Older People: Mental Health and Emotional Wellbeing
The document constitutes chapter 6 of the 2015/16 Older People’s JSNA for Halton. It describes the policy context, estimated prevalence, risk factors and sub-groups of need, current service provision and national best practice in relation to mental health, emotional wellbeing and mental illness amongst people aged 65 and over in Halton.

Please quote the JSNA

We would like to know when and how the JSNA is being used. One way, is to ask people who use the JSNA when developing strategies, service reviews and other work to quote the JSNA as their source of information.
List of Abbreviations

5BP  5 Boroughs Partnership (Mental Health Foundation Trust)
BME  Black & Minority Ethnic
BMI  Body Mass Index
CAMHS  Child & Adolescent Mental Health Service
CAMI  Community Attitudes toward the Mentally Ill
CAT  Cognitive Analytic Therapy
CCG  Clinical Commissioning Group
CBT  Cognitive Behavioural Therapy
CMD  Common Mental health Disorder
ePACT  Electronic, prescribing, analysis and cost
FFT  Friends and Family Test
GP  General Practitioner
HSCIC  Health and Social Care Information Centre
HSE  Health Survey for England
IAPT  Improving Access to Psychological Therapies
JSNA  Joint Strategic Needs Assessment
MV IAPT  Military Veterans Improving Access to Psychological Therapies
NHS  National Health Service
NICE  National Institute for Health and Clinical Excellence
ONS  Office for National Statistics
PHO  Public Health England
PICU  Psychiatric Intensive Care Unit
POPPI  Projecting Older People Information system
QIPP  Quality, Innovation, Productivity and Prevention
WE  Wellbeing Enterprises
WHHFT  Warrington & Halton Hospitals Foundation Trust
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Key priorities for consideration by commissioners

1. Local demographics
In Halton there are a higher proportion of females accessing secondary care mental health services to males and only a very small number of ethnic minority individuals, compared to white British. More work needs to be done to understand why this is and what can be done to change it. It may link to pride in males seeking help and for ethnic groups, religion and culture plays a strong part in not speaking out about mental health.

2. Increasing Older Population
Due to an increasing population nationally, there is forecast to be an increase in the number of older people with depression, within a few years. However, the resources available for health services given the current financial restraints, will at best remain the same, requiring the development of new service models to meet the need using a holistic approach.

3. Risk factors of depression
Older people’s mental health needs are complex. They cause substantial impact on wellbeing and the ability to lead a normal life. They have wider impacts on the family and other carers. Mental health needs interact in complex ways with long-term physical health problems. People with severe mental illness have a substantially reduced life expectancy due to both mental and physical ill health. There is often inequality of access to health services for physical illness for people who use mental health services. Physical health and mental health are inseparable and demand a holistic approach to the care of all patients with mental health problems. In light of this and the recognition of the parity of esteem agenda, there will be an opportunity later in the year for commissioners to bid for recurrent funding to incorporate Long Term Conditions (LTC) Services into the Improving Access to Psychological Therapies (IAPT) Service for low to moderate mental health problems.

4. Acute Bed Base
Halton do not currently commission secondary and acute care mental health services specifically for older people, as they provide the same support for older people as they do adults. It has been identified as part of the 5 Boroughs Partnership (5BP) Footprint Review (see key area number 5 below) that there is a significant cohort of older people whose specific clinical needs would be better met within a dedicated facility and by staff who are trained and experienced in managing their needs. Local MH providers and commissioners have been asked to ensure that the needs of each individual will be better met by adopting a more appropriate clinical bed model.

5. 5BP Independent Review
The mental health services provided across Halton are complex and varied. There are many areas of positive work being undertaken in each of the services which should be commended, particularly at a time when resources are stretched and also under threat of being reduced. There are also a number of areas for improvement both in relation to individual services and also the wider system they operate within, many have been identified within the independent review of the adult and older adult acute care pathways within the 5 Boroughs Mental Health Trust undertaken in 2015.
The following **five key areas** for future development were identified within the 5BP footprint review:

1. The interface between primary and secondary care - The way in which people are supported in primary care and also move between primary and secondary care
2. How people with a personality disorder or highly distressed emotional disorders are supported by the whole system
3. The whole service model across the Borough (including 5 Boroughs Partnership NHS Foundation Trust services and all others)
4. Step down from in-patient services and the use of out of areas placements in the private sector
5. The proposed future bed model

All of the five key areas mentioned above are inter-dependent and will all be implemented as part of a whole system approach to delivering the best quality, most efficient and value for money services that are possible within the resources available across the footprint.

Finally, the older people who use these services and families and carers require their voice to be heard within the on-going changes that will occur. How this is achieved needs to be agreed, but their voice is of great importance, whether through “user” / “carer” representatives or professional organisations acting on their behalf.
1. Introduction

This chapter of the 2015 Halton Older People’s JSNA looks at the mental wellbeing and mental ill health needs of people over the age of 65 years. It is important to be clear about the differences between mental wellbeing (or general mental health), and mental illness. In this document we refer to both using the definitions below:

**Mental wellbeing (or mental health):** There are many different definitions of mental wellbeing but they generally include factors known to promote mental health such as: life satisfaction, optimism, self-esteem, mastery and feeling in control, having a purpose in life, and a sense of belonging and support. Good mental health is not simply the absence of diagnosable mental health problems, although good mental health is likely to help protect against the development of many such problems.

**Mental illness or disorder:** Mental illness or disorder refers to a diagnosable condition that significantly interferes with an individual’s cognitive, emotional or social abilities eg depression, anxiety, and schizophrenia.

Older adults, those aged 60 or above, make important contributions to society as family members, volunteers and as active participants in the workforce. While most have good mental health, many older adults are at risk of developing mental disorders, neurological disorders or substance use problems as well as physical illness or disability.[1]

Over a third of older people in the UK are likely to experience mental health problems. Depression and anxiety are the most common conditions, followed by dementia. Other less common conditions include delirium (acute confusion), schizophrenia, bipolar disorder, alcohol and drug (including prescription drug) misuse. [2]

Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest. It affects how one feels, thinks and behaves. It may make it difficult to carry out normal day-to-day activities and make one feel that life is not worth living.

The chapter does not look at dementia. This is covered in a separate chapter.
2. Policy Context

There have been a range of national policy drivers which support and provide a context for local strategies. The National Service Framework (NSF)\[^3\] published in 1999 by the Department of Health was a ten-year programme designed to set consistent and measurable standards for the delivery of mental health care across England and Wales and the framework within which health and social care services were required to work.

In later years, the previous Government’s mental health policy became more focused on themes which promoted social inclusion and the individual’s engagement with their communities and working life, and which challenged inequality and stigma. At the end of ten years the NSF was replaced by New Horizons: A Shared Vision for Mental Health.\[^4\] This was a cross-government programme of action to improve the mental health and wellbeing of the population. It aimed to:

- Improve the mental health and wellbeing of the population
- Improve the quality and accessibility of services for people with poor mental health

New Horizons described factors that affect wellbeing and some everyday strategies for preserving and boosting it. It also sets out the benefits, including economic benefits, of doing so.

Following the formation of the Coalition Government in May 2010, it became clear that New Horizons was not to be fully implemented and the Government announced that it would introduce a replacement mental health strategy that built upon the strengths of New Horizons but placed a clearer focus on outcomes and greater clarity on delivery. No Health without Mental Health\[^5\] replaced New Horizons as the main policy driver for mental health services in England.

The strategy is supported by a series of documents, including the economic case for improving efficiency and quality in mental health, an outcomes paper, a four-year action plan, to improve access to talking therapies and an impact assessment. The overall aims of the strategy are to improve outcomes for people with mental health problems, to improve the mental health and wellbeing of the population and to keep people well.

The aims and principles are underpinned by six high-level mental health objectives:

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

Each objective is supported by a series of actions. No Health without Mental Health is described as a cross-cutting and cross-Government strategy linked to the NHS, public health and local authority outcomes frameworks. The Government’s cabinet sub-committee on public health will oversee the implementation of the strategy.
Local government will play a central role in ensuring that local partners and partnership arrangements can deliver the shared mental health objectives via the local health and wellbeing boards. The new enhanced role played by local government in delivering public health recognises that mental health is intrinsic to positive health and wellbeing.

No Health without Mental Health: Delivering better mental health outcomes for people of all ages sets out a range of local approaches to improve physical and mental health in older people. They include:

- Reducing isolation, support during times of difficulty, and increasing social networks and opportunities for community engagement[^6][^7]
- Providing easy access to continued learning
- Improving support for informal carers[^8]
- Warm homes initiatives[^9]
- Promotion of physical activity and physical health[^10]

Locally, Halton’s first Joint Health and Wellbeing Strategy, developed by the Health and Wellbeing Board, includes mental health as one of its five priorities. As part of this a new Mental Health Strategy has been developed across the lifecourse. Many of the targets for working age adults are applicable to older people; issues such as reducing alcohol related hospital admissions and GP support access to community based services, some of which include the use of the short-form mental wellbeing tool called SWEMWBS. In addition, specific targets for older people are:

- Reduction in the number of lonely older people
- Reduction in the number of older people with low to moderate mental health conditions in Care Homes and for those that receive domiciliary care
- Review of dementia strategy
- Completion of carers strategy
- Completion of the evaluation of the Later Life and Memory Service pathway
3. Level of need in the population

3.1. Prevalence of risk and protective factors

3.1.1. Deprivation
There is a strong body of evidence that living in poverty brings with it poorer mental health, and that the stresses of living in poverty increases the risk of developing mental health problems. In addition that living with a mental health problem brings with it increased social disadvantage, such as higher levels of unemployment. Across the UK, we experience mental health inequities. These inequities are often experienced by the same people and accumulate over a lifetime, placing older people who experience poverty at increased risk of poor mental health and of developing mental health problems.

As seen in chapter 2 of this JSNA, a substantial proportion of Halton’s older residents live in poverty.

3.1.2. Ethnicity
The relationship between ethnicity and mental ill health is complex. National survey findings estimate there to be little difference in prevalence rates of common mental health problems between minority ethnic groups and the white population. However, specific group differences showed that Irish men and Pakistani women had higher rates, while Bangladeshi women had lower rates.

In relation to severe mental health problems, significant variations were found. Black Caribbean people showed a two-fold excess; Pakistani people had a 60% higher and Bangladeshi people a 25% lower rate, both with no apparent gender difference. Irish people showed similar rates to the rest of the white population.[11]

3.1.3. Housing
The provision of appropriate housing is clearly important for Halton’s growing population of older people with safe and secure housing being important to mental health.[12] Most older people live in the community: nationally only 5% of older people live in supported sheltered schemes; 95% of older people live in the wider community.[13] From a prevention perspective, it is essential to ensure that the majority of older people in their own home are supported or have easy access to support where required, including mental health and wellbeing support. The majority of Halton older people own their own homes. Whilst the number of homes with central heating has risen over the last decade or so, older people remain an ‘at risk’ group for fuel poverty.[14]

Details of older people’s living circumstances can be found in Chapter 2: Demographics, economic, living and social circumstances.

3.1.4. Social connections
In the most fundamental ways, social and emotional functioning changes little with age. At no point in life does the need to feel accepted in larger groups lessen or the negative consequences of social isolation diminish.[15] Having good social networks and an active social life can reduce the risks of depression in later life and staying socially connected appears to protect against dementia.[16] It is very important for older people to maintain a sense of their own self-identity and purpose and the
quality of these social relationships can influence the way the brain processes information.\[^{17}\] Research focusing on older people in local communities has reported their sociability and engagement as central to their conception of wellbeing. Although family – children, siblings, grandchildren, nieces and nephews are a primary source of comfort and support for many older people - it is often evident that friends and neighbours are the mainstay of most people’s day to day lives. Friends and neighbours are the people with whom many older people share experiences, enjoy companionship in social activities and support people through life changes such as illness or bereavement.\[^{18}\] For many older people, contact declines due to reasons such as being in poor physical health, having no access to a car and not using public transport, moving into a care home or becoming a carer. The English Longitudinal Study of Ageing found that participation in social or recreational activities fell with age and women were more affected than men. The research also found that around one in ten people aged 50 and over in England in 2006 were not a member of any political party, environmental or resident group, neighbourhood watch, religious or charitable association. Sixteen per cent had not participated in social or recreational activities and did not have a hobby or pastime.\[^{19}\]

Neighbourhood environments can play a key role in influencing health. Much of the research has centred on material conditions are area-level effects of socioeconomic status. However, perceptions of a neighbourhood’s physical and social characteristics can also impact on health outcomes and can even mediate the impacts of such characteristics, for example, on mental health.\[^{20}\] The Health & Wellbeing of Older People survey carried out by Liverpool John Moores University in 2014/15 included a range of questions about satisfaction with, connections to and involvement in the local community.

In answer the the question “How satisfied are you with the community you live in?” Halton older people had low levels of satisfaction, in fact, they had the second lowest satisfaction score of all local authority residents questioned, with only Liverpool being lower.

Figure 1: Satisfaction with local community
More detailed analysis shows that whilst a higher percentage of Halton residents were satisfied, a lower percentage were very satisfied.

**Figure 2: Satisfaction with local community, detailed results, Halton and survey average**

When asked “Do you feel you have a strong connection to the community you live in?” only 33% of Halton residents said they had strong connections, joint lowest with Liverpool and Warrington, and 66% saying they had no strong connections.

**Figure 3: Proportion of respondents who feel a strong connection to the local community**

Of those that did have strong connections, most did so because of nearby support from friends and neighbors, with having lived in the area a long time being mentioned second most frequently.
Table 1: Reasons given for respondents feeling connected to the community

<table>
<thead>
<tr>
<th>Reason they feel connected to community</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neighbours/nearby friends are supportive/helpful</td>
<td>77</td>
</tr>
<tr>
<td>Lived in community a long time</td>
<td>23</td>
</tr>
<tr>
<td>Involved with church</td>
<td>8</td>
</tr>
<tr>
<td>Community</td>
<td>7</td>
</tr>
<tr>
<td>Specific facilities/activities</td>
<td>5</td>
</tr>
<tr>
<td>Worked in the area</td>
<td>5</td>
</tr>
<tr>
<td>Family nearby</td>
<td>4</td>
</tr>
<tr>
<td>No further information given</td>
<td>2</td>
</tr>
<tr>
<td>Other(^2)</td>
<td>7</td>
</tr>
</tbody>
</table>

Social capital

In general terms, social capital represents social connections and all the benefits they generate. The benefits for people having these social connections can occur either at an individual level (for example, through family support) or at a wider collective level (for example, through volunteering). It is important because of its positive contribution to a range of wellbeing aspects relevant to policy makers and researchers, such as personal wellbeing and health.

The Office for National Statistics have developed a methodology for measuring social capital which was used for the 2012/13 North West Mental Wellbeing Survey.\(^{[2]}\) The five areas are:

- **Social Participation**: variety and breadth of participation in community organisations.
- **Social Networks**: frequency of contact with friends, relatives or neighbours, social support and social satisfaction.
- **Social Cohesion**: length of residence in local area, sense of belonging to neighbourhood and trust.
- **Civic Participation**: perception of local influence and life satisfaction.
- **Local Area Views**: satisfaction with local area and perception of safety in local area.

The overall findings were that over a quarter (27.8%) of respondents were categorised as low, 45.7% as moderate and 26.5% as high. There was a similar distribution for the North West respondents, with 28.4% categorised as low, 47.3% as moderate and 24.3% as high. The mean social capital score was 29.06, similar to the North West mean of 28.95. There was a significant relationship between social capital and deprivation; low social capital most likely in the most deprived quintile (36.9%) with high social capital most likely in the least deprived. High social capital was most likely in over 65’s.

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\(^{[2]}\)The total number of responses should not be summed as some participants discussed more than one issue.

\(^2\)‘Other’ category included unspecified support/visitors.
### Table 2: Levels of social capital, Halton 2012/13

<table>
<thead>
<tr>
<th>Age</th>
<th>Number</th>
<th>Social Capital Category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>16-24</td>
<td>64</td>
<td>50.0%</td>
</tr>
<tr>
<td>25-39</td>
<td>117</td>
<td>31.6%</td>
</tr>
<tr>
<td>40-54</td>
<td>132</td>
<td>21.2%</td>
</tr>
<tr>
<td>55-64</td>
<td>83</td>
<td>33.7%</td>
</tr>
<tr>
<td>65+</td>
<td>91</td>
<td>11.0%</td>
</tr>
</tbody>
</table>

| Gender  | Male   | 229 | 34.5% | 43.2% | 22.3% |
|         | Female | 254 | 21.7% | 48.0% | 30.3% |

<table>
<thead>
<tr>
<th>Index of Multiple Deprivation</th>
<th>Number</th>
<th>Social Capital Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>least deprived</td>
<td>45</td>
<td>11.1%</td>
</tr>
<tr>
<td>4th most deprived</td>
<td>87</td>
<td>19.5%</td>
</tr>
<tr>
<td>3rd most deprived</td>
<td>40</td>
<td>27.5%</td>
</tr>
<tr>
<td>2nd most deprived</td>
<td>80</td>
<td>18.8%</td>
</tr>
<tr>
<td>Most deprived</td>
<td>233</td>
<td>36.9%</td>
</tr>
</tbody>
</table>

Source: McHale, Hughes and Jones, 2013

### 3.1.5. Social isolation and loneliness

In chapter 2 of this JSNA we detailed the concept, risk factors and levels of social isolation and loneliness amongst older people. It is estimated, based on national research[^22] applied to the Halton population aged 65+, that 4,203 people over the age of 65 in Halton may be experiencing mild loneliness, and a further 1,681 to 2,101 over 65s experiencing intense loneliness.

Loneliness is a subjective, negative feeling associated with lack or loss of companionship.[^29] ‘Social isolation’ is a sociological category relating to imposed isolation from normal social networks. This can lead to loneliness and can be caused by loss of mobility or deteriorating health. It is possible to be lonely whilst not isolated, for example amongst those caring for a dependent spouse with little help.[^23]

Loneliness has a bearing on mental health as well as physical health. The relationship between loneliness and depression is multidirectional: loneliness can be both a cause and consequence of depression. Loneliness may affect cognitive behaviours, encouraging a more negative outlook and a greater focus on self-preservation. Loneliness is often described as a vicious cycle, and these cognitive behavioural impacts may be the means of mediating this as they hamper social interaction; qualitative research suggests loneliness relating to feelings such as ‘anger, sadness, depression, worthlessness, resentment, emptiness, vulnerability and pessimism’.[^24] Lonely or isolated older people have an increased risk of developing dementia, specifically in developing Alzheimer’s disease, as self-perceived loneliness doubles the risk.[^25]

Due to the nature of loneliness, there are no reliable local sources of data which can tell us how many people in the borough experience loneliness. Using research[^26] we estimate 4,203 older people experience mild loneliness and a further 1,681-2,101 experience intense loneliness. Assuming the underlying prevalence remains static, this number will increase as the number of older people in the population increases.
3.2. Levels of Mental Wellbeing amongst older people

There is increasing evidence that positive mental wellbeing is important for a person’s ability to function well, be productive, healthy and cope with adversity or change. Those with good mental wellbeing have a higher life satisfaction and are much more likely to be in work, be healthy and have closer relationships.\[27\] It is important to distinguish between ‘mental health or wellbeing’ and ‘mental illness’ or ‘mental disorders’. While the former is something everyone has and can seek to improve, the latter affects up to one in four people and some of the determinants of each are different.\[28\] As such, staying mentally healthy is more than treating or preventing mental illness. The Foresight Report\[29\] found that action to improve mental wellbeing could have very high economic and social returns. Some of the available evidence on the mental health and wellbeing of older people is however somewhat mixed. Studies in the UK and the US show that both younger and older people are happier than those who are middle aged.\[30\]

Halton’s mental wellbeing survey provided an overview of mental wellbeing of older adults aged 65 and over in the borough and factors that may impact upon it. The results are shown broken down by broad age bands and show that the 65+ age band had the second highest proportion of people with low mental wellbeing and lowest proportion with high mental wellbeing when compared to other age bands. Results by age were statistically significant.\[31\]

Table 4: Levels of mental wellbeing in Halton, by broad age bands, North West Mental Wellbeing Survey 2012/13

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-24</td>
<td>64</td>
<td>12.5%</td>
<td>67.2%</td>
<td>20.3%</td>
</tr>
<tr>
<td>25-39</td>
<td>115</td>
<td>9.6%</td>
<td>57.4%</td>
<td>33.0%</td>
</tr>
<tr>
<td>40-54</td>
<td>132</td>
<td>11.4%</td>
<td>62.9%</td>
<td>25.8%</td>
</tr>
<tr>
<td>55-64</td>
<td>83</td>
<td>21.7%</td>
<td>56.6%</td>
<td>21.7%</td>
</tr>
<tr>
<td>65+</td>
<td>91</td>
<td>13.2%</td>
<td>72.5%</td>
<td>14.3%</td>
</tr>
</tbody>
</table>

Source: McHale, Hughes and Jones, 2013

As this sample is statistically representative of the borough population and results statistically significant it is possible to apply these percentages to the population as a whole with some confidence. This would mean that approximately that for Halton’s 20,306 people aged 65 and over:

- 2,680 may have low mental wellbeing
- 14,722 may have moderate mental wellbeing
- 2,904 may have high mental wellbeing
3.3. Prevalence of mental ill health

There is evidence available from the King’s Fund Paying the Price: The Cost of Mental Health in England to 2026 report showing that prevalence of depression is high for both men and women in older age.\[32\] Depression can particularly affect older people because they face more events and situations that may trigger depression such as physical illness, debilitating physical conditions, loss of social role and bereavement. There are also further psychological problems resulting from isolation and loneliness which may not be recorded by the healthcare system and may have an impact. Depressive symptoms are also thought to worsen cognitive problems in older people and may be an independent risk factor for cognitive impairment and dementia.\[33\]\[34\]

As much of this depression is not recorded, estimates of how many people suffer from depression in older age vary. There are estimated to be currently 2.4 million older people with depression severe enough to impair quality of life.\[35\] Older people are not a homogenous group and those aged 85 years and over for example often suffer significantly worse outcomes than the ‘younger old’ groups. It is also thought that women become more depressed with age and are more likely to be affected by lower life satisfaction, poor quality of life and high ratings of loneliness. As women live longer they are more likely to outlive their partners and therefore experience bereavement and resulting loneliness and isolation. Women are also more likely to be affected by breakdowns in social networks and relationships than men.

The last Health Survey for England that looked in depth at the health of older people was 2005. It used the Geriatric Depression Scale and found that among all people aged 65 and over some 28% of women and 22% of men had high depression scores. The prevalence of high depression scores increased with age leading to 43% of women and 40% of men aged 85 and over compared to 20% of women aged 65 to 69 years and 19% of men in the same age range. With about one in four older people living with symptoms of depression that are severe enough to warrant intervention, estimated to be in excess of two million people in England, it is calculated that around half of this group (12 to 15% of older people) have symptoms that are sufficiently severe to merit a diagnosis of clinical depression. The prevalence of depression is approximately three times greater than dementia and is most prevalent among older people who are living alone in poor material circumstances. However, it is estimated that nearly two-thirds of older people with a depressive illness have never discussed this with their GP.\[36\] Of the third of older people who have discussed their symptoms with their GP, only about half of this group receive treatment. With the ageing of the population, it is estimated that the number of older people experiencing the symptoms of depression will increase to more than three million by 2025.\[37\]\[38\]\[39\]\[40\] However, depression does not have to be an inevitable part of ageing, even for those with poor physical health and limited mobility.\[41\]

3.3.1. Estimated prevalence

POPPI have used research from McDougall et al 2007\[42\] to estimate the number of older people in local authorities across England with depression and severe depression. They found the following prevalence rates:

Table 5: prevalence of depression amongst older people in England and Wales, 2007
Using these prevalence rates we can estimate that, in 2015, twice as many women as men aged 65 and over are likely to have depression, 634 males and 1,211 females with a further 580 likely to have severe depression. These figures are set to increase by 48.6% for males, 41.1% for females and 46.2% for numbers with severe depression. These projections are based on increases in population numbers only and assume prevalence rates remain static.

**Table 6: Number of older people estimated to have depression and severe depression, Halton, 2015 to 2030**

<table>
<thead>
<tr>
<th>Depression</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males aged 65-69</td>
<td>220</td>
<td>209</td>
<td>215</td>
<td>238</td>
</tr>
<tr>
<td>Males aged 70-74</td>
<td>166</td>
<td>235</td>
<td>221</td>
<td>235</td>
</tr>
<tr>
<td>Males aged 75-79</td>
<td>100</td>
<td>118</td>
<td>171</td>
<td>159</td>
</tr>
<tr>
<td>Males aged 80-84</td>
<td>107</td>
<td>126</td>
<td>155</td>
<td>223</td>
</tr>
<tr>
<td>Males aged 85 and over</td>
<td>41</td>
<td>51</td>
<td>66</td>
<td>87</td>
</tr>
<tr>
<td>Total Males aged 65 and over</td>
<td>634</td>
<td>739</td>
<td>828</td>
<td>942</td>
</tr>
<tr>
<td>Females aged 65-69</td>
<td>425</td>
<td>414</td>
<td>436</td>
<td>469</td>
</tr>
<tr>
<td>Females aged 70-74</td>
<td>247</td>
<td>342</td>
<td>333</td>
<td>361</td>
</tr>
<tr>
<td>Females aged 75-79</td>
<td>225</td>
<td>246</td>
<td>342</td>
<td>342</td>
</tr>
<tr>
<td>Females aged 80-84</td>
<td>147</td>
<td>156</td>
<td>175</td>
<td>248</td>
</tr>
<tr>
<td>Females aged 85 and over</td>
<td>167</td>
<td>200</td>
<td>244</td>
<td>289</td>
</tr>
<tr>
<td>Total Females aged 65 and over</td>
<td>1,211</td>
<td>1,359</td>
<td>1,530</td>
<td>1,709</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Severe depression</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>People aged 65-69</td>
<td>193</td>
<td>183</td>
<td>193</td>
<td>210</td>
</tr>
<tr>
<td>People aged 70-74</td>
<td>80</td>
<td>112</td>
<td>107</td>
<td>114</td>
</tr>
<tr>
<td>People aged 75-79</td>
<td>137</td>
<td>151</td>
<td>214</td>
<td>207</td>
</tr>
<tr>
<td>People aged 80-84</td>
<td>81</td>
<td>93</td>
<td>105</td>
<td>150</td>
</tr>
<tr>
<td>People aged 85 and over</td>
<td>90</td>
<td>113</td>
<td>137</td>
<td>168</td>
</tr>
<tr>
<td>Total population aged 65 and over</td>
<td>580</td>
<td>651</td>
<td>755</td>
<td>848</td>
</tr>
</tbody>
</table>

However, these estimates do not cover all types on mental ill health. The national Adult Psychiatric Morbidity Survey is carried out every 7 years. Results from the 2014 survey will not be available until 2016. However the annual Health Survey for England 2014 included the topic of mental ill health. It includes some analysis by age and gender at a national and regional level:[43][44]

- Overall a greater percentage of women reported suffered with a mental illness than men and this pattern was seen across all age groups including those aged 65 and over. However the difference was least in the 85 and over age group where reported mental illness was lowest for both men and women.
Regional analysis was only available by all ages. It showed that men in the North West reported the lowest levels of mental illness. However, this pattern was not seen for women, who reported levels similar to those seen in other regions.

For both men and women of all ages, including 65 and over, there was a substantial proportion reporting that they had a mental health problem for which they had not had a diagnosis. Levels of undiagnosed mental illness were highest in the 55-64 age group, lower in those 65 and over and lowest in the 85 and over age group. This pattern was the same for men and women.

Attitudes towards mental illness were also assessed using the Community Attitudes toward the Mentally Ill (CAMI) scale, were higher scores signify more positive attitudes to mental illness. Scores were higher for men than women in relation to prejudice and tolerance and were lower in the 65 and over age groups than the under 65 ones. However, tolerance and support for community care was higher in the older age bands and lowest in the 18-24 age band.

Using this data to estimate numbers amongst Halton’s older people shows 1462 have common mental health disorders (CMD) slightly higher figures than in Table 6 which just looked at depression. Of note also, in addition to CMD, 119 men and 256 women are likely to have two or more psychiatric conditions. 168 men and 285 women aged 65 and over may have had suicidal thoughts in the last year.

Table 7: Estimated number of Halton older people with CMD, by age and sex

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th></th>
<th>Women</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>65-74</td>
<td>75+</td>
<td>Total 65+</td>
<td>65-74</td>
</tr>
<tr>
<td>Mixed anxiety and depressive disorder</td>
<td>236</td>
<td>137</td>
<td>372</td>
<td>537</td>
</tr>
<tr>
<td>Generalised anxiety disorder</td>
<td>175</td>
<td>79</td>
<td>254</td>
<td>225</td>
</tr>
<tr>
<td>Depressive episodes</td>
<td>24</td>
<td>18</td>
<td>42</td>
<td>100</td>
</tr>
<tr>
<td>All phobias</td>
<td>18</td>
<td>...</td>
<td>18</td>
<td>25</td>
</tr>
<tr>
<td>Obsessive compulsive disorder</td>
<td>12</td>
<td>11</td>
<td>23</td>
<td>25</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>61</td>
<td>11</td>
<td>71</td>
<td>6</td>
</tr>
<tr>
<td>Any CMD</td>
<td>454</td>
<td>226</td>
<td>680</td>
<td>837</td>
</tr>
<tr>
<td>Probability of current Post Traumatic Stress Disorder (PTSD)</td>
<td>127</td>
<td>18</td>
<td>145</td>
<td>331</td>
</tr>
<tr>
<td>Suicidal thoughts: past year</td>
<td>103</td>
<td>65</td>
<td>168</td>
<td>162</td>
</tr>
<tr>
<td>Suicidal thoughts: at any time</td>
<td>411</td>
<td>104</td>
<td>516</td>
<td>799</td>
</tr>
<tr>
<td>Suicide attempts: at any time</td>
<td>91</td>
<td>43</td>
<td>134</td>
<td>231</td>
</tr>
<tr>
<td>Self harm</td>
<td>6</td>
<td>25</td>
<td>31</td>
<td>44</td>
</tr>
<tr>
<td>2 or more psychiatric conditions</td>
<td>115</td>
<td>4</td>
<td>119</td>
<td>169</td>
</tr>
</tbody>
</table>

Source: Adult Psychiatric Morbidity Survey 2017 via HSCIC and ONS 2014 mid-year populations

3.3.2. Estimated prevalence of learning disabilities amongst older people

Table 6 and Figure 19 show the number of older people predicted to have a learning disability in future years, based on national prevalence estimates using POPPI. The number is projected to rise from 2,164 in 2012 to 3,105 in 2026, an increase of 43%. People with some forms of learning disability, such as Down syndrome, are at increased risk of dementia, so the expected rise in the prevalence of dementia may reflect this rise in the numbers of older people with learning disability.
Table 8: Estimated number of older people with learning disabilities including autistic spectrum disorder, Halton, 2015 to 2030

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning disability: overall</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65-74</td>
<td>272</td>
<td>311</td>
<td>312</td>
<td>335</td>
</tr>
<tr>
<td>75-84</td>
<td>132</td>
<td>149</td>
<td>195</td>
<td>222</td>
</tr>
<tr>
<td>85 and over</td>
<td>44</td>
<td>56</td>
<td>68</td>
<td>85</td>
</tr>
<tr>
<td>Total population aged 65 and over</td>
<td>448</td>
<td>516</td>
<td>575</td>
<td>641</td>
</tr>
<tr>
<td>Moderate or severe learning disability</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65-74</td>
<td>45</td>
<td>50</td>
<td>51</td>
<td>54</td>
</tr>
<tr>
<td>75-84</td>
<td>14</td>
<td>15</td>
<td>20</td>
<td>23</td>
</tr>
<tr>
<td>85 and over</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Total population aged 65 and over</td>
<td>64</td>
<td>70</td>
<td>77</td>
<td>88</td>
</tr>
<tr>
<td>Autistic spectrum disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65-74</td>
<td>125</td>
<td>141</td>
<td>139</td>
<td>151</td>
</tr>
<tr>
<td>75 and over</td>
<td>75</td>
<td>89</td>
<td>119</td>
<td>138</td>
</tr>
<tr>
<td>Total population aged 65 and over</td>
<td>200</td>
<td>230</td>
<td>258</td>
<td>289</td>
</tr>
</tbody>
</table>

Source: POPPI, version 9.0

3.3.3. Known prevalence

The only routinely collected data on the prevalence of mental ill health is the two GP disease registers for depression and mental illness (psychosis). The 2014/15 register showed 8365 people aged 18 and over diagnosed as having depression, an increase of just over 1,000 since the previous year. The numbers on the depression register constitutes 8.35% of the 18+ population. The number of people aged 18 and over diagnosed as having bipolar or schizophrenia increased a little from 1030 in 2013/14 to 1057 in 2014/15, a prevalence of 0.83%. It is difficult to directly compare the disease register, doctor diagnosed figures with those determined from research as criteria used to estimated and identify those with these conditions is not comparable. However, with research indicating. The 65+ population constitutes 20.76% of the total 18+ population. Applying this percentage to the depression register total gives a figure of 1,956. This is less than the 2,425 estimated number and takes no account of different prevalence rates amongst different age s and genders, so cannot be used as anything other than a very crude way of sumising that there is likley to be a level of those aged 65 and over who have depression but who do not have this diagnosed by a medical professional.

Nationally 6% of older people are known to adult or older people’s mental health services. The percentage increases with age, primarily due to the influence of dementia. Applying the percentage to Halton’s population, gives an estimate of 1,261. Note the age group breakdown’s do not add up to the total due to varying prevalence rates.
Table 9: Estimated numbers accessing adult and older people’s mental health services

<table>
<thead>
<tr>
<th>Age group</th>
<th>Percentage of population accessing service</th>
<th>Halton population</th>
<th>National prevalence rates applied to Halton population</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-64</td>
<td>2%</td>
<td>105,341</td>
<td>2107</td>
</tr>
<tr>
<td>65-74</td>
<td>3%</td>
<td>12,296</td>
<td>369</td>
</tr>
<tr>
<td>75-84</td>
<td>8%</td>
<td>6,549</td>
<td>524</td>
</tr>
<tr>
<td>85+</td>
<td>16%</td>
<td>1,468</td>
<td>235</td>
</tr>
<tr>
<td>65+</td>
<td>6%</td>
<td>21,013</td>
<td>1261</td>
</tr>
</tbody>
</table>

*Source: HSCIC and ONS*

In 2014/15 there were 305 older people known to adult social services who have care needs primarily due to mental ill health. However, many more who are receiving social care may have mental health problems but this has not been assessed to be their primary support need.

3.4. Hospital admissions

National research shows that two-thirds of older patients admitted as an emergency to a general hospital have co-existing mental health problems including delirium, dementia and depression. In a study examining the outcomes of 250 patients aged 70 and over with co-morbid mental health problems after an acute hospital admission, only 31% were not readmitted or moved to a care home and only 42% of survivors recovered to their pre-acute illness level of function. The often adverse outcomes in this group implies a wide range of health and social care needs which community and acute services need to anticipate and meet.\(^{[45]}\)

As older people have higher rates of hospital admissions it is not surprising to find that admissions due to mental ill health rise with age, although the pattern is not completely linear.

Figure 4: Hospital admissions due to mental illness (excluding dementia), Halton 2014/15, by age and gender

![Graph showing hospital admissions due to mental illness](source:SUS+var CSU)
4. Service provision

In this section of the report, information is presented about mental health and emotional wellbeing support available in Halton for older people through a number of primary, secondary and community care services. Dementia is excluded and has its own chapter within this JSNA. There are currently no commissioned secondary and acute care mental health services specifically for older people. They are offered the same level of support as adults, however their age, frailty and vulnerability has been taken into account and work will be done to ensure their needs are better met (see key recommendations for commissioners section) There is however a variety of mental health and emotional wellbeing support available in the community for older people.

There were other sources of information which were not accessible at the time of doing this chapter, and these limited the conclusions we were able to draw. These include details of where people with mental health problems live, the exact nature of all clinical and social care services provided locally and the outcomes of secondary care service interventions. It has not been possible, therefore, to assess the degree of correlation between needs and access to services, and whether services are delivered to national standards.


The strategy had five priority areas:

- Priority 1 - Improve the mental health and wellbeing of Halton people through prevention and early intervention
- Priority 2 – Increase the early detection of mental health problems which will lead to improved mental wellbeing for people with mental health problems and their families
- Priority 3 - Improve outcomes for people with identified mental health problems through high quality, accessible services
- Priority 4 - Broaden the approach taken to tackle the wider social determinants and consequences of mental health problems
- Priority 5 - Optimise value for money by developing quality services which achieve positive outcomes for people within existing resources

The Adults Mental Health Delivery Group, chaired by the CCG GP clinical lead for Adult Mental Health, is responsible for monitoring progress in implementing the adults element of the strategy through the Adults Mental Health Delivery Action Plan. The Dementia Delivery Group, chaired by the CCG GP Clinical Lead for Dementia, is responsible for the delivery of the older people’s element of the strategy which includes Dementia. These multi-disciplinary working groups include commissioning, provider and other public sector representation. They have been active in developing the strategy to improve mental health and reviewing and coordinating operational progress across a wide range of statutory and voluntary organisations in Halton. Oversight of the action plans monitor progress against the local strategic objectives to improve the health and wellbeing of adults and older people with mental health and emotional wellbeing problems.
Examples of work undertaken so far:

- Development of a website where all the information about MH services and a calendar of activities is located in one place, i.e. a single point of access.
- Embedding liaison psychiatry into the acute hospitals.
- Commissioning Operation Emblem, a street triage service established to reduce the use of Section 136, which includes a dedicated patrol vehicle with a Police Officer and a Mental Health Nurse working together responding to incidents as they arise, providing a rapid response with access to both health and criminal justice records.
- Procurement of a North west wide Military Veterans IAPT Service, that includes local clinics for assessments – “Veterans in Mind”
- Review of the wider health and social care system, pathway gaps that may exist and produce improvements in the provision of mental health services incorporating bed base, and out of area placements – ‘5 Boroughs Footprint Review’, as mentioned under the key recommendations.
- Review and re-design of adult community based services

4.1 Services Available

Commissioned services for adults including older people’s mental health and emotional wellbeing services are delivered across 3 settings:

*Primary Care Consists of:*

- Wellbeing Enterprises
- Halton GP Practices/Wellbeing Community Practices

*Secondary & Acute Care consists of:*

- Halton Assessment Team
- Home Treatment Team
- Halton Recovery Team
- 2 Functional Illness Admission Units

*Community services consist of:*

- MH Outreach Team
- Halton MIND
- Widnes Vikings Sports based Projects for Older People
- Veterans in MIND
- Improving Access to Psychological Therapies (IAPT) Service
- Women’s Relationship Centre

There are a wide variety of 3rd sector organisations which are not commissioned, but provide services in the community for people with mental health problems
### Table 10: Service Provision

<table>
<thead>
<tr>
<th>Service Provider</th>
<th>Service Description</th>
<th>Conclusions and outcomes in 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wellbeing Enterprises (WE)</td>
<td>Wellbeing Enterprises (WE) is a social enterprise who support all aged individuals and communities to achieve better health and wellbeing by educating professionals and the public, delivering evidence-based interventions unlocking the potential of people and communities and collaborating with people and partners to deliver large-scale health and social care programmes. WE has a number of community wellbeing officers (CWO) that are based in Primary Care, which all 17 GP practices in Halton are signed up to as part of their commitment to be “Community Wellbeing Practices”. This encourages high referrals from GPs to this service, however any service or individual can refer in. There are a variety of free interventions offered to older people, including a personalised plan for wellbeing, wellbeing courses, activities and volunteering in the community.</td>
<td>During 15/16 WE supported 304 older people, of which 199 were female, 99 male and 6 undisclosed. 151 Wellbeing assessments were carried out on older people in during their first appointment and followed up again four weeks later to monitor their wellbeing after engaging with activities. The results of the tests showed that 64% of older people had improved their wellbeing, 44% reduced their depression, and 52% improved their health status.</td>
</tr>
<tr>
<td>Halton GP Practices/Wellbeing Community Practices</td>
<td>GPs plays a critical role in the care of people with mental illness. This includes diagnosing mental health problems, providing support to the patient and family, prescribing medication and referring to secondary or community services where necessary. Primary care staff have a holistic approach which takes into account the patient’s risk factors, physical and mental comorbidities and domestic and family situation. Training is provided at local CCG led Members Forums for GPs and practice nurses. Mental health issues also get picked up when patients are reviewed under the avoiding unplanned admissions DES or under the £5 / Over 75s scheme.</td>
<td>Halton were the first borough to establish Community Wellbeing Practices, with all 17 GP Practices signing up to the new service model. Practices work with CWOs from Wellbeing Enterprises (above) to provide timely, integrated wellbeing interventions for individuals and communities by adopting a community focused approach.</td>
</tr>
<tr>
<td><strong>Secondary and Acute Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Halton Assessment Team (Step 4/5)</td>
<td>Halton does not commission separate mental health secondary care services for older people. Support is offered in the same way as adults through a number of care pathways. The Assessment Team is based at Wakefield House on the Warrington Hospital Site and provides a triage function and act as a single point of access into secondary care services and provides rapid specialist mental health assessment, advice and signposting for adults and older people with moderate to severe symptoms of mental illness. If after assessment people require further care/treatment they will be transferred to the most appropriate team to meet their needs. The service ensures that anyone requiring specialist mental health assessment or advice has ease of access to a timely response. This forms part of a wider Acute Care Pathway provided by the Trust and this service performs a crucial coordinating function to ensure that service users experience a smooth journey through the most appropriate care pathways.</td>
<td>There were 214 older people seen by the assessment team in 15/16, majority of these were white British between the age of 65 and 75. Of the 214 referrals, 137 were female and 77 male.</td>
</tr>
<tr>
<td>Service Provider</td>
<td>Service Description</td>
<td>Conclusions and outcomes in 2015/16</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Home Treatment Team (Step 4/5)</td>
<td>The Home Treatment Team provides intensive home treatment for people who have mental health needs that can only be addressed by secondary care mental health services. The home treatment team will respond rapidly to referrals supporting people at an early stage, actively involving families and carer’s, and offering a flexible approach to people in the least restrictive environments, thus providing an alternative to inpatient admission and will also support an early discharge from hospital.</td>
<td>Numbers not made available at the time of doing this chapter</td>
</tr>
<tr>
<td>Halton Recovery Team (Step 4/5)</td>
<td>The Recovery Team are based at the Brooker Centre on the Halton Hospital Site and provide a specialist secondary mental health service that provides individualised person centred care &amp; interventions for adults and older people who have mental health needs that require coordinated support from a secondary mental health service provider. The team promote active participation in treatment decisions and support self-management. The team support patients to relieve their symptoms but also to improve their quality of life by focusing on building mental strength and resilience and being in control of their own lives using the recovery model. Following assessment a care plan is put in place depending on the need of the individual. Care plans include treatment such as Cognitive Behavioural Therapy (CBT), physical health screening, Occupational therapy, independent living skills support, psychological therapy or social worker support. Treatment pathways are dependent on diagnosis and follow the NICE guidance. The service also offers a number of activities to help aid recovery including gardening, walking, exercising and cooking and they offer courses for anxiety, assertiveness, depression etc.</td>
<td>Due to high demand for the service, there is usually a waiting list for psychological therapy, however there are activities and courses run regularly to help individuals to manage their difficulties whilst they wait. The current care pathways are in development as part of the footprint review. Recommendations and outcomes for this service are done on an individual basis, as there are currently only a small number of discharges from the service. Information was therefore not readily available. Numbers not made available at the time of doing this chapter</td>
</tr>
<tr>
<td>Short stay Acute Inpatient Wards (step 4/5)</td>
<td>The Halton in-patient service at the Brooker centre provides a multi-disciplinary assessment and where appropriate, treatment and care plans to adults and older people in the borough who due to the complexity of their psychiatric, mental and/or physical health problems cannot be assessed or cared for in any other community setting. They provide assessments and treatment to help patients to achieve optimum functioning to enable discharge to an appropriate setting in the community. There are 2 functional illness wards, Weaver and Bridge, based in the Brooker Centre on the Halton Hospital Site, that are currently occupied by both adults and older people. Occasionally when the Brooker centre beds are full, patients will be sent to other OOA beds, and in situations where they are all full, patients will be admitted to private facilities such as the Priory, until they can be repatriated back to a local bed, when one becomes available or into the community.</td>
<td>Data was not available by breakdown of age for patients admitted to the Brooker centre wards, therefore the numbers of older people accessing local acute beds in 15/16 is unknown. There were 19 older people admitted to OOA acute beds in 15/16, with only 5 of them male and 14 female. There were no older people admitted to OOA private facilities or PICU beds in 15/16.</td>
</tr>
<tr>
<td>Service Provider</td>
<td>Service Description</td>
<td>Conclusions and outcomes in 2015/16</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Community Based Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Community Outreach Team (step 2/3)</td>
<td>The service is commissioned by the local authority, and is based at Vine Street Resource Centre in Widnes. It offers 1:1 support in the community for people who have either mental health issues or a physical and sensory disability. It is an enabling service encouraging and supporting individuals around managing their illness / anxieties etc., budgeting issues, educational / vocational and social activities, physical health and home maintenance etc. They refer people onto other appropriate agencies / groups such as Wellbeing, Sure Start and other community groups. They are involved with people for both short and long term interventions depending on their referral route into the service. Short term is usually for those referred in by primary care routes and is up to approx. 6 months. Long term is for those who we have been commissioned to support from a secondary care service and this is for approx. 2 years, however I can be longer if needed. They regularly review all cases and will close when either they feel the person can manage independently or if it is identified they will always require support, then they will organise additional care, PA etc.</td>
<td>In 15/16 the service worked with 21 older people, who primarily had a diagnosis of early onset dementia, anxiety, depression, and physical health issues. Outcomes data was not available for older people as the service does not provide an age breakdown of data</td>
</tr>
</tbody>
</table>

*Halton IAPT (Step 2/3)*  
*See care pathway page 27*

| Halton IAPT (Step 2/3) | The service is based in St Johns, Widnes and provides a primary mental health service for adults and older people. It focuses on psychological interventions for mild to moderate common mental health problems. Secondary level psychology includes neuropsychological assessments, psychological interventions such as cognitive behaviour therapy (CBT), Cognitive Analytic Therapy (CAT) psychotherapy, and training and supervision of other staff. The locality teams include mental health nurses, social workers, occupational therapists, psychologists, psychiatrists and support workers. Day therapy focuses on specific evidence-based interventions rather than long-term attendance for social support. Interventions include cognitive stimulation therapy and psychologically focused group therapy for recovery, anxiety and mood management. Some groups take place in local centres but there is also an emphasis on outreach and supporting people to use local community services. | In 15/16 there were 205 older people referred to the service. 139 were female, 59 male and 7 undisclosed. Of the 205 referred, 137 went on to receive first treatment, 88 females, 47 males and 2 undisclosed. It is not clear whether they attended more than one treatment session and whether they went on to make a full recovery. 60 military veterans were also referred to the service, however it is not clear if they are in addition to the numbers of referrals received. The data also does not indicate age breakdown and treatment or recovery rates. |

*Veterans in MIND (step 2/3/4)*  
*See care pathway page 25*

<p>| Veterans in MIND (step 2/3/4) | The service is based at Greater Manchester West Mental Health Foundation Trust (GMW) and provides support to military veterans (MVs) aged 16 or over who are experiencing low to severe mental health problems in Halton. The service offers the same interventions to older people as it does to adults and young people. The service is part of a care pathway working collaboratively in multi-agency partnerships with a variety of statutory, voluntary and private providers to promote recovery. The service adopts a stepped care approach, using screening and assessment processes to ensure the veteran’s needs are addressed by the most appropriate agency. For a referral to be accepted, mental health problems must relate to the veteran’s military service or being linked to difficulties adapting to civilian life post-service. | The service operates a local assessment clinic at Upton Rocks Surgery in Widnes, however due to the new service provider model being in operation since July 2015, it has received only a small number of referrals so far for older people, however neither were from Halton, and therefore outcome data was not available at this stage. |</p>
<table>
<thead>
<tr>
<th>Service Provider</th>
<th>Service Description</th>
<th>Conclusions and outcomes in 2015/16</th>
</tr>
</thead>
</table>
| Widnes Vikings Rugby Club            | **Golden Generation**  
Weekly reminiscence session based at Halton Stadium. They have guest speakers including current and past players, club staff along with pub quizzes and question of sport type afternoons. The group also watches old game footage. This service is open to anyone over 55, with a regular group of around 15-20 participants. The service is looking to expand the sessions into the community, including Runcorn.  
**Guys & Goals**  
Weekly walking rugby session for over 50’s, with a number of up to 75 year olds participating. This is a very popular session with great health benefits being shown by all who attend.  
**Golden Point**  
This is a project based in local Care Homes consisting of 12 sessions, 6 reminiscence based around the history and culture of rugby league in Widnes and 6 physical activity sessions personalised to the needs and limitations of the residents. This offers the care homes a personalised activity to the residents of Widnes and has proven to be a great success for those in the later stages of life. | The recorded outcomes of guys and goals included reducing isolation and depression by creating a great social group for men but also improving physical health. |
| Halton MIND                          | Mind is linked to the Improving Access to Psychological Therapies programme. The service provided reflect the focus of the programme in helping people with mental health problems improve their general health and wellbeing and promotes social inclusion and economic productivity. The particular focus of the service is people who struggle to access mainstream mental health services provided by NHS statutory providers.  
Mind also provides a counselling service in Halton, complementing other local provision for people with mental health problems for whom counselling would be a beneficial intervention. MIND also hosts a befriending service, social & peer support groups and assertiveness courses. | Numbers not made available at the time of doing this chapter |
| Women’s Relationship Centre          | The womens centre caters for ladies of all ages and abilities. Their experience with women who are approaching their mid 60’s is that they can become socially isolated through being widowed, divorced, retired/unemployed, experience physical disability or illness. This can result feelings of loneliness and isolation directly linked to becoming anxious and depressed. The centre work with in partnership with many multidisciplinary agencies in the Halton area for women who would particularly benefit from an integrated coordinated approach to promote independence. | In 2015/16 9 women over 65 attended the centre and accessed various activities such as yoga, crafts, counselling. The main reasons for referrals where due to social isolation, pain relief and anxiety. All have shown an increase in their confidence since attending the various classes, with good improvements in their mood and wellbeing. The yoga classes have shown to release tension and improve relaxation. |
4.2 Care Pathways

4.2.1 The Veterans in Mind service

The service accept referrals from a wide range of statutory and non-statutory organisations such as: GP’s, nurse practitioners, probation, voluntary agencies, charities, single point of access teams, counselling services, primary and secondary care mental health services, educational facilities, relatives (with informed consent) and self-referrals.

Referrals can be made using the on-line referral form on [https://www.gmw.nhs.uk/military-veterans-services](https://www.gmw.nhs.uk/military-veterans-services) or by email to military.veteran@gmw.nhs.uk. Referrals will also be taken via the phone on 0151 908 0019. The email address and answerphone will be monitored by administration staff in core hours. Any referrals received outside of these hours will be processed the next working day.

All veterans will receive an initial telephone screening from one of the veterans in mind clinicians with the first contact attempt being made within 3 working days of referral.

Where appropriate, veterans will receive a face-to-face assessment with a veterans in mind military clinician, with an assessment appointment being offered within 28 working days of referral.

Referrals that are not suitable for the Service

The specification for the service only encompasses mental health difficulties that are as a direct result of the veteran’s military service. If a veteran’s mental health difficulties are evidently not as a direct result of their military service then the Veterans in Mind team will signpost to more appropriate services e.g. Primary or Secondary Care. If this is unclear at the point of referral, triage or assessment this is taken to the team meeting for further discussion.

Case management of people with a stable psychosis/severe mental illness will be outside the scope of this service. However, when an individual with psychosis is being stably managed within secondary care, veterans may benefit from access to psychological therapies and the service may provide in reach to secondary care services where clinically appropriate. This would involve regular liaison with their Care Co-ordinator and feeding into CPA reviews.

People who pose a high risk to themselves, high risk to others or who are at significant risk of self-neglect that is beyond the remit of the Veterans in Mind military service would be referred onto specialist or secondary care services. This may include “hard-to-engage” veterans who have consistently rejected various treatment options offered.

Veterans who have a moderate or severe impairment of cognitive function (eg Dementia); or moderate or severe impairment due to autistic spectrum problems or learning disabilities must be referred to specialist services if it is felt to be clinically appropriate. This may also include veterans who need to be primarily referred for forensic or neuropsychological assessment.
Interventions offered by Veterans in Mind

The Veterans in Mind Service will link closely with other NHS and voluntary veteran service providers in the North West of England in order (a) to deliver outreach to veterans with mental health problems and not currently receiving treatment, (b) to provide effective case management of veterans with a range of different health and social needs, and (c) to provide advice, consultation, and training to health services working with veterans across the region.

The Veterans in Mind service will provide psychological intervention to address mental health needs at the following levels:

- Specialist preparatory psychosocial support for military veterans who need to acquire pre-therapy skills and experiences for Steps 2, 3 and 3+ interventions.

- **Step 2** – Common mental health problems (low severity with greater need). This group of veteran clients have definite but low intensity problems of depressed mood, anxiety or other disorder, but not with any psychotic symptoms.

- **Step 3** – Non-Psychotic (Moderate Severity). This group of veteran clients have moderate higher intensity problems involving depressed mood, anxiety or other disorder (not including psychosis).

- **Step 3+**: This is specialist psychological care to people between Step 3 and Step 4. This group of veteran clients is characterised by severe intense depression and/or anxiety and/or other disorders, and increased complexity of needs but who do not need to be under secondary care mental health services. They may experience disruption to function in everyday life and there is an increasing likelihood of significant risks.

The Veterans in Mind recovery co-ordinator will take the lead on case managing substance misuse/dependency issues. This clinician has knowledge of the physical, psychological and social effects of substance misuse and has experience of working with clients who present with co-morbid mental health and substance misuse difficulties. Anyone presenting with acute or complex substance misuse/dependency issues will be signposted to the relevant local services.
4.2.2. IAPT Clinical Pathway

Depression and/or anxiety disorder identified

Client stable enough to be managed in primary care

Professional Referral or Self Referral

85% triaged to Step 2

15% triaged directly to Step 3

Step 2
Low intensity interventions
(e.g. individual guided self-help)
4-8 sessions approximately

Recovered = discharge

Approx 35% stepped up to Step 3

Step 3
High intensity interventions
Drawing on NICE guidelines
Treatment techniques

Recovered = discharge

Managed transition to secondary services
And/or step 4 psychological therapies

Discharged to primary care
4.2.3. Community Wellbeing Practices Model of Delivery

<table>
<thead>
<tr>
<th>Children CAMHS (Inspire Project)</th>
<th>Mental Health IAPT Team</th>
<th>Older People Demen Tea, Discharge Team (Dementia Navigation)</th>
<th>Community Outreach Self-referral, VCSE Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAMHS waiting times</td>
<td>IAPT waiting times</td>
<td>Readmission rates</td>
<td>Hidden 40%</td>
</tr>
</tbody>
</table>

GP Referrals
Targeted work in GP practices (action plans)
Primary Care MDTs

Community Wellbeing Practices
Wellbeing Review (personalised 1 to 1 assessment; wellbeing plan; navigation; Social prescribing service; Volunteering)

Patient Outcomes
An improvement in subjective wellbeing levels (SW/B/WBQ) A reduction in depression symptoms (PHQ9) A reduction in anxiety symptoms (GAD7) Patient satisfaction rating (1 to 10) Staff satisfaction rating (1 to 10) Friends and family test

System Outcomes
Demand management strategy – reduce pressures Improve patient flow Step down option for patients exiting clinical services Integrated care – wellbeing integral to clinical care Targeted interventions – identified needs Holistic care, timely support

4.3 Mental Health Prescribing

CCG mental health prescribing data is available via the electronic ePACT system and can identify the cost and volume of prescribing at an organisational and practice level, month on month or year on year, it can also identify prescribing down to drug presentation level. Unfortunately the data does not break data down to age range and so whilst we can show the trend and level of prescribing of common mental health drug types we cannot show with any accuracy the prescribing that is taking place for older people. Much of what we know is based on assumptions informed by prevalence data, national data and practice level audits. The tables below show the breakdown of items prescribed over a 3 year period against the actual prescribing costs.
4.3.1 Issues with Specific Drug Groups

Hypnotic/Anxiolytic (also known as tranquillisers) prescribing within Halton has increased year on year by a similar amount since 2012 and as a CCG our prescribing is higher than the national average. A significant number of elderly people will have been on these drugs very long term and reducing prescribing poses a challenge.

Whilst withdrawal strategies are promoted, it is difficult to implement with elderly people who have taken these drugs for significant periods of time and consider themselves ‘stable’;
specialist input to support withdrawal is often required. Use of these drugs in elderly people, especially those that are ‘long acting’, increase the risk of confusion, renal and hepatic impairment and significantly increase the risk of falls – there should be a clear decision making process assessing benefits and risk when considering starting one of these drugs and treatment should be for the shortest possible time at the lowest possible dose;

Antipsychotic prescribing has remained quite static since 2012 and in the main this is likely to be due to a specific focus on reducing use of these drugs for Behavioural and Psychological Symptoms (BPSD) of Dementia as well as a number of patients still being prescribed by secondary care rather than by GP practices. The risks of prescribing these drugs in elderly people are significant and vary depending on the type of drug involved. Use of these drugs is associated with a risk of confusion, hypotension, cardiac effects, falls and extra pyramidal side effects such as restlessness, tremor and muscle spasms but the main issue is the significantly increased risk of stroke and death.

Antidepressant prescribing has increased by 6% year on year since 2012 and it is common for these drugs to be prescribed in the elderly due to depression being a frequent issue within this population. Antidepressants are one of the most common types of drugs associated with hospital admission in the elderly due to adverse drug reaction, especially with the older types of antidepressant. Antidepressants have varying degrees of anticholinergic side effects (such as drowsiness, hallucinations, memory impairment and sedation), a number of commonly prescribed drugs also have similar effects and the risk is additive when using more two or more of these drugs in elderly people. Due to the effects on renal function from aging the newer Selective Serotonin Reuptake Inhibitors can cause a fall in sodium levels (hyponatraemia), this may lead to a build-up of fluid inside the body's cells, which can be potentially dangerous. The risks are increased further with concomitant use of drugs such as diuretics which are also commonly used in the elderly.

In terms of costs, prices have reduced over time as drugs come off patent, therefore figures will reflect a drop for cheaper prices as opposed to reduced prescribing.

4.4. Social Care
Changes to the annual return from 2014/15 mean it is not possible to determine, at a local level, how many older people receive social care services due to mental ill health and how this compared to the regional and national picture. Data from the Referrals, Assessments and Packages of Care (RAP) between 2010/11 and 2013/14 shows that against a backdrop of falling numbers regionally and nationally and total numbers, Halton had an increasing number of older people in receipt of services due to mental illness.
Table 11: Number and crude rate per 100,000 population, people aged 65 and over in receipt of community-based services due to mental health needs, 2010/11 to 2013/14

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Mental Health</th>
<th>Learning Disability</th>
<th>All</th>
<th>Count</th>
<th>Per 100,000 Population</th>
<th>Count</th>
<th>Per 100,000 Population</th>
<th>Count</th>
<th>Per 100,000 Population</th>
<th>Count</th>
<th>Per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>Halton</td>
<td>250</td>
<td>1375</td>
<td>30</td>
<td>170</td>
<td>3490</td>
<td>19285</td>
<td>4935</td>
<td>5110</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>North West</td>
<td>21995</td>
<td>1895</td>
<td>2020</td>
<td>175</td>
<td>158055</td>
<td>13615</td>
<td>235360</td>
<td>4265</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>England</td>
<td>145310</td>
<td>1695</td>
<td>13290</td>
<td>155</td>
<td>1064475</td>
<td>12430</td>
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<td>3805</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011/12</td>
<td>Halton</td>
<td>270</td>
<td>1445</td>
<td>25</td>
<td>145</td>
<td>3660</td>
<td>19635</td>
<td>5090</td>
<td>5220</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>North West</td>
<td>22045</td>
<td>1870</td>
<td>2095</td>
<td>175</td>
<td>151015</td>
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<td></td>
<td>England</td>
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<td>1620</td>
<td>14490</td>
<td>165</td>
<td>991230</td>
<td>11355</td>
<td>1462290</td>
<td>3500</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012/13</td>
<td>Halton</td>
<td>280</td>
<td>1425</td>
<td>25</td>
<td>135</td>
<td>3580</td>
<td>18270</td>
<td>4905</td>
<td>5020</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>North West</td>
<td>21920</td>
<td>1795</td>
<td>2075</td>
<td>170</td>
<td>138770</td>
<td>11360</td>
<td>205265</td>
<td>3680</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>136260</td>
<td>1505</td>
<td>15225</td>
<td>170</td>
<td>895940</td>
<td>9885</td>
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<td>3155</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013/14</td>
<td>Halton</td>
<td>290</td>
<td>1430</td>
<td>40</td>
<td>200</td>
<td>3435</td>
<td>16915</td>
<td>4750</td>
<td>4855</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>North West</td>
<td>21760</td>
<td>1735</td>
<td>2185</td>
<td>175</td>
<td>133260</td>
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<td>197760</td>
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<td></td>
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<td></td>
<td>England</td>
<td>130540</td>
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<td>15755</td>
<td>170</td>
<td>853615</td>
<td>9175</td>
<td>1273280</td>
<td>3005</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: RAP, PF2, NASCIS, HSCIC

As with all clients, older people with mental health problems use professional support and homes care as well as other services most often. Relatively few use direct payments or equipment & adaptations (this last category is mostly used amongst those with physical and/or sensory needs).

Table 12: Community-based services used by older people with mental health needs, 2013/14

<table>
<thead>
<tr>
<th></th>
<th>Mental Health</th>
<th>Dementia</th>
<th>Mental Health Total</th>
<th>Learning Disabilities (LD)</th>
<th>All clients age 65 and over</th>
<th>All Clients 18+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Care</td>
<td>25</td>
<td>90</td>
<td>20</td>
<td>920</td>
<td>1240</td>
<td></td>
</tr>
<tr>
<td>Day Care</td>
<td>10</td>
<td>30</td>
<td>15</td>
<td>120</td>
<td>310</td>
<td></td>
</tr>
<tr>
<td>Meals</td>
<td>5</td>
<td>25</td>
<td>10</td>
<td>295</td>
<td>310</td>
<td></td>
</tr>
<tr>
<td>Short Term Residential - not respite</td>
<td>5</td>
<td>20</td>
<td>0</td>
<td>280</td>
<td>300</td>
<td></td>
</tr>
<tr>
<td>Direct Payments</td>
<td>5</td>
<td>10</td>
<td>5</td>
<td>60</td>
<td>365</td>
<td></td>
</tr>
<tr>
<td>Professional Support</td>
<td>20</td>
<td>95</td>
<td>5</td>
<td>520</td>
<td>1075</td>
<td></td>
</tr>
<tr>
<td>Equipment &amp; Adaptations</td>
<td>0</td>
<td>10</td>
<td>5</td>
<td>610</td>
<td>845</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>20</td>
<td>95</td>
<td>25</td>
<td>2160</td>
<td>2525</td>
<td></td>
</tr>
<tr>
<td>2013/14 Total</td>
<td>40</td>
<td>180</td>
<td>40</td>
<td>3080</td>
<td>4330</td>
<td></td>
</tr>
</tbody>
</table>

Source: RAP, PF2, NASCIS, HSCIC
5. Projected levels of need

Assuming the prevalence of depression and severe depression remain static, the most significant driver for changing levels of need will be the increase in the population aged 65 and over. As seen in Table 4, it is estimated that:

- the number of men with depression will rise from 634 in 2015 to 642 by 2030
- the number of women with depression will rise from 1,211 in 2015 to 1,709 in 2030
- the number of people with severe depression will rise from 580 in 2015 to 848 in 2030

However, the resources available from statutory agencies for health services given the current financial restraints will at best remain the same, requiring the development of new service models to meet need. This will place increasing strain on health and social care, as well as on carers and the voluntary sector unless a preventative and holistic approach is taken. There are examples of good practice in Halton; the challenge will be to provide the scale needed in a cost effective way to reduce both demand on services and improved quality of life for local people.
6. User views

The UK Inquiry into Mental Health and Well-being in Later Life identified five themes that older people said were important to their mental health and wellbeing:

- **Discrimination** – Age discrimination, both in service provision and in wider society, was seen as the biggest barrier to mental health and well-being in later life.
- **Participation** – Older people need to be able to participate in economic, civic, social, cultural and political life.
- **Relationships** – Having friends, family and neighbours are all important, as is feeling part of a wider community.
- **Health** – Good physical and mental health and having access to high-quality care services is key.
- **Income** – Older people say that they want to have enough money, but view the ability to provide for others and feel part of society as more important.

The Community Mental Health survey questionnaire has been substantially redeveloped and updated for 2014. The new questionnaire has been designed to reflect changes in policy, best practice and patterns of service. This means that the results from the 2014 survey are not comparable with the results from the surveys carried out between 2010 and 2013. The 2015 survey surveyed people who had been in contact with community mental health services in England between 1 September and 30 November 2014. Involved 55 NHS trusts in England. There were 13,292 respondents to this survey, a response rate of 29%. In total, 46,750 people were sent questionnaires. For many of the topics covered by the survey, the majority of respondents reported positive experiences. The majority also said that they felt listened to, involved, and treated with respect and dignity.

- As noted throughout this report, many of the existing standards and guidelines for providing mental health care focus on improving people’s experiences. The survey results for this year show very little evidence of change from the 2014 survey results.
- One of the key aims of the Crisis Care Concordat, established in February 2014, is that ‘people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously’. Since the 2014 survey there has been no change in responses to questions about crisis care and out of hours’ services.
- Over a fifth (22%, compared with 20% in 2014) of respondents said they are not being seen often enough for their needs. More respondents reported that the people they see for the care or services they use had changed in the last 12 months (43%, compared with 41% in 2014), and more respondents said that this change had a negative impact on their care (29%, compared with 27% in 2014).
- When compared with the previous survey results, more respondents reported negative experiences in terms of being listened to, having enough time to discuss their needs and treatment, and being treated with respect and dignity.
- On average, around one in 10 respondents reported not being fully involved in their care.
- Despite research showing that there is a strong link between social inclusion and recovery the survey found that of the respondents who wanted or needed this support (and excluding those who already have support in place) many were not receiving help or advice in finding support for physical health needs, financial matters, work, accommodation, peer support and local activities.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Detailed indicator</th>
<th>Score (out of 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and social care workers</td>
<td>Listening</td>
<td>8.3</td>
</tr>
<tr>
<td></td>
<td>for the person or people seen most recently listening carefully to them</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Time</td>
<td>7.8</td>
</tr>
<tr>
<td></td>
<td>for being given enough time to discuss their needs and treatment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Understanding</td>
<td>7.1</td>
</tr>
<tr>
<td></td>
<td>for the person or people seen most recently understanding how their mental health needs affect other areas of their life</td>
<td></td>
</tr>
<tr>
<td>Organising care</td>
<td>Being informed</td>
<td>7.2</td>
</tr>
<tr>
<td></td>
<td>for having been told who is in charge of organising their care and services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contact</td>
<td>9.9 (Better)</td>
</tr>
<tr>
<td></td>
<td>for those told who is in charge of organising their care, being able to contact this person if concerned about their care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Organisation</td>
<td>8.3</td>
</tr>
<tr>
<td></td>
<td>for those told who is in charge of organising their care, that this person organises the care and services they need well</td>
<td></td>
</tr>
<tr>
<td>Planning care</td>
<td>Agreeing care</td>
<td>6.1</td>
</tr>
<tr>
<td></td>
<td>for having agreed with someone from NHS mental health services what care and services they will receive</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Involvement in planning care</td>
<td>7.3</td>
</tr>
<tr>
<td></td>
<td>for those who have agreed what care and services they will receive, being involved as much as they would like in agreeing this</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Personal circumstances</td>
<td>7.6</td>
</tr>
<tr>
<td></td>
<td>for those who have agreed what care and services they will receive, that this agreement takes into account their personal circumstances</td>
<td></td>
</tr>
<tr>
<td>Reviewing Care</td>
<td>Care review</td>
<td>7.6</td>
</tr>
<tr>
<td></td>
<td>for having had a formal meeting with someone from NHS mental health services to discuss how their care is working in the last 12 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Involvement in care review</td>
<td>7.1 (Worse)</td>
</tr>
<tr>
<td></td>
<td>for those who had had a formal meeting to discuss how their care is working, being involved as much as they wanted to be in this discussion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Shared decisions</td>
<td>7.8</td>
</tr>
<tr>
<td></td>
<td>for those who had had a formal meeting to discuss how their care is working, feeling that decisions were made together by them and the person seen</td>
<td></td>
</tr>
<tr>
<td>Changes in who people see</td>
<td>Continuity of care</td>
<td>7.5</td>
</tr>
<tr>
<td></td>
<td>for those for whom the people they see for their care changed in the last 12 months, that their care stayed the same or got better</td>
<td></td>
</tr>
<tr>
<td>Indicator</td>
<td>Detailed indicator</td>
<td>Score (out of 10)</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Information</td>
<td>for those for whom the people they see for their care changed in the last 12 months, knowing who was in charge of their care during this time</td>
<td>5.4</td>
</tr>
<tr>
<td>Contact</td>
<td>for knowing who to contact out of office hours if they have a crisis</td>
<td>7.1</td>
</tr>
<tr>
<td>Support during a crisis</td>
<td>for those who had contacted this person or team, receiving the help they needed</td>
<td>7</td>
</tr>
<tr>
<td>Involvement in decisions</td>
<td>for those receiving medicines, being involved as much as they wanted in decisions about medicines received</td>
<td>7.2</td>
</tr>
<tr>
<td>Understandable information</td>
<td>for those prescribed new medicines, being given information about it in a way that they could understand</td>
<td>7</td>
</tr>
<tr>
<td>Medicine review</td>
<td>for those receiving medicines for 12 months or longer, that a mental health worker checked how they are getting on with their medicines</td>
<td>8.2</td>
</tr>
<tr>
<td>Other treatments and therapies</td>
<td>for those who received treatments or therapies other than medicine, being involved as much as they wanted in deciding what treatments or therapies to use</td>
<td>7.3</td>
</tr>
<tr>
<td>Help finding support for physical health needs</td>
<td>for those with physical health needs receiving help or advice with finding support for this, if they needed this</td>
<td>5.1</td>
</tr>
<tr>
<td>Help finding support for financial advice or benefits</td>
<td>for receiving help or advice with finding support for financial advice or benefits, if they needed this</td>
<td>4.7</td>
</tr>
<tr>
<td>Help finding support for finding or keeping work</td>
<td>for receiving help or advice with finding support for finding or keeping work, if they needed this</td>
<td>4</td>
</tr>
<tr>
<td>Help finding support for finding or keeping accommodation</td>
<td>for receiving help or advice with finding support for finding or keeping accommodation, if they needed this</td>
<td>5.3</td>
</tr>
<tr>
<td>Local activities</td>
<td>for someone from NHS mental health services supporting them in taking part in a local activity, if they wanted this</td>
<td>5.1</td>
</tr>
<tr>
<td>Involving family or friends</td>
<td>for NHS mental health services involving family or someone else close to them as much as they would like</td>
<td>6.8</td>
</tr>
<tr>
<td>Information on support from others</td>
<td>for being given information about getting support from others with experiences of the same mental health needs, if they wanted this</td>
<td>3.7</td>
</tr>
<tr>
<td>Understanding</td>
<td></td>
<td>6.7</td>
</tr>
<tr>
<td>Indicator</td>
<td>Detailed indicator</td>
<td>Score (out of 10)</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Support</td>
<td>for the people seen through NHS mental health services helping them achieve what is important to them</td>
<td>6.3</td>
</tr>
<tr>
<td>Feeling hopeful</td>
<td>for the people seen through NHS mental health services helping them feel hopeful about what is important to them</td>
<td>6.4</td>
</tr>
<tr>
<td>Contact</td>
<td>for feeling that they have seen NHS mental health services often enough for their needs in the last 12 months</td>
<td>6.2</td>
</tr>
<tr>
<td>Respect and dignity</td>
<td>for feeling that they were treated with respect and dignity by NHS mental health services</td>
<td>8.4</td>
</tr>
<tr>
<td>Overall experience</td>
<td>Overall view of mental health services</td>
<td>7.1</td>
</tr>
</tbody>
</table>

| Source: 2015 Community Mental Health Survey, CQC |

The 5 Borough Partnership Trust results were similar to other areas, with only two of the detailed indicators having a score different to the England results, one better and one worse.

**Friends and Family Test (FFT)**

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. Combined with a supplementary follow-up question asking why they gave their response, the FFT provides a mechanism to highlight both good and poor patient experience.

The feedback gathered through the FFT is being used across WHHFT Trust to stimulate local improvement and empower staff to carry out the sorts of changes that make a real difference to patients and their care. FFT questionnaires are based on service used and not diagnosis. The Later Life and Memory Services feedback is from people with a functional mental illness, as opposed to Dementia or Alzheimers, which is covered under a separate chapter.

The rating 1-6, is in response to the question “We would like you to think about your recent experience of the service and how likely they are to recommend the service to friends and family if they needed similar care or treatment. 1-Extremely likely. 2-Likely. 3-Neither likely nor unlikely. 4-Unlikely. 5-Extremely unlikely. 6-Don’t know

Overall the feedback appears very positive, with majority of patients reporting that they were extremely likely or likely to recommend the service to family and friends.
7. Unmet need and service gaps

Increasing older population

Due to an increasing population there is likely to be an increase in the number of older people with depression in the next few years, due to different factors, in particular isolation and loneliness. However, the resources available for health services, given the current financial restraints, will at best remain the same, requiring the development of new service models to meet need. A holistic approach is vital.

Risk factors for depression and dementia

Older people’s mental health needs are complex. They cause substantial impact on wellbeing and the ability to lead a normal life. They have wider impacts on the family and other carers.

Mental health needs interact in complex ways with long-term physical health problems. Adults with severe mental illness have a substantially reduced life expectancy due to both mental and physical ill health. There is often inequality of access to health services for physical illness for people who use mental health services. Physical health and mental health are inseparable and demand a holistic approach to the care of all patients with mental health problems.

Future Bed Base for Older People

 Whilst there are no secondary care services commissioned specifically for older people in Halton, there is future assurance from local MH providers and commissioners that the needs of each individual will be better met.

As highlighted in the 5BP Footprint review, currently there are older people with very different needs being supported on the same wards in Halton. Older people with a functional illness and frailty/comorbid physical health conditions are being treated in the same environment as general adults or very occasionally in wards specialising in dementia. Neither of these environments are the most appropriate to deliver the best outcomes and can result in a longer in-patient stay. There are also often increased risks when on an adult ward if they were frail. This resulted in inefficiencies and delayed recovery. A more appropriate clinical model has been agreed between the Trust and its commissioners, who identified that there is a significant cohort of service users whose specific clinical needs would be better met within a dedicated facility and by staff who are trained and experienced in managing their needs.

Current service provision

There are other sources of information which were not available or accessible during this time, and these limited the conclusions we are able to draw. These include details of where people with mental health problems live, the exact nature of all clinical and social care services provided locally and the outcomes of secondary care service interventions. It has not been possible therefore to assess the degree of correlation between needs and access to services, and whether services are delivered to national standards.
8. Best practice interventions

NICE Pathways

Home care for older people

Mental wellbeing and independence in older people

Social care for older people with multiple long-term conditions

NICE quality standards

Mental wellbeing of older people in care homes (QS50) December 2013

NICE guidelines

Home care: delivering personal care and practical support to older people living in their own homes (NG21) September 2015

Mental wellbeing in over 65s: occupational therapy and physical activity interventions (PH16) October 2008

Older people with social care needs and multiple long-term conditions (NG22) November 2015

Older people: independence and mental wellbeing (NG32) December 2015

NICE guidelines and quality standards in development

Older people: promoting mental wellbeing and independence through primary, secondary and tertiary prevention (GID-QS10008) December 2016 Quality standards

Care and support of older people with learning disabilities (GID-SCWAVE0776) October 2017 NICE guidelines

Older people with social care needs and multiple long-term conditions (GID-QSD144) September 2016 Quality standards

Other sources

IAPT Older People Positive Practice Guide January 2009

Mental Health Foundation Mental health in later life

Joint Commissioning Panel for Mental Health Guidance for commissioners of older people’s mental health services 2013

Annual Report of the Chief Medical Officer 2013 Public Mental Health Priorities: Investing in the Evidence
References

http://www.who.int/mediacentre/factsheets/fs381/en/


4. NICE (2008) Occupational Therapy Interventions and Physical Activity Interventions to Promote the Mental Wellbeing of Older People in Primary Care and Residential Care. NICE Public Health Guidance 16


. Age UK (2014) Evidence review: loneliness


. Mental Health Foundation (2009). All things being equal: Age Equality in Mental Health Care for Older People in England


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**Older People:**
Mental Health and Emotional Wellbeing

Please quote the JSNA

We would like to know when and how the JSNA is being used. One way, is to ask people who use the JSNA when developing strategies, service reviews and other work to quote the JSNA as their source of information.

10. NICE (2008) Occupational Therapy Interventions and Physical Activity Interventions to Promote the Mental Wellbeing of Older People in Primary Care and Residential Care. NICE Public Health Guidance 16


13. **National Housing Federation (2011) Breaking the Mould, NHF**


24. **Oxfordshire Age UK (2012)** *Loneliness: the state we’re in. A report of evidence compiled for the Campaign to End Loneliness* Available at: [http://www.ageuk.org.uk/brandpartnerglobal/oxfordshirevpp/documents/loneliness%20the%20state%20we%20are%20in%202013.pdf](http://www.ageuk.org.uk/brandpartnerglobal/oxfordshirevpp/documents/loneliness%20the%20state%20we%20are%20in%202013.pdf)

25. **Age UK (2014) Evidence review: loneliness**


39. Mental Health Foundation (2009). All things being equal: Age Equality in Mental Health Care for Older People in England


42. McDougall et al, Prevalence of depression in older people in England and Wales: the MRC CFA Study in Psychological Medicine, 2007, 37, 1787-1795.


