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To all Members of the Coventry Health and Well-being Board

31st January, 2017
Our ref: C/EMK

Dear Member,

Supplementary Agenda – Meeting of the Coventry Health and Well-being Board - Monday, 6th February, 2017

The papers for the above meeting were circulated on 27th January, 2017. At the time of publication, the following document was not available. This document has now been received and is attached to this letter. Please include it with your papers for the meeting.

- **Agenda Item 5.** **WEST MIDLANDS COMBINED AUTHORITY MENTAL HEALTH COMMISSION REPORT - STRIVE WEST MIDLANDS** (Pages 3 - 44)

  Simon Gilby, Coventry and Warwickshire Partnership Trust will report at the meeting

If you have any queries, please do not hesitate to contact me.

Yours sincerely

Liz Knight
Governance Services Officer

Membership: Councillors F Abbott, K Caan (Chair), G Duggins, E Ruane and K Taylor

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THRIVE
WEST MIDLANDS

An Action Plan to drive better mental health and wellbeing in the West Midlands

WEST MIDLANDS COMBINED AUTHORITY

MENTAL HEALTH COMMISSION

West Midlands Combined Authority Mental Health Commission

The West Midlands Combined Authority Mental Health Commission was established in October 2015. Rt. Hon. Norman Lamb MP, former coalition government Minister of State for Care and Support and Liberal Democrat MP for North Norfolk chaired the Commission.

This Action Plan is the result of work carried out by the Commission.

Please cite this document as: Thrive West Midlands: An Action Plan to drive better mental health and wellbeing in the West Midlands (2017). Lamb, N. Appleton, S. Norman, S. Tennant, M. (Eds.).

Independence and funding

The Commission's work has been funded by the West Midlands Combined Authority with additional resource provided by NHS England.

Commissioners and members of the steering group all have, or have had, some engagement in the field of mental health or related fields. All Commission members are independent of the West Midlands Combined Authority.

CONTENTS

OUR COMMITMENT

The following Concordat for Action statement demonstrates the commitment of key organisations from across the West Midlands to improving the mental health and wellbeing of people within our region:

"**WE WILL** work together to improve mental health and wellbeing, to reduce the burden of mental ill health across the West Midlands. We will work to improve people's lives and to encourage healthy communities.

WE WILL ensure services meet the needs of people with mental ill health and are provided with empathy and compassion. We will involve people who have experienced mental ill health and their carers at the earliest opportunity in decisions about services.

WE WILL work together to develop and deliver the actions in this Action Plan across the West Midlands Combined Authority area"

STAKEHOLDERS AND PARTNERS

WHO HAVE DEVELOPED AND SIGNED UP TO THIS ACTION PLAN ARE:

- the West Midlands Combined Authority (WMCA)
- the Police and Crime Commissioner
- Local authorities in the West Midlands
- NHS Trusts (mental health and acute providers)
- NHS England Midlands and East
- Public Health England
- Clinical Commissioning Groups (CCGs)
- Sustainability and Transformation Plan system leaders
- West Midlands Ambulance Service NHS Foundation Trust
- West Midlands Police, Probation and the courts, including Community Rehabilitation Companies
- West Midlands Fire Service
- Housing Associations
- People with lived experience and their carers
- The West Midlands Cooperative (the Citizens Jury)
- Those working in the community and voluntary sector
- The charity, Mind
- Universities
- Local Enterprise Partnerships in the West Midlands
- Chambers of Commerce
- Chartered Institute of Personnel and Development
- Business in the Community

LETTER FROM
NORMAN LAMB MP

People with mental ill health get a raw deal. Too often, people suffer in silence, unable to get help. Many people across the West Midlands are touched by mental ill health and the impact on families is sometimes overwhelming. Some of our communities suffer disproportionately. Tragically, too often people end up taking their own lives.

The cost of mental ill health to the West Midlands is estimated to be £12.6 billion per year. We now have the knowledge and understanding to address this, to make better use of public and private resources to achieve better results for people. So the moral and the economic case for acting is unanswerable.

When we started this work, the Commission felt we should be more ambitious than simply producing a report with more recommendations. I have seen so many commission reports which come up with good ideas but which change nothing. Instead, we decided to develop an Action Plan which key organisations across the region have signed up to.

In this document, we have mapped out the way forward for each of the actions. We have also ensured that the necessary leadership is in place to implement the Action Plan. And there will be governance arrangements to hold organisations to account in delivering the actions.

We have directed our actions to other areas of public services and the wider community, not just the NHS and social care. We know that to reduce the impact of mental ill health in this region, we not only have to improve the treatment of those who are already ill, but we must seek to prevent ill health and a deterioration of health, and promote good mental health and wellbeing.

I want this to be a start of a journey for the West Midlands.

I want to challenge this region to lead the way in demonstrating how we can use public money and private resources more effectively to build strong, happy communities.

We recognise that this Action Plan cannot address all the deficits in mental health services, or achieve the necessary improvement in mental health and wellbeing in one go. Our work and this Action Plan is the start of a process to identify areas that can have a positive impact, so that we begin a longer term programme of improvement. This first set of actions can be built upon to create an ongoing process that brings organisations and the public together to improve mental health and wellbeing in the region.

To build this Action Plan, we have drawn upon research, evidence, professional opinion and expertise. We have considered the views and experience of people who use services and the wider public and applied those to stimulate and support work at a local level.

Public and patient involvement has been central to our approach. We have engaged with members of the public, people who use or have used services, and people who care for others using services. Establishing a Citizens Jury, holding listening events and enabling comments via the West Midlands Combined Authority (WMCA) website are ways we have reached out beyond the confines of professionals and 'experts' to ensure that our thinking has been grounded in the reality of the experience of those living with mental health problems and the wider public who use local services.

We have sought, wherever possible, to begin the groundwork necessary to ensure that the actions happen and that they really make a difference to people's lives. We have worked with others to attract investment, brought partners together and laid the foundations for more detailed work to take place. We didn't want to just make recommendations and walk away. We wanted to get change under way. In most of the areas which we have addressed, we have already started to develop plans to implement the agreed actions.

As this region builds on the foundation stones we lay, it will be important to develop a whole life approach, recognising that to reduce the impact of mental ill health in this region, we have to start at the very beginning of life, supporting parents and building strong communities.

We recognise that addressing these issues will be challenging. But the scale of need means that we have to act. Business as usual is not acceptable. We can all play our part in helping to end the injustice suffered by those with mental ill health. If we have the will, we can have a massive impact on the lives of people and communities across the West Midlands.

Rt. Hon. Norman Lamb MP
Chair of the Mental Health Commission

MESSAGE FROM THE **CITIZENS JURY**

On behalf of the Citizens Jury, it has been a great pleasure to help achieve this Action Plan. It has been a fantastic opportunity to meet new people from various backgrounds and to work together to change attitudes towards mental health.

As members of the Citizens Jury, we have worked extremely hard by pushing ourselves out of our comfort zones and taking on many challenges such as public speaking. We all felt that with the right building blocks and information that our recommendations should be taken on board by the West Midlands Combined Authority.

Each of the actions in this plan will make a significant difference to improving the current mental health system within the West Midlands.

We would like to thank the West Midlands Combined Authority for allowing us to be a part of this project as it gave us the chance to voice our opinions and to have our views listened to. We would like to say a huge thank you to Peter Bryant, Nick Beddow and Jenny Willis for facilitating and organising the sessions we attended, and for supporting our ideas.

We are continuing to work as a group (now known as The West Midlands Cooperative) to make sure these actions are implemented.

Holly Moyse, Member of the Citizens Jury

On behalf of the Jury members

SECTION ONE

THRIVE WEST MIDLANDS – A PLAN FOR CHANGE

Poor mental health and wellbeing is a significant problem for the West Midlands. It impacts on individuals and families, and more widely on communities and the economy, costing our region over £12 billion per year.

Too often, people with mental health needs feel let down. They either don't receive adequate care, or it is simply not designed to meet their individual needs.

The West Midlands Combined Authority's Mental Health Commission chaired by Rt. Hon. Norman Lamb MP, has worked with organisations within the WMCA including the Police and Crime Commissioner, Public Health England (West Midlands), local NHS organisations, the local Department for Work and Pensions, the voluntary sector, police, fire service, courts, housing agencies, employment organisations, and people with personal experience of mental ill health. Together, we have developed this Action Plan for change – called Thrive West Midlands.

This Action Plan sets out how the region will seek to reduce the impact of mental ill health. We want to build happy, thriving communities and to support those who experience mental ill health.

Together, we will deliver these actions that will make a real, positive difference to people's lives in the West Midlands.

"There is no joined up service that is accessible to all. This needs to change. urgently"

Member of the Citizens Jury

SECTION TWO

ACTION PLAN SUMMARY

OUR PLAN OF ACTION

THEME 1

SUPPORTING PEOPLE INTO WORK, AND WHILST IN WORK

WE WILL:

Launch a three year programme in 2017 to trial expanding **Individual Placement and Support (IPS)** provision for people with severe and enduring mental health issues, demonstrating how IPS could achieve employment outcomes at a significant scale. We will also trial extending the IPS model to people with common mental health issues, and potentially people with chronic physical health issues, who are being treated in a primary care setting. We will be working with the Government's Work and Health Unit, NHS England and others to deliver this project.

Launch a **'West Midlands Workplace Wellbeing Commitment'** in Spring 2017, where public and private sector employers sign up to demonstrate their commitment to the mental health and wellbeing of their staff.

Encourage companies bidding for public sector contracts to **sign up to the West Midlands Wellbeing Commitment**, or demonstrate an equivalent commitment to the wellbeing of their staff. We will encourage large companies in the region to secure commitment from their supply chain to also commit to such standards.

Work with the Government to trial an innovative **'Wellbeing Premium' - a tax incentive that rewards employers demonstrating their commitment to staff wellbeing.** The trial will reveal if such a financial incentive, accompanied by an employer action plan, reduces staff sickness absence, improves productivity and prevents people leaving work due to ill health.

OUR PLAN OF ACTION

THEME 2

PROVIDING SAFE AND STABLE PLACES TO LIVE

WE WILL:

Build on great work already happening on our region by trialling an innovative scheme to **offer a Housing First service with intensive mental health support** in the West Midlands. This scheme will support those with complex needs or who are homeless to move into good quality housing and where possible, into work.

THEME 3

MENTAL HEALTH AND CRIMINAL JUSTICE

WE WILL:

Help to implement a programme to make more regular and widespread use of the **Mental Health Treatment Requirement** in the Magistrates and Crown Courts, which offers offenders with mental health problems the option of a treatment plan that addresses the underlying causes of offending. This programme should help recovery, reduce reoffending, and reduce the cost and impact of crime on the local community.

THEME 4

DEVELOPING APPROACHES TO HEALTH AND CARE

WE WILL:

- launch a Zero Suicide Ambition approach, which together with the recently launched National Suicide Prevention Strategy, aims to prevent and reduce suicides across the region
- establish a group of local and national experts to recommend a primary mental health care model for the region that ensures people's mental health needs are more effectively supported
- help to ensure the region meets national access and waiting time standards for early intervention in psychosis services
- establish a group of local and national experts to examine how the principle of early intervention should be applied to other areas of mental health care, so we support people much earlier, whatever their age
- end out of area mental health hospital placements for acute mental health care in the region by the end of 2017. Occasionally, patients need specialist inpatient care that is only available elsewhere
- help to explore effective alternatives to inpatient care that meet the individual needs of people with mental ill health, and test which work best before implementing them
- building on existing progress, apply for a grant from the National Institute for Health Research (NIHR) for a major project to substantially reduce the use of restraint in inpatient settings
- help to trial 'Integrated Personal Commissioning', a new approach to joining up health, social care and other services, in the region for those with mental ill health
- establish a group to ensure access to specialist 'perinatal' mental health services across the region for women during pregnancy and after they give birth
- examine why detentions under the Mental Health Act are rising in the region, particularly repeat detentions, and if inequalities need addressing

THEME 5

GETTING THE COMMUNITY INVOLVED

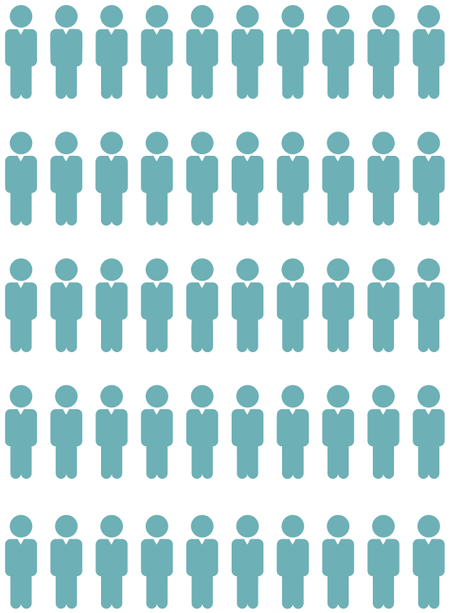
WE WILL:

- Launch a programme of **community initiatives to raise awareness of mental health and wellbeing**, guided by people with experience of mental ill health and driven by the community.

This includes:

- an annual 'Walk out of Darkness' - a 10 mile sponsored walk through the region to raise funds for organisations supporting people with mental ill health and raising awareness of mental health
- an annual awards ceremony to recognise people in local communities who do amazing work supporting others
- exploring if a community art initiative such as that carried out in Philadelphia could help to improve public mental health and wellness in our region

- Launch a large public health programme to **train up to 500,000 people across the region in Mental Health First Aid** or other equivalent programmes over the next ten years, that will improve people's knowledge of mental health and how they can support each other. We'll campaign for Government to amend First Aid legislation for employers, to include mental health first aid



SECTION THREE

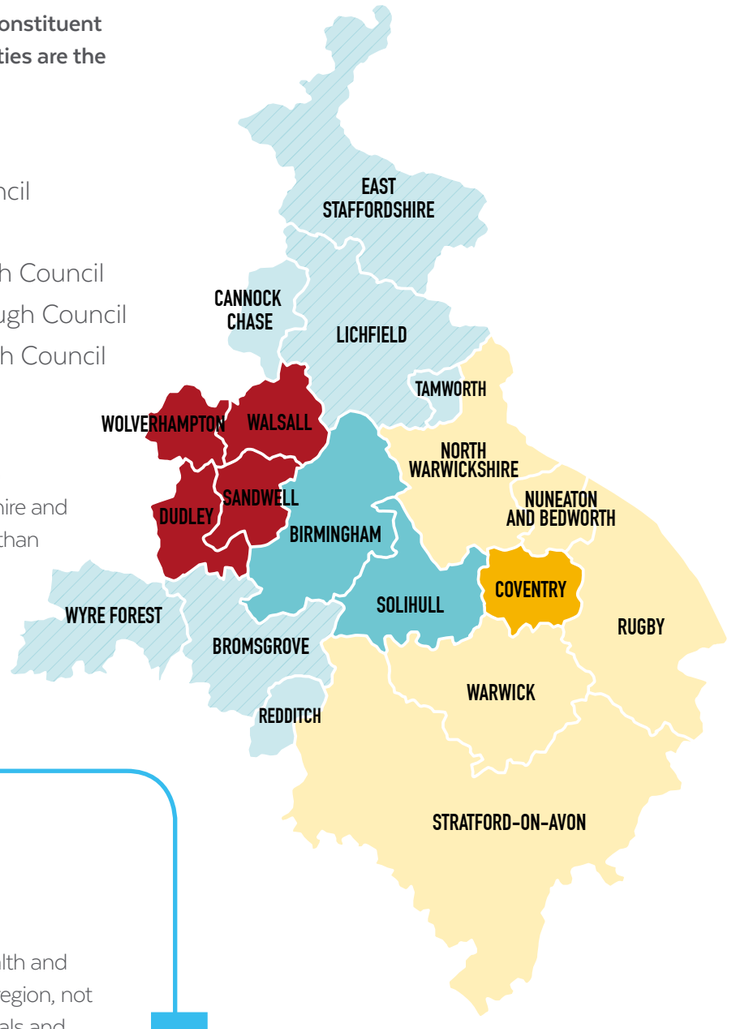
ABOUT THE WEST MIDLANDS COMBINED AUTHORITY (WMCA) AND THE MENTAL HEALTH COMMISSION

The West Midlands Combined Authority (WMCA) became a substantive body in July 2016. The WMCA is using the benefits of devolution to use their resources so that it more effectively meets the needs and challenges of the West Midlands region.

It consists of constituent and non-constituent authorities. The constituent authorities are the seven metropolitan councils:

- Birmingham City Council
- City of Wolverhampton Council
- Coventry City Council
- Dudley Metropolitan Borough Council
- Sandwell Metropolitan Borough Council
- Solihull Metropolitan Borough Council
- Walsall Council

Non-constituent authorities reach into South Staffordshire, North Worcestershire and Warwickshire, have fewer voting rights than constituent members, and may sign up to more than one combined authority if they wish. Constituent members may only be signed up to one combined authority.



MENTAL HEALTH IS A PRIORITY FOR THE WEST MIDLANDS

The WMCA identified poor mental health and wellbeing as a significant issue for the region, not only in terms of the effects for individuals and families, but more widely on the communities and the economy of the area. It results in enormous distress for people, greater demand for public services and reduced productivity, and so has been identified as a priority area where the WMCA could deliver public sector reform.

THE MENTAL HEALTH COMMISSION

WHO WE ARE

The WMCA Mental Health Commission was established to work out how the opportunities of devolution could help to address poor mental health and wellbeing across the region.

The plan was that we would make recommendations to the WMCA (and to government) about ways to improve mental health and wellbeing services and improve outcomes, for people in our region and across the country.

THE COMMISSIONERS

RT. HON. NORMAN LAMB MP (CHAIR OF THE COMMISSION)
Former coalition government Minister of State for Care and Support at the Department of Health (September 2012 – May 2015). Liberal Democrat health spokesperson and MP for North Norfolk.

PAUL ANDERSON
Managing Director – Deutsche Bank Birmingham

PROFESSOR KEVIN FENTON
Director of Health and Wellbeing – Public Health England

PROFESSOR DAME CAROL BLACK
Advisor to government on employment and health and Principal of Newnham College, Cambridge

STEVE GILBERT
Serious Mental Illness - Lived experience consultant

CRAIG DEARDEN-PHILLIPS
Chief Executive and founder of Stepping Out

STEVE SHRUBB
Former NHS mental health Trust Chief Executive and Director of the NHS Confederation Mental Health Network

DR GERALDINE STRATHDEE OBE
Former National Clinical Director for Mental Health at NHS England

PROFESSOR SWARAN SINGH
Head of Mental Health & Wellbeing Division at Warwick Medical School, University of Warwick

KAREN TURNER
Director of Mental Health – NHS England

OTHER ATTENDEES AT COMMISSION MEETINGS

SARAH NORMAN
Chief Executive of Dudley Council and lead officer for the Commission

STEVE APPLETON
Managing Director - Contact Consulting
Secretariat to the Commission

SIMON GILBY
Chief Executive of Coventry & Warwickshire Partnership NHS Foundation Trust
Attending on behalf of local NHS mental health provider trusts

DR PAUL TURNER
Clinical commissioning lead for mental health at Birmingham South Central Clinical Commissioning Group (CCG). Attending on behalf of clinical commissioners

SUPERINTENDENT SEAN RUSSELL
Mental health lead for West Midlands Police. Attended as Chair of the Commission's steering group, before being appointed as Implementation Director

WMCA SPONSORS OF THE MENTAL HEALTH COMMISSION

COUNCILLOR PETE LOWE
Combined Authority Leader Champion, Vice Chair of WMCA, Wellbeing Portfolio Holder and Leader of Dudley Metropolitan Borough Council

The Mental Health Commission would like to take this opportunity to acknowledge the significant contribution that Cllr Darren Cooper, former leader of Sandwell Council, made to the mental health agenda. Darren sadly passed away in 2016.

SECTION FOUR

THE WEST MIDLANDS, A CULTURALLY DIVERSE AND VIBRANT AREA

The Commission's work covers an area of

just over four million people

across an array of vibrant cities, towns and villages.

Our region is incredibly diverse. There are areas of affluence, but also areas with significant social and economic deprivation.

PEOPLE FROM BLACK, ASIAN AND MINORITY ETHNIC (BAME) COMMUNITIES, make up around 1/5 of the total population in our region

NEARLY 2/3 of people in our region are 16-65 years old

OVER HALF OF THE PEOPLE IN OUR REGION live in localities within the 20% most deprived areas in England, including Walsall, Wolverhampton, Sandwell and Birmingham.

SECTION FIVE

THINGS MUST CHANGE

Mental ill health has a massive impact on people in the UK and our region. It affects many aspects of people's lives, and aside from individuals and their families, it impacts on communities, workplaces, public services, our economy, and our society as a whole.

1 IN 4 PEOPLE will experience a mental health problem during their lifetime

1 IN 10 MEN AND 3 IN 10 WOMEN have had a previous psychiatric admission before they entered prison[2]

1 IN 10 CHILDREN between 5 and 16 years has a mental health problem

AMONG PEOPLE UNDER 65 nearly half of all ill health is mental illness

SUICIDE is the biggest killer of men under 49 in the UK

1 IN 6 adults have a mental health problem at any one time

People with severe mental illnesses such as schizophrenia **DIE AROUND 20 YEARS EARLIER**

1 IN 5 MOTHERS suffer from depression, anxiety or psychosis during pregnancy or in the first year after childbirth

SUICIDE is the second leading cause of maternal death

3 OUT OF 4 PEOPLE with mental health problems receive no support

9 OUT OF 10 people in prison have a mental health, drug or alcohol problem[1]

PARTICULAR GROUPS OF PEOPLE ARE AT GREATER RISK OF MENTAL ILLNESS, including Black, Asian and minority ethnic communities

1. Five Year Forward View, NHS England 2014
2. Source - Prison Reform Trust: http://www.prisonreformtrust.org.uk/projectsresearch/mentalhealth

Page 15

ACROSS OUR REGION, MENTAL ILL HEALTH IS HAVING A HUGE IMPACT

1 IN 4
adults in the West Midlands have a mental health problem

477 PEOPLE
lost their lives through suicide in the West Midlands in 2015

AROUND 1 IN 5
people using mental health services were also using alcohol or substance misuse services

These figures demonstrate the scale of the effect of poor mental health and the challenges faced by those who experience them.

The Health Services Management Centre at the University of Birmingham has also analysed and estimated the economic costs of poor mental health and wellbeing within our region[3]. They found mental health is having a massive impact:

£12.6 BILLION
= estimated cost of mental ill health to the West Midlands

JUST OVER £1 BILLION
= cost of presenteeism per year[4]

6.9 average sick days someone takes in our region – around 40% could relate to a mental health problem[5]

4.159 MILLION
estimated working days lost for mental health reasons

NEARLY £1 BILLION
= NHS spending on mental health problems per year.[6]

JUST OVER £0.5 BILLION
= cost of mental health related sickness absence per year

70,000 PEOPLE
cannot work due to mental health problems in the region

£1 BILLION
= cost of crime related to mental health problems

AROUND £1.7 BILLION
= cost of lost output and productivity by employers in our region

JUST OVER £2 BILLION
= cost of mental health related economic inactivity per year

WE MUST address the causes of poor mental health and wellbeing, do much more to prevent mental ill health, and also ensure access to high quality specialist services, to improve people's lives.

3. Newbigging, K. and Parsonage, M. (2017). Mental Health in the West Midlands Combined Authority. University of Birmingham: Health Services Management Centre.
4. When people who are unwell turn up for work but are less productive
5. Analysis for the Commission
6. Around 1/4 is spent in primary care, and around 3/4 in secondary care

MENTAL HEALTH IN MINORITY GROUPS AND VULNERABLE COMMUNITIES

Mental health problems can affect everyone, regardless of their background. Many factors influence the risk, including social and economic factors, and physical environment.

People from Black, Asian and minority ethnic (BAME) communities, and other minority groups such as lesbian, gay, bisexual and transgender (LGBT), the homeless, those dealing with addictions and those in contact with the criminal justice system, are at higher risk of experiencing mental ill health, and are less likely to seek and access support. Specific issues relating to their mental health needs can be ignored or can be a secondary consideration in the design of mental health services. Given that our region is so diverse, we must consider the needs of these minority groups and ensure that they are met.

The issues relating to mental health in these groups are often ignored and there are acknowledged failures within the system that disadvantage people from these communities.

FOR EXAMPLE, BLACK BRITISH MEN:

- are more likely to be diagnosed and admitted to hospital for schizophrenia[7]
- are more likely to be detained under the Mental Health Act[8] and have more difficulties accessing care[9]

We must act to improve the mental health of all the citizens in our region.

In the actions we have committed to, we have sought to address a number of issues of particular concern to minority groups and vulnerable communities. Our objective is to ensure that everyone affected by mental ill health in this region benefits from the actions we are pursuing.

To ensure we meet the needs of those people and communities who are particularly disadvantaged, the WMCA will appoint a panel of Equality Champions. See page 72.

7. Fearon P, Kirkbride J, Morgan C et al (2006) Incidence of schizophrenia and other psychoses in ethnic minority groups: results from the MRC AESOP Study . Psychological Medicine, 36, 1541-1550
8. Singh SP, Greenwood N, White S, Churchill R (2007) Ethnicity and the Mental Health Act 1983, British Journal of Psychiatry, 191, 99-105
9. Bhui K, Stansfeld S, Hull S et al (2003). Ethnic variations in pathways and use of specialist mental health services in the UK. British Journal of Psychiatry, 182, 105-116

SECTION SIX

WORKING TOGETHER TO MAKE A DIFFERENCE – A CONCORDAT FOR ACTION

We are aware of the risk faced by many commissions - that worthy recommendations fail to get translated into actions, so no one actually benefits. So we have taken a different approach.

To ensure that all key organisations in the WMCA play their part, we decided to seek an agreement whereby organisations commit to action – **a Concordat for Action for the West Midlands**. This is a significant statement of commitment and common purpose that has been shared, agreed and signed by senior representatives in the partner organisations. These organisations have subsequently agreed to implement this Action Plan.

The following Concordat for Action statement demonstrates our commitment to improving mental health and wellbeing in people within our region:

"**WE WILL** work together to improve mental health and wellbeing, to reduce the burden of mental ill health across the West Midlands. We will work to improve people's lives and to encourage healthy communities.

WE WILL ensure services meet the needs of people with mental ill health and are provided with empathy and compassion. We will involve people who have experienced mental ill health and their carers at the earliest opportunity in decisions about services.

WE WILL work together to develop and deliver the actions in this Action Plan across the West Midlands Combined Authority area."

This approach has resulted in this Action Plan. Key organisations across the West Midlands have worked together to develop and shape it, informed by a set of clear principles. The organisations and leaders have agreed and accepted the actions set out in this plan, and have signed up to demonstrate their commitment to implementing the plan in full.

They have accepted responsibility to work together to improve the mental health and wellbeing of the people within our region. They will work together over the next two years, and on a longer term basis, to make this Action Plan a reality.

PRINCIPLES

GUIDING EVERYTHING WE DO

1. OUR CORE PURPOSE
to promote healthier communities by reducing the impact of mental ill health

2. WE WILL DO THIS THROUGH PREVENTION
and improving access to compassionate and high quality treatments that stop people's health deteriorating

3. WE WILL EMPOWER PEOPLE
to take more control of their lives

4. WE WILL GIVE A STRONG VOICE
and listen to people who have personal experience of, or cared for, loved ones with mental ill health

5. WE WILL PROVIDE A HOLISTIC APPROACH
- services must support both physical and mental health recovery

6. WE WILL ENSURE
services intervene early

7. WE WILL COLLABORATE
with others and work with diverse communities to address inequalities that exist between different groups and ensure equal treatment for all

8. WE WILL USE DATA BETTER
to ensure effective and efficient use of resources

WE HAVE TRANSLATED THESE PRINCIPLES INTO THIS ACTION PLAN, WHICH WILL HAVE A REAL IMPACT ON PEOPLE'S LIVES.

With colleagues in the USA, Scandinavia, Australasia and other parts of the UK, we're building a global network of cities pursuing major initiatives on mental health and wellbeing. We want this to become a growing movement of change. With the help of the International Initiative for Mental Health Leadership (IIMHL), we are building links with key leaders in these cities, and sharing learning, ideas and programmes of work with each other, so we are using the best examples of evidence and innovation to shape our work.

SECTION SEVEN

PEOPLE WITH EXPERIENCE OF MENTAL ILL HEALTH HAVE PLAYED A VITAL ROLE

Too often, people with mental health needs feel let down. They either don't receive adequate care, or it is simply not designed to meet their individual needs.

To help ensure our Action Plan is fit for purpose, we wanted people with experience of using mental health services, either for themselves or for people they care for, to get involved and influence our decision making. We were clear that they wouldn't just endorse decisions that have already been made.

We are very grateful to people from across the West Midlands who joined our Citizens Jury, and who have played a vital role in developing this Action Plan. This diverse group of people have actively participated in this project and helped us to shape this Action Plan.

People with experience of mental ill health will continue to shape our work in the future, and will have a key role in the governance arrangements to ensure that things get done.

You can read the full Citizens Jury report at
www.westmidlandscombinedauthority.org.uk/mhc

SECTION EIGHT

OUR PLAN OF ACTION – WHAT WILL WE DO?

It would have been impossible to consider every factor that influences mental health straight away. So the region has concentrated on areas where we feel we can have the most immediate impact.

This is the start of a journey. In the long run, the region will develop a whole life approach so we achieve the best results for people. But first the Commission is focusing on people of working age. Getting the foundations right in childhood is vital, so that will be a focus of the WMCA's future work. The WMCA will look at this as part of a broader 'Best Start in Life' programme.

As far as possible, our actions are based on evidence of what works, and what will make a difference to people's lives. Where evidence is lacking, we aim to test ideas and to build evidence, which will guide and inform our future actions.

OUR PLAN OF ACTION

Our Action Plan has five themes:

1. SUPPORTING PEOPLE INTO WORK, AND WHILST IN WORK
2. PROVIDING SAFE AND STABLE PLACES TO LIVE
3. MENTAL HEALTH AND CRIMINAL JUSTICE
4. DEVELOPING APPROACHES TO HEALTH AND CARE
5. GETTING THE COMMUNITY INVOLVED

This Action Plan has a whole system approach. We aim to improve mental health and wellbeing in a number of ways, from housing, to criminal justice, to work. The actions are inextricably linked, forming a coherent whole and complementing each other. For example, intervening early features frequently across a number of our actions.

Action Checklist **Every one of our actions**:

- ✓ is consistent with the principles we have set out to follow
- ✓ is informed by the evidence we have received and reviewed
- ✓ has been cross-referenced and influenced by the Citizens Jury recommendations to ensure they have addressed concerns and needs of people with mental ill health
- ✓ will require a coordinated approach to delivery.

Local organisations must actively work together to implement them and to make them a success.

For most of the actions, work has already begun or plans are in the pipeline.

SECTION NINE

OUR PLAN OF ACTION IN DETAIL

In this section of the report, you can find out more about each action, how they'll be delivered and the difference they could make to people with mental health needs.

THEME 1

SUPPORTING PEOPLE INTO WORK AND WHILST IN WORK

Work is good for our mental and physical health and wellbeing, while being unemployed has a negative effect[10]. People in the UK who are unemployed are between 4 and 10 times more likely to develop anxiety and depression[11]. Helping people into work also benefits the local economy. It boosts productivity by reducing unemployment, and therefore reducing welfare benefit spending.

But challenges remain for people with mental ill health in gaining and maintaining employment, sometimes because of negative attitudes and stigma, and concerns from employers who are less knowledgeable about mental health. Those with mental ill health are more likely to stop working than the general population and other disadvantaged groups. In 2014, we estimate that around 69,800 people in our region were economically inactive for mental health reasons - they were not working, but may not necessarily be registered as unemployed.

In our region the number of people working while being on the Care Programme Approach (CPA) varies widely between the Clinical Commissioning Group (CCG) areas[12] . The CPA is the way that health and social care services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or related complex needs, who need specialist care and support.

Making a difference

These actions can make a real impact by helping people with mental health needs back into work.

10. Is Work Good for Your Health & Wellbeing? Waddell, G. & Burton, K. 2006 London TSO
11. Ref - Lelliott, P., Tulloch,S ., Boardman, J ., Harvey, S., Henderson, H. 2008. Mental Health and Work. Royal College of Psychiatrists.
12. Newbigging, K. and Parsonage, M. (2017). Mental Health in the West Midlands Combined Authority. University of Birmingham: Health Services Management Centre.

Action 1

HELPING PEOPLE WITH MENTAL HEALTH NEEDS BACK TO WORK

We will launch a three year programme, starting in 2017, to expand evidence-based supported employment provision in line with the principles of the Individual Placement and Support (IPS) model. The programme will work with people with severe and enduring mental health issues, common mental health issues and potentially people with chronic physical health issues, who are being treated in a primary care setting. This programme, which is subject to ministerial approval, would be internationally significant in its scale and scope.

What is IPS?

IPS is a 'place then train' supported employment model, in which trained employment specialists work intensively with clients to quickly help them find paid, competitive work and then continue to support them and their employer for as long as necessary. The central principle of IPS is that paid employment (full or part-time) is a realistic goal for everyone who wants a job[13]. It also aims to get people into competitive employment, is open to everyone who wants to work, tries to find jobs that people want to do, and brings employment specialists into clinical teams so that health treatment and employment support are tightly linked. Employment specialists also develop relationships with employers to identify jobs that meet their client's work preferences.

Why IPS?

Supported employment, including Individual Placement and Support (IPS), is a proven way to support people to gain work. Several international studies have shown that people find jobs quicker and stay in employment for longer. Using IPS with young people who present with a first episode of psychosis can increase employment success by as much as 85%[14,15] . The Five Year Forward View for Mental Health recommended that access to IPS across England should be doubled by 2020/21.

There is evidence that IPS services saves around £3,000 a year because of reduced use of mental health care. These savings may be sustained for a number of years and compare with a one-off cost of IPS support of around £2,700 per client.[16]

Who will we work with on this?

Subject to final ministerial approval, we will be working with the Government's Work and Health Unit and NHS England, alongside the local NHS, Academic Health Sciences Network (AHSN) and employers to deliver this project. It will supplement existing resources currently invested by the West Midlands in employment services, such as existing IPS services in Coventry, Dudley and Walsall and the BITA Pathways service in Birmingham.

Our progress and vision

The Government funding will boost the investments already being made to expand IPS for people with mental ill health across our region.
We have received the go-ahead to design the large scale trial. Once we receive final ministerial approval for the agreed design, we will establish a team to make this a reality. They will establish the services we will use and set up contracts, monitor performance, work with local and national stakeholders, and evaluate the programme on an ongoing basis.

The difference this could make

IIPS represents the best-evidenced model of support to enable people with mental health problems to get into work in the world. This programme is ambitious, and could help a significant number of people in the West Midlands with mental health needs over the next five years to secure employment, speeding up their recovery and giving them more independence. It will reduce the welfare bill and demand on mental health services funded by public money.

13. Doing what works: IPS into employment Sainsbury Centre for Mental Health 2009
14. Vocational intervention in first-episode psychosis: individual placement and support v. treatment as usual. Killackey, E., Jackson, H.J. and McGorry, P.D., The British Journal of Psychiatry, 193(w2), pp.114-120. 2008
15. Making the case for IPS supported employment. Bond, G.R. and Drake, R.E., Administration and Policy in Mental Health and Mental Health Services Research, 41(1), pp.69-73. 2014.
16. Priorities for Mental Health, Centre for Mental Health, January 2016

Mental health in the workplace

Two thirds of UK staff feel scared, embarrassed or unable to talk about mental health concerns with their employer. Staff worry about being demoted, missing out on promotions, being seen as less capable or judged negatively, or even losing their jobs[17]. Fearing possible stigma or discrimination, staff turn up for work even if feeling unwell, but they cannot function as normal. Otherwise they may take lengthy periods of sickness absence.

Mental ill health has a significant impact on employers. At any one time nearly one in six of their workforce is affected by a mental health condition such as depression or anxiety[18]. If people leave due to mental ill health, they must recruit new staff, which costs the employer money, and sickness absences pile on further costs. Mental health related absences cost UK employers an estimated £26 billion per year[19]. In our region alone, employers experience around £1.72 billion per year lost output and productivity because of mental health problems in working people.

Public and voluntary sector organisations are far more likely to support employees who experience mental health problems compared to the private sector[18].

But overall, many people are not clear about how their employer supported people with mental ill health, if at all[18].

A healthy workplace leads to happier, more engaged and loyal staff, and a more productive business. A business that commits to wellbeing will retain staff and attract new employees. Costs related to sickness absence will fall and work performance and productivity will rise.

Better managing mental health in the workplace, including preventing and spotting problems early, could save employers 30% or more of the costs outlined in the previous section[20].

A 'whole workplace approach' is needed to improve mental health and wellbeing and create a positive and mentally healthy working environment for all[21]. Effective action includes ensuring that there are supportive managers who help support people's development, and creating a working environment that fosters a sense of ownership and commitment amongst staff.

Making a difference

These actions can make an impact on mental health and wellbeing in the workplace. They can improve lives, boost productivity, cut costs for business, reduce the number of people who end up out of work and claiming benefits, and reduce costs for the NHS.

"Back into work schemes are really important - being in work is good for mental wellbeing, building confidence and combating isolation"

Member of the Citizens Jury

17. How to be mentally healthy at work Mind 2013
18. Employee Outlook CIPD July 2016
19. Mental health at work Centre for Mental Health 2007 http://www.centreformentalhealth.org.uk/employment-the-economic-case
20. Employment: the economic case Centre for Mental Health 2007
21. Written evidence paper to Commission Mental Health Foundation 2016
22. Public Health England paper for the Commission 2016

Action 2

ENCOURAGING EMPLOYERS TO LOOK AFTER THE MENTAL HEALTH AND WELLBEING OF THEIR STAFF

We will launch a 'West Midlands Workplace Wellbeing Commitment' in Spring 2017, where public and private sector employers sign up to demonstrate their commitment to the mental health and wellbeing of their staff.

What is a Wellbeing Commitment?

This local, voluntary commitment is based on the Public Health England Workplace Wellbeing Charter national standard that provides employers with a structured approach to workplace health and wellbeing. Employers will also be given a toolkit to help them improve mental wellbeing in particular. They can implement a range of measures that could help keep their staff well, such as mindfulness, cognitive behavioural therapy (CBT), or line manager training.

Why do this?

We believe this will enable employers in both the public and private sector to take a new approach to the wellbeing of their employees, helping them be more productive and creating more attractive places to work.

Who will we work with?

We will do this in association with Public Health England (PHE) West Midlands and the Chartered Institute of Personnel and Development (CIPD). We'll also collaborate with local employers, Business in the Community and local Chambers of Commerce. We will look to develop a local approach, based on the PHE mental health toolkit for employers.

Our progress and vision

We have worked with our partners to shape plans for this Wellbeing Commitment across our region, building on the excellent work already underway in Coventry. We want the number of employers who are signed up to the Charter in our region to grow, so that we build a growing movement of change.
We want all public sector employers in our area to lead by example. In our first year, our ambition is to recruit 200 organisations from a whole range of sectors to this initiative, and for this to move towards 500 by the end of year two. This will create a cultural shift in the way we provide wellbeing approaches to our staff. A baseline assessment will be conducted across the region with a number of key initiatives being developed which will focus on retaining people in the workplace and enabling organisations to develop improved services for staff who are off sick.

The difference this could make

This initiative could improve employers' perception of mental health and wellbeing so they provide more effective support for their staff to help them to keep well. As well as making a difference to people's lives, employers will also benefit economically. The National Institute of Clinical Excellence (NICE) estimates that implementing interventions to promote staff wellbeing could save employers between £130 and £5,020 per participating employee, by reducing absence or illness at work[22]. We want employees in the 500 organisations to see a difference by 2020.

Action 3

ENSURING THE WELLBEING COMMITMENT HAS A WIDER REACH

We will encourage companies bidding for public sector contracts to sign up to the West Midlands Wellbeing Commitment, or demonstrate an equivalent commitment to the wellbeing of their staff. We will also encourage large companies in the region to have an expectation that companies in their supply chain also commit to such standards.

Why do this?

We want to ensure that our regional Wellbeing Commitment has as wide a reach as possible – and the biggest impact on employers' attitude to their staff's mental health and wellbeing. We believe that it is reasonable to expect any company tendering for a contract funded by public money to demonstrate they have a clear commitment to the wellbeing of their staff.

Our progress and vision

A group of employment experts including the Chartered Institute for Personnel and Development (CIPD) together with business leaders, councils, police and healthcare employers from the West Midlands, are working together to develop and implement the Wellbeing Commitment. One exciting initiative is already being led by the local authority in Coventry - a number of businesses have already signed up to it, and although it is early days, evidence suggests it is making a difference.

Our vision is that when companies tender for public sector contracts, those signed up to the West Midlands Wellbeing Commitment or who demonstrate similar commitments to the wellbeing of their staff will be considered positively by the public body concerned.

The difference this could make

This action will ensure that the impact the wellbeing commitment makes spreads as far as possible in our region, making a difference to many people with mental ill health and helping to prevent their health deteriorating. We believe we can have a positive impact on productivity, reduce costs to business, reduce costs to the NHS and reduce the costs of benefits in our region.

Action 4

EVALUATING A FINANCIAL INCENTIVE TO ENCOURAGE EMPLOYERS

We will work with the Government to trial an innovative 'Wellbeing Premium', a tax incentive that rewards employers demonstrating their commitment to mental health and wellbeing. This trial will reveal if such a financial incentive, accompanied by an employer action plan, reduces staff sickness absence, improves productivity and prevents people leaving work due to mental ill health.

What is the Wellbeing Premium?

The Wellbeing Premium is a financial incentive for employers who demonstrate their commitment to the wellbeing of their workforce by implementing measures that we know can help people's mental health and wellbeing.

Why do this?

We believe we must get employers more engaged in the wellbeing of their staff. Improving staff mental health and wellbeing could have a massive impact, reducing sickness absence, improving productivity, preventing people losing their jobs and reducing NHS costs. In its Five Year Forward View, NHS England highlighted the potential value of developing new workplace incentives to promote employee health and cut sickness-related unemployment[23]. It stressed the importance of engaging employers more effectively in the wellbeing of their workforce and suggested there would be merit in extending incentives for employers in England who provide effective NICE recommended workplace health programmes for employees.

Who will we work with?

We will work with Public Health England, the Department for Work and Pensions (DWP) and the Treasury in the Government, and NHS England, together with the local Chambers of Commerce to do this.

Our progress and plans

We will continue to work with the Government's Health and Work Unit, the Treasury and Public Health England to design this Wellbeing Premium – essentially it would give companies a financial incentive, which might include a discount on their business rates, in return for action to improve the wellbeing of their workforce. If we can secure funding for a trial, we will initially look for 100 employers of all sizes, from small businesses to large companies, to trial and evaluate this Wellbeing Premium. In return for a financial incentive, companies would commit to implementing key actions which we know work, such as a line manager training programme, a mental health first aid programme, and giving a board member direct responsibility for wellbeing and for implementing the interventions. This is the first time such a scheme has been pursued in this country – it would be ground-breaking and internationally significant.

The difference this could make

This trial will last two years and will reveal if a financial incentive such as this Wellbeing Premium works. If it is successful, the trial will pave the way for a Wellbeing Premium to be rolled out to employers across our region, and potentially, nationally. We envisage that, if rolled out, it would entitle companies to receive the Wellbeing Premium for two to three years. In that time, we believe companies will see improvements in productivity, reduced sickness absence and greater profitability. As those benefits accrue, public subsidy would no longer be required.

23. Five Year Forward View NHS England 2014

THEME 2

PROVIDING SAFE AND STABLE PLACES TO LIVE

A settled home is vital for good mental health. People with mental health problems are less likely to be homeowners and more likely to live in unstable environments. Housing support can improve people's health and help reduce overall demand for health and social care services.

The national Commission on Acute Inpatient Psychiatric Care for Adults (CAAPC) and NHS England's Five Year Forward View for Mental Health both recognise that housing is important in preventing mental health problems and promoting recovery[24].

In 2014, just under two thirds of people aged 18-69 being treated by secondary mental health services were living in settled accommodation. Even when in accommodation, the risk of common mental health problems is almost double for people living in fuel poverty – and this costs the NHS in England around £859 million each year.[25] Stress caused by housing insecurity or sub-standard housing may exacerbate people's vulnerabilities, worsening their condition, increasing the likelihood of relapse and/or the need for an inpatient admission.[26, 27]

Many people who are homeless also suffer mental ill health. Some people experience a period of sustained housing, followed by a crisis, they lose the tenancy, then are homeless before stable housing is secured again. Mental ill health and drug and alcohol misuse is one of the factors that fuel this cycle.

Making a difference

We must take action to provide safe and stable places to live for people with mental ill health.

24. Five Year Forward View for Mental Health February 2016
25. No health without mental health Supporting document: The economic case for improving efficiency and quality in mental health 2011
26. Mental Health and Social Exclusion, Social Exclusion Unit 2004, Office of the Deputy Prime Minister
27. A basic need: housing policy and mental health Bradshaw, I. Centre for Mental Health 2016
28. Housing First in England An evaluation of nine services Bretherton J & Pleace N University of York February 2015

Action 5

HELPING PEOPLE TO GAIN HOUSING AND WORK

We will build on great work already happening on our region by trialling an innovative scheme to offer a Housing First service with intensive mental health support in the West Midlands. This scheme will support those with complex needs or who are homeless to move into good quality housing and, where possible, into work.

What could this scheme look like?

A number of housing initiatives exist that could help us achieve this. One of these is called 'Housing First' - a form of supported housing which works on the principle that getting someone into a secure home immediately with the right level of support, without needing to go through a series of stages to attain 'housing readiness', helps them address mental ill health, substance misuse and alcohol issues more effectively. It regards housing as a basic right, and emphasises self-determination, choice and a recovery-orientated approach. The housing provided is permanent with a secure tenure, and the offer of housing is not conditional on receiving treatment although support can be offered on a long term basis if required.

Why do this?

Housing initiatives could complement and enhance current housing provision in our region, and could improve mental health and wellbeing, reduce crime, and tackle homelessness. The Housing First approach has already been adopted in Camden, London and in nine other centres in England on a small scale. A recent study found Housing First successfully engaged with long-term homeless people with often very high support needs, delivered housing sustainment and showed progress in improving health, well-being and social integration. It could also save the public purse between £3,048 and £4,794 per person by creating a more holistic approach where organisations are collaborating to work directly with individuals, and their families and carers.[28]

Our progress and plans

A regional pilot of the Housing First model is already taking place in the West Midlands, providing accommodation and support for vulnerable adults with complex needs. We will build on this great work by trialling an innovative scheme to offer a Housing First service with intensive mental health support in the West Midlands. We are now developing these plans.

Who will we work with?

We have been working closely with local authorities, housing associations, and national voluntary sector agencies including Housing First England, a charity which runs social enterprises called BITA Pathways, St Basil's, Changing Futures, Birmingham Voluntary Service Council (BVSC) and Crisis.

The difference this could make

We believe that housing initiatives, including Housing First, provide an opportunity to deliver housing and support that can promote independence and recovery for people with mental health needs. They will ensure that access to housing becomes the central component of the wider package of the support they receive, laying the foundations for successful treatment and recovery, and the potential for employment.

THEME 3

MENTAL HEALTH AND CRIMINAL JUSTICE

People who have been through the criminal justice system are more likely to experience poorer health than the general population. Mental health problems, including conditions such as depression and anxiety as well as more severe mental health problems such as psychosis and personality disorders, have been found to be more prevalent among offenders than the general population[29].

The Bradley Report[30] identified that there are more people with mental ill health in prison than ever before and that being in custody can increase the risk of suicide and self-harm. According to the Ministry of Justice, 107 people in prison took their own lives in the year up until September 2016 - that's almost double the number in 2011-12[31]. The number of self-harm injuries in prisons rose by 26% in the year until June 2016 – around 100 per day. In men this statistic has more than doubled in six years.

For many people, leaving prison is a time of crisis[32]. Commissioned mental health care in prisons is limited except for those with the severest problems and care after leaving prison is particularly lacking for those with short sentences.

Access to mental health support is essential for people throughout the criminal justice system and when they return to the community. The Bradley Report recognised that the majority of offenders with lower-level mental health disorders are not dangerous and could be better treated outside the prison system without any risk to the public. Support when people leave prison must be holistic, starting with basic needs such as accommodation, money and safety.

29. Transforming Rehabilitation: a summary of evidence on reducing reoffending. Ministry of Justice 2013
30. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/562897/safety-in-custody-bulletin.pdf
31. www.gov.uk/government/uploads/system/uploads/attachment_data/file/562897/safety-in-custody-bulletin.pdf
32. Mental Health and Criminal Justice Durcan, G. Centre for Mental Health 2016
33. Offender HNA and Consultancy projects West Midlands Prison Health Needs Assessment 2014-15 2015 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/449652/HMP_Birmingham_HNA_West_Mids_2015.pdf
34. COCOA: Care for Offenders Continuity of Access Byng, Prof. R. et al HMSO 2012

The Government's Transforming Rehabilitation policy outlines the strategy for reducing reoffending rates and, in doing so, is reducing the number of victims and the costs to the taxpayer. The policy acknowledges that, whilst there is a need to punish people when they break the law, there is also a need to support people so that they do not commit crime in the future. It suggested that local partnerships that bring together the full range of support, be it in housing, employment advice, drug treatment or mental health services would be central to success.

Our region is already leading the way

Health and criminal justice agencies have already made a concerted effort to improve the way the system supports those with mental ill health who enter the criminal justice system. They have implemented the national agreement to improve crisis care (the Crisis Care Concordat), developed street triage (notably in the West Midlands), and have provided mental health in-reach services in prisons.

The West Midlands is leading the way in a number of areas. Mental health nurses operate within all of the custody facilities across the West Midlands Police Force area under the Liaison and Diversion from custody programme. Liaison and Diversion services link directly into the local Crown and Magistrates courts to identify offenders of any age who have mental health, learning disability or substance misuse vulnerabilities and refer them to appropriate services for support and treatment. The West Midlands is the only police force with 100% coverage of Liaison and Diversion services ahead of the national roll-out deadline of 2019. Our region has developed robust approaches to reduce the use of police cells for people detained under Section 136 of the Mental Health Act.

There are 12 prisons in our region. Around 3,700 adult male prisoners are referred to primary mental health care in prison every year[33]. But there are gaps in provision relating to primary care mental health and counselling. Addressing offenders' mental health problems would have a number of benefits - improving their health, improving the wellbeing of their families and communities, and having wider economic and social benefits by reducing reoffending[34].

Making a difference

Despite big improvements, the issues remain as challenging as ever. We have therefore focused our actions on two areas of work, where we think we can make the biggest impact in relation to criminal justice and mental health.

Action 6

DIVERTING PEOPLE FROM THE CRIMINAL JUSTICE SYSTEM

We will help to implement a programme to make more regular and widespread use of the Mental Health Treatment Requirement (MHTR) in the Magistrates and Crown Courts.

What is the MHTR?

The MHTR is a sentencing option which offers offenders with mental health problems the option of a treatment plan that addresses the underlying causes of offending. It is intended for the sentencing of offenders convicted of (an) offence(s) and who have a mental health problem which does not require secure in-patient treatment[35].

Nationally, the MHTR is rarely used. Aside from the fact that many people may not meet the threshold for a service from specialist mental health services, other barriers to use include a lack of suitable mental health community services in many places, poor processes at the court stage to ensure assessments are readily available to magistrates, unwillingness on the part both of offenders and of psychiatric services, and poor liaison between probation and community mental health treatment providers[36].

Why use the MHTR?

Where MHTRs have been used, people value the stability it can help to bring[37]. There is also emerging evidence from a site trialling MHTR in Milton Keynes that uptake can be increased significantly (and successfully) by having a more proactive approach and having clear arrangements between the courts, health providers and probation services, and Community Rehabilitation Companies (CRCs).[38] The Milton Keynes trial is beginning to show evidence of improved mental health and wellbeing, better coping skills and improved criminal justice outcomes.[39]

Our progress and plans

Although the evidence is still building, we believe more MHTRs should be used. We have already started to examine how to extend the use of MHTRs in our region and have had positive discussions with the Ministry of Justice, CRCs, local court officials and magistrates. We will now work together to establish a programme to ensure much more regular and widespread use of the Mental Health Treatment Requirement as a sentencing option. We have started work in three pilot areas - funding from the Office of the Police and Crime Commissioner (OPCC) will support projects in Coventry and Wolverhampton, and funding from NHS England will support a project in Birmingham.

Who will we work with?

We will work with the Police and Crime Commissioner's Office, the local Community Rehabilitation Company, National Offender Management Service (NOMS), community health commissioners and providers, and the prison service on this programme.

The difference it could make

This programme should help recovery, reduce reoffending, and reduce the cost and impact of crime on the local community. By linking to IPS (see action 1), it could help people back into employment. MHTR offers offenders a choice and an opportunity to regain some control over their lives, giving them the chance to stay in the community and in touch with existing support systems and networks. It shows they are valued as members of society, as opposed to a problem to be dealt with.

35. MHTRs – A guide to integrated delivery National Offender Management Service
36. A Missed Opportunity: Community Sentences and the Mental Health Treatment Requirement' Khamon, Samele & Rutherford Sainsbury Centre for Mental Health 2009
37. The Mental Health Treatment Requirement. Scott G and Moffatt S Criminal Justice Alliance and Centre for Mental Health 2012
38. Mental health and criminal justice Durcan G. Centre for Mental Health 2016
39. http://www.academyforjusticecommissioning.org.uk/wp-content/uploads/2015/01/MHTR-seminar-pres-140115.pdf

Action 7

SUPPORTING PEOPLE WITH MENTAL HEALTH NEEDS WHEN THEY LEAVE PRISON

We will develop a programme that more effectively supports people with mental ill health as they prepare to leave prison and settle back in the community.

Why do this?

When people with mental ill health leave prison there is generally little coordinated support to help them manage their condition. Too often they reoffend and the cycle starts over again.

What initiatives are happening across the country?

There are a number of initiatives taking place across the country that could help us develop this programme.

The Engager project is a five year project taking place in the North West and the South West to develop and evaluate a collaborative care intervention that engages with offenders with common mental health problems, who are close to release, and to set up a pathway of care in preparation for discharge and for up to 16 weeks out in the community. The intervention aims to overcome a number of challenges this group face, including the transition between prison and community, fragmented services based on diagnosis (e.g. substance misuse, depression) and social problems (homelessness, unemployment).

Another national initiative is 'Through the Gate' - a National Offender Management Service/ Community Rehabilitation Company (CRC) led programme to identify opportunities to resettle people as they leave prison. Working with providers, plans are put in place to ensure housing, health and social needs are addressed prior to release, and they work with people for a fixed period after release.

Who will we work with?

We will work with the Police and Crime Commissioner's Office, the local Community Rehabilitation Company, National Offender Management Service (NOMS), community health commissioners and providers, and the prison service on this programme.

Our progress and plans

We believe the Through the Gate and Engager projects are emerging as effective ways to help offenders with mental health needs when they leave prison. As a result, we will develop a programme of work based on these projects within the prisons in our region. We aim to build on the Engager project involving a trial in two prisons in Manchester and Plymouth. We will develop our first programme based on the Engager project in a prison in our region. This programme will support people with mental ill health more effectively from before they leave prison through to release, and while they re-establish themselves back in the community.

The difference it could make

We need to address the challenges faced by people with mental ill health as they leave prison and return to the community. Preparing them for the transition will help them maintain good mental health, and gain access to accommodation, training or work. Having access to services and support will also help to reduce the chances of reoffending.

THEME 4

DEVELOPING APPROACHES TO HEALTH AND CARE

Mental ill health can affect anyone of any age, or from any community. It is vital that people with mental health needs get the right support to treat their condition, as quickly as possible. Neglecting mental ill health can have dreadful consequences for those affected and for their loved ones. Sometimes the consequences are fatal.

In 2015, 477 people lost their lives in the West Midlands through suicide. This has a profound impact on loved ones, friends, work colleagues, and communities. Suicide and self-harm can affect anyone, but is the biggest killer of men under 49.[40] People from minority and ethnic groups are also affected - for example, a study in three cities found that Asian women aged between 15 and 35 are more vulnerable to suicide and self-harm. Self-harm is common among young African-Caribbean women.[41]

There is a growing interest in how we can support people experiencing mental ill health more effectively in primary care. Getting the support right at this point can help prevent people's health deteriorating and can aid recovery. One in four of a GP's patients will need treatment for a mental health problem at some point in their lives. But currently, our health and social care system is not set up well enough to deal with this. Although there have been some great initiatives across the country, we are not meeting patients' needs in many areas.

In the West Midlands, we are not meeting the new national access standards for early intervention in psychosis (EIP) and for psychological therapies. When people are admitted as inpatients in secondary care hospitals, they do not always get the most therapeutic care, with too many cases of people being moved around the country in search of a bed, and too much use of restraint in inpatient wards.

Making a difference

We have identified a number of actions which apply the guiding principles we set out to follow. They address the priorities of improving access to support, intervening more quickly, providing compassionate evidence-based care to meet individual needs, and giving power to people to have a say over their care.

40. Office for National Statistics 2014 (http://visual.ons.gov.uk/what-are-the-top-causes-of-death-by-age-and-gender/)
41. Ethnic differences in self-harm, rates, characteristics and service provision: three-city cohort study Cooper, J., Murphy, E., Webb, R., Hawton, K., Bergen, H., Waters, K. and Kapur, N. The British Journal of Psychiatry,197(3), pp.212-218. 2010

Action 8

A COMMITMENT TO THE CONCEPT OF ZERO SUICIDE

We will launch a 'Zero Suicide Ambition' for the West Midlands - which together with the recently updated National Suicide Prevention Strategy, aims to prevent and reduce suicides across the region.

What is the Zero Suicide approach?

Professor Ed Coffey developed the concept of 'zero suicide' at the Henry Ford Hospital system in Detroit, Michigan. It is based on the concept of suicide not being inevitable and of having ambitious goals rather than planning for incremental progress. The cornerstone of the programme is Perfect Depression Care[42], which has one objective – do everything that can help address depression and avoid doing things that stand in the way of that. Patients are actively engaged and supported to talk about suicide and despair. They are also supported to rediscover hope and find ways to survive, with a continuous eye to re-engaging with and contributing to the communities in which they may live, work, and play for a lifetime. It particularly aims to reach people who have not been reached through previous initiatives and to address gaps in existing provision[43].

Why do this?

The zero suicide approach is showing promising results in the US. The Henry Ford Health System delivered a 75% drop in suicides in the first four years. For two years, there was not a single suicide amongst the patient population[44]. Suicides in the US Airforce fell by one third over six years. At Magellan Health in Arizona there was a 38% reduction in the first two years.

England's Mental Health Trusts have achieved some of the most successful reductions of suicide rates in the world, but the lack of focus on primary care and alcohol services now needs to be addressed. A small number of zero suicide ambition pilot projects in Merseyside, the East of England and the South West are evaluating the improvements they have made using creative and effective local approaches to suicide reduction[44].

The moral imperative of saving lives is what drives this approach but it also saves resources which can then be used to support others. It is hard to place a monetary value on suicide reduction, but other forms of fatality do have such measures attributed to them. Recent work by the Centre for Mental Health suggested that each case of suicide costs around £1.5 million.[45] The human cost is incalculable.

Our progress and plans

We think developing a similar approach in our region could help us significantly reduce the number of suicides. By 2020, NHS England wants to reduce suicides by 10% and for all areas to have multi-agency prevention plans in place by 2017. Inspired by the Detroit programme, but recognising that the Detroit cohort was a more affluent employed group, we will apply and adopt their methods to all our communities and develop and launch a Zero Suicide Ambition across the West Midlands. We want to build on work already being done locally, such as 'Balls to Talk', a campaign in Coventry which uses sporting themes and key messages to direct people to help and support, when they need it. The idea is to encourage people, particularly men, to talk about how they feel. We will ensure that there is an open learning culture so that, when a tragedy occurs, lessons are learnt. We will apply the lessons from Detroit and the East of England where they are adapting the concept of 'perfect depression care', ensuring, for example, that people with chronic physical health conditions who have psychological needs are identified early and get access to support without delay. We have established links with Professor Coffey and those leading the approach in Mersey Care NHS Trust in Merseyside, to learn from their experiences.

Who will we work with?

This action will involve NHS organisations, local authorities, the police, Public Health England, community organisations and the wider community.

The difference it could make

We believe that together with the multi-agency National Suicide Prevention Strategy,[46] a commitment to 'zero suicide' is an important step in reducing the incidence of suicide. We aspire to save lives. This approach challenges the assumption that for some people, suicide is inevitable.

Action 9

WORKING TOWARDS EMBEDDING MENTAL HEALTH IN PRIMARY CARE

We will establish a group of local and national experts to recommend a primary mental health care model for the region that ensures people's mental health needs are more effectively supported. We want to promote and support a new era in mental health promotion, prevention and use of best practice treatments within primary care by the end of 2018.

What happens now?

The concept of primary mental health care is still relatively new in some parts of the world. It is defined by the World Health Organisation as 'mental health care that is provided by primary care workers who are skilled, able and supported to provide mental health services.'[47] Currently, most people with poor mental health and wellbeing will have contact with primary care services through their GP practice.

Why do this?

Primary care is the main source of help for many people with mental ill health. It offers many opportunities to address mental ill health, related physical health issues and medically unexplained symptoms. But currently effective mental health support is lacking in many areas of primary care.

NHS England's Five Year Forward View for General Practice published in April 2016 set out plans to invest in an additional 3,000 mental health workers to work in primary care by 2020.[48] But it is not clear how this will happen.

In Swindon, commissioners responded to pressure on services by developing a primary care triage unit. Patients are referred there by their GP and triaged on the same day. Most people are then referred to an organisation which offers a wide range of support to anyone with common emotional and mental health difficulties, particularly anxiety and depression. This initiative has relieved pressure on the local mental health trust and has significantly reduced inpatient occupancy in adults of working age.[49]

Our progress and plans

Our region is already taking action in this area. Sandwell introduced the Sandwell Wellbeing Hub,[50] offering a range of support[51]. Other CCGs in our region are redesigning primary care mental health services to strengthen provision in primary care and the community. Birmingham South and Central CCG introduced the Edgbaston Wellbeing Hub in 2014, and Birmingham Cross City CCG has commissioned Birmingham Mind to deliver a Wellbeing Hub. Dudley CCG is introducing a new model of care[52] called a 'Multispecialty Community Provider' (MCP), which includes a network of integrated multidisciplinary teams to provide mental health and wellbeing support at a primary care level. These services have developed independently, but show that things are changing in primary care mental health.

We must embrace these developments so we better respond to the range of mental health needs in primary care settings. It must also be joined up and reflect the diversity of the local population and need, avoiding inequalities of access across the region. Resolving primary care in mental health is a huge task, and we must get it right.

We will establish a working group of local and national experts to examine evidence and recommend the best primary care model(s) for the West Midlands. This group will propose practical actions to help GPs, such as drop-down menus to help assess the physical health needs of those with severe and enduring mental ill health. It will consider the case for trialling screening in primary care to identify people with psychological needs.

In particular the group will consider issues such as:

- Social prescribing - a way of linking patients in primary care with sources of support within the community, that work alongside existing treatments to improve health and wellbeing.
- Co-ordinated triage for talking and listening therapies
- Support and training to enhance knowledge and skills of practice nurses
- Pathways for areas such as medically unexplained symptoms, perinatal mental health and psychological trauma
- Effective interventions to support physical health improvements for people with severe and enduring mental health problems

They will make their recommendations in summer 2017, with a view to implementing recommendations by the end of 2018.

> *"There were so many opportunities for early intervention and services to help but because of the disjointed approach and lack of communication, I just fell through the cracks"*
>
> **Member of the Citizens Jury**

Who will be in this working group?

NHS England will coordinate this group, which will be comprised of representatives from local CCGs, provider trusts, and those with national expertise. The full membership of this working group will be agreed by the Implementation Director and NHS England, but will also include:

- Dr Ian McPherson (psychologist and senior mental health leader)
- Dr Paul Turner (GP Clinical Commissioner)
- Dr Geraldine Strathdee (Commission member)
- Dr David Smart (GP Clinical Commissioner)
- Dr Rhiannon England (GP and mental health lead)
- Dr Carrie Ladd (Royal College of GPs Perinatal clinical champion)
- Dr Elizabeth England (Royal College of GPs mental health lead)

We will also seek input from the Centre for Mental Health and the Care Quality Commission.

The difference it could make

Embedding mental health in primary care will make a huge difference to people within our region. This is not just about getting people access to treatment quickly. We want people to receive the right treatment earlier before it gets more serious, increasing the chances of success.

42. Definition reference - https://zerosuicide.org/2016/01/30/international-declaration/
43. Zero suicides Moulin, L. Centre for Mental Health 2015
44. Depression care effort brings dramatic drop in large HMO population's suicide rate Hampton, T. JAMA, May 19, 2010—Vol 303, No. 19
45. Zero suicides Moulin, L. Centre for Mental Health 2015
46. http://16878-presscdn-0-18.pagely.netdna-cdn.com/wp-content/uploads/2015/02/Annual_Report_acc.pdf
47. Integrating mental health into primary care: a global perspective. Funk, M., Ivbijaro, G. Geneva: World Health Organisation/WONCA 2008
48. Five Year Forward View for General Practice NHS England April 2016
49. Evidence to the Commission from Thomas Kearney, Swindon CCG
50. http://www.sandwell.gov.uk/info/200222/healthy_sandwell_healthy_you/762/mental_health_and_wellbeing
51. The Esteem Team: Co-ordinated care in the Sandwell Integrated Primary Care Mental Health and Wellbeing Service. Thiel, V., Sonola, L., Goodwin, N. and Kodner, D. King's Fund. 2013
52. Dudley is one of 29 areas selected to test a new model of care following the publication of the Five Year Forward View (5YFV) in October 2014. http://www.dudleyccg.nhs.uk/about-commissioning/integration/

Action 10

ENSURING OUR REGION TREATS PSYCHOSIS EARLY AND EFFECTIVELY

We will help to ensure the region meets national access and waiting time standards for early intervention in psychosis (EIP) services[53].

What is Early Intervention in Psychosis (EIP)?

Psychosis is a mental health problem that causes someone to perceive or interpret things differently from those around them. EIP is a safe and effective programme that identifies and treats people with psychosis, so they can receive effective treatment early and can get on with their lives.

Why do this?

Intervening early in psychosis is critical to maximise the chances of successful treatment. Disability plateaus quickly in psychosis and the early phase of the condition is a critical period to intervene to have the maximum impact in the longer term. A recent economic evaluation based on the OPUS study in Denmark shows that EIP has a 97% chance of being cost effective over five years[54]. It shows that EIP is very effective and represents good value for money - for every £1 invested in EIP a return of £15 could be expected over a ten-year period. It has shown that EIP generates costs savings of £2,234 per person over three years from improved employment and education outcomes.

Room for improvement

The evidence is clear - EIP works. But provision across the country and in the West Midlands is concerning. Half of EIP services in England have experienced budget cuts in the past four years, some by as much as 20%[55]. Current Department of Health and NHS England referral and treatment guidelines say that over half of people across the country experiencing a first episode of psychosis should be treated with a NICE approved care package within two weeks of referral. But many patients face unacceptable delays in accessing EIP services, greatly reducing their chances of recovery[55].

Our region is not immune to these issues. We are failing, nationally and in the West Midlands, to meet the access standard, with most areas failing to invest sufficient funds necessary to provide the full, evidence-based treatment programme.

Our progress and plans

Our region led the way in this area by developing EIP during the early 1990s. Now, we agree that the organisations in our region must work together to address the issues of funding and provision of EIP. NHS England will lead a programme to ensure the national standard for treatment and maximum waiting time standard are met.

Who will be involved?

This action will be led by NHS England in the region working with CCG commissioners and mental health providers, with the support of the Strategic Clinical Networks (SCNs) and Academic Health Sciences Networks (AHSNs). They will implement plans to ensure the national standard is achieved by the end of 2017.

The difference it could make

Getting EIP funding and provision right in our region could mean everyone with psychosis in our region gets access to the right treatment, quickly. NICE found that EIP services reduce the likelihood that individuals with psychosis will relapse or be detained under the Mental Health Act, potentially saving the NHS £44 million each year through reduced hospital admissions[56].

Action 11

EXAMINING THE PRINCIPLE OF EARLY INTERVENTION

We will establish a group of local and national experts to examine how the principle of early intervention should be applied to other areas of mental health care, so we could support people much earlier, whatever their age.

What does early intervention mean?

As with psychosis, intervening early with a range of mental health problems is critical to prevent it escalating and causing a range of further problems and even disability. Emerging evidence suggests that applying the principle of early intervention could benefit other disease areas alongside psychosis. There is also a powerful case for taking a whole life approach, by intervening in the early years of a child's life.

Why do this?

We believe that there are potentially large improvements that could be achieved for people by intervening earlier and intervening with effective healthcare. We want to assess the evidence for this.

Our progress and plans

We will establish a working group to examine whether applying early intervention approaches could benefit people who experience other mental health conditions. For example, it could include evaluating the impact of early interventions during a child's early years and through school. They will examine schemes such as that in Philadelphia where children are screened for multiple 'adverse child events (ACE)', such as violence, sexual abuse, and drug and alcohol addiction. Those children identified are given early support before significant mental health issues set in. The working group will report their findings by summer 2017.

Who will we work with?

Members of this group include Professor Swaran Singh (University of Warwick), Max Birchwood (University of Warwick), Karen Edwards (NHS England West Midlands), Tom Fox (Dudley Early Intervention Service), and Dr David Shiers (former GP and EIP national lead).

The difference it could make

By examining the evidence for early intervention, this action will reveal if having a clear early intervention treatment approach could enable doctors to provide the best care and improve the lives of people with mental health needs in our region.

> *" [In hospital] I was assessed to see if I was a risk to myself, but I wasn't referred to anyone, and no one checked to see if I had a support network when I got home"*
>
> **Member of the Citizens Jury**

53. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/361648/mental-health-access.pdf
54. Investing in recovery: Making the business case for effective interventions for people with schizophrenia and psychosis. Knapp M, Andrew A, McDaid D, et al The London School of Economics and Political Science, Centre for Mental Health and Department of Health 2014
55. Lost Generation – protecting EIP services Rethink Mental Illness 2014
56. National Institute for Health and Care Excellence, 2014. Costing statement: Psychosis and schizophrenia in adults: treatment and management.
57. Old Problems, New Solutions: Improving Acute Psychiatric Care for Adults in England Crisp, N. Smith, G. Nicholson, K 2016
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59. Patient suicide: the impact of service changes. A UK wide study. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness University of Manchester (NCISH) 2015
60. Evidence to the Commission from Prof. Tim Kendall, NHS England National Clinical Director for Mental Health
61. http://www.ardengemcsu.nhs.uk/files/7114/3265/7953/Case_Study_-_Mental_Health_Repatriation.pdf
62. http://www.covwarkpt.nhs.uk/aboutus/news-events/press-releases/Pages/September%202015/NHS-services-land-national-award.aspx

Action 12

Ending out of area placements

We will end out of area mental health hospital placements – where mental health patients are placed in an in-patient bed at a hospital outside the area of the five mental health NHS Trusts in our region – for acute mental health care by the end of 2017.

Why do out of area placements happen?

Out of area placements usually happen when the local provider NHS Trust does not have bed capacity. Out of area placements in mental health has been an issue for some time. The Commission to review acute inpatient psychiatric care provision for adults (CAAPC), chaired by Lord Crisp, highlighted out of area placements as an issue of particular concern.

In September 2015, 499 adults in England had to travel more than 30 miles, for admission to a service which should be provided locally, such as acute care, psychiatric intensive care or rehabilitation services[57]. A more recent report following a Freedom of Information Act request showed that 5,411 patients were sent to out of area hospitals in 2015-16[58]. Although some out of area placements are provided by other NHS Trusts, often these beds are purchased from independent sector mental health care providers.

Why should we stop it?

We acknowledge that occasionally, patients do need specialist inpatient care that is not available in our region. But if care is available, we should use it. We know that when people are sent out of area, there is an increased risk of suicide[59]. The distances often make it harder for family and friends to visit and this can cause additional distress for them and patients. Out of area placements are also expensive – although we have no national figures, one English NHS Trust spent £4.8 million on such placements.

New initiatives are emerging to deal with this. For example, Sheffield Health & Social Care NHS Foundation Trust has undertaken a radical programme of repatriating patients from out of area placements whilst reducing bed numbers, in part by reducing length of stay, at the same time. They have reinvested the resources saved into local provision - in a crisis house and in improved community and crisis support - which resulted in reduced admissions. The number of out of area placements fell from almost 40 to under five[60].

Our progress and plans

Great work is already happening in our region to reduce out of area placements. Over the past four years, NHS provider trusts, CCGs and a Commissioning Support Unit have worked together to repatriate 100 people, saving £12 million[61,62]. This programme has been award winning. The MERIT Vanguard, an alliance of NHS trusts in the West Midlands working to transform the way acute mental health services are provided, is leading work to reduce out of area placements.

Nationally, NHS England wants to end out of area placements for all adult acute mental health care by 2020. But we are more ambitious. We will end out of area placements for routine admissions in all mental health services, for all age groups, by the end of 2017. No one will be sent out of the area of the four Trusts making up the MERIT Vanguard. The MERIT Vanguard will establish a small working group to work out how to achieve this.

Who will we work with?

Organisations across the MERIT Vanguard, including local authorities, will be involved in delivering this action.

The difference it could make

We believe that out of area placements are bad for patients, too expensive and have a negative effect on recovery. Ending this practice will ensure people in our region receive the best care, closer to home. This is an exciting opportunity to develop pathways into and out of hospital care, acute care and supported housing, and will be an important initiative for the whole country.

Action 13

REDUCING INAPPROPRIATE INPATIENT ADMISSIONS

We will help to explore effective alternatives to inpatient care that meet the individual needs of people with mental ill health, including those in crisis, and test which work best before implementing them. We will look at successful schemes such as crisis houses, and explore the case for establishing a network of host families in the region. We will learn from others across the country, such as Hertfordshire, Cambridge and South London, where digital systems to manage bed capacity are now in place.

What are the options?

When an individual is in a distressed state and in need of support, there is often no alternative but to admit them into inpatient care. A recent study found that over half of inpatients could have been treated effectively in community settings if appropriate services had been available[63]. Alternative options are being developed across the country. We are working to understand bed capacity, and how effectively these alternative options reduce unnecessary admissions.

Crisis houses - accommodation that provides for people who find themselves in significant mental distress and crisis - are one such alternative for some people with acute mental health problems[63]. Crisis houses are community-based alternatives to hospital admission, providing support and temporary respite from the person's usual place of residence. In Leeds, there is an alternative non-residential model to crisis houses, Dial House, which operates without overnight beds. The Richmond Fellowship service, Box Tree Farm, in Ratby near Leicester is also another great example of crisis house provision.

Emerging evidence suggests people prefer residential crisis houses to inpatient wards, they carry less stigma, and are a good alternative for people not needing close supervision and observation[64,65]. Crisis houses may be more cost-effective than psychiatric care[66,67], and can help people meet others that can help them cope in the event of future difficulties. A bed in a crisis house in Tower Hamlets costs half that of an inpatient bed in the local mental health trust.
In Sheffield, a crisis house has helped to reduce out of area placements, reduce pressure on inpatient services and has provided positive support to people in crisis. Research found that patients had better alliances with staff in community crisis houses because they were given more freedom than in standard acute psychiatric wards[68].

Another approach is to develop a network of host families - where a patient stays with a family that supports them. Host families provide an alternative to hospital for people experiencing a period of mental ill health. This approach has been pioneered by Hertfordshire Partnership NHS Foundation Trust. The scheme, the first of its kind in the UK, is based on evidence that people with mental ill health recover better if they are out in the community, in a supportive family setting, and taking part in a daily routine.

Our progress and plans

We want to explore different models that are alternatives to inpatient care. We believe crisis houses, and other alternatives such as host families, could help to provide a range of options so that we can better tailor support to an individual person's needs, including needs of people from diverse communities. Despite an increase in the number of crisis houses across England in the last two years, crisis house provision in the West Midlands is limited, although there are emerging plans within Birmingham and Walsall.

We will build on this encouraging work and develop plans to establish or expand crisis houses and other alternatives in the West Midlands that are effective alternatives to inpatient care.

Who will we work with?

We will work with housing associations, other third sector organisations, the NHS and local authorities to make this action a reality.

The difference it could make

Crisis houses and other services could offer a more accessible alternative and reduce demand to inpatient care that improves outcomes for people. It could provide good value for money.

Action 14

REDUCING RESTRAINT IN INPATIENT CARE

Building on existing progress, we will apply for a grant from the National Institute for Health Research (NIHR) for a major project to substantially reduce the use of restraint in inpatient settings.

Why use restraint at all?

Physical restraint has always been used in mental health settings to manage patients. Incidences of violence towards staff and other patients, or where a person poses a significant risk to themselves, can result in the use of restraint and/or seclusion[68]. Between 2011 and 2012 there were 60,000 assaults reported against NHS staff in England, and just over two thirds of these were in mental health or learning disability settings[70].

Why reduce restraint?

Physical restraint can cause injuries to patients and staff, and can be highly distressing for patients, who often associate it with psychological trauma and loss of dignity. It can destroy trust between staff and patients. Restraint incidents are often followed by additional containment measures, such as medication or restrictions, which patients may see as controlling and coercive[71].

Physical restraint is still common in UK mental health settings. In England during 2015/16, 66,681 physical restraints, and 12,347 face-down restraints were reported across 49 mental health trusts. In 2014, new national guidance called Positive and Proactive Care was published to address this and encourage a culture where restrictive interventions are only ever used as a last resort.

There are examples of promising practice in various parts of the country. For example, the concept of No Force First was introduced by Mersey Care NHS Foundation Trust, to change ward cultures from containment to recovery and coercion-free environments. No Force First is reducing restrictive practices in in-patient environments, with restraint halving on pilot inpatient sites in the first year and significantly lowering staff absence rates[72].

Who will we work with?

We will work with Professor Joy Duxbury at the University of Central Lancashire, a leading academic voice pursuing restraint reduction. We will also ensure the involvement of representatives of the four local mental health trusts in the region.

Our progress and plans

We believe that it is not possible to provide good therapeutic care and deliver on the principles of recovery when force or coercion is heavily used in inpatient care. We therefore want to significantly reduce the use of restraint and seclusion. We will learn from others who are doing this now and build on existing progress.. With Professor Duxbury and the local mental health trusts, we will apply for funding from the National Institute for Health Research (NIHR) to complete a major programme across the North West and the West Midlands aimed at substantially reducing the use of force, and to evaluate the impact such a programme could have. We aim to substantially reduce force across the West Midlands by December 2017 and in the longer term.

The difference it could make

This programme will inform ways to avoid restraint except in exceptional circumstances, restoring dignity and improving care for patients in our region and beyond.

63. Is there a crisis about Crisis Houses? Obuaya, C. Stanton, E. Baggaley, M. J R Soc Med 106: 300 July 2013
64. Sweeney, A. et al The relationship between therapeutic alliance and service user satisfaction in mental health inpatient wards and crisis house alternatives: a cross-sectional study. 2014.
65. Admission to women's crisis houses or to psychiatric wards: women's pathways to admission Howard, L.M., et al. Psychiatric Services.59 (12), 1443-1449 2008
66. Cost and cost-effectiveness of hospital vs residential crisis care for patients who have serious mental illness. Fenton, Wayne S., Hoch, J., Herrell, J. and Mosher, L. Archives of General Psychiatry 59 (4): 357-364. 2002
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68. An Investigation of Therapeutic Alliance and its Relationship to Service User Satisfaction in Acute Psychiatric Wards and Crisis Residential Alternatives. Johnson, Prof. S. et al University College London June 2014
69. Seclusion is defined in the Mental Health Act Code of Practice as: The supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others.
70. Violence and aggression: NICE guideline DRAFT November 2014
71. Should nurses restrain violent & aggressive patients Duxbury, Prof. J & Wright, K. Nursing Times; 107: 9,early on-line publication 2011
72. http://www.merseycare.nhs.uk/about-us/striving-for-perfect-care/no-force-first/

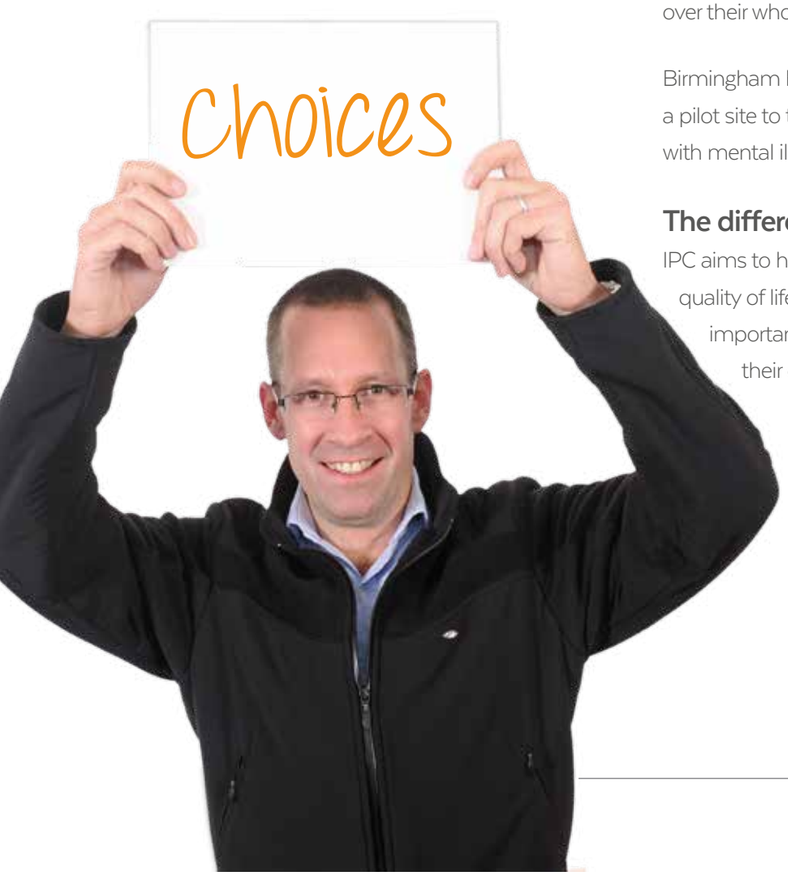
Action 15

GIVING CHOICE TO PEOPLE

Integrated Personal Commissioning (IPC) is a new approach to joining up health, social care and other services. We will help to trial IPC in the region for those with mental ill health. This approach gives power and control to people over the funds available for their care.

Why do this?

The principle of giving control of the budget for care to people has been developed in social care in local government. The right to a personal budget in social care is now enshrined in the Care Act, 2014. The principle gives people choice over their own care. Now, the principle is developing within the NHS in the form of personal health budgets.



IPC helps people manage their own health by giving them more choice and control about the personal care they receive. It enables people, carers and families to combine and control the resources available to them across the system, to 'commission' their own care through personalised care planning and personal budgets. IPC also supports people to develop their knowledge, skills and confidence to self-manage through partnerships with the voluntary and community sector, and peer support. IPC also accords strongly with the Commission's guiding principles.

Who will we work with?

We'll work with NHS England, local councils and the IPC programme nationally.

Our progress and plans

NHS England wants to trial pooling social care and NHS funds for individual people so they have control over their whole budget.

Birmingham has been selected by NHS England as a pilot site to trial the development of IPC for people with mental ill health.

The difference it could make

IPC aims to help people take control, have a better quality of life, achieve the outcomes that are important to them, have greater involvement in their care and design the support they need.

Action 16

IMPROVING PERINATAL MENTAL HEALTH

We will establish a group to ensure access to specialist 'perinatal' mental health services across the region for women during pregnancy and after they give birth to their babies, in line with the national priority for perinatal mental health.

Why do this?

One in five mothers suffer from depression, anxiety or psychosis during pregnancy or in the first year after childbirth, and suicide is the second leading cause of maternal death in the UK behind heart and circulatory disease. This can have devastating effects on the family and affect children for their whole lives. Perinatal mental illnesses cost the NHS significant amounts of money. The total long-term cost of perinatal depression and anxiety is estimated at around £550 million for each one-year cohort of births in our region.[73] Giving early, effective help to people affected by postnatal depression and psychosis is vital to prevent symptoms worsening, to reduce these awful statistics and to prevent the devastating effects on families.

What is happening?

NHS England's Five Year Forward View for Mental Health has proposed a major national programme aimed at ensuring that every part of the country has access to specialist perinatal mental health services. In November 2016, NHS England set out plans to fund new specialist community mental health services that provide evidence-based specialist perinatal mental health care for mums before and after birth in 20 areas of the country – including Birmingham South Central CCG in our region - so they reach 30,000 more women a year by 2021. A further £20 million will be allocated in 2017.

Our progress and plans

We will establish a working group to develop a plan to ensure access to specialist perinatal mental health services across the region. We will build on the local expertise available and ensure that an effective specialist perinatal mental health service is developed in our region as a high priority.

Who will we work with?

We will work in partnership with the Associate National Clinical Director for Perinatal Mental Health, Dr Giles Berrisford, who is also a Consultant Psychiatrist based in the region. We will also work with local commissioners and providers.

The difference it could make

Improving perinatal mental health could improve the quality of life for many women and families, and save the NHS money in the long term.

73. Newbigging, K. and Parsonage, M. (2017). Mental Health in the West Midlands Combined Authority. University of Birmingham: Health Services Management Centre.

Action 17

INVESTIGATING WHY MENTAL HEALTH ACT DETENTIONS ARE RISING

We will examine why detentions under the Mental Health Act are rising in the region, particularly numbers of repeat detentions, and if there are inequalities which need addressing.

What is the Mental Health Act?

The Mental Health Act 1983 includes powers which enable people to be admitted, detained and treated in hospital against their wishes. This power can be used if you are putting your own safety or someone else's at risk and you have a mental disorder. It is commonly known as being 'sectioned.' The Mental Health Act applies in England and Wales, and covers what rights you have, how you can leave hospital and what aftercare you can expect to get.

Why investigate why detentions are rising?

Detentions under Section 136 of the Mental Health Act have been increasing nationally for the past twenty years and this is reflected in the figures for the WMCA region. In 2015-2016, people from specific Black and Asian Minority Ethnic (BAME) communities constituted nearly 40% of people detained under the Mental Health Act (MHA) in the region.[74]

The recent Care Quality Commission annual report[75] of the use of the MHA in England and Wales also showed a continuing rise in detentions under Sections 2 and 3 of the MHA. This is a trend that has been continuing for the past five years. Understanding why this is happening could reveal new ways to reduce these levels and deal with detentions better.

Our progress and plans

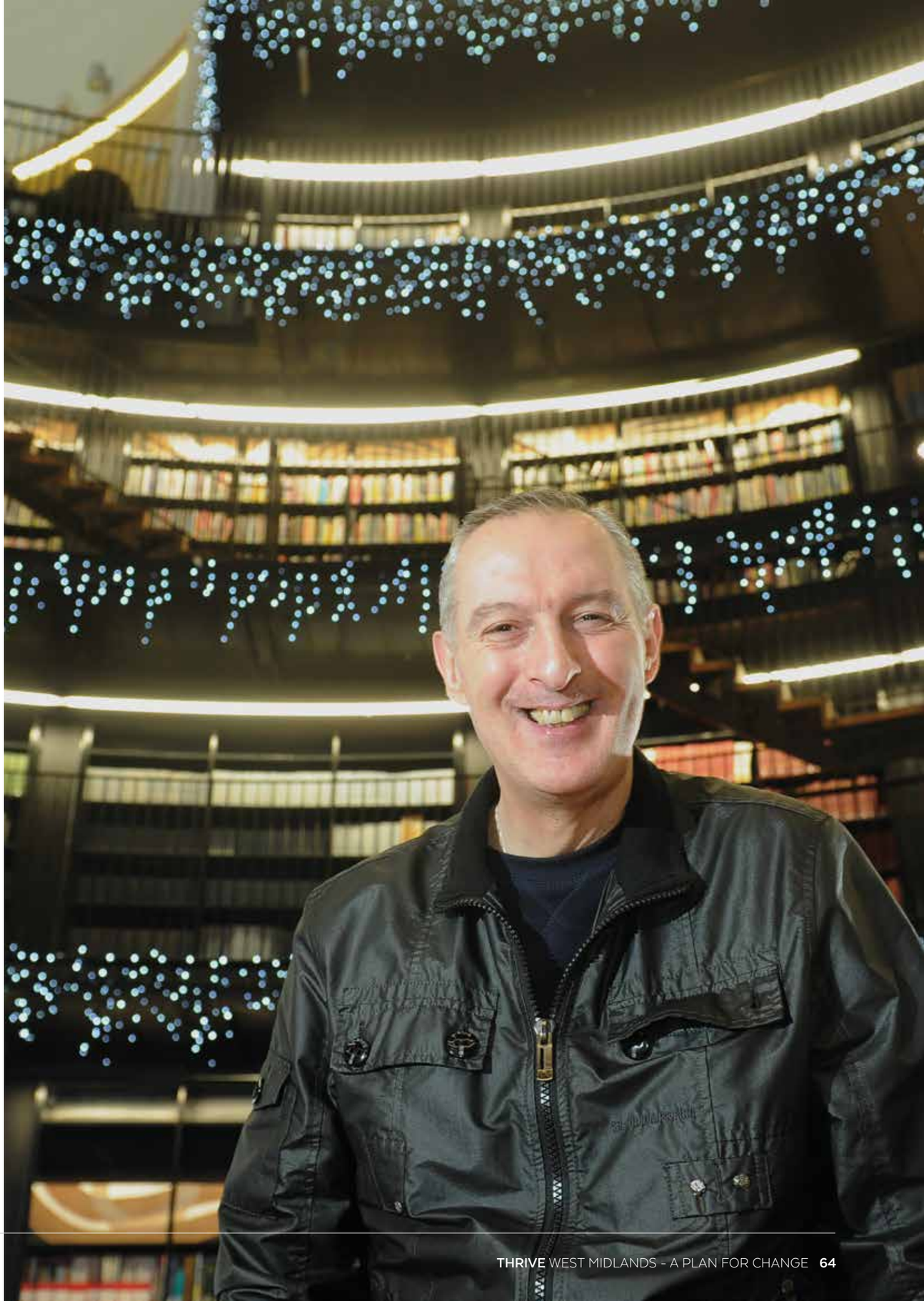
We want to examine why detentions are rising with the aim of finding ways to deal with this better. We want to find out why particular diverse communities are also affected more than other people. We want to know how many are repeat detentions within three months of release and what factors contribute to this. We will establish a working group to do this.

Who will we work with?

We will work with mental health trusts, criminal justice agencies, the ambulance service, NHS England and our local Crisis Care Concordat groups. We particularly want to ensure that we develop approaches which prevent repeat crisis episodes within a three month period of initial detention.

The difference it could make

The approach will establish the evidence so that we understand current trends better and apply what we learn. We will identify the best way to improve the way people are treated.



74. Newbigging, K. and Parsonage, M. (2017). Mental Health in the West Midlands Combined Authority. University of Birmingham: Health Services Management Centre.
75. Care Quality Commission Mental Health Act Review 2016

THEME 5

GETTING THE COMMUNITY INVOLVED

A recent survey found most people had high levels of awareness of 'mental wellbeing' as a concept, and most had positive attitudes towards improving their own mental wellbeing[76]. Campaigns such as Time to Change have helped to change public attitudes to mental health. People also have greater access to information about mental health, including through the NHS Choices website, which is now the world's most popular mental health information site.

But still people with mental health problems continue to experience stigma and discrimination, and negative attitudes towards them. A person with schizophrenia is less likely to be accepted into society compared with a person with depression, and people are not very willing to interact with people with either condition in more personal settings. In the workplace, only a few people think that depression or schizophrenia would not be detrimental to an employee's promotion prospects[76].

Many people cannot recognise symptoms of mental ill health and don't know which interventions or treatments could help[77]. Training people in mental health first aid is one way to improve their knowledge. People who have completed this training say they are more knowledgeable and understand how to help people with mental health problems[78]. Over half of UK employers would like to do more to raise levels of mental health awareness and knowledge within the workplace and improve staff wellbeing, but don't feel they have the right training or guidance[79]. Initiatives that do this would help to reduce stigma and help people experiencing mental ill health to get the help they need, faster. A good example of this in the West Midlands is the charity St Basil's, who alongside local health trusts, developed a programme to make the charity a 'psychologically informed environment'. This involved providing core training in psychological skills for their staff so they can better support their young clients.

Making a difference

Raising awareness and knowledge of mental health and how to support people in our communities will go some way to reducing this stigma and help people to be more understanding. These actions will help to do this in our region. Our ambition is for the West Midlands to lead the way in eradicating stigma and in raising awareness and understanding of mental ill health and wellbeing.

Action 18

RAISING AWARENESS OF MENTAL HEALTH AND WELLBEING IN THE COMMUNITY

We will launch a programme of community initiatives to raise awareness of mental health and wellbeing, guided by people with experience of mental ill health and driven by the community.

Why do this?

Encouraging the wider community to talk about mental health, and participate in events and initiatives that raise awareness of it, help to break down stigma and discrimination. Campaigns such as Time to Change are having a positive effect on public attitudes to mental health. Across the country, many community based organisations and sports clubs, including professional football, rugby and cricket teams, are also raising awareness of mental health in the community.

Our progress and plans

We are launching some specific initiatives in Mental Health Awareness Week in May 2017, and hope others in our region develop them with WMCA support. These initiatives will include:

- launching an annual 'Walk out of Darkness' in May 2017 - a 10 mile sponsored walk through the region to raise funds for organisations supporting people with mental ill health and raising awareness of mental health
- an annual awards ceremony to recognise people in local communities who do amazing work supporting others - health and care workers, volunteers, loved ones, other public and private sector workers, those involved in vital research, managers who lead and achieve change
- exploring whether a community art initiative such as that developed in Philadelphia could help to improve public mental health and wellness in our region
- developing a network of 'Mental Health Champions' - organisations and individuals who commit to promoting positive mental health and wellbeing, such as football and rugby teams, and cricket clubs.

Who will we work with?

Partners could include community and voluntary organisations, Public Health England, local sports teams and businesses to develop a programme of community involvement events. We will work with the charity Clasp on the Walk out of Darkness. We hope members of our Citizens Jury, who have helped us to shape this action plan, will play a key role in this initiative. We hope that the first Mayor of the West Midlands Combined Authority launches a Mayoral fund to support community initiatives.

The difference it could make

This initiative will build momentum in the region around mental health and will raise awareness and improve understanding in our communities.

76. Attitudes to mental health problems and mental wellbeing British Social Attitudes NatCEn Social Research July 2016
77. The public's ability to recognize mental disorders and their beliefs about treatment: Changes in Australia over 8 years Jorm, A. F., Christensen, H., & Griffiths, K. M. (2006). Australian and New Zealand Journal of Psychiatry, 40, 36-41.
78 Mental Health First Aid England: is improving the mental health literacy of the population contributing to a public health priority? Jaman, P., Paterson, P. and Pearson, L. 2014
79. How to be mentally healthy at work Mind 2013

Action 19

A LARGE PUBLIC HEALTH PROGRAMME IN MENTAL HEALTH FIRST AID

We will launch a large public health programme to train up to 500,000 people across the region in Mental Health First Aid (MHFA) or other equivalent programmes over the next ten years. We will explore public and private partnerships to fund such a programme. We'll also campaign for Government to amend First Aid legislation for employers, to include mental health.

Why do this?

Those with mental ill health still experience stigma. Although it has an impact on many people, families and workplaces, there is a significant lack of awareness and understanding of how best to support people with mental ill health. Giving people information about mental health conditions and what to do if someone is affected will give people the skills to support someone in crisis and will help people understand what help is available. It will help people spot symptoms earlier and seek help earlier.

The concept of MHFA is gathering support across the world and is showing promising results in Australia. The Thrive programme in New York will train 250,000 New Yorkers in MHFA to help change the culture around mental health[80].

Emerging evidence suggests that with a good workplace mental health strategy (where MHFA is a component), staff are more willing to report mental ill health as the reason for absence. It can facilitate a return to work and people return more quickly. Generic mental health literacy initiatives to help people spot mental health problems could also be cost effective - Public Health England has estimated that for every £1 spent on training people to spot depression in workplaces, society will save £5.03, and for every £1 spent on workplace health promotion programmes, society will save £9.69.

What will mental health first aid consist of?

Mental Health First Aid (MHFA) training is an accredited educational course designed for the public which aims to improve knowledge of mental health in the general population and reduce stigma around mental illness and suicide. It was first introduced in England in 2007 as part of a national approach to improving public mental health.

Since then, it has been delivered to young people, in schools, in workplaces and with health care workers, and the general public. Some organisations choose to deliver other, equivalent programmes, such as the one developed by the charity St Basil's to make the charity a 'psychologically informed environment.'

Our progress and plans

MHFA is already being commissioned in the WMCA by some local authorities and provided through local Mind associations. MHFA courses are also offered by local NHS trusts and many West Midlands employers, as well as through independent training providers.
We will build on this great work by training up to 500,000 people across the West Midlands over the next ten years. There will be two levels of training - one for front line workers across the public, private and voluntary sectors and another for the wider community. We want to substantially raise awareness and understanding of mental health and wellbeing in our region to help people support those with mental health problems more effectively.

We'll also campaign for Government to amend First Aid legislation for employers, to include mental health first aid.

Who will we work with?

We will work with Public Health England, Mental Health First Aid England and other providers of training.

The difference it could make

We believe this large mental health first aid programme across our region could bring significant benefits to our community and to employers. Educating people how to support people with mental ill health will improve people's knowledge of mental health and how they can support each other, helping to bring our communities together. It would improve mental health literacy and understanding across the region, reducing stigma and discrimination.

80. https://thrivenyc.cityofnewyork.us/

SECTION TEN

PAVING THE WAY FOR SUCCESS - ENSURING OUR ACTIONS BECOME A REALITY

Key organisations across the West Midlands have worked together to agree to this action plan and are committed to fully implementing it.

We are also committed to doing this work in a way that complements and is integrated with other initiatives and programmes of development and various NHS plans, including those requirements set out in the Five Year Forward View for Mental Health and its implementation plan. The Commission's work has been reflected in in the Sustainability and Transformation Plans (STPs) covering the WMCA area and relevant actions are reflected in the plans for the Merit Vanguard.

To ensure our actions become a reality, we have put the following leadership and governance structures in place:

DIRECTOR LEVEL LEADERSHIP

Superintendent Sean Russell has been appointed as the new Implementation Director within the WMCA. He is responsible for implementing these actions, and driving and co-ordinating the work needed to make them happen.

Sean has already been working closely with us to ensure this Action Plan is supported by concrete plans which are owned and endorsed by the organisations that will implement them.

His role will also involve establishing robust governance, programme and project management arrangements that support implementation.

A NEW WELLBEING BOARD

This new Board will support Sean and will oversee the implementation of the actions and ensure this Action Plan is delivered. It will be responsible for monitoring progress, including keeping the WMCA Board updated. It will hold organisations to account to ensure they do what they have said they will.

It will align this Action Plan with other existing areas of work including Sustainability and Transformation Plans (STPs), Health and Wellbeing Boards, and the national Five Year Forward View for Mental Health, to ensure we do not duplicate effort and provide real value to the public through our work.

A steering group will support the Wellbeing Board. It will be responsible for guiding the local work needed to develop and deliver the Action Plan.

Working groups that focus on each of the actions will report to the steering group. They will be responsible for getting the day-to-day work done to implement the actions.

"I am delighted to be appointed as the WMCA's Implementation Director. I welcome the opportunity to build a stronger collaboration between our partners to improve the mental health of people in our region. Ultimately, I am determined to improve the way we use the resources available to us to reduce the impact of mental ill health, to improve the service the public receive and reduce the stigma that mental ill health has in our communities."

Superintendent Sean Russell

AN ONGOING ROLE FOR THE CITIZENS JURY

We have worked with people with experience of mental ill health to develop and shape this action plan. Members of our Citizens Jury will continue to have a key role in the implementation phase.

Now known as the West Midlands Cooperative, Citizens Jury members will be supported by the WMCA to continue their valuable engagement and challenge role. Their experience will give us invaluable insight from experts by experience and carers, and play a key part in shaping and doing the work to implement our actions.

WE WILL APPOINT A PANEL OF EQUALITY CHAMPIONS

The report of the independent taskforce report on mental health, the Five Year Forward View for Mental Health, recommended that the Department of Health appoint an equalities champion to address the disadvantages experienced by certain groups of people with mental health needs.

We believe we must address discrimination and inequality in mental health services in the West Midlands. Our work provides an opportunity to both acknowledge and tackle these inequalities.

We know that particular individuals and communities experience multiple disadvantage, including those from black and minority ethnic backgrounds, lesbian, gay, bisexual and transgender people, those who face inequality as a consequence of age and those with physical disability. We must champion the principle of equal treatment for all with mental ill health.

To ensure we address inequalities, the WMCA will appoint a panel of Equality Champions to work with the Implementation Director and others across the region to ensure that people get equal access and equal treatment regardless of their ethnicity, age, gender, and sexual orientation. Having a panel will ensure that every strand of the Action Plan accurately reflects our regional diversity and demographics.

MENTAL HEALTH CHAMPIONS WITH THE SEVEN COUNCILS

When we started this work, the WMCA had plans to recruit mental health champions within the seven councils. The Champions initiative is part of a national mental health challenge set up through a collaboration between the Centre for Mental Health, the Mental Health Foundation, Mind, Rethink Mental Illness, the Royal College of Psychiatrists and Young Minds[81].

The seven constituent member councils of the WMCA have an elected member who is a mental health champion. We have worked with the champions to encourage them to work together and be part of the implementation process, ensuring the priority of this work and of mental health more generally is reflected in the work of their councils and the WMCA as a whole. We'll encourage the non-constituent member councils and other organisations in the public and private sectors to follow suit. Warwickshire, one of the non-constituent member councils, already has one in post.

The council champions are all personal signatories to this Action Plan. They will champion mental health and wellbeing across the local authorities and ensure guidance is being followed.

81. www.mentalhealthchallenge.org.uk

SECTION ELEVEN

THIS IS THE BEGINNING OF A JOURNEY

Our ambition is clear – we want the West Midlands to lead the way on reducing the burden of mental ill health, promoting mental wellbeing and using public and private resources more effectively.

Great work is already taking place in the West Midlands. But we can and must do more. We will build on great practice wherever it exists.

This Action Plan is the start of a programme of work involving many people and organisations, who have worked together to agree these actions and are now actively working together to deliver them.

As we build momentum we aim to address further issues over the whole life cycle and develop a comprehensive public health approach aimed at reducing the burden and impact of mental ill health.

For the majority of the actions we know there is an evidence base. For some actions, it may not be as well developed as for others. Therefore a programme of evaluation will be commissioned to assess and report on how effectively each action is implemented, and how they strengthen pathways and equalities in these challenging economic times.

This evaluation will need to be undertaken thoroughly and over a reasonable period. We expect the WMCA to commission an evaluation programme, working with organisations with expertise in evaluation work.

We will share our learning with other city regions participating in the global network.

And people with experience of mental health issues will continue to shape our work, ensuring we meet the mental health needs of people in our region.

SECTION TWELVE

THANK YOU TO:

- All who have contributed to and supported the Commission's work
- Those who joined our **Citizens Jury**, and who have played a vital role in developing this Action Plan. This diverse group of people have actively participated in and influenced our decision making, and will continue to play a central role
- **Stakeholders and members of the public** who took part in our listening events
- Individuals and organisations who submitted evidence
- **Karen Newbigging** (Health Services Management Centre at the University of Birmingham), **Michael Parsonage** and **Andy Bell** (Centre for Mental Health) for their work on the baseline assessment report and scrutiny of evidence
- **Kerry Jones** and **Ajaib Paul** at Dudley Borough Council
- **Will Woodward** and **Meliz Ahmet**, from Norman Lamb's office for their work in supporting the Commission.

Read this Action Plan and follow our progress on the WMCA website

www.westmidlandscombinedauthority.org.uk/mhc

APPENDIX

WORK UNDERPINNING THIS REPORT

Since it began, we have completed a range of work, supported by a Steering Group of representatives from local organisations in the public and third sector. We have also sought advice and input from other organisations on particular areas of work.

STEERING GROUP

We established a steering group to ensure we remained in touch with the views of the community and of local public services, and to give advice about how best to provide additional support to people living with mental ill health.

The steering group consists of representatives of the local NHS, both provider and commissioning sectors, adult social care, housing associations, third sector groups, a local representative of the Department for Work and Pensions and the police.

BASELINE ASSESSMENT

Through the WMCA, we engaged the Health Services Management Centre (HSMC) of the University of Birmingham, working with the national Centre for Mental Health (CfMH) to conduct a baseline assessment of current mental health and wellbeing in the area covered by the WMCA.

We asked them to:

- **establish and understand the costs of poor mental health to the West Midlands**
- **provide an audit of current public sector (NHS/ local authority) and voluntary sector mental health service provision in the WMCA area**
- **provide an audit of all current or planned initiatives relating to mental health whether public, private or voluntary sector**

Read this baseline report at **www.birmingham.ac.uk/ hsmc/mh-wm-combined-authority**

PUBLIC ENGAGEMENT

We wanted to enable people not involved with the Commission to deliberate, have their voices heard and to influence the outcomes of the process. We felt this was central to our success.

To do this, we engaged Social Future, a community interest company to lead the development and delivery of three listening events held in Birmingham, Coventry and Dudley during April and May 2016. Participants discussed subjects of their choice.

Social Future also helped to create, and supported, our Citizens Jury. Read more on page 31.

SCRUTINY OF EVIDENCE

We invited a range of individuals and organisations to submit evidence relating to our key areas of work. Thirty sources submitted written evidence.

We engaged the Centre for Mental Health to independently scrutinise this evidence. This process involved:

- reading, summarising and providing a critique of the submissions received
- exploring how far the submissions concur with existing published evidence in relation to the Commission's key areas of work
- highlighting any gaps in the written evidence or relevant counter-evidence
- producing a synopsis of the evidence available in relation to each key area of work

This evidence has helped to shape this Action Plan.

NOTES

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