Foreword

Rt. Hon. Norman Lamb MP

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 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 the picture in relation to poor mental health across the region, in terms of services, emerging good practice and the economic impact.

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.

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.

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Executive Summary

Mental health in the WMCA

- There are an estimated 4,032 million people in 2014–15 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.

- Over 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.

- The aggregate economic and social cost of mental health problems in the WMCA is estimated at around £12.6 billion in 2014–15, equivalent to a cost of about £3,100 per head of population.

- 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, account for 28% of the total.
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 is attributable to the fact that large numbers of people with long-term physical conditions, such as diabetes and asthma, also suffer from depression or anxiety. That greatly increases the costs of physical health care.

Spending on physical healthcare is also pushed upwards because of medically unexplained symptoms, ie, physical symptoms which have no 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 illness is also mental 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 of the WMCA are estimated at just over £4.9 billion a year equivalent to 31.5% of total costs. These divide more crucially into 31% for sickness absence and presenteeism among people with mental health problems who are currently in work and (ii) the costs of worklessness among those unable to find employment because of mental health problems.

Human costs, representing a monetary estimate of the less tangible but crucially important adverse impact of mental ill health on people’s wellbeing and coping skills; and assertive outreach teams; generic community mental health services; early intervention teams; intensive home treatment and prevention programmes, such as anti-bullying

- Workplace interventions, such as healthy workplace programmes - Targeted initiatives for at risk groups, including social and community activities for people from Black and Minority Ethnic (BME) and Black and Asian communities to raise awareness of mental health and wellbeing, provide peer support and promote access to services

The human costs of mental ill health in the WMCA are estimated at £0.2 billion a year. 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.

The aggregate 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, which greatly increases the costs of physical health care.

The benefits of early intervention (EIP) are particularly notable for people with an early detectable risk of a deteriorating mental health state or against a particular risk of a deterioration of mental health state. EIP programmes are designed to prevent mental ill health from occurring, to help improve outcomes for those already suffering from mental ill health and to improve outcomes for those who are at risk of developing mental ill health.

The introduction of the Prevention Programme: the Mental Health Alliance, in 2015/16 by NHS England and data collected by the West Midlands Health and Care NHS Trust has identified that mental health conditions are the second biggest drivers of preventable, persistent, and socioeconomically challenging health problems in the West Midlands.

Crisis intervention

The Care Quality Commission has recently identified that mental health care systems are often inconsistent and inadequate. All CCGs in the WMCA have developed action plans to improve services.

Promising initiatives in the WMCA include street triage, the redesign of the urgent care pathways and crisis houses. These developments show that crisis houses are more cost-effective than inpatient care and are more valued by service users, but there are currently only 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 250. The picture is similar for self-harm. There is, however, significant variation across CCGs in the WMCA and variations of 40% of CCGs are below the average for England.

Early intervention

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

Health and care 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 (EIP) for young people with a first onset of psychosis are wide ranging and the WMCA is a pioneer in implementing early intervention services for this group. Such services are provided by all the four main specialist mental health trusts in the WMCA, and are thought to be psychological in origin.

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 £184 per head of population, with a range from approximately £110 to £220, compared with an England average of £154.

The four 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.

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 (MERIT), 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 severe beds and a reduction in the number of beds for older adults.

There was an average of 185 admissions to psychiatric inpatient services per 100,000 population during 2013/14, compared with an England average of 227. Admission rates are influenced by a range of factors including the commissioning of community 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 rate of detentions was 81.2 per 100,000 population, slightly above the England average of 77.2. In 2015/2016, people from Black/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 focus is largely on people with a severe mental health condition: early intervention teams; intensive home treatments; crisis response teams; generic community mental health teams; recovery and wellbeing teams, enabling daily living, problem-solving and coping skills; and occasional outreach teams.
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 peri-natal mental health services, with better services for women of white ethnicity than for women from BAME communities. Organisations in the WMCA have been pioneering in developing innovative models of care and this includes mental health in primary care; early intervention; at 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, as well as services to provide social work services and commissioning a broad range of mental health services from the third sector. The role of social work in mental health involves 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, including financial inclusion, 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 (18–64) received Local Authority funded Mental Health Support in the WMCA: 12.3% received a direct payment, 21.8% received a personal budget. The use for mental health clients is substantially lower than for other client groups.

The implementation of personalisation varies across the WMCA, with Warwickshire having the highest rate for its use of direct payments and Birmingham for personal budgets. There are other Local Authorities, specifically Walsall and Staffordshire, where implementation of direct payments and personal budgets is appearing to be lagging behind.

There are approximately 420,000 carers in the WMCA and this figure is increasing. The Care Act 2014 placed a duty on Local Authorities to assess, and provide support to carers in their own right. A recent review of this Care Act duty found that the implementation was poor, with the majority of carers unaware of their rights. The review highlighted the need to ensure that all social workers and assessors are appropriately trained, and reflect the wellbeing principle in assessment and care and support planning.

THE THIRD SECTOR

The third sector, often referred to as the voluntary sector, comprises charities, community groups, and the associated 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; or 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-focused 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 supported
- Mental health awareness training including Mental Health First Aid and suicide prevention training

Funding sources for these services include: CCG and Local Authority funding; charitable donations; income-generation activities; and awards from national grant-making bodies, such as the Big Lottery and Comic Relief.

The third sector brings in additional resources from various sources external to the WMCA, either on its own or as a partner with other organisations, including the statutory sector.

The short-term nature of much of this funding potentially jeopardises the activity of the third sector and there are concerns about the impact of Local Authority austerity measures.

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

- People with a diagnosis of severe mental illness have a much shorter life expectancy than the population average and high priority should be given to addressing this inequality.
- Recovery-focused approaches to mental health care require a different relationship between service providers and service users and Recovery Colleges are identified as central to leading this transformation. There are two out of a total of 38 listed in England in the WMCA: in Sandwell and Walsall.
- However, Birmingham and Solihull Mental Health NHS Foundation Trust introduced a Recovery College in summer 2018 and the Forward Thinking Partnership, Birmingham, is also developing a Recovery College for young people up to the age of 25 to enable them to continue with their studies.
- Peer support is now widely recognised as helpful in promoting wellness and empowerment, with many voluntary and community organisations encouraging peer support. The CQC, however, found that only about half of those people who felt they would benefit from peer support were offered it. Many third sector organisations are organised around peer support or provide a range of peer support, and there is a wide range of initiatives in the WMCA including Hearing Voice in West Bromwich; Bigdad (Birmingham Gay and Lesbians against Depression) and First Person Plural for people identifying with complex dissociative identity disorders in Wolverhampton; those provided by the six local Mind organisations (Birmingham, Coventry and Warwickshire, Dudley, Mid Staffs, Solihull and Springfield Mind in South Warwickshire); and Kaledoscope Plus, in Sandwell.

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 authorities have 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 housing allowance that 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.
- Walsall, West Bromwich and Solihull have all been identified as supporting areas for women from BAME communities.

EMPLOYMENT

- There are strong links between employment and mental health. The DWP-funded Work Choice Programme for people with mental health problems benefits from organisations in Sandwell, Solihull, Coventry, Dudley and Walsall. Employment support, often combined with volunteering opportunities and welfare advice, is frequently provided by the voluntary sector, sometimes in conjunction with the voluntary sector or CCGs.
- The international evidence base for supported employment, including Individual Placement and Support (IPS), is very encouraging particularly in enabling people to find jobs more quickly to stay in employment for longer, and in reducing health service costs.
- There are currently eight providers of IPS in the WMCA, five of which have been rated as good or excellent by the Centre for Mental Health in terms of fidelity to the model.

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
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 mental 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.
- 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

- There is little evidence of a golden thread in the transformation but there is a long strand of effectiveness and could save a good deal of money.
- Persistent offenders are likely to have experienced severe and multiple disadvantage. Increased risk of suicide and self-harm.
- Diversion teams provided by the mental health trusts.

### OVERALL ASSESSMENT

- 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.
- The intelligence for developing 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 needs to be completed.
- There is a link between those with severe mental health problems and the use of seclusion and restraint.

### RECOMMENDATIONS

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 looks like and different models are emerging across the WMCA. Identifying the components of good provision for mental health which could 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 within the West Midlands where the evidence is incomplete. Where this is the missing, the evaluation of such initiatives will be an important step 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 require 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 mental health targets, 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.
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 assessment of the current position in the West Midlands in respect of the mental health and wellbeing 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 commissioning 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 Wolverhampton Council. Together these cover approximately 70% of the population of the three LEPs. The WMCA also includes the 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 recovery 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:

- 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 and which should 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 esteem of with physical health, providing a central focus for NHS England. 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 physical health conditions, two access and waiting time standards were introduced across 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% of people will be treated 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 May 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 cross-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:

- 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
- 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 AIMS 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; and
- 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 children and young people 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 also is important to recognise that research and evidence on mental health in early and mid-adulthood can also impact upon the prevalence of mental health disorders for older adults, including dementia (Heathbroth and Newbigging, 2013).

METHODS

In summary, this has involved:

1. A rapid appraisal of the literature starting with the Centre for Mental Health publications that have distilled key messages.
2. 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 2013/14 and published by Health and Social Care Information Centre; and the Social Care Institute for Excellence.

When comparing values of mental health interventions in a broad range of areas. Additional material relating to the costs of mental ill health, and promising initiatives in mental health was also identified from analysis of key national reports and databases (eg, Black Mental Health; Cochrane CCG Care Concordat; Joseph Rowntree Foundation; King’s Fund; Local Government Association; Mental Health National Institute for Health and Social Care; National Survivor User Network; and the Social Care Institute for Excellence) and reports and evaluations from key stakeholders in the WMCA.

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.

2. www.england.nhs.uk/mentalhealth/party
Mental Health in the West Midlands Combined Authority

3. An audit of current public sector (NHS/Local Authority) and voluntary sector mental health service provision using a bespoke audit form (see Appendix 1) and data in the public domain (eg, Health and Social Care Information Centre*; Mental Health Minimum Data Set (MHMDS); Public Health England Fingertips Tools; and Adult Social Care Outcomes Framework (ASCOF)), and data made available by the NHS Benchmarking Network. These sources have been analysed to identify current and community and inpatient services provided for adults and young people in the NHS and current performance against mental health indicators using data from local sources. 

4. Documentary analysis of key strategic plans and evaluation reports and a small number of scoping interviews to identify promising initiatives.

The work was undertaken from January to July 2016 and provides a rapid appraisal of the current situation, and was limited by the time and resources available. There have been additional challenges in undertaking this work. First, there are different jurisdictions and configurations for public service delivery in the Combined Authority area. Second, there are also different understandings concerning the focus of the WMCA and whether it is solely concerned with the constituent members (ie, the seven metropolitan councils), includes the non-constituent members or is wider to encompass the areas covered by three LEPs, recognising that the wider partnership with business through the LEPs and with neighbouring councils is critical to the success of the WMCA. Our brief was to undertake an analysis for this wider area but other key organisations, for instance Public Health England West Midlands Region, 7.4% of the population in England and 6.2% of the population in the UK (the overall figure is projected to increase by 8% 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 co-morbidity being highly prevalent in community mental health teams (Weaver et al., 2003). In the West Midlands in 2014/15, 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%)4.

4 NHS Digital is the new name for the Health and Social Care Information Centre. See https://digital.nhs.uk [accessed 16/10/16].

www.pansi.org.uk/index.php?pageNo=407&PHPSESSID=315v74tec3qjl1tbhfmc73ipb5&sc=1&loc=8653&np=1 [accessed 14/10/16].


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

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

There are an estimated 4.032 million people living in the Combined Authority area (2014/15 data) corresponding to 70.5% 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 overall figure is projected to increase by 8% 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 co-morbidity being highly prevalent in community mental health teams (Weaver et al., 2003). In the West Midlands in 2014/15, 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%)4.

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 (Weaver et al., 2003). In the West Midlands in 2014/15, 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%)4.

4 As above

5 The results of the 2014 survey was published in September 2016 and is available at: http://digital.nhs.uk/catalogue/PUB21749 [accessed 16/10/16].

Figure 1: A population perspective to improving mental health (Heugribotham and Newbigging, 2013 adapted from Barry and Jenkins, 2007)
In the West Midlands, in 2015, there were 477 deaths recorded as suicide, which at 9.6 deaths per 100,000 population is lower than the rate for England at 10.92. The rate for men in the West Midlands was 15 deaths per 100,000, 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 2, there is a slight downward trend for men in the number of suicides reported from 2010 to 2013, but figures for 2014 show a slight decrease in the rate for men and an increase for women.

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Socio-economic inequalities in suicide risk are evident. A thematic review by the Sanamitaris identified that middle-aged men in lower socio-economic groups are at particularly high risk of suicide (Wylie 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 notions of masculinity and reluctance to access formal support, personal crises such as divorce, as well as a general ‘dip’ in subjective well-being among people in their mid-years, compared as a general ‘dip’ in subjective well-being among people in their mid-years, compared with both younger and older people (Wylie et al., 2012). Furthermore, there is emerging evidence that this has been exacerbated by the current post-2008 economic crisis (Gutman et al., 2015; McGrath 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).

Figure 3 provides an illustration of the relationship between diagnosed condition and gender and household quintile, income, from the 2014 Health Survey. They show a stark illustration of the relationship between household income and both diagnosis and the type of mental health condition. From the 2014 Health Survey, 22% of women and 12% of men in the highest income quintile are likely to have ever been diagnosed with a common mental disorder compared with 4% of women and 7% of men ever diagnosed with a serious or complex mental illness. For those in the lowest income quintile, 39% of women reported being diagnosed with a common mental disorder and 10% with a serious or complex mental illnes, compared with 23% and 11% of men. It is important to note that there are gender differences in alcohol and substance abuse (and suicide) which more adversely affect men more than women.

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 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 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 disorder are more than three times 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’ (Heigbotham and Newbigging, 2013). However, the causation also runs the other way, in mental ill health leading 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.

POPTATIONS 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 health67. However, as observed above, the risks of developing a mental health problem, and times for help, problem, are not equally distributed across the population. Homogenising the risks in this way may result in further widening the gaps, eg, between populations that 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 situated nature 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 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; Heigbotham 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.
Adverse Childhood Events

Many studies have identified that the number of different risk factors (including adverse childhood events (ACEs)) that children are exposed to increases the risk of poor mental health, and their effects appear to be multiplicative, rather than additive. This includes increased incidence of psychosis, substance abuse, physical health problems and reduced social functioning and increased likelihood of unemployment and risk-taking behaviour in adulthood (Rosenberg et al., 2007; Vaneechoutte et al., 2012). ACEs include physical, sexual or emotional abuse; witnessing domestic violence; loss of a parent; parental substance abuse and/or mental illness. Specific groups of children and young people may be at particular risk and looked after children are such an example; many, if not all, of whom may have been exposed to one or more of the ACEs mentioned above but whose care under the Local Authority provides an opportunity for prevention and early intervention.

Looked after children and young people leaving care

According to national data from the Department of Education, 60 per 10,000 children under the age of 18 are in Local Authority care and overall, the number of looked after children is increasing year on year (National Audit Office, 2015). Disadvantaged children living in private placements because of behavioural difficulties or other mental health needs, which are likely to persist into adulthood and may be associated with offending behaviour (National Audit Office, 2015). Research has indicated that children in care face a higher prevalence of both psychosocial adversity and psychiatric disorder than the most socio-economically disadvantaged children living in private households (Ford et al., 2007). In 2015, 25% of people who are homeless were in care at some point in their lives; in 2008, 49% of young men under the age of 21 who had come into contact with the criminal justice system had a care experience; and in 2014, 22% of female care leavers became teenage parents (National Audit Office, 2015). Young people leaving care are four to five times at greater risk of poor mental health and looked after children and care leavers are between four and five times more likely to attempt suicide or self-harm in adulthood (Department of Health, 2012; National Audit Office, 2015). Despite mental health and emotional wellbeing being identified as important issues by young people leaving care, Local Authorities reported that access to mental health support was problematic (National Audit Office, 2015).

Nearly two-thirds of children are placed into care as a consequence of abuse or neglect and over a third have had successive placements because of behavioural difficulties or other mental health needs, which are likely to persist into adulthood and may be associated with offending behaviour (National Audit Office, 2015). Researchers have identified that children in care face a higher prevalence of both psychosocial adversity and psychiatric disorder than the most socio-economically disadvantaged children living in private households (Ford et al., 2007). In 2015, 25% of people who are homeless were in care at some point in their lives; in 2008, 49% of young men under the age of 21 who had come into contact with the criminal justice system had a care experience; and in 2014, 22% of female care leavers became teenage parents (National Audit Office, 2015). Young people leaving care are four to five times at greater risk of poor mental health and looked after children and care leavers are between four and five times more likely to attempt suicide or self-harm in adulthood (Department of Health, 2012; National Audit Office, 2015). Despite mental health and emotional wellbeing being identified as important issues by young people leaving care, Local Authorities reported that access to mental health support was problematic (National Audit Office, 2015).

2. People from Black, Asian and Minority ethnic communities

BAME communities across the WMCA are heterogeneous with the 2011 census identifying that residents born in India represent the most numerous non-UK born group in the West Midlands followed by residents born in Pakistan, Poland, Ireland, and Jamaica (Varese et al., 2012). However, China is well represented, 6% of student populations and most asylum seekers come from Iraq, Iran, Somalia, Afghanistan, Pakistan, Sudan, Ethiopia, Eritrea, Congo and latvia (Lankelly Chase, 2014). The intelligence on the mental health needs, access to and preferences for the style of mental health support is scant, and that which is available is often skewed towards specific groups. eg, African Caribbean men, South Asian women, and this tends to dominate this agenda such that the needs of other groups may be overlooked, eg, Chinese people, asylum seekers and refugees or people from the Somali community, which is the fastest growing community in Birmingham.

The National Psychiatric Morbidity Survey in 2007 and more recently 2014 (McManus et al., 2007; McManus et al., 2016) found little differences in the prevalence rates of common mental health problems between minority ethnic groups and the white population. There is, however, an increased prevalence of common mental health problems amongst Black/Black British women (McManus et al., 2016). There is also evidence that self-harm is more common among young African-Caribbean women, who are also less likely to be receiving help (Cooper, 2010).

People from BAME communities are more likely to be disadvantaged in accessing enabling forms of support (Varese et al., 2012). Conversely, this is also true for Black British men; they are five times more likely to be diagnosed and admitted to hospital for schizophrenia; have disadvantageous pathways into mental healthcare; higher than expected rates of detention under the Mental Health Act (MHA) (see the section on specialist mental health services); are more likely to be prescribed medication; and have difficulties accessing services and poorer outcomes when they do (Lankelly Chase, 2014). Black Caribbean young men are also twice as likely to die as a result of suicide as White psychiatric in-patients and there have been a number of deaths of Black men with mental health problems while in police custody (Inquest, 2014).

The report of an inquiry into ethnic inequalities in mental health (Lankelly Chase, 2014) summarises a number of contributory factors contributing including:

- Social disadvantage, including living in poverty and homelessness
- Racism, discrimination and harassment
- Higher rates of exclusion from school
- Higher rates of unemployment, with African and Caribbean men and those from minority backgrounds, which is the fastest growing community in Birmingham.

This disadvantage is compounded by mental health services that are not designed or may be ill equipped to deal with the diverse needs of BAME communities, compounded by a lack of trust in public services, language barriers or previous negative experiences of mental health services. People from some social participation in BAME communities experience difficulties in accessing appropriate support, although their issues may not be as visible and, therefore, overlooked in commissioning and providing effective services to meet their specific needs.

Asylum seekers and refugees

The most recent statistics indicate that there are 4,454 asylum seekers on Section 20, 42% are living in the WMCA, with 42% living in Birmingham, including 75 unaccompanied minors under Local Authority care; 19% in Sandwell; 16% in Wolverhampton; 9% in Dudley; 8% in Walsall and 5% in Coventry; in Walsall and 5% in Dudley (www.gov.uk/government/publications/immigration-statistics-january-to-march-2016/list-of-tables [accessed 150816]). People from other asylum claims have been accepted and the estimates cited in the Birmingham City Council equity analysis indicate there are approximately 35,000 refugees living in Birmingham, although these estimates are not based on current data. In addition, there will be a number of people who have no recourse to public funds (i.e., whose asylum application has been denied), and who may be supported by the Local Authority.

Asylum seekers and refugees have mental health needs arising from torture, persecution and other adverse experiences pre- and post-migration, including stigmatisation by the state and racism (Phillips et al., 2007). Consequently, asylum seekers and refugees are at increased risk of experiencing post-traumatic stress, depression, perinatal mental health problems, suicide and psychotic disorders with co-morbidity common (Alisop et al., 2014; Holland et al., 2016; Alisop et al., 2014; McColl & Johnson, 2006). Despite this, asylum seekers and refugees will face barriers to accessing effective mental health support, which are similar to those experienced by other minority communities but may be further compounded by their citizenship status.

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, per 1,000,000 households, which is higher than the national average of 2.4, with the rate ranging from 0.8 in Dudley to 7.4 in Birmingham. This is highest in Birmingham with 9.06% of households living in one bedroom or less, nearly twice the national average of 4.8% (see Appendix 2).

A recent review for the Joseph Rowntree Foundation highlighted strong links between mental health problems and housing conditions, with housing costs having a significant impact on poverty and material deprivation (Tunstall & Johnson, 2006). Despite this, asylum seekers and refugees will face barriers to accessing effective mental health support, which are similar to those experienced by other minority communities but may be further compounded by their citizenship status.

- People from BAME communities are more likely to be disadvantaged in accessing enabling forms of support and have poorer outcomes than other people when they do access services

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- The report of a review into ethnic inequalities in mental health summarises a number of contributory factors contributing, including social disadvantage, including living in poverty and homelessness, racism, discrimination and harassment, higher rates of exclusion from school, higher rates of unemployment, with African and Caribbean men and those from minority backgrounds, which is the fastest growing community in Birmingham.

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Austerity measures, which have hit poorer people the hardest, have damaging psychological consequences

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 (Gold 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 fulfill 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 97% since 2010 (Department of 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 4.9% for the Coventry and Warwickshire LEP to 8.8% for the Black Country LEP, compared with an England average of 5.3%25.

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 (Henkl, 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 (Boydell 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 will include young carers. In England, estimates indicate there are approximately 166,363 young carers, including 9,371 aged between 5– and 17-years-old (Black Country Partnership NHS Foundation Trust, 2014). They are just as likely to be a boy as a girl; one and half times more likely to come from a BAME background, more than 1.5 times more likely to have 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 population ranging from 9% in Staffordshire and Worcestershire and 11% in Warwickshire (Carers UK, 2011)).

People with a diagnosis of mental illness are likely to die 12–13 years younger than other people

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%32. Challenging behaviours (aggression, destruction, self-harm and other) are also evident for 10%–15% of people with learning disabilities33, and, consequently they are 47% more 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 have typically failed to receive appropriate treatment and 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).

8. People with learning disabilities and/or sensory impairments

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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).

25 Data available for different areas at: www.nomisweb.co.uk/reports/lmp/gor/contents.aspx [accessed 150816].
26 As above.
27 www.learningdisabilities.org.uk/help-information/Learning-Disability-Statistics-/187699/ [accessed 1508516].
People in custody are particularly vulnerable to poor mental health. The total prison population in the West Midlands on 31 December 2014 was 9,443. Eleven of the prisons are for men. Women comprise 3.32% of the prison population in the West Midlands (offenders aged 18 and over). (32) Asians/British Asian (higher than the national average of 6%). The rates of self-harm are higher among women because they have been designed for women; prison is disproportionately harsher for women because they have been designed for women; prison is disproportionately harsher for

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.

Some Local Authorities have undertaken JSNAs on specific mental health themes, for example veterans’ mental health in Warwickshire and mental health needs in primarly carers of young children, community engagement and asset mapping as ways of understanding the needs, system gaps and potential contribution of communities to health improvement (Public Health Midlands, 2016). However, we were only able to identify one JSNA where there was any evidence of asset mapping: Coventry and Rugby CCG’s 2015 Mental Health and Wellbeing assets and needs assessment.

Public Health West Midlands has a role in playing in developing and promoting guidance and standards to support improvements in the quality of JSNAs, to include asset mapping, and provide tangible examples of how this intelligence, alongside that from suicide and other audits, can be used to inform commissioning for prevention and quality, and support the wider mental health system 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 that access 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 (Ellerton and Evans, 2012). The importance of co-production in commissioning, designing and providing mental health support cannot be over-emphasised and is 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 an 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 access 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. Quidley Healthwatch, for example, has developed an Activate approach for involving communities.
in partnership with Dudley CVS and the All Together Better Partnership; recently receiving an award for this work from Healthwatch England\textsuperscript{26}. 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:

\begin{itemize}
  \item 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\textsuperscript{27}. 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.
  \item Experience-based co-design of hospitalisation in early psychosis in Coventry and Warwickshire Partnership NHS Trust. This project piloted this collaborative approach between 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 EBCD projects. (Larkin et al., 2015).
  \item 300 Voices\textsuperscript{28}, 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, there are a number of legacy projects being taken forward (see Appendix 4).
  \item Citizens UK Birmingham\textsuperscript{29}, 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\textsuperscript{30}.
\end{itemize}

**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 co-production 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\textsuperscript{31} 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\textsuperscript{32}**

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.

\textsuperscript{26} See: http://healthwatchdudley.co.uk [accessed 270716]
\textsuperscript{27} The CFT programme is now going to be linked with the Troubled Individuals strand of work for the West Midlands Mental Health Commission.
\textsuperscript{28} www.bsmhft.nhs.uk/about-us/engaging-with-our-communities/300-voices [accessed 150816].
\textsuperscript{29} www.citizensuk.org/birmingham [accessed 150816].
\textsuperscript{30} www.bsmhft.nhs.uk/about-us/engaging-with-our-communities/300-voices [accessed 150816].
\textsuperscript{31} This is supported by the University of Birmingham so please note the potential conflict of interest.
\textsuperscript{32} www.citizensuk.org/around-every-corner [accessed 150816].
\textsuperscript{33} www.changingourlives.org/a-uk-first-mental-health-parliament-launched-in-sandwell
\textsuperscript{34} www.standup2mentalhealth.org.uk/membership/members-platform-mad-alliance
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 unrecognised 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; Bucker 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 appraisal 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.

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, 23.9% 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 6.2% 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-psychiatric) 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 Combined Authority Area amounts to around £0.905 billion a year. Of this total, £0.207 billion (23%) relates to spending on primary care, including £0.148 billion on GP consultations, while the remaining £0.698 billion (77%) covers expenditure in secondary care.

All of these figures relate to the direct costs of treatment and care for people with mental health problems. It is, however, clear that the full impact of mental illness on the finances of the NHS goes well beyond these direct costs. Not only because of physical/mental health co-morbidities and medically unexplained symptoms, both of which add greatly to NHS spending on physical health care, but also due to the co-morbidities, it is well established that, for a wide range of long-term physical health conditions, a co-existing mental health problem (eg, diabetes and depression) leads not only to worse health outcomes but also to greatly increased costs. As a result, it is clear that the NHS spending on mental health problems in the WMCA of around £0.905 billion a year significantly underestimates the true cost of mental ill health in the region.

**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 authorities published by the Health and Social Care Information Centre (HSCIC), gross total expenditure on these social care 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 (BCG), 2015) estimated that the identified mental health-related expenditure of around £9.2 billion a year in England on public sector programmes other than health and social care services is estimated at around £3.25 million (BCG, 2015). The remaining £1.7 billion was made up of relatively small amounts of spending in a number of different areas including: schools (Special Educational Needs (SEN) pupils with behavioural, emotional and social difficulties); criminal justice (mental health-related services funded by the police, courts and prisons); and Department for Work and Pensions (DWP) 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-average prevalence of mental health problems, implies additional NHS spending in the WMCA of around £0.19 billion a year.

**4. Indirect consequences of mental ill health**

In the case of co-morbidities, it is well established that, for a wide range of long-term physical health conditions, a co-existing mental health problem (e.g., diabetes and depression) leads not only to worse health outcomes but also to greatly increased costs. As a result, it is clear that the NHS spending on mental health problems in the WMCA of around £0.905 billion a year significantly underestimates the true cost of mental ill health in the region.

In relation to social security payments, BCG’s national estimate of £7.5 billion covers mental health-related spending on three main benefits: Employment and Support Allowance, Disability Allowance and Carer’s Allowance. Detailed DWP data by individual Local Authority allows direct calculation of the amounts spent on these benefits in the WMCA in 2014/15, as follows: Employment and Support Allowance £410 million, Disability Allowance £132 million and Carer’s Allowance £18 million (DWP, 2016). For reasons not explained, the BCG calculations exclude spending on Housing Benefit for people who are claiming disability benefits because of mental ill health. As there seems no obvious logic for this, DWP data has been used to calculate that relevant spending on this benefit in the WMCA in 2014/15 was £1.92 million, resulting in an overall (rounded) total of £0.755 billion for the mental health-related cost of social security payments.

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.
4. Costs of informal care

Informal care provided to people with mental health problems by relatives and friends is not generally paid for and so does not feature in GDP. It is nevertheless of economic significance and the usual convention is to impute a monetary value on the basis of what it would cost to provide an equivalent service if undertaken as paid employment by a homemaker worker. This is in effect a cost of informal care study, which – when combined with survey data on the amount of informal care provided to people with mental health problems – results in a national cost estimate of £14.2 billion a year. Based on relative population numbers and the prevalence of mental health problems, it is calculated that the cost of informal care in the WMCA is £1,085 million a year. The true costs may be far higher than this only includes direct care costs in the absence of an informal carer – not the wider impact on the informal carer.

5. Care funded by individuals and charities

Further detail on the cost of informal care available in Buckner and Yeandle (2011).

THE MAJORITY OF WORKING-AGE ADULTS WITH A MENTAL HEALTH CONDITION HAVE A JOB AND ARE ALMOST AS LIKELY TO BE WORKING AS ANYBODY ELSE

Employment costs

Mental ill health is the dominant health problem of working age. This is partly because mental health problems are very common, but also because the burden associated with these problems falls heavily 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 stark contrast to physical health, which for all major conditions shows a very pronounced age gradient going the other way. Indeed, the great bulk of the burden of physical ill health increases steadily 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 lose their 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 have a job and are more likely to seek help when they suffer from mental health problems. The most widely cited statistics on the aggregate cost of mental ill health in the WMCA are set out below, dealing firstly with mental health problems among people who are currently in work and then with mental ill health among those who are not in work.

1. Employment costs among people in work

Costing people who are working-age adults with a mental health condition have a job and are almost as likely to be working as anybody else. On average, employees earning below-average wages earn around £1,500 less a year, compared to average earnings, which is equivalent to a loss of 1.5 times as much working days lost to sickness absence (see below-average earnings for the average gross daily rate of earnings in the WMCA on this method of estimation comes as indicated by the data on Employment Support Allowance given above, this is a national cost of £37.6 billion attributable to mental health conditions. Taking into account the numbers of people in the WMCA who are long-term sick as a proportion of the equivalent national total and the lower level of average local pay, it can be calculated that the mental health-related cost of long-term sickness in the WMCA on this method of estimation comes out at £2.45 billion. 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 ONS 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 measures years of life lost from premature mortality with equivalent years of life lost from disability and morbidity. DALYs are calculated as a sum of years of life lost because of premature mortality with equivalent years of life lost from disability and morbidity, calculated as the consequences of a health condition in the quality-adjusted life-year (QALY) which combines years of life lost from premature mortality with equivalent years of life lost from disability and morbidity, and the lower level of average local pay, it can be calculated that the mental health-related cost of long-term sickness in the WMCA on this method of estimation comes out at £2.45 billion. Given the number of assumptions invoked in both cases, this is reassuringly similar to the figure of £2.2 billion given above.

48Further detail on the cost of informal care available in Buckner and Yeandle (2011).
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 established 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 £5.27 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 based on a broad-brush assessment of the impact of mental/physical health co-morbidities. As noted earlier, the co-existence of a mental health problem with a long-term physical condition is associated not only with increased costs of physical health care but also – and indeed because of – poorer health outcomes for the physical condition, including higher rates of mortality, disability and morbidity. These additional human costs of physical illness have not been included. And third, an increasing body of evidence, both in this country and elsewhere, suggests that the QALY as conventionally measured substantially underestimates the value of mental health, certainly relative to physical health (Bickel et al., 2012; Fujiwara and Doi, 2014). There are a number of possible reasons for this. One is that the dimensions of health used in the QALY are not adequate for capturing the full impact of mental illness; for example, no allowance is made for the stigma and discrimination which add to the burden of many types of psychiatric disorder. Another is that QALY’s are based on hypothetical preferences of the general public which may in some cases fail to anticipate correctly the real impact that different health states may have. In particular, there is evidence that it is much more difficult to adapt to mental illness than it is to most physical health problems.

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. All 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, 2007) and partially updated five years later (Dubourg et al., 2012). 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 emotional and physical impact of crime on victims. The steady fall in the volume of crime since the mid-1990s obviously serves to bring down its aggregate cost. On the other hand, unit costs have been rising because of general inflation and related pressures, 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). And 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.

Assuming that levels of crime are broadly the same in the West Midlands as they are in the rest of the country, an apportionment based on relative population numbers implies an aggregate cost of crime in the WMCA area of around £4.9 billion a year.

On the conservative assumption that the proportion of crime attributable to mental health, including personality disorder and substance misuse, is around 20%, the mental health-related cost of crime in the WMCA comes out at about £0.99 billion a year. Based on Home Office estimates for the breakdown of crime costs, this includes costs of £190 million incurred by the criminal justice system and £22 million by the NHS (for the treatment of crime-related injuries), with most of the remainder falling directly on the victims of crime.

Because of the considerable degree of uncertainty that surrounds any quantification of the share of crime attributable to mental disorder, these estimates are clearly subject to wide margins of error and at best should be regarded as rough ball-park figures. Much more analysis and much better data is needed to produce more reliable results.

AGGREGATE COSTS IN 2014/15

Piling 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 conventionally measured; and
(iii) Eschequer costs, representing the overall impact of mental ill health on the public finances.

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 1: Cost of mental ill health to the WMCA

<table>
<thead>
<tr>
<th>Cost</th>
<th>£ 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>

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 £0.755 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 £30 a week. The cost to the economy of this change is £202 a week, representing the amount that is lost by the individual, whose weekly income falls by this amount, and the remaining £80 is borne by taxpayers, to fund the new payment of benefits. On this basis, it would clearly be double-counting to include both the
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 way of analysing the costs of mental illness, drug misuse, smoking, suicide, early death and crime (Friedli and Parsonage, 2007). Overall, it is calculated that the lifetime cost of these adverse outcomes is around £275,000 per case in today’s prices, measured against a baseline given by people who had no conduct problems in childhood. Again the bulk of costs were found to be crime-related.

In mid-2014 there were 53,685 children aged five in the WMCA (ONS, 2016b). Based on a national prevalence rate of 4.9%, this would imply a total of 2,630 children with conduct disorder in this local one-year cohort and an aggregate lifetime cost of around £0.725 billion.

2. Childhood conduct disorder

Early-onset conduct disorder, defined as persistent disobedient, disruptive and aggressive behaviour, is one of the most common mental health condition in childhood, affecting 4.9% of all children aged 5–10 (Green et al., 2005). Most attention is given to problems in the postnatal period, particularly postnatal depression, but data from longitudinal surveys increasingly suggests that maternal depression and anxiety are at least as common during pregnancy as in the year after childbirth. One in five mothers of children born after a postnatal depression and anxiety are in fact new cases, arising for the first time after childbirth rather than being a continuation of conditions which initially developed during pregnancy (Heron et al., 2004).

Perinatal depression and anxiety are of major importance as a public health issue, not only because of their high prevalence and adverse impact on the wellbeing of 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 costs 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, is one of the most common mental health condition in childhood, affecting 4.9% of all children aged 5–10 (Green et al., 2005). Most attention is given to problems in the postnatal period, particularly postnatal depression, but data from longitudinal surveys increasingly suggests that maternal depression and anxiety are at least as common during pregnancy as in the year after childbirth. One in five mothers of children born after a postnatal depression and anxiety are in fact new cases, arising for the first time after childbirth rather than being a continuation of conditions which initially developed during pregnancy (Heron et al., 2004).

Perinatal depression and anxiety are of major importance as a public health issue, not only because of their high prevalence and adverse impact on the wellbeing of 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 West Midlands Combined Authority (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 in aggregate income in the WMCA.

3. Exchequer costs

The exchequer costs of mental illness include all public spending on the care and support of people with mental health problems, including social security payments, and also the losses of tax revenue that result from the adverse effects of mental ill health on employment and earnings.

Publicly funded care costs include social security costs amount to £3,045 million a year. In relation to tax costs, it is estimated in Professor Dame Carol Black’s report on the health of Britain’s working-age population referenced earlier (Black, 2009) that at the national level the value of tax revenue forgone because of working-age ill health is broadly similar in magnitude to the social security costs of worklessness. Based on the relative figures given in this report, the overall loss of tax revenue associated with mental health problems in the WMCA may be estimated at around £835 million a year. On this basis, total exchequer costs come to around £3.88 billion a year.
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. Promotion in the WMCA

These interventions are targeted at the general population and designed to promote 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, Warwickshire46.

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 three main health boards is also available. It is also evident that the voluntary sector plays an important role in providing preventive interventions, at an individual, collective and community level. 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 Wolverhampton47.

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:
1. Training and events to promote awareness and tackle stigma for the general public, front-line services and employers, including Mental Health First Aid (MHFA) and First Aid training
2. Parenting programmes, including programmes targeted at high risk families
3. School-based mental health promotion and prevention programmes, such as anti-bullying
4. Workplace interventions, including Healthy Workplaces programmes
5. Targeted initiatives for at risk groups
6. Tackling violence and abuse, often through responding to domestic violence and abuse
7. Programmes to improve the physical health of people with mental health problems
8. 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 by some Local Authorities and provided through local Mind associations, for example Coventry and Warwickshire, and Birmingham, MHFA has been introduced 99 times 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; BTA Pathways; Community Wellbeing Solutions (own company); Coventry and Warwickshire Mind; Coventry University; Dudley MBC; Dudley Mind; Kaleidoscope Pi; Lode Street Project; Midlands Heart; Sandwell Mind; Seven 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 questions and the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS).

The ONS subjective wellbeing measure comprises four questions that are included in the Annual Population survey to assess the personal wellbeing of the population. WEMWBS is often used to evaluate the impact of interventions, 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 UK since the data started to be collected in 201348. A summary of the data from 2011–2014 indicates that the overall average for the highest levels of personal wellbeing on the Life Satisfied by Local Authority Districts, April 2011 to March 2014.

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; excess 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/headstartprojects [accessed 150816]
49 Source: ONS Reference Tables: Life Satisfactor by Local Authority Districts, April 2011 to March 2014.
50 Birmingham, Coventry, Dudley, Sandwell, Solihull, Walsall, Warwick and Wolverhampton.
51 See https://thrive.nyc.cityofnewyork.us/ [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 (Heginbotham and Newbigging, 2013). As with other reviews, this highlighted the importance of:

- Promoting good parental mental and physical health
- Promoting good 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 health promotion and responding to emotional, physical and/or sexual abuse
- Improving parenting (e.g. support for unemployed) creating healthy working environments
- Early recognition and intervention for those with mental health problems
- Tackling violence 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 police serving 2000 patients. It would provide an estimation of the numbers and types of mental health problems for a practice serving 2000 patients. It was 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 employment.

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 prescription
- 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 (Camic and Chattoeje, 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 therapies.

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 the Warwickshire’s Health and Wellbeing Portal).

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). 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 the 15 CCGs in the WMCA, and some of these will be located outside of the WMCA (see Appendix 7). Of mental health problems for a practice serving 2000 patients, it is evident that the 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.

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.

Figure 4: Estimated numbers and types of mental health problems for a practice serving 2000 patients (Source: Joint Commissioning Panel for Mental Health, 2013)

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, needs urgent consideration by the Commission.

2. Performance against national indicators

Primary Care Prescribing

A dedicated primary care prescribing for mental health is £12 per head in the WMCA, compared with a national average of £13 (NHS Benchmarking, 2016). This masks 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.

Primary care plays a central role in prevention, early intervention and access to specialist services, social support and community resources, how this can be better recognised and supported is a key strategic question.
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.

IAPT provides Cognitive Behaviour Therapy (CBT), and other interventions approved by NICE, to people with common mental health problems, such as mild to moderate 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 621, 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 current 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 Walsall CCG (need index = 0.96).

There may be a number of explanations for this, including better overall provision and a more developed voluntary 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 2014/15. The CCGs saw an increase from 56% to 63% in 2013/14 and to 76% in 2014/15. Figure 6 illustrates the range from 46% 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 shortest average waiting time from referral to the first treatment appointment was Dudley CCG at 67 days (HSCIC, 2016a). It is interesting to note that despite Walsall having the highest number of referrals per 100,000 population it also has the highest rate of 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 severe 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 mental health 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 health illness to respond to the broad range of mental health need that presents in primary care for example. With increasing 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 people with long term physical health conditions and there are opportunities to strengthen these at a practice level.

Figure 7: Percentage of patients with a diagnosis of SMI having different types of physical health checks for 2012/2013 and 2013/2014 (Source: NHS Benchmarking, 2016)

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 Parsons et al. (2014) found 75% 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, Parsons et al. (2014) estimated that treatment by the PCPCS reduced the costs of NHS service use by £435 per patient in the 22 months following the start of treatment. This significantly offsets the cost of the service. The service performs very 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.

Maximising recovery and preventing psychosis

Mental Health in the West Midlands Combined Authority

A GP to Consultant Helpline to help primary care liaison teams to deal with a single point of access is run by Social prescribing, which includes GPs, carers, physiologists and health trainers.

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 gyms; 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 and skills.

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 therapy and helping people to connect with friends and neighbours; recovery colleges; and will join up a range of organisations and agencies proving 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.

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 health care for under-served groups (Dowrick et al., 2013). This model, Improving Access to Mental Health in Primary Care (IMHP) (Allgrove et al., 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.

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HOMELESS PEOPLE ARE TWICE AS LIKELY TO EXPERIENCE A COMMON MENTAL HEALTH PROBLEM AND 4-15 TIMES MORE EXPERIENCE PSYCHIC SYMPTOMS THAN THE GENERAL POPULATION

PROMISING PRACTICE: EARLY INTERVENTION IN PSYCHOSIS

The Worcestershire EIP service has been identified as an example of promising practice 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.

The service (covering Bromsgrove, Redditch and Wyre Forest elements of the WMCA) comprises two teams covering north and south Worcestershire, with a skill mix in keeping with that recommended for delivery of NICE-recommended care. The service places a strong emphasis on carer support and has a project underway to recruit more peer support workers. It has developed a physical health intervention programme – Supporting Health and Promoting Exercise (SHAPE); a structured and intensive 12-week course with follow-up, drawing on the expertise of nutritionists, exercise physiologists and health trainers.

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The general principle of early intervention in mental health is widely promoted and its application can be seen in the Health and Wellbeing Hub; Mental Health First Aid training; Street Trauma Training; and Diversion schemes for offenders with mental health problems. However, the main focus of any early intervention strategy to impact upon mental health should be on children.

1. Current provision in the WMCA

The West Midlands was a pioneer in terms of early intervention for psychosis (EIP) services in the UK in Birmingham (Birdwood et al., 2013; Lester et al., 2009). These services are a crucial element of improving outcomes for people with severe mental illness and typically targeted at people aged 14–35 experiencing a first episode of psychosis. The aim of EIP services is summarised in Figure 8. The services provided include individual psychological therapy, family interventions, vocational and educational support and case management. A three year study was undertaken from 2003–2007 of 14 EIP teams across the West Midlands and highlighted some of the difficulties with implementation and variation across the Region (Birdwood et al., 2007).

EIP teams are provided by three of the four main specialist mental health providers with the Early Intervention and Detection Team transferring from Birmingham and Solihull Mental Health Foundation Trust (BSMHT) to Forward Thinking Birmingham in April 2016. Forward Thinking Birmingham is a partnership between Birmingham Children’s Hospital NHS Foundation Trust, Wolverhampton Foundation Trust, Beacon UK, The Children’s Society, Children’s Hospital NHS Foundation Trust, and The Royal Wolverhampton NHS Foundation Trust.

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

Reduce the duration of untreated psychosis by promoting early detection and engagement by young people, and comprehensive initial mental health assessments and diagnosis.

Optimise initial experience of acute care and treatment by providing ‘You friendly’ Acute Home based/Hospital Treatment.

Maximise recovery and prevent relapsing by providing care in the community. This includes focusing on functional/vocational as well as symptomatic recovery; addressing issues of resistance and support.

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

40 www.associationwccg.nhs.uk/guide-to-social-prescribing-presentation

41 www.healthchanges.org.uk/services/social-anti-social-prescribing-

42 www.bcpft.nhs.uk/services/mental-health/35-for-adults/community-services/21-primary-care-liaison-teams

43 www.slideshare.net/NCVO/museums-on-prescription-social-prescribing-presentation
CRISIS INTERVENTION

1. Provision in the WMCA

If not managed well, the experience of a mental health crisis can have a long-lasting and negative impact not only for the individual concerned but also their family, and may influence their capacity for self-management and willingness to seek help in the future. The CQC has identified that mental health crisis care provision is both inconsistent and inadequate (CQC, 2015a). Resonating with the findings from a survey of user and families’ experiences of crisis care (McPherson, 2010), the CQC have concluded that many people in crisis are unable to access the help they need when they need it and are dissatisfied with the help they receive.

The opportunities 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 inpatient admission
- Recovery and relapse prevention enabling people to stay well

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 are having a mental health crisis, and action plans of the necessary steps needed to improve local access. The action plans are developed collaboratively between commissioners, local authorities, mental health and non-mental health providers, police, local ambulance services and voluntary sector 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. These references other initiatives in particular in relation to early intervention, such as the provision of IAPT, and to varying degrees they emphasise the importance of building resilience and capacity building as well as fast tracking through to appropriate services. For example, the Staffordshire Crisis Concordat partners are exploring options for peer-supported hub model.

The 111 helpline and A&E also play a role in enabling people in A&E or access 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 (Fenton et al., 2009; Sweeney et al., 2014). The provision of women-only crisis houses enables women to be accommodated with their young children. There is some evidence that they may be more cost-effective than psychiatric inpatient care (Fenton et al., 2002; Howard et al., 2008; Johnson et al., 2010), can facilitate effective and timely discharge (Appleton and Appleton, 2014) and, in building on informal peer support, extend networks and repertoire for crisis management in the event of future difficulties (Sweeney et al., 2014). A recent evaluation of a crisis house in Tower Hamlets found that the cost of a bed in the Crisis House was half that of an inpatient bed in the mental health Trust (Appleton and Appleton, 2014).

A recent review of the evidence by the Early Intervention Foundation identified that the evidence is strongest for programmes that target children and parents based on early signals of risk, particularly child behaviour problems, insecure attachment, delayed development of speech and lack of maternal sensitivity (Aarnoudsen et al., 2016). The authors note that universal services are vital, therefore, to support families and children as a whole and as a means to identifying risk and targeting support on those who need it most. Blackpool with Darwen CCG is using the Routine Enquiry about Adversity in Childhood (REACH) screening tool to identify adults with high ACE scores, which may lead to poorer health and social care outcomes and expose their children to risk of adverse experiences, and is identifying interventions to provide support to these families (66).

Four beds for men and women, managed jointly by the charity P3 and Sandwell Crisis Home Treatment team in Sandwell, with 24-hour support providing an alternative to hospital admission

A three-bedded house in Leamington Spa, provided by Rethink, where people can stay for a maximum of 14 nights, during which time staff will provide emotional and practical support to assist people using the service to resolve their crisis and focus on recovery

A three-bedded house in North Warwickshire provided by Friendship Care and Housing in partnership with Between at Community Housing, providing accommodation and support between 8.00am and 10.00pm for people living in North East Warwickshire: Nuneaton, Bedworth, North Warwickshire and Rugby

A review of the current Crisis Care Concordat action plans for the six 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.
2. Performance against national indicators

Nationally, A&E attendances for mental health problems or self-harm represent 1.5% of all A&E attendances (NHS Benchmarking, 2016). The rate of attendances at A&E for people with a mental health problem, in the WMCA, was 180 per 100,000 population, below the England average of 250 per 100,000 for 2012/13 (NHS Benchmarking, 2016). The rate for admissions for self-harm was 183 per 10,000 population for the WMCA, also below the national average of 191. It is difficult to know, in the absence of other data, whether this indicates that people who would have presented at A&E are well served by other services, such as primary care mental health services, or whether there are barriers to access. Figure 9 illustrates the variation between CCGs in 2012/2013, which may reflect differences in proximity to A&E departments and/or under-development of accessible crisis support.

3. Redesigning the urgent care pathway

As noted earlier the redesign of the crisis care pathway is a key NHS England target for CCGs and likely to be a central theme within the STPs. An example of redesigning the crisis care pathway is the work undertaken by BSFM-FT, to design an urgent care pathway to offer comprehensive crisis support to the population of Birmingham and Solihull. This includes the Rapid Assessment, Interface and Discharge (RAID) liaison psychiatry services, Psychiatric Decisions Unit (PDU), Street Trage, British Transport Police, 111 and active bed management. RAID, an award-winning service, available 24/7 to all people aged over 16, provides a liaison psychiatry service in acute (non-psychiatric) hospitals. It is integrated within five such hospitals in Birmingham and Solihull, and receives an average of 1,400 referrals per month.

A notable example of redesigning the crisis care pathway is also provided by North West London Urgent Care Assessment and Care Pathway Redesign in which 8 CCGs are working together with key stakeholders on the redesign70.

4. 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. An 18-year follow-up study (Seikkula 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

Comparable 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, 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.

Figure 9: Attendances at A&E for a psychiatric disorder per 100,000 population (2012/13) (Source NHS Benchmarking 2016)

SECONDARY MENTAL HEALTH SERVICES

1. 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). There is, however, considerable variation 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 (BSFM-FT) 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.
- Dudley and Walsall Mental Health Partnership NHS Trust (DWMMHT) provides a wide 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 ranges 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 560,000, but also to neighbouring Trusts in Worcestershire, Staffordshire, Birmingham and Walsall. 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.

Figure 10: Proportion of adults who attended primary mental health services (Source: NHS Benchmarking 2016)

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. An 18-year follow-up study (Seikkula 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

ORGANISATIONS IN THE WMCA HAVE BEEN PIONEERS IN DEVELOPING INNOVATIVE MODELS OF CARE


Figure 11: Open Dialogue leadership team in Western Lapland
The four main providers (BSMHFT; BCPFT; CWPT; 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 (MERIT). 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 boundaries. 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 9.

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 – 456). 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 20155. This compares with 1,322 beds in 2012, representing an increase of 1.9% over two years. The data for 2015/2016 is not entirely clear because one of the Trusts (CWPT) 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, 26% 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 1,086 (or 5.7 per cent) 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 population 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 (in 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.


6. From April 2018, specialist inpatient beds for O–25 year-olds are provided by FTB.

7. Includes people over 65 as the service moved to an age independent service from 2014.
Table 4: Use of physical restraint 2012-2014

<table>
<thead>
<tr>
<th>NHS Mental Health Trust</th>
<th>Number of restraints 2012-13</th>
<th>Number of restraints 2014-15</th>
<th>Number of restraints 2015-16</th>
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<tr>
<td>BCT</td>
<td>77</td>
<td>75</td>
<td>74</td>
</tr>
<tr>
<td>Beekley SWSFT</td>
<td>2</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>CMHT</td>
<td>140</td>
<td>58</td>
<td>56</td>
</tr>
</tbody>
</table>

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 BSMMHT 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 1000 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 9–18 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 friends 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 strategies;
- Assertive outreach teams, supporting people with severe and persistent mental health problems and complex needs who are hard to engage.

Appendix B 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.

The figures on their own do not enable an understanding of the service provided or outcomes for service users. As a minimum, there needs to be an analysis of the relationship between need, service provision and outcomes. A comparison of the population of women 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 (Randall 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 that women from BAME communities (Randall et al, 2015).
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. In 2007, the West Midlands Combined Authority (WMCA) was £164 per head of population, with a range from approximately £110 to £220 (South Warwickshire CCG).

8. Out of Area Placements

Individuals may be placed in residential or inpatient settings, either for patients with a mental disorder, or with a comorbid mental health problem. Specialised accommodation such as locked rehabilitation beds or Psychiatric Intensive Care Unit (PICU) beds in the absence of local provision can be used.

The variation between CCGs will reflect acuity and the range of local provision. Further clarification on how locked rehabilitation beds are being used is needed as this type of provision lacks a clear service description, the people that these services are designed for and their interfaces with low secure beds (Dye et al., 2016).

Mental Health Trusts may also be spending money on placing people that require a bed which cannot be accommodated as the CCG may include that requirement within a block contract. The CCGs may also be making a contribution to the specialist health component of Local Authority spending on out of area placements.

Not being able to accommodate people requiring assessment and treatment in local acute provision is a concern for BCGs and mental health Trusts, as well as individuals and their families, and regulatory bodies. National reports, notably the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, (2015).

The data collected for this report relates to expenditure by the NHS but previous research indicates that nearly half of the expenditure on mental health services in the West Midlands is made by Local Authorities (Ryan et al., 2007) and, thus, further inquiry as to the Local Authority expenditure in the WMCA is needed.

NHS England is responsible for commissioning Tier 4 OATs for children, young people and adults. In 2014/15, NHS England spent £40 million on Tier 3 OATs, 79% of which was spent on secure mental health beds for adults. In addition approximately £20 million was spent on two independent sector providers based in the WMCA.

Based on data from 12 CCGs for 2015/16, the spend by these CCGs on OATs was £20 million giving an average spend for OATs of £1.7 million with a range from around £70,000 to over £2.9 million. This is an underestimate because not all CCGs responded and there are differences in the way CCGs collate the data on OATs expenditure. The expenditure covers:

- Acute overspill beds for people who require an assessment and treatment admission but there are no local beds available
- Specialist placements, notably for people with a diagnosis of personality disorder and autism or a comorbid mental health problem
- Locked rehabilitation beds
- Psychiatric Intensive Care Unit (PICU) beds in the absence of local 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 CCGs – Coventry and Rugby, North Warwickshire and the NHS Arden and Great East Midlands Commissioning Support Unit, demonstrates that there is an opportunity for multi-agency partnerships and the Trust and the CSU recently won an award for this work.

The €IP work stream in Wolverhampton has been developed as a focus on reducing OATs for people with psychosis.

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 help line (CWPT) (see primary care section)
- Early intervention in psychosis (WHCT) (see early intervention section)
- RAID and redesign of the urgent care pathway (BSSFH) (see crisis intervention section)
- Recovery Colleges (BCPT; BSSFH and FTB) (see quality of life and mental health section)
- Street Trauma (BSSFH; CWPT) in partnership with West Midlands Flash team (see crisis intervention section)
- Individual Placement and Support (see employment section)

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

300 Voices and community engagement (BSMHFT) (see co-production section)

Four mental health Trusts are part of the West Midlands Hub, which is a collaboration between eight providers and the Trust and the CSU recently won an award for this work.

The £IP work stream in Wolverhampton has been developed as a focus on reducing OATs for people with psychosis.

10. Changing practice

As can be seen by the majority of these examples focus on the development of new services and there is also scope for shifting ‘one size fits all’ approaches to people and their families, and delivering training for CWPT.

Walsall Carers Support Service (DVHMW) 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 providing a service for veterans as a focus on an enhanced standard care pathway tailored for them and their carers to be referred to IAPT and other secondary care services.

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.

11. Promising practice: reducing the use of restraint

Six core strategies aimed at reducing the use of seclusion and restraint have been identified: (LeBel et al., 2014) and are:

1. Counties are members of senior organisational leadership (ie, 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 in mental health settings
4. Use of formalised 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 mechanisms to support the willingness to engage and preventive trauma-informed approach (Huckshorn, 2008).
5. Inclusion of service users, carers and families in inpatient care as advocates and peer support
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 adapted 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).

PEER SUPPORT

The contribution of peer support is now widely recognised as helpful in promoting wellness and recovery. There is increasing demand for peer support and it is of value across public services. In a mental health context, the key elements include building on shared personal experiences to support others to promote wellness and recovery, through self-help groups, mutual peer support, and peer support and online peer support (Mental Health Foundation, 2012; Faulkner and Kalathil, 2011; National Voices, 2010).

ADVOCACY

Advocacy, in its various forms, has an important role to play in ensuring that a 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 their 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 views are at risk of being discounted 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 from 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 Act advocacy). There are initiatives that can support changes in practice to a more empowering stance, and whose potential is not fully realised in the WMCA.

82. Use of data to inform practice at the individual level
advocacy at risk (e.g. generic advocacy and community advocacy), such that advocacy becomes increasingly professionalised. It would, therefore, be timely to review this provision; particularly in light of findings that access to statutory advocacy can be problematic (Abou-Saada et al, 2016). The co-option of methods to review detainees under the Mental Health Act, with the CQC recently highlighting their finding that 20% of detained patients had not had appropriate proper experts present (CQC, 2015). Furthermore, a national evaluation of IMHA provision found that people most 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 awaiting approval. The project’s aim is to develop a clearly defined framework to support safe crisis intervention and care, and to make use of the expertise and experience of individuals with lived experience of mental health problems. Figure 15: Percentage of mental health incidents resulting from suicide

LOCAL AUTHORITY PROVISION
Local Authorities provide social work services and commission a broad range of mental health services from the third sector. The Local Authority’s role in social work in adult mental health includes ensuring eligible people can access social care services and resources, including direct payments and personal budgets, and acting as Approved Mental Health Practitioners, alongside other mental health professionals. Social workers also have a role in building community capacity: ‘working with groups and networks of citizens to foster citizen mutual support and social capital’ (Allen, 2014: 15). The Care Act 2014 also placed a duty on Local Authorities to promote wellbeing, physical and emotional, when carrying out their duties (Department of Health, 2014).

However, increasing thresholds for eligibility, reflecting changes to personal budgets, the amount of resources that people can have means that many people simply are not getting the support they need. This will mean that the responsibility for providing care will shift to informal carers. Five years ago, Age UK estimated that a 7% cut to Local Authority spending would lead to a 25% rise in the hours of personal care provided by carers (Carers UK, 2011). The National Audit Office (2014) has indicated a 37% real-terms reduction in government funding to local authorities between 2010/11 and 2015/16. While children’s social care has been protected there has been a reduction in adult social care of 9% for this period with further reductions anticipated (National Audit Office, 2014: 26). It is inevitable that this will have had profound implications for the mental health of carers.

Local Authorities commission the third sector to provide a broad range of support (as described below). This includes day services, which were historically provided by the Local Authority. A further line of inquiry for the Commission is whether people with a diagnosis of severe mental illness have been disadvantaged in the modernisation of these services and their alignment with wellbeing hubs for people with more common mental health problems.

1. Direct payments and personal budgets
Direct payments and personal budgets are two specific methods that have been introduced to give people greater control and choice over the support they receive, and, as discussed later, are key to a strategy focused on promoting self-determination and recovery.

- Personal budgets are the allocation of funding available to people with eligible needs and the budget can be taken as a direct payment, or as services commissioned on the person’s behalf by the council, or by an organisation contracted by the Local Authority. In some cases, part of the budget is taken as a Direct Payment and the other part managed by the Local Authorities. From 2015, the expansion of personal health budgets has been led by CCGs and people with mental health problems whose needs cross health and social care boundaries may be able to have integrated budgets across health and care (NHS Confederation, 2015).

- Direct payments are cash payments and can be made directly to the person, to a trusted third party or to an organisation that manages the direct payment on the person’s behalf.

During 2014–15, approximately 4,380 people (18-64) received Local Authority funded Mental Health Support in the WMCA; 540 received a direct payment (either in full or in part) (12.3%) and 1105 people (18-64) received Local Authority Managed Personal budget (25%). The use for mental health clients is substantially lower from other client groups.

However there is substantial variation across the WMCA, as illustrated in Figure 17 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). These 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 had been 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 Trust found carers was promising 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, have a closeness to and expertise on communities, and because services are often provided by volunteers, many of whom will be peers with lived experience, the power differential between service users and service provider is reduced. The third sector, therefore, has a ‘comparative advantage’ in service delivery, especially for those who are traditionally excluded from mental health provision and concern about the experience of people from BAME communities, as a possible driver. Mental health support may also be a component of wider support to BAME communities, that also provide advice and support.

Similarly, organisations providing other welfare services have a mental health component, especially for communities supporting homeless people; drug and alcohol support; support groups for people with long excluded health problems; and organisations like Parkison’s UK and service for people, predominantly women, affected by abuse or domestic violence, including Refuge in Birmingham; Birmingham and Solihull Women’s Aid; Coventry Women’s Aid; the Haven in Walsall; and Roshni providing support for South Asian women and children.

Such organisations vary in size and capacity, with larger organisations having a well-developed profile and often offering a range of services, and there are also many small-scale less formalised groups that 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
- Workshops and webinars
- Access to key workers and services providing seven-day-a-week direct access for all to information, advice and support; peer support/ friendship and being isolation; and the opportunity to engage in social/exercise/arts activities as well as access to 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 courses

Figure 17: Percentage of mental health clients receiving a direct payment or managed personal budget in the WMCA

*34 Although the co-option of these methods by public services has been the focus of critique by service user activists as fundamentally altering them to serve professional or organisational interests.*
Advocacy, both statutory and non-statutory advocacy, to enable people to have a voice and greater choice and control over their mental health. These groups 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 formats, including job-retention, negotiating reasonable adjustments; supporting leaving negative 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 psychotherapeutic treatment for children, young people, and adults who are survivors of torture, including individual and group work, and a family therapy service to families that have been affected by torture.

Initiatives have also been developed by statutory services and these include Community Development Workers (CDW), working with different BAME communities to help prevent mental ill health and support access to services. Examples include:

- The community engagement team at BSMHT who have played a central role in relation to 300 Voices and work closely with Trust staff and community groups to engage and empower people and are consulted and involved in developments or changes to services provided by the Trust.
- The community engagement team at BAME communities to tackle the stigma associated with mental health, and to reduce the barriers to getting the right help at the right time.
- Community Development Workers, who work with people from BAME and increasing cultural diversity and inclusion on an Eastern European background, including in and surrounding Warwickshire and the West Midlands, promotes a holistic approach to mental, physical and social wellbeing for Asian and British Asian women, aged 26 and over. The group provides a range of activities, including yoga and meditation, social and wellbeing sessions as well as themed activities such as singing and music.

And there are initiatives that recognize 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 embedded 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 development approach to tackle the intersecting structural inequalities that limit life chances. Therefore, although specific services are considered 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 psychotherapeutic treatment for children, young people, and adults who are survivors of torture, including individual and group work, and a family therapy service to families that have been affected by torture.

Initiatives have also been developed by statutory services and these include Community Development Workers (CDW), working with different BAME communities to help prevent mental ill health and support access to services. Examples include:

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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 locality and to challenge stigma in their daily lives.
- Funded and supported the delivery of the 300 Voices Programme (see Appendix 4).
- Run a high number of profile 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 250 employers to sign a pledge to embed changes in policy and practice to transform the culture of their workplaces.

Over the next 5 years, Time to Change aims to empower communities to lead and embed change locally 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


http://www.time-to-change.org.uk [accessed 050117]

www.time-to-change.org.uk [accessed 050117]


http://www.freedomfromtorture.org.uk/about/1515529 [accessed 150816].


Mental Health in the West Midlands Combined Authority

PROMISING PRACTICE: RECOVERY COLLEGES

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 plan 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 gains 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).

PEER SUPPORT

A scoping study of mental health peer support in England identified a 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, BIGLAD (Birmingham Gays and Lesbians against Depression), 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, in Sandwell, was 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 41)
- Facilitating peer support groups for people who hear voices (eg Hearing Voices Network 42)
- Self-help groups (as above)
- Online peer support
- Peer mentoring (eg in schools to build emotional resilience, Wolverhampton 43)
- Peer support and recovery in the workplace, with special reference to workplace mental health initiatives and self-help groups (Knapp et al., 2015). However, for the role 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 by NUSL, which provides support to a network of peer support experts who share fresh approaches to developing and running peer support programmes, the IMROC programme, which provides support to NHS providers and their partners to become more recovery-focused; and the Institute of Mental Health, Nottingham, which delivers peer support training accredited with the Open University, and a range of other courses and evaluations of services aimed at developing the role of peer supporters within both the voluntary and statutory sectors. Their recovery-focussed training is applicable to a broad range of settings and they have recently worked with the Devon & Cornwall police service to support the development of peer supporters within the police workforce.

Much of the available evidence relates to formal peer support workers (Gillard et al., 2014) and changing the skill mix of the workforce to include peer support workers has been identified as one of the most important factors in contributing towards changes in more recovery-oriented services (Repper, 2013), bringing benefits both to those supported by peers and to the peer support workers themselves (Repper, 2011) and also to mental health services (Gillard et al., 2013). The 2015 Community Mental Health Survey, however, found that only about half of those people who felt they would benefit from peer support were offered it (CQC, 2015), resonating with findings relating to access to advocacy (CQC, 2014). The evidence base in terms of delivering outcomes is inconclusive and while peer support groups have been identified they are not replicated across all studies (Knapp et al., 2015). However, for the role 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, some limited evidence that peer support workers can provide value for money through reducing psychiatric inpatient and acute care use, either by preventing admissions or by shortening lengths of stay (Traichtenberg et al., 2013). This review suggested that the evidence for the use of peer support was not robust enough to be recommended for funding, but ultimately it would be gained for every £1 invested, although the studies that provided the basis for these calculations were from the US and Australia and their generalisability to a UK context may be limited. There is a clear need to develop the evidence, focusing on voluntary sector as well as statutory sector implementation of peer support roles, and comparing which achieves better outcomes and provides better value for money.

RECOVERY AND RECOVERY COLLEGES

From a national list of Recovery Colleges (mROC, 2015), there are two out of a total of 38 in England for West Midlands residents currently operating, although there are other initiatives that provide recovery-oriented courses and programmes. The two Recovery Colleges are in Sandwell, provided by the Black Country Partnership NHS Foundation Trust and which started in October 2015 44, and Walsall, provided by Dudley and Walsall Mental Health Partnership NHS Trust 45. A Recovery College, provided by BSMMU, went live in November 2014 46 and the Black Country and Staffordshire Health and Wellbeing Board, and on 18 December 2014, the Black Country Partnership NHS Foundation Trust announced the formation of a Recovery Partnership for young people up to the age of 25 is proposing Recovery Colleges in educational settings to enable young people to continue with their studies 47 in Birmingham. There are no evaluation reports of these local developments available, as yet.

PRO-RECOVERY WORKING

There are other approaches to service delivery that have been identified as pro-recovery working practices, which have not developed explicitly from a recovery perspective but will none the less support recovery. These include: Housing First; Individual Placement and Support (IPS); and use of ‘personal budgets’ in health and social care (Parker et al., 2012).

HOUSING

1. Provision in the WMCA

Only 1.1,440 homes in the WMCA (the majority (879,260 homes) are in private hands, either in the private rented sector or owned by Registered Social Landlords, Home Associations, charities and the local authorities own over 264,000 homes, providing accommodation for people on low incomes (social housing) or with particular needs (supported housing). 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. From 2011–12, the funding fence was removed from Supporting People funding and was rolled into the Formula Grant – a single grant given by central government to Local Authorities. This means that there is now no specific budget allocation for Supporting People services, consequently meaning funding for supported housing schemes has often been diverted, creating gaps in provision and reducing the overall quality of provision (Homeless Link, 2013; Waddle, 2010).

This lack of revenue funding for supported housing has been compounded by the introduction of a cap (at Local Housing Allowance levels) on the amount of housing benefit that can be claimed. The lack of the Care and Support Grant, and the general 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 funded by the National Housing Federation found that at the national level 156,000 units of existing supported and sheltered housing would become unviable and subject to closure. This is 41% of all existing schemes. This has resulted in a huge amount of uncertainty among 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

41 www.hearing-voices.org.uk/area/west-midlands/ [accessed 150816].
43 www.firstpersonplural.org.uk/about-first-person-plural/ [accessed 150816].
44 www.kaleidoscopeplus.org.uk/ [accessed 150816].
45 http://ssnmentalhealth.btck.co.uk/ [accessed 150816].
46 www.hearing-voices.org.uk/tag/peer-support/ [accessed 150816].
48 www.bbc.co.uk/news/uk-england-31515884 [accessed 150816].
50 www.kaleidoscopeplus.org.uk/ [accessed 150816].
51 www.swnhs.nhs.uk/about-first-person-plural/ [accessed 150816].
52 www.bbc.co.uk/news/uk-england-31515884 [accessed 150816].
54 www.hearing-voices.org.uk/tag/peer-support/ [accessed 150816].
55 www.hearing-voices.org.uk/tag/peer-support/ [accessed 150816].
56 Wadley, 2015.}

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56 www.hearing-voices.org.uk/area/west-midlands/ [accessed 150816].
57 www.hearing-voices.org.uk/tag/peer-support/ [accessed 150816].
58 www.hearing-voices.org.uk/tag/peer-support/ [accessed 150816].
59 www.hearing-voices.org.uk/tag/peer-support/ [accessed 150816].
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 (Pleace et al., 2009). Furthermore, the majority of the costs were being spent on the housing component suggesting that this population may be underestimated 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**

All the Local Authorities indicate that they commission floating support. In general, the aims of this are to:

- Promote confidence, reduce anxiety, build resilience and better self-management of mental health problems in including safety and risk
- Provide access to opportunities, such as volunteering, education and/or employment
- Build practical living skills including managing finances, travel training, and food preparation and use of mainstream services; linking with community activities and volunteering opportunities, and wider activities to promote good health and wellbeing.

**SUPPORTED HOUSING**

Supported housing differs from general needs housing because support and care services are provided in addition to housing management. The people living in supported housing have specific needs, often relating to mental health problems. Their 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 Heartart 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 fleeing violence and abuse, young people including care leavers and for offenders and ex-offenders.

Accommodation may be on a short-term basis (ie, 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

**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, reap 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.

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.

In England, 57% of adults on a CPA are taking as a proxy for the ability of services to help service users to optimise functioning and recovery (NHS Benchmarking, 2016). The CPA covers approximately 25% of people registered with specialist mental health services. "The WMCA as a whole, 74% of adults on a CPA were living in stable and appropriate accommodation. This compares favourably with an England average of 59% (NHS Benchmarking, 2016), but as Figure 1 shows there are some outliers, and it would be useful to understand the factors influencing this variation in performance, including the availability of housing stock and the collaboration between mental health services and housing providers. The relationship between the range of housing provision, the length of stay and use of Out of Area Placements needs further inquiry.

A previous study in Wales identified the practice of residential sorting from anecdotal evidence (Jones and Gulliver, 2009) and this requires further analysis.

**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 range of housing and mental health, building on the work of housing associations and other partners the time and stability to build or expand successful services in the region.

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 the emerging evidence on Housing First.

* See for example a summary with case studies developed by a group of housing providers in the West Midlands: Working together in the Midlands. Available at: http://www.housinglin.org.uk/Topics/browse/HousingMentaHealth/?parent=6081&child=10082

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**Promising Practice: Housing First**

The evidence from the US and Europe indicates success for the Housing First model and is being implemented in Finland as a new national strategy to eliminate long-term homelessness (Pleace et al., 2010). A study of nine relatively new Housing First services in England evidenced improvements in physical and mental health for their clientele (Bretherton and Pleace, 2015). There was also evidence of reductions in alcohol or drug use, antisocial behaviour and positive evidence of social integration with neighbours and re-establishing links with families. The Housing First services were valued by service users for the choice and sense of freedom they offered, as well as the intensive, flexible and open-ended support (Bretherton and Pleace, 2015). This study was relatively small scale and the positive results were not uniform with some instances of deterioration of physical or mental health. There was, however, no evidence of increased drug use or anti-social behaviour. The study also indicated the potential to save money and on the assumption that, in the absence of Housing First support, people would have required high intensity supported accommodation, the annual savings were estimated to be between £3,048 to £4,794 in support costs per person. Focusing on the potential reduction in the use of other services (emergency medical services and the criminal justice system), the potential overall saving in public expenditure was estimated to be £15,000 per person. However, Housing First is not a low cost option but it may well be more cost effective than the alternatives, although it is clear that further research is needed (Bretherton and Pleace, 2010, Pleace et al., 2010).

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

![Figure 18: Proportion of working age adults (18-69) on the CPA recorded as living independently (with or without support) for 2014-15](http://example.com/figure18)

![Figure 19: Percentage of adults on the CPA in settled accommodation for each CCG in the WMCA (April – June 2013) (Source: NHS Benchmarking, 2016)](http://example.com/figure19)
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-hub 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 (2013), which may not be a comprehensive list, are as follows:

- Sandwell Council
- Advance Employment, Solihull
- Hereford College, Coventry
- Pathway First, Momentum and Shellstock 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 City Commissioners 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 2014-15 (Figure 21). There are striking differences between the LEPs with an average employment rate for less than 5% for the Black Country LEP in comparison with around 15% for Coventry and Warwickshire LEP. This data is also available from ASCO data at Local Authority level for 2014/15 (2014) 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 (113).

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, ie, conformity to the key principles listed above. The Centre for Mental Health has carried out independent fidelity reviews and has recognised the quality of IPS services in Walsall (provided by Dudley and Walsall Mental Health Partnership), Coventry (MBC) and North Staffordshire (provider Work4You, Making Space and covering Lichfield) (provided by Worcestershire Health and Care Trust covering Bromsgrove and Redditch), as excellent; Sandwell (Sandwell MBC) and Wolverhampton (Healthy Minds and Wellbeing) as good fidelity; Birmingham (BSMHT) as fair fidelity; and Wolverhampton (Wolverhampton MBC) as low fidelity. An inaugural meeting of an IPS network was held in May 2016 with the aim of developing a West Midlands IPS strategy and scaling up provision (114).

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 concludes 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 prison officers with the mainstay of custody provision with smaller custody facilities at Coventry, Solihull, Bournville in Birmingham, and Wolverhampton. The Liaison and Diversion staff provide an all age service and link directly into the local Crown and Magistrates court to support ongoing diversion opportunities. The West Midlands is the only Force with 100% coverage ahead of the national roll out by 2019 which is currently the object to further Treasury decisions.

The Crisis Care Conundrum Action Plan identifies 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 MHTs. Examples of initiatives to support this include:

- A Pathway pack in Dudley for people leaving custody to enable them to get in touch should the need arise
- Stolliff 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 in Midlands 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 indictable convictions for men. The next most common offence among women was violence against the person, around a third of all female convictions were accounted for by Actual Bodily Harm. Drugs offences were the rest most common, although the proportion of the wider prison population for these types of offences has dropped considerably, from 25.2% in 2009 to 13.8% in 2014 (115).

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.

113 http://base-uk.org/services-offender/work-choice/?page=1
115 This is surprising because the ASCO data is drawn from MIDS.
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 Worcestershire 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) toolkit programme which seeks to identify opportunities to resettle 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 (87% missed).

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

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 current 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 JSNHs 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 local and national evidence.

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 (e.g. 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 those 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 systemic and evidence-based 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 shied away from innovation, having developed service models that have consequently been adopted elsewhere, early intervention for psychosis and street transport 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 gathered data 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 systematic approach. These plans and strategies 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 concepts 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 abuse.

7. Primary care has a key role to play in prevention, early intervention and recovery. A focus on promoting parity of esteem between physical and mental health.

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 the cases 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 across the WMCA and will help ensure that the full potential of primary care is maximised.

10. 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.

11. The WMCA should aim to reduce the rate of Out of Area Treatments by developing appropriate local provision and strengthening and investing in community-based services, including crisis and recovery houses.

12. Co-production should be a foundation to improving the quality of mental health services, US Department of Health and Human Services.

13. The WMCA should aim to reduce the rate of Out of Area Treatments by developing appropriate local provision and strengthening and investing in community-based services, including crisis and recovery houses.

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 of 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 to implement direct payments and personal budgets to ensure they achieve this.

16. 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.

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

18. This is challenging work, systems are hard-edges.

References


Bonner, F. (2016). Personal communication from the Chief Operating Officer for Mental Health First Aid England.


Mental Health in the West Midlands Combined Authority


Colman, I., Ploubidis, G., Wadsworth, 1362.


### 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>Spent (£000s) 2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children (0-16)</td>
<td></td>
</tr>
<tr>
<td>Adults of working age</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:**

   |---------------------------|-------------------|-------------------|------------------|--------------------------|------------------------------------------|

Please add additional rows as necessary.

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### Please add additional rows as necessary.

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<table>
<thead>
<tr>
<th>LEP</th>
<th>Local Authority</th>
<th>Status as of July 2016</th>
<th>Link to JSNA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walsall</td>
<td>Refreshed in 2013</td>
<td><a href="http://www.walsallintelligence.org.uk/themedpages-walsall/JSNA">http://www.walsallintelligence.org.uk/themedpages-walsall/JSNA</a></td>
<td></td>
</tr>
<tr>
<td>Sandwell</td>
<td>0-25 yrs MH JSNA in final draft form Work underway on adult MH JSNA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dudley</td>
<td>Unable to locate JSNA synthesis 2012, no specific section on mental health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coventry</td>
<td>2015. Also covers Ruby but limited information available</td>
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</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>
<th>Area</th>
<th>Name of Group</th>
<th>Description</th>
<th>Recent examples of involvement/co-production</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>See Me user engagement project at BSMHT</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 SmokeFree NHS introduction across all teams in the mental health trust.</td>
<td></td>
<td>Dudley and Walsall</td>
<td>Experts by Experience Dudley and Walsall MH Partnership Trust. 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 Trauma Service which has been very well received.</td>
</tr>
</tbody>
</table>
|      | 300 voices                                         | A partnership between BSMHT, 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 BSMHT (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. | 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:  
- Engaging a diversity of professionals in training workshops  
- Changing attitudes (particularly among police)  
- Influencing individuals to reflect on and change their practice.  
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. |      | South Staffordshire Network for Mental Health    | 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. | White Paper on ‘Alternative Places of Safety’ and are developing a standardised person centred Mental Wellbeing Plan and a set of standards for crisis care. |
|      | Birmingham and Solihull Mental Health NHS Foundation Trust User Watch | A blog presenting ‘an independent, occasionally very satirical view’ of mental health and NHS issues.  
- Independent Mental Health User Involvement Service – a registered charity which is user led and has an entire staff team of people who have lived experience of mental ill health.  
- A monthly user forum  
- Weekly peer support groups (mental health and veterans)  
- Weekly face to face evaluation of mental health services in the locality  
- Partnership working with Healthwatch. | 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. |      | Dudley and Walsall                                  | Experts by Experience Dudley and Walsall MH Partnership Trust. 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. | Urgent care services comprehensive review and redesign was conducted which led to the development of the Street Trauma Service which has been very well received. |
|      | Burton and South Staffordshire Health Network for Mental Health | An independent charity promoting and developing mental health services from the perspective of people who have an experience of mental ill health 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:  
- Ongoing qualitative evaluation of five local mental health services and associated care planning documentation.  
- Quarterly high standard newsletter and podcast led and edited by service members.  
- Four research reports each year covering topics deciding by members (previous reports have included GP Awareness of mental health, Experience of Bolsover Plus, Barriers to Employment, Quality of Care in Recovery).  
- Ongoing delivery of four workshops promoting recovery and encouraging self-management and participation within care planning.  
- An investing in Volunteers accredited volunteer programme providing the opportunity for people with experience of mental ill health to become community developers. | Successful in lobbying and campaigning for a short term nonclinical crisis prevention service. Currently exploring partnership working to fund and deliver a second service (the current project is volunteer led)  
SUCCESSFUL IN GETTING A RING AND RIDE SCHEME FOR PEOPLE LIVING IN RURAL PARTS OF STAFFORDSHIRE WHO WERE HAVING DIFFICULTY ACCESSING SERVICES.  
SUCCESSFUL IN OBTAINING NATIONAL LOTTERY FUNDING TO DELIVER A MENTAL HEALTH PROMOTION SERVICE DEDICATED TO REDUCING ADMISSION INTO MENTAL HEALTH SERVICES FOR NEXT FOUR YEARS. |
|      | Coventry and Warwickshire                         | Actively Influencing Mental health services (AIMHS)  
- A monthly peer support group for people who have lived experience of mental ill health  
- Weekly peer support groups (mental health and veterans)  
- Regular feedback from service users and carers | 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. |      | Dudley and Walsall                                  | Experts by Experience Dudley and Walsall MH Partnership Trust. 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. | Urgent care services comprehensive review and redesign was conducted which led to the development of the Street Trauma Service which has been very well received. |
|      | Birmingham and Solihull Mental Health NHS Foundation Trust User Watch | A blog presenting ‘an independent, occasionally very satirical view’ of mental health and NHS issues.  
- Independent Mental Health User Involvement Service – a registered charity which is user led and has an entire staff team of people who have lived experience of mental ill health.  
- A monthly user forum  
- Weekly peer support groups (mental health and veterans)  
- Weekly face to face evaluation of mental health services in the locality  
- Partnership working with Healthwatch. | 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. |      | Dudley and Walsall                                  | Experts by Experience Dudley and Walsall MH Partnership Trust. 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. | Urgent care services comprehensive review and redesign was conducted which led to the development of the Street Trauma Service which has been very well received. |
<table>
<thead>
<tr>
<th>Area</th>
<th>Name of Group</th>
<th>Description</th>
<th>Recent examples of involvement/outputs produced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wolverhampton</td>
<td>Positive Action for Mental Health (PAMH)</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 also 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-led registered charity and company limited by guarantees, with approximately 190 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 require action. A quarterly magazine with a readership of potentially 1000 readers which includes all members, statutory Bodies, Mental Health professionals, libraries, pharmacists, Community Centres, Housing officers, and doctors’ surgeries. If 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>
<td></td>
</tr>
<tr>
<td>Worcestershire</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 Week. 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>
<td></td>
</tr>
<tr>
<td></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 has a membership of over 150. The SUREsearch 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 SUREsearch 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)

<table>
<thead>
<tr>
<th>Public health intervention</th>
<th>Examples</th>
<th>Wolverhampton</th>
<th>Dudley</th>
</tr>
</thead>
<tbody>
<tr>
<td>General public frontline services to promote wellbeing, awareness and tackle stigma</td>
<td>Mental health awareness</td>
<td>Mental Health and Wellbeing service providing one to one support; Five Ways to Wellbeing MHFA</td>
<td>Sandwell’s feel good 6 wellbeing engagement campaign from 15/16. Building resilience training – training frontline staff in mental health and wellbeing awareness.</td>
</tr>
<tr>
<td>Perinatal and infant mental health programmes</td>
<td>Breast feeding support Family Support Services</td>
<td>Breast feeding support Family Support Services</td>
<td></td>
</tr>
<tr>
<td>Parenting programmes (including targeted programmes at high risk families)</td>
<td>Parenting Team Triple P</td>
<td>Parenting team Mellow, Triple P and Stollhill</td>
<td>CHANGES local Parenting Programme – universal and targeted offer for parents of children 0–19</td>
</tr>
<tr>
<td>School-based mental health promotion and prevention programmes</td>
<td>Support for teachers Anti-bullying</td>
<td></td>
<td>Primary Whole School Approach (WSA) to Emotional Wellbeing: emotional health and wellbeing audit for schools; action planning to address ‘gaps’ and implementation of a social and emotional learning programme incorporated into the taught curriculum. Audit includes staff emotional health and wellbeing training. 15/16: Agreed funding to offer WSA to Secondary Schools</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 training 15/16</td>
</tr>
</tbody>
</table>

125 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.
<table>
<thead>
<tr>
<th>Public health intervention</th>
<th>Examples</th>
<th>Walsall</th>
<th>Sandwell</th>
<th>Dudley</th>
</tr>
</thead>
<tbody>
<tr>
<td>Targeted initiatives for at risk groups</td>
<td>Community and social activities: Addressing social isolation. Access to education and employment Support for carers Building confidence and well-being targeted at: Young people BAME groups Unemployed men.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>A community service for African Caribbean/Dual Heritage for people at risk of developing or recovering from NCDs.</td>
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<td></td>
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<tr>
<td>Tailoring violence and abuse services</td>
<td>Domestic abuse services</td>
<td>Domestic abuse family hostel</td>
<td>Domestic violence perpetrator programme</td>
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</tr>
<tr>
<td></td>
<td>Reducing physical inactivity</td>
<td>Healthy Weight Services: ‘Food Dude’ Healthy Eating Programme Dynamic Dudes – physical activity program</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Suicide prevention training</td>
<td>Forward for Life for frontline workers and senior managers: 4 x half-day SaferTALK basic suicide prevention accredited training courses 2 x ASIB 2-day suicide prevention accredited training courses</td>
<td>Applied suicide prevention training Mental health and wellbeing 14/15 ASIB and SaferTALK suicide prevention training for front line staff from 15/16</td>
<td>Forward for Life for frontline workers and senior managers: 4 x half-day SaferTALK basic suicide prevention sessions 3 x ASIB 2-day suicide prevention accredited training courses.</td>
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<tr>
<td>Other</td>
<td>General Art, Craft and Health sessions of 2 hours</td>
<td></td>
<td></td>
<td>Bids invited for mental health promotion activity reflecting the Five Ways to Wellbeing (not continuing).</td>
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<tr>
<td>Programmes to improve the physical health of people with mental health problems</td>
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<tr>
<td></td>
<td>Reducing physical inactivity</td>
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<td></td>
<td>Specialist weight management</td>
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<td></td>
<td>Smoking cessation</td>
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<td></td>
<td>Screening and adult lifestyle services</td>
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<tr>
<td>Workforce interventions</td>
<td>Healthy Workplace Programmes</td>
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<tr>
<td></td>
<td>Community and social activities: Addressing social isolation. Access to education and employment Support for carers Building confidence and well-being targeted at: Young people BAME groups Unemployed men.</td>
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<tr>
<td></td>
<td>Social inclusion project which works with Asian people with mental health needs. Tamarind, a mental health resource centre for Asian people with mental health needs.</td>
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<td></td>
<td>Workforce Wellbeing Charter promoting good practice among local employers, including training Occupational health support to Council staff, Mental Wellbeing Single Point Access tool to help managers in dealing with mental wellbeing issues in the workplace</td>
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<td>Workforce interventions</td>
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<tr>
<td></td>
<td>Parenting programmes (including targeted programmes at high risk families)</td>
<td>Parenting Team</td>
<td>Triple P</td>
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<tr>
<td></td>
<td>Parenting programmes: Community Wellbeing Team Parenting Team – Triple P programme, living with confidence (to improve self esteem), family links nurturing programme, Parenting Team.</td>
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<tr>
<td>School-based mental health promotion and prevention programmes</td>
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<td>Support for teachers</td>
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<td></td>
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<td></td>
<td>Work with individual schools to increase emotional resilience and also challenge discrimination.</td>
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<td>Parenting programmes</td>
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</tbody>
</table>
Suicide prevention

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

Public health intervention

<table>
<thead>
<tr>
<th>Public health intervention</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tackling violence and abuse</td>
<td>Domestic abuse services</td>
</tr>
<tr>
<td>Suicide prevention</td>
<td>Individuals with mental health needs who risk suicide</td>
</tr>
<tr>
<td>Other</td>
<td>Training in using WSRMB, and secondary research of the local household survey</td>
</tr>
</tbody>
</table>

**Annex 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> to improve early child development and wellbeing, maternal wellbeing</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 (McElroy et al., 2003)</td>
</tr>
<tr>
<td><strong>Promote good parenting skills – universal as well as targeted early intervention programmes for common parenting problems and more intensive interventions for high risk families.</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; Prioritising support for parents from higher risk groups and with children with emotional and behavioural problems.</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>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 (SEL) programmes achieving pupil’s core competencies; Self-management and social skills training; Build financial literacy; Mentoring programmes Family Intervention Projects</td>
<td>Integrated approach, using universal and targeted interventions in primary school are cost effective.</td>
<td>Curriculm 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. (Broid et al., 2004; McElroy et al., 2003; Bywater et al., 2009)</td>
</tr>
</tbody>
</table>

**Notes:**

- Community based group programmes: Planned activities for groups of participants, led by trained leaders, usually in the community, and conducted on a regular basis.
- Home based individual programmes: Planned activities for individuals conducted at home, again usually on a regular basis.
- Pre-school/early childhood education programmes: Planned activities for children and parents, usually conducted on a regular basis, but may be at home.
- Supporting development of home learning environment: Planned activities for children and parents, usually conducted at home.
- Prioritising support: Support for parents from higher risk groups and with children with emotional and behavioural problems.
- Universal: Provided to all children and families.
- Targeted: Provided to children and families at increased risk.
- Social and emotional learning: Programmes aimed at promoting social and emotional skills.
- Self-management: Programmes that teach children and young people skills to manage their own behaviour.
- Financial literacy: Programmes that teach children and young people how to manage their money.
- Mentoring: One-to-one support from a trained mentor.
- Family intervention projects: Community-based interventions that work with the family as a whole.

**References:**

- Payton et al., 1997; Cornah, 2003; Caan & Jenkins, 2009; Olds, 2002; Wright et al., 2006; Schachter et al., 2004; Meade & Lamb, 2003; Heginbotham & Newbigging, 2013.
<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 hurdles</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workplace screening for risk of depression followed by CBT where indicated. Early intervention to reduce risks of unemployment through primary care and job Centre and promote engagement and participation for those who are unemployed. Providing volunteering opportunities. Support NHS, LA and Third Sector organisations to develop interventions to improve healthy living and support occ. health schemes. Stress management interventions tailored to the needs of the employees. Supported work for those recovering from mental illness.</td>
<td>Increased employment, and reduction in last employment years due to reduced health service and welfare costs. Costs of programme quickly translate into financial benefits mainly in form of cost savings. Reduction in health costs of depression and anxiety disorders. Improved wellbeing due to reduced financial distress impacts on reduced housing stress etc. Significant reduction in financial distress (M). Reduction in sickness absence.</td>
<td>a) Adopt integrated interventions which combine organisational and individual level approaches. b) Job retention and re-employment programmes which support reemployment and promote the mental health of unemployed people. c) Supported employment programmes and specialist work schemes are most effective. d) Reduce mental health stigma and discrimination in the workplace. e) Support NHS, LA and third sector organisations to develop local interventions to improve healthy working lives, reduce stressors that are beyond the individuals’ control.</td>
<td>Early diagnosis and intervention with employees with depressive symptoms offers good financial return (Reynolds et al., 2005). Adults who are economically inactive are at increased risk of mental illness (Black, 2008). Lack of income may lead to increased housing risk and an increased risk of mental disorder (Weich &amp; Lewis, 1998).</td>
<td>Abbott &amp; Hobby, 2003.</td>
</tr>
<tr>
<td>Meanings group activities. With educational and support input based on participation of older people. Volunteering and peer support programmes for to foster contact between generations. Increasing physical activity in residential care settings and through social prescribing. Ensure staff in leisure centres are appropriately qualified to provide exercise programmes for older people.</td>
<td>Improving the quality of older people’s lives through psychosocial interventions which enhance control, prevent isolation, and enhance physical activity.</td>
<td>b) Improved social inclusion. Effective befriending services would generate significant cost savings. Improved quality of life. Reduced A&amp;E attendances and admissions to hospital.</td>
<td>Successful social prescribing and prescriber training.</td>
<td>(Friedli et al., 2008; Casidy et al., 2008).</td>
</tr>
<tr>
<td>Build collaborative community partnerships based on existing strengths and resources. Use innovative approaches such as social prescribing and mutual volunteering schemes to engage the participation of socially excluded groups. Ensure access to education, learning, arts, leisure, personal development and local support services based on consultation with key stakeholder groups. Place-shaping by LAs to create opportunities for people to come together. Primary care can provide good access to advice services for people in middle and old age.</td>
<td>Access to social interventions in primary and community care pathways eg. through social prescribing - specifically volunteering, including time banks, exercise arts and creativity, learning and educational opportunities, and green activities. Signposting to key welfare advice, particularly employment, provision of support for benefit uptake, debt advice, financial literacy and information and self help. Debt counseling and advice.</td>
<td>Self help groups and peer support effective in reducing social isolation/loneliness and provide meaningful occupation locally, leads to increased quality of life through social interaction and having practical needs met. Improved mental and physical health. Improved confidence, sense of community, social cohesion Increased levels of social support and caregiver skills. Reduced demands on primary care and reduced levels of antidepressant prescribing. Self-management and healthy behaviours. Increase in benefits through providing access to benefits advice in GP surgeries.</td>
<td>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.</td>
<td>Etnier et al., 1997.</td>
</tr>
<tr>
<td>Multi-component interventions that integrate skills development and training of teachers and parents supported by specialists (see areas 1 above) Key role of primary care and the wider health and social care services to offer a holistic approach to abuse with an understanding of the contribution of violence and abuse to health and social care problems. Reducing the availability and harmful use of alcohol. Victim identification and care and support programmes.</td>
<td>Implementing initiatives to prevent, identify and respond to emotional, physical and/or sexual abuse.</td>
<td>b) Reduced levels of mental health problems and physical injuries as a consequence of abuse. c) Reduced crime, aggression and violence. d) Improved long term self-management of other conditions.</td>
<td>Improve mental wellbeing through universal access to lifestyle programmes to reduce smoking alcohol use, substance use, and obesity. Universal access to lifestyle programmes. Targeting higher risk groups, for example people with a mental illness or learning disability, older people and pregnant women. Target people with disabilities that are known to be at risk of depression.</td>
<td>Blything et al., 2001.</td>
</tr>
<tr>
<td>Successful social prescribing and prescriber training.</td>
<td>Tackling alcohol and substance abuse, including screening programmes and direct community mental health with those abusing alcohol.</td>
<td>a) Reduced depression and better self-management of diabetes; reduced dependency on primary care b) Improved physical health and reducing in already. c) Tackling alcohol and substance abuse, including screening programmes and direct community mental health with those abusing alcohol.</td>
<td>Metropolitan trauma intervention in primary care Target problem drinking and alcohol abuse through multi-sectoral action (local authority, health, police, education)</td>
<td>Egan et al., 2008; Abbott &amp; Hobby, 2003.</td>
</tr>
<tr>
<td>Improved physical and mental health behaviour change through brief interventions. Opportunistic health promotion interventions for high risk groups through primary care. Skilled staff oriented to respond to the mental health needs of primary care patients.</td>
<td>Build collaborative community partnerships based on existing strengths and resources. Use innovative approaches such as social prescribing and mutual volunteering schemes to engage the participation of socially excluded groups. Ensure access to education, learning, arts, leisure, personal development and local support services based on consultation with key stakeholder groups. Place-shaping by LAs to create opportunities for people to come together. Primary care can provide good access to advice services for people in middle and old age.</td>
<td>Successful social prescribing and prescriber training.</td>
<td>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.</td>
<td>Etnier et al., 1997.</td>
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<td>Egan et al., 2008; Abbott &amp; Hobby, 2003.</td>
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### 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
### 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 Redditch and Bromsgrove CCG</td>
<td>22</td>
<td>172,435</td>
<td>111,058</td>
<td>0.64</td>
</tr>
<tr>
<td>NHS Sandwell and West Birmingham CCG</td>
<td>107</td>
<td>542,706</td>
<td>669,742</td>
<td>1.23</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 Seisdon 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>
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### Appendix 8

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

| :---: |
| **NHS Trust** |
| **Day Care Services** |
| **Crisis Resolution Team/Home Treatment** |
| **Adult Community Mental Health Team** |
| **Assertive Outreach Team** |
| **Rehab. Recovery Team** |
| **General Psychiatry** |
| **Psychiatric Liaison** |
| **Psychotherapy Service** |
| **Psychological Therapy Service (non-IAPT)** |
| **Young Onset Dementia Personality Disorder Service** |
| **Early Intervention in Psychosis Team** |
| **Forensic Service** |
| **Community Forensic Service** |
| **Peri-Natal Mental Illness** |
| **Eating Disorders/Dietetics** |
| **Substance Misuse Team** |
| **Criminal Justice Liaison and Diversion Service** |
| **Prison Psychiatric Inreach** |
| **Asylum Service** |
| **Other MH Service – in scope of PBR** |
| **Other MH Service – out of scope of PBR** |
| **Day Care Facility Attendance** |
| **Invalid / Missing** |

*Note: Some services may not be included in the PBR*
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 outcomes.

Under the new provider system patients, 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, 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>
</table>
| Birmingham                  | 1,450 adult men               | Mental health inpatient ward
Primary healthcare is provided through BSMHFT and Birmingham Community NHS Trust
Mental Health In-Reach and Substance Misuse services are provided by BSMHFT.
Psychosocial Services are provided by the South Stafford and Shropshire NHS Foundation Trust Drug and Alcohol Recovery Team |
| Black Country Staffordshire | 569 young adult men aged 18–21| 11 bedded mental health inpatient ward providing a regional resource for men up to aged 21
Primary healthcare provider is Staffordshire and Stoke-on-Trent Partnership NHS Trust (SSOTP)
Mental Health In-Reach services are delivered by South Staffordshire and Shropshire Healthcare NHS Foundation Trust
Drug and Alcohol service (DARS) is provided by Lifeline and Delphi Medical |
| Shrewsbury                  | 1,060 adult men               | GP, Primary Care, and Integrated Substance Misuse staff are directly employed by Care UK
12 bedded mental health inpatient ward
Integrated Mental Health Services provided by Care UK and South Staffordshire and Shropshire Healthcare NHS Foundation Trust
Drug and Alcohol service (DARS) is provided by Lifeline and Delphi Medical |
| Dudley Hall Staffordshire   | 315 women aged 18              | The current primary healthcare provider is SSOTP
Mental Health In-Reach services are delivered by South Staffordshire and Shropshire Healthcare NHS Foundation Trust
Drug and Alcohol Recovery Service provided by Lifeline and Delphi Medical |
| Featherstone Wolverhampton | 697 adult men                 | Primary healthcare provider is SSOTP
Mental Health In-Reach services are delivered by South Staffordshire and Shropshire Healthcare NHS Foundation Trust
Drug and Alcohol recovery service is provided by Lifeline and Delphi Medical |
| Hewell Redditch             | 1,261 adult men               | Primary healthcare provider is Worcestershire Health Care NHS Trust (WHCT)
Integrated Mental Health Services and Integrated Substance Misuse Service, incorporating clinical and psychosocial services, provided by WHCT |
| Long Lane Warwickshire      | 622 adult men                 | Primary healthcare provider is WHCT
10 bedded inpatient unit for both physical and mental health needs
Integrated Mental Health Services and Integrated Substance Misuse Service, incorporating clinical and psychosocial services, provided by WHCT |
| Delancey Wolverhampton      | 1,605 adult men               | Primary healthcare provider is WHCT
Integrated Mental Health Service provided by WHCT, with Forensic Psychiatry support from BSMHFT
Integrated Substance Misuse Service, incorporating clinical and psychosocial services, is provided by WHCT |
| Stafford                    | 741 adult men                 | Primary healthcare provider is SSOTP
Mental Health In-Reach services are delivered by South Staffordshire and Shropshire Healthcare NHS Foundation Trust
Drug and Alcohol service (DARS) is provided by Lifeline and Delphi Medical |
| Stoke Health Shropshire     | 766 adult and young adult men aged 18+ | Primary healthcare provider is Shropshire Community Health NHS Trust
Mental Health In-Reach services are delivered by South Staffordshire and Shropshire Healthcare NHS Foundation Trust
Substance Misuse Services provided through a partnership between RAPs (Rehabilitation for Addicted Prisoners Trust) and North Staffordshire Combined NHS Trust |
| Swinhoe Hall Lichfield      | 654 young men aged 15–18      | Primary healthcare provider is SSOTP
Mental Health In-Reach services are delivered by South Staffordshire and Shropshire Healthcare NHS Foundation Trust
Drug and Alcohol services provided by Lifeline and Delphi Medical |
| Warrington Stoke-on-Trent   | 160 young men aged 15–18      | Primary care services provided by SSOTP
CAMHS provision is by ENGAGE (South Staffordshire and Shropshire NHS Foundation Trust)
The Young Persons Drug and Alcohol Support Service is provided by Lifeline and Delphi Medical |

### 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
- BSIPP: Black Country Partnership NHS Foundation Trust
- BSIMHFT: Black Country Partnership NHS Foundation Trust
- CBT: Cognitive Behavioural Therapy
- CMHS: Child and Adolescent Mental Health Services
- CIPD: Chartered Institute of Personnel and Development
- CPA: Care Programme Approach
- CPN: Community Practice Nurse
- CQC: Care Quality Commission
- CRRs: Community Rehabilitation Companies
- CJJS: 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 Recovery Service
- DWMHPT: Dudley and Walsall Mental Health Partnership NHS Trust
- EPS: Early intervention
- EPS: Early intervention for psychosis
- FTB: Forward Thinking Birmingham
- GOOP: Gross Domestic Product
- HSCIC: Health and Social Care Information Centre
- HSJ: Health Service Journal
- IAPT: Improving Access to Psychological Therapies
- IMHA: Independent Mental Health Advocacy
- IMCA: Independent Mental Capacity Advocacy
- IPS: Individual Placement and Support
- JHWS: Joint Health and Wellbeing Strategy
- JSNA: Joint Strategic Needs Assessment
- LA: Local Authority
- LEP: Local Enterprise Partnership
- LOS: Length of stay
- MERT: Mental Health Alliance for Excellence, Resilience, Innovation and Training
- MHA: Mental Health Act
- MHA: Mental Health First Aid
- MMDS: Mental Health Minimum Data Set
- MUS: Medically unexplained symptoms
- NICE: National Institute for Health and Care Excellence
- NOMIS: NOMIS is part of ONS and provides Official Labour Market Statistics
- NSUN: National Survivor User Network
- OAT(s): Out of Area Treatment(s)/Placements
- ONS: Office for National Statistics
- PCT: Primary Care Trust
- PCU: Psychiatric Intensive Care Unit
- QALY: Quality-adjusted life-year
- QOF: Quality Outcomes Framework
- RAID: Rapid, Assessment, Interface and Discharge
- RCT: Randomised Control Trials
- SSOTP: Staffordshire and Stoke-on-Trent Partnership NHS Trust
- STPs: Sustainability and Transformation Plans
- TMG: Think Modern Government
- WHS: Worcestershire Health and NHS Trust
- WHCT: Worcestershire Health and NHS Trust
- WHO: World Health Organization
- WMCA: West Midlands Combined Authority
