

Warrington

Joint Strategic Needs Assessment (JSNA)

Adult Mental Health Chapter 2016/17

October 2016

Version Control

Version	Description of amendments	Date of amendment
	Copy of old chapter circulated to commissioners for discussion	10/7/15
1	New version updated with analysis and information	28/7/15
2	Extra information added and circulated to commissioners for feedback and comments	24/5/16
3	Updated with information following feedback by commissioners	15/07/16
4	Further information added	21/07/16
5	Final amendments, updates and proofreading	14/9/16
Final	Chapter sent for approval and sign off	4/10/16

The Joint Strategic Needs Assessment (JSNA) considers a wide range of factors that affect the health and wellbeing of the people of Warrington. The objective of the JSNA is to involve partner organisations, such as the local NHS, local authorities, Police, Fire and third sector organisations in order to provide a top level, holistic view of current and future need within the borough. The JSNA is used to agree key priorities to improve the health and wellbeing of all our communities at the same time as reducing health inequalities.

Summary: Key Points

Promoting Mental Wellbeing / Preventing Mortality	Primary Care
<ul style="list-style-type: none"> Nearly 1 in 4 residents responding to a local health and wellbeing survey reported having low mental wellbeing. Younger women and middle aged men were more likely to have low mental wellbeing (Warrington Public Health, 2013). Low emotional wellbeing and diagnosed mental illnesses have a higher prevalence in the more deprived areas of Warrington. Approximately 28,600 adults in Warrington will be experiencing a common mental health disorder (national prevalence rates applied to local population estimates). Between 2012 and 2014 there were 64 deaths due to suicide or injury undetermined of Warrington residents (3 times more men than women)(PHE, 2016a). This is equivalent to a rate of 11.8 per 100,000 population, higher than the England average (10.0) and North West average (11.5), but not statistically significantly higher. 	<ul style="list-style-type: none"> There are 13,953 people in Warrington recorded by GPs as having a diagnosis of depression; the prevalence rate is slightly higher than the England average (HSCIC, 2015a). There are 1,798 people in Warrington with a diagnosis of a serious mental illness, and the prevalence rate is in keeping with the prevalence reported for England as a whole (HSCIC, 2015a). Referrals received by the IAPT service in 2014/15 have seen a small reduction since the previous year (HSCIC, 2015c). Service users continue to receive treatment from secondary care services when they would receive the same level of care/management within primary care.
Acute Care	Severe and Specialist Mental Health Services
<ul style="list-style-type: none"> Secondary mental health services in Warrington have seen increases in referrals (5BP, 2015). A proportion of these referrals could potentially be dealt with at a primary care level in the first instance. This suggests that there is still a need for these services, but it would be beneficial to raise awareness of services in primary care that could deal with less severe mental illness. 	<ul style="list-style-type: none"> People suffering from severe mental disorders are more likely to have a higher prevalence of many chronic diseases, and are at a higher risk for premature death associated with these diseases than the general population (WHO, 2014b). In 2014/15, 7,255 people used Warrington's NHS funded adult secondary mental health and learning disability services, 475 (6.6%) of whom spent time in hospital during the year. This compares with 5.7% in England who spent time in hospital (HSCIC, 2015b). In 2014/15 Warrington had a rate of 321.6 emergency hospital admissions per 100,000 for self-harm, significantly higher than England's rate of 191.4 (PHE, 2016b).
Wider Determinants of Health	
<ul style="list-style-type: none"> 47.1% of employment and support allowance claimants were recorded as having a 'mental and behavioural disorder' (n=3,250). This is lower than the England proportion of 48.1% (ONS, 2015b). National evidence suggests that the recent increases in the suicide rate are likely to be linked to the recession and increased levels of unemployment (HM Government, 2014). People who experience severe and enduring mental health problems have one of the lowest employment rates (ChaMPs, 2013). 	

Recommendations for Commissioning

Updates to previous recommendations from last chapter

1. That investment is analysed in line with the needs of the population, with a view to redirecting resources into primary/preventative services. **See update under recommendation 4.**
2. That outcomes are evaluated for all services, with a view to redesigning those that are not achieving outcomes or contributing to the improved wellbeing of the population. **See update under recommendation 4.**
3. That commissioners work collaboratively when commissioning high-cost/low-volume specialist mental health services. **See update under recommendation 4.**
4. That all care pathways are reviewed and redesigned to ensure the patient's journey is efficient and effective. **These first four recommendations are incorporated into the commissioner's role as a matter of course, and are already being undertaken.**
5. That, in accordance with patient, carer and GP views, services are easily accessible and responsive. This is in line with current considerations which include the development of a Single-Point of Access into services and, improved 24 hour assessment and crisis services. The 5 Boroughs Partnership NHS Foundation Trust is currently developing new care pathways for adult and older person's mental health services. **See update under recommendation 6.**
6. To include a focus on public mental health using the best practice from the national document *No Health Without Mental Health: a Toolkit for Commissioners*. **The above two recommendations will fall within a review of services that is to be undertaken, following an independent report (Ryan and Hodgetts, 2015) investigating the mental health care pathways in Warrington provided by 5 Boroughs Partnership.**
7. To develop a clear process for receiving information from Significant Events Audits

conducted in primary care following a suicide, and put in place actions to address any lessons learned from these audits. **The suicide audit tool offers the opportunity to collect information about Significant Event Audits¹ (SEAs) conducted within primary and secondary care settings. Requests to 5 Boroughs Partnership NHS Foundation Trust (mental health) and Warrington GP practices to provide information about SEAs has resulted in varying levels of participation. Due to inconsistent information, analysis of the findings has not been conducted. However, to ensure that in future SEA information is provided consistently to the suicide audit process, awareness raising sessions with Warrington GPs have been planned for 2016. Recommendation to be updated and carried forward.**

Recommendations and Actions based on current JSNA chapter

Promoting Mental Wellbeing:

- Development of self-care in primary care as per independent review, the approach should consider the skills to enable people to self-manage their conditions and seek help when necessary to avoid escalation.
- Communities will be supported to maintain their own mental health and wellbeing, building resilience at a local neighbourhood level.
- Development of hubs throughout Warrington to address the wider determinants of good mental health such as good quality housing, debt advice, employment and benefits, and education.
- Mental Health awareness should continue to be raised within Warrington, promoting ways to ensure good wellbeing – through #maketimewarrington campaign, and the use of the best practice toolkits.

¹ SEA has been defined as occurring when "individual cases in which there has been a significant occurrence (not necessarily involving an undesirable outcome for the patient) are analysed in a systematic and detailed way to ascertain what can be learnt about the overall quality of care and to indicate changes that might lead to future improvements" (Gillam and Siriwardena, 2013, cited in Patient, 2015).

Prevention of Suicide:

- Commission and monitor Amparo suicide liaison services – supporting those bereaved or exposed to suicide (people exposed to suicide are more likely to attempt to take their own life).
- Work with the local Rugby Club to promote mental health awareness and suicide prevention for males.
- Reduce the number of suicides each year across Warrington, working in line with the Cheshire and Merseyside zero suicide strategy.
- To raise awareness with Warrington GPs to ensure Significant Event Audits are conducted in primary care following a suicide, and to ensure that any findings from the suicide audit and Significant Event Audits are used to inform local planning.

Primary Care:

- Ensure robust pathways and contingency plans are in place so that GPs become more confident in adopting 'Watch and Wait' approach to patients presenting with mental health crises.
- Development of the primary care workforce in the ability to recognise mental health illnesses and proactively manage low level conditions within primary care.
- Develop the approach for managing patients who present with Medically Unexplained Symptoms. NHS commissioners will implement a pilot of managing this cohort of patients – in addition this will form part of an IAPT (Improving Access to Psychological Therapies) expansion programme.
- Crisis intervention – alternatives to hospital admission. Health and Local Authority commissioners are working together to provide an alternative to hospital admission for residents who are experiencing acute episodes of emotional distress.
- GPs and secondary care services will work together and formalise a pathway that allows the smooth transition of patients back to primary care but allows for rapid re-access to secondary care if needed.

Improving Access to Psychological Therapies:

- To raise awareness with primary care practitioners and Warrington residents of the IAPT service and the Single Point of Access (SPA).
- That the Warrington IAPT service improves data collection on disability of service users to

enable better profiling of users which will help towards understanding their clients and ensuring the service meets their needs.

- IAPT services will comply with access and waiting time standards of 75% of referrals starting therapy within 6 weeks of referral and 95% starting therapy within 18 weeks of referral, ensuring parity of esteem between physical and mental health.
- IAPT services will expand to work with service users with co-morbid long term conditions such as diabetes and Chronic Obstructive Pulmonary Disorder (COPD) by participating in the national IAPT expansion programme.
- Access and waiting times of counselling services commissioned by NHS Warrington CCG and managed through the SPA will be actively monitored to ensure the population has timely access to counselling services.

Acute Pathway Services:

- Continue to develop the Psychiatric Liaison Service to primarily meet the needs of the local population and move towards a service that meets the requirements outlined in the Five Year Forward View for Mental Health i.e. 24/7 service delivery, and to access time standards where appropriate.
- Develop the use of NICE-approved care packages within the Early Intervention services by working with provider teams and quality improvement organisations.
- GPs in Warrington will use protected learning time to develop their understanding of the services within the acute care pathway in order to contribute to appropriate access and referral to services.
- Health commissioners should consider adapting the referral process to allow for the triage of referrals before a face to face assessment is undertaken.

Inpatient and Specialist Services:

- GPs and secondary care services will work together and formalise a pathway that allows the smooth transition of patients back to primary care but allows for rapid re-access to secondary care if needed.
- Maximisation of the use of in-patient beds and specialist services will be tackled by a whole system approach. A thorough understanding of service users with complex emotional disorders or with a personality disorder is required.
- 5 Boroughs Partnership will be the lead partner in a review of the whole service model

across not only Warrington but St Helens, Knowsley, Halton and Wigan. The review should focus on recovery, ensuring service users are in the right part of the system to meet their needs, whilst maximising community provision and alternatives to hospital admission.

- A review of, and stepping down of, service users from in-patient services, especially patients who are receiving care in out-of-area beds, including developing effective working relationships with housing providers within Warrington.

Additional Services:

- Continued monitoring of service users at 6 months following discharge for Outreach STAR teams.
- Development of outcomes based reporting of services for all teams.

General:

- Strengthen relationships with relevant partner organisations to encourage sharing of information to inform future commissioning intentions.

1. Introduction

Health and Social Care commissioners believe that the local population should be equipped with skills and knowledge, and have access to services that will contribute to their mental wellbeing, not only in relation to health but the wider determinants of mental health. When primary care or low level interventions are required, access should be timely and on par with physical health services. Admission into the acute pathway should only happen when absolutely necessary. When it is required, service users should expect to be admitted to a local bed and be treated in a safe environment, supported for their recovery beyond discharge.

Good mental health is critical for the wellbeing and effective functioning of individuals, families, communities and society. Its absence has implications far beyond individuals. In other words, although mental health is very personal, the quality of the population’s mental health affects every aspect of the shared life of the community.

Mental health is described by the World Health Organization (WHO, 2014a) as:

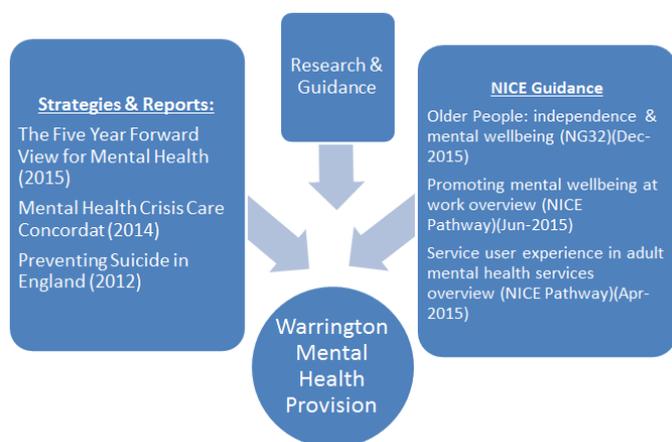
“A state of well-being in which the individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.”

Mental wellbeing is influenced by many factors, including genetic inheritance, childhood experiences, life events, individual ability to cope and levels of social support, as well as factors like adequate housing, employment, financial security and access to appropriate health care.

Income deprivation, low educational attainment, high proportions of self-reported ill-health and low-skilled, poorly paid employment, adversely affect mental and emotional wellbeing. Conversely, mental illness generates deprivation, as a person with mental health problems is more likely to be unemployed, excluded and socially isolated, with poor physical health.

There is strong evidence that supports the adverse effect of severe mental health conditions on physical health and wellbeing. People suffering from severe mental disorders are more likely to suffer from chronic diseases, and are at a higher risk for premature death associated with these diseases than the general population (WHO, 2014b).

Therefore it is pivotal that the level of need and current service provision is considered and what might need to be done to further to support the population of Warrington by not only Health, Social Care, and Third Sector and Voluntary Services, but individuals, and communities.



Within Warrington, the Mental Health Strategy sets out how commissioners will achieve the overall aim set out at the beginning of this introduction. The strategy was developed in partnership with local residents, service providers, and commissioners. The achievement of commissioners’ vision is underpinned by relevant strategies, reports, and guidance (a list of reference documents can be found in appendix 1).

2. Who is At Risk and Why

It is widely recognised that a person's health and wellbeing is influenced by a wide range of lifestyle factors, social and community networks and general socioeconomic, cultural and environmental determinants (Dahlgren & Whitehead, 1991). Poor mental health is both a cause and consequence of social, economic and environmental inequalities.

2.1. Employment

- A protective factor for the health and wellbeing of the general population, and positive long-term outcomes for people with mental health conditions.
- People who experience severe and enduring mental health problems have one of the lowest employment rates (ChaMPs, 2013).
- In Warrington, between October 2014 and September 2015 (latest available), 38.7% (4,500) of people with a mental health problem or learning disability lasting more than 12 months were classed as being employed. This compares with 40.0% in England (ONS, 2015a).
- There were 6,900 employment and support allowance claimants in Warrington in August 2015, of which 3,250 claimants were recorded as having a 'mental and behavioural disorder' (47.1%). The England rate was 48.1% (ONS, 2015b).

2.2. Stable/Appropriate Accommodation

- Important for people who have a mental illness as it improves their safety and reduces their risk of social exclusion. Providing social care in this environment helps to promote their independence, quality of life and reduces the need to readmit people into hospital or residential care (PHE, 2016a).
- According to the Public Health Outcomes Framework (PHE, 2016a), in 2014/15, 59.0% of adults in Warrington who are in contact with secondary mental health services live in stable and appropriate accommodation. This is a big improvement since 2013/14 in which the proportion was 52.4%, and similar to England (59.7%).

2.3. Carers

- Over 6 million people provide informal unpaid care in the UK and this is estimated to increase to 9 million by 2037, making it even more important that the Government and public health bodies ensure carer wellbeing is improved and their burden is reduced (Davies, 2014).
- In 2013/14, there were 167.9 carer assessments per 100,000 in Warrington; this was equivalent to 270 assessments, and was much higher than the England average of 64.3 (PHE, 2016b).
- In 2013/14, 75.0% of carers (255) in Warrington received services or advice or information; this compares to 19.5% in England overall (PHE, 2016b).

2.4. Homelessness

- A Health Needs Audit (Homeless Link, 2014), conducted across England, found that homeless people suffer from high levels of stress, anxiety, and other signs of poor mental health, with 45% of homeless having diagnosed mental health problems compared to approximately 25% of the general population.
- Homeless people can often experience obstacles which prevent them from getting the help and support they need for their mental health (Homeless Link, n.d. cited in Savage, 2016 p.17).
- The Health Needs Audit found that 12% of participants diagnosed with mental health issues also suffered from drug and alcohol issues, meaning that homeless people may experience even more difficulty accessing support if services are unable or unwilling to offer support for mental health while an individual is still using drugs or alcohol (Homeless Link, 2014).

- A Homeless Health Needs Audit undertaken in Warrington (Brighter Futures, 2014) found that 89% of respondents (36 out of 40) reported having a mental health issue, with the most common being stress, anxiety and panic attacks.
- Of those with a mental health need, 18% reported receiving treatment which met their needs; however 58% reported “self-medicating” using drugs or alcohol.

2.5. Offenders

- Nationally, over 70% of prisoners have two or more mental health disorders (DOH, 2011).
- Female prisoners are at 20 times higher risk of suicide, and male prisoners five times higher, compared to the general population (DOH, 2011).
- Ex-prisoners in particular have the greatest suicide risk, immediately following release (DOH, 2011).

This list isn’t exhaustive and there are many other groups within society that are at an increased risk of developing poor mental health including Black and Ethnic Minority populations, people identifying as non-heterosexual, and military veterans.

2.6. Physical and Mental Health

- People suffering from severe mental illness on average tend to die earlier than the general population, often dying of causes that are largely preventable such as cardiovascular, respiratory and infectious diseases, diabetes, hypertension, and suicide. Their lifespan is shortened by an average of 10-25 years (WHO, 2014b).
- Premature mortality in Warrington adults (aged under 75) with serious mental illness accounted for 87 deaths in 2012/13 (latest data available), a rate of 1,347 per 100,000 population. This is not significantly different to England’s rate of 1,319 per 100,000 (PHE, 2016b).
- People with long-term health conditions are also at increased risk of suffering from a mental illness, and evidence consistently highlights that people who have long-term conditions are two to three times more likely to experience mental health problems than the general population (The King’s Fund, 2012).
- The Warrington Health and Wellbeing Survey (Warrington Public Health, 2013) found that of those reporting very good general health, only 11% had low emotional wellbeing compared to 68% of those reporting bad general health.
- People with mental health problems are more prone to factors that lead to worse health outcomes, such as poor diet, smoking, drug and alcohol misuse, and low rates of physical activity (WHO, 2014b). The charity Action on Smoking and Health (ASH, 2016) reports that high rates of smoking by people with mental health issues have changed very little over the past 20 years.
- The Warrington Health and Wellbeing Survey (Warrington Public Health, 2013) highlighted that 37.9% of smokers reported having low emotional wellbeing compared to 22.2% of non-smokers, which was significantly lower. Results also showed that 34.4% of people with low emotional wellbeing had 3 or more lifestyle risk factors².
- People with mental health problems are more likely to receive lower quality health and social care than the general population, and experience stigma and discrimination associated with mental illness (WHO, 2014b). It is estimated that only a quarter of all those with a mental illness are receiving treatment (NHS England, n.d).
- The government requires NHS England to work for ‘Parity of Esteem’ (the principle by which mental health must be given equal priority to physical health) through the NHS Mandate.

² 5 lifestyle risk factors were reported in the survey – smoking, overweight, low physical activity, high alcohol consumption and poor diet.

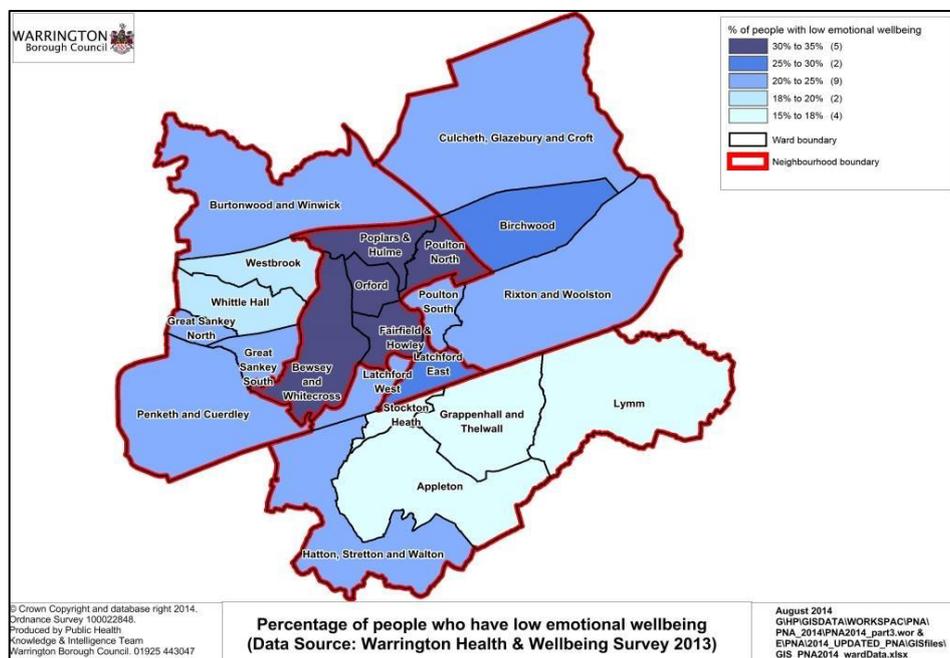
3. Levels of Need in Warrington and Current Services

3.1. Mental Wellbeing

The Health and Wellbeing Survey, conducted in 2013, measured mental wellbeing, as well as a number of other health related topics, amongst the adult population in Warrington (Warrington Public Health, 2013). All survey results were weighted to account for different response rates in sub-groups of the population. Survey data were also analysed by levels of socio-economic deprivation (based on Indices of Deprivation 2010). Small geographical areas of Warrington are categorised into “deprivation quintiles” which range from quintile 1 (those areas of Warrington that are within the 20% most deprived areas in England) to quintile 5 (those areas of Warrington that are within the 20% least deprived in England).

Nearly a quarter of respondents (24.2%) in Warrington reported having low levels of mental/emotional wellbeing, with very little difference between men and women. Survey respondents were grouped by age band (18-39, 40-64 and 65+). Younger women (27.1%) and middle aged men (27.3%) were more likely to have low mental wellbeing.

There are very strong social inequalities around levels of mental wellbeing. Prevalence³ of low mental wellbeing ranged from 35.7% in deprivation quintile 1 (most deprived) to 19.5% in quintile 5 (least deprived). Quintile 1 was also significantly worse than the Warrington average of 24.2%. In quintile 1, women aged 18-39, and both men and women aged 40-64 had significantly worse levels of low mental wellbeing than the Warrington average of 24.2%. This geographic split is further emphasised in map 1. Please note, since the analysis has been done, ward boundaries in Warrington have been revised in May 2016. There are still the same number of wards (22) but some boundaries and ward names have changed.



Map 1: Percentage of people with low emotional wellbeing

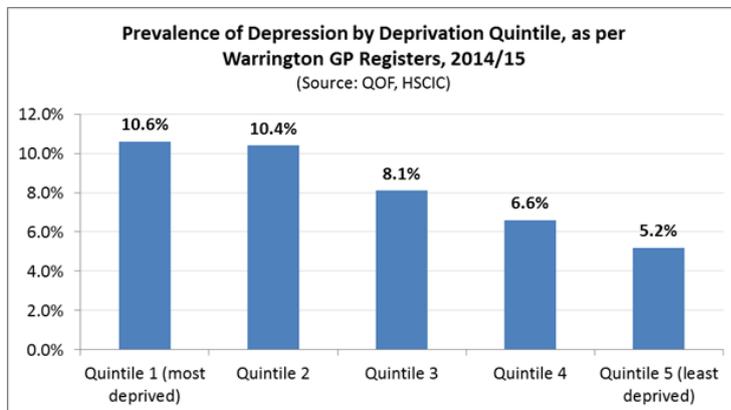
³ Prevalence refers to the proportion of individuals in a population who have a disease at a given time, often expressed as a percentage.

The percentage of people with low emotional wellbeing was significantly higher than the Warrington average in the central wards which are also the more deprived areas of Warrington – Poplars & Hulme, Poulton North, Orford, Bewsey & Whitecross, and Fairfield & Howley.

High mental wellbeing in Warrington overall was 7.2% and it increased with age. A significantly higher proportion of men aged 65+ (10.4%) had a high mental wellbeing compared to Warrington overall (7.2%). Although 9.3% of women aged 65+ had high mental wellbeing, it was not significantly higher than the Warrington average. By deprivation, only 4.9% of people in quintile 1 felt they had high mental wellbeing; this was significantly worse than the Warrington average.

3.2. Common Mental Health Problems

In 2014/15, Warrington had a prevalence rate of 8.28%, for adults aged 18 or over with a diagnosis of depression (HSCIC, 2015a). This compares to England’s rate of 7.33%. Prevalence rates relate to people who **have been diagnosed**, and it is likely that prevalence is under-reported.



Recorded prevalence in Warrington GP practices ranged from 3.75% to 14.75%. Analysing GP practices by deprivation⁴ shows a strong relationship with prevalence of depression, see chart 1. In quintile 1 (most deprived) recorded prevalence of depression was 10.6% compared to 5.2% in quintile 5 (least deprived).

Chart 1: Prevalence of Depression

3.3. Serious Mental Illness

Psychosis is one of the more serious mental illnesses. It causes people **to perceive or interpret things differently** from those around them and might involve hallucinations or delusions (NHS Choices, 2014). Public Health England estimates that there are approximately 24 new cases of psychosis per year in Warrington, equivalent to an estimated incidence⁵ of 18.0 per 100,000 population aged 16-64. This compares to the England average of 24.2 (PHE, 2016b).⁶

In 2014/15, Warrington had a prevalence rate of 0.84%, for adults recorded as having a diagnosis of a serious mental illness⁷ (HSCIC, 2015a). England had a prevalence rate of 0.88%. Again this highlights only those people diagnosed.

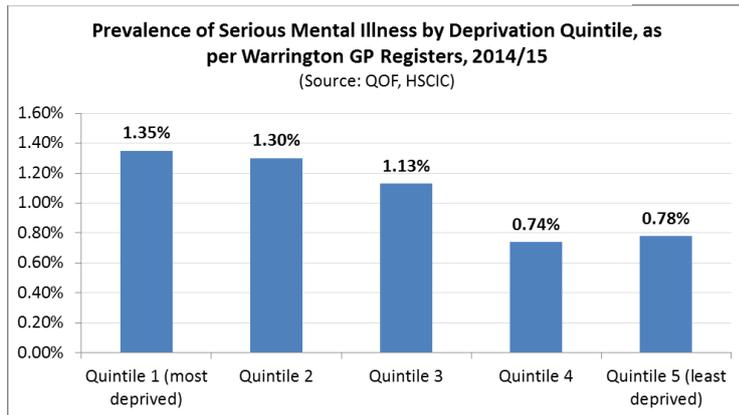
⁴ An average deprivation score was calculated for each GP practice based on all their patients’ postcodes. Practices were then grouped into 1 of 5 deprivation quintiles based on their average deprivation score (quintile 1 being the most deprived and quintile 5 the least deprived).

⁵ Incidence: rate of new/newly diagnosed cases of a disease, different to prevalence which relates to all cases

⁶ This is a modelled prediction applied to local population factors to estimate number of new cases per year, and there will be a degree of imprecision and uncertainty in the figures quoted.

⁷ People diagnosed with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy

Chart 2: Serious Mental Illness and Deprivation



Recorded prevalence rates in individual Warrington practices ranged from 0.29% to 1.73%. Quintile 1 (most deprived)⁵ had a prevalence rate of 1.35%, compared to 1.0% in the 80% less deprived areas.

Prevalence of serious mental illness reduces as the level of deprivation reduces (chart 2).

More detailed data extracted from GP clinical systems as at March 2015 (supplied by Warrington Clinical Commissioning Group) show that:

- Of all people diagnosed with a serious mental illness in quintile 1 (most deprived) the highest proportion is those aged between 41 and 50 years (28%). This age group is overrepresented when compared to the proportion of all registered patients in quintile 1 of that same age group (estimated at 18%).
- In the less deprived areas (quintiles 2 to 5), of all people diagnosed with a serious mental illness the highest proportion is those aged over 60 (30%). This is, however, in line with the proportion of all older people registered at those practices in quintiles 2 to 5 of the same age group (estimated at 28%).

3.4. Promoting Mental Wellbeing

Promoting mental wellbeing is about increasing awareness and recognition, and promoting self-management and appropriate support networks around mental health and emotional wellbeing. Services and initiatives at this level in Warrington include:



3.4.1. Happy? OK? Sad?: A mental health awareness Warrington campaign, relevant to people who currently have a good level of mental health as well as to those who are having problems coping and need immediate support. The website www.happyoksad.org.uk, signposts people to a wide range of links for local and national support services.

3.4.2. Make Time: A mental wellbeing campaign for Cheshire and Merseyside. The aim of the campaign is to make the Five Ways to Wellbeing (5WW) more accessible and relevant to the general public. The 5WW are simple evidence based actions, which have been shown to improve self-reported wellbeing. Make Time frames the 5WW as questions, to prompt people to think about what they currently do that makes them feel good and how they might fit more of the 5WW into their daily lives and so maintain or improve their mental wellbeing. The Make Time campaign asks us all: a) When was the last time you laughed until you cried? b) When was the last time you got up and out? c) When was the last time you noticed things around you? d) When was the last time you tried something new? e) When was the last time you made someone smile?

3.4.3. Wellbeing Service: Part of a Government initiative to reduce health inequalities in Warrington. Wellbeing Mentors are based in communities across Warrington, supporting individuals to make healthier lifestyle choices. This could



include advice and support on, for example, reducing smoking, losing weight or building confidence. The service provides one to one support for people aged over 16 in Warrington by developing personal wellbeing plans with individuals to help them achieve their lifestyle goal.

Between April 2015 and March 2016, 29.6% of people who accessed the Wellbeing Service did so with mental health/emotional wellbeing as their primary reason. This is equivalent to 269 people. Numbers accessing the Wellbeing Service for mental health and emotional wellbeing issues have increased year on year since 2012/13, as have the overall numbers of people accessing the service, as seen in chart 3.

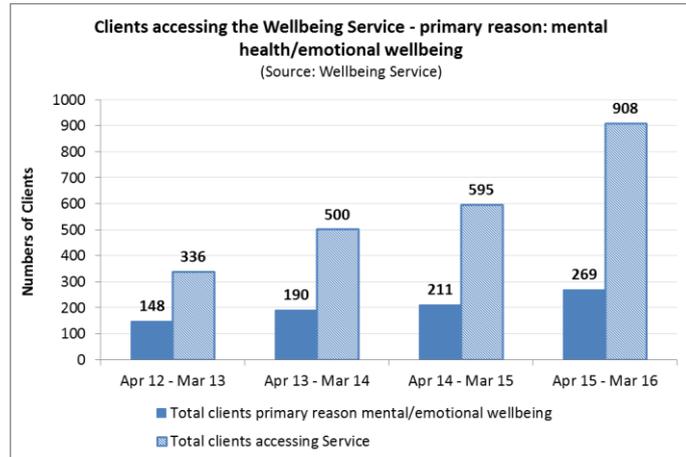


Chart 3: Mental Health and the Wellbeing Service

Although numbers have increased, the proportion of those for mental health/emotional wellbeing (as a percentage of the total clients) has reduced each year, from 44.0% in 2012/13, to 29.6% in 2015/16.

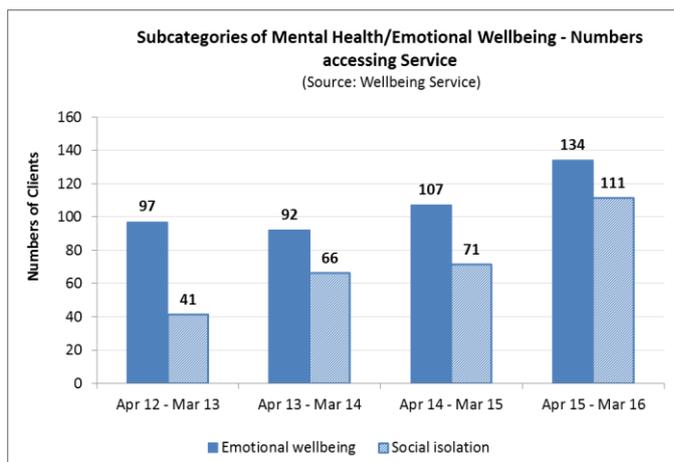


Chart 4: Subcategories of Mental Health

Looking at the type of reasons within the ‘mental health/emotional wellbeing’ category for accessing the service, the two main reasons are emotional wellbeing followed by social isolation. As can be seen in chart 4, numbers with emotional wellbeing issues have increased from 97 in 2012/13 to 134 in 2015/16, a 38% increase. Numbers feeling socially isolated have increased year on year from 41 in 2012/13 to 111 in 2015/16, a 171% increase.

Other issues falling within the overall category “mental health/emotional wellbeing”, include anxiety, bereavement, bullying, depression, domestic violence, and stress. However numbers are small and it is difficult to produce robust analysis looking at these individual categories. It should be noted that the sub-category of emotional wellbeing may include some of these other issues. Learning difficulties and financial issues were not extracted from the data and have not been included in this analysis.

3.4.4. Prevention Hub: The prevention hub will bring together current local prevention services, and will aim to ensure Warrington residents have easy access to a wide variety of services that can support them to improve their health and wellbeing, whether that be weight management, mental health or stopping smoking. The hub is currently under development and will be operational in 2017.

Promoting Mental Wellbeing – Actions for Partners:

- Development of self-care in primary care as per independent review (Ryan and Hodgetts, 2015), the approach should consider the skills to enable people to self-manage their conditions and seek help when necessary to avoid escalation.
- Communities will be supported to maintain their own mental health and wellbeing, building resilience at a local neighbourhood level.
- Development of hubs throughout Warrington to address the wider determinants of good mental health such as good quality housing, debt advice, employment and benefits, and education.
- Mental Health awareness should continue to be raised within Warrington, promoting ways to ensure good wellbeing – through #maketimewarrington campaign, and the use of the best practice toolkits (available from Warrington Public Health Resource Library, and online toolkit at <http://www.rcgp.org.uk/clinical-and-research/toolkits/mental-health-toolkit.aspx>)

3.5. Prevention of Suicide

Suicide prevention is a collective responsibility. Services and initiatives in Warrington include:

3.5.1. Mental Health Training: Connect 5 Mental Wellbeing training and Basic Suicide Prevention are offered and delivered by Warrington Public Health Team to Warrington Borough Council and NHS staff, as well as to staff and volunteers from voluntary sector groups and not-for-profit organisations supporting Warrington residents. The purpose is to train staff and volunteers who work with adults so they have a better understanding of emotional wellbeing and commonly experienced mental health problems.

Between 1 April 2015 and 31 March 2016 Warrington Public Health Team ran 41 sessions and trained 524 people in the Connect 5 training. They also ran 15 sessions of suicide prevention and trained 226 people over the year.



3.5.2. Amparo Suicide Liaison Service: Provides support to anyone who has been affected by suicide within Merseyside & Cheshire. This may include members of the deceased family, a partner, friends, work colleagues, or the ‘found by person’. This list is not exhaustive and is meant only as a guide. The service provides one to one support from an Amparo Liaison Worker, liaises with other agencies such as the Coroner’s Office and Police, provides support at Inquest, helps with any media enquiries, helps overcome isolation, provides information, emotional and practical support, and provides referrals and signposting to other statutory and voluntary services as appropriate.



AMPARO
support following suicide

3.5.3. State of Mind: A project that aims to get men talking more about their mental health and wellbeing and all the things that can affect it, by using rugby as an engagement tool. In Warrington, a 4 week programme was held in 2015 in collaboration with Warrington Wolves, 5 Boroughs Partnership NHS Foundation Trust and Warrington Borough Council. The project involved using the history of the local rugby league club to entice people to come and watch classic games and meet former stars who played in the games. Discussions took place around their preparation physically and mentally, the mood at half-time and the post-match events, and how the players dealt with the ups and downs of playing sport at the highest level. Over the 4 weeks 62 people attended, 54 men and 8 women. Attendees had their quality of life assessed, using a recognised measure, with the scores suggesting a number of people experienced mental health problems. All attendees had access to mental fitness and mental health support information from the Health Improvement team.

3.5.4. Suicide Statistics: Latest data for Warrington (3 year period 2012-14) shows there were 64 deaths due to suicide or injury undetermined of Warrington residents (3 times more men than women: 48 male and 16 female). This is equivalent to a rate of 11.8 per 100,000 population, and although higher than the England average of 10.0 it is not statistically significant. The North West had a rate of 11.5 (PHE, 2016a).

Table 1: Suicide Numbers and Rate (Persons)						
	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14
Warrington Numbers	46	39	39	41	55	64
Warrington Rate*	8.7	7.4	7.3	7.6	10.3	11.8
England Rate*	9.3	9.4	9.5	9.5	9.8	10.0

Source: PHOF, Public Health England (based on ONS source data)

* Directly standardised rate per 100,000

A Suicide Audit is undertaken annually in Warrington. Some of the key findings from the most recent audit (Warrington Public Health, 2015) show that:

- Higher suicide rates were seen in men, particularly Polish men, middle-aged people (aged 45-59), those living in socio-economically deprived areas, or who live alone or are unemployed. These groups also have higher suicide rates nationally.
- Although based on small numbers, a disproportionate number of Polish-born men died by suicide. There is no national data to confirm this pattern, but there is anecdotal evidence in other areas of the UK.
- During 2012-14, suicide was the leading cause of death for men in the 20-34 age band (34% of deaths).
- Over a third of local people who died by suicide had visited their GP within the month before their death.

A report by Liverpool John Moores University (Madden et al., 2014) on the health needs of the Eastern European population in Warrington acknowledges the higher than expected numbers of recent suicides of young Polish men. The authors suggest that this may be because there is a larger proportion of young Polish men in the country without family compared to, for example, Latvians who tend to come as a family, and therefore have the support. In Warrington, the Polish population is bigger than those of other non-English communities.

Findings from the local suicide audit help inform the Warrington Suicide Reduction Plan (SRAP). The SRAP for Warrington describes actions, level of intervention, key leads, responsibility and milestones. A full self-assessment for Warrington in relation to the SRAP was conducted in November/December 2014; this highlighted actions needed locally which relate to the key objective areas. These are in line with the Cheshire and Merseyside actions.

In 2015, as part of a new initiative, Champs Public Health Collaborative launched its new Cheshire and Merseyside zero suicide strategy. The “NO MORE” zero suicide strategy and action plan sets out in more detail the national and local picture and key drivers for action.

Prevention of Suicide – Actions for Partners:

- Commission and monitor Amparo suicide liaison services – supporting those bereaved or exposed to suicide (people exposed to suicide are more likely to attempt to take their own life).
- Work with the local Rugby Club to promote mental health awareness and suicide prevention for males.
- Reduce the number of suicides each year across Warrington, working in line with the Cheshire and Merseyside zero suicide strategy.
- To raise awareness with Warrington GPs to ensure Significant Event Audits are conducted in primary care following a suicide, and to ensure that any findings from the suicide audit and Significant Event Audits are used to inform local planning.

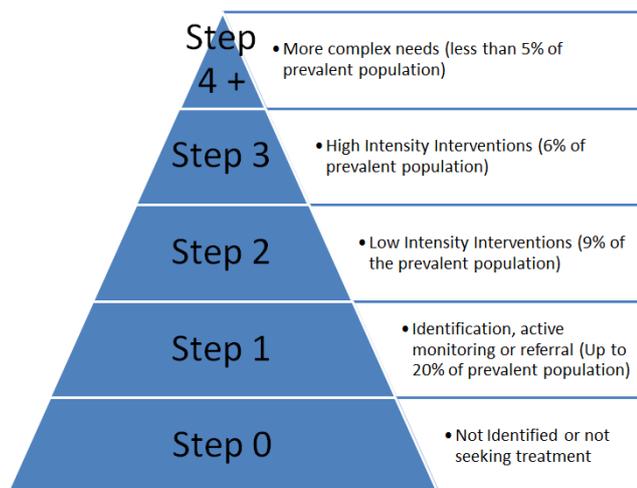
3.6. Primary Care

The 2014 Adult Psychiatric Morbidity Survey (McManus et al., 2016) found that 17.0% of the adult population (aged 16 and over) interviewed in England had a common mental disorder⁸ in the week before interview. This is equivalent to one in six people. All types of common mental disorders were more prevalent in women than in men, and all types of common mental disorders (except for panic disorder which had low prevalence), were more common in people aged 16-64 than in those aged 65 and higher. Of those with common mental disorders, 36.2% reported receiving mental health treatment.

Applying the 17.0% national prevalence to the 2015 population estimates in Warrington (age 16+), suggests that approximately 28,600 adults in Warrington are experiencing a common mental disorder. However, not all will have been diagnosed.

In 2014/15 there were 13,953 people aged 18 and over with a diagnosis of depression on Warrington GP registers (HSCIC, 2015a). This is a prevalence of 8.28%, slightly higher than the England average of 7.33%. Furthermore, 1,798 people are recorded by GPs as having a diagnosis of a serious mental illness (schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy). This is equivalent to a prevalence rate of 0.84%, compared to 0.88% in England.

The GP surgery is the first point of contact for most people when they are unwell or need medical advice and this presents a real challenge in dealing with common mental health problems. GPs work within 'Step 1' of the stepped care model.



By working on the development of a robust stepped care model, where patients can easily move between services so that they are dealt with at the appropriate level and in a timely manner, GPs in Warrington will be able to adopt a 'Watch and Wait' approach to dealing with patients who are experiencing acute episodes of mental crisis.

During this period GPs will assess and monitor patients who consult them over mental health issues. GPs will refer patients to services offering more specialist support where appropriate.

3.6.1. Medically Unexplained Symptoms (MUS): Up to 70% of people presenting to primary care with medically unexplained symptoms will also suffer from depression and/or anxiety (DoH, 2008). Research indicates that an estimated 15% of GP consultations relate to persistent physical symptoms (equivalent to 1 service user per hour of clinic time). An estimated 2% of a GP practice population (with a higher prevalence in socioeconomically deprived localities) repeatedly attend GP clinics for complaints associated with persistent MUS.

Service users with MUS use a substantial proportion of healthcare resources; one recent estimate puts the cost of MUS to the UK NHS at around £3.1 billion per year (The Forum for Mental Health in Primary Care, 2011). Compared to service users with explained illness, service users with MUS

⁸ Common mental disorders assessed as part of the survey include depression, generalised anxiety disorder, panic disorder, phobias, obsessive compulsive disorder, and common mental disorders not otherwise specified

commonly have more investigations, more protracted service user journeys, feeding ongoing disability cycles. Approximately 75% of service users with MUS will report symptoms of depression and / or anxiety, approximately twice the rate seen in service users with an equivalent physical disability from organic disease.

3.6.2. Crisis Intervention – Alternatives to Inpatient Admission: Warrington GPs and counselling service providers report seeing an increasing number of people who are experiencing acute episodes of crisis that evidently require some form of intervention but would not necessitate an admission to secondary care mental health services. Recent information from Warrington and Halton Hospitals Foundation Trust reported that in the 10 months between April 2015 and January 2016 there were 381 short stay admissions (3 days or less) of patients aged 19-69 with a primary mental health diagnosis (source Lorenzo, WHHFT, provided by Warrington CCG). With the tariff payable per patient stay quoted as £952, a considerable amount of money could be saved if people had access to alternative crisis support rather than being unnecessarily admitted to hospital.

3.6.3. Long Term Mental Health: Primary Care and GPs also have an increasing role to play in the care of service users who continue to receive treatment from secondary services but who require minimal input from secondary care.

These service users may, for example, be on long term medication and have to return to secondary care on an annual basis for medication reviews. This could be done via the service user's GP with the benefit of reduced stigma of having to return to a specific mental health site, and with a lesser financial impact to the local health economy.

Primary Care – Actions for Partners:

- Ensure robust pathways and contingency plans are in place so that GPs become more confident in adopting 'Watch and Wait' approach to patients presenting with mental health crises.
- Development of the primary care workforce in the ability to recognise mental health illnesses and proactively manage low level conditions within primary care.
- Develop the approach for managing patients who present with Medically Unexplained Symptoms. NHS commissioners will implement a pilot of managing this cohort of patients – in addition this will form part of an IAPT (Improving Access to Psychological Therapies) expansion programme.
- Crisis intervention – alternatives to hospital admission. Health and Local Authority commissioners are working together to provide an alternative to hospital admission for residents who are experiencing acute episodes of emotional distress.
- GPs and secondary care services will work together and formalise a pathway that allows the smooth transition of patients back to primary care but allows for rapid re-access to secondary care if needed.

3.7. Improving Access to Psychological Therapies (IAPT)

IAPT is a government initiative designed to help anyone living in England deal with common mental health problems. These may include stress, anxiety or depression, as well as panic, phobias, obsessive compulsive disorder (OCD) and post-traumatic stress disorder. IAPT delivers a stratified service at steps 2-4 of the NICE pathway for common mental health problems (NICE, 2011).

Warrington Clinical Commissioning Group (CCG) commissions Mental Health Matters to deliver the IAPT service in Warrington. In addition to its own therapies (such as education groups, guided self-help, cognitive behavioural therapy), IAPT provides access to additional services commissioned by Warrington CCG - St Joseph's Family Contact Centre who provide a counselling service, and Making Space who provide computerised cognitive behavioural therapy (CCBT).

The Health and Social Care Information Centre (HSCIC) reports annually on the national IAPT dataset. The following analysis is based on the most recent published data for Warrington for 2014/15 (HSCIC, 2015c).

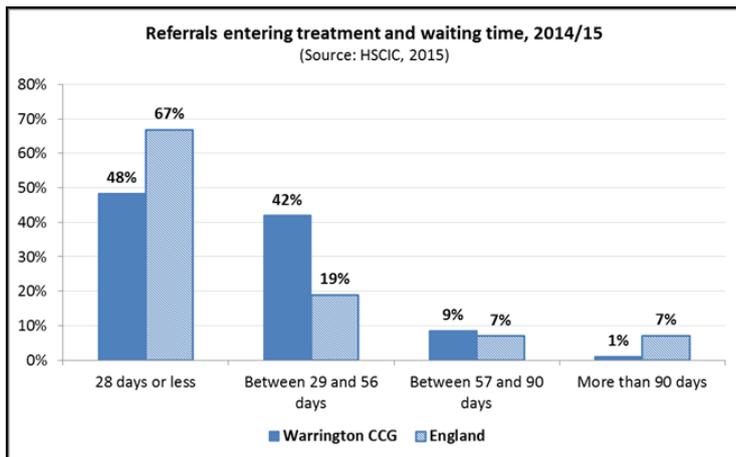
3.7.1. Referrals Received: Between 1 April 2014 and 31 March 2015, Warrington IAPT received 5,520 referrals, a small reduction of 4.8% since the previous year, in which there were 5,800 referrals.

Referrals in 2014/15 show that:

- Nearly two thirds of referrals received were female (62.6%) compared to 37.4% male. This is similar to the England average
- Males aged 36 - 64 accounted for 50.4% of all male referrals received, and was also the most common age group for males entering treatment (54.6%), and completing treatment (57.7%)
- Female referrals differ slightly in that females aged 18 - 35 formed the biggest proportion of all female referrals received (45.8%); however in terms of entering treatment and completing treatment the 36 - 64 age group accounted for the main proportion of female referrals (average 49% of the total)
- England shows the same pattern for the main age groups and by gender, including the 2 different female age groups seen in Warrington
- Where ethnicity is known, the vast majority of referrals received in Warrington were White British (96.8%), followed by White Other Background or Irish (1.1%), and then Asian or Asian British (0.9%); this reflects the fact that Warrington has a very large White British population (92.9%, Census 2011)
- Although disability can be recorded, this is only known in 4% of referrals – the remainder are classed as having 'no code recorded'. The same proportion (4%) entered treatment with disability being recorded.

3.7.2. Entering Treatment and Waiting Time: The number of referrals entering treatment in 2014/15 in Warrington was 3,265 (59% of all referrals received). The average (mean) waiting time between the referral and the first treatment appointment was 30.9 days, compared to a national average of 32 days.

Chart 5 shows that although the England average for those entering treatment within 28 days or less is higher than Warrington (67% v. 48%), Warrington also has a high proportion accessing treatment between 29 and 56 days. Combined, 90% of referrals in Warrington enter treatment within 56 days, compared to 86% for England.



A new IAPT standard was introduced by March 2016 that 75% of people referred to IAPT begin treatment within 6 weeks of referral, and 95% begin treatment within 18 weeks of referral (NHS England, 2015). During 2014/15, 72% of referrals entering treatment at Warrington IAPT started in less than 6 weeks, and 100% started in less than 18 weeks.

Chart 5: Referrals and Waiting Times

3.7.3. Finishing Treatment and Recovery Status: The numbers of referrals in Warrington finishing a course of treatment was 2,120⁹, of which 1,250 (58.9%) showed reliable improvement¹⁰ (England average 60.8%). Table 2 shows those finishing a course of treatment in Warrington (2,120) and the problem descriptor as a proportion of the overall total.

There were 1,930 referrals in Warrington finishing a course of treatment that were initially “at caseness”¹¹.

865 (44.9%) moved to recovery¹², very similar to the England average of 44.8%. The government target for recovery, up to 31 March 2015, was that 50% of referrals should move to recovery by the end of their course of treatment.

825 (42.7%) showed reliable recovery¹³ (England 42.8%).

Table 2: Referrals Completing Treatment in Warrington and Problem Descriptor, 2014/15

Anxiety & stress related disorders, of which:	30%
<ul style="list-style-type: none"> • Generalized anxiety disorder • Other anxiety or stress related disorder • Panic disorder (episodic paroxysmal anxiety) • Social phobias • Mixed anxiety and depressive disorder • Post-traumatic stress disorder • Obsessive-compulsive disorder • Specific (isolated) phobias • Agoraphobia 	8.3% 5.5% 3.5% 3.1% 3.0% 2.7% 1.9% 1.7% 0.3%
Depression	28.1%
Other mental health problems	2.4%
Unspecified	39.4%
Total	100%

⁹ In order to finish a course of treatment, a referral must have ended in the year with at least two treatment appointments having been attended in the course of the referral.

¹⁰ Referrals are classed as having reliable improvement if the patient shows a reliable decrease in anxiety or depression score between the first and last measurement, and the other clinical state (depression or anxiety) either also reliably decreases or shows no reliable change.

¹¹ “At caseness” is the term used to describe a referral that scores highly enough on measures of depression and anxiety to be classed as a clinical case.

¹² Referrals with a completed course of treatment are classed as having recovered if they are classified as clinical cases when they enter treatment but no longer classified as clinical cases when they have completed a course of treatment. Recovery is measured in terms of the anxiety and depression scores. For a referral to be considered recovered, the patient needs to score below the clinical threshold on BOTH scores at the end of treatment, to ensure that recovery is measured by looking at the welfare of the individual rather than one specific symptom.

¹³ Reliable recovery: where a patient meets the criteria for both recovery and reliable improvement when they have finished a course of treatment.

Improving Access to Psychological Therapies – Actions for Partners:

- To raise awareness with primary care practitioners and Warrington residents of the IAPT service and the Single Point of Access (SPA).
- That the Warrington IAPT service improves data collection on disability of service users to enable better profiling of users which will help towards understanding their clients and ensuring the service meets their needs.
- IAPT services will comply with access and waiting time standards of 75% of referrals starting therapy within 6 weeks of referral and 95% starting therapy within 18 weeks of referral, ensuring parity of esteem between physical and mental health.
- IAPT services will expand to work with service users with co-morbid long term conditions such as diabetes and Chronic Obstructive Pulmonary Disorder (COPD) by participating in the national IAPT expansion programme.
- Access and waiting times of counselling services commissioned by NHS Warrington CCG and managed through the SPA will be actively monitored to ensure the population has timely access to counselling services.

3.8. Acute Care

Secondary care mental health services provide care for people with serious mental health issues. The types of services that a secondary care provider is responsible for include in-patient hospital care, crisis intervention services, recovery services and eating disorder services. Serious mental health problems include schizophrenia, bipolar disorder or severe depressive disorder. It is estimated that, nationally, 1 adult in 28 are in contact with secondary mental health services (The Kings Fund, 2015, p.2).

In 2014/15, Warrington Clinical Commissioning Group (CCG) had 7,255 people using its NHS funded adult secondary mental health and learning disability services¹⁴, 475 (6.6%) of whom spent time in hospital during the year. This compares with 5.7% in England (HSCIC, 2015b).

According to Public Health England (2016b), over the last 4 years there has been an average of 662 emergency hospital admissions (per year) of Warrington residents for intentional self-harm. Latest data (2014/15) gives a rate of 321.6 admissions per 100,000 for Warrington, which is significantly higher than England's rate of 191.4 per 100,000¹⁵.

3.8.1. Acute Care Pathway: In Warrington the Acute Care Pathway comprises the Assessment Team, Home Treatment Service, and Recovery Service, provided by 5 Boroughs Partnership NHS Foundation Trust. 5 Boroughs Partnership is currently the main provider of specialist mental health services in Warrington.

Ryan and Hodgetts (2015) carried out an independent review of the mental health services across the 5 Boroughs Partnership footprint; Warrington, Halton, Knowsley, St Helens and Wigan. The review examined the acute care pathway for adult mental health services and all the inter-related services that impact upon the pathway, including those not delivered by 5 Boroughs Partnership. The review generated 5 main recommendations for service development or improvement ("big tickets") as well as an additional suite of further recommendations, some specifically related to the acute care pathway.

3.8.2. 5 Boroughs Partnership has provided service user data based on referrals through the assessment teams. A fuller analysis has been conducted on data from 2014/15 provided at the time. A snapshot of 2015/16 has been provided more recently to give a more current picture.

Between April 2015 and March 2016, 5 Boroughs Partnership received 3385 referrals from Warrington residents for their mental health services. This is an increase of 22% since 2014/15, in which numbers of referrals were 2767. Numbers of referrals have seen a year on year increase from 2013/14, which had 2321 referrals. It should be noted that this data is based on number of *referrals*, not numbers of *people*, and there will be repeat service users within this count who have been referred more than once.

Characteristics of service users in 2015/16:

- 53.0% (1795) of referrals were female and 47.0% (1590) male
- Over half of referrals (53.8%) were aged under 45; those aged 25-34 accounted for the largest proportion of referrals (19.1%)

¹⁴ This is the first year the dataset has been expanded to include people in contact with learning disability services

¹⁵ Not all who self-harm present at A&E or are admitted to hospital. Also underlying factors may influence the rate of hospital admissions for self-harm eg hospital admissions policies

- Of those known, the main ethnicities of referrals were White British (90.9%, 3077), followed by other White background, including Irish (1.8%, 61). Other ethnicities such as Asian/Asian British, mixed background, Black/Black British and other ethnic groups (including Chinese) accounted for a small proportion of referrals (between 0.3% and 0.5%). In 5.4% of referrals ethnicity was not known or not stated
- 257 people had more than one referral in the year.

The referral reason is not captured within the data set and therefore it is not possible to explore reasons why people are referred to 5 Boroughs Partnership.

All referrals received by 5 Boroughs Partnership are screened before being allocated to the appropriate team or discharged elsewhere. In 2014/15 discharge to GP/Primary Care and discharge to IAPT accounted for nearly half of all referrals received (46%, 1269), and have increased since the previous year. A Primary Care Pathway Review, undertaken by Warrington Clinical Commissioning Group (Warrington CCG, n.d), found evidence of people being referred inappropriately to secondary care in Warrington for low level mental health problems which could have been dealt with in a primary care setting or promotion and prevention provision. In 2014/15, 503 referrals received by 5 Boroughs Partnership were discharged to the IAPT service, an increase of 37% since the previous year (367). These are referrals which potentially could have been directed to IAPT initially, instead of 5 Boroughs Partnership. Further interrogation of the data shows that those referrals which 5 Boroughs Partnership discharged to IAPT, were primarily referred by GPs for both years (55% of referrals were from GPs), followed by self-referral (15%). This would suggest that better signposting, aimed at both GPs and individuals, would benefit service users in order to direct them to the most appropriate services initially.

Nearly two thirds of referrals (61.6%) over 2 years summed together (2013/14 and 2014/15) to the Assessment Team, Home Treatment Service, and Recovery Service teams come from those wards in the most deprived areas of Warrington. Chart 6 shows numbers of referrals by ward, and chart 7 shows rate per 1000 persons 18+ by ward. In both charts the same 7 wards have the highest numbers and highest rates of referrals. Warrington overall has a rate of 15.8 per 1000 persons, and all the top 7 wards have rates higher than this. Bewsey and Whitecross, in particular, stands out, ranking worst out of all wards for both numbers and rates.

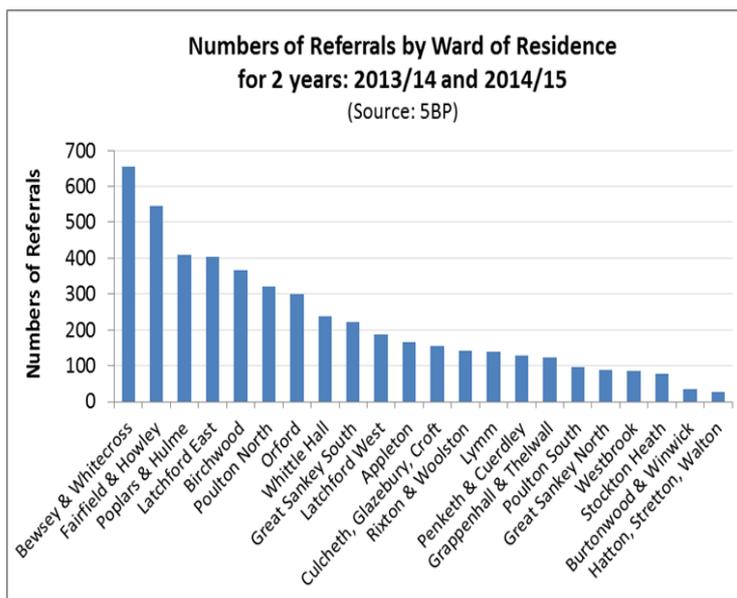


Chart 6: Number of Referrals

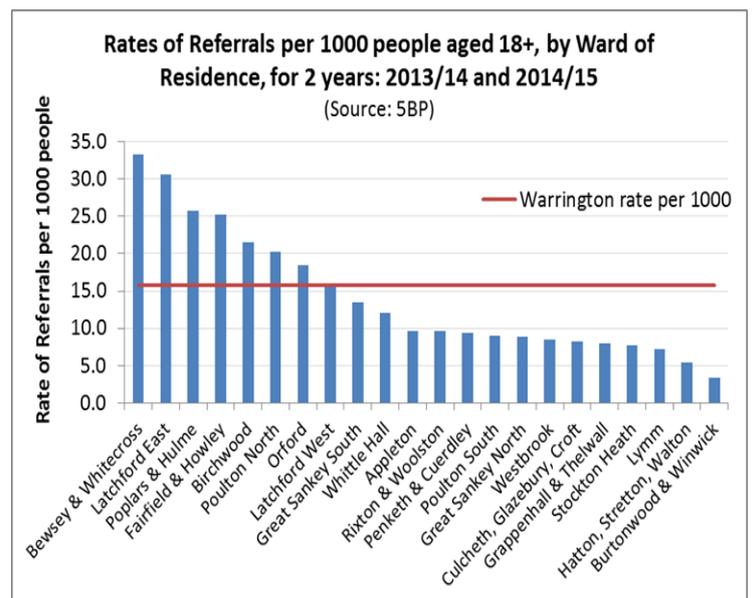


Chart 7: Rate of Referrals

3.8.3. Liaison Psychiatry refers to a team of mental health practitioners based within the general acute hospital, Warrington General. The team provide psychiatric treatment to patients who require it when they attend Accident and Emergency or as an admitted patient. For patients diagnosed 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. Assessment and management of care would be carried out by the team.

A mental health team providing a service to A&E and inclusive of Ward Liaison Psychiatry, based at the general hospital, integrated with physical health care can:

- Improve patient flow and the appropriate utilisation of resources
- Improve patient safety
- Increase the quality of care
- Improve staff safety.

The provision of liaison psychiatry services forms part of the Five Year Forward View for Mental Health (Mental Health Taskforce, 2016) which stipulates that by 2020/21 all acute hospitals will have all-age mental health liaison teams in place. It is expected that, by 2020/21, 50% of national services will meet the 'Core 24' service standard as a minimum. 'Core 24' services meet specific staffing criteria but the main benefits for people accessing services include:

- Service provision beyond office hours and for some periods at weekends. Outside of these hours, rapid access to consultant support provided by on-call services using provision already in place
- The support and training of mainstream hospital staff
- Co-ordination with out-of-hospital care providers and housing services through integration within broader health and social care system.

Within Warrington the liaison team was established as a pilot project in 2015. As part of the development of the service, utilisation is monitored to ensure future delivery meets the needs of the local population.

3.8.4. Early Intervention in Psychosis: Psychosis is characterised by hallucinations, delusions and a disturbed relationship with reality, and can cause considerable distress and disability for the person and their family or carers. People who experience psychosis can and do recover. The time from onset of psychosis to the provision of evidence-based treatment has a significant influence on long-term outcomes. The sooner treatment is started the better the outcome for the patient and the lower the overall cost of care.

As part of the drive for parity of esteem of mental health conditions and service delivery, national waiting time standards were introduced in April 2016 that stipulate that 50% of people experiencing first episode psychosis will be treated with a NICE-approved care package within two weeks of referral. The standard also extended the eligibility criteria for entry into first episode psychosis treatment to service users aged 14 – 65 years.

The continued development and investment in early intervention services is outlined in the Five Year Forward View (Mental Health Taskforce, 2016) which sets the goal that by 2020/21 at least 60% of people with first episode psychosis start their treatment within two weeks of referral.

3.8.5. Operation Emblem – Street Triage: Section 136 of the Mental Health Act is used by the Police to take people to a place of safety if they consider the person to be mentally ill and in need of care and they are in a public place. In recent years Section 136 was increasingly being used in Cheshire (Johnson et al., 2015). Operation Emblem is a service jointly provided by Cheshire Constabulary and 5 Boroughs Partnership NHS Foundation Trust. It is commissioned jointly by Warrington CCG and Halton CCG. The aim of the service is to enable police and health care professionals to work together when dealing with members of the public who may be presenting as a danger to themselves or to other people. The overarching aim of the operation is to reduce the need to place people on a Section 136 of the Mental Health Act. Operation Emblem was introduced at the end of 2013.

Table 3 shows that there has been a 37% reduction in the number of referrals relating to Section 136 of the Mental Health Act, from 125 in 2013 to 79 in 2014. There was little change in 2015 (78 referrals). Reductions suggest that the introduction of Operation Emblem has contributed towards the downwards trend in referrals.

Table 3: Numbers of Referrals for Section 136 – Warrington

	2012	2013	2014	2015
Section 136 (referrals received)	110	125	79	78

Source: Warrington Borough Council

Acute Pathway Services – Actions for Partners:

- Continue to develop the Psychiatric Liaison Service to primarily meet the needs of the local population and move towards a service that meets the requirements outlined in the Five Year Forward View for Mental Health i.e. 24/7 service delivery, and to access time standards where appropriate.
- Develop the use of NICE-approved care packages within the Early Intervention services by working with provider teams and quality improvement organisations.
- GPs in Warrington will use protected learning time to develop their understanding of the services within the acute care pathway in order to contribute to appropriate access and referral to services.
- Health commissioners should consider adapting the referral process to allow for the triage of referrals before a face to face assessment is undertaken.

3.9. Inpatient and Specialist Services

3.9.1. Inpatient Facilities: Secure beds (low, medium, and high) are commissioned on Warrington's behalf by the North West Specialist Commissioning Team, for Warrington patients who require a secure inpatient facility.

Locally, it is the aim of partners that only the most unwell people should be admitted into hospital and, where possible, people should be nursed at home with the support of highly specialised community services. Thus, over time, the number of patients admitted overall may be expected to reduce. However, we may expect to see a corresponding increase in the proportion of these patients who are detained in hospital under the Mental Health Act, as these, by definition, are likely to be more unwell and, therefore, be more likely to benefit from a hospital stay.

Data on inpatient admissions into acute mental health beds (table 4) suggests that, over the last financial year, there has been an increase in quarter 4 of 2015/16, due to increases seen in older people and males. Further information to evidence trends would be useful to obtain a fuller picture.

Table 4: Number of Warrington Admissions to Acute Inpatient Facility in 2015/16					
	Q1 (Apr – Jun)	Q2 (Jul – Sep)	Q3 (Oct – Dec)	Q4 (Jan – Mar)	Total
Older persons wards	13	15	12	20	60
Male wards	49	38	49	56	192
Female wards	45	38	45	44	172
Total	107	91	106	120	424

Source: 5BP

3.9.2. Psychiatric Intensive Care Unit (PICU) & Eating Disorders: Cheshire and Wirral Partnership deliver a community eating disorder service, commissioned in line within the recommendations of NICE guidance for Eating Disorders for children aged 8 years through to adults (NICE, 2004). They also provide PICU beds.

Inpatient and Specialist Services - Recommendations for Commissioners:

- GPs and secondary care services will work together and formalise a pathway that allows the smooth transition of patients back to primary care but allows for rapid re-access to secondary care if needed.
- Maximisation of the use of in-patient beds and specialist services will be tackled by a whole system approach. A thorough understanding of service users with complex emotional disorders or with a personality disorder is required.
- 5 Boroughs Partnership will be the lead partner in a review of the whole service model across not only Warrington but St Helens, Knowsley, Halton and Wigan. The review should focus on recovery, ensuring service users are in the right part of the system to meet their needs, whilst maximising community provision and alternatives to hospital admission.
- A review of, and stepping down of, service users from in-patient services, especially patients who are receiving care in out-of-area beds, including developing effective working relationships with housing providers within Warrington.

Appendix 2 of this report highlights national feedback from service users on mental health services, which is then followed by feedback from consultations carried out locally to gather Warrington service user views of local mental health services.

3.10. Additional Services

3.10.1. Warrington Borough Council (WBC) works in partnership with statutory, voluntary, third sector and private organisations to arrange or deliver social care services for adults and informal carers. The role of social care in adult mental health services is to:

- Enable people to access the statutory social care and social work services, information and advice.
- Provide an assessment and care management service for adults and to commission support which meets eligible needs as defined by the Care Act 2014.
- Work in partnership with other organisations to improve mental health and wellbeing and promote recovery and social inclusion.
- Deliver the statutory functions of the Local Authority including Adult Safeguarding and responsibilities under the Mental Health Act 2007 and Mental Capacity Act 2005.

At the time of writing, the following information was correct. Since then, a restructure has taken place in Adult Services in Warrington Borough Council in 2016, no further detail currently available.

Warrington Borough Council provides the following services:

a) The Adult Mental Health Team provides assessment and care management for people with complex mental health needs aged 18 to 65 to maximise their recovery and wellbeing. The Team supports people to achieve and maintain their independence, identify and manage risk and promote social inclusion.

b) The Mental Health Outreach Team is a short term reablement service which aims to help people out of long term mental health service whilst preventing others from needing to access services.

The service has three main functions:

i) Outreach STAR Support

The team provides one-to-one non-medical interventions of between 8 – 10 weeks, to people with common, moderate, severe and persistent mental disorders. The Wellbeing Star is used as an assessment and outcome tool.

In 2014/15 there were 679 referrals, a 13.4% increase since 2013/14 in which there were 599 referrals. Since January 2015 the Mental Health Outreach Team has established closer working links with the Psychiatric Liaison Team, Operation Emblem, and the wards at Hollins Park (part of 5 Boroughs Partnership). A member of staff works one day per week with the Psychiatric Liaison Team and attends Austen and Sheridan wards at Hollins Park on a fortnightly basis.

Two thirds of referrals (66.5%, 452 of the 679 referrals received) were supported by the Mental Health Outreach Team. The remainder of referrals highlighted that a fifth of them led to no action (people declined services, inappropriate referrals, too ill to engage, not ready for hospital discharge, unable to contact).

The Mental Health Outreach Team conducted a piece of work early in 2015 to follow up those people they supported 6 months earlier. After examining the cases of 73 people whose cases were closed between June and August 2014, in the subsequent 6 month period it was found that 52 (71%) of the people had no further referrals to ANY service. The team will continue to conduct follow up records and aim to improve this level to 75% during 2015/16.

ii) Provision of group therapies

Individuals can attend group therapies to learn practical skills to help them manage their symptoms such as anxiety management and positive thoughts. The courses last for 7 weeks and consist of 2 hour weekly modules for 6-8 people. Individuals are able to self-refer. The Outreach Team uses the Warwick, Edinburgh Mental Wellbeing Scale (WEMWBS) to assess progress of individuals.

During 2014/15 the Outreach Team ran 18 groups with 98 people starting the groups and 59 (60%) attending the full 7 week course. All 59 showed an increase in their WEMWBS scores of between 3 and 5%.

The team is currently commissioned to deliver 8 programmes of 4 x 2 hourly sessions for groups of 6-10 prisoners at Risley Prison. All of the prisoners are also clients of CGL (providers of substance misuse treatment services). The team has currently completed 2 of the 8 programmes and will have completed the other 6 by the end of February 2016.

iii) Provision of creative remedies

A range of arts and wellbeing groups provide individuals with the opportunity to develop new skills, confidence and social contacts. Eleven groups are run each week, attended by approximately 80-90 people. Many people who attend are no longer in service. During 2014/15, 408 individuals accessed the range of groups on offer.

In addition the team is commissioned to run a further 6 groups at the recovery hub for clients of Change Grow Live (CGL). The recovery hub is funded by the Warrington Borough Council Public Health Drugs & Alcohol Action Team

The team also provides support to the Complex Families Programme, which helps families identified as part of the government's "Troubled Families Programme", where the lead member of the family has mental health needs.

Additionally the team runs a programme called Support for Change which offers offenders with mental health needs a mandatory support package aimed at addressing issues which influence their offending behaviour as an alternative to custody.

c) The Criminal Justice Liaison Team offers a range of services to partner agencies within the criminal justice arena.

- New Directions receive referrals directly from the Cheshire Police Public Protection Unit for adults who are considered to have some level of vulnerability.
- The Team undertakes social care assessments for prisoners in Risley and Thorn Cross prisons.
- Support for Change is a project that offers an alternative to custody, and is delivered in partnership with colleagues from the probation service and the courts.

d) Mental Health Act Responsibilities: The Council has specific statutory responsibilities which include the Mental Health Act 1983 (with subsequent amendments), which provides for forced detention in hospital for people who are suffering from a mental illness or disorder which results in dangerous and problematic behaviours and who potentially pose a risk to themselves or other people.

Approved Mental Health Professionals (AMHP) assess people under the Mental Health Act. Their role is to protect people's rights and they consider the least restrictive alternative of ensuring the

person in mental health crisis receives the care, including medical care, they need. Detention in hospital is subject to a section of the Mental Health Act, and it is arranged by the Approved Mental Health Professional where necessary, in coordination with doctors and ambulance services.

The Mental Health Act has several sections, which cover different reasons/rules of detaining a person. Table 5 shows a breakdown of some of the different types of sections under which people have been detained, in Warrington, over a 3 year period.

Increases have been seen in detentions under Section 2 (detained in hospital for assessment) and Section 3 (detained in hospital for treatment) over the 3 years shown. Section 2 detentions have increased by about 50% from 2012/13 to 2014/15. Section 3 detentions have more than doubled between 2012/13 and 2014/15.

Over the same period, nationally there was a 23% increase in detentions under Section 2, and a 1% reduction for Section 3 (HSCIC, 2015d).

Table 5: Detentions under the Mental Health Act in Warrington

Outcome	Apr 12 – Mar 13	Apr 13 – Mar 14	Apr 14 – Mar 15
Section 2	91	119	137
Section 3	47	66	95
Section 4	<5	0	<5
Section 7	<10	6	<5
Informal Admission *	39	49	48
Advice/Alternative Plan	142	132	99
Community Treatment Orders – new, reviewed, revoked **	24	19	29
Abandoned ***	64	55	69
TOTAL	419	446	482

Source: Warrington Borough Council, AMHP Statistics

*Informal admission refers to people who are admitted following assessment but not requiring detention under the Mental Health Act

**Community Treatment Orders are when people are put under supervised community treatment when discharged from certain sections of the Mental Health Act and must meet certain conditions to stay in the community

***Abandoned could be incorrect referral (request for Mental Health Assessment, not Mental Health Act assessment, person absconded before assessment took place, transfer to another AMHP due to difficulties in completing assessment (e.g. bed availability) or alternative arrangements (use of Home Treatment Team etc.), before Mental Health Act Assessment was co-ordinated and occasionally form generated in error).

These increases in Warrington will almost certainly be impacted upon by the Cheshire West judgement (The Supreme Court Judgement on Deprivation of Liberty: P v Cheshire West and P & Q v Surrey County Council¹⁶) resulting in more detentions rather than relying on incapacitated compliant people (usually older people with cognitive impairment).

3.10.2. Offender Health: Evidence shows that, nationally, prisoners are more likely to have mental illnesses than the general population, and estimates indicate that over 70% suffer from two or more mental disorders, including substance misuse (Cairns, 2014). Cairns et al. (2014) conducted a health needs assessment at HMP Risley and HMP Thorn Cross in Warrington and found that the main presentations, in both prisons, were anxiety and depressive disorders. Reporting of schizophrenia, post-traumatic stress disorder and psychotic disorders were also relatively common at HMP Risley; in HMP Thorn Cross numbers were too low to provide further detail.

Lloyd (2013) carried out a health needs assessment of offenders in the community in Cheshire. The author reported that there is very little research relating to the health of offenders in the community. The relatively poor health of prisoners often gets worse on release and offenders can have difficulty in accessing health services. Furthermore, national research shows that less than 1% of ex-offenders living in the community are referred for mental health treatment. Lloyd (2013) highlighted in his health needs assessment, that of the 33 offenders interviewed, 11 cited mental

¹⁶ <http://www.scie.org.uk/mca-directory/files/1506-dols-amhp-report.pdf>

health problems as being areas of concern to them that affected their day-to-day lives, with mental health issues ranging from schizophrenia through to anxiety and paranoia.

From April 2015 a prison wellbeing mentor, part of the Wellbeing Service referred to earlier, began at Warrington's HMP Risley and HMP Thorn Cross, providing one to one support to offenders at both sites. The aim is for the mentor to help offenders make changes they want in their lifestyles to improve their health and wellbeing by offering practical advice and signposting them to services. Improving mental wellbeing is also a key element of this service. Offenders work towards achieving goals set in a jointly agreed wellbeing plan. Between April 2015 and March 2016, 30 offenders were seen at Thorn Cross and 42 at Risley.

3.10.3. Substance Misuse: Data from the Public Health England profiling tools (PHE, 2016b) shows Warrington has a very high proportion of its residents who, when assessed for drug or alcohol treatment, were receiving treatment from mental health services for reasons other than substance misuse. In 2014/15:

- 52.5% of people in Warrington had concurrent contact with mental health services and services for drug misuse. This is much higher than the North West (20.1%) and England (21.0%)
- 61.4% of people in Warrington had concurrent contact with mental health services and services for alcohol misuse, again much higher than the North West (18.0%) and England (20.0%).

Warrington has also seen an increase, in both indicators, since the previous year.

The measures are indicative of levels of co-existing mental health problems in the drug and alcohol treatment population. However, they should not be regarded as a comprehensive measure of dual diagnosis as they only capture whether a person is receiving mental health treatment at a given point in time.

Warrington has made massive changes to ensure that its residents who present with substance misuse also access mental health services as part of their treatment pathway. This relationship of "dual diagnosis" ensures that people's addiction, alongside their mental health issues, are dealt with "in tandem", rather than dealing with one element and not the other.

In 2013, Warrington Council tendered out its alcohol services and so both drug and alcohol treatment was under the auspice of the same provider. This helped ensure more seamless pathways between substance misuse and a range of mental health provision. Given that those in treatment present with a range of issues on the mental health spectrum, it was deemed critical that people access the correct services. This pathway has certainly assisted Warrington in ensuring that people are discharged from drug treatment free of opiates and non-opiates – the opiate free indicator has been a very successful one for Warrington being the top of the family cluster (comparator local authorities) for each quarter of 2015-2016.

Client demographic data collected by the provider (CGL, formerly CRI) also helps provider and commissioner understand what mental health needs exist and ensures that clients are signposted or referred appropriately.

Additional Services: Recommendations for Commissioners:

- Continued monitoring of service users at 6 months following discharge for Outreach STAR teams.
- Development of outcomes based reporting of services for all teams.

4. Projected Service Use

4.1. Ages 18-64: Projections of the potential future burden of disease are available from the Projecting Adult Needs and Service Information (PANSI) system. The system provides population data by various factors, and prevalence rates from research have been used to estimate the impact of various conditions.

Table 6 presents numbers of Warrington residents aged 18-64 predicted to have a mental health problem, projected to 2030. The projected numbers in the adult population obtained from the tool do not suggest a considerable increase. Between 2014 and 2030 projected increases for each of the mental health conditions shown range from 2.3% increase to 2.9%. This is lower than England's projected increases which range from 3.1% to 4.4% for the same time period.

It should be noted, however, that these figures are calculated using national prevalence rates from the 2007 Adult Psychiatric Morbidity Survey, and applied to ONS population projections to give estimates. They do not take account of any potential changes in underlying prevalence rates, ie the projected increases are due purely to an increasing population and not due to any increase in prevalence.

However, the impact of the recession, whilst not robustly quantifiable, is likely to lead to an increase in prevalence of mental health problems, with rises in known associated risk factors such as unemployment and financial worries. The JSNA chapter on Unemployment and Worklessness provides further information.

Table 6: Projected Numbers of People with Mental Health Disorders in Warrington

Mental Health Condition	2014	2015	2020	2025	2030	Increase from 2014 to 2030	
						No.	%
People aged 18-64 predicted to have a common mental disorder	20,297	20,374	20,733	20,855	20,763	466	2.3%
People aged 18-64 predicted to have a borderline personality disorder	567	569	579	582	580	13	2.3%
People aged 18-64 predicted to have an antisocial personality disorder	443	445	454	457	456	13	2.9%
People aged 18-64 predicted to have psychotic disorder	504	506	515	518	516	12	2.4%
People aged 18-64 predicted to have two or more psychiatric disorders	9,085	9,120	9,285	9,342	9,305	220	2.4%

Source: PANSI: <http://www.pansi.org.uk>

4.2. Ages 65 and over: For people aged 65 and above, projections of older people with depression can be obtained from the Projecting Older People Population Information System (POPPI).

In Warrington, older people with depression are expected to increase from 3,098 in 2014 to 4,440 by 2030, a 43% increase. This compares to a 39% increase projected for England. Warrington's projections are also expected to increase at a slightly faster rate than England. Again, this large increase is due to the increasing population aged 65+, rather than any increase in underlying prevalence of depression.

4.3. Suicide: It is difficult to provide projected numbers for suicide as the PANSI system uses suicide data from 2006 to 2008 to project forward. This, therefore, does not take into account the recent increases in suicides in Warrington over the last three time periods, 2010-12, 2011-13 and 2012-14.

5. Community Mental Health Profiles

Public Health England produces Mental Health Profiles¹⁷ that looks at local level data and allows for benchmarking with England and regional positions. The following was extracted in July 2016.

Indicator	Period	Warrington		Sub-regionEngland		England		
		Count	Value	Value	Value	Lowest	Range	Highest
Depression: Recorded prevalence (aged 18+)	2014/15	13,953	8.3%	-	7.3%	3.6%		13.3%
Depression: QOF incidence (18+)	2014/15	2,687	1.6%	1.4%	1.2%	0.6%		2.3%
Depression and anxiety prevalence (GP survey)	2014/15	367	11.7%	15.1%	12.4%	8.0%		20.0%
Mental health problem: QOF prevalence (all ages)	2014/15	1,798	0.84%	0.99%	0.88%	0.51%		1.51%
% reporting a long-term mental health problem	2014/15	122	4.4%	-	5.1%	2.8%		8.3%
Indicator	Period	Warrington		Sub-regionEngland		England		
		Count	Value	Value	Value	Lowest	Range	Highest
Patients with a diagnosis recorded	2015/16 Q2	360	8.1%	12.5%	15.9%	0.4%		66.8%
Patients assigned to a mental health cluster	2015/16 Q2	1,960	40.8%	57.5%	58.9%	0.8%		84.4%
Patients with a comprehensive care plan	2012/13	1,298	89.7%	-	87.3%	79.9%		95.0%
Patients with severity of depression assessed	2012/13	1,873	95.2%	87.4%	90.6%	77.4%		97.8%
Antidepressant prescribing (ADQs/STAR-PU)	2014/15	7,150,681	1.5	1.6	1.3	0.5		1.9
People with a mental illness in residential or nursing care per 100,000 population	2012/13	60	47.8	46.8	32.7	0.0		124.3
Service users in hospital: % mental health service users who were inpatients in a psychiatric hospital	2015/16 Q2	155	3.5%	1.5%	2.6%	0.9%		43.4%
Detentions under the Mental Health Act per 100,000 population	2014/15 Q2	30	18.7	19.2	17.7	1.6		78.8
Attendances at A&E for a psychiatric disorder per 100,000 population	2012/13	48	23.6	383.8	243.5	3.0		925.5
Number of bed days per 100,000 population.	2013/14 Q1	6,366	3,990	4,125	4,686	685		11,073
People in contact with mental health services per 100,000 population	2015/16 Q2	4,445	2,744	3,663	2,134	47		6,259
Carers of mental health clients receiving of assessments	2012/13	225	141.0	73.0	68.5	0.0		343.4
Indicator	Period	Warrington		Sub-regionEngland		England		
		Count	Value	Value	Value	Lowest	Range	Highest
People on Care Programme Approach per 100,000 population	2013/14 Q1	880	554	591	531	17		1,895
% CPA adults in settled accommodation	2015/16 Q2	345	59.5%	64.2%	59.0%	2.1%		92.6%
% CPA adults in employment	2015/16 Q2	35	6.0%	5.3%	6.7%	0.3%		22.0%
Emergency admissions for self harm per 100,000 population	2012/13	638	306.5	-	191.0	49.8		595.6
4.10 - Suicide rate	2010 - 12	-	-	-	8.5	-	<i>Insufficient number of values for a spine chart</i>	-
Hospital admissions for unintentional and deliberate injuries, ages 0-24 per 10,000 population	2012/13	1,056	173.9	140.6	116.0	68.6		201.7
Rate of recovery for IAPT treatment	2012/13	550	42.7%	39.6%	45.9%	22.6%		80.3%



¹⁷ <http://fingertips.phe.org.uk/profile-group/mental-health/profile/cmhp>

6. Unmet Needs and Service Gaps

Evidence highlights the links between poor physical health and poor mental health. Those suffering from severe mental health issues are more likely to have a shorter life span than those without. Equally those people who have long term conditions are more susceptible to poor mental health. In terms of services, ensuring that there is enough promotion and prevention provision in Warrington, and that it's used as part of the pathway can help to address low mental wellbeing at an early stage, and enable people to self-manage. Additional focus may need to be placed on the more socio-economically deprived areas of Warrington as analysis shows a strong association between low mental wellbeing and deprivation.

At primary care level, statistical modelling suggests there may be under-diagnosis of depression, as the prevalence models suggest higher estimates than the number of people actually recorded on GP systems with a diagnosis of depression (as reported in QOF data). Analysis shows reductions in numbers of referrals at IAPT, and people accessing higher threshold services than they may require.

There are reported increases in people experiencing acute episodes of crisis requiring some type of intervention but not necessarily needing hospital admission. Currently in Warrington there is no alternative to hospital admission.

A Liaison Psychiatry Service was piloted in Warrington. The service continues to be developed. This will achieve one of the goals within the 'Five Year Forward View for Mental Health' (Mental Health Taskforce, 2016) – for a liaison psychiatry service to be in place by 2020/21.

Trend data on inpatient admissions into acute mental health beds is limited and insufficient to base firm conclusions on. However, early intervention before people's mental health deteriorates to the point of inpatient admission is always preferable. The required funding is tied up in inpatient admissions, and work has begun on mitigating the costs, with the repatriation of out of area patients, which is a more expensive option. But this is likely to be a long term goal, and will not address immediate shortfalls.

Data collected (or readily available) by services, whilst providing an indication of service activity, does not always allow for the outcomes of services or interventions to be fully assessed as to whether they're meeting the populations needs.

There is also a need for all partner organisations to contribute fully towards the production of the JSNA to ensure all relevant information is captured to enable a complete assessment to be undertaken.

7. Recommendations for Needs Assessment Work

- Examine the 2014 Adult Psychiatric Morbidity Survey (McManus et al., 2016), published by the Health & Social Care Information Centre in September 2016, to understand how prevalence of psychiatric disorders in the adult population has changed since the last survey in 2007. Use national prevalence rates within the report to apply to local population figures to estimate Warrington prevalence for different types of mental health disorders.
- Better profiling of service users into secondary mental health services, to include referral reason/diagnosis (this field not currently available in provider's data), and further analysis of geographical data as a large proportion of services users of secondary services come from the more deprived areas of Warrington.

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Key commissioning groups for mental health include: Mental Health Partnership Board (covers all ages), Emotional Mental Health and Wellbeing Group (CAMHS), Health and Wellbeing Board, Children's Partnership Board, Crisis Concordat Group, and Primary Care and Secondary Care Interface Group

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Appendix 1: Evidence of what works

National Strategies and Reports:

In England various key national strategies and reports to improve the mental wellbeing of the population have been published in recent years.

The Five Year Forward View for Mental Health (Mental Health Taskforce, 2016) was recently published, making a set of recommendations to tackle parity of esteem, ensuring access to good quality mental health care, and reducing the gap in inequalities.

Bringing together physical and mental health (The King's Fund, 2016) highlighted four major challenges in achieving this, and identified 10 areas where there is particular scope for improvement. It is hoped that commissioners and providers can use these areas as a guide to identify where some of the most significant opportunities for quality improvement and cost control lie.

The Mental Health Foundation has published a strategy, **A New Way Forward** (2015), highlighting the case for a fresh emphasis on the prevention of mental health issues. The Foundation identifies patterns of mental health problems and their causes.

Guidance for commissioners of financially, environmentally, and socially sustainable mental health services, published by the Joint Commissioning Panel for Mental Health (2015), supports commissioners, local health authorities and providers in building sustainable services that support secondary and tertiary prevention.

The Mental Health Crisis Care Concordat (DoH, 2014a) is a national agreement which has been signed by more than 20 national organisations, including police, mental health trusts and paramedics, in a bid to drive up standards of care for people experiencing crisis such as suicidal thoughts or significant anxiety. The Concordat covers four main areas:

- Access to support before crisis point – ensuring people with mental health problems can get help 24 hours a day
- Urgent and emergency access to crisis care – ensuring that a mental health crisis is treated with the same urgency as a physical health emergency

- Quality of treatment and care when in crisis – ensuring people are treated with dignity and respect in a therapeutic environment
- Recovery and staying well – ensuring people are referred to appropriate services in order to prevent future crises.

Closing the Gap: Priorities for Essential Change in Mental Health (DoH, 2014b) sets out a series of priorities for the commissioning of mental health care for both children and adults, and builds on the Mental Health Strategy “No Health without Mental Health

The report, **Whole-Person Care: From Rhetoric to Reality** (Royal College of Psychiatrists, 2013), highlights the significant inequalities that exist between physical and mental health care. Key recommendations are included for how parity for mental health might be achieved in practice and includes commitments to actions that will be taken to help achieve parity of esteem.

In 2012 **Preventing Suicide in England: A cross-government outcomes strategy to save lives** (HM Government and Dept. of Health, 2012) was published. The overall objectives of the strategy are to:

- Reduce the suicide rate in the general population
- Provide better support for those bereaved or affected by suicide
- Reduce the risk of suicide in high risk groups.

The Implementation Framework (Centre for Mental Health et al., 2012) was published, following the release of the Coalition Government's Mental Health Strategy: **No Health without Mental Health** (HM Government, 2011). The Implementation Framework sets out how progress of the Strategy will be monitored, and includes a number of recommendations for local and regional organisations to take forward.

Research and Evidence:

Behavioural risk factors are known to have negative effects on health outcomes and be strongly associated with mental illness. A systematic review and meta-analysis by Taylor et al. (2014) investigated changes in mental health after smoking cessation compared with continuing to smoke. The authors examined 26 randomised controlled trials and cohort studies, and found that those who stopped smoking experienced reduced

depression, anxiety and stress and improved positive mood and quality of life compared to those people who continued to smoke.

The authors concluded that, whether or not smoking cessation directly causes the observed improvement in mental health, there are direct clinical implications. Regular smokers often feel smoking helps to alleviate emotional problems and reduce stress and anxiety. This pattern of thought applies to both smokers with or without diagnosed mental disorders, and therefore smokers may be more disinclined to stop smoking if they think their mental health is likely to suffer. However this study shows that smokers can be reassured that stopping smoking is associated with mental health benefits, and could also overcome barriers that health professionals have towards intervening with smokers with mental health problems.

Another study sought to examine behavioural correlates of high and low mental well-being in the Health Survey for England (Stranges et al, 2014). Participants, aged 16 and older, with valid responses for the combined 2010 and 2011 Health Survey for England were used. The Health Survey for England collected data on mental wellbeing using the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS), as well as information on body weight, smoking, alcohol consumption, and fruit and vegetable intake. The study indicated that individuals with low mental wellbeing were more likely to be obese, current smokers, never-drinkers or ex-drinkers and to report lower intakes of fruit and vegetables than those with 'middle' or high mental wellbeing. Individuals with high mental wellbeing were more likely to be never smokers and to report higher intakes of fruit and vegetables than those in the low or middle category. They were also more likely to be overweight but not more likely to be ideal body weight.

Stress, depression or anxiety account for the majority of days lost due to work-related ill health, according to the Labour Force Survey (HSE, 2015). Evidence suggests that many mental health issues may be prevented, and workplaces could be an ideal site for prevention programmes (Tan et al, 2014). The authors undertook a study to test the feasibility of workplace interventions aimed at universal prevention of depression within an entire workforce population. They identified nine workplace-based randomised controlled trials, the majority of which used cognitive behavioural therapy (CBT) techniques. The study concluded that universally delivered workplace mental health interventions can reduce the level of depression

among workers, with a range of different depression prevention programmes producing small but overall positive effects in the workplace. CBT-based interventions, in particular, significantly reduced levels of depressive symptoms among workers.

Twomey et al. (2015) carried out a systematic review to examine variables that predict health service utilisation (HSU) by adults with mental disorders in the UK, and to establish the evidence level for these predictors. The NHS, in recent years, has been looking into developing an activity-based payment system for its mental health services, and typically for these type of systems, patient 'clusters' are used to allocate resources. This review could help to inform decisions about which variables might be used to develop mental health clusters. Most studies included in the review were set in health services across primary, secondary, specialist and inpatient care. Some studies used data from household and postal surveys. Participants had a range of mental disorders including psychotic disorders, personality disorders, depression, anxiety disorders, eating disorders and dementia. HSU outcomes examined included GP contacts, medication use, psychiatrist contacts, psychotherapy attendances, inpatient days, accident and emergency admissions and 'total HSU'.

Results of the review found that 28 studies, after taking into account study quality, identified a range of variables with good preliminary evidence supporting their ability to predict HSU. Of these variables, comorbidity, personality disorder, age (heterogeneous age ranges), neurotic symptoms, female gender, a marital status of divorced, separated or widowed, non-white ethnicity, high previous HSU and activities of daily living, were associated with increased HSU. Moreover, good preliminary evidence was found for associations of accessing a primary care psychological treatment service and medication use with decreased HSU.

The National Institute for Health Research (NIHR, 2016) has issued a Highlight that brings together four studies, funded by the NIHR, which examine the use of cognitive therapies to treat depression. The Highlight is not a systematic review, but instead focuses on a small group of new studies. All the studies discussed within the Highlight are randomised controlled trials, with between 400 and 700 participants, and are considered good quality evidence.

The studies within this Highlight examined cognitive behavioural therapy (CBT) and mindfulness based cognitive therapy (MBCT). It was found that MBCT may be useful as an alternative therapy for people with recurrent depression, particularly for those who struggle to keep to anti-depressant medication. Face to face CBT was shown to be effective, alongside anti-depressant medication, for people who did not respond to medication alone. Two types of computerised CBT, delivered in primary care, did not appear to be more effective than usual care alone in reducing depression. Each study provides evidence on a specific aspect of depression care that was previously missing or weak, and they either support guidance published by the National Institute for Health and Care Excellence (NICE) or provide additional information.

Natural England commissioned a review on nature-based interventions where improving an individual's mental health was a primary goal of the service (Bragg and Atkins, 2016). There is an increasing recognition of the importance of nature and how it impacts positively on a person's mental health. A number of nature-based interventions, operating throughout the UK, work with people experiencing mental health issues. Some interventions are commissioned by local CCGs (Clinical Commissioning Group), but the vast majority are funded via grants and community fundraising. The authors highlight that 56% of CCG commissioners and GPs are interested in learning more about these nature-based interventions (research carried out by MIND in 2013). However increasing awareness and access to green care interventions raise some challenges due to the number of organisations delivering nature-based projects, the variety of terms and language used to describe their activity and benefits, and the differences in delivery models and in the measurements of impact.

The review explored these issues in more depth, and examined the benefits, commonality and outcomes of the three largest and most commonly occurring forms of green care – social and therapeutic horticulture, environmental conservation interventions, and care farming. The study also examined the scale of the three types of green care interventions in the UK and the current commissioning routes for green care. A number of recommendations were made in the study to take things forward.

Findings revealed that the mental health benefits for all three types of green care interventions were

similar and include, but are not limited to, psychological restoration and increased general mental wellbeing; reduction in depression, anxiety and stress related symptoms; improved self-esteem, confidence and mood; and improved happiness, satisfaction and quality of life. The evidence base for the three types of green care is mixed, with social and therapeutic horticulture having the largest and most established evidence base (quantitative and qualitative studies, quasi-experimental and several Randomised Controlled Trials).

NICE Guidance:

The National Institute for Health and Care Excellence (NICE) has published a number of guidelines, quality standards and pathways applicable to mental health. The following lists the most recent publications since 2012.

- [Older people: independence and mental wellbeing](#) NICE guideline NG32 (December 2015)
- [Promoting mental wellbeing at work overview](#) NICE Pathway (June 2015)
- [Antenatal and postnatal mental health overview](#) NICE Pathway (June 2015)
- [Violence and aggression: short-term management in mental health, health and community settings](#) NICE guideline NG10 (May 2015)
- [Service user experience in adult mental health services overview](#) NICE Pathway (April 2015)
- [Mental wellbeing and older people overview](#) NICE Pathway (March 2015)
- [Antenatal and postnatal mental health: clinical management and service guidance](#) NICE guideline CG192 (December 2014)
- [Mental wellbeing of older people in care homes](#) NICE quality standard QS50 (December 2013)

Additional publications are available from NICE addressing specific types of mental health issues, including:

- [Learning disabilities: challenging behaviour](#) NICE quality standard QS101 (October 2015)

- [Depression overview](#) NICE Pathway (August 2015)
- [Transcranial direct current stimulation \(TDCS\) for depression](#) NICE interventional procedure guidance IPG530 (August 2015)
- [Social anxiety disorder overview](#) NICE Pathway (April 2015)
- [Common mental health disorders in primary care overview](#) NICE Pathway (December 2014).

NICE is producing a [new guidance](#) that will help to support anyone needing to move between hospital and community mental healthcare. August 2016 is the anticipated publication date.

A number of clinical guidelines are also published, pre 2012, for the treatment of specific mental health issues. Please see the earlier version of this chapter (2012) for further details. It can be found by clicking on the following link:
<https://www.warrington.gov.uk/jsna>

Appendix 2: (Target) population/service user views

In a national drive to shape the future of mental health services, the Mental Health Taskforce (2015) engaged with service users, carers, and health and social care professionals to gather views and experiences to help form recommendations on a way forward. Following the consultation, three themes emerged: prevention, access, and quality. Some of the key issues highlighted within the report include:

- *Prevention*: 25% of people listed prevention in their top three priorities, specifically mentioning points like being able to self-manage mental health, and getting help early before problems escalate
- *Access*: 52% said access is one of their top three priorities, and 33% mentioned needing choice of treatment. People commented on needing access to help 24 hours a day, 7 days a week, particularly for crisis or inpatient care
- *Quality*: it was raised that care plans should be agreed between professionals and individuals, and involve carers where necessary; people expressed the view of needing to have more control over their own care and being able to access support that would work best for them as an individual.

A report, by the Care Quality Commission (2015), also consulted with users of mental health services, and highlights that although attitudes to mental health are changing, there is still a long way to go until a person having a mental health crisis receives the same response as someone with a physical health emergency. For people in crisis, the quality of care experienced varied depending on where they lived and what part of the system they came into contact with. Issues raised included poor attitudes of staff towards people in need of support, accessibility and availability of care at all times, and the quality and responsiveness of services to people's needs.

In Warrington, consultations have been carried out to gather people's experiences, often reflecting the same views expressed nationally.

Healthwatch is an independent consumer champion which gathers and represents the views of the public in health and social care. The local Warrington Healthwatch undertook engagement with the Warrington community between April 2014 and August 2015, and spoke to, or were

contacted by, 806 individuals. Of the people they engaged with, 15% fed back general experiences of mental health issues, wellbeing or mental health care, making it the second most popular topic for the community. Participants provided feedback on the following issues (extracted directly from Healthwatch material):

- Problems with lack of 'rapid access' and long waiting times with the Mental Health Assessment Team and Recovery Team
- Loss of key staff, causing a 'revolving door system' for patients, who then struggle to engage with the services they need most
- Lack of information for patients
- Alzheimer's, dementia or neurological support or advice
- Signposting for mental health support eg anxiety, depression, stress, suicide
- Medication access or rights eg antidepressants
- A need for joined up approaches with partners like Warrington Borough Council especially around social care, mental health, and dementia
- A need for a 'family approach' to counselling for some neurological/mental health issues
- The need for support information after discharge, eg signposting into other support services or information on how to re-refer
- Issues arising at Hollins Park (a 5 Boroughs Partnership site) eg poor patient treatment (often due to capacity issues), dignity in care, requests for more consistent monitoring for high risk self-harmers, and family inclusion in discharge planning.

Warrington Clinical Commissioning Group (CCG) undertook a Primary Care Mental Health Review in 2014, part of which involved engaging with service users, carers, third sector organisations and support staff, to obtain their experiences. Key issues regarding the IAPT service (Improving Access to Psychological Therapies) are summarised below. Due to the limited number of respondents, the results should be seen as a 'snapshot' only of the service. The following is extracted directly from the Engagement report of the Primary Care Mental Health Review (Warrington CCG, 2014):

- Consider improving the referral route (GP referral or self-referral) or GP to clarify the route to service users and support service users to self-refer
- Having only three attempts to answer the telephone assessment was a concern

considering the mental illness of the service users

- There seems to be a lack of carer involvement throughout the whole treatment pathway
- Evaluate telephone assessments – may not be appropriate for all service users
- Improve partnership working between Mental Health Matters and 5 Boroughs Partnership Assessment Team
- Improve partnership working between other agencies who are already supporting the service user
- Consider more or other support after the number of allocated sessions
- More identifiable care plans for all service users on discharge including information on third sector support
- Improve support if referred to another service
- Extremely positive experiences were shared of the service.

“follow ups” after treatment would benefit patients

- People commented that carers should be more involved in the care of people they look after.

In 2015, Warrington CCG facilitated a Mental Health Strategy Workshop to bring together commissioners, providers, health professionals, service users and carers, and third sector organisations to discuss what was wanted from the new Warrington Mental Health Strategy (which runs from 2015-2018). In terms of services, some of the key issues raised included:

- Many people in the workshop were unaware of the current services already operational and available, and felt a ‘directory of services’ or similar should be easily accessible
- The waiting times to access services were repeatedly mentioned and were felt to be too long – suggestions in the interim while people were waiting to engage services was a café or something similar where people could get support
- People felt that the current response service is not easily accessible, and the crisis intervention pathway should be reviewed; there is a need for a ‘true’ 24/7 response service
- Clear care plans and improved discharge plans and packages are needed as it was felt that levels of aftercare are non-existent which impacts on people’s recovery
- Service users felt that once they were discharged from services and perceived as being “well”, they were left with no further support, information or clear plans to keep them well, and people often relapsed. It was felt that a “return to service card” or more