Sandwell Joint Strategic Needs Assessment

Adult Mental Health and Well-being in Sandwell

A Needs and Assets Assessment

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Background

The overarching priority for the Sandwell Health and Wellbeing board, over the next five years, is to increase healthy life expectancy for people living and working in Sandwell. As part of this, the board recognises the critical role of mental health and wellbeing as a determinant of healthy life expectancy and wider health and wellbeing.

The independent Foresight Mental Capital and Wellbeing Project Final Report states that;

> *An individual's mental capital and mental wellbeing crucially affect their path through life. Moreover, they are vitally important for the healthy functioning of families, communities and society. Together, they fundamentally affect behaviour, social cohesion, social inclusion, and our prosperity.*[1]

This joint strategic needs and assets assessment (JSNAA) is how the board will start to understand the level of need in Sandwell in relation to adult mental health and wellbeing. This includes an understanding of what will help promote and maintain positive mental health and what support people with mental health problems need.

Purpose

This JSNAA describes the mental health and well-being needs of adults in Sandwell to inform the future planning, commissioning and delivery of services. It also looks at the assets that exist in Sandwell, the strengths and current good practice that we can build on to improve services.

This JSNAA is the first phase of a longer-term assessment of need and services in Sandwell. The focus for this first phase is to assess how people access mental health and wellbeing services. It describes what is working well, where improvement is needed, and the barriers and challenges that people experience when they need support and care with mental health problems. The JSNAA also provides a summary of current policy, guidance and evidence for best practice and for what will work to improve and maintain positive mental health.

The needs and assets assessment draws conclusions about current need in Sandwell and makes specific recommendations for what will improve mental health and what needs to inform future commissioning and service provision. These recommendations will need consideration by key stakeholders at strategic and operational levels.

Local Context

The needs assessment provides an analysis of the demographics of the population and forecasts for future trends. It also summarises the available evidence about the determinants of mental health and wellbeing. The determinants that influence mental health and wellbeing are wide ranging and complex. Alongside direct individual factors such as gender and ethnicity there are the experiences people have over their lives.

The evidence is clear that the social determinants of health such as housing, education, employment and environment, are major influences on peoples mental health and

wellbeing. Analysis of risk and protective factors for Sandwell shows that the people of Sandwell face a number of challenges related to the high levels of disadvantage when compared to the rest of England. Balancing these challenges are strong communities and a vibrant voluntary sector.

The impact of mental health

The West Midlands Combined Authority (WMCA) has established a mental health commission, which has recently published a report that examines mental health in the West Midlands. The report estimates that nearly a quarter of adults living in the WMCA are experiencing a mental health problem at any one time. The report highlights the impact of mental health problems, which affect every aspect of people's lives, as well as those of their carers, families and communities. The report states that people must receive the help they need to maintain their mental health, and be able to access the support they need quickly and effectively when they are experiencing problems.

The report also estimates the aggregate economic and social cost of mental health problems in the WMCA. The estimate is that in 2014-15 the aggregate cost of mental health problems was around £12.6 billion, equivalent to a cost of about £3,100 per head of population. The estimated aggregate costs of mental ill health in Sandwell for 2014-15 were £958 million.

Wellbeing, mental health and mental illness in Sandwell

When looking at the evidence for levels of mental health and wellbeing in Sandwell, and the need for treatment and support, the strength of the evidence is variable. There is a lack of solid data and evidence for the levels of wellbeing in Sandwell. This lack of information about wellbeing is a national as well as a local problem that needs addressing.

For common mental health disorders, the evidence is not consistent. Data from the Quality and Outcomes Framework in primary care shows lower levels of depression compared to England average and levels of prescribing for common mental health disorders are lower than the average for England. However, data from surveys of GP patients, along with patterns of service use, suggest that there are higher levels of common mental health disorders in Sandwell.

For severe and enduring mental illness, the evidence is more consistent, and suggests that Sandwell has higher rate of severe mental illness, including psychotic illness, than the England average.

The number of hospital stays for self-harm are higher in Sandwell than they are in the wider West Midlands or England. The rate of suicide in Sandwell is not significantly different from the England average. However, recent reports have stated that variations in suicide rates between areas may by partly due to differences in how coroners record deaths.

The needs assessment does show significant differences in the levels of reported mental illness between people from different ethnic backgrounds. Referrals into services, which will tend to be for lower levels of mental health problems, do not show a marked variation across ethnicities. Hospital admissions, which will tend to be more severe mental health

problems, do show marked variations between ethnicities, with males from a black background having substantially higher rates of admission than the general population.

People with Caribbean, any other white background, any other Asian background and any other black background all have higher rates of admission than the population average. The highest rate of hospital admissions is for 'Any other Black Background', who have a rate nearly four times higher (1,602.6 admissions per 100,000 people) than the population average (412.1 admissions per 100,000 people). The highest rate for admissions is for males from any other Black background (1971.1 per 100,000 people). These findings are generally is in line with the findings from national reports on service use by different ethnicities.

The needs assessment has identified particular challenges for people with both substance misuse and mental health problems. The available data suggests that overall drug use is higher in Sandwell than in England, and admissions to hospital for alcohol related behavioural disorders are higher than the England average. Concurrent contact with mental health services and substance misuse services are similar to the England average.

Services supporting people with substance misuse problems have identified that people with mental health problems are able to access support with substance misuse problems, however there are barriers for people with substance misuse problems accessing mainstream mental health services.

People with severe mental illness have a 10 to 25 year shorter life expectancy than the general population. The majority of these deaths are due to long-term health conditions such as cardiovascular disease, respiratory and infectious diseases, diabetes and hypertension.

Smoking is the single largest cause of the gap in life expectancy between people with mental illness and the general population. The other major cause of death is suicide. The available data suggests that mortality rates in Sandwell for people with mental illness are similar to the England average. The positive impact of stopping smoking on anxiety and depression appears to be at least as significant as antidepressants

Only limited data is available on how the physical health of people in Sandwell with mental health problems is monitored, and how they are supported with adopting and maintaining healthier lifestyles. This needs addressing and there need to be robust mechanisms to ensure people with mental health problems receive the support they need.

There are vulnerable groups within Sandwell who are at substantially higher risk of poor mental health. These groups often find it more difficulty to access support and care. There is a lack of intelligence on the mental health needs of some of these groups and they are substantially under-represented in services. Specific groups identified are carers, people who are homeless, new arrivals, asylum seekers and refugees, people in contact with criminal justice, people who define themselves as lesbian, gay, bisexual and transgender and victims of modern day slavery.

Current services

In developing the JSNAA, we consulted widely with commissioners and providers of services. We also worked with people with lived experience of mental illness and of using services and non-mental health providers who support people with mental health problems.

This review of current services identified the substantial contribution from non-mental health organisations, and non-mainstream mental health providers, in supporting people outside of formal mental health services. This is an important asset in Sandwell and provides valuable support to vulnerable people. This contribution is not always fully recognised and there is real potential for improved joint working across sectors to improve support for people with mental health problems or low wellbeing.

Realising the potential of these providers will need different approaches to how organisations and sectors work together. One approach where there is some, developing, evidence of benefit is the use of social prescribing. This is fully in line with the focus on prevention and wellbeing as set out in the Five Year Forward View.

The review of services identified areas where commissioning and service delivery could be better coordinated. It also identified that people can experience significant challenges in navigating services to obtain the support they need. This is not a criticism of any particular commissioner or provider of services. There are systemic problems and unclear pathways between services that all partners need to address.

The main themes that emerged from the review of services were;

- Substantial challenges in emergency crisis referral pathways and access to assessment and treatment
- Unclear pathways into assessment and treatment for routine referrals, including inconsistencies in when people are discharged for non-attendance and a lack of clarity about pathways for re-referral.
- Difficulties for people with substance misuse problems accessing mainstream mental health services.
- A lack of overall coordination of pathways, referral routes, and access to assessment and treatment across all partners
- There needs to be more coordination of approaches, pathways and support between statutory and voluntary mental health providers and the non-mental health providers that are supporting vulnerable people and people with mental health problems.
- A need for a coordinated approach to workforce development across all partners, including improved training and support for non-mental health providers.
- Gaps in data collection and reporting that need addressing. There are developments underway which will improve this situation but all partners need to ensure there is robust data collection. This must include monitoring and standardisation of data across organisations, for example, in the recording of ethnicity data.

Recommendations

Principles that have emerged from the assessment

Make sure that people in Sandwell who need support or treatment to help them maintain their mental health and wellbeing, know what services are available, what support they will receive and can easily access the services they need when they need them.

- People, who use services, and their carers, must be fully involved throughout the review, re-design, commissioning and evaluation of services. All partners to work towards a co-design / co-production approach.
- People must have rapid access to the support and treatment they need as soon as they need it.
- Early identification of people at risk of, or experiencing, mental health problems must be a priority across all partners.
- Commissioning of services must have a prevention focus in line with the Five Year Forward View for Mental Health. This includes improving population and individual wellbeing and promoting positive mental health as well as treatment to support people with mental health problems
- All commissioning and services must be evidence based, effective and outcomes focused. Where the evidence base is weak, we must ensure that robust evaluation is in place to build the evidence base. All services must be assessed against NICE guidance and evidence and this must be built into the future commissioning of all services.
- Focus on the reduction of inequalities; make sure that everyone has equal access to information and to services. Assess all services, as part of the commissioning process, to make sure they provide equal access to all sections of the population and will reduce inequalities in health.

Partnership and engagement is the only way to achieve our ambitions for better mental health and wellbeing services

- Identify capacity and resources to develop a clear partnership vision and commissioning strategy for promoting mental health and wellbeing and supporting people with mental health problems and their carers.
- The partnership strategy must address the current fragmentation of services and ensure that there are clear pathways through services and across the whole life course.
- Non-mainstream mental health providers are supporting significant numbers of people with mental health and wellbeing needs and their carers. We need to recognise their significant contribution and work with them as partners in providing better support outside of formal mental health services. This includes the role of peer led support within the community.

Commissioning will be an important tool for success

- Agree a joined-up commissioning approach across all partners with a comprehensive transformation plan for adult mental health services. Develop the existing mental health steering group to act as the steering and delivery group for this transformation plan.
- Commissioning must align to current and emerging strategies and developments affecting all partners. This will include NHS and social care re-configuration and the development of the West Midlands Combined Authority.
- Review all current investment across partners with a comprehensive review of the outcomes delivered by all services. Identify how investment in mental health and wellbeing services will increase in line with parity of esteem with physical health services.
- Identify how the balance of investment will change to reduce investment in intensive services and increase investment in prevention and early intervention.
- Agree outcome measures across partners and with providers to enable robust evaluation of effectiveness and value for money for all services.

Recommendation 1: Crisis and emergency referral pathways for mental health and wellbeing services

There is urgent need to review and streamline routes into acute mental health services to establish a clear emergency pathway that is understood by everyone. Current access can be confusing and less than effective in providing appropriate and acceptable emergency access. This must include consideration of groups that are currently over or under-represented in services**.**

Recommendation 1a: The review of provision and systems for people needing mental health assessment and treatment in emergency / crisis situations should include people;

- Already known to local mental health services
- Making a 1st time emergency presentation
- From Black and minority Ethnic backgrounds
- Requiring in-patient and secondary care provision
- Who could be supported through community provision
- Attending A&E and admitted to Acute Medical Unit A or B because they are at risk or waiting for Psychiatric assessment
- Within the Five Year Forward View for Mental Health, there is a requirement for urgent care services and all acute hospitals to have an all-age mental health liaison team which is compliant with the 'CORE24' service standard

Recommendation 1b: Ensure that the agreed emergency/crisis pathway is communicated to everyone including the public and that all providers, including GP's and non-mainstream mental health providers, are able to refer into appropriate mental health services

Recommendation 1c: The above recommendations must feed into and inform the work of the Crisis Care Concordat for Sandwell, which will monitor progress in delivering this recommendation.

Recommendation 2: Routine and non-emergency service referral pathway for mental health and wellbeing services

Barriers to engaging in routine mental health and wellbeing services include long and unpredictable wait times for first appointments and treatment. Waiting times need to be reduced and clear referral pathways developed.

Recommendation 2a: Ensure that everyone is aware of the routine mental health and wellbeing services available, and how to access them. This includes the public, and all providers including GP's and non-mainstream mental health providers.

- Clarify the referral routes into routine mental health and wellbeing services and ensure everyone knows how to access services.
- Agree standard, and reasonable, response time for patients to accept first time appointments before being discharged as non-attenders. Clarify re-referral routes where needed. This should be in line with national guidance on management of non-attendance.
- Reduce waiting times between the first assessment contact and receiving treatment and provide clients with a point of contact for advice and support while they are waiting for treatment.
- Improve communication systems between service providers, patients/clients and referrers to maximise engagement with services and reduce non-attendance. This could include providers acknowledging receipt of a referral with the patient and the referrer. In addition, to meet the needs of patients, including for people who work full time, a wider range of appointment times need to be available.

Recommendation 2b:

- Ensure all services have effective and publicised gender specific and culturally sensitive provision to meet the needs of the diverse minority ethnic communities in Sandwell including the deaf community
- Review and agree with relevant services, access criteria for clients who are using drugs and/or alcohol and ensure information on access for this group is widely available and understood

Recommendation 2c:

The responsibility for addressing and monitoring progress on the above recommendation is the responsibility of all commissioners of services, through service commissioning and contracting. This includes commissioners from SWBCCG and from Sandwell council.

Recommendation 2d: Provide opportunities for better joint working between mental health and wellbeing services and those non-mainstream mental health providers' services that support people with low level and or common mental health problems.

Recommendation 3: Non-mainstream mental health providers

Non-mainstream mental health providers are supporting significant numbers of people with mental health and wellbeing needs as well as their carers and families. There is a need to recognise the significant contribution from these non-mainstream providers, and work with them as partners in providing better support outside of formal mental health services.

Recommendation 3a: New approaches to working together
Work with non-mainstream mental health and wider providers to develop approaches that build on the existing support they provide. This includes peer led support for people with mental health problems and supporting the role of the Sandwell Mental Health People's Parliament. Explore and develop social prescribing to further develop the links between health and social care services and the non-mainstream mental health providers.

Recommendation 4: Achieving parity of esteem for mental and physical health
Recognise that, for individuals, their physical and mental health is inextricably linked and that neither can be treated in isolation. All partners must work towards parity of esteem between physical and mental health with clear and consistent pathways between services.

Recommendation 4a: Physical health of people with mental health problems
Ensure there is an equitable health screening and lifestyle offer to users of mental health and wellbeing services. This must include:

- Providing tailored provision to meet the additional challenges people with mental health disorders face when trying to e.g. give up smoking, manage their weight
- recording of health checks and standardised recording
- monitoring of uptake by people using mental health services

Recommendation 4b: Mental health of people with poor physical health or disability
Ensure people with long-term health problems or disability are assessed for mental health problems and offered appropriate treatment and support

Recommendation 4c:
Ensure that all lifestyle provision integrates mental health and wellbeing measures to show the impact of adopting healthy lifestyle behaviour on mental wellbeing outcomes.

Recommendation 4a
Continue to build on the activity and engagement with the Sandwell Feel Good 6 programme. There are approx. 76 statutory, voluntary organisations and community groups signed up to Sandwell's Feel Good 6 and they are already contributing to supporting people to take action on the 6 ways (Connect, Move, Notice, Learn, Give & Talk)

Recommendation 5: Addressing the social determinants of mental health and wellbeing
Consider the impact of the social determinants of mental health and wellbeing in all commissioning. Specific areas where there is potential for improving mental health and wellbeing include;

- Education
- Employment
- Housing
- The impact of poverty and disadvantage

Recommendation 5a:
All anti-Poverty strategies and provision must include how they will meet people's mental health needs.

- Continually raise the importance of understanding the impact of poverty on mental health and wellbeing.
- Ensuring those with mental health problems have better access to education opportunities, jobs, housing and receive welfare support and advice including debt advice – link to WM Combined Authority mental health commission
- Services delivering anti-poverty provision actively look out for people with un-met mental health needs e.g those working with the homeless

Recommendation 5b:
People with poor educational attainment

- Raise the importance of good education learning and development opportunities to protect mental health and wellbeing. Measure mental health and wellbeing outcomes of learning and development programmes
- Provide access to education learning and development opportunities for residents with mental health problems

Recommendation 5c:
The unemployed

- Support job creation that meets the mental health and wellbeing needs of the unemployed.
- Support Sandwell residents with mental ill health to access good jobs, working with the West Midlands Combined Authority mental health commission.

Recommendation 6: Supporting vulnerable groups
All commissioning and provision of services should consider the needs of vulnerable groups, including;

- Black and Minority Ethnic groups
- Parental Mental Illness

- Victims of domestic abuse
- Migrants, refugees and asylum seekers.
- People at risk of/within the criminal justice system
- Older people and carers
- Deaf community
- lesbian, gay, bisexual, transgender community
- Victims of modern day slavery

This must include gaining an understanding of the specific needs of these groups, their current service use, and identifying whether there is a need for a targeted service/provision.

Recommendation 7: Data and intelligence

Recommendation 7a

Ensure that the development of a partnership strategy and joint commissioning plan includes comprehensive data collection requirements. Partners to develop data sharing agreements and systems to support the development of joined up services.

Recommendation 7b:

Ensure that:

- All routine/primary care and community-based mental health and wellbeing services regularly collect and provide activity and outcome data to commissioners as contracted.
- The minimum data set for secondary care services is accurately recorded and reported within agreed timescales.
- Data collection includes monitoring of vulnerable groups, as identified in the needs assessment, to monitor possible over and under representation in services and to ensure equality and equity.

Recommendation 7c:

Ensure all services have robust, and standardised, monitoring of the ethnicity of people referred into, and using, their services. Partners must share this data, where appropriate, to enable monitoring of service use and possible over and under representation of different sections of the population in services.

Recommendation 8: Workforce planning and development

Recommendation 8a:

Map and review all current mental health, wellbeing and suicide prevention training across universal, targeted and specialist services to identify gaps and duplications. This must cover purpose, audience, scope and a review of any existing evaluations of the training.

Recommendation 8b:

Develop a partnership training and workforce development plan that includes non-mainstream mental health providers.

- Align commissioning of training across all partners to provide more comprehensive and consistent training and workforce development, including joint training where appropriate. This could include combined mental health service and non-mental health provider training.
- Training must include information about services and how to access them.
- Training must include information on meeting the mental health needs of vulnerable groups.
- Training must include, but go beyond, simple awareness raising and include skills development.

Recommendation 8c:
All Health and Wellbeing Board partner organisations should ensure they provide responsive and effective mental health and wellbeing services and support for their employees. This practice should be shared and promoted with all employers as part of workplace health and wellbeing plans.

Recommendation 8d: Workforce planning should ensure that all mental health and wellbeing services employ a diverse workforce that is reflective of the local population.

Recommendation 9: Areas for further investigation

The needs assessment has identified a number of areas where there is not enough information to make a clear assessment of the needs of the population, or where there are indications of need but not enough evidence to quantify the level of need.

Take a partnership approach to understanding the different experiences of mental health and mental health services for vulnerable people and those currently under or over represented in services, including;

- People from Black and minority Ethnic backgrounds
- Migrant and new arrivals
- Homeless
- People who identify as lesbian, gay, bisexual and transgender
- People who have experienced modern day slavery

Adult Mental Health and Wellbeing in Sandwell: A Needs and Assets Assessment

1. Introduction

1.1 Objectives for the Joint Strategic Needs and Assets Assessment

The purpose of this Joint Strategic Needs and Assets Assessment (JSNAA) is to support the people of Sandwell, and the commissioners and providers of services, in maintaining and improving mental health and wellbeing in Sandwell. The JSNAA will,

- Identify the assets that exist within the communities of Sandwell to support people's mental health and wellbeing
- Identify the levels of need in relation to mental health and wellbeing
- Provide an overview of the relevant evidence and guidance
- Describe how these needs are currently addressed and identify gaps in provision
- Make recommendations for action

This will help with;

- Recognising, supporting and building on the existing assets within the communities of Sandwell
- Developing joint approaches to support people with maintaining and improving their mental wellbeing and mental health
- Commissioning interventions that will improve mental health and well-being and support early intervention
- Commissioning services for people experiencing both common and severe and enduring mental health problems

1.2 Asset Based Approach

The Department of Health, in Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategies Explained, describes joint strategic needs assessments as "*The means by which local leaders work together to understand and agree the needs of all local people*[2]".

However, understanding the needs alone can lead to a deficit-based approach. This can fail to recognise the value of the assets that already exist within communities. These include community leaders and activists, community and voluntary sector organisations and the knowledge, skills and experience that exist within communities.

In producing this needs and assets assessment, the intention was to capture the assets as well as the needs in Sandwell. To do this we aimed to use a co-design approach. Co-design is a stage within co-production, which is defined as;[3]

> "*Delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours*."

Local people with lived experience (including the Sandwell Mental Health People's Parliament), voluntary sector organisations and statutory commissioner and provider organisations have been involved throughout the writing of the JSNAA.

1.3 Definitions of mental health and well-being

There are a number of different terminologies used to describe mental wellbeing and mental health. For the purposes of this needs assessment the definitions used are taken from Better Mental Health for All, published by the Faculty of Public Health in 2016[4].

Public mental health

Public mental health is a term that has been coined to underline the need to emphasise the neglected element of mental health in public health practice. It spans promotion, prevention, effective treatment, care and recovery. It is built on the same principles as all areas of public health.

Mental health

The term *mental health* describes a spectrum from mental health problems, conditions, illnesses and disorders through to mental wellbeing or positive mental health.

This emphasises positive health rather than illness, and is informed by the widely recognised WHO definition of mental health, '... a state of wellbeing in which the individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community'.

Wellbeing

We use the term *wellbeing* as synonymous with the 1946 WHO definition of health – a state of mental, physical and social wellbeing. This is a holistic state to which all aspects of the human being contribute. The term wellbeing is often used as synonymous with mental wellbeing partly, perhaps, to counterbalance prevailing trends to focus on physical wellbeing. Mental and social wellbeing are inextricably linked in both cause and effect ways. Indeed the definition of mental wellbeing includes the capacity for healthy relationships.

Mental wellbeing

The term *mental wellbeing* is used in this report to cover the positive end of mental health covering both the hedonic (feeling good) and eudemonic components (functioning well). Feeling good is subjective and embraces happiness, life satisfaction and other positive affective states. Functioning well embraces the components of psychological wellbeing (self-acceptance, personal growth, positive relations with others, autonomy, purpose in life and environmental mastery).

Resilience

The term *resilience* is used to mean 'being able to cope with the normal stress of life' and 'bounce back from problems'. This is an important component of many definitions of mental wellbeing, with great relevance for the prevention of mental health problems.

Mental health problems

We use the term *mental health problems* synonymously with *poor mental health* or to cover the range of negative mental health states including, mental disorder – those mental health problems meeting the criteria for psychiatric diagnosis, and mental health problems that fall short of diagnostic criteria threshold. Mental health problems can be further categorised into the common mental problems such as anxiety and depression which may be transient (relapsing, remitting and recovered); and severe mental health problems such as schizophrenia and bipolar disorder; and the various behavioural disorders.

Person with lived experience/experts by experience

There has been a move within the field of mental health, largely led by people with lived experience, to avoid the term 'patient' and use instead alternatives including 'survivor, 'service user' and person with lived experience/experts by experience. This language draws on the social model of disability, which moves away from defining people by a clinical diagnosis or service use to focus on people's individual and collective everyday realities. Seventy five per cent of people with a mental health problem of a severity to warrant diagnosis, do not receive secondary mental health services, and thus may never regard themselves as a 'patient' or 'service user'.

2. The determinants of mental health and wellbeing

This section will provide a brief overview of the determinants of mental health and wellbeing and, where possible, descriptions of how these determinants affect the people of Sandwell. Within the narrative, there are references that provide more detailed information and discussion. Unless otherwise indicated, the data used is from the Public Health Outcomes Framework website[5].

The social, economic and physical environments in which people live have a strong influence on their mental health and wellbeing; these are the social determinants of health. The World Health Organisation report "Social Determinants of Mental Health" provides a detailed examination of this topic[6].

The independent Foresight Mental Capital and Wellbeing Project Final Report states that;

> *An individual's mental capital and mental wellbeing crucially affect their path through life. Moreover, they are vitally important for the healthy functioning of families, communities and society. Together, they fundamentally affect behaviour, social cohesion, social inclusion, and our prosperity*[1].

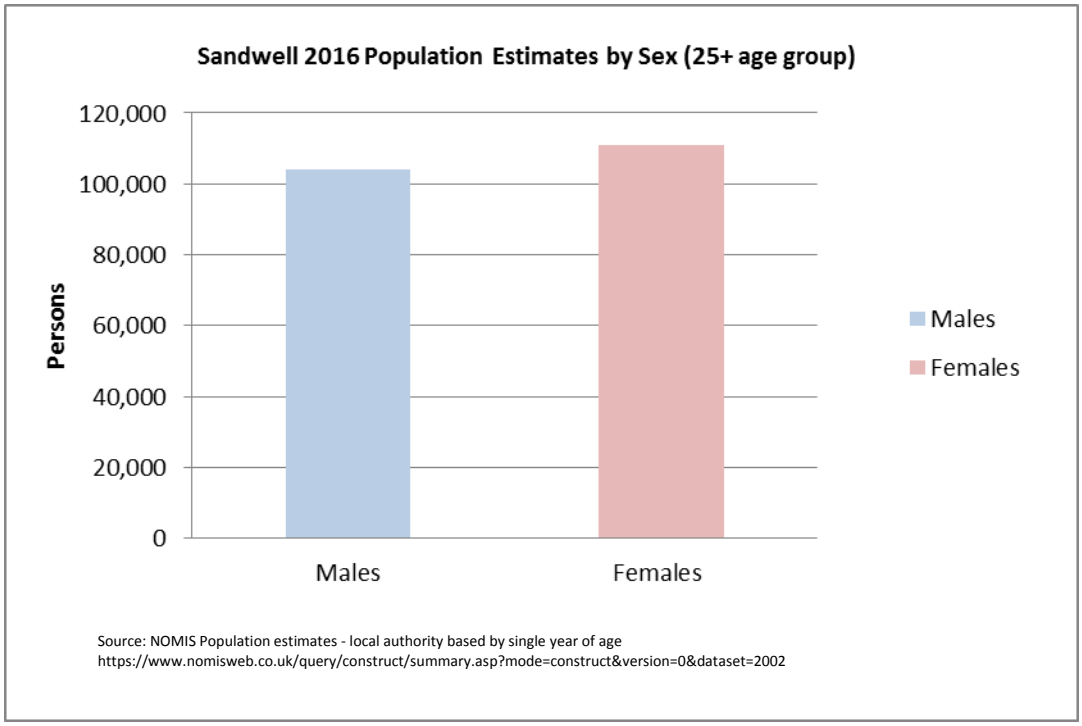
At all stages of life, the risk factors for common mental health disorders are strongly associated with poverty and disadvantage. The relationship with wellbeing is less clear, wellbeing is more strongly associated with education and the quality of social relationships.

The British Social Attitudes Survey 2016 explores people's attitudes towards mental health and wellbeing[7]. People said that spending time with family, work-life balance, having enough sleep and finances were the most important influences on their mental wellbeing. These findings from the survey align with the New Economics Foundation five ways to wellbeing[8].

2.1 Individual Factors

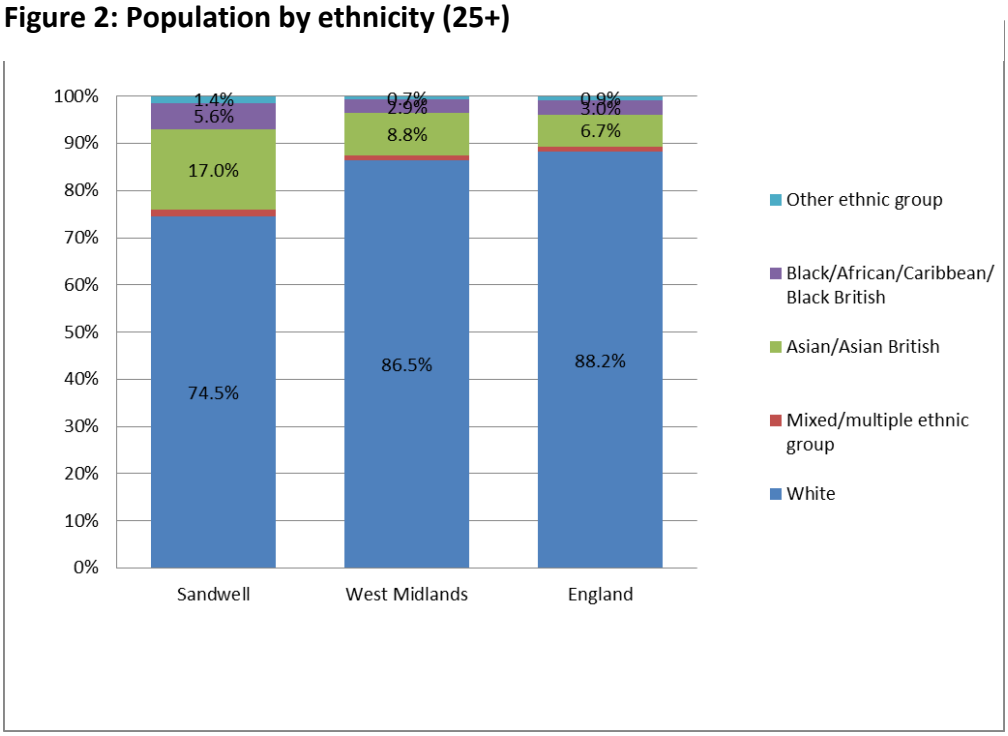
Gender is a factor in the risk of common mental disorders such as depression, with women having a higher prevalence, incidence and morbidity associated with depressive disorders compared with men. It is thought that these differences are due to a combination of biological, psychological and sociocultural vulnerabilities[9]. The population of Sandwell over the age of 25 has a higher proportion of females than males, in line with the national population[10]. Figure 1 shows estimates of the Sandwell population by gender.

Figure 1: Sandwell population estimates by gender (25+)



The risk of depression is disproportionately higher in people from the African-Caribbean, Asian, refugee and asylum seeker communities[11]. The Ethnic profile in Sandwell differs to the national average, with a higher proportion of ethnic minorities, as shown in figure 2.

Figure 2: Population by ethnicity (25+)



Source: Nomis - % derived from ONS 2011 Census data - Ethnic group by sex by age

As illustrated above, Sandwell has a higher proportion of people aged 25 and above from the Black and Minority Ethnic (BME) community (25.5%) compared to both the West Midlands (13.5%) and England (11.8%)[10].

- The 2011 census showed that in the Sandwell 25+ age group there were:
    - 34,841 people of 'Asian/Asian British' ethnicity
    - 11459 people of 'Black/African/Caribbean/Black British' ethnicity
    - 2966 people of 'Mixed/multiple ethnic group' ethnicity
    - 2935 people of 'Other ethnic group' ethnicity

2.2 Education, Learning and Development

A higher level of educational attainment is a protective factor for mental health[6]. Inversely, low educational attainment is linked to a higher risk of common mental health conditions (anxiety and depression)[12]. Access to educational opportunities is important in promoting mental health, resilience and wellbeing, and lifelong learning reduces the risk of mental illness[13]. It is thought that learning improves overall wellbeing and recovery from mental health problems by improving self-esteem, self-efficacy, sense of purpose and social integration[8].

- Sandwell has a relatively poor level of educational attainment, with only 48.9% of pupils achieving 5 or more A*-C GCSEs (compared to England average of 57.3% and West Midlands average of 55.0%).
- 22.2% of Sandwell residents have no qualifications (compared to England average of 8.6% and the West Midlands average of 13.0%)[10].

2.3 Childhood

While children and adolescents are outside the scope of this document, childhood mental health and wellbeing is important to consider in relation to adulthood. The Children and Young People's Emotional Health and Wellbeing in Sandwell (2016) JSNA report provides more detail on this area.

The evidence is clear that the social determinants of health such as housing, education, employment and environment, are major influences on children and young people's emotional health and wellbeing. Poor mental health and wellbeing in childhood is negatively associated with many adult health outcomes, including poor adult mental health, higher rates of alcohol and substance misuse and an increased risk of suicide[14].

- 27.6% of Children (under 16) in Sandwell live in low-income households compared to 18.6% nationally and 21.5% regionally.
- Single parent households make up 9.0% of Sandwell households, compared to 7.1% nationally and 7.5% regionally.

Being in care when young is also a determinant of adult mental health, such as levels of antisocial behaviour, emotional instability and psychosis.

- 69.5 out of every 10,000 children in Sandwell are in local authority care, lower than the national average of 60.0/10,000, and lower than the West Midlands average of 74.5/10,000.

Teenage pregnancy is a risk factor for poor mental health outcomes. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers.

- In children aged 13-15, the annual rate of conception is 8.2 per 1000 females, higher than the national rate of 4.4 and the regional rate of 5.2.
- In children aged 15-17, the annual rate of conception is 38.3 per 1000 females, higher than the national rate of 22.8 and the regional rate of 26.5.

Parental mental illness is a risk factor for childhood mental illness, with children of mothers with mental ill health being five times more likely to have a mental disorder[15].

- There are 108.3 parents attending treatment for substance misuse for every 100,000 children in Sandwell. This is on par with the national rate of 110.4.
- There are 63.2 parents attending treatment for alcohol misuse for every 100,000 children in Sandwell. This is significantly lower than the national rate of 147.2.

2.4 Relationships

Having an intimate, trustworthy partner is a protective factor for mental health. Being married appears to be beneficial to mental wellbeing. Married individuals have a greater reported satisfaction with life compared to those who are unmarried. High marital relationship quality is associated with higher wellbeing and lower risk of depression[16].

- 11.2% of people in Sandwell report their marital status to be separated or divorced. This is slightly lower than the national average of 11.6 and comparable to the regional average of 11.3%.

2.5 Lifestyle

Several epidemiological studies have shown that physical activity can delay or even prevent the onset of different mental disorders. Exercise also has therapeutic benefits when used as sole or adjunct treatment in mental disorders[17]. People with psychiatric disorders who exercised regularly reported higher health-related quality of life in a cross-sectional study[18].

- Regular exercise and physical activity are associated with improved mental health and wellbeing. Sandwell's is a relatively inactive population, with only 47.1% engaging in recommended levels of physical activity (compared to 55.5% in the West Midlands, 57.0% in England).
- It is estimated that only 12.4% of the population use outdoor space for exercise (compared to 17.9% of England, 16.9% of the West Midlands).

Smoking is associated with psychiatric disorders but the causal pathways are unclear. There is some evidence that those who smoke are more likely to develop a mental disorder but further studies are needed to validate this and investigate why[19]. People with a mental health problem smoke approximately 42% of all cigarettes smoked in England[20]. Those with severe mental health problems have an average life expectancy of between 10 and 25 years lower than the national average, and it is suspected that smoking is responsible for a large proportion of this excess mortality[21,22]. Other risk factors include physical inactivity and obesity[21].

- 20.6 % of people over the age of 18 are current smokers; higher than the national and regional averages of 18.0% and 16.9% respectively.
- 27.2% of adults in Sandwell are obese – compared to 24.0% nationally and 26.1% regionally.

People with disorders of substance use have higher rates of co-morbid mental disorders than vice versa. The causal pathways differ between both substances and disorders. There is strong evidence in particular that alcohol misuse increases the risk of depression[23].

- The percentage of Sandwell residents who drink alcohol at 'increasing risk' or 'higher risk' levels are estimated to be relatively low at 18.5% (compared to 22.3% nationally and 21.4% regionally). This may be due to differences in ethnic groups.
- The estimated prevalence of opiate and/or crack cocaine use is 10.7/1000 of the population aged 15-64 (higher than the national average of 8.4/1000 and the regional average of 9.5/1000).

2.6 Health

Mental health and physical health are interlinked, mutually affecting each other. Chronic physical health problems are associated with increased risk of mental health disorders. Depression is 2-3 times more common in people with long-term health conditions[13]. Equally, poor mental health leads to poor physical health. A person suffering from a mental illness is almost twice as likely to die from coronary heart disease and four times more likely to die from respiratory disease[24]. An estimated 12-18% of NHS expenditure on the management of long-term conditions is associated with poor mental health and wellbeing[25].

- 20.9% of people in Sandwell have a long-term health problem or disability that limits their daily activities. This is higher than the national average of 17.6% and the West Midlands average of 19%.
- 6.47% of households with dependent children have at least one person with a long-term health problem or disability, higher than the national and regional averages of 4.62% and 5.14% respectively.
- The health-related quality of life for older people (measured in those over 65 years of age using the EQ-5D scale) is 0.652 in Sandwell (compared to 0.709 in the West Midlands and 0.726 in England).

2.7 Social and Economic Factors

Deprivation is associated with an increased risk of mental illness. Those in the lowest socio-economic classes have the highest prevalence of psychiatric disorders[26,27]. Common mental disorders such as anxiety and depression are distributed along a gradient of economic disadvantage such that the poor and disadvantaged suffer disproportionately from common mental disorders[6,28]. As an example, the incidence of mental health problems in children from the lowest income families is 12-15%, compared to 5% in children from families with the highest income[13]. Poorer areas have higher rates of hospital admission for mental illness, and more outpatient mental health service use[29]. Higher income inequality is linked to higher rates of mental illness, lower social capital, and increased hostility, violence and racism. While poor mental health and well-being can be an outcome of poverty, it can also be a determinant of it, further compounding the problem[30].

- There are high levels of deprivation in Sandwell. 55.7% of people living in Sandwell are currently living in the 20% most deprived areas in England. (England average 20.2%, the West Midlands average 29.3%).
- This fact is also reflected in Sandwell's index of multiple deprivation score (IMD 2015) of 34.6 – significantly higher than the country's average score of 21.8. [PHOF]
- 16.4% of the households experience 'fuel poverty' – more than the national average of 10.4% and the regional average of 13.9%.
- Average (median) gross weekly pay is lower in Sandwell at £453.00 compared to £492.50 in the West Midlands and £532.60 in England[10].
- The Average (median) gross annual pay is £23,241 in Sandwell, £25,650 in the West Midlands, £27,869 in England[10].
- The average gross disposable household income (GDHI) in Sandwell is £12,100, compared to £15,551 in the West Midlands and £17,842 in England.

2.8 Employment

Having a permanent job is a protective factor for mental health[31]. Unemployment is associated with poor mental health, increasing both the risk of common mental disorders by a factor of 2.7 and of disabling mental disorders by a factor of 4.3[27].

- 67.0% of people of working age (16-64) are in employment (compared to the average of 73.9% in England 70.7% in the West Midlands)[10].
- 8.2% are currently unemployed (compared to England average of 5.1% and the West Midlands average of 5.8%)[10].
- 1.62% of people of working age living in Sandwell are in long-term unemployment (compared to England average of 0.61%, and the West Midlands average of 0.93%).
- 7% of families in Sandwell have no adults in employment; compared to 4.2% nationally and 4.8% regionally.
- 3.25% of the local population are providing substantial unpaid care (50+ hours/week) – compared to 2.37% nationally and 2.68% regionally.

- There is a job density in Sandwell of 0.70 (i.e. there are 7 jobs for every 10 people aged 16-24) – compared to 0.83 in England and 0.78 in the West Midlands[10].

2.9 Social Cohesion and Capital

Social networks and good social support promote wellbeing may be protective against mental health problems[12, 32]. As stated previously, migrants, refugees and asylum-seekers have a disproportionately higher risk of depression[11].

- Sandwell scores favourably compared to the rest of the country when looking at social isolation. Surveys of users of social care services and of adult carers show that 51.5% and 45.7% respectively have as much social contact as they would like (compared to national averages of 44.8% (44.2% West Midlands) and 38.5% (38.4% West Midlands) respectively). These figures are of limited usefulness however, as they focus on social care users and carers rather than the broader population. The problems of loneliness and social isolation are obviously not limited to these groups.
- 4.26% of people in Sandwell state they cannot speak English or speak it well. This percentage is dramatically higher than the national average of 1.65% and the regional average of 1.99%.
- Migrant GP registration provides a proxy measure for the migrant population in a local authority. The Sandwell rate of migrant GP registration is 9.9 per 1000 residents – lower than the national average of 11.7 per 1000 residents.
- Population turnover is lower in Sandwell than the national average (85.3/1000 compared to England's 90.7/1000), perhaps suggesting a higher degree of social cohesion.

2.10 Environmental Factors

Violence is negatively associated with mental health and wellbeing. Countries afflicted by violence and war have particularly high rates of mental health problems[6]. Children exposed to physical and psychological abuse, and those growing up in families with domestic violence are more likely to have psychiatric disorders in adulthood[33].

- Levels of violent crime are relatively low in Sandwell; with 11.4 annual offenses per 1000 population (compared to England average of 13.5/1000, and the West Midlands average of 12.8/1000).
- The incidence of reported domestic abuse in Sandwell (22.4/1000 population) is higher than the national and regional averages (20.4/1000 & 20.3/1000 respectively).

2.11 Housing

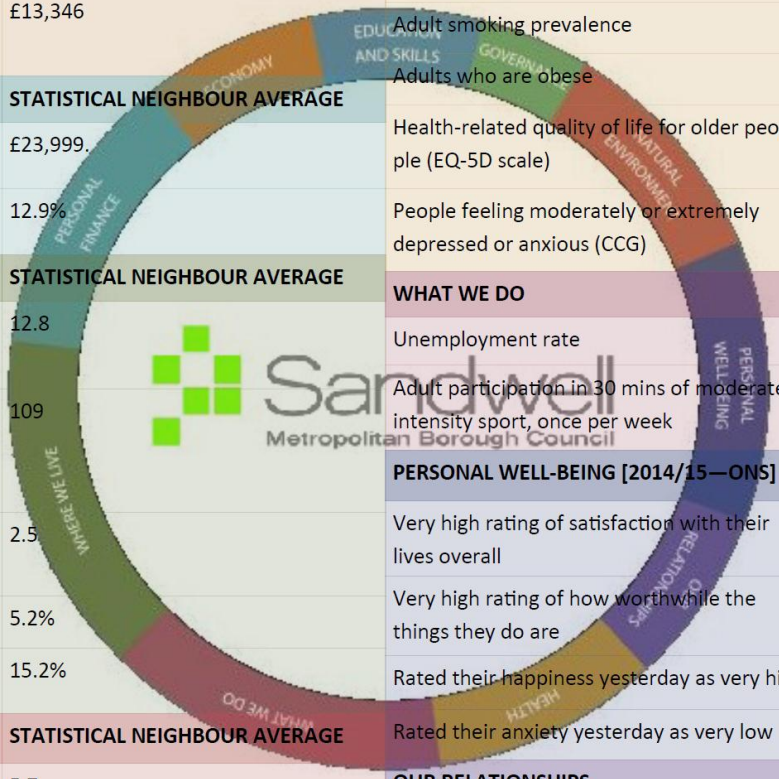
Being homeless increases the risk of mental disorders. In particular, it multiplies the risk of developing probable psychosis by 11.3 and of neurotic disorder by 3.9. The risk of substance misuse is also associated with homelessness, increasing the risk of alcohol and drug dependence by a factor of 5.5 and 5.6 respectively[13].

- 4.5 per 1000 people in Sandwell are homeless (compared to England average of 2.4/1000 and the West Midlands average of 3.4/1000).
- 6.8% of Sandwell households are overcrowded (i.e. having an occupancy rating of -1 or lower); compared to 4.8 nationally and 4.6 regionally.

Figure 3: Risk and protective factors in Sandwell

EDUCATION AND SKILLS	SANDWELL	STATISTICAL NEIGHBOUR AVERAGE
Five or more GCSEs A* to C including English and Maths	48.9%	50.2%
UK residents aged 16 to 64 with no qualifications	22.2%	13.49%
ECONOMY	**SANDWELL**	**STATISTICAL NEIGHBOUR AVERAGE**
Real net national disposable income per head	£12,505	£13,346
PERSONAL FINANCE	**SANDWELL**	**STATISTICAL NEIGHBOUR AVERAGE**
Median annual income	£23,241	£23,999.
Households experiencing fuel poverty	16.4%	12.9%
WHERE WE LIVE	**SANDWELL**	**STATISTICAL NEIGHBOUR AVERAGE**
Violent crime (including sexual violence) offenses per 1,000 population	11.4	12.8
Households with good transport access to key services or work (Indexed against England average of '100')	125	109
Statutory homelessness (per 1,000 households)	4.5	2.5
Overcrowded households	6.8%	5.2%
People using outdoor space for exercise	12.4%	15.2%
NATURAL ENVIRONMENT	**SANDWELL**	**STATISTICAL NEIGHBOUR AVERAGE**
Total greenhouse gas emissions (millions of tonnes)	5.9	5.7
Green belt areas (hectares per 1,000 people)	2.57	16.5
All-cause adult mortality attributable to particulate air pollution	6.1%	5.3%.
Household waste that is recycled (including composted and reused)	42.7%	44.9% (UK)

GOVERNANCE	SANDWELL	STATISTICAL NEIGHBOUR AVERAGE
Voter turnout in UK General Elections	59.53%	59.57%
HEALTH	**SANDWELL**	**STATISTICAL NEIGHBOUR AVERAGE**
Healthy life expectancy at birth (years — male/female)	58.7/58.4	59.2/58.3
Reported a long term illness and disability	20.91%.	20.16%
Adult smoking prevalence	20.6%	21.0%
Adults who are obese	27.2%	26.7%
Health-related quality of life for older people (EQ-5D scale)	0.668	0.692
People feeling moderately or extremely depressed or anxious (CCG)	13.9%	13.4% (Average of 10 similar CCGs)
WHAT WE DO	**SANDWELL**	**STATISTICAL NEIGHBOUR AVERAGE**
Unemployment rate	7.75%	7.98%
Adult participation in 30 mins of moderate intensity sport, once per week	31.1%	34.6%
PERSONAL WELL-BEING [2014/15—ONS]	**SANDWELL**	**STATISTICAL NEIGHBOUR AVERAGE**
Very high rating of satisfaction with their lives overall	22.96%	25.90%
Very high rating of how worthwhile the things they do are	29.37%,	31.76%
Rated their happiness yesterday as very high	33.49%	31.80%
Rated their anxiety yesterday as very low	40.71	42.45%
OUR RELATIONSHIPS	**SANDWELL**	**STATISTICAL NEIGHBOUR AVERAGE**
Adult social care users who have as much social contact as they would like	51.5%	44.0%
Adult carers who have as much social contact as they would like	45.7%	39.1%
People who are separated or divorced	11.2%	12.0%



3 Wellbeing, mental health and mental illness in Sandwell

The Health Survey for England monitors trends in the nation's health to estimate the proportion of people in England who have specified health conditions. The most recent survey, published in December 2016, reports the results from a survey undertaken in 2014[34]. This includes a chapter on prevalence of mental illness in the population, including lifetime experience, recent treatment and experience and the relationships between mental illness and the other aspects of people's lives. Some key findings from this survey were that, in England;

- 26% of all adults reported having ever been diagnosed with at least one mental illness. A further 18% of adults reported having experienced a mental illness but not having been diagnosed
- Women were more likely than men to report ever having been diagnosed with a mental illness (33% compared with 19%).
- The most frequently reported mental illness ever diagnosed was depression, including post-natal depression, with 19% of adults (13% of men, 24% of women) reporting this.
- The next most frequently reported conditions ever diagnosed were panic attacks, mentioned by 8% of adults, and generalised anxiety disorder, mentioned by 6%. Lifetime prevalence of each other condition was very low, at 3% or less.
- People may have more than one condition, and may have conditions and disorders in more than one type (for example, a common mental disorder and a serious mental illness). There is considerable overlap between types.

This section will describe the levels of wellbeing and mental health disorders in Sandwell. The data and intelligence presented come from a range of data sources. Some of these report data by local authority boundaries. Other data sources report data for clinical commissioning group boundaries. For each data source, the population referred to will be stated.

This variation in reporting geographies does make it difficult to draw definitive conclusions about the level of need and of services provision at a Sandwell MBC level. Where possible data will be compared between data sources to provide the most accurate possible picture of the level of need in Sandwell.

3.1 The impact of mental ill health

The West Midlands Combined Authority (WMCA) has established a mental health commission, which has recently published a report that examines mental health in the West Midlands[35]. This report includes estimates of the levels and impact of mental ill health across the WMCA. It reports that nearly a quarter of adults living in the WMCA are experiencing a mental health problem at any one time and that the pattern of mental health problems is influenced by the social, economic, environment and social inequalities.

Mental health problems affect every aspect of people's lives, as well as those of their carers, families and communities. People must receive the help they need to maintain their mental

health, and be able to access the support they need quickly and effectively when they are experiencing problems.

The report also estimates that the aggregate economic and social cost of mental health problems in the WMCA. This estimate includes costs of health, social care, crime, lost economic productivity, informal care by family and friends, and the costs associated with worklessness. The estimate of the aggregate cost in the WMCA for the year 2014-15 was around £12.6 billion, equivalent to a cost of about £3,100 per head of population. For Sandwell this would equate to an estimated aggregate cost of £958 million.

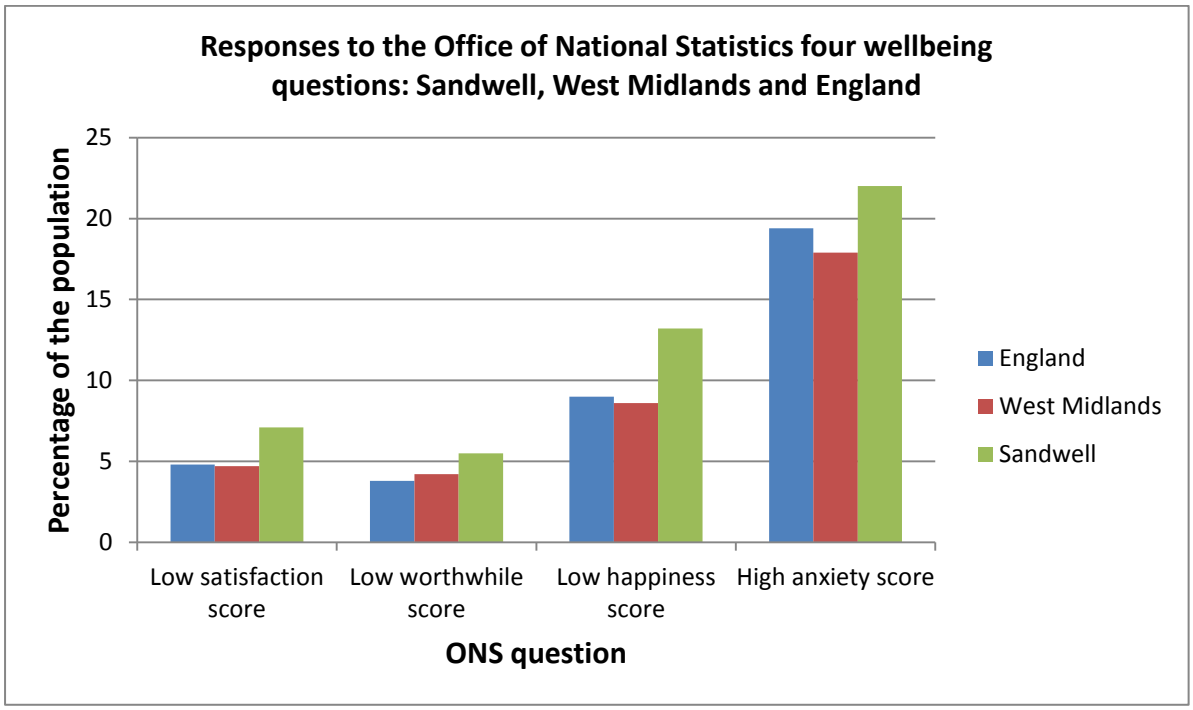
3.2 Wellbeing in Sandwell

The Office of National Statistics (ONS) publishes estimates of well-being for UK local authorities[36]. These are based four personal wellbeing questions. The questions are based on ten aspects of life that people said mattered to their wellbeing. These include; personal wellbeing, relationships, health, economy and environment. The questions are;

- Overall, how satisfied are you with your life nowadays?
- Overall, to what extent do you feel the things you do in your life are worthwhile?
- Overall, how happy did you feel yesterday?
- Overall, how anxious did you feel yesterday?

People are asked to respond on a scale of 0 to 10, where 0 is "not at all" and 10 is "completely". Figure 4 shows a comparison between Sandwell, the West Midlands and the England average. This chart shows the percentage of the population who scored low (0-4) for satisfaction, worthwhile and happiness and high (6-10) for anxiety.

Figure 4: Wellbeing in Sandwell, responses to the ONS 4 wellbeing questions



Source: Public Health Profiles

The differences in low satisfaction and low happiness scores between Sandwell and England are statistically significant. The difference in the number of people reporting a low score for worthwhile and people reporting a high level of anxiety are not statistically significant when compared to the England average.

In 2014, the Public Health Department undertook a population wellbeing survey in Sandwell. This was a postal survey based on the Short Warwick and Edinburgh Mental Wellbeing Scale (WMWBS). This seven-item questionnaire covers subjective wellbeing and psychological functioning.

The profile of the respondents to the survey was biased towards the groups listed below. The findings therefore include consideration of this bias;

- The older population aged 65+ (43%)
- Those who are retired from work (44%)
- Those who suffer from a limiting long term illness (42%)

The survey identified that the average wellbeing score for Sandwell as measured by SWEMWBS was 24.37 which was slightly lower than the national average of 25.3 (Health Survey for England 2010, Understanding Society, the UK's Household longitudinal study 2011).
Further analysis of the SWEMWBS scores has shown that the main risk factor is likely to be the presence of a long-term illness that significantly limits the individual's activities. Similarly, those who subjectively assessed their health as bad or very bad had significantly lower wellbeing (20) than those who rated it both fair (22.5) and good or very good (26.5).

A limiting long-term illness and subjective assessment of one's health as bad correlated to the lowest SWEMWBS scores more than all other demographic factors. This finding is supported by the qualitative analysis of the responses to the questions 'what has the biggest positive and biggest negative effect on your wellbeing'. The responses to this question indicated that participation in hobbies and activities was one of the positive contributing factors and ill health was one of the strong negative contributing factors.

Other factors that showed a significant correlation with SWEMWBS wellbeing scores were:

- Older age, where those aged 65-74 had a significantly higher level of wellbeing compared to all other age groups. This finding concurs with previous studies on wellbeing that indicate that wellbeing follows a U shaped pattern across the life course[37].
- Being a carer was positively correlated with higher levels of wellbeing.
- Being single or living alone was negatively correlated with wellbeing, which became evident in the qualitative responses where many respondents talked about loneliness having a negative impact on their wellbeing.
- In terms of ethnicity, black respondents reported significantly higher wellbeing than all other ethnic groupings.
- Non-smokers had higher wellbeing than people who smoke.

- Individuals who practice or participate actively in their faith (whether religious or spiritual) have significantly higher wellbeing than those who are non-practicing.
- Individuals with higher levels of social trust had significantly higher wellbeing than individuals with low levels of social trust.

3.3 Mental health service use by ethnicity

People from BME backgrounds form 30.06% of the Sandwell population. Data from the Public Health Outcomes Framework on the overall use of mental health services by BME groups shows that 36.78% of service users in 2012/13 were from a BME background.

This shows a possible over-representation of people from BME backgrounds in mental health services. However, there are uncertainties and possible inconsistencies in the recording of ethnicity. At this time, it is not possible to determine whether this difference between population and service use is statistically significant.

Sandwell and West Birmingham Clinical Commissioning Group commission the Black Country Partnership Foundation Trust (BCPFT) to provide mental health services for the population of Sandwell. Figures 5 and 6 show the data from BCPFT on referrals into their services. Figure 5 shows the proportion of referrals by ethnicity for each of the previous five years. This shows a possible increase in referrals from black and Asian groups, although it is not possible to identify whether this trend is significant.

Figure 5: Referrals by ethnicity 2011/12 to 2015/16

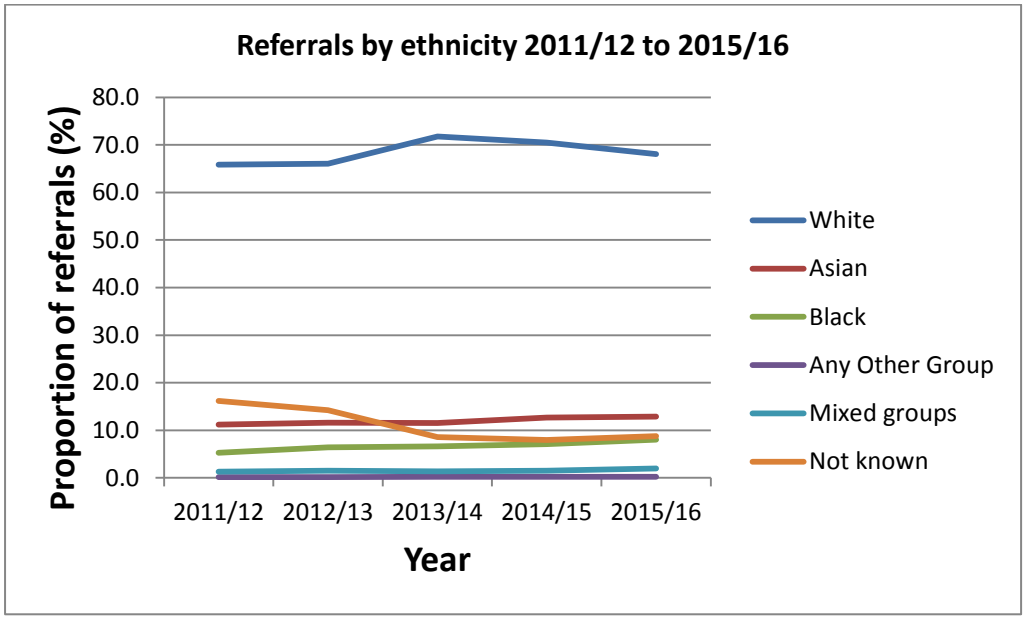
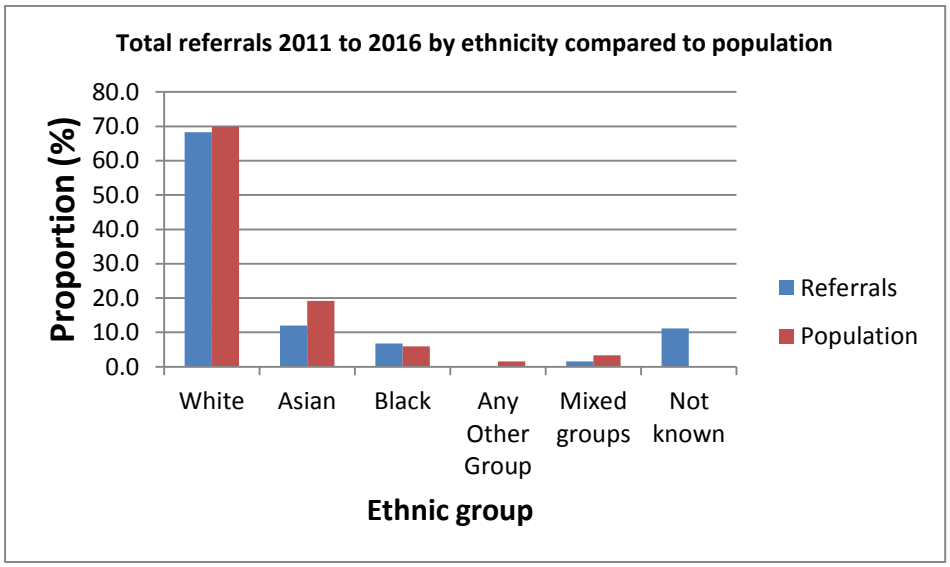


Figure 6 shows the proportion of referrals from each ethnic group compared to the proportion of that group within the population. This shows a possible under representation of Asian groups in referrals into services compared to the proportion of Asian groups in the population.

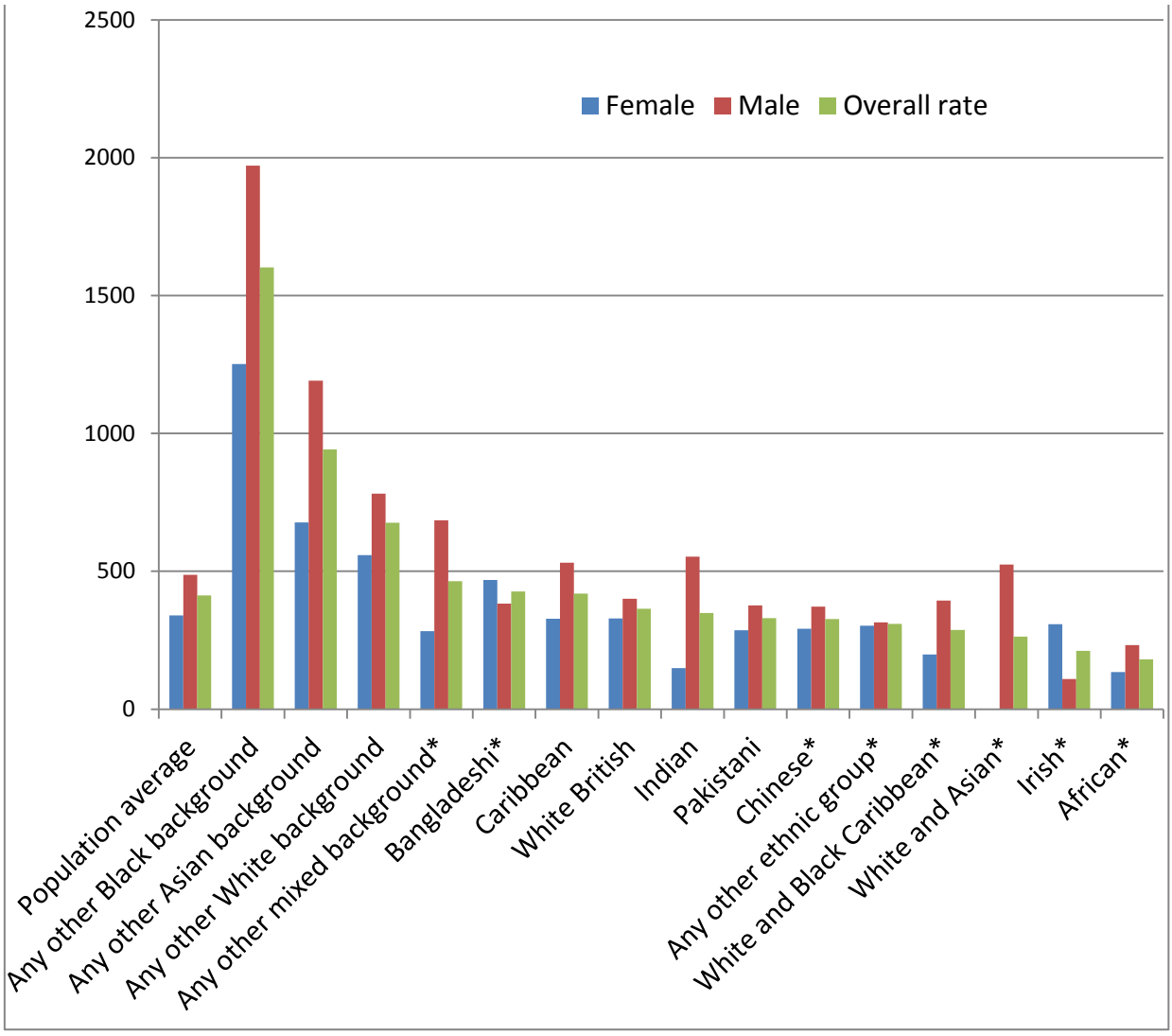
Figure 6: Referrals by ethnicity: Ethnicity compared to population proportion: total referrals 2011 to 2015



Recent studies have shown that, in general, people from Black backgrounds are over-represented in mental health services, especially in acute services and in people subject to detention under the Mental Health Act[38]. From the data from BCPFT, this over representation is not apparent in referrals into services in Sandwell. However, this data will reflect referrals for, in the main, less acute mental health problems.

When the data on hospital admissions for mental health disorders are analysed they do show an over-representation of people from some minority backgrounds. This data will include more acute and severe mental health problems and admissions to acute mental health services. Figure 7 shows the hospital admission rate for the general population and for different ethnic groups.

Figure 7: Overall hospital admissions by gender and ethnicity, 2015-16. Rate per 100,000 population (First diagnosis code)



*= less than 20 admissions over the year.

For the marked ethnicities (*) there have been low numbers of admissions over the year, reflecting the proportion of the population from these backgrounds. Due to these small numbers, it is not possible to state whether the differences in admission rates for these groups are significant.

This data shows a large variation in the rates of hospital admissions by ethnicity. People with Caribbean, any other white background, any other Asian background and any other black background all have higher rates of admission than the population average.
The highest rate of hospital admissions is for 'Any other Black Background', who have a rate nearly four times higher (1,602.6 admissions per 100,000 people) than the population average (412.1 admissions per 100,000 people). The highest rate for admissions is for males from any other Black background (1971.1 per 100,000 people).

The remaining ethnicities have lower rates of hospital admissions than the population average. However, this does not necessarily mean that levels of need in these populations are lower. There is evidence that people from different ethnic backgrounds have different

cultural understandings of mental health. The differences in admission rates may be partly due to lower rates of seeking help.

These findings are generally is in line with the findings from the national reports referenced above[38]. Referrals into services, which will tend to be for lower levels of mental health problems, do not show a marked variation across ethnicities. Hospital admissions, which will tend to be more severe mental health problems, do show marked variations between ethnicities, with males from a black background having substantially higher rates of admission.

3.4 Referrals into services

Referrals into mental health services provide information on the numbers of people accessing mental health services in Sandwell. The data presented in this section does not identify the reasons for referral or separate common mental health disorders from severe and enduring mental illness, but it does provide information to support triangulation across data sources.

Sandwell and West Birmingham Clinical Commissioning Group commission the Black Country Foundation Partnership Trust (BCPFT) to provide mental health services for the population of Sandwell.

Figure 8 shows the pattern of referrals by age of the person referred. This shows an increase in the number of referrals at age 9, reflecting the age criteria for the services provided. The number of referrals then decreases between 40 and 60. After this, the number of referrals increases to a peak at around age 80 years. It is likely that this is due to increased referrals for age related mental illness including dementia.

Figure 8: Referrals by age: Total referrals 2011 to 2016

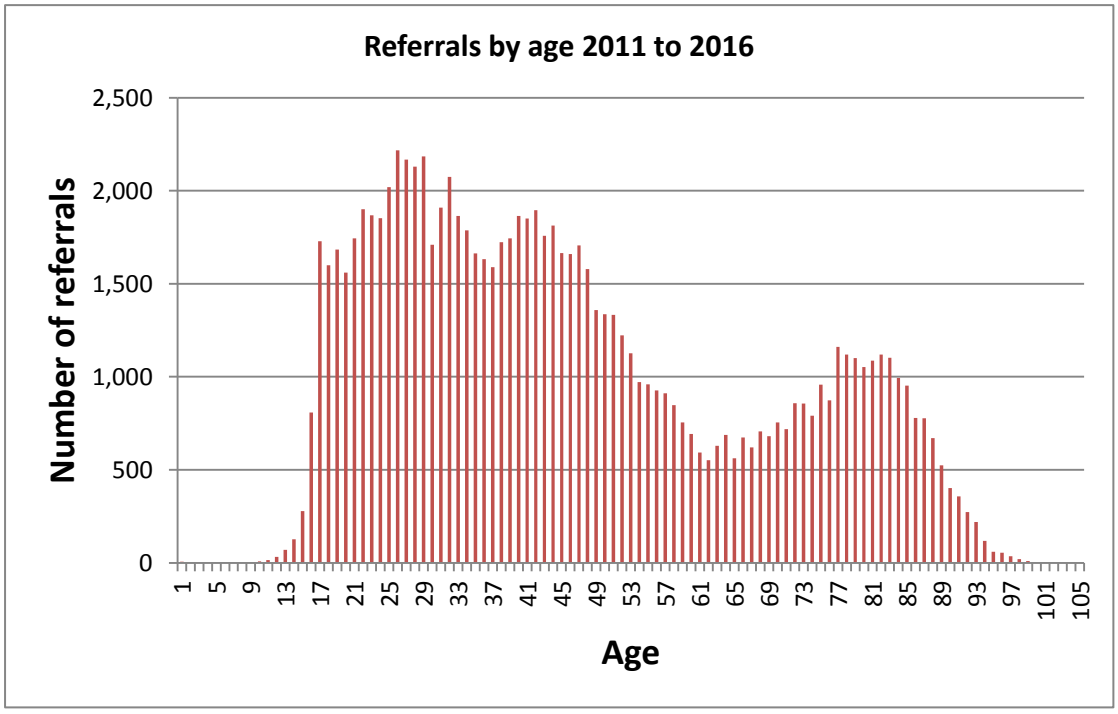


Figure 9 shows the pattern of referrals by gender over the past five years. Over 2011 to 2013 the data show a higher rate of referrals for females, whereas in 2015/16 there is a possible higher rate of referral for males. At this point, the data does not allow for a clear conclusion about whether these are significant differences or normal variation.

Figure 9: Referrals by gender 2011/12 to 2015/16

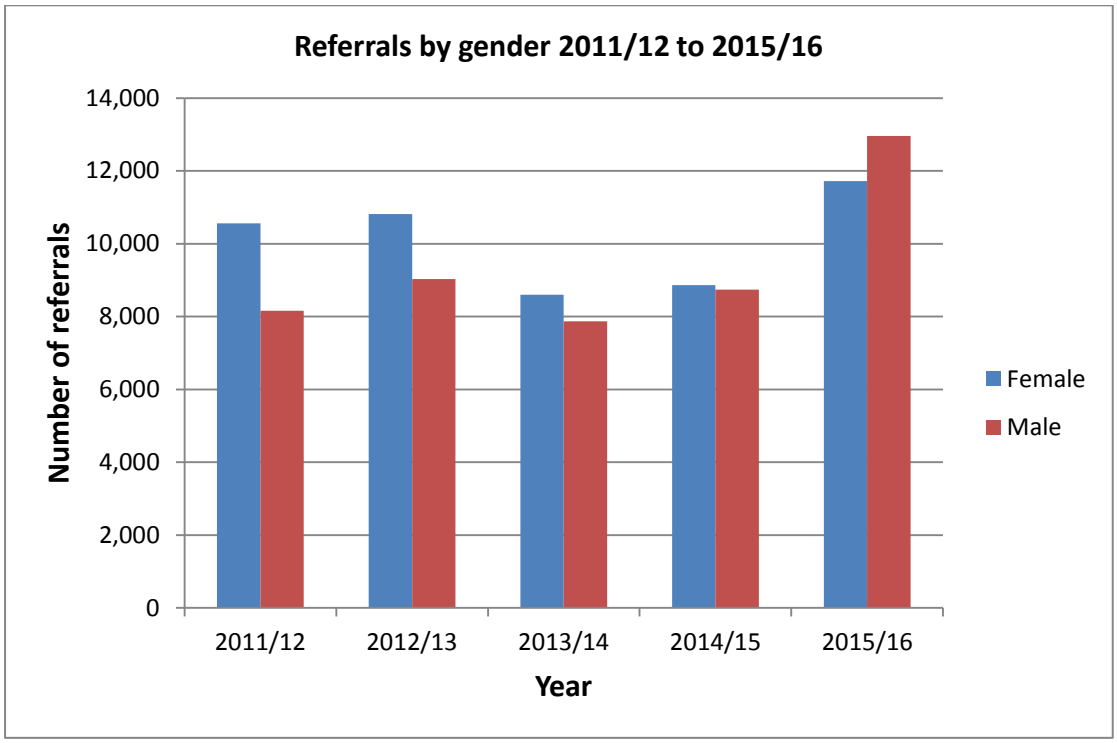
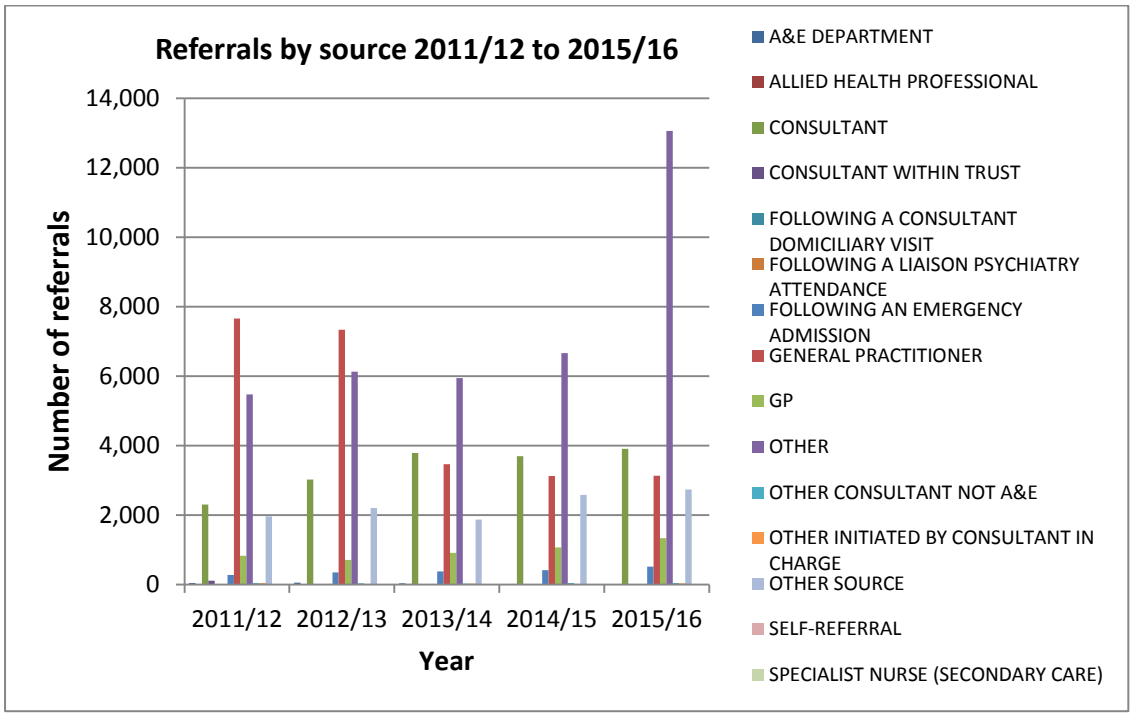


Figure 10 shows the routes of referrals into mental health services. This is relevant to this needs assessment because of the focus on access into services. However, with the substantially increased proportion from the non-defined 'other' category it is not possible to be clear on whether the pattern of referrals has changed over this period. The change in source of referral does coincide with the development of a 'single point of referral' with Black Country Partnership Foundation Trust. This may account for the changes in the pattern of referrals

Figure 10: Referrals by source of referral



3.5 Common mental health conditions:

Estimates of prevalence for common mental health disorders vary considerably. NICE guidance provides estimates for prevalence based on the Office of National Statistics 2007 national survey[39].

- Generalised anxiety disorder – 4.4%
- PTSD – 3.0%
- Depression – 2.3%
- Phobias – 1.4%
- Obsessive-compulsive disorder – 1.1%
- Panic disorder – 1.1%

Estimates of proportion of people who are likely to experience specific disorders during their lifetime are;

- Major depression – 4%-10%
- Generalised anxiety disorder – 5.7%
- Panic disorder – 1.4%
- Specific phobias – 12.5%
- Social anxiety disorder – 1.6%
- Obsessive compulsive disorder – 1.6%
- Post-traumatic stress disorder – 6.8%

There are limitations to the data available to describe the levels of common mental health disorders in Sandwell. Much of the data comes from GP practice data, for which there are difficulties with recording and variations between practices in data completion and quality. This approach will not identify people not in contact with primary care. Other data comes from hospital admissions, and there are variations in the recording of admissions and hospital contacts between areas and providers.

Where data is limited or contradictory, it is important to examine different sources of intelligence to support triangulation of intelligence. This can provide the most complete picture possible given the available data. The following section will examine a number of different data sources.

Public Health England publishes annual local area profiles that summarise the data and intelligence about common mental health disorders based on clinical commissioning group boundaries[40]. Table 1 provides a summary of these indicators based on the geographical footprint of Sandwell and West Birmingham clinical commissioning group (SWCCG).

Table 1: Common mental health conditions: summary indicators

Indicator	Time period	SWBCCG	England	Statistical significance
People estimated to have any common mental health disorder. Estimated % of population aged 16-74	2014/15	16.10	10.29	Not measured
Recorded prevalence of depression aged 18+	2015/16	6.61	8.26	Sandwell lower

New cases of depression: Adults with a new diagnosis of depression as a % of all patients on the GP register	2014/15	0.98	1.20	No difference
Depression and anxiety among GP survey respondents: % of people completing GP patient survey reporting they feely moderately or extremely anxious or depressed	2013/14	14.1	7.2	Sandwell higher
Secondary care contacts for common mental health disorders: Rate per 100,000 population aged 18+	2014/15	803	532	Sandwell higher
Use of mental health services by BME groups Percentage of mental health service users	2012/13	36.78	11.19	Sandwell higher

Source: Public Health Outcomes Framework

In 2015/6, the Sandwell and West Birmingham CCG prevalence of depression was lower than The West Midlands NHS Region and England but there is a major variation between different GP practices within SWBCCG. The lowest recorded prevalence is 1.64% and the highest 17.85%. It is not possible to estimate how much of this variation reflects different levels of common mental health disorders and how much is due to differences in diagnostic practice and data recording.

Much of the data on common mental health disorders comes from general practice registers. This introduces possible bias into the data. Not all people register with GPs, and people who are particularly vulnerable may be less likely to register with a GP. For example, people who are homeless, people misusing alcohol or drugs and new arrivals.

There are also concerns regarding the variation in the quality and completeness of data recording between primary care practices. There are inconsistencies between the data sources. For example, the levels of common mental health problems identified through GP practice surveys are higher than the levels of these problems registered on practice registers.

Other intelligence comes from hospital contacts for people with mental health disorders. Although the rates of diagnosis for common mental health disorders on GP registers are lower than England, the number of secondary care contacts for common mental health disorders are higher than England. Table 2 summarises this data.

Table 2: Hospital contacts for common mental health disorders

Indicator	Time period	SWBCCG	England	Statistical significance
Emergency admissions for depression per 100,000 population	2014/15	36	32.1	Similar
Emergency admissions for neuroses per 100,000 population	2014/15	27.1	21.7	Similar
A&E attendances for a psychiatric disorder	2014/15	54.4	243.5	Sandwell lower
People coming into contact with CCG mental health services per 100,000 population	2013	2732	2160	Sandwell higher

Source: Public Health Outcomes Framework

Prescribing levels for medications used for common mental health disorders also provide information on the level of identified need in Sandwell. This will only identify people who have been diagnosed with a mental health disorder, so will be subject to the same limitations as other GP practice based data.

To compare one GP practice or clinical commissioning group to another, the size of the practice or CCG has to be taken into account. Practices with more patients on their lists will need to prescribe more. Prescribing rate can be expressed as the number of prescriptions per patient (or per number of patients) on the practice list. However, comparative data can be analysed using a variety of patient denominators such as STAR-PU; (specific therapeutic group age-sex related prescribing units) that allow for benchmarking of spend between areas. Table 3 shows the prescribing levels for common mental health disorders in Sandwell compared to the England average.

Table 3: Prescribing levels of medications for common mental health disorders

Indicator	Time period	SWBCCG	England
Primary care prescribing spend on mental health (£) per person	2013/14	11.47	12.31
Antidepressant prescribing: average daily qualities (ADQs) per STAR-PU	2015/16	1.09	1.36
Hypnotics prescribing: average daily qualities (ADQs) per STAR-PU	2015/16	0.90	0.99

Source: Public Health Outcomes Framework

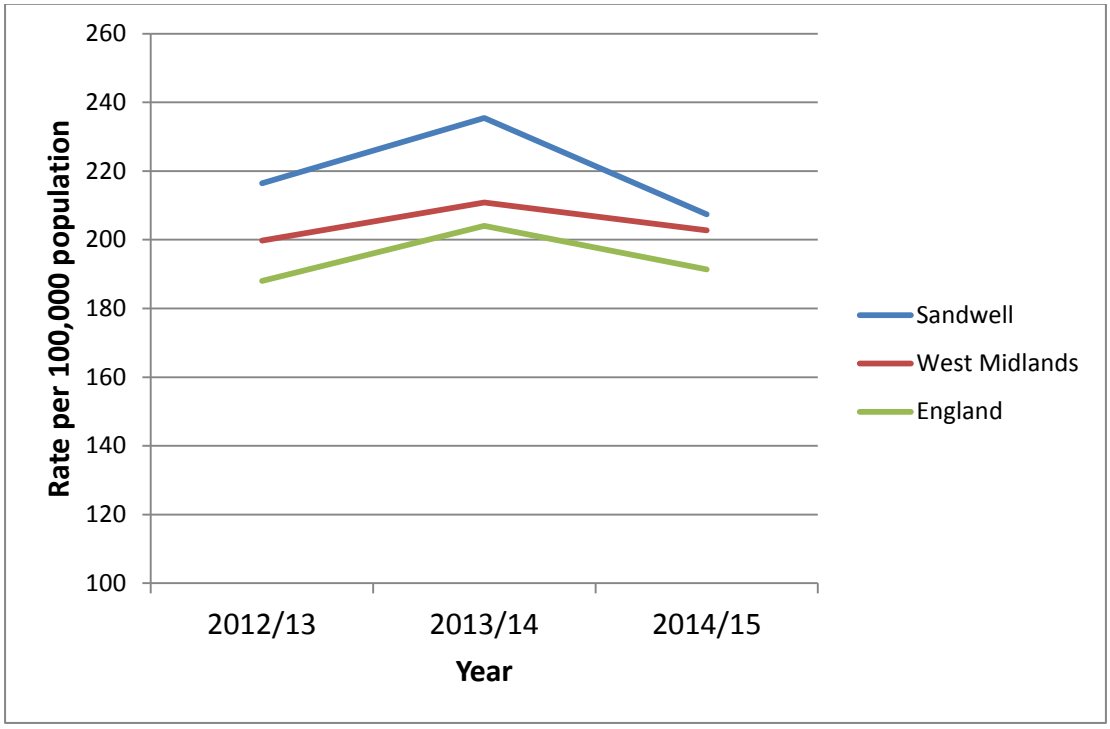
These show that the levels of prescribing of antidepressants and hypnotics are lower in Sandwell than the England average. The statistical significance of these differences between Sandwell and England is not benchmarked within the data source.

These data as presented provide an indication of the prevalence of common mental health disorders within the population. However, due to the limitations of the data, as discussed, they cannot provide a complete and definitive picture of the level of need in Sandwell.

3.6 Suicide and self-harm

Data on self-harm is available from the public health outcomes framework. The data available are hospital stays due to self-harm in Sandwell (figure 11). The difference in the rates between England and Sandwell are statistically significant, with Sandwell having consistently higher rates of hospital admission due to self-harm.

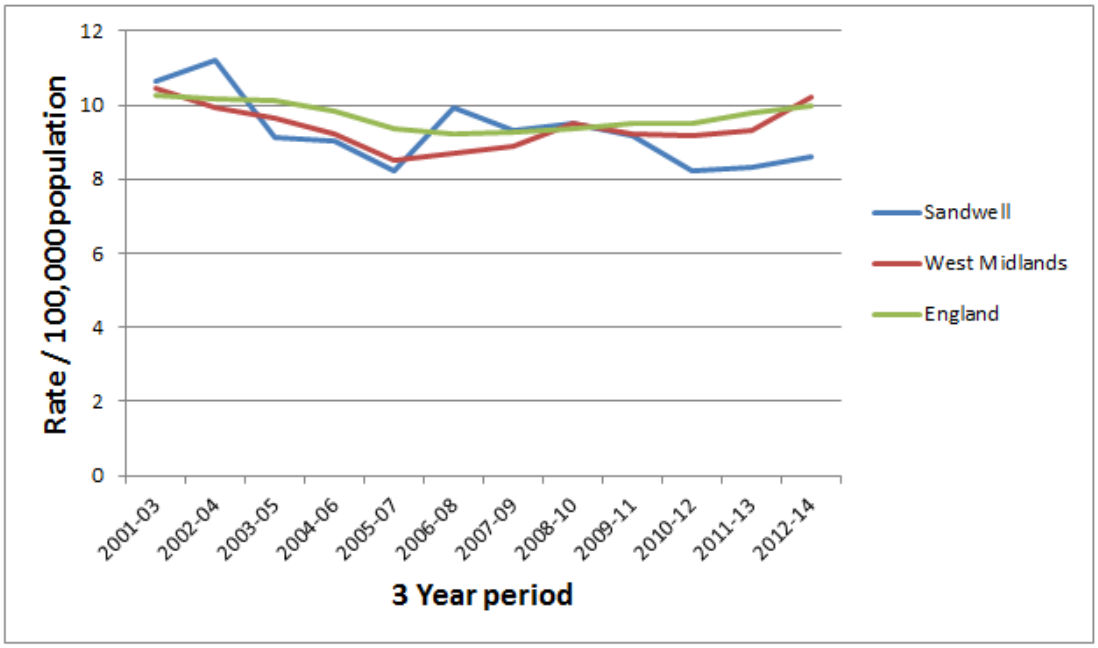
Figure 11: hospital stays for self-harm, Sandwell and England: 2012/13 to 2014/15



The Office of National Statistics collates data on suicide at a local authority level. This includes both deaths due to suicide and those due to injury of undetermined intent. Figure 12 shows the level of suicide in Sandwell compared to the West Midlands region and England. The trend is for the suicide rate in Sandwell to be slightly lower than that for West Midlands and for England, though this difference is not statistically significant.

The Parliamentary Health Select Committee has recently published a report from a review of suicide and suicide prevention in England. This has found that there is significant variation in the recording of suicide between areas, largely due to the differences in how coroners record deaths[41]. This means that the variation in suicide rates between areas may not reflect the actual number of suicides. The report has recommended a national programme to improve consistency in the recording of suicide.

Figure 12: Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population: Sandwell, West Midlands and England



3.7 Severe and enduring mental illness

Table 4 shows summary indicators from the public health outcomes framework for severe and enduring mental illness in Sandwell and West Birmingham CCG, compared to England.

Table 4: Severe and enduring mental illness: summary indicators

Indicator	Time Period	SWBCCG	England	Statistical significance
Estimated prevalence of psychotic disorder – percentage of population aged 16+	2012	0.51	0.40	Not measured
QOF prevalence of severe mental illness: percentage of people on GP register	2014/15	1.05	0.88	Sandwell higher
Detentions under the Mental Health Act, annual rate per 100,000 population	2012/13	78.20	58.60	Sandwell higher
GP prescribing of drugs for psychoses and related disorders: items (quarterly) per 1000 population	2015/16	45.04	46.87	Sandwell lower
Schizophrenia emergency admissions: rate per 100,000 population aged 18+	2009/10 – 11/12	58.00	57.0	Similar

Source: public health outcomes framework

This data indicates that Sandwell may have a higher rate of severe mental illness, including psychotic illness, than the England average.

3.8 Perinatal Mental Health

It is estimated that between 10% and 20% of women are affected by mental health problems at some point during pregnancy or in the first year after childbirth[42].

Perinatal mental health is a priority in Sandwell, particularly in relation to children's and young people's mental health and wellbeing. It is a priority within the Sandwell Child and Adolescent Mental Health Services (CAMHS) Transformation Plan[43].

The National Child and Maternal Health Intelligence Network provides estimates of the prevalence of perinatal mental health disorders in Sandwell. These estimates are calculated by applying the national prevalence to the population of Sandwell. Due to the limitations associated with the estimates it is not possible to benchmark against other areas[44]. This data is summarised in table 5.

Table 5: Estimates of women with mental health problems during pregnancy and after childbirth

Indicator	Time period	Sandwell (number)
Estimated number of women with postpartum psychosis	2013/14	10
Estimated number of women with chronic serious mental illness	2013/14	10
Estimated number of women with severe depressive illness	2013/14	135
Estimated number of women with mild-moderate depressive illness and anxiety (lower estimate)	2013/14	450
Estimated number of women with mild-moderate depressive illness and anxiety (upper estimate)	2013/14	675
Estimated number of women with post-traumatic stress disorder	2013/14	135
Estimated number of women with adjustment disorders and distress (lower estimate)	2013/14	675
Estimated number of women with adjustment disorders and distress (upper estimate)	2013/14	1,345

3.9 Co-existing mental illness and substance misuse

Dual diagnosis refers to people with a severe mental illness (including schizophrenia, schizotypal and delusional disorders, bipolar affective disorder and severe depressive episodes with or without psychotic episodes) combined with misuse of substances (the use of legal or illicit drugs, including alcohol and medicine, in a way that causes mental or physical damage). Recent studies have estimated prevalence rates of 20-37% in secondary mental health services and 6-15% in substance misuse settings[45].

Difficulties in accessing services for this group have been reported both nationally and locally[45]. During the stakeholder consultation for this needs assessment there was anecdotal reporting of people with a substance misuse problem having difficulty accessing both mental health and wider physical health services.

People who misuse alcohol over a long period are at risk of alcohol related brain damage (ARBD). This can lead to difficulty with memory and possible confusion. This can make it more difficult for people with ARBD to access services and to maintain treatment. They are likely to need more intensive support to manage their alcohol intake[46].

Table 6 shows the summary indicators for co-existing mental illness and substance misuse in Sandwell compared to England.

Table 6: Co-existing mental illness and substance misuse: summary indicators

Indicator	Time period	Sandwell	England	Statistical significance
Estimated prevalence of opiate and/or crack cocaine use per 1000 population aged 15-64	2011/12	10.73	8.40	Sandwell higher
Admission to hospital for mental and behavioural disorders due to alcohol per 100,000 population	2014/15	105.69	84.39	Sandwell higher
Concurrent contact with mental health services and substance misuse services for alcohol misuse (proportion of all individuals entering alcohol services)	2014/15	25.28	20.01	Similar
Concurrent contact with mental health services and substance misuse services for drug misuse (proportion of all individuals entering drug services)	2014/15	17.46	20.96	Similar

Source: Public Health Outcomes Framework

These indicators suggest that overall drug use is higher in Sandwell than in England, and admissions to hospital for alcohol related behavioural disorders are higher than the England average. Concurrent contact with mental health services and substance misuse services are similar to the England average.

Local service data provides more detail for Sandwell. Of 901 individuals commencing a new treatment journey in 2015/16, 149 (16.5%) were recorded as having a dual diagnosis need.

Analysis by substance type shows:

Alcohol only:	15.5%
Opiates:	14.9%
Non-opiates:	21.5%
Non-opiates and alcohol:	24.7%

Those individuals with a dual diagnosis need receive additional support from a community psychiatric nurse within the service but this does not negate the need for clients to be able to access mainstream mental health services.

3.10 Health of people with mental illness

People with severe mental illness have a 10 to 25 year shorter life expectancy than the general population. The majority of these deaths are due to long-term health conditions such as cardiovascular disease, respiratory and infectious diseases, diabetes and hypertension. The other major cause of death is suicide.[47]

This higher prevalence of long-term conditions in this population is largely caused by unhealthy lifestyles such as smoking, physical inactivity and diet. People with severe mental illness are often at a socioeconomic disadvantage, are far less likely to be employed and to suffer substantial discrimination.

Table 7 summarises the main available indicators for the health of people with severe mental illness in Sandwell.

Table 7: Health of people with severe mental illness in Sandwell: summary indicators

Indicator	Time period	Sandwell	England	Significance
Premature (<75) mortality in adults with serious mental illness	2012/13	1361.60	1319	Similar
Excess under 75 mortality rate in adults with serious mental illness	2013/14	369.3	351.8	Not calculated
Smoking prevalence in adults with severe mental illness (%)	2014/15	41.3	40.5	Similar
Smoking prevalence in adults – current smokers	2015	17.7	16.9	Similar

Source: public health outcomes framework

These indicators show that people in Sandwell with serious mental illness, in common with the rest of England, have a higher rate of premature mortality than the general population. The indicators suggest that the level of premature mortality is not significantly different from the England average.

The primary care quality outcome framework includes indicators that report on how the health of people with severe and enduring mental health illnesses is monitored in primary care. There are concerns regarding the completeness and accuracy of the reporting, and substantial variations between practices, but it does provide an indication of how well primary care is supporting the physical health of people with severe mental illness.

For recording blood pressure;

- In 2012-3 and 2013/4 the Sandwell and West Birmingham CCG had higher rates of having blood pressure recorded for patients in this measure than England but in 2014/5 rates were lower than England before being very slightly higher in 2015/6.

- Although rates are similar to England, it is a concern that rates are not as high as in 2013/4.
- In the Sandwell and West Birmingham CCG in 2015/6 there is a wide variety in the rates recorded by different GP surgeries with the worst surgery only reaching 33.3% of patients in this measure compared to 100% for the best.
- In 2015/6, 57 surgeries were higher than the Sandwell and West Birmingham CCG level of 81.1% and 44 surgeries were lower.

For recording of body-mass index;

- Between 2012-3 and 2015-6 the Sandwell and West Birmingham CCG has had slightly higher rates of measuring BMI for this patient group than England but has followed a similar trend to England over this time period.
- The fall in rates in the Sandwell and West Birmingham CCG and England from 2014-5 onwards may just reflect poorer data quality when the data no longer needed to be collected for payment purposes.
- In the Sandwell and West Birmingham CCG in 2015/6 there is a wide variety in the rates recorded by different GP surgeries with the worst surgery reaching 3.7% of patients in this measure compared to 93.5% for the best.
- In 2015/6, 46 surgeries were higher than the Sandwell and West Birmingham CCG level of 48.7% and 55 surgeries were lower.

For cervical screening;

- Between 2012-3 and 2015-6 the Sandwell and West Birmingham CCG had lower rates of cervical screening test for women in this measure than England.
- It is a concern that between 2012-3 and 2015-6 the rates for Sandwell and West Birmingham CCG are on a falling trend like for England.
- In the Sandwell and West Birmingham CCG in 2015/6 there is a wide variety in the rates recorded by different GP surgeries with the worst surgery reaching none of patients in this measure compared to 100% for the best.
- In 2015/6 54 surgeries were higher than the Sandwell and West Birmingham CCG level of 68.51% and 46 surgeries were lower (1 surgery had no data).

The smoking prevalence in adults with severe mental illness is substantially higher than the general population. This is in agreement with a number of studies that have shown that people with mental illness have higher rates of smoking[48],[49].

Smoking is the single largest cause of the gap in life expectancy between people with mental illness and the general population. While smoking rates in the general population have steadily fallen over the past 20 years, in people with mental illness they have hardly changed. Smoking can be part of a coping mechanism for managing the mental illness, though the evidence suggests that smoking in itself can be harmful for mental health. The positive impact of stopping smoking on anxiety and depression appears to be at least as significant as antidepressants[50].

A recent study by the Action on Smoking and Health identified that people with mental illness want to stop smoking, but that they face more barriers to quitting. They may also be more dependent and need more intensive support than the general population[49].

3.11 Vulnerable groups

There are vulnerable groups within the population who are at a substantially higher risk of experiencing poor mental health but who are likely to find it more difficult to access support and services. Many of the people within these groups will be socially isolated and excluded. These groups include people who are homeless, new arrivals including asylum seekers, refugees and undocumented migrants. People who are carers, or have been carers but have suffered bereavement are also at a higher risk of poor mental health and mental illness.

The nature of these groups means that it can be difficult to gather accurate data on the number of people, where they are living and what health issues they experience. There are recent reports that provide information on the levels of mental illness experienced by these groups.

Carers

Information on the number of carers shows that there are;

- Approximately 35,000 adult carers in Sandwell
- Approximately 4,500 children with special educational needs, all of which will have at least one parent carer
- There is no data available on the numbers of young carers in Sandwell; in 2015/16, nearly 700 young carers accessed a commissioned service. It is likely that this is an underestimate of the number of young and child carers.

Carers have worse general physical and mental health than the general population. Their caring responsibilities can mean that they neglect their own health. People who are caring for someone else often become socially isolated. Carers UK undertook research that found that 80% of carers have felt lonely or socially isolated because of their caring responsibilities. They found that this could be due to a lack of understanding from friends, colleagues and families, inadequate care services and financial pressures[51]. When the person someone is caring for dies, the carer can become increasingly socially isolated. This can have a detrimental impact on their health and mental health.

In Sandwell, in 2015, there was a consultation with carers to inform a refresh of the Sandwell Carers Strategy and to understand the needs of carers in Sandwell. The Sandwell Carers Alliance, made up of 15 organisations working with carers in Sandwell, carried out the survey. This survey highlighted that carers valued emotional support to deal with the isolation and loneliness associated with the caring role.

People who are homeless

Homeless Link undertook a health audit of homelessness in 2014. This audit was based on 2590 responses from people using services in 19 areas across England. The audit identified that 80% of homeless people reported some form of mental health issue, with 45% diagnosed with a mental health disorder[52].

Figure 13 shows the rate of statutory homelessness in Sandwell, compared to regional and national rates.

Figure 13: number of statutory homeless households per 1000 households

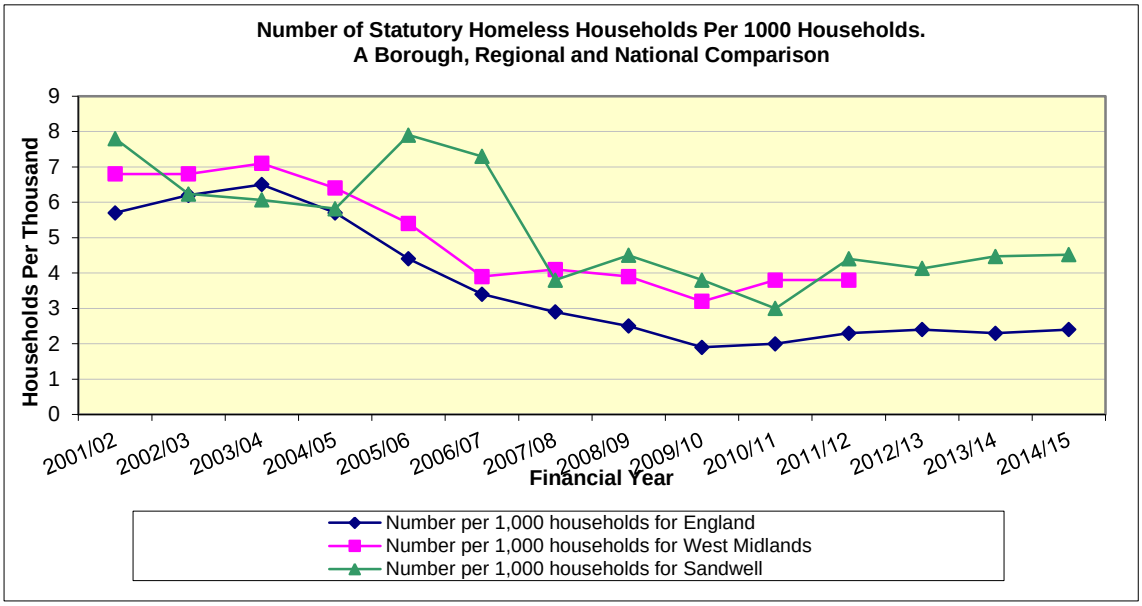


Table 8 shows the number of reported rough sleepers in Sandwell, compared to neighbouring areas.

Table 8: Reported numbers of rough sleepers by local authority (DCLG)

	2012	2013	2014	2015
Birmingham	8	14	20	36
Dudley	4	6	6	3
Sandwell	14	3	2	4
Walsall	9	8	5	7
Wolverhampton	8	6	7	13

In 2009 Crisis, the homelessness charity, published Mental Ill Health in the Adult Single Homeless Population: a review of the literature[53]. This suggested that the prevalence of common mental health problems is more than twice that of the general population, and psychosis 4-15 times as high. People who are street homeless may be 50 – 100 times more likely to have a psychotic illness compared to the general population. Other key findings were;

- Homeless people, in particular those with mental ill health, have higher mortality rates than the general population. They are up to nearly 5 times more likely to die than the equivalent age group of the general population.
- Rates of reported personality disorder are also high. In a recent survey of homeless services in England, staff estimated two thirds of their clients presented with characteristics consistent with personality disorder, many of whom were thought to be undiagnosed.
- Among people who are in touch with psychiatric services, a significant minority are homeless. A recent European study found that just under a third of the British sample of

patients with schizophrenia had experienced homelessness in their lifetime, with over a tenth having experienced “rooflessness.”

- Women experience some risk factors (such as physical and sexual violence as a child) for both mental health and homelessness to a greater extent than men.
- The proportion of homeless people who are mentally ill from BME groups is disproportionate compared to their proportion in the general population.
- Overall research shows that as the stability of housing increases then rates of serious mental illness decrease.

New arrivals, asylum seekers and refugees

Whilst many asylum seekers do arrive in the UK in relatively good physical health, health problems can rapidly develop whilst they are in the UK[54]. Reasons for this include;

- Difficulty in accessing healthcare services
- A lack of awareness of entitlement;
- Problems in registering and accessing primary and community healthcare services, particularly if their claim has been refused;
- Language barriers.

However, some asylum seekers can have increased health needs relative to other migrants. There are a number of reasons for this;

- A number have faced imprisonment, torture or rape prior to migration, and will bear the physical and psychological consequences of this
- Many may have come from areas where healthcare provision is already poor or has collapsed
- Some may have come from refugee camps where nutrition and sanitation has been poor so placing them at risk of malnourishment and communicable diseases
- The journey to the UK can have effects on individuals through the extremes of temperatures, length of the journey, overcrowded transport and stress of leaving their country of origin

Mental health needs of asylum seekers can be significantly worsened (and even start to develop in the UK) because of the loss of family and friends' support, social isolation, loss of status, culture shock, uncertainty, racism, hostility, housing difficulties, poverty and loss of choice and control. Some asylum seekers and refugees will have also experienced traumatic experiences, such as torture, loss of relatives and abuse, possibly during the journey to England.

Mental health problems can include depression and anxiety. Post-traumatic stress disorder due to traumatic experiences can also be present, though it is likely that this is under-diagnosed. Different cultural understandings of mental health can mean that mental distress may manifest as physical complaints, this can influence the diagnosis and treatment of mental illness in this population[55].

Lesbian, gay, bisexual and transgender

The majority of people who identify themselves as lesbian, gay, bisexual or transgender (LBGT) have and maintain good mental health and wellbeing. However, there is evidence that they are at greater risk for developing mental health problems. This includes major depression, bipolar disorder and generalised anxiety disorder[56].

This increased risk of mental health problems is likely to be associated with people experiencing homophobia, discrimination, bullying and isolation. There can also be problems when an individual's family or social contacts do not accept their sexual orientation.

Experiencing these difficulties can mean many gay and bisexual people face mental health issues, including[57]:

- difficulty accepting their sexual orientation, leading to conflicts, denial, alcohol abuse and isolation
- trying to keep their sexuality a secret through lying, pretending or leading a double life
- low self-esteem
- increased risk of self-harm and suicide attempts
- damaged relationships or lack of support from families
- post-traumatic stress disorder and depression from long-term effects of bullying

There is also evidence that people who identify as LGBT also have higher rates of drug and alcohol misuse. It can be difficult to gather accurate data because of the reluctance of some people to disclose their sexuality, and some professionals are reluctant to ask the relevant questions.

Public Health England has published estimates of the LGBT population for England and for different areas within England[58]. This report estimates that the proportion of the population identifying as LGBT is between 2.5% and 5.8%. For Sandwell, this gives an estimate of between 7,700 and 18,000 people.

Criminal Justice

People in contact with the criminal justice system experience substantial health inequalities. The mortality rate for prisoners is 50% higher than the rest of the population. A recent study by the Centre for Mental Health estimates that up to 90% of prisoners have some form of mental health problem, personality disorder or substance misuse problem[59]. This has an impact on the individual; it also has a large impact on their families and on communities. Compared to their peers, children of offenders are three times more likely to have mental health problems or to engage in anti-social behaviour[60].

Although there is no prison in Sandwell, a proportion of the population will be in contact with criminal justice services or will have been recently discharged from prison. This is a highly vulnerable population, often with complex needs and needing intensive support and complex interventions.

The Centre for Mental Health report makes a number of recommendations for
Robust screening and assessment processes for a range of vulnerabilities in all justice settings[59];

- Wider availability of support and care for people's vulnerabilities regardless of setting
- Providing pragmatic and practical support (e.g. with housing and debt) at critical periods (e.g. on release from prison)
- Adopting a psychological and trauma focused approach across all justice services and providing training in these for all who work in them
- Increasing access in both the community and custodial settings to psychological interventions that are adapted to reflect complex and multiple need
- Increasing the use of mentors and peers, and the voice of service users in the planning and provision of services.

In Sandwell there are support services working within the police custody suite. This includes a liaison and diversion service that identifies people with mental health problems and diverts them into appropriate mental health services rather than police custody. There is also a drug identification and diversion service that will identify people with substance misuse problems and direct them into appropriate support. This service also ensures continuity of support for people on discharge from prison.

Modern Day Slavery

An emerging challenge is the impact of modern day slavery (MDS). Although this has probably existed for many decades, or longer, it is now gaining more recognition. The current scale and scope of MDS is becoming apparent through partnership approaches across the government, police, local authorities, the voluntary sector and businesses. The Modern Day Slavery Act (2015) established a 'duty to notify'. This means that anyone who is a 'first responder', including council and NHS services, must notify the relevant body if they suspect modern day slavery. This will provide more intelligence on the numbers of people affected, though this will be a small proportion of the total number of people experiencing MDS.

The British Government estimated in 2013, that there are around 13,000 people in MDS in the UK today. PROTECT, a recent research project, showed that 1 in 8 NHS professionals reported having contact with a patient they suspected might have been trafficked[61].

People subjected to MDS can be new arrivals, or can come from the resident population. MDS can include sexual exploitation and trafficking, forced labour, domestic servitude and forced into criminal activity. This is often associated with substance and alcohol misuse[62].

People who are experiencing, or have experienced, modern day slavery are likely to have complex health needs, including mental health needs. Services will need to have the expertise, and capacity to support these people.

4 Policy and Guidance

4.1 National policy

All government and wider policy can potentially have a direct or indirect impact on mental health and wellbeing. The following summaries of policy and guidance are restricted to those that will directly influence the interventions to improve population mental wellbeing and the commissioning of services for people with mental health problems.

New Horizons – confident communities, brighter futures: a framework for developing well-being.

HM Government (2010)
This document describes the government's vision for improving the mental health and wellbeing of the population as a whole.

- Use a life course approach to ensure a positive start in life and healthy adult and older years.
- Build strength, safety and resilience: address inequalities and ensure safety and security at individual, relationship, community and environmental levels.
- Develop sustainable, connected communities: create socially inclusive communities that promote social networks and environmental engagement.
- Integrate physical and mental health: develop a holistic view of well-being that encompasses both physical and mental health, reduce health-risk behaviour and promote physical activity.
- Promote purpose and participation to enhance positive well-being through a balance of physical and mental activity, relaxation, generating a positive outlook, creativity and purposeful community activity

No health without mental health: delivering better mental health outcomes for people of all ages.

Department of Health (2011)

This policy document outlines the governments overall approach to improving mental health outcomes. It describes the government's key pledges. It also explains how public sector reform will transform public mental health and mental health services. It has six main objectives and, along with an implementation plan, describes the roles of health, social care, wider local government (including housing and education) and wider stakeholders in delivery of these objectives.

i. More people will have good mental health
ii. More people with mental health problems will recover
iii. More people with mental health problems will have good physical health
iv. More people will have a positive experience of care and support
v. Fewer people will experience stigma and discrimination

The report also includes a commitment to develop intelligence about mental health and wellbeing and the measurement of outcomes including the development of a national mental health dashboard.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215811/dh_124057.pdf

Closing the Gap: priorities for essential change in mental health.

Department of Health (2014)

Closing the Gap sets out the challenge that, although progress is being made, much more needs to happen to achieve the objectives set in No Health Without Mental Health. It identifies twenty-five areas of mental health care and support where there need to be tangible changes within the next two years. These areas are grouped into four themes.

- Increasing access to mental health services
- Integrating physical and mental health care
- Starting early to promote mental wellbeing and prevent mental health problems
- Improving the quality of life of people with mental health problems

Commitments within the report include improving information and intelligence around mental health, involving people in their own care, improved management of mental health crisis and increased integrated working. The report also covers the role of wider stakeholders including criminal justice and schools and supporting people with mental health problems to gain and maintain employment.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

Mental health crisis care concordat: improving outcomes for people experiencing mental health crisis

HM Government (2014)

The Mental Health Crisis Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis. The concordat is arranged around;

- Access to support before crisis point
- Urgent and emergency access to crisis care
- The right quality of treatment and care when in crisis
- Recovery and staying well, and preventing future crisis

Local areas are required to develop a local crisis care concordat agreed by relevant local organisations. In Sandwell the concordat has been co-produced with the Sandwell Mental Health Parliament and is overseen by the health and wellbeing board.
http://www.crisiscareconcordat.org.uk/

Achieving better access to mental health services by 2020

Department of Health / NHS England (2014)

This report builds on *No Health Without Mental Health* and *Closing the Gap* to support parity of esteem for mental health. It identifies that when the report was published there were no waiting time standards for mental health services. The report introduced access standards and waiting times that will be introduced during 2015 to 2016.

- Treatment within 6 weeks for 75% of people referred to the Improving Access to Psychological Therapies programme, with 95% of people being treated within 18 weeks.
- Treatment within 2 weeks for more than 50% of people experiencing a first episode of psychosis.
- A £30 million targeted investment to help people in crisis to access effective support in more acute hospitals.

https://www.england.nhs.uk/wp-content/uploads/2015/02/mh-access-wait-time-guid.pdf

Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16

NHS England (2015)

This report provides detailed guidance on the introduction of access and waiting time standards for mental health services. The report describes the funding support available and the expectations of commissioners and providers in introducing and embedding the standards.

The document aims to;

1. Clarify the requirements of each of the new 15/16 mental health access and waiting time standards and associated expectations of CCG commissioners in line with the planning guidance.
2. Outline the intention to implement access and waiting time standards for eating disorders in community CAMHS from 2016.
3. Update commissioners, providers, commissioning support units, regional and sub-regional teams and wider system stakeholders regarding the national programme of support for implementation of the new access and waiting time standards.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/361648/mental-health-access.pdf

This report is supported by a range of more detailed and technical guidance available from NHS England. https://www.england.nhs.uk/mentalhealth/resources/access-waiting-time/

The five year forward view for mental health

Independent Mental Health Taskforce report to NHS England (2016)

Implementing the Five Year Forward View for Mental Health

NHS England (2016)

The Five Year Forward View for Mental Health sets out the start of a ten-year transformation to the approach to preventing and treating mental health problems. It

makes recommendations about what the NHS needs to do to achieve parity of esteem between mental and physical health for the whole population.

- A 7 day NHS
- An integrated mental and physical mental health approach
- Promoting good mental health and preventing poor mental health

The report makes recommendations about the need for wider action in relation to housing, jobs and social networks. Mental health problems disproportionately affect people living in poverty, people who are unemployed and who already face discrimination. The report has a particular focus on tackling these inequalities.

The implementation report sets out the blueprint for delivery of the five year forward view. It describes five common principles for implementation.

- Co-production with people with lived experience of services, their carers and families
- Working in partnership with local public, private and voluntary sector organisations
- Identifying needs and intervening at the earliest appropriate opportunity
- Designing and delivering person-centred care, underpinned by evidence
- Outcome focused, intelligent and data driven commissioning

https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

Mental health and prevention: taking local action for better mental health
Public Health England / Mental Health Foundation (2016)

Public Health England (PHE) commissioned the Mental Health Foundation to review the evidence for prevention in mental health. It explores the evidence across a number of domains, setting out the case for change, the evidence for intervention and recommendations for action. The report is cross-referenced with the Five Year Forward View for Mental Health. The high-level domains are;

- Whole population approaches
    - Mental health literacy
    - Mentally healthy communities and places
    - Reducing stigma and discrimination
    - Integrated approaches to health and social care

- Life course approach
    - Pregnancy and young people
    - Working age
    - Ageing well

https://www.mentalhealth.org.uk/publications/mental-health-and-prevention-taking-local-action-better-mental-health

Better Mental Health for all: a public health approach to mental health improvement
Faculty of Public Health (2016)

This report focuses on what can be done, individually and collectively, to enhance the mental health of individuals, families and communities by using a public health approach. Its objective is to act as a resource for public health practitioners to support the development of knowledge and skills in public mental health. The report explains why public mental health is essential to improving the health of the population. It outlines the risk and protective factors for positive mental health and addresses approaches and interventions to improve mental health across the life course and in different settings.

The report recognises the lack of robust evidence for what works in improving public mental health, partly due to the complex interactions of the determinants. It calls for an expanded approach to research and methodology to build the evidence base for public mental health. The report finishes with a practical guide to enable practitioners to support their own mental wellbeing.
http://www.fph.org.uk/better_mental_health_for_all

4.2 Local Policy

Sandwell Joint Health and Wellbeing Strategy
The Sandwell Health and Wellbeing Board agreed, following consultation with local people and stakeholders, five new priorities for the next five years. These have been included within a new Joint Health and Wellbeing Strategy (JHWS), which the health and wellbeing board endorsed in March 2016. The main priority for the board is to increase healthy life expectancy in Sandwell. This recognises that the main influences on healthy life expectancy are people's lifestyle choices, and that these choices are heavily influenced, and constrained, by people's mental health and wellbeing and the social determinants of health.

The refreshed Joint Health and Wellbeing Strategy provides a clear partnership strategy describing how all partners will work together to improve the mental health and wellbeing of people of all ages in Sandwell. It will provide a framework for improving wider health and wellbeing and reducing the gap in healthy life expectancy.

Crisis Care Concordat
The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

Local areas are required to develop a local crisis care concordat. Sandwell and West Birmingham CCG are leading on the development of the Sandwell crisis care concordat on behalf of the health and wellbeing board. A partnership planning group is in place and the work is informed by a co-produced plan developed with the third sector through the Sandwell Mental Health Parliament.

Sandwell Mental Health Quality Standards

Sandwell Mental Health People's Parliament is a strategic body led by people with lived experience of mental health difficulties. These people receive training to support them in acting as Members of the Parliament. Its function is to hold decision makers to account for improvements in services and supports so that people who experience mental health difficulties can have an improved quality of life and be in greater control of their own mental wellbeing.

The Mental Health Parliament has developed a series of quality of life standards for mental health services in Sandwell[63]. These standards were developed in coproduction with people who have either current or recent lived experience of mental health problems. The standards have been endorsed by the Sandwell Health and Wellbeing Board and are being incorporated into commissioning by Sandwell and West Birmingham Clinical Commissioning Group.

West Midlands Combined Authority – Mental Health Commission

The West Midlands Combined Authority has commissioned research in to mental health and its impact on the public sector. It is believed this commission is the first of its type in the country

The commission will consider evidence from around the West Midlands region and beyond and it will consider the experiences of real people with real mental health experiences, as well as the knowledge of professional mental health practitioners and mental health organisations. The commission is chaired by Norman Lamb MP, former minister of state for care and support and has identified the following key areas of enquiry:

- Employment and housing
- Early intervention principles
- Criminal justice/troubled individuals
- Role of employers
- Primary care

5. Evidence: National Institute of Health and Clinical Excellence

CG 123 Common mental health problems: identification and pathways to care
This guidance relates to common mental health disorders. These include depression, generalised anxiety disorder (GAD), obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and social anxiety disorder. The report highlights that treatment for up to 90% of diagnosed depressive and anxiety disorders takes place in primary care. These figures may be underestimates because many individuals do not seek treatment, especially for mild disorders. Recognition of these problems in primary care may be low, with recognition of anxiety disorders particularly poor.

The intention of this guideline, which focuses on primary care, is to improve access to services (including primary care services themselves), improve identification and recognition, and provide advice on the principles that need to adoption to develop appropriate referral and local care pathways. It brings together advice from existing guidelines and combines it with new recommendations concerning access, assessment and local care pathways for common mental health disorders.

The key priorities for implementation are;

- Improving access to services
    - Primary and secondary care clinicians, managers and commissioners should collaborate to develop local care pathways that promote access to services.
- Identification
    - Be alert to possible depression (particularly in people with a history of depression, somatic symptoms of depression or a long-term health condition with functional impairment. The guideline recommends two questions to identify depression.
    - Be alert to possible anxiety disorders (particularly in people with a history of anxiety disorder, somatic symptoms or a recent traumatic event. Use the GAD-2 scale.
- Developing local pathways
    - Primary and secondary care clinicians, managers and commissioners should design local care pathways that promote a stepped-care model of delivery. The NICE pathway contains a stepped-care model and an algorithm for identification and assessment.
    - Primary and secondary care clinicians, managers and commissioners should design local care pathways that provide an integrated care programme across primary and secondary care.
    - Primary and secondary care clinicians, managers and commissioners should ensure effective communication about the functioning of the local care pathway.

CG 90 Depression in adults: recognition and management
This guideline makes recommendations on the identification, treatment and management of depression in adults aged 18 years and older, in primary and secondary care. This guideline covers people whose depression occurs as the primary diagnosis; the relevant NICE guidelines should be consulted for depression occurring in the context of other disorders.

The key priorities for implementation are;

- When assessing a person who may have depression, conduct a comprehensive assessment that does not rely simply on a symptom count. Take into account both the degree of functional impairment and/or disability associated with the possible depression and the duration of the episode.
- All interventions for depression should be delivered by competent practitioners. Psychological and psychosocial interventions should be based on the relevant treatment manual(s), which should guide the structure and duration of the intervention. Practitioners should consider using competence frameworks developed from the relevant treatment manual(s).
- Be alert to possible depression (particularly in people with a history of depression, somatic symptoms of depression or a long-term health condition with functional impairment. The guideline recommends two questions to identify depression.
- For people with persistent subthreshold depressive symptoms or mild to moderate depression, consider offering one or more of the following interventions, guided by the person's preference:
    - Individual guided self-help based on cognitive behavioural therapy (CBT)
    - Computerised CBT
    - Structured group physical activity programme
- Guidance on when antidepressants are indicated, they should not be used routinely to treat persistent subthreshold depressive symptoms or mild depression.
- Use of antidepressants and high intensity psychological intervention for moderate to severe depression.
- Continuation of medication for at least 6 months after remission.
- Recommendations for treatment in people at risk of relapse, individual CBT or mindfulness-based cognitive therapy.

CG 91 Depression in adults with a chronic physical health problem: recognition and management
This guideline makes recommendations on the identification, treatment and management of depression in adults aged 18 years and older who also have a chronic physical health problem (such as cancer, heart disease, diabetes, or a musculoskeletal, respiratory or neurological disorder).

The key priorities for implementation are;

- Principles for assessment, take into account both the degree of functional impairment and/or disability associated with the possible depression and the duration of the episode.
- All interventions should be delivered by competent practitioners and based on the relevant treatment manuals.
- Be alert to possible depression in patients with a past history of depression or a chronic physical health problem. The guideline recommends two screening questions.
- The guideline recommends appropriate interventions and treatment for persistent subthreshold depressive symptoms, mild to moderate depression and moderate depression.
- The guideline recommends when antidepressant drugs are appropriate for use with patients.
- Collaborative care is recommended for patients with moderate to severe depression when it has not responded to appropriate treatment.

QS95 Bipolar disorder in adults
This quality standard covers recognition, assessment and management of bipolar disorder (including bipolar I, bipolar II, mixed affective and rapid cycling disorder) in adults (18 years and older) in primary and secondary care

The quality standard states that services for adults with bipolar disorder should be commissioned from and coordinated across all relevant agencies encompassing the whole bipolar disorder care pathway.

The quality standard sets out seven quality statements for care for adults with bipolar disorder;

1. Adults presenting in primary care with symptoms of depression are offered a referral for a specialist mental health assessment if they have experienced over activity or disinhibited behaviour lasting 4 days or more.
2. Adults with bipolar disorder have their early warning symptoms and triggers of relapse, preferred response during relapse and personal recovery goals specified in their care plan.
3. Carers of adults with bipolar disorder are involved in care planning, decision-making and information sharing about the person as agreed in the care plan.
4. (developmental) Adults with bipolar disorder are offered psychological interventions.
5. Adults with bipolar disorder prescribed lithium have their dosage adjusted if their plasma lithium levels are outside the optimum range.
6. Adults with bipolar disorder have a physical health assessment at least annually.
7. Adults with bipolar disorder who currently work, and those who wish to find or return to work, receive supported employment programmes.

CG 178: Psychosis and schizophrenia in adults: prevention and management
This guideline covers the treatment and management of psychosis and schizophrenia and related disorders in adults (18 years and older) with onset before 60 years. The term 'psychosis' is used in this guideline to refer to the group of psychotic disorders that includes schizophrenia, schizoaffective disorder, schizophreniform disorder and delusional disorder. The key priorities for implementation are;

- The use of cognitive behaviour therapy for people at increased risk of developing psychosis and interventions recommended in NICE guidance with any of the anxiety disorders, depression, emerging personality disorder or substance misuse.
- Recommendations regarding appropriate treatment and interventions for first episodes of psychosis.
- Recommendations regarding appropriate treatment and interventions for subsequent acute episodes of psychosis or schizophrenia and referral in crisis
- The promotion of recovery and possible future care

NG 32 Older people: independence and mental wellbeing
This guideline provides recommendations on how older people can be supported to maintain their independence and mental wellbeing. The key recommendations are;

- Support, publicise and, if there is not enough provision, consider providing a range of group, one-to-one and volunteering activities that meet the needs and interests of local older. In particular, target older people who are identified as being most at risk of a decline in their independence and mental wellbeing.
- Provide a range of group activities combining singing programmes, arts and crafts, tailored community based physical activity programmes, intergenerational activities.
- Offer one to one activities such as;
    - Programmes to help people develop and maintain friendships
    - Befriending opportunities
    - Information and advice on available services
- Make older people aware of the value and benefits of volunteering and provide opportunities.
- Recommendations on identifying those at most risk of a decline in their independence and mental wellbeing.

CG 192: Antenatal and postnatal mental health: clinical management and service guidance
General guidance

- Guidance on areas for discussion and advice for women who have a new, existing or past mental health problem.
- Guidance on recognising mental health problems in pregnancy and the postnatal period and appropriate referral. This includes the use of the 2 item generalized anxiety disorder scale (GAD-2)
- The development of clinical networks for perinatal mental health services managed by a coordinating board of healthcare professionals, commissioners, managers and service users and carers.

During pregnancy and the postnatal period

- Develop an integrated care plan which includes care of the mental health problem and which identifies the responsibilities of the professionals involved.
- Advice that should be provided by mental health professionals to the woman and other professionals.
- Advice on starting, using and stopping treatment for mental health problems during pregnancy and the postnatal period, including specific advice on different types of medication
- Care for women who have experienced a traumatic birth, stillbirth or miscarriage.

CG113 Generalised anxiety disorder and panic disorder in adults: management
Generalised anxiety disorder (GAD) is one of a range of anxiety disorders that includes panic disorder (with and without agoraphobia), post-traumatic stress disorder, obsessive–compulsive disorder, social phobia, specific phobias (for example, of spiders) and acute stress disorder. Anxiety disorders can exist in isolation but more commonly occur with other anxiety and depressive disorders. This guideline covers both 'pure' GAD, in which no comorbidities are present, and the more typical presentation of GAD comorbid with other anxiety and depressive disorders in which GAD is the primary diagnosis. NICE is developing a guideline on case identification and referral for common mental health disorders that will provide further guidance on the identification and treatment of comorbid conditions.

The key priorities for implementation are;

Identification: identify and communicate the diagnosis of GAD as early as possible to help people understand the disorder and start effective treatment promptly.

The remaining guidance provides a stepped approach to treatment of GAD. The level of treatment is dependent on severity of symptoms and response to treatment at each step.

G16: Self-harm: short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care
This guideline makes recommendations for the physical, psychological and social assessment and treatment of people in primary and secondary care in the first 48 hours after having self-harmed.

This guidance includes statements about the experience of service-users who have self-harmed and the challenging nature of this work.

- The experience of care for people who self-harm is often unacceptable. All healthcare practitioners involved in the assessment and treatment of people who self-harm should ensure that the care they offer addresses this as a priority.
- Providing treatment and care for people who have self-harmed is emotionally demanding and requires a high level of skills. All staff undertaking this work should have regular clinical supervision in which the emotional impact upon staff members can be discussed and understood.

The key priorities for implementation are;

- People who have self-harmed should be treated with the same care, respect and privacy as any patient. In addition, healthcare professionals should take full account of the likely distress associated with self-harm.
- Ensuring all staff that may meet someone who has self-harmed should have appropriate training.
- Activated charcoal should be immediately available in all settings where care is needed for people who have self-harmed by poisoning.
- Guidance on triage of people who have self-harmed including use of the Australian Mental Health Triage Scale and providing an appropriate safe and supportive environment.
- Guidance on treatment, including addressing the physical consequences of the self-harm and assessment of physical, emotional and social needs.
- Risk assessment for the individual.
- Psychological, psychosocial and pharmacological interventions where appropriate.

CG 133: Self-harm: longer-term management

This guideline is concerned with the longer-term psychological treatment and management of both single and recurrent episodes of self-harm, and does not include recommendations for the physical treatment of self-harm or for psychosocial management in emergency departments. The guideline is relevant to all people aged 8 years and older who self-harm, and it addresses all health and social care professionals who come into contact with them. Where it refers to children and young people, this applies to all people who are between 8 and 17 years inclusive.

- Guidance for professionals on the principles that should be applied when working with people who self-harm.
- Use of integrated and comprehensive psychosocial assessment of needs.
- Detailed guidance for the risk assessment of people who self-harm or are at risk of suicide. The guideline states that risk assessment tools and scales to predict future suicide or self-harm should not be used.
- The use of care plans and the aims of longer term treatment which have been discussed and agreed with the individual.
- The use of risk management plans which should be a clearly identifiable part of the overall care plan.
- Offering 3 to 12 sessions of psychological interventions that are specifically structured for people who self-harm.
- The treatment of associated mental health conditions including psychological, pharmacological and psychosocial interventions.

CG 31: Obsessive compulsive disorder
This guideline provided detailed guidance on services for people, adults and children, with obsessive compulsive disorder and body dysmorphic disorder. This summary covers the guidance relevant to children and young people.

General guidance

- All organisations that provide mental health services should have access to a specialist obsessive-compulsive disorder (OCD)/body dysmorphic disorder (BDD) multidisciplinary team offering age-appropriate care.
- OCD and BDD can have a fluctuating or episodic course, or relapse may occur after successful treatment. Therefore, people who have been successfully treated and discharged should be seen as soon as possible if re-referred with further occurrences of OCD or BDD, rather than placed on a routine waiting list.

Children and young people with OCD or BDD

- The guideline recommends a stepped approach based on the severity of the condition and the level of functional impairment experienced. This is based on the use of CBT as a first intervention and the use of pharmacological interventions (SSRI) where this is not effective. This treatment should involve the family or carers and be suited to the developmental age of the child or young person.

CG 9: Eating disorders
This provides guidance on the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. The priorities for implementation within the guidance are;

Anorexia nervosa

- Most people should be managed on an outpatient basis from a service with the relevant specialist knowledge and experience.
- Where in-patient treatment is needed this should be in a specialist unit.
- Family interventions that directly address the eating disorder should be offered to children and adolescents.

Bulimia Nervosa

- A possible first step is an evidence based self-help programme.
- Adults may be offered a trial of an antidepressant drug and a specifically adapted form of CBT (CBT-EN).
- Adolescents may be treated with CBT-EN adapted to their age and including the family as appropriate.

Atypical eating disorders

- It is recommended that treatment follows the guidance on the treatment of the eating problem that most closely resembles the individual patient's eating disorder.

CG72 Attention deficit hyperactivity disorder: diagnosis and management
This guideline recommends an evidence based approach to diagnosis and treatment of attention deficit hyperactivity disorder.

The guideline includes recommendations on;

- Organisation and planning of local services
- Information, consent and support for people with ADHD and their carers
- Training of healthcare and education professionals
- Identification, pre-diagnostic intervention in the community and referral to secondary services
- Identification and referral in adults with ADHD
- Dietary and general advice
- Treatment for children and young people
- Pre-drug treatment assessment and medication
- Transition to adult services
- Treatment of adults with ADHD

PH48 Smoking: acute, maternity and mental health services
Stopping smoking at any time has considerable health benefits for people who smoke, and for those around them. For people using secondary care services, there are additional advantages, including shorter hospital stays, lower drug doses, fewer complications, higher survival rates, better wound healing, decreased infections, and fewer re-admissions after surgery.

Secondary care providers have a duty of care to protect the health of, and promote healthy behaviour among, people who use, or work in, their services. This duty of care includes providing them with effective support to stop smoking or to abstain from smoking while using or working in secondary care services.

This guidance aims to support smoking cessation, temporary abstinence from smoking and smoke free policies in all secondary care settings. It recommends:

- Strong leadership and management to ensure secondary care premises (including grounds, vehicles and other settings involved in delivery of secondary care services) remain smoke free –to help to promote non-smoking as the norm for people using these services.
- All hospitals have an on-site stop smoking service.
- Identifying people who smoke at the first opportunity, advising them to stop, providing pharmacotherapy to support abstinence, offering and arranging intensive behavioural support, and following up with them at the next opportunity.
- Providing intensive behavioural support and pharmacotherapy as an integral component of secondary care, to help people abstain from smoking, at least while using secondary care services.

- Ensuring continuity of care by integrating stop smoking support in secondary care with support provided by community-based and primary care services.
- Ensuring staff are trained to support people to stop smoking while using secondary care services.
- Supporting all staff to stop smoking or to abstain while at work.
- Ensuring there are no designated smoking areas, no exceptions for particular groups, and no staff-supervised or staff-facilitated smoking breaks for people using secondary care services.

Wider NICE guidance

Other NICE documents relate to mental health and wellbeing but are outside of the scope of this JSNAA.

- Mental wellbeing in over 65s: occupational therapy and physical activity interventions
- Autism in adults: diagnosis and management.
- Violence and aggression: short-term management in mental health, health and community settings.
- Mental wellbeing at work
- Workplace health management practices

NICE guidance under development

- Healthy workplaces, improving employee mental health and physical health and lowering sickness absence (Jan 2017)
- Mental health problems with learning disability – quality standard (Jan 2017)
- Mental health of adults in contact with the criminal justice system (Feb 2017)
- Severe mental illness and substance misuse (dual diagnosis) – community health & social care services (Nov 2016)
- Transition between inpatient mental health settings and community and care home settings (Guideline Aug 2016, Quality Standard July 2017)

6. Service Mapping

Twenty-three mental health providers in Sandwell responded to a service-mapping questionnaire. The services included provide support for wellbeing, low-level mental health problems and severe and enduring mental health problems. In addition to targeting mental health, many services offer social and supportive care services. In some cases, these services extend to the patient's family and carers.

Tables 9 and 10 provide a list of these mental health providers, organised by commissioning organisation.

6.1 Mental health providers commissioned by Sandwell and West Birmingham Clinical Commissioning Group

Table 9: Mental health providers commissioned by the Clinical Commissioning Group

Name of Service	No. of users (approx. per annum)	Activities Provided
P3 Cooperage Court	52	24 hours supported housing Support customers' needs including alcohol and substance misuse, mental health, offending, complex and chaotic behaviour
Sandwell African Caribbean Mental Health Foundation	150	Counselling for individual, couples or family therapy. Outreach support service to offer practical support. Ujima user-led service. Mentoring, volunteering opportunities, organising social activity co-production. Carers support service.
Kaleidoscope (Community Wellbeing and Khushi)	9500 attendances	Group therapies: Self-help support groups, educational and vocational groups Individual therapies; Eco therapies Social, leisure and physical groups and events Information, advice and signposting
Kaleidoscope (IAPT – Improving Access to Psychological Therapies)	2000	Cognitive behavioural therapy (CBT) interventions 6-8 sessions each session lasting approximately 45 min - 1 hour through face to face, telephone, email and text.
Mental Health Team (Street Triage)	797	Attend scenes / provide telephone advice to 999 services regarding persons experiencing a mental health crisis. Triage and signposting into mental health services.
The Wellbeing Hub	12,500	Acts as a single point of access for Primary Care. All referrals triaged by a Clinical Duty Officer. Emotional and Mental Health Services and Support
Treatment Teams North and South	1894	MH and other professional specific assessments, risk assessments and management. PA framework including care/crisis planning, 1:1 intervention with specific professionals.

		Recovery Model including WRAP plans, psycho-education, psychological interventions/Talking Therapies including CBT/SFT/DBT, Assertive Engagement, Access to a Duty Officer. Signposting to appropriate services, joint work with other services and agencies, medication administration and monitoring, MH/Physical health comorbidity monitoring, social needs assessment, group work.
Therapy and recovery unit	384 per annum	Therapeutic Group work
Single Point of Referral Service	2467	Screening, triage and assessment of all referrals into the service. Clinicians are also able to provide short term solution focussed interventions and to provide advice and information to non-mental health medical and nursing staff
Criminal Justice Team	340	Assessments, liaison and joint working with other services and agencies, Psychological/Talking Therapies including CBT, MH monitoring, signposting, risk assessments and management, Coping strategies, psycho-education.
Mental Health Liaison Team at Sandwell A&E	1086	Psychosocial assessment of patients in ED, including risk assessment, liaison with stat and non-stat services, safe discharge planning. Signposting and referral into appropriate community, or inpatient service. Teaching to colleagues within the acute trust regarding mental health related issues.
Early Intervention Service in First Episode Psychosis	130	CBT informed care (e.g. Graded Exposure and Behavioural Activation). NICE level Family Therapy, Family Intervention Brief Family Therapy, Psycho-Social Training, Relapse prevention Social groups, Vocational support, Occupational Therapy assessment and intervention, Family support groups Physical health monitoring, Welfare rights advice
Crisis and Home Treatment Team Adults	1059	Assess and treat Service users in their Home environment. Assessment 24 hours a day, 7 days a week. The team responds to requests for assessment from Accident and Emergency Departments; Mental Health Liaison teams and Single Point of Referral services, or signpost to appropriate others. Assessing admissions into adult acute wards in Sandwell, and face to face in reach / contact within 48hours. Wellness Recovery Action Plan (WRAP) Provide psychological approaches and Interventions. E.g. Mindfulness, relaxation, techniques for managing difficult experiences and emotions. Advocate for Service Users, Carers and Relatives
Sandwell IAPT	Information not yet available	Predominantly counselling and structured psychological therapies CBT, psycho-education

		psychological interventions and group work
Recovery College	50	Coproduced Educational courses Opportunities for people with lived experience to undertake volunteering roles Opportunities for people to coproduce /co-facilitate courses to share experiences.

6.2 Mental health providers commissioned by Sandwell Metropolitan Borough Council

Table 10: Mental health providers commissioned by SMBC

Name of Service	No. of users (approx. per annum)	Activities Provided
SMBC (Specialist Employment Team)	175	Support to find and sustain paid employment.
Kaleidoscope (Nicholl Grange)	15-20	14 bed registered care home for people with mental health problems. 24 hour staffing. Residents in these flats budget and shop for their own food, and prepare it themselves.
Kaleidoscope (Mental Health Grant)	3,653	Promote the preservation and the safeguarding of mental health and the relief of persons suffering from mental disorder through the provision of a range of care, support and advisory services. Covers organisational activities and community engagement and development of services
Kaleidoscope (SORT - Floating Support)	150 - 200	Provides support with daily living ie, bills, finances and routine household tasks. Services does not offer personal care, however are able to refer to other agencies who can help.
Ideal for All (Growing Opportunities)	691	Health and wellbeing activities utilising community garden sites. Variety of community based programmes: healthy eating/cooking, therapeutic gardening, floristry, seasonal crafts, packaging and distribution of produce, money management, keeping active outdoors and learning and skills development.
Ideal for All (Independent living services)	>4000	Information and advice on disability-related issues. Promoting and encouraging participation of disabled people, their families and carers in services and activities. Occupational Therapy (OT) Service: information and advice on daily routine, leisure or work activities. Drop in Duty Service: provides equipment for maintaining independence. Fibromyalgia, Arthritis, Deaf and Hard of Hearing support groups.

		Employment and Skills development provide a range of employment training and courses, including a high level of learning support. Young people peer support group offers young people from the age of 14 to 25 not in education, employment or training.
Pohwer IMHA	264	Comprehensive support and advocacy under the MHA - Information and Advice/ signposting. Aspects of the MCA / Equality Act
Community Mental Health Team	500 +	Intervention under 1983 Mental Health Act Assessment/review/care management Duty service/advice/signposting.

6.3 Access to Mental Health Providers

Operating Hours

Most services were available during normal working hours of 0900 to 1700. with a small number providing out of hours services.

Services that offer accommodation are listed below as operating 24 hours a day. The rest operating between 12 and 24 hrs are services specialising in assessment and triage, and/or severe mental health disease. The information gathered is summarised in table 11.

Table 11: Service operating hours

Weekdays 0900-1700	
Sandwell African Caribbean Mental Health Foundation	Criminal Justice Team
Community Mental Health Team	Sandwell IAPT
The Wellbeing Hub	Recovery College
Treatment Teams North and South	SMBC (Specialist Employment Team)
Therapy and recovery unit	Pohwer IMHA
Single Point of Referral Service	Ideal for All (Growing Opportunities)
Ideal for All (Independent Living Services)	
Out of Hours on a needs basis	
Kaleidoscope (IAPT – Improving Access to Psychological Therapies)	evenings and weekends by arrangement
Kaleidoscope (Mental Health Grant)	Out of hours on a needs basis.
Kaleidoscope (SORT - Floating Support)	Out of hours on a needs basis.
Out of Hours	
Kaleidoscope (Nicholl Grange)	24/7
Mental Health Team (Street Triage)	10am-2am Sun – Thurs 10am-3am Fri and Sat
Crisis and Home Treatment Team Adults	24 hour service 7 days a week
Mental Health Liaison Team at Sandwell A&E	08.00-22.00 covering ED for all

	ages 18 and over; Mon-Fri 08.00-16.00 for Older Adults referred from the wards
Early Intervention Service in First Episode Psychosis	8am – 8pm
Kaleidoscope (Community Wellbeing and Khushi)	6 days a week evenings and day times
P3 Cooperage Court	24 hours

6.4 Referral Pathways

Twelve services accepted referrals from anyone (individual, family, and health professionals), whereas others only accepted referrals from professionals within the multidisciplinary team, or via specific routes such as the Wellbeing hub.

Thirteen mental health services reported that they accept self-referrals. This is summarised in table 12.

Table 12: Referral pathways and routes

Mental Health Provider	Accepts Referrals From:	Self-referrals?
Crisis and Home Treatment Team Adults	Anyone	No
Mental Health Liaison Team at Sandwell A&E	Any clinician from the MDT within the acute trust	No
Early Intervention Service in First Episode Psychosis	Anyone	Yes
Kaleidoscope (Community Wellbeing and Khushi)	Anyone	Yes
P3 Cooperage Court	Accepts referrals from Black Country Foundation Trust Crisis Home Treatment Team only	No
Mental Health Team (Street Triage)	Police and Ambulance	No
The Wellbeing Hub	Anyone	Yes
Treatment Teams North and South	GPs, others services and agencies, other Trusts, internal teams and services including wards/acute, outpatients, medics, crisis team etc.	No
Therapy and recovery unit	Consultants psychiatric nurse, occupational therapy ,Memory service	No
Single Point of Referral Service	GP's, Psychiatric outpatients, IAPT, A&E and any other health professional	No
Criminal Justice Team	GPs, police, court, probation, prison	Yes
Sandwell IAPT	GPs, others services and agencies, other Trusts, internal team.	Yes
Recovery College	Self-referral only	Yes
Sandwell African Caribbean Mental Health Foundation	Individual, health professional and families	Yes
Ideal for All (Growing opportunities)	Anyone	No

Ideal for All (Independent Living Services)	Anyone	No
Pohwer IMHA	Individual, health professional and families	Yes
SMBC (Specialist Employment Team)	Anyone	Yes
Community Mental Health Team	Anyone	Yes
Kaleidoscope (IAPT – Improving Access to Psychological Therapies)	Via the Wellbeing Hub	Yes
Kaleidoscope (Mental Health Grant)	TBC	TBC
Kaleidoscope (SORT - Floating Support)	Anyone	Yes
Kaleidoscope (Nicholl Grange)	Anyone	Yes

Crisis referrals are accepted by nine services:

1. Crisis and Home Treatment Team
2. Mental Health Liaison Team at Sandwell A&E
3. Kaleidoscope (Community Wellbeing and Khushi)
4. P3 Cooperage Court
5. Mental Health Team (Street Triage)
6. Community Mental Health Team
7. Kaleidoscope (IAPT – Improving Access to Psychological Therapies)
8. Kaleidoscope (SORT - Floating Support)
9. Kaleidoscope (Nicholl Grange)

The other services do not accept crisis referrals, and almost exclusively refer/signpost to the Crisis Team, Emergency Department or Mental Health liaison service.

6.5 Waiting Lists

Most mental health providers taking crisis referrals do not have a waiting list. For services that do have a waiting list, waiting times range from between 5 to 42 days, with an average of 18 days. This is summarised in table 13.

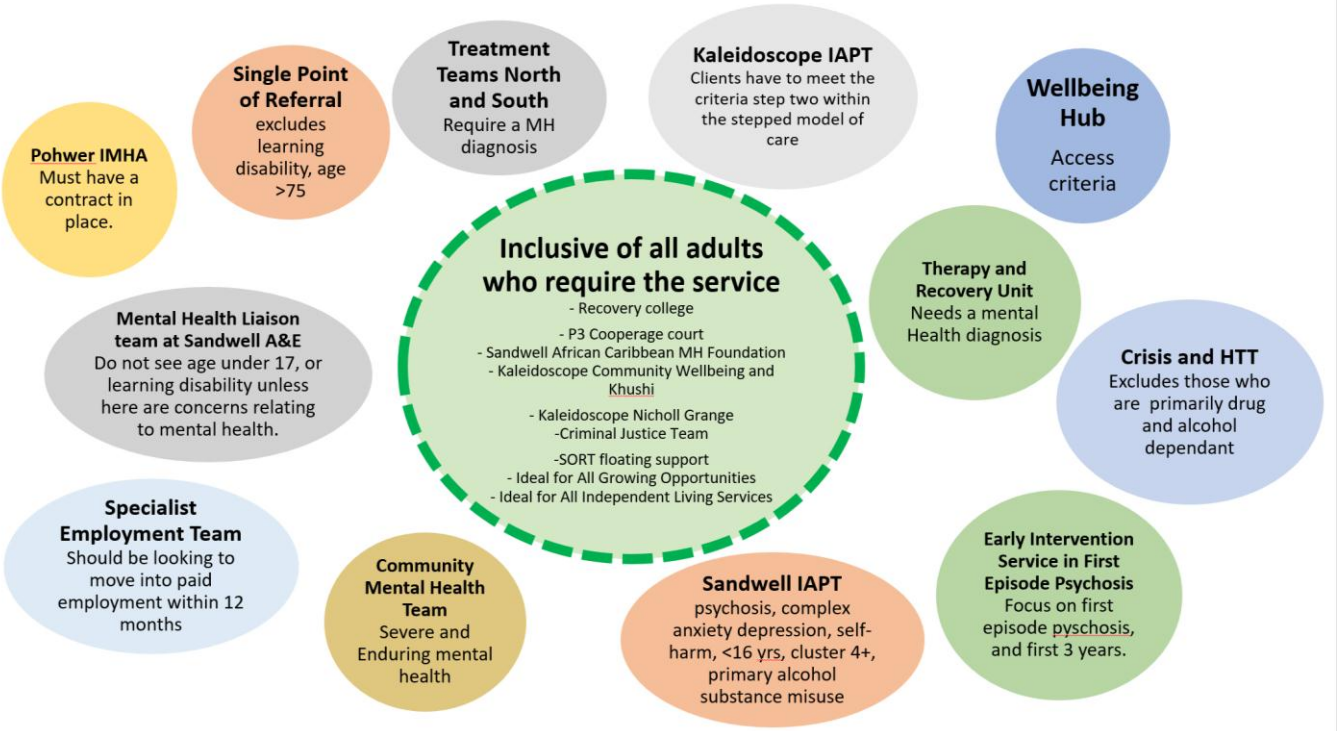
Table 13: Waiting lists

Service	**Waiting List?**	**How long (days)?**
Crisis and Home Treatment Team Adults	No	
Mental Health Liaison Team at Sandwell A&E	No	
Early Intervention Service in First Episode Psychosis	Yes	8
Kaleidoscope (Community Wellbeing and Khushi)	No	
P3 Cooperage Court	No	
Mental Health Team (Street Triage)	No	
The Wellbeing Hub	No	
Treatment Teams North and South *Data systems under review, accurate current position not available	Yes	(28)* target time

Therapy and recovery unit	Yes	16
Single Point of Referral Service	Yes	25
Criminal Justice Team	Yes	5
Sandwell IAPT	Yes	28
Recovery College	Yes	14
Sandwell African Caribbean Mental Health Foundation	Yes	5
Ideal for All (Growing opportunities)	No	
Ideal for All (Independent Living Services)	No	
Pohwer IMHA	Yes	5
SMBC (Specialist Employment Team)	Yes	5
Community Mental Health Team	No	
Kaleidoscope (IAPT – Improving Access to Psychological Therapies)	Yes	42
Kaleidoscope (Mental Health Grant)	TBC	
Kaleidoscope (SORT - Floating Support)	No	
Kaleidoscope (Nicholl Grange)	No	

6.6 Exclusion Criteria

Exclusion criteria set out by the mental health service provider are describes in the figure below. Several services (ie, Therapy and recovery unit, Treatment Teams North and South, and Community Mental Health Team) require a pre-existing mental health diagnosis. Some services such as The Wellbeing Hub and Kaleidoscope IAPT specified they do have criteria, but did not give details.



6.7 Non Mental Health Providers

Twenty non-mental health providers, who have contact with service users who have mental health problems, were asked to participate in a questionnaire. The aim was to understand the characteristics of their service users with mental health problems, and how well equipped the service provider felt they were at managing their mental health needs.

This needs assessment has demonstrated the contribution from non-mental health providers in supporting vulnerable people and people with mental health problems. This support is helping people to maintain their independence and may be reducing the demand for mainstream mental health services. It is important that this contribution is fully recognised and that all partners work together to join up mainstream and non-mainstream services to better support local people.

One possible approach is through social prescribing. Social prescribing is a way of linking patients in primary care with sources of support within the community. It provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and well-being. While there is no widely agreed definition of social prescribing, or 'community referrals', reports on social prescribing include an extensive range of prescribed interventions and activities[64]. The Care Services Improvement Partnership has published a guide on social prescribing for mental health, commissioning and delivery[65].

Non-mental health providers:

1. Ideal for All Growing Opportunities
2. Carers Advice & Resource Establishment, Sandwell (CARES)
3. Fry Housing Trust
4. West Midlands Ambulance Service
5. Trident Reach
6. SHARP
7. Healthy Sandwell, Public Health
8. Tipton COG
9. Midland heart
10. Sandwell Libraries
11. West Midlands Police
12. Sandwell Women's Aid
13. P3
14. IRiS Sandwell
15. action on hearing loss
16. Agewell CIC
17. Citizens Advice Sandwell
18. KeyRing Living Support Networks
19. YMCA Black Country Group Supported Lodgings
20. Swanswell

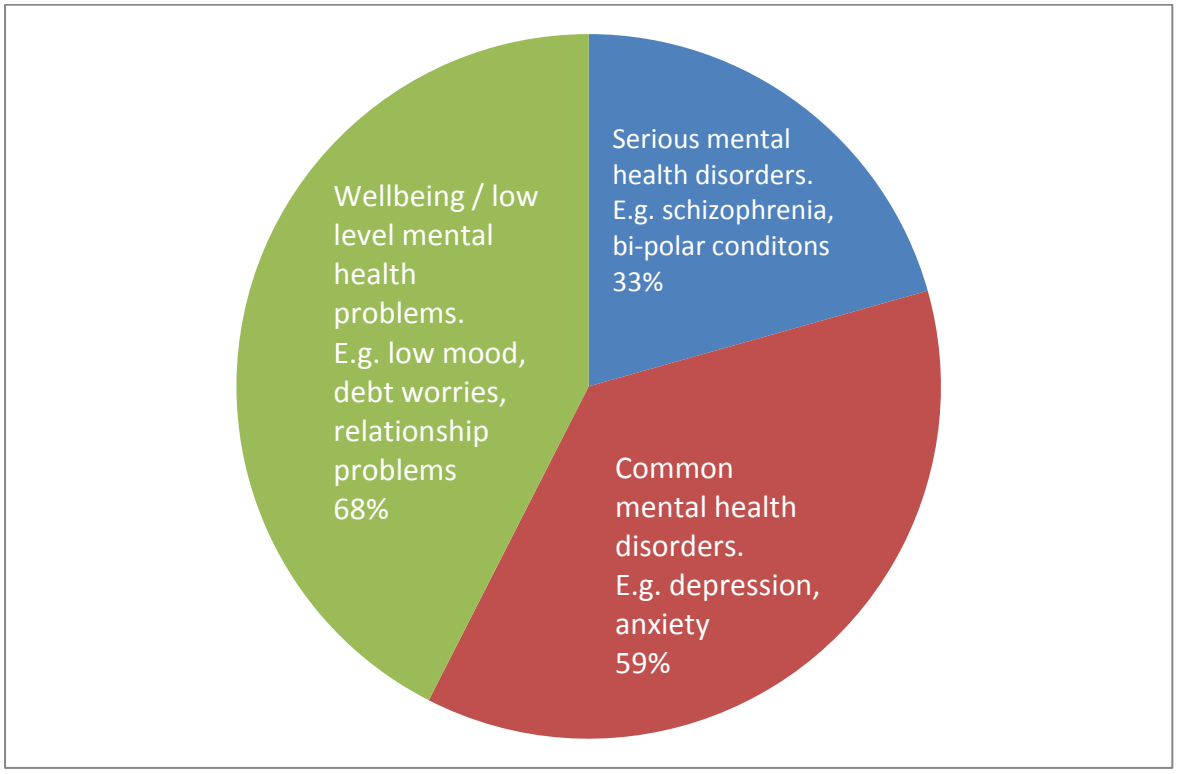
We asked the non-mental health providers “What proportion of the people you work with experience the following levels of mental health and wellbeing?” with 3 categories of mental health severity:

1. Wellbeing/low level mental health issues like low mood, debt worries, poor relationships
2. Common mental health disorders: Like depression, anxiety
3. Serious mental health illness: like bi-polar, schizophrenia

For each category, the options were **0%, 25%, 50%, 75%** or **100%**.

Figure 14 shows the results. The majority of service users had wellbeing and low-level mental health issues. One third of the service users had serious mental illness.

Figure 14: Levels of mental health and wellbeing problems in services



We also asked how well the non-mental health service providers felt they were meeting the needs of their service users with mental health problems: Table 14 summarises the responses received.

Table 14: How well providers feel they meet the needs of service users

Provider	To what extent do you feel you are doing well?
Swanswell action on hearing loss KPG Sandwell Women's Aid	Very well
Tipton COG Midland heart Sandwell Libraries West Midlands Police KeyRing Living Support Networks Carers Advice & Resource Establishment, Sandwell (CARES) Healthy Sandwell, Public Health Ideal For All SHARP West Midlands Ambulance Service YMCA Black Country Group Supported Lodgings	Fairly well
IRiS Sandwell Citizens Advice Sandwell Trident Reach Sandwell MBC Healthy Sandwell, Public Health Fry Housing Trust	Not very well

6.8 Non mental health providers: referral pathways

We asked non-mental health providers about the referral pathways into their services.

We found that most routine referrals are either to the client's GP or to the Wellbeing Hub. Other referrals are to various support groups, employment support, welfare rights, friendship groups and community services.

The police refer to Street Triage, Psychiatric Liaison (Mental Liaison team Sandwell A&E) and Crisis team and use the Mental Health Act and Mental Capacity Act,.

Referral pathways are not adequately catering for clients with sensory deprivation such as hearing loss. Action on Hearing Loss reported that there are almost no routes for deaf people to access services and reported that they are often sent away and told to come back with an interpreter.

How effective are the referral pathways into mainstream mental health services?

The non-mental health providers were asked, from their experience, about the effectiveness of current referral routes into mental health services. They reported positive experiences of making referrals to Adult Services, the Crisis team and for group activities with Kaleidoscope Plus.

They also reported a range of negative experiences when referring into mental health services. These include;

- Long waiting times, either for the first appointment or between the first assessment and starting treatment.
- Inconsistent responses to referrals.
- A lack of feedback from the service that received the referral.
- Difficulties in accessing services for some vulnerable groups, including people with hearing impairments and people with alcohol and substance misuse problems.
- Transitions between children's and adults services can be problematic.

Table 15 shows the comments from a range of stakeholders regarding the effectiveness of existing referral pathways.

Table 15: Effectiveness of referral pathways

Positives	Negatives
• Adult service referrals are effective because there is feedback or two-way communication regarding clients. • In a crisis, we contact the Crisis Team and generally the response is good.	**Waiting times and communication** • Waiting times can be long, effective sometimes, not consistent service. • Timescales for other agency response is adequate however different services have

• When we need emergency services for support the response is also good. • Kaleidoscope: Waiting times for the groups provided is within 24 hours.	different sections that may not respond equally well dependent upon demand. • Referrals to counselling services and psychology take a while due to their waiting list. • Referrals to the Wellbeing Hub: We have experienced offer of assessment appointments are fairly quick but follow on appointments can take up to 12 weeks • Referrals for structured one to one sessions can wait up to 12 weeks. • No feedback from GPs or Primary Care Teams. • With Wellbeing Service there is only signposting and there is no feedback or follow up **Vulnerable groups** • Almost no routes for deaf people to access, no interpreters provided at initial enquiry stage. Deaf people are usually sent away by well-meaning staff and told to come back with an interpreter. • Referrals to IRiS Dual Diagnoses Service: IRiS provide the dual diagnoses service for Sandwell residence. Waiting times can be up to 3 weeks • Referrals to the Wellbeing Hub: We can experience blockages with referrals due to some of our client's level of alcohol use • **Transition** • When a Young Person turns 18, there is a lack of continuity for them and I don't think the transition is always as smooth as it could be.

6.9 Non mental health providers: suggested improvements to mental health services

The non-mental health providers were asked for suggestions on how access to mental health services could be improved.

Information and awareness

- Providers and service users need improved access to information about access and pathways.
- There needs to be a greater awareness of services, the defined access criteria and a clear and defined service offer.
- Hold open days/ "market place" events so staff can meet each other and understand roles/ functions

Joint working

- An agreement is needed on joint working protocols between agencies for Dual Diagnosis clients.
- To make referrals rather than signposting and include follow as part of the pathway, with the wellbeing service in particular.
- Explanations and notifications fed back to the referrer if cases are not accepted, including guidance on possible alternative provision.
- Links between primary care and the police to enable the police to pass on concerns regarding people about who they have concerns.

Crisis and emergency pathways

- Another option to A&E and the Mental Health Act. The suggestions were for an alternative to these options for people who are experiencing a mental health crisis but who could be supported without admission to secondary care. One option suggested was a community place of safety outside of hospital or secondary care provision.

Making referrals and assessment

- Shorter waiting times, easier referrals as some can only be made by professionals.
- Being able to phone to make appointments for clients while the client is with us.
- Currently, the service is not able to refer directly to tier three mental health services, referrals have to be made via the clients G.P. It would reduce the wait to access tier three mental health services, if medical staff (nurses and non- medical prescribers) were able to directly refer.
- Direct support from our local mental health service for Swanswell patients when they are in crisis. Immediate access to telephone assessment may prevent the need call to 111/request an ambulance/police presence.

Training

- Ensure staff are trained on what to do if they have a referral from a deaf person.

6.10 Patient and service users experience of accessing mental health and wellbeing services

We collated comments from people with lived experience of mental health services on access to mental health services. This built on themes that had emerged from previous consultations undertaken by Changing our Lives, a third sector rights based organisation which supports the Sandwell People's Mental Health Parliament. This included

- Approximately 40 responses expressing views on mainstream mental health and wellbeing services which are commissioned and provided by the NHS, Sandwell Council and the voluntary and community sector.
- The service areas and themes included:
    - Accident and emergency
    - Crisis and home treatment
    - Experience with the police
    - Talking therapies
    - Referral routes/waiting times
    - Vulnerable and minority ethnic groups
    - Recovery and staying well, groups (treatment & self-help)
    - Patient and mental health advocacy groups

There are limitations in the range of consultation responses received. While they may not be wholly representative, as individual responses, they remain valid. No responses were received from people accessing primary care for mental health support. Future consultations will be planned to capture a wider range of responses.

Some of the negative and positive comments we received about accessing mental health and wellbeing services are shown below in table 16.

Table 16: Access to mental health services: positive and negative stakeholder responses

Negatives	Positives
• Long waits and difficulties accessing out of hours - A&E, Crisis Team, Home Treatment, CBT, CPN, and psychologist • Some negative experience with the police, lack of police awareness/training • Talking therapies: access, thresholds to receive treatment – not ill enough *(to be treated).* • Cancelations, one chance to turn up or the referral process has to start all over again. • Mainstream mental health services not understanding or meeting cultural needs & lack of knowledge of availability of culturally sensitive services. • Asking GP repeatedly for help, having to self-refer • Refusing to treat people with drug or alcohol problems • Recovery model – hospital should be the last resort, being discharge home too early • Groups can create dependency need to normalise recovery	• not a long waiting list (IAPT) • Ability to self -refer and easy access (Kaleidoscope Plus Group) • Positive, quick and easy access to culturally sensitive services (Sandwell African Caribbean Health Foundation) • positive staff attitude/approach (A&E) • Fast access to talk to someone about my mental health (KPG) • Peer groups, Mental Health Parliament • Groups - you can just turn up for immediate access (PIM & Wellbeing Group) Meeting others with mental health problems

6.11 Patients and service users: what could make things better?

The patients and service users were asked what changes would improve mental health services. They said that there is a need to recognise where things are working well and build on these to address the problems with services. Suggestions for improvements included:

- The development of a single partnership point of access into mental health services
- Support for GP's to provide them with more information on what services are available,
- Providers to have a diverse staff team trained in cultural understanding and awareness. Development of more choice in culturally sensitive services
- Recovery support should be available in the community. People in recovery should be supported in taking part in normal community based activities rather than mental health service based activities., doing normal things in the community,
- Develop peer support for people in recovery
- More and longer group sessions

The Crisis Care Concordat Action Plan in Sandwell was co-produced by people who with lived experience of mental health crisis. All partners should commit to delivery of the action plan themes;

- Access to support before a crisis
- Urgent & emergency aces to crisis care
- Recovery & staying well/preventing further crisis
- Quality of treatment & care when in a crisis

The Quality of Life Standards launched by the Sandwell Mental Health People's Parliament must be fully implemented. These standards were developed to ensure everyone gets good quality support that promotes good mental health and wellbeing, prevents mental ill health and enables recovery when a person becomes mentally unwell. All partners should include these standards in the commissioning of services.

7.0 Workforce development

As part of service mapping, providers were asked about the training their staff received on mental health and wellbeing. Mainstream mental health providers had a wide range of training depending on the staff group concerned.

- A wide range of service based and professional training,
- Training related to continuing professional development
- Mandatory training including safeguarding and in-house training
- Suicide Prevention training – ASIST & STORM,
- Mental Health First Aid

We also asked non-mental health service providers what training their staff had received. For these providers the responses were far broader.

- Responses ranged from 'very little' to a number of service specific training, informal and in-house training, basic mental health awareness/training (KPG) including Mental Health First Aid and ASIST
- Non-mental health providers suggested that joint training with mainstream mental health services would be beneficial, for example, joint training for police officers on mental health and wellbeing and managing people experiencing mental health crisis.

Suggestions were also received on what further training is needed:

- On-going, regular and refresher training from basic awareness, different agency perspectives, to specific areas e.g. bereavement, impact of medication, dealing with difficult situations and complex mental health needs.
- These could be delivered by mental health services and combined input e.g. mental health professional and specialist police officer

The information gathered on workforce development and training was limited to brief descriptions of the training provided. This demonstrated that;

- There is a wide range of training underway across mainstream mental health services and non-mental health providers.
- Some of this training, especially for non-mental health providers, is small scale and may be duplicated across a number of organisations.
- Non-mental health providers reported that their staff needed better training. Current training is often aimed at raising awareness of mental health problems. This does not provide staff with the knowledge and skills they need to support people with mental health problems.

Appropriately trained and supported staff are essential to the delivery of high quality and effective services. For statutory organisations, there are clear guidelines and requirements for staff training.

The needs assessment has identified the contribution of non-mental health providers in supporting people with mental health problems, and that this helps people to maintain their mental health and independence. The review of current workforce development and training, while limited, has shown that these providers would benefit from improved training for their staff to equip them with improved knowledge and skills.

The service mapping, and conversations with providers, has also shown that there is scope for reviewing and rationalising training across Sandwell. This could provide an improved training offer while ensuring consistency in knowledge and skills across providers in different sectors.

8.0 Feel good 6 Wellbeing Activity in Sandwell

Sandwell Feel Good 6 is a population wellbeing campaign. It aims to;

- Raise awareness and getting people talking about wellbeing
- Recognising and building on what is already happening
- Provide tools that partners can use with local people to help improve wellbeing

The campaign is based on the New Economics Foundation five ways to wellbeing that help to maintain mental health and wellbeing [66]. In Sandwell, we have included 'talk' as a sixth way to wellbeing.

- **Connect**: Meet up, build relationships, make friends
- **Move**: Whatever you can do, being active makes you feel good
- **Notice**: Take time, focus on the moment, enjoy the outdoors
- **Learn**: Try something new, see what's out there, surprise yourself
- **Give**: Give your time, do something nice for someone
- **Talk**: Talk about what's important for you

Since Sandwell Feel Good 6 was launched in April 2016, 76 statutory, voluntary organisations and community groups have signed up to Sandwell's feel good 6. They are already supporting people to take action on the 6 ways.

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