MENTAL HEALTH IN THE WEST MIDLANDS COMBINED AUTHORITY

A report for the West Midlands Mental Health Commission

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Good mental health and wellbeing is something we should all be able to experience, but sadly it is not the case for everyone. Too often people who experience poor mental health don't get the help they need when they need it. The consequences can be long lasting and can have a significant impact on individuals, their families, friends and colleagues.

The economic case for action to improve the mental health and wellbeing of our communities is therefore overwhelming.

Allied to this, there is a moral imperative for improving the mental health and wellbeing of those living in the Combined Authority area. Providing people with the opportunity to prevent poor mental health, or to recover should be a central aim of our public services. We should also focus on how we can reduce the overall impact of mental ill health.

Drawing on the evidence and findings of this report, the Commission will set out a plan of action aimed at making better use of the resources that are available.

This report demonstrates clearly why we must act to improve the mental health and wellbeing of the region.

The West Midlands Mental Health Commission asked the Health Services Management Centre at the University of Birmingham, in partnership with the Centre for Mental Health, to develop this report, to provide us with a baseline audit of Birmingham, in partnership with the Management Centre at the University of Birmingham: Health Services Management Centre.

This report describes some of the services and initiatives already in place and highlights examples of good work already being done. In doing so it illustrates the high cost of poor mental health on the region. The current financial impact is estimated to be over £12 billion per year.
There are an estimated 4.032 million people in 2015 living in the West Midlands Combined Authority (WMCA). The population is culturally diverse, with over 22% from Black and Asian Minority Ethnic communities, ranging from 2.3% in Cannock Chase to 43% in Birmingham.

Nearly half of the population of the WMCA live in the 20% most deprived areas in England. There are links between insecure housing, financial stress, mental health and child development, which influence life chances and social mobility.

Data from the ONS subjective wellbeing survey points to wide variations between West Midlands Local Authorities with rates of wellbeing that are below the national average for Wolverhampton, Birmingham and Coventry and above average for Sandwell.

Nearly a quarter of adults living in the WMCA are experiencing a mental health problem at any one time. The risks of poor mental health are not uniformly distributed across the WMCA population. They are influenced by social, economic and physical environmental factors and social inequalities in particular.

Women living in the poorest households are nearly three times as likely as men living in the most well-off households to be diagnosed with a common mental health problem such as anxiety or depression. On the other hand, men are more than four times more likely than women to die as a result of suicide.

In 2015, there were 477 deaths recorded as suicide in the West Midlands which at 9.6 deaths per 100,000 population is lower than the rate for England at 10.9 deaths per 100,000 population. People living in the poorest socio-economic circumstances are ten times more at risk of suicide than those in well-off households.

People with an increased risk of developing mental health problems and/or for whom access to effective help is problematic are:
- Looked after children and young people leaving care
- Homeless people and people living in poor quality housing
- Unemployed people
- People from Black, Asian and Minority Ethnic communities
- Lesbian, Gay, Bisexual and Trans people
- People with long-term physical health conditions
- People with disabilities, including learning difficulties and sensory impairments
- Carers
- Survivors of sexual, emotional and physical abuse
- People experiencing severe and multiple disadvantage

Detailed profiling of mental health needs in the WMCA has yet to be provided. Local Authorities have a responsibility to undertake Joint Strategic Needs Assessments (JSNAs) in their localities and these should provide a detailed picture of the local population and their mental health needs. The quality of JSNAs across the WMCA is variable, and poor quality JSNAs will hamper strategic planning and understanding of whether progress is being made on addressing inequities in access to effective support, and the promotion of health and wellbeing.

Co-production and community engagement are central to developing an understanding of the mental health needs of the WMCA population, the challenges they face, and the opportunities to strengthen resilience. They provide a foundation for service transformation.
Mental ill health is estimated to cost the NHS nearly £2 billion a year in the WMCA. Only about half of this represents direct costs of treatment and care for people with diagnosable mental health problems. The other half represents indirectly by large numbers of people with long-term physical conditions, such as diabetes and asthma, also suffer from depression or anxiety. This greatly increases the costs of physical health care.

Spending on physical healthcare is also pushed upwards because of medically unexplained symptoms, which may not be so apparent underlying organic cause and are thought to be psychological in origin.

The cost of Local Authority Care for children in care because of parental mental ill health and/or substance abuse is estimated at £0.1 billion a year.

The value of informal care provided by family and friends for people in the WMCA with mental health problems is estimated at £1.1 billion a year.

Employment costs are at the costs of output losses in the local economy that result from the damaging effects of mental ill health on people’s ability to work and to earn. Total estimated around £3.9 billion a year equivalent to 31.9% of total costs. These divide more or less equally between: (i) the costs of sickness absence and presenteeism among people with mental health problems, and are currently in work and (ii) the costs of worklessness among those unable to find employment because of their mental ill health condition.

Human costs, representing a monetary estimate of the less tangible but crucially important adverse impact of mental ill health on people’s wellbeing and quality of life, are put at just over £5 billion a year, accounting for 40.9% of the total. This is based on an estimate of the total number of quality-adjusted life-years (QALYs) that are lost each year as a result of mental health problems.

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Mental Ill Health

The programmatic societal cost of crime in the WMCA is estimated at around £4.9 billion a year. Assuming that the proportion of offending linked to mental disorders, particularly personality disorders and substance misuse, is around 20%, the mental health-related cost of crime in the WMCA comes out at just under £1 billion a year. This figure is, however, subject to a wide margin of uncertainty.

Many mental health conditions are persistent and recurrent, with a particularly high degree of continuity between adverse mental states in childhood and those in adult life. Taking a life course perspective, the total long-term cost of perinatal depression and anxiety is estimated at around £0.55 billion for each one-year cohort of births in the WMCA. National prevalence data suggest that about 2,600 five-year-old children in the WMCA are likely to have conduct disorder, and the estimated aggregate lifetime cost for this one-year cohort is £0.7 billion.

Mental Health Support in the West Midlands

Mental Health in the West Midlands Combined Authority

Promoting Public Mental Health

Local authorities and CCGs are investing in public mental health initiatives targeted at the general population or at specific populations. These include:

- Training and events to promote awareness and tackle stigma for the general public, front-line professionals, and employers, including Mental Health First Aid.
- Perinatal and parent/infant health and mental health programmes.
- Parenting programmes, including programmes targeted at high-risk families.
- School-based mental health promotion and prevention programmes, such as anti-bullying.
- Workplace interventions, such as healthy workplaces programmes.
- Targeted initiatives for at risk groups, including social and community activity for people from Black and Asian communities to raise awareness of mental health and wellbeing, provide peer support and promote access to services.
- Tackling violence and abuse, often through responding to domestic violence and abuse

Programmes to improve the physical health of people with mental health problems

- Suicide prevention

Some of these initiatives are short-term projects and at particular risk of austerity measures being taken by Local Authorities to reduce overall expenditure.

Universal services notably, the police, fire service, libraries and museums have an important role to play in prevention, as front-line services, by promoting awareness of health and wellbeing and self-management, and access to appropriate support.

There is considerable scope to develop a strategic approach to public mental health and prevention, and the introduction of the Prevention Concordat offers a critical opportunity for the WMCA to adopt prevention, in a context of a life course approach, as a key focus.

Primary Care

There are 716 GP practices covered by the 15 CCGs in the WMCA. It has been estimated that about one in four adults of a GP’s patients will need treatment for mental health problems but there is substantial variation in practice sizes and the level of mental health needs in each CCG.

Primary care plays a central role in any prevention strategy because of its provision of universal services, eg, to pregnant women and new mothers; sexual health and STI testing services, as well as approaches for people with long-term physical health conditions, and there may be opportunities to strengthen these at a practice level. It is not clear the extent to which this is happening at practice level or being promoted by CCGs.

There is no single model or agreement about what good primary mental health care looks like across the WMCA. However, several CCGs are in the process of redesigning primary care mental health services to strengthen mental health provision in primary care, with early intervention and access to specialist support.

Early Intervention

Any general strategy for early intervention should focus mainly on childhood. Targeting people and aiming to reduce the impact of Adverse Childhood Experiences (ACEs), such as abuse or neglect.

Health and Wellbeing Hubs being developed across the WMCA are an important strand of enabling people to access appropriate support as early as possible and these need to be complemented by initiatives to engage with socially disadvantaged groups.

The benefits of early intervention (EI) for young people with a first onset of psychosis are wide ranging and the West Midlands was a pioneer in implementing early intervention services for this group. Such services are provided by three of the four main specialist mental health Trusts and Forward Thinking Birmingham, and the service provided by Worcestershire Health and Care NHS Trust has been identified as positive practice.

Access and waiting time standards for EI services were introduced in 2015/16 by NHS England and data on performance against this target is only largely available and access is not, as yet, comprehensive for the WMCA.

Annual expenditure on primary care prescribing spend on mental health is £12 per head in the WMCA, compared with a national average of £13. Spending per head by CCG ranges from £8 to £15.50.

Improving access to Psychological Therapies (IAPT) is a key strand of primary mental health care. The referral rates for IAPT vary across the country and in 2013/14, 13% of people with anxiety and depression across WMCA (compared with 12% across England) accessed IAPT services at any one point. The West Midlands was below the national average for IAPT; 421 people compared with a national average of 691 referrals per 100,000 population. Although there has been an improvement in the number of people waiting less than 28 days for therapy, there is considerable variation across the CCGs in the WMCA and 40% of CCGs are below the average for England.

Specialist Mental Health Services

At any given point, around 2% of service users in secondary mental health care will be in mental health inpatient beds. The average number of psychiatric inpatient beds per 100,000 population which is below the national average of 250. The picture is similar for self-harm. There is, however, significant variation across CCGs in the WMCA, from less than ten to more than 400 attendances per 100,000 population.

The West Midlands has lower numbers of people in contact with specialist mental health services than other areas of England.

In the WMCA, the average spend on specialist mental health services is £164 per head of population, with a range from approximately £110 to £220, compared with an England average of £154.

The three main providers are Birmingham and Solihull Mental Health NHS Foundation Trust; Black Country Partnership NHS Foundation Trust; Coventry and Warwickshire Partnership NHS Trust; and Dudley and Walsall Mental Health Partnership NHS Trust. Specialist mental health services are also commissioned from South Staffordshire and Shropshire Mental Health Trust and from Worcestershire Health and Care NHS Trust for residents of Bromsgrove, Redditch and Wyre Forest. Forward Thinking Birmingham provides mental health services to children and young people up to the age of 25. The four main providers have come together to form an alliance under NHS England’s New Care Models Vanguard Programme: the mental Health Alliance for Excellence, Resilience, Innovation and Training (MEND), which aims to spread best practice and reduce variations in cost and quality.

The overall bed numbers are broadly similar to four years ago, although there has been an increase in the number of secure beds and a reduction in the number of beds for older adults.

There was an average of 185 admissions to psychiatric inpatient beds per 100,000 population during 2013/14, compared with an England average of 227. Admission rates are influenced by a number of factors, including population demographics and bed occupancy as well as access to community support and supported accommodation.

Approximately a quarter of people admitted were detained under the 1983 Mental Health Act. The rates of detention have been increasing nationally for the past 20 years and this is reflected in the figures for the WMCA. In 2014/15, the average annual rate of detention per 100,000 population, slightly above the England average of 77.7. In 2015/2016, people from Black/British/Black/Mixed and British Asian/Asian/Mixed Asian together constituted 42% of people detained under the MHA and this is above the expected rate.

The four NHS Trusts provide a broad range of outpatient and community services. The single focus is largely on people with a severe mental health condition: early intervention teams; intensive home brokerage; becoming crisis response teams; generic community mental health teams; recovery and wellbeing teams, enabling daily living, problem-solving and coping skills; and outreach teams.

CRISIS INTERVENTION

The Care Quality Commission has recently identified that mental health crisis care represents an issue of significant, persistent and inadequate. All CCGs in the WMCA have developed action plans.

Promising initiatives in the WMCA include street triage, the redesign of the urgent care pathways and crisis houses. Those who are most disadvantaged have to travel further to crisis houses that are more cost-effective than inpatient care and are more valued by service users. However, only one in four in the WMCA.

The rate of attendance at A&E for people with mental health problems in the WMCA is 180 attendances, per 100,000 population which is below the national average of 290. The picture is similar for self-harm. There is, however, significant variation across CCGs in the WMCA, from less than ten to more than 400 attendances per 100,000 population.

The AGGREGATE COSTS OF MENTAL HEALTH PROBLEMS IN THE WMCA IS ESTIMATED AT AROUND £12.6 BILLION IN 2014/15

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There were a total of 1,284,255 contacts with community teams in 2014–2015, but the figures on their own do not enable an understanding of the relationship between need, referrals and service location or the extent to which health and social care needs were met.

A mismatch between estimated need and provision has been highlighted for specialist community perinatal mental health services, with better figures for women of white ethnicity than for women from BAME communities. Organisations in the WMCA have been pioneers in developing innovative models of care and this includes mental health in primary care; early intervention; home treatment; street triage; Rapid Assessment, Interface and Discharge. The WMCA provides an opportunity to scale these up across the area, and to reduce variations in access and uptake of well evidenced interventions.

**LOCAL AUTHORITY**

The majority of mental health-related spending on mental health by Local Authorities is on accommodation services, social work services and commissioning services to provide social work services and commission a broad range of mental health services from the third sector. The role of social work in mental health includes ensuring eligible people can access social care resources, including direct payments and personal budgets, and acting as Approved Mental Health Practitioners, alongside other mental health professionals, and in building community capacity.

The Care Act 2014 placed a duty on Local Authorities to promote wellbeing (physical and emotional, when carrying out their duties (Department of Health, 2014). Increasing thresholds for eligibility, reflecting reductions in Local Authority budgets, may mean that many people simply are not getting the support they need, with the responsibility for providing care shifting to informal carers.

During 2014/15, approximately 4,380 people (1.8% of the WMCA population) received Local Authority-funded Mental Health Support in the WMCA: 12.9% received a direct payment and 87.1% received the personal budget. The use for mental health clients is substantially lower than for other client groups.

**THE THIRD SECTOR**

The third sector, often referred to as the voluntary sector, comprises charities, private companies, and the assorted community groups, which are typically driven by a social mission, are close to and have expertise in communities, and involve service users and local people in their governance arrangements. It occupies a specialist niche within a wider ecosystem of mental health support, reflecting the marked involvement of current and former service users.

This report does not do justice to the wealth and diversity of the third sector across the WMCA in relation to mental health. This requires further work to better understand the sector’s contribution. Third sector services serving individuals with mental health problems are provided by: specialist mental health organisations, for example Mind; organisations primarily concerned with social issues, such as domestic violence, for example Women’s Aid, or homelessness, for example St Mungo’s; those primarily concerned with a client group, for example Sight & Health for Deaf people; or with a community, for example organisations providing services to African-Caribbean, South Asian or asylum seekers and refugees; and universal services, such as Citizens’ Advice. Such organisations vary in size and capacity. The types of services provided across the WMCA by the third sector include:

- Well-being hubs and open access services
- Advocacy, both statutory and non-statutory advocacy to enable people to have a voice and greater choice and control
- Carers’ support groups and events to promote their wellbeing
- Counselling, including bereavement counselling and trauma-focused counselling
- IAPT services and stress and anxiety management courses
- Creative sessions: art, writing and music
- Horticulture/conservation/sports projects, for example, football targeted at men who would not ordinarily access mental health services
- Community development workers to increase engagement with particular groups
- Welfare rights advice, including benefits, debt and housing
- Recovery-oriented courses and workshops
- A wide range of employment support
- A range of support with housing including accommodation, floating support to enable people to maintain their independence, while ensuring that their mental health needs and daily living skills are being developed
- Mental health awareness training including Mental Health First Aid and suicide prevention training

**INITIATIVES TO PROMOTE GOOD MENTAL HEALTH ARE AT RISK OF AUSTERITY MEASURES BEING TAKEN BY LOCAL AUTHORITIES**

**QUALITY OF LIFE FOR PEOPLE WITH A DIAGNOSIS OF MENTAL ILLNESS**

**HOUSING**

Over 75% of the 1,144,050 homes in the WMCA are either in the private rented sector or owned by individuals. Housing Associations, charities and the local authority are over a quarter of a million homes, providing social housing or supported housing for people with particular needs. The majority of housing provision (out of a care or hospital environment) is in the form of supported housing or floating support for those in general needs housing.

There has not been a strategic assessment of mental health needs and housing and this has not been considered in any detail within the JSNAs. The Local Housing Allowance cap on the amount of housing benefit that can be claimed means that there is a substantial shortfall between the rent for supported housing, and the amount of rent which will be funded. The delay on the introduction of this cap is adversely impacting upon the development of supported housing and, if introduced, will mean that 41% of all schemes will become unviable. In addition, 20% of adults who are in contact with secondary mental health services and on a Care Programme Approach (CPA) are unable to access appropriate accommodation. This compares favourably with an England average of 55% but there are some other factors which are useful to identify how to improve their performance.

There is a general dearth of research into housing models for people with mental health problems. However, promising evidence for improved health and social outcomes as well as economic benefits, is emerging for Housing First. Housing First services are provided for people who are homeless and have: a history of exclusions in Birmingham, Solihull, Coventry and Stratford-upon-Avon, as well as in other providers in the West Midlands. TheWMCA Strategic Housing Group, whose aim is to promote further partnership working between Housing Associations, the NHS and local authorities based on evidence, from their work to date, that

**THE INTELLIGENCE ON WHICH TO DEVELOP A STRATEGIC APPROACH TO MENTAL HEALTH IN THE WMCA IS NEITHER COMPREHENSIVE NOR COORDINATED AND THIS HAMPER STRATEGIC DEVELOPMENT AT BOTH A LOCAL AND WMCA WIDE LEVEL**
In the WMCA, the average employment rate for people on the CPA was 10%, above the England mean of 7%, but there was considerable variation between the CCGs, ranging from 4–22%. There are initiatives underway to promote health and wellbeing at work.

**CRIMINAL JUSTICE SYSTEM**

- Offenders and ex-offenders are at increased risk of poor mental health and people leaving prison are at an increased risk of suicide and self-harm. Persistent offenders are likely to have experienced severe and multiple disadvantage. Poor mental health and/or substance abuse increases the risk of re-offending, strengthening the case for effective mental health support, including early intervention, family-based approaches and increasing capacity across the criminal justice system to identify and respond to good mental health.
- Integrated offender management is a key operating approach within the West Midlands Police area and has resulted in the West Midlands being within the lowest ten top areas for reoffending for the last two years.
- There are 17 prisons, including one for women, in the West Midlands. Gaps in provision relating to primary care mental health and counselling have been identified with a recommendation that IAPT is introduced to address common mental health needs for people in prisons.
- Problems in obtaining secure beds for people requiring transfer under the Mental Health Act have also been highlighted along with a lack of capacity for prison staff to attend relevant training.
- Initiatives in the WMCA to provide support include: Criminal Justice Liaison and Diversion Teams provided by the mental health trusts – Prison in-reach teams provided by the mental health trusts – Support for prisoners ‘through the gate’

**THE MENTAL HEALTH OF CHILDREN AND YOUNG PEOPLE NEEDS TO BE A PRIORITY, AS INTERVENTION IN THE EARLY YEARS HAS BEEN SHOWN TO REDUCE MENTAL HEALTH PROBLEMS IN ADULTHOOD**

- A considerable investment in mental health is being made across the WMCA and this report provides a starting point for discussion about how well this is currently deployed.
- If the high costs of poor mental health are to be substantially reduced, the mental health of children and young people needs to be a priority, both for its immediate benefits and because intervention in the early years has been shown to reduce mental health problems in adulthood.
- There are strong links between mental health and socio-economic conditions and the risks of experiencing poor mental health are not uniformly distributed across the WMCA.
- The intelligence on which to develop a strategic approach to mental health in the WMCA is neither comprehensive nor coordinated and this hampers strategic development at both a local and WMCA – wide level.
- Personalised approaches that respond to what people say and what they think they need to happen, are an important strand of effectiveness and could save money. Meaningful co-production and co-design of services with local people and mental health service providers are central components of service transformation but there is a long way to go to embed this approach as a golden thread in the transformation of mental health in the WMCA.

**RECOMMENDATIONS**

- In order to develop a strategic approach to promoting mental health across the WMCA, the following recommendations are made based on our appraisal of costs and provision across the area:
  1. The intelligence for developing a strategic approach by the WMCA is under developed and the overall quality – and indeed availability - of current needs and strategic Needs Assessment is very variable. An intelligence hub to bring together local data to provide mental health systems intelligence across the WMCA should be developed.
  2. The approach to intervention and monitoring needs to encompass both quantitative data on access and outcomes and fine-grained qualitative data to understand the real life experience of people with mental health problems and their preferences for support and the outcomes they are seeking to achieve.
  3. Co-production should be a foundation for mental health service transformation across the WMCA and will help ensure that accessible, acceptable and appropriate services are commissioned, developed and delivered to meet the diverse needs of the WMCA population.
  4. It is essential to understand the diversity of the WMCA population, in terms of inequalities in outcomes; conceptions of mental health; barriers to access; and preferences in terms of service design and support. This needs to include those who do not currently access any support and may be further marginalised by an emphasis on self-management. This is central to ensuring that inequalities are not embedded in the approach of the West Midlands Mental Health Commission.
  5. This assessment has identified groups who are at particular risk of poor mental health and who may be in contact with a range of public services, with effort duplicated between them. Improving coordination and partnership working for these populations should be a priority.

6. A strategy for public mental health needs to be developed for the WMCA. Any strategy to improve the mental health of the WMCA population has to invest in the mental health of children and young adults and this will prove to be cost-effective. This includes attention to parental mental health and substance misuse.

7. There is not a shared understanding of what good primary mental health care looks like and different models are emerging across the WMCA. Identifying the components of good primary mental health care should facilitate a coherent approach across the WMCA and ensure that the full potential of primary care is maximised to support people with mental health problems, including people with co-morbid physical health problems.

8. Organisations and communities in the WMCA have pioneered innovative approaches in mental health that have been adopted outside the area. There are also examples of promising practice where the evidence is incomplete. Where this is the missing, the evaluation of such initiatives will be an important part in understanding the feasibility for scaling up across the WMCA.

9. There is good evidence for a range of interventions that have yet to be adopted at any scale within the WMCA. The implementation of evidence-based practice needs to be understood within the WMCA context and prioritised.

10. There are clear variations in system performance across the WMCA and the factors influencing both good and poor performance requires investigation and action by the relevant organisations to improve overall system performance.

11. There should be a commitment by CCGs and the main mental health providers, supported by achievable aims and objectives, to reduce the overall rate of detentions under the Mental Health Act and particularly those of people from BAME communities, and the use of seclusion and restraint.

12. Commissioners across the WMCA should aim to reduce the rate of Out of Area placements by developing appropriate local provision and strengthening investment in community based services, including crisis and recovery houses.

13. The evidence for personalised approaches that give people greater choice and control align with what service users and carers are asking for and are supported by evidence that indicates that they lead to better outcomes. Local Authorities should identity action to increase the use of direct payments and personal budgets.

14. A comprehensive audit of housing provision to support people with mental health problems would enable the West Midlands Mental Health Commission to further investigate the range of provision and develop a strategic approach to housing and mental health, building on the emerging evidence for Housing First.

15. The wider adoption of high quality Individual Placement and Support services should be encouraged.

16. This is challenging work, systems are slow to change and it is not a linear process. The key issue going forward is to ensure the spread of good practice and build on and strengthen the positive partnerships and collaborations which are clearly evident. The Commission should, therefore, identify the workforce development implications for achieving the required transformation.
Introduction

The University of Birmingham’s Health Services Management Centre (HSMC), in partnership with the Centre for Mental Health, was commissioned by the West Midlands Combined Authority (WMCA) Mental Health Commission to undertake a baseline assessment of the costs of mental ill health and current service provision across the Authority. The main objective of this report is to provide an ‘audit’ of mental health and well-being in respect of the mental health and well-being of adults of working age in the WMCA, in order to inform work of the Mental Health Commission.

THE WEST MIDLANDS COMBINED AUTHORITY

The WMCA covers the geography of three Local Enterprise Partnerships (LEPs) – Black Country, Coventry and Warwickshire, and Greater Birmingham and Solihull, which currently covers 12 councils (seven metropolitan and five district councils, within 3 County Councils with a further five awaiting membership) and 15 Clinical Commissioning Groups (CCGs), some of which have shared arrangements for mental health with other CCGs or with the Local Authority. The core of the WMCA is the seven metropolitan councils, which are Birmingham City Council, City of Wolverhampton Council, Coventry City Council, Dudley Metropolitan Borough Council, Sandwell Metropolitan Borough Council, Solihull Metropolitan Borough Council and Walsall Council. Together these cover approximately 70% of the population of the three LEPs. The WMCA also includes Sustainability and Transformation footprints for Black Country, Birmingham and Solihull, Coventry and Warwickshire and parts of Staffordshire, Herefordshire and Worcestershire footprints, established to deliver the Five Year Forward View.1

Devolution provides an opportunity to better understand how public services, communities and local organisations can promote public mental health and better work together to prevent poor mental health and provide an efficient and effective response to people experiencing mental health problems, and enable them to realise their ambitions and enjoy a good quality of life. Devolution also provides an opportunity for the WMCA to look longer term and to combine this with early investment to herald a ‘new dawn’ in mental health and tackle inequalities (Social Mobility and Child Poverty Commission, 2015, p.15).

POLICY CONTEXT AND THE WEST MIDLANDS

Mental health has been a policy priority for successive governments and there has been a sustained concern as to whether people of all ages experiencing mental health problems are getting the right help and support at the right time to support their health and wellbeing. No Health without mental health, a cross-government mental health strategy published under the Conservative-Liberal Coalition, made it clear that mental health is everyone’s business (HM Government, 2011). The strategic objectives were focused on:2

- More people having good mental health
- People with mental health problems having a good quality of life with an emphasis on stronger social relationships, employment, stable housing and greater ability to control their own lives
- Ensuring that people with mental health problems do not die prematurely and have good physical health
- More people having a positive experience of care and support
- Access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment
- To ensure that people’s human rights are protected
- Services that people receive being of the highest quality and in which they can have confidence
- Fewer people experiencing stigma and discrimination

This policy direction was subsequently reinforced by the priorities set out in Closing the Gap: Priorities for Essential Change to support the transformation of mental health services (Department of Health, 2014). A central ambition is for mental health to have parity of esteem with physical health, providing a central focus for NHS England3. Parity of esteem means valuing mental health and physical health equally and ensuring that access to appropriate treatment and support, early intervention and response in a crisis, as well as inequalities in the life expectancy of people with a severe mental illness are addressed. It also means that reducing inequalities in the levels of resourcing for mental health services compared with physical health services should be a strategic priority. To promote parity with treatment for physical health conditions, two access and waiting time standards were introduced on 1 April 2015 for mental health (Department of Health, 2014), so that:

- 75% of people referred to the Improving Access to Psychological Therapies (IAPT) programme will be treated within 6 weeks of referral, and 95% within 18 weeks of referral
- More than 50% of people experiencing a first episode of psychosis will be treated with an evidence based care package within two weeks of referral

In March 2015, NHS England established an Independent Mental Health Taskforce to develop a five-year strategy for mental health and its report, The Five Year Forward View (SYPF) for Mental Health, was published in February 2016. This sets out 57 recommendations, requiring a range of government action and multi-sector collaboration, under the following themes:

- Commissioning for prevention and quality
- Good quality care for all, seven days a week
- Innovation and research to drive change
- Strengthening the workforce
- Transparency and a data revolution
- Incentives, levers and payments
- Fair regulation and inspection

The SYPF for mental health makes clear that a robust governance framework needs to be put in place to implement this five-year programme to transform mental health care. Alongside this, attention has also been paid to the commissioning and provision of accessible support for children and young people. A Children and Young People’s Mental Health and Wellbeing Taskforce was established in September 2014 and the strategy, Future in Mind published in 2015 (Department of Health, 2015). The focus of this is improving access to care and treatment for young people to support them to realise their ambitions.

These priorities are reflected in the 2016/17 CCG performance framework, which includes five indicators for mental health:4

- IAPT recovery rates
- People with first episode of psychosis starting treatment with a NICE recommended package of care treated within two weeks of referral
- Children and young people’s mental health services transformation
- Crisis care and liaison mental health service transformation
- Out of area placements for acute mental health inpatient care transformation

These policy developments reinforce that mental health is a priority for the NHS. They do, however, need to be set within a wider context of changes to public services, and in particular the impact of austerity measures on Local Authority budgets, which combined with shifting eligibility criteria will impact adversely on access to services and the range of support available.

THE AIM S AND SCOPE OF THIS PROJECT

Against this policy background the West Midlands Mental Health Commission was established in September 2015 to identify the contribution that the WMCA could make to addressing poor mental health and wellbeing for adults of working age. The brief for this project, defined by the West Midlands Mental Health Commission, was to identify:

- The costs to the West Midlands of poor mental health, including the costs to public services, employers, and the welfare system as a result of mental ill health; current spending on mental health by CCGs and local authorities in the WMCA; and the overall cost of mental ill health to the region;
- An audit of current statutory sector (NHS/Local Authority) and voluntary sector mental health service provision in the WMCA to describe current community and inpatient services provided for adults and young people and current performance against key mental health indicators;
- An audit of current or planned initiatives relating to mental health, whether public, private or voluntary sector to include crisis care; housing and related support; employment; recovery colleges; services for use of substances and prevention and promotion.

While recognising that the mental health of children and young people is of fundamental importance in shaping mental health in adulthood, the scope, determined by the Mental Health Commission, is adults of working age in the area covered by the three LEPs. It is also important to recognise that child and adolescent mental health problems can impact upon the prevalence of mental health disorders for older adults, and so these were included in the study. The aim was to identify both published and unpublished material. The analysis focused on identifying examples of promising current and emerging directions to be pursued.

Calculation of broad estimates of the overall economic and social costs for the population of the WMCA as a consequence of mental ill health, using nationally and locally available data. Data was sought from Local Authorities and CCGs using a bespoke audit form to provide detail on expenditure for 2014/15 (see Appendix 1). However, as the responses were extremely patchy and incomplete, use was made of NHS programme budgeting data available to identify CCG expenditure, for 2014/15 and published in Analysis of Personal Social Services Expenditure and Unit Costs for Councils in England for 2014/15 for spending by Local Authorities. Where local cost data has not been readily available, other – usually national – sources have been drawn upon, and assumptions were made for the West Midlands have been produced by making adjustments for such factors as: (i) local health care costs and differences in prevalence of mental health problems in the WMCA compared with the national average in the population of working age. In one or two cases, most notably criminal justice, important methodological problems remain unresolved, e.g., the exact relationship between offending and mental health, and in these cases the best approach may be to offer a range of illustrative figures based on different assumptions.

2 www.england.nhs.uk/mentalhealth/party
There are strong links between mental health and socio-economic conditions. Over half of the population of the WMCA is living in the 20% most deprived areas in England.

The material on promising practice makes no claims to comprehensiveness but provides an indication of the breadth of activity and highlights variations in provision. It raises important considerations for a strategic approach by the West Midlands Mental Health Commission. First, while the research evidence points to promising interventions, it is clear that their implementation in a WMCA context is patchy, for reasons that are not always clear. Second, the available research evidence never provides the full story and there are examples of innovations and promising initiatives that are being developed but have yet to be scaled up or evaluated. Third, the implementation of promising practice raises questions about fidelity to the model and the role of contextual factors, particularly in a context of co-production.

Mental health of the West Midlands Combined Authority

Population

There are an estimated 4,032 million people living in the Combined Authority area (2014/15 data) corresponding to 7.0% of the population in the West Midlands Region, 7.4% of the population in England and 6.2% of the population in the UK. The population is projected to increase by 9% by 2030*. Sixty four per cent of the population of the WMCA are adults of working age, aged 16–65 (Appendix 2). Overall, the population of the WMCA is culturally diverse and in the 2011 Census people from Black, Asian and Minority Ethnic (BAME) communities made up 22% of the total population, compared with an average of 20% for England and Wales*. However, the overall figure obscures important demographic variations across the WMCA with some Local Authorities having a substantially higher percentage of people from BAME communities. For example, Birmingham’s population, which constitutes a quarter of the overall WMCA population, has 42% of its residents from an ethnic group other than White British* (and a younger profile than the English average) in comparison with 23% for Cannock Chase and 2.7% for Stratford-upon-Avon and Tamworth. None of the population groups are homogeneous and understanding differences within populations groups is important for developing approaches to improving the mental health of the population (see for example: Newbugging, Bola and Shah, 2008) and ensuring that inequalities are not embedded in the development of a strategic approach by the West Midlands Mental Health Commission.

In order to conceptualise the mental health of the WMCA population it is useful to distinguish between: the general population who have good mental health and for which the task is sustaining this; the population at risk where the focus becomes reducing avoidable risks; the population with symptoms and where the need is to ensure early identification and intervention; and the population with a diagnosed mental disorder for whom the focus is on optimal management and support to promote recovery and inclusion (as depicted in Figure 1).

Prevalence of mental health problems in WMCA

The National Psychiatric Morbidity Survey identified 23.8% of all adults in the West Midlands Region with some kind of mental health problem, compared with 23.0% in England as a whole (McManus et al, 2009). Any survey of the household population is likely to underestimate prevalence, as people with psychosis and alcohol dependence are more likely to be homeless or reluctant to answer questions.

There are strong links between poor mental health, smoking, alcohol and substance use. People with mental health problems are more likely to smoke (McManus et al, 2007) and most people using substance misuse services have mental health problems, with co-morbidity being highly prevalent in community mental health teams populations (Weaver et al, 2003). In the West Midlands in 2014/15, approximately a fifth of people in contact with mental health services were also in contact with alcohol (23.4%) and/or substance misuse services (18.5%)*.6

This report provides a baseline of costs, service provision and initiatives across the WMCA.

Notes

4 See the Projecting Adult Needs and Services Information tool. Available at: www.pansi.org.uk/index.php?page=407&PHPSESSID=313347c383b18f9739b7b1c6c51=8685b&np=1 [accessed 141016].
6 As above.
7 The results of the 2014 survey was published in September 2016 and available at: http://content.digital.nhs.uk/catalogue/PUB21748 [accessed 161016].
8 www.youtube.com/watch?v=1Zj9MKr4DXk [accessed 150816].
9 See the Projecting Adult Needs and Services Information tool. Available at: www.pansi.org.uk/index.php?page=407&PHPSESSID=313347c383b18f9739b7b1c6c51=8685b&np=1 [accessed 141016].
In the West Midlands, in 2015, there were 477 deaths recorded as suicide, which is 9.6 deaths per 100,000 population, lower than the rate for England at 10.9\(^\text{10}\). The rate for men in the West Midlands was 15 deaths per 100,000 population, slightly lower than the England average but more than three times higher than for women at 4.1 deaths per 100,000, broadly in line with national trends. As illustrated in Figure 1, there is a slight downward trend for women, but an upward trend for men in the number of suicides reported from 2010 to 2013, but figures for 2015 showed a slight decrease in the rate for men and an increase for women.

Socio-economic inequalities in suicide risk are evident. A thematic review by the Samartan Network identified that middle-aged men in lower socio-economic groups are at particularly high risk of suicide (Wyllie et al., 2012). The research evidence indicates a complex interplay of factors including unemployment and economic hardship, lack of close social and family relationships, restricted access to supportive networks, reluctance to access formal support, personal crises such as divorce, as well as a general ‘drift’ in subjective well-being among people in their mid-years, compared with both younger and older people (Wyllie et al., 2012). Furthermore, there is emerging evidence that this has been exacerbated by the current post-2008 economic crisis (Wyllie et al., 2012).

People experiencing a severe mental illness have a much lower life expectancy than average, with a mortality rate, more than three times higher than the general population\(^\text{11}\). They are four times more likely to die from diseases of the respiratory system and circulatory system, and two and a half times more likely to die from diseases of the circulatory system\(^\text{12}\). This reflects a variety of influences, including lifestyle factors; the fragmentation of services; a variety of influences, including lifestyle factors; the fragmentation of services; and access to healthcare services including screening (Jones et al., 2008; Lawrence and Keesly, 2010).

**FACTORS INFLUENCING MENTAL HEALTH**

There are a wide range of factors influencing mental health. Social, economic, and physical environmental influences have been shown to be critical, with social inequalities increasing the risk of many common mental health problems (WHO and the Calouste Gulbenkian Foundation, 2014). From a life course perspective, there are risks associated with the inter-generational transmission of inequality and increased risks of poor mental health.

The WMCA covers areas of affluence as well as those with significant socio-economic deprivation and this is reflected in the prevalence data. Eight of the councils have indicators of socio-economic deprivation that are lower than the average for England, while over half of the WMCA population is living in areas, which are among the 20\% most deprived areas in England namely: Walsall, Wolverhampton, Sandwell (Black Country) and Birmingham (Greater Birmingham), which constitute part of the core of the WMCA. In these areas nearly 30\% of children are living in low income households and rates of overcrowding are higher than the average for England (see Appendix 2). The Social Mobility and Child Poverty Commission (2015) recently highlighted the links between financial stress, mental health and child development, which influence life chances and social mobility. Gutman et al., (2015) using data from the Millennium cohort study, identified that the prevalence of diagnosable mental health problems in children is strongly related to parental education, parental occupation and family income. In 2012, 17\% of 11-year-olds from families in the bottom fifth of the income distribution were identified as having severe mental health problems compared with only 4\% among those from families in the top fifth. This income-related gradient is much steeper among children than it is among adults and appears to have become steeper in recent years (Gutman et al., 2015). Another recent review of the evidence has concluded that austerity measures, which have hit poorer people the hardest, have damaging psychological consequences, including humiliation and shame; fear and distrust; instability and insecurity; isolation and loneliness; and feeling trapped and powerless (McGrath et al., 2015: 1).

**The Risk of Experiencing Poor Mental Health Are Not Uniformly Distributed Across the WMCA. There are Links Between Insecure Housing, Financial Stress, and Mental Health and Child Development**

The research evidence indicates that there are links between household income and both suicide and mental health (WHO and the Calouste Gulbenkian Foundation, 2014). From a life course perspective, there are risks associated with the inter-generational transmission of inequality and increased risks of poor mental health.

In 2015 there were 477 deaths recorded as suicide, men more than three times more likely to kill themselves than women. In 2015 there were 477 deaths recorded as suicide, men more than three times more likely to kill themselves than women (Source: ONS Suicides in the United Kingdom, 1981-2001).

**Alternative explanations for these differences point to the differences in social contexts for women’s and men’s lives: women are more likely to be single parents and to have experiences of domestic violence, sexual abuse and discrimination or harassment in the workplace, while men may face unemployment, relationship breakdown and are generally less keen to seek help and support, as noted before. The correlations between Adverse Childhood Events (ACEs) and poor mental health among adult life are well established, as discussed below, and there is increasing evidence that the links between childhood sexual abuse and psychosis is particularly strong, as well as other mental health problems (Bebbington et al., 2011).**

The relationship between deprivation and suicide prevalence is also highlighted by Joint Strategic Needs Assessments (JSNAs) that have examined data at a ward level; for example the Solihull JSNA for 2012 identified that the rates of mental disorders are three times more common in North Solihull than more affluent areas. This analysis emphasises the importance of understanding the impact of deprivation on mental health and its differential effect in terms of demographic characteristics. This is clearly important in considering the mental health of future generations in the WMCA: ‘Invest in children, start with parents’ (Heigbornath and Newbigging, 2013). However, the causation also runs the other way, ie mental health leads to deprivation, eg because it prevents people from working. This phenomenon, sometimes termed social drift, is particularly evident for people with a diagnosis of severe mental illness.

**POPULATIONS AT RISK OF POOR MENTAL HEALTH**

The message that one in four of the adult population will experience a mental health problem in any given year is now widely promoted and forms an important strand of the stigma around poor mental health\(^\text{13}\). However, as observed above, the risks of developing a mental health problem, and the times when this problem, are not equally distributed across the population. Homogenising the risks in this way may result in further stigmatising people who are at risk for poor mental health and where access to appropriate support may be problematic and, thus, where targeted action should be considered, are listed below. There will be other groups who are not listed below, eg veterans, where attention should be paid to their specific needs. There is always a danger in drawing attention to people as having specific needs that they are framed in problematic terms. The West Midlands Mental Health Commission need to be alert to the this and locate the issues in the situation and social context of people’s life experiences, as well as understanding population characteristics that may increase vulnerability to poor mental health.

1. **Children and young people Mental health problems in childhood:**

Mental health problems in children and young people can be long-lasting and 50\% of mental illness in adult life (excluding dementia) starts before age 15 and 75\% by the age of 18 (Department of Health, 2013a: 177). As outlined in the Chief Medical Officer’s report for 2013, there are strong associations with socio-economic deprivation with both mothers and children at increased risk of psychological problems and poor general health (Department of Health, 2013a). This underlines the importance of a life course approach and the early years as being a critical opportunity for intervention to promote good mental health. Any strategy to improve the mental health of the WMCA population has, therefore, to address the foundations for good mental health in adulthood by also focusing on children and young adults (WHO and the Calouste Gulbenkian Foundation, 2014; Heigbornath and Newbigging, 2013). There is a growing body of evidence for interventions, to strengthen parenting, develop emotional and social learning and respond to mental health problems in childhood and adolescence on which to build this.
Social disadvantage, including living in receipt of means-tested benefits, is associated with higher rates of unemployment, with rates of unemployment among people from BAME communities being significantly higher than those among the White population. There is, however, some evidence that discrimination and harassment are more likely to be experienced among young BAME British people (Challinor et al., 2016). As we will see in the next section, BAME communities are more likely to be disadvantaged in accessing mental health services, and therefore may be more likely to experience mental health problems than the White population.

3. Homeless people and people living in poor housing

Having a settled home is vital for good mental health for everyone and for people with mental health problems it needs to be considered as a core element of support for recovery (NHS Confederation, 2011). In 2014/15, the mean rate of statutory homelessness, poor housing and overcrowding was 16 per 1,000 households, which is higher than the national average of 2.4 per 1,000 households. It is estimated that around 25% of all people in the West Midlands combined authority are in overcrowded conditions, which are similar to those experienced by other minority communities but may be further compounded by their citizenship status.

Figure 3: Diagnosis of mental illness by equivalent household income and gender (Source: Health Survey for England 2014)24


26 As above, see page 2.

27 Specific request to the constituent members of the WMCA and responses indicated that this information may not be routinely recorded and, thus, the variation in the numbers may reflect this.

28 http://www.migrationsobservatory.co.uk/resources/briefings/west-midlands-census-profile/

29 86% of the total in the West Midlands area.

People who are homeless are typically in a poor state of health and homelessness has been characterised as ‘the silent killer’ because the average age of death for homeless men is 47 years old and even lower for homeless women at 43 (Crisis, 2011). Homeless people are over nine times more likely to commit suicide than the general population. They are substantially more likely to have alcohol and substance abuse problems, with studies indicating that more than half of the population of homeless people are dependent on alcohol or drugs (Fazel et al., 2008). It is estimated that the prevalence of common mental health problems is twice as high and 4.15 times higher for psychosis for homeless people (50–100 times greater for people who are street homeless) compared with the general population (Homeless Link, 2014). As substance abuse problems are also common, it is estimated that 10–20% of the homeless population would fulfil the criteria for a dual diagnosis of mental illness and substance abuse, with nearly half using drugs and alcohol to cope with mental health problems (Homeless Link, 2014). Mental health services have traditionally been reluctant to provide care and support to people with a dual diagnosis and this should be a focus for further inquiry by the Commission.

The rate of rough sleeping has increased by 37% since 2010 (Department of the Environment, Communities and Local Government, 2013) and despite housing being recognised as an important determinant of health, only 4% of homelessness services received any investment from the health sector (Homeless Link, 2014). Whether this is the case for the West Midlands merits further inquiry.

4. Unemployed people

Unemployment is technically defined as not working but actively looking for work, as distinct from economic inactivity, which is defined as not working and not looking for work. Becoming unemployed can have a negative impact on mental health, associated with a loss of income, reduced standard of living, loss of social contacts and a loss of self-esteem. There were 121,400 working age adults recorded as unemployed across the three LEPs, between January and December 2015. The average rate was 6.6% of the 16–64 population ranging from 2.9% for the Coventry and Warwickshire LEP to 8.8% for the Black Country LEP, compared with an England average of 5.3%27.

People who have been unemployed for more than 12 weeks show between four and ten times the prevalence of depression and anxiety and are also more likely to kill themselves (Waddell and Burton, 2006). Poverty and unemployment tend to increase the duration of common mental health problems and debt and financial strain, which can arise from job loss, are also associated with common mental health problems (McManus et al., 2007). Unemployment is also a risk factor for substance abuse (Henkel, 2011). People with mental health problems are more likely to be sensitive to the negative effects of unemployment and there is no evidence that work is harmful to people with a diagnosed severe mental illness (Royal College of Psychiatrists, 2008).

5. Carers

Caring for a family member, partner or friend with a mental or physical health condition can be difficult, demanding and potentially isolating. People who are informal carers may experience considerable feelings of distress. This has been noted in relation to people whose family members are subject to compulsion, experiencing psychosis or dementia and other complex mental health problems as well as long-term physical health conditions (Boydel et al., 2010). The lack of support or ambivalent attitudes towards informal carers from health professionals can compound the experience of distress (Albert and Simpson, 2015).

The 2011 census results indicated that there were nearly 600,000 carers in the West Midlands, equating to approximately 420,000 in the WMCA. The percentage of people providing informal care had increased by 7% between 2001 and 2011 (ranging from 3% in Dudley and Wolverhampton to 7% in Birmingham, Coventry and 8% in Staffordshire and Worcestershire and 11% in Warwickshire (Carers UK, 2011)). This may suggest inequalities in accessing support from statutory services in more rural locations.

These figures include young carers. In England, estimates indicate there are approximately 166,393 young carers, including 9,371 aged between 5- and 7-year-olds. This is an underestimate as many young carers go unrecognised by services and receive no support (Becker, 2012). They are just as likely to be a boy as a girl; one and half times more likely to come from a BAME background and twice as likely not to have English as their first language (The Children’s Society, 2013). Their needs often go unrecognised, although they may miss school, have lower educational attainment and may themselves have a long-standing illness or disability (The Children’s Society, 2013).

6. Lesbian, Gay, Bisexual and Trans people

A recent systematic review identified that people who identify as lesbian, gay or bisexual are twice as likely as heterosexual adults to experience anxiety or depression, suicidality and substance misuse and to have lower wellbeing scores (Seminari et al., 2016). Depression, anxiety, self-harm and suicidality are common among Trans people, amplified by lack of understanding by mental health services and experiences of harassment and misgendering, social exclusion at work, homelessness and relationship breakdown (McNaid et al., 2012).

A survey of Wolverhampton’s LGBT community highlighted significant mental health difficulties including an increased prevalence of self-harm, suicidal ideation, depression and experience of bullying amongst the LGBT community (LGBT Wolverhampton, 2013). The role of peer support in terms of improving outcomes and facilitating access to care pathways and services within the City was emphasised as important in addressing this.

7. People with long-term physical health conditions

Physical and mental health are interdependent and many risk factors are common to both, including social determinants of inequalities; abuse; social isolation; poor diet; physical inactivity and barriers to effective health care (Naylor et al., 2016).

About 4.6 million people in England with a long-term physical health problem also have a mental health problem, typically depression or anxiety, and if left untreated this can intensify their physical health problem, leading to worse outcomes and substantially increased costs of care (Naylor et al., 2012). Medically unexplained symptoms (MUS), ie, physical symptoms with no clear biological basis, are more common than previously thought and are often long-term, impacting significantly on an individual’s quality of life (Naylor et al., 2016). People with learning disabilities and/or sensory impairments

People with learning disabilities, and people who are deaf, have higher rates of mental health problems than the general population, with estimates for people with learning disabilities, from 25–40%. Challenging behaviours (agression, destruction, self-injury and other) are also evident for 10%–15% of people with learning disabilities and, consequently, they are often represented in the criminal justice system. People with learning disabilities are also vulnerable to violence and abuse. As with other socially disadvantaged groups, access to appropriate services has been problematic and people typically face barriers in accessing services and learning disability services.

9. Offenders and ex-offenders

The relationship between mental health problems and offending is complex, but the following broad generalisations are supported by the available evidence:

Most crime is committed by young males, many with a history of serious behavioural problems in early life

The mental health conditions most commonly associated with offending are substance misuse (alcohol and drugs) and a diagnosis of personality disorder, particularly anti-social personality disorder

Multiple diagnoses significantly increase the risk of offending, for example anti-social personality disorder combined with hazardous drinking (Coit, 2010).
People in custody are particularly vulnerable to poor mental health. The total prison population in the West Midlands on 31 December 2014 was 9,442. Eleven of the prisons are for men. Women comprise 3.32% of the prison population in the West Midlands, with an average of 4.51%. Approximately two thirds (64.9%) of people accommodated in prisons are aged between 21–39, 71% of the prison population are White British, 11% are Black or Black British (equivalent to the national average but higher than the population percentage of 9%), and 19% are Asian/Indian Asian (higher than the national average of 6%). The rates of self-harm are extremely high, with rates on an upward trend (Offender HNA and Consultancy Projects, 2015) and young men are 18 times more likely than the general population to take their own lives (Offender HNA and Consultancy projects, 2015).

10. People experiencing violence and abuse
There are various forms of abuse: emotional, physical and sexual, including human trafficking, affecting people of all ages and backgrounds. Women are more at risk from sexual abuse and domestic violence with men more at risk from physical violence in public places. There are 48 cases of domestic violence in the West Midlands every day with two women killed every day in England. It is estimated that there are approximately 400,000 people living in the West Midlands who are survivors of childhood sexual abuse. The consequences can be long-lasting and debilitating and include a broad range of physical and mental health conditions. The psychological consequences include anxiety, depression, post-traumatic stress disorder (PTSD), self-harm, suicide, sleep disturbances and emotional detachment. Survivors of domestic violence will also have needs relating to debt, finances and housing. Survivors of sexual abuse are over-represented in mental health services but may not be able to access appropriate support or may experience re-traumatisation, or further violence and abuse, during their contact with services.

11. People experiencing severe and multiple disadvantage
Many people experiencing severe and multiple disadvantage (homelessness, substance misuse and offending) have experienced trauma and neglect, poverty, family breakdown and disrupted education as children and as adults, and have much higher levels of loneliness, isolation, unemployment, poverty and mental health (Bramley and Fitzpatrick, 2015). Both Coventry and Birmingham have well above the national average number of people experiencing severe and multiple disadvantage: an index of 216 and 171 respectively, where 100 is the national average (Bramley and Fitzpatrick, 2015: 22), with none of the Local Authorities in the WMCA featuring in the list with the lowest prevalence. A workshop in January 2016, as part of the WMCA scoping work around Troubled Families, involving experts by experience, identified the importance of a holistic approach underpinned by partnership working, specifically between drug and alcohol and mental health services, early intervention and prevention and listening properly to what people need and responding accordingly.

UNDERSTANDING MENTAL HEALTH ASSETS AND NEEDS
Local Authorities have a responsibility to undertake Joint Strategic Needs Assessments (JSNAs) of their local population. The purpose of JSNAs is to assess current and future health and social care needs within the Health and Wellbeing Board area, to inform strategic planning, and the guidance makes it clear that they must cover the whole population, and ensure that mental health receives equal priority to physical health (Department of Health, 2013).

As illustrated by Appendix 3, the comprehensiveness and the quality of the JSNAs varies between Local Authorities in the WMCA and, thus, the extent to which they provide useful intelligence to inform mental health transformation.

Co-production means shifting the balance of power and expertise from public services and professionals towards local people and service users and carers so issues and solutions are jointly considered and solutions co-designed, and may be co-delivered (Needham and Carr, 2009). This builds on an established tradition of service user and carer involvement but is more radical in its ambition and consequently more challenging for public services and local people (Ellert and Evans, 2012). The importance of co-production in commissioning, designing and providing mental health support cannot be over-emphasised and a now widely promoted as enabling public services to address the challenges they face in terms of rising demand and expectations, falling investment and the democratic deficit in public services (The National Survivor User Network (NSUN) 2012).

The value of co-production lies in harnessing the expertise of people who are experts by experience, who will lead to better services that enable people to have better lives. In a WMCA context it would help ensure that the diversity of the WMCA is properly considered to ensure that access is equitable for all and that the transformation of mental health is grounded in understanding of what matters to people and what they need from public services to get on with their lives.

There are formally constituted independent service user groups that aim to help people who have accessed or are accessing services be involved in the way services are planned, delivered and evaluated, either initiated by service users or by commissioners or providers (see Appendix 4). Such groups provide a foundation for co-production and are an invaluable source of expertise and good practice to support the mental health system transformation through the Vanguards and STPs. As well as being involved in service design, such organisations also provide a range of resources, information and peer support, and respond to user-defined needs that do not necessarily align with the interests of public services. User and carer groups play an invaluable role for the mental health, and wider, system in agitating for change. As well as calling for better access to supportive care, improved understanding of the realities of poor mental health, and a shift in public and professional attitudes, such groups often take a critical stance to initiatives that may be promoted by public services as unproblematic.

There are ten Healthwatch organisations across the WMCA, which serve as the consumer champion of health and social care. They were established as a sub-committee of the Care Quality Commission (CQC), to provide information and advice to government, various NHS bodies and Local Authorities on the views of the local population, and people who use health and social care services, on their needs and experiences of health and social care services, and on the standard of health and social care provision and how it should be improved. Healthwatch organisations across the WMCA are involved in mental health system development and have established networks, and can offer specific expertise in engaging with local communities and OLDF, for example, has developed an Activate approach for involving communities.


34 35 36 37 38
Many organisations in the WMCA express a commitment to co-production and this is particularly challenging for public services who are working within a national policy and a local political context. In a mental health context, a token commitment to co-production will perpetuate services that have little efficacy and are perceived as unhelpful, controlling or profoundly damaging (Needham and Carr, 2009).

Co-production initiatives in the WMCA include:

- Every Step of the Way (ESOW), is a key strand of the Changing Futures Together (CFT), a seven-year lottery funded project (£10M) designed to not only support some of the most complex needs of people in Birmingham but also to ensure system change.
- Birmingham Mind are delivering the service user involvement strand of ESOW and this involves training up 120 Experts by Experience and 30 Involvement Champions each year and matching them with opportunities within the CFT programme and in wider systems.
- Experience-based co-design of hospitalisation in early psychosis in Coventry and Warwickshire Partnership NHS Trust. This project piloted this collaborative approach between service professional and service users to identify areas for service change. The project identified a range of service improvements that are generalisable to other contexts and the learning both about the process and the implementation challenges are informative for future EBCCD projects.
- 300 Voices, a partnership between Birmingham and Solihull Mental Health NHS Foundation Trust, West Midlands Police, Birmingham City Council and Time to Change that seeks to engage with young African and Caribbean men aged between 18 and 25 to engage with communities and hear experiences of inpatient and outpatient care.

Although funding ended in March 2016, these legacy projects being taken forward (see Appendix 4).

Citizens UK Birmingham, an independent membership alliance of civil society institutions acting together for the common good of the city. Founded in 2013, they have trained over 300 leaders on acting in public life through the method of community organising. Over 1,500 people, drawn from Birmingham’s faith, education, trade union and community sectors have participated in public action and building accountable relationships with those in power in the city. Issues they have focused on include access to specialist mental health services for 16-17-year-olds, support for the Living Wage and resettlement of Syrian refugees.

EXPERIENCE-BASED CO-DESIGN IS ONE WAY THAT MENTAL HEALTH STAFF AND SERVICE USERS CAN WORK TOGETHER TO REDESIGN SERVICES AND CARE PATHWAYS

PROMISING PRACTICE: THE UK’S FIRST MENTAL HEALTH PARLIAMENT IN SANDWELL

Launched by the Members of People’s Parliament (MPs) in Sandwell in July 2015, the People’s Parliament enables MPs with lived experience of mental ill health to work in coproduction with strategic leaders and decision makers to lead policy development, shape strategy and improve services and support. They have launched a White Paper and have developed a set of standards for crisis care with local people with recent experience of crisis care that will be embedded locally as a driver to shape what the future looks like. They are aiming to develop employment opportunities with ‘smart’ businesses and community places of safety with the local community across all sectors. There is a launch of the Quality of Life standards in October 2016 in conjunction with Sandwell Health and Wellbeing Board. This parliament will be able to check people’s experience against those standards and the CCG and LA are looking at embedding these into commissioning to drive up quality and direct local need.

The model for the People’s Parliament puts people with lived experience at the heart of strategic decision making and ensures that local people are working in co-production with strategic leaders to find their own solutions. MPs that lead the Parliament are developed by Changing Our Lives through a leadership development programme, ongoing supervision and an array of opportunities to develop their skills in leadership. Based on this experience, time needs to be invested in people to enable them to truly coproduce and be an equal and reciprocal partners at strategic level.

PROMISING PRACTICE: MAKING A DIFFERENCE (MAD) ALLIANCE IN NORTH WEST LONDON

Founded by the National Survivor User Network (NSUN), the Mad Alliance is formed of 32 leaders representing the diversity of eight London Borough Communities. The experiential knowledge of the Alliance includes seeking asylum, poverty, isolation, psychological, physical, sexual, relational abuse and trauma, homelessness, racism, inequality and discrimination. They are involved in Local Authority and CCGs and two NHS Mental Health Trusts and the Like Minded North West London Transformation Board, which involves all system partners, and aims to address unacceptable variations in mental health support and to improve multiagency working. Each Monthly Transformation Board meeting begins with a five-to-ten-minute video summary of current service user and carer experience together with two Alliance advisors attending to represent the Alliance expertise. Cultural change is often difficult to measure over short spaces of time but board members have said that this brings debate closer to the power of their actions and that local decisions have been taken as a result.

See: http://healthwatchdudley.co.uk [accessed 27/07/16]

The CFT programme is now going to be linked with the Troubled Individuals strand of work for the West Midlands Mental Health Commission.

www.birmingham.ac.uk/about-us/engaging-with-our-communities/300-voices [accessed 15/08/16].

This is supported by the University of Birmingham so please note the potential conflict of interest.

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www.changingourlives.org/a-uk-first-mental-health-parliament-launched-in-sandwell

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The economic and social costs of poor mental health in the West Midlands

**ESTIMATING COSTS**

Mental health problems have high rates of prevalence; they are often of long duration, even lifelong in some cases; and they have adverse effects on many different aspects of people’s lives, including their education, employment, social participation, personal relationships and physical health. No other health condition matches mental ill health in the combined extent of prevalence, persistence and breadth of impact. Despite this, the majority of mental health problems go unreognised and untreated (McManus et al., 2009).

In assessing the scale of this impact, the approach taken here is to identify and quantify all the main costs of mental ill health in the WMCA and then to combine these in a single annual total using the common measuring rod of money. Cost is defined broadly to include any adverse effect of mental ill health, wherever it falls and whether or not it is conventionally measured in monetary terms or included in national income.

Using this approach, costs can be grouped together under three main headings: Care costs, covering the costs of health and other services provided for people with mental health problems by the NHS, social services, schools etc. and also the informal care provided by family and friends; Employment costs, covering the costs of output losses in the local economy that result from the damaging effects of mental ill health on people’s ability to work; and Human costs, representing a monetary estimate of the less tangible but crucially important adverse impact of mental ill health on people’s wellbeing and quality of life.

Also provided are some broad illustrative estimates of some costs linked to mental disorder including substance misuse. It is well established that people with mental health problems are heavily over-represented in the criminal justice system (Ministry of Justice, 2008; Boxer et al., 2011), but the nature of the relationship between mental illness and offending is complex and further research is needed before a fully reliable appropriation of the societal costs of crime can be made between mental disorder and other causal influences.

Finally, there is a brief discussion of the lifetime costs of mental health problems, as an alternative to the conventional measures which focus on costs in a single year.

**Mental ill health problems are heavily over-represented in the criminal justice system (Ministry of Justice, 2008; Boxer et al., 2011), but the nature of the relationship between mental illness and offending is complex and further research is needed before a fully reliable appropriation of the societal costs of crime can be made between mental disorder and other causal influences.**

All estimates of costs given relate to the financial year 2014/15, the most recent year for which all relevant data is available, and they cover the full population of the WMCA, estimated at 4.032 million people in 2014/15. Two other pieces of background information, used at various points in the analysis, may also be mentioned at this stage. First, according to the 2007 survey of psychiatric disorder, 23.8% of all adults in the West Midlands Region (taken as a proxy for the WMCA) experience some kind of mental health problem, compared with 23.0% in England as a whole (McManus et al., 2009). Prevalence is thus slightly higher than the national average. Secondly, among all people in work, average pay in the West Midlands in 2014/15 was 7.5% below the England average and 6.7% below the UK average (NOMIS, 2016).

**CARE COSTS**

1. **NHS costs**

The most comprehensive source of data on the direct costs of NHS treatment for people with mental health problems is the annual NHS programme budget published by the Department of Health. This provides a detailed breakdown of health service spending between different disease areas (infectious diseases, cancers, respiratory problems, mental health disorders etc.) and is available both nationally and by individual CCG (Department of Health, 2016).

For mental health disorders, the bulk of expenditure relates to the provision of specialist or secondary mental health services, such as those provided in psychiatric inpatient units and in the community by specialist mental health teams. However, the data also includes mental health-related spending in other settings, such as Accident and Emergency (A&E) departments in acute (non-specialist) hospitals, and on prescriptions for mental health problems dispensed by high street pharmacists. The one major area of spending not allocated by disease relates to GP consultations and for this project it is assumed 25% of all consultations are mental health-related. Based on the latest available programme budget data, it is estimated that total NHS spending on mental health problems in the West Midlands in 2014/15 was 7.5% below the England average and 6.7% below the UK average (NOMIS, 2016).

Medical unexplained symptoms (MUS) are physical symptoms that do not have a readily identifiable medical cause or are disproportionate to the severity of medical illness, and are assumed to be attributable to underlying psychological causes. The prevalence of patients with MUS is high in all health care settings and a significant proportion of these patients become frequent users of services in both primary and secondary care. The overall cost of MUS to the NHS is unknown but results from the additional use of physical health care services is estimated at around £3.25 billion a year (update of data in Birmingham et al., 2010).

Taken together, these estimates for the aggregate costs of co-morbidities and MUS imply that in England as a whole the NHS spends at least as much on dealing with the indirect consequences of mental ill health as it does on the direct provision of services for people with diagnosable mental health problems. The extra costs of physical health care linked to poor mental health come to around £14.25 billion a year in England, and an apportionment of these costs on the basis of population numbers, adjusted for differences in the relative prevalence of mental health problems, implies additional NHS spending in the WMCA of around £0.29 billion a year.

2. **Social care costs**

This component of cost covers spending on social care services, including residential accommodation, funded by local authorities where the primary reason for support is mental health. According to data for local social authorities published by the Health and Social Care Information Centre (HSCIC), gross total expenditure on these services in the WMCA amounted to £0.115 billion in 2014/15 (HSCIC, 2015a).

The annual cost of Looked After Children as a consequence of poor parental mental health and/or substance abuse, based on the estimates of numbers and costs provided by the constituent members of the WMCA, is £0.1 billion.

3. **Other public sector costs**

A recent national study of the public sector costs of mental ill health carried out for the NHS England Mental Health Taskforce (HSCIC) estimated mental health-related expenditure of around £9.2 billion a year in England on public sector programmes other than health and social services (BCG, 2015). Some £7.5 billion of this was accounted for by social security payments, discussed separately below. The remaining £1.7 billion was made up of relatively small amounts of spending in a number of different areas including: schools (specialist educational needs), employment programmes used by people with mental health problems.

The allocation of a share of this £1.7 billion to the WMCA on the basis of population numbers, adjusted for the above-mentioned prevalence of mental health problems, results in an estimated annual cost of £0.13 billion. A further adjustment is made, drawing on evidence not considered in the BCG study which suggests that less than half of all mental health spending in schools is SEN-related, with the bulk going on
Mental Health in the West Midlands Combined Authority

Employment Costs

Mental ill health is the dominant health problem of working adults. This is partly because mental health problems are very common, but also because the burden associated with these problems falls primarily on people during their working lives. The prevalence of mental ill health is highest when people are in their 20s and 30s and then declines steadily with age. This is in striking contrast to physical health, which for all major conditions shows a very pronounced age gradient going in the other way. Indeed, the great bulk of the burden of physical ill health increasingly falls in the post-retirement years.

Poor mental health is thus very common among people of working age and has a major impact on individuals and the economy. For individuals, it can mean difficulties in finding employment, increased risk of losing a job, frequent or prolonged periods of sickness absence and, at worst, long-term unemployment and detachment from the labour market, leading to a downward cycle of low income, worsening health and social exclusion. The longer people are out of work, the lower their chances of ever getting back. For the economy, there are very substantial costs because of the lost production of people who are unable to work or who are under attendance and performance at work are disrupted by their mental health condition.

There is compelling evidence of a positive link between employment and mental health (Waddell and Burton, 2000). People enjoy better mental health when they are in work and worse mental health when they are out of work. The longer they are workless, the more damaging the consequences for their mental health, even leading in some cases to suicide. For people with mental health problems, work can be therapeutic. A return to work improves mental health by as much as the loss of employment worsens it. Some aspects of the work environment can in fact pose a risk to mental health and wellbeing, for example excessive hours, work overload or lack of control, but the overall balance of evidence is that the work environment is not in doubt; work is good for mental health. The benefits of employment greatly outweigh the risks, which are very many and diverse. People with mental health problems often work with harmful effects of long-term worklessness.

Adjustments result in an estimate of around £130 a day for the cost of sickness absence in the WMCA. Allowing also for the above-averages prevalence of mental health problems in the West Midlands, the total cost of mental health-related sickness absence in the WMCA comes out at around £0.56 billion a year.

Turning now to presenteeism, this is more difficult to measure, but adding up evidence such as depression and anxiety on health at work suggests that output losses from these causes are if anything larger, perhaps several times as large but from a cost perspective the most important relate to sickness absence, presenteeism (the loss in productivity that occurs when employees come to work even when unwell and consequently function at less than full capacity) and staff turnover.

In costing this, survey data indicates that in 2014 employees in the UK took an average of 6.9 days off work for health reasons (CIPD, 2015). Evidence from a range of sources suggests that at least 40% of these are due to mental health reasons – and the true proportion may be even higher, for example because it is known that some commonly recorded causes of sickness absence such as back pain are in reality often described as medically unexplained symptoms. Taking 40% as a conservative estimate, this implies an average loss of 2.76 days a year per employee for mental health reasons, equivalent to a total of £1.59 billion working days lost in the WMCA (based on data in ONS, 2016a).

In costing this, it is conventional to assume that from work entails a loss of output whose value in a competitive labour market is equivalent to the money wage, or – more accurately – total compensation per employee, i.e., the money wage plus on-costs such as national insurance and pension contributions. Using national accounts data for 2014 (ONS, 2015a), this implies an average cost of absence of around £165 a day at the national level. Two adjustments are required to take into account: first, the fact that rates of sickness absence are higher for people working with below-average earnings than among the higher-paid; and second, the lower general level of earnings in the WMCA relative to the national average. Taken together, these adjustments result in an estimate of around £130 a day for the cost of sickness absence in the WMCA.

Finally, concerning staff turnover, about four million jobs change hands each year in the UK, with mental health problems accounting for a third of these changes. Based on evidence on the costs of staff turnover given in the Centre for Mental Health review cited above, the total annual aggregate cost of mental health-related turnover in the WMCA is around £0.155 billion. Adding together the above costs of sickness, the above-averages presenteeism and staff turnover, it is calculated that the aggregate cost of lost output because of mental health problems is £2.45 billion a year. Given the number of assumptions invoked in both cases, this is reassuringly similar to the figure of £2.2 billion given above.

Human Costs

The most widely cited statistics on the overall burden of ill health and its breakdown between different health conditions are those produced by the Office for National Statistics in its work on the global burden of disease. These figures are based on a composite health measure, the disability-adjusted life-year (DALY), which is based on the loss of work-years caused by premature mortality and/or serious morbidities. DALYs are defined as years of life lost because of premature mortality with equivalent years of life lost from disability and morbidity. Conseguently, the DALY is a composite measure or quality-adjusted life-year (QALY), which is used by NICE and others in this country for the evaluation of health care interventions. The main practical difference between the two is that the DALY is a composite measure and it is used by NICE and others in this country for the evaluation of health care interventions. The main practical difference between the two is that the DALY is a composite measure and it is used by NICE and others in this country for the evaluation of health care interventions. One of the main practical differences between the two is that the DALY is a composite measure and it is used by NICE and others in this country for the evaluation of health care interventions. The main practical difference between the two is that the DALY is a composite measure and it is used by NICE and others in this country for the evaluation of health care interventions. The main practical difference between the two is that the DALY is a composite measure and it is used by NICE and others in this country for the evaluation of health care interventions.
THE AGGREGATE COST OF MENTAL ILL HEALTH IN THE WMCA IN 2014/15 IS ESTIMATED AT £12.6 BILLION, EQUIVALENT TO A COST OF AROUND £3.100 PER HEAD OF POPULATION

available the total number of DALYs lost in the UK because of mental health problems was 2.618 million (WHO, 2016). This excludes learning difficulties and organic disorders such as dementia but includes alcohol and drug use disorders and self-harm as well as the conditions commonly described as mental illnesses such as schizophrenia, bipolar disorder, depression and anxiety.)

To convert this total into a monetary equivalent, it is assumed that the value of a DALY or QALY is £30,000. This is at the upper end of the £20,000–30,000 range used by NICE in assessing the cost effectiveness of health service interventions are good value for money and is also consistent with the rule of thumb sometimes advocated by the WHO and other international organisations that the value of a QALY should be broadly the same as each country's national income per head of population, which in the UK is currently just under £30,000.

On this basis, the aggregate monetary value of DALYs lost in the UK for mental health reasons is around £78.5 billion a year. Taking into account relative population numbers and the local prevalence of mental health problems, this implies an equivalent cost estimate for the WMCA of about £25.07 billion a year. Sizeable as this figure is, there are a number of reasons for thinking that it is, if anything, on the low side.

First, the value of a QALY used by NICE has remained unchanged since at least 1999/2000, despite the fact that between 1999/2000 and 2014/15 the general level of prices in the economy increased by 40%, money GDP per head of population increased by 60% and NHS spending per head measured in money terms by no less than 125%. The last of these in particular is hard to square with a fixed monetary value for the QALY, as it clearly represents a substantial increase in society’s willingness to pay for better health. The recorded view of the Department of Health is that the value of a QALY should rise over time at least in line with money GDP per head and a guidance document on quantifying the health impacts of government policies published by the Department in 2010 put the value of a QALY in that year at £60,000 (Department of Health, 2010).

Second, the estimates of aggregate cost are not independent of each other, as conduct disorder in childhood and adolescence is a risk factor not only for offending but also for alcohol and drug misuse. Adding together the above figures would therefore entail an element of double counting.

As noted, the current aggregate cost of crime in England and Wales may be estimated at around £70 billion a year. Assuming that levels of crime are broadly the same in the West Midlands as in the rest of the country, an apportionment based on relative population numbers implies an aggregate cost of crime in the WCMA area of around £4.9 billion a year.

In all cases we leave to one side the costs of crime as discussed above, on the grounds that for the time being these are best seen as illustrative estimates.

1. Total costs

The aggregate cost of mental ill health in the WMCA in 2014/15 is estimated at £12.6 billion, equivalent to a cost of around £3,100 per head of population. The breakdown is as follows:

<table>
<thead>
<tr>
<th>Cost Item</th>
<th>Cost (£ billion)</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care costs</td>
<td>3.59</td>
<td>28.0</td>
</tr>
<tr>
<td>Employment costs</td>
<td>3.94</td>
<td>31.5</td>
</tr>
<tr>
<td>Human costs</td>
<td>5.07</td>
<td>40.5</td>
</tr>
</tbody>
</table>

Table 1: Cost of mental ill health to the WMCA

It should be noted that care costs do not include the costs of social security benefits paid to people with mental health problems, estimated earlier at £20.75 billion a year. This is to avoid double-counting with employment costs.

To elaborate briefly, suppose someone currently earning £200 a week has to give up their employment for mental health reasons and make no allowance for out-of-work benefits at £300 a week. The cost to the economy of this change is £200 a week, representing the total cost of the output that is lost. Of this amount, £120 is borne by the individual, whose weekly income falls by this amount, and the remaining £80 is borne by the state in the form of two types of benefit: one helps to pay for social security benefits. On this basis, it would clearly be double-counting to include both the

CRIME COSTS

The overall level of crime in this country reached a peak in about 1995 and has since been falling steadily at around 2–3% a year. At major types of offending have declined at broadly comparable rates, including both violent and non-violent crime. Despite this welcome fall in offending, crime continues to impose huge costs, most obviously on individual victims but also on the rest of society. Comprehensive estimates of the costs of crime were first published by the Home Office in 2007 (Brand and Price, 2009) and partially updated five years later (Dubourg et al., 2014). These show, for example, that the total cost of crime in England and Wales in 1999/2000 was around £60 billion. This covers not just costs falling on the criminal justice system but also – and much more importantly in quantitative terms – costs falling on the victims of crime, including the value of stolen or damaged property, losses in earnings associated with crime-related injuries etc., and an imputed monetary value of the additional and pre-existing costs associated with crime.

To convert this total into a monetary equivalent, it is assumed that the value of a QALY should rise over time at least in line with money GDP per head and a broad assessment is that these two opposing influences have largely cancelled each other out, implying that the total cost of crime in monetary terms is much the same now as it was in 1999/2000.

Two qualifications should, however, be noted. First, there is good evidence that the scale and costs of domestic violence are under-recorded in the Home Office figures, as documented in an analysis produced in 2004 for the government’s Women and Equality Unit (Walby, 2004). Second, there is also more recent evidence that the available sources of data on the numbers of crimes committed each year underestimate the scale of fraud and cyber-crime (ONS, 2015b). A rough allowance for these two factors suggests that the current aggregate cost of crime in England and Wales is of the order of £70 billion a year.

Because of the considerable degree of uncertainty that surrounds any quantification of the social and economic costs of mental illness, these estimates are clearly subject to wide margins of error and at best should be regarded as rough ballpark figures. Much more analysis and much better data is needed to produce more reliable results.

AGGREGATE COSTS IN 2014/15

Puling together the threads, this section provides estimates of the overall costs of mental ill health in the WMCA. Three main measures are used:

(i) Total costs;
(ii) GDP costs, including only those cost components which are covered in national accounts published by NICE; and
(iii) Exchequer costs, representing the overall impact of mental ill health on the public finances.

For the purposes of these calculations, the breakdown is as follows:

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LIFETIME COSTS

Evidence from longitudinal studies shows that, in the absence of effective intervention, many mental health problems tend to be highly persistent and recurrent. There is a particularly high degree of continuity between adverse mental health states in childhood and those in adult life. Most children who have mental health difficulties will also have mental health problems as adults and conversely most adults who have mental health problems will also have had mental health problems as children.

To illustrate, the 1946 British birth cohort survey provides data on symptoms of depression and anxiety measured in the same sample of individuals at various ages between 13 and 53.

A study using this information (Colman et al., 2007) has shown that, looking forward, among all children with depression or anxiety as many as 86% continued to have these problems in adult life and similarly, looking back, among all adults with depression or anxiety 71% first manifested symptoms in childhood.

The importance of continuity as shown by these figures suggests that a valuable way of analysing the costs of mental health problems is over the lifetime, as a supplement to the annual figures of the type given so far in this paper. To illustrate this approach, two examples are given below, the first relating to maternal depression and anxiety during the perinatal period and the second to childhood conduct disorder.

1. Perinatal depression and anxiety

Evidence from a range of sources indicates that around 15–20% of all new or expectant mothers but also because they have been shown to compromise the healthy emotional, behavioural, cognitive and even physical development of children, with serious and costly long-term consequences (NICE, 2014). The risks of these adverse developmental consequences are roughly doubled as a result of perinatal mental illness, after controlling for other influences.

A recent study of the costs of perinatal mental health problems (Bauer et al., 2014) has found the following:

Population data indicate that in mid-2014 there were 53,367 children aged 0–1 in the WMCA (ONS, 2016b), implying a total long-term cost of perinatal depression and anxiety of around £0.55 billion for this local one-year cohort of births, including costs of over £80 million falling on the NHS and social services.

2. Childhood conduct disorder

Early-onset conduct disorder, defined as persistent disobedient, disruptive and aggressive behaviour from very early childhood, is the most common mental health condition in childhood, affecting 4.9% of all children aged 5–10 (Green et al., 2005), and there is strong evidence to suggest that its prevalence has increased significantly over the last 30 years (Collishaw et al., 2004). Longitudinal studies show that the condition is predictive of a wide range of adverse outcomes in later life, including not only continuing mental health problems (uniquely, childhood conduct disorder is a risk factor for all major types of adult psychiatric disorder) but also poor educational and labour market performance, substance misuse, criminality, disrupted personal relationships and even reduced life expectancy (NICE, 2013).

An unsurprising consequence of this array of negative outcomes is that conduct disorder imposes a very heavy cost burden. One study which followed a sample of children from age ten until they were 28 found that the cumulative cost of public services used by those who had conduct disorder at age ten was around $300,000 per head higher in today’s prices than among those with no problems, equivalent to extra spending of around $5,000 a year (Scott et al., 2001). About two-thirds of the additional cost fell on the criminal justice system, with most of the remainder being divided between the education sector and health and social services.

Another study has attempted a broad-based estimate of the lifetime costs of conduct disorder measured from a societal perspective, covering the costs of adverse outcomes relating to mental illness, drug misuse, smoking, suicide, earnings, employment cost of £80 million falling on the NHS and social services.

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employment cost of £200 and the benefit cost of £80. Put another way, there is an important distinction to be made between the cost of an output loss and who pays for it.

2. GDP costs

Total costs as calculated above include two major components which are not usually measured in monetary terms and are therefore excluded from national income as conventionally defined. These are the costs of informal care and the quality-of-life or human costs of mental illness. When these items are excluded, the GDP costs of mental health in the WMCA work out at £6.355 billion a year, made up of care costs of £2.415 billion and employment costs of £3.940 billion.

The aggregate GDP cost of £6.355 billion a year is equivalent to an annual cost of around £1,575 per head of population in the WMCA. In comparison, GDP per head in the area is around £22,700 a year (based on data in ONS, 2014). Taken together, these figures imply that mental ill health imposes a cost in GDP terms which is equivalent to a loss of about 6.9% a year.

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Mental health support in the West Midlands

Mental health support in the West Midlands is provided by a diverse range of providers including: primary care; specialist mental health services; acute non-psychiatric hospitals; community mental health services; social services; third sector organisations; housing organisations; employment services; the private sector; and front-line public services including the police, fire and ambulance services. Each section provides an overview of the main types of services available in the WMCA, current performance against national indicators and illustrative examples of promising practice.

1. Provision in the WMCA

These interventions are targeted at the general population and designed to promote public mental health and wellbeing, and tackle stigma surrounding poor mental health. It is recommended that they should adopt a life course approach, and be based on the best available evidence (Davies, 2013). Initiatives to promote public mental health may be part of a wider approach, for example programmes in prison or in planning urban spaces and are, therefore, not always easy to identify. For the majority of Local Authorities, mental health is included as part of Health and Wellbeing strategies with a small minority having developed a public mental health strategy, for example, Warwickshire18.

Examples of public mental health initiatives being commissioned by Local Authorities in the WMCA are summarised in Appendix 5. These may be funded by Public Health rather than through adult social care or through children’s services in Local Authorities and the equivalent information from the public mental health strategy, for example, Warwickshire18.

There will also be organisational approaches, for example healthy school or workplace initiatives, and community level interventions that may be below the radar of public services but, nonetheless, are important in shaping the context for people’s everyday lives. Social marketing approaches are also popular, and the Five Ways to Wellbeing are widely promoted, although their evidence base and relevance to a multicultural and diverse population is contested. Furthermore, charitable organisations outside the WMCA are providing funding for health and wellbeing initiatives, for example the Big Lottery’s Headstart pilots, to identify ways of helping young people (aged 10-14) deal with life’s challenges, in Birmingham and Wolverhampton46.

This analysis, therefore, makes no claims to comprehensiveness but provides a basis for further interrogation in order to develop a framework for public mental health to inform the strategic commissioning and provision of public mental health interventions.

The activities commissioned by Local Authorities include:
- Training and events to promote awareness and tackle stigma for the general public, front-line services and employers, including Mental Health First Aid
- Parenting programmes, including programmes targeted at high risk families
- School-based mental health promotion and prevention programmes, such as anti-bullying
- Workplace interventions, including Healthy Workplace programmes
- Targeted initiatives for at risk groups
- Tackling violence and abuse, often through responding to domestic violence and abuse
- Programmes to improve the physical health of people with mental health problems
- Suicide prevention

Mental Health and Wellbeing Awareness

This includes events and training courses, usually aimed at the general public and staff working in front-line services. Such events and courses have a broader focus than Mental Health First Aid training and may adopt an explicitly social and public health focus. For example, Sandwell Council commissions awareness courses for any individual working within Sandwell, including a range of health, social care and voluntary sector services, faith workers, statutory services such as police and fire departments, and workplaces in general. Coventry and Warwickshire Mental Health Foundation Trust are providing mental health awareness training in A&E to support their Crisis Care Concordat.

Mental Health First Aid (MHFA) was introduced to England in 2007 as part of a national approach to improving public mental health and has been provided for young people, in schools, in workplaces and with front-line services as well as members of the general public. MHFA is being commissioned in the WMCA across England, and in the WMCA this includes staff from Accord Housing Association Ltd; Birmingham City Council; Birmingham Mind; Birmingham and Solihull Mental Health NHS Foundation Trust; Bita Pathways; Coventry and Warwickshire Solutions (Own company); Coventry; Coventry and Warwickshire Mind; Coventry University; Dudley MBC; Dudley Mind; Kaleidoscope Plus Group; The Lateef Project; Midlands Heart; Sandwell Mind; Severn Trent Water; Specialist Inclusion Support Service; Tranquility Counselling Service; Worcestershire Rape and Sexual Abuse Support Centre; University of Warwick; University of Worcester and Walsall Council.

Suicide prevention

Applied Suicide Intervention Skills Training (ASIST) is a recognised two-day Suicide Prevention course, which goes into more detail than MHFA, which only briefly covers suicide prevention. This training is being commissioned and provided for any individual working within several Local Authorities (Dudley, Sandwell, Walsall, and Warwickshire) including a range of health, social care, primary care and voluntary sector services, faith workers, statutory services such as police and fire departments. Mandatory mental health training, that includes suicide prevention, is increasingly being promoted for GPs to enable them to identify patients at risk and appropriate interventions.

2. Performance against national indicators

There are two main indicators that are currently being used to evaluate mental wellbeing: the ONS subjective wellbeing and the Warwick Edinburgh Mental Wellbeing Scale (MEWBS). The ONS subjective wellbeing measure comprises four questions that are included in the Annual Population survey to assess the personal wellbeing of the population. MEWBS is often used to evaluate the impact of interventions, as for example the evaluation of the Easteem Team, an integrated primary care mental health and wellbeing service in Sandwell (Thiel et al., 2013).

Using the ONS subjective wellbeing scale, the ONS reports that personal wellbeing has increased over the past five years but the data started to be collected in 201247. A summary of the data from 2011 – 2014 indicates that the overall average for the highest levels of personal wellbeing on the Life Satisfation index is decreasing48.

The Public Health Outcomes Framework also provides a number of indicators focused on mental illness: those with a diagnosis of mental illness living independently; mental illness in the prison population; those with a diagnosis of mental illness in employment; self-harm and suicide; mortality with a diagnosis of mental illness; suicide and dementia rates. These are reported under the relevant section in this report. There are also wider indicators in the Public Health Outcomes Framework which can be interpreted as a consequence or determinant of poor mental health eg. domestic abuse, homelessness, absence from school or work, social connectedness and physically active adults.

47 www.biglotteryfund.org.uk/healthprojects [accessed 150816]
48 http://mhwangland.org/ [accessed 150816]
50 Source: ONS Reference Tables: Life Satisfaction by Local Authority Districts, April 2011 to March 2014.
51 Birmingham, Coventry, Dudley, Sandwell, Solihull, Walsall, Warwick and Wolverhampton.
52 See https://thrive.wcp.org.uk/ [accessed 150816]
3. A strategic approach to public mental health

There have been several recent reviews of the evidence base for public mental health and there is a consensus that a life course approach is needed with the greatest gains being made by promoting the mental health of parents and children. An example is provided in Appendix 6, from a review of the evidence for public mental health to inform the ten best buys for commissioners to promote public mental health and inform commissioning strategies (Reginebotham and Newbigging, 2013). As with other reviews, this highlighted the importance of:

- Promoting good parental mental and physical health to promote child development and wellbeing, maternal wellbeing
- Promoting good parenting skills – universal as well as targeted early intervention programmes for common parenting problems and more intensive interventions for high risk families at high risk of poor mental health (see section on Adverse Childhood Events)
- Building social and emotional resilience of children and young people through whole school approaches
- Improving quality of life through increasing opportunities for participation, personal development and problem-solving
- Physical activity and responding to emotional, physical and/or sexual abuse
- Improving working lives: a) support for unemployed b) creating healthy working environments c) early recognition and intervention for those with mental health problems d) supported work for those recovering from mental illness
- Integrating physical and mental wellbeing through universal access to lifestyle programmes to reduce smoking alcohol use, substance use, and obesity
- Tackling poverty and substance abuse, including screening programmes and direct measures with those abusing alcohol.

- Community empowerment and development interventions that encourage communities to improve physical and social environments, participation and strengthen social networks.

In the context of the above summary, the analysis of public health initiatives in the WMCA indicates that there is considerable scope for developing a strategic approach that adopts a life course and multisector approach. This should be facilitated by the national Mental Health Prevention Concordat programme, which aims to support all Health and Wellbeing Boards (along with CCGs) to have an updated JSNa and joint prevention plans that include mental health and comorbid alcohol and drug misuse, parenting programmes, and housing. In addition, all local areas are required to have multi-agency suicide prevention plans in place by 2017.

OTHER UNIVERSAL SERVICES

Many universal services have opportunities for promoting mental health and responding to people who may be experiencing a mental health crisis and have an important role to play in social inclusion. Examples are:

1. Police service

The police service across the WMCA has been active in changing its approach to dealing with mental health problems and in particular through the introduction of street triage and liaison and diversion services. This is discussed in more detail later in this report.

2. Fire service

The West Midlands Fire Service is making vulnerable people its priority, with a strong emphasis on prevention. While this has been a long-standing aspect of the Fire Service’s role through Home Safety checks, these were extended in 2015 to include advice to help people improve their health and wellbeing. Known as Safe and Well visits, if the resident agrees, operational firefighters will cover a range of topics that include mental health, weight, exercise and healthy eating, social isolation, loneliness, hoarding and employment64.

3. Libraries and museums

Libraries provide access to information and resources, in different formats and languages, about mental health as well as non-stigmatising spaces for people to meet to explore health and wellbeing, and to relax and unwind, providing:

- A parents’ collection of books on children’s health and wellbeing
- A partnership for NHS Books on prescription65
- Mindful mediation sessions
- Health checks
- Drop-in sessions with mental health experts for people feeling anxious or depressed
- Volunteering opportunities to encourage people to join the library and provide customer feedback.

Similarly, museums are an important universal public service and there is increasing interest in the role that they can play in contributing to health and wellbeing, offering a range of opportunities to participate in cultural or creative activities (Camc and Chattoeyee, 2013; Dodd and Jones, 2014). The Royal Society for Public Health (2013) advocates that museums and galleries have an important role to play in promoting emotional resilience, coping skills, strengthening identity and social inclusion (Dodd and Jones, 2014). The Birmingham Museums Trust has started a number of health and wellbeing initiatives across its nine sites, including: free creative sessions for carers; gardening for mental health; support for people with dementia; and a day full of activities which offered free taster sessions of a range of therapies66. Museum visits and events can be included as part of social prescribing or recovery college courses, although it is not clear the extent to which this is happening within the WMCA.

4. Wellbeing Hubs

The majority of Local Authorities and/or CCGs in WMCA have developed Wellbeing Hubs to provide the general public with information about health and wellbeing and signpost to appropriate services (see for example Sandwell’s Confidence, and Wellbeing Hub). In some instances, third sector organisations have been commissioned to provide this alongside peer support or one to one support (see for example the Wellbeing Hub provided by Birmingham Mind). Information about mental health and wellbeing is increasingly available through the development of electronic resources (see for example Warwickshire’s Health and Wellbeing Portal67).

PRIMARY CARE

1. Current provision in the WMCA

The great majority of people experiencing mental health problems are seen in primary care and GPs are increasingly seen as being at the centre of ‘providing whole person care to people with overt or covert mental health issues’ (Joint Commissioning Panel for Mental Health: 2013)68. Primary care also plays a key role in the emotional wellbeing of people with physical health problems and in preventative strategies.

There are 716 GP practices covered by 62 CCGs in the WMCA, with some of these being located outside of the WMCA (see Appendix 7). There are on average 1.8 mental health problems per 1,000 patients (Joint Commissioning Panel for Mental Health: 2013)69. The great majority of people experiencing mental health problems are seen in primary care and GPs are increasingly seen as being at the centre of ‘providing whole person care to people with overt or covert mental health issues’ (Joint Commissioning Panel for Mental Health: 2013)68. Primary care also plays a key role in the emotional wellbeing of people with physical health problems and in preventative strategies.

It has been estimated that about one in four of a GP’s adult patients will need treatment for mental health problems. Figure 4 provides an estimate of the numbers and types of mental health problems for a practice serving 2000 patients. It would be helpful for the WMCA to have this information for a sample of practices to test these assumptions.

As this suggests, the needs of many people presenting with mental health problems in primary care are relatively straightforward, but there will be a significant cohort whose needs are complex, who have a range of physical and mental health symptoms or co-morbid conditions, and have associated social difficulties. From discussions during this project, it is evident that the level of support to GPs and, therefore, to such patients in primary care, is urgent consideration by the Commission.

2. Performance against national indicators

Primary Care Prescribing

Appendix 7 provides an example of primary care prescribing for mental health is £12 per head in the WMCA, compared with a national average of £13 (NHS Benchmarking, 2013)70. This mask variation between CCGs, with Redditch and Bromsgrove spending the least at £8 per person and South Warwickshire the most, at £17 per head of population. South Warwickshire has a higher level of mental health need than Redditch and Bromsgrove, but is substantially lower than the Birmingham CCGs, (see Appendix 7), which spend between £11-£12 per head of population.

56. https://apps.who.int/healthinfo/graphs/primarycare.pdf
60. Warwickshire’s Health and Wellbeing Hubs to provide the general public with information about health and wellbeing and signpost to appropriate services (see for example Sandwell’s Confidence and Wellbeing Hub).
61. For Birmingham Cross City CCG, which covers areas with a high level of need, the three CCGs in the WMCA have a higher level of mental health need, with Birmingham South and Central CCG having over 50% more need than the mean (needs index = 1.56) and Bromsgrove and Redditch nearly 40% less (needs index = 0.64). The populations covered by CCGs range from approximately 113,000 for Wyre Forest to nearly 750,000 for Birmingham Cross City CCG, which increases to just short of a million when the population is weighted for need (see Appendix 7).
Improving Access to Psychological Therapies

The Improving Access to Psychological Therapies (IAPT) programme started in 2008, originally for adults of working age and now extended to older adults and children and young people. It is also has one of the highest rates for depression and anxiety. There are a range of providers, with 10 services listed on the NHS Choices website for the West Midlands, in addition to those provided by the specialist mental health Trusts and in primary care.

Referral rates for IAPT vary across the country in 2014, and the West Midlands was below the national average for IAPT referrals per 100,000 population, with a mean of 691, compared with a national average of 691, referrals per 100,000. However, the rate varies by CCG from approximately 290 referrals per 100,000 population in Redditch and Bromsgrove to 1200 plus in Walsall. This raises some questions about the relationship between level of need and referral rates. For example, Birmingham South and Central CCG (need index = 1.56) has a lower rate of referral than Wyre Forest (need index = 4.96). There may be a number of explanations for this, including better overall provision and a more managedvolunteer sector in Birmingham through which people can access psychological support.

Nationally, the number of people waiting less than 28 days for IAPT, between April 2013 and 2014, rose from 57% to 64% and to 67% in 2014/2015. The West Midlands saw an increase from 56% to 63% in 2013/14 and to 76% in 2014/15. Figure 6 illustrates the range from 44% to 97% of people being seen in less than 28 days in 2014/15, broadly similar to the pattern for 2013/14.

The CCG with the lowest average waiting time from referral to the first treatment appointment was Dudley CCG at 6.7 days (HSCIC, 2015b). It is interesting to note that despite Walsall having the highest number of referrals per 100,000 population it also has one of the highest rates for people seen in less than 28 days in 2014/15, broadly similar to the pattern for 2013/14.

This suggests a good fit between the referral process and capacity to respond, whereas in other areas, the capacity may not be able to keep pace with the demand. This warrants further inquiry.

The number of people who were above a diagnostic threshold before treatment and below it following treatment provides a measure of people who are moving to recovery but does not take account of the extent of improvement or the complexity of the presenting issues. Nonetheless, the mean for the WMCA in 2013/14 was on this measure is 39% (range 10–70%) in 2014/2015. The highest recovery rate was in Cannock Chase CCG (69.4% of 680 referrals) (HSCIC, 2015b) compared with a national average of 41%. Further interrogation of this data could be helpful to identify whether the variation reflects service user characteristics, organisational arrangements or effectiveness of the IAPT services provided.

Physical health checks for people with a severe mental illness

As noted before, there are serious inequalities in mortality rates for people with a diagnosis of severe mental illness, with contributory factors including socioeconomic circumstances, lifestyle and medication. 46% of people with a diagnosis of mental illness also have a long term physical illness (compared with 30% in the general population). Figure 7 provides a summary of the percentage of physical health checks for people diagnosed with a serious mental illness in the WMCA for 2012/13 and 2013/14 compared with national data. Across the CCGs there is generally little variation in these percentages. Further information on what treatment is subsequently offered, the uptake and its impact on health inequalities for this group of patients would be informative.

3. Redesigning primary care mental health services

Despite its potential and central role, primary care’s capacity to respond effectively has been problematic and consequently relationships with specialist services have become fractious as these services increasingly focused on people with a diagnosis of serious mental illness. Various models have been tried over the past 20 years to improve access to mental health support in primary care but there is no clear model for how such services should be provided. It is clear, however, that the primary care offer needs to go beyond providing access to psychological therapies and physical health checks for people with a severe mental illness to respond to the broad range of mental health need that presents in primary care and including psychological issues associated with abuse and trauma, medically unexplained symptoms and co-morbidities such as autism and accompanying mental health problems, for example. As well as responding to expressed need and intervening early, primary care has a central role to play in any prevention strategy because of its provision of universal services, eg, to pregnant women and new mums, sexual health and screening services and to people with long-term physical health conditions and there are opportunities to strengthen these at a practice level.

PROMISING PRACTICE: CITY AND HACKNEY PRIMARY CARE PSYCHOTHERAPY CONSULTATION SERVICE

City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS), is an innovative outreach service provided by the Tavistock and Portman NHS Foundation Trust and supports local GPs in the management of their patients with complex mental health and other needs that result in frequent health service use. This includes people with medically unexplained symptoms, diagnoses of personality disorders or long-term mental health problems, not currently being managed by secondary mental health services, and many of these people have poor physical health and social difficulties.

The PCPCS operates in two distinct ways: (i) as a referral service, ie, providing talking therapy interventions to individual patients; and (ii) as a consultancy service for GP and other primary care staff, advising them on the management of patients with complex needs. Forty to fifty GP patients a month are referred to the PCPCS service, over 60% of whom are from BAME groups. A typical course of treatment by the PCPCS lasts for 12 or 13 sessions at an estimated average cost of £1,348 per patient.

An evaluation of the service by Parsonage et al. (2014) found 79% of people using the service showed improvements in their mental health, wellbeing and functioning and 55% were below the threshold for symptoms they had prior to treatment, ie, ‘recovered’. These results compare favourably with IAPT services, which tend to see people with less complex problems. Based on data from a sample of 282 patients, Parsonage et al. (2014) estimated that treatment by the PCPCS reduced the costs of NHS service use by £493 per patient in the 22 months following the start of treatment. This significantly offsets the cost of the service. The service performs well in terms of cost-effectiveness, with a cost per QALY gained of £10,900, which is well below the bottom end of the NICE threshold range of £20,000–£30,000. Furthermore, a survey of local GPs using the PCPCS found very high levels of satisfaction with the service, covering such aspects as the referral process and the accessibility and responsiveness of the service.

For example, screening and early intervention to prevent and treat perinatal mental health problems, estimates suggest that 1 in 5 women and 1 in 6 men of all ages and 1 in 5 women at some point during pregnancy and for the first year after birth (Khan, 2015).

Sandwell was an early pioneer in initiating improvements in primary care mental health service with the introduction of the Sandwell Wellbeing hub; offering a range of self-help material, group work and individual support, including the Esteem Team supporting people with mild to moderate problems (Thel et al., 2006). Other CCGs in the WMCA are currently in the process of redesigning primary care mental health services to strengthen mental health provision in primary care and access to wider services to support people in the community. These include:

- Birmingham: Birmingham South and Central CCG introduced the Edgbaston Wellbeing Hub in 2014, and more recently Birmingham Cross City CCG has commissioned Birmingham Mind to deliver a Wellbeing Hub, providing support to one support/assessment and a range of workshops, groups and courses, including five ways to wellbeing, relaxation, mindfulness, self-esteem and confidence building and coping with anxiety and depression. Services at Edgbaston Wellbeing Hub include emotional counseling, listening and guiding sessions, life skills and befriending, community and practical support, self-help information and link workers for one session. The Sandwell Wellbeing Hub has an Esteem Team, provided by Birmingham Mind and based on the Sandwell model. This Team provides care coordination for people coming into the Hub and provides emotional and practical support to enable people to navigate the system. An initial evaluation suggests that the service can pick up people who may have fallen through the net of health and social care provision and become frequent attenders to their GP as a consequence (Menda Associates, 2015).

All these wellbeing hubs appear to be well regarded and it is interesting to note that they have developed independently with the consequence that there is not a single city wide wellbeing hub.

Dudley CCG is introducing a new model of care – a ‘Multiphase Community Provider’ (MCP), which includes a network of integrated multidisciplinary teams (MDT) consisting of a GP, specialist nurses, social workers, mental health services and voluntary sector link workers to provide mental health and wellbeing support at an early care level. A network of young health champions to promote health and wellbeing is also being introduced.

The three Clinical Commissioning Groups (CCGs) across Worcestershire, NHS Wyre Forest CCG, NHS Redditch and Bromsgrove CCG and NHS South Worcestershire CCG, with Worcestershire County Council, are redesigning the primary care mental health service to increase the wellbeing provision for people experiencing low mood or anxiety; reduce variations in access; strengthen partnerships and coordination with employment services, Local Authorities and the third sector; ensure that people with more complex mental health problems can step up and down between primary and secondary care services; and to identify potential saving from secondary care to invest in primary care. The proposed model will include a single point of access and provide a range of wellbeing and psychological therapy services in primary care and local communities, including wellbeing courses; personal development; lifestyle advice and guidance; community therapies and helping people to connect with friends and neighbours; recovery colleges; and will join up a range or organisations and agencies providing relevant support, eg, support regarding violence and abuse; drug and alcohol service; education and employment and providing quick access to IAPT; mental health professionals within primary care; gateway workers; and support from secondary care services.

There is a range of other initiatives to support and develop the capacity of primary care mental health including: Health trainers to support lifestyle changes;

Social prescribing, which includes GPs prescribing exercise, books, art, museums, computerised Cognitive Behavioural Therapy (CBT); educational activities; green gym; museums; social enterprise schemes; time banks; supported employment and volunteering.

A wide range of benefits have been identified for social prescribing including increases in self-confidence and esteem; improvement in psychological wellbeing and positive mood; reduction in anxiety and depression; improvements in physical health and reduction in GP and primary care visits; reduction in social isolation; improved motivation and meaning in life and acquisition of new learning skills. Social prescribing is, for example, linked to GP Practices in Dudley, while Solihull has a Social Prescribing Team and offers a ‘personal buddy’ to help people to identify social activities to improve their health and wellbeing.

A GP to Consultant Helpline to help improve the liaison with GPs and ensure speedy access to clinical advice, introduced by Coventry and Warwickshire Partnership Trust.

A single point of access is run by Birmingham Solihull Mental Health Foundation Trust for all CCGs for GPs to refer for secondary care assessment.

Primary care liaison teams to deal with non-urgent referrals from primary care provided by Black Country Partnership NHS Foundation Trust.

Primary care generally relies on people presenting and this can disadvantage particular groups, particularly if this is associated with an emphasis on self-management, raising issues regarding equity of access. It has not been possible to establish the scope of this project but this warrants further consideration. A recent study suggests that a multi-faceted intervention comprising community engagement, high quality primary care and psychosocial interventions adapted to the needs of particular groups, can improve access to psychological and social care (Dowrick et al., 2013). This model, Improving Access to Mental Health in Primary Care (AIMS) (CCGs, 2012) is worth considering for implementation and evaluation in a WMCA context.

This analysis indicates that developments have largely been led by the initiative of local primary care services, which may result in inequities in access and variations in the range of support available. Above all, the WMCA should foster further development of a framework of the key components of primary care mental health that is grounded in an appreciation of the wide range of roles that primary care plays in promoting health and well-being.

To promote health and wellbeing is widely promoted and its extent to which this has been implemented partnership between Children’s Hospital NHS Foundation Trust, Worcestershire Health and Care Trust, Dudley Group of NHS Foundation Trust, Solihull Mental Health Foundation Trust, Priory Group and a number of CCGs in the Birmingham area. The EP teams are located in development of a network of community mental health services (North Warwickshire CCG, Leamington Spa (South Warwickshire CCG), Walsall and Dudley; West Bromwich (West Midlands CCG) and Walsall and Wolverhampton. Guidance has also been developed for GPs on the early identification mental health needs of people with severe mental illness and the extent to which this has been implemented across the WMCA is unclear.

2. Performance against national indicators

In 2014, the Department of Health and NHS England produced a first set of mental health access and waiting time standards for introduction during 2015/16 (NHS England, 2015). This included the target that more than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral. Data on performance against this target has only started to be made available from January 2016 and at the time of writing this report was only available for one of the providers in the WMCA.

Prevent psychosis in the ultra-high risk individuals by identifying and intervening on cues of psychosis

Reduce the duration of untreated psychosis by promoting early detection and engagement by people experiencing symptoms

Optimise initial experience of acute care and treatment by providing ‘You friendly’ Acute Home base/Hospital Trust

Maximise recovery and prevent relapsing during critical period by providing integrated biopsychosocial care and/or focusing on functional/vocational as well as symptomatic recovery; addressing social needs and improving resistance early and supporting carers and network of community support agencies

Figure 8: Aims of Early Intervention in Psychosis services (Source: French, 2016)

The West Midlands was a pioneer in terms of early intervention for psychosis (EP) services in the UK. The West Midlands Wellbeing Hub, offering one to one care coordination for people coming into the Hub and provides emotional and practical support to enable people to navigate the system. An initial evaluation suggests that the service can pick up people who may have fallen through the net of health and social care provision and become frequent attenders to their GP as a consequence (Menda Associates, 2015).

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Joint ownership at senior management
Integration of Street Triage with the
Effective information sharing between
A three-bedded house in in North Walsall CCG/Council plans to
Birmingham Cross City CCG is
Mental Health in the West Midlands Combined Authority
"(HM Government, 2014) are:
The opportunities for crisis intervention (CQC, 2015a).

While primary care and specialist mental health services form a key strand of the mental health crisis response across these domains, the broad range of voluntary sector and community contributions is key in promoting resilience, wellbeing, empowerment and care for people in crisis. The Crisis Care Concordat established in 2014 provides a map of services and organisations that have agreed to work together, to make sure that people get the help they need when they have a mental health crisis, and action plans of the necessary steps needed to improve local access. The action plans are developed calls for local communities, local authorities, mental health and non-mental health providers, police, local ambulance services and voluntary sector, particularly organisations and it is clear that an effective crisis response will only be achieved by all these organisations working in partnership. Many of the action plans outline steps to develop a single point of access, the development of an urgent care pathway, Police Custody Liaison and Diversion schemes, improved support for children and young people and for people from BAME communities. They reference other initiatives, particularly in relation to early intervention, such as the provision of AIP, and to varying degrees they emphasise the importance of building resilience and capacity building as well as fast tracking through to appropriate processes.

The 111 helpline and A&E also play a role in enabling people in A&E or urgent and emergency care in a crisis and for some people will be a first port of call. The specialist mental health NHS Trusts also provide Crisis Resolution Teams (see Appendix 8). The recent CQC report looking at experiences of crisis care found that people valued the support that they received from volunteers and charities, GPs, ambulance staff and the police far more than that received in A&E or from specialist mental health teams (CQC, 2015b).

Street Triage
In Birmingham and Solihull, the recognition that mental health relates to about 20% of police activity, and that the service delivered was considered by service users to be poor, Street Triage (mental health nurse, police officer and paramedic) was piloted in 2014. Between January and August 2015, street triage dealt with 4,409 incidents. It prevented 1,160 people attending A&E, prevented the use of 1,654 ambulance journeys and 1,025 police resources being dispatched. Since Street Triage was introduced in Birmingham and Solihull in 2014, only two people have been detained in a police cell under s136 of the MHA 1983. The national evaluation reported that approximately a quarter of incidents (20.4%) involved people from BAME communities (Reveruzzi and Pilling, 2016). In 2015, the triage team were able to provide a response to 85% of the incidents on site. Of the remainder 41% were taken to A&E, 7% to a specialist hospital and the rest a range of destinations, including home, to a relative’s home or a place of safety in a voluntary capacity. The service was extended to the Black Country in September 2014 and a different model piloted in Coventry (CPN and police officer available from 5.00pm–3.00am). West Mercia Police in alliance with Warwickshire Police have recently commissioned a mental health nurse in the control room to support the police in responding to emergency calls and South Staffordshire Police have a triage team (police officer and mental health nurse) who provide on the street support and phone advice from staff within the Liaison and Diversion Programme. The British Transport Police have also adapted a non-mobile model but will route through to the appropriate police force to provide immediate crisis intervention if available. The focus of their model is to prevent further crisis through preventative intervention. Of note is the partnership working across organisational boundaries and different sectors to facilitate people receiving an appropriate and timely response. There has been no comparison of these different models at a local level but the national comparative evaluation of nine pilot sites identified a number of factors associated with better outcomes (Reveruzzi and Pilling, 2016). These include:

- Joint ownership at senior management level and regular review of joint working
- Effective information sharing between services, in particular, access to health information
- Provision of timely advice to police officers at the point of initial contact and during the assessment process
- Integration of Street Triage with the health service-based crisis pathway
- Joint training programmes for Street Triage staff.

The authors recommended the provision of a 24-hour service seven days a week. They identified the co-location of health and police staff (eg, linked to a Control Room) or dedicated phone line(s) as an important component of effective Street Triage schemes, which could support a cost-effective roll out of the programme.

Crisis Houses
Despite an increase in the number of crisis houses across England in the last two years, there are only four crisis houses in the West Midlands.

A review of the current Crisis Care Concordat action plans for the core members of the WMCA identified the following proposals in relation to crisis accommodation:

- Walsall CCG/Council plans to develop a specification for social care crisis accommodation.
- Birmingham Cross City CCG is proposing to develop a strategy for needs of people with non-psychotic personality issues, which will include non-statutory crisis houses.

The opportunity for crisis intervention identified by the Crisis Care Concordat (HM Government, 2014) are:

- Access to support before a crisis through provision of information, preventive activities and supporting self-directed care
- Urgent and emergency access to crisis care
- Quality of care during a crisis including alternatives to involuntary admission
- Recovery and relapse prevention enabling people to stay well

67 www.elf.org.uk/case-study/falcon-burn-walsall-acute-adverse-childhood-experiences-screening-pilot/ [accessed 05/06/16]
69 S136 of the 1983 Mental Health Act allows the police to take anyone, who they believe is mentally unwell and in need of care and assistance, from a public place to a place of safety.
In recognition of the potentially problematic pathways into services and poor experience of support in a crisis for people from BAME communities (Race Equality Foundation, 2015), some areas are taking targeted action to address this. In Dudley, for example, the Equalities Act provides a framework for improving the equality of access and outcomes for people from communities with protected characteristics under the Act. This includes: involving people from those communities in the commissioning of crisis services; ensuring the services commissioned can deliver a range of care options that meet a diverse range of needs; empowering people by providing appropriate information, access to advocacy services, and ensuring that they are engaged in, and have control over, their care and treatment needs for severe mental illness; and providing with community leaders to understand any barriers that may get in the way of people accessing help when they need it and reviewing service access data against demographic and prevalence data to identify gaps in access rates for people with protected characteristics. It is very clear that some communities prefer and will use services provided by their community, in which they have higher levels of trust and this has implications for commissioning these organisations to provide the necessary support.

Secondary mental health services

Provision in the WMCA
Nationally, approximately 2% of the adult population have some contact with specialist mental health services during the course of a year (NHS Benchmarking, 2016). While it is, however, considerable variation across the country, as illustrated by Figure 10, and the West Midlands has lower numbers of people in contact with specialist mental health services than other areas of England, notably the East Midlands, North West and London. There are four main providers of specialist mental health services, providing inpatient and community services to the majority of WMCA residents: Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) provides a wide range of inpatient, community and specialist mental health care to those people living in Birmingham and Solihull who are experiencing severe mental health problems, serving a culturally and socially diverse population of over a million. The Trust provides specialist services for residents outside of the area including the national deaf mental health service (Birmingham-based), perinatal mental health, neuropsychiatry and eating disorders. The Trust also provides forensic services for children and adolescents, men and women and manages the delivery of all healthcare services at HMP Birmingham. The Trust employs approximately 4,000 staff.

Birmingham and Solihull Mental Health Partnership NHS Trust (BWMHPT) provides a full range of mental health treatment and rehabilitation services for children, adults and older adults, that manage both common and complex mental health conditions. The Trust’s range of services spans primary care counselling and psychological therapies for common mental health problems through to the treatment and care of people detained under the Mental Health Act and those with severe and enduring conditions. Core services are provided predominately to Dudley and Walsall, with a population of around 540,000, but also to neighbouring trusts in Worcestershire, Staffordshire, Birmingham and Warwickshire. The Trust employs just over 1,000 health and social care staff.

Specialist mental health services for adults are also commissioned from South Staffordshire and Shropshire Mental Health Trust and Worcestershire Health and Social Care Trust, particularly for residents of Bromsgrove, Redditch and Wyre Forest, Forward Thinking Birmingham (FTB) provides a broad range of services for 0–25-year-olds across Birmingham and has been fully operational since April 2016. FTB is responsible for all pathways for 0–25-year-olds, with the exception of place of safety arrangements.

Promising practice: rapid assessment intervention and discharge (RAID) service

The RAID service has been the focus of a number of evaluations at all which have been positive about its impact including improvements to health and wellbeing as a consequence of providing mental health care for people with physical health problems in acute hospital (Todros et al. 2013). There is also evidence that the RAID service is good value for money saving money through reduced bed use with a return of $3–4 for every $1 invested (Parsons and Foxsey 2011; West Midlands CSU). An evaluation undertaken by Griffiths and Glashy (2015) identified the lessons for the roll out of RAID and noted that the key factors influencing its success were the way in which it was planned, resourced, staffed, and supported. While fidelity to the model is, in Dudley, a key feature of the model was important the role of contextual factors needs to be recognised and thus sufficient planning and time allowed for successful adaptation of the model to local circumstances.

Promising practice: open dialogue

Open Dialogue offers a model of crisis response, service delivery and therapeutic engagement that has delivered exceptional shorter and longer term outcomes in Western Lapland where it has been developed over the last 20 years. A ten-year follow up study (Sekikul et al. 2011) found that:

- 81% of patients did not have any residual psychotic symptoms
- 84% had returned to full time employment or studies
- Only 39% had used neuroleptic medication

Comparative figures for services in other western countries suggest a norm of only around one-third of people with psychosis achieving a full clinical recovery. An early evaluation of the introduction of this approach in the USA found that it could deliver good clinical outcomes, high satisfaction, and shared decision making, although introducing the new service model required a substantial investment in training – an investment that would easily be recouped if outcomes were as good as in Western Lapland (Gordon et al., 2016). Key features of the approach are an immediate crisis response, continuity in the therapeutic team over the course of crisis and recovery, and full involvement of the person and their family and significant others in regular network meetings at which difficulties and experiences are discussed and at which any decisions regarding treatment are made.
The four main providers (BSMHFT; BCPFT; CWPFT; DWMHFT) have come together to form an alliance under NHS England’s New Care Models Vanguard Programme: the Mental Health Alliance for Excellence, Resilience, Innovation and Training (MHERI). The alliance will focus on three priority areas to rapidly realise quality and efficiency benefits, spread best practice and reduce variations in cost and quality through integration across current geographical and organisational boundaries78. These areas are seven day working in acute services; crisis care and the reduction of risk; and promoting a recovery culture. Detail on the four Vanguards in the WMCA is provided in Appendix B.

2. Number of people in contact with secondary mental health services

This measure uses the number of service users registered (on caseload) with mental health Trusts, against wider England population data (NHS Benchmarking, 2016). In the WMCA in 2013, there were 2,205 people per 100,000 population in contact with specialist mental health services compared with the national average of 2,210. A more detailed analysis of caseloads indicates that very few people are registered with specialist mental health services if they are living in a residential or care home. In the WMCA, there is an average of 31 people in residential or nursing care in touch with specialist mental health services per 100,000, very similar to the national average. It is suggested that this may reflect a multidisciplinary input to the home rather than on an individual case basis (NHS Benchmarking, 2016). There was an average of 185 (range 164-230) admissions to inpatient care per 100,000 population during 2013/14, compared with an England average of 227 (range 190 – 240). Admission rates are influenced by a range of factors including bed numbers, bed occupancy and access to community support and supported accommodation.

3. Number and use of inpatient beds

At any given point, around 2% of service users in secondary mental health care will be in mental health inpatient beds. The remaining 98% will be under the care of community mental health teams. From data provided by the four main NHS Trusts, there were 1,343 beds available for adults of working age, which includes inpatient, rehabilitation and low and medium secure beds, for 201579. This compares with 1,322 beds in 2012, representing an increase of 1.9% over two years. The data for 2015/16 is not entirely clear because one of the Trusts (CWPFT) amalgamated their services for older people and adults of working age during 2014/15 so that services are age independent and the apparent reduction may reflect the different way of categorising beds. The main finding from this analysis is that while the overall bed numbers are broadly similar to four years ago, there has been an increase in the number of secure beds and a reduction in the number of beds for older adults, as illustrated in Figure 11.

The mean length of stay (LOS) for acute inpatient wards for each of the providers is provided in Table 2, with the combined average slightly above the England average of 33 days. This excludes people placed out of area and specialist placements, which will have longer LOS, reflecting the complexity of people’s mental health difficulties.

4. Use of the Mental Health Act

In 2013/14, 29% of people admitted to inpatient care were detained under the MHA, slightly above the national average of 23%. In England in 2014-2015, there were a total of 25,117 people subject to the 1983 Mental Health Act (MHA). Of these, 19,856 were detained in hospital and 5,461 were being treated under Community Treatment Orders (CTOs). This represents an increase in the number of people subject to the Act of 1.6% over two years. The data for 2013/14, compared with an increase of 4,179 (or 20%) compared to 31st March 2014, and an increase of 4,179 (or 20%) compared to the 31st March 2013 snapshot count. This national increase is reflected in the increase in the numbers of people detained in the main NHS provider Trusts in the West Midlands (as illustrated in Figure 12). Differences between providers will reflect the size of population covered and provision of secure services and national specialist services, with BSMHFT being the main provider of these services. In the West Midlands, in 2014/15, the average rate of detentions was 81.2 per 100,000 population, slightly above the England average of 77.2. However, the rate ranged from 43.7 for Warwickshire North CCG to 165.4 per 100,000 population10 for Birmingham South and Central CCG. This variation is likely to reflect differences in acuity and complexity of people living in an urban environment as well as the local system configuration and culture.

The increased use of the MHA in a context of stability in the number of beds available raises questions about the number of people that are being admitted to units outside the West Midlands. The national figures show that there has been an increase in use of both Section 2 (on admission) and Section 3 (following admission). The number of uses of Community Treatment Orders (CTOs) has also been increasing (Health and Social Care Information Centre, 2015b). Further analysis is required to establish whether this is the case for the WMCA.

Table 2: Mean lengths of stay (LOS) for the NHS Trusts 2013-2016 (Source: Trust data 2016)

Table 3: Place of safety detentions for 2015-2016 (Source: West Midlands Police)

Figure 12: No of people detained on March 31st by NHS provider (Source: KP90, Health and Social Care Information Centre)
From NHS Trust data, of the total number summarised in Table 3. A comparison of the population of people in Birmingham and Solihull accessing specialist community perinatal mental health services over an 18-month period from 1 December 2012–1 August 2013 with census data, indicated a bias in referrals and provision (Randal et al., 2015). Figure 16 illustrates the mismatch between estimated need and provision, with more referrals coming from the areas closer to the perinatal mental health unit (located by the Women’s Hospital). GPs in the South of the city were also more likely to make a referral and the community services were achieving better outcomes for women of white ethnicity than women from BAME communities (Randal et al., 2015).

### Table 4: Use of physical restraint 2012-2014

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>2012-13</th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of uses of restraint</td>
<td>Number of people restrained</td>
<td>Number of uses of restraint</td>
<td>Number of people restrained</td>
<td>Number of uses of restraint</td>
</tr>
<tr>
<td>England</td>
<td>17,308</td>
<td>3,999</td>
<td>23,095</td>
<td>6,380</td>
</tr>
<tr>
<td>BSMHFT</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>BCFT</td>
<td>20</td>
<td>12</td>
<td>14</td>
<td>20</td>
</tr>
<tr>
<td>CMHT</td>
<td>380</td>
<td>195</td>
<td>466</td>
<td>190</td>
</tr>
<tr>
<td>DWPT</td>
<td>140</td>
<td>55</td>
<td>140</td>
<td>55</td>
</tr>
</tbody>
</table>

The percentage of people who were under 18; as police cell as a place of safety between 2011 and 2012. From data collected by West Midlands Mental Health, there is an over-representation of people from BAME communities, detained under the MHA, has been consistently highlighted by the Count Me In census reports and subsequently the Care Quality Commission annual reports (CQC, 2012; 2014; 2016). The local data fits this pattern with people from BAME communities accounting for approximately 42% of the number of detentions compared with 22% of the overall population for WMCA. It is likely that the detention figures do not correspond exactly with the WMCA population because of different catchment areas. Nonetheless, this is a trend that deserves further investigation alongside analysis of the profile of those people detained in secure services and placed out of area.

### 5. Use of restraint and deaths in inpatient care

From data provided by the four main providers, the number of uses of restraint for 2015/2016 was just under 3,000 (2,914): a 25% increase from 2013-2014. These figures include all episodes of physical restraint, and physical restraint and rapid tranquillisation. Table 4 provides a summary of the use of physical restraints for the Trusts from the Minimum Mental Health Data Set (MHMDS). However, the higher rates for BSMHFT reflects that they are a provider of specialist secure services, which will have higher uses of restraint than acute inpatient service because of the greater complexity of people’s needs, which is likely to include substance abuse as well as mental illness.

In order to make more meaningful comparisons between the Trusts, data on the use of restraints for acute adult inpatient care was obtained and the rate of restraints calculated per 1,000 bed days for each Trust, as summarised in Figure 14. The mean rate for all types of restraint over the last three years was 14 uses of restraints per 1,000 bed days (range 9–19 restraints per 1,000 bed days).

From data provided by one of the Trusts, the use of restraints for people with a learning disability was substantially higher and the data in Figure 14 excludes this data and that for secure services, where the rates are also likely to be higher. An FOI request by Mind has indicated variation between Trusts in the use of restraint and recommended that face down restraint should be a ‘never event’ (Mind, 2013). The Mind report reinforces the need for a proactive and preventative approach by commissioners and providers to reducing the use of restraint, which is experienced as traumatic and dehumanising and runs counter to a recovery-focused service (Huckshorn, 2006).

The total number of deaths in inpatient care for the four main providers between 2013-2016 was 22: 14 as a result of suicide and eight unexpected deaths, generally attributed to natural causes.

## 6. Outpatient and community services

The functionalised model for community mental health teams, as described in the mental health National Service Framework (Department of Health, 1999), emerged from innovations in the West Midlands, particularly in relation to early intervention, crisis intervention and home treatment teams. The four NHS Trusts currently provide a broad range of community services, which focus largely on people with a diagnosis of mental illness, personality disorder and co-morbid conditions.

The main community teams are:
- Early intervention teams, providing assessment and interventions for people with a first presentation of psychosis;
- Intensive home based treatment teams, providing rapid response and crisis support for service users and family members and, potentially, providing an alternative to inpatient care;
- Community mental health teams, providing assessment, care planning and support;
- Recovery and wellbeing teams, enabling daily living, problem-solving and coping skills;
- Assertive outreach teams, supporting people with severe and persistent mental health problems and complex needs who are hard to engage.

Appendix 8 provides a breakdown of the contacts by organisation and team type. While information on contacts alone is not particularly meaningful or illuminating it provides an indication of the balance of activity, as illustrated by Figure 15, which provides a breakdown of contacts between services that account for 84% of the total contacts for adults aged 18–65, for mental health problems*. As this illustrates, approximately half of the contacts were with CMHTs or Crisis Resolution/Home Treatment Teams representing 40% of the total number of contacts.

7. Spend on specialist mental health services by CCGs

Across England, the average CCG spend in 2013/14 was £154 per head of population and there was nearly a threefold variation in the level of CCG spend on specialist mental health services (Huckshorn, 2006). These variations in expenditure may reflect a quality improvement perspective using a preventive trauma-informed approach (LeBel et al., 2014) and are:

1. Improvement of senior organisational leadership (i.e., the CEO).
2. Use of data to inform practice at the individual level
3. Ongoing staff training and education, including mentoring and supervision, focused on primary prevention on mental health interventions;
4. Use of shared outcome tools: to identify persons with high risk factors for death and injury; use of safety plans; the use of person-first, non-discriminatory language; environmental changes to include comfort and sensory rooms; and meaningful activity designed to teach people emotional self-management skills (Huckshorn, 2008).
5. Inclusion of service users, carers and families in inpatient care as advocates
6. Debriefing techniques developed from evidence and analysis of incidents.

This approach has been implemented in different health care contexts, particularly mental health, in various countries and has been adopted as a programme known as RESTRAIN YOURSELF, which is being piloted and evaluated for mental health in the North West of England (LeBel et al., 2014).

There are also initiatives that are targeted at specific populations and these include:

- 300 Voices and community engagement (BSMHT) (see co-production section)
- The four mental health Trusts are part of the West Midlands Hub, which is a collaboration between eight providers to coordinate, and promote the mental health and appropriate care of veterans as a focus on reducing OATs for people with psychosis.
- Walsall Carers Support Service

9. Local initiatives

Examples of promising practice for secondary mental health care are described in detail under the relevant sections as they typically involve partnerships with other organisations. They include:

- Support to primary care – GP crisis hub (CWPT) (see primary care section)
- Early intervention in psychosis (WHCT) (see early intervention section)
- RAID and redesign of the urgent care pathway (BSMHT) (see crisis intervention section)
- Recovery Colleges (BCPT; BSMHT and FTB) (see quality of life and mental health section)
- Street Trauma (BSMHT; CWPT) in partnership with West Midlands Health Services (CAMHS) FLASH team, which has a specific remit to support veterans, their families and carers, and delivering training for CWPT.
- Walsall Carers Support Service (DVWMHT) for any carer supporting someone aged 18 and over living in Walsall who has complex mental health needs: offering a wide range of advice, information and support for carers, and which was founded on the basis of the Commission’s general observations about the quality of care in acute inpatient settings, this should be a focus, with a particular emphasis on assessment and treatment under the MH Act. The experience of detention and compulsion can be unsettling, profoundly disempowering and humiliating, and whilst some people find it helpful it can have a long-lasting impact and is seen as contradictory. These carers need support (Repper and Perkins, 2014).

As well as developing alternatives to in-patient care, there are three particular initiatives that can support changes in practice to a more empowering stance, and whose potential is not fully realised in the WMCA:

10. Changing practice

As can be seen the majority of these examples focus on the development of new services and there is also scope for shifting ‘low hanging fruit’ (e.g., CWPT) from the Commission’s general observations about the quality of care in acute inpatient settings, this should be a focus, with a particular emphasis on assessment and treatment under the MH Act. The experience of detention and compulsion can be unsettling, profoundly disempowering and humiliating, and whilst some people find it helpful it can have a long-lasting impact and is seen as contradictory. These carers need support (Repper and Perkins, 2014).

As well as developing alternatives to in-patient care, there are three particular initiatives that can support changes in practice to a more empowering stance, and whose potential is not fully realised in the WMCA:

There is a range of advocacy provision across the WMCA, typically based on a model of independent advocacy and including statutory advocacy (Independent Mental Health Advocacy (IMHA); Independent Mental Health Advocacy (IMHA) and Independent Care Advo.

There are initiatives in the WMCA to reduce the use of Out of Area Placements. Solihull CCG, for example, has developed a step-down/in-take unit within Aviary House, a supported living facility in North Solihull, with 28 self-contained, one bed rooms, from flats proving long term placements to clients. Although a recent report, this is impacting positively on the use of acute overspill beds. In addition, the CCG is actively supporting three clients to return to Solihull by the autumn and using the resources released to invest in stronger community personality disorder provision.

A repatriation project to bring people with mental health problems, and learning disabilities, from Coventry and Warwickshire closer to home has been running for four years. To date 100 people have been repatriated at a cost saving £12 million. This project between CWPT, three CCG – Coventry and Rugby, North Warwickshire and the NHS Arden and Great East Midlands Commissioning Support Unit, demonstrates the need for strong local partnerships and commitment of the Trusts and the CSU recently won an award for this work.

The EP work stream in Wolverhampton with the focus on reducing OATs for people with psychosis.

Inclusion of service users, carers and families in inpatient care as advocates

Debriefing techniques developed from evidence and analysis of incidents.

This approach has been implemented in different health care contexts, particularly mental health, in various countries and has been adopted as a programme known as RESTRAIN YOURSELF, which is being piloted and evaluated for mental health in the North West of England (LeBel et al., 2014).

The CCGs, Mental Health Trusts and their partners are also actively working on the redesign of mental health services as part of their Transformation Plans to meet national policy objectives, particularly in relation to parity of esteem to ensure mental health services have the same priority as physical health services across all age groups, and to ensure that people can access care as close to home as possible. This includes developing better crisis and urgent care and strengthening early intervention; as well as building the positive impact of existing services.

PEER SUPPORT

The contribution of peer support is now widely recognised as helpful in promoting wellness and optimism, aligning with values of peer advocacy and voluntary and community organisations encouraging peer support (National Voices, 2010). There is a range of local initiatives to encourage peer support and online peer support (Mental Health Foundation, 2012; Faulkner and Kalathil, 2012; National Voices, 2010).

ADVOCACY

Advocacy, in its various forms, has an important role to play in ensuring that an individual’s voice is heard and in promoting empowerment. Many people will be able to advocate for themselves but having someone else to speak on your behalf at a time of crisis can be vital and is one measure for ensuring that people’s rights are protected (Newbigging et al., 2015a). This is particularly important when people’s voices may be not be heard, with an emphasis in order to prevent distress and misunderstandings resulting in negative, and potentially costly, outcomes (Centre for Social Justice, 2011). Although the evidence base for advocacy is underdeveloped, a wide range of impacts have been identified through practice evidence from advocacy projects and service user groups (Macadam et al, 2018). They include: increasing people’s ability to make informed decisions and be involved in decision-making; being able to exercise greater choice and control; better relationships between individuals and professionals, and improving access to services, including diversion to less restricted forms of care (Newbigging et al, 2015b).

There is a range of advocacy provision across the WMCA, typically based on a model of independent advocacy and including statutory advocacy (Independent Mental Health Advocacy (IMHA); Independent Mental Health Advocacy (IMHA) and Independent Care Advocacy (ICA)) and voluntary and community organisations encouraging peer support (National Voices, 2010).
advocacy at risk (e.g. generic advocacy and community advocacy), such that advocacy becomes increasingly professionalised. It would, therefore, be important to review this provision; particularly in light of findings that access to statutory advocacy can be problematic. The situation is not helped by the closure of many local health advocate posts under the Mental Health Act, with the CQC recently highlighting their finding that 20% of detained patients had not had access properly explained (CQC, 2015). Furthermore, a national evaluation of IMHA provision found that people must in need of advocacy are the least likely to access it (Newbigging et al., 2015a).

OPEN DIALOGUE

The potential and evidence for open dialogue was discussed under the previous section in relation to crisis interventions. Within the UK, a development of the Open Dialogue model to incorporate peer support is currently being piloted in four Mental Health Trusts (North East London Foundation Trust – NELFT; North Essex; Nottinghamshire; and Kent and Medway) and is the subject of a major evaluation study for which a final funding decision is awaited from the National Institute for Health Research (2013). In-service training programme is available across the WMCA, as illustrated in Figure 19 for the constituent Local Authorities. For direct payments, this ranges from 22.9% (Solihull) to 4.5% (Walsall) and for personal budgets from 70.9% (Birmingham) to 4.5% (Walsall). There are examples of higher rates of direct payments (Warwickshire) and personal budgets (Worcestershire) in other Local Authorities in the WMCA, from which other Local Authorities can learn. However, further inquiry is needed to understand how meaningful the implementation of direct payments and personal budgets is in supporting personalisation. This will involve capturing the experience of service users to be confident that personalisation is being implemented as intended.

2. Support to Carers

The Care Act 2014 reinforced a focus on the needs of carers and providing assessment and support to carers in their own right. A recent review of the implementation of this Care Act duty found that the majority of carers, responding to a survey, were unaware of their rights; nearly two thirds had not received an assessment and some that had were dissatisfied with the assessment process (Carers Trust and University of Birmingham, 2016). Furthermore, many carers found engagement with the NHS problematic. The review concluded that the Carers Act failed to engage carers and had transformative potential but active implementation support is required, including ensuring that all social workers and assessors are appropriately trained, and reflect the wellbeing principle in assessment and care and support planning (Carers Trust and University of Birmingham, 2016: 5).

THIRD SECTOR PROVISION

The third sector, often referred to as the voluntary sector, comprises charities, social enterprises, and community groups, which are typically driven by a social mission, and have a closeness to and expertise on the range of third sector across the WMCA. The third sector is particularly adept at identifying and introducing innovative ways of working that are then adopted by the statutory sector, as it is the case with direct payments, advocacy, peer support and recovery. The sector is particularly adept at identifying and responding to gaps in provision and in engaging with people who would not engage with statutory services.

There is a dynamic and extensive third sector, which is inevitably more developed in urban centres, and it is estimated that there are approximately 450 voluntary sector organisations, across the WMCA. In addition, there will be small organisations ‘below the radar’ of public services but are an important community asset (Mohani, 2011). Third sector services serving individuals with mental health problems are provided by: specialist mental health organisations, for example Mind; organisations primarily concerned with a social issue, such as domestic violence (e.g. Women’s Aid, or homelessness (e.g. St Mungo’s); with a client group, for example SignHealth for Deaf people; or a community organisation supported by the capacity of smaller organisations to engage with statutory services. The third sector, therefore, plays an invaluable role in supporting people who are ‘below the radar’ (Mohan, 2011).

Consequently, any mapping of the third sector activity is complicated and compromised by the capacity of smaller organisations to support such an exercise. The response to the audit from third sector organisations was very limited, possibly reflecting their capacity. From the information provided, the range of third sector across the WMCA includes:

- Training on mental health awareness including Mental Health First Aid and suicide prevention training.
- Voluntary sector organisations providing seven-day-a-week direct access for all information, advice and support peer support/ support groups/ befriending; and the opportunity to engage in socialise/arts activities as well as access other services eg, advocacy, counselling, LGBT and women only support groups, employment support etc.
- Carers support groups and events to promote their wellbeing.
- Creative sessions: art, writing and music to enable people to develop creative skills and develop friendships.
- Horticulture/conservation/sports projects; for example, football targeted at men who would not ordinarily access mental health services and provides a safe space and route through to other services.
- Counselling, including bereavement counselling and trauma-focused consultations.

Additionally, many third sector organisations are well placed to address mental health problems in particular populations, such as BAME or LGBT communities, women and people with learning disabilities, and have a close understanding of the experiences of people with mental health problems. For example, organisations currently providing services include: SignHealth for Deaf people; or a community organisation supporting people who are ‘below the radar’ (Mohan, 2011). Consequently, any mapping of the third sector activity is complicated and compromised by the capacity of smaller organisations to support such an exercise. The response to the audit from third sector organisations was very limited, possibly reflecting their capacity. From the information provided, the range of third sector across the WMCA includes:

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- Carers support groups and events to promote their wellbeing.
- Creative sessions: art, writing and music to enable people to develop creative skills and develop friendships.
- Horticulture/conservation/sports projects; for example, football targeted at men who would not ordinarily access mental health services and provides a safe space and route through to other services.
- Counselling, including bereavement counselling and trauma-focused consultations.
Advocacy, both statutory and non-statutory advocacy, to enable people to have a voice and greater choice and control. These are configured differently but have all sorts of benefits in terms of increasing confidence and the capacity to self-advocate, improving access to services and rights, eg, welfare benefits; protecting rights and shifting the dynamic with professionals toward co-production (Newbigging et al., 2015a).

Employment support in a wide range of forms, including job-retention and development. A number of respondents drew attention to the impact of Local Authority austerity measures and this is worth focused inquiry. Furthermore, the third sector is rarely commissioned in a strategic way and the WMCA, in the context of the Care Act’s emphasis on market shaping, provides an opportunity for Local Authority commissioners, in partnership with CCGs, to review how they are investing and developing the capacity of the third sector across the WMCA.

There are various initiatives that recognise the needs of different groups, as outlined in the earlier section of this report, and there is still work to be done to ensure that inequalities are not entrenched into a strategic approach adopted by the WMCA.

This section considers provision to people from BAME communities, to reflect the diversity of the WMCA. In doing so, it is important, as Tang (2016) has observed in relation to Chinese mental health service users: ‘to understand cultural fluidity and the necessity for a transformative approach to tackle the intersecting structural inequalities that limit life chances’. Therefore, although specific services are considered valuable, it is also required to address the broader social determinants of mental health that disadvantage BAME communities. People from BAME communities face specific barriers in accessing appropriate support and, as noted above, are at greater risk of detention under the MH Act than people from British white communities. Consequently, community organisations and the voluntary sector have developed services in response to identified need and gaps in provision as well as concerns about the disproportionate treatment experienced by people from their communities. Examples across the WMCA include:

- African Caribbean Community Initiative (ACCI)® in Wolverhampton, providing comprehensive support service for people from African Caribbean communities with mental health problems. Services include supported housing and advice; day opportunities; specialist outreach; counselling and a dedicated Carers’ Support Group.
- The Tamarind Centre in Coventry, providing outreach, including support with mental health Tribunals, counselling and drop-in services to the BAME communities, particularly African Caribbean and Asian people.
- Sandwell African Caribbean Mental Health Foundation, providing a range of culturally responsive mental health services, including counselling, outreach and a Ujima, a user-led service providing volunteering, peer support and mentoring to develop community meet ups and other social activities.
- Eksa Unity Volunteer Group®, based in Coventry and also in an Eastern European background, including Czech, Slovakian and Polish people as well as people with protected characteristics under the Equality Act®. The team works in partnership with other community organisations to provide support to individuals, raise awareness of mental health and wellbeing; provide cultural competence training and set up support groups; for example Pyari Sangat - Asian Women’s Mental Health Support Group; Community Creations – An Initiative for Asian Women; Migrant Support Group in Walsall. CDWs also help to ensure that the views of the communities that they work with are represented in the development and delivery of services.

Community Development Workers (CDW) in working with different BAME communities to help prevent mental ill health and support access to services. Examples include:

- The community engagement team at BSHMFT who have played a central role in relation to 300 Voices and work closely with Trust staff and community groups to empower and engage people that are consulted and involved in developments or changes to services provided by the Trust.
- The community engagement team at Black Country and Sandwell Partnership to increase the voice and the views of the communities that they work with and without experience of mental health issues (social contact).

CDWs also help to ensure that the views of the communities that they work with are represented in the development and delivery of services.

2. Improving the life span of people diagnosed with a severe mental illness

Reducing premature mortality and improving physical health outcomes for people with a severe mental illness is a priority for NHS England. Over the last five years across the West Midlands Time to Change have:

- Recruited over 500 people as Champions to take action in their community.
- Facilitated and supported eight campaign groups that have brought together people with a lived experience to run campaign activities in their local area and in挑战 stigma in their daily lives.
- Funded and supported the delivery of the 300 Voices Programme (see Appendix 4).
- Run a high number of pop up time to Change mental events to encourage mental health conversations; produced an educational pack for professionals, volunteers and youth leaders, with guidance and, materials around tackling mental health stigma.
- Supported over 20 employers to sign a pledge to embed changes in policy and practice to transform the culture of their workplaces.

Over the next five years, Time to Change aims to empower communities to lead and shape local change together by setting up ‘Time to Change Hubs’. In these Hubs the Campaign will support partnerships of local organisations and individuals to work with people with lived experience of mental health problems to convene and coordinate local action.

England and guidance was produced in May 2016 (NHS England, 2016), which outlined key action areas:

- Support to quit smoking
- Tackling obesity
- Improving physical activity levels
- Reducing alcohol and substance use
- Sexual and reproductive health
Mental Health in the West Midlands Combined Authority

3. Promoting choice, self-determination and recovery

There is a growing evidence base that self-determination and choice promote prevention and early intervention in contrast to a traditional model of intervening after an acute crisis (Alakeson, 2007a; Forder et al., 2012). This section considers three particular strands for a mental health strategy for the WMCA that is underpinned by the principle of personalisation and autonomy.

PERSONALISATION IN HEALTH AND SOCIAL CARE: LEADING APPROACHES AND PERSONAL BUDGETS

Although the definition of personalisation can be open to interpretation and is evolving, it is an approach that seeks to secure empowerment, citizenship and equality. In a public services context, it is used to refer to recognising people as equals, the secure empowerment, citizenship and evolving, it is an approach that seeks to enable individuals who have strengths and meets their needs to enable them to live their lives.

Direct payments and personal budgets are two ways in which people can have greater control over their care. The 2013 POET survey found that people who took the personal budget as a direct payment felt more in control and had greater choice than those using a personal budget (Hatton and Waters, 2013). Furthermore, the evidence indicates that people experiencing poor mental health are most likely to benefit from the choice and control offered by a direct payment of personal budget (Alakeson, 2007b; Knapp et al., 2015). However, for the role of peer support to be meaningfully adopted the experiential user-focused findings relating to access to advocacy (CCQC, 2014). The evidence base in terms of delivering outcomes is inconclusive and where peer support has been identified they are not replicated across all studies (Knap et al., 2015). However, for the role of peer support to be meaningfully adopted the experiential knowledge that peer workers bring to the work that enables them to engage and build qualitatively different relationships with service users has to be understood, acknowledged and valued (Gillard et al., 2014).

There is a range of organisations to provide guidance and facilitate the development of peer support including Peer2Peer, hosted in Sandwell, was highlighted for its potential role in developing the role of peer supporters within both the voluntary and statutory services, (Repper, 2013), bringing benefits to both those supported by peers and to the peer support workers themselves (Repper, 2013). In (ImROC, 2015), there are two out of a range of settings and they have recently focussed training is applicable to a broad range of services aimed at developing the range of peer support initiatives in the West Midlands, including user-led initiatives, such as Hearing Voices Groups, of which there is one, based in West Bromwich, which meets weekly in Birmingham’s gay village area and provides informal peer support, and the national organisation, based in Wolverhampton, First Person Plural for people identifying with complex dissociative identity disorders as well as those provided by the six local Mind organisations (Birmingham, Coventry and Warwickshire, Dudley, Mid Staffs, Solihull and Springfield Mind in South Warwickshire). Kaleidoscope (Birmingham and Solihull), is highlighted for being particularly innovative in providing a range of services with peer support as the focus (Faulkner et al., 2013). Peer support takes many forms and includes:

- Providing support with recovery and care planning (eg, South Staffordshire Network for Mental Health) 144
- Facilitating peer support groups for people who hear voices (eg, Hearing Voices Networks) 145
- Self-help groups (as above)
- On-line peer support
- Peer mentoring (eg, in schools to build emotional resilience, Wolverhampton) 146

The voluntary sector plays an important role in providing preventative interventions, at an individual, collective and community level, and actively promotes peer support

PROVIDING SUPPORT FOR PEOPLE WITH MENTAL HEALTH PROBLEMS

The development of Recovery Colleges in England is relatively young and as yet there are few systematic evaluations of the impact on the quality of lives of people with long term mental health problems, although the narrative accounts are promising. A pilot study in London found that 69% of the students felt more hopeful and 81% had developed their own plans for self-management with those that attend more than 70% of the sessions showing a reduction in their use of community mental health services (Cited in North Essex Research Network and South Essex Service User Research Group, 2014). A small scale study of Recovery Colleges in Mid Essex found in self-confidence, motivation, ability to self-manage and improved relationships with others (North Essex Research Network and South Essex Service User Research Group, 2014).

The analysis of information from Local Authority Area, and actively provides personal budgets which will be funded via housing benefit or via the Housing Allowance levels) on the amount of housing benefit that can be claimed. The level of the Care and Support Grant, which provides a substantial shortfall between the rent for supported housing schemes and the amount which will be funded via housing benefit or via the housing element of Universal Credit. This hits a wide variety of provision, including mental health services. Research conducted by the National Housing Federation found that at the national level 156,000 units of existing supported and sheltered housing would become unavailable and subject to closure. This is 41% of all existing schemes. This has resulted in a huge amount of uncertainty amongst providers and has resulted in 80% new developments of specialist housing being put on hold. The government has delayed the introduction of the cap by 12 months, and not announced the results of its research into supported housing provision

144 www.hearing-voices.org.uk/area/west-midlands [accessed 150816]
146 www.tablesonline.org.uk/about-first-person-plural [accessed 150816]
147 www.kaleidoscope.org.uk [accessed 150816]
148 www.hearvoice.org.uk/services/personal-support [accessed 150816]
149 www.hearing-voices.org/tag/peer-support [accessed 150816]
150 www.hec.org.uk/news/uk-england-3151/584 [accessed 150816]
151 Data provided by the National Housing Federation 2016.
There is a general dearth of research into housing models for people with mental health problems but a mapping study in 2009 identified considerable overlap between the characteristics of the clientele of residential care; building based support and floating support and significant variation in costs (Priebe et al., 2009). Furthermore, the majority of the costs were being spent on the housing component suggesting that this population may be underserved by mental health services. Watts et al. (2015) argue that psychologically informed environments are crucial in addressing youth homelessness because of the high proportion of young people using homelessness services that have complex needs, including mental health and behavioural problems. Partnership working between housing providers and mental health services is, therefore, increasingly emphasised (NHS Confederation and National Housing Federation, 2011). However, the separation between housing and non-housing support, complexity of funding arrangements and the reduction of available resources compounded by the differing approaches of housing, health and social services, has resulted in a lack of a coherent view on the most effective models.

People with mental health issues are housed in a variety of stock, both general need rented accommodation (possibly with floating support) and in specific provision designed for people with mental health needs, notably floating support and supported housing:

FLOATING SUPPORT
The aim is to support people in their recovery and to live more independently. Some support is targeted at particular groups, for example the services provided by the Heartum Housing, based in Wolverhampton, offering supported housing and floating support for South Asian men and gender specific support, including supported housing, for South Asian women. There is also a dedicated provision for women and children facing violence and abuse, young people including care leavers and for offenders and ex-offenders.

Accommodation may be on a short-term basis (i.e., up to a year) or a longer term basis. A wide range of support is provided in addition to housing, such as building-based or floating support with developing skills for independence, including budgeting and food preparation and use of mainstream services; linking with community activities and volunteering opportunities, and wider activities to promote good health and well-being.

STEP-DOWN
Step-down provision is a key component of a mental health housing strategy to enable people to live independently and leave hospital, when there is no suitable alternative. This type of provision will, therefore, reaps benefits to the NHS in terms of cost savings and ensure that people do not stay as inpatients any longer than is necessary. There are several providers of step-down provision across the WMCA, including housing associations, charities and independent sector providers.

HOUSING FIRST
The Housing First model focuses on rapidly finding a permanent home in the community for someone without this being conditional on mental health, employment or not abusing alcohol or drugs. It uses a client-led approach and is designed to provide open-ended support to people with complex needs, including severe mental health problems, homelessness, poor physical health and physical or learning difficulties.

The Housing First model is designed to provide open-ended support to people with complex needs, including severe mental health problems, homelessness, poor physical health and physical or learning difficulties.

There are Housing First services for people who are sleeping rough and facing multiple exclusions in Birmingham, Solihull, Coventry and Stratford on Avon to help them directly into permanent accommodation, with comprehensive support tailored to meet their individual needs. Many are piloting the use of Psychologically Informed Environments, which recognises the potential for change and ensure that staff are psychologically minded and able to work with the complex dynamics that can arise as a consequence of trauma and retraction.

2. Performance against national indicators
ASCOF data provides a measure of the proportion of adults using secondary mental health services on the Care Programme Approach (CPA) who are living independently (with or without support) as summarised in Figure 18.

A previous study in Walsall identified the practice of residential sorting from anecdotal evidence (Jones and Gulliver, 2009) and this further research is required.

3. Working together
Housing Association providers of services for those with mental health issues have formed the Health, Wellbeing and Housing Group. This group’s aim is to promote further partnership working between Housing Associations, the NHS and local authorities based on evidence, from their work to date, that a joined-up approach can save money and provide a better services to users. The WMCA provides an opportunity for a strategic approach to the provision of mental health services; providing a comprehensive approach to improving the health and mental health, building on the emerging evidence on Housing First.
EMPLOYMENT

1. Provision in the WMCA

People with severe mental health problems have very low employment rates and are at greater risk of falling out of work than the general population and other disadvantaged groups. Although the majority of people with mental health problems want to work, there is a growing concern about the relationship between employment support, entitlement to Employment Support Allowance (ESA) and mental health support. In relation to the range of employment support, a comprehensive mapping of DWP provision has not been undertaken for this exercise and, in any event, changes are planned for 2017 with the merger of the Work Programme and Work Choice to form a new Work and Health Programme to support people with long-term health problems, including mental health, into work. There are currently a number of providers of the DWP-funded Work Choice Programme for people with mental health problems in the West Midlands and those listed by the British Association for Supported Employment (BASE) which may not be a comprehensive list, are as follows:

- Sandwell Council
- Advance Employment, Solihull
- Hereford College, Coventry
- Pathway First, Momentum and Shelforce in Birmingham
- Dudley MBC
- Seetec and Dudley and Walsall Mental Health Partnership NHs Trust in Walsall

Employment support, often combined with volunteering opportunities and welfare advice, is frequently provided by the voluntary sector, sometimes funded by the Local Authority or CCG. BITA Pathways, in Birmingham, for example, are funded by the Birmingham and Black Country Commissioning Team and provide education, volunteering and an employment service to adults aged 18-65. They provide training and work experience with one of their five social enterprises in a variety of industry sectors.

Individual Placement and Support (IPS) has been introduced to enable people who experience severe and enduring mental health problems to find employment in the open market. Previous approaches for this group have largely been based on sheltered work or a ‘train and place’ model. IPS is a form of supported employment, which seeks to place people in open market jobs as quickly as possible, with continuing support, and the specific components of this approach are outlined in Figure 21.

2. Performance against national indicators

The Public Health Outcomes Framework data indicates that the average employment rate for people on the CPA in England is 7%. In the WMCA, the average is 10%, but there is considerable variation between the CCGs, ranging from just under 4% to 22% in 2015-16 (Figure 21). There are striking differences between the LEPs with an average employment rate for less than 5% for Black Country LEP in comparison with around 15% for Coventry and Warwickshire LEP. This data is also available from ASCOF data at Local Authority level for 2014/15 and demonstrates a pattern, with a similar range from Birmingham, Dudley, Wolverhampton and Sandwell having the lowest number of people on CPA in employment and Warwickshire, Staffordshire and Coventry the highest.

It is evident that some areas have made progress since 2013/2014, most notably Coventry, which has increased its percentage of people on CPA in employment from 9.8% to 13%, and more modestly Dudley, which has increased from 4.3% to 6.2%. However, in many areas, there has been little change.

In order to promote the outcomes that have been identified by research, attention is paid to how well IPS is implemented in terms of fidelity to the model. This is a key principle related to the Centre for Mental Health which has carried out independent fidelity reviews and has recognised the quality of IPS services in Walsall (provided by Dudley and Walsall Mental Health Partnerships), Coventry (MBC) and North Staffordshire (provider Work4You, Making Space and covering Local Partnerships - provided by Worcestershire Health and Care Trust). As excellent; Sandwell (Sandwell MBC) and Wolverhampton (Healthyc Minds and Wellbeing) as good fidelity; Birmingham (BSMHFT) as fair fidelity; and Wolverhampton (Wolverhampton MBC) as low fidelity. An inaugural meeting of an IPS network has been held in May 2016 with the aim of developing a West Midlands IPS strategy and scaling up provision.

CRIMINAL JUSTICE SYSTEM

The Bradley Report (2009) identified that there are more people in prison than ever before and that being in custody can heighten vulnerability and increase the risk of suicide and self-harm. It emphasised the importance of early intervention, family-based approaches and increasing capacity across the criminal justice system to identify and respond to poor mental health and reduce re-offending rates. A review of progress on the report’s recommendations concluded that progress needs to be sustained and that partnership working is vital to support this effort (Centre for Mental Health, 2014).

1. Liaison and Diversion services

Criminal Justice Liaison and Diversion services exist to identify offenders who have mental health, learning disability or substance misuse vulnerabilities when they first come into contact with the criminal justice system and refer them to appropriate services for support and therapeutic help. Criminal Justice Liaison and Diversion teams are funded by NHS England Offender Health. The West Midlands now has three pilots covering all of the custody facilities across the West Midlands Police Force area. New designed 60 cell super custody blocks at Oldbury and Perry Barr provide the majority of custody provision with smaller custody facilities at Coventry, Solihull, Bournemouth in Birmingham, and Wolverhampton. The Liaison and Diversion staff provide an all age service and link directly to the local Crown and Magistrates court to support pre-sentencing diversion opportunities.

The Crisis Care Concordat Action Plans identify the need to improve access to liaison and diversion services and action plans for the constituent members of the WMCA have identified measures, including closer working between the police and MH Trusts. Examples of initiatives to support this include:

- A Pathway in Dudley for people leaving custody to enable them to get in touch should the need arise
- Solihull has a Pathways pack on arrest for all offenders to help police officers identify the cause of criminal activity and signpost to the relevant agencies for further follow-up work, including mental health as well as substance misuse
- Wolverhampton has a well-established Youth pathway to support wider intervention and diversion linked through the offender health pathways and Youth Offending Service

West Midlands Police has recently been successful in obtaining funds from the Home Office Innovation Fund to establish diversionary programmes for people with causal factors, such as substance misuse and mental health. The programmes will align to the use of conditional cautions and will include CBT and substance misuse therapies. There is an academic review linked to this process to establish what works and ability to evidence a scale up approach.

In 2013, a third of women cautioned for or convicted of offences inTimms and Walsall were first-time offenders. Nearly half of all the indictable convictions of women were for shoplifting, compared with just under a quarter of men. This proportion is highest for men. The next most common offence among women was violence against the person, around a third of which was accounted for by Actual Bodily Harm. Drugs offences were the next most common, although the proportion of women in prison for those types of offences has declined overall, from 25.2% in 2009 to 13.8% in 2014.

Anawim in Birmingham provides a female offender programme which feeds from the Liaison and Diversion staff. This has been seen as very successful but funding continues to be an issue for sustainability and the programme may seek to be included in the wider commissioning of female offender health services.


117 This is unsurprising because the ASCOF data is drawn from MHDIS

118 www.wmahsn.org/events/2016/05/11/West_Midlands_Mental_Health_Innovation_Network_Event_-_Individual_Placement_and_Support [accessed 03/16 15/05/16]


121 http://base-uk.org/services-offered/work-choice/?page=1
2. Prison

There are 12 prisons in the West Midlands and their mental health provision, in addition to availability of nursing and emergency services to people accommodated in prison, is detailed in Appendix 10. Approximately 3,700 primary mental health referrals of adult male prisoners are made on an annual basis (Offender HNA and Consultancy Projects, 2015: 28). Gaps in provision relating to primary care mental health and counselling have been identified with a recommendation that IAPT is introduced to address low levels of mental health needs and that innovative approaches to delivering primary mental health support in prisons is required. Problems in obtaining secure beds for people requiring transfer under the MHA were also identified by the 2013/14 Health Needs Assessment (Offender HNA and Consultancy Projects, 2015). In addition a lack of capacity for prison staff to attend mental health awareness training was highlighted.

3. Community Rehabilitation Companies

In 2014, changes to the delivery of probation services were introduced, with responsibilities for most offender being transferred to 21 Community Rehabilitation Companies (CRCs). There are two CRCs covering the WMCA population: Staffordshire and West Midlands CRC covering Staffordshire and the West Midlands, and West Mercia covering the Warwickshire and Worcestershire elements of the WMCA. They provide probation services for low and medium risk offenders alongside the national probation service, which serves the most high-risk offenders. This split has increased the complexity around information sharing.

4. Support for prisoners ‘through the gate’

‘Through the gate’ is a National Offender Management Service (NOMS) initiative which seeks to identify opportunities to resettlement individuals as they leave prison. Working with providers, plans are put in place to ensure housing, health and social needs are addressed prior to release. There is a significant challenge in addressing missed opportunities around pick up of treatment post release especially for substance misuse; West Midlands (85% missed) compared to the national average (67% missed).

The regional approach to rehabilitation has a governance structure (West Midlands Reducing Reoffending Steering Group) supporting housing, employment and resettlement.

Overall assessment

This exercise has provided a rapid appraisal of the position of mental health in the WMCA, as defined by the geography of the three LEPs. It is not comprehensive but provides a complement to other work being undertaken by the West Midlands Mental Health Commission and its partners.

It is clear that considerable investment in mental health is being made across the WMCA and this report provides a starting point for discussion about how well this is currently deployed.

The overall conclusion from this appraisal is that there is considerable scope for the WMCA to improve the mental health of working-age adults through a strategic and system wide approach. The framework provided in Figure 1 in the introduction is offered as a basis for identifying how action could be taken to provide a systemic approach to future development by the WMCA and its partners.

There are two key issues that require further consideration by the West Midlands Mental Health Commission and its partners. First is addressing the question of how children and young people can be better supported to ensure they have a reduced chance of developing a mental health problem in later life? This has been outside the scope of the rapid appraisal but, nonetheless, the evidence strongly indicates that many children who experience mental health problems, often in response to adverse childhood events, go on to have mental health problems as adults. Over time, evidence-based intervention early in the life course, including during the perinatal period, is almost certainly the most effective and cost-effective means of reducing the overall prevalence of mental health problems in the adult population.

Second is the quality of mental health related intelligence across the WMCA footprint. We have found the JSHAs to be of variable quality in terms of how current and comprehensive they are. This has implications for support from West Midlands Public Health, as well as by its partner Local Authorities. Better intelligence will enable a clearer picture of the current position and the priorities for action. We have highlighted the relationship between inequalities and mental health and how the risks of developing poor mental health are not evenly distributed across the WMCA.

It is important that the diverse needs of different populations, including those that we identified as being at risk, are properly considered, and what needs to happen to make access to support more equitable.

A key message from the emerging evidence and the promising practice is that personalised approaches, built on and responding to what people with mental health problems, their families and communities, say, and what they think needs to happen, is an important strand of effectiveness and may save money.

It is, therefore, encouraging to see a commitment to co-production widely expressed by public services in the WMCA and some examples of this being translated into action. There is clearly further scope for action on this front, drawing on both local and national expertise.

It is nevertheless the case that the introduction of promising initiatives that have the potential to bring social and economic benefits is patchy, and the West Midlands Mental Health Commission is in a good position to evaluate these and support their implementation. Scaling up these initiatives – MHFA, IPS, Housing First, Crisis Houses, for example, needs to be actively considered and evaluation of these models in a WMCA context is needed to understand the role of contextual factors that may influence effectiveness and outcomes. There are also areas, particularly in primary care, where different models are being developed and comparison of these in terms of access and impact (eg, patient and economic outcomes) would be of benefit.

The third sector – voluntary and community organisations – play a key role in supporting people who may not be supported by public services, because they are unable to meet their needs appropriately or because of reluctance to engage with these services. They are built on an ethos of open door and spirit, often supporting the most marginalised populations. Throughout the process of gathering data for this appraisal, we have heard concerns about the impact of budget reductions on this sector in particular, with valued services having to be cut or no longer commissioned. Adopting a system-wide and a strategic approach to mental health offers the opportunity of a clear-sighted view on what services need to be protected and further developed.

The West Midlands has been a pioneer in many areas and not shed away from innovation, having developed service models that have consequently been adopted elsewhere, early intervention for psychosis and street triage for example, and been an early adopter of service models from good quality evidence elsewhere, Housing First for example. The establishment of the West Midlands Mental Health Commission reflects this pioneering spirit, and the capacity to work together, to work differently and to invest resources differently to better effect for people living in the WMCA.
The following recommendations are made based on the findings and the costs and provision across the WMCA:

1. All Local Authorities should be required to have an up-to-date JSNA for mental health to provide the intelligence on which to build a strategic and systemic approach. The process should be coordinated through an intelligence hub for the WMCA.

2. The approach to intelligence and monitoring needs to encompass both quantitative data on access, experience and outcomes as well as more fine-grained qualitative data to understand the real-life experience of people with mental health problems.

3. Co-production should be a foundation for mental health service transformation across the WMCA and will help ensure that accessible, acceptable and appropriate services are commissioned, developed and delivered to meet the diverse needs of the WMCA population.

4. In order to tackle inequalities, it is essential to understand the diversity of the WMCA population, in terms of perceptions of mental health; barriers to access any support and may be further marginalised by an emphasis on service delivery and design. This needs to include those who do not currently access any support and may be further marginalised by an emphasis on self-management. This is a crucial to ensuring that inequalities are not embedded in the approach of the West Midlands Mental Health Commission.

5. This assessment has identified groups which are at particular risk of poor mental health and who may be in contact with a range of public services, with effort duplicated between them. Improving coordination and partnering working for these populations should be a priority.

6. A strategy for public mental health needs to be developed for the WMCA. Any strategy to improve the mental health of the WMCA population has to invest in the mental health of children and young adults and this will prove to be cost-effective. This includes attention to parental mental health and substance abuse.

7. Primary care has a key role to play in prevention, early intervention and treatment, and, promoting parity of esteem between mental and physical health. This includes attending to the emotional and mental wellbeing of people with physical health problems, medically unexplained symptoms and other forms of complexity, and the physical health needs of people with severe and enduring mental health problems. Identifying the components of good primary care mental health would facilitate a coherent approach across the WMCA and ensure that the full potential of primary care is maximised.

8. Organisations and communities in the WMCA have pioneered innovative approaches in mental health that have been adopted outside the WMCA. There are examples of promising practice developing and, in some instances the evidence for these is not yet developed. Where this is missing, the evaluation of such initiatives will be an important strand of understanding the feasibility for scaling up across the WMCA.

9. There is evidence for interventions that have yet to be adopted on any scale within the WMCA. The implementation of evidence-based practice needs to be understood within the WMCA context and prioritised.

10. There are clear variations in system performance across the WMCA and the factors influencing both good and poor performance requires inquiry and action taken to improve overall system performance.

11. There should be an investment in piloting and evaluating alternative approaches to in-patient care, including crisis houses and open dialogue.

12. There should be a commitment, supported by achievable action plans, to reduce the overall rate of detentions under the Mental Health Act and particularly those of people from Black and Minority Ethnic communities, and the use of restraint.

13. The WMCA should aim to reduce the rate of Out of Area Treatments by developing appropriate local provision and strengthening the experience of being a carer during a mental health crisis. Journal of Advanced Nursing, 71(2), pp.2753-2762.

14. All CCGS and Local Authorities should identify how they can better support and build the capacity of the voluntary sector to ensure the substantially valued services and approaches.

15. The evidence for personalised approaches that give greater choice and control to service users aligns with what they are asking for, supported by evidence that indicates that such approaches lead to better outcomes. Local Authorities should identify how they can implement direct payments and personal budgets to ensure they achieve this.

16. A comprehensive audit of housing provision to support people with mental health problems would enable the WMCA to further investigate the range of provision and develop a strategic approach to housing and mental health, building on existing emerging evidence on Housing First.

17. The wider adoption of high quality Individual Placement and Support services should be encouraged.

18. This is challenging work, systems are slow to change and it is not a linear process. The key issue going forward is to ensure the spread of good practice and to build on and strengthen the positive partnerships and collaborations, which are already clear. The Commission should, therefore, identify the workforce development implications for achieving the required transformation. This will need to include attention to system leadership.

References


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National Mental Health Development Unit (2011). In Sight and In Mind: A toolkit to reduce the use of out of area mental health services. Available at: www.rcpsych.ac.uk/pdf/insightandmindmind.pdf [accessed 000616].


Appendix 1
Audit of Mental Health Activity Commissioned by CCGs and Local Authorities in WMCA2014/15

1. Name of organisation:
Details of person completing the audit: ____________________________

2. Please provide a breakdown by age for the year 2014-15 below:

<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th>Spend (£000s) 2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children (0-16)</td>
<td></td>
</tr>
<tr>
<td>Adults of working age (17-65)</td>
<td></td>
</tr>
<tr>
<td>Older adults (65-plus)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>

3. For adults of working age, please complete the table:

<table>
<thead>
<tr>
<th>Organisation commissioned</th>
<th>Target population</th>
<th>Activity specified</th>
<th>Expected outcomes</th>
<th>Contract value (£000s) 2014-15</th>
<th>Performance monitoring details for 2014-15 Please either provide commentary here</th>
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</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Please add additional rows as necessary


## Appendix 3

### Mental Health Joint Strategic Needs Assessments for the WMCA

<table>
<thead>
<tr>
<th>LEP</th>
<th>Local Authority</th>
<th>Status as at July 2015</th>
<th>Link to JSNA</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Midlands</td>
<td>Wolverhampton</td>
<td>Refreshed in 2014</td>
<td><a href="https://wolverhampton.moderngov.co.uk/documents/i6336/item/2012/2012010320140328/Appendix1.pdf">https://wolverhampton.moderngov.co.uk/documents/i6336/item/2012/2012010320140328/Appendix1.pdf</a></td>
</tr>
<tr>
<td></td>
<td>Sandwell</td>
<td>0-25 yrs MH JSNA in final draft form</td>
<td>Work underway on adult MH JSNA</td>
</tr>
<tr>
<td>Coventry and Warwickshire</td>
<td>Coventry</td>
<td>2015. Also covers Ruby, but limited information available</td>
<td><a href="http://www.coventry.gov.uk/download/.../mental_health_needs_assessment">www.coventry.gov.uk/download/.../mental_health_needs_assessment</a></td>
</tr>
</tbody>
</table>
## Appendix 4

### Service user engagement groups in the West Midlands Combined Authority

<table>
<thead>
<tr>
<th>Area</th>
<th>Name of Group</th>
<th>Description</th>
<th>Recent examples of involvement/co-production</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birmingham</td>
<td>See Me user engagement project at BSMHFT</td>
<td>A project that promotes greater engagement of service users in the planning and delivery of mental health services in Birmingham and Solihull through feedback; ensuring users’ views are represented at all levels of the Trust and See Me user involvement workers have a place on all key Trust meetings and support service users to attend many of these meetings as User representatives too.</td>
<td>New Dawn, a comprehensive review of community mental health services, was undertaken with the support of the See Me team to ensure service users and carers could inform and support development of new ways of working. The See Me team have also sought feedback and informed views of service users regarding the recent Smoke Free NHS introduction across all teams in the mental health trust.</td>
</tr>
<tr>
<td></td>
<td>300 voices</td>
<td>A partnership between BSMHFT, West Midlands Police, Birmingham City Council and Time to Change that seeks to engage with young African and Caribbean men aged between 18 and 25 to hear their experiences of inpatient and outpatient care. 300 Voices was funded by the Big Lottery Fund, the Department for Health and Comic Relief, and the funding came to an end in March 2016. Different elements of the programme are being taken forward by BSMHFT (peer support programme) and by West Midlands Police (engagement of workforce with 300 voices). The 300 Voices project adopted a person-centred approach to mental healthcare that aims to engage with African and Caribbean men and hear their stories to determine how mental health services will be delivered in the future. The project is underpinned by a model of community engagement to create a dialogue and healthy transformative conversations. Activities include community engagement events, the experience booth to capture experiences; plays; and the development of a practical toolkit aimed at staff.</td>
<td>An evaluation undertaken at the end of the programme (Rowe et al., 2018) identified a number of positive changes from the introduction of 300 voices, including:</td>
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<td></td>
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<td></td>
<td>⬠ Engaging a diversity of professionals in training workshops</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>⬠ Changing attitudes (particularly among police)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>⬠ Influencing individuals to reflect on and change their practice.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The authors of the evaluation report (Rowe et al., 2018) conclude that there is a clear case to build on the achievement of 300 voices to date in the future.</td>
</tr>
<tr>
<td></td>
<td>Birmingham and Solihull Mental Health NHS Foundation Trust User Watch</td>
<td>A blog presenting an independent, occasionally satirical view of mental health and NHS issues</td>
<td>An evaluation undertaken at the end of the programme (Rowe et al., 2018) identified a number of positive changes from the introduction of 300 voices, including:</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>⬠ Engaging a diversity of professionals in training workshops</td>
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<tr>
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<td></td>
<td>The authors of the evaluation report (Rowe et al., 2018) conclude that there is a clear case to build on the achievement of 300 voices to date in the future.</td>
</tr>
<tr>
<td></td>
<td>Dudley and Walsall MH Partnership Trust</td>
<td>A team of eleven expert service users and carers, who use their experience to influence the delivery and quality of services provided by Dudley and Walsall MH Partnership Trust. The work of EBEs forms a significant part of the Trust’s Service User and Carer Involvement Strategy, which aims to deliver the vision of involving service users and carers in all areas of work.</td>
<td>Urgent care services comprehensive review and redesign was conducted which led to the development of the Street Triage Service which has been very well received.</td>
</tr>
<tr>
<td>Sandwell</td>
<td>Mental Health People’s Parliament</td>
<td>The People’s Parliament enables people, with lived experience, to develop into leadership roles as MPs. These MPs work in co-production with senior leaders and decision makers from a range of agencies such as the local Council or Clinical Commissioning Group, to improve services and support needed to achieve equality, good health and social inclusion.</td>
<td>An overview of the Crisis Resolution and Home Treatment Service including identifying training needs for staff.</td>
</tr>
<tr>
<td></td>
<td>South Staffordshire Network for Mental Health</td>
<td>An independent charity promoting and developing mental health services from the perspective of people who have an experience of mental illness throughout the six districts and borough of South Staffordshire. Funded by Staffordshire County Council to provide a mental health participation service called ‘Your Voice’. Represent people with experience of mental illness within local Healthwatch and local Clinical Commissioning Groups. Activities include:</td>
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<td>⬠ Ongoing qualitative evaluation of five local mental health services and associated care planning documentation.</td>
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<td>⬠ Quarterly high standard newsletter and podcast led and edited by service members.</td>
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<td></td>
<td>⬠ Four research reports each year covering topics deciding by members (previous reports have included GP Awareness of mental health, Experience of Jobcentre Plus, Barriers to Employment, Quality of Care in Recovery).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>⬠ Ongoing delivery of four workshops promoting recovery and encouraging self-management and participation within care planning.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>⬠ An investing in Volunteers accredited volunteer programme providing the opportunity for people with experience of mental illness to become community developers.</td>
</tr>
</tbody>
</table>

### Croydon and Morpeth

<table>
<thead>
<tr>
<th>Area</th>
<th>Name of Group</th>
<th>Description</th>
<th>Recent examples of involvement/co-production</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon and Morpeth</td>
<td>Independent Mental Health User Involvement Service (IMHUIS)</td>
<td>A blog presenting an independent, occasionally satirical view of mental health and NHS issues</td>
<td>Recent and regular consultation with the Care Quality Commission and Monitor. Co-production of a variety of peer support groups (Mental health and Veterans). Co-production of accredited training packages. Provide local authorities and NHS with trained panel members for interview and selection procedures. Contribute to local and national research project, and currently engaged with National Mind on a Peer Research Project. Continue to campaign locally for non-clinical changes that affect inpatient care. Successful in obtaining additional grant funding to set up a Veterans Peer Support Group.</td>
</tr>
<tr>
<td></td>
<td>Actively Influencing Mental Health services (AIMHS)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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*Note: The text has been formatted to improve readability, with headers added for clarity and the table structure optimized for better presentation.*
<table>
<thead>
<tr>
<th>Area</th>
<th>Name of Group</th>
<th>Description</th>
<th>Recent examples of involvement/co-production</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wolverhampton</td>
<td>Positive Action for Mental Health (PA MH)</td>
<td>A service user group, set up by Wolverhampton Empower Me team at Wolverhampton CVS, to influence and improve mental health services in Wolverhampton. Members meet twice a year at membership events to have their say on mental health services, and how they can be improved. There is a Steering Group, which represents the voice of the wider membership at meetings across Wolverhampton on a regular basis, including peer support groups that have over 350 members.</td>
<td>Introducing a requirement into contracts that services are obliged to have a system in place to respond to issues raised by service user groups. Influencing commissioners, along with Hear-our-Voice and other service groups to develop the Community Wellbeing Hub.</td>
</tr>
<tr>
<td></td>
<td>Hear-our-Voice</td>
<td>A Mental Health Action Group that is a completely user-ex-user led registered Charity and Company Limited by Guarantee, with approximately 150 members. All members must live within the Wolverhampton City boundary. The group activities include: Support for recovery by holding monthly Forum meetings with specific topics: workshops, including seasons, such as relaxation, aromatherapy, and educational trips. Events to raise public awareness of Mental Health issues. Communicating members’ ideas to CCGs, Mental Health Trusts and the Local Authority to improve the mental health services and requiring action. A quarterly magazine with a readership of potentially 1,000 readers which includes all members, statutory Bodies, Mental Health professionals, Libraries, Pharmacists, Community Centres, Housing offices, and Doctors’ surgeries.</td>
<td>The group is developing an approach ‘Mental Health and Physical Health As One’ and aims to shift the focus from a biomedical approach to one focused on the problems and circumstances of people experiencing mental health problems. It is, therefore, promoting greater access to psychological therapies and counselling in primary care.</td>
</tr>
<tr>
<td></td>
<td>Redditch Mental Health Action Group</td>
<td>MHAG is made up of individuals and representatives of organisations from Redditch, who meet monthly to discuss mental health, raise money for projects within the town and host events including an annual Wellbeing Wrek.</td>
<td>Members have launched a coaching scheme which works with people to set and achieve their goals. They have trained up various coaches to be able to expand the service. Representation on a County Council committee to decide what action is taken at a suicide hotspot in the town. MHAG regularly has speakers from the Health and Care Trust at their meetings, raising concern about issues such as the closure of Orchard Place.</td>
</tr>
<tr>
<td>Worcestershire</td>
<td>SURESEARCH-Service Users in Research and Education</td>
<td>A Midlands network of people who have used and/or survived mental health services and their allies-mental health workers, academics, carers. SURESEARCH aims to promote service user involvement in mental health education, training and research and it has a membership of over 150. The Survsearch network exchanges information, supports its members and develops projects and opportunities in education, research and the creative arts, through its regular monthly meetings. There are also regular smaller meetings: Issues for patients and staff on psychiatric wards – The In-Patient Care Forum Writing and Reading – The Writers and Readers Group Creative Work in the Arts – Survivor Arts</td>
<td>Individual Survsearch members collaborate in mental health research projects and contribute to training practitioners at various institutions including University of Birmingham social work courses.</td>
</tr>
</tbody>
</table>

**Appendix 5**

Audit of public mental health initiatives being commissioned in WMCA (Source: Local Authority Audit responses 2016)²²⁵

<table>
<thead>
<tr>
<th>Public health intervention</th>
<th>Examples</th>
<th>Wolverhampton</th>
<th>Walsall</th>
<th>Sandwell</th>
<th>Dudley</th>
</tr>
</thead>
<tbody>
<tr>
<td>General public/primary care</td>
<td>Mental health awareness</td>
<td>Mental Health and Wellbeing service providing one to one support; Five Ways to Wellbeing MHFA, Youth MHFA and Stress Management Training, Mental health training for key workers (eg, health visitors, school nurses etc.) incl. MHFA.</td>
<td>Emotional Health and Wellbeing service</td>
<td>Sandwell’s feel good it wellbeing engagement campaign from 15/16. Building resilience training – training frontline staff in mental health and wellbeing awareness.</td>
<td></td>
</tr>
<tr>
<td>Perinatal and infant mental health programmes</td>
<td>Breast feeding support</td>
<td>Breast feeding support</td>
<td>Family Support Services</td>
<td>Family Support Services</td>
<td></td>
</tr>
<tr>
<td>Parenting programmes (including targeted programmes at high risk families)</td>
<td>Parenting Team</td>
<td>Parenting Team Mellow, Triple P and Solihull</td>
<td>Parenting Team Mellow, Triple P</td>
<td>CHANGES local Parenting Programme a universal and targeted offer for parents of children 0–19</td>
<td></td>
</tr>
<tr>
<td>School-based mental health promotion and prevention programmes</td>
<td>Support for teachers</td>
<td>Support for teachers</td>
<td>Anti-bullying</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workplace interventions</td>
<td>Healthy Workplace Programmes</td>
<td>Healthy Workplace Programme Lifestyle Link</td>
<td>Audit of emotional health and wellbeing in schools as above) includes staff emotional health and wellbeing 15/16</td>
<td>Workplace wellbeing initiative led by HR for Dudley MBC staff: Five Ways to Wellbeing training course</td>
<td></td>
</tr>
</tbody>
</table>

²²³ Funding discontinued 31.3.16.
²²⁴ http://wolverhamptoncvs.org.uk/our-projects/mental-health-empowerment/ [accessed 15/08/16]
²²⁵ Some of the public mental health work detailed is developmental or project based and has ended or was under review at the time of data collection.
Public health interventions for mental health in the West Midlands Combined Authority

**Examples:**

- **Walsall:**
  - Targeted initiatives for at risk groups
    - Community and social activities: Addressing social isolation, access to education and employment, support for carers
    - Physical health: Tackling violence and abuse
    - Programme to improve the physical health of people with mental health problems
    - Targeted initiatives for at risk groups

- **Wolverhampton:**
  - A community service for African Caribbean Dual Heritage for people at risk of developing or recovering from 6 mental health.

- **Sandwell:**
  - Community Development workers: BME Mental Health and Wellbeing Prevention Service includes short-term counselling, awareness raising and practical and emotional support.
  - Mental Health assessment of all those referred to health trainer services.

**Tailoring violence and abuse:**

- Domestic abuse services
  - Domestic abuse family hostel
  - Domestic violence perpetrator programme

**Programmes to improve the physical health of people with mental health problems:**

- Reducing physical inactivity
  - Specialist weight management services
  - Smoking cessation
  - Screening and adult lifestyle services

**Suicide prevention training:**

- Forward for Life for frontline workers and senior managers: 4 x half-day SaLTA L basic suicide prevention accredited training courses

**Other:**

- General Art, Craft and Health sessions of 2 hours

**Targeted initiatives for at risk groups:**

- Young people
  - BAME groups
  - Unemployed men

**School-based mental health promotion and prevention programmes:**

- Primary Whole School Approach to Emotional Wellbeing: emotional health and wellbeing audit, action planning to address ‘gaps’ and implementation of a social and emotional learning programme incorporated into the taught curriculum.
  - Agreed funding to offer WSA to Secondary Schools

**Workplace interventions:**

- Healthy Workplace Programmes
  - Training and a review of processes and pathways for frontline staff at the Local Authority’s employment service.
  - Workplace Wellbeing Charter promoting good practice among local employers, including training.

**Targeted initiatives for at risk groups:**

- Young people
  - BAME groups
  - Unemployed men

<table>
<thead>
<tr>
<th>Public health intervention</th>
<th>Examples</th>
<th>Water(\text{\textregistered})</th>
<th>Walkall</th>
<th>Sandwell</th>
<th>Dudley</th>
</tr>
</thead>
<tbody>
<tr>
<td>General public/frontline services to promote awareness and tackle stigma</td>
<td>Mental health awareness/ Mental Health First Aid Community wellbeing services</td>
<td>MHFA for frontline workers</td>
<td>Mental Health First Aid training Ways to Wellbeing e-learning module</td>
<td>Mental health awareness/ Mental Health First Aid Mental wellbeing hub</td>
<td></td>
</tr>
<tr>
<td>Parenting programmes (including targeted programmes at high risk families)</td>
<td>Parenting Team Triple P</td>
<td>Triple P programme, living with confidence (to improve self esteem), family links nurturing programme, Parenting Team</td>
<td>Parenting Team – Solihull Approach Antenatal, Postnatal and Understanding Your Child’s Behaviour courses and Mellow Parenting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School-based mental health promotion and prevention programmes</td>
<td>Support for teachers Anti-bullying</td>
<td>Locality based Acting Early (MED) teams for School focusing on various areas including mental health School Nursing service</td>
<td>Work with individuals schools to increase emotional resilience and also challenge discrimination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workplace interventions</td>
<td>Healthy Workplace Programmes</td>
<td>Training and a review of processes and pathways for frontline staff at the Local Authority’s employment service. Workplace Wellbeing Charter promoting good practice among local employers, including training.</td>
<td>Training on mental health awareness and on workplace wellbeing</td>
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<tr>
<td>Work with individual schools to increase emotional resilience and also challenge discrimination</td>
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</tr>
<tr>
<td>Solihull healthy Schools Emotional Health programmes</td>
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</tr>
<tr>
<td>Targeted initiatives addressing mental wellbeing and target groups at risk including people with mental health issues, isolated individuals, substance users: Horticultural and Eco projects; social prescribing, Bespoke Lifestyle Services such as Health Trainers, Stop Smoking, Weight Management target specific groups</td>
<td>Urburn, a Youth Social Inclusion project for ‘hard to reach’ young/BME people in Birmingham Community Development Workers Community Health Champions model of recruiting people from local communities who suffer the worst health experience</td>
<td>Targeted initiatives addressing mental wellbeing and target groups at risk including people with mental health issues, isolated individuals, substance users Hortalicultural and Eco projects; social prescribing, Bespoke Lifestyle Services such as Health Trainers, Stop Smoking, Weight Management target specific groups</td>
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</tbody>
</table>
### Appendix 6

**Suggested commissioning priorities for public mental health**

(Source: Heginbotham and Newbigging, 2013)

Full references available in source document

<table>
<thead>
<tr>
<th>Commissioning area</th>
<th>Specific interventions</th>
<th>Some examples of the impact or outcomes achieved</th>
<th>Implementation aspects and feasibility</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Promote good parental mental and physical health</strong></td>
<td>Universal routine enquiry and targeted treatment for women at risk of depression with as part of a package of measures to improve perinatal mental health.</td>
<td>Improved maternal mental health</td>
<td>Routine enquiry at ante-natal clinics. Perinatal programmes with postnatal follow up in the first year after birth are most effective. Interventions with first-time mothers show best effects.</td>
<td>Independent risk factors for conduct and emotional disorders (Moliver et al., 2003)</td>
</tr>
<tr>
<td><strong>Promote good parenting skills</strong></td>
<td>Universal access to training programmes: - Community based group programmes; - Home based individual programmes; - Pre-school/early childhood education programmes, supporting development of home learning environment.</td>
<td>Improved parental efficacy and parenting practice</td>
<td>Ensure that parenting programmes are universal but where targeting is undertaken match programmes to social context and family circumstances. 10% of parents with children with conduct disorders receive evidence based parenting programmes. Preschool programmes that combine high quality education with parental support are most effective.</td>
<td>Group based parenting programmes have a positive effect on mental health and lead to improved self-esteem (Barlow et al., 2003)</td>
</tr>
<tr>
<td><strong>Promote good parenting relationships and improved parental mental health</strong></td>
<td>Universal routine enquiry and targeted treatment for women at risk of depression with as part of a package of measures to improve perinatal mental health.</td>
<td>Improved maternal mental health</td>
<td>Routine enquiry at ante-natal clinics. Perinatal programmes with postnatal follow up in the first year after birth are most effective. Interventions with first-time mothers show best effects.</td>
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<td>Improved maternal mental health</td>
<td>Routine enquiry at ante-natal clinics. Perinatal programmes with postnatal follow up in the first year after birth are most effective. Interventions with first-time mothers show best effects.</td>
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<td>Group based parenting programmes have a positive effect on mental health and lead to improved self-esteem (Barlow et al., 2003)</td>
</tr>
<tr>
<td><strong>Build social and emotional resilience of children and young people through whole school approaches</strong></td>
<td>Healthy schools; extended schools including supporting families; School based mental health promotion. School based Social and Emotional Learning (SEI) programmes achieving pupil's core competencies. Self-management and social skills training. Build financial literacy. Mentoring programmes Family Intervention Projects</td>
<td>Improved integrated approach, using universal and targeted interventions in primary school are cost effective.</td>
<td>Curriculums should integrate development of social and emotional skills within all subjects, delivered by trained teachers supported by parents. Targeted approaches to children showing early signs of emotional and social difficulties are recommended</td>
<td>Peer-led ‘emotional intelligence’ effective in combating low self-esteem. Universal school-wide mental health promotion better than classroom based brief interventions. (Bond et al., 2004; Meade &amp; Lamb, 2007; Schachtier et al., 2008; Wright et al., 2006)</td>
</tr>
<tr>
<td><strong>Build social and emotional resilience of children and young people through whole school approaches</strong></td>
<td>Healthy schools; extended schools including supporting families; School based mental health promotion. School based Social and Emotional Learning (SEI) programmes achieving pupil's core competencies. Self-management and social skills training. Build financial literacy. Mentoring programmes Family Intervention Projects</td>
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<td>Peer-led ‘emotional intelligence’ effective in combating low self-esteem. Universal school-wide mental health promotion better than classroom based brief interventions. (Bond et al., 2004; Meade &amp; Lamb, 2007; Schachtier et al., 2008; Wright et al., 2006)</td>
</tr>
</tbody>
</table>
### Improving working lives: a) support for unemployed

- Early intervention to reduce risks of unemployment through primary care and job centres, and promote engagement and participation for those who have become unemployed.
- Providing volunteering opportunities.
- Support NHS, LAs, and third sector organisations to develop interventions to improve healthy working lives and support those recovering from mental illness.

#### Commissioning area: Work

<table>
<thead>
<tr>
<th>Specific interventions</th>
<th>Some examples of the impact or outcomes achieved</th>
<th>Implementation aspects and healthly</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workplace screening for risk of depression followed by CBT where indicated</td>
<td>Early diagnosis and re-employment, with provision of depression management in primary care.</td>
<td>£54 million over five years compared to usual care.</td>
<td>National Institute for Health and Care Excellence (2013)</td>
</tr>
<tr>
<td>Increased employment, and reduction in long-term unemployment</td>
<td>Early diagnosis and re-employment with employees with depressive symptoms offering good financial return (Vilotion, 2003).</td>
<td>£54 million over five years compared to usual care.</td>
<td>National Institute for Health and Care Excellence (2013)</td>
</tr>
</tbody>
</table>

### Improving the quality of older people’s lives through psychosocial interventions which enhance control, prevent isolation, and enhance physical activity.

- Enhancing services (third sector and social care) via social prescribing to target loneliness and social isolation.
- Group interventions aimed to prevent social prescribing to target loneliness and social isolation.
- Falls prevention through social support and education.

#### Commissioning area: Age

<table>
<thead>
<tr>
<th>Specific interventions</th>
<th>Some examples of the impact or outcomes achieved</th>
<th>Implementation aspects and healthly</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meaningful group activities with educational and social support programmes for falls prevention</td>
<td>Increases functional status and reduced institutional care needs in older people.</td>
<td>£2.3 million over three years compared to usual care.</td>
<td>National Institute for Health and Care Excellence (2013)</td>
</tr>
<tr>
<td>Improved social inclusion</td>
<td>Volunteering and peer support programmes for falls prevention</td>
<td>£2.3 million over three years compared to usual care.</td>
<td>National Institute for Health and Care Excellence (2013)</td>
</tr>
<tr>
<td>Improved quality of life</td>
<td>Improving social prescribing for falls prevention</td>
<td>£2.3 million over three years compared to usual care.</td>
<td>National Institute for Health and Care Excellence (2013)</td>
</tr>
<tr>
<td>Reduced A&amp;E attendance and admissions to hospital</td>
<td>Reducing social isolation and loneliness among older people.</td>
<td>£2.3 million over three years compared to usual care.</td>
<td>National Institute for Health and Care Excellence (2013)</td>
</tr>
</tbody>
</table>

### Improving quality of life through increasing opportunities for participation, personal development and problem-solving.

- Enhancing social prescribing - specifically volunteering, including time banks, exercise arts and creativity, learning and educational opportunities, and green activity.
- Signposting to welfare advice, particularly employment, provision of support for benefit uptake, debt advice, financial literacy and information and self-help. Debt counseling and advise.

#### Commissioning area: Health

<table>
<thead>
<tr>
<th>Specific interventions</th>
<th>Some examples of the impact or outcomes achieved</th>
<th>Implementation aspects and healthly</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Build collaborative community partnerships based on existing strengths and resources</td>
<td>Reducing physical and mental health problems and increasing participation of socially excluded groups.</td>
<td>£54 million over five years compared to usual care.</td>
<td>National Institute for Health and Care Excellence (2013)</td>
</tr>
<tr>
<td>Meaningful occupation and physical activity increases overall wellbeing</td>
<td>Use innovative approaches such as social prescribing and mutual volunteering schemes to engage the participation of socially excluded groups.</td>
<td>£54 million over five years compared to usual care.</td>
<td>National Institute for Health and Care Excellence (2013)</td>
</tr>
<tr>
<td>Time can generate new social networks and relationships</td>
<td>Enhance access to education, learning, arts, leisure, personal development and local support services based on consultation with key stakeholder groups.</td>
<td>£54 million over five years compared to usual care.</td>
<td>National Institute for Health and Care Excellence (2013)</td>
</tr>
<tr>
<td>Place-shaping by LAs to create opportunities for people with dementia to come together.</td>
<td>Enhance access to education, learning, arts, leisure, personal development and local support services based on consultation with key stakeholder groups.</td>
<td>£54 million over five years compared to usual care.</td>
<td>National Institute for Health and Care Excellence (2013)</td>
</tr>
</tbody>
</table>

### Implementation of initiatives to prevent, identify and respond to emotional, physical and/or sexual abuse

- Building life skills in children and young people including school-based violence prevention programmes including sexual abuse and bullying prevention.
- Promoting gender equality for women.
- Reducing the availability and harmful use of alcohol.
- Victim identification and care and support programmes.

#### Commissioning area: Social

<table>
<thead>
<tr>
<th>Specific interventions</th>
<th>Some examples of the impact or outcomes achieved</th>
<th>Implementation aspects and healthly</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volunteering enhances wellbeing more than in younger people (Age Concern and MIND, 2008)</td>
<td>Volunteering enhances wellbeing more than in younger people (Age Concern and MIND, 2008)</td>
<td>£2.3 million over three years compared to usual care.</td>
<td>National Institute for Health and Care Excellence (2013)</td>
</tr>
<tr>
<td>Reduced loneliness and anxiety by providing means to stay active</td>
<td>Lower levels of depression and anxiety in older people (Age Concern and MIND, 2008)</td>
<td>£2.3 million over three years compared to usual care.</td>
<td>National Institute for Health and Care Excellence (2013)</td>
</tr>
<tr>
<td>Improved physical health and mental wellbeing through universal access to lifestyle programmes to reduce smoking, alcohol use, substance use, and obesity</td>
<td>Improved physical health and mental wellbeing through universal access to lifestyle programmes to reduce smoking, alcohol use, substance use, and obesity</td>
<td>£2.3 million over three years compared to usual care.</td>
<td>National Institute for Health and Care Excellence (2013)</td>
</tr>
<tr>
<td>Improved physical and mental health and behaviour change through brief intervention programmes</td>
<td>Reducing depression and better self-management of diabetes; reduced dependency on primary care</td>
<td>£2.3 million over three years compared to usual care.</td>
<td>National Institute for Health and Care Excellence (2013)</td>
</tr>
<tr>
<td>Tackling alcohol and substance abuse, including screening programmes and direct care and mental health services for those with problem drinking</td>
<td>Tackling alcohol and substance abuse, including screening programmes and direct care and mental health services for those with problem drinking</td>
<td>£2.3 million over three years compared to usual care.</td>
<td>National Institute for Health and Care Excellence (2013)</td>
</tr>
<tr>
<td>Universal access to lifestyle programmes</td>
<td>Universal access to lifestyle programmes</td>
<td>£2.3 million over three years compared to usual care.</td>
<td>National Institute for Health and Care Excellence (2013)</td>
</tr>
<tr>
<td>Improved physical and mental health and behaviour change through brief intervention programmes</td>
<td>Improved physical and mental health and behaviour change through brief intervention programmes</td>
<td>£2.3 million over three years compared to usual care.</td>
<td>National Institute for Health and Care Excellence (2013)</td>
</tr>
</tbody>
</table>

### Multi-component interventions that integrate skills development and training of teachers and parents supported by specialists (see area 1 above)

- Key role of primary care and the wider health and social care services to offer a holistic approach to support with an understanding of the contribution of violence and abuse to health and social care problems.

#### Commissioning area: Education

<table>
<thead>
<tr>
<th>Specific interventions</th>
<th>Some examples of the impact or outcomes achieved</th>
<th>Implementation aspects and healthly</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multi-component intervention to integrate skills development and training of teachers and parents supported by specialists</td>
<td>Multi-component intervention to integrate skills development and training of teachers and parents supported by specialists</td>
<td>£2.3 million over three years compared to usual care.</td>
<td>National Institute for Health and Care Excellence (2013)</td>
</tr>
</tbody>
</table>

### Physical and social victimisation have direct health consequences and are risk factors for a wide range of long term health problems including mental health, alcohol use, sexual orientation, sexually transmitted diseases and risky sexual behaviour.

- Taking a life-course approach demonstrates the impact of childhood abuse on lifestyle choices and poor self-management leading to further problems such as diabetes (DH, 2010)
- Bullying has negative consequences on school health and performance (Bond et al, 2001)
## Appendix 7

### CCG Weighted populations (Mental Health)

<table>
<thead>
<tr>
<th>CCG Weighted Populations (Mental Health)</th>
<th>Number of GP Practices in CCG</th>
<th>Total Registered Population</th>
<th>Total Need Weighted Population</th>
<th>Need index</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Birmingham CrossCity CCG</td>
<td>116</td>
<td>739,238</td>
<td>987,078</td>
<td>1.34</td>
</tr>
<tr>
<td>NHS Birmingham South and Central CCG</td>
<td>45</td>
<td>247,127</td>
<td>386,727</td>
<td>1.56</td>
</tr>
<tr>
<td>NHS Cannock Chase CCG</td>
<td>27</td>
<td>132,981</td>
<td>91,834</td>
<td>0.69</td>
</tr>
<tr>
<td>NHS Coventry and Rugby CCG</td>
<td>77</td>
<td>474,552</td>
<td>516,732</td>
<td>1.09</td>
</tr>
<tr>
<td>NHS Dudley CCG</td>
<td>50</td>
<td>312,962</td>
<td>342,340</td>
<td>1.09</td>
</tr>
<tr>
<td>NHS East Staffordshire CCG</td>
<td>19</td>
<td>136,061</td>
<td>96,632</td>
<td>0.71</td>
</tr>
<tr>
<td>NHS Solihull CCG</td>
<td>32</td>
<td>239,035</td>
<td>252,996</td>
<td>1.06</td>
</tr>
<tr>
<td>NHS South East Staffs and Seidon Peninsular CCG</td>
<td>31</td>
<td>212,546</td>
<td>145,340</td>
<td>0.68</td>
</tr>
<tr>
<td>NHS South Warwickshire CCG</td>
<td>36</td>
<td>274,817</td>
<td>267,941</td>
<td>0.97</td>
</tr>
<tr>
<td>NHS Walsall CCG</td>
<td>63</td>
<td>275,130</td>
<td>210,632</td>
<td>0.77</td>
</tr>
<tr>
<td>NHS Warwickshire North CCG</td>
<td>28</td>
<td>184,661</td>
<td>219,213</td>
<td>1.19</td>
</tr>
<tr>
<td>NHS Wolverhampton CCG</td>
<td>51</td>
<td>261,596</td>
<td>271,167</td>
<td>1.04</td>
</tr>
<tr>
<td>NHS Wyre Forest CCG</td>
<td>12</td>
<td>112,622</td>
<td>74,044</td>
<td>0.66</td>
</tr>
</tbody>
</table>


## Appendix 8

### Outpatient and community contacts by organisation and team type


<table>
<thead>
<tr>
<th>Team Type</th>
<th>Units</th>
<th>NHS Birmingham CrossCity CCG</th>
<th>NHS Birmingham South and Central CCG</th>
<th>NHS Cannock Chase CCG</th>
<th>NHS Coventry and Rugby CCG</th>
<th>NHS Dudley CCG</th>
<th>NHS East Staffordshire CCG</th>
<th>NHS Solihull CCG</th>
<th>NHS South East Staffs and Seidon Peninsular CCG</th>
<th>NHS South Warwickshire CCG</th>
<th>NHS Walsall CCG</th>
<th>NHS Warwickshire North CCG</th>
<th>NHS Wolverhampton CCG</th>
<th>NHS Wyre Forest CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Care Facility Attendance</td>
<td>35,710</td>
<td>70,005</td>
<td>77,985</td>
<td>45,005</td>
<td>96,985</td>
<td>45,005</td>
<td>45,005</td>
<td>45,005</td>
<td>45,005</td>
<td>45,005</td>
<td>45,005</td>
<td>45,005</td>
<td>45,005</td>
<td>45,005</td>
</tr>
<tr>
<td>Invalid / Missing</td>
<td>3,010</td>
<td>3,010</td>
<td>3,010</td>
<td>3,010</td>
<td>3,010</td>
<td>3,010</td>
<td>3,010</td>
<td>3,010</td>
<td>3,010</td>
<td>3,010</td>
<td>3,010</td>
<td>3,010</td>
<td>3,010</td>
<td>3,010</td>
</tr>
</tbody>
</table>

*Note: Source: Health & Social Care Information Centre Mental Health Outcomes Dataset (MHD) (2014-15) [licensed 190616]*
Appendix 9

Vanguards

MODALITY BIRMINGHAM AND SANDWELL
Patient population: 70,000

The vanguard is made up of a single, local GP partnership called Modality Birmingham and Sandwell which operates from 15 practice sites across Birmingham and Sandwell and serves a registered population of 70,000 patients.

The vision for the vanguard is to develop a health and social care system accessible through GP practices, with a care-coordinator to support patients on their journey.

This will be achieved by delivering medical services from a number of primary care centres across Birmingham and Sandwell.

The larger centres will expand the range of social, mental, community and enhanced secondary care services on offer to patients by delivering community outpatient and diagnostic services. This will mean that, for example, a person who has diabetes and suffers from high blood pressure will benefit from being treated in a familiar environment that is close to home and will be supported by a care co-ordinator to help manage their care plan.

DUDLEY MULTISPECIALTY COMMUNITY PROVIDER
Patient population: 318,000

This Vanguard is led by Dudley Multispecialty Community Provider and includes Dudley Metropolitan Borough Council, Black Country Partnership NHS Foundation Trust, Dudley Group NHS Foundation Trust, Dudley and Walsall Mental Health Partnership NHS Trust, Dudley Council for Voluntary Services and Future Proof Health Ltd.

The Multispecialty Community Provider model proposed by the partnership in Dudley aims to develop a network of integrated, GP-led providers across health and social care, each working at a level of 60,000 people, reaching a total population of around 318,000 across Dudley. This system will see the frontline of care working as “teams without walls” for the benefit of patients, taking shared mutual responsibility for delivering shared care.

Under the new provider system, for example a lady with frailty and long-term conditions and registered with a GP in Dudley, will have her care overseen by a multi-disciplinary team in the community including specialist nurses, social workers, mental health services and voluntary sector link workers. This will ensure holistic care that better meets all of her medical and social needs at one time in one place, but allows her to access advice and support for the isolation she can feel at living alone far from her family, and combating her episodes of anxiety. When she needs help urgently there is a 24 hour rapid response and urgent care centre which provide a single coordinated point of access for her so she doesn’t need to call 999.

As a result of the health and care system working better together in this way, patients are not only receiving the coordinated support necessary for their health needs but they are also linking to the wider network of care and social interaction in their community to help them to live more independently for longer.

THE MENTAL HEALTH ALLIANCE FOR EXCELLENCE, RESILIENCE, INNOVATION AND TRAINING (MERIT)

This comprises Birmingham and Solihull Mental Health NHS Foundation Trust, Black Country Partnership NHS Foundation Trust, Coventry and Warwickshire Partnership NHS Trust and Dudley and Walsall Mental Health Partnership NHS Trust.

The alliance will focus on three priority areas where the greatest challenges for urban mental health services exist and where it can rapidly realise quality and efficiency benefits, spread best practice and reduce variations in cost and quality through integration across current geographical and organisational boundaries. These areas are seven day working in acute services, crisis care and the reduction of risk, and promoting a recovery culture. Some of the specific transformations MERIT will work to achieve are:

- Consistency in services seven days a week and in pathways, so services fit people’s lives
- Less variation in services
- Faster decision making, such as discharges seven days a week and a co-ordinated emergency response
- A shared care plan, meaning one assessment and only having to tell their story once
- More likelihood of staying closer to home if a bed isn’t available in the immediate area
- Less unnecessary time spent in A&E or police cells
- More support for recovery in the community and less chance of a relapse or return to secondary care services
- Wider access to clinical trials, leading to improved treatments, models and outcomes
- Greater participation in our services across all communities.

Key to achieving this impact at scale and pace will be shared models for support services, including research and innovation, staffing, workforce planning, information technology, equality and diversity and quality governance.

SOLIHULL TOGETHER FOR BETTER LIVES

The project covers North and South Solihull and is a partnership between the Heart of England NHS Foundation Trust, BSMHFT, West Midlands Police, Solihull MBC; Solihull CCG; voluntary and community sector providers; primary care; the West Midlands academic Health sciences Network and representatives of service users, carers and the wider Solihull community.

The vision is to create a maximally integrated health and social care system that optimises preventative out of hospital care with rapid access to specialist care both in and out of hospital, when needed, including access to other services including charities, leisure services, council and police. The ambition is to extend healthy active life and independence with equal focus on physical and mental health through encouraging lifestyle choices, care-coordination and empowerment for self-management of long-term conditions, reducing pressures on secondary care services and altering the balance of care provided in hospital and the community. This includes:

- Establishment of a Primary Care Centre within a health and wellbeing campus (on hospital site).
- Co-location of GP Out of Hours, Urgent Care Walk In / Minor Injury services into a single Urgent Care Centre.
- Establishment of a GP led step-up / step-down unit within the hospital.
- Improved access to diagnostics and secondary care specialists for primary care / community teams supported by innovative information technologies.
- Mental Health services; building on Rapid Assessment Interface and Discharge, Street Triage, Dementia and Delirium Team, Outreach.
- Supporting Patients/ Carers in their homes and the health and wellbeing campus through open and accessible information and services using various portals, building on the local authority “Solihull Connect” service
- Integrated Community Teams, supporting admission avoidance.

Appendix 10
The West Midlands Prisons Cluster

<table>
<thead>
<tr>
<th>Prison</th>
<th>Prison Group</th>
<th>Mental Health provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birmingham</td>
<td>1,450 young men aged 18–21</td>
<td>Mental health inpatient ward provided by BSMHFT and Birmingham Community NHS Trust. Drug and Alcohol services provided by Lifeline and Delphi Medical</td>
</tr>
<tr>
<td>Birmingham</td>
<td>589 young adult men aged 18–21</td>
<td>Mental Health In-Reach services are provided by South Staffordshire and Shropshire Healthcare NHS Foundation Trust. Integrated Mental Health Services and Integrated Substance Misuse Service, incorporating clinical and psychosocial services, provided by WHCT</td>
</tr>
<tr>
<td>Coventry</td>
<td>1,060 young men aged 18–21</td>
<td>GP Primary Care, and Integrated Substance Misuse service are directly employed by Care UK. Drug and Alcohol services provided by Lifeline and Delphi Medical</td>
</tr>
<tr>
<td>Dudley Northfield</td>
<td>315 women aged 18</td>
<td>Mental Health In-Reach services are provided by South Staffordshire and Shropshire Healthcare NHS Foundation Trust. Drug and Alcohol services provided by Lifeline and Delphi Medical</td>
</tr>
<tr>
<td>Dudley Northfield</td>
<td>697 young men aged 18–21</td>
<td>Mental Health In-Reach services are provided by South Staffordshire and Shropshire Healthcare NHS Foundation Trust. Drug and Alcohol services provided by Lifeline and Delphi Medical</td>
</tr>
<tr>
<td>Dudley Northfield</td>
<td>1261 young men aged 18–21</td>
<td>Mental Health In-Reach services are provided by South Staffordshire and Shropshire Healthcare NHS Foundation Trust. Drug and Alcohol Recovery Service provided by Lifeline and Delphi Medical</td>
</tr>
<tr>
<td>Dudley Northfield</td>
<td>622 young men aged 18–21</td>
<td>Primary healthcare provider is WHCT. Drug and Alcohol services provided by Lifeline and Delphi Medical</td>
</tr>
<tr>
<td>Dudley Northfield</td>
<td>1,605 young men aged 18–21</td>
<td>Primary healthcare provider is WHCT. Drug and Alcohol services provided by Lifeline and Delphi Medical</td>
</tr>
<tr>
<td>Dudley Northfield</td>
<td>741 young men aged 18–21</td>
<td>Primary healthcare provider is WHCT. Mental Health In-Reach services are provided by South Staffordshire and Shropshire Healthcare NHS Foundation Trust. Drug and Alcohol services provided by Lifeline and Delphi Medical</td>
</tr>
<tr>
<td>Dudley Northfield</td>
<td>766 young men aged 18–21</td>
<td>Primary healthcare provider is SSOTP. Drug and Alcohol services provided by Lifeline and Delphi Medical</td>
</tr>
<tr>
<td>Dudley Northfield</td>
<td>654 young men aged 18–21</td>
<td>Primary healthcare provider is SSOTP. Mental Health In-Reach services are provided by South Staffordshire and Shropshire Healthcare NHS Foundation Trust. Drug and Alcohol services provided by Lifeline and Delphi Medical</td>
</tr>
<tr>
<td>Dudley Northfield</td>
<td>180 young men aged 18–21</td>
<td>Primary care services provided by SSOTP. Mental Health In-Reach services are provided by South Staffordshire and Shropshire Healthcare NHS Foundation Trust. The Young Persons Drug and Alcohol Support Service is provided by Lifeline and Delphi Medical</td>
</tr>
</tbody>
</table>

Abbreviations and acronyms

- A&E: Accident and Emergency
- ACEs: Adverse Childhood Events
- ASIST: Applied Suicide Intervention Skills Training
- BAME: Black, Asian and Minority Ethnic
- BCG: Boston Consulting Group
- BCSPT: Black Country Partnership NHS Foundation Trust
- BSMHFT: Birmingham and Solihull Mental Health NHS Foundation Trust
- CBT: Cognitive Behavioural Therapy
- CCG: Clinical Commissioning Group
- CAMHS: Child and Adolescent Mental Health Services
- CICA: Chartered Institute of Personnel and Development
- CPA: Care Programme Approach
- CPN: Community Practice Nurse
- CQC: Care Quality Commission
- CCRs: Community Rehabilitation Companies
- CJS: Criminal Justice System
- CWPT: Coventry and Warwickshire Partnership NHS Trust
- DALY: Disability-adjusted life-year
- DWP: Department of Work and Pensions
- DARS: Drug and Alcohol Services
- DARS: Drug and Alcohol service (DARS) is provided by Lifeline and Delphi Medical
- EIP: Early intervention for psychosis
- EIP: Early intervention for psychosis
- EIP: Early intervention for psychosis
- FTP: Forward Thinking Birmingham
- GOO: Gross Domestic Product
- HSCIC: Health and Social Care Information Centre
- HSJ: Health Service Journal
- IMP: Improving Access to Psychological Therapies
- MCA: Independent Mental Capacity Advocacy
- MHA: Independent Mental Health Advocacy
- NICE: National Institute for Health and Care Excellence
- NSUN: National Survivor User Network
- NOMIS: NOMIS is part of ONS and provides Official Labour Market Statistics
- OAT(+)s: Out of Area Treatments/Placements
- ONS: Office for National Statistics
- PACU: Psychiatric Intensive Care Unit
- QALY: Quality-adjusted life-year
- QOF: Quality Outcomes Framework
- RAID: Rapid, Assessment, Interface and Discharge
- RCCT: Randomised Controlled Trial
- SOCT: Staffordshire and Stoke-on-Trent Partnership NHS Trust
- STPs: Sustainability and Transformation Plans
- WEMWEBS: Warwickshire, East Warwickshire and Birmingham Local Health Board
- WHCT: Worcestershire Health Care and NHS Trust
- WHO: World Health Organization
- WMCA: West Midlands Combined Authority
