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.

The West Midlands

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

The West Midlands Combined Authority

The economic and social costs of poor mental health in WMCA

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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 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 inequalities 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.

We are grateful for the support that we received from stakeholders in the West Midlands, who provided us with information and those who made this possible, often within a demanding timescale.

In particular we would like to thank Dr Lola Abudu, Paul Sanderson and the team at Public Health England West Midlands; Gemma Duggan, National Housing Federation; Professor Jon Glasby, University of Birmingham; Karen Machin, independent service user consultant; Sarah Norman, Dudley Metropolitan Council and lead Chief Executive from the West Midlands Combined Authority supporting the Mental Health Commission; Zoe Page, NHS Benchmarking; Jenny Riley, Birmingham City Council; Sean Russell, West Midlands Police; Dr Geraldine Stratthdee, former National Clinical Director for Mental Health; Jim Symington, Crisis Care Concorde; Professor Jerry Tew, University of Birmingham; Helen Wadayi, Birmingham Mind; Belinda Weir, University of Birmingham; and Sarah Yannoullou and colleagues at the National Survivor and User Network (NSUN). We are also grateful to Steve Appleton for his ongoing support and advice; to the West Midlands Mental Health Commission for funding this work, and to the Rt. Hon Norman Lamb, MP and Chair of the Mental Health Commission for his advice and encouragement. Particular thanks are owed to Liz Maydon, Public Services Academy, and Christian Bohm, HSMC Library, and Creative Media at the University, for their support in the final production of the report.

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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 costs indirectly because large numbers of people with long-term physical conditions, such as diabetes and asthma, also suffer from depression or anxiety which 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 ill health and/or substance abuse is estimated at £0.1 billion a year.

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

Empirical estimates of 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 have been estimated at around £3.9 billion a year equivalent to 31.5% of total costs. These divide more crucially into two important adverse impacts: (i) the costs of 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 their mental ill health condition.

Human costs, representing a monetary estimate of the less tangible but crucially important adverse impact of mental ill health on people’s wellbeing and quality of life, are put at just over £5 billion a year, accounting for 40.5% of the total. This is based on an estimate of the total number of quality-adjusted life-years (QALYs) that are lost each year as a result of mental health problems. The human costs of mental ill health in the WMCA were estimated at just over £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.

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

PRIMARY CARE

- There are 716 GP practices covered by the 15 CCGs in the WMCA. It has been estimated that about one in four adults of a GP’s patients will need treatment for mental health problems but there is substantial variation in practice sizes and the level of mental health needs in each CCG.
- Primary care plays a central role in any prevention strategy because of its provision of universal services, eg, to pregnant women and newborns. Sexual health and sexual and mental health services, as well as approaches for people with long-term physical health conditions, and there may be opportunities to strengthen these at a practice level. It is not clear the extent to which this is happening at practice level or being promoted by CCGs.

EARLY INTERVENTION

- Any general strategy for early intervention should focus mainly on child and young people and aim to reduce the impact of Adverse Childhood Experiences (ACEs), such as abuse or neglect.
- Health and wellbeing hubs being developed across the WMCA are an important strand of enabling people to access appropriate support as early as possible and these need to be complemented by initiatives to engage with socially disadvantaged groups.
- The benefits of early intervention (EI) for young people with a first onset of psychosis are wide ranging and the West Midlands was a pioneer in implementing early intervention services for this group. Such services are provided by three of the four main specialist mental health Trusts and Forward Thinking Birmingham, and the service provided by Worcestershire Health and Care NHS Trust has been identified as positive practice.
- Access and waiting time standards for EI services were introduced in 2015/16 by NHS England and data on performance against this target is only currently available in Worcestershire Health and Care NHS Trust and is not, as yet, comprehensive for the WMCA.

SPECIALIST MENTAL HEALTH SERVICES

- At any given point, around 2% of service users in secondary mental health care will be in mental health inpatient units, the number of beds for older adults.
- There was an average of 185 admissions to psychiatric inpatient beds per 100,000 population during 2013/14, compared with an England average of 227. Admission rates are influenced by a range of factors including social deprivation, 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 number of people held under the Mental Health Act in the WMCA was below the national average at 227 per 100,000 population, slightly above the England average of 227. In 2015/16, 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 bakery; become available; crisis response teams; generic community mental health teams; recovery and wellbeing teams, enabling daily living, problem-solving and coping skills; and 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 perinatal mental health services, with better responses for women of white ethnicity than for women from BAME communities. Organisations in the WMCA have been pioneers in developing innovative models of care and this includes mental health in primary care; early intervention; home treatment; street triage; Rapid Assessment, Interface and Discharge. The WMCA provides an opportunity to scale these up across the area, and to reduce variations in access and uptake of well evidenced interventions.

### Local Authority

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

The Care Act 2014 placed a duty on Local Authorities to promote wellbeing in physical and emotional health, and on the third sector, 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 width 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 Citizen’s 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
- Advisory, 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 addressed.

Mental health awareness training including Mental Health First Aid and suicide prevention training

### Funding 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

In the West Midlands Combined Authority (WMCA) there is a general dearth of research into the nature and extent of need for mental health services. However, a review of need and provision in the Authority is the subject of this report. It 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 strong links between employment and mental health. The DWP-funded Work Choice Programme for people with mental health problems benefited from in Sandwell, Solihull, Coventry, Birmingham, Dudley and Walsall. Employment support, often combined with volunteering opportunities and welfare advice, is frequently provided by the voluntary sector, sometimes the local authority or CCG.

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.

People with a diagnosis of severe mental illness (DSM-IV) 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 36 listed for England and six in the WMCA: in Sandwell and Walsall. However, Birmingham and Solihull Mental Health NHS Foundation Trust introduced a Recovery College in summer 2016 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 life in a college environment.

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; BigLAD (Birmingham Gay and Lesbians against Depression) and First Person Plural for people identifying with complex diagnosis, personality disorders in Wolverhampton; those provided by all the WMCA mental health CCGs; and the Etwall and Ashorne Hub, which is a local authority co-funded with the NHS and provides a better service to people who use mental health services.

### 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 own over a quarter of a million homes, providing social housing or supported housing for people with particular needs. The majority of social 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, care and other accommodation, and what will be funded. The delay on the introduction of this cap is adversely impacting upon the development of supported housing and, if introduced, will mean that 41% of all schemes will become unviable.

In all 24% of adults who are in contact with secondary mental health services and on a Care Programme Approach (CPA), living in inadequate and inappropriate accommodation. This compares favourably with an England average of 59% but there are some outlier areas which could be useful to identify how to improve their performance.

There is a general dearth of research into housing models for people with mental health problems. However, promising evidence for improved health and social outcomes as well as economic benefits, is emerging for Housing First. Housing First services are provided for people who are streetliving or recently housed and provide a better service to people who use mental health services.

### Employment

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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.

### Quality of life for people with a diagnosis of mental illness

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In the WMCA, the average employment rate for people on the CPA was 10%, above the England mean of 7%, but there was considerable variation between the CCGs, ranging from 4%–22%.

There are initiatives underway to promote health and wellbeing at work.

CRIMINAL JUSTICE SYSTEM

- Offenders and ex-offenders are at increased risk of poor mental health and people leaving prison are at an increased risk of suicide and self-harm. Persistent offenders are likely to have experienced severe and multiple disadvantage. Poor mental health and/or substance abuse increases the risk of re-offending, strengthening the case for effective mental health support, including early intervention, family-based approaches and increasing capacity across the criminal justice system to identify and respond to poor mental health.
- Integrated offender management is a key operating approach within the West Midlands Police area and has resulted in the West Midlands being within the lowest ten top areas for reoffending for the last two years.
- There are 12 prisons, including one for women, in the West Midlands. Gaps in provision relating to primary care mental health and counselling have been identified with a recommendation that IAPT is introduced to address common mental health needs for people in prison.
- Problems in obtaining secure beds for people requiring transfer under the Mental Health Act have also been highlighted along with a lack of capacity for prison staff to attend relevant training.
- Initiatives such as WMCA to provide support include: – Criminal Justice Liaison and Diversion Teams provided by the mental health trusts – Prison in-reach teams provided by the mental health trusts – Support for prisoners ‘through the gate’

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

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

- The approach to public mental health and prevention requires strengthening. Overall, there is little evidence of a strategic approach to public mental health and prevention, utilising the adapting the best available evidence. Projects designed to strengthen public mental health are often short-term or at risk of austerity measures.
- Problems in obtaining secure beds for people requiring transfer under the Mental Health Act have also been highlighted along with a lack of capacity for prison staff to attend relevant training. The implementation of promising initiatives, with an evidence base, is key to meeting the West Midlands Mental Health Commission is in a good position to promote the scaling up of the following: personal mental health support; whole school approaches to mental health; targeting families with experience of Adverse Childhood Experiences; Housing First; social and emotional learning in schools; early intervention in psychosis; street trage and expanding IAPT provision to socially disadvantaged groups.
- The third sector promotes an ethos of open doors and spirit, often supporting the most marginalised populations. There are concerns about the impact of budget reductions on this sector in particular, with valued services having to be cut or no longer commissioned.
- There is variation between CCGs and Local Authorities in terms of the range of provision and performance on national performance indicators.

RECOMMENDATIONS

- In order to develop a strategic approach to promoting mental health across the WMCA, the following recommendations are made based on our appraisal of costs and provision across the area.
  1. The intelligence for developing a strategic approach by the WMCA is under developed and the overall quality – and indeed availability – of current and strategic Needs Assessment is very variable. An intelligence hub to bring together local data to provide mental health systems intelligence across the WMCA should be developed.
  2. The approach to intelligence and monitoring needs to encompass both qualitative and quantitative data to understand the real life experience of people with mental health problems. Priorities for support and the outcomes they are seeking to achieve.
  3. Co-production should be a foundation for mental health service transformation across the WMCA and will help ensure that accessible, acceptable and appropriate services are commissioned, developed and delivered to meet the diverse needs of the WMCA population.
  4. It is essential to understand the diversity of the WMCA population, in terms of inequalities in outcomes; perceptions 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 living in contact with a range of public services, with effort duplicated between them. Improving coordination and partnership working for these populations should be a priority.
  6. A strategy for public mental health needs to be developed for the WMCA. Any strategy to improve the mental health of the WMCA population has to invest in the mental health of children and young adults and this will prove to be cost-effective. This includes attention to parental mental health and substance misuse.
  7. There is not a shared understanding of what good primary mental health looks like and different models are emerging across the WMCA. Identifying the components of good primary mental health work should facilitate a coherent approach across the WMCA and ensure that the full potential of primary care is maximised to support people with mental health problems, including people with co-morbid physical health problems.
  8. Organisations and communities in the WMCA have pioneered innovative approaches in mental health that have been adopted outside the area. There are also examples of promising practice in the area where the evidence is incomplete. Where this is the missing, the evaluation of such initiatives will be an important strand 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 by any scale within the WMCA. The implementation of evidence-based practice needs to be understood within the WMCA context and prioritised.
  10. There are clear variations in system performance across the WMCA and the factors influencing both good and poor performance requires investigation and action by the relevant organisations to improve overall system performance.
  11. There should be a commitment by CCGs and the main mental health providers, supported by achievable outcomes, 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.
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 total cost of mental ill health in the West Midlands Combined Authority (WMCA) 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 care with other CCGs or with the Local Authority. The core of the WMCA is the seven metropolitan councils, which are Birmingham City Council, City of Wolverhampton Council, Coventry City Council, Dudley Metropolitan Borough Council, Sandwell Metropolitan Borough Council, Solihull Metropolitan Borough Council and Walsall Council. Together these cover approximately 70% of the population of the three LEPs. The WMCA also covers Sustainability and Transformation footprints for Black Country, Birmingham and Solihull, Coventry and Warwickshire and parts of Staffordshire, Herefordshire and Worcestershire footprints, established to deliver the Five Year Forward View.1

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

POLICY CONTEXT AND THE WEST MIDLANDS

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

- 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, accessing 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 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

The 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 treatment for physical health conditions, two access and waiting time standards were introduced in April 2015 for mental health (Department of Health, 2014), so that:

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

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

- Commissioning for prevention and quality
- Good quality care for all, seven days a week
- Innovation and research to drive change
- Strengthening the workforce
- Transparency and a data revolution
- Incentives, levies 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. Across 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 transformation
- Out of area placements for acute mental health inpatient care transformation

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

THE 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 and planned initiatives (NHS/Local Authority) and voluntary sector mental health service provision in the WMCA to describe current community and inpatient services provided for adults and young people and current performance against key mental health indicators;
- An audit of current or planned initiatives relating to mental health, whether public, private or voluntary sector to include crisis care; housing and related support; employment; recovery colleges; services for 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 is also important to recognise that policies and changes in early and mid-adult life can also impact upon the prevalence of mental health disorders for older adults, including dementia (Hegroothan and Newbrick, 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 evidence on effectiveness and cost-effectiveness for 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 Libration that the WMCA could make to addressing poor mental health and wellbeing for adults of working age.
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 response was extremely patchy and incomplete, use was made of NHS programme budgeting data available to identify CCG expenditure, for 2013/14 and published in August 2015. Personal Social Services Expenditure and Unit Costs for Councils in England for 2014/15 for spending by Local Authorities. Where local cost data has not been readily available, other – usually national – sources have been drawn upon, and where possible the contribution that the WMCA could make to addressing poor mental health and wellbeing for adults of working age in the three LEPs. It is also important to recognise that policies and changes in early and mid-adult life can also impact upon the prevalence of mental health disorders for older adults, including dementia (Hegroothan and Newbrick, 2013).

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); 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 interventions provided for adults and young people in the NHS and current performance against mental health indicators. The data from these sources have been collated and combined to provide a comprehensive and consistent data set for use in the analysis. The data included in the analysis included both local authority and voluntary sector services. The analysis of the mental health needs across the WMCA and the local authority of mental health needs assessments is variable and differs in format. While a mental health needs assessment was outside our brief, we have provided a brief overview in order to contextualise the expenditure and data on provision. Finally, despite support from the Commission’s Steering Group, Public Health England West Midlands and Birmingham Mind, some organisations have been slow to respond or have not provided the necessary information. Feedback suggests that the timing of this exercise, coinciding with the end of the financial year and the introduction of Sustainability and Transformation Plans (STPs) for the NHS, was problematic. However, it may also indicate a lack of awareness and understanding of, or resistance to, the aims of the Commission.

Intelligence about the local system is vital to developing a strategic plan. There is a site hosted by Public Health England’s Knowledge and Intelligence Team (West Midlands), which provides health profiles for the Local Authorities within the WMCA and mental health-specific information is available via the Fingertips Tools and the National Mental Health, Dementia and Neurology Intelligence Network, sponsored by NHS England. This provides a basis to develop an intelligence hub to bring together local data to provide systems intelligence across the WMCA.

**THIS REPORT**

This report provides a baseline of costs, service provision and initiatives across the WMCA. Our hope is that it provides a living document for the West Midlands Mental Health Commission and its partners to develop further. The report is organised in three sections, which: (1) provide an overview of mental health in the WMCA; (2) identify the social and economic costs of mental ill health in the WMCA; and (3) provide an overview of current service provision and identify current and emerging promising practice. Inevitably, the service data presented in this report is skewed towards specialist mental health provision because this data is most readily available, whereas that relating to primary care is relatively scant.

### THERE ARE STRONG LINKS BETWEEN MENTAL HEALTH AND SOCIAL/ECONOMIC CONDITIONS

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 Combined Authority. First, while the research evidence points to promising interventions, it is clear that their implementation in a WMCA context is patchy, for reasons that are not always clear. Second, the available research evidence never provides the full story and there are examples of innovations and promising initiatives that are being developed but have yet to be scaled up or evaluated. Third, the implementation of promising practice raises questions about fidelity to the model and the role of contextual factors, particularly in a context of co-production.

### MENTAL HEALTH OF THE WEST MIDLANDS COMBINED AUTHORITY

#### POPULATION

There are an estimated 4,032 million people living in the Combined Authority area (2014/15 data) corresponding to 70.6% of the population in the West Midlands Region; 7.4% of the population in England and 6.2% of the population in the UK. The population is projected to increase by 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 figuredoes obscure 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 (3) and a younger profile than the English average, compared to 23% for Cannock Chase and 27% for Stratford-upon-Avon and Tamworth. None of the population groups are homogenous and understanding differences within population groups is important for developing approaches to improving the mental health of the population (see for example: Newbigging, Bola and Shah, 2008) and ensuring that inequalities are not embodied in the development of a strategic approach by the West Midlands Mental Health Commission.

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

#### PREVALENCE OF MENTAL HEALTH PROBLEMS IN WMCA

The National Psychiatric Morbidity Survey identified 23.8% of all adults in the West Midlands Region with some kind of mental health problem, compared with 23.0% in England as a whole (McManus et al., 2009).

Any survey of the household population is likely to underestimate prevalence, as people with psychosis and alcohol dependence are more likely to be homeless or reluctant to answer questions.

There are strong links between poor mental health, smoking, alcohol and substance use. People with mental health problems are more likely to smoke (McManus et al., 2007) and most people using substance misuse services have mental health problems, with co-morbidity being highly prevalent in community mental health teams populations (Weaver et al., 2003). In the West Midlands in 2014/15, approximately a fifth of people in contact with mental health services were also in contact with alcohol (23.4%) and/or substance misuse services (18.6%) (9).

### Figure 1: A population perspective to improving mental health

(Heghrobothen and Newbigging, 2013 adapted from Barry and Jenkins, 2007)
In the West Midlands, in 2015, there were 477 deaths recorded as suicide, which was 9.6 deaths per 100,000 population, lower than the rate for England at 10.9%. The rate for men in the West Midlands was 15 deaths per 100,000 population, slightly lower than the England average but more than three times higher than for women at 4.1 deaths per 100,000, broadly in line with national trends. As illustrated in Figure 2, there is a slight downward trend for women but an upward trend for men in the number of suicides reported from 2010 to 2013, but figures for 2015 show a slight decrease in the rate for men and an increase for women.

Socio-economic inequalities in suicide risk are evident. A thematic review by the Samaritans identified that middle-aged men in lower socio-economic groups are at particular high risk of suicide (Wylie et al., 2012). The research indicates a complex interplay of factors including unemployment and economic hardship, lack of close social and family relationships, restricted options of self-harm, 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 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 (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 provide 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 (i.e. 20%) reported ever being 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 illness compared with 23% and 11% of men. It is important to note that there are gender inequalities in alcohol and substance abuse (and suicide) which more adversely affects 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 in both women and men are strong, with particular associations found between experiences of domestic violence and poor mental health. This may be due to the correlation between domestic violence and poor mental health but it may also be that women are more likely to seek help and support as noted above, while men are less likely to do so. The message that one in four of the adult population suffer from a mental health problem is important in promoting services but also in promoting and encouraging the use of mental health services. However, as observed above, the risk of developing a mental health problem, and, therefore, having specific needs that they are framed as, are not equally distributed across the population. Homogenising the risks in this way may result in the risks above, specific 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, eg, veterans, who 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 to 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 undermines the importance of a life course approach and the early years as being a critical opportunity for intervention. No 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; Heghobrath 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; Vanese et al., 2010). 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 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. This includes unaccompanied asylum seeking children, which increased by 9% between 2013 and 2014 and by 29% between 2015 and 2016. The number of children and young people in Local Authority care at the end of March 2016 was 5,233 in the constituent Local Authorities in the West Midlands area. In 2014/15, the mean rate of statutory 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 have 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 2010, 25% of people who are homeless and 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 history; and in 2014, 22% of female care leavers became teenage parents (National Audit Office, 2015). Young people leaving care are four to five times 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). Research has indicated that children in care have 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 2010, 25% of people who are homeless and 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 history; and in 2014, 22% of female care leavers became teenage parents (National Audit Office, 2015). Young people leaving care are four to five times 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.24 However, China is well-represented, 8% of student population and most asylum seekers come from Iraq, Iran, Somalia, Afghanistan, Pakistan, Sudan, Ethiopia, Eritrea, Congo and Latvia etc. 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 communities, which is the fastest growing community in Birmingham.

The National Psychiatric morbidity survey in 2007 and even more recently (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., 2010). 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 and over a third have had successive care as a consequence of abuse or neglect. People from these communities have particularly low treatment rates (McManus et al., 2016). The focus is often on Black/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 overdose under the Mental Health Act (MHA) (see the section on specialist mental health services); 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 inequities 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; and Higher rates of unemployment, with African and Caribbean men and those from Asian 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 participating 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 4,45425 asylum seekers on Section 95 living in the WMCA, with 42% living in Birmingham, including 75 unaccompanied minors under Local Authority care; 19% in Sandwell; 16% in Walsall and 5% in Dudley.26 Refugees are people whose 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 (Phillipson 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 (Alisopp et al., 2014; Hollander et al., 2016; Alisopp 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 homeless people or people from poor housing was 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 and housing, with housing costs having a significant impact on poverty and material deprivation (Tunstall et al., 2013). Poor housing conditions affect the mental health and wellbeing of children and adults and the links between homelessness and poor mental health and substance abuse are well established, although there is debate over the direction of this relationship. Higher levels of mental troubles were found in places where people lived in an area perceived to have an attractive pleasant environment and to have good reputation; and satisfaction with the house and landlord (Bond, 2012). Conversely, poor quality housing overcrowding and noise; multiple occupancy and temporary accommodation; lack of choice over housing; high rise housing and limited access to green spaces and open spaces; unsafety; and dissatisfaction with all contributed to poor mental health (as summarised by Boardman, 2015).

26 86% of the total in the West Midlands area.
28 Of the total in the West Midlands area.
29 2nd 3rd 4th Lowest quintile (i.e. 20%)
30 (Cooper, 2010).
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 (and 50–100 times greater for people who are street homeless) compared with the general population (Homeless Link, 2014). As substance abuse problems are also common, it is estimated that 10–20% of the homeless population would fulfil the criteria for a dual diagnosis of mental illness and substance abuse, with nearly half using drugs and alcohol to cope with mental health problems (Homeless Link, 2014). Mental health services have traditionally been reluctant to provide care and support to people with a dual diagnosis and this should be a focus for further inquiry by the Commission.

The rate of rough sleeping has increased by 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 England as opposed to the three LEPs, between January and December 2015. The average rate was 6.6% of the 16–64 population ranging from 2.9% for the Coventry and Warwickshire LEP to 8.8% for the Black Country LEP, compared with an England average of 5.3% 27.

People who have been unemployed for more than 12 weeks show between four and ten times the prevalence of depression and anxiety and are also more likely to kill themselves (Waddell and Burton, 2006). Poverty and unemployment tend to increase the duration of common mental health problems and debt and financial strain, which can arise from job loss, are also associated with common mental health problems (McManus et al., 2007).

Unemployment is also a risk factor for substance abuse (Henkal, 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 Staffordshire 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 166,383 young carers, including 9,371 aged between 5– and 17-years old (Young Carers in Mind, 2013). This is an underestimate as many young carers go unrecognised by services and receive no support (Becker, 2012). They are just as likely to be a boy as a girl; one and half times more likely to come from a BAME background and twice as likely not to have English as their first language (The Children’s Society, 2013). Their needs often go unrecognised, although they may miss school, have lower educational attainment and may themselves have a long-standing illness or disability (The Children’s Society, 2013).

6. Lesbian, Gay, Bisexual and Trans people

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

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

7. People with long-term physical health conditions

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

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

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 (Coed, 2010).
People in custody are particularly vulnerable to poor mental health. The total prison population in the West Midlands on 31 December 2014 was 9,443. Eleven of the prisons are for men. Women comprise 3.32% of the prison population in the West Midlands. Women from men in prison. Women are 18 times more likely than the national average of 6%. The rates of self-harm and suicide within prison are on an upward trend (Offender HNA and Consultancy Projects, 2015) and young men are 18 times more likely than the general population to take their own lives (Offender HNA and Consultancy projects, 2015).

The Corston Report (Home Office, 2007) highlighted the very different needs of women from men in prison. Women with histories of violence and abuse are over-represented in the criminal justice system; they commit different offences from men; prison is disproportionately harsher for women because they have been designed for men, and women are far more likely to be primary carers for young children and men, making the prison experience significantly different for women. Mental health problems are associated with services. Mental health and/or substance abuse, the risk of re-offending is increased and there is a clear need for effective mental health support for this population.

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 than men 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.

**People experiencing violence and abuse**

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.

**People experiencing severe and multiple disadvantage**

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

**Understanding mental health assets and needs**

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

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

**Co-production and user engagement**

Co-production means shifting the balance of power and expertise from public services and professionals towards local people and service users and carers so issues and solutions are jointly considered and solutions co-designed, and may be co-delivered (Needham and Carr, 2009). This builds on an established tradition of service user and carer involvement but is more radical in its ambition and consequently more challenging for public services and local people (Sewell 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, which 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 provide (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.
Many organisations in the WMCA express a commitment to co-production and this is particularly challenging for public services who are working within a national policy and a local political context. In a mental health context, a token commitment to co-production will perpetuate services that have little efficacy and are perceived as unhelpful, controlling or profoundly damaging (Needham and Carr, 2009). Co-production initiatives in the WMCA include:

- Every Step of the Way (ESOW), is a key strand of the Changing Futures Together (CFT), a seven-year lottery funded project (£1.1m) designed to not only support some of the most complex needs of people in Birmingham but also to ensure system change. Birmingham Mind are delivering the service user involvement strand of ESOW and this involves training up 120 Experts by Experience and 30 Involvement Champions each year and matching them with opportunities within the CFT programme and in wider systems.

- Experience-based co-design of hospitalisation in early psychosis in Coventry and Warwickshire Partnership NHS Trust. This project piloted this collaborative approach between 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).

- 300 Voices**, a partnership between Birmingham and Solihull Mental Health NHS Foundation Trust, West Midlands Police, Birmingham City Council and Time to Change that seeks to engage with young African and Caribbean men aged between 18 and 25 to engage with communities and hear experiences of inpatient and outpatient care. Although funding ended in March 2016, there are a number of legacy projects being taken forward (see Appendix 4).

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

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

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

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

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

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

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**See: http://healthwatchdudley.co.uk [accessed 270716]

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


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

**www.nsun.org.uk/membership/members-platform-mad-alliance

24 Mental Health in the West Midlands Combined Authority

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

ESTIMATING COSTS

Mental health problems have high rates of prevalence; they are often of long duration, even lifelong in some cases; and they have adverse effects on many different aspects of people’s lives, including their education, employment, social participation, personal relationships and physical health. No other health condition matches mental ill health in the combined extent of prevalence, persistence and breadth of impact. Despite this, the majority of mental health problems go 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 or physical health, wherever it falls and whether or not it is conveniently 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.

All provided are some broad illustrative estimates of the 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; Brooker 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 apportionment 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 inpatient beds, 23.8% of all adults in the West Midlands Region (taken as a proxy for the WMCA) experience some kind of mental health problem, compared with 23.0% in England as a whole (McManus et al., 2009). Prevalence is thus slightly higher than the national average. Secondly, among all people in work, average pay in the West Midlands in 2014/15 was 7.5% below the England average and 6.3% 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 emergency 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. In particular, because of physical/mental health co-morbidities and medically unexplained symptoms, both of which add greatly to NHS spending on physical health care.

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 (eg, diabetes and depression) leads not only to worse health outcomes but also to greatly increased costs of treatment and care for the physical complaint. The scale of this increase is estimated at around 45–75% per case, based on costs measured after adjustment for the severity of physical disease (Naylor et al., 2012). Taking 60% as a mid-point, this implies that on average the NHS spends an extra £2,000 a year on every individual patient who has co-morbid physical and mental health problems as against a physical condition on its own.

(Average costs per patient are estimated at £6,600 a year in the former case and £4,000 a year in the latter.)

At the aggregate level, given the evidence reviewed in Naylor et al. that there are altogether about 4.6 million people in England with a long-term physical health condition and a co-existing mental health problem, extra spending on physical health care because of mental health co-morbidities costs the NHS no less than £1.1 billion a year, equivalent to 1% of the total health service budget.

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

Taken together, these estimates for the aggregate costs of co-morbidities and MUS imply that in England as a whole the NHS spends at least as much on dealing with the indirect consequences of physical health problems as it does on the direct provision of services for people with diagnosable mental health problems. In addition, the extra costs of physical health care linked to poor mental health come to around £14.25 billion a year in England, and an apportionment of these costs on the basis of population numbers, adjusted for differences in the relative prevalence of mental health problems, implies additional NHS spending in the WMCA of around £0.919 billion a year.

2. Social care costs

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

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

3. Other public sector costs

A recent national study of the public sector costs of mental ill health carried out for the NHS England Mental Health Taskforce identified mental health-related expenditure of around £9.2 billion a year in England on public sector programmes other than health and social care (Bristol Consulting Group (BCG), 2015). Some £7.5 billion of this was accounted for by social security payments, discussed separately below. The remaining £1.7 billion was made up of relatively small amounts of spending in a number of different areas including; schools (£285 million), Educational Needs Assessment (ENA) (SEN) pupils with behavioural, emotional and social difficulties; criminal justice (£160 million), policing (£60 million) and sentenced offenders (£20 million) in prison; 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, results in an estimated annual cost of £0.13 billion. A further adjustment is made, drawing on evidence not considered in the BCG study which suggests that less than half of all mental health spending in schools is SEN-related, with the bulk going on
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 striking 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 increasingly falls in the post-reirement 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 have to reduce 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 are in work and worse mental health when they are out of work. The longer they are workless, the more damaging the consequences for the mental health, even leading in some cases to suicide. For people with mental health problems, work can be therapeutic. A return to work improves mental health by as much as the loss of employment worsens it. Some aspects of the work environment can of course pose a risk to mental health and wellbeing, for example excessive hours, work overload or lack of control, but the overall balance of evidence is that work is not in doubt: work is good for mental health. The benefits of employment greatly outweigh the risks, which are very heterogeneous and can result from work-related stress with harmful effects of long-term worklessness.

Estimates of the employment-related costs of mental ill health in the WMCA are set out below, dealing first 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

Calculating the total cost of mental ill health working-age adults with a mental health condition have a job and are almost as likely to be working as anybody else. On average, employed people suffer a 21.6% reduction in life expectancy, rising to around one in five if some substance problems are also included. The consequences of this may take a variety of forms, but from a cost perspective the most important relate to sickness absence, presenteeism (the loss in productivity that occurs when employees come to work even when unwell and consequently function at less than full capacity) and staff turnover.

Taking these in turn, survey data indicates that in 2014 employees in the UK took an average of 6.9 days off work for health reasons (CIPD, 2015). Evidence from a range of sources suggests that at least 40% of these days are for mental health reasons – and the true proportion may be even higher, for example because it is known that some commonly recorded causes of sickness absence are often a result of mental ill health or stress. The consequence is that in the UK we have overestimated the costs of worklessness in the WMCA.

According to one review of the available evidence, it is conservatively estimated for the UK that among employed people with mental health problems presenteeism accounts for 1.5 times as much working time lost as sickness absence (Centre for Mental Health, 2007). In addition, the average employer cost per day lost because of presenteeism is higher than the equivalent cost for sickness absence, as the wage rate that is commonly observed between earnings and rates of sickness absence (i.e., lower-paid workers taking more time off than higher-paid workers) is not found in the case of presenteeism. A reasonable central assumption is that the national average cost of presenteeism is around £165 per day, corresponding to average gross daily compensation per employees in the UK.

Taking together these assumptions imply that the total cost of mental health-related presenteeism is higher than the corresponding cost of sickness absence. Application of this ratio in the WMCA context results in an estimated annual cost of presenteeism for the area of around £0.005 billion.

Finally, concerning staff turnover, about four million jobs change hands each year in the UK, with mental health problems accounting for a substantial proportion. Based on data from the on the costs of staff turnover given in the Centre for Mental Health review cited above, the average cost of staff turnover is £1.72 billion a year. Adding together the above costs of sickness absence, presenteeism and staff turnover, it is calculated that the aggregate cost of lost output because of mental health problems is £1.72 billion a year in the WMCA.

2. Employment costs among people not in work

In 2014/15 there were 662,000 working-age adults in the WMCA categorised as economically inactive, accounting for 26.1% of the overall population in this age group (ONS, 2016a). Within the total, 143,000 (21.6%) were inactive because of long-term health. Local information is not available on the numbers who were long-term sick for mental health reasons, but use can be made instead of national data on the reasons why people claim Employment and Support Allowance to measure the cost of sickness absence. Using the employment rates for people of working age, and this shows that in 2014/15 nearly half (48.8%) did so because of mental health problems (DWP, 2016a). Payment of benefit for sickness absence in the WMCA is therefore calculated to be £2.45 billion. Given the number of assumptions involved 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 and published in its in-work in the global burden of disease. These figures are based on a composite health measure, the disability-adjusted life-year (DALY), which combines the incidence of mortality and premature mortality with equivalent years of life lost from disability and morbidity. DALYs are considered more appropriate than the quality-adjusted life-year (QALY) which is used by NICE and others in this country for the evaluation of health service interventions. The main practical difference between the two is that the numerical weights attached to different levels of disability and morbidity are based on the opinions of experts in the DALY and on the opinions of the general public in the QALY. Both concepts seek to combine the adverse effects of ill health on the quantity and quality of life in a single measure and they provide a key building block for the global burden of disease. DALYs are calculated by taking the number of years of life lost or years lived with disability, multiplied by 100 to give a 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 worklessness in the WMCA on this method of estimation comes out at £2.45 billion. Given the number of assumptions involved in both cases, this is reassuringly similar to the figure of £2.2 billion given above.

The aggregate cost of lost output because of mental health problems among employed people in the WMCA is about £1.72 billion a year.

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Further detail on the cost of informal care available in Buckner and Yeandle (2011).
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 health service interventions are good value for money and is also consistent with the rule of thumb set 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 DALY’s 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 £6.075 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 DALY 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 do not reflect 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 under-estimates the value of mental health, certainly relative to physical health (Blockerman et al., 2011; Fujinara and Doián, 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. At major types of offending have declined at broadly comparable rates, including both violent and non-violent crime. Despite this welcome fall in offending, crime continues to impose huge costs, most obviously on individual victims but also on the rest of society. Comprehensive estimates of the costs of crime were first published by the Home Office in 2007 (Brand and Price, 2000) and partially updated five years later (Dubourg et al., 2010). These show, for example, that the total cost of crime in England and Wales in 1999/2000 was around £60 billion. This covers not just costs falling on the criminal justice system but also – and much more importantly in quantitative terms – costs falling on the victims of crime, including the value of stolen or damaged property, losses in earnings associated with crime-related injuries etc., and an imputed monetary value of the additional and psychological 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 by 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 in the same as, an appropriate cost 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

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

(i) Total costs;
(ii) GDP costs, including only those cost components which are covered in national as 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 £3,310 per head of population. The breakdown is as follows:

Table 1: Cost of mental ill health to the WMCA

<table>
<thead>
<tr>
<th>Costs</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 £20.755 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 receive no allowance in out-of-work benefits at £30/week. The cost to the economy of this change is £200 a week, representing the full cost of the output that is lost. Of this, £120 is borne 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
employment cost of £200 and the benefit cost of £380. Put another way, there is an important distinction to be made between the cost of an output loss and who pays for it.

2. GDP costs

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

The aggregate GDP cost of £6.355 billion a year is equivalent to an annual cost of around £1,175 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, 2016b). 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 including social security 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 £2.955 million a year. On this basis, total exchequer costs come to around £0.725 billion a year.

LIFETIME COSTS

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

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

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

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

1. Perinatal depression and anxiety

Evidence from a range of sources indicates that around 15–20% of all new or expectant mothers suffer from clinically diagnosable depression or anxiety at some point during the perinatal period, defined as the period during pregnancy and the first year after childbirth. Most attention has been 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. Over a minority of women, 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 their 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 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.

THE HIGH DEGREE OF CONTINUITY BETWEEN ADVERSE MENTAL HEALTH STATES IN CHILDHOOD AND THOSE IN ADULT LIFE SUGGESTS THAT A VALUABLE WAY OF ANALYSING THE COSTS OF MENTAL HEALTH PROBLEMS IS OVER THE LIFETIME

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., 2006). Most attention has been 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. Over a minority of cases of 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).

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An unsurprising consequence of this array of negative outcomes is that conduct disorder imposes a very heavy cost burden. One study which followed a sample of children from age ten until they were 28 found that the cumulative cost of public services used by those who had conduct disorder at age ten was around £390,000 per head higher in today’s prices than among those with no problems, equivalent to extra spending of around £5,000 a year (Scott et al., 2001). About two-thirds of the additional cost fell on the criminal justice system, with most of the remainder being divided between the education sector and health and social services.

Another study has attempted a broad-based estimate of the lifetime costs of conduct disorder measured from a societal perspective, covering the costs of adverse outcomes relating to mental illness, drug misuse, smoking, suicide, earnings, offending, early death, arrested crime (Friedi and Parsonsage, 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.
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 hospital services; 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.

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 Concorde.

Mental Health First Aid (MHFA) was introduced to England in 2007 as part of a national approach to improving public mental health and has been provided for young people, in schools, in workplaces and with front-line services as well as members of the general public. MHFA is being commissioned in the WMCA across England, and in the WMCA this includes staff from Accord Housing Association Ltd.; Birmingham City Council; Birmingham Mind; Birmingham and Solihull Mental Health NHS Foundation Trust; BITA Pathways; Community Wellbeing Solutions (own company); Coventry and Warwickshire Mind; Coventry University; Dudley MBC; Dudley Mind; Kaliedoscope Pl; Kidderminster JobCentre Plus; Kidderminster's 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.

1. Provision in the WMCA

These interventions are targeted at the general population and designed to promote public mental health and wellbeing, and tackle stigma surrounding poor mental health. It is recommended that they should adopt a life course approach, and be based on the best available evidence (Davies, 2013). Initiatives to promote public mental health may be part of a wider approach for example programmes in prison or in planning urban spaces and are, therefore, not always easy to identify. For the majority of Local Authorities, mental health is included as part of Health and Wellbeing strategies with a small minority having developed a mental health strategy, for example, Warwickshire48.

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 Nuffield Trust’s Audit is detailed below. It is also evident that the voluntary sector plays an important role in providing preventative 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 Wolverhampton49.

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

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

2. Performance against national indicators

There are two main indicators that are currently being used to evaluate mental wellbeing: the ONS subjective wellbeing and the Warwick Edinburgh Mental Wellbeing Scale (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, as for example the evaluation of the Esteem Team, an integrated primary care mental health and wellbeing service in Sandwell (Thel 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 201150. A summary of the data from 2011–2014 indicates that the overall average for the highest levels of personal wellbeing on the Life Satisfaction item, range from 14.7% of the population in Wolverhampton to 28.75% of that in Newham, compared with 26.69% of the overall UK population. Other Local Authorities which were below the national average are Coventry (19.59%) and Birmingham (19.98%). The highest levels of Life Satisfaction across the UK were reported by Pakistani and Bangladesh communities (29.2% and 27.58% respectively), with the lowest levels reported by Black African Caribbean and Black British People (19.81%) compared with 26.95% of the White population. There is a similar pattern of results for Local Authority CCGs; however, this is only a partial picture of the Happiness item, although a much more mixed picture on the other scales (Anxiety and Feeling is worthwhile).

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 of people 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.

49 www.biglotteryfund.org.uk/heartheartprojects [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 to influence 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 healthcare (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 and responding to emotional, physical and/ or sexual abuse
- Improving public health (e.g. support for unemployed) b) creating healthy working environments c) early recognition and intervention for those with mental health problems d) supported work for those recovering from mental illness
- Integrating physical and mental wellbeing through universal access to lifestyle programmes to reduce smoking and alcohol use, substance use, and obesity
- Tackling substance abuse 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 multisection 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 presenting with mental health problems and in particular through the introduction of street triage and liaison and diversion services. This is discussed in more detail later in this report.

2. Fire Service

The West Midlands Fire Service is making vulnerable people its priority, with a strong emphasis on prevention. While this has been a long-standing aspect of the Fire Service’s role through Home Safety checks, these were extended in 2015 to include advice to help people improve their health and wellbeing. Known as Safe and Well visits, if the resident agrees, operational firefighters will cover a range of topics that include mental health, weight, exercise and healthy eating, social isolation, loneliness, hoarding and employment62.

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 prescription63
- 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 Chatterjee, 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 therapies64. 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 Conference, and Wellbeing Hub). In some instances, third sector organisations have been commissioned and provided this alongside peer support or one to one support (see for example the Wellbeing Hub provided by Birmingham Mind). Information about mental health and wellbeing is increasingly available through the development of electronic resources (see for example Warwickshire’s Health and Wellbeing Portal65).

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)66. 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). Estimated numbers and types of mental health problems for a practice serving 2000 patients is:

- It is estimated that a practice of 2000 patients will have:
  - 352 people with a common mental health problem
  - 352 people with a common mental health problem below the diagnostic threshold
  - 8 people with psychosis
  - 120 people with below the diagnostic threshold for psychosis
  - 120 people with alcohol dependency
  - 120 people with drug dependency
  - 176 people with a personality disorder

2. Performance against national indicators

Primary Care Prescribing

According to NHS England, the primary care prescribing for mental health is £12 per head in the WMCA, compared with a national average of £13 (NHS Benchmarking, 2016)67. 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.

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

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 estimation 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.

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

64 www.wmca.net/news-safe-and-well-visits [accessed 15/08/16]
65 http://reading-well.org [accessed 15/08/16]

https://apps.warwickshire.nhs.uk/PublHealthDr [accessed 15/08/16].
See: www.nhsbenchmarking.nhs.uk/CubeCore/uploads/2014/03/d-nph-mental-health.xlsx for data and information on the components of this indicator [accessed 15/08/16].
Mental Health in the West Midlands Combined Authority (HSCIC, 2015b). It is interesting to note time from referral to the first treatment. The CCG with the shortest average waiting time is Wyre Forest, whereas in other areas, the capacity may not be able to keep pace with the demand. 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 do 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.

3. Redesigning primary care mental health services

2016). It is interesting to note that despite Walsall having the highest number of referrals per 100,000 population it is also has one of the highest rates for people seen in less than 28 days in 2014/15, broadly similar to the pattern for 2013/14.

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

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4. The IAPT programme for children and young people differs from that for adults in being geared towards training staff to embed IAPT in Child and Adolescent Mental Health services (CAMHS). See: www.england.nhs.uk/mentalhealth/cyp/iapt// [accessed 150816].

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 service arrangements at level of need and referral rates. For example, Birmingham South and Central CCG (need index = 1.56) has a lower rate of referral than Wyre Forest (need index = 0.66). 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 69% in 2014/15. This is considerably lower than the bottom 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.

As well as responding to expressed need and intervening early, primary care has a central role to play in any prevention strategy because of its provision of universal services, eg, to pregnant women and new mums, sexual health and screening services and to people with long-term physical health conditions and there are opportunities to strengthen these at a practice level.
Health trainers to support lifestyle
Optimise initial experience of Mental Health in the West Midlands Combined Authority
A GP to Consultant Helpline to help Adults with psychosis or schizophrenia being offered combined healthy eating in the community. These include:

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

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

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

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

There is a range of other initiatives to support and develop the capacity of primary care mental health including: Health trainers to support lifestyle changes. Social prescribing, which includes GPs prescribing exercise, books, art, museums, computerised Cognitive Behavioural Therapy (CBT); educational activities; green gym; museums; social enterprise schemes; time banks; supported employment and volunteering. A wide range of benefits have been identified for social prescribing including increases in self-confidence and esteem; improvement in psychological wellbeing and positive mood; reduction in anxiety and depression; improvements in physical health and reduction in GP and primary care visits; reduction in social isolation; improved motivation and meaning in life and acquisition of new learning and skills. Social prescribing is, for example, linked to GP Practices in Dudley, while Solihull has a Social Prescribing Team and offers a ‘personal buddy’ to help people to identify social activities to improve their health and wellbeing. A GP to Consultant Helpline to help improve the liaison with GPs and ensure speedy access to clinical advice, introduced by Coventry and Warwickshire Partnership Trust.

A single point of access is run by Birmingham Solihull Mental Health Foundation Trust for all CCGs for GPs to refer for secondary care assessment. Primary care liaison teams to deal with non-urgent referrals from primary care provided by Black Country Partnership NHS Foundation Trust.

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

![Figure 8](https://example.com/figure8.png)

### Early Intervention

The general principle of early intervention in mental health is widely promoted and its application can be seen in the Health and Wellbeing Hubs; Mental Health First Aid training; Street Triage; and Liaison 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, with Birmingham and Solihull Mental Health Foundation Trust (BSMHTF) introducing the first EIP services in the UK in Birmingham (Birchwood et al., 2013; Lester et al., 2009). These services are a crucial element of improving outcomes for people with severe mental illness and are 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 across the West Midlands and highlighted some of the difficulties with implementation and variation across the Region (Birchwood 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 to Forward Thinking Birmingham in April 2016. Forward Thinking Birmingham is a partnership between Children’s Hospital NHS Foundation Trust, Worcestershire Health and Care NHS Trust, Black Country Partnership Foundation Trust, Priory Group and a number of CCGs in the Birmingham area. The EIP teams are located in Birmingham City Council (North Warwickshire CCG), Leamington Spa (South Warwickshire CCG); Walsall and Dudley; West Bromwich (West Birmingham CCG); Solihull and Wolverhampton. Guidance has also been developed for GPs on the early identification and management of psychosis (Merida Associates, 2015) but the extent to which this has been implemented across the WMCA is unclear.

### 2. Performance against national indicators

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

- Prevent psychosis in the ultra-high risk individuals by identifying and intervening on coup de grace psychosis
- Reduce the duration of untreated psychosis by promoting early detection and engagement by providing psychosis awareness raising for 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 integrated biopsychosocial interventions; focusing on functional/vocational as well as symptomatic recovery; addressing social exclusion and providing support for people in resistance early and supporting carers and network of community support agencies
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 CCQ has identified that mental health crisis care provision is both inconsistent and inadequate (CCQ, 2015a). Resonating with the findings from a survey of service user and families’ experiences of crisis care (McPir, 2015), the CCQ 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 when they receive it (CCQ, 2015a).

The opportunities for crisis intervention identified by the Crisis Care Accordat (HM Government, 2014) are:
- Access to support before a crisis through provision of information, preventative 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 Accordat, established in 2014 provides a map of services and organisations that have agreed to work together, to make sure that people get the help they need when they have a mental health crisis, and action plans of the necessary steps needed to improve local access. The action plans are developed collaboratively by local authorities, local 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. They reference other initiatives, particularly 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 Accordat 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 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 CCQ 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 (CCQ, 2015b).

PROMISING PRACTICE: CRISIS HOUSES

Crisis houses provide an alternative to inpatient wards and there is a growing body of evidence that not only do service users prefer residential crisis houses, mainly provided by the voluntary sector, they are also safer and easier for staff to manage (Howard et al., 2002; Johnson 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., 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 local mental health Trust (Appleton and Appleton, 2014).

PROMISING PRACTICE: EARLY INTERVENTION FOR ADVERSE CHILDHOOD EVENTS

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 (Aarnusen 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. Blackburn with Darwen CCC 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 families66.

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 201467. Between January and August 2015, staff triage dealt with 4,409 incidents. It prevented 1,160 people attending A&E, prevented the use of 1,654 ambulance journeys and 1,025 police resources being deployed. Since Street Triage was introduced in Birmingham and Solihull in 2014, only two people have been detained in a police cell under s136 of the MHA 1983. The national evaluation reported that approximately a quarter of incidents (20.4%) involved people from BAME communities (reversuzu and Piling, 2016). In 2015, the triage team was able to provide a response to 85% of the incidents on site. Of the remainder 41% were taken to A&E, 7% to a specialist hospital and the rest to a range of destinations, including home, to a relative’s home or a place of safety in a voluntary capacity. The service was extended to the Black Country in September 2014 and a different model piloted in Coventry (CPN and police officer available from 5:00pm–3:00am). West Mercia Police in alliance with Warwickshire Police have recently commissioned a mental health nurse in the control room to support the police in responding to emergency calls and South Staffordshire Police have a triage team (police officer and mental health nurse) who provide on the street support and phone advice from staff within the Liaison and Diversion Programme. The British Transport Police have also adopted a non-mobile model but will route through to the appropriate police force to provide immediate crisis intervention if available. The focus of their model is in prevent further crisis through preventative intervention. Of note is the partnership working across organisational boundaries and different sectors to facilitate people receiving an appropriate and timely response.

There has been no comparison of these different models at a local level but the national comparative evaluation of nine pilot sites identified a number of factors associated with better outcomes (Reversuzu and Piling, 2016). These include:
- Joint ownership at senior management level and regular review of joint working
- Effective information sharing between services, in particular, access to health information
- Provision of timely advice to police officers at the point of initial contact and during the assessment process
- Integration of Street Triage with the health service-based crisis pathway
- Joint training programmes for Street Triage staff.

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

CRISIS HOUSES

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

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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 the Black Country, provided by Housing Plus and Richmond Fellowship and providing a short term 24-hour supported Intervention Service accommodation for a three day placement for people in the South Staffordshire area

A three-bedded house in North Warwickshire provided by Friendship Care and Housing in partnership with Beechdale 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 Accordat action plans for the core members of the WMCA identified the following proposals in relation to crisis accommodation:

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

68 S136 of the 1983 Mental Health Act allows the police to take anyone, who they believe is mentally unwell and in need of care and assistance, from a public place to a place of safety.

SINCE STREET TRIAGE

WAS INTRODUCED IN BIRMINGHAM AND SOLIHULL IN 2014, ONLY TWO PEOPLE HAVE BEEN DETAINED UNDER S136 IN POLICE CELLS

43 Mental Health in the West Midlands Combined Authority
In recognition of the potentially problematic pathways into services and poor evidence of support in a crisis for people from BAME communities (Fair Equality Foundation, 2015), some areas are taking targeted action to address this. In Dudley, for example, the Equalities Act provides a framework for improving the equality of access and outcomes for people from communities with protected characteristics under the Act. This includes: involving people from those communities in the commissioning of crisis services; ensuring the services commissioned can deliver a range of care options that meet a diverse range of needs; empowering people by providing appropriate information, access to advocacy services, and ensuring that they are engaged in, and have control over, their care and treatment processes; and providers meeting with community leaders to understand any barriers that may get in the way of people accessing the help they need, and reviewing service access data against demographic and prevalence data to identify gaps in access rates for people with protected characteristics. It is very clear that some communities prefer and will use services provided by their communities, in which they have higher levels of trust and this has implications for commissioning these organisations to provide the necessary support.

2. Performance against national indicators

Nationally, A&E attendances for mental health problems or self-harm represent 1.9% 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 291. 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 1 shows 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 BSMHFT, 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 service, Psychiatric Decisions Unit (PDU), Street Triage, 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 about 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 redesign76.

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 between areas as illustrated by Figure 10, and the West Midlands has lower numbers of people in contact with specialist mental health services than other areas of England, notably the East Midlands, North West and London. There are four main providers of specialist mental health services, providing inpatient and community services to the majority of WMCA residents:

- Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) provides a wide range of inpatient, community and specialist mental health care to those people living in Birmingham and Solihull who are experiencing severe mental health problems, serving a culturally and socially diverse population of over a million. The Trust provides specialist services for residents outside of the area including the national deaf mental health service (Birmingham-based), perinatal mental health, neuropsychiatry and eating disorders. The Trust also provides forensic services for children and adolescents, men and women and manages the delivery of all healthcare services at HMP Birmingham. The Trust employs approximately 4,000 staff.
- Dudley and Walsall Mental Health Partnership NHS Trust (DWMHT) provides a full range of mental health treatment and rehabilitation services for children, adults and older adults, that manage both common and complex mental health conditions. The Trust’s range of services spans primary care counselling and psychological therapies for common mental health problems through to the treatment and care of people detained under the Mental Health Act and those with severe and enduring conditions. Core services are provided predominately to Dudley and Walsall, with a population of around 560,000, but also to neighbouring Trusts in Worcestershire, Staffordshire, Birmingham and Walsall.
- Specialist mental health services for adults are also commissioned from South Staffordshire and Shropshire Mental Health Trust and Walsall 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 safer arrangements.

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

Promising Practice: Improving Access to Appropriate Support for People from BAME Communities

Open Dialogue offers a model of crisis response, service delivery and therapeutic engagement that has delivered exceptional shorter and longer term outcomes in Western Lapland where it has been developed over the last 20 years. A 10-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, 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.
The four main providers (BSMHFT; BCPFT; CWPT; DWMHPT) 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: reducing waits and increasing access to mental health services; reducing hospital admissions, inpatient, and outpatient bed days and improving community services; and promoting a recovery culture. Detail on the four Vanguard schemes 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 – 450). 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 201570. 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 Trust providers 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 population71 for Birmingham South and Central CCG. This variation is likely to reflect differences in acuity and complexity of people living in an urban environment as well as the local system configuration and culture.

The increased use of the MHA in a context of stability in the number of beds available raises questions about the number of people that are being admitted to units outside the West Midlands. The national figures show that there has been an increase in use of both Section 2 (on admission) and Section 3 (following admission). The number of uses of Community Treatment Orders (CTOs) has also been increasing (Health and Social Care Information Centre, 2015b). Further analysis is required to establish whether this is the case for the WMCA.
From NHS Trust data, the total number of people detained on a Section 2 or 3 in 2015-2016 26: 57.8% were White British; 14.3% British Asian (Bangladeshi, Pakistani and Indian), mixed White/Asian or Other Asian; 21.9% Black British (African Caribbeans), mixed White/Black and Black other and less than 1% were Chinese, with the remainder coming from other ethnic groups or for whom ethnic origin was not stated, as illustrated in Figure 13. The over-representation of people from specific BAME communities, detained under the MHA, has been consistently highlighted by the Count Me In census reports and subsequently the Care Quality Commission annual reports (CQC, 2012; 2014; 2016). The local data fits this pattern with people from BAME communities accounting for approximately 42% of the number of detentions compared with 22% of the overall population for WMCA, it is likely that the detention figures do not correspond exactly with the WMCA population because of different catchment areas. Nonetheless, this is a trend that deserves further investigation alongside analysis of the profile of those people detained in secure services and placed out of area.

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

In order to make more meaningful comparisons between the Trusts, data on the use of restraints for acute adult inpatient care was obtained and the rate of restraints calculated per 1,000 bed days for each Trust, as summarised in Figure 14. The mean rate for all types of restraint over the last three years was 14 uses of restraints per 1,000 bed days (range 9–18 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, 2008).

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 skills;
- 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*. As this illustrates, approximately half of the contacts were with CMHTs or Crisis Resolution/Home Treatment Teams representing 40% of the total number of contacts.

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 (Randal et al., 2015). Figure 16 illustrates the mismatch between estimated need and provision, with more referrals coming from the areas closer to the perinatal mental health unit (located by the Women’s Hospital). GPs in the South of the city were also more likely to make a referral and the community services were achieving better outcomes for women of white ethnicity than women from BAME communities (Randal et al., 2010).

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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 specific mental health services. In the West Midlands Combined Authority (WMCA), this was assessed as a percentage of total CCG expenditure. For the same period, the average amount spent per head of population in the 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 as a result of the statutory, voluntary and independent sector, outside their geographical area of origin (known as Out of Area Placements or Out of Area Treatments (OATs)). This happens because the provision required is not available in the specific locality either because there is none or because the demand in the area outstrips the supply, and is therefore, an indicator of performance. The national picture suggests that spending on OATs is increasing, reflecting reductions in the numbers of acute hospital beds and changes to community services, following the merger of specialist functions into general community mental health teams (King’s Fund, 2015). Out of Area placements are expensive and are likely to impact on service user experience and have been associated with increases in patient suicides (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 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 4 OATs, 73% of which was spent on Tier 4 acute beds for adults. In addition approximately £20 million was spent on two independent sector providers based in the WMCA.

81 See for example Mental Health National Health Unit (2011). In Sight and In Mind: A toolkit to reduce the use of out of area mental health services. Available at: www.rcahpy.ac.uk/nghs/nhs-reform/insightandmind.pdf [accessed 060616]
82 www.argenpecs.nhs.uk/file/711/29750/7050/Care%20Study__Mental%20Health%20Repatriation%20[accessed 030116]
86 at: www.rcpsych.ac.uk/pdf/insightandinmind.pdf [accessed060616]

There are also initiatives that are targeted at specific populations and these include: 300 Voices and community engagement (BSMHFT) (see co-production section)
The four mental health Trusts are part of the West Midlands Hub, which is a collaboration between eight providers to coordinate, and promote the mental health and appropriate care of veterans; as a focus on reducing OATs for people with psychosis.

9. Local initiatives

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

- Support to primary care – GP crisis hub (CWPT) (see primary care section)
- Early intervention in psychosis (WHCT) (see early intervention section)
- Recovery Colleges (BCPT; BSMHFT and FTB) (see quality of life and mental health section)
- Street Triage (BSMHFT; CWPT) in partnership with West Midlands Flash team (see crisis intervention section)
- Individual Placement and Support (see employment section)

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.

10. Changing practice

As can be seen the majority of these examples focus on the development of new services and there is also scope for shifting ‘knowledge to practice’ (Crisp et al., 2016). The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness also notes that an early identification of those at risk, and an early intervention can have a significant impact on the outcomes for those identified as needing mental health support, in particular those who are at risk of self-harm or suicide.

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advocacy at risk (eg. generic advocacy and community advocacy), such that advocacy becomes increasingly professionalised. It would, therefore, seem appropriate to review this provision; particularly in light of findings that access to statutory advocacy can be problematic.\(^{49}\) Further, the Care Act 2014 also placed a duty on Local Authorities to build ‘social capital’ (Allen, 2014: 15). The Care Act 2014 focuses on carers: for example the Care Act duty on Local Authorities to assess and support carers was promising as a Direct Payment and the other part of the Care Act focus on carers was promising, but active implementation of this Care Act duty found two thirds had not received an assessment and some that had were dissatisfied with the assessment (Carers Trust and University of Birmingham, 2016). Furthermore, many carers found engagement with the NHS problematic. The review concluded that the Care Act focuses on 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 well-being 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 providers is reduced. The third sector, therefore, has a ‘comparative advantage’ in service delivery, especially because of the relatively flat hierarchies and blurring between staff, volunteer and ‘user’ roles in the organization, aligned with cultures of non-judgementalism, nurture/ care, and ‘relational skill’ (Billis and Glennerster, 1998; Macmillan, 2013). The third sector, therefore, plays an invaluable role in providing an alternative approach to statutory provision and often introducing innovative ways of working that are then adopted by the statutory sector; as is the case with direct payments, advocacy, peer support and recovery.\(^{50}\) The sector is particularly adept at identifying and responding to gaps in provision and in engaging with people who would not engage with statutory services.

There is a dynamic and extensive third sector, which is inevitably more developed in urban centres, and it is estimated that there are approximately 450 voluntary sector organisations, across the WMCA. In addition, there will be small organisations ‘below the radar’ of public services but are an important community asset (Mohan, 2011). Third sector services serving individuals with mental health problems are provided by: specialist mental health organisations, for example Mind; organisations closely associated with a social issue, such as domestic violence (eg. Women’s Aid, or homelessness (eg, St Mungo’s); with a client group, for example SignHealth for Deaf people; or a community group, for example organisations providing services to African-Caribbean people, South Asian people, or asylum seekers and refugees; and universal services, such as Citizens’ Advice. There is a diverse third sector of BAME organisations, many of which have their foundations in grassroots organisations, with people from 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, for example, services supporting homeless people; drug and alcohol support; support groups for people with long excluded health problems, eg Parkinson’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 Stepping Stones in Walsall; Coventry Haven 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.
- **Wellbeing** to access services providing seven-day-a-week direct access for all to information, advice and support; peer support/ friends who are being isolation; and the opportunity to engage in social/isolation/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 counselling.

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

![Figure 17](http://example.com/figure17.png)


\(^{50}\)Although the co-option of these methods by public services has been the focus of critique by service user activists as fundamentally alienating 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. These services 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, e.g. 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 negotiating reasonable adjustments; supporting leaving negative employment experiences and job-hunting; improving outcome; Individual Placement and Support (which is discussed later under promising practice); linking people in work with other services and training on workplace wellbeing.

Community development workers to increase engagement with particular groups.

Advice on welfare rights, including benefits, debt and housing.

Recovery-oriented courses and workshops, for example: coping with depression; confidence building; self-esteem, anger management, mindfulness and tackling sleep problems.

A range of support with housing including accommodation, floating support to enable people to maintain their tenancies, and short-term housing.

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

SPECIFIC PROVIDENCE FOR PEOPLE FROM BLACK ASIAN AND MINORITY ETHNIC COMMUNITIES

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

This section considers provision to people from BAME communities, to reflect the diversity of the WMCA. In doing so, it is important, as Tang (2016) has observed in relation to Chinese mental health service users: ‘to understand cultural fluidity and the necessity for a transformative approach to tackle the intersecting structural inequalities that limit life chances’. Therefore, although specific services are considered to be important, 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 inappropriate treatment of children and young people by from their communities. Examples across the WMCA include:

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

QUALITY OF LIFE AND MENTAL ILLNESS

A broad range of initiatives are required to improve the quality of life of people with a diagnosed mental illness and who may be particularly affected by stigma, discrimination, cultural and religious beliefs and attitudes. People with mental health problems are at increased risk of violence victimisation and a recent study found that they were three times more likely to be a victim of any crime and five times more likely to be a victim of a sexual assault (Petitti et al., 2013). The study also found that when people reported a crime they felt they were disbelieved or the appropriate action was not taken.

1. Tackling stigma and discrimination

Shifting social norms and reducing mental illness-related stigma is the focus of Time for Change85. The campaign is run by the charities Mind and Rethink Mental Illness, with several partners across the Department of Health, Comic Relief and the Big Lottery Fund. The campaign has developed a comprehensive programme, adopting a strategy of targeting people through interrelated activities that ensure mass reach (social marketing), empower local people with a lived experience to lead change (community leadership) and bringing together people with and without experience of mental health problems to talk openly about mental health issues (social contact).


85www.time-to-change.org.uk [accessed 050117]

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

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 communities and challenge stigma in their daily lives.

Supported 200 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 social change together by setting up ‘Time to Change Hubs’. In these Hubs the Campaign will support partnerships of local organisations and individuals to work with local 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

84Available at: www.sacmhf.co.uk/user-led.html [accessed 150816].

8885www.tamarindcentre.co.uk/id2.html [accessed 150816].

Available at: www.nhsiq.nhs.uk/media/2696378/nhsiq_perinatal_mental_health_sml__0915final.pdf [accessed 060616].


90www.time-to-change.org.uk [accessed 050117]


92www.time-to-change.org.uk [accessed 050117]

92www.time-to-change.org.uk [accessed 050117]
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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 plans for self-management with those that attend more than 70% of the sessions showing a reduction in their use of community mental health services (Cited in North Essex Research Network and South Essex Service User Research Group, 2014). A small scale study of Recovery Colleges in Mid Essex found 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). There is a range of organisations to provide guidance and facilitate the development of peer support including Peer2Peer, hosted by NUSL, which supports the development of an evidence based network of peer support experts who share fresh approaches to developing and running peer support services. 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 consultancy and evaluation services aimed at developing the role of peer supporters within both the voluntary and statutory sectors. Their recovery focussed training is available 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 the single most important factor 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, 2013). Kaleidoscope – In South Warwickshire, (Glendenning et al., 2008); and to also deliver the personalisation strategy for the WMCA that is underpinned by the principle of personalisation and autonomy. The 2013 POET survey found that people who took the personal budget as a direct payment felt more in control and had greater choice than those using a personal budget (Hatton and Waters, 2013). Furthermore, the evidence indicates that people experiencing poor mental health are most likely to benefit from the choice and control offered by a direct payment of personal budget (Alakeson, 2007b); to report a significantly higher quality of life than the comparison group (Glendenning et al., 2008); and to also report improvements in their physical health (Davidson, Gadsby, 2013).

Integrated personal commissioning (IPC) is now being piloted to join up commissioning at the level of the individual. A national pilot is focused on people with complex needs, including people with significant mental health needs, ie, people eligible for the Care Programme Approach (CPA), or those who use high levels of unplanned care, but none of the initial nine IPC demonstrator sites are in the WMCA.

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3. Promoting choice, self-determination and recovery

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

PERSONALISATION IN HEALTH AND SOCIAL CARE: DIRECT PAYMENTS AND PERSONAL BUDGETS

Although the definition of personalisation can be open to interpretation and is evolving, it is an approach that seeks to secure empowerment, citizenship and equality. In a public services context, it is used to refer to recognising people as individuals who have strengths and preferences and putting them at the centre of the care planning process (SCIE, 2008). Personalisation enables the social context of people’s lives to be taken into account and the impact it has on individual health and wellbeing (Forder et al., 2012). Personalisation, therefore, sits alongside co-production in ensuring that the support and services people use recognise their strengths and meets their needs to enable them to live their lives.

Direct payments and personal budgets are two ways in which people can have greater control over their care. The 2013 POET survey found that people who took the personal budget as a direct payment felt more in control and had greater choice than those using a personal budget (Hatton and Waters, 2013). Furthermore, the evidence indicates that people experiencing poor mental health are most likely to benefit from the choice and control offered by a direct payment of personal budget (Alakeson, 2007b); to report a significantly higher quality of life than the comparison group (Glendenning et al., 2008); and to also report improvements in their physical health (Davidson, Gadsby, 2013).

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 Bromwch**; 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 South Warwickshire, (Glendenning et al., 2008); and to also be 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**); facilitating peer support groups for people who hear voices (eg, Hearing Voices Network**); self-help groups (as above);
- Peer mentoring (eg, in schools to build emotional resilience, Wolverhampton**); Peer support includes the introduction of a cap (at Local Housing Allowance levels) on the amount of housing benefit that can be claimed. The level of the cap is calculated by subtracting the National Housing Federation found that at the national level 156,000 units of existing supported and sheltered housing would become unaffordable and subject to closure. This is 41% of all existing schemes. This has resulted in a huge amount of uncertainty amongst providers and has resulted in 80% new developments of specialist housing being put on hold. The government has delayed the introduction of the cap by 12 months, and not announced the results of its research into supported housing provision
or what the future funding for supported housing will look like.

There is a general dearth of research into housing models for people with mental health problems but a mapping study in 2009 identified a considerable overlap between the characteristics of the clientele of residential care, building based support and floating support and significant variation in costs (Priebe et al., 2009). Furthermore, the majority of the costs were being spent on the housing component suggesting that this population may be underserved by mental health services. Watt 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 Heartburn 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 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 and

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See for example a summary with case studies developed by a group of housing providers in the West Midlands: Working together in the Midlands Environments, which recognises the use of Psychologically Informed Environments, which recognises the potential for change and ensure that staff are psychologically minded and able to work with the complex dynamics that can arise as a consequence of trauma and retraction.

2. **Performance against national indicators**

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

3. **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.

A preview study in Walsall identified the practice of residential sorting from anecdotal evidence (Jones and Gulliver, 2009) and this requires further analysis. The location and quality of the accommodation is key to people’s mental health and recovery.

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 framework to local health and social care 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.

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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 (Pease et al., 2015). A study of nine relatively new Housing First services in England evidenced improved physical and mental health for their clientèle (Bretherton and Pease, 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 Pease, 2015).

**HOUSING FIRST**

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Employment

1. Provision in the WMCA

People with severe mental health problems have very low employment rates and are at greater risk of falling out of work than the general population and other disadvantaged groups. Although the majority of people with mental health problems want to work, there is a growing concern about the relationship between employment support, entitlement to Employment Support Allowance (ESA) and mental health support. In relation to the range of employment support, a comprehensive mapping of DWP provision has not been undertaken for this exercise and, in any event, changes are planned for 2017 with the merger of the Work Programme and Work Choice to form a new Work and Health Programme to support people with long-term health problems, including mental health, into work. There are currently a number of providers of the DWP-funded Work Choice Programme for people with mental health problems in the West Midlands and those listed by the British Association for Supported Employment131, which may not be a comprehensive list, are as follows: Sandwell Council, Advance Employment, Solihull, Hereford College, Coventry, Dudley MBC, Walsall, Solihull, 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 Joint Commissioning Team and provide education, volunteering and an employment service to adults aged 18–65. They provide training and work experience with one of the three 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 29% in 2015 (see 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 2014/15132 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 highest133.

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 (MCBC) and North Staffordshire (provider Work4You, making Space and covering Lichfield and Staffordshire) (provided by Staffordshire Health and Care Trust covering Bromsgrove and Redditch), as excellent; Sandwell (Sandwell MBC) and Wolverhampton (Healthyl 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 provision134.

CRIMINAL JUSTICE SYSTEM

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

1. Liaison and Diversion services

Criminal Justice Liaison and Diversion services exist to identify offenders who have mental health, learning disability, brain injury or substance misuse vulnerabilities when they first come into contact with the criminal justice system and refer them to appropriate services for support and therapeutic help. Criminal Justice Liaison and Diversion Teams are funded by NHS England Offender Health. The West Midlands now has three pilots covering all of the custody facilities across the West Midlands Police Force area. New designed 60 cell super custody blocks at Oldbury and Perry Barr provide the majority of custody provision with smaller custody facilities at Coventry, Solihull, Bournville in Birmingham, and Wolverhampton. The Liaison and Diversion staff provide an all age service and link directly to the local Crown and Magistrates court to support reoffending diversionary programmes for people with mental health, learning disability, brain injury or substance misuse. The West Midlands is the only Force with 100% coverage ahead of the national roll out by 2019 which is currently subject to further Treasury decisions.

The Crisis Care Concordat 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 MH Trusts. 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
- Solihull has a Pathways pack on arrest for all offenders to help police officers identify the cause of criminal activity and support to the relevant agencies for 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 Shropshire and Wales were first-time offenders. Nearly half of all the indictable convictions of women were for shoplifting, compared with just under a quarter of men. While the proportion of women in prison for indictable offences has dropped considerably, the proportion of women in prison for these types of offences has increased from 5% in 2001 to 7% in 2010, and then to 7.8% in 2015. The next most common offence among women was violence against the person, around a third of which was accounted for by Actual Body Harm. Drugs offences were the next most common, although the proportion of women in prison for these types of offences has dropped considerably, from 25.2% in 2009 to 13.8% in 2014135.

Aasim 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.

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131 http://base-uk.org/services-offered/work-choice?page=1
133 This is unsurprising because the ASCOF data is drawn from MH/IDS
2. Prison
There are 12 prisons in the West Midlands and their mental health provision, in addition to availability of nursing and emergency services to people accommodated in prison, is detailed in Appendix 10. Approximately 3,700 primary mental health referrals of adult male prisoners are made on an annual basis (Offender HNA and Consultancy Projects, 2015: 28). Gaps in provision relating to primary care mental health and counselling have been identified with a recommendation that IAPT is introduced to address low levels of mental health needs and that innovative approaches to delivering primary mental health support in prisons is required. Problems in obtaining secure beds for people requiring transfer under the MHA were also identified by the 2013/14 Health Needs Assessment (Offender HNA and Consultancy Projects, 2015). In addition a lack of capacity for prison staff to attend mental health awareness training was highlighted.

3. Community Rehabilitation Companies
In 2014, changes to the delivery of probation services were introduced, with responsibilities for most offender being transferred to 21 Community Rehabilitation Companies (CRCs). There are two CRCs covering the WMCA population: Staffordshire and West Midlands CRC covering Staffordshire and the West Midlands, and West Mercia covering the Warwickshire and Worcestershire elements of the WMCA. They provide probation services for low and medium risk offenders alongside national probation services, 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’s CRC led 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.

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

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

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

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

Second is the quality of mental health related intelligence across the WMCA footprint. We have found the JSNAs 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 this relationship between inequalities and mental health and how the risks of developing poor mental health are not evenly distributed and across the WMCA. It is important that the diverse needs of different populations, including those that we identified as being at risk, are properly considered, and what needs to happen to make access to support more equitable.

A key message from the emerging evidence and the promising practice is that personalised approaches, built on and responding to what people with mental health problems, their families and communities, say, and what they think needs to happen, is an important strand of effectiveness and may save money. It is, therefore, encouraging to see a commitment to co-production widely expressed by public services in the WMCA and some examples of this being translated into action. There is clearly further scope for action on this front, drawing on both local and national expertise.

It is nevertheless the case that the introduction of promising initiatives that have the potential to bring social and economic benefits is patchy, and the West Midlands Mental Health Commission is in a good position to evaluate these and support their implementation. Scaling up these initiatives – MHFA, IPS, Housing First, Crisis Houses, for example, needs to be actively considered and evaluation of these models in a WMCA context is needed to understand the role of contextual factors that may influence effectiveness and outcomes. There are also areas, particularly in primary care, where different models are being developed and comparison of these in terms of access and impact (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 these services. They are built on an ethos of open door and spirit, often supporting the most marginalised populations. Throughout the process of gathering data for this appraisal, we have heard concerns about the impact of budget reductions on this sector in particular, with valued services having to be cut or no longer commissioned. Adopting a 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 trage 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.

STRENGTHENING AND BUILDING THE MENTAL HEALTH OF PEOPLE LIVING IN THE WEST MIDLANDS REQUIRES A STRATEGIC AND SYSTEMIC APPROACH, THAT RECOGNISES AND DEVELOPS THE ROLE OF ALL ORGANISATIONS IN ACHIEVING THIS.
Recommendations

The following recommendations are made based on our analysis of costs and provision across the WMCA:

1. All Local Authorities should be required to have an up-to-date JSNA for mental health to provide the intelligence on which to build a strategic and systemic approach. This will need to 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 conceptions of mental health; barriers to access any support and may be further understood within the WMCA context.

5. This assessment has identified groups based on our appraisal of the costs and health of the WMCA population. Any strategy to improve the mental health of people with severe and complex needs of people with physical health problems, medically unexplained mental health problems, and minority ethnic communities, particularly those of people from Black and Minority Ethnic communities, and the use of restraint.

6. The evidence for personalised approaches that give greater choice and control to service users aligns with what they are asking for, supported by evidence that indicates that such approaches lead to better outcomes. Local Authorities should identify how they can better support and control to service users aligns with what they are asking for, supported by evidence that indicates that such approaches lead to better outcomes.

7. Primary care has a key role to play in prevention, early intervention and care pathways to developing a strategic approach to mental health problems, including mental wellbeing of people with physical health problems, medically unexplained symptoms and other forms of complexity, and the physical health needs of people with severe and enduring mental health problems.

8. Identifying the components of good primary care mental health will need to be a coherent approach across the WMCA and ensure that the full potential of primary care is maximised.

9. Organisations and communities in the WMCA have pioneered innovative approaches in mental health that have been adopted outside the WMCA. There are examples of promising practice developing and, in some instances the evidence for these is for 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.

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

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

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

13. The WMCA should aim to reduce the rate of Out of Area Treatments by developing appropriate local provision and strengthening 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 they can better support and control to service users aligns with what they are asking for, supported by evidence that indicates that such approaches lead to better outcomes.

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

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

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

References


### Appendix 1

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

1. **Name of organisation:**

   Please provide the details for 2014-15.

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

<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th>Spend (£000s) 2014-15</th>
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<tbody>
<tr>
<td>Children (0-18)</td>
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<tr>
<td>Adults of working age (18-65)</td>
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<tr>
<td>Older adults (65+)</td>
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<td>Total</td>
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</table>

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

<table>
<thead>
<tr>
<th>Organisation commissioned</th>
<th>Target population</th>
<th>Activity specified</th>
<th>Expected outcomes</th>
<th>Contract value (£000s)</th>
<th>Performance monitoring details for 2014-15</th>
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   Please add additional rows as necessary.
## Appendix 4

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

| Area | Name of Group | Description | Recent examples of involvement/product
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>See Me</td>
<td>See Me user engagement project at BSMHFT</td>
<td>A project that promotes greater engagement of service users in the planning and delivery of mental health services in Birmingham and Solihull through feedback; ensuring users’ views are represented at all levels of the Trust and See Me user involvement workers have a place on all key Trust meetings and support service users to attend many of these meetings as User representatives too.</td>
<td>New Dawn, a comprehensive review of community mental health services, was undertaken with the support of the See Me team to ensure service users and carers could inform and support development of new ways of working. The See Me team have also sought feedback and informed views of service users regarding the recent SmokeFree NHS introduction across all teams in the mental health trust.</td>
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</table>
| Staffordshire | South Staffordshire People’s Parliament | A partnership between BSMHFT, West Midlands Police, Birmingham City Council and Time to Change that seeks to engage with young African and Caribbean men aged between 18 and 25 to hear their experiences of inpatient and outpatient care. 300 Voices was funded by the Big Lottery Fund, the Department for Health and Comic Relief, and the funding came to an end in March 2016. Different elements of the programme are being taken forward by BSMHFT (peer support programme) and by West Midlands Police (engagement of workforce with 300 voices). The 300 Voices project adopted a person-centred approach to mental health care 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., 2016) 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., 2016) conclude that there is a clear case to build on the achievement of 300 voices to date in the future. |
| Birmingham | Birmingham and Solihull Mental Health NHS Foundation Trust User Watch | A blog presenting ‘an independent, occasionally satirical view’ of mental health and NHS issues | An overview of the Crisis Resolution and Home Treatment Service including identifying training needs for staff. |
| Dudley and Walsall | Dudley and Walsall MH Partnership Trust | A team of eleven expert service users and carers, who use their experiences to influence the delivery and quality of services provided by Dudley and Walsall MH Partnership Trust. The work of EBUs 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 Trage Service which has been very well received.  
- An overview of the Crisis Resolution and Home Treatment Service including identifying training needs for staff.  
- Enhanced care and compassion through the introduction of ‘Hello my name is’ campaign Trustwide. |
| Sandwell | Mental Health People’s Parliament | 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. |
| South Staffordshire Network for Mental Health | South Staffordshire Network for Mental Health | An independent charity promoting and developing mental health services from the perspective of people who have an experience of mental illness throughout the six districts and borough of South Staffordshire. Funded by Staffordshire County Council to provide a mental health participation service called ‘Your Voice’. Represent people with experience of mental illness within local Healthwatch and local Clinical Commissioning Groups. | 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 aimed at reducing admission into mental health services for next four years. |
| Cannock and Walsall | Cannock and Walsall Mental Health NHS Foundation Trust User Watch | A blog presenting ‘an independent, occasionally satirical view’ of mental health and NHS issues | An overview of the Crisis Resolution and Home Treatment Service including identifying training needs for staff. |
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A Mental Health Action Group that is a completely user/sex-user led Registered Charity and Company Limited by Guarantee, with approximately 150 members. All members must live within the Wolverhampton City boundary. The group activities include:
- Support for recovery by holding monthly Forum meetings with specific topics; workshops, including sessions, such as relaxation, aromatherapy, and educational trips.
- Events to raise public awareness of Mental Health issues
- Communicating members’ ideas to CCGs, Mental Health Trusts and the Local Authority to improve the mental health services and requiring action.
- A quarterly magazine with a readership of potentially 1000 readers which includes all members, Statutory Bodies, Mental Health professionals, Libraries, Pharmacists, Community Centres, Housing officers, and Doctors’ surgeries.

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.

Mental Health in the West Midlands Combined Authority

Appendix 5
Audit of public mental health initiatives being commissioned in WMCA (Source: Local Authority Audit responses 2016)125

<table>
<thead>
<tr>
<th>Area</th>
<th>Name of Group</th>
<th>Description</th>
<th>Recent examples of involvement/production</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dudley</td>
<td>Positive Action for Mental Health (PAMH)126</td>
<td>A service user group, set up by Wolverhampton Empower Me team at Wolverhampton CVS126, 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>
</tbody>
</table>
| West Midlands         | Hear-our-Voice                        | A Mental Health Action Group that is a completely user/sex-user led registered charity and company limited by guarantee, with approximately 150 members. All members must live within the Wolverhampton City boundary. The group activities include:  
- Support for recovery by holding monthly Forum meetings with specific topics; workshops, including sessions, such as relaxation, aromatherapy, and educational trips.
- Events to raise public awareness of Mental Health issues
- Communicating members’ ideas to CCGs, Mental Health Trusts and the Local Authority to improve the mental health services and requiring action.
- A quarterly magazine with a readership of potentially 1000 readers which includes all members, Statutory Bodies, Mental Health professionals, Libraries, Pharmacists, Community Centres, Housing officers, and Doctors’ surgeries. | 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. |

123 Funding discontinued 31.3.16.
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.
### Public Health Intervention Examples Water苋菜属 Walsall Sandwell Dudley Solihull

<table>
<thead>
<tr>
<th>Targeted initiatives for at risk groups</th>
<th>Examples</th>
<th>Water.SQLException</th>
<th>Walsall</th>
<th>Sandwell</th>
<th>Dudley</th>
<th>Solihull</th>
<th>Dudley</th>
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<tr>
<td>Community and social activities Addressing social isolation. Access to education and employment Support for carers Building confidence and self-esteem targeted at: Young people BAME groups Unemployed men</td>
<td>Community Development workers BME Mental Health and Wellbeing Prevention Service includes short-term counselling, awareness raising and practical and emotional support Mental health assessment of all those referred to health trainer services</td>
<td>Expert Patient programme for 18+ living with a long-term health condition (anxiety/depression) Community Development Worker Service for mental health Mammade Dudley 9 week courses for unemployed men 30-50 years of age to improve mental health and wellbeing (pilot project), included Five Ways to Wellbeing: basic suicide prevention training; and Mental Health First AidLite. Caring Relaxation Toolkit and mindfulness session</td>
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<tr>
<th>Tailoring violence and abuse</th>
<th>Domestic abuse services</th>
<th>Domestic abuse family hostel</th>
<th>Domestic violence perpetrator programme</th>
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<tbody>
<tr>
<td>Reducing physical inactivity</td>
<td>Specialist weight management</td>
<td>Smoking cessation</td>
<td>Screening and adult lifestyle services</td>
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<tr>
<td>Health Services</td>
<td>&quot;Food Dude&quot; Healthy Eating Programme Dynamic Dudes – physical activity program</td>
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<td>Workplace interventions</td>
<td>Healthy Workplace Programmes</td>
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<td>School-based mental health promotion and prevention programmes</td>
<td>Support for teachers Anti-bullying</td>
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<td>Parenting programmes (including targeted programmes at high risk families)</td>
<td>Parenting Team</td>
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<td>School Nursing service</td>
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<td>Work with individual schools to increase emotional resilience and also challenge discrimination</td>
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<td>Workplace Wellbeing Programme</td>
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<td>Solihull healthy Schools Emotional Health programmes</td>
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<td>Parenting Team</td>
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<td>Solihull MBC: Workplace Wellbeing Charter and Workplace Mental Wellbeing a council priority</td>
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</tbody>
</table>

### Mental Health in the West Midlands Combined Authority

- **Sandwell**
- **Walsall**
- **Healthy Workplace**
- **Wolverhampton**

**Examples**

- **Wolverhampton**
- **Dudley**

**Targeted initiatives for at risk groups**

- **General public/front line services to promote awareness and tackle stigma**
- **Mental health awareness/ Mental Health First Aid Community wellbeing services**
- **Mental Health First Aid training**
- **Mental health awareness/ Mental Health First Aid Mental wellbeing hub**

**Public health intervention**

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<tr>
<th>General public/front line services to promote awareness and tackle stigma</th>
<th>Mental Health awareness/ Mental Health First Aid Community wellbeing services</th>
<th>Mental Health First Aid training</th>
<th>Mental Health First Aid awareness/ Mental Health First Aid Mental wellbeing hub</th>
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<td>Mental health awareness/ Mental Health First Aid Community wellbeing services</td>
<td>Mental Health First Aid training</td>
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<tr>
<td>Commissioning area</td>
<td>Specific interventions</td>
<td>Outcomes achieved</td>
<td>Implementation aspects and feasibility</td>
</tr>
<tr>
<td>--------------------</td>
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</tr>
<tr>
<td><strong>Build social and emotional resilience of children and young people through whole school approaches</strong></td>
<td>Healthy school; extended schools including supporting families; School based mental health promotion; School based Social and Emotional Learning (SEIL) programmes achieving pupils’ core competencies. Self-management and social skills training. Build financial literacy. Mentoring programmes Family Intervention Projects</td>
<td>Improved maternal and child mental health.</td>
<td>Improved maternal and child mental health. Improved infant and child mental wellbeing. Reduced maternal postnatal depression. Improved parental psychological health. Improved mother’s employment after maternity leave.</td>
</tr>
<tr>
<td><strong>Promote good parental mental and physical health to improve early child development and wellbeing, maternal wellbeing</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. Improved maternal sensitivity. Reduced use of NHS social care, criminal justice and third sector provision. Build social and emotional resilience from an early age.</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. Group based parenting programmes have a positive effect on mental health and lead to improved self-esteem (Barlow et al., 2003). Good parenting skills promote wellbeing and reduce incidence of conduct disorders. (Olda et al., 1997; Coram, 2002; Brywater et al., 2009). Social and emotional learning programmes; improve skills and self-esteem (Payton et al., 2008).</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>Work with owners of car parks/bull ring to reduces risk of tall building suicide. Assist and Salestak suicide prevention training.</td>
<td>Improved maternal mental health. Improved infant and child mental wellbeing. Reduced maternal postnatal depression. Improved parental psychological health. Improved mother’s employment after maternity leave.</td>
<td>Routine enquiry at ante-natal clinics. Prenatal programmes with postnatal follow up in the first year after birth are most effective. Interventions with first-time mothers show best effects. Group based parenting programmes have a positive effect on mental health and lead to improved self-esteem (Barlow et al., 2003). Good parenting skills promote wellbeing and reduce incidence of conduct disorders. (Olda et al., 1997; Coram, 2002; Brywater et al., 2009). Social and emotional learning programmes; improve skills and self-esteem (Payton et al., 2008).</td>
</tr>
</tbody>
</table>

**Appendix 6**

Suggested commissioning priorities for public mental health

(Source: Heginbotham and Newbigging, 2013) Full references available in source document

| Public health intervention | Examples | Wolverhampton | Sandwell | Dudley | Walsall | Suicide prevention training | Health Check Scheme provided for clients of community mental health services (BSMHFT) | Work with owners of car parks/bull ring to reduces risk of tall building suicide. Assist and Salestak suicide prevention training. | Improved maternal mental health. Improved infant and child mental wellbeing. Reduced maternal postnatal depression. Improved parental psychological health. Improved mother’s employment after maternity leave. | Routine enquiry at ante-natal clinics. Prenatal programmes with postnatal follow up in the first year after birth are most effective. Interventions with first-time mothers show best effects. Group based parenting programmes have a positive effect on mental health and lead to improved self-esteem (Barlow et al., 2003). Good parenting skills promote wellbeing and reduce incidence of conduct disorders. (Olda et al., 1997; Coram, 2002; Brywater et al., 2009). Social and emotional learning programmes; improve skills and self-esteem (Payton et al., 2008). |

| Programmes to improve the physical health of people with mental health problems | Reducing physical inactivity | Specialist weight management | Smoking cessation | Screening and adult lifestyle services | New recovery services being procured in 2017, will have physical health as key performance indicator – providers to offer physical activities to service users. | Health Check Scheme provided for clients of community mental health services (BSMHFT) | Work with owners of car parks/bull ring to reduces risk of tall building suicide. Assist and Salestak suicide prevention training. | Improved maternal mental health. Improved infant and child mental wellbeing. Reduced maternal postnatal depression. Improved parental psychological health. Improved mother’s employment after maternity leave. | Routine enquiry at ante-natal clinics. Prenatal programmes with postnatal follow up in the first year after birth are most effective. Interventions with first-time mothers show best effects. Group based parenting programmes have a positive effect on mental health and lead to improved self-esteem (Barlow et al., 2003). Good parenting skills promote wellbeing and reduce incidence of conduct disorders. (Olda et al., 1997; Coram, 2002; Brywater et al., 2009). Social and emotional learning programmes; improve skills and self-esteem (Payton et al., 2008). |

| Suicide prevention | Suicide prevention training | Suicide Strategy draft has been completed | ASIST Suicide Prevention Training GP Suicide Prevention Training | Work with owners of car parks/bull ring to reduces risk of tall building suicide. Assist and Salestak suicide prevention training. | Improved maternal mental health. Improved infant and child mental wellbeing. Reduced maternal postnatal depression. Improved parental psychological health. Improved mother’s employment after maternity leave. | Routine enquiry at ante-natal clinics. Prenatal programmes with postnatal follow up in the first year after birth are most effective. Interventions with first-time mothers show best effects. Group based parenting programmes have a positive effect on mental health and lead to improved self-esteem (Barlow et al., 2003). Good parenting skills promote wellbeing and reduce incidence of conduct disorders. (Olda et al., 1997; Coram, 2002; Brywater et al., 2009). Social and emotional learning programmes; improve skills and self-esteem (Payton et al., 2008). |

| Other | Training in using WEMWBS; and secondary research of the local household survey | Big White Wall, a safe online community providing peer support and guided by health professionals | Long term conditions programme for people newly diagnosed with arthritis, heart disease and diabetes. | Cancer survivorship programme | Improved maternal mental health. Improved infant and child mental wellbeing. Reduced maternal postnatal depression. Improved parental psychological health. Improved mother’s employment after maternity leave. | Routine enquiry at ante-natal clinics. Prenatal programmes with postnatal follow up in the first year after birth are most effective. Interventions with first-time mothers show best effects. Group based parenting programmes have a positive effect on mental health and lead to improved self-esteem (Barlow et al., 2003). Good parenting skills promote wellbeing and reduce incidence of conduct disorders. (Olda et al., 1997; Coram, 2002; Brywater et al., 2009). Social and emotional learning programmes; improve skills and self-esteem (Payton et al., 2008). |

Full references available in source document

References

- Social and emotional learning programmes: improve skills and self-esteem (Payton et al., 2008)
- Improved maternal efficacy and parenting practice. Improved maternal sensitivity. Reduced use of NHS social care, criminal justice and third sector provision. Build social and emotional resilience from an early age. (Bond et al, 1997; Cornah, 2003; Caan & Jenkins, 2009; Olds, 2002) Improvement in child and emotional health and lead to improved self-esteem (Barlow et al., 2003).
- Good parenting skills promote wellbeing and reduce incidence of conduct disorders. (Olda et al., 1997; Coram, 2002; Brywater et al., 2009)
- Social and emotional learning programmes: improve skills and self-esteem (Payton et al., 2008)
### Improving working lives:

<table>
<thead>
<tr>
<th>Workspace interventions</th>
<th>Specific Interventions</th>
<th>Time example of the impact or outcomes achieved</th>
<th>Implementation aspects and feasibility</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 become unemployed. Providing volunteering opportunities. Support NHS, LA and Third Sector organisations to develop interventions to improve healthy working lives 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>n Increased employment, and reduction in lost employment years due to reduced health service and welfare costs</td>
<td>a) Adopt integrated interventions which combine organisational and individual level approaches. b) Job retention and re-employment programmes with employees with depressive symptoms offer good financial return (Wilson 2003). c) Improved wellbeing due to reduced financial distress impacts on reduced housing stress etc. d) Significant reduction in financial distress (M). e) Reduction in sickness absence.</td>
<td>n Early diagnosis and intervention with employees with depressive symptoms offers good financial return (Wilson 2003). n Adults who are economically inactive are at increased risk of mental illness (Black 2008). n Lack of income may lead to increased housing risk and an increased risk of mental disorder (Weich &amp; Lewis, 1998).</td>
<td>n Moderate physical activity improves mental wellbeing (Henry et al., 2010). n Moderate physical activity improves mental wellbeing (Henry et al., 2010).</td>
</tr>
<tr>
<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 activity. 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>n 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. n Improved mental and physical health. n Increased confidence, sense of community, social cohesion. n Increased levels of social support and caregiver skills. n Reduced demands on primary care and reduced levels of antidepressant prescribing. n Self-management and healthy behaviours.</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 services for people in middle and old age.</td>
<td>n Meaningful occupation and physical activity increase overall wellbeing (NICE, 2008b; Cassidy et al., 2008). n Time banks generate new social networks and relationships (Freed et al., 2008). n Adults who are economically inactive are at increased risk of developing a mental disorder (Black, 2008). n Local community welfare advice in general practice increases benefits, particularly disability-related benefits and is an excellent strategy by which primary care organisations can influence their population’s health (Greasley &amp; Small, 2005).</td>
<td>n Physical and sexual violence have direct health consequences and are risk factors for a wide range of long term health problems including mental health, substance abuse, unwanted pregnancy, sexually transmitted diseases and risky sexual behaviour.</td>
</tr>
</tbody>
</table>

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

| Group interventions Falls prevention through social support and education | n Improved social inclusion | n Effective befriending services would generate significant cost savings. n Increased quality of life | n Reduced A&E attendances and admissions to hospital | n Volunteering enhances wellbeing more than in younger people (Age Concern and MHI, 2008). n Reduce loneliness and anxiety by providing means to stay active. (Lampinen et al., 2006; NICE 2008b) |

### Improved mental health and wellbeing

| Meaningful group activities with educational and/or support input based on participation of older people. Volunteering and peer support programmes for to foster contact between generations. | n Increased 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. | n Moderate physical activity improves mental wellbeing (Henry et al., 2010). n Exercise of moderate intensity has a positive effect on physical and mental wellbeing (NICE, 2008b; NICE 2008b), and reduces anxiety, enhances mood and improves self esteem (Egan et al., 2008; Eisner et al., 1997) |
| Tackling alcohol and substance abuse, including screening programmes and direct interventions to reduce alcohol use, substance use, and obesity. | n Increased 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. | n Volunteering enhances wellbeing more than in younger people (Age Concern and MHI, 2008). n Reduce loneliness and anxiety by providing means to stay active. (Lampinen et al., 2006; NICE 2008b) |

### Community empowerment and development interventions that encourage communities to improve physical and social environments, participation in decision making, strengthening social networks

| Bullying has negative consequences for both the individual and the wider community. Bullying is an excellent strategy to reduce isolation and ‘hidden crime’ amongst older people. | n Screening and brief intervention in primary care Target problem drinking and alcohol abuse through multi-sectoral action (local authority, health, police, education) | n Screening and brief intervention in primary care. | n Integrated physical and mental health behaviour change through brief interventions. Multi-sectoral action through multi-agency arrangements between NHS, LAs, Police, Probation, Third sector etc |

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

| Building life skills in children and young people including school-based violence prevention programmes including sexual abuse and bullying prevention. Promoting gender equality for women. Reducing the availability and harmful use of alcohol. Victim identification and care and support programmes. | n Reducing health costs of depression followed by CBT where indicated. n Early intervention to reduce risks of unemployment through primary care and job Centre and promote engagement and participation for those who become unemployed. Providing volunteering opportunities. Support NHS, LA and Third Sector organisations to develop interventions to improve healthy working lives and support occ. health schemes. Stress management interventions tailored to the needs of the employees. Supported work for those recovering from mental illness. | n Increased employment, and reduction in lost employment years due to reduced health service and welfare costs | n Early diagnosis and intervention with employees with depressive symptoms offers good financial return (Wilson 2003). n Adults who are economically inactive are at increased risk of mental illness (Black 2008). n Lack of income may lead to increased housing risk and an increased risk of mental disorder (Weich & Lewis, 1998). | n Physical and sexual violence have direct health consequences and are risk factors for a wide range of long term health problems including mental health, substance abuse, unwanted pregnancy, sexually transmitted diseases and risky sexual behaviour. |

### 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. | n Reduced levels of mental health problems and physical injuries as a consequence of abuse. n Reduced crime, aggression and violence. n Improved long term self-management of other conditions | n Reduced levels of mental health problems and physical injuries as a consequence of abuse. n Reduced crime, aggression and violence. n Improved long term self-management of other conditions | n Reduced levels of mental health problems and physical injuries as a consequence of abuse. n Reduced crime, aggression and violence. n Improved long term self-management of other conditions | n Physical and sexual violence have direct health consequences and are risk factors for a wide range of long term health problems including mental health, substance abuse, unwanted pregnancy, sexually transmitted diseases and risky sexual behaviour. |

### Multi-component interventions that integrate skills development and training of teachers and parents, supported by specialists (see area 1 above) Key role of primary care and the wider health and social services to offer a holistic approach to abuse with an understanding of the contribution of violence and abuse to health and social care problems. | n Reduced levels of mental health problems and physical injuries as a consequence of abuse. n Reduced crime, aggression and violence. n Improved long term self-management of other conditions | n Reduced levels of mental health problems and physical injuries as a consequence of abuse. n Reduced crime, aggression and violence. n Improved long term self-management of other conditions | n Reduced levels of mental health problems and physical injuries as a consequence of abuse. n Reduced crime, aggression and violence. n Improved long term self-management of other conditions | n Physical and sexual violence have direct health consequences and are risk factors for a wide range of long term health problems including mental health, substance abuse, unwanted pregnancy, sexually transmitted diseases and risky sexual behaviour. |

### Multi-sectoral action through multi-agency arrangements between NHS, LAs, Police, Probation, Third sector etc

| n Physical and sexual violence have direct health consequences and are risk factors for a wide range of long term health problems including mental health, substance abuse, unwanted pregnancy, sexually transmitted diseases and risky sexual behaviour. | n Physical and sexual violence have direct health consequences and are risk factors for a wide range of long term health problems including mental health, substance abuse, unwanted pregnancy, sexually transmitted diseases and risky sexual behaviour. | n Physical and sexual violence have direct health consequences and are risk factors for a wide range of long term health problems including mental health, substance abuse, unwanted pregnancy, sexually transmitted diseases and risky sexual behaviour. | n Physical and sexual violence have direct health consequences and are risk factors for a wide range of long term health problems including mental health, substance abuse, unwanted pregnancy, sexually transmitted diseases and risky sexual behaviour. | n Physical and sexual violence have direct health consequences and are risk factors for a wide range of long term health problems including mental health, substance abuse, unwanted pregnancy, sexually transmitted diseases and risky sexual behaviour. |

### Integrated physical and mental health promotion interventions for high risk groups through primary care. Skilled staff orientated to respond to the mental health needs of primary care patients.

| Improved physical and mental health behaviour change through brief interventions. Opportunistic health promotion interventions for high risk groups through primary care. | n Integrated physical and mental health promotion interventions for high risk groups through primary care. Skilled staff orientated to respond to the mental health needs of primary care patients. | n Integrated physical and mental health promotion interventions for high risk groups through primary care. Skilled staff orientated to respond to the mental health needs of primary care patients. | n Integrated physical and mental health promotion interventions for high risk groups through primary care. Skilled staff orientated to respond to the mental health needs of primary care patients. | n Integrated physical and mental health promotion interventions for high risk groups through primary care. Skilled staff orientated to respond to the mental health needs of primary care patients. |
### Appendix 7

**CCG Weighted Populations (Mental Health)**

<table>
<thead>
<tr>
<th>CCG Weighted Populations (Mental Health)</th>
<th>Weighted Population</th>
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<tbody>
<tr>
<td>NHS Birmingham CrossCity CCG</td>
<td>279,258</td>
</tr>
<tr>
<td>NHS Birmingham South and Central CCG</td>
<td>987,078</td>
</tr>
<tr>
<td>NHS Cannock Chase CCG</td>
<td>112,456</td>
</tr>
<tr>
<td>NHS Coventry and Rugby CCG</td>
<td>472,627</td>
</tr>
<tr>
<td>NHS Dudley CCG</td>
<td>386,727</td>
</tr>
<tr>
<td>NHS East Staffordshire CCG</td>
<td>111,058</td>
</tr>
<tr>
<td>NHS Redditch and Bromsgrove CCG</td>
<td>352,942</td>
</tr>
<tr>
<td>NHS Sandwell and West Birmingham CCG</td>
<td>252,996</td>
</tr>
<tr>
<td>NHS South East Staffs and Seisdon Peninsular CCG</td>
<td>145,340</td>
</tr>
<tr>
<td>NHS South Warwickshire CCG</td>
<td>119,213</td>
</tr>
<tr>
<td>NHS Walsall CCG</td>
<td>271,167</td>
</tr>
<tr>
<td>NHS Wyre Forest CCG</td>
<td>27,590</td>
</tr>
</tbody>
</table>

Source: NHS England


[accessed 120516]

### Appendix 8

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


<table>
<thead>
<tr>
<th>NHS Trust</th>
<th>Day Care Services</th>
<th>Crisis Resolution Team/Home Treatment</th>
<th>Adult Community Mental Health Team</th>
<th>Assertive Outreach Team</th>
<th>Reh. Recovery Team</th>
<th>General Psychiatry</th>
<th>Psychiatric Liaison</th>
<th>Psychotherapy Service</th>
<th>Psychological Therapy Service (non-IAPT)</th>
<th>Young Onset Dementia Personality Disorder Service</th>
<th>Early Intervention in Psychosis Team</th>
<th>Forensic Service</th>
<th>Community Forensic Service</th>
<th>Peri-Natal Mental Illness Eating Disorders/Dietetics Substance Misuse Team</th>
<th>Criminal Justice Liaison and Diversion Service</th>
<th>Prison Psychiatric Inreach</th>
<th>Asylum Service</th>
<th>Other MH Service – in scope of PBR</th>
<th>Other MH Service – out of scope of PBR</th>
<th>Day Care Facility Attendance</th>
<th>Other Service Attendance</th>
<th>Total Day Care Facility Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>BSMT</td>
<td>32.435</td>
<td>70.025</td>
<td>179.975</td>
<td>40.925</td>
<td>*</td>
<td>25.690</td>
<td>20.160</td>
<td>5.920</td>
<td>4.115</td>
<td>1.195</td>
<td>1.585</td>
<td>2.875</td>
<td>27.590</td>
<td>2.273</td>
<td>8.745</td>
<td>8.745</td>
<td>7.65</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>130</td>
<td>1.6415</td>
</tr>
<tr>
<td>BUFPT</td>
<td>3.370</td>
<td>18.980</td>
<td>5.020</td>
<td>5.920</td>
<td>*</td>
<td>51.440</td>
<td>2.885</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>8.480</td>
<td>18.5</td>
<td>1.700</td>
<td>110.0</td>
<td>*</td>
<td>3.130</td>
<td>755</td>
<td>*</td>
<td>1.080</td>
<td>1.0740</td>
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</tr>
<tr>
<td>DWMPFT</td>
<td>545</td>
<td>31.725</td>
<td>4.325</td>
<td>70</td>
<td>*</td>
<td>92.220</td>
<td>4.590</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>6.525</td>
<td>*</td>
<td>4.980</td>
<td>*</td>
<td>3.030</td>
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<td>8.040</td>
<td>2.15</td>
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</tbody>
</table>

126Data source: Health & Social Care Information Centre Mental Health Minimum Dataset MHN05/MHLD003 2015 (accessed 150816)
Appendix 9

**Vanguards**

**MODALITY BIRMINGHAM AND SANDWELL**

*Patient population: 70,000*

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

The vision for the vanguard is to develop a health and social care system accessible through GP practices, with a care-coordinator to support patients on their journey. This will be achieved by delivering medical services from a number of primary care centres across Birmingham and Sandwell.

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

**DUDLEY MULTISPECIALTY COMMUNITY PROVIDER**

*Patient population: 318,000*

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

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

Under the new provider system 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, council and police. The ambition is to extend healthy active life and independence with equal focus on physical and mental health through encouraging lifestyle choices, care-coordination and empowerment for self-management of long-term conditions, reducing pressures on secondary care services and altering the balance of care provided in hospital and the community. This includes:

- Establishment of a Primary Care Centre within a health and wellbeing campus (on hospital site).
- Co-location of GP Out of Hours, Urgent Care Walk In / Minor Injury services into a single Urgent Care Centre.
- Establishment of a GP led step-up / step-down unit within the hospital.
- Improved access to diagnostics and secondary care specialists for primary care / community teams supported by innovative information technologies.
- Mental Health services; building on Rapid Assessment Interface and Discharge, Street Traige, 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>Primary Group</th>
<th>Mental health provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birmingham</td>
<td>1,450 young men aged 18-21</td>
<td>Primary care provided by SSOTP and South Staffordshire and Shropshire Healthcare NHS Foundation Trust. Drug and Alcohol service (DARS) is provided by Lifeline and Delphi Medical.</td>
</tr>
<tr>
<td>Dudley and Walsall</td>
<td>569 young men aged 18-21</td>
<td>Primary care provider is SSOTP and South Staffordshire and Shropshire Healthcare NHS Foundation Trust. Drug and Alcohol service (DARS) is provided by Lifeline and Delphi Medical.</td>
</tr>
<tr>
<td>Dudley</td>
<td>1,060 men</td>
<td>GP, Primary Care, and Integrated Substance Misuse staff are directly employed by Care UK. Primary care provider is SSOTP. Mental Health In-Reach and Substance Misuse services are provided by BSMHFT.</td>
</tr>
<tr>
<td>Drake Hall</td>
<td>315 women aged 18</td>
<td>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 service (DARS) is provided by Lifeline and Delphi Medical.</td>
</tr>
<tr>
<td>Featherstone</td>
<td>687 men</td>
<td>Primary care 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.</td>
</tr>
<tr>
<td>Hewell</td>
<td>1,281 men</td>
<td>Primary care provider is Worcestershire Healthcare NHS Trust (WHCT). Integrated Mental Health Services and Integrated Substance Misuse Service, incorporating clinical and psychosocial services, provided by WHCT.</td>
</tr>
<tr>
<td>Long Lartin</td>
<td>622 men</td>
<td>Primary care provider is WHCT. 10 bedded inpatient unit for both physical and mental health needs. Integrated Mental Health Services and Integrated Substance Misue Service, incorporating clinical and psychosocial services, provided by WHCT.</td>
</tr>
<tr>
<td>Lifecircle</td>
<td>1,605 men</td>
<td>Primary care 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, provided by WHCT.</td>
</tr>
<tr>
<td>Stafford</td>
<td>741 men</td>
<td>Primary care 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.</td>
</tr>
<tr>
<td>Stoke Heath</td>
<td>766 adult and young adult men aged 18+</td>
<td>Primary care provider is SHCNT. Mental Health In-Reach services are delivered by South Staffordshire and Shropshire Healthcare NHS Foundation Trust. Substance Misuse Services provided through a partnership between RAPPS (Rehabilitation for Addicted Prisoners Trust) and North Staffordshire Combined NHS Trust.</td>
</tr>
<tr>
<td>Solihull</td>
<td>654 men aged 15-18</td>
<td>Primary care provider is SSOTP. Mental Health In-Reach services are delivered by South Staffordshire and Shropshire Healthcare NHS Foundation Trust. Drug and Alcohol service provided by Lifeline and Delphi Medical.</td>
</tr>
<tr>
<td>Walsall</td>
<td>160 young men aged 15-18</td>
<td>Primary care provider is SSOTP. CAMHS provision is by EVADE (South Staffordshire and Shropshire NHS Foundation Trust). The Young Persons Drug and Alcohol Support Service is provided by Lifeline and Delphi Medical.</td>
</tr>
</tbody>
</table>

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### Abbreviations and acronyms

- **A&E**: Accident and Emergency
- **ACEs**: Adverse Childhood Events
- **ASIST**: Applied Suicide Intervention Skills Training
- **BAME**: Black, Asian and Minority Ethnic
- **BCU**: Boston Consulting Group
- **BSMHFT**: Birmingham and Solihull Mental Health NHS Foundation Trust
- **CBT**: Cognitive Behavioural Therapy
- **CCG**: Clinical Commissioning Group
- **CAMHS**: Child and Adolescent Mental Health Services
- **CPD**: Chartered Institute of Personnel and Development
- **CPA**: Care Programme Approach
- **CPN**: Community Practice Nurse
- **CQC**: Care Quality Commission
- **CRCs**: Community Rehabilitation Companies
- **CIS**: Criminal Justice System
- **CWPT**: Coventry and Warwickshire Partnership NHS Trust
- **DALS**: Disability-adjusted life-year
- **DWMMFT**: Dudley and Walsall Mental Health Partnership NHS Trust
- **DWP**: Department of Work and Pensions
- **EIP**: Early intervention
- **EPI**: Early intervention for psychosis
- **FTB**: Forward Thinking Birmingham
- **GOOP**: Gross Domestic Product
- **HSCIC**: Health and Social Care Information Centre
- **HSJ**: Health Service Journal
- **HSSFT**: Health Service Journal
- **JHWB**: Joint Health and Wellbeing Strategy
- **JSNA**: Joint Strategic Needs Assessment
- **LA**: Local Authority
- **LCG**: Local Enterprise Partnership
- **LOSC**: Length of stay
- **MERT**: Mental Health Alliance for Excellence, Resilience, Innovation and Training
- **MHA**: Mental Health Act
- **MFA**: Mental Health First Aid
- **MMDS**: Mental Health Minimum Data Set
- **MUS**: Medically unexplained symptoms
- **NAC**: 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**: Out of Area Treatment/Placements
- **ONS**: Office for National Statistics
- **NCU**: Psychiatric Intensive Care Unit
- **OS**: Quality-adjusted life-year
- **QOF**: Quality Outcomes Framework
- **RAI**: Rapid, Assessment, Interface and Discharge
- **RCT**: Randomised Control Trial
- **SSOTP**: Staffordshire and Stoke-on-Trent Partnership NHS Trust
- **STPs**: Sustainability and Transformation Plans
- **WMCA**: West Midlands Combined Authority
- **WHO**: World Health Organization

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