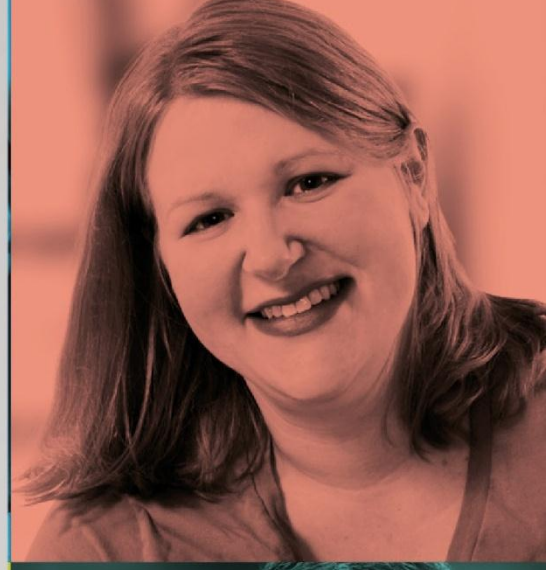
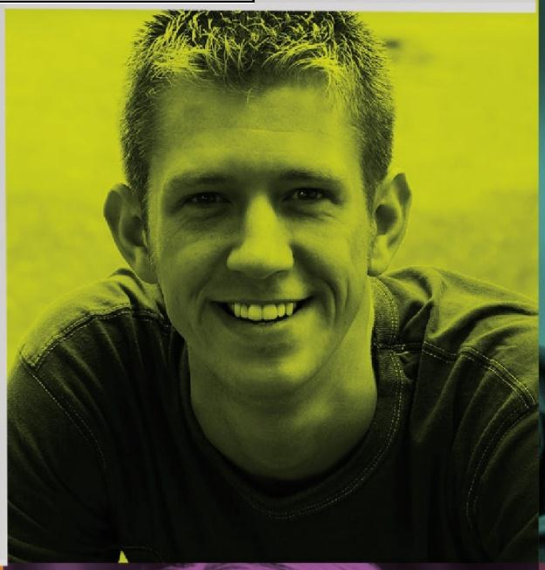
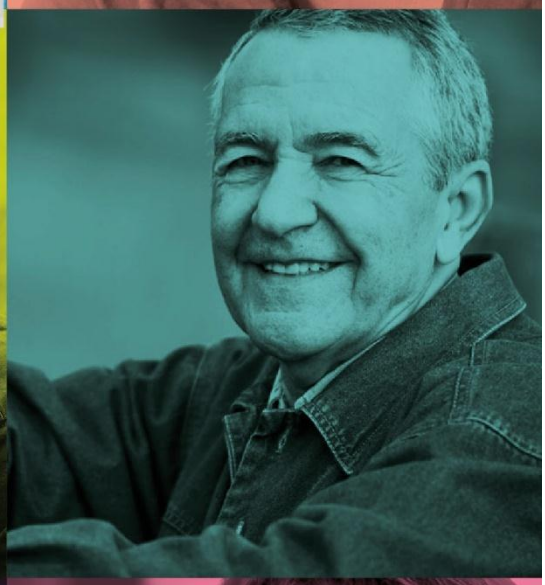
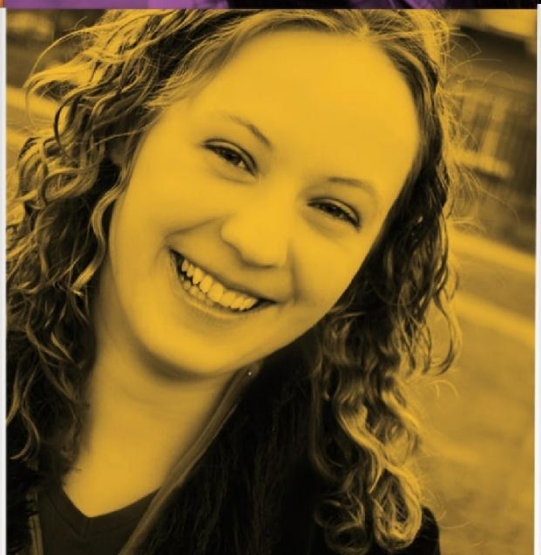
A Mental Health and Wellbeing Commissioning Strategy for Halton

2013 to 2018

Evidence Paper





myhalton living life well

NHS Halton Clinical Commissioning Group

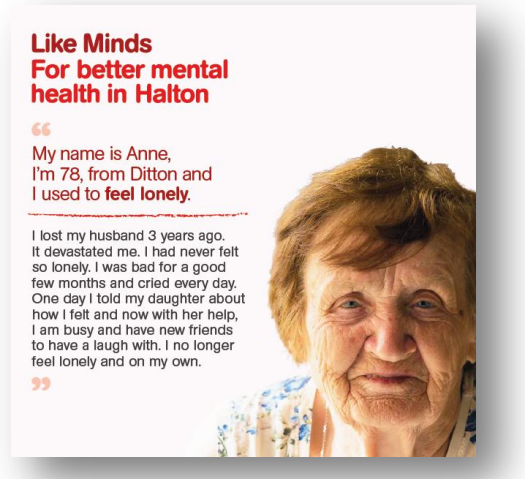
HALTON BOROUGH COUNCIL

Contents

Glossary

ACP	Acute Care Pathway
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autistic Spectrum Disorder
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CMD	Common mental disorders
COF	NHS Commissioning Outcomes Framework
CURT	CAMHS Urgent Response Team
DOLS	The Deprivation of Liberty Safeguards was introduced by the Mental Capacity Act 2007 to protect individuals from the unlawful deprivation of their liberty. The concepts of restraint, restriction and deprivation of liberty are best understood as existing on the same 'spectrum of control', with deprivation of liberty involving a higher degree or intensity of control over that individual. Ultimately, the concept is one to be interpreted in view of the specific circumstances of that individual.
Dual diagnosis	Dual diagnosis is the term used to describe patients with both severe mental illness (mainly psychotic disorders) and problematic drug and/or alcohol use
HWBB	Health and Wellbeing Board
IAPT	Improving Access to Psychological Therapies
IMCA	Independent mental capacity advocate
IMHA	Independent mental health advocate
LAT	Local Area Team
NICE	National Institute for health and Care Excellence
Open Mind	Single point of access for primary and secondary care mental health services.
PBR	Payment by results
Stigma	A negative association attached to some activity or condition. A cause of shame or embarrassment.

Foreword



The Halton Mental Health Strategic Commissioning Board has been established with a remit to develop a Mental Health Strategy and action plan. This plan has been based on national best practice as outlined in The national Mental Health Strategy 'No Health without Mental Health' (2011)which takes a life course approach and prioritises action to enhance wellbeing and increase the early detection and treatment of mental health problems at all ages.

It also promotes robust and comprehensive services for people with severe and enduring mental health problems. The strategy promotes independence and choice for people and recognises that good mental wellbeing brings much wider social and economic benefit for the population.

Mental health problems cost individuals, their families and the economy an enormous amount. There is a growing body of evidence that some approaches to addressing mental health issues can produce better outcomes while achieving significant reductions in costs. This is of particular relevance at a time of economic constraint. Although the NHS is as a whole was protected from cuts in the government spending Review, rising demand means that the NHS has to find up to £20 billion in efficiency savings by 2014. As nearly 11% of England's annual secondary care health budget is allocated to mental health care, the mental health sector cannot be exempt from having to make savings. There are many interdependencies between physical and mental health, so any efficiencies in mental health services need to be carefully thought through so that false economies and greater costs elsewhere in the health and social care system are avoided.

This document provides an overview of the national policies that have influenced the Mental Health and Wellbeing Strategy, and gives in more detail the local context through a range of resources and information as well as key statistical information to demonstrate the work that has taken place within Halton by all partners. It is intended to provide the evidence base that supports Halton's Mental Health and Wellbeing Strategy 2013-2018 which describes the strategic approach to tackle mental health and wellbeing within the Borough of Halton. The findings of the evidence paper will also enable partners, stakeholders and the wider community to understand the impact that mental ill health has within the Borough.

This document is intended to provide evidence to support the strategy, and uses the same definitions and priorities. It is for people of all ages – children and young people and older people, as well as working age adults. It underlines the importance of providing equal access to age appropriate services for everyone. It applies to the full range of services, from public mental health promotion through to suicide prevention, forensic mental health services, services for people with personality disorders, severe and enduring mental illness, people with learning disabilities and people detained under the Mental Health Act or subject to the Mental Capacity Act. The strategy and associated action plan compliments other work programmes, including the local Dementia Strategy, the new Suicide Prevention Strategy and Child & Adolescent Mental Health (CAMHS) Strategies which are currently in development, and should be read in conjunction with these pieces of work. In demonstrating the importance of mental health outcomes, it is the intention of this document to explicitly recognise the importance of putting mental health on a par with physical health.

For further information on this paper and the Mental Health and Wellbeing Strategy 2013 -18 please contact Liz Gladwyn, Halton Borough Council, on 0151 511 8120 or email liz.gladwyn@halton.gov.uk

Part One – What are mental health and mental wellbeing?

- **Mental health problems may be more or less common, may be acute or longer lasting and may vary in severity and may manifest themselves in different ways at different ages.**
- **At least one in four people will experience a mental health problem at some point in their life and one in six adults will have a mental health problem at any one time.**
- **One in 10 new mothers experience postnatal depression.**
- **One in 10 children aged between five and 16 years of age has a mental health problem, and many continue to have mental health problems into adulthood.**
- **Half of those with lifetime mental health problems first experience symptoms by the age of 14 and three-quarters before their mid-20s.**
- **Self-harming in young people is not uncommon – an estimated one in ten 15 to 16-year olds has self-harmed.**
- **Looked After Children and care leavers are between four and five times more likely to attempt suicide in adulthood**
- **Young people in prison are 18 times more likely to take their own lives than others of the same age**
- **About one in 100 people has a severe mental health problem.**
- **The cost to the economy of mental health problems is over £100bn.**
- **Nearly nine out of 10 people who experience mental health problems say they face stigma and discrimination as a result.**

Mental health is central to our quality of life, central to our economic success and interdependent with our success in improving education, training and employment outcomes and tackling some of the persistent problems that scar our society, from homelessness, violence and abuse, to drug use and crime.

Mental health encompasses mental wellbeing, good mental functioning and the absence of problems in relation to thinking, feelings or behaviour. The World Health Organization (WHO) defines mental health as:

"a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."

Mental illness encompasses a broad range of mental health problems ranging from common mental disorders (CMDs) such as anxiety and depression to severe forms such as psychosis. Results from the 2007 Adult Psychiatric Morbidity in England Survey showed that at least 1 in 4 people will experience a mental health problem, while 1 in 6 (17.6%) were diagnosed with a common mental disorder.

The two continua model of mental illness and mental health holds that both are related, but distinct dimensions: one continuum indicates the presence or absence of mental health, the other the presence or absence of mental illness. Therefore the presence of a mental illness does not imply poor mental health: a person with a mental illness may experience high levels of mental health while a person with poor mental health may not suffer from a mental illness[1]. This continuum is best represented diagrammatically – page 8.

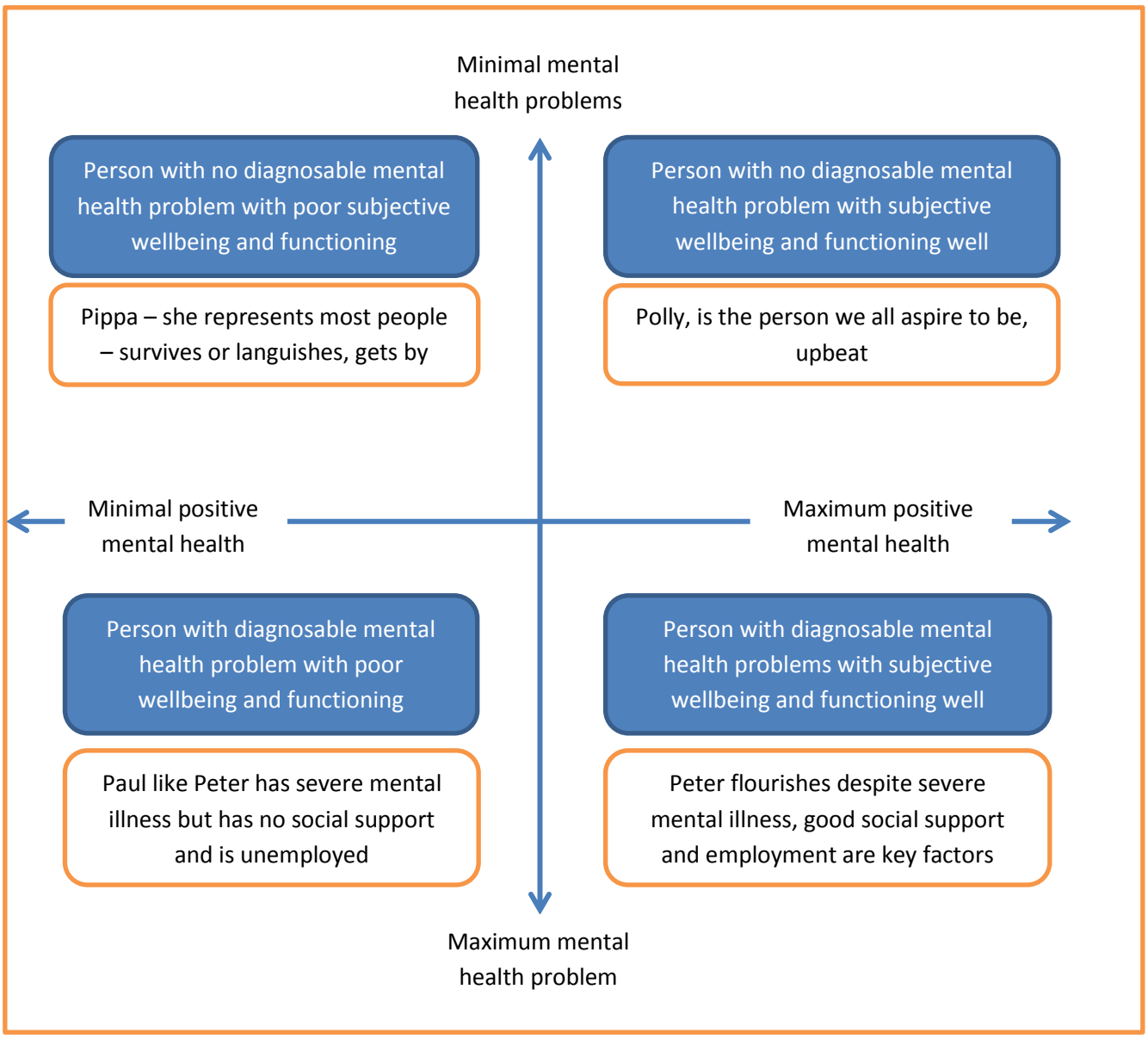
Mental illness is common and is associated with significant individual, social and economic costs. In England, one in six adults and one in ten children will experience a mental illness at any one time. This compares to one in ten people with cardiovascular disease and one in twenty with diabetes. This means that in 2012 across Cheshire and Merseyside around a quarter of a million adults suffered from a common mental disorder and just fewer than 6,000 people had a psychotic disorder. Among people under 65, nearly half of all ill health is due to mental illness. Mental illness represents the single largest cost to the NHS.

Only a sustained approach across the life course will equip Halton to meet the social, economic and environmental challenges it faces and deliver the short- and long-term benefits needed.

[1] Keyes, C.L.M. (2002) The mental health continuum: from languishing to flourishing in life. J Health Soc Res 43:207---22: http://tinyurl.com/8ox38p5

The Mental Health 2 Continua

(Adapted from The Mental Health Continuum: From Languishing to Flourishing in Life, Corey L. M. Keyes 2002)



The concept of well-being comprises two main elements: feeling good and functioning well. Feelings of happiness, contentment, enjoyment, curiosity and engagement are characteristic of someone who has a positive experience of their life. Equally important for well-being is our functioning in the world.

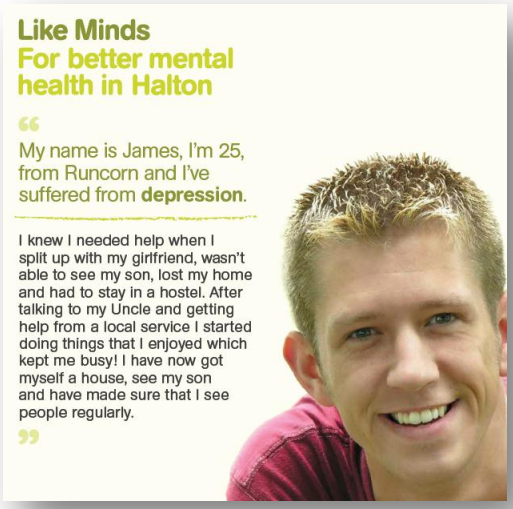
Experiencing positive relationships, having some control over one's life and having a sense of purpose are all important attributes of wellbeing.[2]

There are five simple and practical steps that can be taken to improve wellbeing, called the 'five ways to wellbeing' they are:

- **Connect – connect with the people around you**
- **Be active – physical activity is good for the mind and the body**
- **Take notice – become aware of the world around you**
- **Keep learning – learn new skills and set yourself challenges**
- **Give – be a good citizen and help others**

In contrast to the negative focus of mental illness, mental health and wellbeing focus on positive aspects of a person's attitude and situation that can promote human flourishing (i.e. being happy, healthy and prosperous). Mental wellbeing is not the absence of negative emotions (e.g. disappointment, failure, grief) but the ability to manage these emotions.

The Local Authority, Health and Wellbeing Board, Clinical Commissioning Group, providers of health and social care, education, employment and housing are ideally placed to take a strategic role and support effective partnership working to promote positive mental health and wellbeing and to reduce the burden of mental illness within Halton.



[2] www.fivewaystowellbeing.org

Part Two – No Health without Mental Health - The National Policy Context

In 2010 the Health and Social Care Act brought about a major reorganisation of the National Health Service, so that from April 2013, upper tier local authorities assumed lead responsibility for improving public health, coordinating local efforts to protect the public's health and wellbeing, for ensuring health services effectively promote population health and for addressing health inequalities. At a local level these issues are overseen by Health and Wellbeing Boards (HWBBs), whilst the national lead comes from Public Health England. Directors of Public Health, employed by local authorities and members of Health and Wellbeing Boards, are responsible for delivering public health outcomes, of which mental health and wellbeing is one.

Clinical Commissioning Groups (CCGs) are the body responsible for the design and commissioning of local health services such as acute hospital services and mental health services. CCGs are comprised of local GPs and in addition to being statutory members of HWBBs, are required by law to consult with HWBBs over their plans. Mental health is now near the top of the national policy agenda. This section sets out the key national policies which are shaping priorities and activity within this area.

The Mental Capacity Act (MCA) came into force on 1 October 2007 and created a framework to provide protection for people who cannot make decisions for themselves. The Act contains provision for assessing whether people have the mental capacity to make decisions, and procedures for making decisions on behalf of those people who lack mental capacity, as well as measures to ensure that vulnerable people are safeguarded. It applies to anyone whose mental capacity to make decisions is affected by what the MCA refers to as "an impairment of, or a disturbance in the functioning of, the mind or brain" which may be long or short term. The underlying philosophy of the MCA is that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves must be made in their best interests. The MCA is supported by a Code of Practice and has been further enhanced through the Mental Health Act 2007 to include the duty of access to Independent Mental Health Advocates and Deprivation of Liberty Standards. (DOLS) In 2010 the Marmot Review of Health Inequalities "Fair Society, Healthy Lives" proposed a new way to reduce health inequalities by action across all the social determinants of health including education, employment, housing transport and community. It stated that this could be achieved through two overarching policy goals:

1. **Create an enabling society maximising individual and community potential**
2. **Ensure social justice, health and sustainability is at the heart of all policies.**

Local Authorities have a key role in shaping the wider determinants of good health and supporting individuals, carers and communities. The public health white paper *Healthy lives, healthy people*[3] provided a comprehensive definition of public health, as aiming to improve public mental health and well-being alongside of physical health.

No health without mental health[4] is a cross-government mental health strategy that sets out the ambition to mainstream mental health, and establish parity of esteem between services for people with a mental and physical illness. The strategy is underpinned by two aims - Firstly, to improve the mental health and wellbeing of the population and to keep people well; Secondly, to improve outcomes for people with a mental illness through high quality services which are equally accessible to all.

In order to achieve these aims the strategy sets six overarching objectives:

--- More people will have good mental health
--- More people with mental health problems will recover
--- More people with mental health problems will have good physical health
--- More people will have a positive experience of care and support
--- Fewer people will suffer avoidable harm
--- Fewer people will experience stigma and discrimination

Alongside *No health without mental health* the government also published supporting documents; No health without mental health: Delivering better mental health outcomes for people of all ages[5] which explains in detail each objective and outlines effective interventions; and the No health without mental health: implementation framework[6] which aims to ensure that the commitment to parity of esteem between physical and mental health becomes a reality at a local level. The framework sets out what a range of organisations (including local public health teams, Public Health England, clinical commissioning groups, mental health providers, local authorities, and health and wellbeing boards) can do to implement the No health without mental health strategy**.**

---

[3] Department of Health (2010) Healthy Lives, healthy people. Available from: https://www.gov.uk/government/publications/healthy---lives---healthy---people---our---strategy---for---public---health---in---england

[4] Department of Health (2011) No health without mental health A Cross---Government Mental Health Outcomes Strategy for People of All Ages. Available from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf

[5] Department of Health (2011) No health without mental health: Delivering better mental health outcomes for people of all ages. Available from: https://www.gov.uk/government/publications/delivering---better---mental---health---outcomes---for---people---of---all---ages

[6] Department of Health (2012) No health without mental health: implementation framework. Available from: https://www.gov.uk/government/publications/national---framework---to---improve---mental---health---and---wellbeing

At a time of financial and demographic pressure, improving quality while increasing productivity and effectiveness is vital for any improvements in care. The national strategy advocates local areas to consider the importance of mental health services and the resources that are allocated to provide them. It suggests that each local area should focus upon three work streams when considering the development of local strategies:

- **The acute care pathway** – avoiding hospital admissions through effective joined-up community care and ensuring that hospital inpatient care itself is effective and that unnecessarily long stays are avoided (for example, by action to tackle delayed discharges)
- **out of area care** – getting better quality and better value through ensuring that appropriate in-area care is available where this is a better solution and commissioning effectively so that care is managed well, in terms of both care pathways and unit costs;
- and **physical and mental health co-morbidity** – getting better diagnosis and treatment of mental health problems for those with long-term physical conditions, and getting identification and treatment of anxiety or depression for those with medically unexplained symptoms.

The recent vision for adult social care also emphasised that the delivery of adult social care must be accompanied by re-design of services to deliver efficiencies. This could include:

- better joint working with the NHS;
- helping people to stay independent for longer, with a focus on re-ablement services, and more crisis or rapid response services;
- more streamlined assessment;
- reduce spend on residential care and increase community-based provision.

In addition, a new cross-government strategy *Preventing suicide in England*[7] highlights that local responsibility for coordinating and implementing work on suicide prevention has become, from April 2013, an integral part of local authorities' new responsibilities for leading on local public health and health improvement. This focus on suicide prevention is reflected within the Public Health Outcomes Framework which includes the suicide rate as an indicator and aims to reduce suicide rates in the general population in England and better support for those bereaved or affected by suicide.

The Welfare Reform Act 2012 and resilience to the economic downturn

The Welfare Reform Act received Royal Assent on 8th March 2012. The Act has been described as the biggest shake up of the benefits system in 60 years. It aims to simplify the system and create the right incentives to get people into work by ensuring that no individual is better off by not working. Key features of the Act that will have the most significant impact on Halton's residents are:

[7] Department of Health (2012). Preventing suicide in England: A cross---government outcomes strategy

- Introduction of Universal Credit. The level of Universal Credit is to be capped at £26,000. While it is estimated that only a small number of Halton residents will see their income reduce as a result of the cap, some will be significantly affected. In addition, Housing Benefit is to be included in Universal Credit and will consequently be paid directly to tenants of social housing.
- Replacement of Disability Living Allowance with a Personal Independent Payment (PIP) for those of working age. Halton, which has been selected as a pilot area for the scheme, has a disproportionate amount of disabled residents and the change to PIP will involve a reduction in the numbers of those receiving financial assistance.
- Changes to Housing Benefit including the introduction of an under occupancy penalty for households whose homes are deemed to be too large for their needs. Described as the "Bedroom Tax", this change will have a very significant impact in Halton residents.

It is too early to assess the impact of other reforms such as the ongoing reassessment of Incapacity Benefit claimants against the stricter criteria of the Employment Support Allowance, changes to Community Care Grants and Crisis Loans and recent reforms to Council Tax benefit which will include a 10% cut in scheme funding and "localised" benefit schemes.

Studies[8] show coping with the impact of the current recession and rising costs of living creates a stressful burden by having to economise on food, heating and travel. Such effects occur disproportionately among people with disabilities, ethnic minorities, the poor, some women and single mothers (and their children), young unemployed and older people.

Cuts in public spending are affecting services that promote long-term health and wellbeing (such as: adult social care, libraries, community centres) and their reduction or closure could threaten the health of the vulnerable and the elderly. There is also substantial evidence that poverty is both a determinant and a consequence of mental health problems.

It is estimated that 50-60% of disabled people live in poverty and are particularly vulnerable to cuts in public sector services and any changes in levels of entitlement or support can have life changing implications. People suffering from financial strain are particularly at risk of mental health problems.

These impacts are long term and will continue beyond entering financial recovery. The report suggests consideration should be given to:

[8] Assessing the impact of the economic downturn on health and wellbeing - Liverpool Public Health Observatoryhttp://www.liv.ac.uk/PublicHealth/obs/publications/report/88_Assessing_the_Impact_of_the_Economic_Downturn_on_Health_and_Wellbeing_final.pdf

- Health and social care professionals being trained to recognise debt triggers and sources of help for money problems
- Base debt/welfare benefit advisors in GP surgeries and hospital clinics
- Review access to welfare benefit/debt advice services and Credit Union.
- Continue programs of integration of care, health and potentially housing and leisure to minimise back office costs, maintain front line services and improve outcomes through seamless and jointly commissioned support.
- Develop a strategy of progression – 'Just Enough Support' so there is less reliance on formal services and more community based support (Prevention and Early Intervention Strategy)

A Vision for Social Care: Capable Communities and Active Citizens DH 2010 / Caring for our future: reforming care and support - White Paper 2012

This document sets out the overarching principles for adult social care and gives context for future reform. It sets the vision of services being more personalised, more preventative and more focussed on delivering best outcomes for those who use them. It also reaffirms the Government's commitment to devolving power from central government to communities and individuals.

Capable Communities aims to deliver the transformation of adult social care. This strategy is one element of a much wider programme designed to introduce a new system of care and support that gives communities, and the voluntary sector, a bigger role in maintaining the independence of vulnerable people. This system links strongly into and is supported by policies relating to the Big Society.

Capable Communities promotes independence, choice, well-being and dignity to enable people to live their lives as they wish. Commissioners are challenged to ensure there is personalised support for people with multiple and complex needs, for people to maintain their independence and for people with emerging needs. In doing so commissioners must recognise the impact of services outside social care such as advocacy, housing, education and leisure.

Part Three – Mental Health and Wellbeing in Halton

Halton's Vision

"Halton will be a thriving and vibrant Borough where people can learn and develop their skills; enjoy a good quality of life with good health; a high quality, modern urban environment; the opportunity for all to fulfil their potential; greater wealth and equality; sustained by a thriving business community; and a safer, stronger and more attractive neighbourhood." (Sustainable Community Strategy 2011-2026)[9]

Halton Core Strategy Local Plan

The Core Strategy[10] provides the overarching strategy for the future development of the Borough, setting out why change is needed; what the scale of change is; and where, when and how it will be delivered. It does this through identifying the current issues and opportunities in the Borough, how we want to achieve change and stating the future vision for Halton to 2028. To deliver this vision the Core Strategy sets out a spatial strategy stating the extent of change needed and the core policies for delivering this future change.

The Core Strategy will help to shape the future of Halton, including its natural and built environments, its communities and ultimately peoples' quality of life. The Core Strategy therefore joins up a range of different issues such as housing, employment, retail, transport and health. This is known as 'spatial planning'.

[9] (http://www3.halton.gov.uk/lgnl/pages/86821/86827/174277/Sustainable_Comunity_Strategy_2011__final_Nov_11_.pdf)

[10] http://www3.halton.gov.uk/lgnl/policyandresources/policyplanningtransportation/289056/289063/314552/1c)_Final_Core_Strategy_18.04.13.pdf

Halton Priorities

Halton's Strategic Partnership has set out five strategic priorities for the Borough, in its Sustainable Community Strategy 2011-2026, which will help to build a better future for Halton:

- A Healthy Halton
- Employment learning and skills in Halton
- A Safer Halton
- Children and Young people in Halton
- Environment and Regeneration in Halton

Corporate Plan

The Corporate Plan[11] presents the councils response to how it will implement the Community Strategy. This is achieved through a framework consisting of a hierarchy of Directorate, Division and Team Service Plans known as 'the Golden Thread' this ensure that all strategic priorities are cascaded down through the organisation through outcome focused targets. The Five strategic priorities discussed above are mirrored in the makeup of the Councils Policy and Performance Boards which together with the Executive Board provide political leadership of the Council.

Health and Wellbeing Board and Strategy

From a Halton perspective, the local Health and Wellbeing Board has developed a vision that aims "To improve the health and wellbeing of Halton people so they live longer, healthier and happier lives".

The Board has developed a strategy which has been informed by the Joint Strategic Needs Assessment (JSNA) and in consultation with local residents, strategic partners and other stakeholders, and has identified five key priorities for action.

- Prevention and early detection of cancer
- Improved child development
- Reduction in the number of falls in adults
- Reduction in the harm from alcohol
- Prevention and early detection of mental health conditions

The Joint Health and Wellbeing Strategy set the framework for the commissioning of health and wellbeing services in Halton with a particular emphasis on prevention and early intervention. It does

[18] http://councillors.halton.gov.uk/documents/s14868/ExecB%2022Sept11%20DftCorpPlanAppend.doc.pdf

not replace existing strategies, commissioning plans and programmes, but influences them. For example, NHS Halton Clinical Commissioning Group (CCG) has adopted the Strategy as a key document that will shape their commissioning plans and the Local Children's Trust has responded to the priorities identified in the formulation of its Children and Young Peoples strategic plan. Within Halton there is an increasing shift to improving the prevention and early intervention services in the Borough, including public health improvement/promotion services. There is evidence from the evaluation of the Partnerships for Older People (POPP) programme that the funding of more prevention and early intervention services has a positive impact on acute services. The development of preventative services with higher emphasis on mental health and wellbeing will continue to shift the focus from being reactive to proactive reducing the demand for more acute interventions.

A set of Action Plans have been developed to meet the key priorities with ultimate responsibility for the monitoring of the implementation of the Strategy and Action Plans against set outcomes and key performance indicators with the Health and Wellbeing Board who are accountable to the public.

There is also a Mental Health Strategic Commissioning Board established with a remit to develop and oversee the implementation of a Mental Health and Wellbeing Strategy and action plan. This plan has been based on national best practice as outlined in Section 1 including The National Mental Health Strategy 2011 "No Health without Mental Health".

This strategy takes a life course approach and prioritises action to increase prevention, early detection and treatment of mental health problems at all ages, as well as robust and comprehensive services for people with severe and enduring mental health problems.

Underpinning this strategy is a philosophy of personalisation which maximises independence and control by encouraging an individual to take responsibility for their own support on the road to recovery. The strategy also recognises that good mental wellbeing brings much wider social and economic benefit for the population.

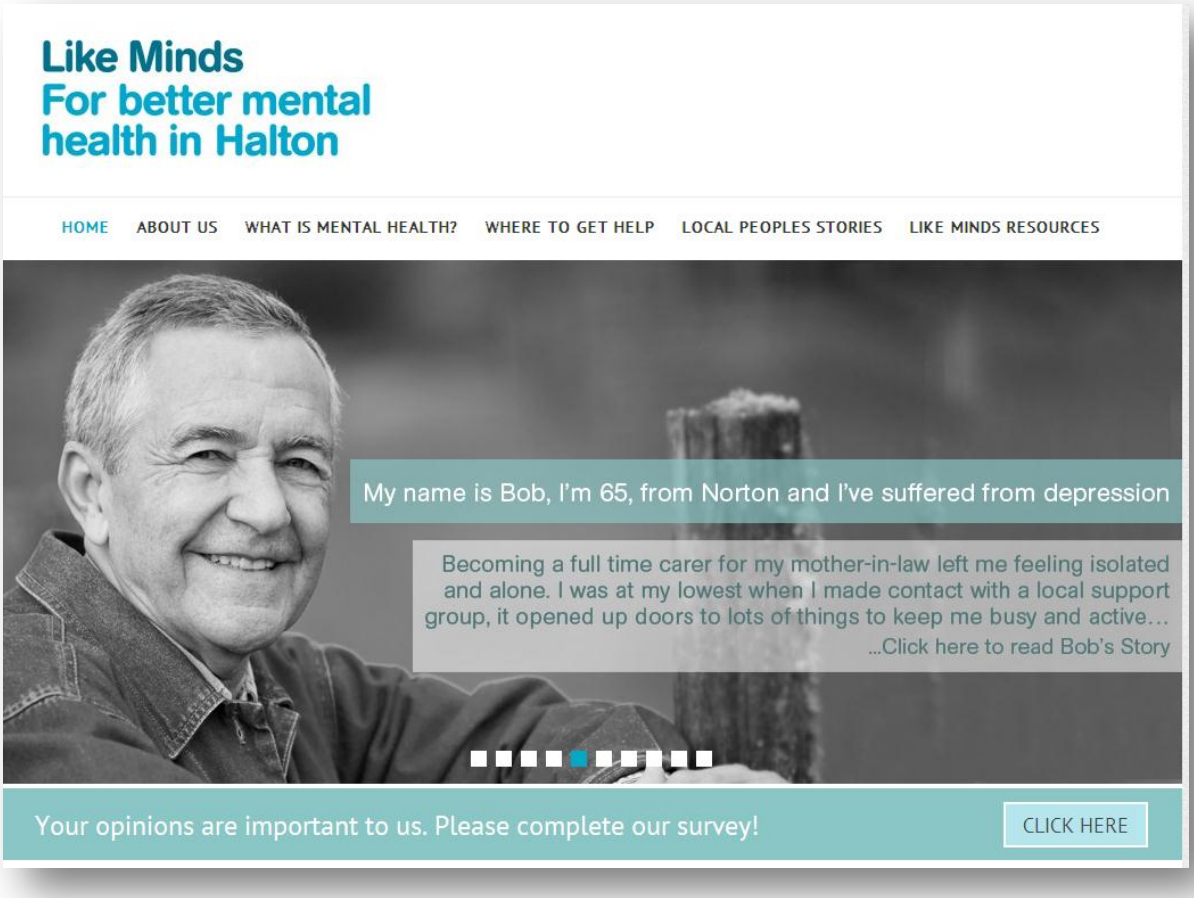
Integrated working

As national reforms continue to take shape, work has already taken place locally to look more strategically at improving models for integrated working and this vision has been captured within the **Framework for Integrated Commissioning in Halton (2012).** The Framework outlines the current strategic landscape of commissioning across Halton and explores national good practice translating this into an action plan.

In support of the implementation of the Framework, work is currently progressing in respect of the development of a Section 75 Partnership Agreement between Halton CCG and HBC which will provide robust arrangements within which Partners will be able to facilitate maximum levels of integration in respect of the commissioning of Health and Social Care services in order to address the causes of ill health as well as the consequences. Part of this Agreement will focus on the commissioning of Mental Health services.

Halton has identified further integration to support its the strategic approach with all partners working together to deliver:

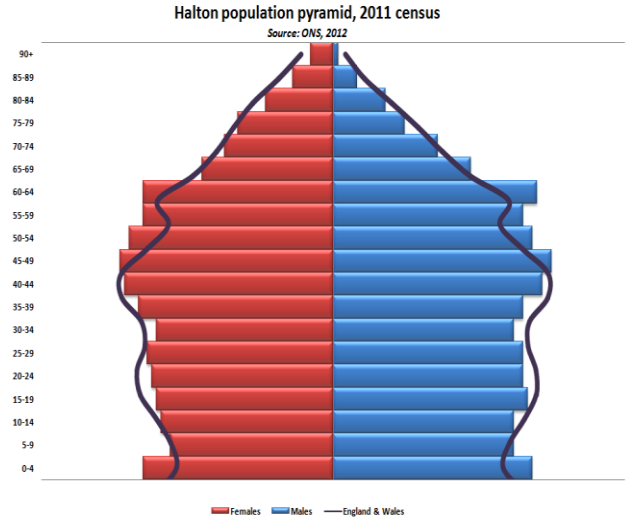
- joint commissioning
- culture change through community development
- training for all staff in how to deliver health messages so every contact counts, development of multi-disciplinary teams and joint advocacy and policy work

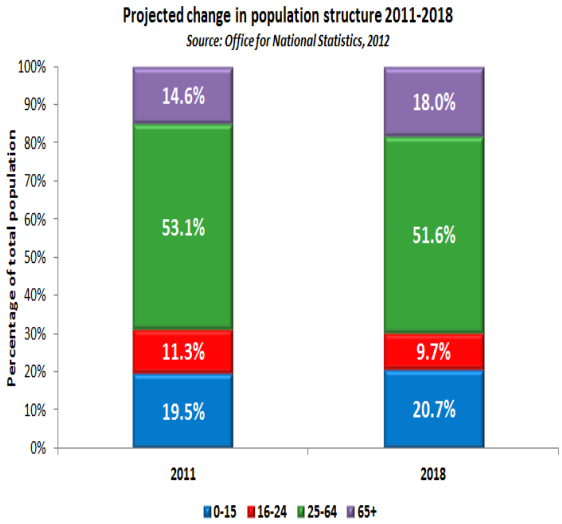


Halton's Demographic Information

Population

Halton is a largely urban area of 125,700 (2011 Census) people. Its two biggest settlements are Widnes and Runcorn. The population is predominantly white (98.6%) with relatively little variation between wards.





Halton's population structure is slightly 'younger' than that seen across England as a whole. However, in line with the national trend, the proportion of the population in the working age bands i.e. 16-24 years and 25-64 years is projected to fall with the younger age band i.e. 0-15 years, projected to rise slightly. The most significant shift is the proportion of the population in the older age band.

Deprivation

Deprivation is a major determinant of health. Lower income levels often lead to poor levels of nutrition, poor housing conditions, and inequitable access to healthcare and other services. Deprivation, measured using the English index of Multiple Deprivation (IMD) 2010, ranks Halton as ranked 27th most deprived out of 326 local authorities (a ranking of 1 indicates the area is the most deprived).

The 2010 IMD shows that deprivation in Halton is widespread with 60,336 people (48% of the population) in Halton living in 'Lower Super Output Areas' (LSOA's) that are ranked within the most deprived 20% of areas in England.

In terms of Health and Disability, the IMD identifies 53 SOA's (Super Output Areas) that fall within the top 20% most health deprived nationally and that approximately 40,000 people in Halton (33% of the

population) live in the top 4% most health deprived areas in England. At ward level, Windmill Hill is the most deprived area in terms of health. However, health deprivation is highest in a LSOA within Halton Castle, ranked 32nd most deprived nationally.

Health is also a key determinant of achieving a good quality of life and the first priority of Halton's Sustainable Community Strategy. This states that 'statistics show that health standards in Halton are amongst the worst in the country and single it out as the aspect of life in the Borough in most urgent need of improvement'.

In Halton, one in four people attending GP surgeries seek advice on mental health, and the number of people suffering from depression is 11,924 (11.94% of the GP population who are aged 18+). Whilst the prevalence of mental health problems is comparable with regional and national rates, deaths from suicides and undetermined injuries have reduced but remain higher than national averages (Rate 8.2 per 100,000 population during 2008-10 compared to England (7.2), and the North West (9.07)) and the rate of hospital admissions due to self- harm for under 18s is high.

Halton has also seen an estimated prevalence of 1,082 people aged 65+ with dementia compared to 634 people identified on GP registers in 2010-11.

More than 1 in 5 of Halton's population live with a limiting long term condition (20011 Census). Those living with long term physical conditions are the most frequent users or health and care services and commonly experience mental health problems such as depression and anxiety and in older people dementia.

The Halton Joint Strategic Needs Assessment and the North East Public Health Observatory Community Mental Health Profile and The Mental State of the North West (AQuA Observatory Dec 2012) contain more detailed analysis of local need.[12]

The headline messages conveyed from these analyses are:

- Halton experiences significantly higher rates of adults (18+) with depression than England or the North West region
- There will be a 60% increase in numbers of older people (age 65+) suffering with depression and 65% increase in those with severe depression
- Research has shown that mental illness and harmful/dependent alcohol consumption are very closely linked and over a quarter of all alcohol-related admissions are those conditions caused

[12] Halton Community Mental health Profiles 2013 can be found at: http://www.nepho.org.uk/cmhp

by mental and behavioural disorders due to alcohol (dual diagnosis). Halton's admission rate is significantly higher than both England and North West averages.

Employment for people with mental illness is important in promoting recovery and social inclusion and can have a positive effect on mental health, although benefits depend on the nature and quality of work. However having a mental illness is associated with an increased risk of unemployment; having a common mental disorder is associated with a three-fold increased risk of unemployment while only one in five specialist mental health service users are either in paid work or full-time education[13].

The economic cost of mental illness to the English economy was estimated at £105 billion in 2010. Mental illness is the largest area of NHS spending; spending on mental health services accounts for £11.9 billion (11 per cent) of the NHS secondary health care budget, more than spending on either cardiovascular disease or cancer services[14].

As well as being common mental illness also leads to a reduced quality of life. Mental illness is the single largest source of burden of disease in the UK. In 2004, 22.8% of the total burden of disease in the UK was attributable to mental illness, this compares to 16.2% for cardiovascular disease and 15.9% for cancer, as measured by disability adjusted life years (DALYs)[15].

Unlike other health problems such as cardiovascular disease or many cancers mental illness begins early in life and persists over the life course. Half of those suffering from a lifetime mental illness first experience symptoms by age fourteen and three quarters by before their mid-twenties[16].

Morbidity due to mental illness peaks at age 15 to 29 and remains higher than or equal to morbidity due to physical illness until age 45 to 59. This means that among people under 65, nearly half of all ill health is due to mental illness.

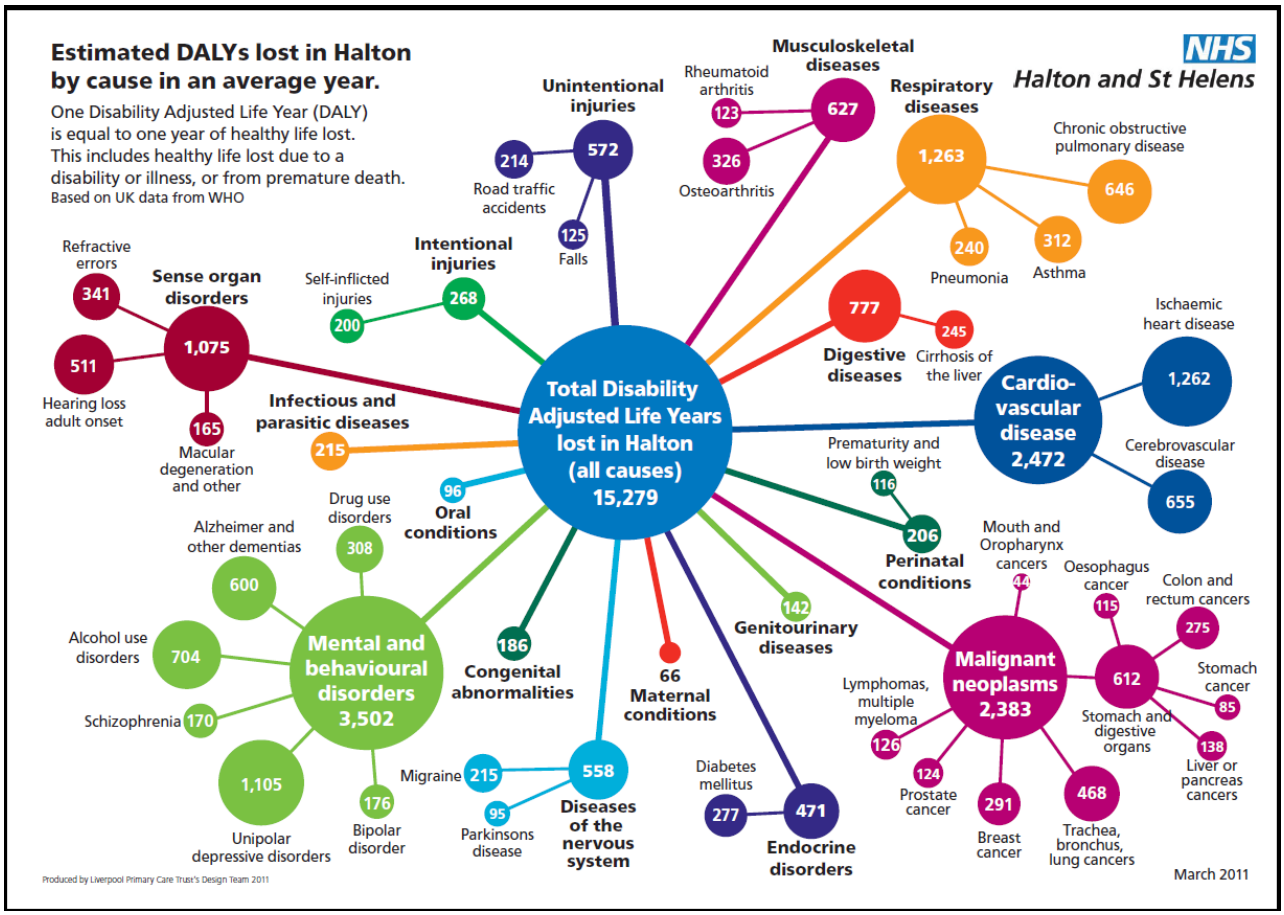
[13] Royal college of psychiatrists (2010) No health without public mental health http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf

[14] Department of Health (2011) National expenditure data 2003---04 to 2010---11. Available from: https://www.gov.uk/government/publications/2003---04---to---2010---11---programme---budgeting---data

[15] A disability adjusted life year (DALY) is a time---based measure that combines years of life lost due to premature Mortality and years of life lost due to time lived in states of less than full health. Further information on the Global burden of disease study is available from: http://www.who.int/healthinfo/global_burden_disease/en/index.html

[16] Kim---Cohen J, Capsi T, Moffitt E et al (2003). Prior juvenile diagnosis in adults with a mental disorder: Developmental follow---back of a prospective---longitudinal cohort. Archives in General Psychiatry 60: 709---717. Available from: http://archpsyc.jamanetwork.com/article.aspx?articleid=207619

Fig – Estimated DALYs lost in Halton by cause in an average year



The prevalence of mental illness

Mental illness is common. In England, one in six adults and one in ten children will experience a mental illness at any one time. This compares to one in ten people with cardiovascular disease and one in twenty with diabetes.

The Quality Outcome Framework (QOF) depression register for Halton in 2011/12 is 12,471 persons aged 18+ (prevalence 12.4%) whilst the QOF mental health register for people with schizophrenia, bipolar disorder and other psychoses for 2011/12 shows 959 people, 0.7% prevalence. Psychoses are defined as disorders that produce disturbances in thinking and perception severe enough to distort perception of reality. The main types are schizophrenia and affective psychosis, such as bi-polar disorder.

Recent research has shown that having a mental health problem increases the chances of a person's developing substance misuse problems, independently of adverse childhood impacts[17].

Research by Green et al[18] showed that 7.7% of 5-10 year olds and 11.4% of 11-16 year olds were likely to have experienced a mental health disorder. As well as age differences, there were gender differences, with prevalence being greater amongst boys (11.4%) than girls (7.8%). Applying prevalence rates for the different mental health disorders to the 2013 population estimates for Halton residents aged 5 to 19, the numbers likely to have mental health disorders and been estimated. Numbers for all types and each type do not add us as some children will have more than one disorder.

Estimated number of children with mental health disorders, by age group and gender, 2013

			Mental Health Disorder		Conduct Disorder		Emotional Disorder		Hyperkinetic Disorder		Less Common Disorders		Totals
Gender	Age group	Population	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number	
females	5 to 10	4,586	5.1%	234	2.8%	129	2.5%	115	0.4%	18	0.4%	18	514
	11 to 16	4,485	10.3%	462	5.1%	229	6.1%	274	0.4%	18	1.1%	49	1032
	17 to 19	2,170	10.3%	224	5.1%	111	6.1%	132	0.4%	7	1.1%	24	498
males	5 to 10	4,784	10.2%	488	6.9%	330	2.2%	105	2.7%	129	2.2%	105	1117
	11 to 16	4,476	12.6%	564	8.1%	363	4.0%	179	2.4%	107	1.6%	72	1285
	17 to 19	2,387	12.6%	301	8.1%	193	4.0%	96	2.4%	57	1.6%	38	685
persons	5 to 10	9,370	7.7%	722	4.9%	459	2.4%	225	1.6%	150	1.3%	122	1556
	11 to 16	8,961	11.5%	1031	6.6%	591	5.0%	448	1.4%	125	1.4%	125	2320
	17 to 19	4,557	11.5%	524	6.6%	301	5.0%	228	1.4%	64	1.4%	64	1181
total all ages		22,888		2277		1351		901		339		311	5179

Source: Green 2005 & ONS 2012

The numbers for 17-19 year olds may be underestimates as mental health problems are more prevalent in 18 year olds than 15 year olds as studies in New Zealand[19] and the USA[20] have shown. Other studies confirm the finding that the late teens and early twenties are periods of especially high risk of mental disorder– possibly the highest of any stage in the life course[21]. Young people over the

[17] Harrington M,Robinson J, Bolton SL, *et al.*A longitudinal study of risk factors for incident drug use in adults: findings from a representative sample of the US population. *Can J Psychiatry* 2011;**56**:686–95.

[18] Green, H., McGinnity, A., Meltzer, H., Ford, T. and Goodman, R. (2004) *Mental health of children and young people in Great Britain*, Office for National Statistics

[19] Fergusson D M and Horwood J (2001) The Christchurch Health and development Study: Review of findings on child and adolescent mental health. *Australian and New Zealand Journal of Psychiatry* **35,**287-296

[20] Merikangas KR, He JP, Burstein M, Swanson SA, Avenevoli S, Cui L, Benjet C, Georgiades K, &Swendsen J (2010). Lifetime prevalence of mental disorders in U.S. adolescents: results from the National Comorbidity Survey Replication–Adolescent Supplement (NCS-A). *Journal of the American Academy of Child and Adolescent Psychiatry, 49* (10), 980-9

[21] Newman D L, Moffit T E, Caspi A, Magdol L, Silva PA and Stanton WR (1996) Psychiatric disorder in a birth cohort of young adults: Prevalence, co-morbidity, clinical significance and new case incidence from ages 11-21. *Journal of Consulting and Clinical Psychology.**64*** 552-562

age of 16 were included in the Adult Psychiatric Morbidity Survey in England 2007[22]. The mental disorders classified in the adult's survey are different to children's disorders. The adult mental disorders are:

- Depressive episodes
- Obsessive compulsive disorders
- Psychotic disorders

The Adult Psychiatric Morbidity Survey (APMS) was a point prevalence survey of UK residents aged between 16 and 75 years old. Prevalence estimates for young people aged 16 to 24 are presented in Table 3 and applied to the estimated Halton population of 16-19 year olds at 2013 and projected population for 2021 (the population aged 16-19 is projected to fall from 6090 in 2013 to 5455). These estimates assume no change in prevalence over this time.

Estimated number of children aged 16-19 with neurotic disorders

	Men			Women			Persons		
		Estimated Numbers			Estimated Numbers			Estimated Numbers	
	%	2013	2021	%	2013	2021	%	2013	2021
mixed anxiety and depressive disorder	8.2%	257	221	12.3%	364	340	10.2%	621	556
Generalised anxiety disorder	1.9%	60	51	5.3%	157	146	3.6%	219	196
Depressive episode	1.5%	47	40	2.9%	86	80	2.2%	134	120
All phobias	0.3%	9	8	2.7%	80	75	1.5%	91	82
Obsessive compulsive disorder	1.6%	50	43	3.0%	89	83	2.3%	140	126
Panic disorder	1.4%	44	38	0.8%	24	22	1.1%	67	60
Any Common Mental Health Disorder	13.0%	407	350	22.2%	656	613	17.5%	1066	955

Source: McManus et al 2009 and ONS 2012

Children's emotional and mental health and wellbeing

9.6% of all children and young people aged 16 and under will have some form of mental disorder (ONS 2005). This equates to 2500 Halton children aged 0-15 with a diagnosable emotional and mental health condition. There is wide spread evidence suggesting that vulnerable groups are more at risk of developing mental health problems:

Children with disabilities

Research suggests that almost 1 in 4 children with a disability have an emotional disorder. In Halton there are more SEN children as a proportion of all children than the national average.

[22] McManus S., Meltzer H., Brugha T., Bebbington P. & Jenkins R. (2009) *Adult psychiatric morbidity in England, 2007: Results of a household survey* The Health & Social Care Information Centre

Young people who smoke and drink

Of 11-15 year-olds who smoke regularly, 41% have a mental disorder, as well as 24% of those who drink alcohol at least once a week, and 49% of those who use cannabis at least once a month (MHF, 2007). In Merseyside, levels of those under 18s admitted to hospital with alcohol specific conditions are more than twice as high as the national rate of 55.8 per 100,000. Local Alcohol Profiles for England demonstrate that there has been significant reduction in Under 18's admitted to Hospital with Alcohol Specific Conditions within Halton.

Halton Under 18s admitted to hospital with alcohol specific conditions
Published data from LAPE (Local Alcohol Profiles for England) Persons, crude rate per 100000 population

04/05 to 06/07	05/06 to 07/08	06/07 to 08/09	07/08 to 09/10	08/09 to 10/11	09/10 to 11/12*
161.1	182.6	180.9	153.9	122.9	110.00

* local data

Not in education, employment, or training (NEET)

Being in education, employment and training between the ages of 16-18 increases a young person's resilience (ChiMat, 2012). In 2011 10.3% of Halton young people were 'NEET' and this is significantly higher than the average of 6.2%. The latest information from Halton indicates that at the end of 2012 the NEET figure was 9% of the cohort.

Pregnant teenagers

Although early parenthood can be a positive experience for some young people, low levels of emotional health and wellbeing can often be regarded as both a cause and a consequence of teenage pregnancy. Halton has been able to reduce the numbers of pregnant teenagers locally, although Halton still remains above the regional and national average with the (ONS 2011) confirming that Halton has 40 per 10000 15-17 year old girls conceiving.

Asylum Seekers, Refugees and Immigrants

Mental health problems in some migrant groups are higher than in the general population, for example migrant groups and their children are at two to eight times greater risk of psychosis (DH, 2011a).

Gypsy, Roma and Traveller children

Gypsy, Roma and Traveller children have the worst educational outcomes of any ethnic group in the UK and high rates of school exclusion. Currently in January 2013, there are five gypsy and traveller sites across Halton.

Young carers

There is unfortunately a strong relationship between poor mental health and caring. There are 296 known young carers as of November 2012 within Halton, although it is widely recognised that many young carers are not known to service provision.

There are also risk factors associated with increased prevalence of mental ill health such as single parent households, poverty and lack of educational attainment. These can be countered by development of resilience factors such as improved appropriate relationships and opportunities for improved self-esteem and confidence.

Children with a parent/carer experiencing mental ill health

A thematic inspection by Ofsted and the Care Quality Commission [23] explored how well adult mental health services and drug and alcohol services considered the impact on children (up to age 18) when their parents or carers had mental ill health and/or drug and alcohol problems; and how effectively adult and children's services worked together to ensure that children affected by their parents' or carers' difficulties were supported and safe.

Data is not collected nationally about how many of the adults receiving specialised mental health services are parents or carers, but it is estimated that 30% of adults with mental ill health have dependent children.[24]

Key findings from the inspection highlighted considerable variations in the extent to which adult and children's services worked effectively together to assess concerns and support and challenge parents and carers. Overall, the quality of joint working was much stronger between children's social care and drug and alcohol services than between children's social care and adult mental health services.

---

[23] What about the children? Joint working between adult and children's services when parents or carers have mental ill health and/or drug and alcohol problems (Ofsted 2013)

[24] D Meltzer, *Inequalities in mental health: a systematic review*, The research findings register, Summary No.1063, Department of Health; www.dh.gov.uk/health/category/publications/.

Thinking about the impact of parents' or carers' difficulties on children was more strongly embedded in drug and alcohol services than in adult mental health services. This stronger focus on children by drug and alcohol services has been driven by the requirement for local areas to gather information on the number of adults with children and report on this to the National Treatment Agency for Substance Abuse. Within adult mental health services, while it is expected that the care programme approach considers safeguarding of children, there are no national requirements to gather information and report on the number of parents or carers who have serious mental health difficulties. Therefore, in the absence of any national drivers there is limited scrutiny of this issue within mental health services generally.

The inspectors make a number of recommendations across government and agencies including Local Safeguarding Children's Boards, mental health service providers, commissioners and local authorities.

Self-harm

Self-harm is a public health issue, particularly among children and young people. It is difficult to measure the extent of the issue in the population, but evidence suggests that self-harm affects at least one in 15 young people and is one of the top five causes of acute hospital admission for people of all ages in the UK. Within Cheshire and Merseyside, rates of emergency hospital admissions for self-harm vary substantially with eight out of nine local authorities having rates that are significantly higher than the England average.

Published national statistics show that Halton has a significantly higher rate of emergency hospital admissions resulting from people across all ages self-harming. The rate for age 0-17 shows a substantial reduction in numbers though remains significantly higher than national average.[25]

Halton Rate per 100,000 population

	2009/10		2010/11		2011/12	
	Number	Rate	Number	Rate	Number	Rate
All ages	400	349.9	453	399.8	*	415
Age 0-17	Data not provided		90	329.6	59	208.7

Analysis of referrals to CAHMS Urgent Response Team Data (CURT)[26] from April 2012 to March 2103 provides greater intelligence on the local perspective for children and young people:

[25] Data from Halton Public Health Evidence and Intelligence Team

Total number of referrals to CURT	119
Referrals from hospital	115
Referrals already open to CAMHS	52
Referrals from females	79
Referrals from males	40
Age at referral: Under 13 13-15 16+	 24 52 43

Suicide

Each year, an audit is performed with the aim of learning lessons from local suicides to try to identify ways of preventing future deaths. Each year in the UK, there are approximately 6000 suicides, every single one having a great impact on those involved and representing a large number of years of life lost. This number has not changed dramatically over the years but the age-standardised rate of suicide per 100,000 population has decreased since 1981 (from 14.9 per 100,000 population to 11.8 per 100,000 population in 2011).

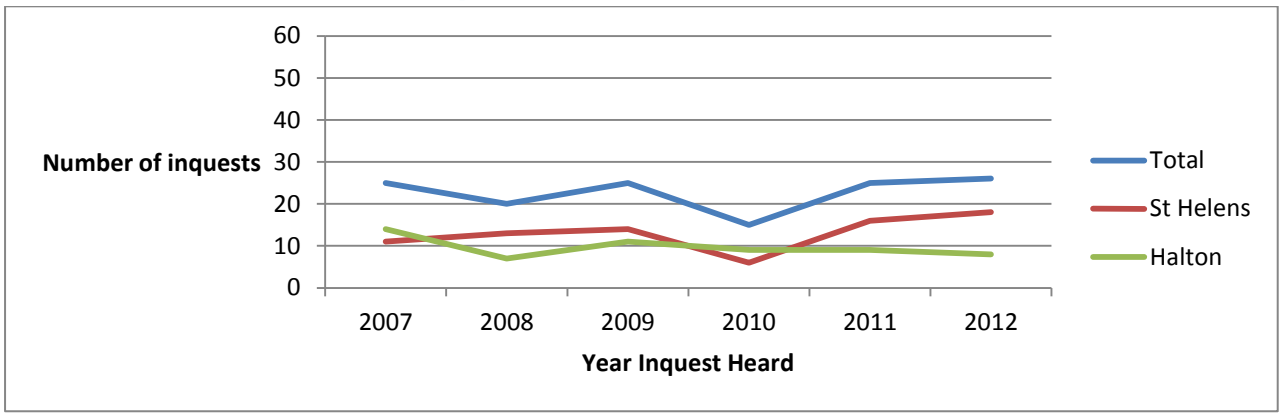
It is known that the circumstances surrounding suicides are complex; however, there are important recurring features. Most people who complete suicide are male (18.2 per 100,000 population vs. 5.6 per 100,000 population), they live alone and often have or have had mental health problems.

In 2012, there were 26 suicide inquests heard for the St Helens and Halton area, 18 for St Helens and 8 for Halton, and 24 were suicide verdicts, and 2 open verdicts (both Halton). The data does not show any significant differences from the national trends.

The graph below shows the number of suicide inquests heard over the past 6 year in St Helens and Halton. This graph does not represent the annual figures of suicides as this audit is completed by date inquest heard, not date of death. Annual suicide rates per local authority can be found on the NHS Indicator Portal website.

[26] Data from 5BP NHS FT CURT Team

Table - Suicide trends over past 6 years in St Helens and Halton[27]



Some key trends in suicides in the St Helens and Halton area are:

1. Men continue to have a higher rate of suicide than women (92% overall, 100% St Helens, 75% in Halton).
2. Hanging at home was the single most common method of suicide (13/26, 50%)
3. The majority of the deceased were living alone at the time of death (54%)
4. The most common marital status at time of death was single (39%)
5. There was evidence of personal problems in the majority of cases (85%), most were relationship problems (50%)
6. Nearly 25% of the deceased had been in contact with mental health services within the 6 months prior to death, with a total of 19 people (73%) having had a diagnosis of mental health problems at some point in their life.
7. Substance misuse was present in nearly a third of cases.

These findings appear to follow national trends and there does not appear to be any specific areas of concerns (i.e. methods of suicide) that are particular to the area with the main groups of concern being middle-aged men, those living alone and single people.

A new 'Suicide Prevention Strategy' is under development and the work of the strategy will compliment further activity to tackle this area of focus to ensure that local teams can deliver effective care utilising local resources for the benefit of those at highest risk of suicide.

Dual diagnosis

Dual diagnosis is the term used to describe people with mental illness and problematic drug and/or alcohol use. Historically the term has been used for those with "severe and enduring mental illnesses" such as psychotic/ mood disorders. More recently there has been an acceptance that personality disorder may also co-exist with psychiatric illness and/or substance misuse. The relationship between both conditions is complex. Concurrent mental health problems and substance misuse increases potential risks to the individual and is associated with; increased likelihood of suicide; more severe mental health problems; increased risk of violence;

[27] Data taken from the NHS Indicator Portal https://indicators.ic.nhs.uk/webview/

increased risk of victimisation; more contact with the criminal justice system; family problems; more likely to slip through services; less likely to adhere to medication or engage with other services; and more likely to lose accommodation and be at risk of homelessness.

With regards to prevalence; about half of patients in drug and alcohol services have a mental health problem, most commonly depression or personality disorder; about a third to a half of those with severe mental health problems will also have substance misuse problems; and alcohol misuse is the most common type of substance misuse and, where drug misuse occurs, it tends also to coexist with alcohol misuse.

In Halton, adult mental health services are delivered by the 5 Boroughs Partnership NHS Foundation Trust and the Council's mental health social care team. Following a recent configuration, the social care team are co-located with the Trust's Recovery Team. A recent audit of individuals in these mental health services identified 51% (n=198) individuals as having previous or current substance misuse.

In 2012, NHS Mersey led on a review of the response to Dual Diagnosis involving substance misuse in Liverpool, St Helens, Knowsley, Sefton and Halton. Two of the aims of the review were to 'highlight opportunities for change which could benefit all areas, and to identify gaps in provision'. The key issues that arose from the review and discussions with key stakeholders were;

- Transitions between services are problematic and are the points at which some individuals drop out of treatment.
- Clarification of the roles and responsibilities of the service and staff working within them in relation to dual diagnosis.
- Creating a network between the medical professionals working in substance misuse, mainstream mental health services and primary care.

- Both substance misuse and mental health services are increasingly 'recovery driven' and subject to 'payment by results', presenting opportunities for shared learning and development between the two sectors.
- Service users and their carers need to be involved at every stage in service improvement and development.

Drug use amongst people with mental health problems

Research shows that substance use, intoxication, harmful use, withdrawal and dependence may lead to or exacerbate psychiatric or psychological symptoms or syndromes. Conversely, psychological morbidity and psychiatric disorder may lead to substance use, harmful use and dependence (addiction). The most common associations for substance misuse are with depression, anxiety and schizophrenia, post-traumatic stress, attention deficit, hyperactivity and memory disorders also occur[28].

For young people, emotional and behavioural disorders are associated with an increased risk of experimentation, misuse and dependence[29]. Recent research showed that pupils with a wellbeing score less than 10 (considered to be relatively low level of wellbeing) were more likely than pupils whose wellbeing scores were higher to have taken drugs in the last year (odds ratio=1.55)[30].

Research suggests 21.4% of people in contact with community mental health services also have a problem with drugs[31]. Other studies suggest the prevalence of dual diagnosis is between 30% and 50% of psychiatric caseloads, with some mental health conditions being more often associated with substance misuse than others e.g. Schizophrenia, Psychosis, Severe Depression: and Personality Disorder[32]. Indeed, a study using data from the Scottish Drug Misuse Database, April 2001 and March 2002, revealed that over 40% of individuals who sought

[28] Crome I., Chambers P., Frisher M., Bloor R. & Roberts D. (2009) The relationship between dual diagnosis: substance misuse and dealing with mental health issues London: Social Care Institute for Excellence

[29] Green H, McGinnity A, Meltzer H et al (2005). Mental Health of Children and Young People in Great Britain 2004. Office for National Statistics

[30] Fuller E., Henderson H. Nass L., Payne C., Phelps A. & Ryley A. (2013) *Smoking, drinking and drug use among young people in England in 2012* London: Health and Social Care Information Centre

[31] Weaver, T., et al (2003) Co-morbidity of substance misuse and mental illness in community mental health and substance misuse services. *British Journal of Psychiatry,* **183**, 304-313.

[32] Banerjee, J., Clancy, C., Crome, I. (2002). *Co-existing problems of mental disorder and substance misuse (dual diagnosis): an information manual 2002*. London: The Royal College of Psychiatrists Research Unit.

treatment for problem drug use (3,236 out of a total of 10,798 individuals) reported that their mental health was one of the issues which led them to seek treatment[33].

With an estimated 2277 young people under age 16 (Table 3), 1066 young adults aged 16-19 years (Table 4), 12,583 adults aged 18-64 years estimated to have common mental health disorders and 5,606 two or more psychiatric disorders in Halton a significant proportion of these are also likely to have substance misuse issues. Even applying the lowest estimated prevalence rate of 21.4% identified in the research to the number of adults estimated to have common mental health problems and two or more psychiatric disorders would suggest **3,813** people in Halton with mental health problems also use drugs.

People aged 18-64 predicted to have a mental health problem, projected to 2020

	2012	2013	2014	2015	2016	2018	2020
Common Mental Disorder	12,608	12,583	12,499	12,442	12,365	12,269	110.00
Borderline Personality Disorder	353	353	350	349	347	344	341
Antisocial Personality Disorder	270	268	267	265	263	261	256
Psychotic Disorder	313	313	311	309	307	305	303
Two or more Psychiatric Disorder	5,620	5,606	5,570	5,542	5,506	5,463	5,420

Source: PANSI,2013

Mental illness and physical ill health

There is a strong interconnection between a person's mental and physical health. 30% of people with long-term conditions have a mental health problem, whilst 46% of people with mental health problems have a long term condition.[34]

People with a mental illness have higher rates of physical illness and die earlier than the general population, largely from treatable conditions associated with modifiable risk factors such as smoking, obesity, substance abuse, and inadequate medical care. Having depression is associated with a 50% increase in mortality. While in the UK people with schizophrenia die an average of 16 to 20 years earlier than the general population largely due to physical health problems. Smoking is twice as common among people with a mental illness and is a significant cause of morbidity and mortality among those with a mental illness. Adults with mental health problems, including those who misuse alcohol or drugs, smoke 42% of all the tobacco in England.

[33] Scottish Advisory Committee on Drug Misuse (SACDM) & Scottish Advisory Committee on Alcohol Misuse (SACAM) (2003) *Mind the Gaps: meeting the needs of people with co-occurring substance misuse and mental health problems* Edinburgh: The Scottish Executive

[34] Data source: http://www.champspublichealth.com/sites/default/files/media_library/files/Reducing%20the%20burden%20of%20mental%20illness%20-%20Report@1.pdf

Learning Disabilities and Mental Health

There are estimated to be 1.14m people with learning disability in England[35] and estimates of prevalence of mental health problems vary from 25-40%, depending on the population sampled and the definitions used.

'No health without mental health' notes the increased risk of mental health problems faced by people with learning disabilities and sets two aims for improvement:

- inclusivity of mainstream mental health services for people with learning disabilities who have mental health problems
- development of appropriate skills and provision of adjustments to meet the individual needs of people with learning disabilities and autism.

Prevalence of anxiety and depression in people with learning disabilities is the same as the general population, yet for children and young people with a learning disability, the prevalence rate of a diagnosable psychiatric disorder is 36%, compared with 8% of those who do not have a learning disability. These young people were also 33 times more likely to be on the autistic spectrum and were much more likely than others to have emotional and conduct disorders.

Children and young people with learning disabilities are much more likely than others to live in poverty, to have few friends and to have additional long term health problems and disabilities such as epilepsy and sensory impairments. All these factors are positively associated with mental health problems.

Key highlights of research evidence on the Health of People with Learning [Intellectual] Disabilities[36] offers the following summary relating to mental health:

- People with learning disabilities demonstrate the complete spectrum of mental health problems, with higher prevalence than found in those without learning disabilities
- The prevalence of dementia is much higher amongst older adults with learning disabilities compared to the general population (21.6% vs 5.7% aged 65+)
- People with Down's syndrome are at particularly high risk of developing dementia, with an age of onset 30-40 years younger than the general population
- Prevalence rates for schizophrenia in people with learning disabilities are approximately three times greater than for the general population (3% vs 1%)
- Reported prevalence rates for anxiety and depression amongst people with learning disabilities vary widely, but are generally reported to be at least as prevalent as the general population and higher amongst people with Down's syndrome

[35] People with learning disabilities in England 2012 IHAL
[36] http://www.learningdisabilities.org.uk/help-information/Learning-Disability-Statistics-/187699/

- Challenging behaviours (aggression, destruction, self-injury and others) are shown by 10%-15% of people with learning disabilities, with age-specific prevalence peaking between ages 20 and 49

The Mental Health Foundation have highlighted the following areas to be addressed to improve the mental health of people with learning disabilities

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

Autistic Spectrum Disorder

People with Autistic Spectrum Disorder (ASD) may experience a range of mental health issues relating to their ASD symptoms or from the social isolation it generates. People with autism or Asperger syndrome are particularly vulnerable to mental health problems such as anxiety and depression, especially in late adolescence and early adult life37. Ghaziuddin et al (1998) found that 65 per cent of their sample of patients with Asperger syndrome presented with symptoms of psychiatric disorder. Whilst the National Autistic Society has evidence that as many as 71% of children with autism have mental health problems, such as anxiety disorders, depression, and obsessive compulsive disorder (OCD), and 40% have two or more[38].

People with ASD may experience higher rates of:

- Low self esteem
- Depression
  Anxiety
- Obsessive Compulsive Disorders
- Attention Deficit Hyperactivity Disorder
- Self-Harm- People with autism will often engage in self-harming behaviours as a response to stress, anxiety or depression.
- Dual Diagnosis - when an intellectual disability is present with a mental health condition such as schizophrenia

[37] Tantam & Prestwood, 1999
[38] You Need to Know Campaign – National Autistic Society

It is very important people with ASD seek appropriate supports when suffering depression, anxiety or other mental health issues. It can be very difficult to distinguish mental health problems in those with severe autism and poor verbal skills as mental health diagnosis often is dependent on the ability of the person to describe their symptoms or on a skilled clinician to be able to observe symptoms and distinguish them from autism related behaviour. This can mean that it is not until the mental illness is well developed that it is recognised, with possible consequences such as total withdrawal; increased obsessional behaviour; refusal to leave the home, go to work or college etc.; and threatened, attempted or actual suicide.

Mental health and Wellbeing in Older People

As life expectancy increases healthy life expectancy also needs to increase. Healthy ageing is a concept promoted by the World Health Organisation that considers the ability of people of all ages to live a healthy, safe and socially inclusive lifestyle. It recognises the factors beyond health and social care that have a major effect on health and well-being, and the contribution that must be made by all sectors with an influence on the determinants of health. It also embraces a life course approach to health that recognises the impact that early life experiences have on the way in which population groups' age[39].

Healthy ageing may be considered as the promotion of healthy living and the prevention and management of illness and disability associated with ageing. There is an appreciation that the locus of responsibility for the prevention and management of many chronic diseases lies with the individual through their behaviour and the recognition that a range of factors – socio-economic, environmental and cultural – influences this behaviour.

This points to one of the key challenges for the preventive approach – it is not just about providing good information and services. Crucially, it is about persuading people of the healthy ageing argument to change their behaviour[40] By adopting a more pro-active approach to ageing through the 'five ways to wellbeing' highlighted earlier (page 9) the onset of loneliness, social isolation or depression can be avoided or delayed and a sense of wellbeing maintained.

In Halton's older population, levels of depression and dementia are significant. However it is recognised that loneliness and social isolation impact on the wellbeing of older people.

[39] http://www.ageuk.org.uk/documents/en-gb/for-professionals/health-and-wellbeing/evidence%20review%20healthy%20ageing.pdf?dtrk=true

[40] The Case for Healthy Ageing: Why it needs to be made, P. Holmes and P. Rossall, Help the Aged, 2008

Loneliness and Social Isolation

Whilst 'social isolation' and 'loneliness' are often used interchangeably, people attach distinct meanings to each concept[41]. 'Loneliness' is reported as being a subjective, negative feeling associated with loss (e.g. loss of a partner or children relocating), while 'social isolation' is described as imposed isolation from normal social networks caused by loss of mobility or deteriorating health. Although the terms might have slightly different meanings, the experience of both is generally negative and the resulting impacts are undesirable at the individual, community and societal levels.

Estimates of prevalence of loneliness tend to concentrate on the older population and they vary widely, with reputable research coming up with figures varying between 6 and 13 per cent of the UK population being described as often or always lonely[42.] There is growing recognition that loneliness is a formidable problem which impacts on an individual's health and quality of life and even on community resilience. There is increasing evidence that people who are lonely are more likely to use health and social care services and a developing confirmation, through personal stories, of the emotional costs and misery that loneliness can cause. Those with less than three close relatives or friends are more likely to experience mental health problems.[43]

Loneliness has a very negative impact on health and this impact has been estimated as equivalent to smoking fifteen cigarettes each day, of greater severity than not exercising and twice as harmful as obesity[44]. The lonelier a person is, the more likely they are to experience increased depressive symptoms. Loneliness has been linked to hypertension and high blood pressure and in developing cardiovascular disease. Lonely individuals have double the risk of contracting Alzheimer's disease while having a dementia increases our chance of feeling lonely. Lonely people also have an increased chance of being admitted to care homes and hospitals.

[41] http://www.scie.org.uk/publications/briefings/files/briefing39.pdf

[42] http://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation.pdf?dtrk=true

[43] http://s.bsd.net/nefoundation/default/page/-/files/Five_Ways_to_Wellbeing.pdf

[44] Holt-Lundstad 2010

National statistics about loneliness:

- **6 - 13% of older people say they feel very or always lonely**
- **6% of older people leave their house once a week or less**
- **17% of older people are in contact with family, friends and neighbours less than once a week, and 11% are in contact less than once a month**
- **Over half (51%) of all people aged 75 and over live alone**
- **Almost 5 million older people say that the television is their main form of company**
- **ELSA estimates 1 in 6 adults aged over 50 are socially isolated (Campaign to End Loneliness)**

Depression

Depression though common is not an inevitable part of aging. Early signs of depression need to be acted on to improve wellbeing and maintain quality of life. Failure to respond can increase risk of further illnesses developing.

Data analysis by the National Mental Health Development Unit[45] tells us that one in four older people in the community have symptoms of depression. The risk of depression increases with age so that 40% of those over 85 are affected. Major depression is a chronic disorder with the majority of older patients having a recurrence within three years.

Some groups are at higher risk of depression: Care home residents (where up to 40% may be depressed) and 20 - 25% of people with dementia also have symptoms of depression. Co-morbidities are the norm in later life. Thus, mental and physical health problems of older people are entwined and manifested in complex co-morbidity.

Physical illness is associated with increased risk of depression:

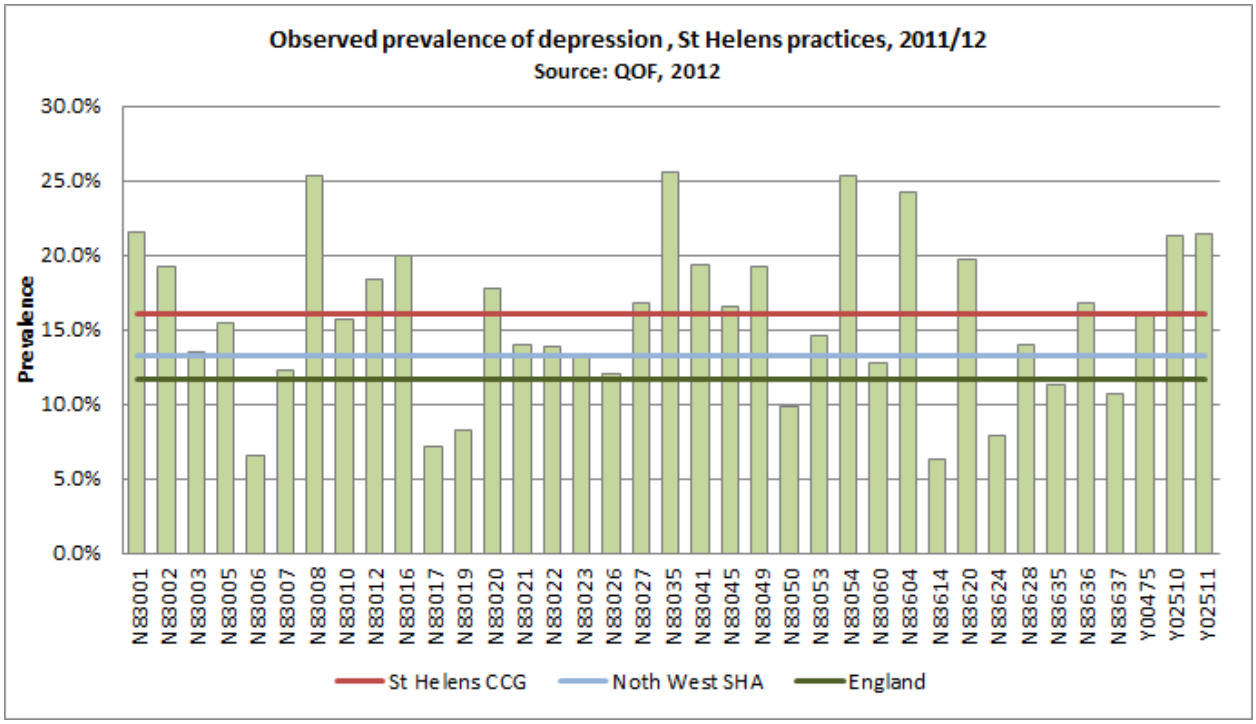
- Depression is three times as common in people with end-stage renal failure, chronic obstructive pulmonary disease and cardiovascular disease as in people who are in good physical health.

[45] http://www.nmhdu.org.uk/silo/files/management-of-depression-in-older-people.pdf

• Depression is more than seven times more common in those with two or more chronic physical conditions.

Locally the GP depression registers for 2011/12 shows that 12,471 persons aged 18+ had a diagnosis of depression. Prevalence at a practice level varied substantially from 1.6% to 22.1%, with an average of 12.4%. This is an increase from 2010/11 figures (11,924 or 11.94%). This may be as much due to a combination of active case finding as well as the potential increase in numbers of people experiencing depression and their willingness to discuss it with their GP.

Observed prevalence of depression, Halton GP practices, 2011/12



Depression is also associated with increased mortality and risk of physical illness.

- Increased mortality: a diagnosis of depression in those aged over 65, increased subsequent mortality by 70%. Depression is associated with 50% increased mortality after controlling for confounders, which is comparable with the effects of smoking.
- Increased risk of coronary heart disease: depression almost doubles risk of later development of coronary heart disease after adjustment for confounding variables.
- Increased risk of stroke: increased psychological distress is associated with 11% increased risk of stroke.

Identified risk factors for depression in older people include:

- Recent (less than 3 months) major physical illness or hospital admission
- Chronic illness
- In receipt of high levels of home care, including residential care
- Recent bereavement
- Social isolation and loneliness
- Excessive alcohol use
- Fuel poverty
- Persistent sleep problems
- Living in a care home
- Dementia
- Some ethnic groups are at higher risk

Dementia

Dementia can affect adults of working age, but is most common in older people. One in six people aged over 80 and one in 14 people aged over 65 have a form of dementia.

In Halton the number of people with dementia is set to rise by 62% by 2030, largely due to the projected increase in the older population. 690 people registered with a Halton GP have a diagnosis of dementia. It is projected that there are 1,143 people aged 65+ living in Halton who have some form of dementia and by 2030 this figure is estimated to be as high as 2,050. In addition the borough currently has 33 working age adults aged 30-64 who have a formal diagnosis of dementia.

Hospital admissions for people living in Halton for Alzheimer's and other related dementia are the highest in the country[46] (2009/10 to 2011/12). It is uncertain whether this results from a higher prevalence of dementia locally or from higher rates of diagnosis. However Halton's ratio of recorded to expected prevalence of dementia is significantly higher than England suggesting that earlier diagnosis is the explanation. Further detail of the prevalence and severity of dementia in the Borough can be found in the Halton Dementia Strategy Refresh 2013

Dementia is characterised by a collection of symptoms, including a decline in memory, reasoning and communication skills needed to carry out daily activities. Alongside this decline, individuals may develop behavioural and psychological symptoms such as depression, psychosis, aggression and wandering, which complicate care and can occur at any stage of the illness. Family carers of people with dementia are often old and frail themselves, with high levels of depression and physical illness, and a diminished quality of life. Dementia is a terminal condition but people can live with it for 7–12 years after diagnosis.

There is evidence that early provision of support at home can decrease institutionalisation by 22% and even in complex cases, case management can reduce admission to care homes by 6%. Older people's mental health services can help with behavioural disturbance, hallucinations and depression in dementia, reducing the need for institutional care.

In response to the National Dementia Strategy 2009 local support has been commissioned through a partnership with Alzheimer's Society and Age UK Mid Mersey who have developed Dementia Care Advisors and Dementia Cafés.

Evaluation of the redesign of the later Life and Memory Service (LLAMS) pathway being piloted in Wigan demonstrates that the changes introduced delivered a positive impact upon service

[46] www.nepho.org.uk/cmhp Halton Community Mental health Profile 2013

efficiencies and the timeliness of response to referrals. That contributed to a positive experience of the new service for Service Users and Carers. Similarly, there is evidence to show that collaborative working between staff and the integration of teams improved the speed with which diagnoses were arrived at, the availability of support for the management of memory problems and an increase in the levels of support provided within community settings. A LLAMS for Halton has now been implemented and its impact will be kept under review.

Ex-Armed Forces Personnel and their families

Liverpool Public Health Observatory published a Health needs assessment for ex-armed forces personnel aged under 65, and their families Cheshire and Merseyside (2013)[47]

Extrapolation of estimates within this report for Halton CCG footprint indicate a veteran population under age 65 of 3,700 which is predominantly male. These figures are likely to be an underestimate due to recent redundancies in military personnel.

Overall rates of common mental health problems and Post Traumatic Stress Disorder remain low. Alcohol misuse on return home is an issue for Regulars whilst Reservists are more likely to experience psychological impact of deployment.

There is limited research on the impact of deployment on children and families. One study found 30% of children with a currently deployed or recently returned parent showed clinical level of anxiety which persisted for up to a year after the parents return. A separate health needs assessment has just been commissioned to look at the health needs of Ex-armed forces personnel in Halton.

[47] http://www.liv.ac.uk/PublicHealth/obs/publications/report/93%20Health%20needs%20assessment%20for%20ex-Armed%20Forces%20personnel.pdf

Armed Forces Personnel – Community Covenant

This agreement has been developed across Cheshire, Halton and Warrington to help veterans of the armed forces "live at ease". The initiative provides wrap around support to issues impacting on the mental health and wellbeing of veterans including debt advice, addiction support, counselling etc. In Halton as there is no garrison veterans are integrated into the community and work is on-going to identify the potential level of need.

Mental Health and the Criminal Justice System

Offenders, ex-offenders and those at risk of offending experience significant health inequalities compared to the general population. They experience higher rates of mortality and suicide; drug and alcohol misuse; mental and physical health problems; homelessness, literacy and numeracy difficulties, and unemployment; and poor access to and uptake of health and care services.

Since there is an identifiable link between health inequalities and offending behaviour, improving their health outcomes can markedly reduce re-offending rates. In turn, a reduction in re-offending is likely to bring health and wellbeing benefits to a wider local population as a result of improved community safety.

Liverpool Public Health Observatory published "Health needs assessment of young offenders in the youth justice system on Merseyside" (2013)[48] which evidences mental health needs of the prison population in the region:

	Female %	Male %
Suffer 2 or more mental disorders	70	72
Psychotic disorder	14	7
Drug use in previous year	55	65
Hazardous drinking	39	63

[48] Liverpool Public Health Observatory published "Health needs assessment of adult offenders across the criminal justice system on Merseyside" (2012) http://www.liv.ac.uk/PublicHealth/obs/publications/report/87_Health%20needs%20assessment%20of%20adult%20offenders_210612.pdf

From April 2013 responsibility for prison healthcare has transferred to the NHS England whilst CCG'S have responsibility for offenders managed in the community or released from custody. This will require development of strong links between the NHS England and CCG to deliver the core recommendations within the report. NICE is currently developing guidance on prisoner physical and mental health.

Young Offenders

The age of criminal responsibility in England and Wales is 10 years. The youth justice system (YJS) was set up under the Crime and Disorder Act 1998, to prevent young people offending or reoffending. The formal youth justice system begins once a child aged 10 and over has committed an offence and receives restorative solutions and cautions, or is charged to appear in court. Ministry of Justice figures show the child custodial population has reduced by 44% over the 4 years to 2012. Typically almost 80% of young people sentenced to custody are reconvicted within 2 years.

Amongst children and young people in custody over 30 per cent have a diagnosed mental health problem. Evidence also suggests there is considerable overlap between looked after children and those in the Youth Justice System.

Youth Offending Services

The Crime and Disorder Act requires local authorities, the police, probation, and Clinical Commissioning Groups, to set up Youth Offending Services (YOSs) to work with children and young people offending or at risk of offending. YOSs must include representatives from the police, probation, health, education and children's services. YOSs continue to have responsibility for children and young people sentenced or remanded to custody.

Youth justice liaison and diversion schemes

The cross-government Health and Criminal Justice Liaison and Diversion programme, led by the DOH, includes a major national programme of pilot youth justice liaison and diversion (YJLD) schemes for children and young people with mental health, learning or communication difficulties, or other vulnerabilities affecting their physical and emotional well-being. The purpose of the programme is to identify all health and social care needs at whatever point children and young

people enter the YJS, with a view to securing more systematic access to services and enabling the police and courts to make informed decisions about charging and sentencing.

In Halton there is a CAMHS worker attached to the YOS working 2 days YOS and 3 days with the Divert programme. The Divert programme aims to intervene at the point of arrest and divert young people with mental health issues away from the Criminal Justice System. There is one full-time substance misuse worker covering both Halton and Warrington and all case managers and support staff are trained in the basics of substance misuse.

In October 2012 Halton and Warrington YOS managed 40 young offenders from Halton, 38 male and 2 female. 95% were White British and 27 were in the age range 15-17.

Section 136 – Mental Health Act 1983 – Place of safety

This legislation allows police officers to remove a person they think is mentally disordered and "in need of care and control" from a public place to a place of safety in the interests of that person or for the protection of others. The person can then be examined by a medical practitioner and interviewed by an approved mental health professional (AMHP) to arrange any treatment or care. In such circumstances a person can be taken into police custody under section 136 of the Mental Health Act 1983. Under this power police custody is viewed as a 'place of safety', where a person can be held without harm until the examinations/interview can take place. Police custody is widely viewed as not being a suitable environment for people with mental disorder as it has the effect of criminalising people for what is essentially a health need and the environment may exacerbate their mental state and, in the most tragic cases, can lead to deaths in custody[49]

In February 2013 a multi-agency Mental Health Act group chaired by the Royal College of Psychiatrists published Guidance for commissioners[50]:
The report made a number of recommendations:

1. The custody suite should be used in exceptional circumstances only.
2. A vehicle supplied by the ambulance provider should be able to attend promptly so that it is used for conveyance unless the person is too disturbed.
3. The AMHP and doctor approved under Section 12(2) of the Mental Health Act should attend within 3 hours in all cases where there are not good clinical grounds to delay assessment.
4. The first doctor to perform a Mental Health Act assessment should be approved under Section 12(2) of the Act.

[49] **Police Custody as a "Place of Safety":** Examining the Use of Section 136 of the Mental Health Act 1983 http://www.ipcc.gov.uk/sites/default/files/Documents/guidelines_reports/section_136.pdf
[50] Guidance for commissioners: Service provision for Section 136 of the Mental Health Act 1983

5. A monitoring form should be agreed locally to meet all the national requirements and should be completed in all cases.
6. Commissioners should ensure that there is a multi-agency group meeting to develop, implement and quality assure the agreed policy. This group should review the monitoring data. It should also consider how the need for use of Section 136 might be reduced

The place of safety is generally a designated NHS resource in the area if the person does not have any additional injury or illness requiring treatment at an Emergency Department. Alternatives include a domestic address - the persons own home or friend a relative's home.

It has been nationally reported that the use of Section 136 has been increasing, placing additional demands on Police, Health and Social Services resources. To gain a greater understanding of how the use of Section 136 was impacting upon resources within the Cheshire Police area an analysis of data from Section 136 assessments completed in 2012 has been undertaken:

Profile of 2012 Section 136 detentions in Halton

- 92 S136 assessments completed
- 61% of detainees were male
- Average age of detainees is 35
- 5 detainees were aged under 18 no detainees were aged 65+
- 62% were classed as unemployed

Place of Safety following detention

	Brooker Centre	Hollins Park	Runcorn Custody Suite	Warrington General Hospital	Other	Unknown
Number	26	7	39	13	5	2
Percentage	28%	8%	42%	14%	6%	2%

In Halton a revised S136 is being drafted. Within the current protocol attendance as described in recommendation 3 above is two hours rather than three. The local designated place of safety was the Brooker Unit at Halton Hospital. Recent redesign of the Acute Care Pathway has centred support at Hollins Park in Warrington leading to more local options being considered. These alternatives are often not the most appropriate and a review of local provision is needed.

Psychiatric Liaison Service - Warrington and Halton Hospitals Foundation Trust and St Helens and Knowsley

Accident and Emergency (A&E) Services are involved with the assessment and treatment of acute illness and injury suffered by patients of all ages including patients with an acute change in mental status. It also addresses the needs of people who have presented themselves to the A&E department rather than seeking help from their GP or directly from local mental health services.

For patients with mental health problems, this might include those who have suffered self-inflicted injuries, or management of patients presenting with acute mental health problems.

A&E Departments have a short stay ward which has the facilities for the temporary observation of patients who have taken minor toxic overdoses, where more thorough mental health evaluation can be carried out following recovery.

Across the Mid Mersey footprint 5BP liaison teams carry out the assessment and management of care of identified patient within AED. The service aims and Objectives are:

- To ensure that people attending the A&E Department who have mental health needs have them addressed and receive the psychiatric care or social support required or arranged to improve their physical and psychological wellbeing.
- Improve the quality of care provided by A&E staff to mental health service users by improving their knowledge and skills regarding common psychiatric conditions.
- Conduct Risk Assessments for self harm and harm to others.
- Provide brief interventions and advice to people who present with self harming behaviour and arrange for referral to primary care or specialist mental health services depending on risk and severity.
- To provide specific advice to people with depression, anxiety or other mild to moderate mental health problems.
- Provide signposting to appropriate mental health services following discharge from A&E.
- Provide support and advice to the acute general hospital staff for people with physical health problems caused by alcohol or substance misuse that are not linked into appropriate services for these conditions.
- Support people with complex behaviour patterns requiring interventions under the Mental Health Act 2007 and Mental Capacity Act 2005.
- Conduct Mental Health Act and Mental Capacity Act Assessments.
- Provide expert advice regarding capacity to consent for medical treatment in complex presentations.

Physical Health Care

- Physical health needs other than the reason for A&E attendance should be assessed at the same time where possible and action and/or advice given if indicated. Assessing and addressing the physical health needs of the service user should be given a high priority particularly those people on anti-psychotic medication.

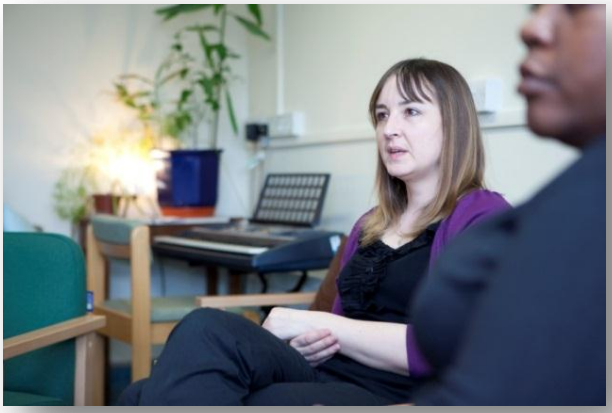
- Opportunity taken to address physical health promotion such as improving lifestyle where the presenting problem is likely to affect the patient's physical health. E.G. diet, smoking, alcohol consumption, breast, bowel and cervical screening.

- Activities should be recommended to improve diet, nutrition; substance misuse, sexual health, smoking cessation, and exercise will be facilitated and encouraged. This service should also encourage access to dental and optical examinations and flu vaccinations where appropriate.

- Where the patient's mental state allows, the assessment/ liaison service will also address the adequacy of housing needs and where appropriate service users employment and accommodation status should be assessed and action taken to signpost to appropriate agencies for assistance. This information will be shared with other mental health services when signposting to them.

Future redesign should include:

- Development of arrangements for Section 136 including liaison suite and wet rooms
- Review and manager of Section 12 (mental health act trained) doctors
- Continued review of both Psychiatric liaison service and its impact and potential redesign to meet local need
- Review of assessment team activity and links to Acute Care Pathway
- Mental health capacity assessments
- Ward liaison



Personality disorder

Personality disorder typically occurs in adolescence, though it may start in childhood, and continues into adulthood. It is a condition in which an individual differs significantly from an average person in terms of how they think, perceive, feel or relate to others. These changes in feelings and distorted beliefs can lead to odd behaviour which can be distressing and upsetting to others. Those experiencing personality disorder are known to encounter significant social exclusion which impacts on demand for health, social care and other public services.

It is estimated that 1 in 20 people have a personality disorder. For many this is mild and they may only require help at time of stress e.g. bereavement. Nationally hospital admissions 2009-10 suggest 70% of inpatient personality disorder cases are diagnosed in females. Borderline and Histrionic Personality Disorder are more common among females whilst Antisocial and Obsessive Compulsive Personality Disorder are more commonly diagnosed among males.

With help many people can lead a normal and fulfilling life and for those with mild to moderate personality disorder access to psychological (talking) therapies can be an effective alternative to medication. Research[51] suggests that progress in recovery is a continuum of co-existing support drawing on crisis support, therapy services and social inclusion development with an emphasis on human interaction rather than drug treatment. Working in groups alongside people with similar problems can be very helpful. Therapeutic Communities have traditionally been residential settings but alternative service user-led networks are developing using web-based messaging as well as face-to-face meetings.

Carers

Carers are key partners in the service user's journey through mental health services. The Triangle of Care: Carers Included: A Guide to Best Practice in Mental Health Care (Carers Trust 2013) sets 6 standards to engage with carers creating an inclusive attitude where they are listened to and consulted more closely. Commissioners will ensure local service provision adopts these standards for engagement within working practices.

In the North West it is estimated that 17% of the adult population over age 16 are carers while only 7% are known to services. Carers themselves are at increased risk of developing mental health problems particularly anxiety and depression. Halton Carers Action Plan June 2013 is owned by the Halton Carers Strategy Group and sets four key objectives for offering support to those in a caring role to alleviate some of the pressures experienced and enable carers to maintain their own health and emotional wellbeing:

[51] A Recovery Journey for People with Personality Disorder (May 2013, The Institute Journal of Psychiatry)

- Supporting those with caring responsibilities to identify themselves as carers at an early stage
- Recognising the value of Carers contributions and involving them from the outset both in designing local care provision and in planning individual care packages
- Enabling those with caring responsibilities to fulfil their educational and employment potential
- Personalised support both for carers and those they support enabling them to have a family and community life
- Supporting carers to stay healthy and well

Promoting Equality and Reducing Inequality

No health without mental health and the Marmot Review place emphasis on tackling health inequalities and promoting equality. Marmot showed that, among other factors, poor childhood, housing and employment (and also unemployment) increase the likelihood that people will experience mental health problems and that the course of any subsequent recovery will be affected. These factors vary across different sections of society, with the result that some groups suffer multiple disadvantages.

Aspects of people's identity and experiences of inequality interact with each other, for example people from black and minority ethnic (BME) groups are more likely to live in deprived areas and have negative experiences, both as a result of their ethnic identity and because of their socio-economic status and living environment.

It is important to work with local communities when developing services, facilities and resources to ensure that they promote equality through the inclusion and equitable treatment whilst eliminating discrimination, advancing equality of opportunity and fostering good relations within communities without disadvantaging people as a result of any of the nine protected characteristics under the Equality Act 2010[52]

People with some of these characteristics for example disabilities, Lesbian, Gay Bisexual and Transgender people and those from BME groups, may already face significant challenges to their resilience and wellbeing as a result of stigma, discrimination and other issues. It is therefore all the more important that they are able to access appropriate services, leisure facilities and other activities to promote wellbeing and resilience.[53]

[52] These can be found at: https://www.gov.uk/discrimination-your-rights/types-of-discrimination

[53] Building Resilient Communities: Making every contact count for public health (August 2013 Mind, Mental Health Foundation)

- People from Black and minority ethnic groups are nearly three times more likely to attempt suicide
- The risk of suffering from depression and anxiety disorders is about twice as high for lesbian, gay and bisexual people.
- Rates of depression among those with two or more long term physical conditions are almost seven times higher than in the rest of the population.

No heath without mental health identifies three aspects to reducing mental health inequality:

i. tackling the inequalities that lead to poor mental health;

ii. tackling the inequalities that result from poor mental health – such as lower employment rates, and poorer housing, education and physical health; and

iii. tackling the inequalities in service provision – in access, experience and outcomes.

Whilst tackling inequalities in service provision is addressed through delivering a truly personalised approach that identifies the specific needs of each individual and their family and carers, so that they have more control over the support they receive.

Stigma and Discrimination

People with mental health problems say that the social stigma attached to mental ill health and the discrimination they experience can make their difficulties worse and make it harder to recover. [54]

Mental illness is common as already evidenced it affects thousands of people in the UK, and their friends, families, work colleagues and society in general.

Most people who experience mental health problems recover fully, or are able to live with and manage them, especially if they get help early on. But even though so many people are affected, there is a strong social stigma attached to mental ill health, and people with mental health problems can experience discrimination in all aspects of their lives.

Many people's problems are made worse by the stigma and discrimination they experience – from society, but also from families, friends and employers.

[54] http://www.mentalhealth.org.uk/help-information/mental-health-a-z/S/stigma-discrimination/

Nearly nine out of ten people with mental health problems say that stigma and discrimination have a negative effect on their lives.

We know that people with mental health problems are amongst the least likely of any group with a long-term health condition or disability to:

- find work
- be in a steady, long-term relationship
- live in decent housing
- be socially included in mainstream society.

This is because society in general has stereotyped views about mental illness and how it affects people. Many people believe that people with mental ill health are violent and dangerous, when in fact they are more at risk of being attacked or harming themselves than harming other people.

Stigma and discrimination can also worsen someone's mental health problems, and delay or impede their getting help and treatment, and their recovery. Social isolation, poor housing, unemployment and poverty are all linked to mental ill health. So stigma and discrimination can trap people in a cycle of illness.

The situation is exacerbated by the media. Media reports often link mental illness with violence, or portray people with mental health problems as dangerous, criminal, evil, or very disabled and unable to live normal, fulfilled lives.

Research shows that the best way to challenge these stereotypes is through first-hand contact with people with experience of mental health problems. A number of national and local campaigns are trying to change public attitudes to mental illness. These include the national voluntary sector campaign Time to Change and Halton's social marketing campaign Like Minds.

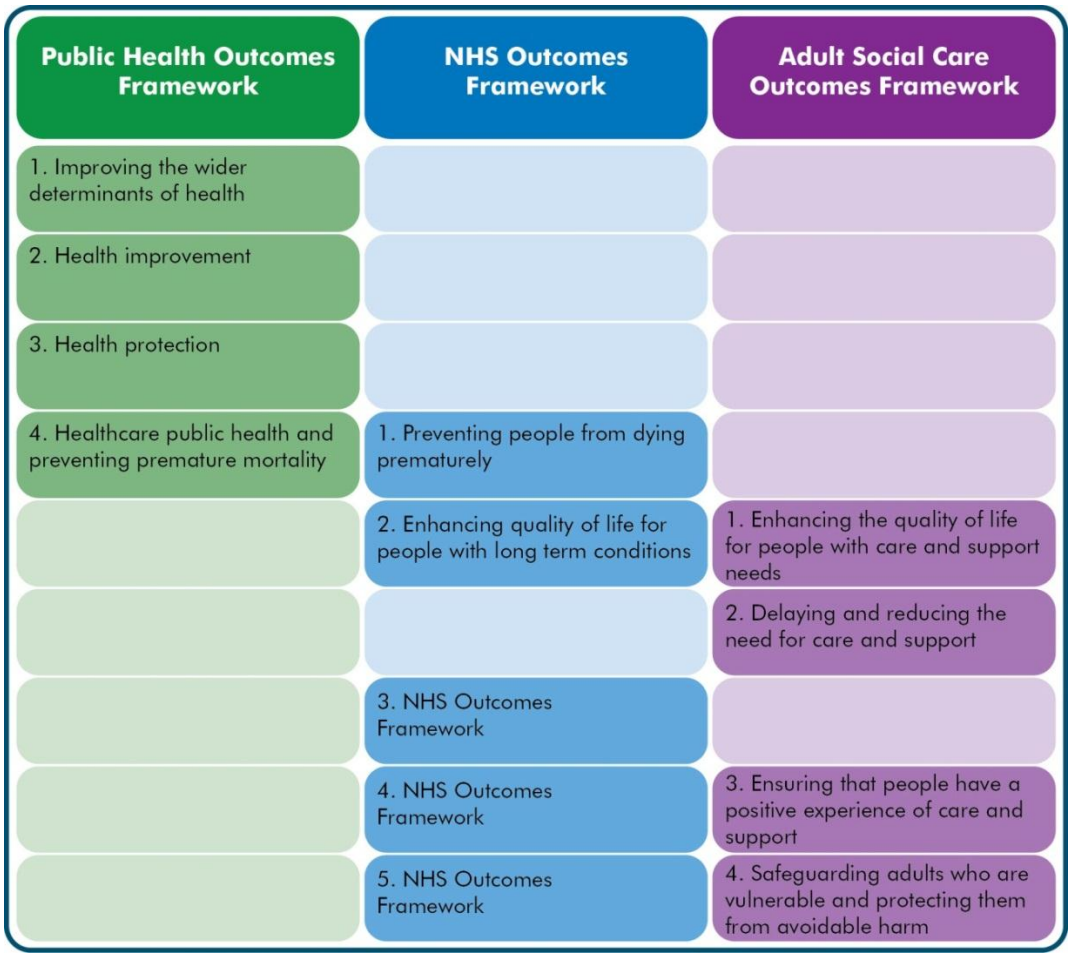
The Equality Act 2010 makes it illegal to discriminate directly or indirectly against people with mental health problems in public services and functions, access to premises, work, education, associations and transport.

Part Four – Outcomes Frameworks

Outcomes Frameworks 2013/14

Outcome measures provide a description of what a good mental health system should aim to achieve, as well as a method of checking progress against achieving these aims. All three of the Outcome Frameworks – Public Health[55], NHS[56], and Adult Social Care[57] contain objectives related to mental illness, with several of the outcomes being shared across outcome frameworks. This close alignment reflects that in order to improve the wellbeing of communities and to improve outcomes for individuals with a mental illness all three sectors must play an effective role.

The 3 outcomes frameworks 2013/14



The detailed indicators relating to Mental Health and Wellbeing are summarised below along with the outcomes they contribute to:

[55] Available from: http://www.phoutcomes.info/
[56] Available from: https://www.gov.uk/government/publications/nhs---outcomes---framework---2013---to---2014
[57] Available from: https://www.gov.uk/government/publications/the---adult---social---care---outcomes---framework---2013---to---2014

Mental Health and Wellbeing Indicators and outcomes framework domain

Indicators in italics are placeholders pending development or identification

National Indicators	NHS	Public Health	Adult Social Care
Excess under 75 mortality rate in adults with serious mental illness	1.5	4.9	
Proportion of people feeling supported to manage their condition	2.1		$
Health related quality of life for carers	2.4		1D
Employment of people with mental illness	2.5	1.8	1F
Estimated diagnosis rate for people with dementia	2.6i	4.16	
A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life	2.6ii		2F
Total health gain as assessed by patients for elective procedures – Psychological therapies	3.1v		
Patient experience of community mental health services	4.7		
Adults with a learning disability in contact with secondary mental health services who live in stable and appropriate accommodation		1.6	1G 1H
People in prison who have a mental illness or significant mental illness		1.7	
Employment for those with long-term health conditions including adults with a learning disability or who are in contact with a secondary mental health services	2.2 2.5	1.8	1E 1F
Hospital admissions caused by unintentional and deliberate injuries in under 18s		2.7	
Suicide Rate		4.10	
Proportion of people who use services and who reported they had as much social contact as they would like			1I

$ Indicator complementary with Adult Social Care Outcomes Framework

NHS England (supported by NICE) has developed a Commissioning Outcomes Framework (COF)[58], which builds upon the NHS Outcome Framework and measures the health outcomes and quality of care provided by Clinical commissioning Groups (CCGs).

COF indicators related to mental illness include:

- 1.30: People with severe mental illness who have received a list of physical checks
- 2.79: People on Care Programme Approach (CPA) followed-up within 7 days of discharge from psychiatric inpatient stay
- 3.26i: Recovery following talking therapies for people of all ages
- 3.26ii: Recovery following talking therapies for people older than 65
- 4.20: Access to community mental health services by people from black and minority ethnic groups
- 4.21: Access to psychological therapies services by people from black and minority ethnic groups

Children's Outcome Framework

The Children and Young People's Health Outcomes Forum was asked by the Secretary of State to look at how best the health outcomes of children in Britain could be improved. The forum included a Mental Health Sub Group which made recommendations related to promoting mental health and improving outcomes for children with a mental illness[59]. In view of the paucity of data on the scale and nature of poor mental health among children and young people, the Forum recommended a new survey to support measurement of outcomes for children with mental health problems. The Department of Health has recently published its response to the Children and Young People's Health Outcomes Forum's recommendations outlining actions the government and partners will take to improve the health of children and young people.[60]

[58] Available from: http://www.nice.org.uk/aboutnice/ccgois/CCGOIS.jsp

[59] Report of the children and young people's health forum – mental health sub group. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/156063/CYP---Mental---Health.pdf

[60] Department of Health (2013). Improving Children and Young People's Health Outcomes. Available from: http://tinyurl.com/cq43yhg

Part Five – Evidence based interventions

National Standards

NICE quality standards are for use by the NHS in England and do not currently have formal status in the social care sector. However, the NHS will not be able to provide a comprehensive service for all without working with social care communities. Social care commissioners and providers are encouraged to use the standards, both to improve the quality of their services and support their colleagues in the NHS.

Quality standards are also expected to contribute to the following overarching outcomes from the Public Health Outcomes Framework; improving the wider determinants of health; health improvement; health protection; and preventing premature mortality.

The quality standards outline the level of service that people using the NHS mental health services should expect to receive. High-quality care should be clinically effective, safe and be provided in a way that ensures the service user has the best possible experience of care. The standards require that services should be commissioned from and coordinated across all relevant agencies encompassing the whole care pathway. An integrated approach to the provision of services is fundamental to the delivery of high quality care to service users.

Quality standards describe markers of high-quality, cost-effective care that, when delivered collectively, should contribute to improving the effectiveness, safety and experience of care for service users in the following ways:

- enhancing quality of life for people with long-term conditions.
- ensuring that people have a positive experience of care.
- treating and caring for people in a safe environment and protecting them from avoidable harm.

These overarching outcomes are from the NHS Outcomes Framework 2013/14

The quality standards are also expected to contribute to the following overarching indicators from the 2013/14 Adult Social Care Framework; enhancing quality of life for people with care and support needs; ensuring that people have a positive experience of care and support; safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm.

Community, in-patient and residential mental health services, where the service employs a doctor, nurse or social worker, are required to be registered with the Care Quality Commission (CQC). It is expected that CQC will align any future work it does with the NICE Quality Standards. More information on the NICE quality standards applicable to mental health services can be found on the NICE website.[61]

The No Health without Mental Health Strategy (DOH 2011) recognises the importance of early intervention to prevent serious mental health issues developing amongst children and young people. The comprehensive Children and Adolescent Mental Health Services (CAMHS) agenda has been well documented since the development of Every Child Matters (DFE 2004) and supports the tiered response to levels of need as demonstrated below.

Tiered Response to Levels of Need all children

Tier 1: Universal Provision, working with all children

This involves the adoption of a range of services designed to create the best developmental and emotional start for all children and which are sustained through to adulthood. They include family/infant mental health and emotional wellbeing approaches.

Tier 2: **Early intervention/targeted provision**

This involves early detection and provision of preventative support to children and families in need. At this step structured self-help approaches, behavioural, and/or family support are provided to reduce the impact of mental health and emotional problems and prevent their escalation to greater/more significant difficulties.

Tier 3: Specialist provision for those with complex needs

This involves specialist diagnostic assessment and the provision of psychological, systematic and/or pharmacology therapy. Intervention at this step is provided to children and young people who are experiencing moderate mental health and emotional difficulties which are having a significant impact on daily psychological/social/educational functioning. Intervention at this level is normally provided through specialist/specific multi-disciplinary teams.

Tier 4 Highly specialised provision.

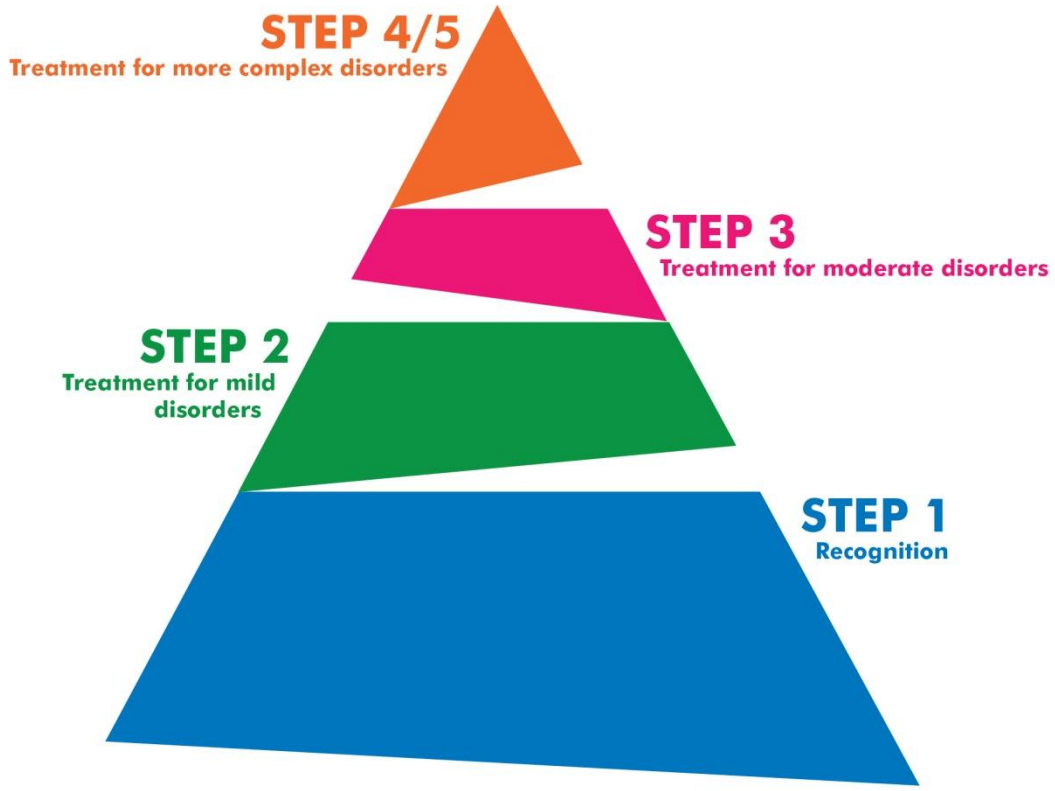
This involves provision of crisis resolution and intensive home/residential/or day care services designed to reduce and/or manage those children and young people who are at immediate risk or who need intensive therapeutic care.

[61] http://www.nice.org.uk/guidance/qualitystandards/qualitystandards.jsp

Stepped Care Model

Halton operates a stepped model of mental health and wellbeing services where people can step up or down according to their need. Stepped care is an evidence based model of healthcare delivery with 2 fundamental features:

i. The recommended treatment/intervention should be the least restrictive of those available but still likely to provide significant health gain.
ii. The stepped care model is self-correcting through systematic monitoring and changes made (stepped up) if current treatments are not achieving significant health gains[62]



Halton's Stepped Care Model (based on Kaiser Permanente risk stratification model)

Halton is committed to providing quality evidence based, cost effective and efficient services that meet the varying needs of local people.

[62] Bower & Billbody, The British Journal of Psychiatry 2005

Part Six – Paying for local services

As the Government's policy of deficit reduction continues, the impact on the public sector is significant and with the public sector having to make unprecedented decisions about the services that it continues to deliver, this ultimately has an impact on service delivery and residents expectations. The current investment into mental health and wellbeing services within Halton will be explored within this part of the document.

It is for local commissioners to ensure that when services are commissioned, the needs of the whole population and the best evidence of what works are taken into account there are four main ways of increasing value for money in mental health services:

- improving the quality and efficiencyof current services;
- radically changing the way that current services are delivered so as to improve quality and reduce costs;
- shifting the focus of services towards promotion of mental health, prevention of mental illness and early identification and intervention as soon as mental illness arises; and
- broadening the approach taken to tackle the wider social determinants and consequences of mental health problems.

Future costs of mental ill health are forecast to double in real terms over the next 20 years (No health without mental health: the economic case for improving efficiency and quality in mental health). Some of this cost could be reduced by greater focus on whole population mental health promotion and prevention, alongside early diagnosis and intervention. Early detection services for people with earlier symptoms of psychosis (at-risk mental state) have also been estimated to deliver savings–in this case around £23,000 per person over 10 years (about 25% of these costs were incurred in the NHS).

Intervening early for children with mental health problems has been shown not only to reduce health costs but also to realise even larger savings from improved educational outcomes and reduced unemployment and crime. These approaches not only benefit the individual child during their childhood and adulthood but also improve their capacity to parent. They can therefore break cycles of inequality running through generations of families. Conduct disorder is the most common childhood mental disorder, for which parenting support interventions are recommended as first-line treatment. A number of

studies have shown that effective parenting interventions and school-based programmes can result in significant lifetime savings.

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

Other areas for potential intervention identified in the document along with evidence of deliverable savings include:

1. Addressing the social determinants and consequences of mental health problems;

- Debt advice
- Befriending for older people
- Reducing stigma and discrimination
- Targeted employment support for those recovering from mental health problems
- Housing support services
- Warm housing

2. The promotion of positive mental health and prevention of mental health problems in childhood and adolescence;

- Health visitor interventions to reduce postnatal depression
- Prevention of conduct disorder through social and emotional learning programmes
- School-based violence prevention programmes

3. The promotion of positive mental health and prevention of mental health problems in adults;

- Time banks and community navigators
- Work-based mental health promotion
- Suicide prevention

4. Early identification and intervention as soon as mental health problems emerge;

- Conduct disorder - parenting interventions for families
- Early intervention for psychosis
- Early detection of psychosis
- Screening and brief intervention in primary care for alcohol misuse
- Early diagnosis and treatment of depression at work

5. Improving the quality and efficiency of current services.

- Improvements to the acute care pathway
- Managing ‘out of area’ placements in acute and secure services more efficiently
- Reducing unplanned ‘out of area’ placements
- Reducing Out of Area placements in medium secure services
- Reducing physical and mental co-morbidity
- Early detection and treatment of depression in diabetes
- Medically unexplained symptoms - CBT approach

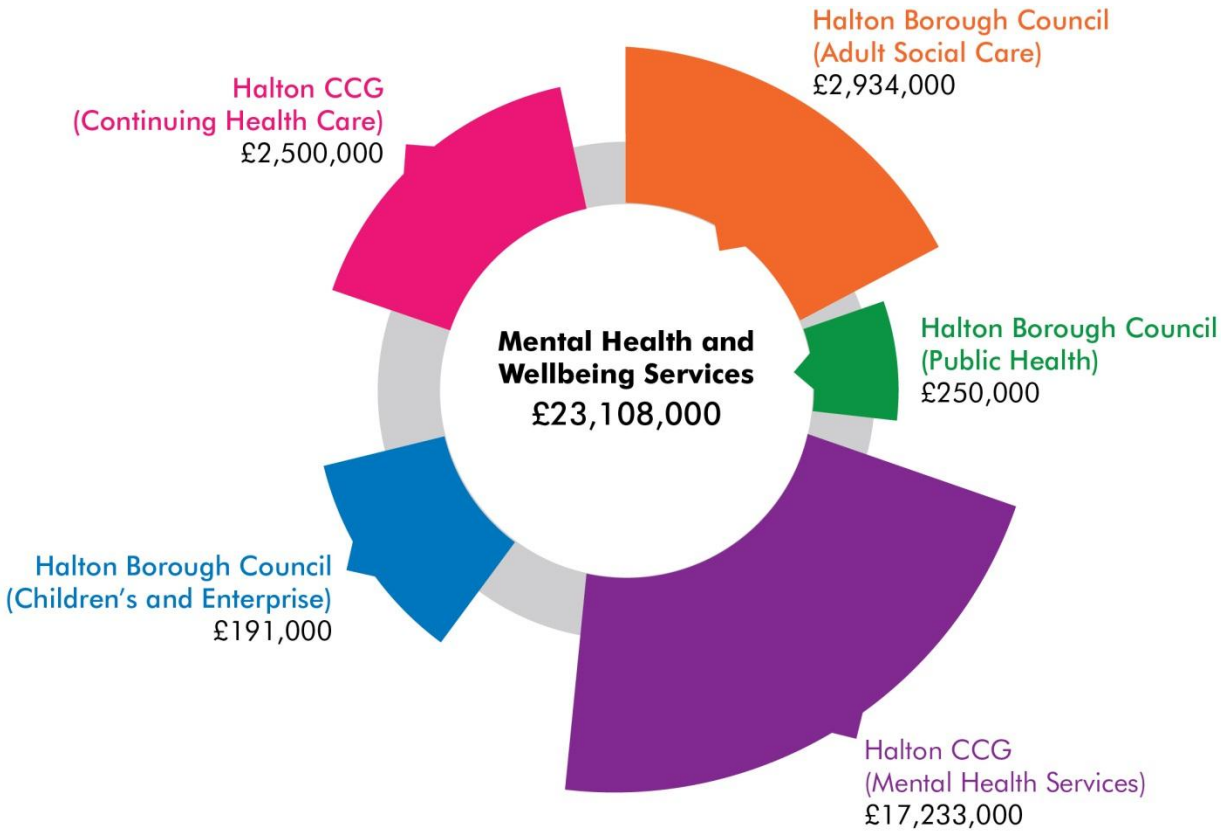
Many of these interventions are already being progressed in Halton. The commissioning intentions set out in the Mental Health and Wellbeing Strategy continues to promote action in these areas.

Current expenditure

The following financial breakdown is based upon current direct expenditure in mental health and wellbeing services and does not reflect the wider universal and targeted activity that is commissioned locally. Such expenditure, on areas as diverse as weight management, Primary Care, or voluntary and community sector activity, can have a direct impact upon the mental health and wellbeing of local communities, but does not fall within the direct influence of the mental health and wellbeing strategy and action plan.

Paying for Mental Health and Wellbeing Services 2013/14

The following is a breakdown of how resources have been allocated for the financial year 2013/14.



Budget received for 2013/14 for Mental Health Services

	£000
Halton Clinical Commissioning Group	17,223
Halton Borough Council - Adult social Care	2,934
Halton Clinical Commissioning Group – Continuing Health Care (Mental Health)	2,500
Halton Borough Council - Public Health	250
Halton Borough Council - Children's and Enterprise	191
TOTAL	**23,108**

How the budget was allocated 2013/14

Halton Clinical Commissioning Group	**£000**
5 Boroughs Partnership NHS FT	13,508
5 Boroughs Partnership ADHD Clinic	35
5 Boroughs Partnership Asperger's Pilot	23
5 Boroughs Partnership State of Mind	4
5 Boroughs Partnership ADOS (CAMHS)	8
Cheshire & Wirral Partnership	44
Manchester Mental Health & Social Care	6
MerseyCare	64
CAB Halton	116
Making Space	22
Women Supporting Women	20
MIND	20
Halton Service User Forum	10
SHAP	22
Bereavement Service	1
Youth Offending Team	8
IAPT (Including Open mind and Well Being Nurses)	986
MH Access	737

PICU - Vancouver House	150
PICU - Other	50
MH Capacity	77
Dementia Nurses and Care Advisors	200
WHHFT (A&E Liaison)	35
StHKHFT (A&E Liaison)	85
Primary CAMHS	492
High Cost Mental Health Funding	500
Continuing Health Care	2,500
Adult Social Care	
Older people community mental health team	147
Mental Health Support (Outreach)	194
Mental Health Resource Centre	117
Mental Health Recovery Team and Community Care	2,366
Emergency Duty Team	103
Women's Centre	7
Public Health	
Campaign against living miserably (CALM)	10
Health Improvement Team & Weight Management Service – Bridgewater	240
Children's and Enterprise	
Children in Care Service	59
Hear 4 U	132

Value for Money

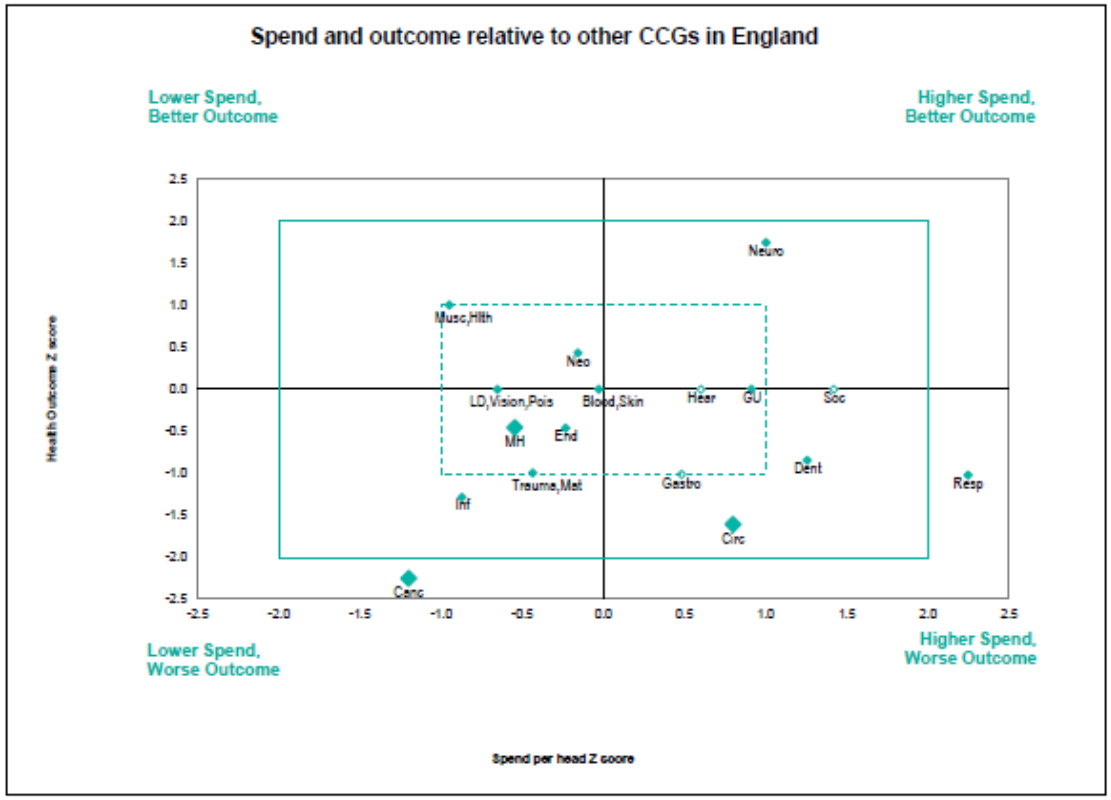
Halton Unit Costs of Adult Social Care - Mental Health

Service	2011/12 Unit Cost	2011/12 England Average	2012/13 Cost	% Change 12/13 v 11/12
Nursing	512	736	423	-17.47
Residential	873	732	878	0.61
Home Care	68	140	106	54.49
Direct payments	99	106	110	11.34
Day Care per person	50	93	59	17.64
Day Care per person per week	56	123	60	8.74

Source: PSSEX1

In general the costs of Adult Social Care appear to be below average costs for England. The exception is residential care which spiked higher than average costs in 2011/12. Whilst unit costs are a useful benchmark they are not representative as a value for money indicator as they do not consider qualitative data and outcomes achieved.

Halton Clinical Commissioning Group Spend per head (excluding Primary Care)[63]



◇ No outcome indicators readily available
◆ Outcome indicators available

Programme Area Abbreviations

Infectious Diseases	Inf	Hearing	Hear	Disorders of Blood	Blood
Cancers & Tumours	Canc	Circulation	Circ	Maternity	Mat
Respiratory System	Resp	Mental Health	MH	Neonates	Neo
Endocrine, Nutritional & Metabolic	End	Dental	Dent	Neurological	Neuro
Genito Urinary System	GU	GI System	Gastro	Healthy Individuals	Hlth
Learning Disabilities	LD	Musculoskeletal	Musc	Social Care Needs	Soc
Adverse effects & poisoning	Pois	Trauma & Injuries	Trauma		

This diagram represents an overview of spend and outcomes for Halton Clinical commissioning Group categorised into 4 quadrants in terms of spend and outcomes to allow easy identification of those areas that require priority attention by the CCG . The data is based on that submitted by the former Halton and St Helens PCT.

One of the highest areas of expenditure for Halton CCG is mental health at £185 per head per year. This is considerably lower than England average (£212). However outcomes being achieved are also lower suggesting that review is needed to move into the lower costs better outcomes quadrant.

[63] Source: www.yhpho.org.uk/quad/Default.aspx

Payment by Results

Payment by Results (PBR) is a system introduced in England under which commissioners pay health care providers for each patient seen or treated taking into account the complexity of patient need. The theory is that resources follow the patient rather than the traditional block contract approach.

Currencies are the unit of healthcare for which a payment is made and tariffs are the set prices paid for each currency. Tariffs are currently set locally but will be moving to national tariffs in future.

Appendix A- Local Services - 2013

Current Tiered CAMHS Provision across Halton

Tier 1: Universal Provision, working with all children

Midwifes, health visitors, school teachers, school nurses and youth workers supporting all children and young people in their development.

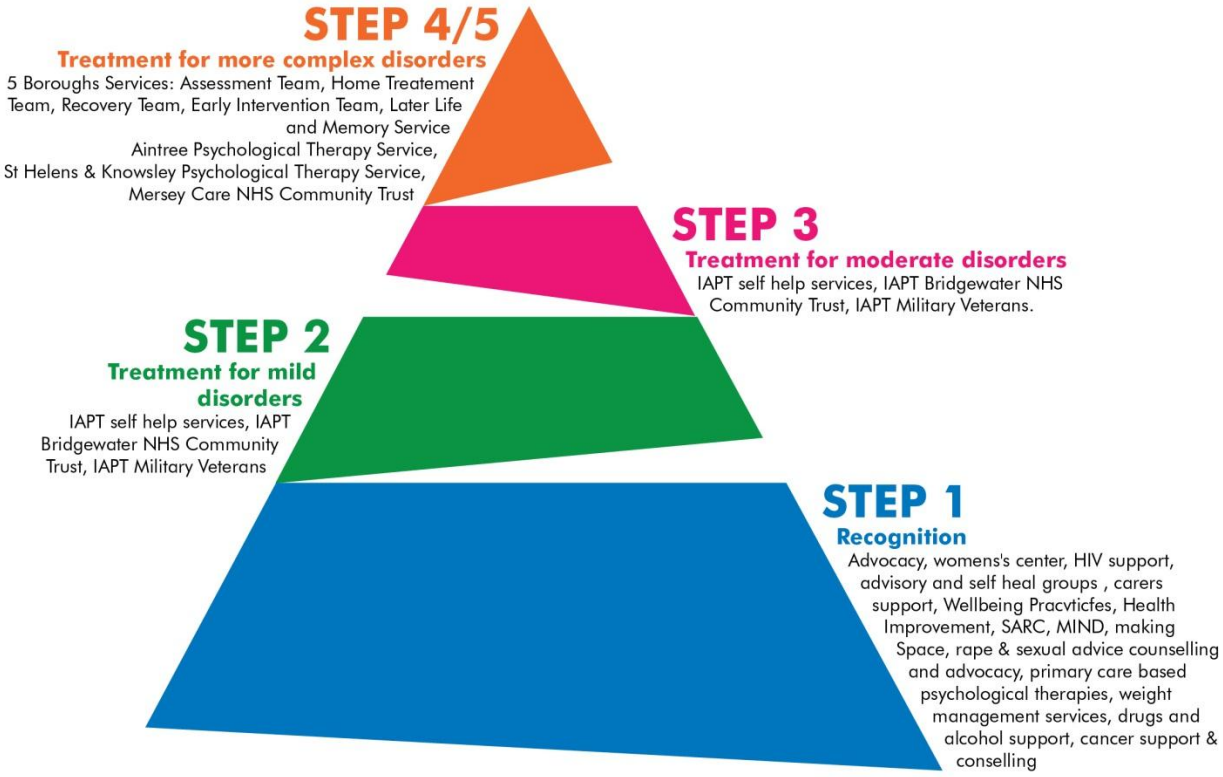
Tier 2:

- Barnardo's Hear for U provision. This service provides interventions such as individual counselling and solution focussed interventions to young people up to the age of 19.
- Barnardo's Go Forward Service (Children in Care). This service provides specialist mental health assessment, advice and support to Children in Care and their carers.
- Bridgewater Community NHS Trust Provider – This service provides consultation, training and interventions to children and young people. This includes preventing mental ill health developing and targeting vulnerable children and young people.
- Paediatric Liaison St Helens Service A+E. This service provides swift emotional and mental health support to children and young people who access A+E.
- YOS CAMHS Service. This service is specifically for children and young people who are young offenders.

Tier 3:

- 5 Boroughs Partnership CAMHS. The tier 3 specialist CAMH service is provided for the most severe, complex and persistent of child mental health problems/disorders and risk factors which have multi-factorial causation, psychological and social outcomes and which require interventions across the same domains to be delivered on a multi-agency basis. The service will deliver specialist services, including assessment, triage, consultation, diagnosis, formulation and treatment in a range of settings, including community and locality settings which meet children and young people's needs for timely and efficient service delivery.
- 5 Boroughs Partnership CURT Service. This urgent response team provide urgent assessment and service to young people up to their 18th birthday within 24 hours.

Tier 4 Highly specialised provision


STEP 4/5
Treatment for more complex disorders
5 Boroughs Services: Assessment Team, Home Treatement Team, Recovery Team, Early Intervention Team, Later Life and Memory Service
Aintree Psychological Therapy Service,
St Helens & Knowsley Psychological Therapy Service,
Mersey Care NHS Community Trust
STEP 3
Treatment for moderate disorders
IAPT self help services, IAPT Bridgewater NHS Community Trust, IAPT Military Veterans.
STEP 2
Treatment for mild disorders
IAPT self help services, IAPT Bridgewater NHS Community Trust, IAPT Military Veterans
STEP 1
Recognition
Advocacy, womens's center, HIV support, advisory and self heal groups , carers support, Wellbeing Pracvticfes, Health Improvement, SARC, MIND, making Space, rape & sexual advice counselling and advocacy, primary care based psychological therapies, weight management services, drugs and alcohol support, cancer support & conselling

Existing Mental Health Services (As at September 2013)

General mental health promotion.	Programmes related to infants and pre-school children within high-risk groups.	Programmes related to school aged children or young people within high-risk groups.	Programmes related to adults or older people within high-risk groups.	Programmes related to individuals or groups with an early or less disabling mental health or behaviour problem, or their carers.	Programmes related to individuals or groups with an identified severe mental health or behavioural problem or a diagnosed mental illness, or their carers.
Live Life Well Directory	Inspiring Families Programme	Inspiring Families Programme	Ashley House	Supported Housing	Suicide prevention section on the live life well website as an online link for suicide prevention support. **http://www.live-lifewell.net/** and click on the blue box called –thoughts of suicide
Wellbeing Areas	Inspiring Families Programme	CAMHS	Halton Employment Programme / HPIJ	The Halton & St Helens Community Mental Health Directory is an up-to-date directory listing useful contacts and helpful information relating to mental health	Carer's Assessments
Leaflets at GPs & HCRC	Team Around the Family	Team Around the Family	Community Midwives	H&STH Community Mental Health Directory Self Help guides	Social Services Mental Health Outreach Workers

The Halton & St Helens Community Mental Health Directory is an up-to-date directory listing useful contacts and helpful information relating to mental health	Children's Centres	Social care Transition Services	Halton Domestic Abuse Service	Halton Employment Programme / HPIJ	Halton Carers Centre
H&STH Community Mental Health Directory Self Help guides	Integrated Working Support Team	Children's Centres	HBC Housing Solutions	The Halton & St Helens Community Mental Health Directory is an up-to-date directory listing useful contacts and helpful information relating to mental health	MIND Halton
Sure Start to Later Life	Antenatal Groups/Community Midwives	5 Borough Partnership CAMHS Website	Extra Care Housing	H&STH Community Mental Health Directory Self Help guides	Open Mind
Carer's Assessments	Halton Family Voice	Young Addaction	Bridge Builders	Social Services Mental Health Outreach Workers	SHAP Mental health Advocacy
Help 4 Me website	Halton Health Visiting Service	Integrated Working Support Team	Suicide prevention section on the live life well website as an online link for suicide prevention support.	Halton Carers Centre	Assessment team
HealthWatch	Early Help Family Work Service	Young Carers	SHAP Mental health Advocacy	MIND Halton	Home Treatment Team
Community Wellbeing Practices	Intensive Family Work Service (IFWS)	Halton Short Break Service	British Pregnancy Advisory Service / Post Termination Support	Open Mind	Recovery Team

Health Improvement Team		Early Help Family Work Service	C.I.C Alcohol Community Link	SHAP Mental Health Advocacy	Psychological Therapy Service
Welfare Rights		Intensive Family Work Service (IFWS)	Merseyside Sexual Assault Referral Centres	Assessment Team	Merseycare NHS Community Trust
Wellbeing Enterprises		Halton School Nursing programme	Rape and Sexual Abuse Relationship Centre Independent Sexual Violence Advocates	Later Life and Memory Services	
Halton Women's Centre		Integrated Behaviour Support Team	Military Veterans IAPT Service		
Halton Citizens Advice Bureau		British Pregnancy Advisory Service / Post Termination Support	Early Intervention Team 5 Borough's Partnership		
Community Weight Management Service (Fresh Start)		Merseyside Sexual Assault Referral Centres	Merseyside Sexual Assault Referral Centres / Crisis Service		
Cancer Support Centre		Rape and Sexual Abuse Relationship Centre ISVA	Military Veterans Improved Access to Psychological Therapies Service		
IAPT Self Help Services		Merseyside Sexual Assault Referral Centres / Crisis Service			

Appendix B

Mental Health Commissioning Strategy Consultation: September 2013

Background

The World Health Organisation defines Mental Health as:
"A state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community"

At least one in four people will experience a mental health problem at some point in their life and around half of people with lifetime mental health problems experience their first symptoms by the age of 14.

Halton Borough Council and the NHS Clinical Commissioning Group (CCG) are committed to involving Halton residents in shaping local services. Their views are very important and will help to inform the strategy for developing mental health and wellbeing services over the next five years.

Results

The online survey received 132 responses during September and October 2013.

In addition to this, on Oct 10th 2013 a 'Fact or Fiction' workshop was held with over 80 Healthwatch Halton members and the structure of the consultation was used in the agenda for the day – with voting buttons used to collect responses on the closed questions and discussions used to collect responses on the open questions.

The overall response from both methods of consultation is shown in this report.

Summary Findings – *key themes that are mentioned throughout (from the open comments received)*

Education: Of the general public, in schools, colleges and the workplace. Health professionals should be trained to give the correct advice. Everyone should understand that mental health can affect anybody.

Consistent: Continued service provision / after care. Clear messages to the public about mental health - the more consistent the messages are the more understanding there will be.

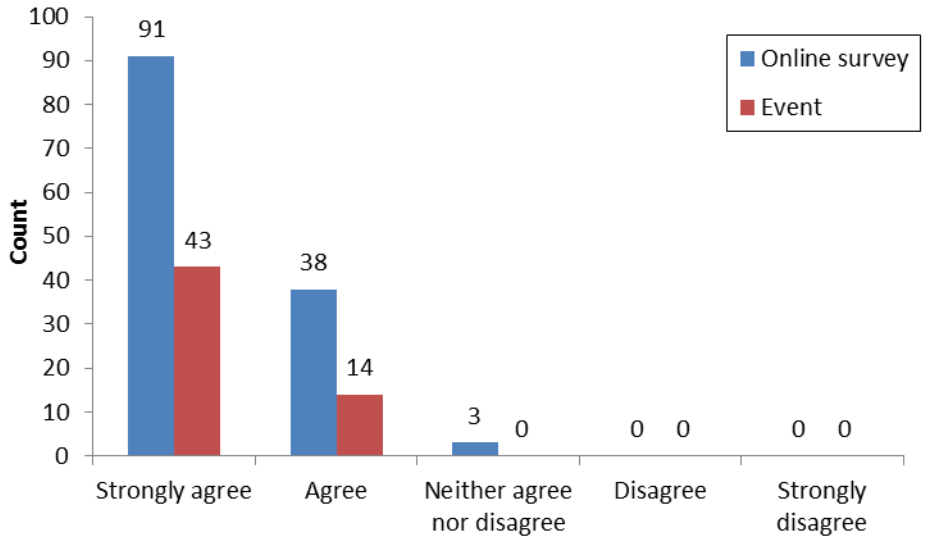
Provision of service: Out of hour's provision, support for families and carers. More service provision for children and young people. Early intervention services are important.

Local Concerns to be addressed

Through talking to local people we know you think that mental health is a priority and we know that:

- *Halton has high numbers of people suffering with depression*
- *Hospital admission rate due to self-harm in under 18's is high*
- *Current economic climate and welfare reforms are likely to increase numbers of people suffering from mental ill health*
- *Those with mental health problems have the lowest employment rate of any disability group*
- *There remains a stigma in the wider community relating to mental ill health*

How much do you agree or disagree that these concerns need to be addressed? (responses received: 132 online survey, 57 event)



Are there any other local concerns relating to mental health and wellbeing in Halton which you feel need to be addressed?

Access to service / information	11
Continued / service provision for children and young people	10
Support and advice for carers / families	8
Correct advice / experts in the field	7
Joined support for homeless and addiction	5
Isolation	4
Continued support - not just in a crisis	3
Support services	2
Support for those who are no longer a carer	1
Professionals working more closely together	1
Attitudes	1
Other	3

Main themes from comments received:

***Access**:*
Access to out of hour's services and early intervention services is a problem as is access to services such as 'Open Mind'. There should also be quicker access into current services.

***Continued / service provision for children and young people**:*
Improve services that are tailored for children and young people. Schools should be key to not only learning about mental health but also identifying people who may have issues.

***Support and advice for carers / families**:*
Information and provision for carers should be given as they provide the main support for those who have problems. Information about support groups etc. should be freely available.

***Correct advice / experts in the field**:*
Medical staff should be fully trained in Mental Health issues if they are giving advice / diagnosing problems that are mental health related. Patients should be able to gain access to staff who specialise in the field rather than a general practitioner or nurse.

***Joined support for homeless and addiction**:*
Services should be joined up e.g. drugs and alcohol, homelessness

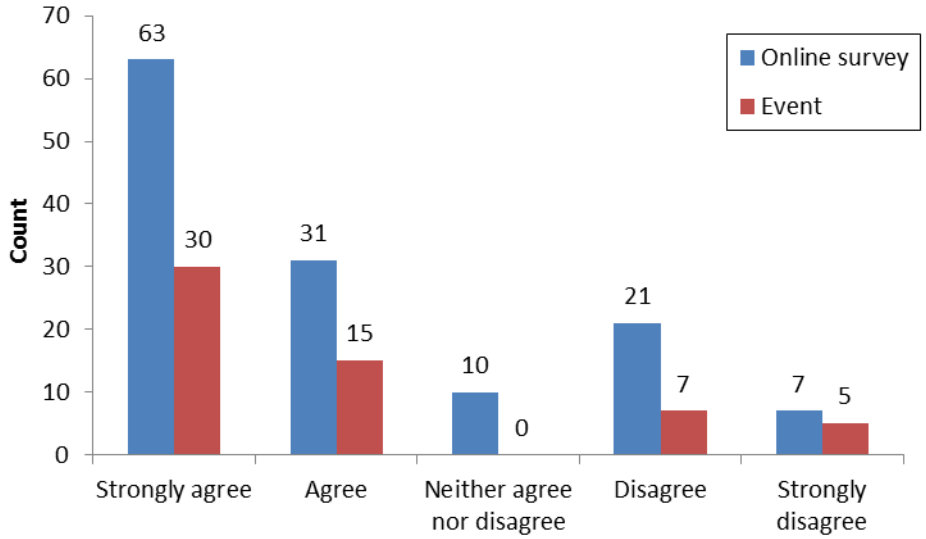
***Other**:*
Other comments focussed on continued support – not just when a person has hit crisis stage. Isolation and support for those who are no longer a carer were also mentioned.

What is our vision of improved mental health and wellbeing in Halton?

"People of all ages living in Halton will have a high level of self-reported wellbeing, having happy and fulfilling lives, being able to contribute economically and socially to their own networks and the community as a whole"

"Those who do experience mental ill health will not feel any stigma attached to the condition and be able to easily and quickly access appropriate levels of professional support to help them recover"

How much do you agree or disagree with this vision of mental health and wellbeing in Halton? (responses received: 132, 57)



Do you think there is anything which has been overlooked in this vision of mental health and wellbeing in Halton?

Rights / stigma for people with Mental Health	11
Loneliness / isolation	7
Access / Information	7
Happiness Statement	4
Resource	2
Monitoring	1
Other	11

Main themes from comments received:

***Rights / stigma for people with Mental Health**:*
Respondents feel that the statement “Those who do experience mental ill health will not feel any stigma..." is incorrect and will not work as it is not just about helping those with an illness to feel there is no stigma attached, but also about reducing the stigma that other people put on the illness.

***Access / Information**:*
Access to and knowledge of services is very important.

***Happiness Statement**:*
Happiness is very subjective and just because a person may feel unhappy for a certain period does not mean that they do not have good wellbeing. Feeling unhappy or sad is a natural part of life and does not mean that you automatically have mental health problems if you are experiencing it.

***Loneliness / isolation**:*
Loneliness / isolation should be tackled either through volunteers or drop in sessions, peer groups or respite for carers / families.

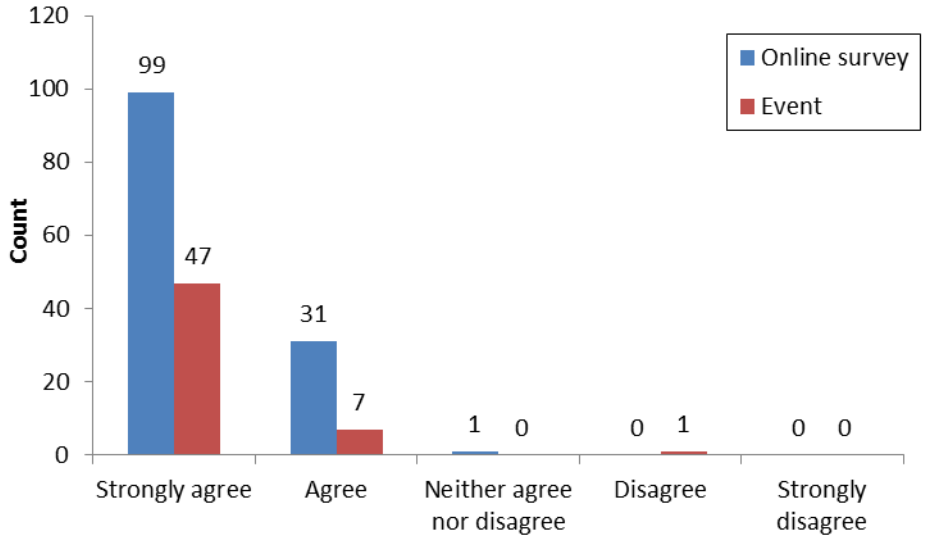
***Other**:*
Other comments related to resource and monitoring.

Our Priorities for Change

Prevention and Early Intervention

To improve mental health and wellbeing for the people of Halton we think when possible we need to prevent problems affecting mental health and when they do happen offer an early response to avoid people developing more serious problems later.

How much do you agree or disagree that prevention and early intervention is a priority? (responses received: 131, 55)



Is there anything you would like to say about the priority area of prevention and early intervention?

Early Intervention	15
Access / provision of information	12
Carers	2
Service provision	9
Support	5
Related Issues	5
Other	3

Main themes from comments received:

***Early Intervention**:*
Early intervention is key to service provision for the person needing treatment and help but also for the costs involved when a mental health problem is diagnosed at a later stage in life. Gaps in provision should also be part of this.

***Access / provision of information**:*
Information about and access to services is important but also that the provision of service is continuous. People being able to recognise the signs of somebody who has mental health issues is also important.

***Service provision**:*
Mental health leads in GP surgeries, mentors, key staff in schools and the work place.

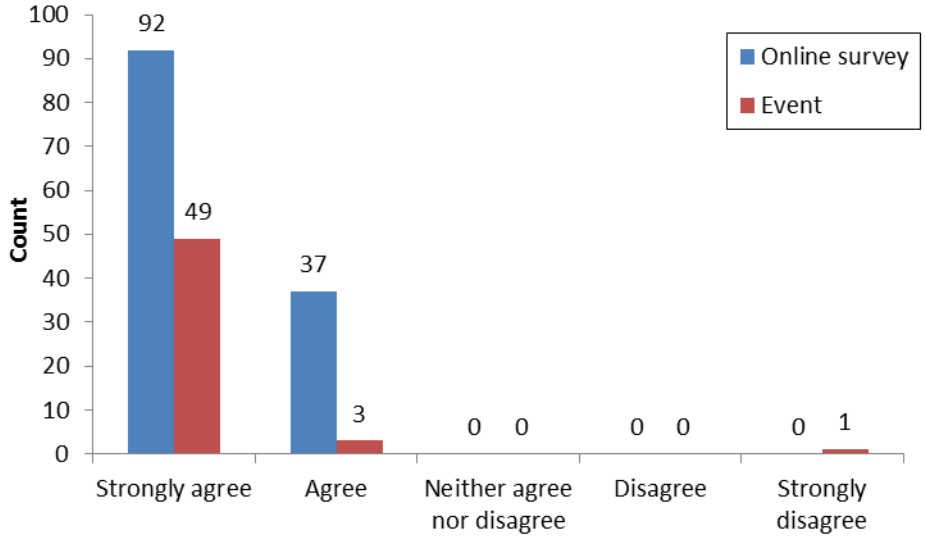
***Support**:*
Support should be available in terms of people having someone to talk to and looking at other issues in a person's life.

***Related Issues**:*
Need to look at alcohol, stress and homelessness.

Early Detection

We think that by increasing early detection of mental health problems we can improve mental wellbeing for both the person experiencing mental health problems and their families.

How much do you agree or disagree that earlier detection of mental health problems is a priority? (responses received: 129, 53)



Is there anything you would like to say about the priority area of earlier detection of mental health problems?

Education / training for professionals	16
Support / information for carers and patients	11
Education / Campaign	9
Resource	2
Other	5

Main themes from comments received:

Education / training for professionals:
Professionals should be more aware of symptoms and how to refer and treat.

Support / information for carers and patients:
Support should be holistic for the whole family / carers. Information should be provided to carers and services should listen to carers.

Education / Campaign:
Information and advice to the public as to what symptoms, signs etc. to look out for.

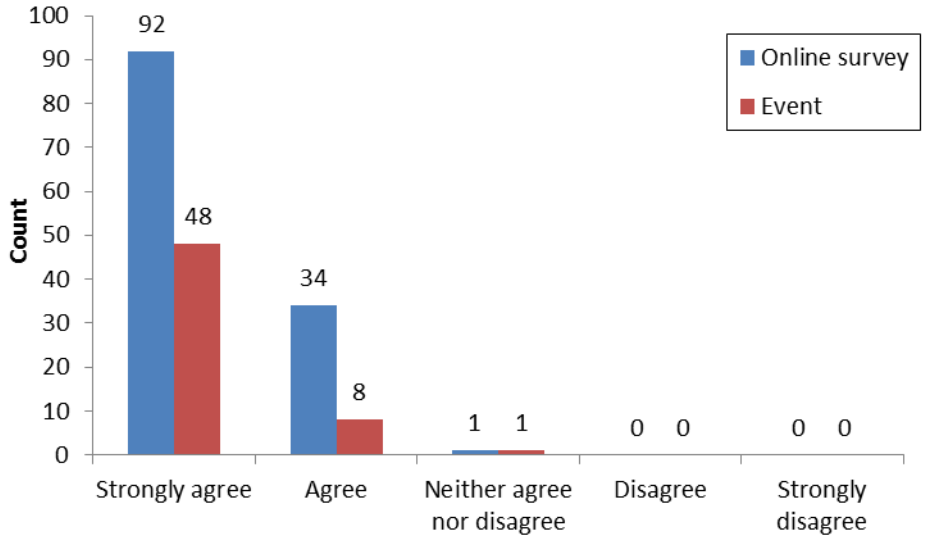
Resource
Is the resource there to be able to meet these objectives?

Other
Concern that early detection means over-diagnosis and one persons 'urgent' is not another persons 'urgent' so who makes the decision?

Better Outcomes and Quality Services

We think that those experiencing mental health problems want better outcomes from local, accessible, high quality services.

How much do you agree or disagree that better outcomes and quality services are a priority? (responses received: 127, 57)



Is there anything you would like to say about the priority area of better outcomes and quality services?

Service Provision e.g. waiting lists / opening times / specialists	13
Service Provision e.g. training / support services / whole family and carer approach	10
Not one approach	3
Other	4

Main themes from comments received:

***Service Provision**:*

Waiting lists to receive treatment / access services are too long. Opening times of services should be looked into, people don't just have problems during the day. Also location of out of hours services should be looked at as people don't want to be taken to Warrington. More specialist staff required within services.

***Service Provision e.g. training / support services / whole family and carer approach**:*

Aftercare is very important as is having a single point of contact. Support / information for the carer and patient, training for professional staff in how to explain what is happening.

***Not one approach**:*

Service should be more flexible around the patient as every person is different.

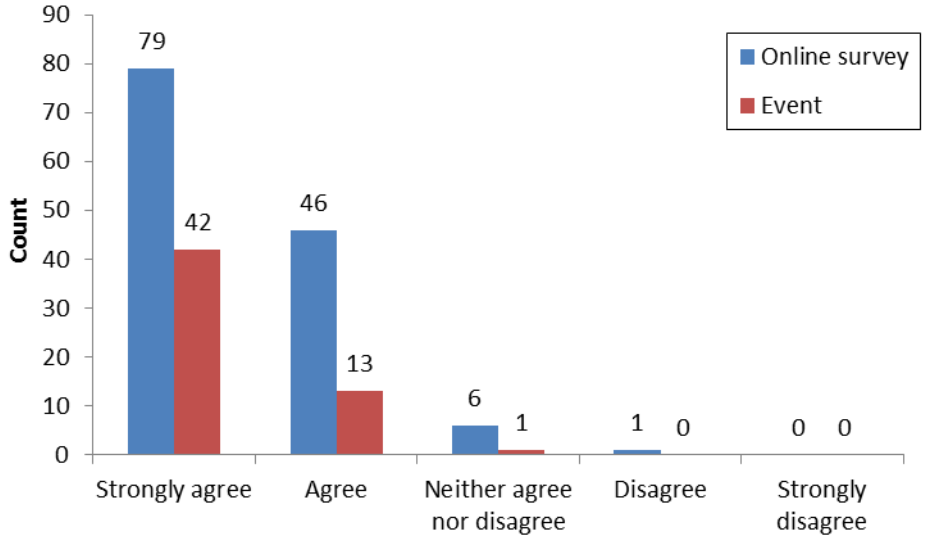
Other

Service should be measured on outcomes not the number of contacts, also the services that are more cost effective in the long term are always the first to be cut. Be honest as to what can be afforded don't make promises that can't be delivered.

Social Determinants

As the Government's policy of deficit reduction continues, both the CCG and Council must ensure value for money across all services. As well as the areas highlighted earlier we think a broader approach to tackle the wider social determinants of mental health is needed. This would place a focus on suitable housing, education, employment, local communities and the local environment.

How much do you agree or disagree that tackling the social determinants of mental health is a priority? (responses received: 132, 56)



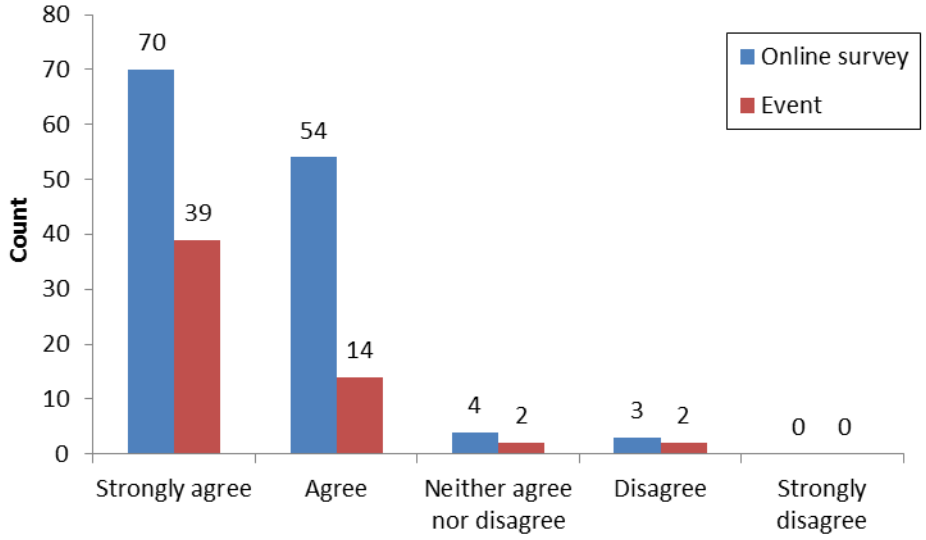
Is there anything you would like to say about the priority area of tackling the social determinants of mental health?

41 comments were received in total to this question. The comments provided were broad in nature and therefore no defined categories could be created from these comments.

The full list of open comments received from this question (and all questions in the survey) will be forwarded to the relevant team for further analysis.

Other Mental Health Related Issues

How much do you agree or disagree that there is a stigma attached to mental illness? (responses received: 131, 57)



What do you think can be done to increase the public understanding of mental illness?

Awareness / Campaigns	24
Understanding of mental health	22
Education: schools	22
Open days / Talks / fact sheets / high profile	21
Education: General	13
Other	6

Main themes from comments received:

***Awareness / Campaigns**:*
Awareness campaigns, media campaigns, clear messages about the signs and problems, clear publication of information / support available. Places to advertise, GP practice, work place, school.

***Understanding of mental health**:*
More understanding of mental health, that it can affect anybody. Mental health as a state of mind rather than an illness to be ignored.

***Education: schools**:*
Better education in schools from an early age. Mental health should be addressed along with other topics. Example of how mental health can affect people, have children help to mentor other children who may have problems.

***Open days / Talks / fact sheets / high profile**:*
Local events / open days / social media / local people who are affected / famous people who are affected / fact sheets

***Education: General**:*
Educate the general public about the signs and symptoms of mental health.

Tell us what you think?

If you could do one thing to improve general mental health in Halton what would it be? (open comment question)

Social / Economic	23
Information / support e.g. helplines, drop in	22
Access / more service provision	22
Training Professionals	17
Education / Awareness	11
Children / Young People	11

Main themes from comments received:

***Social / Economic**:*
Social and economic deprivation / community projects / jobs / lower costs for leisure activities / use current assets e.g. schools, community centre / tackle isolation

***Information / support e.g. helplines, drop in**:*
Helplines / clear information / one stops shops in GP or hospital / support for families.

***Access / more service provision**:*
Easier and quicker access to current service provision to help earlier detection. More provision or trained staff in GP practices

Training Professionals:
More understanding and more awareness from professionals / awareness training / better communication / changing attitudes and approaches

Education / Awareness
Better education and awareness, that mental health can effect anybody.

Children / Young People
More work with children and young people, especially in schools. Also provide a children drop in where children and young people can go and talk to someone. Encourage children and young people, particularly boys, to talk about any worries they may have.

How do you feel we can raise more awareness of the importance of good mental health? (open comment question)

Advertising e.g. Open days / talks / social media / raising funds	31
Schools / college	21
Advertising e.g. leaflets / posters / articles	16
Campaign the same for other illnesses / consistent / on-going / local	12
Investment	11
Other determinants	7
Isolation / Stigma	4

Main themes from comments received:

***Advertising e.g. Open days / talks / social media / raising funds**:*
Open days / awareness days / coffee and tea mornings / open days or events at schools, work place, local groups / positive stories and information via social media, press, TV.

***Schools / college**:*
Go into schools / college with DVD, drop in, chats, information

***Advertising e.g. leaflets / posters / articles**:*
Articles in paper / flyers / posters.

***Campaign the same for other illnesses / consistent / on-going / local Investment**:*
More investment in services / link with carers and families, especially at a local level.

Investment:
Investment should be made with continuous service provision, also investment should be made to work with carers, the carers centre, and those who provide services.

Other Determinants:
Promotion of healthy lifestyles e.g. healthy eating, exercise, laughter and sports.

Isolation / Stigma:
Help to reduce stigma and isolation with good role models and encourage residents to attend activities.

How do you feel we can educate younger people on the importance of good mental well-being? (open comment question)

Sessions / posters / talks	39
Curriculum / lessons	36
Other determinants / normalise / community	25
TV, Radio, Social Media	7

Main themes from comments received:

***Sessions / posters / talks**:*
Go and talk to schools, use examples that students can relate to. Train those who work with children and young people. Advisor or professionals going to schools, encouraging the students to talk about their feelings or issues they may be having.

***Curriculum / lessons**:*
Mental health should be included in lessons / curriculum / activities - including debates and leaflets. Start early in schools.

***Other determinants / normalise / community**:*
Give an understanding of what mental health is, talking about it makes it normal. Teach what good mental health is and encourage good mental health. Integration and working with those who may have mental health problems. Community activity with children and young people around mental health. Local mental health ambassadors.

***TV, Radio, Social Media**:*
Facebook, Twitter, Youtube. Local people and famous people should be highlighted in promotion. Promote eating healthy and exercise.