



UNIVERSITY OF
BIRMINGHAM

MENTAL HEALTH IN THE WEST MIDLANDS COMBINED AUTHORITY

**A report for the West Midlands
Mental Health Commission**

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Dr Karen Newbigging,
Health Services Management Centre, University of Birmingham

Michael Parsonage,
Centre for Mental Health



Foreword

Rt. Hon. Norman Lamb MP

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

The West Midlands Mental Health Commission asked the Health Services Management Centre at the University of Birmingham, in partnership with the Centre for Mental Health, to develop this report, to provide us with a baseline audit of the picture in relation to poor mental health across the region, in terms of services, emerging good practice and the economic impact.

This report describes some of the services and initiatives already in place and highlights examples of good work already being done. In doing so it illustrates the high cost of poor mental health on the region. The current financial impact is estimated to be over £12 billion per year.

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

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

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

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



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Executive Summary

Mental health in the WMCA

- There are an estimated 4.032 million people in 2014–15 living in the West Midlands Combined Authority (WMCA). The population is culturally diverse, with over 22% from Black and Asian Minority Ethnic communities, ranging from 2.3% in Cannock Chase to 42% in Birmingham.
- Over half of the population of the WMCA live in the 20% most deprived areas in England. There are links between insecure housing, financial stress, mental health and child development, which influence life chances and social mobility.
- Data from the ONS subjective wellbeing survey points to wide variations between West Midlands Local Authorities with rates of wellbeing that are below the national average for Wolverhampton, Birmingham and Coventry and above average for Sandwell.
- Nearly a quarter of adults living in the WMCA are experiencing a mental health problem at any one time. The risks of poor mental health are **not uniformly distributed** across the WMCA population. They are influenced by social, economic and physical environmental factors and social inequalities in particular.
- Women living in the poorest households are nearly three times as likely as men living in the most well-off households to be diagnosed with a common mental health problem such as anxiety or depression. On the other hand, men are more than four times more likely than women to die as a result of suicide.
- In 2015, there were 477 deaths recorded as suicide in the West Midlands which at 9.6 deaths per 100,000 population is lower than the rate for England at 10.9 deaths per 100,000 population. People living in the poorest socio-economic circumstances are ten times more at risk of suicide than those in well-off households.
- People with an increased risk of developing mental health problems and/or for whom access to effective help is problematic are:
 - Looked after children and young people leaving care
 - Homeless people and people living in poor quality housing
 - Unemployed people
 - People from Black, Asian and Minority Ethnic communities
 - Lesbian, Gay, Bisexual and Trans people
 - People with long-term physical health conditions
 - People with disabilities, including learning difficulties and sensory impairments
 - Carers
 - Survivors of sexual, emotional and physical abuse
 - People experiencing severe and multiple disadvantage.
- Detailed profiling of mental health needs in the WMCA has yet to be provided. Local Authorities have a responsibility to undertake Joint Strategic Needs Assessments (JSNAs) in their localities and these should provide a detailed picture of the local population and their mental health needs. The quality of JSNAs across the WMCA is variable, and poor quality JSNAs will hamper strategic planning and understanding of whether progress is being made on addressing inequities in access to effective support, and the promotion of health and wellbeing.
- Co-production and community engagement are central to developing an understanding of the mental health needs of the WMCA population, the challenges they face, and the opportunities to strengthen resilience. They provide a foundation for service transformation.

NEARLY A QUARTER OF ALL ADULTS LIVING IN THE WMCA ARE EXPERIENCING A MENTAL HEALTH PROBLEM AT ANY ONE TIME



THE COSTS OF POOR MENTAL HEALTH TO THE WMCA

- The aggregate economic and social cost of mental health problems in the WMCA is estimated at around **£12.6 billion in 2014–15**, equivalent to a cost of about **£3,100 per head of population**.
- Care costs, covering the costs of health and other services provided for people with mental health problems by the NHS, social services, schools etc., and also the informal care provided by family and friends, account for **28.0% of the total**.

- Mental ill health is estimated to cost the NHS nearly **£2 billion** a year in the WMCA. Only about half of this represents the direct costs of treatment and care for people with diagnosable mental health problems. The other half arises mainly because large numbers of people with long-term physical conditions, such as diabetes and asthma, also suffer from depression or anxiety and this greatly increases the costs of physical health care.
- Spending on physical healthcare is also pushed upwards because of medically unexplained symptoms, ie, physical symptoms which have no apparent underlying organic cause and are thought to be psychological in origin.
- The cost of Local Authority Care for children in care because of parental mental illness mental health and/or substance abuse is estimated at **£0.1 billion a year**.
- The value of informal care provided by family and friends for people in the WMCA with mental health problems is estimated at **£1.1 billion a year**.
- Employment costs, measuring 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, are estimated at around **£3.9 billion a year** equivalent to **31.5% of total costs**. These divide more or less equally between: (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 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 are estimated at just over **£5 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 conduct disorder, and the estimated aggregate lifetime cost for this one-year cohort is over **£0.7 billion**.

MENTAL HEALTH SUPPORT IN THE WEST MIDLANDS

PROMOTING PUBLIC MENTAL HEALTH

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

- Programmes to improve the physical health of people with mental health problems
- Suicide prevention
- Some of these initiatives are short-term projects and at particular risk of austerity measures being taken by Local Authorities to reduce overall expenditure.
- Universal services notably, the police, fire service, libraries and museums have an important role to play in prevention, as front-line services, by promoting awareness of health and wellbeing and self-management, and access to appropriate support.
- There is considerable scope to develop a strategic approach to public mental health and prevention, and the introduction of the Prevention Concordat offers a critical opportunity for the WMCA to adopt prevention, in a context of a life course approach, as a key focus.

PRIMARY CARE

- There are 716 GP practices covered by the 15 CCGs in the WMCA. It has been estimated that about one in four adults of a GP's patients will need treatment for mental health problems but there is substantial variation in practice sizes and the level of mental health needs in each CCG.
- Primary care plays a central role in any prevention strategy because of its provision of universal services, eg, to pregnant women and new mums, sexual health and screening services, as well as approaches for people with long-term physical health conditions, and there may be opportunities to strengthen these at a practice level. It is not clear the extent to which this is happening at practice level or being promoted by CCGs.
- There is no single model or agreement about what good primary mental health care looks like across the WMCA. However, several CCGs are in the process of redesigning primary care mental health services to strengthen mental health provision in primary care, early intervention and access to specialist support.

- Annual expenditure on primary care prescribing spend on mental health is £12 per head in the WMCA, compared with a national average of £13. Spending per head by CCG ranges from £8 to £15.50.
- Improving access to Psychological Therapies (IAPT) is a key strand of primary mental health care. The referral rates for IAPT vary across the country and in 2014, 13% of people with anxiety and depression across WMCA (compared with 12% across England) accessed IAPT services at any one point. The West Midlands was below the national average for IAPT; 621 people compared with a national average of 691 referrals per 100,000 population. Although there has been an improvement in the number of people waiting less than 28 days for therapy, there is considerable variation across the CCGs in the WMCA and 40% of CCGs are below the average for England.

EARLY INTERVENTION

- Any general strategy for early intervention should focus mainly on children 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 (EIP) 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 EIP services were introduced in 2015/16 by NHS England and data on performance against this target is only starting to become available and is not, as yet, comprehensive for the WMCA.

CRISIS INTERVENTION

- The Care Quality Commission has recently identified that mental health crisis care provision remains both inconsistent and inadequate. All CCGs in the WMCA have developed action plans to improve local access.
- Promising initiatives in the WMCA include street triage, the redesign of the urgent care pathways and crisis houses. There is emerging evidence that crisis houses are more cost-effective than inpatient care and are more valued by service users but there are currently only four in the WMCA.
- The rate of attendance at A&E for people with mental health problems in the WMCA is 180 attendances, per 100,000 population which is below the national average of 250. The picture is similar for self-harm. There is, however, significant variation across CCGs in the WMCA, from less than ten to more than 400 attendances per 100,000 population.

SPECIALIST MENTAL HEALTH SERVICES

- At any given point, around 2% of service users in secondary mental health care will be in mental health inpatient beds. The remaining 98% will be under the care of community mental health teams.
- The West Midlands has lower numbers of people in contact with specialist mental health services than other areas of England.
- In the WMCA, the average spend on specialist mental health services is £164 per head of population, with a range from approximately £110 to £220, compared with an England average of £154.
- The four main providers are Birmingham and Solihull Mental Health NHS Foundation Trust; Black Country Partnership NHS Foundation Trust; Coventry and Warwickshire Partnership NHS Trust; and Dudley and Walsall Mental Health Partnership NHS Trust. Specialist mental health services are also commissioned from South Staffordshire and Shropshire Mental Health Trust and from Worcestershire Health and Care NHS Trust for residents of Bromsgrove, Redditch and Wyre Forest. Forward Thinking Birmingham provides mental health services for children and young people up to the age of 25. The four main providers have come together to

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

- form an alliance under NHS England's New Care Models Vanguard Programme: the Mental Health Alliance for Excellence, Resilience, Innovation and Training (MERIT), which aims to spread best practice and reduce variations in cost and quality.
- The overall bed numbers are broadly similar to four years ago, although there has been an increase in the number of secure beds and a reduction in the number of beds for older adults.
- There was an average of 185 admissions to psychiatric inpatient beds per 100,000 population during 2013/14, compared with an England average of 227. Admission rates are influenced by a range of factors including bed numbers and bed occupancy as well as access to community support and supported accommodation.
- Approximately a quarter of people admitted were detained under the 1983 Mental Health Act. The rates of detention have been increasing nationally for the past 20 years and this is reflected in the figures for the WMCA. In 2014/15, the average rate of detentions was 81.2 per 100,000 population, slightly above the England average of 77.2. In 2015/2016, people from Black British/Black/Mixed and British Asian/Asian/Mixed Asian together constituted 42% of people detained under the MHA and this is above the expected rate.
- The four NHS Trusts provide a broad range of outpatient and community services. Their focus is largely on people with a severe mental health condition: early intervention teams; intensive home based treatment teams; crisis response teams; generic community mental health teams; recovery and wellbeing teams, enabling daily living, problem-solving and coping skills; and assertive 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 outcomes 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. Local Authorities also provide social work services and commission a broad range of mental health services from the third sector. The role of social work in adult mental health includes ensuring eligible people can access social care resources, including direct payments and personal budgets, and acting as Approved Mental Health Practitioners, alongside other mental health professionals, and in building community capacity.
- The Care Act 2014 placed a duty on Local Authorities to promote wellbeing, physical and emotional, when carrying out their duties (Department of Health, 2014).
- Increasing thresholds for eligibility, reflecting reductions in Local Authority budgets, may mean that many people simply are not getting the support they need, with the responsibility for providing care shifting to informal carers.
- During 2014/15, approximately 4,380 people (18–64) received Local Authority funded Mental Health Support in the WMCA: 12.3% received a direct payment and 25% a managed personal budget. The use for mental health clients is substantially lower than for other client groups.

- The implementation of personalisation varies across the WMCA, with Warwickshire having the highest rate for its use of direct payments and Birmingham for personal budgets. There are other Local Authorities, specifically Walsall and Staffordshire, where implementation of direct payments and personal budgets is appearing to be lagging behind.
- There are approximately 420,000 carers in the WMCA and this figure is increasing. The Care Act 2014 placed a duty on Local Authorities to assess and provide support to carers in their own right. A recent review of this Care Act duty found that the implementation was poor, with the majority of carers unaware of their rights. The review highlighted the need to ensure that all social workers and assessors are appropriately trained, and reflect the wellbeing principle in assessment and care and support planning.

THE THIRD SECTOR

- The third sector, often referred to as the voluntary sector, comprises charities, social enterprises, and community groups, which are typically driven by a social mission, are close to and have expertise in communities, and involve service users and local people in their governance arrangements. It occupies a specialist niche within a wider ecosystem of mental health support, reflecting the marked involvement of current and former service users.
- This report does not do justice to the wealth and diversity of the third sector across the WMCA in relation to mental health. This requires further work to better understand the sector's contribution. Third sector services serving individuals with mental health problems are provided by: specialist mental health organisations, for example Mind; organisations primarily concerned with social issues, such as domestic violence, for example Women's Aid, or homelessness, for example St Mungo's; those primarily concerned with a client group, for example SignHealth 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
- Advocacy, both statutory and non-statutory advocacy to enable people to have a voice and greater choice and control
- Carers' support groups and events to promote their wellbeing
- Counselling, including bereavement counselling and trauma-focused counselling, IAPT services and stress and anxiety management courses;
- Creative sessions: art, writing and music
- Horticulture/conservation/sports projects, for example, football targeted at men who would not ordinarily access mental health services
- Community development workers to increase engagement with particular groups
- Welfare rights advice, including benefits, debt and housing;
- Recovery-oriented courses and workshops
- A wide range of employment support
- A range of support with housing including accommodation, floating support to enable people to maintain their independence, while ensuring that their mental health needs and daily living skills are being addressed
- Mental health awareness training including Mental Health First Aid and suicide prevention training

Funding sources for these services include: CCG and Local Authority funding; charitable donations; income-generation activities; and awards from national grant-making bodies, such as the Big Lottery and Comic Relief. The third sector brings in additional resources from various sources external to the WMCA, either on its own or as a partner with other organisations, including the statutory sector.

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

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

QUALITY OF LIFE FOR PEOPLE WITH A DIAGNOSIS OF MENTAL ILLNESS

- People with a diagnosis of severe mental illness have a much shorter life expectancy than the population average and high priority should be given to addressing this inequality.
- Recovery-focused approaches to mental health care require a different relationship between service providers and service users and Recovery Colleges are identified as central to leading this transformation. There are two out of a total of 36 listed for England 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 with their studies.
- Peer support is now widely recognised as helpful in promoting wellness and empowerment, with many voluntary and community organisations encouraging peer support. The CQC, however, found that only about half of those people who felt they would benefit from peer support were offered it. Many third sector organisations are organised around peer support or provide a range of peer support, and there is a wide range of initiatives in the WMCA including Hearing Voice in West Bromwich; BGLAD (Birmingham Gays and Lesbians against Depression) and First Person Plural for people identifying with complex dissociative identity disorders in Wolverhampton; those provided by the six local Mind organisations (Birmingham, Coventry and Warwickshire, Dudley, Mid Staffs, Solihull and Springfield Mind in South Warwickshire); and Kaleidoscope Plus, in Sandwell.

- Housing First, Individual Placement and Support and personal budgets have all been identified as supporting recovery because their starting point is accommodating support to individuals, rather than vice versa.

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 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 schemes and the amount which will be funded. The delay on the introduction of this cap is adversely impacting upon the development of supported housing and, if introduced, will mean that 41% of all schemes will become unviable.
- In the WMCA, 74% of adults who are in contact with secondary mental health services and on a Care Programme Approach (CPA), live in stable and appropriate accommodation. This compares favourably with an England average of 59% but there are some outliers, and it would 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 sleeping rough and facing multiple exclusions in Birmingham, Solihull, Coventry and Stratford-upon-Avon.
- There is an active Health, Wellbeing and Housing Group, whose aim is to promote further partnership working between Housing Associations, the NHS and local authorities based on evidence, from their work to date, that

a joined-up approach can save money and provide a better service to people who use mental health services.

EMPLOYMENT

- There are strong links between employment and mental health. The DWP-funded Work Choice Programme for people with mental health problems has providers 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 funded by 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.
- There are currently eight providers of IPS in the WMCA, five of which have been rated as good or excellent by the Centre for Mental Health in terms of fidelity to the model.



THE INTELLIGENCE ON WHICH TO DEVELOP A STRATEGIC APPROACH TO MENTAL HEALTH IN THE WMCA IS NEITHER COMPREHENSIVE NOR COORDINATED AND THIS HAMPERS STRATEGIC DEVELOPMENT AT BOTH A LOCAL AND WMCA WIDE LEVEL



- In the WMCA, the average employment rate for people on the CPA was 10%, above the England mean of 7%, but there was considerable variation between the CCGs, ranging from 4–22%.
- There are initiatives underway to promote 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 top ten 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 in the WMCA to provide support include:
 - Criminal Justice Liaison and Diversion Teams provided by

- the mental health trusts
 - Prison in-reach teams provided by the mental health trusts
 - Support for prisoners ‘through the gate’

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 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

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

- adapting the best available evidence. Projects designed to strengthen public mental health are often short-term or at risk of austerity measures.
- Primary care has a key role to play and there are interesting developments at a local level but, as yet, there is no agreed vision of what good primary care looks like for the WMCA.
- The implementation of promising initiatives, with an evidence base, is patchy, but the West Midlands Mental Health Commission is in a good position to promote the scaling up of these including: perinatal mental health support; whole school approaches to mental health; targeting families with experience of Adverse Childhood Events; wellbeing at work; Individual Placement and Support; Housing First; social and emotional learning in schools; early intervention in psychosis; street triage and expanding IAPT provision to socially disadvantaged groups.
- The third sector promotes an ethos of open door 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 Joint 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 quantitative data on access and outcomes and fine-grained qualitative data to understand the real life experience of people with mental health problems, their preferences for support and the outcomes they are seeking to achieve.
3. Co-production should be a foundation for mental health service transformation across the WMCA and will help ensure that accessible, acceptable and appropriate services are commissioned, developed and delivered to meet the diverse needs of the WMCA population.
4. It is essential to understand the diversity of the WMCA population, in terms of inequalities in outcomes; conceptions of mental health; barriers to access; and preferences in terms of service design and support. This needs to include those who do not currently access any support and may be further marginalised by an emphasis on self-management. This is central to ensuring that inequalities are not embedded in the approach of the West Midlands Mental Health Commission.
5. This assessment has identified groups who are at particular risk of poor mental health and who may be in contact with a range of public services, with effort duplicated between them. Improving coordination and partnership working for these populations should be a priority.

6. A strategy for public mental health needs to be developed for the WMCA. Any strategy to improve the mental health of the WMCA population has to invest in the mental health of children and young adults and this will prove to be cost-effective. This includes attention to parental mental health and substance misuse.
7. There is not a shared understanding of what good primary mental health care looks like and different models are emerging across the WMCA. Identifying the components of good primary care mental health would facilitate a coherent approach across the WMCA and ensure that the full potential of primary care is maximised to support people with mental health problems, including people with co-morbid physical health problems.
8. Organisations and communities in the WMCA have pioneered innovative approaches in mental health that have been adopted outside the area. There are also examples of promising practice where the evidence is incomplete. Where this is the missing, the evaluation of such initiatives will be an important 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 on any scale within the WMCA. The implementation of evidence-based practice needs to be understood within the WMCA context and prioritised.
10. There are clear variations in system performance across the WMCA and the factors influencing both good and poor performance requires 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 action plans, to reduce the overall rate of detentions under the Mental Health Act and particularly those of people from BAME communities, and the use of seclusion and restraint.

12. Commissioners across the WMCA should aim to reduce the rate of Out of Area placements by developing appropriate local provision and strengthening investment in community based services, including crisis and recovery houses.
13. The evidence for personalised approaches that give people greater choice and control align with what service users and carers are asking for and are supported by evidence that indicates that they lead to better outcomes. Local Authorities should identify action to increase the use of direct payments and personal budgets.
14. A comprehensive audit of housing provision to support people with mental health problems would enable the West Midlands Mental Health Commission to further investigate the range of provision and develop a strategic approach to housing and mental health, building on the emerging evidence for Housing First.
15. The wider adoption of high quality Individual Placement and Support services should be encouraged.
16. This is challenging work, systems are slow to change and it is not a linear process. The key issue going forward is to ensure the spread of good practice and build on and strengthen the positive partnerships and collaborations, which are clearly evident. The Commission should, therefore, identify the workforce development implications for achieving the required transformation.

Introduction

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

THE WEST MIDLANDS COMBINED AUTHORITY

The WMCA covers the geography of three Local Enterprise Partnerships (LEPs) – Black Country, Coventry and Warwickshire, and Greater Birmingham and Solihull, which currently covers 12 councils (seven metropolitan and five district councils, within 3 County Councils with a further five awaiting membership) and 15 Clinical Commissioning Groups (CCGs), some of which have shared arrangements for mental health commissioning with other CCGs or with the Local Authority. The core of the WMCA is the seven metropolitan councils, which are Birmingham City Council, City of Wolverhampton Council, Coventry City Council, Dudley Metropolitan Borough Council, Sandwell Metropolitan Borough Council, Solihull Metropolitan Borough Council and 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 View¹.

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, access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure that people's human rights are protected

- Services that people receive being of the highest quality and in which they can have confidence
- Fewer people experiencing stigma and discrimination

This policy direction was subsequently reinforced by the priorities set out in *Closing the Gap: Priorities for Essential Change* to support the transformation of mental health services (Department of Health, 2014). A central ambition is for mental health to have parity esteem of with physical health, providing a central focus for NHS England². 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% will be treated within 18 weeks of referral
- More than 50% of people experiencing a first episode of psychosis will be treated with an evidence based care package within two weeks of referral

In 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 (5YFW) for Mental Health*, was published in February 2016. This sets out 57 recommendations, requiring cross-government action and multi-sector collaboration, under the following themes:

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

The 5YFW for mental health makes clear that a robust governance framework needs to be put in place to implement this five-year programme to transform mental health care. Alongside this, attention has also been paid to the commissioning and provision of accessible support for children and young people. A Children and Young People's Mental Health and Wellbeing Taskforce was established in September 2014 and the strategy, *Future in Mind* published in 2015 (Department of Health, 2015). The focus of this is improving access to care and treatment for young people to support them to realise their ambitions.

These priorities are reflected in the 2016/2017 CCG performance framework, which includes five indicators for mental health³:

- 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 services 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 statutory sector (NHS/Local Authority) and voluntary sector mental health service provision in the WMCA to describe current community and inpatient services provided for adults and young people and current performance against key mental health indicators;
- An audit of current or planned initiatives relating to mental health, whether public, private or voluntary sector to include crisis care; housing and housing related support; employment; recovery colleges; service user engagement, 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 interventions in early and mid-adulthood can also impact upon the prevalence of mental health disorders for older adults, including dementia (Heginbotham and Newbigging, 2013).

METHODS

In summary, this has involved:

1. A rapid appraisal of the literature starting with the Centre for Mental Health publications that have distilled the 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 Collaboration; Crisis Care Concordat; Joseph Rowntree Foundation; King's Fund; Local Government Association; Mental Health Foundation; National Institute for Health and Social Care; National Survivor User Network; and the Social Care Institute for Excellence) and reports and evaluations from key stakeholders in the WMCA. The aim was to identify both published and unpublished material. The analysis focused on identifying examples of promising current and emergent directions to be pursued.

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 data on 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 estimates for the West Midlands have been produced by making adjustments for such factors as: (i) relative population size; and (ii) differences in the prevalence of mental health problems in the WMCA compared with the national average in the population of working age. In one or two cases, most notably criminal justice, important methodological problems remain unresolved, eg, the exact relationship between offending and mental health, and in these cases the best approach may be to offer a range of illustrative figures based on different assumptions.

¹ www.england.nhs.uk/wp-content/uploads/2016/02/stp-footprints-march-2016.pdf

² www.england.nhs.uk/mentalhealth/parity

³ www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/03/ccg-iaf-mar16.pdf [accessed 150816].

- An audit of current public sector (NHS/ Local Authority) and voluntary sector mental health service provision using: a bespoke audit form (see Appendix 1); data in the public domain (eg, Health and Social Care Information Centre⁴; 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 community and inpatient services provided for adults and young people in the NHS and current performance against mental health indicators. Where data from local sources is reported, efforts to validate this have been made.
- Documentary analysis of key strategic plans and evaluation reports and a small number of scoping interviews to identify promising initiatives.

The work was undertaken from January to July 2016 and provides a rapid appraisal of the current situation, and was limited by the time and resources available. There have been additional challenges in undertaking this work. First, there are different jurisdictions and configurations for public service delivery in the Combined Authority area. Second, there are also different understandings concerning the focus of the WMCA and whether it is solely concerned with the constituent members (ie, the seven metropolitan councils), includes the non-constituent members or is wider to encompass the areas covered by three LEPS, recognising that the wider partnership with business through the LEPS and with neighbouring councils will be critical to the success of the WMCA. Our brief was to undertake an analysis for this wider area but other key organisations, for instance Public Health England West Midlands, have adopted a narrower definition. Third, there has not been an analysis of the mental health needs across

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

the WMCA and the quality of local 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 England⁵. 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 SOCIO-ECONOMIC CONDITIONS. OVER HALF OF THE POPULATION OF THE WMCA IS LIVING IN THE 20% MOST DEPRIVED AREAS IN ENGLAND

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

⁴ NHS Digital is the new name for the Health and Social Care Information Centre. See <https://digital.nhs.uk> [accessed 161016].

⁵ www.youtube.com/watch?v=c1ZqRmK4DXk [accessed 150816].

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 70.5% of the population in the West Midlands Region, 7.4% of the population in England and 6.2% of the population in the UK. The population is projected to increase by 8% by 2030⁶. 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 Wales⁷. However, the overall figure, obscures important demographic variations across the WMCA with some Local Authorities having a substantially higher percentage of people from BAME communities. For example, Birmingham's population, which constitutes a quarter of the overall WMCA population, has 42% of its residents from an ethnic group other than White British⁸ (and a younger profile than the English average) in comparison with 2.3% for Cannock Chase and 2.7% 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 embedded in the development of a strategic approach by the West Midlands Mental Health Commission.

In order to conceptualise the mental health of the WMCA population it is useful to distinguish between: the general population who have good mental health and for which

the task is sustaining this; the population at risk where the focus becomes reducing avoidable risks; the population with symptoms and where the need is to ensure early identification and intervention; and the population with a diagnosed mental disorder for whom the focus is on optimal management and support to promote recovery and inclusion (as depicted in Figure 1).

PREVALENCE OF MENTAL HEALTH PROBLEMS IN WMCA

The National Psychiatric Morbidity Survey identified 23.8% of all adults in the West Midlands Region with some kind of mental health problem, compared with 23.0% in England as a whole (McManus et al., 2009)⁹.

Any survey of the household population is likely to understate 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 team populations (Weaver et al., 2003). In the West Midlands in 2014/15, approximately a fifth of people in contact with mental health services were also in contact with alcohol (23.4%) and/or substance misuse services (18.5%)¹⁰.

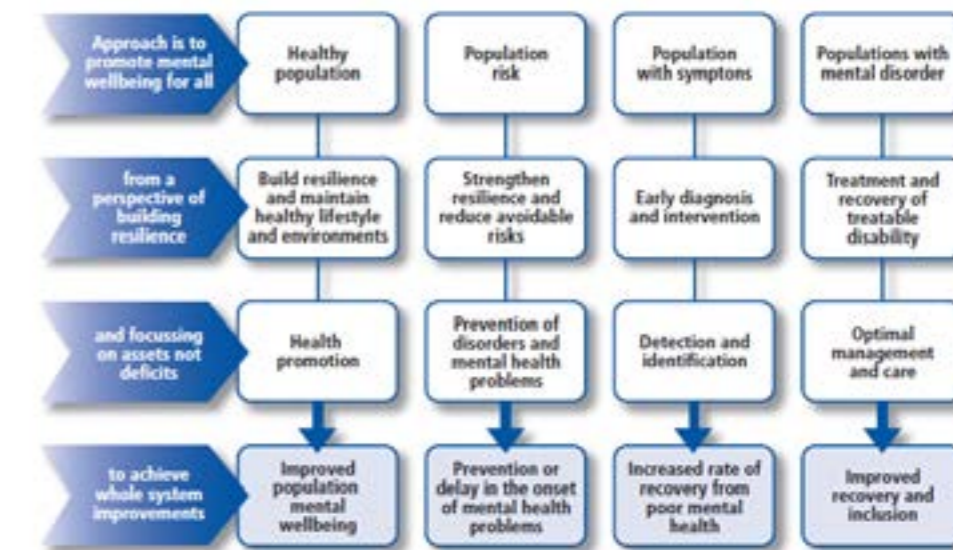


Figure 1: A population perspective to improving mental health (Heginbotham and Newbigging, 2013 adapted from Barry and Jenkins, 2007)

⁶ See the Projecting Adult Needs and Service Information tool. Available at:

www.pansi.org.uk/index.php?pageNo=407&PHPSESSID=315v74tec3qj1tbhfm73ipb5&sc=1&loc=8653&np=1 [accessed 141016].

⁷ www.ons.gov.uk/ons/rel/census/2011-census/key-statistics-for-local-authorities-in-england-and-wales/ft-table-ks201ew.xls [accessed 161016].

⁸ As above

⁹ The results of the 2014 survey was published in September 2016 and available at: <http://content.digital.nhs.uk/catalogue/PUB21748> [accessed 161016].

¹⁰ <http://fingertips.phe.org.uk/profile-group/mental-health/profile/drugsandmentalhealth/data#page/0/gid/1938132791/pat/6/par/E1200005/ati/102/are/E0800025> [accessed 150816].

In the West Midlands, in 2015, there were 477 deaths recorded as suicide, which at 9.6 deaths per 100,000 population is lower than the rate for England at 10.9¹¹. 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 point to 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 particularly high risk of suicide (Wyllie et al., 2012). The research evidence indicates a complex interplay of factors including unemployment and economic hardship, lack of close social and family relationships, restricted notions of masculinity and reluctance to access formal support, personal crises such as divorce, as well as a general 'dip' in subjective well-being among people in their mid-years, compared with both younger and older people (Wyllie et al., 2012). Furthermore, there is emerging evidence that this has been exacerbated by the current post-2008 economic crisis (Wyllie et al., 2012).

People experiencing a severe mental illness have a much lower life expectancy than average, with a mortality rate, more than three times higher than the general population¹². They are four times more likely to die from diseases of the respiratory system and digestive system, and two and a half times more likely to die from diseases of the circulatory system¹³. This reflects a variety of influences, including lifestyle factors; the fragmentation of services; missed or incorrect diagnoses of physical

health problems, including diagnostic overshadowing; and barriers to accessing healthcare including screening (Jones et al., 2008; Lawrence and Kisely, 2010).

FACTORS INFLUENCING MENTAL HEALTH

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

The WMCA covers areas of affluence as well as those with significant socio-economic deprivation and this is reflected in the prevalence data. Eight of the councils have indicators of socio-economic deprivation that are lower than the average for England, while over half of the WMCA population is living in areas, which are among the 20% most deprived areas in England namely: Walsall, Wolverhampton, Sandwell (Black Country) and Birmingham (Greater Birmingham), which constitute part of the core of the WMCA. In these areas nearly 30% of children are living in low income households and rates of overcrowding are higher than the average for England (see Appendix 2). The Social Mobility and Child Poverty Commission (2015) recently highlighted the links between financial stress, mental health and child development, which influence life chances and social mobility. Gutman et al., (2015) using data from the Millennium cohort study, identified that the prevalence of diagnosable mental health problems in children is strongly related to parental education, parental occupation and family income. In 2012, 17% of 11-year-olds from families in the bottom fifth of the income

THE RISK OF EXPERIENCING POOR MENTAL HEALTH ARE NOT UNIFORMLY DISTRIBUTED ACROSS THE WMCA. THERE ARE LINKS BETWEEN INSECURE HOUSING, FINANCIAL STRESS, AND MENTAL HEALTH AND CHILD DEVELOPMENT

distribution were identified as having severe mental health problems compared with only 4% among those from families in the top fifth. This income-related gradient is much steeper among children than it is among adults and appears to have become steeper in recent years (Gutman et al., 2015). Another recent review of the evidence has concluded that austerity measures, which have hit poorer people the hardest, have damaging psychological consequences, including humiliation and shame; fear and distrust; instability and insecurity; isolation and loneliness; and feeling trapped and powerless (McGrath et al., 2015: 1).

Figure 3 provides an illustration of the relationship between diagnosed condition¹⁴ and gender and household quintile¹⁵ 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 (ie, 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 illness¹⁶. For those in the lowest income quintile, 39% of women reported being diagnosed with a common mental disorder and 10% with a serious¹⁷ or complex mental illness¹⁸, compared with 23% and 11% of men. It is important to note that there are gender

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differences in alcohol and substance abuse (and suicide) which more adversely affect men more than women.

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

The relationship between deprivation and prevalence is also highlighted by Joint Strategic Needs Assessments (JSNAs) that have examined data at a ward level; for example the Solihull JSNA for 2012 identified that the rates of mental disorder are three times more common in North Solihull than more affluent areas. This analysis emphasises the importance of understanding the impact of deprivation on mental health and its differential effect in terms of demographic characteristics. This is clearly important in considering the mental health of future generations in the WMCA: 'invest in children, start with

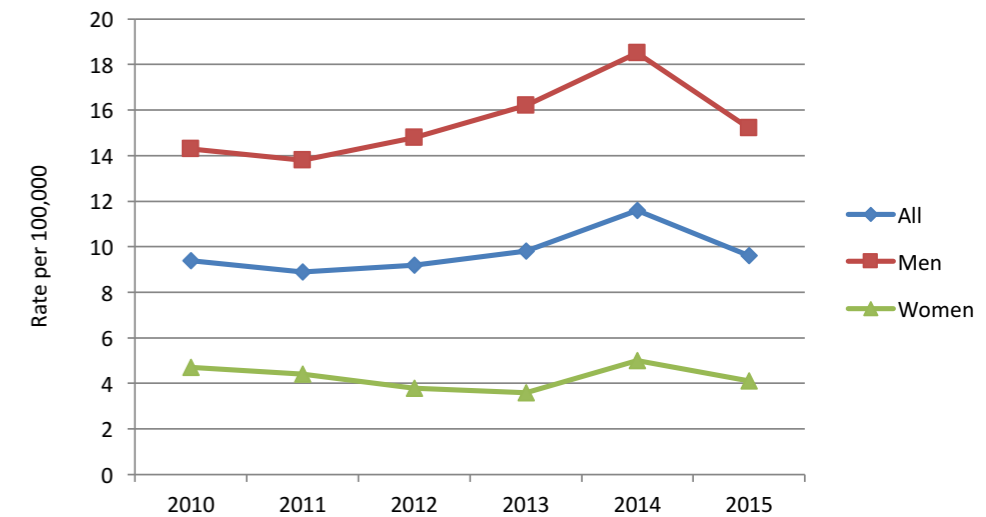


Figure 2: Rates of deaths by suicide per 100,000 population in the West Midlands (Source: ONS Suicides in the United Kingdom, 1981-2001)

parents' (Heginbotham and Newbigging, 2013). However, the causation also runs the other way, ie, mental ill health leads to deprivation, eg, because it prevents people from working. This phenomenon, sometimes termed social drift, is particularly evident for people with a diagnosis of severe mental illness.

POPULATIONS AT RISK OF POOR MENTAL HEALTH

The message that one in four of the adult population will experience a mental health problem in any given year is now widely promoted and forms an important strand of shifting the stigma around poor mental health¹⁹. However, as observed above, the risks of developing a mental health problem, and the nature of that problem, are not equally distributed across the population. Homogenising the risks in this way may result in further inequity. As well as 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 below, eg, veterans, where attention should be paid to their specific needs. There is always a danger in drawing attention to people as having specific needs that they are framed in problematic terms. The West Midlands Mental Health Commission need to be alert to the this and locate the issues in the situated nature and social context of people's life experiences, as well as

understanding population characteristics that may increase vulnerability to poor mental health.

1. Children and young people Mental health problems in childhood

Mental health problems in children and young people can be long-lasting and 50% of mental illness in adult life (excluding dementia) starts before age 15 and 75% by the age 18 (Department of Health, 2013a: 177). As outlined in the Chief Medical Officer's report for 2012, there are strong associations with socio-economic deprivation with both mothers and children at increased risk of psychological problems and poor general health (Department of Health, 2013a).

This underlines the importance of a life course approach and the early years as being a critical opportunity for intervention to promote good mental health. Any strategy to improve the mental health of the WMCA population has, therefore, to address the foundations for good mental health in adulthood by also focusing on children and young adults (WHO and the Calouste Gulbenkian Foundation, 2014; Heginbotham 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.

¹¹ Suicides in the United Kingdom, 2013 Registration. This rate differs from the rate given by the National Confidential Inquiry into Suicides and Homicides See National Confidential Inquiry into Suicides and Homicides by People with Mental Illness: Annual report and 20 year review, October 2016. Available at: <http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/2016-report.pdf> [accessed 051216].

¹² <http://content.digital.nhs.uk/article/2543/Mortality-rate-three-times-as-high-among-mental-health-service-users-than-in-general-population>

¹³ As above.

¹⁴ Defined as having a diagnosed mental illness if they reported they had ever experienced a condition and had been diagnosed by a doctor, psychiatrist or professional. There were self-reports of a mental health condition, which had not been diagnosed.

¹⁵ A quintile means one fifth of the total ie, 20%.

¹⁶ Including attention deficit hyperactivity disorder, seasonal affective disorder and any other mental, emotional or neurological condition.

¹⁷ Including psychoses, eating disorder, bipolar disorder or personality disorder.

¹⁸ Including attention deficit hyperactivity disorder, seasonal affective disorder and any other mental, emotional or neurological condition.

¹⁹ www.time-to-change.org.uk/mental-health-statistics-facts

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 including 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; Varese et al., 2012). ACEs include physical, sexual or emotional abuse; witnessing domestic violence; loss of a parent; parental substance abuse and/or mental illness. Specific groups of children and young people may be at particular risk and looked after children are such an example; many 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 year²¹. This includes the numbers of unaccompanied asylum seeking children, which increased by 5% between 2013 and 2014 and by 29% between 2015 and 2016²². The number of children and young people in Local Authority care at the end of March 2016 was 5,233 in the constituent Local Authority members of the WMCA (ie, the seven metropolitan councils). Data on whether parental mental illness or substance abuse was the reason for children or young people entering care is not routinely recorded, but estimates from these Local Authorities, suggest that approximately 37% of children and young people entering care did so because of parental substance misuse and/or parental mental illness (with estimates ranging from 10% to 64%)²³. It is highly likely that if the prime reason recorded is abuse or neglect, poor parental mental health will be implicated.

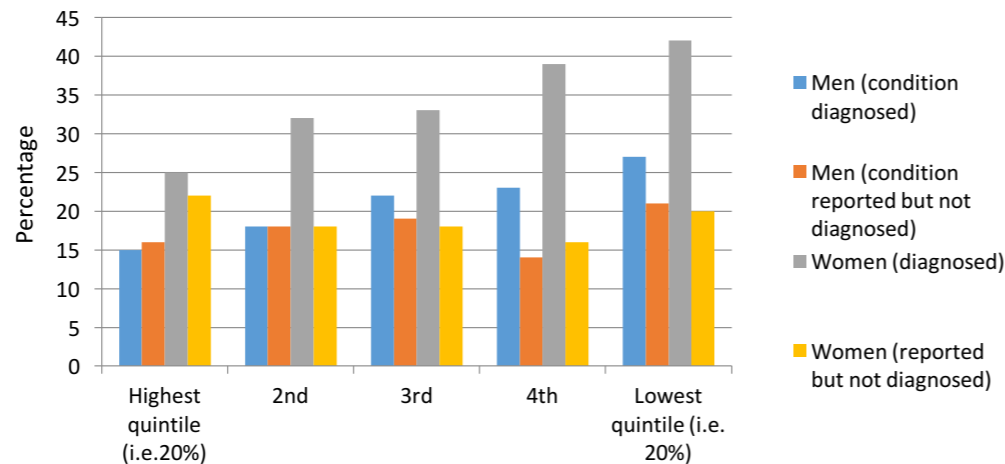


Figure 3: **Diagnosis of mental illness by equivalised household income and gender** (Source: Health Survey for England 2014²⁰)

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 had been in care at some point in their lives; in 2008, 49% of young men under the age of 21 who had come into contact with the criminal justice system had a care experience; and in 2014, 22% of female care leavers became teenage parents (National Audit Office, 2015). Young people leaving care are four to five times at greater risk of poor mental health and Looked After Children and care leavers are between four and five times more likely to attempt suicide or self-harm in adulthood (Department of Health, 2012; National Audit Office, 2015). Despite mental health and emotional wellbeing being identified as important issues by young people leaving care, Local Authorities reported that access to mental health support was problematic (National Audit Office, 2015).

2. People from Black, Asian and Minority Ethnic communities

BAME communities across the WMCA are heterogeneous with the 2011 census identifying that residents born in India represent the most numerous non-UK born group in the West Midlands followed by residents born in Pakistan, Poland, Ireland, and Jamaica²⁴. However, China is well-represented by the student population and most asylum seekers come from Iraq, Iran, Somalia, Afghanistan, Pakistan, Sudan, Ethiopia, Eritrea, Congo and latterly Syria. The intelligence on the mental health needs, access to and preferences for the style of mental health support is scant, and that which is available is often skewed towards specific groups, eg, African Caribbean men, South Asian women, and this tends to dominate this agenda such that the needs of other groups may be overlooked, eg, Chinese people, asylum seekers and refugees or people from the Somali community, which is the fastest growing community in Birmingham.

The National Psychiatric Morbidity Survey in 2007 and more recently 2014, (McManus et al., 2007; McManus et al., 2016) found little difference in the prevalence rates of common mental health problems between minority ethnic groups and the White population. There is, however, an increased prevalence of

common mental health problems amongst Black/Black British women (McManus et al., 2016). There is also evidence that self-harm is now 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 overall, 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 detention under the Mental Health Act (MHA) (see the section on specialist mental health services); are more likely to be prescribed medication; and have difficulties accessing services and poorer outcomes when they do (Lankelly Chase, 2014). Black Caribbean young men are also twice as likely to die as a result of suicide as White psychiatric in-patients and there have been a number of deaths of Black men with mental health problems while in police custody (Inquest, 2014).

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

- Social disadvantage, including living in poverty and homelessness
- Racism, discrimination and harassment
- Higher rates of exclusion from school for African Caribbean boys
- Higher rates of unemployment, with African and Caribbean men and those from mixed backgrounds 10–20% more likely to be unemployed

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 those services. People from some 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 Wolverhampton; 12% in Coventry; 6% in Walsall and 5% in Dudley²⁶. 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 (ie, 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 (Phillimore 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 (Allsopp et al., 2014; Hollander et al., 2016; Allsopp 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 quality housing

Having a settled home is vital for good mental health for everyone and for people with mental health problems it needs to be considered as a core element of support for recovery (NHS Confederation, 2011). In 2014/15, the mean rate of statutory homelessness in the WMCA was 3.2 per 1,000 households, which is higher than the national average of 2.4, with the rate ranging from 0.8 in Dudley to 7.4 in Birmingham (see Appendix 2). In five Local Authorities

PEOPLE FROM BAME COMMUNITIES ARE MORE LIKELY TO BE DISADVANTAGED IN ACCESSING ENABLING FORMS OF SUPPORT AND HAVE POORER OUTCOMES THAN OTHER PEOPLE WHEN THEY DO ACCESS SERVICES

in the WMCA (Birmingham, Coventry, Sandwell, Walsall, and Wolverhampton), living in overcrowded conditions is a significant problem, as measured by the percentage of households with an occupancy rating for bedrooms of 1 or less. This is highest in Birmingham with 9.06% of households living in one bedroom or less, nearly twice the national average of 4.8% (see Appendix 2).

A recent review for the Joseph Rowntree Foundation highlighted strong links between poverty and housing circumstances, 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 wellbeing are associated with living in an area perceived to have an attractive peaceful environment and to have a good reputation; and being satisfied 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 opportunities for social participation all contribute to poor mental health (as summarised by Boardman, 2015).

²⁰ <http://digital.nhs.uk/catalogue/PUB19295> [accessed 150816].

²¹ www.gov.uk/government/uploads/system/uploads/attachment_data/file/464756/SFR34_2015_Text.pdf [accessed 150816].

²² As above, see page 5.

²³ Specific request to the constituent members of the WMCA and responses indicated that this information may not be routinely recorded and, thus, the variation in the numbers may reflect this.

²⁴ <http://www.migrationobservatory.ox.ac.uk/resources/briefings/west-midlands-census-profile/>

²⁵ 86% of the total in the West Midlands area.

²⁶ www.gov.uk/government/publications/immigration-statistics-january-to-march-2016/list-of-tables [accessed 150816].



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 37% since 2010 (Department of Communities and Local Government, 2013) and despite housing being recognised as an important determinant

of health, only 4% of homelessness services received any investment from the health sector (Homeless Link, 2014). Whether this is the case for the West Midlands merits further inquiry.

4. Unemployed people

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

People who have been unemployed for more than 12 weeks show between four and ten times the prevalence of depression and anxiety and are also more likely to kill themselves (Waddell and Burton, 2006). Poverty and unemployment tend to increase the duration of common mental health problems and debt and financial strain, which can arise from job loss, are also associated with common mental health problems (McManus et al., 2007). Unemployment is also a risk factor for substance abuse (Henkel, 2011). People

with mental health problems are more likely to be sensitive to the negative effects of unemployment and there is no evidence that work is harmful to people with a diagnosed severe mental illness (Royal College of Psychiatrists, 2008).

5. Carers

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

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

These figures will include young carers. In England, estimates indicate there are approximately 166,363 young carers, including 9,371 aged between 5- and 7-years-old but this will be 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 (Semlyen et al., 2016). Depression, anxiety, self-harm and suicidality are common among Trans people, amplified by lack of understanding by mental health services and experiences of harassment and misgendering, social exclusion at work, homelessness and relationship breakdown (McNeil et al., 2012).

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

7. People with long-term physical health conditions

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

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

PEOPLE WITH A DIAGNOSIS OF MENTAL ILLNESS ARE LIKELY TO DIE 12–13 YEARS YOUNGER THAN OTHER PEOPLE



8. People with learning disabilities and/or sensory impairments

People with learning disabilities, and people who are deaf, have higher rates of mental health problems than the general population, with estimates for people with learning disabilities, from 25–40%²⁸. Challenging behaviours (aggression, destruction, self-injury and others) are also evident for 10%–15% of people with learning disabilities²⁹, and, consequently they are over-represented in the criminal justice system. People with learning disabilities are also vulnerable to violence and abuse. As with other socially disadvantaged groups, access to appropriate services has been problematic and people have typically fallen between mental health services and learning disability services.

9. Offenders and ex-offenders

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

- Most crime is committed by young males, many with a history of serious behavioural problems in early life
- The mental health conditions most commonly associated with offending are substance misuse (alcohol and drugs) and a diagnosis of personality disorder, particularly anti-social personality disorder

Multiple diagnoses significantly increase the risk of offending, for example anti-social personality disorder combined with hazardous drinking (Coid, 2010).

²⁸ www.learningdisabilities.org.uk/help-information/Learning-Disability-Statistics-/187699/ [accessed 1508516].

²⁹ As above

³⁵ www.nepho.org.uk/topics/Offender%20health [1508516].

²⁷ Data available for different areas at: www.nomisweb.co.uk/reports/lmp/gor/contents.aspx [accessed 150816].

People in custody are particularly vulnerable to poor mental health. The total prison population in the West Midlands on 31 December 2014 was 9,442. Eleven of the prisons are for men. Women comprise 3.32% of the prison population in the West Midlands, compared with a national average of 4.51%. Approximately two thirds (64.5%) of people accommodated in prisons are aged between 21–39. 71% of the prison population are White British, 11% are Black or Black British (equivalent to the national average but higher than the population percentage of 2.8%) and 10% are Asian/British Asian (higher 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 of young children than men, making the prison experience significantly different for women. Mental health problems

THE CONSEQUENCES OF SEXUAL ABUSE, DOMESTIC VIOLENCE AND EMOTIONAL ABUSE CAN BE LONG-LASTING AND DEBILITATING AND ARE ASSOCIATED WITH A BROAD RANGE OF PHYSICAL AND MENTAL HEALTH CONDITIONS

among people living in prison are common³⁰. It is estimated that:

- 90% of prisoners have substance misuse problems, mental health problems or both
- 9% of the UK prisoner population suffer from severe and enduring mental illness
- 10% of prisoners have a learning disability
- 40% of prisoners report no contact with primary care prior to detention
- People who have been in prison are up to 30 times more likely than the general population to die from suicide in the first month after discharge from prison

For people leaving prison with poor 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.

10. People experiencing violence and abuse

There are various forms of abuse: emotional, physical and sexual, including human trafficking, affecting people of all ages and backgrounds. Women are more at risk from sexual abuse and domestic violence with men more at risk from physical violence in public places. There are 48 cases of domestic violence in the West Midlands every day³¹ 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 abuse³². The consequences can be long-lasting and debilitating and include a broad range of physical and mental health conditions. The psychological consequences include anxiety, depression, post-traumatic stress disorder (PTSD), self-harm, suicide, sleep disturbances and emotional detachment. Survivors of domestic violence will also have needs relating to debt, finances and housing. Survivors of sexual abuse are over-represented in mental health services but may not be able to access appropriate support or may experience re-traumatisation, or further violence and abuse, during their contact with services.

11. People experiencing severe and multiple disadvantage

Many people experiencing severe and multiple disadvantage (homelessness, substance misuse and offending) have experienced trauma and neglect, poverty, family breakdown and disrupted education as children and as adults, and have much higher levels of loneliness, isolation, unemployment, poverty and mental ill-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 accordingly³³.

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).

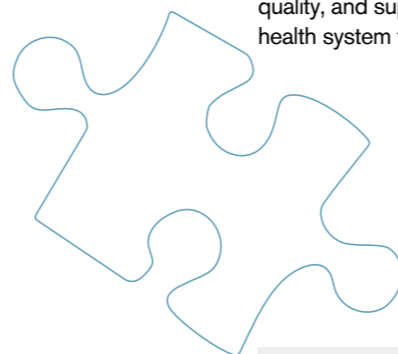
As illustrated by Appendix 3, the comprehensiveness and the quality of the JSNAs varies between Local Authorities in the WMCA and, thus, the extent to which they provide useful intelligence to inform mental health transformation.

CO-PRODUCTION AND COMMUNITY ENGAGEMENT PROVIDE A SOLID FOUNDATION FOR SERVICE TRANSFORMATION

Some Local Authorities have undertaken JSNAs on specific mental health themes, for example veterans' mental health in Warwickshire and mental health needs in primary care in Worcestershire. In addition a health needs assessment, including mental health, of the West Midlands prison population was undertaken in 2014/15 (Offender HNA and Consultancy projects, 2015). Of note is the mental health equity audit being undertaken by Birmingham City Council to identify how fairly services and resources are distributed in relation to the mental health needs of different ethnic groups living in the city.

Good practice promotes co-production, community engagement and asset mapping as ways of understanding the needs, system gaps and potential contribution of communities to health improvement (Public Health England, 2015). However, we were only able to identify one JSNA where there was any evidence of asset mapping: Coventry and Rugby CCG's 2015 Mental Health and Wellbeing assets and needs assessment.

Public Health West Midlands has a role to play in developing and promoting guidance and standards to support improvements in the quality of JSNAs, to include asset mapping, and provide tangible examples of how this intelligence, alongside that from suicide and other audits, can be used to inform commissioning for prevention and quality, and support the wider mental health system transformation.



CO-PRODUCTION 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 (Ewert 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 lives³⁴. In a WMCA context it would help ensure that the diversity of the WMCA is properly considered to ensure that access is equitable for all and that the transformation of mental health is grounded in an understanding of what matters to people and what they need from public services to get on with their lives.

There are formally constituted independent service user groups that aim to help people who have accessed or are accessing services be involved in the way services are planned, delivered and evaluated,

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

There are ten Healthwatch organisations³⁵ across the WMCA, which serve as the consumer champion of health and social care. They were established as a sub-committee of the Care Quality Commission (CQC), to provide information and advice to government, various NHS bodies and Local Authorities on the views of the local population, and people who use health and social care services, on their needs and experiences of health and social care services, and on the standard of health and social care provision and how it should be improved. Healthwatch organisations across the WMCA are involved in mental health system development and have established networks, and can offer specific expertise in engaging with local communities. Dudley Healthwatch, for example, has developed an Activate approach for involving communities,

³⁰ www.nepho.org.uk/topics/Offender%20health [1508516]

³¹ www.westmidlands-pcc.gov.uk/news/news-2015/48-cases-of-domestic-violence-crime-every-day-in-the-west-midlands-as-new-standards-are-signed-up-to-for-a-co-ordinated-response/ [accessed 150816].

³² www.pansi.org.uk/index.php?pageNo=407&PHPSESSID=315v74tec3qj1tbhmc73ipb5&sc=1&loc=8653&np=1 [accessed 150816].

³³ Source: Notes from Workshop 2.

³⁴ Glasby, J. (2016). Personal communication.

³⁵ Birmingham; Coventry; Dudley; Sandwell; Solihull; Staffordshire; Walsall; Warwickshire; Wolverhampton and Worcestershire. See www.healthwatch.co.uk/find-local-healthwatch [accessed 030516].

in partnership with Dudley CVS and the All Together Better Partnership; recently receiving an award for this work from Healthwatch England³⁶.

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

- Every Step of the Way (ESOW), is a key strand of the Changing Futures Together (CFT), a seven-year lottery funded project (£10M) designed to not only support some of the most complex needs of people in Birmingham but also to ensure system change³⁷. Birmingham Mind are delivering the service user involvement strand of ESOW and this involves training up 120 Experts by Experience and 30 Involvement Champions each year and matching them with opportunities within the CFT programme and in wider systems.
- Experience-based co-design of hospitalisation in early psychosis in Coventry and Warwickshire Partnership NHS Trust. This project piloted this collaborative approach between service professional and service users to identify areas for service change. The project identified a range of service improvements that are generalisable to other contexts and the learning both about the process and the implementation challenges are informative for future EBCD projects. (Larkin et al., 2015).
- 300 Voices³⁸, 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 Birmingham³⁹, 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 refugees⁴⁰.

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

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

Launched by the Members of People's Parliament (MPs) in Sandwell in July 2015. The People's Parliament enables MPs with lived experience of mental ill health to work in coproduction with strategic leaders and decision makers to lead policy development, shape strategy and improve services and support. They have launched a White Paper and have developed a set of standards for crisis care with local people with recent experience of crisis care⁴² that will be embedded locally as a driver to shape what the future looks like. They are aiming to develop employment opportunities with 'smart' businesses and community places of safety with the local community across all sectors. There is a launch of the Quality of Life standards in October 2016 in conjunction with Sandwell Health and Wellbeing Board. This parliament will be able to check people's experience against those standards and the CCG and LA are looking at embedding these into commissioning to drive up quality and direct local need.

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

PROMISING PRACTICE: MAKING A DIFFERENCE (MAD) ALLIANCE IN NORTH WEST LONDON⁴³

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.

³⁶ See: <http://healthwatchdudley.co.uk> [accessed 270716]

³⁷ The CFT programme is now going to be linked with the Troubled Individuals strand of work for the West Midlands Mental Health Commission.

³⁸ www.bsmhft.nhs.uk/about-us/engaging-with-our-communities/300-voices [accessed 150816].

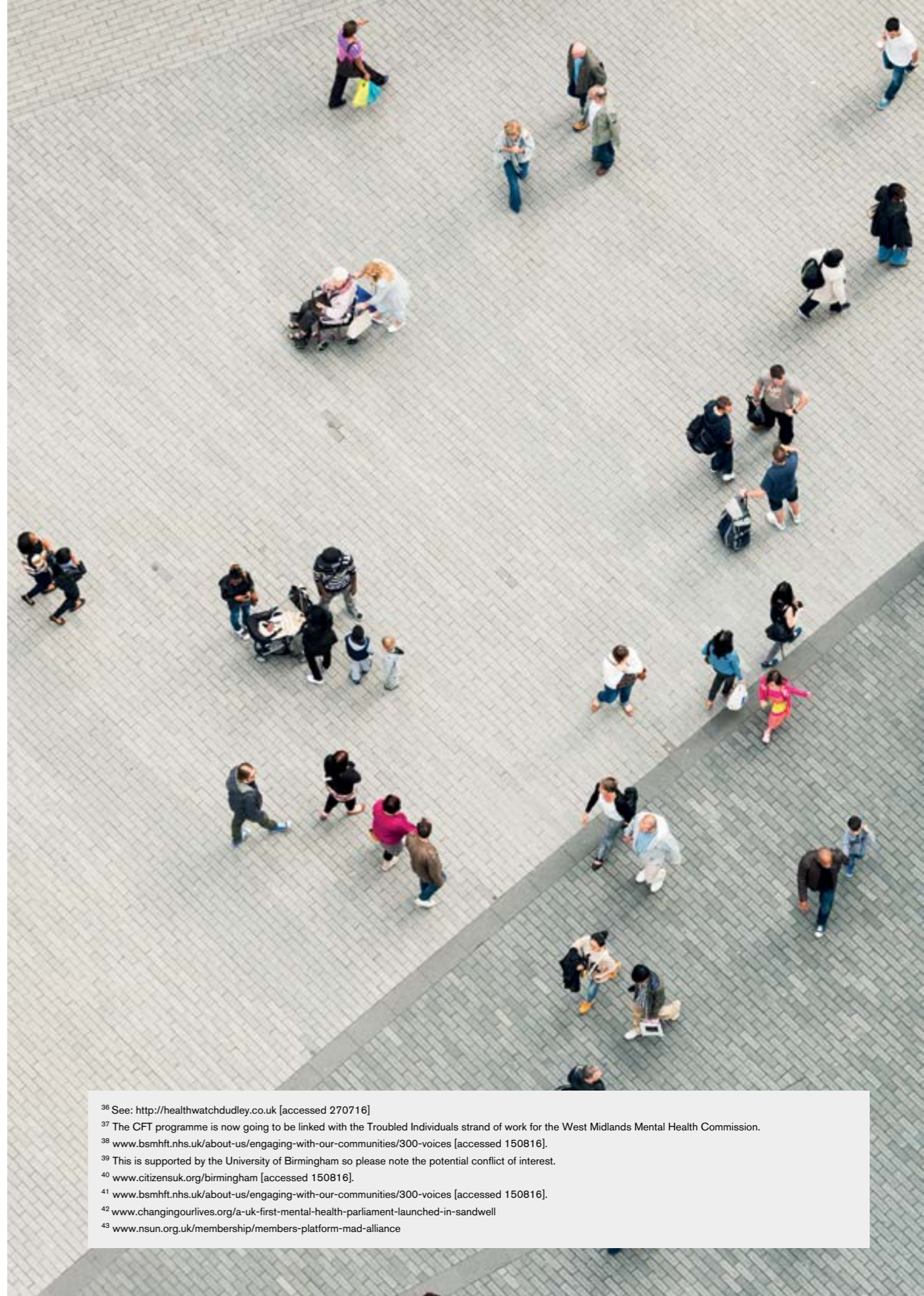
³⁹ This is supported by the University of Birmingham so please note the potential conflict of interest.

⁴⁰ www.citizensuk.org/birmingham [accessed 150816].

⁴¹ www.bsmhft.nhs.uk/about-us/engaging-with-our-communities/300-voices [accessed 150816].

⁴² www.changingourlives.org/a-uk-first-mental-health-parliament-launched-in-sandwell

⁴³ www.nsun.org.uk/membership/members-platform-mad-alliance



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

ESTIMATING COSTS

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

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

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

Also provided are some broad illustrative estimates of **crime 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; Booker 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 disorder, 23.8% of all adults in the West Midlands Region (taken as a proxy for the WMCA) experience some kind of mental health problem, compared with 23.0% in England as a whole (McManus et al., 2009). Prevalence is thus slightly higher than the national average. Secondly, among all people in work, average pay in the West Midlands in 2014/15 was 7.5% below the England average and 6.3% below the UK average (NOMIS, 2016).

Cost is defined broadly to include any adverse effect of mental ill health, wherever it falls.

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 in primary care, including £0.148 billion on GP consultations, while the remaining £0.698 billion (77%) covers expenditure in secondary care.

All of these figures relate to the direct costs of treatment and care for people with mental health problems. It is, however, clear that the full impact of mental illness on the finances of the NHS goes well beyond these direct costs, 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 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 **£2,400 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 £6,400 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 **£11 billion a year**, equivalent to 10% 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 that results from the additional use of physical health care services is estimated at around **£3.25 billion a year** (update of data in Bermingham et al., 2010).

Taken together, these estimates for the aggregate costs of co-morbidities and MUS imply that in England as a whole the NHS spends at least as much on dealing with the indirect consequences of mental ill health as it does on the direct provision of services for people with diagnosable mental health problems. Overall, 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 **£1.09 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 services (Boston 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 (spending on Special Educational Needs (SEN) pupils with behavioural, emotional and social difficulties); criminal justice (mental health-related services funded by the police, courts and prisons); and Department for Work and Pensions (DWP) employment programmes used by people with mental health problems.

The allocation of a share of this **£1.7 billion** to the WMCA on the basis of population numbers, adjusted for the above-average prevalence of mental health problems, 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

frontline education services such as the employment of more teaching assistants (Snell et al., 2013). This increases allocated spending in the WMCA to **£0.18 billion**.

In relation to social security payments, BCG's national estimate of **£7.5 billion** covers mental health-related spending on three main benefits: Employment and Support Allowance, Disability Allowance and Carer's Allowance. Detailed DWP data by individual Local Authority allows direct calculation of the amounts spent on these benefits in the WMCA in 2014/15, as follows: Employment and Support Allowance **£410 million**, Disability Allowance **£132 million** and Carer's Allowance **£19 million** (DWP, 2016). For reasons not explained, the BCG calculations exclude spending on Housing Benefit for people who are claiming disability benefits because of mental ill health. As there seems no obvious logic for this, DWP data has been used to calculate that relevant spending on this benefit in the WMCA in 2014/15 was **£192 million**, resulting in an overall (rounded) total of **£0.755 billion** for the mental health-related cost of social security payments.

THE NHS SPENDS AT LEAST AS MUCH ON DEALING WITH THE INDIRECT CONSEQUENCES OF MENTAL ILL HEALTH AS IT DOES ON THE DIRECT PROVISION OF SERVICES FOR PEOPLE WITH DIAGNOSABLE MENTAL HEALTH PROBLEMS

4. Costs of informal care

Informal care provided to people with mental health problems by relatives and friends is not generally paid for and so does not feature in GDP. It is nevertheless of economic significance and the usual convention is to impute a monetary value on the basis of what it would cost to provide an equivalent service if undertaken as paid employment by a homecare worker. This is the approach taken in the BCG study, which – when combined with survey data on the amount of informal care provided to people with mental health problems – results in a national cost estimate of £14.2 billion a year. Based on relative population numbers and the prevalence of mental health problems, it is calculated that the cost of informal care in the WMCA is **£1.085 billion** a year⁴⁴. The true costs may well be higher as this only includes direct care costs in the absence of an informal carer – not the wider impact on the informal carer.

5. Care funded by individuals and charities

It is estimated in the BCG study that at the national level the cost of mental health services funded by individuals and charities amounts to around £1.6 billion a year. This covers such items as counselling and other services funded by individuals either out of pocket or through private medical insurance, co-payment for NHS prescriptions, employer expenditure on mental health and non-public sector income to the voluntary and charitable sector. The share of this total allocated to the WMCA is **£0.125 billion a year**, again based on relative population numbers and the prevalence of mental health problems.

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



EMPLOYMENT COSTS

Mental ill health is the dominant health problem of working age. This is partly because mental health problems are very common, but also because the burden associated with these problems falls mainly 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-retirement years.

Poor mental health is thus very common among people of working age and has a major impact on individuals and the economy. For individuals, it can mean difficulties in finding employment, increased risk of losing a job, frequent or prolonged periods of sickness absence and, at worst, long-term unemployment and detachment from the labour market, leading to a downward cycle of low income, worsening health and social exclusion. The longer people are out of work, the lower their chances of ever getting back. For the economy, there are very substantial costs because of the lost production of people who are unable to work or whose 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, 2006). People enjoy better mental health when they are in work and worse mental health when they are out of work. The longer they are workless, the more damaging the consequences for their mental health, even leading in some cases to suicide. For people with mental health problems, work can be therapeutic. A return to work improves mental health by as much as the loss of employment worsens it. Some aspects of the work environment can 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 not in doubt: work is good for mental health. The benefits of employment greatly outweigh the risks, which are very small compared with the 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

Contrary to popular belief, the majority of working-age adults with a mental health condition have a job and are almost as likely to be working as anybody else. On average, employers should expect to find that at any one time nearly one in six of their workforce is affected by a mental health condition such as depression or anxiety, rising to around one in five if 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 off 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 such as back pain are in reality often best described as medically unexplained symptoms. Taking 40% as a conservative estimate, this implies an average loss of 2.76 days a year per employee for mental health reasons, equivalent to a total of **4.159 million working days lost** in the WMCA (based on data in ONS, 2016a).

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

adjustments result in an estimate of around **£130 a day for the cost of sickness absence in the WMCA**.

Allowing also for the above-average prevalence of mental health problems in the West Midlands, the total cost of mental health-related sickness absence in the WMCA comes out at around **£0.56 billion a year**.

Turning now to presenteeism, this is more difficult to measure, but accumulating evidence in the international literature on health at work suggests that output losses from this cause are if anything larger, perhaps several times larger, than those associated with sickness absence. Presenteeism is particularly important in the case of mental health. Among other reasons, this is because workers may be particularly concerned about being labelled as mentally ill by their employers and fellow workers. Fearing possible stigma or discrimination, they turn up for work even if feeling unwell. It also appears that the productivity losses caused by mental health problems are more likely to take the form of presenteeism (rather than sickness absence) among white-collar workers than they are among blue-collar workers (Hilton, 2007).

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 cost of a working day lost because of presenteeism is higher than the equivalent cost for sickness absence, as the inverse association that is commonly observed between earnings and rates of sickness absence (ie, 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 employee in the UK.

Taken together, these assumptions imply that the total cost of mental health-related presenteeism is around 1.8 times 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 **£1.005 billion**.

Finally, concerning staff turnover, about four million jobs change hands each year in the UK, with mental health problems accounting for up to 5% of the total. Based on evidence on the costs of staff turnover given in the Centre for Mental Health review cited above, it is estimated that the total annual cost of mental health-related turnover in the WMCA is around **£0.155 billion**. 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 among employed people in the WMCA is about **£1.72 billion** a year.

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 sickness. 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 (the main incapacity benefit for people of working age), and this shows that in 2014/15 nearly half (48.8%) did so because of mental health problems (DWP, 2016b). Assuming that this proportion applies in the WMCA, it follows that the numbers in the area who were economically inactive for mental health reasons total around **69,800**.

For costing purposes, it is assumed as before that the appropriate measure of unit cost is average total compensation per employee. National accounts data indicate that in the UK as a whole this was £34,100 a year in 2014, which reduces to £31,815 a year in the WMCA when allowance is made for the lower average level of pay. Multiplying this by the numbers who were economically inactive for mental health reasons, the annual aggregate cost of mental health-related economic inactivity in the WMCA comes out at **£2.22 billion**. As a cross-check on this estimate, a 2008 report on the health of Britain's working-age population by Dame Carol Black estimated that the total economic cost of health-related worklessness in the UK was £63 billion in 2007 (Black, 2008). Increased in line with money GDP, this is equivalent to a cost of £77 billion in 2014. Assuming that 48.8% of this is for mental health reasons, as indicated by the data on Employment and Support Allowance given above, this

THE AGGREGATE COST OF LOST OUTPUT BECAUSE OF MENTAL HEALTH PROBLEMS AMONG EMPLOYED PEOPLE IN THE WMCA IS ABOUT £1.72 BILLION A YEAR

gives a national cost of £37.6 billion attributable to mental health conditions. Taking into account the numbers of people in the WMCA who are long-term sick as a proportion of the equivalent national total and the lower level of average local pay, it can be calculated that the mental health-related cost of 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.

HUMAN COSTS

The most widely cited statistics on the overall burden of ill health and its breakdown between different health conditions are those produced by the WHO in its work on the global burden of disease. These figures are based on a composite health measure, the disability-adjusted life-year (DALY), which combines years of life lost from premature mortality with equivalent years of life lost from disability and morbidity. Conceptually, the DALY is the same as 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 the quality of life in a single measure and they provide a key building block in estimating the human costs of illness in monetary terms.

Country-specific data from the WHO work on the global burden of disease are available up to 2012 and from these it can be calculated that for the most recent year

⁴⁴ Further detail on the cost of informal care available in Buckner and Yeandle (2011).

THE AGGREGATE COST OF MENTAL ILL HEALTH IN THE WMCA IN 2014/15 IS ESTIMATED AT £12.6 BILLION, EQUIVALENT TO A COST OF AROUND £3,100 PER HEAD OF POPULATION

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

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

On this basis, the aggregate monetary value of DALYs lost in the UK for mental health reasons is around £78.5 billion a year. Taking into account relative population numbers and the local prevalence of mental health problems, this implies an equivalent cost estimate for the WMCA of about £5.07 billion a year. Sizeable as this figure is, there are a number of reasons for thinking that it is, if anything, on the low side.

First, the value of a QALY used by NICE has remained unchanged since at least 1999/2000, despite the fact that between 1999/2000 and 2014/15 the general level of prices in the economy increased by 40%, money GDP per head of population increased by 60% and NHS spending per head measured in money terms by no less than 125%. The last of these in particular is hard to square with a fixed monetary value



for the QALY, as it clearly represents a substantial increase in society's willingness to pay for better health. The recorded view of the Department of Health is that the value of a QALY should rise over time at least in line with money GDP per head and a guidance document on quantifying the health impacts of government policies published by the Department in 2010 put the value of a QALY in that year at £60,000 (Department of Health, 2010).

Second, the estimates of aggregate cost given above make no allowance for 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 (Bockerman et al., 2011; Fujiwara and Dolan, 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 QALYs are based on hypothetical preferences of the general public which may in some cases fail to anticipate correctly the real impact that different health states may have. In particular, there is evidence that it is much more difficult to adapt to mental illness than it is to most physical health problems.

CRIME COSTS

The overall level of crime in this country reached a peak in about 1995 and has since been falling steadily at around 2–3% a year. All major types of offending have declined at broadly comparable rates, including both violent and non-violent crime. Despite this welcome fall in offending, crime continues to impose huge costs, most obviously on individual victims but also on the rest of society. Comprehensive estimates of the costs of crime were first published by the Home Office in 2000 (Brand and Price, 2000) and partially updated five years later (Dubourg et al., 2005). These show, for example, that the total cost of crime in England and Wales in 1999/2000 was around £60 billion. This covers not just costs falling on the criminal justice system but also – and much more importantly in quantitative terms – costs falling on the victims of crime, including the value of stolen or damaged property, losses in earnings associated with crime-related injuries etc., and an imputed monetary value of the emotional and physical impact of crime on victims. The steady fall in the volume of crime since the mid-1990s obviously serves to bring down its aggregate cost. On the other hand, unit costs have been rising because of general inflation and related pressures, and a broad assessment is that these two opposing influences have largely cancelled each other out, implying that the total cost of crime in monetary terms is much the same now as it was in 1999/2000.

Two qualifications should, however, be noted. First, there is good evidence that the scale and costs of domestic violence are under-recorded in the Home Office figures, as documented in an analysis produced in 2004 for the government's Women and Equality Unit (Walby, 2004). And second, there is also more recent evidence that the available sources of data on the numbers of crimes committed each year understate 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.

Some illustrative estimates of the costs of crime linked to mental health problems are as follows:

1. Drawing on the evidence from longitudinal studies that early behavioural problems are a major risk factor for subsequent offending, it has been

estimated that over 20% of all crime in Britain is committed by people who suffered from clinically diagnosable conduct disorder in childhood or adolescence (Centre for Mental Health, 2009). This is after taking into account other possible influences on offending behaviour such as socio-economic background and cognitive ability.

2. According to an estimate published by the Department of Health (DH, 2008), the aggregate economic and social costs of alcohol misuse in England in 2006/07 amounted to £18–25 billion. Crime costs accounted for more than half the total, at £9 - 15 billion.
3. A Home Office study published in 2006 (Gordon et al., 2006) reported that the economic and social costs of class A drug use amounted to £15.4 billion in England in 2003/04, with costs relating to crime accounting for just over 90% of the total.

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

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

On the conservative assumption that the proportion of crime attributable to mental ill health, including personality disorder and substance misuse, is around 20%, the mental health-related cost of crime in the WMCA comes out at about **£0.98 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

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

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

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

1. Total costs

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

	£ billion	% of total
Care costs	3.59	28.0
Employment costs	3.94	31.5
Human costs	5.07	40.5

Table 1: **Cost of mental ill health to the WMCA**

It should be noted that care costs do *not* include the costs of social security benefits paid to people with mental health problems, estimated earlier at £0.755 billion a year. This is to avoid double-counting with employment costs.

To elaborate briefly, suppose someone currently earning £200 a week has to give up their employment for mental health reasons and moves on to out-of-work benefits at £80 a week. The cost to the economy of this change is £200 a week, representing the full value of the output that is lost. Of this cost, £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 £80. Put another way, there is an important distinction to be made between the cost of an output loss and who pays for it.

2. GDP costs

Total costs as calculated above include two major components which are not usually measured in monetary terms and are therefore excluded from national income as conventionally defined. These are the costs of informal care and the quality-of-life or human costs of mental illness. When these items are excluded, the GDP costs of mental 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 £1,575 per head of population in the WMCA. In comparison, GDP per head in the area is around £22,700 a year (based on data in ONS, 2014). Taken together, these figures imply that mental ill health imposes a cost in GDP terms which is equivalent to a loss of about 6.9% a year in aggregate income in the WMCA.

3. Exchequer costs

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

Publicly funded care costs 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 £835 million a year. On this basis, total exchequer costs come to around **£3.88 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 is given to problems in the postnatal period, particularly postnatal depression, but data from longitudinal surveys increasingly suggests that maternal depression and anxiety are at least as common during pregnancy as in the year after childbirth. Only 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).

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.

2. Childhood conduct disorder

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

An unsurprising consequence of this array of negative outcomes is that conduct disorder imposes a very heavy cost burden. One study which followed a sample of children from age ten until they were 28 found that the cumulative cost of public services used by those who had conduct disorder at age ten was around £90,000 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 and crime (Friedli and Parsonage, 2007). Overall, it is calculated that the lifetime cost of these adverse outcomes is around £275,000 per case in today's prices, measured against a baseline given by people who had no conduct problems in childhood. Again the bulk of costs were found to be crime-related.

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

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



Mental health support in the West Midlands

Mental health support in the West Midlands is provided by a diverse range of providers including: primary care; specialist mental health services; acute non-psychiatric hospitals; community health services; social services; third sector organisations; housing organisations, employment services; the private sector and as part of 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.

PROMOTING PUBLIC MENTAL HEALTH

1. Provision in the WMCA

These interventions are targeted at the general population and designed to promote public mental health and wellbeing, and tackle stigma surrounding poor mental health. It is recommended that they should adopt a life course approach, and be based on the best available evidence (Davies, 2013). Initiatives to promote public mental health may be part of a wider approach, for example programmes in prison or in planning urban spaces and are, therefore, not always easy to identify. For the majority of Local Authorities, mental health is included as part of Health and Wellbeing strategies with a small minority having developed a public mental health strategy, for example, Warwickshire⁴⁵.

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 CCGs was not readily available. 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 Wolverhampton⁴⁶.

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

The activities commissioned by Local Authorities include:

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

Mental Health and Wellbeing Awareness

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

Mental Health First Aid (MHFA) was introduced to England in 2007 as part of a national approach to improving public mental health and has been provided for young people, in schools, in workplaces and with front-line services as well as members of the general public. MHFA is being commissioned in the WMCA by some Local Authorities and provided through local Mind associations, for example Coventry and Warwickshire, and Birmingham. MHFA courses are also offered by NHS Trusts and West Midlands Employers as well as independent training providers. Deutsche Bank in Birmingham has trained 16 MH first aiders so that there is someone available on every floor of the bank. MHFA England⁴⁷ has trained 99 instructors 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; Kaleidoscope Plus Group; the Lateef Project; Midlands Heart; Sandwell Mind; Severn Trent Water;

Specialist Inclusion Support Service; Tranquillity Counselling Service; Worcestershire Rape and Sexual Abuse Support Centre; University of Warwick; University of Worcester and Walsall Council.

Suicide prevention

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

2. Performance against national indicators

There are two main indicators that are currently being used to evaluate mental wellbeing: the ONS subjective wellbeing questions and the Warwick Edinburgh Mental Wellbeing Scale (WEMWEBS). The ONS subjective wellbeing measure comprises four questions that are included in the Annual Population survey to assess the personal wellbeing of the population. WEMWEBS 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 (Thiel et al., 2013).

Using the ONS subjective wellbeing scale, the ONS reports that personal wellbeing has increased across the UK since the data started to be collected in 2012⁴⁸. A summary of the data from 2011–2014

PROMISING PRACTICE: MENTAL HEALTH FIRST AID (MHFA)

A recent meta-analysis concluded that the MHFA programme is effective in increasing knowledge about mental health problems, could decrease negative attitudes towards people experiencing mental health problems and is effective in increasing help-seeking (Hadlaczky et al., 2014). Many of the studies reviewed, however, were Australian and the evidence for BAME populations was limited (Wong et al., 2015). Nonetheless, the Thrive programme in New York has set a target of training 250,000 New Yorkers in MHFA in order to change the culture around mental health⁵¹.

A national evaluation of 11,502 course participants reported improvements in their knowledge and understanding of how to help others with mental health problems (Jaman et al., 2014). Local evaluations of the immediate impact of courses have been similarly positive. However, to date, there have been no economic evaluations of MHFA and the impact on help-seeking in a UK context and the implications for public service delivery are, as yet, unexplored. However, there is emerging evidence that with a good mental health strategy (within which MHFA is the literacy component) staff are more willing to report mental health as the reason for absence, it facilitates a return to work and people return more quickly (Bonner, 2016).

There are concerns that MHFA can reinforce a narrow biomedical approach and there is increasing emphasis on psychological first aid, which reinforces an approach that is concerned with 'what happened?' as opposed to 'what's wrong with you?'

indicates that the overall average for the highest levels of personal wellbeing on the Life Satisfaction measure⁴⁹ for West Midlands Local Authorities on which there is data⁵⁰, range from 14.7% of the population in Wolverhampton to 28.75% of that in Sandwell, compared with 26.65% of the overall UK population. Other Local Authorities which were below the national average are Coventry (19.92%) and Birmingham (21.98%). The highest levels of Life Satisfaction across the UK were reported by Pakistani and Bangladeshi 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 Authorities in terms of the Happiness item, although a much more mixed picture on the other scales (Anxiety and Feeling life 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.

⁴⁵ <http://publichealth.warwickshire.gov.uk/files/2012/08/MENTAL-HEALTH-AND-WELLBEING-STRATEGY.pdf> [accessed 161016].

⁴⁶ www.biglotteryfund.org.uk/headstartprojects [accessed 150816].

⁴⁷ <http://mhfaengland.org/> [accessed 150816].

⁴⁸ www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/datasets/measuringnationalwellbeinglifesatisfaction [accessed 150816].

⁴⁹ Source: ONS Reference Tables: Life Satisfaction by Local Authority Districts, April 2011 to March 2014.

⁵⁰ Birmingham, Coventry, Dudley, Sandwell, Solihull, Walsall, Warwick and Wolverhampton.

⁵¹ See <https://thrivenyc.cityofnewyork.us/> [accessed 150816].

3. A strategic approach to public mental health

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

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

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

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

OTHER UNIVERSAL SERVICES

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

1. Police service

The police service across the WMCA has been active in changing its approach to people 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 employment⁵².

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 prescription⁵³
- Mindful meditation 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 therapies⁵⁴. Museum visits and events can be included as part of social prescribing or recovery college courses, although it is not clear the extent to which this is happening within the WMCA.

4. Wellbeing Hubs

The majority of Local Authorities and/or CCGs in WMCA have developed Wellbeing Hubs to provide the general public with information about health and wellbeing and signpost to appropriate services (see for example Sandwell's Confidence, and Wellbeing Hub). In some instances, third sector organisations have been commissioned to provide this alongside peer support or one to one support (see for example the Wellbeing Hub provided by Birmingham Mind). Information about mental health and wellbeing is increasingly available through the development of electronic resources (see for example Warwickshire's Health and Wellbeing Portal⁵⁵).

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)⁵⁶. 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). Based on an index of mental health need⁵⁷, the three CCGs in Birmingham have the highest level of mental health need, with Birmingham South and Central CCG having over 50% more need than the mean (needs index = 1.56) and Bromsgrove and Redditch nearly 40% less (needs index = 0.64). The populations covered by CCGs range from approximately 113,000 for Wyre Forest to nearly 750,000 for Birmingham Cross City CCG, which increases to just short of a million when the population is weighted for need (see Appendix 7).

It is estimated that a practice of 2,000 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
- 60 people with drug dependency
- 176 people with a personality disorder
- 125 people (out of the 500 on an average GP practice list) with a long-term condition with a co-morbid mental illness
- 100 people with medically unexplained symptoms not attributable to any other psychiatric problem

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

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

2. Performance against national indicators

Primary Care Prescribing

Annual expenditure on primary care prescribing for mental health is £12 per head in the WMCA, compared with a national average of £13 (NHS Benchmarking, 2016)⁵⁸. 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.

⁵² www.wmfs.net/new-safe-and-well-visits [accessed 150816]

⁵³ <http://reading-well.org.uk> [accessed 150816]

⁵⁴ www.bvsc.org/news/health-and-wellbeing-birmingham-museums [accessed 150816].

⁵⁵ <https://apps.warwickshire.gov.uk/PublicHealthDir> [accessed 150816].

⁵⁶ www.jcpmh.info/wp-content/uploads/10keymsgs-primarycare.pdf

⁵⁷ See: www.england.nhs.uk/wp-content/uploads/2014/03/d-nph-mental-health.xlsx for data and information on the components of this indicator [accessed 120516].

⁵⁸ NHS Benchmarking (2016). Report prepared by Zoe Page for this project. See www.nhsbenchmarking.nhs.uk/CubeCore/uploads/Marketing/201617%20project%20cards/MentalHealth_Benchmark.pdf for information on NHS Benchmarking [accessed 161016].

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 people⁵⁹.

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 250 referrals per 100,000 population in Redditch and Bromsgrove to 1200 plus in Walsall. This raises some questions about the relationship between level of need and referral rates. For example, Birmingham South and Central CCG (need index = 1.56) has a lower rate of referral than Wyre Forest (need index = 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 67% in 2014/15. The WMCA saw an increase from 56% to 63% in 2013/14 and to 76% in 2014/15. Figure 6 illustrates the range from 46% to 97% of people being seen in less than 28 days in 2014/15, broadly similar to the pattern for 2013/14,

The CCG with the shortest average waiting time from referral to the first treatment appointment was Dudley CCG at 6.7 days (HSCIC, 2015b). 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

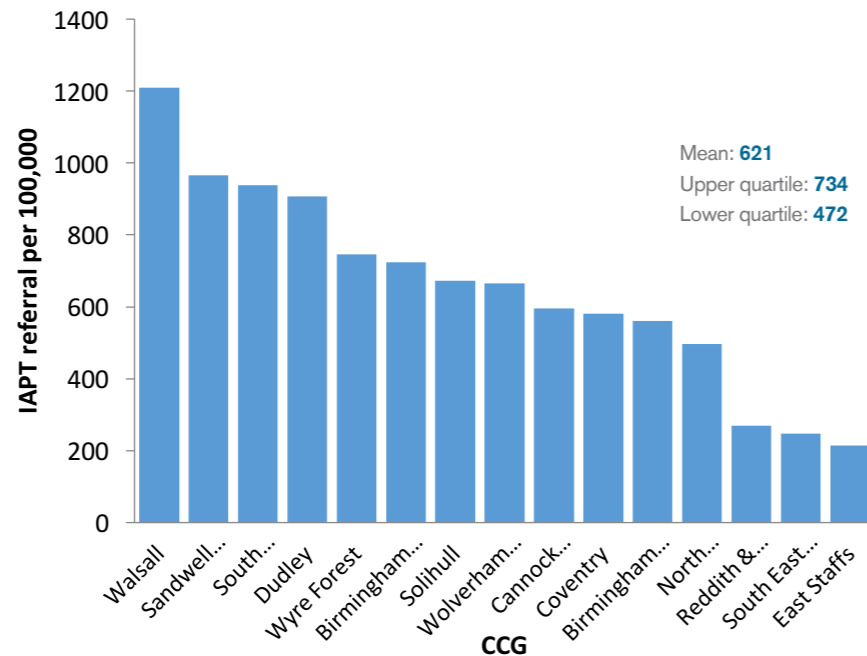


Figure 5: IAPT referral per 100,000 population for WMCA CCGs January - December 2014 (Source: NHS Benchmarking, 2016)

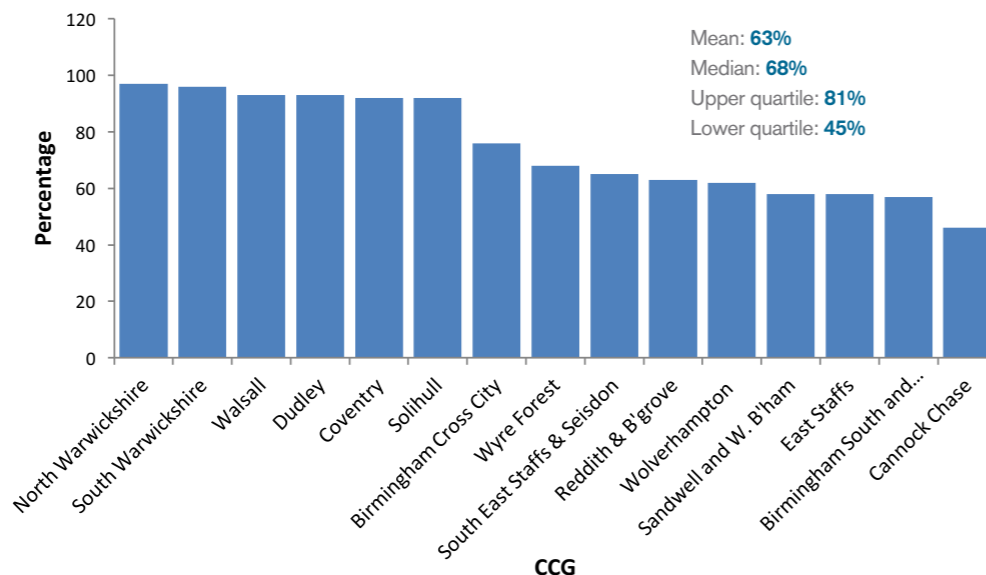


Figure 6: Percentage of people waiting <28 days for IAPT in WMCA in 2014/15

2014/15, broadly similar to the pattern for 2013/14.

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

The number of people who were above a diagnostic threshold before treatment and below it following treatment provides a measure of people who are moving to recovery but does not take account of the extent of improvement or the complexity

of the presenting issues. Nonetheless, the mean for the WMCA in 2013/14 was on this measure is 39% (range 10–70%) in 2014/2015. The highest recovery rate was in Cannock Chase CCG (69.4% of 680 referrals) (HSCIC, 2015b) compared with a national average of 41%. Further interrogation of this data could be helpful to identify whether the variation reflects service user characteristics, organisational arrangements or effectiveness of the IAPT services provided.

Physical health checks for people with a severe mental illness

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

3. Redesigning primary care mental health services

Despite its potential and central role, primary care's capacity to respond effectively has been problematic and consequently relationships with specialist mental health services have become fractious as these services increasingly focused on people with a diagnosis of serious mental illness. Various models have been tried over the past 20 years to improve access to mental health support in primary care but there is no clear model for how such services should be provided. It is clear, however, that the primary care offer needs to go beyond providing access to psychological therapies and physical health checks for people with a severe mental illness to respond to the broad range of mental health need that presents in primary care, including psychological issues associated with abuse and trauma, medically unexplained symptoms and co-morbidities such as autism and accompanying mental health problems, for example.

As well as responding to expressed need and intervening early, primary care has a central role to play in any prevention strategy because of its provision of universal services, eg, to pregnant women and new mums, sexual health and screening services and people with long-term physical health conditions and there are opportunities to strengthen these at a practice level.

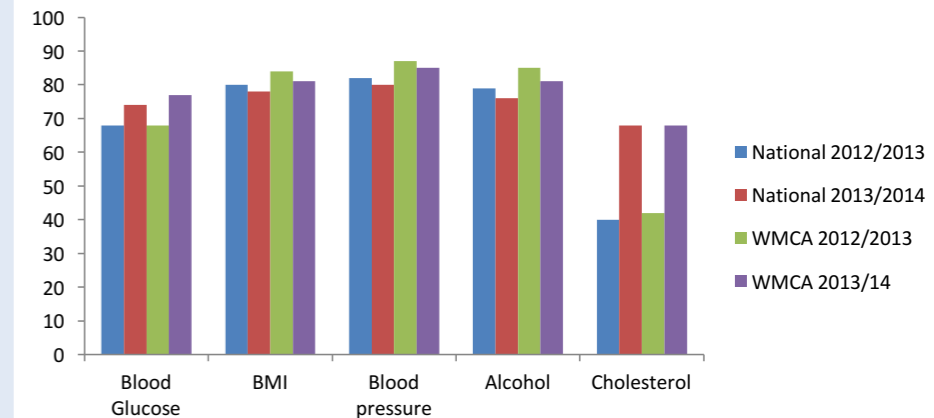


Figure 7: Percentage of patients with a diagnosis of SMI having different types of physical health checks for 2012/2013 and 2013/2014 (Source: NHS Benchmarking, 2016)

PROMISING PRACTICE: CITY AND HACKNEY PRIMARY CARE PSYCHOTHERAPY CONSULTATION SERVICE

City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS), is an innovative outreach service provided by the Tavistock and Portman NHS Foundation Trust and supports local GPs in the management of their patients with complex mental health and other needs that result in frequent health service use. This includes people with medically unexplained symptoms, diagnosis of personality disorders or long-term mental health problems, not currently being managed by secondary mental health services, and many of these people have poor physical health and social difficulties. The PCPCS operates in two distinct ways: (i) as a referral service, ie, providing talking therapy interventions to individual patients; and (ii) as a consultancy service for GP and other primary care staff, advising them on the management of patients with complex needs. Forty to fifty GP patients a month are referred to the PCPCS service, over 60% of whom are from BAME groups. A typical course of treatment by the PCPCS lasts for 12 or 13 sessions at an estimated average cost of £1,348 per patient.

An evaluation of the service by Parsonage et al. (2014) found 75% of people using the service showed improvements in their mental health, wellbeing and functioning and 55% were below the threshold for symptoms they had prior to treatment ie, 'recovered'. These results compare favourably with IAPT services, which tend to see people with less complex problems. Based on data from a sample of 282 patients, Parsonage et al. (2014) estimated that treatment by the PCPCS reduced the costs of NHS service use by £463 per patient in the 22 months following the start of treatment. This significantly offsets the cost of the service. The service performs very well in terms of cost-effectiveness, with a cost per QALY gained of £10,900, which is well below the bottom end of the NICE threshold range of £20,000–30,000. Furthermore, a survey of local GPs using the PCPCS found very high levels of satisfaction with the service, covering such aspects as the referral process and the accessibility and responsiveness of the service.

Source: Parsonage, M., Hard, E. and Rock, B. (2014). Managing patients with complex needs: Evaluation of the City and Hackney Primary Care Psychotherapy Consultation Service. London: Centre for Mental Health.

⁵⁹ 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].

For example, screening and early intervention to prevent and treat perinatal mental health problems, estimated at affecting up to 20% of women at some point during pregnancy and for the first year after birth (Khan, 2015).

Sandwell was an early pioneer in initiating improvements in primary care mental health through its introduction of the Sandwell Wellbeing hub⁶⁰: offering a range of self-help material, group work and individual support, including the Esteem Team supporting people with mild to moderate problems (Thiel et al., 2013). Other CCGs in the WMCA are currently in the process of redesigning primary care mental health services to strengthen mental health provision in primary care and access to wider services to support people in the community. These include:

- **Birmingham:** Birmingham South and Central CCG introduced the Edgbaston Wellbeing Hub in 2014, and more recently Birmingham Cross City CCG has commissioned Birmingham Mind to deliver a Wellbeing Hub, offering one to one support/signposting and a range of workshops, groups and courses, including five ways to wellbeing, relaxation, mindfulness, self-esteem and confidence building and coping with anxiety and depression. Services at Edgbaston Wellbeing Hub include counselling, listening and guidance sessions, life skills and befriending, community and practical support, self-help resources and one-to-one sessions. The Edgbaston 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 (Merida Associates, 2015).

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

- **Dudley CCG**⁶² 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 providing relevant support, eg, support regarding violence and abuse; drug

and alcohol service; education and employment and providing quick access to IAPT; mental health professionals within primary care; gateway workers; and support from secondary care services⁶³.

There is a range of other initiatives to support and develop the capacity of primary care mental health including:

- Health trainers to support lifestyle changes
- Social prescribing, which includes GPs prescribing exercise, books, art, museums, computerised Cognitive Behavioural Therapy (CBT); educational activities; green gyms; museums; social enterprise schemes; time banks; supported employment and volunteering. A wide range of benefits have been identified for social prescribing including increases in self-confidence and esteem; improvement in psychological wellbeing and positive mood; reduction in anxiety and depression; improvements in physical health and reduction in GP and primary care visits; reduction in social isolation; improved motivation and meaning in life and acquisition of new leaning and skills⁶⁴. 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 wellbeing⁶⁵.
- 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 Trust⁶⁶.

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 this within 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 effective support for under-served groups (Dowrick et al., 2013). This model, Improving Access to Mental Health in Primary Care (AMP) (Gask et al., 2012) is worth considering for implementation and evaluation in a WMCA context.

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

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

PROMISING PRACTICE: EARLY INTERVENTION IN PSYCHOSIS

The Worcestershire EIP service has been identified as an example of promising practice by NICE and NHS England (2016) in a resource pack to support the implementation of the waiting time standard in relation to:

- Family members of adults with psychosis or schizophrenia being offered family intervention.
- Adults with psychosis or schizophrenia being offered combined healthy eating and physical activity programmes, and help to stop smoking.
- Carers of being offered carer-focused education and support programmes.

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

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 adult 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, which were first introduced to 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 teams 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 (BSMHFT) to Forward Thinking Birmingham in April 2016. Forward Thinking Birmingham is a

partnership between Birmingham Children's Hospital NHS Foundation Trust, Worcestershire Health and Care NHS Trust, Beacon UK, The Children's Society, Priory Group and a number of CCGs in the Birmingham area. The EIP teams are located in Birmingham; Coventry, Nuneaton (North Warwickshire CCG), Leamington Spa (South Warwickshire CCG); Walsall and Dudley; West Bromwich (West Birmingham and Sandwell CCG) and Wolverhampton. Guidance has also been developed for GPs on the early identification of psychosis (French et al., 2014) 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 cusp of psychosis
- **Reduce the duration of untreated psychosis** by promoting early detection and engagement by community agencies and comprehensive initial mental health assessments and diagnosis.
- **Optimise initial experience of acute care and treatment** by providing 'Youth friendly' Acute Home based/Hospital Treatment
- **Maximise recovery and prevent relapse during critical period** by providing integrated bio/psycho/social interventions; focussing on functional/vocational as well as symptomatic recovery; addressing co-morbidity and treatment resistance early and supporting carers and network of community support agencies

⁶⁰ www.sandwell.gov.uk/info/200222/healthy_sandwell_healthy_you/762/mental_health_and_wellbeing [accessed 150816].

⁶¹ http://birminghammind.org/services/wellbeing-hub/ [accessed 150816].

⁶² Dudley is one of 29 areas selected to test a new model of care following the publication of the Five Year Forward View (5YFV) in October 2014.

See www.dudleyccg.nhs.uk/about-commissioning/integration/ [accessed 040516].

⁶³ www.southworcestershireccg.nhs.uk/get-involved/pmhs/

⁶⁴ www.slideshare.net/NCVO/museums-on-prescription-social-prescribing-presentation

⁶⁵ www.healthexchange.org.uk/services/solihull-social-prescribing/

⁶⁶ www.bcpft.nhs.uk/services/mental-health/83-for-adults/community-services/21-primary-care-liaison-teams

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 less stigmatizing and coercive, thus proving a viable alternative for people not needing close supervision (Howard et al., 2008; 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 repertoires 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).

CRISIS INTERVENTION

1. Provision in the WMCA

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

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

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

While primary care and specialist mental health services form a key strand of the mental health crisis response across these domains, the broad range of voluntary sector and community contributions is key in promoting resilience, wellbeing, empowerment and care for people in crisis. The Crisis Care Concordat, established in 2014 provides a map of services and organisations that have agreed to work together, to make sure that people get the help they need when they are having a mental health crisis, and action plans of the necessary steps needed to improve local access. The action plans are developed between commissioners, local authorities, mental health and non-mental health providers, police, local ambulance services and voluntary sector organisations and it is clear that an effective crisis response will only be achieved by all these organisations working in partnership. Many of the action plans outline steps to develop a single point of access, the development of an urgent care pathway; Police Custody Liaison and Diversion schemes; improved support for children and young people and for people from BAME communities. 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

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 (Asmussen 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 CCG is using the Routine Enquiry about Adversity in Childhood (REACH) screening tool to identify adults with high ACE scores, which may lead to poorer health and social care outcomes and expose their children to risk of adverse experiences, and is identifying interventions to provide support to these families⁶⁷.

services. For example, the Staffordshire Crisis Concordat partners are exploring options for peer support-based hub model.

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



STREET TRIAGE

In Birmingham and Solihull, the recognition that mental health relates to about 20% of police activity, and that the service delivered was considered by service users to be poor, Street Triage (mental health nurse, police officer and paramedic) was piloted in 2014⁶⁸. Between Jan 2014 and August 2015, street triage dealt with 4,409 incidents. It prevented 1,160 people attending A&E, prevented the use of 1,654 ambulance journeys and 1,025 police resources being dispatched. Since Street Triage was introduced in Birmingham and Solihull in 2014, only two people have been detained in a police cell under s136⁶⁹ of the MHA 1983. The national evaluation reported that approximately a quarter of incidents (26.4%) involved people from BAME communities (Reveruzzi and Pilling, 2016). In 2015, the triage team was able to provide a response to 60% 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 to prevent further crisis through preventative intervention. Of note is the partnership working across organisational boundaries and different sectors to facilitate people receiving an appropriate and timely response.

There has been no comparison of these different models at a local level but the national comparative evaluation of nine pilot sites identified a number of factors associated with better outcomes (Reveruzzi and Pilling, 2016). These include:

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

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

CRISIS HOUSES

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

- 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 six-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 Cannock, 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 Concordat action plans for the core members of the WMCA identified the following proposals in relation to crisis accommodation:

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

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

⁶⁷ www.eif.org.uk/case-study/blackburn-with-darwen-ace-adverse-childhood-experiences-screening-pilot/ [accessed 050616]

⁶⁸ www.heartofengland.nhs.uk/wp-content/uploads/Street-triage-presentation-Dec.pdf

⁶⁹ S136 of the 1983 Mental Health Act allows the police to take anyone, who they believe is mentally unwell and in need of care and assistance, from a public place to a place of safety.

PROMISING PRACTICE: IMPROVING ACCESS TO APPROPRIATE SUPPORT FOR PEOPLE FROM BAME COMMUNITIES

In recognition of the potentially problematic pathways into services and poor experience of support in a crisis for people from BAME communities (Race Equality Foundation, 2015), some areas are taking targeted action to address this. In Dudley, for example, the Equalities Act provides a framework for improving the equality of access and outcomes for people from communities with protected characteristics under the Act. This includes: involving people from these 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; commissioners and providers meeting with community leaders to understand any barriers that may get in the way of people accessing the help that 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 community, in which they have higher levels of trust and this has implications for commissioning these organisations to provide the necessary support.

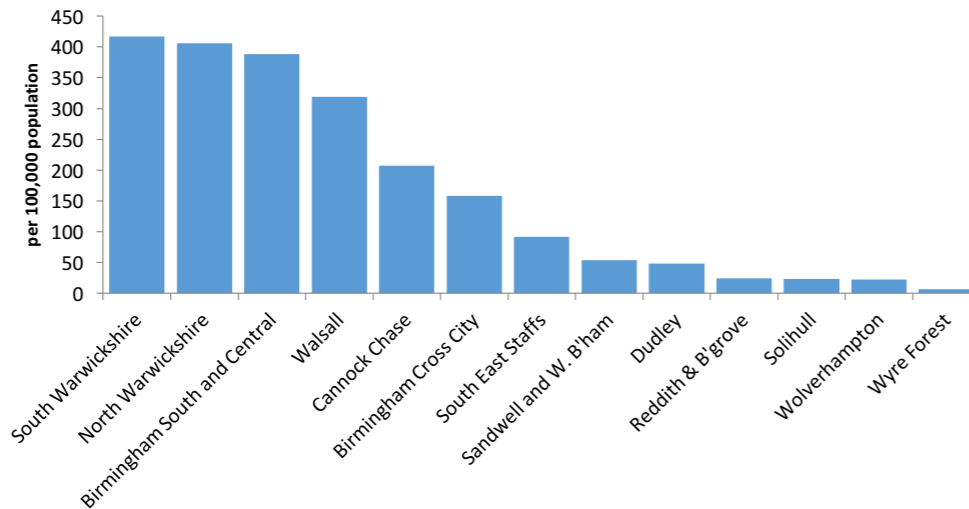


Figure 9: Attendances at A&E for a psychiatric disorder per 100,000 population (2012/13) (Source NHS Benchmarking 2016)

2. Performance against national indicators

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

3. Redesigning the urgent care pathway

As noted earlier the redesign of the crisis care pathway is a key NHS England target for CCGs and likely to be a central theme within the STPs. An example of redesigning the crisis care pathway is the work undertaken by 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 redesign⁷⁰.

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

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 across England, 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.
- Black Country Partnership NHS Foundation Trust (BCPFT) provides mental health and specialist health learning disabilities services to people of all ages in Sandwell and Wolverhampton as well as specialist learning disability services in Walsall, Wolverhampton and Dudley and community healthcare services for children, young people and families in Dudley. The Trust employs approximately 2,000 staff.
- Coventry and Warwickshire Partnership NHS Trust (CWPT) provides a wide range of mental health and learning disability services for people of all ages to a population of about 1 million

PROMISING PRACTICE: RAPID ASSESSMENT INTERVENTION AND DISCHARGE (RAID)

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

people living in Coventry, Warwickshire and Solihull. The Trust provides some specialist services to a wider geographical area, and also provides a wide range of community physical health services for people in Coventry. The Trust employs approximately 4,000 staff.

- Dudley and Walsall Mental Health Partnership NHS Trust (DWMH) 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 Warwickshire. The Trust employs just over 1,000 health and social care staff.

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

PROMISING PRACTICE: OPEN DIALOGUE

Open Dialogue offers a model of crisis response, service delivery and therapeutic engagement that has delivered exceptional shorter and longer term outcomes in Western Lapland where it has been developed over the last 20 years. A ten-year follow up study (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 33% had used neuroleptic medication

Comparable figures for services in other western countries suggest a norm of only around one-third of people with psychosis achieving a full clinical recovery. An early evaluation of the introduction of this approach in the USA found that it could deliver good clinical outcomes, high satisfaction, and shared decision making, although introducing the new service model required a substantial investment in training – an investment that would easily be recouped if outcomes were as good as in Western Lapland (Gordon et al., 2016). Key features of the approach are an immediate crisis response, continuity in the therapeutic team over the course of crisis and recovery, and full involvement of the person, their family and significant others in regular network meetings at which difficulties and experiences are discussed and at which any decisions regarding treatment are made.

⁷⁰ <http://16878-presscdn-0-18.pagely.netdna-cdn.com/wp-content/uploads/2014/07/NWL-Urgent-Care-Programme-Overview-for-MIND-Website-020714.pdf>

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 to rapidly realise quality and efficiency benefits, spread best practice and reduce variations in cost and quality through integration across current geographical and organisational boundaries⁷¹. These areas are seven day working in acute services; crisis care and the reduction of risk; and promoting a recovery culture. Detail on the four Vanguards in the WMCA is provided in Appendix 9.

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

This measure uses the number of service users registered (on caseload) with mental health trusts, against wider England population data (NHS Benchmarking, 2016). In the WMCA in 2013, there were 2,205 people per 100,000 population in contact with specialist mental health services compared with the national average of 2,210. A more detailed analysis of caseloads indicates that very few people are registered with specialist mental health services if they are living in a residential or care home. In the WMCA, there is an average of 31 people in residential or nursing care in touch with specialist mental health services per 100,000, very similar to the national average. It is suggested that this may reflect a multidisciplinary input to

the home rather than on an individual case basis (NHS Benchmarking, 2016). There was an average of 185 (range 164-230) admissions to inpatient care per 100,000 population during 2013/14, compared with an England average of 227 (range 130 – 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 2015⁷². This compares with 1,322 beds in 2012, representing an increase of 1.6% 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.

Trust	Mean length of stay (days)		
	2013-14	2014-15	2015-16
BSMHFT	34	36	34
BCPFT	36	37	35
CWPT	32	43 ⁷³	34
DWMHPT	38	47	38
Overall mean	35	41	35

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

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, 19,656 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 1,586 (or 6.7 per cent) compared to 31st March 2014, and an increase of 4,179 (or 20%) compared to the 31st March 2011 snapshot count. This national increase is reflected in the increase in the numbers of people detained in the main NHS provider Trusts in the West Midlands (as illustrated in Figure 12). Differences between providers will reflect the size of population covered and provision of secure services and national specialist services, with BSMHFT being the main provider of these services. In the West Midlands, in 2014/15, the average rate of detentions was 81.2 per 100,000 population, slightly above the England average of 77.2. However, the rate ranged from 43.7 for Warwickshire North CCG to 165.4 per 100,000 population⁷⁴ 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)

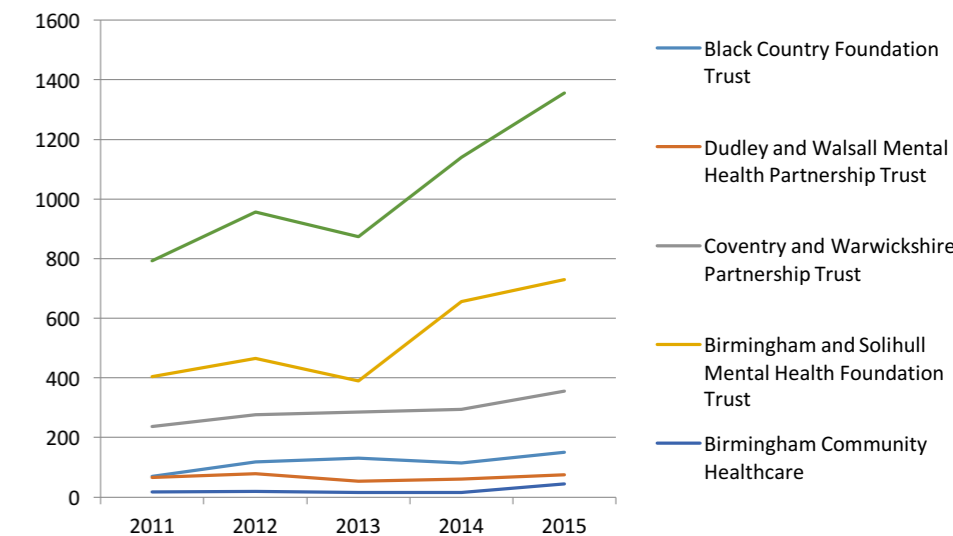


Figure 12: No of people detained on March 31st by NHS provider (Source: KP90, Health and Social Care Information Centre)⁷⁵

	01.04.15-31.12.15	01.01.16-01.03.16	Total 2015-16
The number of section 136 detentions where the person was taken directly to a police station	2	0	2
The number of detainees under 18 that went to a police station	0	0	0
The number of section 136 detentions where the person was taken directly to a health based place of safety	764	225	1019
The number of detainees under 18 that went directly to a health based place of safety	19	10	29

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

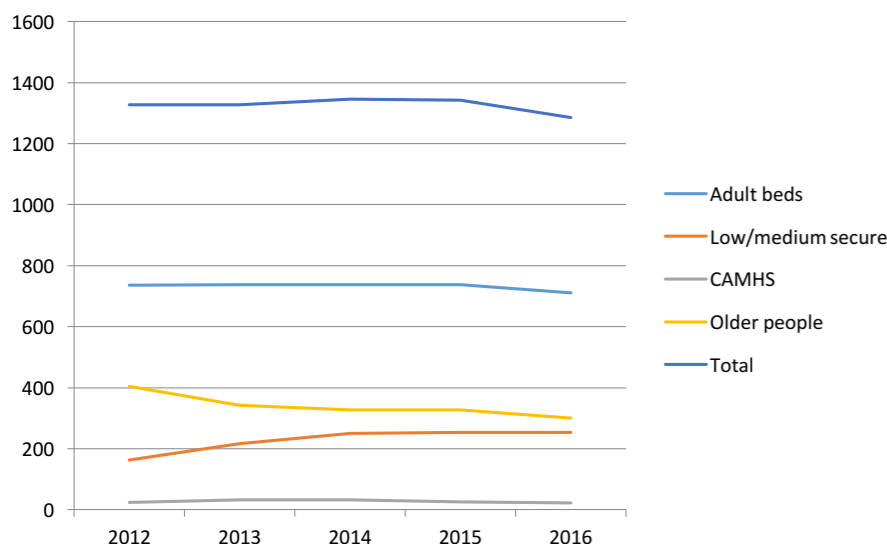


Figure 11: Mental health inpatient beds by the four main providers in the West Midlands 2012-2016 (Source: NHS Trust data 2016)

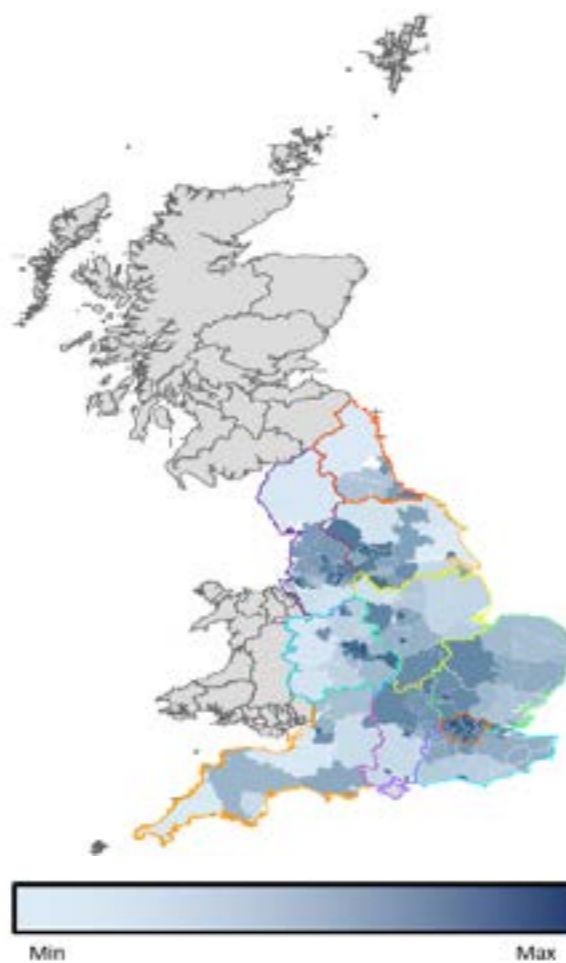


Figure 10: People in contact with mental health services per 100,000 population (April-June 2013) Source: NHS Benchmarking (2016)

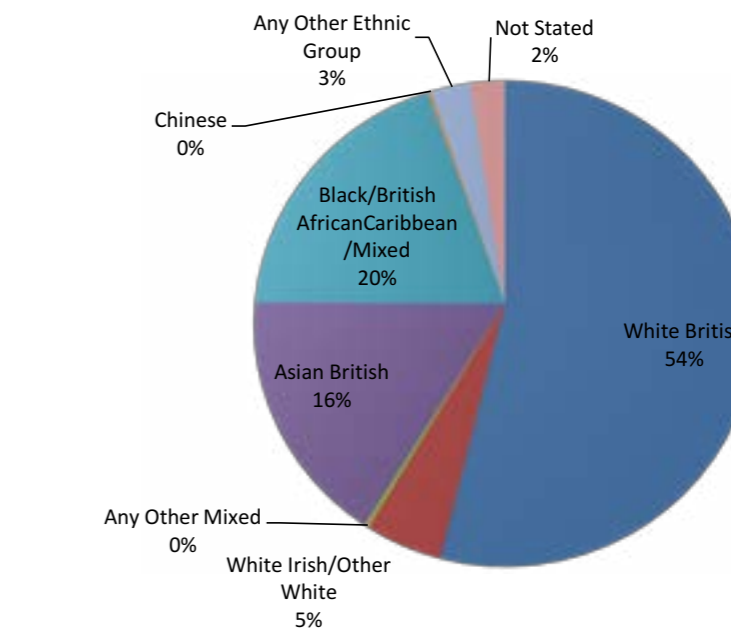


Figure 13: MHA Detentions by ethnicity 2015-2016 (Source: NHS Trust data 2016)

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.

USE OF SECTION 136

From data provided by the four main mental health Trusts, there were over 535 uses of Section 136 in 2015-2016. The ethnicity recorded for the use of Section 136

⁷¹ See: www.dwmh.nhs.uk/west-midlands-mental-health-trusts-forge-alliance-to-transform-acute-care [accessed 030316].

⁷² From April 2016, specialist inpatient beds for 0-25-year-olds are provided by FTB.

⁷³ Includes people over 65 as the service moved to an age independent service from 2014.

Provider Name	2012-13		2013-14	
	Number of uses of restraint	Number of people restrained	Number of uses of restraint	Number of people restrained
England	17,358	3,699	23,926	6,380
BSMHFT	1,475	210	1,750	430
BCPFT	35	15		
CWPT	300	195	495	190
DWMH			140	55

Table 4: Use of physical restraint 2012-2014⁷⁷

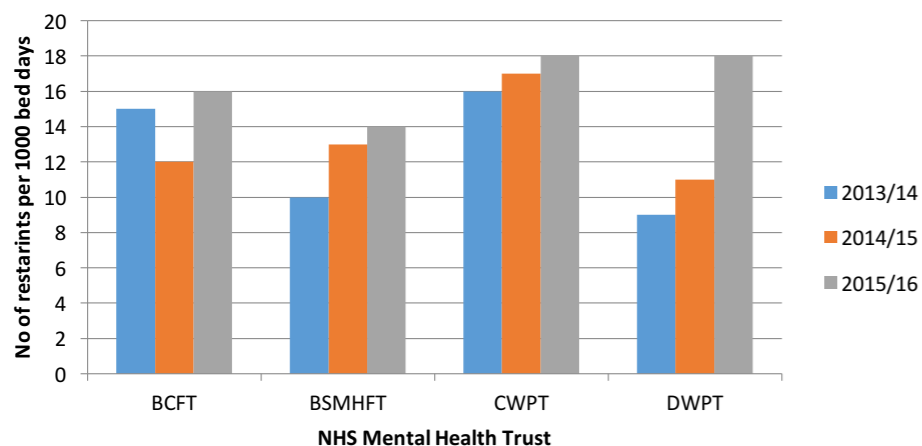


Figure 14: Uses of restraint per 1000 bed days by NHS Trusts in the WMCA

indicates that 55.5% of people were White British and 42% from BAME communities with British Asian and Asian; and Black British, African, Caribbean and people of mixed heritage constituting 15% and 15% of the total respectively. People of Chinese heritage made up less than 1% of the total. From data collected by West Midlands Police, only two people were taken to a police cell as a place of safety between April 2015 and March 2016 and none of these people were under 18; as summarised in Table 3.

MENTAL HEALTH ACT DETENTIONS BY ETHNICITY

From NHS Trust data, of the total number of people detained on a Section 2 or 3 in 2015-2016⁷⁶: 57.8% were White British; 14.3% British Asian (Bangladeshi, Pakistani

and Indian), mixed White/Asian or Other Asian; 21.9% Black British (African/Caribbean), 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 tranquilisation. Table 4 provides a summary of the use of physical restraints for the Trusts from the Minimum Mental Health Data Set (MHMDS). However, the higher rates for BSMHFT reflects that they are a provider of specialist secure services, which will have higher uses of restraint than acute inpatient service because of the greater complexity of people's needs, which is likely to include substance abuse as well as mental illness.

In order to make more meaningful comparisons between the Trusts, data on the use of restraints for acute adult inpatient care was obtained and the rate of restraints calculated per 1000 bed days for each Trust, as summarised in Figure 14. The mean rate for all types of restraint over the last three years was 14 uses of restraints per 1,000 bed days (range 9-18 restraints per 1,000 bed days).

From data provided by one of the Trusts, the use of restraints for people with a learning disability was substantially higher and the data in Figure 14 excludes this data and that for secure services, where the rates are also likely to be higher.

An FOI request by Mind has indicated variation between Trusts in the use of restraint and recommended that face down restraint should be a 'never event' (Mind, 2013). The Mind report reinforces the need for a proactive and preventative approach by commissioners and providers

to reducing the use of restraint, which is experienced as traumatic and dehumanising and runs counter to a recovery-focused service (Huckshorn, 2006).

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

6. Outpatient and community services

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

The main community teams are:

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

Appendix 8 provides a breakdown of the contacts by organisation and team type. While information on contacts alone is not particularly meaningful or illuminating it provides an indication of the balance of activity, as illustrated by Figure 15, which provides a breakdown of contacts between services that account for 84% of the total contacts for adults aged 18-65, for mental health problems⁷⁸. 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 (Randall et al, 2015). Figure 16 illustrates the mismatch between estimated need and provision, with more referrals coming from the areas closer to the perinatal mental health unit (located by the Women's Hospital). GPs in the South of the city were also more likely to make a referral and the community services were achieving better outcomes for women of white ethnicity than women from BAME communities (Randall et al., 2015).

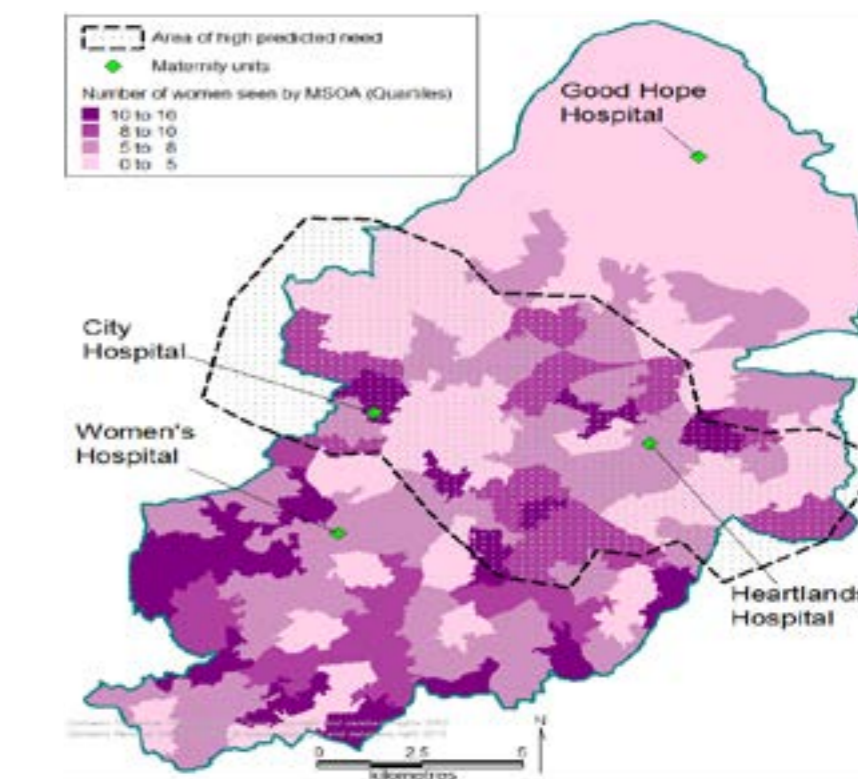


Figure 16: Number of women seen by community perinatal mental health services in each middle super output layer in Birmingham (2013 data). Source: Randall et al., 2015)

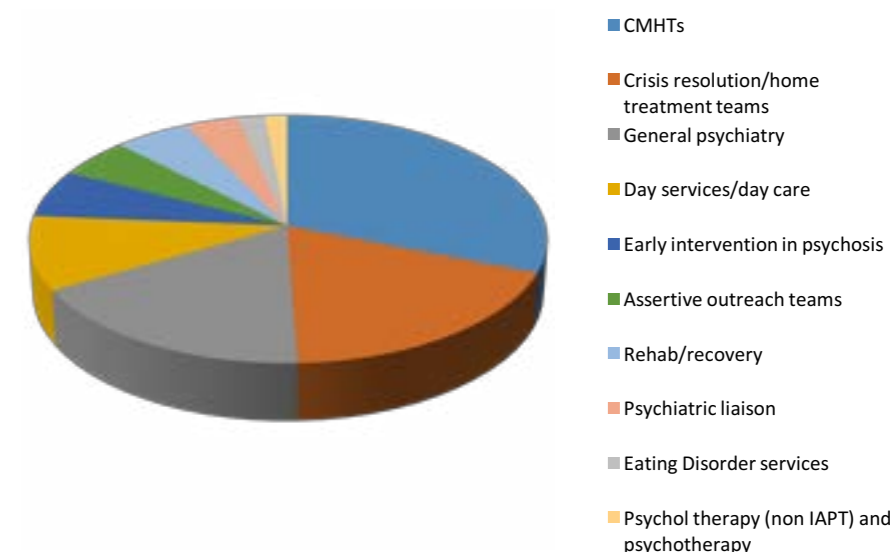


Figure 15: Proportion of contacts by service type for 2014-2015 (Source: Mental Health Bulletin: Annual Statistics 2014-15)

⁷⁴ Inpatients Formally Detained in Hospitals under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment, England – 2014-2015: <http://content.digital.nhs.uk/catalogue/PUB18803> [accessed 160816].

⁷⁵ Birmingham Community Healthcare Foundation Trust provides services to people with learning disabilities.

⁷⁶ Excluding people detained in secure services or specialist provision for BSMHFT.

⁷⁷ Data source: Health and Social Care Information Centre Mental Health Minimum Dataset (MHMDS) 2012-13 [see <http://content.digital.nhs.uk/catalogue/PUB12745>, accessed 141016] and 2013-14 Annual files [see: <http://content.digital.nhs.uk/catalogue/PUB15990>, accessed 141016]

⁷⁸ The remainder, not included, are perinatal; forensic; Liaison and Diversion; substance abuse; early onset of dementia and other services that are unclassified or for which data is missing.

7. Spend on specialist mental health services by CCGs

Across England, the average CCG spend in 2013/14 was £154 per head of population and there was nearly a threefold variation in the level of CCG spend on specialist mental health services when assessed as a percentage of total CCG expenditure. For the same period, the average spend on mental health 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 within 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 generic community mental health teams (King's Fund, 2015). Out of Area placements impact adversely 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 Out of Area Placements 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 OATs, 73% of which was spent on low secure forensic beds for adults. In addition approximately £30 million was spent on two independent sector providers based in the WMCA.

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

- Acute overflow beds for people who require an assessment and treatment admission but there are no local beds available
- Specialist placements, notably for people with a diagnosis of personality disorder, or autism with a comorbid mental health problem
- Locked rehabilitation beds
- Psychiatric Intensive Care Unit (PICU) beds in the absence of local provision

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

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

Not being able to accommodate people requiring assessment and treatment in local acute provision is a concern for CCGs and mental health Trusts, as well as individuals and their families, and regulatory bodies. National reports, notably the National Confidential Inquiry into Suicide and Homicide (2015) and recent Commission on Acute Adult Psychiatric Care (Crisp et al., 2016), recommend ending the practice. There is guidance available⁷⁹ but realising this ambition will require senior level commitment, both clinical and managerial, and addressing complex, and entrenched, problems in other aspects of the mental health system that reinforce the use of

admission as the solution to a mental health crisis (Crisp et al., 2016).

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

A repatriation project to bring people with mental health problems, and learning disabilities, from Coventry and Warwickshire closer to home has been running for four years. To date 100 people have been repatriated at a cost saving £12 million⁸⁰. This project between CWPT, three CCGs – Coventry and Rugby, North Warwickshire and South Warwickshire and the NHS Arden and Great East Midlands Commissioning Support Unit, demonstrates the value of multi-agency strategic partnerships and the Trust and the CSU recently won an award for this work⁸¹. The EIP work stream in Wolverhampton has 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 helpline (CWPT) (see primary care section)
- Early intervention in psychosis (WHCT) (see early intervention section)
- RAID and redesign of the urgent care pathway (BSMHFT) (see crisis 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 Police (see crisis intervention section)
- Individual Placement and Support (see employment section)

PROMISING PRACTICE: REDUCING THE USE OF RESTRAINT

Six core strategies aimed at reducing the use of seclusion and restraint have been identified in the U.S. (Huckshorn, 2006). These strategies are grounded in a quality improvement perspective using a preventive trauma-informed approach (LeBel et al., 2014) and are:

1. Continuous involvement of senior organisational leadership (ie, the CEO)
 2. Use of data to inform practice at the individual unit level
 3. Ongoing staff training and education, including mentoring and supervision, focused on primary prevention and intervention
 4. Use of seclusion/restraint tools: to identify persons with high risk factors for death and injury; use of safety plans; the use of person-first, non-discriminatory language; environmental changes to include comfort and sensory rooms; and meaningful treatment activities designed to teach people emotional self-management skills (Huckshorn, 2008).
 5. Inclusion of service users, carers and families in inpatient care as advocates and peers and event oversight
 6. Debriefing techniques developed from evidence and analysis of incidents.
- This approach has been implemented in different health care contexts, particularly mental health, in various countries and has been adapted as a programme known as REsTRAIN YOURSELF, which is being piloted and evaluated for mental health in the North West of England (LeBel et al., 2104).

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 veterans⁸². CWPT, for example, provides a service for veterans to ensure access to priority treatment for veterans; establishing an enhanced standard care pathway tailored for them and their carers to be referred to IAPT and other secondary care services; developing partnerships with veterans' charities (Combat Stress, Royal British Legion) to pilot a multi-agency 'one-stop shop' approach for veterans and their families, and delivering training for CWPT.

- Walsall Carers Support Service (DWMHPT) for any carer supporting someone aged 18 and over living in Walsall who has complex mental health needs: offering a wide range of advice, information and support for carers; and the Child and Adolescent Mental Health Services (CAMHS) FLASH team, which has a specific remit to support foster carers, adoptive parents, and carers to reduce the risk of placement disruption and/or the subsequent need for the child to move into another placement in or outside of the borough.

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 on 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 clinical practice. Given the Care Quality Commission's general observations about the quality of care in acute inpatient settings, this should be a focus, with a particular emphasis on assessment and treatment under the MH Act. The experience of detention and compulsion can be unhelpful, profoundly disempowering and humiliating, and whilst some people find it helpful it can have a long-lasting impact and is seen as contradicting a recovery focus (Repper and Perkins, 2014). As well as developing alternatives to in-patient care, there are three particular initiatives that can support changes in practice to a more empowering stance, and whose potential is not fully realised in the WMCA:

PEER SUPPORT

The contribution of peer support is now widely recognised as helpful in promoting wellness and empowerment, with many voluntary and community organisations encouraging peer support (National Voices, 2015). There are many different forms of peer support and it is of value across public services. In a mental health context, the key elements include building on shared personal experience to focus on strengths and promote wellbeing and recovery, through self-help groups, mutual peer support, formal peer support and online peer support (Mental Health Foundation, 2012; Faulkner and Kalathil, 2012; National Voices, 2015).

ADVOCACY

Advocacy, in its various forms, has an important role to play in ensuring that an individual's voice is heard and in promoting empowerment. Many people will be able to advocate for themselves but having someone else to speak on your behalf at a time of crisis can be vital and is one measure for ensuring that people's rights are protected (Newbigging et al., 2015a). This is particularly important when people's views are at risk of being discounted in order to prevent distress and misunderstandings resulting in negative, and potentially costly, outcomes (Centre for Social Justice, 2011). Although the evidence base for advocacy is under-developed, a wide range of impacts have been identified and are supported by practice evidence from advocacy projects and service user groups (Macadam et al, 2013). They include: increasing people's ability to make informed decisions and be involved in decision-making; being able to exercise greater choice and control; better communication and relationships between individuals and professionals, and improving access to services, including diversion to less restrictive forms of care (Newbigging et al, 2015b).

There is a range of advocacy provision across the WMCA, typically based on a model of independent advocacy and including statutory advocacy (Independent Mental Capacity Advocacy (IMCA); Independent Mental Health Advocacy (IMHA) and Independent Care Act advocacy). There is a risk that Local Authorities will increasingly commission statutory advocacy, placing other forms of

⁷⁹ See for example: National Mental Health Development Unit (2011). In Sight and In Mind: A toolkit to reduce the use of out of area mental health services. Available at: www.rcpsych.ac.uk/pdf/insightandinmind.pdf [accessed 06/06/16]

⁸⁰ www.ardengemcsu.nhs.uk/files/7114/3265/7953/Case_Study_-_Mental_Health_Repatriation.pdf [accessed 03/03/16].

⁸¹ <https://www.covwarkpt.nhs.uk/our-news/nhs-services-land-national-award-550>

⁸² <http://veterans.ssf.nhs.uk/veteranservices/west-midlands-regional-veterans-service> [accessed 03/03/16].

advocacy at risk (e.g. generic advocacy and community advocacy), such that advocacy becomes increasingly professionalised. It would, therefore, be timely to review this provision; particularly in light of findings that access to statutory advocacy can be problematic for people detained under the Mental Health Act, with the CQC recently highlighting their finding that 20% of detained patients had not had their rights properly explained to them (CQC, 2015). Furthermore, a national evaluation of IMHA provision found that people most in need of advocacy are the least likely to access it (Newbigging et al., 2015a).

OPEN DIALOGUE

The potential and evidence for open dialogue was discussed under the previous section in relation to crisis intervention. Within the UK a development of the Open Dialogue model to incorporate peer support is currently being piloted in four Mental Health Trusts (North East London Foundation Trust – NELFT; North Essex; Nottinghamshire; and Kent and Medway) and is the subject of a major evaluation study for which a final funding decision is awaited from the National Institute for Health Research. A national one year in-service training programme is available and would be open to practitioners and teams from West Midlands Trusts.

LOCAL AUTHORITY PROVISION

Local Authorities provide social work services and commission a broad range of mental health services from the third sector. The role of social work in adult mental health includes ensuring eligible people can access social care services and resources, including direct payments and personal budgets, and acting as Approved Mental Health Practitioners, alongside other mental health professionals. Social workers also have a role in building community capacity: 'working with groups and networks of citizens to foster citizen mutual support and social capital' (Allen, 2014: 15). The Care Act 2014 also placed a duty on Local Authorities to promote wellbeing, physical and emotional, when carrying out their duties (Department of Health, 2014). However, increasing thresholds for eligibility, reflecting reductions in Local Authority budgets, may mean that many people simply are not getting the support they

need. This will mean that the responsibility for providing care will shift to informal carers. Five years ago, Age UK estimated that a 7% cut to Local Authority funding would lead to a 25% rise in the hours of personal care provided by carers (Carers UK, 2011). The National Audit Office (2014) has indicated a 37% real-terms reduction in government funding to local authorities between 2010/11 and 2015/16. While children's social care has been protected there has been a reduction in adult social care of 9% for this period with further reductions anticipated (National Audit Office, 2014: 26). It is inevitable that this will have had profound implications for the mental health of carers.

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

1. Direct payments and personal budgets

Direct payments and personal budgets are two specific methods that have been introduced to give people greater choice and control over the support they receive,

and, as discussed later, are key to a strategy focused on promoting self-determination and recovery.

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

During 2014–15, approximately 4,380 people (18–64) received Local Authority funded Mental Health Support in the WMCA: 540 received a direct payment (either in full or in part) (12.3%) and 1105 received a Local Authority Managed Personal budget (25%)⁸³. The use for mental health clients is substantially lower than for other client groups.

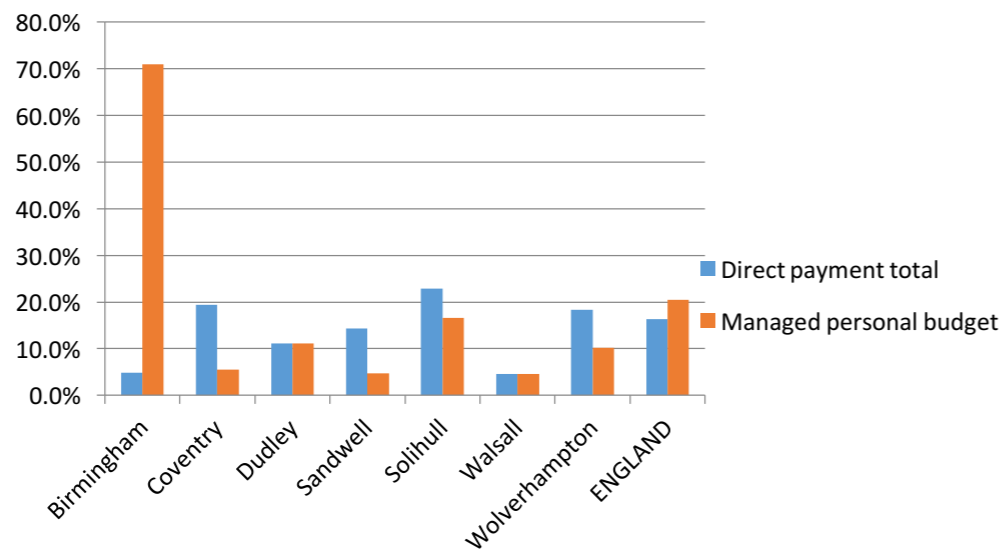


Figure 17: Percentage of mental health clients receiving a direct payment or managed personal budget in the WMCA

However there is substantial variation across the WMCA, as illustrated in Figure 17 for the constituent Local Authorities. For direct payments this ranges from 22.9% (Solihull) to 4.5% (Walsall) and for personal budgets from 70.9% (Birmingham) to 4.5% (Walsall). There are examples of higher rates of direct payments (Warwickshire) and personal budgets (Worcestershire) in other Local Authorities in the WMCA, from which other Local Authorities can learn. However, further inquiry is needed to understand how meaningful the implementation of direct payments and personal budgets is in supporting personalisation. This will involve capturing the experience of service users to be confident that personalisation is being implemented as intended.

2. Support to Carers

The Care Act 2014 reinforced a focus on the needs of carers and providing assessment and support to carers in their own right. A recent review of the implementation of this Care Act duty found that the majority of carers, responding to a survey, were unaware of their rights; nearly two thirds had not received an assessment and some that had were dissatisfied with the assessment (Carers Trust and University of Birmingham, 2016). Furthermore, many carers found engagement with the NHS problematic. The review concluded that the Care Act focus 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 wellbeing principle in assessment and care and support planning (Carers Trust and University of Birmingham, 2016: 5).

THIRD SECTOR PROVISION

The third sector, often referred to as the voluntary sector, comprises charities, social enterprises, and community groups, which are typically driven by a social mission, have a closeness to and expertise on communities, and because services are often provided by volunteers, many of whom will be peers with lived experience, the power differential between service users and service providers is reduced. The third sector, therefore, has a 'comparative advantage' in services for excluded groups 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 mental health, offering 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 recovery⁸⁴. 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 primarily concerned 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, for example organisations providing services to African-Caribbean people, South Asian people, or asylum seekers and refugees; and universal services, such as Citizen's Advice.

There is a diverse third sector of BAME organisations, many of which have their foundations in grassroots organisation, with dissatisfaction with mainstream mental health provision and concern about the experience of people from BAME communities, as a possible driver. Mental health support may also be a component of wider support to BAME communities, that also provide advice and support.

Similarly, organisations providing other welfare services have a mental health component: for example, services supporting homeless people; drug and alcohol support; support groups for people with long-term 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; Sandwell Women's Aid; Stepping Stones in Walsall; Coventry Haven Women's Aid; the Haven in Wolverhampton 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 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
- Well-being hubs and open access services providing seven-day-a-week direct access for all to information, advice and support; peer support/friendships to challenge isolation; and the opportunity to engage in social/leisure/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, IAPT services and stress and anxiety management courses aimed at people with common mental health problems

⁸³ Community Care Statistics, Social Services Activity England 2014-2015. Available at: <http://digital.nhs.uk/catalogue/PUB18663> [accessed 100816]

⁸⁴ Although the co-option of these methods by public services has been the focus of critique by service user activists as fundamentally alerting 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, eg, welfare benefits; protecting rights and shifting the dynamic with professionals toward co-production (Newbigging et al., 2015a)
- Employment support in a wide range of forms, including job-retention; negotiating reasonable adjustments; supporting leaving negative employment with the most favourable 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, improving confidence and 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 independence, while ensuring that their mental health needs and daily living skills are being addressed; 24hr nursing care facilities for adults with severe and enduring mental health needs

The third sector brings in money and resources to the WMCA either on its own or in collaboration with public services. However, the short-term nature of much of the funding for the third sector potentially jeopardises its activity and sustainability. It means that a significant amount of time and capacity is spent on bidding and fund-raising, rather than service delivery

POSITIVE PRACTICE: ACACIA FAMILY SUPPORT

Acacia Family Support, a charity based in Birmingham that provides support to women and families affected by antenatal and postnatal depression. Acacia provides a broad range of emotional and practical support including befriending; psycho-educational group work; CBT and support for fathers. It is an award winning service mentioned by NHSIQ⁸⁵ as a model for perinatal support that could be transferable to other parts of the England. The funding sources for these services include: CCG and Local Authority funding; charitable donations; income-generating activities; and awards from national grant-making bodies, such as the Big Lottery and Comic Relief.

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 PROVISION 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 embedded into the 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 community

development approach to tackle the intersecting structural inequalities that limit life chances'. Therefore, although specific services are considered, action 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 disadvantageous treatment experienced by people from their communities. Examples across the WMCA include:

- African Caribbean Community Initiative (ACCI)⁸⁶ 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 people⁸⁷.
- 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 deliver community meet ups and other social activities⁸⁸.
- Ekta Unity Voluntary Group⁸⁹, based in Coventry but also covering Warwickshire and the West Midlands, promotes a holistic approach to health, mental health and social wellbeing for Asian and British Asian women, aged 26 and over. The group provides a range of activities, including yoga and meditation, social and wellbeing sessions as well as themed activities such as singing and music.

- Chinese Community Centre in Birmingham, providing support to carers and people experiencing mental health issues, including outreach support and workshops covering Wellness Recovery Action Plans; Mental Health awareness and a training for mental health carers⁹⁰.
- IAPT services for people from BAME communities are provided by Mind in Birmingham⁹¹.
- Freedom from Torture West Midlands, based in Birmingham, opened in 2009 in response to the widespread dispersal of asylum seekers across the UK. Services provided include assessment and psychological therapy for children, young people, and adults who are survivors of torture, including individual and group work, and a family therapy service to families that have been affected by torture⁹².

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

- The community engagement team at BSMHFT who have played a central role in relation to 300 Voices and work closely with Trust staff and community groups to ensure local people are consulted and involved in developments or changes to services provided by the Trust. They also work with local communities to tackle the stigma associated with mental health, and to reduce the barriers to getting the right help at the right time⁹³.
- Community Development Workers, who work with people from BAME, and increasingly people with an Eastern European background, including Czech, Slovakian and Polish people as well as people with protected characteristics under the Equality Act⁹⁴. The team works in partnership with other community organisations to provide support to individuals, raise awareness of mental health and wellbeing; provide cultural competence training and set up

support groups: for example Pyari Sangat - Asian Women's Mental Health Support Group; Community Creations – An Interfaith Sewing Group for 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 at particular risk of exclusion and discrimination. Underpinning this is stigma associated with having a severe mental illness and, as discussed below, people's life chances, including life expectancy are drastically reduced. Furthermore people with a mental illness are at increased risk of violent 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 assault. Women with mental health problems were particularly vulnerable being ten times more likely to be assaulted (Pettitt 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 negative attitudes and mental illness-related stigma is the focus of Time for Change⁹⁵. The campaign is run by the charities Mind and Rethink Mental Illness, with funding from 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).

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 local area and to challenge stigma in their daily lives
- Funded and supported the delivery of the 300 Voices Programme (see Appendix 4)
- Run a number of high profile pop up Time to Change mental events to encourage mental health conversations; produced an educational pack for professionals, volunteers and youth leaders, with guidance and materials around tackling mental health stigma
- Supported over 20 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 local change together by setting up 'Time to Change Hubs' In these Hubs the Campaign will support partnerships of local organisations and individuals to work with people with lived experience of mental health problems to convene and coordinate local action.

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

- Support to quit smoking
- Tackling obesity
- Improving physical activity levels
- Reducing alcohol and substance use
- Sexual and reproductive health

⁸⁵ Available at: www.nhs.uk/media/2696378/nhsiq_perinatal_mental_health_sml_0915final.pdf [accessed 060616].

⁸⁶ <http://win.wolverhampton.gov.uk/kb5/wolverhampton/directory/service.page?id=TGndY5gVjoi> [accessed 060616].

⁸⁷ www.tamarindcentre.co.uk/id2.html [accessed 150816].

⁸⁸ www.sacmhft.co.uk/user-led.html [accessed 150816].

⁸⁹ Awarded the Queen's Award for Voluntary Service, in June 2016, along with a number of other voluntary sector and community organisations providing support to disadvantaged and marginalised groups in the WMCA. See: www.gov.uk/government/uploads/system/uploads/attachment_data/file/527091/Queens-award-voluntary-service-winners-2016.csv/preview [accessed 150816].

⁹⁰ www.chinesebirmingham.org.uk/en/supporting_communities/mental_health.htm [accessed 150816].

⁹¹ <https://web.archive.org/web/20151010110033/http://www.iapt.nhs.uk/silo/files/black-and-minority-ethnic-bme-positive-practice-guide.pdf>

⁹² www.freedomfromtorture.org/about/15/5252 [accessed 150816].

⁹³ www.bsmhft.nhs.uk/about-us/engaging-with-our-communities/contacting-our-community-engagement-team/ [accessed 150816].

⁹⁴ Singh, K. (2015) Community Development Worker Report 2014-2015 Making Pathways Clear in Mental Health. Available at: www.dwmh.nhs.uk/wp-content/uploads/2013/06/CDW-Report-2014-2015.pdf [accessed 150816].

⁹⁵ www.time-to-change.org.uk [accessed 050117]

- Medicine optimisation
- Dental and oral health
- Reducing falls

The analysis of information from Local Authorities on public health programmes identified that most but not all have health promotion initiatives targeted at people diagnosed with a severe mental illness to improve their physical health.

As the guidance makes clear, the key to improving health outcomes for this group is better partnership working and the integration of physical and mental health care and as people are likely to experience multiple health problems, the coordination of care is vital (Naylor et al., 2016).

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 their own care and support' (SCIE, 2008). Personalisation enables the social

THE VOLUNTARY SECTOR PLAYS AN IMPORTANT ROLE IN PROVIDING PREVENTATIVE INTERVENTIONS, AT AN INDIVIDUAL, COLLECTIVE AND COMMUNITY LEVEL, AND ACTIVELY PROMOTES PEER SUPPORT

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 68% 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).

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 recognises 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 people 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.

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 Bromwich⁹⁶; BGLAD (Birmingham Gays and Lesbians against Depression), which meets weekly in Birmingham's gay village area and provides informal peer support⁹⁷, and the national organisation, based in Wolverhampton, First Person Plural for people identifying with complex dissociative identity disorders⁹⁸ 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 Plus⁹⁹, in Sandwell, was highlighted for being particularly innovative in providing a range of services with peer support as the focus (Faulkner et al., 2013). Peer support takes many forms and includes:

- Providing support with recovery and care planning (eg, South Staffordshire Network for Mental Health¹⁰⁰)
- Facilitating peer support groups for people who hear voices (eg, Hearing Voices Network¹⁰¹)
- Self-help groups (as above)
- On-line peer support
- Peer mentoring (eg, in schools to build emotional resilience, Wolverhampton¹⁰²)

There is a range of organisations to provide guidance and facilitate the development of peer support including Peer2Peer, hosted by NSUN, an established user-led network of peer support experts who share fresh approaches to developing and running peer support programmes; the ImROC programme, which provides support to NHS providers and their partners to become more recovery-focused; and the Institute of Mental Health, Nottingham, which delivers peer support training accredited with the Open University, and a range of consultancy and evaluation services aimed at developing the role of peer supporters within both the voluntary and statutory sectors. Their recovery-focused training is applicable to a broad range of settings and they have recently worked with the Devon & Cornwall police service to support the development of peer supporters within the police workforce.

Much of the available evidence relates to formal peer support workers (Gillard et al., 2014) and changing the skill mix of the workforce to include peer support workers has been identified as 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 and Carter, 2011) and also to mental health services (Gillard et al., 2013). The 2015 Community Mental Health Survey, however, found that only about half of those people who felt they would benefit from peer support were offered it (CQC, 2015), resonating with findings relating to access to advocacy (CQC, 2014). The evidence base in terms of delivering outcomes is inconclusive and where positive findings have been identified they are not replicated across all studies (Knapp et al., 2015). However, for the role to be meaningfully adopted the experiential knowledge that peer workers bring to their work that enables them to engage and build qualitatively different relationships with service users has to be understood, acknowledged and valued (Gillard et al., 2014).

There is, some limited evidence that peer support workers can provide value for money through reducing psychiatric inpatient bed use, either by preventing admissions or by shortening lengths of stay (Trachtenberg et al., 2013). This review suggested that more than £4 would be gained for every £1 invested, although the studies that provided the basis for these calculations were from the US and Australia and their generalisability to a UK context may be limited. There is a clear need to develop the evidence, focusing on voluntary sector as well as statutory sector implementation of peer support roles, and comparing which achieves better outcomes and provides better value for money.

RECOVERY AND RECOVERY COLLEGES

From a national list of Recovery Colleges (ImROC, 2015), there are two out of a total of 36 in England for West Midlands residents currently operating, although there are other initiatives that provide recovery-oriented courses and programmes. The two Recovery Colleges are in Sandwell, provided by the Black Country Partnership NHS Foundation Trust and which started in October 2015¹⁰³, and Walsall, provided by Dudley and Walsall Mental Health Partnership NHS Trust¹⁰⁴. A Recovery College, provided by BSMHFT, went live in June 2016¹⁰⁵. In addition the Forward Thinking Partnership for young people up to the age of 25 is proposing Recovery Colleges in educational settings to enable young people to continue with their studies¹⁰⁶ in Birmingham. There are no evaluation reports of these local developments available, as yet.

PRO-RECOVERY WORKING PRACTICES

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

HOUSING

1. Provision in the WMCA

Out of the 1,144,050 homes in the WMCA the majority (879,260 homes) are in private hands, either in the private rented sector or owned by individuals¹⁰⁷. Housing Associations, charities and the local authorities own over 264,000 homes, providing accommodation for people on low incomes (social housing) or with particular needs (supported housing). The majority of housing provision (out of a care or hospital environment) is in the form of supported housing or floating support for those in general needs housing. From 2011-12, the ring fence was removed from Supporting People funding and was rolled into the Formula Grant – a single grant given by central government to Local Authorities. This means that there is now no specific budget allocation for Supporting People services, consequently meaning funding for supported housing schemes has often been diverted, creating gaps in provision and reducing the overall quality of provision (Homeless Link, 2013; Wadley, 2015).

This lack of revenue funding for supported housing has been compounded by the introduction of a cap (at Local Housing Allowance levels) on the amount of housing benefit that can be claimed. The level of this cap means that there is a substantial shortfall between the rent for supported housing schemes and the amount which will be funded via housing benefit or via the housing element of Universal Credit. This hits a wide variety of provision, including mental health services. Research conducted by the National Housing Federation found that at the national level 156,000 units of existing supported and sheltered housing would become unviable 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

⁹⁶ www.hearing-voices.org/area/west-midlands/ [accessed 150816].

⁹⁷ <http://blgbt.org/directory/b-glad-birmingham-gays-and-lesbians-against-depression/> [accessed 150816].

⁹⁸ www.firstpersonplural.org.uk/about-first-person-plural/ [accessed 150816].

⁹⁹ www.kaleidoscopeplus.org.uk/ [accessed 150816].

¹⁰⁰ <http://ssnmentalhealth.btck.co.uk/> [accessed 150816].

¹⁰¹ www.hearing-voices.org/tag/peer-support/ [accessed 150816].

¹⁰² www.headstart.fm/news/2015/11/18/headstart-schools-evaluation [accessed 150816].

¹⁰³ www.therecoverycollege.co.uk/ [accessed 150816].

¹⁰⁴ www.wcld.co.uk/kb5/walsall/asch/service.page?id=FKQLHHIRFkw [accessed 150816].

¹⁰⁵ www.bsmhft.nhs.uk/service-user-and-carer/recovery/recovery-college/ [accessed 150816].

¹⁰⁶ www.bbc.co.uk/news/uk-england-31515884 [accessed 150816].

¹⁰⁷ Data provided by the National Housing Federation 2016.

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 considerable overlap between the characteristics of the clientele of residential care; building based support and floating support and significant variation in costs (Priebe et al., 2009). Furthermore, the majority of the costs were being spent on the housing component suggesting that this population may be underserved by mental health services. Watts et al. (2015) argue that psychologically informed environments are crucial in addressing youth homelessness because of the high proportion of young people using homelessness services that have complex needs, including mental health and behavioural problems. Partnership working between housing providers and mental health services is, therefore, increasingly emphasised (NHS Confederation and National Housing Federation, 2011). However, the separation between housing and non-housing support, complexity of funding arrangements and the reduction of available resources, compounded by the differing approaches of housing, health and social services, has resulted in a lack of a coherent view on the most effective models.

People with mental health issues are housed in a variety of stock, both general need rented accommodation (possibly with floating support) and in specific provision designed for people with mental health needs, notably¹⁰⁸ 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,

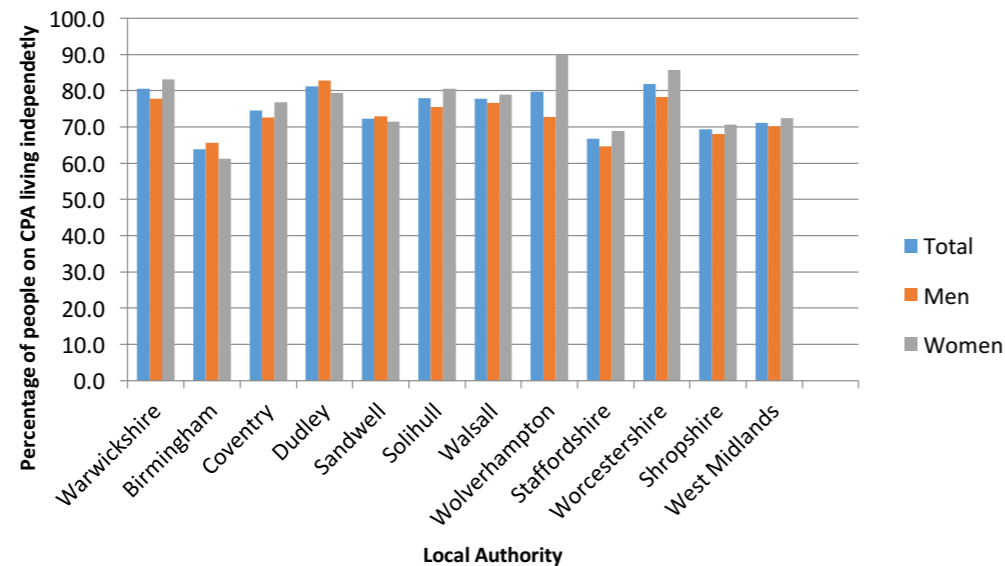


Figure 18: Proportion of working age adults (18-69) on the CPA recorded as living independently (with or without support) for 2014-15¹¹¹

- Develop social networks and use of leisure facilities
- Develop peer support and promote access to universal services
- Address housing and tenancy needs

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 Heantum Housing, based in Wolverhampton, offering supported housing and floating support for South Asian men¹⁰⁹ and gender specific support, including supported housing, for South Asian women¹¹⁰. 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 food preparation and use of mainstream services; linking with community activities and volunteering opportunities, and wider activities to promote good health and wellbeing.

STEP-DOWN

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

HOUSING FIRST

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

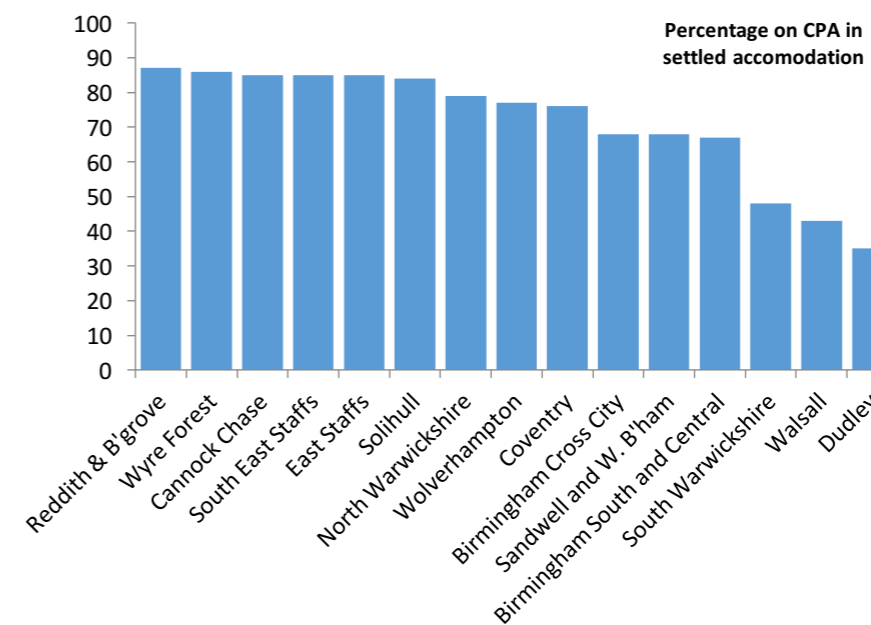


Figure 19: Percentage of adults on the CPA in settled accommodation for each CCG in the WMCA (April - June 2013) (Source: NHS Benchmarking, 2016)

PROMISING PRACTICE: HOUSING FIRST

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

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 rejection.

2. Performance against national indicators

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

Housing status and employment status for people on a CPA are taken as a proxy for the ability of services to help service users to optimise functioning and recovery (NHS Benchmarking, 2016). The CPA covers approximately 25% of people registered with specialist mental health services. In the WMCA as a whole, 74% of adults on a CPA were living in stable and appropriate accommodation. This compares favourably with an England average of 59% (NHS Benchmarking, 2016), but as Figure 20 indicates there are some outliers, and it would be useful to understand the factors influencing this variation in performance, including the availability of housing stock and the collaboration between mental health services and housing providers. The relationship between the range of housing provision, the length of stay and use of Out of Area Placements needs further inquiry.

A previous study in 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 consistent approach, and giving housing associations and other partners the time and stability to build or expand successful services in the region.

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

¹⁰⁸ See for example a summary with case studies developed by a group of housing providers in the West Midlands: Working together in the Midlands to tackle Mental Health issues and Dementia. Available at: <http://www.housinglin.org.uk/Topics/browse/HousingMentalHealth/?parent=6081&child=10082> [accessed 150816].

¹⁰⁹ www.heantum.org/?page_id=127 [accessed 150816].

¹¹⁰ www.heantum.org/?page_id=381 [accessed 150816].

¹¹¹ <http://digital.nhs.uk/catalogue/PUB18657/meas-from-asc-of-eng-1415-fin-rpt.pdf> [accessed 150816].

¹¹² Residential sorting refers to the practice of placing people in local neighbourhoods and housing estates in the same area and leads to increased demand on health and social care services and may further disadvantage those individuals and communities.

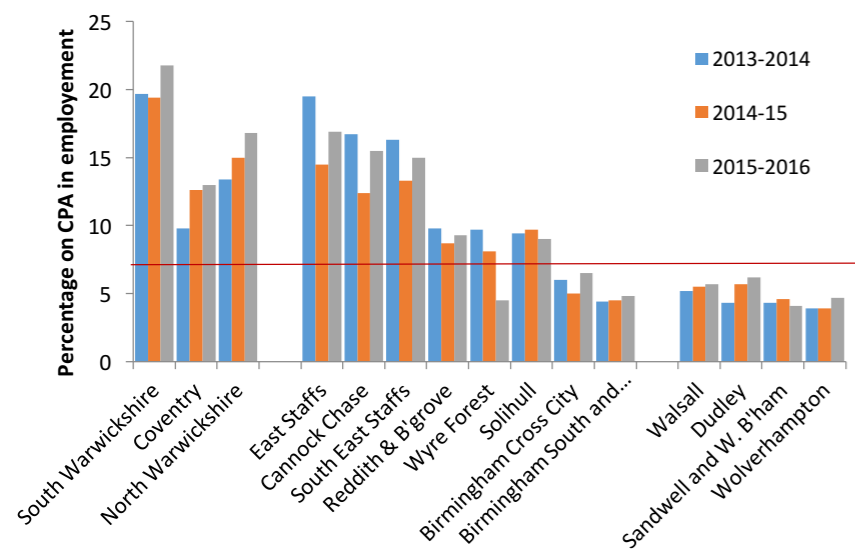


Figure 20: % of adults on the CPA in employment for each CCG in the WMCA grouped by LEP (April 2013–September 2015)

PROMISING PRACTICE: INDIVIDUAL PLACEMENT AND SUPPORT

The international evidence base for supported employment, including IPS, is very encouraging. A Cochrane review of 14 randomised control trials (RCTs) found that supported employment and IPS are better than other approaches in enabling people to find jobs quicker and be in employment for longer, although issues with the quality of the evidence were noted (Kinoshita et al., 2013). Similarly, findings for IPS for young people presenting with a first episode of psychosis indicate that employment outcomes can be as high as 85% (Killackey et al., 2008; Bond et al., 2014). There is also evidence that those on IPS reduce their use of mental health services, including inpatient care, and on this basis it has been estimated that IPS would pay for itself within a year (cost of intervention = £2,700, NHS savings = £3,000) (Parsonage et al., 2016). The Australian government is currently considering IPS for a much wider group of unemployed people with mental health problems (Orygen Youth Health Research Centre 2014).

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 Employment¹¹³, which may not be a comprehensive list, are as follows:

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

Employment support, often combined with volunteering opportunities and welfare advice, is frequently provided by the voluntary sector, sometimes funded by the Local Authority or CCG. BITA Pathways, in Birmingham, for example, are funded by the Birmingham 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 their five social enterprises in a variety of industry sectors.

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

2. Performance against national indicators

The Public Health Outcomes Framework data indicates that the average employment rate for people on the CPA in England is

1. Competitive employment is the primary goal
2. Everyone who wants it is eligible for employment support
3. Job search is consistent with individual preferences
4. Job search is rapid: beginning within one month;
5. Employment specialists and clinical teams work and are located together
6. Employment specialists develop relationships with employers based upon a person's work preferences
7. Support is time-unlimited and individualised to both the employer and the employee;
8. Welfare benefits counselling supports the person through the transition from benefits to work.

Figure 21: The key principles of Individual Placement and Support (Source: Centre for Mental Health, 2009)

7%. In the WMCA, the average is 10%, but there is considerable variation between the CCGs, ranging from just under 4% to 22% in 2014/15 (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 ASCOF data at Local Authority level for 2014/15¹¹⁴ 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 highest¹¹⁵.

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 NHS Trust), Coventry (Coventry MBC) and North Staffordshire (provider Work4You, Making Space and covering Lichfield) and Worcestershire (provided by Worcestershire Health and Care Trust covering Bromsgrove and Redditch), as excellent; Sandwell (Sandwell MBC) and Wolverhampton (Healthy Minds and Wellbeing) as good fidelity; Birmingham (BSMHT) as fair fidelity; and Wolverhampton (Wolverhampton MBC) as low fidelity. An inaugural meeting of an IPS network was held in May 2016 with the aim of developing a West Midlands IPS strategy and scaling up provision¹¹⁶.

CRIMINAL JUSTICE SYSTEM

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

1. Liaison and Diversion services

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

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

- A Pathway 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 signpost to the relevant agencies for further follow-up work, including mental health as well as substance misuse
- Wolverhampton has a well-established Youth pathway to support wider intervention and diversion linked through the offender health pathways and Youth Offending service

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

In 2013, a third of women cautioned for or convicted of offences in England 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 indictable convictions for men. The next most common offence among women was violence against the person, around a third of which was accounted for by Actual Bodily Harm. Drugs offences were the next most common, although the proportion of women in prison for these types of offences has dropped considerably, from 25.2% in 2009 to 13.8% in 2014¹¹⁷.

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

¹¹⁴ <http://digital.nhs.uk/catalogue/PUB18657/meas-from-asc-of-eng-1415-fin-rpt.pdf> [accessed 100516]

¹¹⁵ This is unsurprising because the ASCOF data is drawn from MHMDS.

¹¹⁶ www.wmahsn.org/events/2016/05/11/West_Midlands_Mental_Health_Innovation_Network_Event_-_Individual_Placement_and_Support [accessed 050616]150816].

¹¹⁷ www.gov.uk/government/uploads/system/uploads/attachment_data/file/457922/Better_Outcomes_for_Women_Offenders_September_2015.pdf

¹¹⁸ www.westmidlands-pcc.gov.uk/media/371302/06-spcb-07-jul-15-reducing-offending-and-reoffending.pdf

Integrated offender management is a key operating approach within the West Midlands Police area, being awarded the Tilley prize in 2015. The approach has seen the West Midlands within the lowest top ten areas for reoffending for the last two years¹¹⁸.

2. Prison

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

3. Community Rehabilitation Companies

In 2014, changes to the delivery of probation services were introduced, with responsibilities for most offender being transferred to 21 Community Rehabilitation Companies (CRCs). There are two CRCs covering the WMCA population:

Staffordshire and West Midlands CRC covering Staffordshire and the West Midlands, and West Mercia covering the Warwickshire and Worcestershire elements of the WMCA. They provide probation services for low and medium risk offenders alongside the national probation service, which serves the most high risk offenders. This split has increased the complexity around information sharing.

4. Support for prisoners 'through the gate'

'Through the gate' is a National Offender Management Service/ 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 (67% missed).

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

**PEOPLE IN CUSTODY
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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 current appraisal but, nonetheless, the evidence strongly indicates that many children who experience mental health problems, often in response to adverse childhood events, go on to have mental health problems as adults. Over time, evidence-based intervention early in the life course, including during the perinatal period, is almost certainly the most effective and cost-effective means of reducing the overall prevalence of mental health problems in the adult population.

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

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

It is nevertheless the case that the introduction of promising initiatives that have the potential to bring social and economic benefits is patchy, and the West Midlands Mental Health Commission is in a good position to evaluate these and support their implementation. Scaling up these initiatives – MHFA, IPS, Housing First, Crisis Houses, for example, needs to be actively considered and evaluation of these models in a WMCA context is needed to understand the role of contextual factors that may influence effectiveness and outcomes. There are also areas, particularly in primary care, where different models are being developed and comparison of these in terms of access and impact (eg, patient and economic outcomes) would be of benefit. The third sector – voluntary and community organisations – play a key role in supporting people who may not be supported by public services, because they are unable to meet their needs appropriately or because of reluctance to engage with these services.

They are built on an ethos of open door and spirit, often supporting the most marginalised populations. Throughout the process of gathering data for this appraisal, we have heard concerns about the impact of budget reductions on this sector in particular, with valued services having to be cut or no longer commissioned. Adopting a system-wide and a strategic approach to mental health offers the opportunity of a clear-sighted view on what services need to be protected and further developed.

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

**STRENGTHENING
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MIDLANDS REQUIRES A STRATEGIC
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ROLE OF ALL ORGANISATIONS IN
ACHIEVING THIS.**



Recommendations

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

- 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. These will and should be coordinated through an intelligence hub for the WMCA.
- 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.
- 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.
- 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; 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.
- This assessment has identified groups who are at particular risk of poor mental health and who may be in contact with a range of public services, with effort duplicated between them. Improving coordination and partnership working for these populations should be a priority.
- A strategy for public mental health needs to be developed for the WMCA. Any strategy to improve the mental health of the WMCA population has

to invest in the mental health of children and young adults and this will prove to be cost-effective. This includes attention to parental mental health and substance abuse.

- Primary care has a key role to play in prevention, early intervention and promoting parity of esteem between physical and mental health. This includes attending to the emotional and mental wellbeing of people with physical health problems, medically unexplained symptoms and other forms of complexity, and the physical health needs of people with severe and enduring mental health problems. Identifying the components of good primary care mental health would facilitate a coherent approach across the WMCA and ensure that the full potential of primary care is maximised.
- Organisations and communities in the WMCA have pioneered innovative approaches in mental health that have been adopted outside the WMCA. There are examples of promising practice developing and, in some instances the evidence for these is not yet developed. Where this is missing, the evaluation of such initiatives will be an important strand of understanding the feasibility for scaling up across the WMCA.
- 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.
- 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.
- There should be an investment in piloting and evaluating alternative approaches to in-patient care, including crisis houses and open dialogue.

- 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.
- 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.
- All CCGs and Local Authorities should identify how they can better support and build the capacity of the voluntary sector to ensure the substantiality of valued services and approaches.
- 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 action to implement direct payments and personal budgets to ensure they achieve this.
- 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.
- The wider adoption of high quality Individual Placement and Support services should be encouraged.
- 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 evident. The Commission should, therefore, identify the workforce development implications for achieving the required transformation. This will need to include attention to system leadership.

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Appendix 1

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

1. Name of organisation: _____

Details of person completing the audit: _____

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

AGE GROUP	Spend (£000s) 2014-15
Children (0-16)	
Adults of working age (17-65)	
Older adults (65-plus)	
Total	

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

Organisation commissioned	Target population	Activity specified	Expected outcomes	Contract value (2014-15)	Performance monitoring details for 2014-15 Please attach or provide summary here

Please add additional rows as necessary

Appendix 2

Population and socio-economic deprivation in the West Midlands (Source: ONS)

LEP	Council –Metropolitan or County (District or Borough)	CCG	Population estimates mid-2014	Socioeconomic deprivation in 2010 (England average = 21.68)	Socioeconomic deprivation: people living in 20% most deprived areas 2014 (England average = 20.16)	Statutory homelessness: rate per 1000 households 2014/15 (England average = 2.4)	Children in poverty: % living in low income households 2013 (England average = 18.62)	% of adults that have no qualifications or level one qualifications 2011 (England average = 35.76)	% of households with occupancy rating for bedrooms of -1 or less 2011 (England average = 4.81)
Black Country	City of Wolverhampton Council	Wolverhampton	252,987	34.41	53.58	3.21	29.65	45.32	6.02
	Walsall Council	Walsall	274,173	31.23	48.57	1.31	27.19	48.31	5.19
	Sandwell MBC	Sandwell and West Birmingham	316,719	36.97	55.67	4.52	27.64	49.52	6.84
	Dudley MBC	Dudley	315,799	23.22	23.19	0.76	21.33	44.3	3.74
Coventry and Warwickshire	Coventry City Council	Coventry and Rugby	337,428	28.44	33.01	4.72	23.53	37.22	5.63
	Warwickshire County Council	South Warwickshire	139,396	11.47	1.02	2.37	10.17	26.51	3.05
	Warwickshire County Council (Stratford-on-Avon)	South Warwickshire	121,056	10.42	0	1.6	8.47	31.3	1.74
	Warwickshire County Council (North W'shire)	North Warwickshire	62,468	16.29	5.35	2.67	13.92	43.2	2.65
	Warwickshire County Council (Nuneaton and Bedworth)	North Warwickshire	126,174	22.74	18.26	3.54	19.01	43.67	2.86
	Warwickshire County Council (Rugby)	Coventry and Rugby	102,500	13.76	1.72	4.66	12.46	32.82	2.43
	Birmingham City Council	Birmingham Cross City Birmingham South and Central Sandwell and West Birmingham	1,101,360	37.54	56.65	7.43	29.16	41.53	9.06
	Staffordshire County Council (East Staffordshire) ¹¹⁶	East Staffordshire	115,663	19.14	17.68	2.3	14.7	38.87	3.22
	Staffordshire County Council (Lichfield) ¹²⁰	SE Staffs and Seisdon Peninsula	102,093	12.74	3.9	1.28	12.18	36.13	2.47
	Solihull MBC	Solihull	209,890	16.38	15.72	6.85	15.67	36.31	2.64
Greater Birmingham and Solihull	Staffordshire County Council (Cannock Chase)	Cannock Chase	98,549	20.64	13.69	0.82	17.55	44.49	3.11
	Staffordshire County Council(Tamworth)	SE Staffs and Seisdon Peninsula	77,112	19.66	17.5	5.2	17.86	44.22	2.8
	Worcestershire County Council (Redditch) ¹²⁰	Redditch and Bromsgrove	84,471	21.85	26.41	2.64	16.79	40.91	4.44
	Worcestershire County Council (Bromsgrove) ¹²⁰	Redditch and Bromsgrove	95,485	10.38	1.96	1.74	9.74	34.09	1.8
	Worcestershire County Council (Wyre Forest) ¹²⁰	Wyre Forest	98,960	21.04	22.9	3.24	18.92	42.04	2.47
	TOTAL		4,032,283						

¹¹⁶ Pink denotes that the LA covers an area outside the West Midlands Combined Authority jurisdiction

Appendix 3

Mental Health Joint Strategic Needs Assessments for the WMCA

LEP	Local Authority	Status as of July 2016	Link to JSNA
Black Country	Wolverhampton	Refreshed in 2014	https://wolverhampton.moderngov.co.uk/documents/s5336/Item%2012%20-%20Appendix%201.pdf
	Walsall	Refreshed in 2013 Children and young people emotional wellbeing JSNA 2015 Adult mental health needs Mental health JSNA in preparation	http://www.walsallintelligence.org.uk/themedpages-walsall/JSNA
	Sandwell	0-25 yrs MH JSNA in final draft form Work underway on adult MH JSNA	
	Dudley	Unable to locate JSNA synthesis 2012, no specific section on mental health	http://www.dudley.gov.uk/EasySiteWeb/GatewayLink.aspx?allid=228193
Coventry and Warwickshire	Coventry	2015. Also covers Ruby but limited information available	www.coventry.gov.uk/download/.../mental_health_needs_assessment.pdf
	Warwickshire	JSNA 2011-2012 Specific mental health needs assessment for veterans in 2015	http://apps.warwickshire.gov.uk/api/documents/WCCC-644-291
Greater Birmingham and Solihull	Birmingham	2011, although specific work done on particular themes: employment, equity of access, physical health. Currently undertaking a mental health equity audit for BAME communities	http://birminghampublichealth.co.uk/manager/_mods/_ckfinder/userfiles/files/JSNA%20Mental%20health%20vFINAL(1).pdf
	Staffordshire	JSNA for Staffordshire 2012 covers East Staffordshire, Lichfield, Cannock Chase and Tamworth	http://www.eaststaffsbc.gov.uk/sites/default/files/docs/planning/planningpolicy/examination/c/C39StaffordshireNeedsAssessment2012.pdf
	Solihull	Planned 2016.17 Early Help Needs Assessment March 2016 Resilience Needs Assessment for School Age Children in Solihull February 2016 Dementia Needs Assessment 2016 Physical Health and mental health needs planned for 2016/17	JSNA Summary 2015 http://www.solihull.gov.uk/About-the-Council/Statistics-data/JSNA
	Worcestershire	Refresh 2015 covers Bromsgrove, Redditch and Wyre Forest Primary care mental health needs assessment	www.worcestershire.gov.uk/.../id/.../2015_briefing_on_mental_health.pdf http://www.worcestershire.gov.uk/downloads/file/6527/2015_mental_health_needs_assessment

Appendix 4

Service user engagement groups in the West Midlands Combined Authority

Area	Name of Group	Description	Recent examples of involvement/co-production
Birmingham	See Me user engagement project at BSMHFT	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.	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.
	300 voices	A partnership between BSMHFT, West Midlands Police, Birmingham City Council and Time to Change that seeks to engage with young African and Caribbean men aged between 18 and 25 to hear their experiences of inpatient and outpatient care. 300 Voices was funded by the Big Lottery Fund, the Department for Health and Comic Relief, and the funding came to an end in March 2016. Different elements of the programme are being taken forward by BSMHFT (peer support programme) and by West Midlands Police (engagement of workforce with 300 voices). The 300 Voices project adopted a person-centred approach to mental healthcare that aims to engage with African and Caribbean men and hear their stories to determine how mental health services will be delivered in the future. The project is underpinned by a model of community engagement to create a dialogue and healthy transformative conversations. Activities include community engagement events, the experience booth to capture experiences; plays; and the development of a practical toolkit aimed at staff.	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: <ul style="list-style-type: none"> Engaging a diversity of professionals in training workshops Changing attitudes (particularly among police) Influencing individuals to reflect on and change their practice. <p>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.</p>
	Birmingham and Solihull Mental Health NHS Foundation Trust User Watch	A blog presenting 'an independent, occasionally very satirised view' of mental health and NHS issues	
Coventry and Warwickshire	Actively Influencing Mental health services (AIMHS)	Independent Mental Health User Involvement Service – a registered charity which is user led and has an entire staff team of people who have lived experience of mental ill health. <ul style="list-style-type: none"> A monthly user forum Weekly peer support groups (mental health and veterans) Weekly face to face evaluation of mental health services in the locality Partnership working with Healthwatch. 	Recent and regular consultation with the Care Quality Commission and Monitor. Co-production of a variety of peer support groups (Mental health and Veterans). Co-production of accredited training packages. Provide local authorities and NHS with trained panel members for interview and selection procedures. Contribute to local and national research project, and currently engaged with National Mind on a Peer Research Project. Continue to campaign locally for non-clinical changes that affect inpatient care. Successful in obtaining additional grant funding to set up a Veterans Peer Support Group.

Area	Name of Group	Description	Recent examples of involvement/co-production
Dudley and Walsall	Experts by Experience Dudley and Walsall MH Partnership Trust	A team of eleven expert service users and carers, who use their experience to influence the delivery and quality of services provided by Dudley and Walsall MH Partnership Trust. The work of EBEs forms a significant part of the Trust's Service User and Carer Involvement Strategy, which aims to deliver the vision of involving service users and carers in all areas of work.	Urgent care services comprehensive review and redesign was conducted which led to the development of the Street Triage 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.
Staffordshire	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. Activities include: <ul style="list-style-type: none"> Ongoing qualitative evaluation of five local mental health services and associated care planning documentation. Quarterly high standard newsletter and podcast led and edited by service members. Four research reports each year covering topics decided by members (previous reports have included GP Awareness of mental health, Experience of Jobcentre Plus, Barriers to Employment, Quality of Care in Recovery). Ongoing delivery of four workshops promoting recovery and encouraging self-management and participation within care planning. An Investing in Volunteers accredited volunteer programme providing the opportunity for people with experience of mental illness to become community developers. 	Succeeded 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) Succeeded 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.

Area	Name of Group	Description	Recent examples of involvement/co-production
Wolverhampton	Positive Action for Mental Health (PAMH) ¹²³	A service user group, set up by Wolverhampton Empower Me team at Wolverhampton CVS ¹²⁴ , 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.	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.
	Hear-our-Voice	A Mental Health Action Group that is a completely user/ex-user led Registered Charity and Company Limited by Guarantee, with approximately 150 members. All members must live within the Wolverhampton City boundary. The group activities include: <ul style="list-style-type: none"> 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 offices, 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.
Worcestershire	Redditch Mental Health Action Group	MHAG is made up of individuals and representatives of organisations from Redditch, who meet monthly to discuss mental health, raise money for projects within the town and host events including an annual Wellbeing Week.	Members have launched a coaching scheme which works with people to set and achieve their goals. They have trained up various coaches to be able to expand the service. Representation on a County Council committee to decide what action is taken at a suicide hotspot in the town. MHAG regularly has speakers from the Health and Care Trust at their meetings, raising concern about issues such as the closure of Orchard Place.
West Midlands	SURESEARCH-Service Users in Research and Education	A midlands network of people who have used and/or survived mental health services and their allies-mental health workers, academics, carers. SURESEARCH aims to promote service user involvement in mental health education, training and research and it has a membership of over 100. The Suresearch network exchanges information, supports its members and develops projects and opportunities in education, research and the creative arts, through its regular monthly meetings. There are also regular smaller meetings: <ul style="list-style-type: none"> Issues for patients and staff on psychiatric wards – The In-Patient Care Forum Writing and Reading – The Writers and Readers Group Creative Work in the Arts – Survivor Arts 	Individual Suresearch members collaborate in mental health research projects and contribute to training practitioners at various institutions including University of Birmingham social work courses.

¹²³ Funding discontinued 31.3.16.¹²⁴ <http://wolverhamptonvsc.org.uk/our-projects/mental-health-empowerment/> [accessed 150816].

Appendix 5

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

Public health intervention	Examples	Wolverhampton	Walsall	Sandwell	Dudley
General public/front line services to promote wellbeing, awareness and tackle stigma	Mental health awareness/ Mental Health First Aid (MHFA) Community wellbeing services		Emotional Health and Wellbeing service providing one to one support; Five Ways to Wellbeing MHFA, Youth MHFA and Stress Management Training. Mental health training for key workers (eg, health visitors, school nurses etc.) inc. MHFA.	Sandwell's feel good 6 wellbeing engagement campaign from 15/16. Building resilience training – training front line staff in mental health and wellbeing awareness.	Self-help stress management resources, 1:1 support and peer support for the general public. Mental Health First Aid Lite - half-day training sessions, bi-monthly over a six month period
Perinatal and infant mental health programmes	Breast feeding support Family Support Services		Breast feeding support Family Support Services		
Parenting programmes (including targeted programmes at high risk families)	Parenting Team Triple P		Parenting team Mellow, Triple P and Solihull	CHANGES local Parenting Programme a universal and targeted offer for parents of children 0–19	
School-based mental health promotion and prevention programmes	Support for teachers Anti-bullying			Primary Whole School Approach (WSA) to Emotional Wellbeing: emotional health and wellbeing audit for schools; action planning to address 'gaps' and implementation of a social and emotional learning programme incorporated into the taught curriculum. Audit Includes staff emotional health and wellbeing 15/16 Agreed funding to offer WSA to Secondary Schools	
Workplace interventions	Healthy Workplace Programmes		Healthy Workplace Programme Lifestyle Link	Audit of emotional health and wellbeing in schools as above) includes staff emotional health and wellbeing 15/16	Workplace wellbeing initiative led by HR for Dudley MBC staff: Five Ways to Wellbeing training course

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	Wolverhampton	Walsall	Sandwell	Dudley
Targeted initiatives for at risk groups	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	A community service for African/Caribbean/Dual Heritage for people at risk of developing or are recovering from ill mental health.	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	Worker Service for mental health Manmade Dudley 9 week course 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 Aid Lite. Carers Relaxation Toolkit and mindfulness session	Expert Patient programme for 18+ living with a long-term health condition (anxiety/depression) Community Development Worker Service for mental health Manmade Dudley 9 week course 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 Aid Lite. Carers Relaxation Toolkit and mindfulness session
Tackling violence and abuse	Domestic abuse services		Domestic abuse family hostel	Domestic violence perpetrator programme	
Programmes to improve the physical health of people with mental health problems	Reducing physical inactivity Specialist weight management Smoking cessation Screening and adult lifestyle services		Healthy Weight Services 'Food Dudes' Healthy Eating Programme Dynamic Dudes – physical activity program	Primary Whole-School Approach to Emotional Wellbeing: emotional health and wellbeing audit, action planning to address 'gaps' and implementation of a social and emotional learning programme incorporated into the taught curriculum Agreed funding to offer WSA to Secondary Schools	
Suicide prevention	Suicide prevention training		Forward for Life for frontline workers and senior managers 4 x half-day SafeTALK basic suicide prevention sessions 2 x ASIST 2-day suicide prevention accredited training courses	Applied suicide prevention training Mental health and wellbeing 14/15, ASIST and SafeTALK suicide prevention training for front line staff from 15/16	Forward for Life for frontline workers and senior managers 4 x half-day SafeTALK basic suicide prevention sessions 2 x ASIST 2-day suicide prevention accredited training courses
Other		General Art, Craft and Health sessions of 2 hours			Bids invited for mental health promotion activity reflecting the Five Ways to Wellbeing (not continuing)

Public health intervention	Examples	Wolverhampton	Walsall	Sandwell	Dudley
General public/front line services to promote awareness and tackle stigma	Mental health awareness/ Mental Health First Aid Community wellbeing services	MHFA for frontline workers A mental health training programme for front line professionals	Mental Health First Aid training Ways to Wellbeing e-learning module	Mental health awareness/ Mental Health First Aid Mental wellbeing hub	Mental health awareness / mental Health First Aid for Lifestyles services, school staff and Community Hub staff
Perinatal and infant mental health programmes	Breast feeding support	Newborn Observational Training for Health Visitors, Children Centre workers and Midwives. Infant feeding service MAMTA – BME service for expectant mothers, referring and signposting to relevant agencies			UNICEF Level 3 (Full) accredited Infant Feeding Support Service Health Visiting support to mums with perinatal mental health issues Solihull Approach Postnatal Plus courses Scoping support for infant mental health attachment service from children's MH provider
Parenting programmes (including targeted programmes at high risk families)	Parenting Team Triple P	Triple P programme, living with confidence (to improve self esteem), family links nurturing programme, Parenting Team			Parenting Team – Solihull Approach Antenatal, Postnatal and Understanding Your Child's Behaviour courses and Mellow Parenting
School-based mental health promotion and prevention programmes	Support for teachers Anti-bullying	Locality based Acting Early (MDT) teams for School focusing on various areas including mental health School Nursing service		Work with individual schools to increase emotional resilience and also challenge discrimination	Solihull healthy Schools Emotional Health programme
Workplace interventions	Healthy Workplace Programmes	Training and a review of processes and pathways for frontline staff at the Local Authority's employment service. Workplace Wellbeing Charter promoting good practice among local employers, including training Occupational health support to Council staff. Mental Wellbeing Single Point Access tool to help managers in dealing with mental wellbeing issues in the workplace		Training on mental health awareness and on workplace wellbeing	Solihull MBC: Workplace Wellbeing Charter and Workplace Mental Wellbeing a council priority.
Targeted initiatives for at risk groups	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	Social inclusion project which works with Asian people with mental health needs. Tamarind, a mental health resource centre for BME groups A variety of social and informal educational opportunities for young people with ASD ASD group support services. Family Nurse Partnership for young parents		Urbrum, a Youth Social Inclusion project, for 'hard to reach' young/BME people in Birmingham Community Development Workers Community Health Champions model of recruiting people from local communities who suffer the worst health experience	Targeted initiatives addressing mental wellbeing and target groups at risk including people with mental health issues, isolated individuals, substance users:- Horticultural and Eco projects; social prescribing. Bespoke Lifestyle Services such as Health Trainers, Stop Smoking, Weight Management target specific groups

Public health intervention	Examples	Wolverhampton	Walsall	Sandwell	Dudley
Tackling violence and abuse	Domestic abuse services	Early Intervention service for young people in poor/coercive relationships. CDVASS Coventry domestic violence service providing – single point access to support victims in the community			Domestic abuse services
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	Development of community-led initiatives to reduce physical inactivity. Smoking harm reduction and cessation support	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)
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 reduce risk of tall building suicide Asist and Safetalk suicide prevention training	
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

Appendix 6

Suggested commissioning priorities for public mental health (Source: Heginbotham and Newbigging, 2013) Full references available in source document

Commissioning area	Specific interventions	Some examples of the impact or outcomes achieved	Implementation aspects and feasibility	References
Promote good parental mental and physical health to improve early child development and wellbeing, maternal wellbeing	Universal routine enquiry and targeted treatment for women at risk of depression with as part of a package of measures to improve perinatal mental health.	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> Independent risk factors for conduct and emotional disorders (Meltzer et al., 2003) Maternal depression, especially in teenage mothers, leads to behavioural difficulties. (Caan & Jenkins, 2009; NICE, 2007; Karoly et al, 2005; Olds, 2002)
Promote good parenting skills – universal as well as targeted early intervention programmes for common parenting problems and more intensive interventions for high risk families.	Universal access to training programmes: <ul style="list-style-type: none"> Community based group programmes; home based individual programmes, Pre-school/ early child education programmes, supporting development of home learning environment. Prioritising support for parents from higher risk groups and with children with emotional and behavioural problems. 	<ul style="list-style-type: none"> 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 	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.	<ul style="list-style-type: none"> 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. (Olds et al, 1997; Cornah, 2003; Bywater et al., 2009) Social and emotional learning programmes improve skills and self-esteem (Payton et al., 2008)
Build social and emotional resilience of children and young people through whole school approaches	Healthy schools; extended schools including supporting families; School based mental health promotion. School based Social and Emotional Learning (SEL) programmes achieving pupil's core competencies. Self-management and social skills training. Build financial literacy. Mentoring programmes Family Intervention Projects	<ul style="list-style-type: none"> Integrated approach, using universal and targeted interventions in primary school are cost effective. Improvement in child social and emotional skills, connection to school and positive social behaviour. Reduction in conduct problems and emotional distress. Improved family relationships and improved parental mental health. Improved self-esteem. Reduced problem behaviour and conduct disorders including substance misuse Improved financial skills and reduce indebtedness. Reduced antisocial behaviour reduced domestic violence. 	Curriculum should integrate development of social and emotional skills within all subjects, delivered by trained teachers supported by parents. Targeted approaches to children showing early signs of emotional and social difficulties are recommended	<ul style="list-style-type: none"> Peer-led 'emotional intelligence effective in combatting low self-esteem. Universal school-wide mental health promotion better than classroom based brief interventions. (Bond et al., 2004; Meade & lamb, 2007; Schachter et al., 2008; Wright et al., 2006)

Commissioning area	Specific interventions	Some examples of the impact or outcomes achieved	Implementation aspects and feasibility	References
<p>Improving working lives:</p> <p>a) support for unemployed</p> <p>b) creating healthy working environments</p> <p>c) early recognition and intervention for those with mental health problems</p> <p>d) supported work for those recovering from mental illness</p>	<p>Workplace screening for risk of depression followed by CBT where indicated.</p> <p>Early intervention to reduce risks of unemployment through primary care and Job Centres and promote engagement and participation for those who become unemployed.</p> <p>Providing volunteering opportunities.</p> <p>Support NHS, LA and Third Sector organisations to develop interventions to improve healthy working lives and support occ. health schemes.</p> <p>Stress management interventions tailored to the needs of the employees.</p> <p>Supported work for those recovering from mental illness.</p>	<ul style="list-style-type: none"> Increased employment, and reduction in lost employment years due to reduced health service and welfare costs Costs of programme quickly translate into financial benefits mainly in form of cost savings Reduction in health costs of depression and anxiety disorders Improved wellbeing due to reduced financial distress impacts on reduced housing stress etc. Significant reduction in financial distress (M) Reduction in sickness absence Significantly improved employment rate for those on a scheme Reduction in rehospitalisation Reduced time spent in hospital 	<p>a) Adopt integrated interventions which combine organisational and individual level approaches.</p> <p>b) Job retention and re-employment programmes which support reemployment and promote the mental health of unemployed people.</p> <p>c) Supported employment programmes and specialist work schemes are most effective.</p> <p>d) Reduce mental health stigma and discrimination in the workplace.</p> <p>e) Support NHS, LA and third sector organisations to develop local interventions to improve healthy working lives, reduce stressors that are beyond the individuals' control.</p>	<ul style="list-style-type: none"> Early diagnosis and intervention with employees with depressive symptoms offers good financial return (Hilton 2005). Adults who are economically inactive are at increased risk of mental illness (Black, 2008). Lack of income may lead to increased housing risk and an increased risk of mental disorder (Weich & Lewis, 1998).
<p>Improve the quality of older people's lives through psychosocial interventions which enhance control, prevent isolation, and enhance physical activity.</p>	<p>Befriending services (third sector and social care) via social prescribing to target loneliness and social isolation.</p> <p>Group interventions</p> <p>Falls prevention through social support and education</p>	<ul style="list-style-type: none"> Improved social inclusion Effective befriending services would generate significant cost savings Improved quality of life Reduced A&E attendances and admissions to hospital 	<p>Meaningful group activities with educational and/or support input based on participation of older people.</p> <p>Volunteering and peer support programmes for to foster contact between generations.</p> <p>Increasing physical activity in residential care settings and through social prescribing.</p> <p>Ensure staff in leisure centres are appropriately qualified to provide exercise programmes for older people.</p>	<ul style="list-style-type: none"> Moderate physical activity improves mental wellbeing (Harvey et al., 2010) Exercise of moderate intensity has a positive effect on physical and mental wellbeing (NICE, 2008a; NICE 2008b), and reduces anxiety, enhances mood and improves self esteem (Egan et al., 2008; Etnier et al., 1997) Volunteering enhances wellbeing more than in younger people (Age Concern and MHF, 2006) Reduce loneliness and anxiety by providing means to stay active. (Lampinen et al.,2006; NICE 2008b)
<p>Improving quality of life through increasing opportunities for participation, personal development and problem-solving</p>	<p>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.</p> <p>Signposting to welfare advice, particularly employment, provision of support for benefit uptake, debt advice, financial literacy and information and self help.</p> <p>Debt counselling and advice.</p>	<ul style="list-style-type: none"> Self help groups and peer support effective in reducing social isolation/ loneliness and provide meaningful occupation locally, leads to increased quality of life through social interaction and having practical needs met. Improved mental and physical health. Increased confidence, sense of community, social cohesion Increased levels of social support and caregiver skills. Reduced demands on primary care and reduced levels of antidepressant prescribing. Self-management and healthy behaviours. Increase in benefits through providing access to benefits advice in GP surgeries 	<p>Build collaborative community partnerships based on existing strengths and resources.</p> <p>Use innovative approaches such as social prescribing and mutual volunteering schemes to engage the participation of socially excluded groups.</p> <p>Ensure access to education, learning, arts, leisure, personal development and local support services based on consultation with key stakeholder groups.</p> <p>Place-shaping by LAs to create opportunities for people to come together.</p> <p>Primary care can provide good access to advice services for people in middle and old age.</p>	<ul style="list-style-type: none"> Meaningful occupation and physical activity increases overall wellbeing (NICE, 2008b; Casidy et al., 2008). Time banks generate new social networks and relationships (Friedli et al., 2008). Adults who are economically inactive are at increased risk of developing a mental disorder (Black, 2008). Locating 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 & Small, 2005; Abbott & Hobby, 2003).

Commissioning area	Specific interventions	Some examples of the impact or outcomes achieved	Implementation aspects and feasibility	References
<p>Implementation of initiatives to prevent, identify and respond to emotional, physical and/or sexual abuse</p>	<p>Building life skills in children and young people including school-based violence prevention programmes including sexual abuse and bullying prevention</p> <p>Promoting gender equality for women</p> <p>Reducing the availability and harmful use of alcohol</p> <p>Victim identification and care and support programmes</p>	<ul style="list-style-type: none"> Reduced levels of mental health problems and physical injuries as a consequence of abuse Reduced crime, aggression and violence. Improved long term self-management of other conditions 	<p>Multi-component interventions that integrate skills development and training of teachers and parents supported by specialists (see area 1 above)</p> <p>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.</p>	<ul style="list-style-type: none"> Physical and sexual violence have direct health consequences and are risk factors for a wide range of long term health problems including mental health concerns, alcohol abuse, unwanted pregnancy, sexually-transmitted diseases and risky sexual behaviour. Taking a life-course approach demonstrates the impact of childhood abuse on lifestyle choices and poor self-management leading to further problems such as diabetes. (DH, 2010) Bullying has negative consequences on school health and performance (Bond et al., 2001).
<p>Integrating physical and mental wellbeing through universal access to lifestyle programmes to reduce smoking alcohol use, substance use, and obesity.</p>	<p>Universal access to lifestyle programmes</p> <p>Targeting higher risk groups, for example people with a mental illness or learning disability, older people and pregnant women.</p> <p>Target people with diabetes that are known to be at risk of depression.</p>	<ul style="list-style-type: none"> Reduced depression and better self-management of diabetes; reduced dependency on primary care Improved physical health and reduction in obesity. 	<p>Integrated physical and mental health behaviour change through brief interventions.</p> <p>Opportunistic health promotion interventions for high risk groups through primary care.</p> <p>Skilled staff oriented to respond to the mental health needs of primary care patients.</p>	
<p>Tackling alcohol and substance abuse, including screening programmes and direct measures with those abusing alcohol.</p>	<p>Screening and brief intervention in primary care</p> <p>Target problem drinking and alcohol abuse through multi-sectoral action (local authority, health, police , education)</p>	<ul style="list-style-type: none"> Screening and brief intervention in primary care is highly cost-effective Alcohol use reduction has early paybacks and impacts favourably on the NHS reduction in A&E attendances and domestic violence Reduce isolation and 'hidden drinking' amongst older people Reduction in crime and improved perception of safety 	<p>Multi-sectoral action through multi-agency arrangements between NHS, LAs, Police, Probation, Third sector etc</p>	
<p>Community empowerment and development interventions that encourage communities to improve physical and social environments, participation and strengthen social networks .</p>	<p>Include encouraging active travel, reducing effects of traffic, functionality of neighbourhood, safe green environments, community arts and culture, volunteering</p>	<ul style="list-style-type: none"> Improve wellbeing and quality of life and neighbourhood Outcomes: sense of belonging, participation in decision making, wellbeing/Quality of life, satisfaction with place to live 	<p>Use of community empowerment strategies based on the active engagement and participation of local community members.</p> <p>Create awareness of the impact of the social and physical environment on the community and people's mental health.</p>	

Appendix 7

CCG Weighted populations (Mental Health)

	CCG Weighted Populations (Mental Health)			
	Number of GP Practices in CCG	Total Registered Population	Total Need Weighted Population	Need index
NHS Birmingham CrossCity CCG	116	739,238	987,078	1.34
NHS Birmingham South and Central CCG	45	247,127	386,727	1.56
NHS Cannock Chase CCG	27	132,981	91,834	0.69
NHS Coventry and Rugby CCG	77	474,552	516,732	1.09
NHS Dudley CCG	50	312,962	342,340	1.09
NHS East Staffordshire CCG	19	136,061	96,632	0.71
NHS Redditch and Bromsgrove CCG	22	172,435	111,058	0.64
NHS Sandwell and West Birmingham CCG	107	542,706	669,742	1.23
NHS Solihull CCG	32	239,035	252,996	1.06
NHS South East Staffs and Seisdon Peninsular CCG	31	212,546	145,340	0.68
NHS South Warwickshire CCG	36	274,817	267,941	0.97
NHS Walsall CCG	63	275,130	210,632	0.77
NHS Warwickshire North CCG	28	184,661	219,213	1.19
NHS Wolverhampton CCG	51	261,596	271,167	1.04
NHS Wyre Forest CCG	12	112,622	74,044	0.66

Source: NHS England www.england.nhs.uk/wp-content/uploads/2014/03/d-nph-mental-health.xlsx [accessed 120516]

Appendix 8

Outpatient and community contacts by organisation and team type

Source: Mental Health Bulletin: Annual Statistics 2014-15. ¹²⁶

NHS Trust	Day Care Services	Crisis Resolution Team/ Home Treatment	Adult Community Mental Health Team	Assertive Outreach Team	Rehab. Recovery Team	General Psychiatry	Psychiatric Liaison	Psychotherapy Service	Psychological Therapy Service (non-IAPT)	Young Onset Dementia Service	Personality Disorder Service	Early Intervention in Psychosis Team	Forensic Service	Community Forensic Service	Peri-Natal Mental Illness	Eating Disorders/Dietetics	Substance Misuse Team	Criminal Justice Liaison and Diversion Service	Prison Psychiatric Inreach	Asylum Service	Other MH Service - in scope of PBR	Other MH Service - out of scope of PBR	Day Care Facility Attendance	Invald / Missing Team Type
BSMHT	29,435	70,055	179,875	40,055	*	25,690	20,160	5,800	4,155	1,120	1,585	27,590	1,340	3,270	4,875	8,475	760	*	*	*	130	16,615	27,180	12,115
BCPT	3,970	18,860	50,200	5,995	*	51,440	2,885	*	*	*	*	8,480	185	1,070	*	1,100	*	2,130	*	*	755	*	1,080	10,740
CVPT	2,190	77,490	99,275	9,130	56,890	16,160	12,140	965	5,585	480	4,240	23,705	*	*	1,700	6,195	*	3,315	*	80	40	33,055	7,485	
DVMHPT	545	31,725	4,325	70	*	92,220	4,550	*	*	*	*	6,525	*	*	*	4,960	*	3,030	*	*	*	235	6,040	215
Totals	36,140	198,130	333,675	55,250	56,830	185,510	39,735	6,765	9,740	1,600	5,825	66,300	1,525	4,340	6,575	20,730	760	8,475		965	16,890	67,355	30,555	

¹²⁶ Data source: Health & Social Care Information Centre Mental Health Minimum Dataset (MHMDS/MHLDDS) 2014/15 [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 outcomes.

Under the new provider system patients, for example a lady with frailty and long-term conditions and registered with a GP in Dudley, will have her care overseen by a multi-disciplinary team in the community including specialist nurses, social workers, mental health services and voluntary sector link workers. This will ensure holistic care that better meets all of her medical and social needs at one time in one place, but allows her to access advice and support for the isolation she can feel at living alone far from her family, and combatting 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 series, council and police. The ambition is to extend healthy active life and independence with equal focus on physical and mental health through encouraging lifestyle choices, care-coordination and empowerment for self-management of long-term conditions, reducing pressures on secondary care services and altering the balance of care provided in hospital and the community. This includes:

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

Source: <https://www.england.nhs.uk/ourwork/futurehhs/new-care-models/> [accessed 150816]

Appendix 10

The West Midlands Prisons Cluster

Prison	Prisoner Group	Mental health provision
Birmingham	1,450 adult men	Mental health inpatient ward Primary healthcare is provided through BSMHFT and Birmingham Community NHS Trust Mental Health In-Reach and Substance Misuse services are provided by BSMHFT. Psychosocial Services are provided by the South Stafford and Shropshire NHS Foundation Trust Drug and Alcohol Recovery Team
Brinsford Wolverhampton	569 young adult men aged 18–21	11 bedded mental health inpatient ward providing a regional resource for men up to aged 21 Primary healthcare provider is Staffordshire and Stoke-on-Trent Partnership NHS Trust (SSOTP) Mental Health In-Reach services are delivered by South Staffordshire and Shropshire Healthcare NHS Foundation Trust Drug and Alcohol service (DARS) is provided by Lifeline and Delphi Medical
Dovegate Staffordshire	1,060 adult men	GP, Primary Care, and Integrated Substance Misuse staff are directly employed by Care UK 12 bedded mental health inpatient ward Integrated Mental Health Services provided by Care UK and South Staffordshire and Shropshire Healthcare NHS Foundation Trust
Drake Hall Staffordshire	315 women aged 18	The current primary healthcare provider is SSOTP Mental Health In-Reach services are delivered by South Staffordshire and Shropshire Healthcare NHS Foundation Trust Drug and Alcohol service (DARS) is provided by Lifeline and Delphi Medical
Featherstone Wolverhampton	687 adult men	Primary healthcare provider is SSOTP Mental Health In-Reach services are delivered by South Staffordshire and Shropshire Healthcare NHS Foundation Trust Drug and Alcohol Recovery Service provided by Lifeline and Delphi Medical
Hewell Redditch	1261 adult men	18 bedded inpatient unit for both physical and mental health needs. Primary healthcare provider is Worcestershire Health Care NHS Trust (WHCT) Integrated Mental Health Service and Integrated Substance Misuse Service, incorporating clinical and psychosocial services, provided by WHCT
Long Lartin Worcestershire	622 adult men	Primary healthcare provider is WHCT 10 bedded inpatient unit for both physical and mental health needs Integrated Mental Health Service and Integrated Substance Misuse Service, incorporating clinical and psychosocial services, provided by WHCT
Oakwood Wolverhampton	1,605 adult men	Primary healthcare provider is WHCT Integrated Mental Health Service provided by WHCT, with Forensic Psychiatry support from BSMHT Integrated Substance Misuse Service, incorporating clinical and psychosocial services, is provided by WHCT
Stafford	741 adult men	Primary healthcare provider is SSOTP Mental Health In-Reach services are delivered by South Staffordshire and Shropshire Healthcare NHS Foundation Trust Drug and Alcohol service (DARS) is provided by Lifeline and Delphi Medical
Stoke Heath Shropshire	766 adult and young adult men aged 18+	Primary healthcare provider is Shropshire Community Health NHS Trust Mental Health In-Reach services are delivered by South Staffordshire and Shropshire Healthcare NHS Foundation Trust Substance Misuse Services provided through a partnership between RAPt (Rehabilitation for Addicted Prisoners Trust) and North Staffordshire Combined NHS Trust
Swinfen Hall Lichfield	654 young men aged 15–18	Primary healthcare provider is SSOTP Mental Health In-Reach services are delivered by South Staffordshire and Shropshire Healthcare NHS Foundation Trust Drug and Alcohol services provided by Lifeline and Delphi Medical
Werrington Stoke-on-Trent	160 young men aged 15–18	Primary care services provided by SSOTP CAMHS provision is by ENGAGE (South Staffordshire and Shropshire NHS Foundation Trust) The Young Persons Drug and Alcohol Support Service is provided by Lifeline and Delphi Medical

Source: Offender HNA and Consultancy projects (2015); West Midlands Prison Health Needs Assessment 2014–15

Abbreviations and acronyms

A&E	Accident and Emergency	IPS	Individual Placement and Support
ACEs	Adverse Childhood Events	JHWP	Joint Health and Wellbeing Strategy
ASIST	Applied Suicide Intervention Skills Training	JSNA	Joint Strategic Needs Assessment
BAME	Black, Asian and Minority Ethnic	LA	Local Authority
BCG	Boston Consulting Group	LEP	Local Enterprise Partnership
BCPFT	Black Country Partnership NHS Foundation Trust	LOS	Length of stay
BSMHFT	Birmingham and Solihull Mental Health NHS Foundation Trust	MERIT	Mental Health Alliance for Excellence, Resilience, Innovation and Training
CBT	Cognitive Behavioural Therapy	MHA	Mental Health Act
CCG	Clinical Commissioning Group	MHFA	Mental Health First Aid
CAMHS	Child and Adolescent Mental Health Services	MHMDS	Mental Health Minimum Data Set
CIPD	Chartered Institute of Personnel and Development	MUS	Medically unexplained symptoms
CPA	Care Programme Approach	NICE	National Institute for Health and Care Excellence
CPN	Community Practice Nurse	NOMIS	NOMIS is part of ONS and provides Official Labour Market Statistics
CQC	Care Quality Commission	NSUN	National Survivor User Network
CRCs	Community Rehabilitation Companies	OAT(s)	Out of Area Treatment(s)/Placements
CJS	Criminal Justice System	ONS	Office for National Statistics
CWPT	Coventry and Warwickshire Partnership NHS Trust	PICU	Psychiatric Intensive Care Unit
DALY	Disability-adjusted life-year	QALY	Quality-adjusted life-year
DWMHPT	Dudley and Walsall Mental Health Partnership NHS Trust	QOF	Quality Outcomes Framework
DWP	Department of Work and Pensions	RAID	Rapid, Assessment, Interface and Discharge
EI	Early intervention	RCT	Randomised Control Trial
EIP	Early intervention for psychosis	SSOTP	Staffordshire and Stoke-on-Trent Partnership NHS Trust
FTB	Forward Thinking Birmingham	STPs	Sustainability and Transformation Plans
GDP	Gross Domestic Product	WEMWEBS	Warwick Edinburgh Mental Wellbeing Scale
HSCIC	Health and Social Care Information Centre	WHCT	Worcestershire Health Care and NHS Trust
HSJ	Health Service Journal	WHO	World Health Organization
IAPT	Improving Access to Psychological Therapies	WMCA	West Midlands Combined Authority
IMCA	Independent Mental Capacity Advocacy		
IMHA	Independent Mental Health Advocacy		

Health Services Management Centre
School of Social Policy
The University of Birmingham
Park House
40 Edgbaston Park Road
Birmingham B15 2RT