ST HELENS
BOROUGH COUNCIL

MENTAL HEALTH STRATEGY

SEPTEMBER 2023

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FOREWORD

This all-age Mental Health and Wellbeing Strategy will contribute to ensuring that our community has the framework necessary for everyone to realise their full potential. This means that everyone in St Helens will have access to the services that make them feel good about their lives and the high calibre support and caring services they require when they do.

Mental health is shaped by the wide-ranging characteristics (including inequalities) of the social, economic and physical environments in which people live. It is acknowledged, for example, that people on low incomes have higher rates of mental health conditions, particularly severe and enduring problems, than those in higher income groups.

Mental health and wellbeing is therefore something that affects us all and only by coming together to address the wider factors that affect mental health, by improving services and focusing on prevention, will St Helens achieve our ambition of being a mentally healthy community.

We have strong local partnerships that have already worked closely together to develop the key themes within this Strategy. Indeed, the successful integration of health and social care, our partners, and our local communities is the fundamental building block from which our shared aims and priorities will be delivered.

This Strategy will be enacted through a comprehensive action plan, which will focus on key priority areas for improvement. This will be co-produced with service users, carers and families in our communities to ensure that we can radically improve the emotional health and wellbeing of all who reside within the St Helens Borough.

M. M. Quinn

Councillor Marlene Quinn
Cabinet Member - Integrated Health & Care

1. INTRODUCTION AND CONTEXT

1.1. MENTAL HEALTH AND OUR COMMUNITIES

England is facing a potential 'mental health pandemic' (Mind, 2022) with widening inequality of care, bereavement, and isolation (as a result of the Covid pandemic) and economic recession forming key reasons as to why.

Recent figures from the Office for National Statistics show that one in five adults experienced depressive symptoms in 2022 which is more than double the year before. Moreover, recent research from Mind found that the lack of face-to-face support caused by the Covid pandemic has been particularly hard for those with severe mental health problems such as psychosis and schizophrenia.

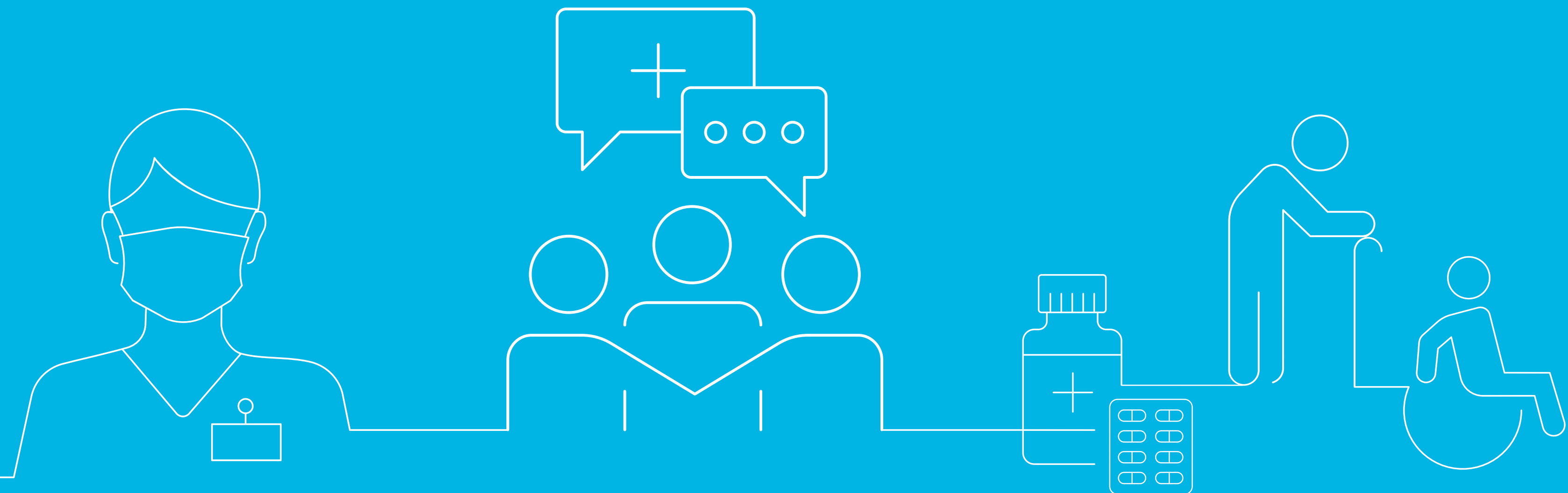
For our communities of St Helens, this means that we must deepen the value and commitment to mental health services and strengthen the services and support on offer. Importantly, we will focus on communities disproportionately affected by mental health, including harder to reach communities and young people. This means that this Strategy is all-encompassing, from birth to death and across all mental health pathways and partners. It also recognises the need to act against social, economic and environmental determinants of mental illness.

1.2. MENTAL HEALTH IN ST HELENS

St Helens has a disproportionately high proportion of residents who suffer from poor mental health and mental illness:

- In 2019, St Helens had the highest rate of admissions due to self-harm in England (Public Health England, 2019)
- In 2020, St Helens had the 4th highest rate of admissions for mental health conditions (0-17 years) in the North West (Public Health England, 2020)
- Analysis of NHS estimates by the House of Commons Library shows 16.2% of adult GP patients across St Helens had a diagnosis of depression in 2019-20. This represents a much higher rate than the 11.5% average across England
- House of Commons Library data also shows that 1% patients across St Helens were diagnosed with schizophrenia, bipolar disorder and other psychoses in 2021. A figure much higher than the national average.

The reasons for the above figures are multi-faceted which means that we cannot deliver this Strategy in isolation from our communities, partners and wider public services. It also means that we have a fundamental challenge to improve the wellbeing of people across our Borough, regardless of background, where they live or how they live their lives. As such, we have set out a series of commitments that form the basis of the priorities we will focus on and the actions that will follow.



1.3. OUR COMMITMENTS

There are a diverse range of organisations, services and groups involved in the delivery of mental health provision. As such, we cannot deliver the actions associated with mental wellbeing without being cooperative and inclusive in approach. Nevertheless, it is also important to set out our commitments, as a Local Authority, to working with others and achieving a step-change in mental health in St Helens. Therefore, we will:

- Ensure that people with lived experience are included in the creation of service re-design and future service improvements. In this method of operation, service recipients and providers will collaborate to find solutions
- Ensure that all decisions, service advancements and design are supported by a strong and relevant evidence base
- Put greater emphasis on the broader social, economic and environmental factors that influence mental health needs. This includes education, housing and employment
- Ensure that mental and physical health are valued equally, or parity of esteem, and we will fight prejudice and stigma
- Adopt a focus on prevention and early intervention with education being the key focus. This means getting help early for people showing the early signs and symptoms of a mental health difficulty and people developing and experiencing a first episode of mental illness
- Adopt a recovery focus where possible in order to support people to gain and retain hope, an understanding of their abilities and needs, engage in an active life, achieve personal autonomy, social identity, meaning and purpose and a positive sense of self
- Focus on communities that are disproportionately affected by mental health conditions, mental wellbeing and access to support.

1.4. WORKING TOGETHER

How we deliver the above commitments, will be contained within the action plan associated with this document. However, this is not a singular Strategy and is created, influenced and delivered through our numerous partnerships which include:

- Service users, carers and families
- Leaders of Integrated Care Boards, local authorities and health partners
- Service providers for social services, health care, social and physical environment
- Health, social, and community service commissioners
- The community and voluntary sector

The delivery of coordinated and seamless services to help people, including those with learning difficulties and autistic people, live healthy, independent, and dignified lives increases with the integration of health and social care, which also improves results for the population as a whole.

2. VISION AND OBJECTIVES

2.1. WHAT WE ARE TRYING TO ACHIEVE

We believe a fundamental shift in focus is essential to improving mental health and well-being in St Helens, requiring a strong emphasis on prevention, early intervention, resilience, and recovery. We will achieve our vision of mental health and well-being while delivering a responsive, efficient, and sustainable mental health system by:

- Providing services in collaboration with medical professionals, seasoned professionals, families, and caregivers
- Utilising the most recent research and clinically recommended practice while also being innovative and attempting new things
- Creating care delivery models that guarantee inclusive, efficient, and accessible services for all
- Continuing to restructure our Services with a focus on recovery support, inclusivity, and empowerment in order to provide assistance to people as soon as possible
- Enabling and assisting people in taking charge of their own health and life by exercising choice and control
- Providing early access to assistance and support can help to rebalance the system and lower the need for acute and crisis services
- Tackling mental health and wellness issues in schools and colleges, acting early, and improving services for children and young people
- Ensuring that any other pertinent partnership initiatives and policies that support the broader determinants of health (including housing, employment, transportation, and access to green spaces) take mental health outcomes into account.

2.2. OUR APPROACH

In order to deliver our intentions and to achieve them in a holistic and person-centred way, we intend to align our priorities and actions to the specific needs of people from birth to old age.

Our approach, therefore, is to improve mental health and well-being across three age ranges, each of which is described in the following section.

STARTING WELL (0-19 YEAR-OLDS)

The NHS Long Term Plan made a commitment to increasing mental health services for all children with needs, cutting down on wasteful red tape, and providing care in ways that benefit the children and their families. This Plan also identifies priority areas for children and young people's mental health services, such as expanding access to community services, investing in services for eating disorders, supporting youth during a mental health crisis, and creating new strategies for supporting young adults between the ages of 18 and 25.

Aligned to this, we will concentrate our efforts on implementing the Department of Education's Green Paper 'Transforming Children and Young People's Mental Health Provision'. This requires continuous engagement with children and young people so they can influence service design and development. Through this, we can help children and young people develop resilience and experience positive emotional health and wellbeing.

To achieve this, we will work across all health and care partners to create a Borough where:

- All children and young people have access to the best help at the earliest opportunity and early indicators and indications of poor mental health and wellbeing will be recognised
- Every child and adolescent has access to excellent emotional health and wellbeing support that is connected to their school or college and, if necessary, fully described within their Education, Health, and Care Plan (EHCP)
- The emotional wellbeing of children, adolescents, and their families will be well-understood by all professionals working with these groups, and interventions will be based on client needs rather than a diagnosis or condition

In order to deliver on the above commitments, we will work across a range of partnerships (such as CAMHS, Mental Health Support Teams in Schools and Colleges, Early Help Services, and other charitable/third sector organisations) to:

- Ensure that our children and young people are given the proper support with regard to the effects of the coronavirus pandemic on themselves, their family, their friends, and their local community
- Extend community perinatal mental health services from conception to 24 months after birth, which is in line with the cross-governmental ambition for women and children, focusing on the first days of a child's life, we will improve the outcomes for pregnant women and their families over the coming years
- Increase access to co-parenting and family therapies within evidence-based psychological therapy services.
- Perform partner assessments to ensure that partners of women who seek out specialised perinatal mental health services and maternal mental health services receive an evidence-based evaluation of their own mental health and are directed to the most suitable care
- Work together to create a clear pathway across all pertinent statutory and nonprofit sector services in an effort to 'Make all Care Count'
- Encourage new people to participate in the service user experience, identify opportunities for peer support development and provide continuing feedback on services

Importantly, this Strategy will align with our recently updated Learning Disability Strategy and All-Age Carers Strategy to provide support for the most at-risk in our community. This includes; younger people with learning disabilities or special educational needs, children in foster care, young carers, youth with autism or attention deficit hyperactivity disorder, educated at home, and those who may previously have been harder to reach.

ONLY BY COORDINATING OUR EFFORTS WE CAN ENSURE THAT WE SUPPORT THE MOST VULNERABLE AND SOMETIMES HARDER TO REACH COMMUNITIES.

LIVING WELL (ADULTS AGED 18-65)

We have an opportunity to move away from isolated, difficult-to-access services and toward joined-up care and whole-population approaches through the Community Mental Health Framework for Adults and Older Adults. This means that we will enhance the standard of living for those with more severe mental illness whilst focussing on the well-being of all adults in our communities. In order to achieve this, we will:

- **Use information & data more effectively** - This includes:
- Maximising the use of a 'shared care record' to enable different professionals to access timely and relevant information
- Cross-referencing GP data as part of the development of Care Communities in order to better collaborate with the individual and their family
- Reviewing and revising the approach to referrals with ICT, information and data a key enabler to this
- **Increase accessibility** - This includes:
- Working with our health partners to enhance Access to Psychological Therapies (IAPT). This supports a more proactive approach by treating common mental health issues like stress, mild to moderate anxiety, and depression.
- Enhancing access to therapy services for people with long-term diseases (such as diabetes, heart disease, and cancer) who may previously only have been supported through physical health services
- Providing a wider range of treatment and referral options, including group treatment where applicable
- Promoting of the St Helens Carers service and its function in giving caregivers ongoing emotional support and participation possibilities
- A greater focus on males accessing support o help lower the frequency of suicides and suicide attempts
- **Focus on proactive care through four integrated Care Communities** - This includes:
- Coordinating all mental health practitioners and services to support community mental health (including dementia)
- Creating strong connections between Primary Care, community, acute inpatient services and local community groups
- Working with St Helens Carers Service to provide knowledge, counselling, emotional support, and practical assistance to prevent carer breakdown
- Revising our approach to conducting needs assessments for people identified as having more complex and multi-faceted needs in order to develop a single holistic care plan
- **Support our staff** - This includes:
- Working with and educating staff on collaborative care planning to promote multi-agency participation
- Offering an integrated staff training and development programme to include wellness practitioner training on physical health interventions, such as quitting smoking, managing weight, exercising, and managing personal health concerns
- **Support acute inpatient pathways** - This includes:
- Working with NHS community and hospital partners to develop a set of combined physical and mental health pathways
- Ensuring that those in acute facilities have a greater degree of access to programmes that offer counselling, direction, and/or treatment for mental health
- Working collaboratively with addiction services to support people with addiction and mental health concerns together (dual diagnosis)
- Ensuring that persons suffering from personality disorders have access to timely assistance
- **Work with businesses, organisations and other agencies** - This includes:
- Working together with business environments as needed to help them develop mental health standards and policies for their own workforce
- Improving access to all services that provide mental health counselling, guidance, and/or treatment.

AGEING WELL (AGED 65+)

We want to develop age-friendly services that combat ageism and involve partners in ensuring that services are equitable, accessible, and available for the older members of our communities. This requires a shift away from being 'age-led' to 'needs-driven' with a greater understanding of life changes such as long-term illness, bereavement, retirement, caregiving responsibilities and financial restraints.

With assistance from the third sector and the voluntary sector, our mainstream primary and secondary health and social care services will assess and provide holistic emotional age-friendly health support either directly or through referral. In line with this, we will build on latest research including:

- Age Friendly Cities - A concept developed from the World Health Organization (WHO) to develop a local approach to supporting active ageing by maximising chances for health, involvement, security and quality of life
- Development of multi-disciplinary approaches, as set out in the NHS Long Term Plan, in which all specialists collaborate in an integrated manner to offer specialised care that enables individuals to live healthily and independently at home for a longer period of time
- The Integrated Access to Psychological Therapies Positive Practice Guide (produced by Age UK and The Mental health Foundation) which provides a resource for therapists to access when supporting older people. Using the above, and focusing our efforts on a needs-driven approach, there are two immediate areas of focus:
- **Tackling loneliness and isolation** - Less than one in six older adults with depression seek medical attention from their GP and one in four older people experience symptoms of depression that need to be treated. In addition, residents at care facilities are more likely to experience depression, and older people in general are more susceptible to its causes, including loneliness, physical disease, grief, and physical impairment. We will therefore focus on reducing loneliness, isolation and happiness across all of our neighbourhoods and include those in care services. Aligned to this, we will develop a more holistic approach to the assessment of needs through our integrated care communities. Through this, our community mental health, physical health and social care teams will work more closely to understand and support older people's needs
- **Dementia** - Being a degenerative illness, dementia's symptoms can initially be somewhat modest but worsen over time. Although there are many other varieties of dementia, Alzheimer's is the most prevalent with vascular dementia the second most typical type. Like mental health, dementia is not a normal component of becoming older and every person with dementia has their own unique needs and changes in mental function. To ensure that these needs are met, we have developed a specific Dementia strategy, aligned to our priorities for the older population.

Within this Strategy, we provide a commitment to prevention, easy access to support and creating more effective pathways of support.

2.3. WHAT SUCCESS LOOKS LIKE

In order to deliver the above objectives, a significant and varied amount of work is required. This means that if we are to understand whether we are achieving what we set out to do, we will need a targeted set of measures that provide a clear indication of success. These are set out as follows:

- Targeted campaigns to raise awareness for people with dementia.
- Commissioning of good quality provision for early diagnosis and intervention in dementia
- Development of dementia advisers in order that people have a single point of contact
- Development of local peer support and learning networks for people with dementia and their carers
- Implement the Putting People First personalisation changes
- Ensure that breaks are commissioned that benefit people with dementia and their carers
- Identification of a senior clinician within acute care to ensure high quality and seamless pathways of care
- Development of different models of housing including extra care

3. DELIVERING THIS STRATEGY

Through our commitments, objectives and measures of success, we have set out what we want to achieve and an indication of how we will know if we are on the right path. Delivering this, though, takes a holistic approach and one that encompasses a range of provision, partners and people. The following section provides an overview of the key elements of this.

3.1. MEETING RISING DEMAND

Progressive planning (which lowers the portion of expenditure on working-age individuals), the anticipated increase in the number of elderly people with mental illness and dementia and the impacts of the Covid pandemic mean that demand, and associated cost of care, will continue to rise.

Clearly, we will not be able to meet this head-on as a single organisation which is where a partnership approach reaps significant benefit. In particular, the physical health, mental health and social needs of our communities needs to be improved in a coordinated way. In particular, we will:

- Share knowledge and skills relating to psychology and mental health
- Remove barriers and restrictions around referrals in order to access inter-professional advice and support
- Support Primary Care teams to address a wider range of needs in practice and through our Care Community approach
- Work with Public Health colleagues to develop a whole-population health model.

In addition to the above, the Government has set aside more monies for the upcoming three years in a variety of distinct financing streams. Accessing this in partnership, through health and charitable sector routes, will support further service integration and funding for larger-scale mental wellbeing programmes.

3.2. MARKET SUPPORT, STIMULATION & MANAGEMENT

As is the case across a number of Boroughs, there are challenges in ensuring market diversity, workforce stability and growth, and sustainable service delivery, especially in light of the present economic environment. Our market has some more susceptible areas than others due to service gaps and high costs. In order to sustain high-quality services in the right volumes to meet demand, all at an acceptable cost of care, ongoing efforts will be enhanced in order to maintain a balance of market support, stimulation, and management.

3.3. CO-PRODUCTION AND CO-DESIGN

The goal of community-based services is to help or empower people to live independently at home as opposed to being admitted to a long-term residential or nursing home. The needs of individuals and their families call for adaptable community services that can meet those specific and varied needs. They must also take into account how they will entice and meet the unique needs of their workforce.

Therefore, in many cases, we work to delay or prevent the need for ongoing Adult Social Care services in order to help people with mental illness maintain their level of independence. We want to actively engage with and listen to communities as equal partners in order to make a difference. By actively participating in developing strategies for how we may build stronger communities now and in the future, as well as by leveraging local working and existing networks and good practice, we can help people understand their role in maintaining fitness and health and reducing reliance on services.

3.4. ENHANCED INFORMATION AND ADVICE

Linked to the above point, the ‘St Helens Information and Advice Service’ will be re-launched, and we’ll make sure that it improves people’s lives by educating, counselling, and promoting self-help and self-management so that they can keep their healthy independence.

As part of this, more people will be made aware of the price of that support and encouraged to buy their own through a Direct Payment. Adults will be able to fully self-regulate from social care-managed support care packages, which will lessen the need for more costly interventions. To ensure that everyone who can receive funding in paying for their own support is helped, we will also review our Direct Payment Assistance Programme.

3.5. LEARNING FROM BEST PRACTICE

Building on what has successful over the past ten years, dementia services in St Helens will learn from residents and other Boroughs about what else could be done more effectively.

4. MONITORING, REVIEW AND CONTINUOUS IMPROVEMENT

Monitoring and evaluating the impacts of this Strategy, and the objectives contained within, is vital in ensuring that our efforts continue to be focused on the cared-for and carer experiences. This, in turn, needs to feed into every commissioning decision that we take.

As such, we are developing an action plan for the whole of Adult Social Care to ensure that we understand progress, tackle any issues that arise and focus on continually improving the services we commission and provide. There are two levels of effectiveness for monitoring this:

LEVEL ONE - GUIDING PRINCIPLES

These principles work to prioritise the needs of the people we support and ensure that the assistance they get will both achieve the desired outcomes and manage any risks:

- **The right people:** those who require assistance are identified and given top priority
- **The right time:** to prevent things from getting worse, to increase resilience, and to encourage independence
- **The best location:** Depending on the need and the most cost efficient solution, at home, in the community, or in a specialised environment
- **The correct support:** Just enough to keep everyone safe while also preventing, minimising, or delaying the need for long-term support, supplied by the appropriate individuals with the appropriate skills
- Improved coordination and cost-effective support may be provided through working more effectively with individuals, their friends and families, as well as in partnership with other organisations

LEVEL TWO - PERFORMANCE REPORTING

To determine whether services for those with learning disabilities are achieving the necessary strategic results, the overall organisation and coherence of those services will be tracked and evaluated. Performance indicators (PIs), regular critical appraisals, satisfaction surveys, and the departmental index of complaints will all serve as guidelines for the reporting structure.

To support the above, we will routinely gather and compile data from a range of sources which will include:

- Employing regional and national performance metrics to compare our performance to that of other local authorities and assess the development of certain goals
- Continually evaluating our actions in light of past, present, and projected requirements in strategic and performance management frameworks to ensure that we have enough capacity to meet any changes in service user demand
- In order to accelerate the implementation of innovative thinking that support the essential elements of the vision, we modified our strategy to take advantage of the most recent best practice.

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