	4	4	3	5	3	4	2	5
Hyndburn CD	DSR	17.70	12.45	27.86	10.76	18.78	28.26	36.73	15.02	12.44	17.18	8.11	18.41	7.85	7.27	26.91	12.09
	OBS	7	5	11	4	7	10	14	6	5	7	3	7	3	3	11	5
Lancaster CD	DSR	13.09	16.90	23.21	27.60	15.08	10.33	23.20	30.13	22.19	11.59	13.39	10.00	4.14	14.44	9.70	10.38
	OBS	9	10	15	18	10	7	15	19	15	8	9	8	3	11	7	7
Pendle CD	DSR	11.88	12.89	23.23	21.55	18.06	25.80	19.48	18.78	33.63	13.93	17.79	14.97	16.68	9.48	4.64	16.02
	OBS	5	5	10	9	8	11	8	8	15	6	8	6	8	4	2	8
Preston CD	DSR	16.90	12.29	30.35	19.07	12.75	35.65	22.92	11.01	15.49	13.93	9.15	18.11	17.42	10.69	31.19	17.18
	OBS	11	8	19	13	9	24	15	7	10	9	6	12	12	7	21	11
Ribble Valley CD	DSR	16.22	6.50	21.00	16.35	18.94	25.37	10.62	8.79	3.30	9.90	6.54	16.69	7.19	13.48	9.03	16.16
	OBS	4	2	5	5	5	6	3	2	1	3	2	5	2	4	3	5
Rossendale CD	DSR	11.14	26.53	24.65	13.89	3.11	11.28	21.36	25.46	15.94	5.83	3.05	17.14	30.80	14.60	19.91	20.12
	OBS	4	8	8	5	1	4	7	8	5	2	1	5	10	5	6	6
South Ribble CD	DSR	13.39	16.16	12.38	14.00	15.21	11.77	23.61	7.59	18.20	11.27	8.62	19.98	15.58	16.91	12.67	11.93
	OBS	7	8	6	7	8	6	12	4	9	6	5	11	9	9	6	7
West Lancashire CD	DSR	11.09	10.91	16.87	9.74	14.06	15.32	13.26	10.70	3.93	1.45	12.31	16.62	14.54	10.24	11.84	19.93
	OBS	6	6	9	5	7	8	7	6	2	1	6	9	7	5	6	10
Wyre CD	DSR	13.17	26.14	16.78	17.14	19.20	26.07	22.06	20.10	13.42	14.44	22.40	16.15	9.46	12.86	9.79	20.46
	OBS	6	12	8	8	9	13	11	9	7	8	11	9	4	6	5	10

		1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Source: NCHOD																	

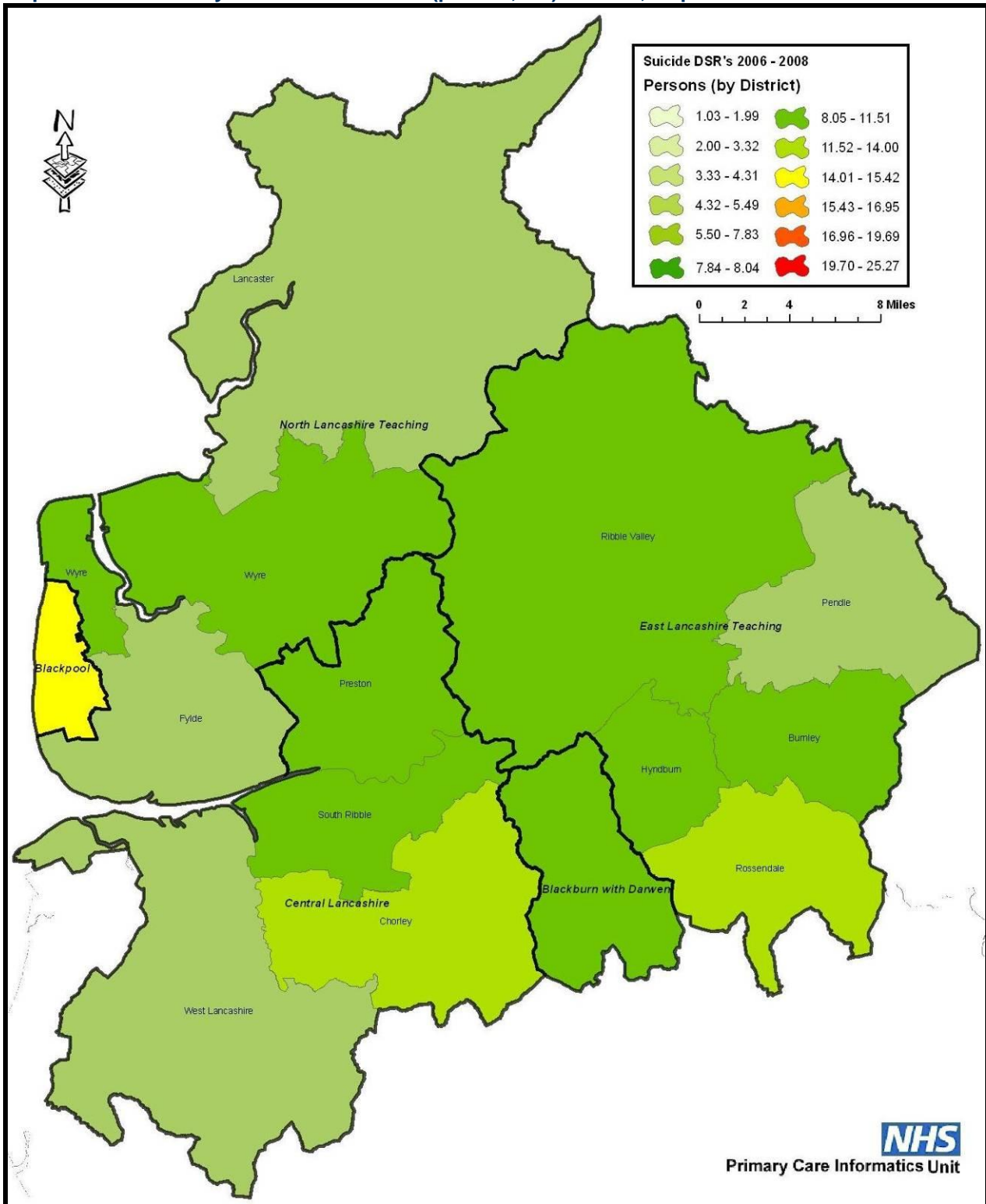
Table 39: DSR mortality from suicide (all persons), 1993 to 2008

		1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
ENGLAND	DSR	4.74	4.38	4.50	4.44	4.46	4.55	4.56	4.60	4.20	4.21	4.16	4.40	4.27	3.81	3.43	3.72
	OBS	1269	1172	1199	1186	1178	1217	1235	1232	1140	1147	1141	1218	1165	1049	952	1027
NORTH WEST	DSR	4.69	4.68	4.98	4.57	5.69	5.13	5.52	4.99	4.96	4.83	4.95	4.27	4.34	4.06	3.73	3.65
	OBS	173	174	182	162	199	187	197	180	182	174	178	160	157	146	137	135
Blackburn with Darwen	DSR	9.96	5.16	8.82	1.65	10.01	3.15	3.82	6.26	7.77	13.34	4.27	7.35	6.34	8.68	5.87	0.00
	OBS	7	4	6	1	7	2	3	5	5	9	3	5	4	6	4	0
Blackpool	DSR	5.88	7.68	6.65	10.08	8.37	7.90	7.96	8.94	3.55	3.74	10.22	1.80	6.56	7.61	0.00	8.86
	OBS	6	7	5	8	7	6	7	7	4	3	8	1	5	6	0	6
North Lancashire PCT	DSR	5.84	5.65	5.44	3.10	4.25	6.17	6.59	6.72	6.19	3.18	6.22	2.90	4.11	2.93	5.20	2.66
	OBS	12	10	8	5	8	11	12	12	9	6	11	5	8	5	8	5
Central Lancashire PCT	DSR	2.70	1.99	4.90	4.82	6.59	5.84	2.44	3.48	6.23	4.10	3.38	3.69	2.34	2.29	3.30	3.42
	OBS	6	5	11	11	15	15	5	9	14	11	8	9	6	6	8	8
East Lancashire Teaching PCT	DSR	7.41	3.52	6.55	5.00	4.27	5.48	4.63	2.54	5.25	5.47	4.58	3.41	4.01	3.64	4.92	3.30
	OBS	14	8	14	10	8	12	9	5	11	11	9	6	8	9	11	7
Lancashire	DSR	5.21	3.58	5.58	4.36	5.28	5.73	4.27	4.06	5.81	4.25	4.59	3.38	3.39	2.87	4.30	3.17
	OBS	32	23	33	26	31	38	26	26	34	28	28	20	22	20	27	20
Burnley CD	DSR	10.91	2.71	13.50	11.49	0.00	3.41	2.03	2.06	11.69	3.86	3.49	4.34	2.32	7.60	0.00	5.33
	OBS	5	2	6	6	0	2	1	1	5	2	2	2	1	4	0	3
Chorley CD	DSR	5.92	2.91	2.02	0.00	9.51	3.64	3.99	0.00	7.24	1.70	1.94	3.93	0.00	1.52	5.73	7.87
	OBS	3	2	1	0	5	2	2	0	4	1	1	2	0	1	4	4
Fylde CD	DSR	8.70	5.28	10.77	0.00	2.84	6.35	2.64	5.66	2.62	0.61	7.92	4.25	3.47	5.42	2.70	3.97
	OBS	4	2	4	0	1	3	2	3	1	1	3	2	2	2	1	2
Hyndburn CD	DSR	6.21	2.48	5.27	4.99	0.00	2.64	8.92	6.80	4.47	8.42	7.54	0.00	8.74	3.29	2.82	2.04
	OBS	2	2	2	2	0	1	3	3	2	4	3	0	4	2	1	1
Lancaster CD	DSR	5.17	7.17	1.65	7.00	3.09	7.57	8.85	9.48	9.63	2.82	9.01	3.97	4.61	1.57	7.08	2.56

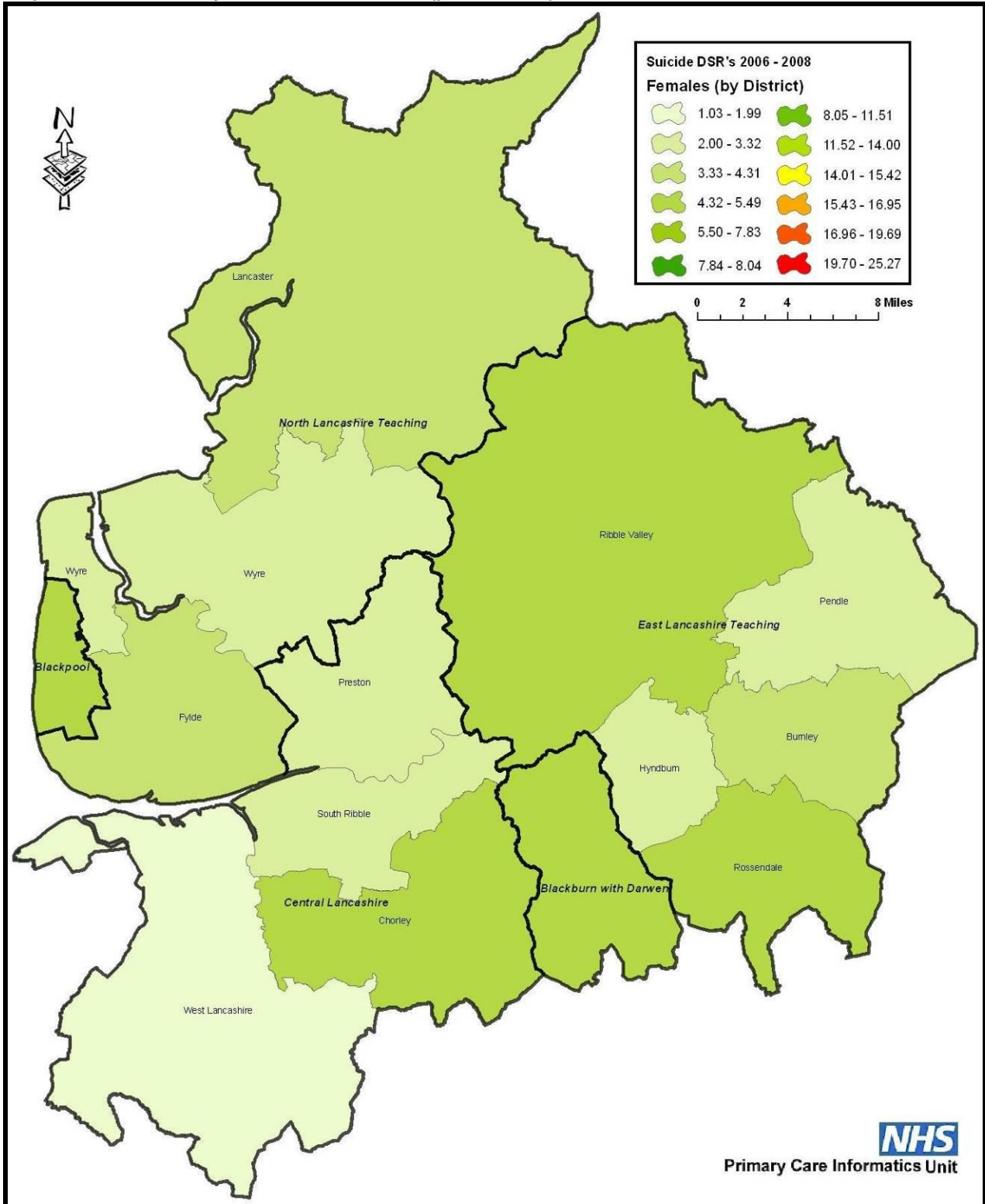
Mental health and wellbeing in Lancashire

		1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
	OBS	4	5	1	5	3	6	6	7	6	2	7	3	3	1	5	2
Pendle CD	DSR	7.52	0.00	2.78	2.29	7.13	7.56	1.90	2.40	4.80	2.41	4.95	7.85	4.73	2.64	2.13	2.75
	OBS	3	0	3	1	3	4	2	1	2	1	2	3	2	1	1	1
Preston CD	DSR	2.69	1.68	7.26	10.20	3.84	8.16	1.89	3.02	10.63	6.86	0.00	9.17	3.90	1.65	3.41	1.85
	OBS	2	1	5	7	3	6	1	2	7	5	0	6	3	1	2	1
Ribble Valley CD	DSR	4.61	12.87	8.25	0.00	7.42	6.74	6.54	0.00	0.00	16.02	0.00	0.00	3.30	2.54	10.46	3.21
	OBS	2	3	2	0	2	2	1	0	0	4	0	0	1	1	4	1
Rossendale CD	DSR	5.84	3.04	3.03	3.52	8.36	7.63	6.29	0.00	3.57	0.00	5.81	2.65	0.00	1.10	11.82	2.79
	OBS	2	1	1	1	3	3	2	0	2	0	2	1	0	1	5	1
South Ribble CD	DSR	0.00	1.72	6.20	3.44	8.68	1.31	0.00	8.00	3.60	2.44	6.98	1.98	3.01	4.84	1.98	2.35
	OBS	0	1	3	2	4	1	0	5	2	2	4	1	2	3	1	2
West Lancashire CD	DSR	1.85	1.79	3.22	3.81	5.29	8.72	4.62	2.46	1.86	5.51	5.20	0.00	1.61	0.66	1.78	2.79
	OBS	1	1	2	2	3	6	2	2	1	3	3	0	1	1	1	1
Wyre CD	DSR	5.10	5.00	6.61	0.00	6.92	4.36	6.35	3.47	4.68	4.87	3.18	0.00	3.61	3.44	4.55	1.96
	OBS	4	3	3	0	4	2	4	2	2	3	1	0	3	2	2	1
Source: NCHOD																	

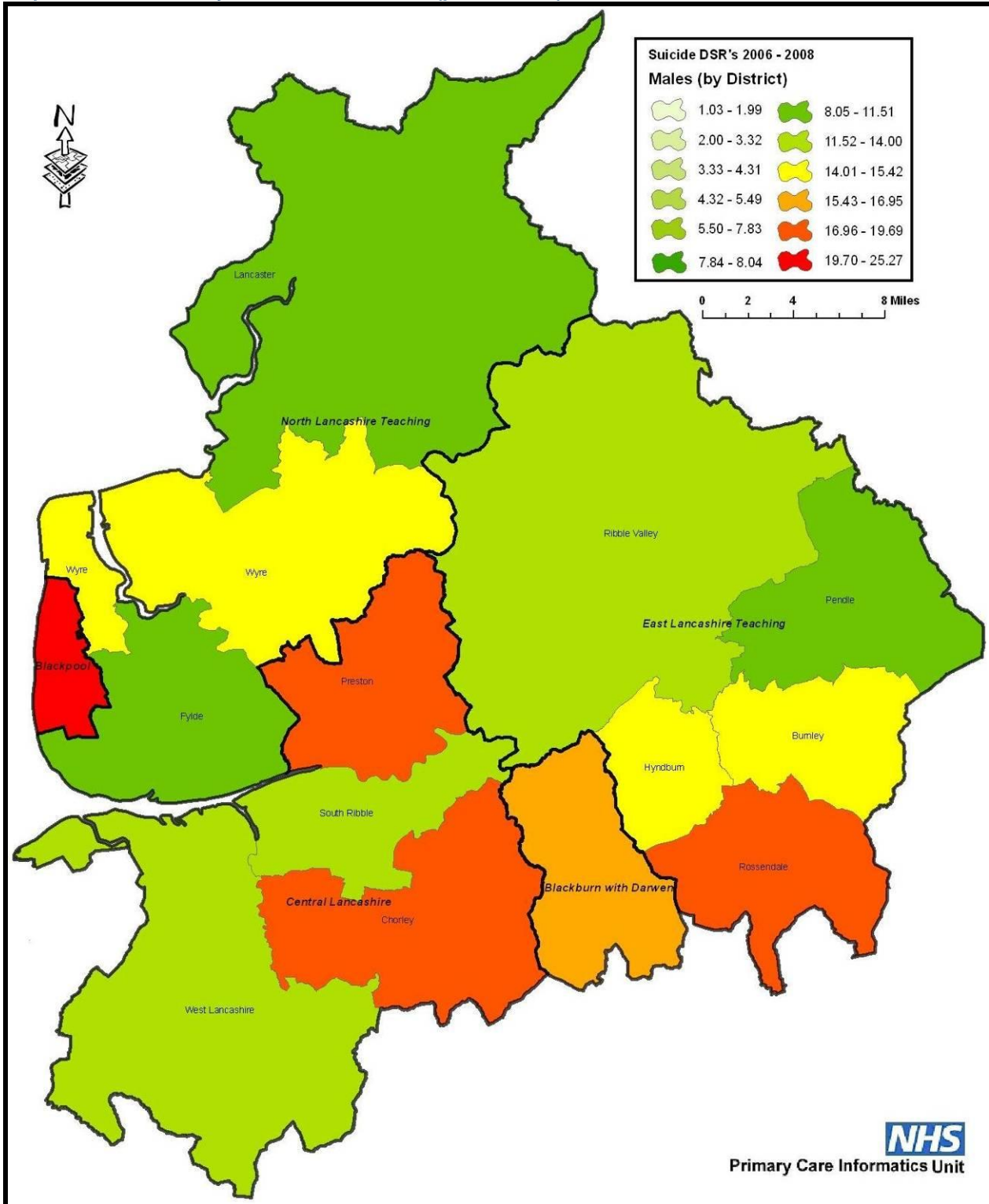
Map 3: Pooled Directly Standardised Rates (per 100,000) 2006-08, all persons



Map 4: Pooled Directly Standardised Rates (per 100,000) 2006-08, female



Map 5: Pooled Directly Standardised Rates (per 100,000) 2006-08, male



Eating disorders

Table 40: Estimated Number of Cases of Anorexia Nervosa

Area Code	Area	Cases		Female Population 15-29 2011	Female Population 15-29 2021
		2011	2021		

30UD	Burnley CD	81	69	8,100	6,900
30UE	Chorley CD	87	81	8,700	8,100
30UF	Fylde CD	49	43	4,900	4,300
30UG	Hyndburn CD	76	69	7,600	6,900
30UH	Lancaster CD	172	156	17,200	15,600
30UJ	Pendle CD	82	74	8,200	7,400
30UK	Preston CD	181	167	18,100	16,700
30UL	Ribble Valley CD	40	37	4,000	3,700
30UM	Rossendale CD	58	53	5,800	5,300
30UN	South Ribble CD	91	84	9,100	8,400
30UP	West Lancashire CD	103	95	10,300	9,500
30UQ	Wyre CD	85	77	8,500	7,700
00EX	Blackburn with Darwen	139	132	13,900	13,200
00EY	Blackpool	126	117	12,600	11,700
5NF	North Lancashire PCT	306	276	30,600	27,600
5NG	Central Lancashire PCT	462	427	46,200	42,700
5NH	East Lancashire Teaching PCT	337	302	33,700	30,200
30	Lancashire CC	1105	1005	110,500	100,500

Source: Population estimate - www.statistics.gov.uk/snpp

Assumed prevalence rate of 1% of 15-29 year old female population

Table 41: Estimated Number of Cases of Bulimia Nervosa

Area Code	Area	Cases		Female Population 15-29 2011	Female Population 15-29 2021
		2011	2021		
30UD	Burnley CD	162	138	8,100	6,900
30UE	Chorley CD	174	162	8,700	8,100
30UF	Fylde CD	98	86	4,900	4,300
30UG	Hyndburn CD	152	138	7,600	6,900
30UH	Lancaster CD	344	312	17,200	15,600
30UJ	Pendle CD	164	148	8,200	7,400
30UK	Preston CD	362	334	18,100	16,700
30UL	Ribble Valley CD	80	74	4,000	3,700
30UM	Rossendale CD	116	106	5,800	5,300
30UN	South Ribble CD	182	168	9,100	8,400
30UP	West Lancashire CD	206	190	10,300	9,500
30UQ	Wyre CD	170	154	8,500	7,700
00EX	Blackburn with Darwen	278	264	13,900	13,200
00EY	Blackpool	252	234	12,600	11,700
5NF	North Lancashire PCT	612	552	30,600	27,600
5NG	Central Lancashire PCT	924	854	46,200	42,700
5NH	East Lancashire Teaching PCT	674	604	33,700	30,200
30	Lancashire CC	2210	2010	110,500	100,500

Source: Population estimate - www.statistics.gov.uk/snpp

Assumed prevalence rate of 2% of 15-29 year old female population

Schizophrenia

To estimate the total number of people with schizophrenia an overall prevalence of 0.5% of the adult population has been applied to population estimates and projections, consistent with "Psychiatric Morbidity Survey (2007), p99".

Table 42: Estimated age and gender of people with schizophrenia – Blackburn with Darwen

Age Band	2011			2021		
	Male	Female	All Persons	Male	Female	All Persons
15–24	25	6	31	22	5	27
25–34	47	25	72	54	26	80
35–44	73	39	112	66	34	100
45–54	65	55	120	62	52	114
55–64	44	60	104	47	66	113
65–74	26	34	60	31	40	71
75–84	11	22	33	13	24	37
85+	2	7	9	3	8	11
Total	293	248	541	298	256	554

Table 43: Estimated age and gender of people with schizophrenia – Blackpool

Age Band	2011			2021		
	Male	Female	All Persons	Male	Female	All Persons
15–24	21	5	26	18	5	23
25–34	39	20	59	46	22	68
35–44	65	36	101	61	29	90
45–54	71	59	129	64	54	118
55–64	51	69	120	55	74	130
65–74	38	46	83	40	46	86
75–84	16	31	47	19	32	51
85+	3	11	15	5	12	17
Total	305	277	582	307	275	582

Table 44: Estimated age and gender of people with schizophrenia - Burnley

Age Band	2011			2021		
	Male	Female	All Persons	Male	Female	All Persons
15–24	13	3	17	11	3	13
25–34	25	14	39	27	14	42
35–44	38	22	61	34	19	53
45–54	40	37	76	34	30	64
55–64	31	42	74	30	44	74
65–74	20	25	45	24	29	53
75–84	8	17	25	10	19	29
85+	2	6	9	3	7	10
Total	178	167	345	173	165	338

Table 45: Estimated age and gender of people with schizophrenia – Chorley

Age Band	2011			2021		
	Male	Female	All Persons	Male	Female	All Persons
15–24	14	4	17	12	3	15
25–34	32	15	47	34	17	51
35–44	56	29	86	52	25	77
45–54	54	45	99	53	43	95

55–64	41	56	97	43	58	101
65–74	28	32	60	32	39	72
75–84	10	18	28	15	25	40
85+	2	7	8	3	9	12
Total	236	206	442	245	219	464

Table 46: Estimated age and gender of people with schizophrenia – Fylde

Age Band	2011			2021		
	Male	Female	All Persons	Male	Female	All Persons
15–24	9	2	10	8	2	9
25–34	18	8	26	19	8	27
35–44	33	19	51	30	15	44
45–54	38	33	71	33	30	63
55–64	31	42	73	34	48	82
65–74	23	30	53	28	34	62
75–84	11	22	33	14	25	39
85+	2	8	11	4	11	14
Total	164	164	328	170	172	342

Table 47: Estimated age and gender of people with schizophrenia - Hyndburn

Age Band	2011			2021		
	Male	Female	All Persons	Male	Female	All Persons
15–24	13	3	16	11	3	14
25–34	24	13	37	27	14	41
35–44	41	22	63	35	18	53
45–54	39	33	72	37	31	68
55–64	28	38	66	30	41	71
65–74	19	23	42	21	26	47
75–84	7	15	22	9	17	27
85+	2	6	7	2	6	9
Total	172	153	325	173	156	330

Table 48: Estimated age and gender of people with schizophrenia - Lancaster

Age Band	2011			2021		
	Male	Female	All Persons	Male	Female	All Persons
15–24	30	8	38	26	7	34
25–34	47	25	71	53	25	78
35–44	65	36	101	66	34	100
45–54	67	57	125	62	52	113
55–64	51	73	124	56	78	134
65–74	36	46	82	43	54	97
75–84	16	33	49	20	36	56
85+	3	12	15	5	15	20
Total	316	289	605	331	301	632

Table 49: Estimated age and gender of people with schizophrenia – Pendle

	2011	2021
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Age Band	2011			2021		
	Male	Female	All Persons	Male	Female	All Persons
15-24	13	3	16	11	3	14
25-34	27	14	41	30	15	45
35-44	42	23	65	40	21	61
45-54	43	37	79	39	33	73
55-64	34	45	79	34	48	82
65-74	21	25	46	27	31	58
75-84	8	18	26	11	20	31
85+	2	6	8	3	8	10
Total	190	172	362	194	179	373

Table 50: Estimated age and gender of people with schizophrenia - Preston

Age Band	2011			2021		
	Male	Female	All Persons	Male	Female	All Persons
15-24	32	9	41	29	8	37
25-34	60	27	87	68	29	96
35-44	70	36	107	70	32	102
45-54	66	54	120	60	49	109
55-64	45	58	103	50	66	115
65-74	28	35	63	33	39	72
75-84	13	26	38	15	26	41
85+	2	8	10	4	10	13
Total	316	253	569	328	257	585

Table 51: Estimated age and gender of people with schizophrenia - Ribble Valley

Age Band	2011			2021		
	Male	Female	All Persons	Male	Female	All Persons
15-24	7	2	9	6	1	8
25-34	12	6	18	13	7	20
35-44	27	16	43	22	13	35
45-54	31	27	58	29	26	55
55-64	23	32	55	26	36	62
65-74	17	20	37	20	24	44
75-84	7	12	19	9	16	25
85+	1	4	5	2	6	8
Total	124	120	244	128	129	257

Table 52: Estimated age and gender of people with schizophrenia - Rossendale

Age Band	2011			2021		
	Male	Female	All Persons	Male	Female	All Persons
15-24	9	2	12	8	2	10
25-34	17	10	27	20	11	32
35-44	33	20	53	31	17	48
45-54	35	29	65	33	28	61
55-64	25	35	61	28	37	65
65-74	15	18	33	19	23	42
75-84	5	11	17	8	14	21

85+	1	4	5	2	5	7
Total	142	130	272	148	138	286

Table 53: Estimated age and gender of people with schizophrenia - South Ribble

Age Band	2011			2021		
	Male	Female	All Persons	Male	Female	All Persons
15-24	14	4	18	12	3	16
25-34	31	17	48	36	18	54
35-44	54	31	85	52	27	79
45-54	53	47	100	51	44	96
55-64	40	57	97	43	62	105
65-74	28	34	63	33	41	74
75-84	11	22	33	15	28	43
85+	2	7	9	4	9	13
Total	235	218	454	247	232	479

Table 54: Estimated age and gender of people with schizophrenia - West Lancashire

Age Band	2011			2021		
	Male	Female	All Persons	Male	Female	All Persons
15-24	16	5	21	15	4	19
25-34	27	15	42	31	17	48
35-44	48	28	76	42	23	65
45-54	55	49	104	46	43	89
55-64	42	61	103	45	66	111
65-74	31	38	69	35	44	79
75-84	12	23	35	17	30	47
85+	2	7	9	4	10	14
Total	233	226	460	235	236	472

Table 55: Estimated age and gender of people with schizophrenia - Wyre

Age Band	2011			2021		
	Male	Female	All Persons	Male	Female	All Persons
15-24	15	4	18	13	3	16
25-34	27	13	40	33	15	48
35-44	46	27	73	44	23	67
45-54	53	46	99	48	44	92
55-64	42	63	106	49	70	119
65-74	35	46	81	41	53	93
75-84	16	32	48	21	37	58
85+	3	10	13	5	14	18
Total	238	241	479	253	258	511

Table 56: Estimated age and gender of people with schizophrenia - Lancashire

Age Band	2011			2021		
	Male	Female	All Persons	Male	Female	All Persons

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15–24	184	48	232	161	41	202
25–34	345	176	521	389	190	579
35–44	554	310	864	516	264	780
45–54	573	495	1069	522	454	976
55–64	434	605	1039	467	654	1121
65–74	302	374	676	356	439	795
75–84	124	249	372	165	293	458
85+	24	86	111	39	108	147
Total	2542	2342	4884	2615	2442	5058

Common mental health disorders

The table below shows the prevalence rates used by the Mental Health Observatory to calculate the number of people with neurotic disorders.

Table 57: Common mental health disorder prevalence rates 2006

Area Code	Area	Rates per 1000 population							Population 16-74
		Any neurotic disorder	All phobias	Depressive episode	Generalised anxiety disorder	Mixed anxiety depression	Obsessive compulsive disorder	Panic disorder	
30UD	Burnley CD	199.20	26.06	27.44	62.46	107.30	17.00	2.90	62,996
30UE	Chorley CD	149.01	19.72	20.36	47.84	79.99	12.71	2.15	77,292
30UF	Fylde CD	143.56	18.65	19.50	46.73	76.86	12.04	2.09	54,613
30UG	Hyndburn CD	192.32	25.27	26.25	60.51	103.81	16.40	2.76	58,045
30UH	Lancaster CD	176.06	23.08	24.20	51.81	96.02	15.88	2.41	105,903
30UJ	Pendle CD	193.31	25.38	26.44	60.82	104.11	16.50	2.80	63,997
30UK	Preston CD	205.13	27.12	27.88	61.16	112.05	18.12	2.80	96,784
30UL	Ribble Valley CD	136.53	17.78	18.83	44.40	73.00	11.47	1.99	41,907
30UM	Rosendale CD	161.08	21.22	22.24	51.55	86.32	13.66	2.35	47,982
30UN	South Ribble CD	177.78	23.29	24.47	56.83	95.44	15.06	2.58	77,944
30UP	West Lancashire CD	157.73	20.39	21.95	49.90	84.69	13.41	2.28	80,406
30UQ	Wyre CD	149.10	19.10	20.52	47.76	79.97	12.47	2.19	78,977
00EX	Blackburn with Darwen	200.03	26.60	27.24	61.75	108.46	17.21	2.85	98,315
00EY	Blackpool	212.28	27.72	29.02	67.47	114.25	18.00	3.05	103,404
5NF	North Lancashire PCT	159.75	20.76	21.91	49.32	86.36	13.88	2.27	239,493
5NG	Central Lancashire PCT	174.20	22.87	23.90	54.32	94.08	15.01	2.47	332,426
5NH	East Lancashire Teaching PCT	180.17	23.63	24.74	57.01	96.93	15.33	2.61	274,927
30	Lancashire CC	172.05	22.52	23.61	53.78	92.82	14.79	2.46	846,846

Source: Mental Health Observatory - <http://www.nepho.org/mho/briefs/>

The rates have been applied to ONS population estimates to estimate the number of cases of neurotic disorders in 2006, shown in the table below.

Table 58: Estimated Number of Cases of common mental health disorders 2006

Cases

For further details please contact: jsna@lancashire.gov.uk

Area Code	Area	Any neurotic disorder	All phobias	Depressive episode	Generalised anxiety disorder	Mixed anxiety depression	Obsessive compulsive disorder	Panic disorder	Population 16-74
30UD	Burnley CD	12549	1642	1729	3934	6760	1071	183	62,996
30UE	Chorley CD	11517	1524	1574	3698	6182	982	166	77,292
30UF	Fylde CD	7840	1018	1065	2552	4197	657	114	54,613
30UG	Hyndburn CD	11163	1467	1524	3512	6026	952	160	58,045
30UH	Lancaster CD	18645	2445	2563	5487	10169	1682	255	105,903
30UJ	Pendle CD	12371	1624	1692	3892	6663	1056	179	63,997
30UK	Preston CD	19853	2625	2698	5920	10845	1754	271	96,784
30UL	Ribble Valley CD	5722	745	789	1861	3059	480	83	41,907
30UM	Rossendale CD	7729	1018	1067	2474	4142	656	113	47,982
30UN	South Ribble CD	13857	1816	1907	4429	7439	1173	201	77,944
30UP	West Lancashire CD	12682	1639	1765	4012	6810	1078	184	80,406
30UQ	Wyre CD	11775	1509	1620	3772	6316	985	173	78,977
00EX	Blackburn with Darwen	19666	2615	2678	6071	10663	1692	280	98,315
00EY	Blackpool	21951	2867	3000	6977	11814	1862	315	103,404
5NF	North Lancashire PCT	38260	4972	5248	11812	20682	3324	543	239,493
5NG	Central Lancashire PCT	57909	7604	7945	18059	31275	4988	822	332,426
5NH	East Lancashire Teaching PCT	49534	6496	6801	15673	26650	4215	718	274,927
30	Lancashire CC	145703	19072	19993	45544	78607	12527	2083	846,846

Source: Mental Health Observatory - <http://www.nepho.org/mho/briefs/>

ONS population projections for 2016 are applied to the neurotic disorder prevalence rates in Table 16 to produce the projected rates in the table below.

Table 59: Projected common mental health disorder prevalence rates 2016

Area Code	Area	Rates per 1000 population							Population 16-74
		Any neurotic disorder	All phobias	Depressive episode	Generalised anxiety disorder	Mixed anxiety depression	Obsessive compulsive disorder	Panic disorder	
30UD	Burnley CD	188.02	24.60	25.90	58.95	101.28	16.05	2.74	59,460
30UE	Chorley CD	154.81	20.48	21.15	49.71	83.10	13.21	2.23	80,300
30UF	Fylde CD	147.10	19.11	19.98	47.88	78.75	12.34	2.14	55,960
30UG	Hyndburn CD	191.91	25.22	26.19	60.38	103.59	16.36	2.76	57,920
30UH	Lancaster CD	179.91	23.59	24.73	52.95	98.13	16.23	2.46	108,220

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30UJ	Pendle CD	195.61	25.68	26.76	61.55	105.35	16.70	2.83	64,760
30UK	Preston CD	219.61	29.04	29.85	65.48	119.96	19.40	3.00	103,620
30UL	Ribble Valley CD	140.42	18.29	19.36	45.66	75.08	11.79	2.05	43,100
30UM	Rossendale CD	167.18	22.03	23.09	53.51	89.60	14.18	2.44	49,800
30UN	South Ribble CD	186.49	24.43	25.67	59.61	100.11	15.79	2.71	81,760
30UP	West Lancashire CD	158.50	20.49	22.06	50.14	85.11	13.48	2.29	80,800
30UQ	Wyre CD	156.84	20.09	21.58	50.25	84.12	13.11	2.31	83,080
00EX	Blackburn with Darwen	200.20	26.62	27.26	61.81	108.56	17.22	2.85	98,400
00EY	Blackpool	199.75	26.09	27.30	63.49	107.51	16.94	2.87	97,300
5NF	North Lancashire PCT	164.93	21.43	22.62	50.92	89.16	14.33	2.34	247,260
5NG	Central Lancashire PCT	181.57	23.84	24.91	56.62	98.06	15.64	2.58	346,480
5NH	East Lancashire Teaching PCT	180.25	23.64	24.75	57.03	96.97	15.34	2.61	275,040
30	Lancashire CC	176.51	23.10	24.22	55.17	95.23	15.18	2.52	868,780

Source: Mental Health Observatory - <http://www.nepho.org/mho/briefs/>

Source: Population estimate - www.statistics.gov.uk/snpp

The rates have been applied to ONS population estimates to estimate the number of cases of neurotic disorders in 2016, shown in the table below.

Table 60: Estimated number of cases of common mental health disorders 2016

Area Code	Area	Cases							Population 16-74
		Any neurotic disorder	All phobias	Depressive episode	Generalised anxiety disorder	Mixed anxiety depression	Obsessive compulsive disorder	Panic disorder	
30UD	Burnley CD	11845	1549	1631	3714	6380	1011	172	59,460
30UE	Chorley CD	11965	1583	1635	3842	6423	1021	173	80,300
30UF	Fylde CD	8033	1044	1091	2615	4301	674	117	55,960
30UG	Hyndburn CD	11139	1464	1520	3505	6013	950	160	57,920
30UH	Lancaster CD	19053	2498	2619	5607	10392	1719	261	108,220
30UJ	Pendle CD	12519	1644	1712	3939	6742	1069	181	64,760
30UK	Preston CD	21255	2811	2889	6338	11610	1878	290	103,620
30UL	Ribble Valley CD	5884	766	811	1913	3146	494	86	43,100
30UM	Rossendale CD	8022	1057	1108	2567	4299	680	117	49,800
30UN	South Ribble CD	14535	1904	2001	4646	7803	1231	211	81,760
30UP	West Lancashire CD	12745	1647	1773	4032	6843	1084	185	80,800
30UQ	Wyre CD	12387	1587	1704	3968	6644	1036	182	83,080

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00EX	Blackburn with Darwen	19683	2617	2680	6077	10673	1693	280	98,400
00EY	Blackpool	20655	2698	2823	6565	11116	1752	297	97,300
5NF	North Lancashire PCT	39501	5133	5418	12195	21353	3432	560	247,260
5NG	Central Lancashire PCT	60358	7926	8280	18822	32598	5199	857	346,480
5NH	East Lancashire Teaching PCT	49554	6499	6803	15680	26660	4217	718	275,040
30	Lancashire CC	149477	19566	20511	46723	80643	12852	2137	868,780

Source: Mental Health Observatory - <http://www.nepho.org/mho/briefs/>

Source: Population estimate - www.statistics.gov.uk/snpp

Learning disability

Table 61: People predicted to have learning disability by age, Lancashire, 2010

	18-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	Total
Lancashire 14	3,790	4,056	4,820	4,721	4,119	2,945	1,719	620	26,792
Lancashire 12	3079	3249	3873	3832	3395	2430	1412	511	21783
Blackburn with Darwen	369	441	482	418	331	210	124	41	2,415
Blackpool	342	366	465	471	393	305	183	68	2594
Burnley	220	244	274	274	242	162	92	40	1547
Chorley	225	301	387	364	323	217	108	38	1964
Fylde	130	169	245	269	249	199	131	51	1443
Hyndburn	198	234	277	257	217	151	84	32	1451
Lancaster	533	431	428	420	384	279	175	68	2718
Pendle	217	261	289	290	261	164	98	38	1618
Preston	561	488	433	399	310	217	136	43	2588
Ribble Valley	98	120	206	216	188	136	76	26	1064
Rosendale	144	177	245	232	201	120	66	25	1210
South Ribble	233	306	387	369	323	229	127	43	2018
West Lancashire	288	264	355	376	341	253	134	43	2054
Wyre	231	254	345	364	355	301	187	64	2102

Source: POPPI. Figures may not sum due to rounding. Crown copyright 2010

These predictions are based on prevalence rates in a report by Eric Emerson and Chris Hatton of the Institute for Health Research, Lancaster University, entitled Estimating Future Need/Demand for Supports for Adults with Learning Disabilities in England, June 2004. The authors take the prevalence base rates and adjust these rates to take account of ethnicity (i.e. the increased prevalence of learning disabilities in South Asian communities) and of mortality (i.e. both

increased survival rates of young people with severe and complex disabilities and reduced mortality among older adults with learning disabilities). Therefore, figures are based on an estimate of prevalence across the national population; locally this will produce an over-estimate in communities with a low South Asian community, and an under-estimate in communities with a high South Asian community.

Table 62: People predicted to have learning disability by age, Lancashire, 2020

	18-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	Total
Lancashire 14	3240	4688	4126	4637	4460	3563	2128	844	27687
Lancashire 12	2627	3750	3338	3756	3673	2984	1784	711	22623
Blackburn with Darwen	321	500	414	425	359	254	139	52	2465
Blackpool	292	438	374	456	428	325	205	81	2599
Burnley	162	274	224	244	243	198	111	50	1507
Chorley	186	344	335	371	341	279	159	56	2072
Fylde	108	187	197	254	282	246	159	71	1504
Hyndburn	167	266	229	259	234	174	105	40	1475
Lancaster	483	483	411	418	418	349	209	91	2863
Pendle	173	299	264	277	268	215	119	50	1664
Preston	511	565	399	383	350	248	153	60	2668
Ribble Valley	81	139	160	221	214	170	105	39	1128
Rosendale	116	212	207	240	216	161	83	31	1265
South Ribble	192	364	342	374	350	283	171	64	2140
West Lancashire	246	311	278	350	361	301	183	67	2098
Wyre	197	314	291	365	398	360	231	91	2246

Source: POPPI. Figures may not sum due to rounding. Crown copyright 2010

These predictions are based on prevalence rates in a report by Eric Emerson and Chris Hatton of the Institute for Health Research, Lancaster University, entitled Estimating Future Need/Demand for Supports for Adults with Learning Disabilities in England, June 2004. The authors take the prevalence base rates and adjust these rates to take account of ethnicity (i.e. the increased prevalence of learning disabilities in South Asian communities) and of mortality (i.e. both increased survival rates of young people with severe and complex disabilities and reduced mortality among older adults with learning disabilities). Therefore, figures are based on an estimate of prevalence across the national population; locally this will produce an over-estimate in communities with a low South Asian community, and an under-estimate in communities with a high South Asian community.

Predictions of the number of people with a learning disability for 2011 and 2021 are as follows:

Table 63: People predicted to have learning disability by age, Lancashire, 2011 and 2021

Age range	% in 2011	% in 2021
15-19	2.77	2.67
20-24	2.69	2.71
25-29	2.49	2.49
30-34	2.49	2.49
35-39	2.45	2.46
40-44	2.45	2.47
45-49	2.28	2.31
50-54	2.37	2.39
55-59	2.33	2.32
60-64	2.2	2.22
65-69	2.01	2.02
70-74	2.34	2.33
75-79	2.07	2.08
80+	1.89	1.93
Prediction rates have been applied to ONS population projections of the 18 and over population in the years 2011 and 2021 and linear trends projected to give estimated numbers predicted to have a mild, moderate or severe learning disability, to 2030.		

Table 64: People predicted to have a moderate or severe learning disability by age, Lancashire, 2010

	18-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	Total
Lancashire 14	869	796	1211	1061	889	478	180	59	5544
Lancashire 12	706	638	973	861	732	395	148	49	4502
Blackburn with Darwen	85	86	121	94	72	34	13	4	509
Blackpool	78	72	117	106	85	49	19	6	533
Burnley	50	48	69	61	52	26	10	4	321
Chorley	52	59	97	82	70	36	11	4	409

Fylde	30	33	62	60	53	32	14	5	289
Hyndburn	46	46	69	58	47	25	9	3	302
Lancaster	123	85	108	94	83	45	18	6	563
Pendle	50	51	73	65	57	27	10	4	336
Preston	128	97	109	90	67	35	14	4	544
Ribble Valley	23	23	52	49	40	22	8	3	219
Rossendale	33	34	61	52	43	20	7	2	254
South Ribble	54	60	97	83	70	37	13	4	418
West Lancashire	66	52	89	84	73	41	14	4	424
Wyre	53	50	87	82	76	49	20	6	422

Source: POPPI. Figures may not sum due to rounding. Crown copyright 2010

These predictions are based on prevalence rates in a report by Eric Emerson and Chris Hatton of the Institute for Health Research, Lancaster University, entitled Estimating Future Need/Demand for Supports for Adults with Learning Disabilities in England, June 2004. The authors take the prevalence base rates and adjust these rates to take account of ethnicity (i.e. the increased prevalence of learning disabilities in South Asian communities) and of mortality (i.e. both increased survival rates of young people with severe and complex disabilities and reduced mortality among older adults with learning disabilities). Therefore, figures are based on an estimate of prevalence across the national population; locally this will produce an over-estimate in communities with a low South Asian community, and an under-estimate in communities with a high South Asian community.

Table 65: People predicted to have a moderate or severe learning disability by age, Lancashire, 2020

	18-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	Total
Lancashire 14	755	999	1037	1038	970	572	220	79	5670
Lancashire 12	612	799	839	841	799	479	185	66	4619
Blackburn with Darwen	75	107	104	95	78	41	14	5	520
Blackpool	68	93	94	102	93	52	21	8	531
Burnley	38	58	56	55	53	32	12	5	308
Chorley	43	73	84	83	74	45	17	5	425
Fylde	25	40	50	57	61	40	16	7	295
Hyndburn	39	57	58	58	51	28	11	4	305
Lancaster	113	103	103	94	91	56	22	8	589
Pendle	40	64	66	62	58	35	12	5	342
Preston	118	120	100	86	76	40	16	6	562
Ribble Valley	19	30	40	49	47	27	11	4	227

Mental health and wellbeing in Lancashire

Rossendale	27	45	52	54	47	26	9	3	262
South Ribble	45	77	86	84	76	45	18	6	437
West Lancashire	57	66	70	78	79	48	19	6	424
Wyre	46	67	73	81	86	58	24	8	443

Source: POPPI. Figures may not sum due to rounding. Crown copyright 2010

These predictions are based on prevalence rates in a report by Eric Emerson and Chris Hatton of the Institute for Health Research, Lancaster University, entitled Estimating Future Need/Demand for Supports for Adults with Learning Disabilities in England, June 2004. The authors take the prevalence base rates and adjust these rates to take account of ethnicity (i.e. the increased prevalence of learning disabilities in South Asian communities) and of mortality (i.e. both increased survival rates of young people with severe and complex disabilities and reduced mortality among older adults with learning disabilities). Therefore, figures are based on an estimate of prevalence across the national population; locally this will produce an over-estimate in communities with a low South Asian community, and an under-estimate in communities with a high South Asian community.

Predictions of the number of people with a moderate or severe learning disability for 2011 and 2021 are as follows:

Table 66: People predicted to have a moderate or severe learning disability by age, Lancashire, 2011 and 2021

Age range	% in 2011	% in 2021
15-19	0.68	0.68
20-24	0.6	0.61
25-29	0.53	0.53
30-34	0.54	0.54
35-39	0.61	0.61
40-44	0.62	0.63
45-49	0.56	0.57
50-54	0.48	0.49
55-59	0.55	0.55
60-64	0.43	0.43
65-69	0.36	0.36
70-74	0.34	0.34
75-79	0.23	0.23
80+	0.18	0.18

Prediction rates have been applied to ONS population projections of the 18 and over population in the years 2011 and 2021 and linear trends projected to give estimated numbers predicted to have a mild, moderate or severe

learning disability, to 2030.

Autism

Table 67: People aged 18-64 predicted to have autistic spectrum disorders, by age, 2010

	18-24	25-34	35-44	45-54	55-64	Total
Lancashire 14	1,426	1,662	1,949	2,020	1,809	8,868
Lancashire 12	1156	1332	1563	1637	1489	7177
Blackburn with Darwen	141	179	199	178	146	844
Blackpool	129	151	187	205	174	847
Burnley	84	96	109	115	104	508
Chorley	87	128	160	158	144	677
Fylde	53	73	98	116	110	450
Hyndburn	75	92	114	112	96	490
Lancaster	194	174	174	180	167	889
Pendle	83	104	118	122	116	543
Preston	206	209	179	172	141	908
Ribble Valley	39	46	81	92	82	340
Rossendale	54	69	98	100	88	409
South Ribble	89	124	155	156	141	665
West Lancashire	103	106	139	159	145	652
Wyre	91	107	136	155	152	639

Source: PANSI. Figures may not sum due to rounding. Crown copyright 2010

The information about ASD is based on Autism Spectrum Disorders in adults living in households throughout England: Report from the Adult Psychiatric Morbidity Survey 2007 was published by the Health and Social Care Information Centre in September 2009.

The prevalence of ASD was found to be 1.0% of the adult population in England, using the threshold of a score of 10 on the Autism Diagnostic Observation Schedule to indicate a positive case. The rate among men (1.8%) was higher than that among women (0.2%), which fits with the profile found in childhood population studies.

The report Prevalence of disorders of the autism spectrum in a population cohort of children in South Thames: the Special Needs and Autism Project (SNAP), Baird, G. et al, The Lancet, 368 (9531), pp. 210-215, 2006. found that

55% of those with ASD have an IQ below 70%.

The prevalence rates have been applied to ONS population projections of the 18 to 64 population to give estimated numbers predicted to have autistic spectrum disorder to 2030.

Table 68: People aged 18-64 predicted to have autistic spectrum disorders, by age, 2020

	18-24	25-34	35-44	45-54	55-64	Total
Lancashire 14	1232	1960	1715	1956	1942	8805
Lancashire 12	998	1570	1382	1582	1595	7127
Blackburn with Darwen	123	208	173	180	157	841
Blackpool	111	182	160	194	190	837
Burnley	62	112	90	101	103	467
Chorley	71	143	142	160	150	666
Fylde	45	81	83	105	122	436
Hyndburn	64	110	94	110	102	479
Lancaster	180	202	171	176	182	911
Pendle	66	123	108	118	116	531
Preston	191	252	171	165	156	936
Ribble Valley	33	58	64	91	92	338
Rossendale	44	84	84	100	94	406
South Ribble	73	149	142	157	151	672
West Lancashire	89	124	112	143	155	623
Wyre	80	134	120	151	169	654

Source: PANSI. Figures may not sum due to rounding. Crown copyright 2010

The information about ASD is based on Autism Spectrum Disorders in adults living in households throughout England: Report from the Adult Psychiatric Morbidity Survey 2007 was published by the Health and Social Care Information Centre in September 2009.

The prevalence of ASD was found to be 1.0% of the adult population in England, using the threshold of a score of 10 on the Autism Diagnostic Observation Schedule to indicate a positive case. The rate among men (1.8%) was higher than that among women (0.2%), which fits with the profile found in childhood population studies.

The report Prevalence of disorders of the autism spectrum in a population cohort of children in South Thames: the Special Needs and Autism Project (SNAP), Baird, G. et al, The Lancet, 368 (9531), pp. 210-215, 2006. found that 55% of those with ASD have an IQ below 70%.

The prevalence rates have been applied to ONS population projections of the 18 to 64 population to give estimated numbers predicted to have autistic spectrum disorder to 2030.

Appendix B: Mosaic group descriptions and maps

Figure 20: I44 – Low income families occupying poor quality older terraces



Key features:

- Young couples
- Children
- Close to town centres
- Terraced housing
- Low car ownership
- Lower income
- High proportion of tenants
- Poor credit history

Communication preferences:

- Access information - SMS text, interactive TV, face-to-face, not magazines
- Service channels – mobile phone, not post

Figure 21: I43 – Older town centres terraces with transient, single populations



Key features:

- Low income
- Unemployment
- Terraced housing
- Few qualifications
- Service jobs
- Manual labour
- Limited car access
- Low technology access

Communication preferences:

- Access information - SMS text, interactive TV, face-to-face, local papers, not magazines, internet, telephone
- Service channels – face-to-face, not post

Figure 22: O69 – Vulnerable young parents needing substantial state support



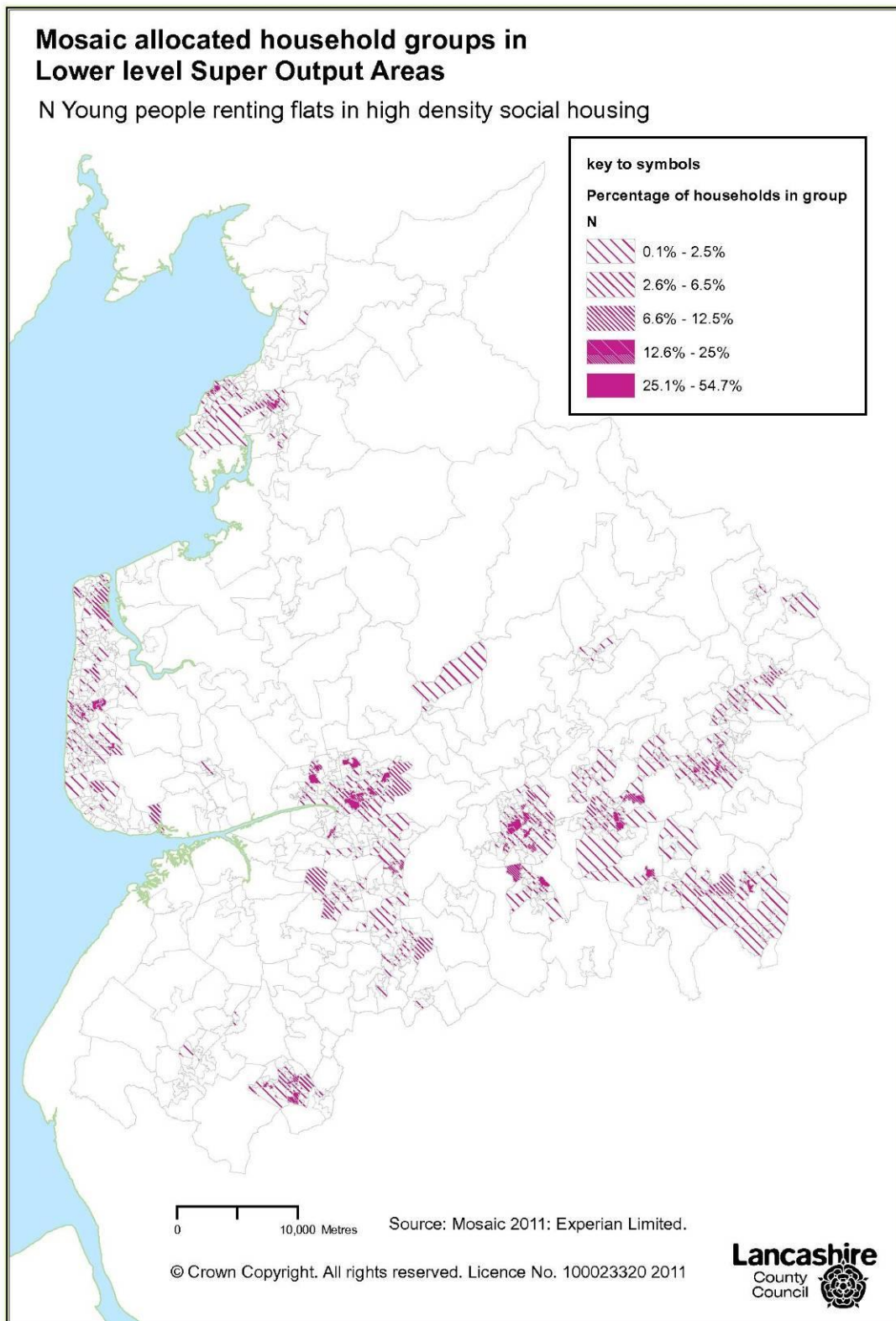
Key features:

- Vulnerable households
- Unemployment
- Single parent
- Young people
- Bus
- Alcohol and tobacco
- Second hand goods
- TV

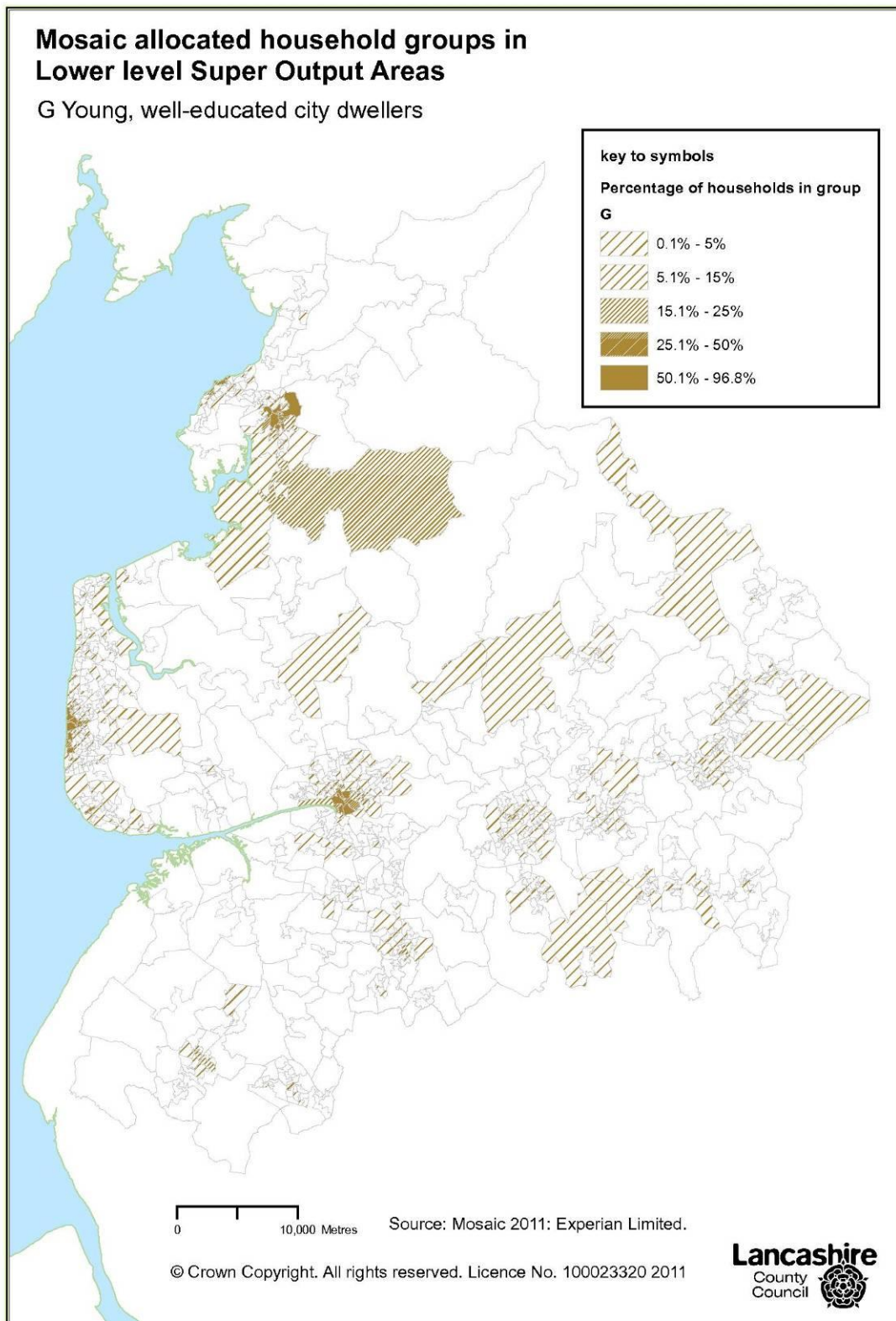
Communication preferences:

- Access information - SMS text, face-to-face, national papers, local papers, not internet, magazines
- Service channels – face-to-face, not internet, telephone, mobile phone, post

Map 6: Percentage of households in Mosaic group N



Map 7: Percentage of households in Mosaic group G



Map 8: Percentage of households in Mosaic group O

