17. Mental health, self-harm and alcohol specific conditions

17.1 Prevalence of chronic mental health conditions (ICD10: F20-F48)

Mental health problems are commonplace, with approximately one in four people in Britain suffering from mental health problems, illnesses and psychiatric conditions at some stage in their lives. There is a great deal of controversy about what mental illness is, what the causes are, and how people can be helped to recover. According to The National Association for Mental Health (MIND), “Mental illnesses are some of the least understood conditions in society. Because of this, many people face prejudice and discrimination in their everyday lives.” Mental illness or distress can take a number of forms, which vary appreciably in severity and level of incapacity. These include depression, anxiety, panic attacks, obsessive-compulsive disorder, phobias, manic depression, and schizophrenia. Mental illness is linked to deprivation and poverty, and varies by gender. Government targets seek to reduce death rates from suicide and undetermined injury by at least a fifth. The conditions included in this analysis are schizophrenia, depression, neuroses and anxiety disorders.

- Map 17.1 displays regional variations in the prevalence of diagnosed mental health conditions (schizophrenia, mood disorders and neuroses), which result in a hospital admission. High ratio levels, based around a regional average of 100, are shown across Rossendale, Burnley, Bury, Salford and central Liverpool, as well as urban areas within Manchester, Warrington, Halton, Wirral and Carlisle. However, higher urban ratios are more concentrated geographically than for many mental health conditions illustrated. Rural localities and counties consistently show lower than average ratios for mental health conditions.

- Figure 17.1a shows a non-linear relationship between deprivation levels and rates of admission for mental health, with the prevalence rate for mental illness 2.75 times higher for the most deprived quintile of population in the region, than that for the most affluent. Poor mental health increases rapidly between the third and fifth poorest quintiles of population. A similar curve in mental health prevalence is shown by geodemographic lifestyle group in Figure 17.1b. However, the New Starters grouping shows appreciably higher levels of mental illness prevalence, than other similar lifestyle groups. Predominantly non-White area populations have statistically significant higher prevalence rates, Chinese excepted (Figure 17.1c), with urban populations showing appreciably higher average rates of prevalence (Figure 17.1d).

- The North West Local Authorities with the highest hospitalised prevalence ratios for mental health conditions are Burnley (151), Halton (144) and Rossendale (141); the lowest are Wyre (51), Barrow-in-Furness (58) and Ribble Valley (59).

17.2 Incidence of self-harm (ICD10: X80-X84, Y10-Y34)

Self-harm occurs when a person deliberately injures or hurts him or herself. Self-harm includes cutting or burning oneself, overdose through tablets or medicines, inhaling or sniffing harmful substances, swallowing non-edible items and self mutilation. Self-harm may be undertaken on a regular basis, or on one or a few occasions. It can be part of coping with a specific problem. Where a hospital admission is reported to be due to self harm the relevant code will be recorded as an ‘external cause’.

- Map 17.2 shows variations in admission ratios for self-harm across the North West. Higher ratios are shown to be localised within urban areas, though in the case of self-harm, Liverpool and central Manchester do not show the typical high ratio levels seen for many health issues linked to deprivation. Within Cumbria, pockets of high ratio self-harm incidence are seen in Barrow-in-Furness, Carlisle and in western coastal towns. Within Lancashire, areas of Lancaster, Blackpool, Preston and Chorley, for example, are amongst those with higher than average ratios. Localised areas with high ratios are seen across Greater Manchester and Merseyside, for example in Wirral, Halton and St Helens. Cheshire, and a greater part of Lancashire than usually seen, in contrast, show lower than average self-harm ratios.

- As with many health conditions, self harm incidence rates increase appreciably by relative levels of deprivation, as shown in Figure 17.2a. The rate of admissions for the most deprived quintile of population is 3.4 times that for the least deprived quintile. The same relationship is seen by geodemographic lifestyle group, though Qualified Metropolitans and Multicultural Centres lifestyle groups show lower rates of admission than neighbouring groups (Figure 17.2b). Predominantly Black and Chinese groups show lower rates of admission for self harm (Figure 17.2c) whilst sparse populations, whether urban or rural based, show the highest admission rates for self-harm (Figure 17.2d).

- The North West Local Authorities with the highest hospitalised incidence ratios for self-harm are Carlisle (229), Barrow-in-Furness (225) and Wirral (201); the lowest are Ribble Valley (25), Hyndburn (29) and Blackburn with Darwen (30).

17.3 Prevalence of alcohol specific conditions (ICD10: F10, K70, K73, K74, X45)

Alcohol misuse is a major cause of ill health and premature death, with only smoking and raised blood pressure representing higher risk factors. Alcohol-related conditions include cirrhosis of the liver, cardiovascular diseases, a heightened risk of developing some cancers, and a greater risk of injury and violence. Certain diagnoses, for example cirrhosis of the liver and alcohol poisoning, are considered to be specific to alcohol.

- Map 17.3 shows regional variations in the prevalence of alcohol specific conditions, which result in a hospital admission. Areas of the North West with the highest ratios include Liverpool, Wirral, St Helens, Blackpool, Halton, parts of Warrington, north and south Manchester and localised central areas within major towns of the North West, for example, Bolton, Bury, Rochdale, Burnley, Oldham, Tameside, Salford and Preston. Rural districts consistently present lower than average admission ratios.

- Figure 17.3a details how alcohol specific prevalence rates increase rapidly for the most deprived quintiles of population within the North West, with prevalence rates being some five times higher for the most deprived quintile of population when contrasted to the most affluent quintile. This steep curved gradient is reflected by geodemographic groupings (Figure 17.3b), although the New Starters lifestyle group exhibits higher alcohol condition rates than similar income group. All areas with predominantly non-White populations show higher rates of alcohol specific prevalence, those for predominantly
Mental health, self-harm and alcohol specific conditions

Black areas being over double that for predominantly White areas (Figure 17.3c). Prevalence rates for predominantly Chinese areas are relatively higher than that seen for the majority of health variables illustrated. Rural populations show appreciably lower rates of alcohol specific prevalence than do urban localities (Figure 17.3d).

- The North West Local Authorities with the highest hospitalised prevalence ratios for alcohol specific conditions are Liverpool (178), Halton (156) and Burnley (145); the lowest are Ribble Valley (42), South Lakeland (44) and Eden (45).
Figure 17.1: Hospitalised Prevalence for Mental Health Conditions
North West residents: HES 1998-2002

Key:
Category
Standardised Rate and 95% Confidence Intervals

North West Standardised Rate and 95% Confidence Intervals

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A

B

C

D

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Map 17.1: Hospitalised Prevalence for Mental Health Conditions

North West residents: HES 1998-2002

Mental health conditions
Standardised hospitalised prevalence ratio
- 150 to 325 (144)
- 125 to 150 (89)
- 100 to 125 (143)
- 75 to 100 (251)
- 28 to 75 (299)

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Map showing Middle Super Output Areas (MSOA) and Local Authority (LA) boundaries
Figure 17.2: Hospitalised Emergency Incidence for Self Harm North West residents: HES 1998-2002

Key:

- Category Standardised Rate and 95% Confidence Intervals
- North West Standardised Rate and 95% Confidence Intervals
Map 17.2: Hospitalised Emergency Incidence for Self Harm

North West residents: HES 1998-2002

Self harm
Standardised hospitalised incidence ratio
- 150 to 535 (161)
- 125 to 150 (83)
- 100 to 125 (120)
- 75 to 100 (149)
- 4 to 75 (413)
Figure 17.3: Hospitalised Prevalence for Alcohol Specific Conditions
North West residents: HES 1998-2002

Key:
Category Standardised Rate and 95% Confidence Intervals
North West Standardised Rate and 95% Confidence Intervals
Map 17.3: Hospitalised Prevalence for Alcohol Specific Conditions

North West residents: HES 1998-2002