Walsall Council

Public Health Walsall 2016 Adult Mental Health Needs Assessment

This needs assessment is part of the Walsall Joint Strategic Needs Assessment process

Contents

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Executive summary

The Adult Mental Health Needs Assessment, written by Walsall Public Health (PH), is a product of collaborative working between PH, colleagues in the CCG, Dudley and Walsall Mental Health Trust, Social Services, Police and a range of stakeholders who contributed by providing essential information and responded to the Consultation. Completed in response to the need identified in Walsall's Joint Strategic Needs Assessment, and Health and Wellbeing Strategy, the Needs Assessment is a timely resource to help shape not only the Walsall CCG Mental Health Strategy, but also promote partnership working to address issues identified and increased emphasis on the prevention agenda to improve the mental health and wellbeing in the borough of Walsall.

A project team was put together for undertaking the work, represented by members of Walsall Public Health and Walsall CCG. Stakeholders were invited to attend periodically and governance was via the CCG Mental Health Programme Board.

The Needs Assessment draws on the intelligence gathered from a range of data sources, findings from consultation with members of the public, service users and stakeholders, and evidence gathered from literature, to present a set of recommendations for addressing the various issues and gaps identified in Walsall. The findings and recommendations were further developed using the feedback received at the Stakeholder Event held in April 2016.

Mental Health and Wellbeing in the general population

Walsall has high levels of obesity, low levels of physical activity, high level of smoking and a high rate of hospital admissions due to alcohol. The impact of healthy lifestyles on mental well being is well evidenced and the prevention of mental ill health needs to address the issues of unhealthy lifestyles in the borough. The need for more preventative services was emphasised by stakeholders. Asset based community development (ABCD) is an emerging approach to developing flourishing communities and enhance population wellbeing, and is becoming increasingly valuable in preserving and developing communities and services. Low mental health literacy limits opportunities for people to be actively involved in decisions about their health and increases delays in help-seeking and access to appropriate services.

Recommendations

- Adequate measures to increase physical activity levels in the borough, including measures such as good quality and adequate access to Green spaces.
- Develop resilience in communities and improve local mental health (MH) literacy using the assets based approach, particularly targeting men, Asian, African and Caribbean groups appropriately.

Factors affecting Mental Health and Wellbeing

Walsall has large areas of deprivation, a higher than regional or national claimant rate for out-of-work benefits, a lower proportion of those on Care Programme Approach (CPA) in paid employment, and higher than national proportion of those aged 16 and over with no or very low level qualification. There is variation in the rate of adults claiming Employment Support Allowance for mental health conditions across Area Partnerships, with highest rates in North Walsall, Darlaston & Bentley and Walsall South.

Those in secondary care in Walsall have a high rate of settled accommodation in comparison to national rate but there is scope for further improvement. The housing needs of those not on CPA are not well understood. Stakeholder consultation identified the lack of housing support as an issue at the time of discharge planning.

A significant number of working days are lost due to mental health related sickness, and it was the biggest cause of sickness for two of the largest employers in Walsall – Walsall Council and Walsall Healthcare Trust.

A need for a holistic approach which takes into account financial and legal help required for those with mental health needs was identified at the stakeholder event, and the evidence also points towards the implementation of accessible financial services to help tackle poverty, empower people (particularly women) and communities.

A holistic approach addressing the social, economic, cultural and environmental determinants of mental health therefore needs to be emphasised.

Recommendations

- All employers should be sensitive to the potential mental health issues underlying sickness absence. Healthy workplaces should be actively promoted and employers supported to protect and improve wellbeing of their workforce.
- Ensure screening for Mental Health and Emotional Wellbeing with appropriate signposting for all those on Employment Support Allowance.
- Undertake an audit to establish the housing support available for vulnerable people with MH needs, and not just those in secondary care
- Ensure effective and timely legal and financial support for people with MH concerns to prevent escalation of mental health concerns and crisis.

Health Inequalities

Black ethnicities were over-represented in accepted referrals to secondary care and in-patient admissions, which could be due to the underlying risks of mental illness in different ethnicities, but it is possible that a number of patients who could have been managed in the community are being diagnosed later and with more severe symptoms. Asian patients were under-represented in the IAPT services which may suggest inequity in access, cultural taboos and stigma associated with mental illness.

The public consultation identified that those from BAME communities feel they are more likely to be prescribed medications than referred for counselling services for common MH conditions like depression. It also raised the issue of men being more likely to be at risk but also less likely to seek help. Besides older people, isolation and loneliness were identified as an issue affecting Asian women.

Recommendations

- A range of early intervention and support services should be considered that are culturally sensitive to Walsall's BAME groups that promote mental health wellbeing and reduce stigma. The services should be targeted and outcome specific.
- Ensure communication with groups and engagement methods is culturally appropriate to meet the needs of the population.
- Develop a clear strategy to tackle the isolation of BAME groups in particular Asian women.
- Develop provision that specifically targets, engages and supports men on issues pertaining to mental health
- Ensure equity of access to mental health services and support by undertaking an annual equity audit .

Stigma

The public consultation highlighted the prevailing issue of stigma associated with mental health. Respondents felt that the media perpetuates this stigmatism through the negative portrayal in news stories. Participants in the focus groups stated that most sufferers seem to internalise problems (rather than seek help), and that the wider public continues to stigmatise those with mental health conditions. Just under three in ten respondents stated that they would feel comfortable talking to their current or prospective employer about their own mental health. Amongst Asian women, Asian men and Afro-Caribbean groups, participants talked about cultural norms and specific religious beliefs that prevented or suppressed discussions around mental wellbeing. Many feel ashamed that they are suffering from a condition and believe that they are weak or that something is wrong with them.

Recommendations

- Develop programmes to reduce stigma across the population, using opportunities like social media.

Integration of Physical and Mental Health

On average those diagnosed with a serious mental health illness die 15-20 years earlier than the general population. Two thirds of these deaths are from avoidable physical illnesses, including heart disease and cancer, many caused by smoking. Walsall has a higher than regional and national prevalence of smoking (18.7%). Integrating physical and mental health is a national priority, and was echoed by the respondents in the consultation responses.

It is also vital that those with long term conditions are screened for mental health and emotional wellbeing, and signposted to the Improving Access to Psychological Therapies (IAPT).

Recommendations

- Screening for mental health and emotional wellbeing with appropriate signposting to be built into all health, social care and community frontline services.
- Mental health staff to be embedded in the Integrated Health and Social Care Locality Teams.
- Ensure the physical health needs of those with mental health needs are appropriately addressed - primary and secondary prevention through screening and NHS Health Checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Ensure parity of esteem for people with mental health problems
- All MH staff to carry out Make Every Contact Count (MECC) and signpost to Stop Smoking Services, and a number of staff, especially inpatients, to provide intensive stop smoking service.
- Mental health inpatient services should be smoke free by 2018.
- Ensure those with Long Term Conditions, have timely access to primary care mental health services.

Older People

Walsall has a higher proportion of older people living in single occupancy households. Anecdotally crime levels are increasing in the older age cohort, and the proportion of referrals for dual diagnosis has increased for the 65+. Mental health problems in this group are under-identified by health-care professionals and by older people themselves, and symptoms of depression are often overlooked.

Concerns were raised with regards to the current older peoples' services in the borough in the stakeholder consultation. The needs of the elderly cohort were felt to be neglected, with problems such as loneliness and social isolation considered as contributing to the development of conditions such as depression and anxiety, and worsening of underlying mental health conditions.

GPs reported as being less confident in assessing the needs of Older People, compared to those of Adults. Issues of lack of clarity of referral criteria, not enough feedback from the older people's services following referral, mixed wards at Bloxwich hospital, and insufficient support and services in the community were raised.

Recommendations

- Develop a clear strategy to tackle the isolation and the needs of older people
- Prioritise the development of the mental health community offer.
- Ensure that both mental and physical health needs of older people are addressed in a holistic manner, including access to IAPT.
- Ensure that single sex provisions for inpatients is made available.

(Also see **Workforce**)

Dementia

With an ageing population, the number of people with dementia is set to increase and therefore the need to halt this by tackling the modifiable risk factors. The recent change in the methodology for the calculation of dementia prevalence means that Walsall's diagnosis rate has dropped. There are still a large number of acute admissions for physical health conditions which can be managed in the community, eg pneumonia and urinary tract infection. A higher proportion of patients with dementia die in hospital in Walsall, compared to nationally, and a lower proportion in care homes.

Recommendations

- Promote healthy ageing through the six pillars of a brain-healthy lifestyle: regular exercise, healthy diet, mental stimulation, quality sleep, stress management and an active social life.
- Continue to work with GPs to screen people for potential dementia .
- Continue to develop the ongoing support for post diagnosis of dementia, for both service users and their carers.
- Adopt an integrated approach for addressing the physical health needs of those with dementia.

- Improvements in the end of life care for those with dementia to reduce dementia deaths in hospital
- Dementia Strategy to be completed as part of life course mental health strategy.

Improving engagement with and support for carers

The proportion of carers providing over 20 hours of unpaid care is higher in Walsall, as compared to West Midlands and England equating to about 30,632 Walsall residents. Walsall carers have reported a significantly lower than regional and national average quality of life. Service mapping identified the gap that all carers are not aware of the provision of carer assessments. Stakeholder feedback suggested that carers of those living with dementia as well as other mental health conditions could benefit from greater resources and information to aid their work.

Recommendations

- Ensure all providers of services are aware of provision of the overall framework of the Care Programme Approach (CPA), offering carer assessments and action plans in line with carer legislation and local policy
- Develop a clear plan to address the well being and tackle the isolation of carers, considering a strategy for Carers of people with mental health issue.

Gaps identified by public consultation

Less than half of the respondents indicated they were aware of services available locally that could support them with mental health, stress and anxiety issues. Even where awareness was relatively high, little information was available on the breadth of services or on the referral pathways for accessing services. Services that provided group support were the most valued as these tended to counter the issue of isolation, loneliness and feelings that sufferers had to deal with conditions on their own. A hub approach, that brought numerous agencies and support services together, was felt to be an appropriate solution. A large number of respondents reported a negative experience of seeing their GP for a mental health and emotional wellbeing need, for reasons including difficulty obtaining appointments, limited time with GP and a perceived emphasis by GPs on prescribing medicine rather than counselling or support services.

Recommendations

- Ensure a current Directory of services which serves as the single source of information, inclusive of mental health service across statutory and voluntary services, and raise awareness of it.

- Develop a virtual mental health hub to facilitate social prescribing and signposting. All staff to be able to signpost to low level interventions (social prescribing) already available in Walsall and not requiring the need to refer to GPs

Gaps identified by stakeholders

The lack of a truly collaborative approach that brings together partners from health, social care, local authority, 3rd sector, police and the service users in both strategic planning and operational issues, was raised across all stakeholders. Communication between agencies and services for planning patient care was considered lacking. Lack of communication to care coordinators and between agencies at the time of discharge, lack of housing support and lack of local places including day care and local support groups, was reported.

Transfer from one service to another was stated to be problematic, especially between Adults to Older Adults, Childrens' to Adults and Primary Care to Secondary Care.

The current crisis service was felt to be inadequate to meet the needs of the borough, across all stakeholders.

It was felt that there was not enough being done for prevention, early intervention and community support, especially in some specific groups eg pregnant women, older people and offenders. The provision of rehabilitation and respite services in the borough was also felt to be insufficient.

Discussions with some of the stakeholders identified specific issues. Providers of Walsall's substance misuse service stated they could no longer refer patients directly to the Trust, and there was a lack of a co-ordinated approach between the services for case management. The issue of dual diagnosis is a significant one for Walsall with number of accepted referrals and inpatient admissions showing an increasing trend. The proportion of those receiving substance misuse treatment and with a dual diagnosis has also risen.

The current psychiatric liaison team is not based on site at Walsall Manor, where it is unable to access patient's mental health records due to IT issues.

A range of service gaps were identified (see section **Areas for further development**).

Recommendations

- Improve response to mental health crisis.

- Mechanisms for supporting smooth transition between different MH services, especially primary care to secondary care, Adults to Older Adults, Childerns and Adolescents MH service to Adults
- Prioritise the development of the mental health community offer to ensure prevention, early intervention and community support adequately meet the diverse needs of the population of Walsall.
- Ensure a fit for purpose 136 suite is provided.
- Work with the police to ensure that the MH needs of those coming in contact with police service are identified and addressed.
- Ensure the accessibility and responsiveness of the Adult Mental Health Psychiatric Liaison service giving consideration to their physical location and IT access.
- Training of GPs and Practice nurses for screening and identifying MH, especially in older people should be developed.
- Develop a single point of access and improve referral pathway to enable ease of appropriate and timely access of the full range of mental health services.
- More joined up Dual diagnosis and MH services .

Increase in self harm, suicide rates and domestic violence

The number of hospital admissions for self harm has increased in Walsall between 2011/12 to 2014/15. The admission rate is significantly higher in the North Walsall Area Partnership. A clear gradient of association was seen between deprivation and self harm. Those in the least deprived areas were significantly less likely to have a hospital admission compared with those in the most deprived areas.

The suicide rate in Walsall had remained below the England and West Midlands averages but a trend increase in Walsall is evident. In the period 2012-14, the average Walsall rate has risen sharply and the gap with regional and national averages has narrowed. The last Walsall suicide strategy refresh was completed in 2013 and strategy for 2013-16 written.

Domestic abuse showed a sharp increase in April 2014, an effect seen across the West Midlands Police Force area. This could be a real increase or due to improved data quality and the launch of Operation Sentinel.

Recommendations

- Take into account the recommendations of the Walsall Suicide Strategy, and consider incorporating it in the overarching Mental Health Strategy.
- Ensure that the Mental Health strategy takes into account the recommendations of the recently completed Domestic Violence needs assessment and the impact of toxic trio.

Improved MH Service Intelligence

Through the course of working on the Needs Assessment, a range of issues around data and intelligence on emotional wellbeing and mental health became evident. There is limited use made of the Trust service activity data available via the Commissioning Support Unit, and currently there is no dashboard available of key performance and quality indicators. There is little or no data collected across a range of services to measure emotional wellbeing. The issue of poor communication and intelligence sharing was raised as an area for improvement by the stakeholders.

Recommendations

- Improve data collection on emotional wellbeing and impact across all services and sectors.
- Routine analysis of Trust data to monitor the trends in referrals, waiting times, and service user demographics.
- Develop a dashboard of key indicators to be reported to the MH Programme Board.
- Enable effective information sharing across partner organisations, specifically but not limited between DWMHT, Walsall Healthcare Trust, Police, Social Care and Locality Teams, giving consideration to developing a digital road map for mental health.

Workforce

The stakeholder consultation and feedback from the stakeholder event identified the need for reviewing not only the current mental health workforce, which needs to be adequately qualified and trained to identify and address mental health, but also the need to develop the wider workforce to improve their mental health literacy, ability to screen for emotional wellbeing and signpost to relevant services. Training need for the Primary Care staff, especially with regards to identifying Older People's mental health and wellbeing were highlighted.

Recommendations

- Frontline workers, across the full range of services – health, social care, community including police and fire services, should be trained to improve their knowledge on mental health and emotional wellbeing, the principles of recovery and able to tackle any stigma related to mental health.
- Training of GPs and Practice nurses for screening and identifying mental health, especially for Older people should be developed
- Ensure a modern and fit for purpose mental health workforce, giving consideration to a mental health workforce strategy to improve workforce across mental health services.

Areas for further development

High spend in some areas
Walsall CCG has been identified as having a higher than national average of per capita spend on mental health. Though this is stated to be associated with various improved outcomes, there are sections of spend that should be reviewed, especially out of area placements. This incurs a huge financial cost and results in people being placed further away from their families and community.

Personality disorders (PD)
Personality Disorder was amongst the top five causes of referrals and inpatient admission to DWMHT. However there is no dedicated service or pathway for this condition. This was raised as a significant gap in the stakeholder consultation.

Learning Difficulties
There are no current pathways to address the mental health needs of those with Learning Difficulties.

Attention Deficit Hyperactive Disorder (ADHD) and Autistic Spectrum Disorder (ASD)
Walsall borough does not have commissioned services for adults with ADHD or Autism.

Maternal Mental Health
Almost one in five women were identified with a mental health concern by the midwifery service during the period April – Dec'15. . Depression and anxiety are believed to affect 15-20% of women in the first year after childbirth. Currently majority of midwives and Health Visitors refer women to their GP (from consultation), which is an extra step before women are referred/signposted to the necessary service. The absence of a specialist perinatal service was identified as a significant issue in the consultation, along with the need for more streamlined pathways to services that are designed to meet the needs of this group of women.

Vulnerable groups
A trend increase in homelessness rates in Walsall is seen. From 2011/12 to 2013/14, the average Walsall rate has risen sharply and has gone above the England average while the gap with regional average has narrowed. There are established links between homelessness and conditions such as schizophrenia, psychoses, drug abuse, self harm and suicide. Little is known about health needs of the homeless population in Walsall. Similarly, those from the Lesbian, gay, bisexual and transgender (LGBT) community experience a number of health inequalities which are often unrecognised in health and social care setting, and little is known about their emotional wellbeing and mental health in Walsall.

Recommendations

- Undertake a review of the out of area placements.
- Develop perinatal mental health services and training for frontline staff.
- Develop a Personality Disorder service which has been identified as a significant gap in the current service provision.
- Develop a Learning Disability service for people with mental health needs.
- Develop an ADHD/ASD service.
- Undertake an audit of the needs of the homeless population, to establish their health and social care needs
- Undertake an audit of the needs of the LGBT community, to establish their health and social care needs

Summary of Findings

Socio-economic determinants of mental health in Walsall (adult population: 208,276 people aged 18 and over)		Compared to West Midlands	Compared to England	Trend	Period	Source
Employment and income	1,985 people long term unemployed (1.19% of working age population in Walsall	**Higher**	**Higher**	**Down**	Oct-14	ONS NOMIS
	Estimated 181 people claiming Employment Support Allowance benefits for a mental or behavioural disorder				Nov 2015	DWP
	10,200 people out of work in the last year (8.1% of working age population)	**Higher**	**Higher**	**Down**	2014	NOMIS
Education	71,839 people with no qualifications (33.7% of resident population 16 years and over)	**Higher**	**Higher**		2011	Census
	Estimated 991 people aged 18 and over with learning disabilities	**Similar**	**Similar**	**Up**	2013/14	QOF
Family and caring	30,771 people living alone (11.5% of all households occupied by a single person	**Lower**	**Lower**		2011	Census
	3,040 lone parents on Income support				May 2014	DWP
	8,777 people providing substantial unpaid care (3.26% of Walsall population 50+ hours of care in a week)	**Higher**	**Higher**		2011	Census
Crime	759 offenders in contact with the criminal justice system (probation service)			Down	2015	
	17,898 crimes recorded by Walsall Police between Nov/14 and Oct/15			**Up**	2014/15	West Midlands Police
	3,649 domestic violence incidents (where police are called but no crime is recorded, such as verbal argument) recorded by Walsall Police Nov/14 and Oct/15			**Down**	2014/15	West Midlands Police
Housing	103 homeless families known to Walsall Council				2014/15	Walsall Council

Mental health	Estimated 25,878 people with a common mental disorder, 61% of whom are women					
	Estimated 25.6 per 100,000 of people with psychosis	**similar**			2011	PHE
	Estimated between 2,099-2,135 people over 65 with dementia					
	Estimated 20% of population aged 16 years and over engage in risky drinking	**Similar**	**Similar**		2008-09	PHE
	5.8% of patients (aged 18 and over) who stated they have a long term mental health problem		**Higher**			GP Patient Survey
	Estimated up to 12,760 people with eating disorders				2007	APMS
	Estimated 6,480 people with Post traumatic stress disorder				2007	APMS
	Estimated 2,096-2,306 people with autistic spectrum disorders				2007	APMS
	Estimated 2,096 people with Bipolar disorders				2007	APMS
	Estimated 1285 people with Personality disorders of whom ~ 561 antisocial disorders and 724 borderline PDs				2007	APMS
	Estimated 14,000 - 20,000 adults aged 16 years and over had engaged in deliberate self harm in their lifetime with higher prevalence in females				2007	APMS
	66 suicides in Walsall between 2012 and 2014 (8.6 rate per 100,00)	**Lower**	**Lower**	**Up**	2012-14	PHOF
	537 admissions for self harm	**Lower**	**Lower**	**Up**	2014/15	SUS
	76 men and 42 women in alcohol treatment				Mar-16	CRi
	702 men and 236 women in drug treatment				Mar-16	CRi
	925 admissions to hospital for alcohol specific causes	Higher	Lower	Up	2013/14	PHOF

Introduction

Every year one in four people in England will experience a mental health problem[1]
No other health condition matches mental illness in the combined extent of prevalence, persistence and breadth of impact[2] . It is one of the major causes of the overall disease burden in England and worldwide[3]. Mental illness has not only a healthcare and human cost, but also a social and economic one. The wider costs in England amount to £105.2 billion a year which includes the costs of health and social care for people with mental health problems, lost output in the economy (sickness absence, unemployment etc) and the human costs of reduced quality of life[4]. There are substantial potential gains for improving mental health, including increased self-esteem, productivity, relationships, economic benefits and a reduction in the burden on health services[5].

World Health Organisation (WHO) defines mental health as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community[6]. It emphasises mental health as not just the absence of illness, but requires an additional positive dimension to be present in an individual. The concept of an individual's mental health state is increasingly being dissociated from mental illness. If someone experiences low mental wellbeing over a long period of time, they are more likely to develop a mental health problem. If someone already has a mental health problem, they are more likely to experience periods of low mental wellbeing than someone who has not[7].

Mental health is affected by a broad range of determinants including gender, age, ethnicity, family, social and environmental determinants such as deprivation, housing, employment, drugs and alcohol, and crime. Men, particularly the young and unemployed, are at a greater risk of suicide, and psychotic disorders, such as schizophrenia or bipolar disorder. Women are more likely to experience common mental problems such as depression and anxiety and are at higher risk of self-harm.

Men and women from some Black and minority ethnic (BAME) communities namely Caribbean, African and Black British are over-represented in secondary care services and on primary care registers for serious mental illness[8]. They are more likely to be admitted to hospital, experience a poor outcome from treatment and suffer a deterioration in their mental health due to social exclusion and disengagement from mainstream services.

People with disabilities or long-term conditions, such as diabetes or heart disease, are at greater risk of depression and other mental health problems, which can lead to poorer health outcomes and reduced quality of life. Those with mental ill health are also likely to suffer poorer physical health and increased mortality from some diseases. This may result from unhealthier lifestyles, for example poor diet, less exercise and higher levels of smoking, misdiagnosis of physical ailments and reluctance or inability to access health services.

Aims of the health needs assessment

The overall purpose of this report is to improve understanding of the distribution of mental health and wellbeing, its determinants and current services in the borough of Walsall, making recommendations for commissioners to prioritise service development based on identified needs and gaps, and influence partners to achieve improvements in the social, physical and economic environments of the borough.

The objectives of this mental health needs assessments are to:

- identify the prevalence of risk and protective factors for mental wellbeing
- identify the prevalence of common mental health conditions and severe mental illness
- identify the current service provision for mental health (for adults, older adults) in Walsall. Map the provision of mental health services according to population need to identify any gaps in service
- engage with a wide range of stakeholders, service users, carers and the general public to explore the different perspectives of existing services
- identify vulnerable groups at higher risk of mental disorder and low wellbeing
- quantify local spend on treatment of mental disorder, prevention of mental disorders and promotion of mental health

Mental health: national, regional and local context

There have been significant improvements in mental health over the last 50 years driven by developments in treatment e.g. anti psychotic and mood stabilising drugs, and service delivery e.g. growth of community based mental health services. A range of national policy drivers over the years have provided support and context for local strategies. In the 1990s, the Care Programme Approach was developed to provide more intensive support to people with severe and enduring mental illness. Department of Health's **National Service Framework (NSF)** published in 1999 was a 10-year programme designed to establish a comprehensive evidence based service delivered by health and social care[9].

The 2007 **Time to Change** campaign, launched with the objective to reduce mental health related stigma and discrimination, helped heighten the understanding of an urgent need to act on improving the experiences of people with mental health problems, both within and beyond the NHS[10].

In 2009 the NSF was replaced **by 'New Horizons: A Shared Vision for Mental Health'** which was a cross-government programme of action to improve the mental health and wellbeing of the population[11].

In 2011, the Coalition government's **'No Health Without Mental Health'** strategy replaced 'New Horizons' as the main policy driver for mental health services in England with a clearer focus on outcomes and greater clarity on delivery[12].

Closing the gap: priorities for essential change in mental health, published in 2014, aimed to bridge the gap between the long-term ambitions of the Mental Health strategy and shorter-term actions[13]. It set out 25 priority areas where changes in local service planning and delivery would make a difference, over the next two or three years, to the lives of people with mental health problems. These areas were grouped under the broader themes of

- increasing access to mental health services
- integrating physical and mental health care
- starting early to promote mental wellbeing and prevent mental health problems
- improving the quality of life of people with mental health problems

The National **Suicide Prevention Strategy 2010-2015** was published under the coalition government with the aim of reducing suicide rates and supporting those bereaved or affected by suicide[14].

It has been recognised that we need standards for access to mental health treatment for people of all ages that are akin to the equivalent standards for physical health. We need the same quality of data and transparency about performance for mental health services for people of all ages so that long waits for effective treatment are visible and tackled. **Achieving Better Access to Mental Health Services by 2020** published in 2014, sets out a pathway from Government to deliver the parity of esteem for mental health services by providing additional investment and setting of access and waiting time standards[15].

The **Five Year Forward View, 2016** for Mental Health sets ambitious targets for mental health and recommends significantly investing to improve care: crisis care, psychological therapies, liaison services in A&E departments, perinatal and children's services and suicide prevention[16].

Living well with dementia: a national dementia strategy was published in February 2009[17]. The **Dementia Challenge 2012** work programme focused on 3 main areas: bringing about improvements in health and care, creating dementia friendly communities and improving research[18]. Prime Minister's **Challenge on Dementia 2020** published in 2015, builds on the achievements of the Dementia Strategy and the Dementia Challenge 2012, aspiring for the best dementia care and support for people with dementia, their carers and families; and increased emphasis on research into dementia and other neurodegenerative diseases.

The Five Year Forward View and the Prime Minister's challenge for dementia set out a clear trajectory for transforming mental health and dementia services in the country.

Established in October 2015, the **West Midlands Mental Health Commission**, is conducting work to assess the scale of poor mental health and wellbeing across the combined authority area and its cost and impact on public sector services, the economy and communities. In doing so it is reviewing local, national and international research and best practice to

establish what works best in addressing the impact that poor mental health and wellbeing has on public services, the economy and local communities. It is also working to establish the relative costs and benefits of the application of this evidence to the West Midlands and to consider the contribution that devolution can make to addressing poor mental health and wellbeing.

The importance of preventing mental health problems and promoting mental wellbeing has been slower but policy makers are realising the need for this and that much more can be done outside of the traditional health systems[19]. The recommendations for a Prevention Concordant, Prevention Plans and a Research strategy in the Five year Forward View are a demonstration of this. There is increasing acceptance that mental health is influenced by a range of public policies and therefore a cross - departmental approach is essential. Mental Health in all Policies is a new approach, drawing on the previous Health in all Policies (HiAP) approach, to facilitate action within different non health public policy areas for promoting population mental health and wellbeing.

There is a vast array of NICE publications on mental health and related conditions. It is not possible to list them all here but the reader is advised to look these up at the NICE website. See: http://www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7281

Background Information

The information in this section provides some background information to the current adult population and population trends across Walsall and their implications for mental health with more localised focus by the six area partnerships boundaries which were launched in May 2010 to allow local residents and community groups to better influence Walsall partnerships organisations (Walsall Council, West Midlands Police, Walsall Housing Group, NHS Walsall and host of community groups)[20].

The distribution of mental health varies by age, gender, ethnicity and other social economic determinants.

Local demographics

The current adult population of Walsall is about 209,594 (total population 274,173) and older people (65 and over years) constitute one-quarter (23.3%) of the adult population. There is slightly higher proportion of adult women (52%) than adult men (48%) and these proportions change significantly between working age (equal split) and older peoples cohort (higher proportion of women) as shown in Table 1.

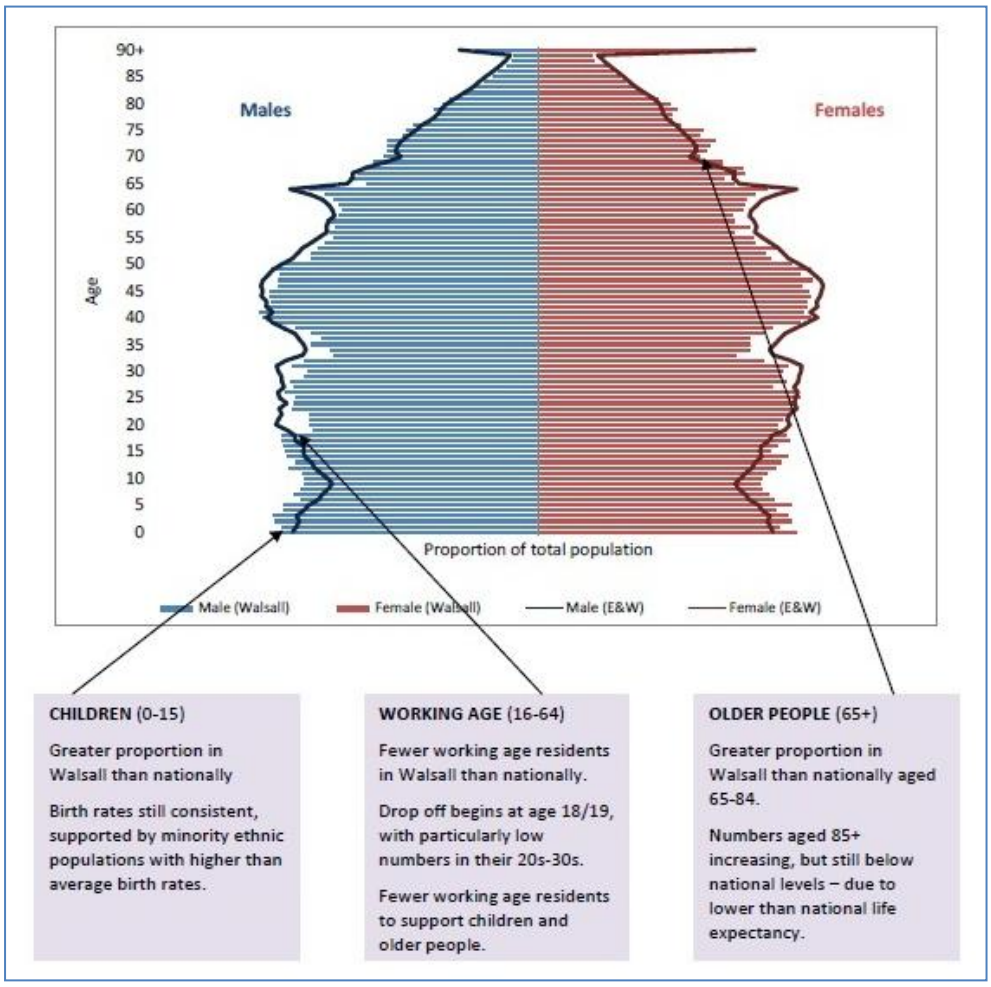
Table 1: Walsall Adult Population Estimates by Gender, 2014

	Male	Female	Total Population
Working age (18-64 yrs)	50%	50%	160,841
Older People (65 and over)	45%	55%	48,753
Adult Population (18 and over)	48%	52%	209,594

Source: Office of national statistic 2014 Mid-year population estimate

The majority of adults in the Walsall borough belong to the working age group (35-64) for both men and women (see Figure 1 and Table 2).

Figure 1: Walsall Population Pyramid, Walsall and England & Wales



Source: Office of National Statistics (ONS), Census 2011

Table 2 below shows variation between six area partnerships (AP) populations, with Aldridge & Beacon (AP2) having the highest proportion of older people (29.6%) and Darlaston & Bentley (AP5) with lowest (19%).

Table 2: Population aged 18+ years in Walsall by area partnership

Area Partnerships	18 and over Population	18-34	35-64	65-74	75-84	85+	Working age (18-64) group as % of Adult Population	Older people (65+) group as % of Adult Population
Brownhills, Pelsall, Rushall, Shelfield	28,676	6,713	14,398	4,121	2,566	878	73.6%	26.4%
Aldridge & Beacon	42,125	9,229	20,440	6,385	4,621	1,450	70.4%	29.6%
North Walsall	40,777	12,480	19,563	4,566	3,004	1,164	78.6%	21.4%
Walsall South	44,744	15,411	20,725	4,528	2,980	1,100	80.8%	19.2%
Darlaston & Bentley	20,716	6,891	9,885	2,086	1,317	537	81.0%	19.0%
Willenhall & Short Heath	31,238	9,172	15,429	3,890	2,110	637	78.8%	21.2%
Walsall	**208,276**	**59,896**	**100,440**	**25,576**	**16,598**	**5,766**	**77.0%**	**23.0%**

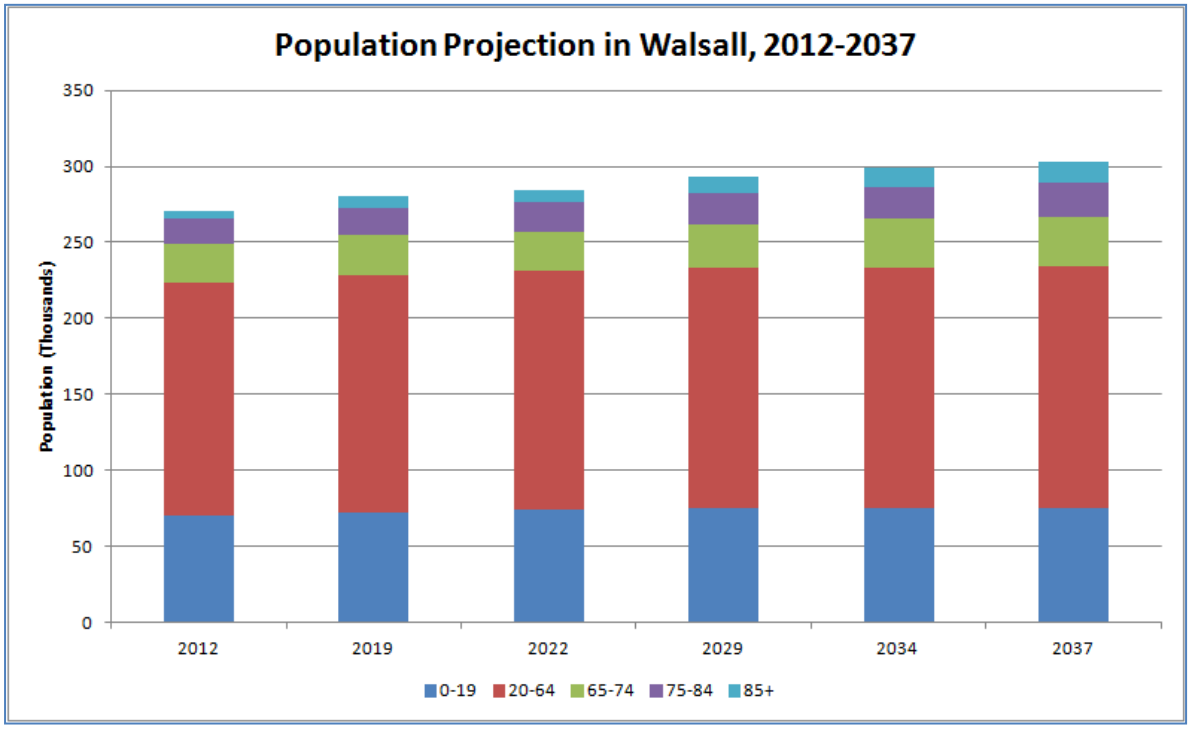
Source: ONS, 2013 Mid-year population estimates – Rounded to nearest 100.

Population projections

Nationally by 2022 there will be a projected 3.2% increase in the working age group (20-64 years) which is similar to Walsall (3.4%) whereas the older people group (65+ years) locally (14%) is lower than national projections (22.4%).

Figure 2 below shows that the older people's population (65 and over) is forecasted to grow by 14% over a ten year period (2012-2022). The 85+ age group is projected to have the highest percentage increase (51.8% ~ extra 3,000 people) followed by 75-84 group (18.5% ~ 3,000 people) over a ten year period.

Figure 2: Walsall population projections from 2012 to 2037 by age groups.



Source: ONS, 2012 based sub national population projections.

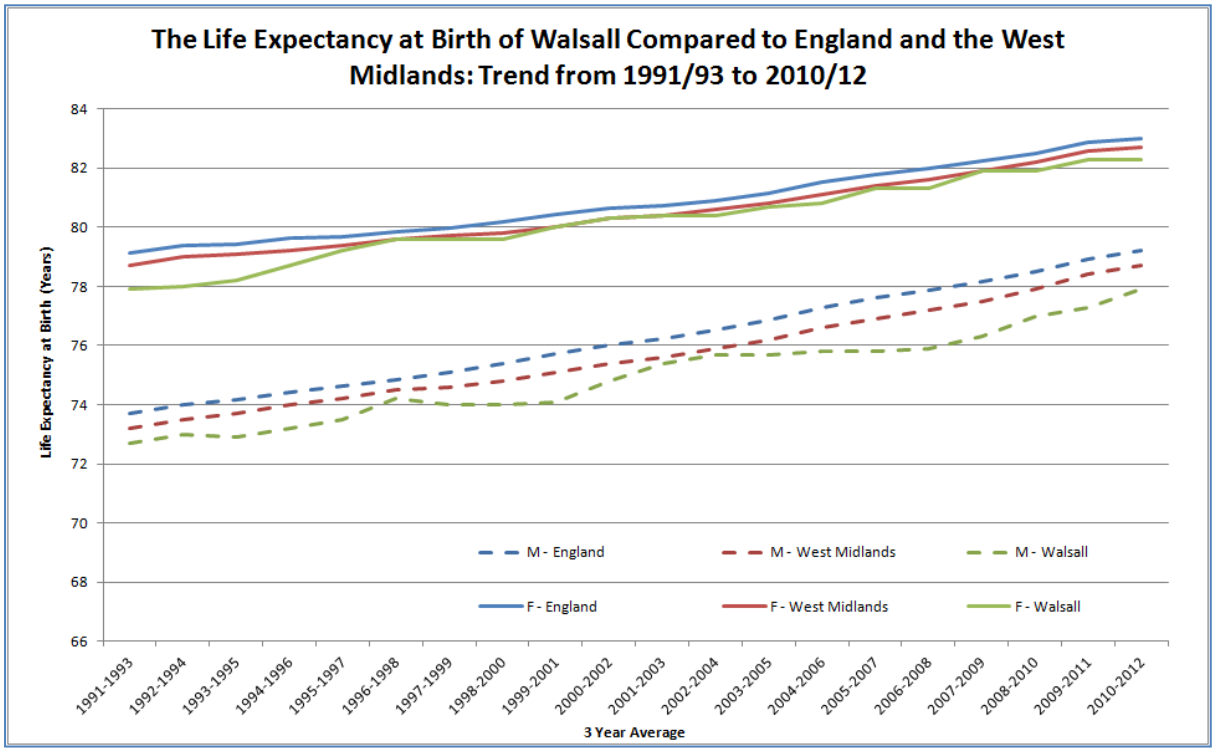
There are a number of implications for mental health illness prevalence and services arising from the different age structures in the local populations. There will be an increased number of diagnoses for conditions such as schizophrenia and bipolar disorder that first present in early adulthood. There will also be a disproportionate increase in diagnosis of conditions that affect the older population, most significantly dementia, which will require significant service input to establish treatment. The larger proportional increase in older population as compared to the working age population will mean that there will be fewer people of working age to care for those needing additional support, both as formal and informal carers.

Life expectancy

Life expectancy at birth is a way of expressing the all-cause mortality for an area and it provides an estimate how long someone is expected to live based on current mortality rates.

Typically, life expectancy is higher in women than men. The latest life expectancy averages that for both men and women in Walsall are lower than regional and national averages (Figure 3).

Figure 3: Life Expectancy at Birth in Walsall compared to Regional and National Average

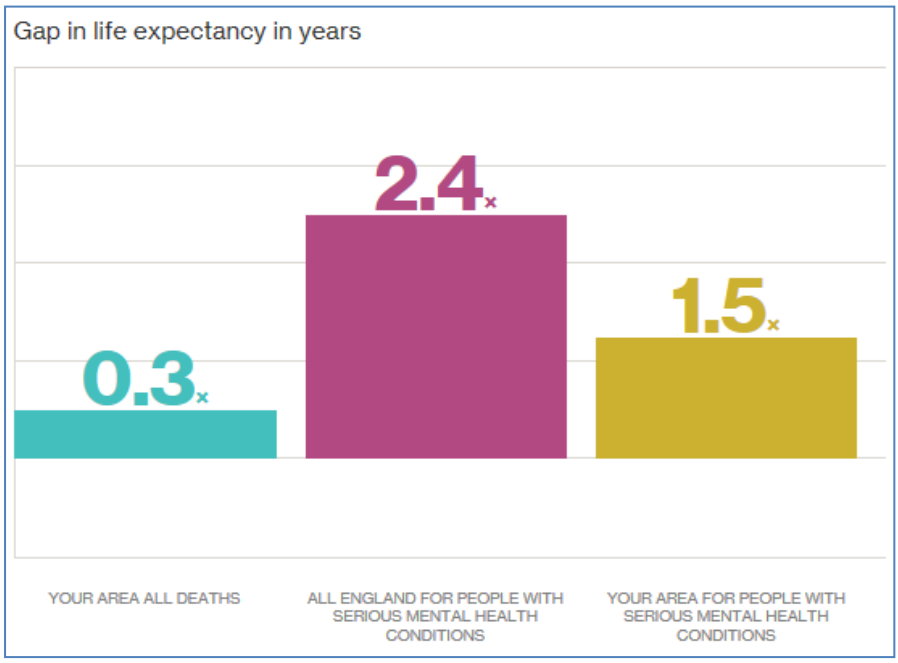


Source: ONS

In England, people living with a serious mental health condition are more than twice as likely to die before the age of 75. The table below compares Walsall residents with UK population and shows how likely people of Walsall are to die before 75. People with serious mental health conditions are 2.4 times more likely to die before 75 compared to the general population[21] (Figure 7 - The purple bar).

There is evidence to suggest that gap in life expectancy between mental health illness cohort compared with the general population can range from 10-20 years[22].

Figure 4: Death rates compare for people with serious mental health conditions



Source: The RSA

The Walsall CCG 5 year strategy 2014-2019 highlights that there is gap in life expectancy within Walsall between people experiencing mental ill health and those who are not. The strategy recognises that many do not seek help because of stigma which often results in their physical health needs not being met. Subsequently this is now a local priority[23].

Factors affecting Mental Health

Ethnicity

There has been a significant increase in the level of ethnic diversity in Walsall over the past decade. Almost one in four residents in Walsall (23.1%) are from a Black and Asian Minority Ethnic (BAME) community (Table 3). 'White British' is the single largest group at 76.9%,

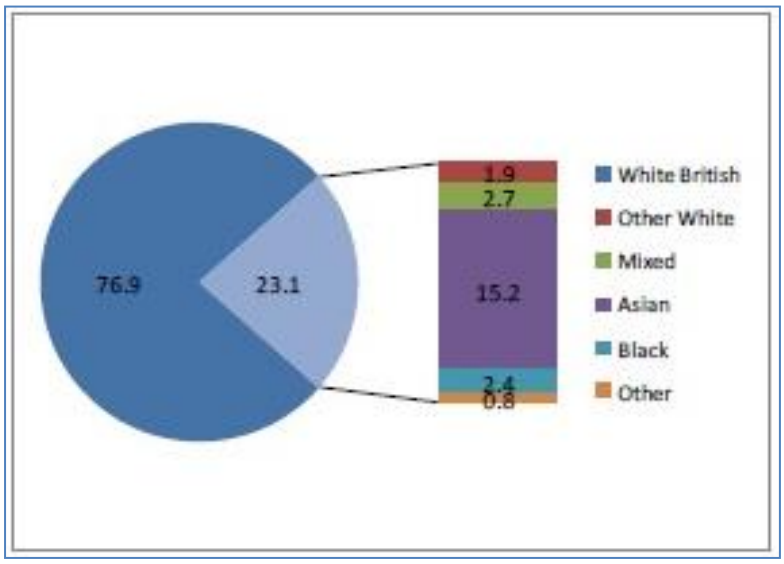
The proportion of people from a BAME community is higher than the regional (20.8%) and national average (20.2%). People of South Asian background, namely Indian, Pakistani and Bangladeshi, form the largest proportion of BAME in Walsall (Figure 5). The number of Non-UK born residents in Walsall has increased by 3.7% (or 9,859 people) between the 2001 and 2011 censuses.

Table 3: Broad ethnic group, as a % of usual residents

	2011		2001
	Walsall %	E & W %	Walsall %
White British	76.9	80.5	85.2
All other White	1.9	5.4	1.2
Mixed	2.7	2.2	1.4
Asian	15.2	7.5	10.4
Black	2.3	3.4	1.4
Other	0.8	1.0	0.4

Source: ONS, Census 2011

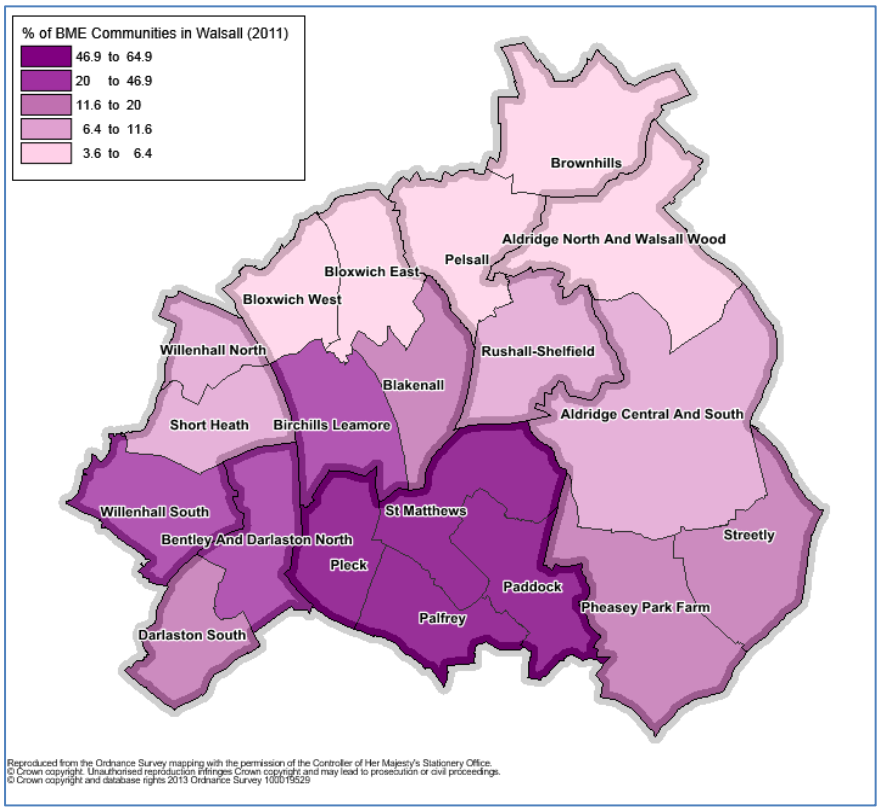
Figure 5: Broad ethnic group



Source: ONS, Census 2011

BME communities are highly concentrated in certain parts of the borough (Figure 6), with Walsall South Area Partnership (AP) having the highest proportion of BME groups and Aldridge and Beacon AP with the lowest.

Figure 6: Black Minority Ethnic Communities in Walsall, 2011



Source: ONS, Census 2011

It is well documented that mental health inequalities exists between socioeconomic and ethnic groups.[24] There is a variation in prevalence of mental health problems between different ethnic groups. Data suggests that the Black ethnic group, especially males, experiences highest rates of PTSD, suicide attempt, psychotic disorder, any drug use and drug dependence while the White population experiences highest rates of suicidal thoughts, self harm and alcohol dependence. Women from the south Asian group experience highest rates for any common mental disorders (Table 4).

Table 4: Age standardised rates of different mental disorder according to ethnicity

	White		Black		South Asian		Other	
	Male	Female	Male	Female	Male	Female	Male	Female
Any Common Mental Disorder	12	19.3	12.9	21	10.3	34.3	20.2	20.6
PTSD	6.9	10.6	16.3	13.2	11	9.1	7.3	5
Suicidal thoughts	15	20	7.1	11.4	6.1	7.7	7.3	12.3
Suicide attempts	4.4	7.1	4.6	7.8	0.6	1.5	4	3.3
Self-harm	4.7	5.7	3.3	1.2	2.2	0.9	2.3	6.7
Psychotic disorder	0.2	0.5	3.1			0.6		
Alcohol dependence	9.6	3.7	3		1		3.5	1.4
Any drug use	12.4	6.8	21.8	5.6	3.5	0.8	9.2	11.5
Drug dependence	4.7	2.2	12.4	4.8	1.5	0.2	2.3	5

Source: Adult Psychiatric Morbidity Survey 2007

Table 5: The Use of mental health services for common mental disorders by ethnicity and gender

	White	Irish	Black Caribbe	Bangladeshi	Indian	Pakistani
Men	11.6	18.4	13.8	12.9	12.1	12.6
Women	19.9	18.6	19.8	12.3	23.8	26
Total	15.8	18.5	17.3	12.3	18.1	19.6

Source: NEPHO

The highest use of mental health services for common mental disorders is seen amongst Indian and Pakistani women (Table 5), although none of the differentials are statistically significant[25,26]. The statistics on the numbers of Asian people in the United Kingdom with mental health problems are inconsistent, although it has been suggested that mental health problems are often unrecognised or not diagnosed in this ethnic group. Asian people have better rates of recovery from schizophrenia, which may be linked to the level of family support.

The highest prevalence of mental ill health exists amongst lower socioeconomic groups. However, irrespective of socio-economic status, some BAME groups aremore likely to experience a mental health problem[27], and are less likely to have their mental health problems detected by their GP[28]. Although fear of stigmatisation makes the general population reluctant to access help, people from some BME groups tend to be even more cautious and more distrusting of conventional mental health services. The view is that

traditional services tend not to be “accessible, welcoming, relevant, culturally appropriate or well integrated” within BME communities.[29]

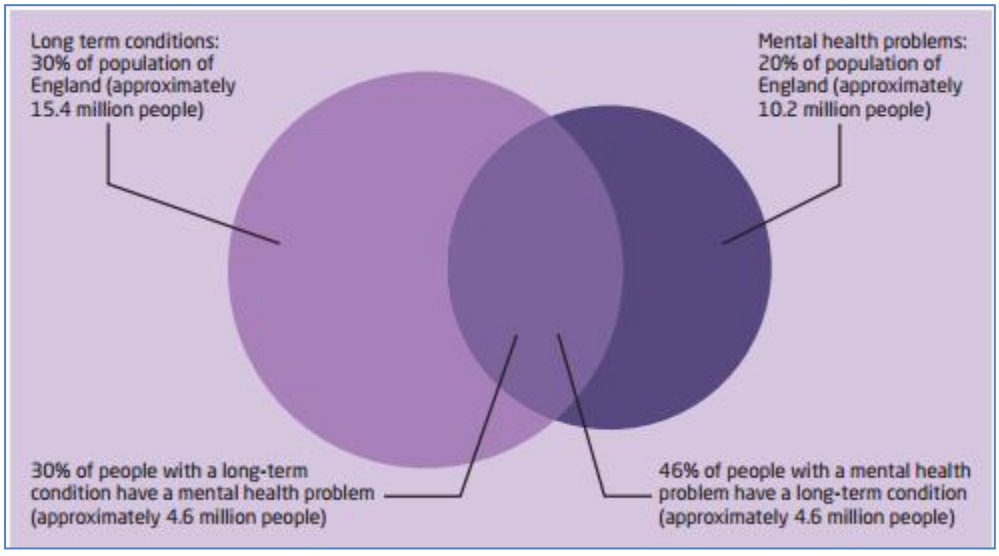
At the same time, some emerging evidence suggests that some BAME groups may have higher levels of mental wellbeing than expected[30]. A need for more research to fully understand differences in mental wellbeing despite adversity/risk alongside higher levels of representation of people from BAME communities within specialist and most restrictive mental health serviceshas been recognised[19].

Physical Health and Mental Health

Mental health is a determinant and consequence of physical health. For too long there was a disconnect between the physical and mental health leading to healthcare being delivered in silos with greater emphasis on physical health. However in recent times the codependence of physical and mental health has not only been recognised but an integrated physical and mental health approach is advocated.

People with a chronic medical condition have a 2.6-fold increase in the likelihood of having mental illness, compared with those without. More than four million people in England with a long term physical health problem also have a mental health problem[31]. Up to 70% of patients with ‘medically unexplained symptoms’ are also living with depression and/or anxiety related conditions[19]. Care for the mental health of these populations will improve the management of their physical condition. People that experience mental illness are less likely to access physical healthcare services and are statistically less likely to receive routine checks, which may identify some of the physical conditions[32] and therefore have much higher level of potentially avoidable mortality[33]. On average those diagnosed with a serious mental health illness die 20 years earlier than the general population. These early deaths are mainly as a result of poorer physical health linked to a number of conditions including; heart disease and stroke[34,35].

Figure 7: Overlap between long-term conditions and mental illness



Source: Naylor C., Parsonage M., McDaid D., Knapp M., Fossey M., Galea A., 2012. Long-term conditions and mental health: the cost of co-morbidities. London. The King's Fund.

Physical health in relation to mental health disorders:

- Depression is 2-3 times more prevalent in people with a chronic physical health problem, such as cancer, heart disease, diabetes or a musculoskeletal, respiratory or neurological disorder.60 Estimates for the prevalence of depression and anxiety in people recovering from an acute exacerbation of chronic obstructive pulmonary disease can be as high as 50%
- Co-morbid mental health problems have a significant impact on the costs related to the management of long-term conditions. For example, the total cost to the health service of each person with diabetes and co-morbid depression is 4.5 times greater than the cost for a person with diabetes alone[36].
- Depression increases the risk of mortality in cancer by 50% and has been associated with a 4-fold increase in the risk of heart disease, even when other factors are controlled for.
- Schizophrenia is associated with a 3-4 times increased risk of death mainly due to respiratory, circulatory, endocrine and digestive disorders[37],[38],[39].
- The risk of developing metabolic syndrome for those with schizophrenia is 2-4 times greater than for the general population[40].
- Long-term conditions, including cardiovascular disease and diabetes, are risk factors for the development of mild cognitive impairment, Alzheimer's disease and vascular dementia. People with diabetes and depression have a 2.7-fold increase in the development of dementia over a 5-year period compared to people with diabetes alone[41].

Lifestyle factors

Positive lifestyle choices including physical activity, avoidance/cessation of smoking and healthy eating facilitate positive mental health, fitness for work, fitness for learning and social interaction both between individuals and between an individual and their community. In contrast, smoking, sedentary behaviour, unhealthy eating and associated obesity can facilitate low self esteem, sickness absence and a wide range of negative health outcomes including heart disease, cancer and stroke.

Physical Activity and Obesity

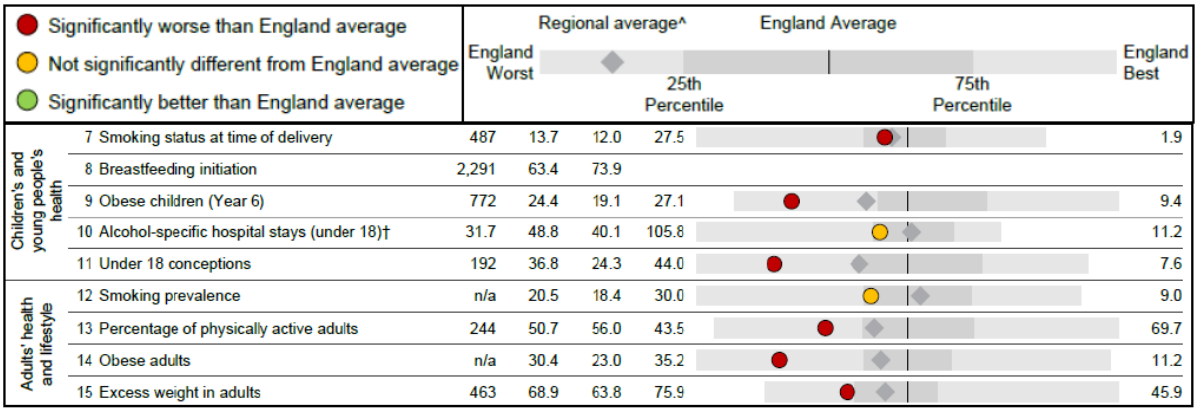
The various positive effects of physical activity on mental health are well documented. Physical activity is known to contribute to preventing mental health problems, lower levels of anxiety, better sleep and improved concentration. Physical activity can also improve the quality of life of those experiencing mental illness. There is approximately a 20% to 30% lower risk for depression and dementia, for adults participating in daily physical activity[42].

NICE recommends structured group physical activity programmes for people with mild to moderate common mental health disorders.

Comfort eating is used by a quarter of people to cope with feelings of anxiety, and women and young people are more likely to use this as a way of coping. Unhealthy eating and diseases such as obesity have many negative health effects. An increasing Body Mass Index (BMI) is an independent risk factor for dementia and those with severe obesity are over four times more likely to suffer from depression[43].

Walsall has a statistically significantly lower proportion of physically active adults as well as higher proportion of adults classified as excess weight and obese indicating an increased prevalence of these two risk factors in the population (Figure 8: Indicator 13-15).

Figure 8: PHE Health Profile for Walsall, 2015



Source: PHE

A detailed Lifestyle needs assessment was developed during 2015 to support the procurement of Lifestyle services. Further information on this issue can be found within the aforementioned needs assessment can be accessed at the following link:- http://www.walsallintelligence.org.uk/WI/navigation/bn_briefing.asp?Page=2

Smoking and Substance Misuse (Alcohol and Drugs)

There is a higher prevalence of Smoking and Substance misuse amongst individuals with mental health conditions. The following sections further elaborate on the local picture.

Smoking and Mental Health

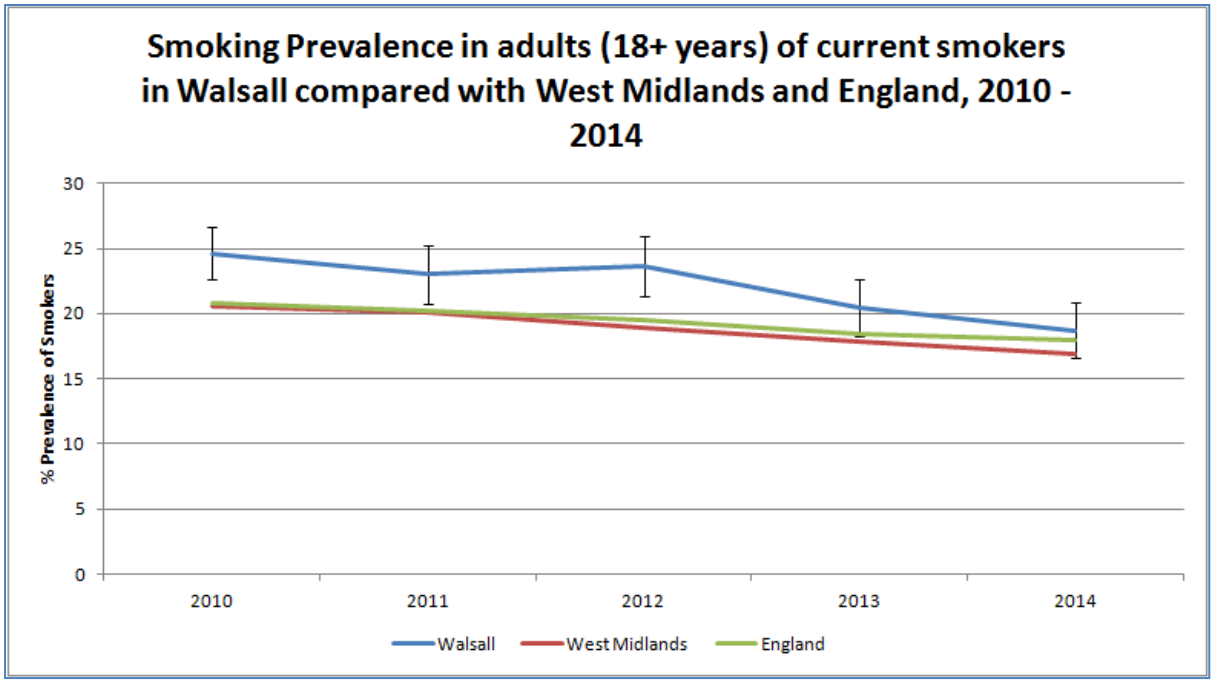
Smoking is the largest direct avoidable cause of death and disability, and the largest cause of inequalities in health in the UK[44]. Smoking rates amongst people with a mental health disorder are significantly higher than in the general population[45,46]. Studies suggest that mental healthcare staff could be more than twice as likely to be smokers as their colleagues in general healthcare[47].

Prevalence and demographics

Up to 70% inpatients in mental health units are likely to be smokers, with 50% smoking heavily[48]. Despite a marked decline in smoking prevalence in the general population, smoking among those with mental disorders has changed little over the past 20 years. It is estimated that there are 10 million smokers in UK of which around 1/3 have a mental health disorder (3 million)[49].

The estimated prevalence of current smokers in Walsall is 18.7% of adult population which has reduced by 5.6% over the last 4 years (Figure 9). However it still remains above the regional and national averages.

Figure 9: Smoking prevalence in adults, 2010 - 2014



Source: Integrated Household Survey (IHS), Tobacco Profiles

The most recent prevalence estimates indicates that around 39,194 - 49,296* adults living in Walsall are smokers. The GP medical records across the UK provided estimated prevalences of smokers by mental health disorders (Table 6) with increasing prevalence of smoking by increasing severity of conditions. Using the estimated number of smokers and the prevalence range amongst the mental health disorders cohort, it can be estimated around 562 to 1,085 of Walsall residents with mental health conditions could be smokers†.

* Prevalence estimates QOF 2013/14 (22.1%) and IHS 2014 (18.7%).
† QOF 2014 Mental illness prevalence

Table 6: Smoking prevalence amongst patients having a mental disorder, 2009-10

	Smoking prevalence (%)
Schizophrenia, schizotypal and delusional disorders	44.6
Bipolar affective disorder	36.7
Depression	31.4
Neurotic, stress-related and somatoform disorders	28.9
Eating disorders	23.1
Specific personality disorders	47.1
Hyperkinetic disorders, including ADHD	27.2

Source: The Health Improvement Network (THIN)

Link to wellbeing and mental health

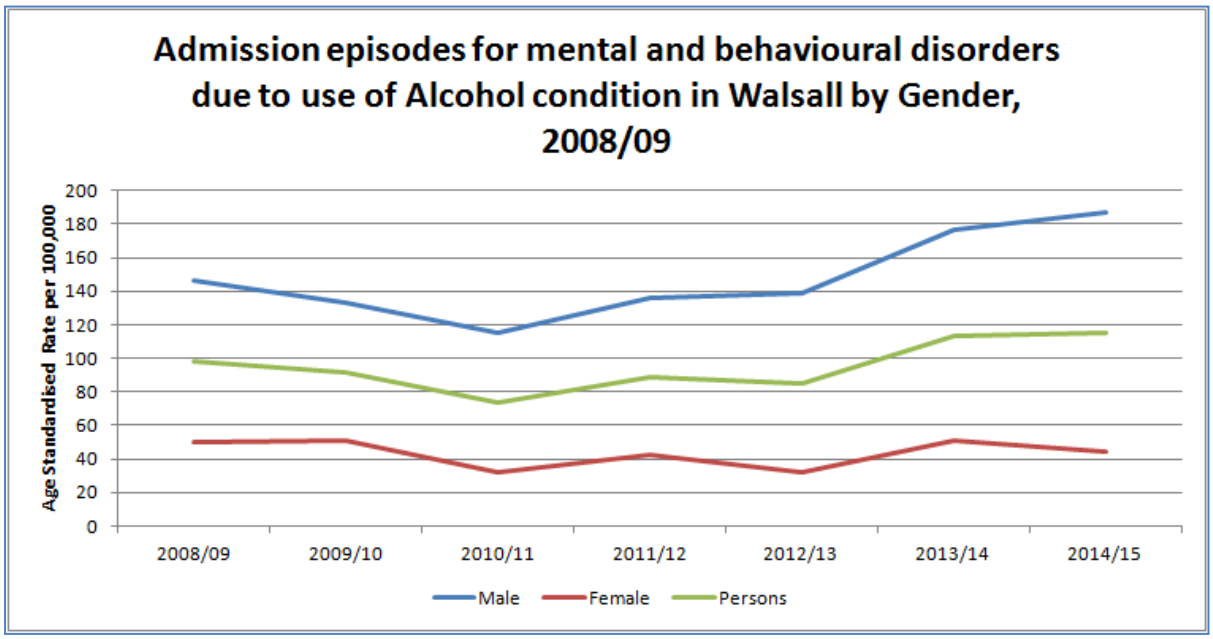
For smokers with a mental illness, the association between smoking and feeling relaxed is more pronounced, and it is commonly believed that people with a mental illness use cigarettes to self-medicate[50]. There is currently no clear evidence to conclude whether smoking is cause or effect of mental illness but the high levels of smokers in this population results in high mortality rates compared to the general population. Smokers with mental disorders more likely to be heavily addicted to smoking and to anticipate difficulty quitting smoking, though they are just as likely to want to quit as those without[51].

Alcohol and Drugs

The North West Public Health Observatory (now part of Public Health England) Annual Local Alcohol Prevalence Estimates (LAPE), estimates that Walsall has 10,772 residents dependent on alcohol.

Hospital admissions related to mental and behavioural disorders due to alcohol are high and the local rate in Walsall (115 per 100,000) is significantly above regional (85 per 100,000) and national rates (84 per 100,000). Over the last two years the gap between males and females has been widening with a higher rate in men (187 per 100,000) compared to women (45 per 100,000)(Figure 10).

Figure 10: Hospital Admissions for Mental disorders due to Alcohol in Walsall, 2008/09



Source: PHE

Most recreational drugs interfere with the chemicals in the brain. Psychoactive substances e.g. cannabis, ecstasy and heroin, have the ability to affect mood and can arouse certain emotions or dampen down others.
Short term effects from recreational drugs include;

- Drug-induced anxiety disorder
- Drug-induced psychosis
- Drug-induced mood disorder

Recreational drug abuse can also lead to long-term mental health problems, such as depression and schizophrenia. Factors that influence long term mental health issues include[52] the type of drug, whether mixed with other substances and purity of drug and amount taken. Substance dependence is a complex disorder with biological mechanisms affecting the brain and its capacity to control substance use. It is not only determined by biological and genetic factors, but psychological, social, cultural and environmental factors as well.

The Centre for Public Health, Liverpool John Moores University and Glasgow University (2014) annual drug prevalence report estimates that Walsall has 2,186 problematic drug users of opiate and crack cocaine[53]. This is a higher rate in comparison to the West Midlands and National rates. Similarly Walsall has a higher rate of injecting drug users.

The estimated number of recorded drug users has increased over last 4 years from 2,052 in 2009/10, and this is contrary to the national trend, which has reduced at a rate of 4%. Despite the challenging prevalence rates the local treatment system has a good penetration of the drug using population with 1,350 service users accessing structured treatment and

500 service users accessing open access services in 2013/14 (See Dual Diagnosis section for more details).

Figure 11: People in contact with mental health and substance misuse services, 2013/14 - 2014/15

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2013/14		91	16.1	13.3	19.3	17.3	19.9
2014/15		107	20.2	17.0	23.8	18.5	21.0

Source: National Drug Treatment Monitoring System

Source: PHOF

Link to Emotional Wellbeing and Mental Health

Nationally, it is recognised that people who experience anxiety or depression are twice as likely to be heavy or problem drinkers. Whilst some individuals will use alcohol to self-medicate to relieve pre-existing symptoms of anxiety or depression, for others drinking may be the root cause of their anxieties[54,55].

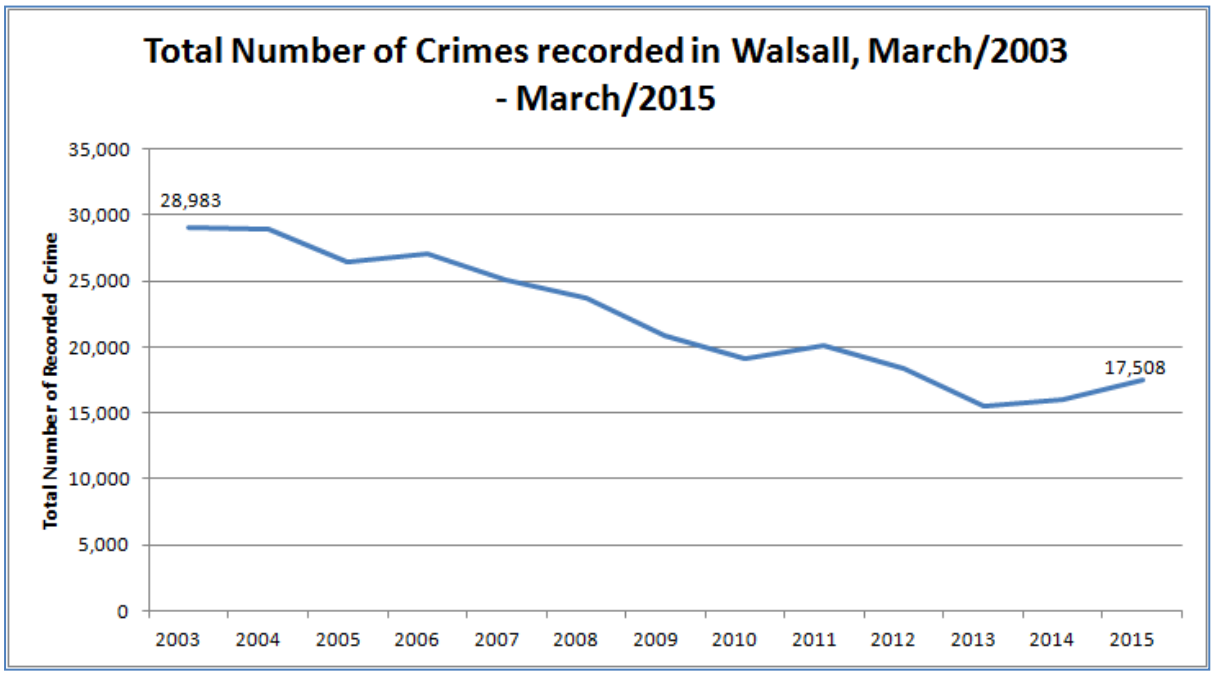
The dual diagnosis section within the needs assessment covers individuals that have issues with substance misuse and mental health issues including information on those in structured treatment programmes and mental health interventions (Link to section: Dual Diagnosis).

Crime and perceptions of community safety

Crime and perceptions on community safety has an impact on mental health. The impact can be physical, financial or psychological and it can vary on the people's responses depending on the type and severity of offence. Evidence suggests that victims of burglary are likely to have sleeping difficulties and those victims who have experienced a violent attack are more likely to suffer depression, anxiety and nearly half of rape victims experience PTSD[56].

According the latest crime figures in Walsall, there were 17,508 recorded crimes between March'14 and March'15 which shows a significant downward trend over last 12 years. However within the last two years the numbers of recorded crimes have begun to increase (Figure 12).

Figure 12: Total Recorded Crimes in Walsall, 2003-2015



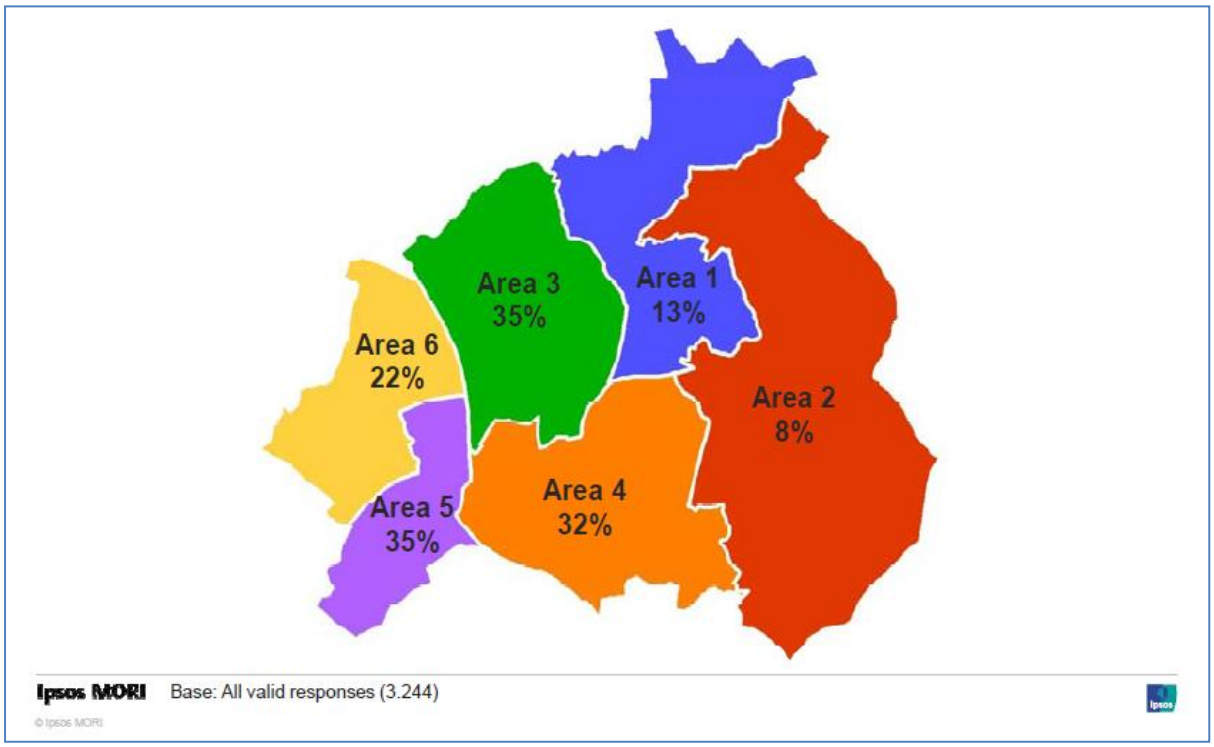
Source: ONS

The top 5 recorded crimes in March 2015 (12 month rolling period) which represent just below two thirds (63%) of all crime were: Criminal Damage and arson (2,556);Vehicle offences (2,456); Shoplifting (2,072); Violence with injury (1,994) and All other theft offences (1,931).

The West Midlands Police Feeling the Difference survey Wave 33 (Dec'12 – Feb'13) reported that 18% of respondents felt fearful of becoming a victim of crime at any stage over the last 12 months. Walsall South Area Partnership respondents were most likely to fear becoming a victim of crime (25%)[57].

Safer and stronger communities have a positive effect on resident's health and wellbeing. The Walsall lifestyle Survey 2012 mapped the perception of high antisocial behaviour across the Area Partnerships. There was a marked divide in the borough with residents in the west of the borough feeling they were more likely to experience ASB. 35% of residents in the North Walsall AP and Darlaston & Bentley AP reporting 'a high level' of ASB compared 8% in Aldridge & Beacon AP (Figure 13).

Figure 13: Proportion of Walsall residents that feel high levels of Antisocial Behaviour by Area Partnership, 2012



Source: Walsall Lifestyle Survey 2012

Relationships and Loneliness

When it comes to wellbeing, other people matter. Evidence shows that good relationships – with family, friends and the wider community are important for mental wellbeing[58] and positive friendships a crucial element in protecting our mental health[59].

Social support, in particular emotional support from close relationships is one important protective factor for mental health problems. Often, but not always, this close relationship is with a spouse/partner or parent. People lacking such a close supportive relationship are at greater risk of anxiety and depression[60].

The emotional support provided by social ties enhances psychological well-being, which, in turn, may reduce the risk of unhealthy behaviors and poor physical health[61]

Social isolation is defined as an absence of contacts[62]whereas loneliness is "an individual's subjective evaluation of his or her social participation or social isolation and is the outcome of having a mismatch between the quantity and quality of existing relationships on the one hand and relationship standards on the other[63]. Loneliness can affect people of all ages, but older people, those experiencing mental ill health and carers are particularly vulnerable.

3.5 million people aged sixty five or more live alone and 17% of older people have less than weekly contact with family, friends and neighbours[19]. 1.2 million people over fifty were severely socially excluded with little to no engagement in their communities, according to Age UK in 2008.

Studies have suggested the negative effects of loneliness on health include poor sleep, hypertension, more adverse reactions to stress[64] and and compromised immune system[65]. Loneliness and isolation have also been linked to depression in middle aged and older age[66] and dementia in older age[67]. The cumulative effect means that being lonely can be as bad for your health as being a smoker[19].

Table 7 shows that Walsall has higher proportion of older people living in single occupancy household compared to national averages with specific area partnerships locations having higher proportion of single occupancy compared to overall borough averages.

Table 7: Household composition in Walsall

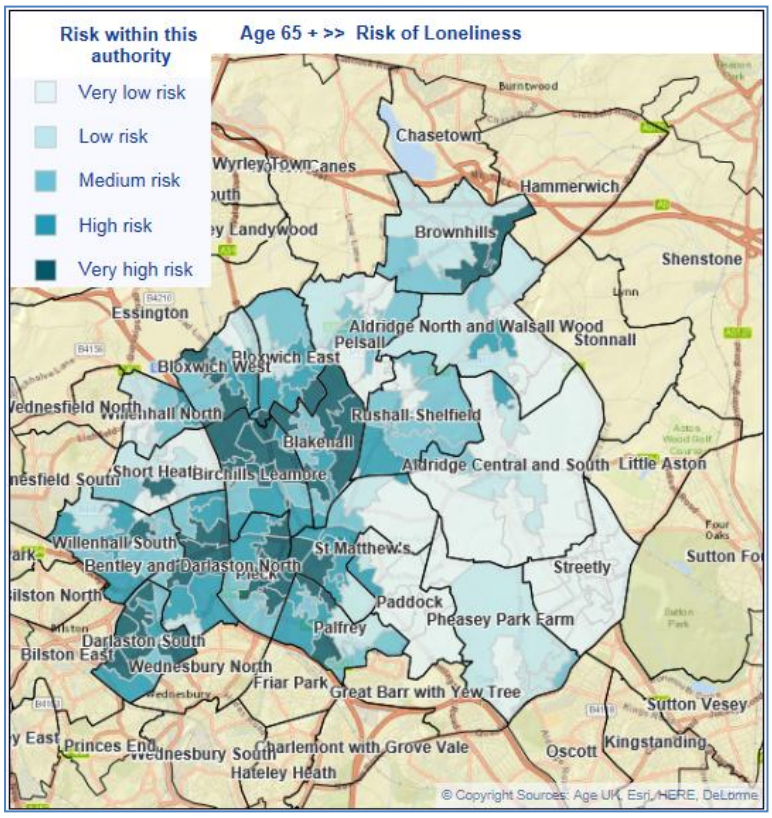
	Total Households	Family: Couple*	Family: Lone parent	One person: Below 65	One person: Over 65	Other household types
Brownhills/Pelsall/Rushall/Shelfield	15,037	46.40%	10.50%	13.20%	13.60%	16.20%
Aldridge & Beacon	21,732	45.50%	8.80%	11.70%	15.20%	18.70%
North Walsall	21,871	41.3%	14.6%	17.2%	13.1%	13.7%
Walsall South	22,040	39.4%	11.1%	19.7%	11.3%	18.5%
Darlaston & Bentley	10,824	43.0%	15.7%	15.7%	12.1%	13.6%
Willenhall & Short Heath	16,318	46.1%	12.7%	15.9%	11.1%	14.2%
Walsall	**107,822**	**43.40%**	**12%**	**15.70%**	**12.80%**	**16.10%**
England & Wales	**23,366,000**	**43%**	**10.60%**	**17.80%**	**12.40%**	**16.10%**

Source: ONS, Census 2011

There can be many reasons why people become isolated. In later years isolation may be as a result of loss of family and friends, poor health, decreased mobility and income. The English Longitudinal Study of Ageing (ELSA) found that factors associated with being lonely were[68] being in poor health and people who were widowed. Factors such as deprivation, poverty and living in a rural area, proved not to be significant.

The predicted risk of loneliness for Walsall wards based on ELSA shows that the central and west of the borough is likely to have 65s and over with the greatest risk of loneliness (very dark blue), which roughly corresponds to the distribution of care homes in the area(Figure 14).

Figure 14: Risk of Loneliness for Walsall



Source: Age UK (http://data.ageuk.org.uk/loneliness-maps/england-2016/walsall/?loadAllData=true&indicator=i0&prop_legendClassifier=quantile&pal_defaultPaletteId=Sequential Cyan&pal_defaultSchemeId=categoricScheme1&pal_noClasses=5&bbox=-232283.4665,6890126.8763137255,-207150.0835,6930537.413686275&printmode=true)

Housing

Though evidence for the impact of poor housing has been more developed for physical health but a strong association between poor housing and mental health problems is now well established. Poor-quality housing, such as dwellings that are damp, have high levels of noise and lack security, is particularly associated with depression[69]. The affordability crisis along with a decrease in social housing can lead to overcrowding which can have negative effects on family relationships, as well as affecting the emotional development of children within those households[70].

Those living in social and private housing tend to have poorer mental health than those in owner occupied accommodation[71]. Around a quarter of residents (24%) in Walsall live in socially rented accomdation which is higher than national average (18%) (Table 8).

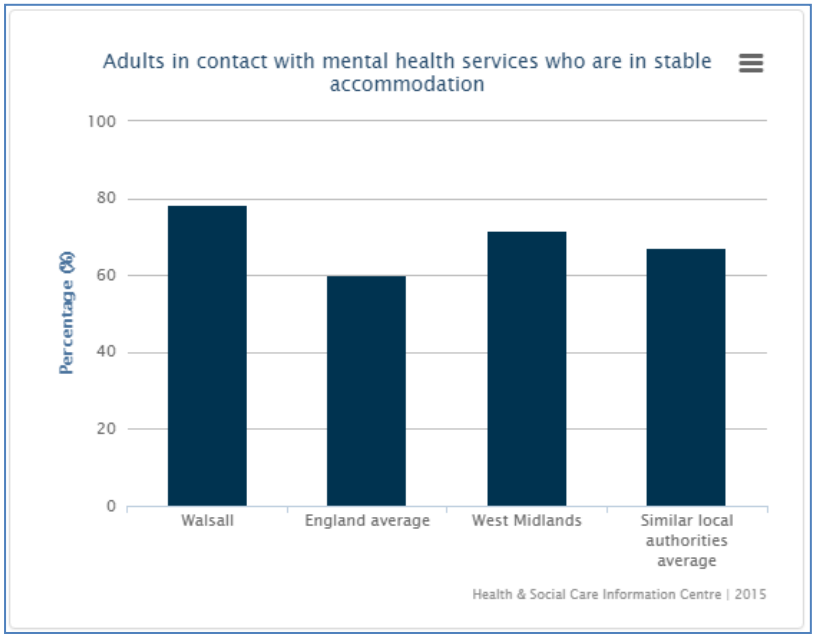
Table 8: Housing Status of Walsall residents

	Total	Owned outright	Owned mortgage	Socially rented	Privately rented	Living rent-free
Brownhills/Pelsall/Rushall/Shelfield	15,037	34.40%	36.70%	19.60%	8.10%	1.20%
Aldridge & Beacon	21,732	43.8%	38.7%	8.7%	7.9%	0.9%
North Walsall	21,871	22.1%	26.3%	37.8%	12.2%	1.6%
Walsall South	22,040	29.3%	27.2%	24.2%	17.7%	1.6%
Darlaston & Bentley	10,824	22.4%	28.0%	37.0%	11.0%	1.6%
Willenhall & Short Heath	16,318	31.2%	34.6%	21.6%	11.4%	1.1%
Walsall	**107,822**	**31.10%**	**32%**	**24.10%**	**11.70%**	**1.30%**
England & Wales	**23,366,000**	**31%**	**33.50%**	**17.60%**	**16.70%**	**1.40%**

Source: ONS, Census 2011

Having a mental health need does not mean that the individual will require Housing services. Some individuals can carry on functioning well, while for some there may be a huge detrimental effect on employment and finances with a potential loss of housing. The current Health and Social care data on adults in contact with mental health services with stable accommodation reports 77.8% of Walsall patients were in stable accommodation which was higher than the regional (71.2%) and national averages (59.7%) (Figure 15).

Figure 15: Adults in contact with Mental Health services in stable accommodation, 2014/15



Source: HSCIC

URL: http://ascof.hscic.gov.uk/Outcome/411/1H

Notes: The percentage of adults who recieve secondary mental health services, were living independently when they had their most recent care planning meeting. Care planning meetings include assessments, informal reviews or other multi-disciplinary care planning meetings.

CCG Commissioners advised that “priority status continues to be given to vulnerable persons requiring step down from hospital, residential/nursing facilities and supported living schemes etc.This arrangement has been in place for sometime and remains effective. A protocol exists between DWMHT and Walsall Councilthat ensures housing advice is provided for inpatients upon admission to DPH/Bloxwich hospital, which has proven successful over the years.

In respect of vulnerable people residing in the community and in need of alternative accommodation, a vulnerable persons priority form to support housing applications was introduced in 2010 and accepted by housing partners”.

Council colleagues have advised that “consideration is given to cases following advice from medical professionals, social services or current providers of care & support”. Each person will have their own mental health floating support package. In cases where there is doubt as to the extent of vulnerability, a clinical opinion may also be required. The final decision on the question of vulnerability will rest with the Council. In considering whether such applicants are vulnerable, factors that the Council may take into account include the nature and extent of the illness and/or disability which may render the applicant vulnerable, and the relationship between the illness and/or disability and the individual’s housing difficulties”.

Religion and spirituality

The people of Walsall have greater level of religious affiliation than in England and Wales overall, with 74% identifying with a religion compared to 68% nationally. The majority of Walsall people view themselves as Christian (59%) which is similar to national average (59.3%). Locally, the proportions of Muslims (8.2%) and Sikhs (4.3%) are significantly higher compared with national averages.

Table 9: Proportion of Walsall Residents by Religion

	Walsall	England & Wales
Christian	59.0%	59.3%
Muslim	8.2%	4.8%
Sikh	4.3%	0.8%
Hindu	1.7%	1.5%
Buddhist	0.2%	0.4%
Jewish	0.0%	0.5%
Other Religion	0.5%	0.4%
No religion	20.0%	25.1%
Not Stated	6.0%	7.2%

Source: Census 2011

The evidence linking spirituality and religious expression with different aspects of mental health is mixed. Expressions of spirituality that encourage personal empowerment, and promote the importance of emotions such as hope, forgiveness and purpose are helpful. Other aspects of spirituality seem to have no effect on mental health or, in some cases, can lead to feelings of guilt, shame or powerlessness, which can be damaging or harmful to a person's mental health[72].

People with certain religious beliefs may be less motivated to see help and engage in mental health services which in turn may lead to higher levels of mental health issues[73]. However, other cultural or social factors that are associated with these religions may compensate for this[74].

The economy and mental health

WHO have published a report 'Impact of economic crises on mental health' which shows that people's mental health is strongly linked to socioeconomic conditions[75]. Unemployment, debt, poor housing and low productivity are a big cause of poor mental health and they can also themselves be caused by poor mental health. In times of recession this vicious is even more pronounced and the poor are particularly hardest hit[76].

Deprivation

The relationship between high levels of deprivation and high rates of mental ill-health is well established[77]. Studies have found an association between mental health and socio-economic status, showing higher rates of psychiatric admissions and suicides in areas of high deprivation and unemployment. A higher prevalence of mental health problems amongst those living in poverty is due to both the higher causation among those living in deprivation and also because of those with mental health problems drifting into poverty[19]. Observations from previous economic downturns in the country suggest that the current recession may result in an increase in mental health problems such as depression, more suicides and suicidal behaviours, increased domestic violence, an increase in drug and alcohol dependency and possible lower levels of wellbeing. Child and working-age poverty is likely to increase across the UK over the next decade[19].

The English Indices of Deprivation, produced by the Department for Communities and Local Government (DCLG), identify small areas of England which are experiencing multiple aspects of deprivation. The Indices of Deprivation 2015 provide a relative measure of deprivation in small areas across Walsall, and are based on seven different aspects of deprivation (income deprivation, employment deprivation, health deprivation and disability, education skills and training deprivation, barriers to housing and services, living environment and crime).

Walsall is now the 33rd most deprived local authority out of 326 nationally. This puts it just outside the most deprived 10% in England and is a change in ranking of 3 places since 2010 (Figure 16)[‡].

[‡] The improvement in 3 places between 2010 and 2015 IMD does not necessarily mean that Walsall is more or less deprived in absolute terms, nor describes how the number of people experiencing deprivation has

Figure 16: Walsall borough's rank of average LSOA scores

Measure	England Percentile (i.e. within the most deprived ...% of local authorities)				England Rank* 2015/2010 rank out of 326 2007/2004 rank out of 354			
	2015	2010	2007	2004	2015	2010	2007	2004
Average of LSOA scores	11%	10%	13%	15%	33	30	45	61

**Where 1 is most deprived*

Source: Deprivation in Walsall, Summary Report 2015

The figure details that 133,200 (48.6%) of Walsall's total population (2014 mid-year estimates) live within the most deprived quintiles compared to 32,400 (11.8%) living in the least. Table 10n shows some supplementary income indices in particular those affecting older people (IDAOPI) with Walsall ranking as 34th (out of 326) in England with 23.7% of older people (aged 60+) experiencing income deprivation.

Table 10: Summary of all deprivation domains for Walsall

Domain	England Rank (out of 326)*		
	Average LSOA Score	% of LSOAs in the most deprived 10%	% of population experiencing deprivation
Index of Multiple Deprivation (IMD)	**33**	**39**	-
Income deprivation	18	11	21.9%
- affecting children (IDACI)	27	23	28.4%
- affecting older people (IDAOPI)	34	21	23.7%
Employment deprivation	30	42	16.9%
Education, skills and training deprivation	12	18	-
Health deprivation and disability	68	92	-
Crime	85	108	-
Barriers to housing & services	218	264*	-
Living environment deprivation	118	231	-

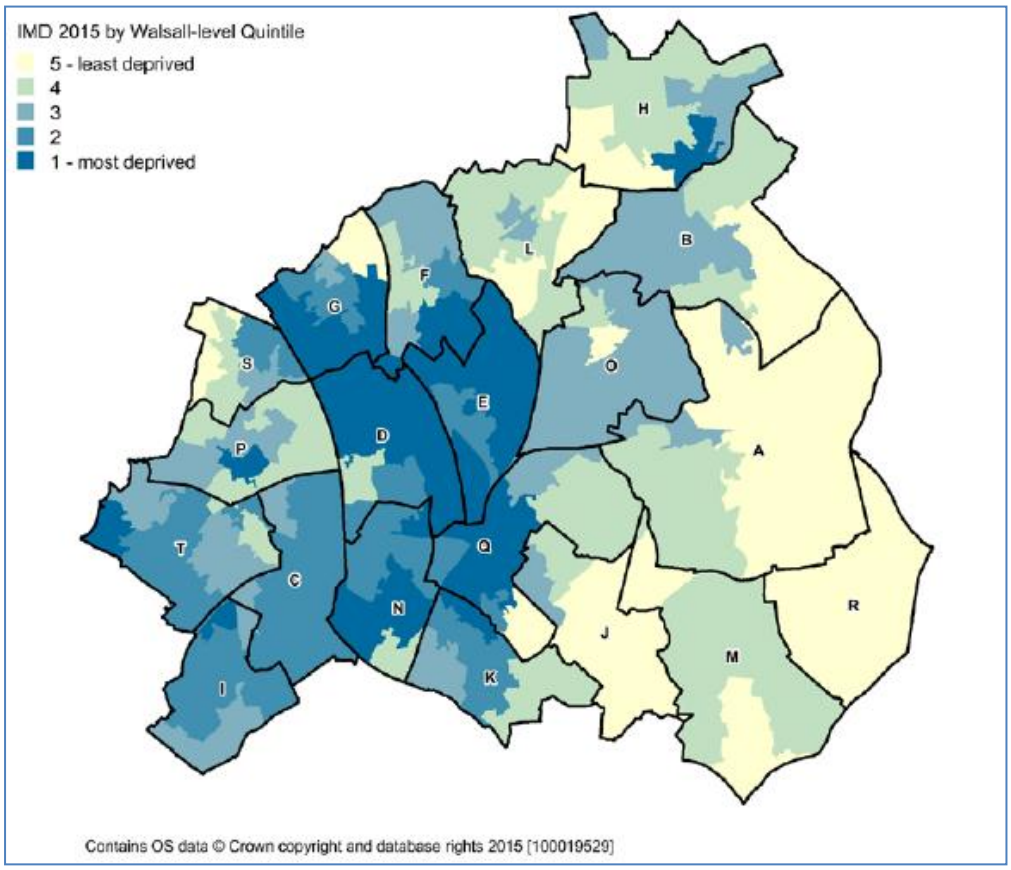
** All local authorities with no LSOAs in the most deprived 10% share a rank of 264*

Source: Deprivation in Walsall, Summary Report 2015

Figure 17 shows IMD relative to the rest of Walsall, split into quintiles. So within the borough as a whole, the most deprived quintile (i.e. the most deprived 20% of Lower Super Output Areas) is shown in the darkest blue and the least deprived is pale yellow. Pockets of deprivation exist across Walsall, however there seems to be a higher concentration of deprivation towards the centre and west of the borough.

changed. What it does show is that the borough is now relatively slightly less deprived when compared to other local authorities

Figure 17: IMD 2015 Walsall level quintiles by Wards



Source: Deprivation in Walsall, Summary Report 2015

Unemployment, Work and Mental Health

Unemployment is consistently related with higher rates of depression, anxiety and suicide, particularly when compounded by inadequate benefits[78]. Several studies have identified increase rates of depression in the unemployed, particular in young men[79,80].

Unemployment Demographics and Prevalence

In November 2015, 20,660 people within Walsall were claiming an out-of-work benefit, equal to 12.3% of the working age population (16-64). Though this was a decrease from 13.2% in November 2014, it is higher than for England (8.7%) and the West Midlands (10%). Those claiming ill-heath related Employment and Support Allowance (ESA) and previously Incapacity Benefits make up around two-thirds of Walsall's out-of-work benefit claimants – with 13,330 claimants equating to 7.9% of all working age adults in the borough. This number has risen from 12,070 (7.2% of adults) in November 2013.

The Area Partnership estimates that has the highest rates of those claiming out of work benefits with mental health conditions are in North Walsall (5.1%), Darlaston & Bentley (4.3%) and Walsall South (3.9%).

Table 11: Employment Support Allowance Claimants in Walsall, November 2015

Area Partnerships	Working age popultion (16-64)	Total ESA claimants	% of Adults claiming ESA	Total ESA Disease: Mental claimants	% of ESA claimants with a mental condition	% of Adults claiming ESA for mental condition
Brownhills/Pelsall/Rushall/Shelfield	22,100	1,555	7.0	665	42.8	3.0
Aldridge & Beacon	31,000	1,215	3.9	540	44.4	1.7
North Walsall	34,100	3,670	10.8	1,740	47.4	5.1
Walsall South	37,600	3,335	8.9	1,480	44.4	3.9
Darlaston & Bentley	17,700	1,685	9.5	755	44.8	4.3
Willenhall & Short Heath	25,400	1,985	7.8	915	46.1	3.6
Walsall Total	**168,000**	**13,445**	**8.0**	**6,095**	**45.3**	**3.6**

Source: Department of Working Pensions (DWP), Working Age Client Group; ONS, Mid-2014 Population Estimates.

Notes: Current ward totals are not supplied by DWP, only LSOA figures. Ward and AP figures here are therefore based on a best fit of LSOA. As these figures are supplied rounded to the nearest 5, there will be some error based on summing the rounded figures. Caution should therefore be used with the derived rates of claimants.

Those receiving Employment and Support Allowance (ESA) and Incapacity Benefits are more likely to be long-term claimants (with 4.1% of adults claiming for over 5 years, accounting for 33% of all Walsall's out-of-work benefits claimants). Conversely, those on Jobseeker's Allowance are more likely to be short-term claimants (with 1.1% of adults claiming for less than 6 months, accounting for 9% of all Walsall's out-of-work benefits claimants). The same pattern is seen across England overall.

Of all the people claiming Incapacity Benefit (IB) or Severe Disablement Allowance (SDA), the most prevalent condition in November 2015 was a 'mental or behavioural disorder' (44%) followed by a 'disease of the musculoskeletal system (13%).

There are three levels of ESA: support group, assessment rate and work related activity group (WRAG). Those in the WRAG are considered capable of work at some point in the future and able to take steps towards moving into work. Of the approximate 2,300 claimants in WRAG in August 2015, 980 people had a primary health condition recorded as mental health. The maximum amount that can be claimed for the WRAG in a year is just over £5,300, meaning that the potential savings for mental health claimants if all these people could be supported back to work is in the region of £5.2million. This does not factor in the cost of any other additional benefits or the costs in supporting people back to work.

Unemployment Link to emotional wellbeing and mental health

Those with a common mental health disorder are four to five times more likely to be permanently unable to work and three times more likely to be receiving benefit payments compared to those without. [81,82,83]. People who are unemployed and experience common mental health problems without accessing support may find that they are progressively further away from the labour market, inhibiting their re-entry to the workplace.

A comprehensive review of the research around effect of work and worklessness on mental health concluded that overall[84]:

- Work is beneficial to health and wellbeing
- Lack of work is detrimental to health and wellbeing. The unemployed consult more with GPs than general population and higher prevalence of depression and anxiety, four and twelve times, if someone is unemployed for 12 weeks or more. Thus the importance of early support to address common mental health conditions.
- Unemployment can be associated with increase rates of suicide.
- For those people without work, those who are sick or disabled and people with mental health problems employment and re-employment improves health and psychosocial status[85].

Work and Mental Health

As discussed in the above sections, work can provide enrichment to people's mental health, prevent mental ill health as well as acting as a positive environment for people recovering from mental ill health. At the same time, poor working conditions including job security, low support, workplace bullying and high stress / low reward have been linked to increased sickness.

Mental health is a leading cause for sickness absence and ill health in the UK[86]. This is evident locally in Walsall amongst the three largest employers (Walsall Council, Walsall Healthcare NHS Trust and Walsall Housing Group).

Table 12 shows that Walsall Council (23%) and Walsall Healthcare NHS Trust (21%) had a similar proportion of the total absences related to mental health and it ranked as the top reason for sickness absence. Walsall Housing Group has lower proportion at 14% but mental health and stress rank amongst the top 10 reasons for absence as well.

Table 12: Sickness absence related to Mental Health for Walsall Largest Employers

Organisation	% of Sickness days related to Mental Health	Period	Definition
Walsall Council	21.68% (12,198 working days lost)	12 Months (Apr-Mar/15)	Stress/Depression/Mental Health/ Fatigue syndrome
Walsall Healthcare	21%	12 Months (Jan-	Anxiety/stress/depression/other

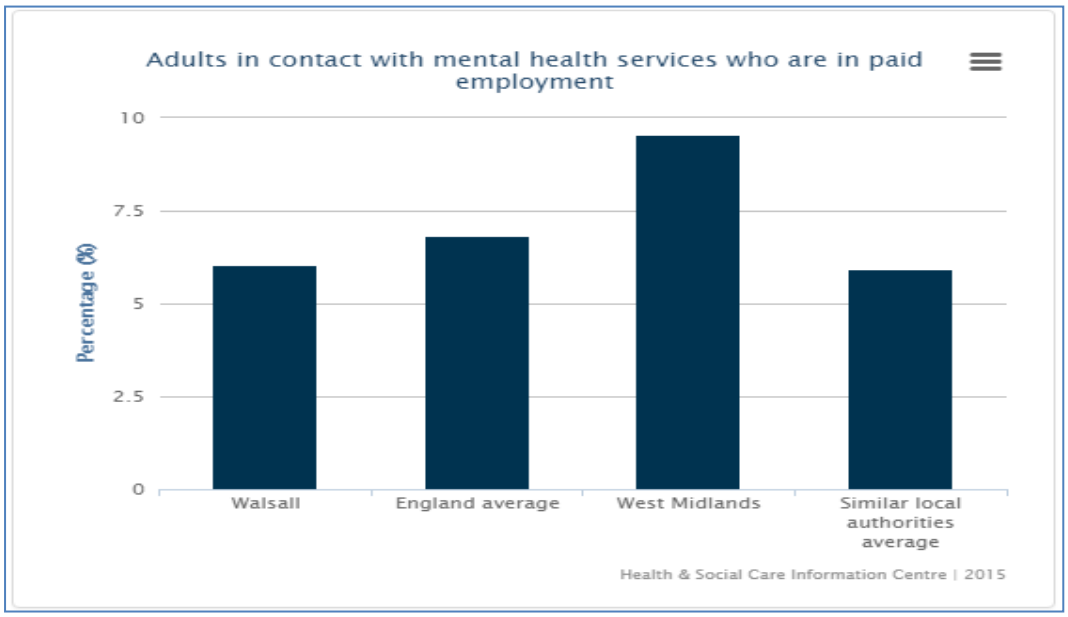
NHS Trust		Dec/15)	psychiatric illness
Walsall Housing Group (WHG)	14.3% (726 working days lost)	12 Months Rolling (Jan/16)	Mental Health/Stress

The employers were asked what arrangements they had in place to support the mental health and wellbeing of staff. WHG advised that on day 8 of a mental health or stress absence, employees are referred to a team through Rehab Works who assess the employee's needs. WHG then pay for CBT/ counselling etc based on this assessment and get a feedback update on their progress. Awareness sessions are run for employees. They have Employer Assistance Programs (EAPs) which is a helpline for employees as part of their health cash plan, which they can access 24/7. They train managers in MH awareness who also have access to a Human Resources Business Partner for guidance. Some have also undertaken mental health first aid. Their e- return to work forms have different questions for different absences to guide managers through the questions to ask.

Walsall Council also reported similar measures including providing flexible working, buying of additional annual leave, free counselling sessions, employee discounts and MH training for managers. There is ongoing work for the adoption of the Wellbeing Charter with the aim to be an exemplar workplace by demonstrating improvements in employee health and improving staff morale.

Having a mental illness can affect an individual's ability to retain employment or seek one. The proportion of Walsall adults on Care Programme Approach in contact with secondary mental health services and in paid employment (6%) is lower than the regional (9.5%) and national averages (6.8%) whereas peer group LAs are similar in comparison (Figure 18). Supporting someone to become and remain employed is a key part of the recovery process[87] and indicative of whether care and support is personalised.

Figure 18: Adults in contact with mental health services who were in paid employment, 2014/15

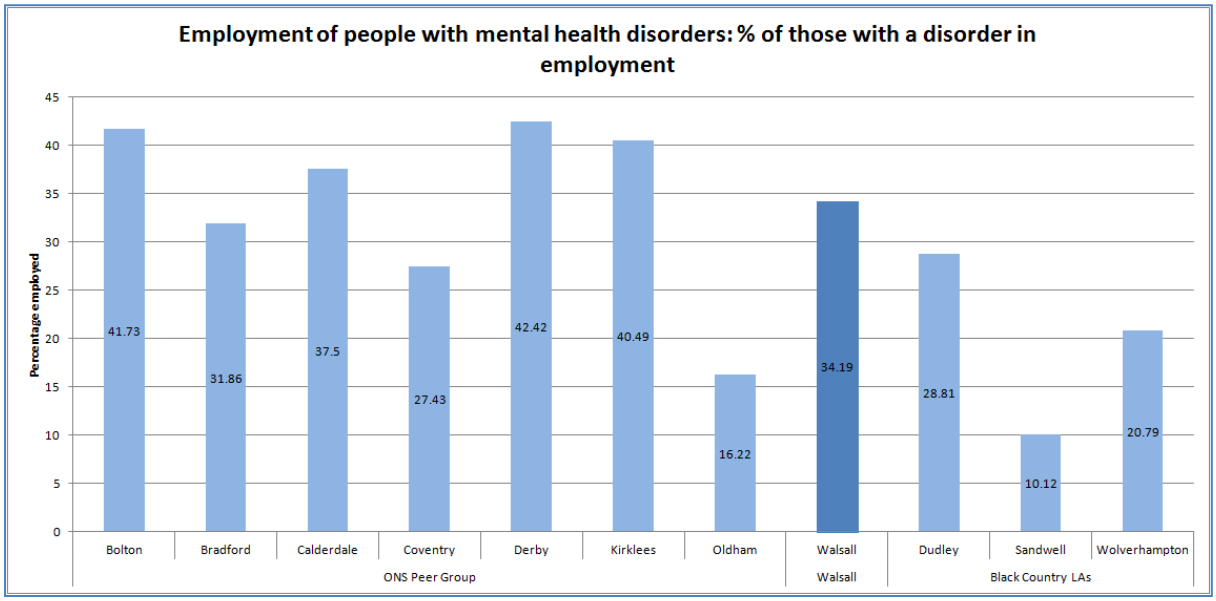


Source: HSCIC

Notes: The adults who receive secondary mental health service were in paid employment confirmed at last care planning meeting (including assessment, informal reviews or other multi-disciplinary care planning meetings). Only includes those with Care Programme Approach and so may not include all of those in contact with secondary MH services.

One in three people with mental health disorders (34.2%) that responded to labour survey are in employment which is higher rate than other Black Country LAs (Figure 19).

Figure 19: Employment of people with mental health disorder



Source: NCHOD

Caveat: The definition of "mental illness" used in the survey is wider than just those with common mental health disorders, but these are likely to be the majority.

Work Link to emotional wellbeing and mental health

The 2006 review 'Is work good for your health and well-being?' concluded that work was generally good for both physical and mental health and wellbeing[88]. It showed that work should be 'good work' which is healthy and safe and offers the individual with a sense of self-worth.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209782/hwwb-working-for-a-healthier-tomorrow.pdf

Along with being a leadig cause of sickness leave, mental health problems often cause fatigue and impaired attention, concentration and poor memory, leading to presenteeism which is where an employee is unwell and remains in work but is less productive. Nationally it has been estimated that as much as 60% of the employment related to costs of mental illness are due to presenteeism[89]. This cohort of people is not likely to show outward signs of mental illness and would be reluctant to inform employers of illness possibly due to resulting stigma[90]. The cost of presenteeism due to mental health conditions is estimated at £1,008 per employee each year. Measuring presenteeism can be difficult but it is an important part of productivity within the area and requires further addressing of mental health issues within the workplace.

In 2007, the total cost to employers of mental health distress and illness is estimated at nearly £26 billion each year[96], though there is not a clear consensus on the cost of lost employment due to mental health, which can vary due to the factors and impacts included in the studies

The Walsall lifestyle needs assessment (Link to needs assessment) identified two key recommendations for workplaces to support the mental wellbeing of staff. These are the implementation of HSE (Health and Safety Executive) set of Management Standards for Work-related stress and adopting an organisation-wide approach to promoting mental wellbeing (flexible hours, working in partnership and systems to assess and monitor mental wellbeing).

From April 2015 – March 2016, tailored employment support (e.g. access to training, job search) was delivered by Regeneration Team, Walsall LA, alongside access to public health services (e.g. emotional health and wellbeing) for young people who are Not in Education, Employment or Training (NEET), particularly care leavers. Individual Placement and Support (IPS) and recovery college model is now being delivered by DWMHT, which provides employment support alongside mental health services.

Educational Attainment

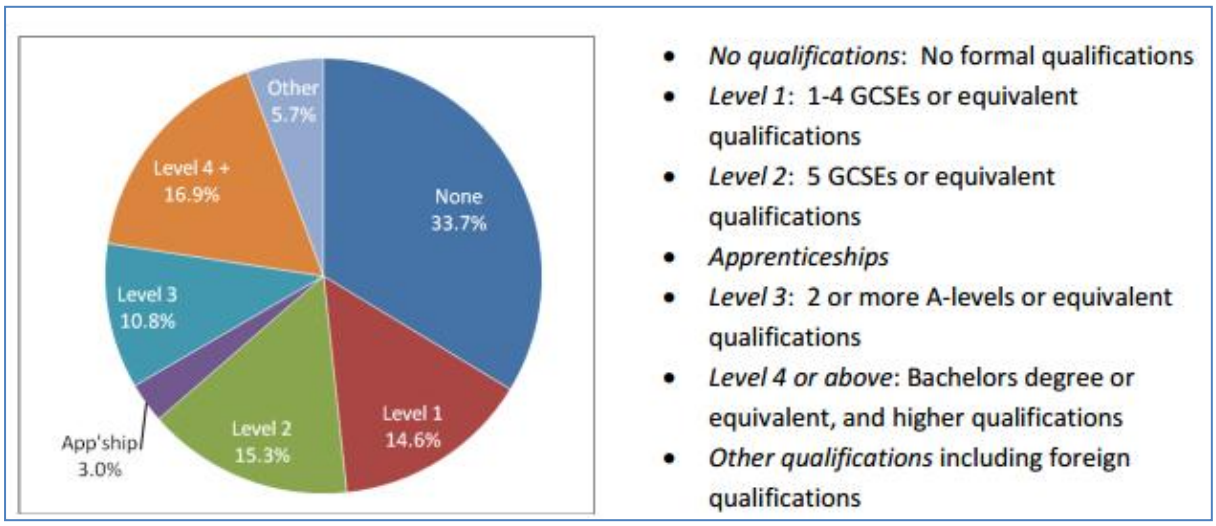
The link between education and poorer mental health has been long established and the lifelong effects that it can have on individual from childhood through life. It is recognised that the attainment of general skills, educational qualifications and productive employment thereafter are facilitated by good mental health[91].

The Children and Young Peoples' Emotional Wellbeing and Mental Health needs assessment (CYPEW) identified that for educational attainment, which is a significant factor affecting children and young people's mental health, Walsall rates were much lower than national averages for each of the key milestones: early years, key stage 2 and key stage 4.

Link to CYP EWMH NA:
http://www.walsallintelligence.org.uk/WI/publications/Emotional%20Wellbeing%20and%20Mental%20Health%20Needs%20Assessment%20v1.0.pdf

One in three Walsall adults has no formal qualification – which equates to over 71,800 people. Walsall has higher proportion of residents over 16(48.3%) with no qualifications or low qualification (Level 1) in comparison to national averages (36%).

Figure 20: Highest level of qualification, Walsall residents aged 16 and above



Source: ONS Census 2011

Pattern of mental health disorders in Walsall

There are 59 member GP practices within Walsall CCG, with 276,296 registered patients (serving 212,707 Adult registered patients and 209,594 Adult Walsall residents)[§].

Common Mental Health Conditions in Walsall

This section outlines common mental health disorders in line with NICE Guidance CG 123[92]. The term common mental health disorders encompasses depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and social anxiety disorder.

The percentage of patients, aged 18 and above, who stated they have a long term MH problem in the GP Patient survey (DH, 2014) was 5.8% for Walsall CCG, as compared to 5.1% nationally. This indicator is not based on a recorded diagnosis and not limited to specific mental health conditions.

Depression

Depression is a broad and heterogeneous diagnosis which is centred on depressed mood and/or loss of pleasure in most activities. Symptoms should be present for at least 2 weeks and each symptom should be present at sufficient severity for most of the day[93].

Anxiety

Anxiety disorders include generalised anxiety disorder, social anxiety disorder, post-traumatic stress disorder, panic disorder, obsessive-compulsive disorder and body dysmorphic disorder. For the disorder to be diagnosed, symptoms should be present for at least 6 months and should cause clinically significant distress or impairment in social, occupational or other important areas of functioning[94]

Anxiety is one of the most prevalent mental health problems in the UK and elsewhere, yet it is still under-reported, under-diagnosed and under-treated[95].

Obsessive Compulsive Disorder

OCD is a common form of anxiety disorder involving distressing, repetitive thoughts. The symptoms can cause significant functional impairment and/or distress. An obsession is defined as unwanted intrusive thought, image or urge. Compulsions are repetitive behaviours or mental acts that the person feels driven to perform.

Post-Traumatic Stress Disorder

Post Traumatic Stress Disorder (PTSD) develops following a reaction to a very stressful and traumatising event(s) which is likely to cause distress in almost anyone[96]. PTSD does not therefore develop following those upsetting situations that are described as “traumatic” in everyday language, for example, divorce, loss of job, or failing an exam. PTSD can affect

[§] Registered population 2014/15: QOF and Walsall Residents: ONS Population estimate mid-years 2014 and information based on 63 GP practices in 2014/15.

people of all ages and around 25-30% of people experiencing a traumatic event may go on to develop PTSD[97].

Prevalence of Common Mental Health Disorders

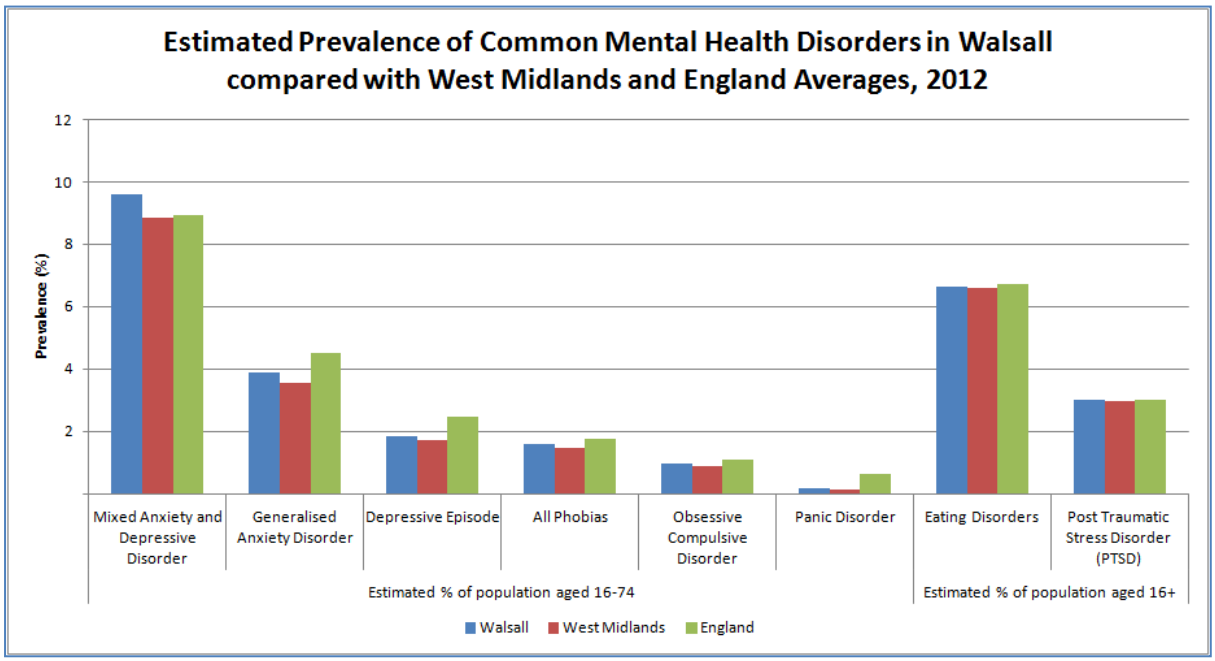
The prevalence of individual common mental health disorders varied considerably, the latest estimates for Walsall is 25,878 according to Projecting Adult Needs and Service Information (PANSI) . The prevalence rates gathered from the Public Health England (PHE) Common Mental Health Disorders Profile[98] provide individual estimates of individual conditions under the common mental disorder umbrella (for those aged 16+). Using the latest Walsall population estimates[**] these have been summarised below (Figure 21):

- 9.59% of the population estimated with **mixed anxiety and depressive disorder** in Walsall (18,581 people), which is **higher** than the regional (8.83%) and national average (8.92%).
- The QOF prevalence of **depression** (those aged 18+) for 2014/15 in Walsall was 7.9% which is higher than the national prevalence of 7.3%.
- 3.9% of the population estimated with **generalised anxiety** in Walsall (7,556 people), which is **higher** than the regional average and **lower** than national average.
- Between 8% and 12% of the population experience depression in any year[99]. Each year in Walsall between 21,840 and 32,760 are estimated to experience depression.
- 1.58% of the population estimated with **phobias** in Walsall (3,061 people), which is higher than regional average and lower than national average.
- 0.95% of the population estimated with **OCD** in Walsall (1,841 people), which is higher than regional average and lower than national average.
- 0.17% of the population estimated with **panic disorder** in Walsall (329 people), which higher than regional average and lower than national average.
- 2.99% of the population estimated with **PTSD** in Walsall (6,480 people), which similar to the regional and national averages.

The above figures will include some people with more than one mental health condition.

[**] ONS 2014 mid-year population estimates

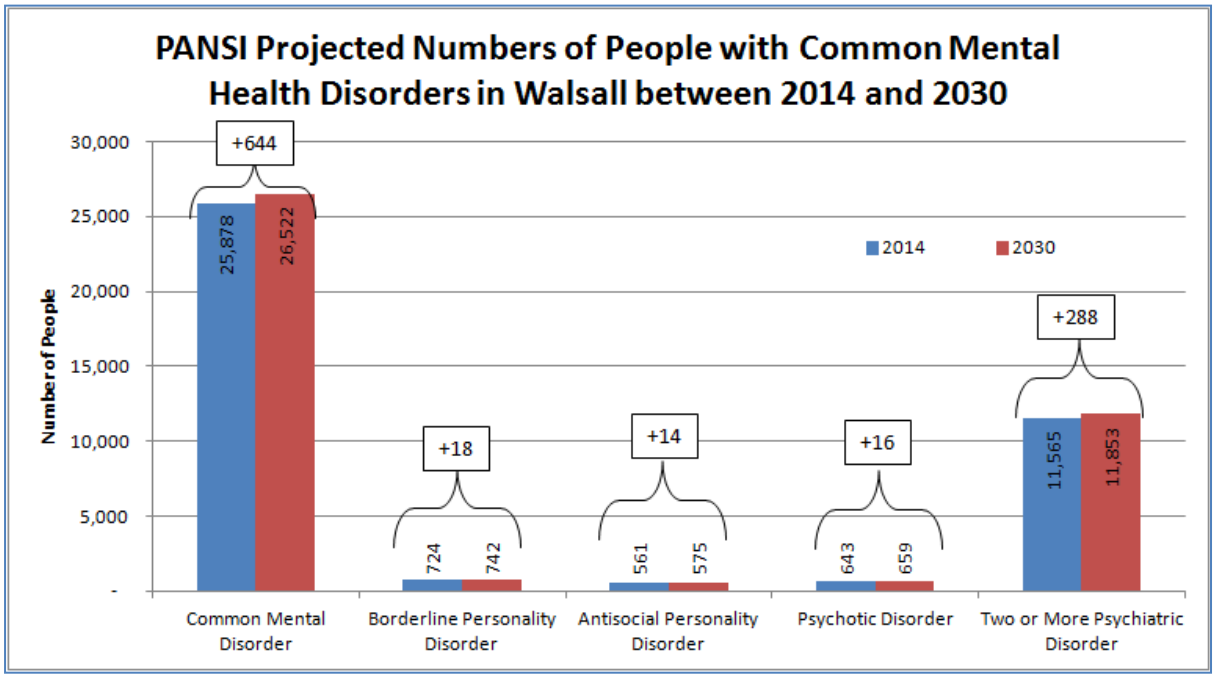
Figure 21: Walsall Estimated Prevalence of Common Mental Health Disorders



Source: PHE

The projected prevalence of common mental health disorders is set to increase by extra 644 people between 2014 and 2030 according to Projecting Adult Needs and Service Information (PANSI). Overall, it is projected that across different conditions that additional 980 people could be in needs of mental health support (Figure 22).

Figure 22: Projected Numbers of Common Mental Health Disorders in Walsall, 2014-2030

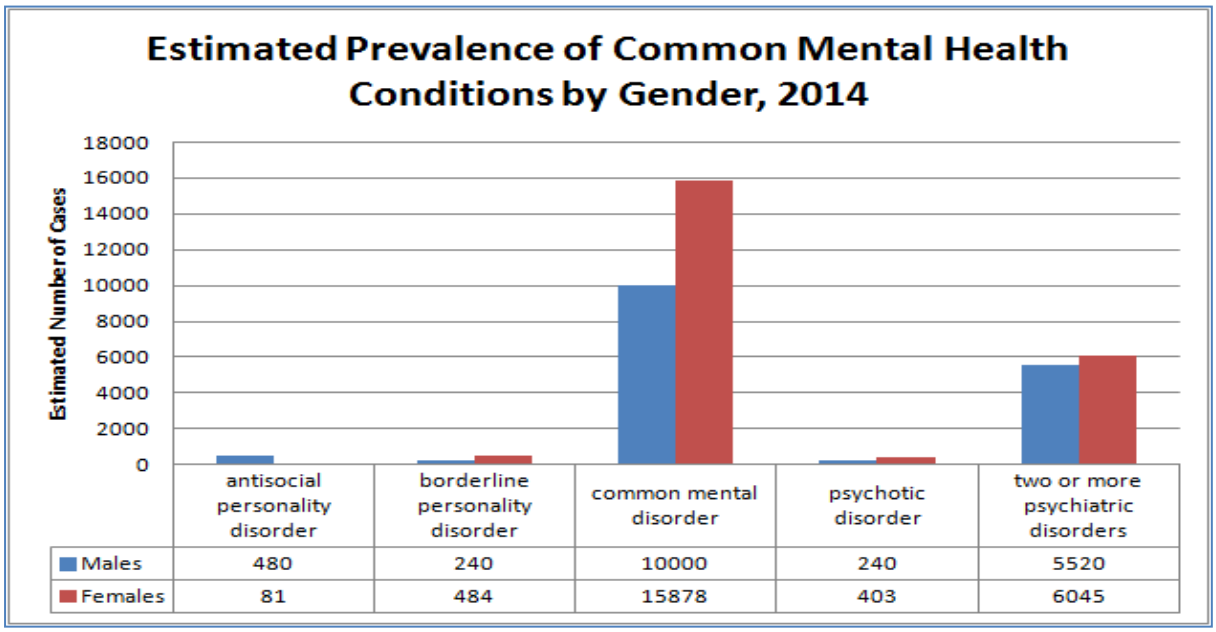


Source: PANSI

Gender variation

Prevalence is higher among females across all conditions at approximately 1.58 female cases to every 1 male. There are more men diagnosed with antisocial personality disorder (Figure 23). As people can be diagnosed with more than one common mental health condition, the number of people with common mental health conditions will actually be lower than the total indicated by the numbers displayed.

Figure 23: Estimated Prevalence of Common Mental Health Conditions, 2014



	antisocial personality disorder	borderline personality disorder	common mental disorder	psychotic disorder	two or more psychiatric disorders
Males	480	240	10000	240	5520
Females	81	484	15878	403	6045

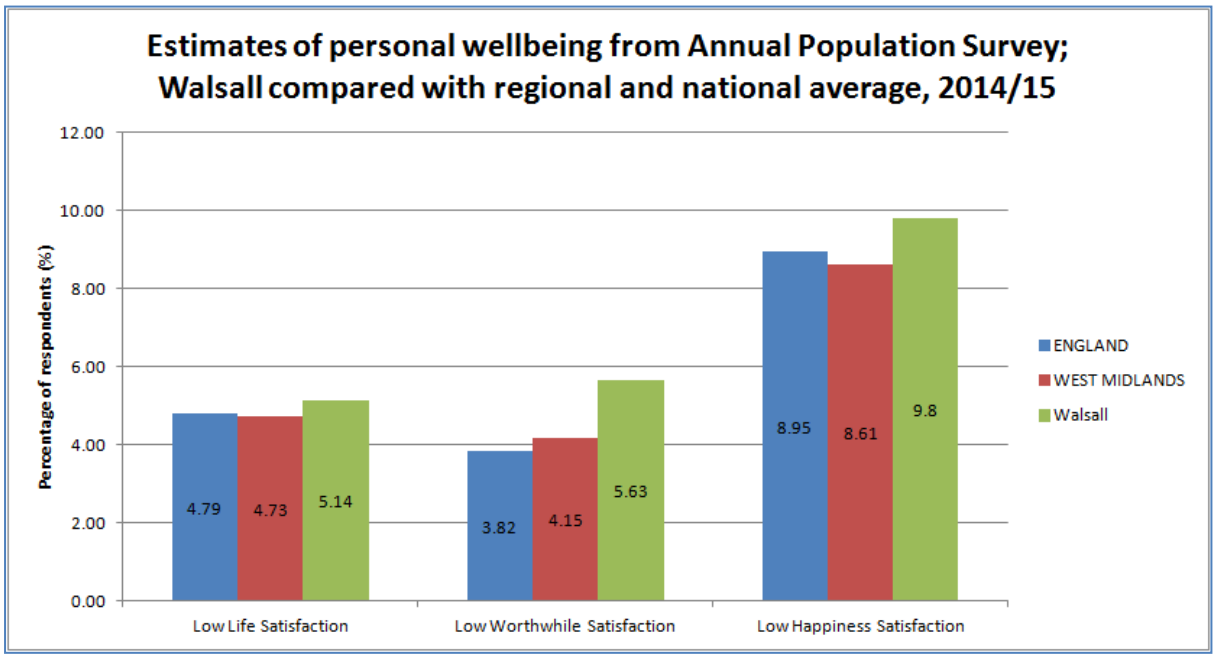
Source: PANSI (Adult psychiatric morbidity in England, 2007).

Caveat: The prevalence rates have been applied to ONS population projections for the 18-64 population to give estimated numbers predicted to have a mental health problem.

Wellbeing

The measure of wellbeing in the borough has limited information. The ONS Annual Population Survey offers insight into people's wellbeing. 5.6% of Walsall respondents reported low levels of satisfaction with life, 5.1% reported low levels of life worth and 9.8% reported low levels of happiness. These rates were higher than regional and national averages suggesting the wellbeing in Walsall is worse (Figure 24).

Figure 24: Proportion of Respondents expressing low life worth, Satisfaction and Happiness



Source: ONS, Annual Population Survey 2014/15

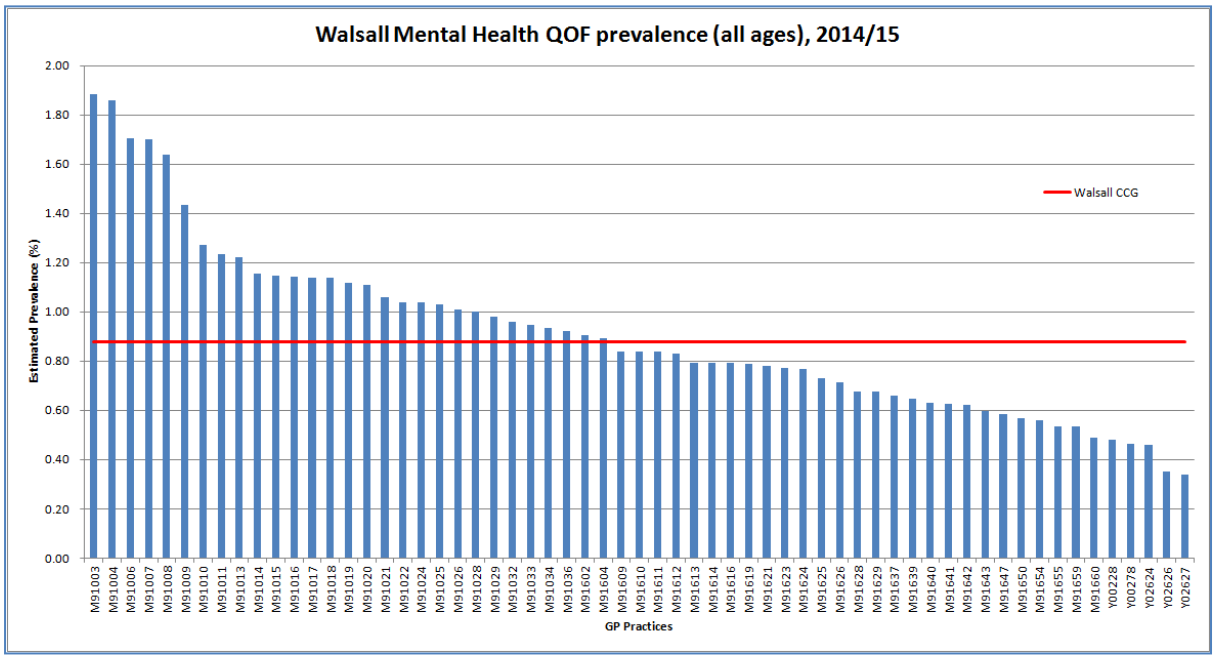
http://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/measuringnationalwellbeing/2015-09-23

Severe and Enduring Mental Health in Walsall

Walsall CCG's mental health prevalence (diagnosis of schizophrenia, bipolar affective disorder or other psychoses) was 0.88%, which is the same as national prevalence, and equates to about 2,433 patients across Walsall practices in 2014/15 based on GP profiles[††]. The estimate in prevalence across practices ranges from 0.34% to 1.88% (Figure 25). There has been a 3.75% increase in prevalence in Walsall between 2013/14 and 2014/15, which could be due to increased diagnosis or an actual increase in prevalence.. Records from mental health services indicate that 4,463 patients were seen[‡‡] in 2014/15. This could indicate an issue with the recording of MH patients in Primary Care, or simply down to the limited diagnoses included in the QOF indicator as compared to the range referred to and seen by the Trust.

[††] GP Practice Profiles: http://fingertips.phe.org.uk/profile/general-practice
[‡‡] Patients seen = At least one seen face to face contact.

Figure 25: Percentage of patients with schizophrenia, bipolar affective disorder and other psychoses as recorded on practice disease registers

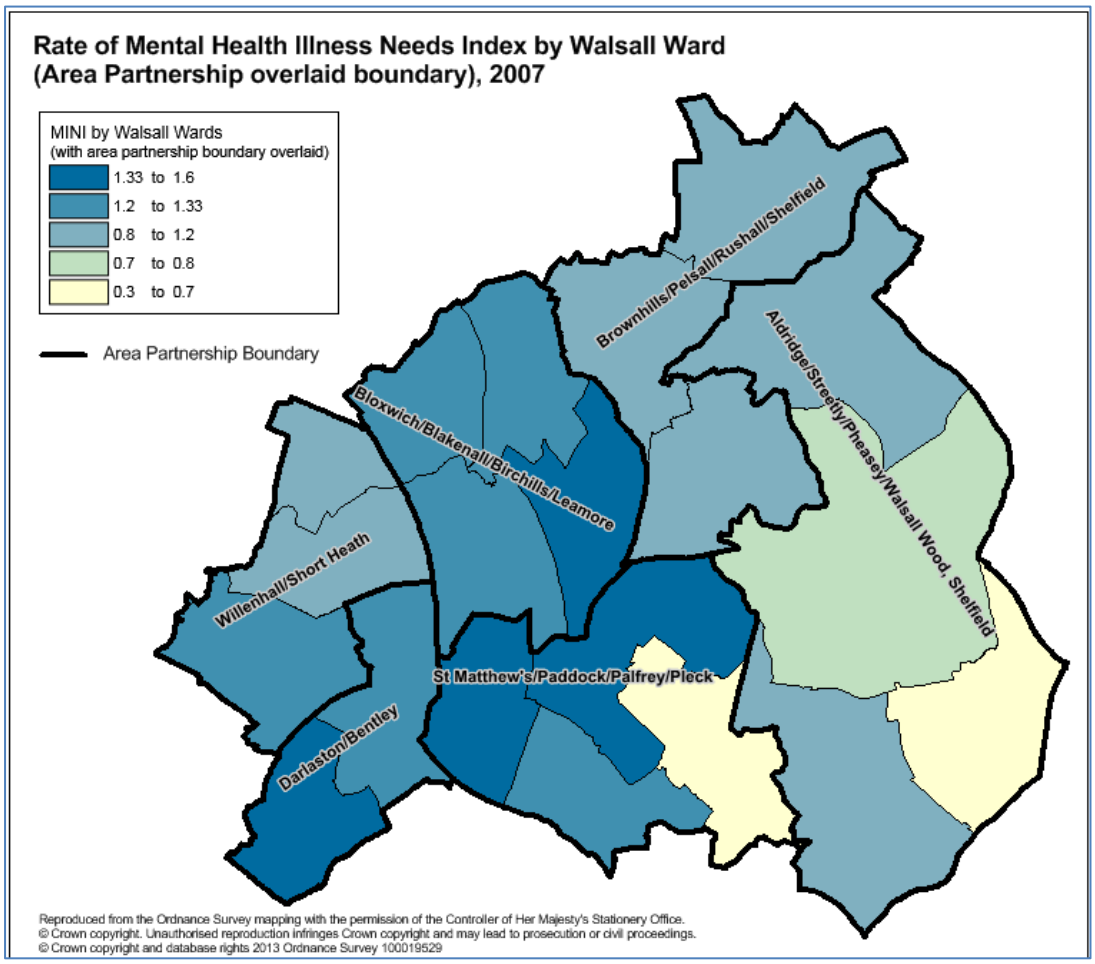


Source: HSCIC, QOF 2014/15

The Mental Health Illness Needs Index (MINI) for Walsall indicates that the highest rates of mental health conditions are seen in the west and central wards of the borough (Figure 26). Although the MINI is based on severe mental health conditions it is also a good indicator for common mental health conditions[100]. The MINI is derived from the Adult Psychiatric Morbidity Survey, a robust, stratified and multi-stage population survey which is conducted every seven years, and is the most extensive source of information on the prevalence of mental health problems in adults within England. The current data is from 2007 but new data from the latest survey is expected to be released in September 2016[19].

The estimates of the prevalence of mental illness in Walsall's population, presented below, are derived from national surveys and local population applied to those rates.

Figure 26: Mental Illness Needs Index by ward



Source: National Psychiatric Morbidity Survey, 2007

Psychosis

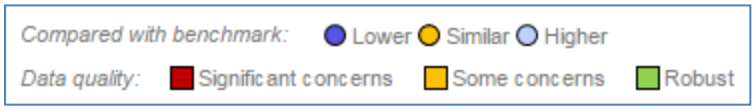
Psychosis describes the distortion of a person's perception of reality and it significantly alters the thoughts, mood and behaviour of individuals in the form of delusions and/or hallucinations[101]. Each person will have a unique combination of symptoms and experiences. It encompasses severe diagnosis of schizophrenia, Bipolar and some forms of personality disorders[102].

The estimate incidence rate for Walsall (25.6%) is slightly higher than regional (25%) and national averages (24.2%). However the data quality of this indicator is not considered very robust (Figure 27).

Figure 27: Estimated incidence of Psychosis rate per 100,000, 2011

Area	Value	Lower CI	Upper CI
England	24.2*	23.8	24.7
West Midlands region	25.0*	-	-
Birmingham	38.9*	33.5	44.3
Coventry	30.2*	23.1	39.0
Dudley	20.7*	14.3	28.2
Herefordshire	16.4*	8.9	24.8
Sandwell	33.4*	25.6	42.6
Shropshire	16.3*	10.5	22.7
Solihull	19.2*	11.7	27.4
Staffordshire	17.5*	14.2	21.2
Stoke-on-Trent	25.0*	17.3	34.0
Telford and Wrekin	19.5*	12.0	28.6
Walsall	25.6*	18.5	35.3
Warwickshire	18.1*	14.1	22.7
Wolverhampton	34.1*	25.7	44.5
Worcestershire	17.5*	13.2	21.9

Source: www.psymaptic.org



Source: PHE

Bipolar Disorder

Bipolar disorder ("manic-depressive illness") is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out daily tasks and symptoms can be severe[103]. It is often comorbid with other disorders such as anxiety disorders, substance misuse, personality disorders and attention deficit hyperactivity disorder (ADHD)[104].

At least half of all cases start before the age of 25. People can exhibit their first signs during childhood and develop symptoms in later life[105].

The depressive phase usually comes first and about ten per cent of people thought to have pure depression have a manic episode six to ten years later. About 15% of those who have an episode of mania never experience another[106].

Bipolar disorder affects about one in 100 people, equalivent to about 2,096 Walsall residents.

Personality Disorders

Antisocial personality disorder can only be diagnosed in adults, whereas borderline personality disorder can also be diagnosed in young people post puberty[107].

Borderline personality disorder

Borderline personality disorder (BPD) is characterised by significant instability of interpersonal relationships, self-image and mood, and impulsive behaviour. There is sometimes a pattern of rapid fluctuation from periods of confidence to despair, with fear of abandonment, rejection and a strong tendency towards suicidal thinking and self-harm. People with borderline personality disorder are particularly at risk of suicide and they have higher levels of comorbidity, including other personality disorders, and are frequent users of psychiatric and acute hospital emergency services[108].

Less than 1% of the population are estimated to have borderline personality disorder and it commonly presents itself in early adulthood, with women presenting to service more often than men. Most of symptoms are identified early adolescence and more often people do not present to mental health services until much later in life.

The Adult Psychiatry Survey 2007 estimated that the overall prevalence of BPD was 0.4% of adults aged 16 and over (0.3% of men, 0.6% of women). PANSI estimates that around 724 residents (working age 18-64 years old) could fall under the diagnoses of borderline personality disorder using the 2014 ONS population estimates.

Antisocial personality disorder

People with antisocial personality disorder exhibit traits of impulsivity, high negative emotionality, low conscientiousness and associated behaviours including irresponsible and exploitative behaviour, recklessness and deceitfulness. Antisocial personality disorder (APSD) is often comorbid with depression, anxiety and alcohol and drug misuse.

There is higher prevalence amongst people in prison around 47%. Criminal behaviour is central to the definition of antisocial personality disorder, but there are people with no criminal history.

ASPD was present in 0.3% of adults aged 18 or over (0.6% of men and 0.1% of women). PANSI estimates that 561 residents (working age 18-64 years old) could fall under the diagnoses of antisocial personality disorder using latest population estimates.

Eating Disorders

Eating disorders can manifest themselves in a variety of ways; the most serious are anorexia and bulimia nervosa.

The prevalence information on eating disorders in adults is very limited and mostly based on survey estimates.

Anorexia Nervosa

This condition is determined food avoidance resulting in weight loss, or failure to maintain a steady weight gain related to increasing age.

The incidence of anorexia nervosa in the general population is 19 per 100,000 per year in females and 2 per 100,000 per year in males. Although not uncommon in ethnic minorities the prevalence still remains low[109].

Bulimia Nervosa

Bulimia nervosa is when a young person experiences recurrent food binges followed by compensatory behaviour, such as vomiting, laxative use, excessive exercise and fasting.

Prevalence

The Adult Psychiatry morbidity survey 2007 estimates that 6.62% of population aged 16+ could be identified some form of eating disorder which represents 12,760 Walsall residents[110]. The prevalence of eating disorders decreases with age, and is particularly pronounced in women.

The lifetime estimated prevalence of binge eating disorders is 3.5% in women and 2.0% in men, which represents about 3,778 women and 2,033 men in Walsall[111], giving a total of 5,811. About 90 per cent of people diagnosed with bulimia nervosa are female. In Britain, young Muslim Asian women may be at particular high-risk of developing bulimia nervosa[112].

Service Activity

There were 78 eating disorder[§§] related referrals to DWMPHT with at least one face to face contact over the last three years (2012/13-2014/15).

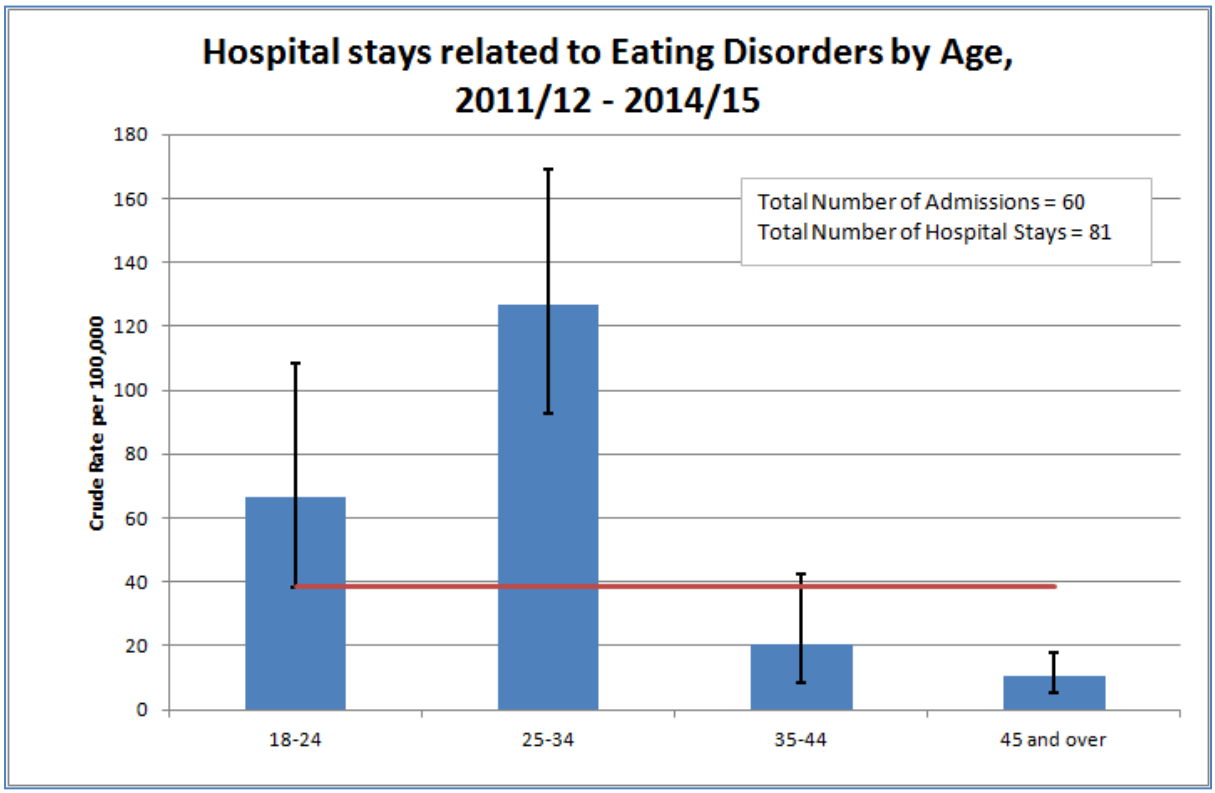
Hospital admissions related to eating disorder

In Walsall, there were 81 hospital stays over the last four years (2011/12 – 2014/15) with vast majority being females and from the White British ethnicity (81%) followed by patients from Asian population (10%). There were 51 patients admitted to hospital and over a quarter had 2 or more stays in a single year (27%).

The rates of hospital stays related to eating disorder conditions (Anorexia, Bulimia and any other eating disorder) are highest for those aged between 25-34 which is significantly higher than the overall adult population crude rate (Figure 28).

[§§] Eating Disorder related referrals ICD10 Codes: F500-F502, F509, R630

Figure 28: Eating Disorder Hospital stays by age, 2011/12 - 2014/15



Source: SUS

Notes: Anorexia(ICD10 Codes: F50.0 & F50.1), Bulimia (ICD10 Codes: F50.2 & F50.3) and Other Eating Disorders (ICD10 Codes: F50.4, F50.5, F50.8 & F50.9)

Self-Harm

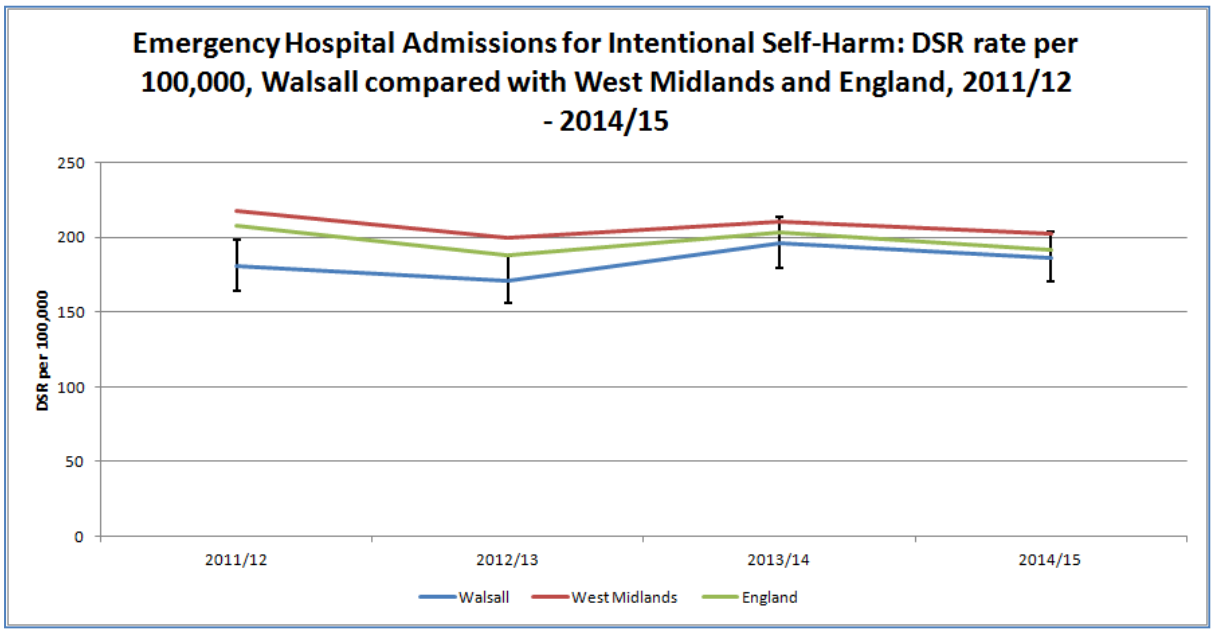
Self-harm is when somebody intentionally harms or injures themselves and/or causes self neglect. This is often a way of coping with or expressing overwhelming and overpowering feelings and emotions. It often takes the form of cutting, burning or non-lethal overdoses, however it can be any behaviour that causes injury, no matter how minor or high risk the behaviour. The UK has the highest self-harm rate of any country in Europe with estimates of 400 in 100,000 people. These figures are likely to be higher as many people who self-harm do not tell anyone about it. Though self-harm can affect anyone, the majority of people who report self-harm are aged between 11 and 25[113].

The Government strategy Preventing Suicide in England (2012) highlighted that people who self-harm are at increased risk of suicide[114]. Risk is increased in those repeating self-harm and in those who have used violent/dangerous methods of self-harm.

A wide range of psychiatric problems are associated with self-harm[115], such as Borderline personality disorder, Depression, Bipolar disorder, Schizophrenia, Drug and alcohol use disorders and Eating disorders.

The number of hospital admissions for self harm has increased from 463 to 512 from 2011/12 to 2014/15. Walsall had previously maintained lower than regional and national rates over the years. The most recent data (2014/15) indicates that the gap has narrowed between Walsall (186.6 per 100,000), regional (202.7 per 100,000), national averages (191.4 per 100,000) (see Figure 29). The trend in the numbers of emergency hospital admissions in Walsall mirrors the regional and national picture.

Figure 29: Emergency Hospital admissions for intentional self harm, 2011/12 - 2014/15



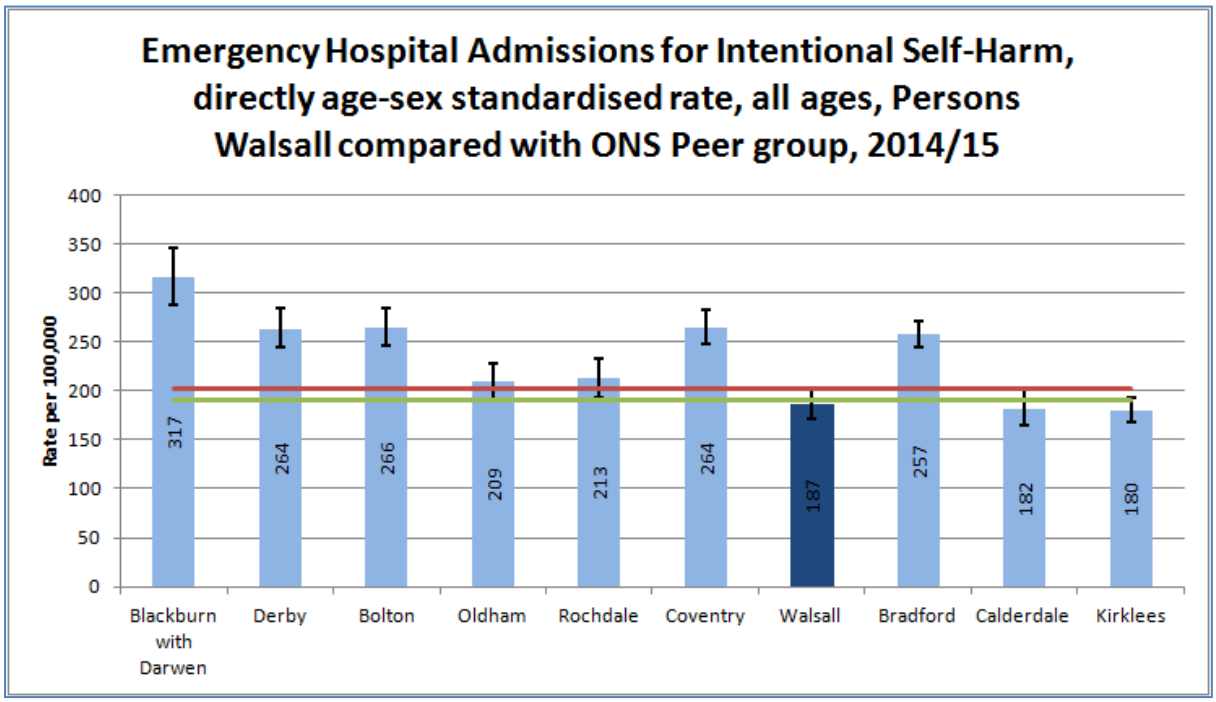
Source: PHE

Notes: Intentional Self-harm ICD10 codes (X60-X84).

http://fingertips.phe.org.uk/search/suicide#page/6/gid/1/pat/6/par/E12000005/ati/102/are/E08000030/iid/21001/age/1/sex/4

Walsall was statistically significantly below vast majority of all the ONS peer groups for self harm related hospital admissions(Figure 30).

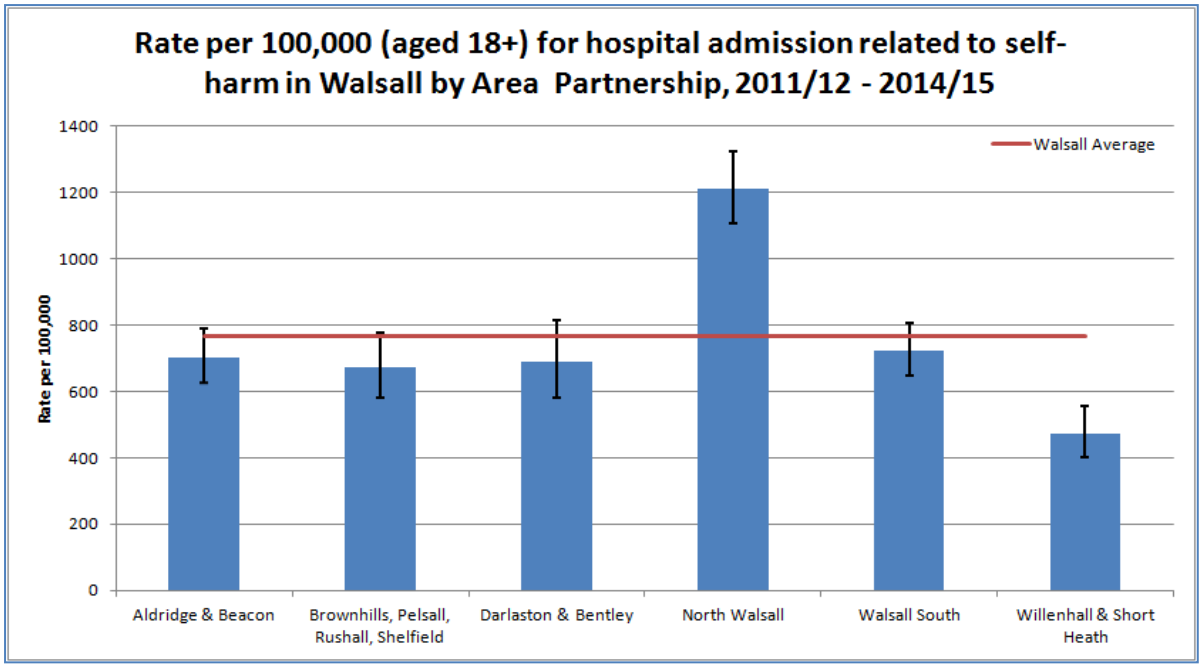
Figure 30: Emergency Hospital admission for intentional self harm, 2014/15



Source: PHE Suicide Profile

North Walsall Area Partnership shows statistically significantly higher rates of self harm related admissions compared to the other APs and Walsall average(Figure 31) . The other AP rates are below Walsall average, with Willenhall & Short Heath having statistically significantly lower ratesthan Walsall.

Figure 31: Rate per 100,000 (aged 18+) for hospital admissions for self-harm, 2011/12 - 2014/15.

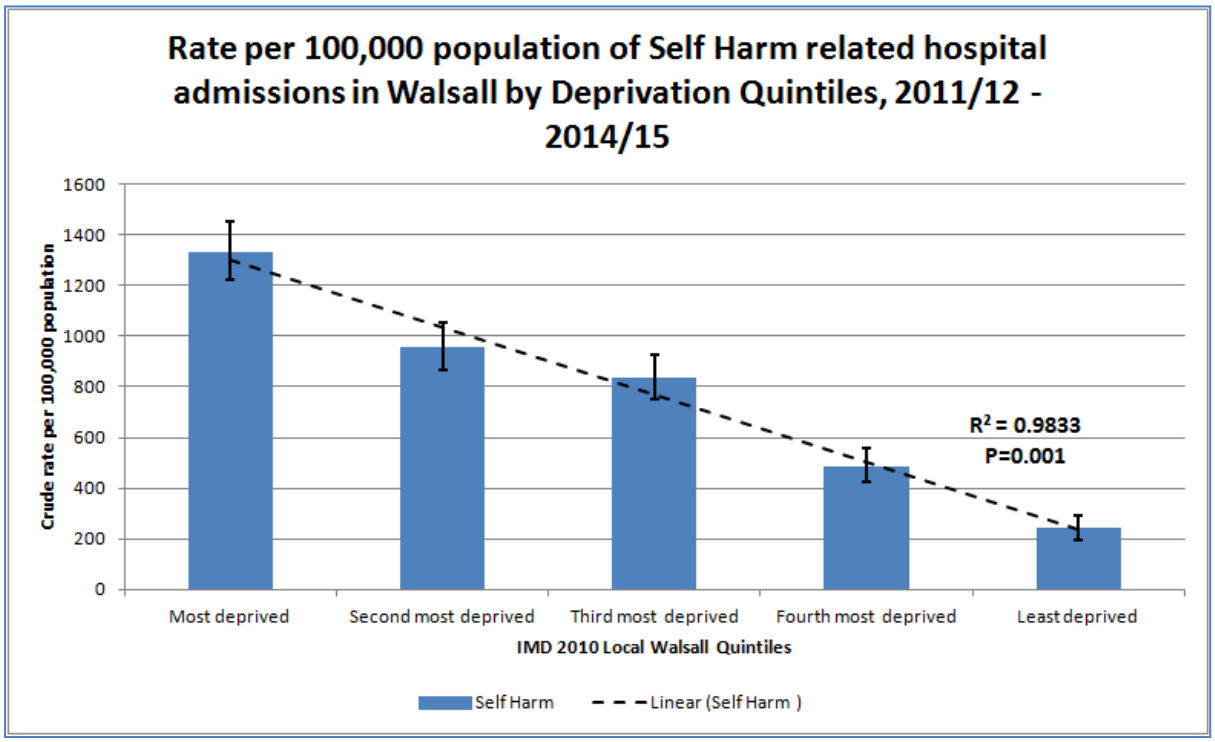


Source: Secondary uses service dataset (SUS) and ONS; census 2013.

An examination of patients admitted to hospital for self-harm by level of deprivation shows a link between an increase in deprivation and propensity to self-harm, suggesting a correlation.

The highest rate of admissions for self harm in adults (18+) was for those from the most deprived population quintile (local IMD quintile 1) and the rate reduces as the level of deprivation reduced. Those in the least deprived areas were significantly less likely to have a hospital admission due to self-harm compared with those in the most deprived areas.

Figure 32: Rate of hospital admission self harm in Walsall by deprivation (local quintiles), 2011/12 - 2014/15.



Source: SUS 2011/12 – 2014/15, ONS 2013 Mid-years population estimates and IMD 2010.

Dementia

Dementia is progressive and largely irreversible condition that involves widespread damage to mental functioning, NICE (2006) describe Dementia as "a disorder that affects how the brain works"[116]. It is an umbrella term used to describe the symptoms that occur when the brain is affected by certain diseases or conditions. There are many different types of dementia, the most common are[117][118]

- **Alzheimer's disease:** is progressive disease which affects the brain resulting increased loss of connection between nerve cells and eventually loss of brain tissue.
- **Vascular dementia**: is damaged to the supply of blood to the brain resulting in memory loss and difficulties with thinking, problem-solving or language.
- **Dementia with Lewy bodies**: shares symptoms with both Alzheimer's disease and Parkinson's disease which accounts for about 10% of all dementia cases.
- **Dementia in Parkinsons disease**: The causes of dementia in Parkinson's disease are not yet fully understood. People who have dementia in Parkinson's disease have been found to have Lewy bodies in their brain and there are similarities with Lewy body dementia. This affects about 15-30% of people diagnosed with Parkinson's disease.
- **Fronto-temporal dementia**: can be referred to as Pick's disease or frontal lobe dementia. Although less common it is significant cause of dementia in younger people (under 65's).

The following are not strictly speaking dementia, but conditions with memory problems and can have similar presentation as dementia:

- **Mild cognitive impairment**: is a condition in which people have minor problems with cognition and memory.
- **Creutzfeldt-Jakob disease**: is caused by abnormally shaped protein infecting the brain, and is a rare and fatal condition where the brain damage worsens rapidly over time.
- **HIV-related cognitive impairment**: People with HIV can develop cognitive impairment in later stage of illness.
- **Korsakoff's syndrome**: it is a condition categorised under Alcohol-related brain damage by regular drinking too much alcohol over several years and in which the main cause is a clear lack of thiamine. In contrast to causes such as Alzheimer's disease, most people with ARBD who receive good support and remain alcohol-free make a full or partial recovery

Risk factors for Dementia

The risk factors for Dementia can be categorised into modifiable and non-modifiable. There is an increasing awareness that lack of social stimulation and mental activities also increases the risk of dementia – a particularly important factor amongst some older people that have loneliness as a major part of their lives[119].

Non-Modifiable Risk Factors

Age

Age is the most significant known risk factor for dementia with prevalence rates increasing with age, though it is possible to develop dementia in earlier in life[120].

Gender

Prevalence studies show that women have higher rates of dementia, especially Alzheimer's disease. The difference in rates reduces in older ages. The higher levels within women could be related to higher life expectancy in women compared with men.

Learning Disabilities

The prevalence of dementia in people with learning disabilities has been reported as two or three times greater than compared with the general population (65+ years age group).

Modifiable Risk Factors

Stroke/Transient Ischemic Attack

Strokes are interruptions to the blood supply of the brain, or its vascular system, causing permanent damage. More than a quarter of people who have a stroke develop vascular dementia within three months. The vascular system can be damaged or made worse by high blood pressure, high cholesterol, diabetes and heart disease so it is important to identify and treat these conditions as early as possible.

Hypertension

NICE defines hypertension as persistent raised blood pressure (140/90mmHg or above). There is evidence to suggest that mid-life established hypertension is linked to development of vascular dementia and Alzheimer's later in life. Hypertension is a preventable condition with evidence showing that lifestyle plays significant role (excessive alcohol consumption, poor diet, lack of exercise and obesity).

Atrial Fibrillation

This is a common disorder in the elderly population and a known risk factor for cerebrovascular disease. A study found that AF appears to show association with vascular dementia particularly in patients with concomitant cerebrovascular disease.

Diabetes

Diabetes is a risk factor for cerebrovascular disease and there is growing evidence linking Type 2 diabetes with an increased risk of dementia.

Obesity

An increased Body Mass Index (BMI) in mid-life has been associated with increased risk of dementia and the risk of type 2 diabetes is increased with elevated BMI.

Smoking

Smoking is risk factor for dementia in general as well major risk factor for cardiovascular and cerebrovascular disease.

Alcohol

Korsaff syndrome has been linked to chronic memory disorder caused by severe deficiency of thiamine (vitamin B-1) which is most commonly caused by alcohol misuse, but certain other conditions also can cause the syndrome[121].

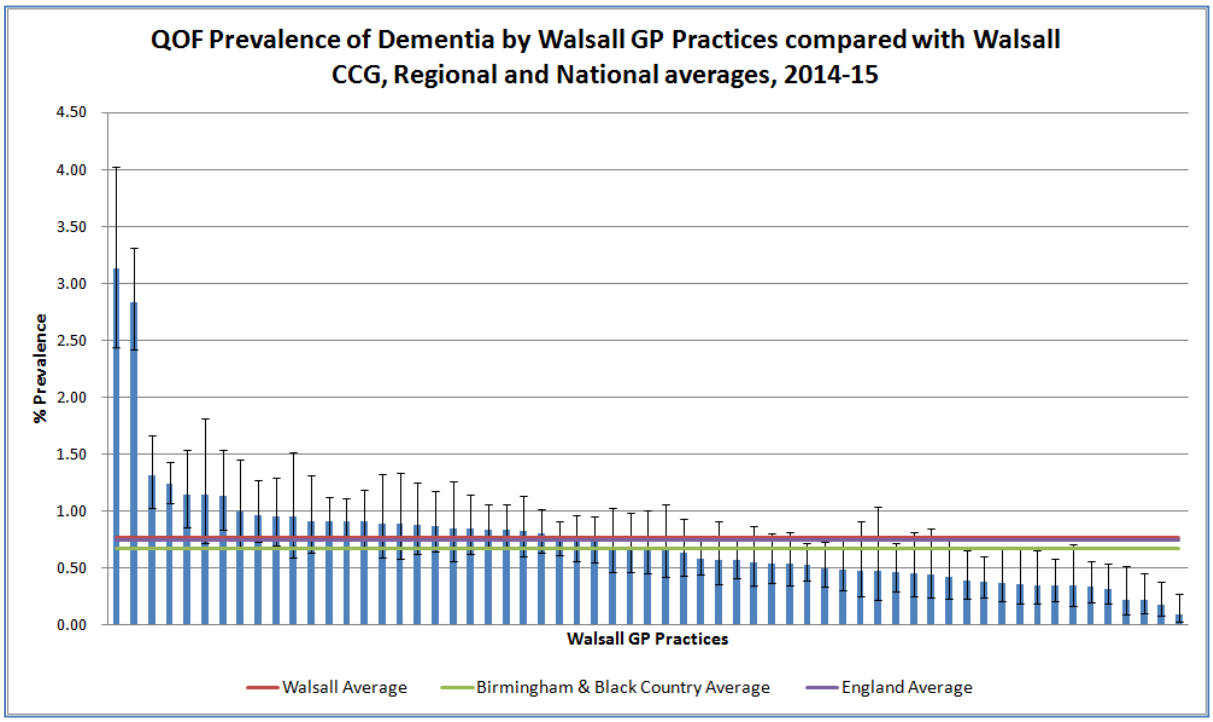
Prevalence

The Alzheimer's society estimated 1 in every 79 people (1.3% of population) and 1 in 14 of the population aged 65 years and above have dementia in the UK[122]. This is approximately equivalent to 3,439 cases[123] for Walsall. The 2014/15 QOF recorded prevalence for Walsall was 0.77% (2,136 people) and 4.47% (2,099 people) for 65 and over population. In April 2015, there was a change in the prevalence rates for dementia used by NHS England based on the CFAS II study[124]. This has resulted in an increase in the estimated prevalence of dementia in diagnosis and an associated decrease in the diagnosis rate of dementia for Walsall, which has varied monthly and tends to be below thetargetr of 66.7%. In April 2016 the diagnosis rate was 66% and for June 2016 it was 66.2%. Anecdotally, there is a variation of diagnosis rate by practices and therefore a need to work with GPs to improve diagnosis rates.

There is variation in dementia prevalence across Walsall practices with the majority not significantly different to Walsall, regional and national average. There were 45 practices out of 59 in Walsall which had significantly higher prevalence of dementia compared with national average (0.74%)[***]. This could be due to the different population structures in different practices, but also could be due to an under diagnosis in some practices.

[***] QOF data 2014-15 for Dementia needs to consider that prevalence is guidance figure rather absolute figure due to data completion.

Figure 33: QOF Dementia prevalence Walsall, 2014-15

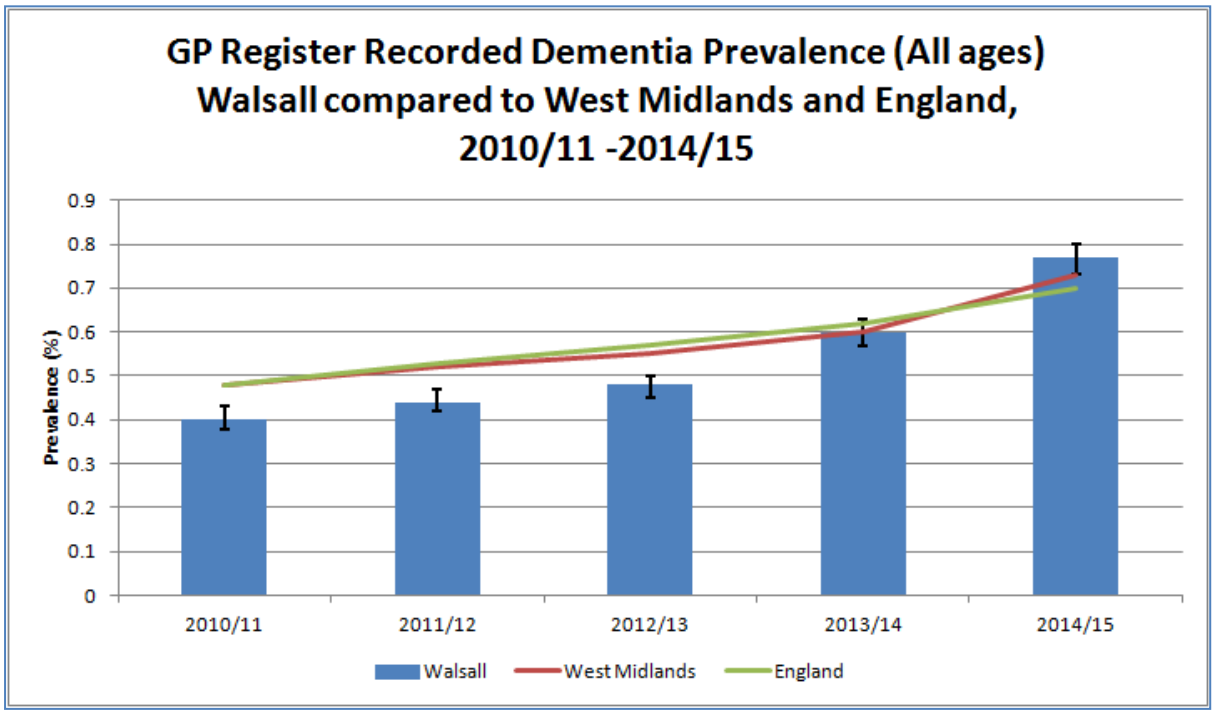


Source: QOF, 2014-15

http://www.hscic.gov.uk/catalogue/PUB18887/qof-1415-prev-all-levels.xlsx

The prevalence of dementia within Walsall has increased by 0.34% over the last 5 years to a point in 2014/15 which is above the regional (0.73%) and national average (0.74%) (Figure 34).

Figure 34: GP Registered Dementia Prevalence, 2010/11 - 2014/15

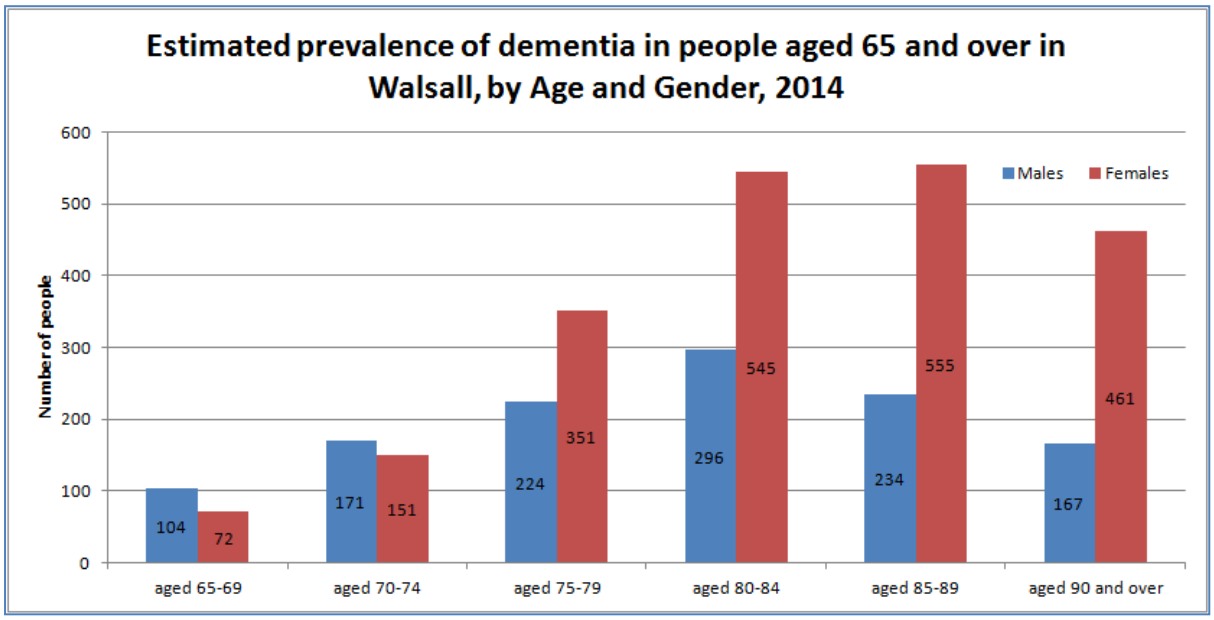


Source: Dementia Profile, PHE (QOF)

Note: Caution should be taken when interpreting this indicator as higher than average value may mean that the prevalence of the condition is high in an area, but it could also indicate that detection is better there; this is for local knowledge to determine.

Dementia is uncommon before the age of 65, but does affect 1 in 1,000 younger people[125]. With onset of age the cases of dementia increase within the 80-84 and 85-89 age group, and this group has the highest number of people with dementia in Walsall overall Figure 35.

Figure 35: Estimated prevalence of dementia in Walsall by Age and Gender, 2014



Source: Projecting Older People Population Information System (POPPI)

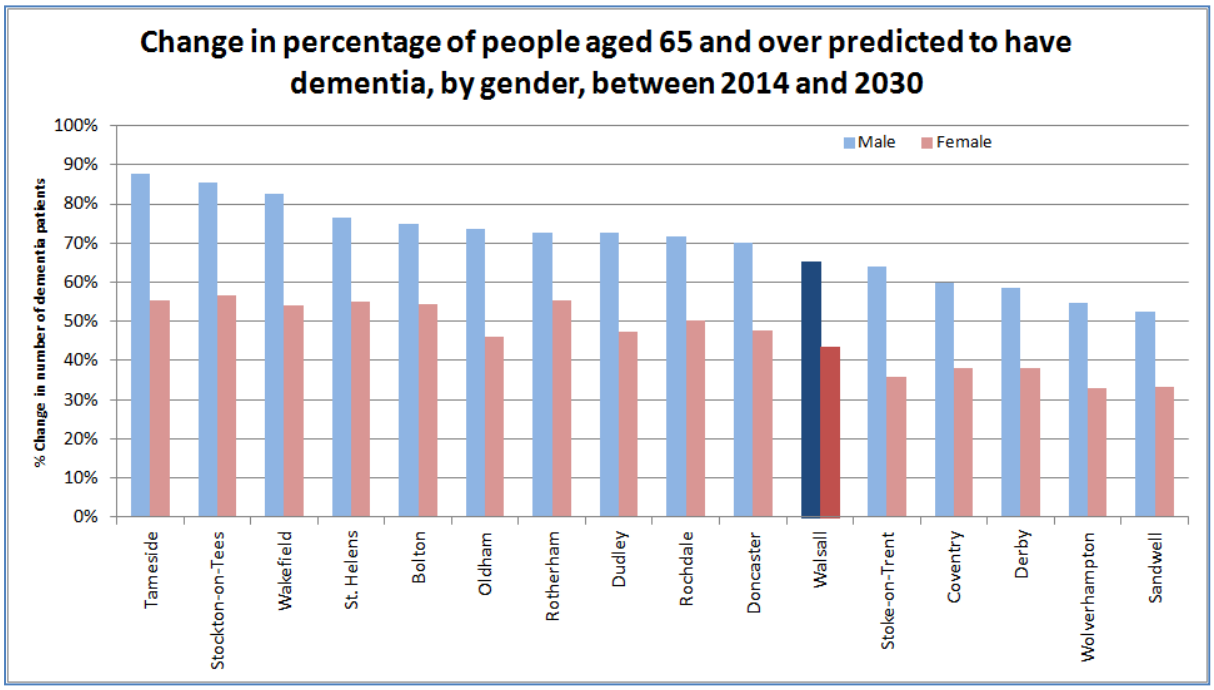
Table produced on 18/11/15 09:48 from (www.poppi.org.uk version 9.0)

If the prevalence of dementia was to remain the same, the number of people with dementia in the UK is forecasted to grow 40% over the next 12 years[126]. The older population in Walsall is projected to increase over the next few years leading to an increased number of people with Dementia (See Population projections section).

The local projections of dementia in people aged 65 and over estimates an increase of 51% over a 16 year period based on POPPI information (from 3,300 people in 2014 to 5,041 in 2030). It is likely to be higher within males (65.3% increase) than females (40% increase).

In comparison with our Black Country neighbours, only Dudley has higher projectied increase in dementia numbers than Walsall for both men and women. Walsall ranks 10th (out of 13 areas) for highest projected increase in dementia numbers compared with our peer group (Figure 36).

Figure 36: Predicted percentage change in People aged 65 and over with dementia between 2014 and 2030



Source: POPPI

Table produced on 18/11/15 09:48 from www.poppi.org.uk version 9.0)

Hospital Admissions for Dementia

In 2014/15 there were 1,510 hospital spells for patients with a diagnosis of dementia. The number of hospital stays have been increasing each year resulting in a total of 5,361 between period 2011/12 – 2014/15 (Table 13).

This increase is mostly considered as a result of increase in registered population, with the activity over and above this increase in population ranging from 4.5% in 2011/12 to 3.2% in 2014/15 (Walsall CCG QIPP analysis, 2015).

Table 13: 2011/12 - 2014/15 Dementia Spells by Provider (Walsall registered patients)

Providers	2011/12	2012/13	2013/14	2014/15	Grand Total
WALSALL HEALTHCARE NHS TRUST	867	1148	1207	1242	4464
THE ROYAL WOLVERHAMPTON NHS TRUST	67	54	80	113	247
HEART OF ENGLAND NHS FOUNDATION TRUST	46	49	74	76	245
DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST	75	39	31	16	161
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	22	21	35	41	119
Other providers	6	13	17	22	58
Grand Total	**1083**	**1324**	**1444**	**1510**	**5361**

Source: SUS

Notes: ICD10 Codes used for Dementia: F00-F03, F05-06, F10-F17, F29-F31, F41 and F91 to all level diagnosis (Primary to Level 8 diagnosis).

Analysis of dementia hospital spells by provider shows that the greatest number were admitted to Walsall Healthcare NHS Trust (83% of all spells) followed by The Royal Wolverhampton NHS Trust and Heart of England NHS foundation Trust both represent under 5%.

The vast majority of hospital stays were not due to dementia but for a primary physical health related diagnoses with the top 5 as identified from the CCG analysis specified below as proportion of total stays:

- Urinary Tract Infections (13%)
- Pneumonia (8%)
- Other Acute Lower Respiratory infections (8%)
- Fracture neck of femur (4%)
- Lung diseases due to external agents; e.g. food and vomit (3%)

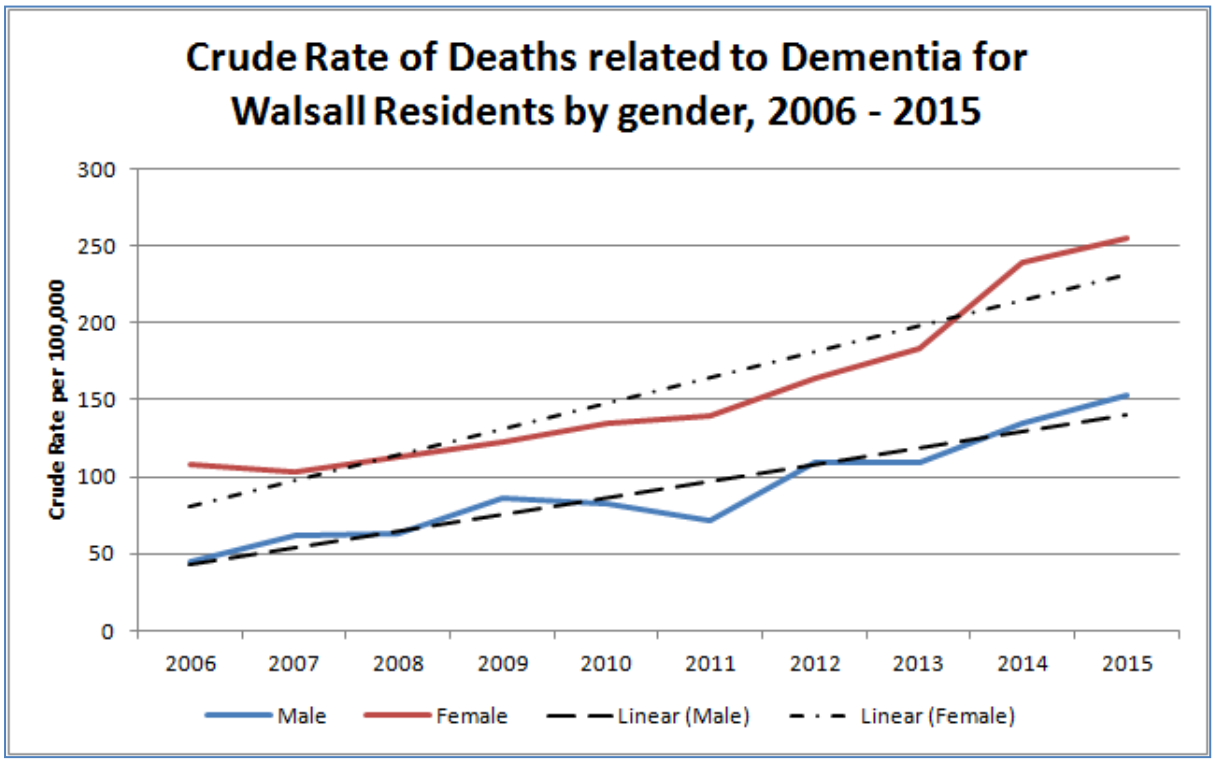
The majority of these conditions can be managed in the community with Primary care, and adequate social care support, suggesting that there is potential to improve the management of patients with dementia in the community and thereby reduce hospital admissions.

Dementia Mortality

1 in 3 people over the age of 65 now die with dementia. Despite having no cure, only 18% of people realise dementia is a terminal illness[127]. The latest data suggests that for the first time dementia or Alzheimer's is now the biggest single cause of death amongst women in England and Wales, having surpassed different forms of cancer for the first time[128]

There were 2,601 deaths related to dementia over the last 9 years with a higher rate for women than men in Walsall. Both sexes have seen upward trend in rate over the period (Figure 37).

Figure 37: Mortality rate related to Dementia in Walsall, 2006 - 2015

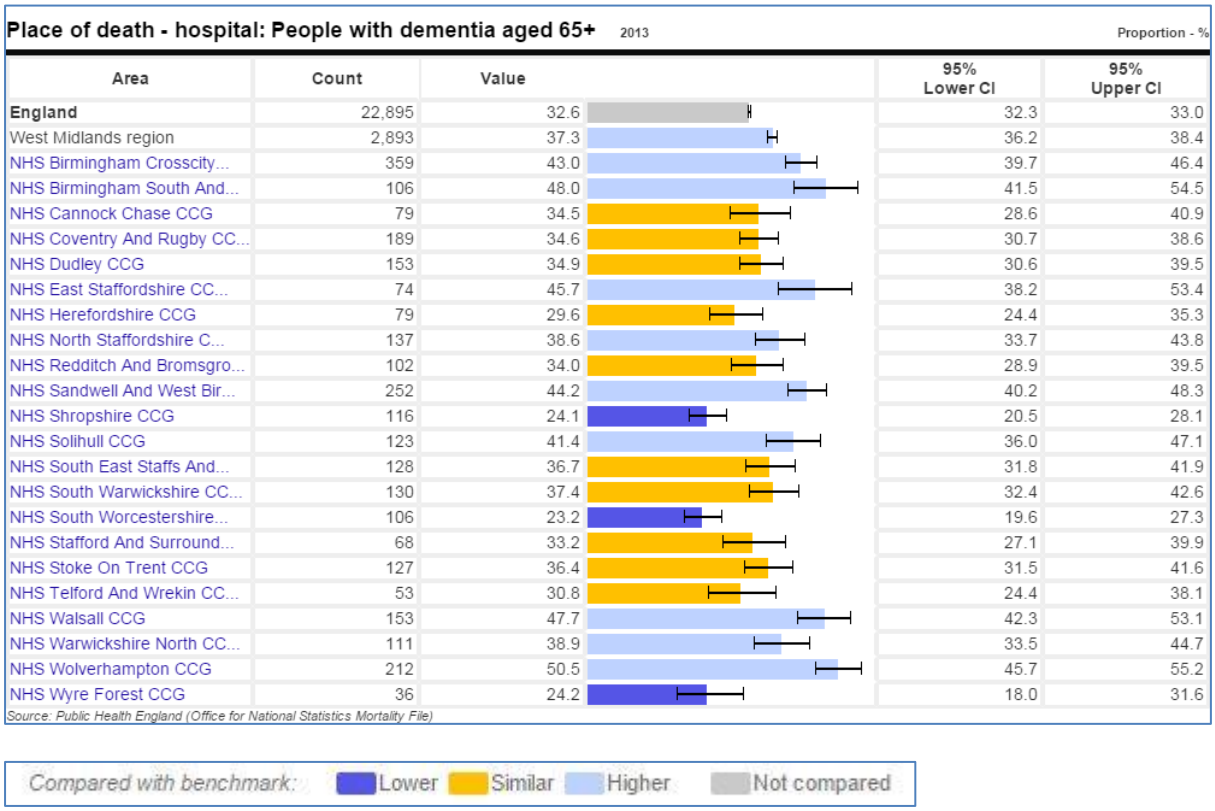


Source: Open Exeter Mortality File and 2014 Mid-year ONS population estimates.

Notes: ICD10 codes F00 – F04 and G30 –G31 and Walsall residents.

Walsall has a higher than average dementia deaths in hospital compared to other CCGs in the region(Figure 38). It is statistically significantly higher than the national average for those dying in their own home (10.6% vs 7.4%), but lower for those dying in a care home (40.2% vs 58.6%). A study has identified that people with dementia in a care home were more likely to be admitted to the hospital with 'avoidable conditions' than those without. Inappropriate admissions can cause unnecessary disruption for a person with dementia in the final days and weeks of life, they may end up not dying in their preferred place or in the most appropriate place for them, and there is also a negative impact on their outcomes as they are more likely to die within six months of the admission. Improving the End of Life care for those with Dementia therefore requires a multifaceted approach of reducing hospital admissions, auditing care in the care homes and improving dementia care. Walsall CCG is already working on a range of End of Life care initiatives.

Figure 38: People with Dementia aged 65+ died in hospital



Place of death - hospital: People with dementia aged 65+ 2013 Proportion - %

Area	Count	Value	95% Lower CI	95% Upper CI
England	22,895	32.6	32.3	33.0
West Midlands region	2,893	37.3	36.2	38.4
NHS Birmingham Crosscity...	359	43.0	39.7	46.4
NHS Birmingham South And...	106	48.0	41.5	54.5
NHS Cannock Chase CCG	79	34.5	28.6	40.9
NHS Coventry And Rugby CC...	189	34.6	30.7	38.6
NHS Dudley CCG	153	34.9	30.6	39.5
NHS East Staffordshire CC...	74	45.7	38.2	53.4
NHS Herefordshire CCG	79	29.6	24.4	35.3
NHS North Staffordshire C...	137	38.6	33.7	43.8
NHS Redditch And Bromsgro...	102	34.0	28.9	39.5
NHS Sandwell And West Bir...	252	44.2	40.2	48.3
NHS Shropshire CCG	116	24.1	20.5	28.1
NHS Solihull CCG	123	41.4	36.0	47.1
NHS South East Staffs And...	128	36.7	31.8	41.9
NHS South Warwickshire CC...	130	37.4	32.4	42.6
NHS South Worcestershire...	106	23.2	19.6	27.3
NHS Stafford And Surround...	68	33.2	27.1	39.9
NHS Stoke On Trent CCG	127	36.4	31.5	41.6
NHS Telford And Wrekin CC...	53	30.8	24.4	38.1
NHS Walsall CCG	153	47.7	42.3	53.1
NHS Warwickshire North CC...	111	38.9	33.5	44.7
NHS Wolverhampton CCG	212	50.5	45.7	55.2
NHS Wyre Forest CCG	36	24.2	18.0	31.6

Source: Public Health England (Office for National Statistics Mortality File)

Source: PHE

Services available

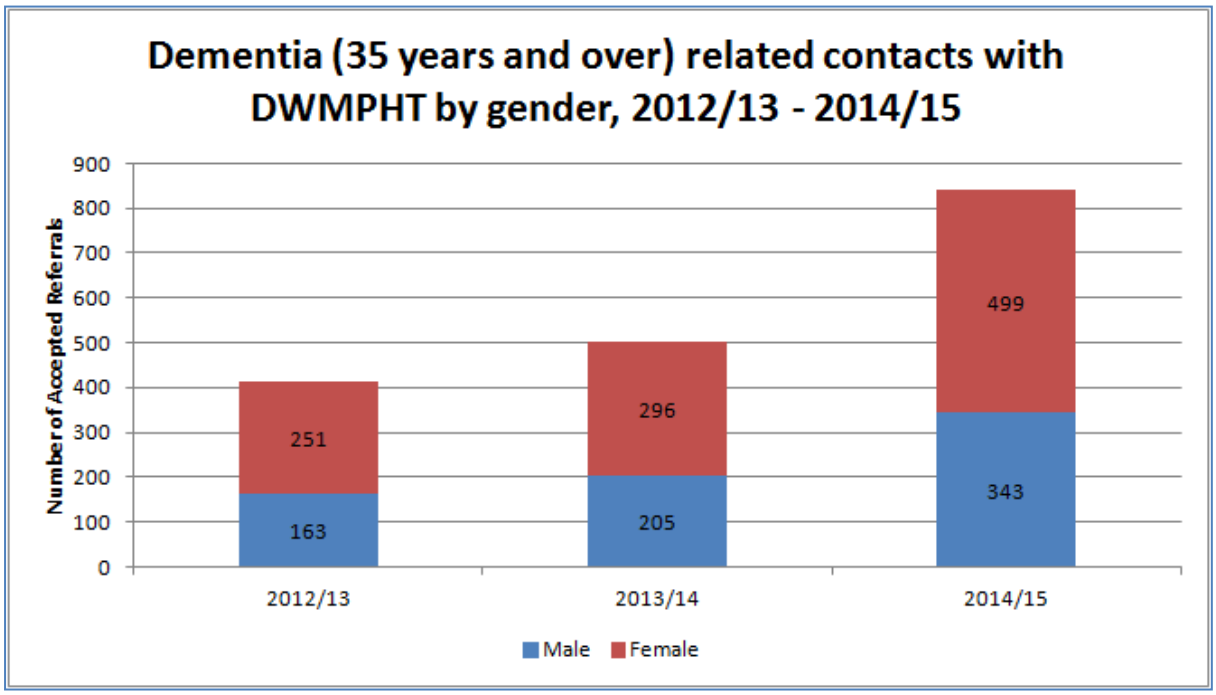
There are a range of services developed to identify people with dementia including through the NHS checks. Walsall also provides a range of community initiatives which aim to improve quality of life for those with dementia. A range of initiatives have been introduced to support the end of life care of those with dementia and reduce the number of deaths in hospital. (See Mapping section)

Service activity

There were 1757 accepted referrals over 3 year period at DWMHT, with referrals increasing each year. The number of referrals have doubled in 2014/15 (Figure 39).

This appears to follow the increase in prevalence of dementia seen since 2012/13. The vast majority of service users were White (88%) and 12% were from BME group. There are more women with dementia which explains the larger number of female service users during this period (approximately 60%).

Figure 39: Dementia related accepted referrals by gender, 2012/13 - 2014/15

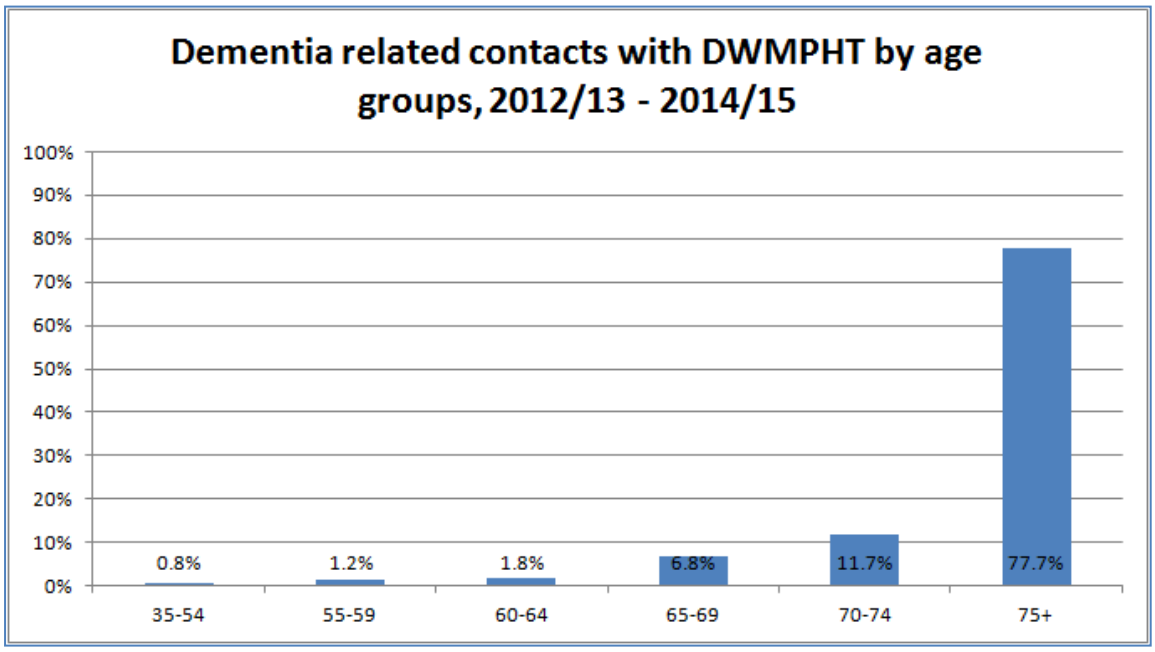


Source: Dudley and Walsall Mental Health Partnership (DWMPHT)

Note: This includes all Diagnosis codes primary and secondary. Codes included Dementia in Alzheimer Disease (F000AG300D, F001AG301D, F002AG308D, F009AG309D), Vascular Dementia (F010-F013 and F018-F019), Dementia in other disease classified elsewhere F023AG20XD and F03X and Other mental disorders due to brain damage and dysfunction and to physical disease (F067).

The age of patients with a dementia diagnosis ranged from 35-75+ with the 75 years and over category having the highest proportion of service users (78%).

Figure 40: Dementia related Contacts with DWMPHT by age group, 2012/13 - 2014/15



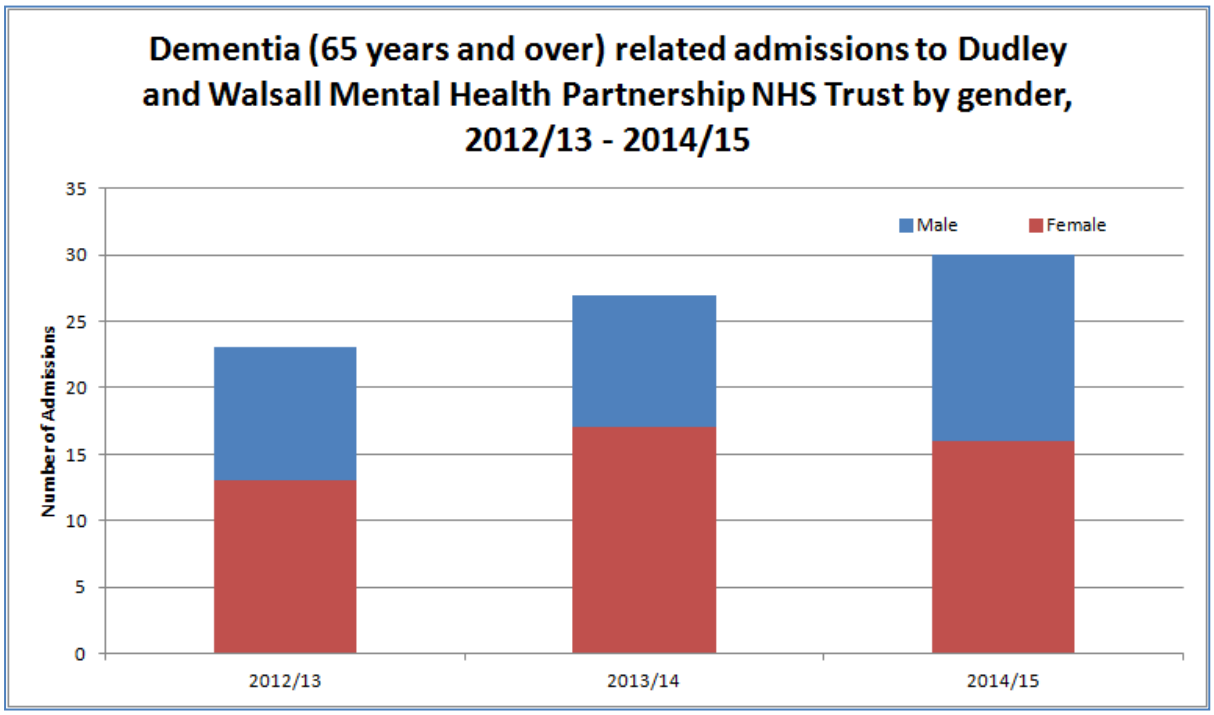
Source: DWMPHT

Note: This includes all Diagnosis codes primary and secondary. Codes included Dementia in Alzheimer Disease (F000AG300D, F001AG301D, F002AG308D, F009AG309D), Vascular Dementia (F010-F013 and F018-F019), Dementia in other disease classified elsewhere F023AG20XD and F03X and Other mental disorders due to brain damage and dysfunction and to physical disease (F067).

Inpatient admissions

There were 80 inpatient admissions over 3 year period with admissions increasing on each year (Figure 41). The vast majority of inpatient service users were White (93%) and 7% were from BME group. Approximately 58% of service users were females.

Figure 41: Dementia admissions by gender, 2012/13 - 2014/15



Source: Dudley and Walsall Mental Health Partnership (DWMPHT)

Note: This includes all Diagnosis codes primary and secondary. Codes included Dementia in Alzheimer Disease (F000AG300D, F001AG301D, F002AG308D, F009AG309D), Vascular Dementia (F010-F013 and F018-F019), Dementia in other disease classified elsewhere F023AG20XD and F03X and Other mental disorders due to brain damage and dysfunction and to physical disease (F067).

Dual Diagnosis

In the context of mental health, the term dual diagnosis is mostly used to refer to an individual who experiences a severe mental illness and a substance use problem, including alcohol, legal and illicit drugs[129]. The label of 'dual diagnosis' is believed by many to be inappropriate for describing the multiple and varying needs of people with these problems, which often encompasses a wide range of social problems as well as medical conditions[130]. People with 'dual diagnosis' typically have multiple and varied needs rather than two separate problems[131]. Drugs, alcohol and addictive behaviours like gambling or unsafe sex exhibited by patients with dual diagnosis are often used as dysfunctional coping mechanisms to help the individual live with the painful symptoms of mental illness.

Dual Diagnosis Prevalence

Estimating the prevalence of dual diagnosis is difficult and depends on the definition used. Most studies are based on surveys and generally will cover those individuals in contact with mental health or substance misuse services as well as not including problematic alcohol use in their definition of substance misuse.

In 2015/16, there were 579 new clients in a structured treatment programme for substance misuse with 190 diagnosed as dual diagnosis.

The National Drug Treatment Monitoring System (NDTMS) data shows that percentage of clients accessing SMS treatment services (Alcohol and Drugs) with dual diagnosis are increasing year on year. The most recent data reported 32.8% of new SMS clients as having a dual diagnosis, whilst the number of new clients in treatment is decreasing. The higher proportion of dual diagnosis clients could be due to a real increase in the number of patients with a dual diagnosis and/or improvements in identification and diagnosis of mental illness. There was a change of service provider for the Walsall SMS service in 2015, and the accompanying change in service provision could be a factor in the reduction in the number of new clients seen in 2015/16.

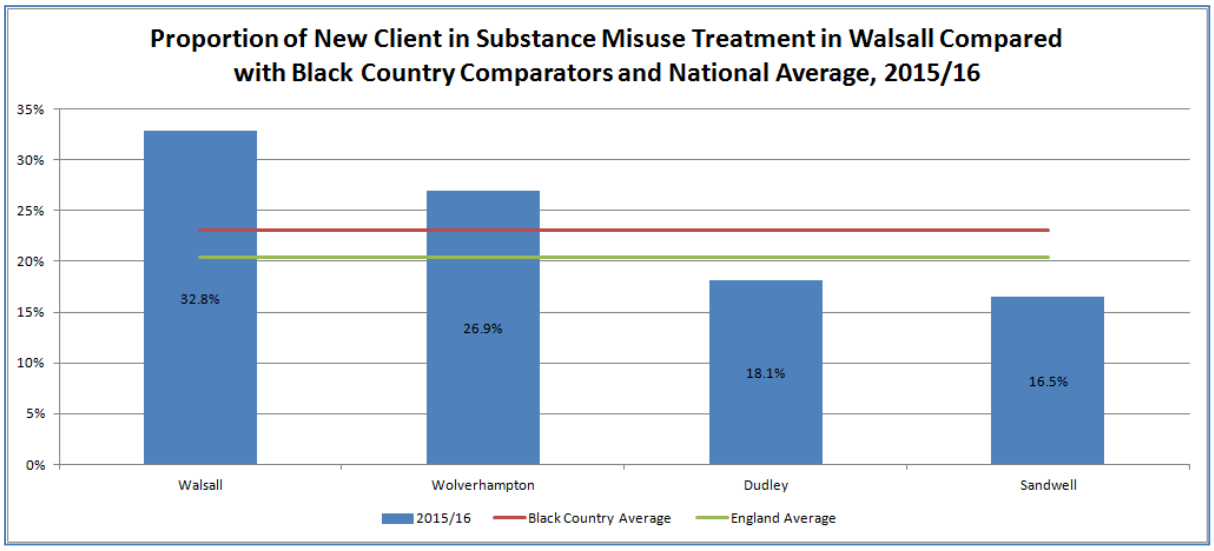
Table 14: Percentage of clients accessing SMS programmes and mental health reviews

Treatment Period	Number of dual diagnosis clients in treatment	Total number of new clients in treatment	% clients diagnosed as dual diagnosis
2013/14	157	780	20.1%
2014/15	158	743	21.3%
2015/16	190	579	32.8%

Source: National Drug Treatment Monitoring System (NDTMS)

Of all the new clients in treatment programme in 2015/16, Walsall (32.8%) is significantly higher than the other Black Country areas (23.1%) and national average (20.4%).

Figure 42: New Clients in SMS treatment programme with dual diagnosis, 2015/16



Source: National Treatment Agency for Substance Misuse

Risks associated with dual diagnosis

Both substance misuse and untreated mental illness are associated with greater risk of suicide with estimated 16% taking their own life. The deterioration of an individual's mental health problems by substance misuse leads to an increased risk of self harm and suicidal thoughts. Substance misuse also plays a key role of escalating suicidal thoughts in people with mental illness to actual suicidal attempts and in severe depression substance misuse is one of the most frequent causes of suicide.

Dual diagnosis is also associated with an increased risk of violence to others[132]

Link to emotional wellbeing and mental health

The Waiting for Change survey (2003) [133] reported that between a third and half of people with severe mental health problems consume alcohol or other substances to problematic level and 51% of alcohol-dependent adults said they have a mental health problem[†††].

Substance misuse among individuals with mental health disorders is associated with significantly poorer outcomes than for individuals with a single disorder. These outcomes include worsening psychiatric symptoms, poorer physical health, increased use of institutional services, poor medication adherence, homelessness, increased risk of HIV infection, greater dropout from services and higher treatment costs. Social outcomes are

[†††] Problems ranged from depressive disorders, including anxiety, panic attacks, depression and phobic illnesses. A minority indicated that they had a severe mental illness.

also significantly worse, including greater homelessness, a higher impact on families and carers, and increased contact with the criminal justice system[134].

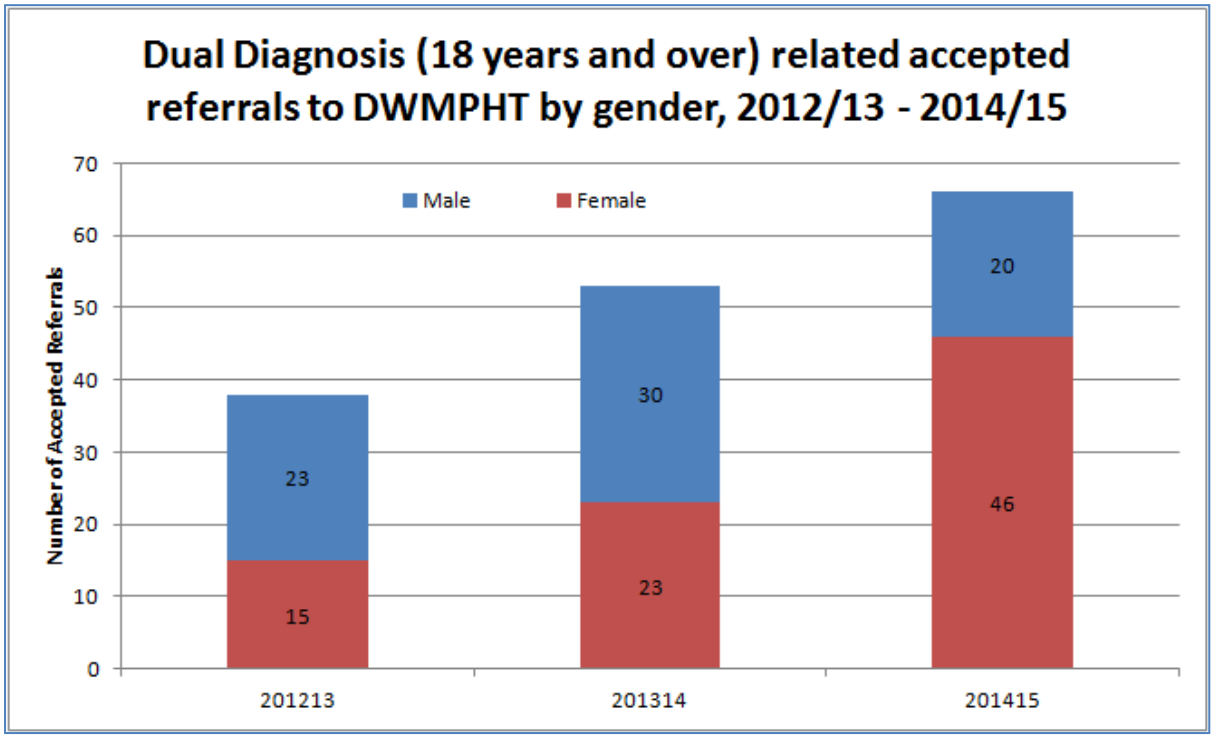
Services available

See service mapping

Service activity

Over the last three years, the number of referrals seen in secondary care have been increasing. The proportion of referrals for female service users has been increasing and in 2014/15 the number of female referrals were more than double as compared to male referrals (Figure 43).

Figure 43: Dual Diagnosis Service Users by gender, 2012/13 - 2014/15



Source: DWMPHT

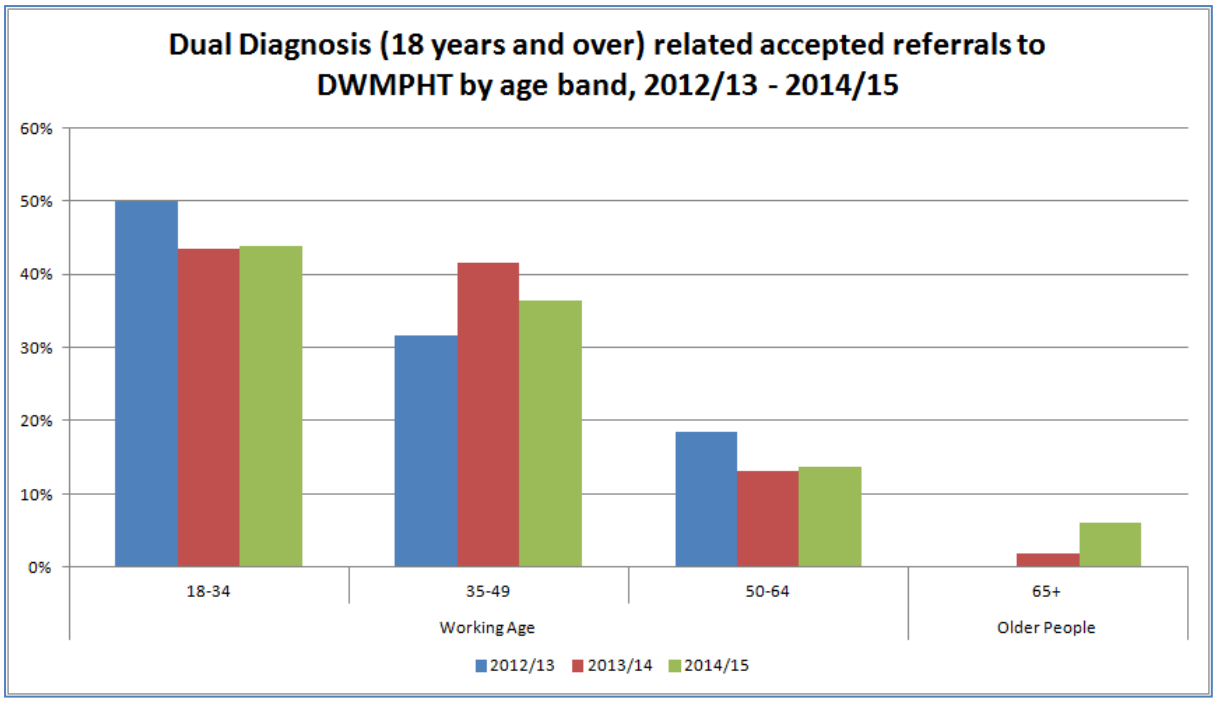
Notes: Substance Misuse diagnosis codes used ICD10 code from F10 – F19 in a primary or secondary position followed by another code from the 'F' chapter.

Accepted Referrals = At Least one seen Face to Face Contact

The largest proportion of service users with accepted referral to DWMPHT was from the working age cohort and specifically 18-34 age bands(Figure 44). A marked increase is seen in the older peoples' cohort (65+ group) where the referrals increased more than three times in the last two years.

The vast majority of accepted referrals were for those from white ethnic group (32 in 2012/13; 45 in 2013/14 and 58 in 2014/15) with 12.2% (19) from BAME group over the last three years[‡‡‡].

Figure 44: Walsall DWMPHT Dual Diagnosis Service User by age bands, 2012/13 - 2014/15



Source: DWMPHT

Notes: Substance Misuse diagnosis codes used ICD10 code from F10 – F19 in a primary or secondary position followed by another code from the 'F' chapter.

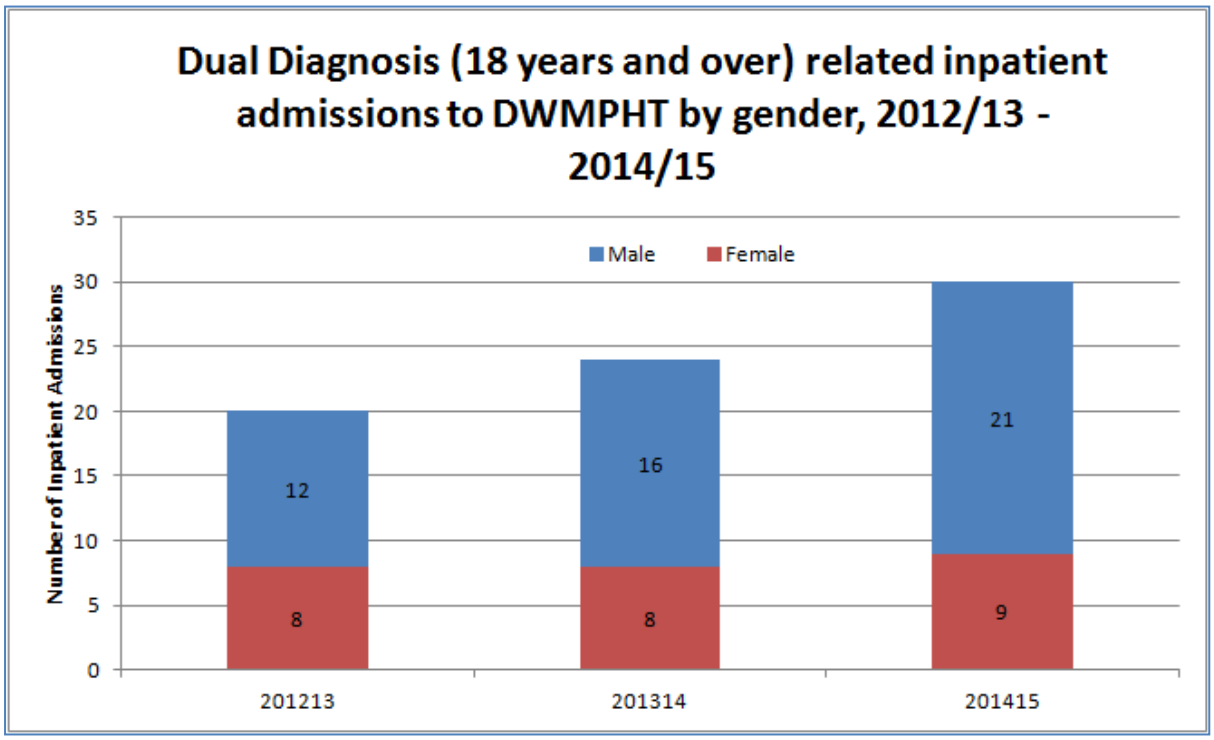
Accepted Referrals = At Least one seen Face to Face Contact

Inpatient admission related Dual Diagnosis

There has been small increase each year over the last three (2012/13 -2014/15) with more males admitted to inpatient services at DWMPHT (see Figure 45). The age range covers 18-69 with no particular difference between different age groups. Due to a small number of individuals there is no significant findings in ethnic groups with 14% from BAME group.

[‡‡‡] Those accepted referrals which had ethnic group recorded as Not stated/Not Recorded/Unknown were removed from calculations but represented 1.3% of total number of accepted referrals between 2012/13 and 2014/15.

Figure 45: Dual Diagnosis Inpatient admission by gender, 2012/13 - 2014/15



Source: DWMPHT

Notes: Substance Misuse diagnosis codes used ICD10 code from F10 – F19 in a primary or secondary position followed by another code from the 'F' chapter.

Suicide

Suicide is a devastating event with far-reaching consequences. It can be described as a fatal act of self-harm initiated with the intention of ending one's own life. Suicide is the leading cause of years of life lost in England after accidents[135].

A number of interrelated factors have been identified as increasing the risk of suicide[136]:

- Previous suicide attempt or previous self-harm
- Men are at greater risk for a number of reasons:
    - Cultural expectations,
    - Reluctance to seek help from friends and services
    - More dangerous methods of self-harming
- Age concurrent mental disorders or previous psychiatric treatment
- Homelessness
- Alcohol and drug abuse
- Physically disabling or painful illness, including chronic pain
- Low social support/living alone
- Significant life events – bereavement, family breakdown
- Being institutionalised – e.g. prisons, army
- Bullying

Prevalence

The number of deaths classified under suicide and injury of undetermined intent is summarised (Table 15).

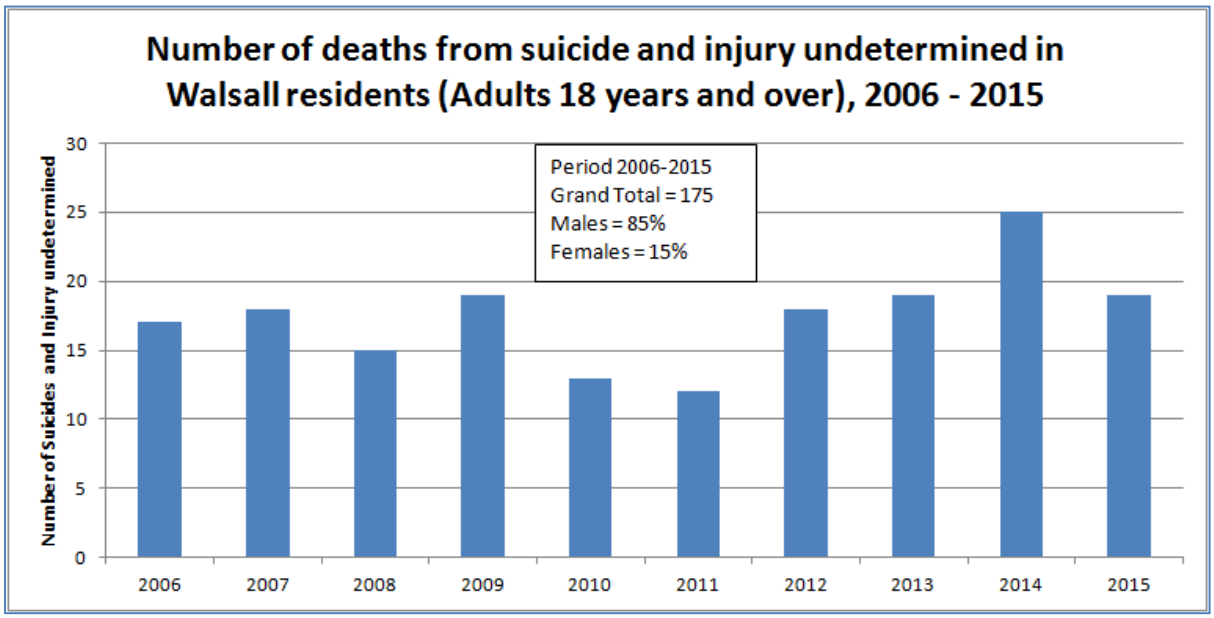
Table 15: Death from suicide and injury undetermined, 2012-14

Indicator	England	West Mids	Walsall
Mortality from suicide and injury undetermined	**14,122**	**1,501**	**66**

Source: PHE

The number of deaths from suicide and injury undetermined fluctuates substantially from year to year. In the last 9 years (2006-2015), the number of such deaths in Walsall has fluctuated from 1 to 4 females in a single year and from 10 males to 21 males in a year. In the most recent five year period (2010-15), there were a total of 106 deaths, of which 89 were male and 17 female (Figure 46).

Figure 46: Number of deaths from suicide and injury undetermined in Walsall residents, 2006-2015

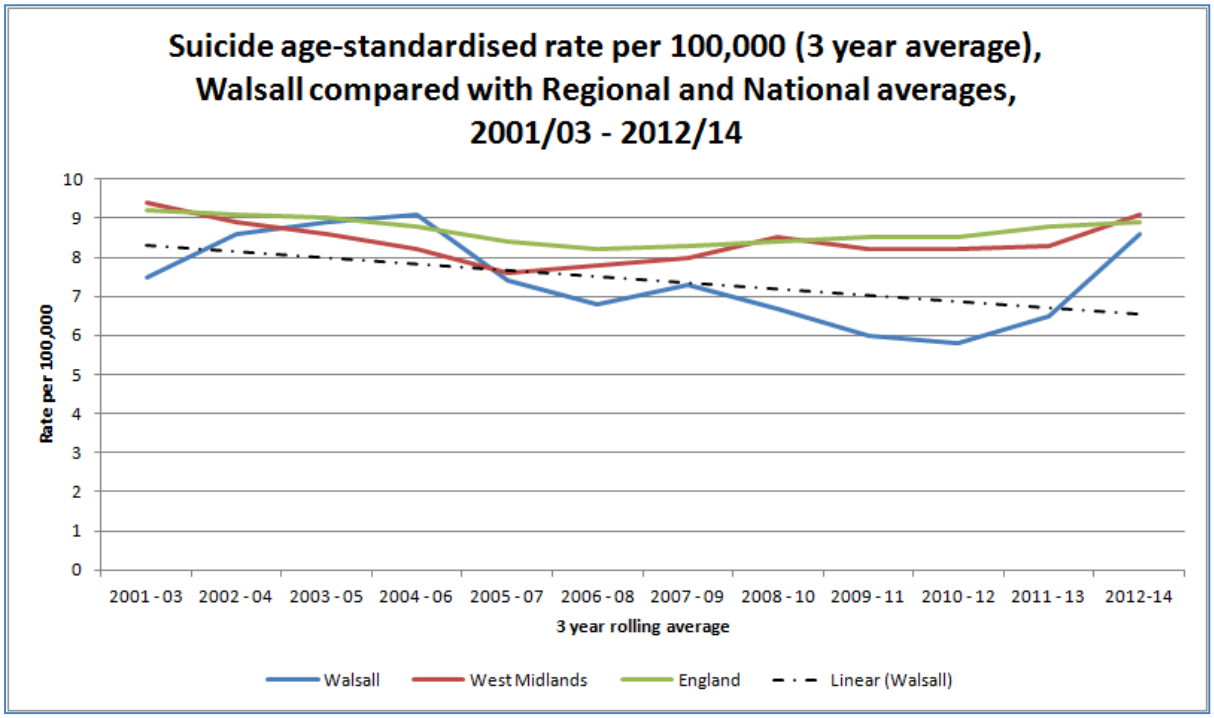


Source: Open Exeter Mortality File

Trends in suicide and injury undetermined rates 2001-2014

In most years, the suicide rate in Walsall has been well below the England and West Midlands averages (Figure 47). A trend increase in Walsall is evident. In the last three years (2012-14) the average Walsall rate has risen sharply and the gap with regional and national averages has narrowed.

Figure 47: Age Standardised Mortality Rates from Suicide and Injury Undetermined, Persons All Ages, 3-year rolling average.

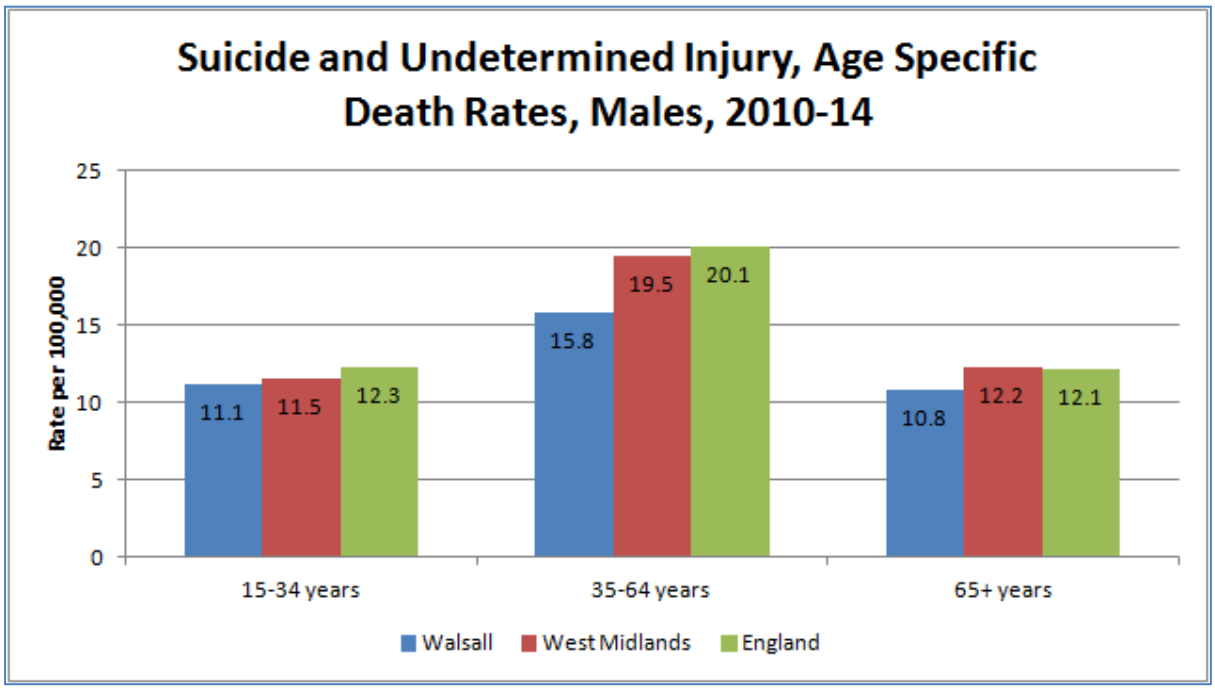


Source: Public Health England (based on ONS source data)

Age distribution of deaths from suicide and injury undetermined 2010-14

Suicide death rates in males in Walsall are highest in the 35-64 age groups. However, Walsall shows lower rates compared with regional and national averages at all age groups (Figure 48).

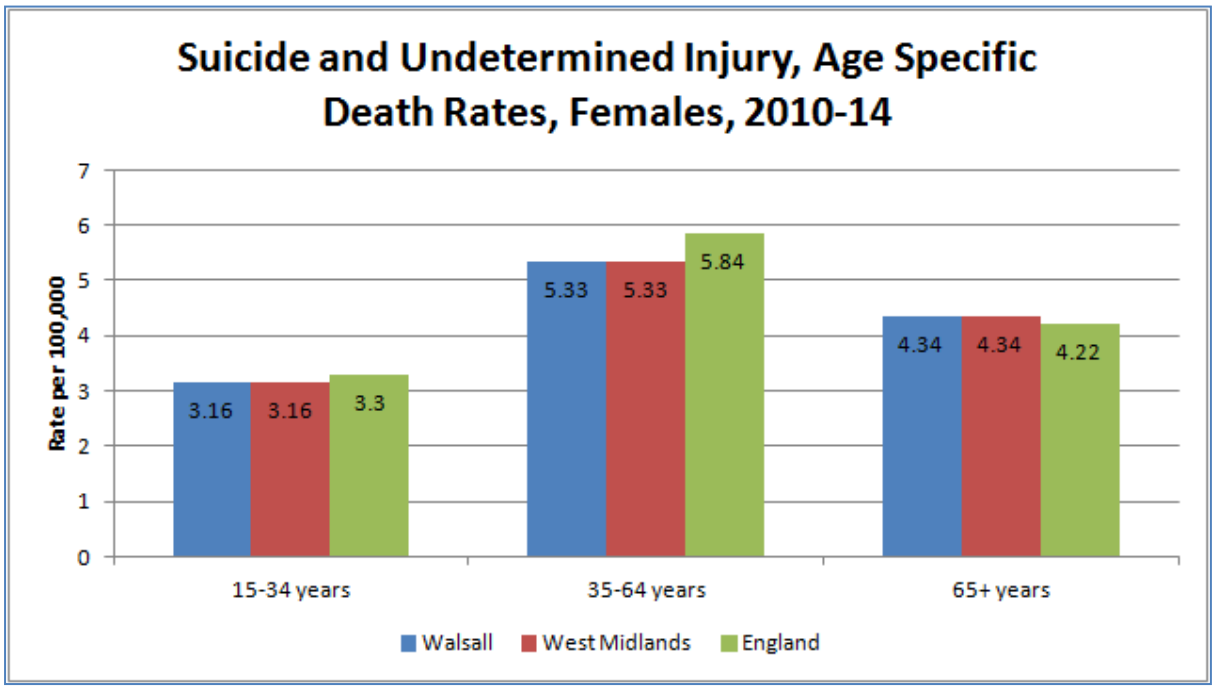
Figure 48: Suicide and Injury Undetermined, Age Specific Death Rates for Males in 2010-14



Source: ONS

Suicide death rates in females is relatively small. Rates at local authority level have been reported as the same as the region which it resides, so in West Midlands the rates are highest in 65+ years age group compared with national average.

Figure 49: Suicide and Injury Undetermined, Age Specific Death Rates for Females, 2010-14



Source: ONS

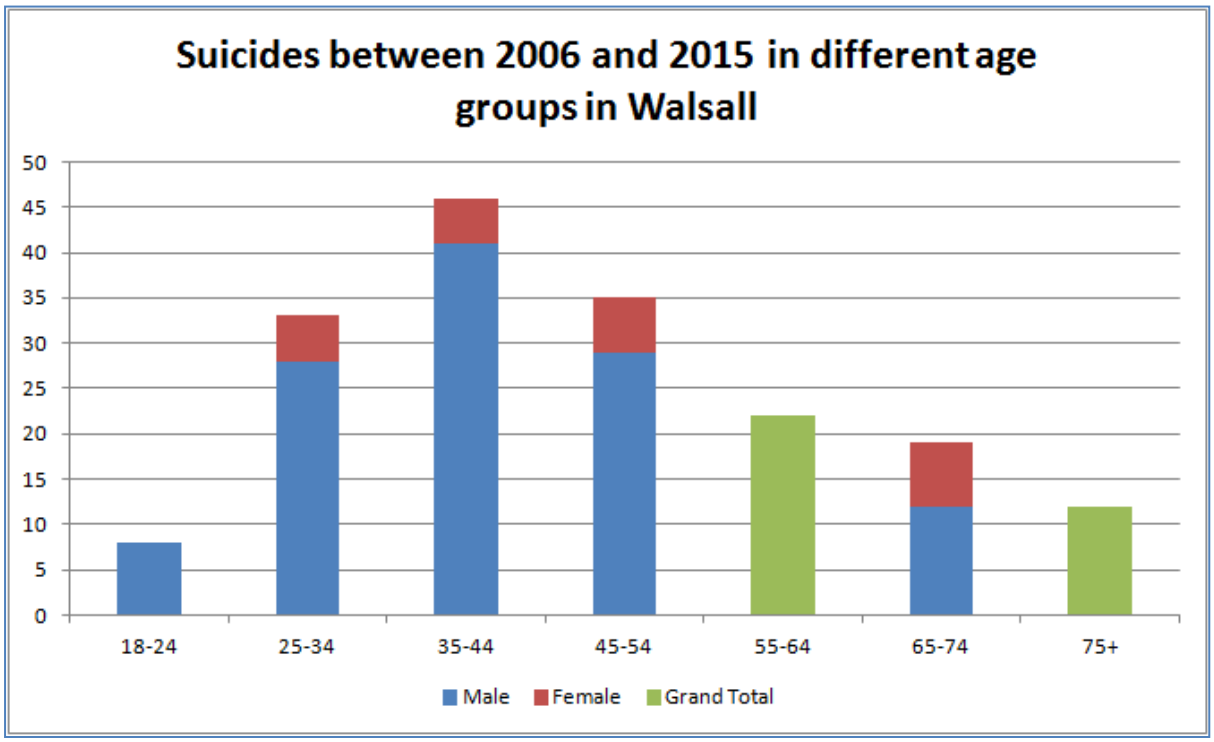
Caveat: Due to the relatively small number of deaths from suicide for females, the counts for local authorities are particularly subject to random variation, making comparisons across years and between areas inappropriate. As a result, the counts and rates reported are those for the region in which the local authority or county resides.

Number of suicide by Age and Gender

Similar to the patterns seen above, there are more suicides among males than females. Male suicides account for 85% (149) of all suicides between 2006 and 2015 in Walsall (175). Since 2011 there has been an increase in suicides by men and cases peaked to 21in 2014. Suicide rates for women have been consistently much lower (15%)in comparison.

The suicide age in Walsall, between 2006 and 2015, varied from 14 to 75+, with average age at 45 and median age 43. The highest suicide rates in Walsall were among those aged 35-44 for males and 65-74 females.

Figure 50: Count of suicide and injury undetermined by age, 2006-15



Source: Open Exeter Mortality File

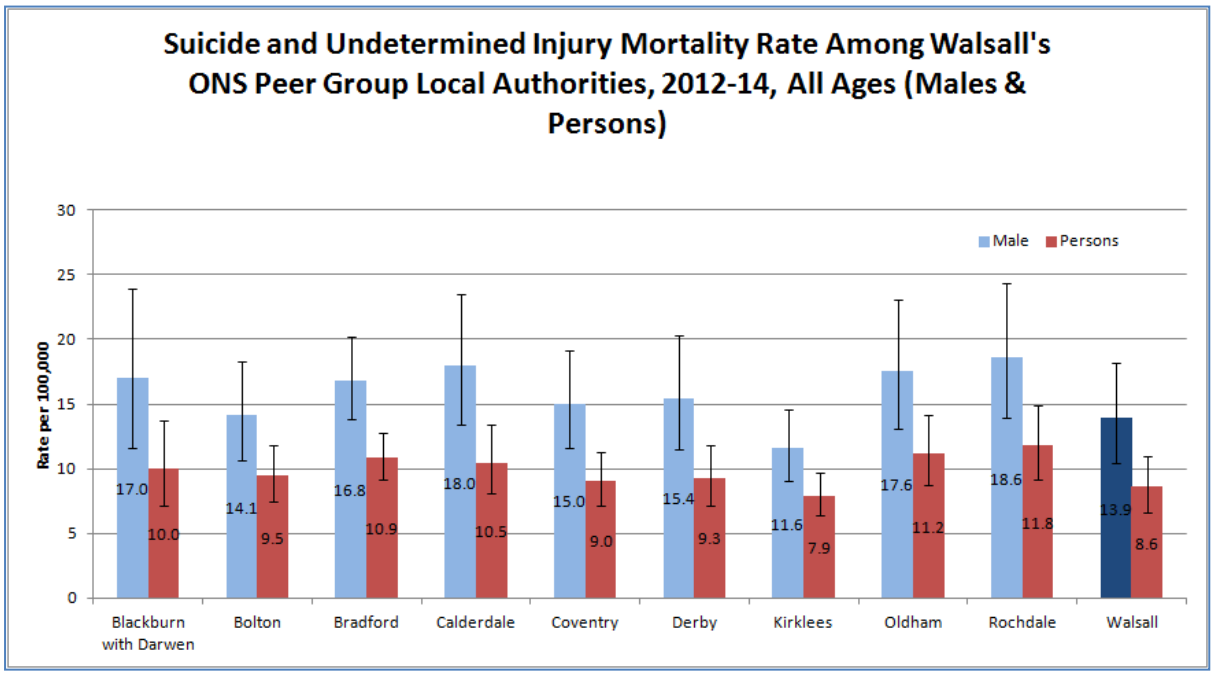
Comparison with Walsall and other Local Authorities

Figure 51 shows how Walsall's mortality rate from suicide and injury undetermined compares with these LAs.

In each of these areas, male suicide rates are substantially higher than for females[§§§]. Walsall's rate ranks the 2nd lowest among males and persons (males and females). Although Walsall ranks lower than majority of the ONS peer groups, the gap in Male suicides between LA with the highest suicide rate Rochdale (18.6 per 100,000) and Walsall (13.9 per 100,000) has reduced significantly between 2011-13 (difference of 6.17 per 100,000) and 2012-14 (difference of 4.7 per 100,000). This indicates that where other areas have managed to reduce their suicide rates, in Walsall the opposite has occurred.

[§§§] Female rates of suicide were very low and therefore numbers were suppressed and not presented in Figure 51.

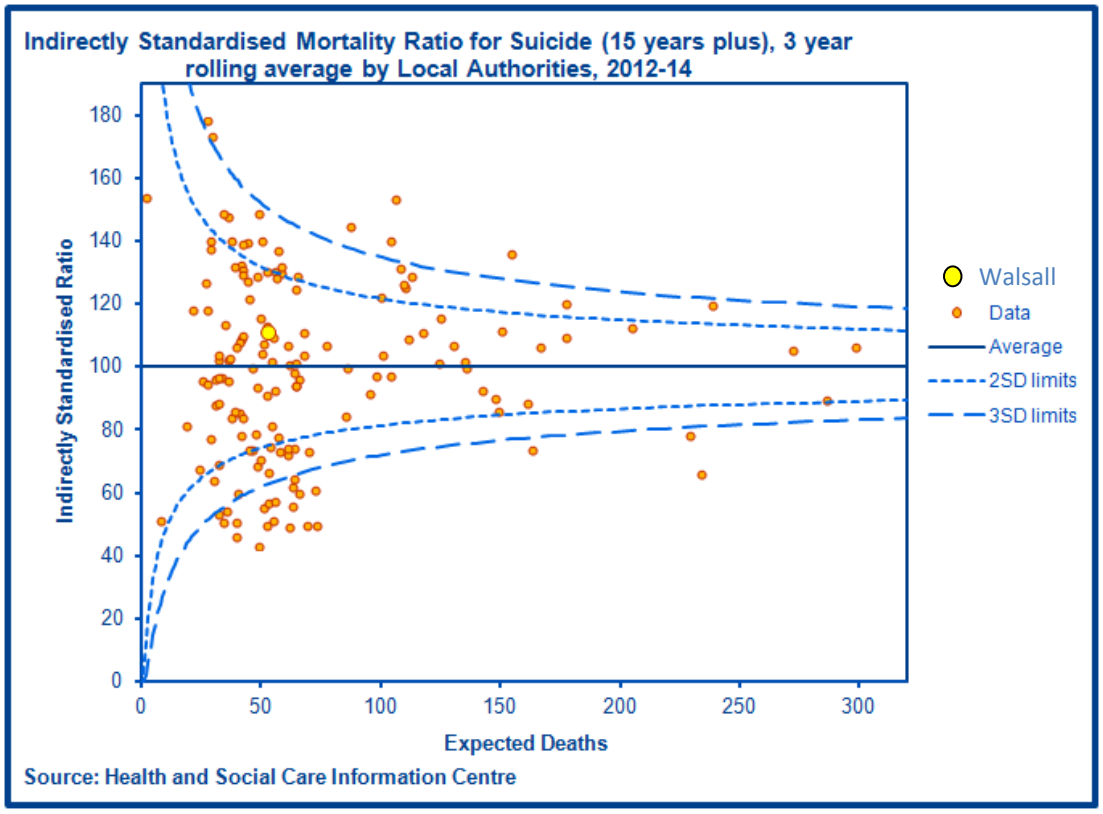
Figure 51: Suicide and Undetermined Injury Mortality Rates across Peer Group LAs



Source: PHE

The funnel plot (Figure 52) below shows Suicides rates over 3 year rolling average by local authorities during 2012-14 and Walsall is above the national average however it is not significantly different within 95% confidence interval and not an outlier (SMR = 111; LCI = 84.46 & UCI =143.11). There are 27 out of 152 which was outside of the controls indicating that they were significantly different to the national rate with 6 LAs being significantly higher (Middlesborough, Blackpool, Bristol, Cumbria, Durham and Devon).

Figure 52: Suicide Rate (SMR) for 15 years plus, 3 year average, 2012-14



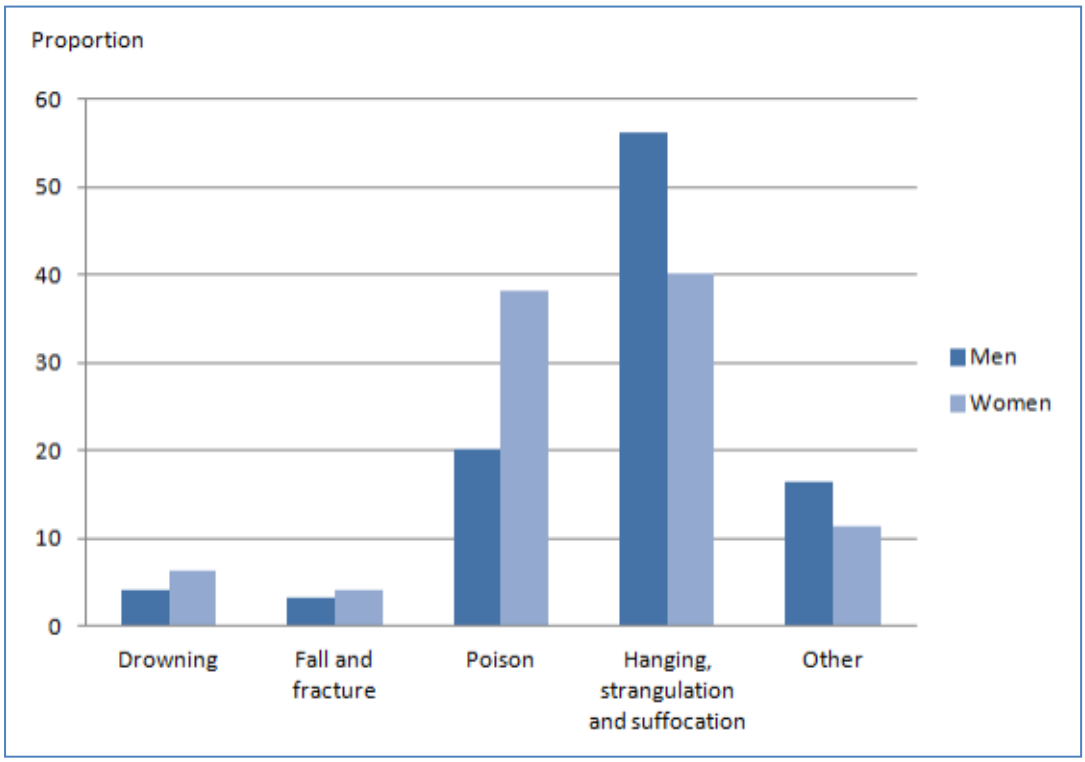
Methods of Suicide

Common methods of suicide/causes of death from injury undetermined were hanging/ suffocation, poisoning by solid or liquid substances, drowning and stabbing/cutting. However, people committed suicide also by jumping from height or before train or lying on railway, electrocution, shooting, gas poisoning, etc.

Hanging, strangulation and suffocation are the most common method of suicide among men historically in Walsall and poisoning for women[****].

[****] Suicide data from 2006 – 2011.

Figure 53: Proportion of suicide by method and sex, United Kingdom, deaths registered in 2013



Source: ONS, Northern Ireland Statistics and Research agency, National records of Scotland.

The most recent national suicide report (2013) showed that Hanging, strangulation and suffocation remained the most frequently used method for men (see Figure 53). For the first time, the same pattern had been seen for women, previously, the most common method of suicide by women was poisoning.

The increase in proportion of suicides from hanging in women could be related to more restrictions on availability of other methods in particular drugs used in overdose and to a misconception that hanging is a quick and painless way to die[137,138].

Services available

All people with a mental health condition are at an increased risk of attempting suicide. All commissioned mental health services in Walsall are ultimately aimed to prevent individuals from reaching a point where they attempt committing suicide(see table of mental health provision). GP, is often the first point of call for an individual who feels unable to cope.

The Walsall Samaritans

The Samaritans service provides anonymous telephone support 24 hours a day. The service allows the individual time and space to talk things through, explore options and find a way to address their problems.

Emotional Wellbeing and Mental Health Services

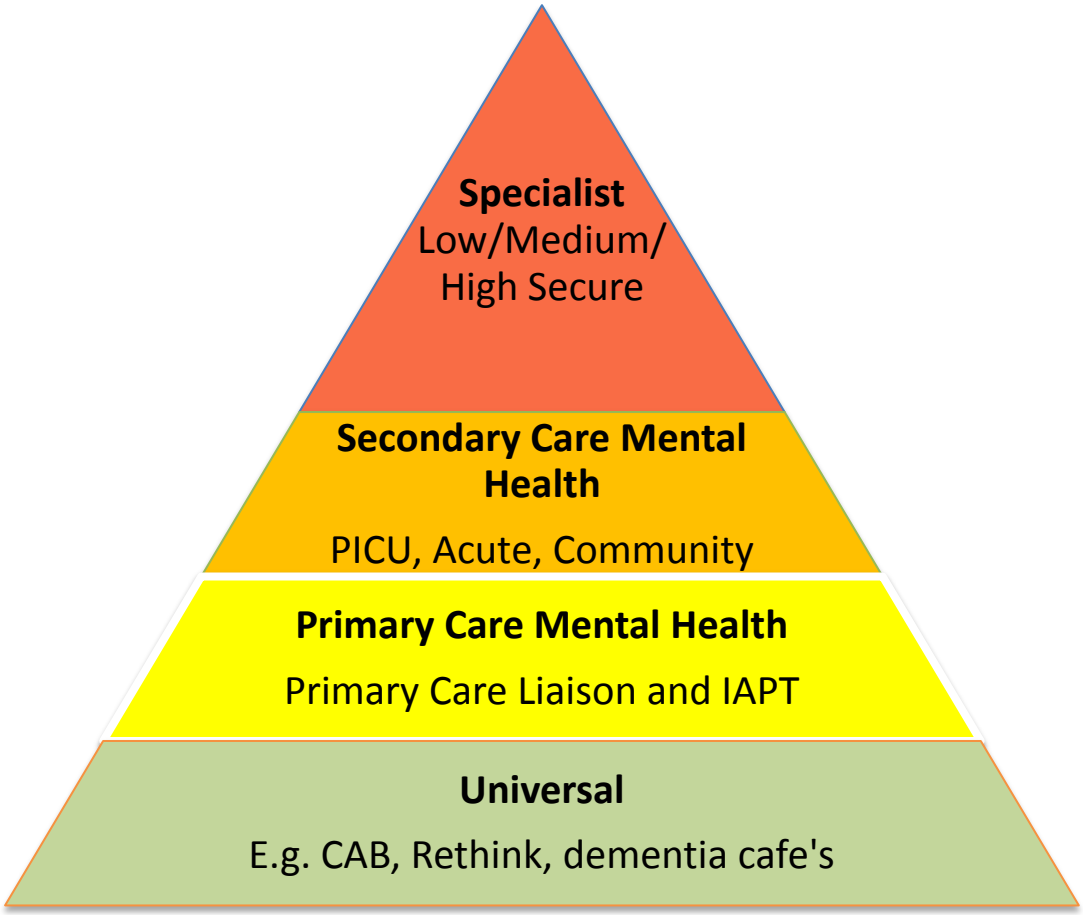
The document provides an overview of the services available within Walsall to the best of our knowledge and at the time of writing this report.

The report provides an overview of the range of services put in place to improve population health and wellbeing, prevent escalation to crisis, to contribute to social care outcomes and reduce demand on health and social care services.

Health Services -Primary, Community and Secondary care are often defined by services provided by family doctors (GPs), community staff (nurses, pharmacists, physiotherapists, etc) and hospital services (out-patient clinics and hospitals).

The mapping includes services which range from prevention to crisis support and is structured in 4 tiers; Specialist**,** Low/Medium/ High Secure.

Figure 54: Levels of emotional wellbeing and mental health for Adults in Walsall



Service	Description	Provided by	Commissioned by	Available to	Engagement route	value	Comments
Specialist provision	Low and medium secure services. Specialist secure hospital services often for forensic clients	Range of providers	Specialist Commissioners, NHS England	Adults aged over 18 with complex mental health issues requiring a secure setting.	Referral via Gateway assessment from Responsible Consultant	£ unknown	High level of provision. Users are often stepped down through to locally based provision
Carers Support Service	Provides support for people with mental health care responsibilities. A single specialist team works across both the Adult Mental Health Service and Older People's Mental Health Services and functions	DWMHPT	WCCG	Individuals 17+	Professional or self referral.	Circa £100k	Under the overall framework of the Care Programme Approach (CPA), offering carer assessments and action plans in line with carer legislation and local policy. **Gap** All carers not aware of provision
Older People Out- patients	Older people liaison includes Beeches Day hospital - a multi-functional mental health unit. Individuals receive time-limited assessment, treatment and rehabilitative care. The service also supports clients on discharge from inpatient services to prevent relapse and enhance recovery.	DWMHPT	Walsall CCG	The service is for individuals over the age of 65 with complex mental health needs and is also accessible to younger clients with cognitive impairment.	Via referral from Community Mental Health Teams and is accessed via psychiatrists. The day hospital provision operating between the hours of 09.00 – 15.00 hours	£260,683 per year	Patients attend for 8 – 10 weeks of programmes. The service has 3 minibuses and a mixture of staff including nurses, support workers supported by Occupational therapists. Clients may attend for full days or specific group sessions depending on need. Services provided to clients will have an individual approach with a recovery focus.

Service	Description	Provided by	Commissioned by	Available to	Engagement route	value	Comments
Community Mental Health for Older Adults	The Community Mental Health Team for Older Adults, and those with working aged dementia, offer assessment and a range of interventions for all mental health problems, with a functional or organic nature.	DWMHPT	Walsall CCG	Older Adults with Dementia and those with working aged dementia,	via GP, social care and existing mental health services	Circa £1.1m	The service is delivered by a multidisciplinary team of nurses, social workers & occupational therapists. It provides a gateway function for all secondary older peoples' mental health services.
Bloxwich Hospital	Specialist assessment, care and treatment to people who are experiencing mental health difficulties. The service assists individuals, their families and carers to understand the nature of their mental health difficulties by providing information and education along with practical and emotional support to achieve optimum recovery for an individual. Cedar Ward has 30 beds for patients with functional mental illness and Linden Ward which has 20 beds for patients with organic mental illness.	DWMHPT	Walsall CCG	People over the age of 65, or in the case of organic illness those under 65.	Via referral from your GP and Consultant Psychiatrists.	Circa £3.8m	**Gap** The Inpatient Wards are mixed-gender wards which only accept older people with dementia. This is not appropriate for people with working age dementia and as such these are cared for through out of borough contracts, which are often far from Walsall.
Adult Mental Health Employment	Provides a range of recovery focused educational, recreational and vocational courses. They promote self-reliance, and enables individuals to achieve their goals	DWMPT	Walsall CCG	Any adult receiving Secondary Mental Health care can access through a Community Mental	Contact can be made through care coordinators in the Secondary Teams or directly by self-referral.	Circa £180k	No waiting time. **Gaps** More referrals required from CRS.

Service	Description	Provided by	Commissioned by	Available to	Engagement route	value	Comments
Services	and build their own recovery capital. Courses and programmes focus on the following key areas: Developing life skills/ learning, Improving physical/mental health, Wellbeing, Getting involved, Understanding / experience of mental health and related issues			Health Team, Home Treatment, Early Intervention Service, the Assertive Outreach Team and Outpatients can make use of this service.			
Criminal Justice Mental Health Team	Undertakes assessment, support and advice. The service is mainly provided on a short-term basis and will assist with the transfer to longer-term (secondary care) services where this is indicated. The service is 'hosted' in Walsall Probation office	DWMPT	Walsall CCG	The service supports those experiencing mental health difficulties who are involved within the criminal justice system.	Via criminal justice or other mental health services.	Circa £124k	The service is offered within a variety of settings across Walsall, including police custody, court, bail hostels and secure units. **Gap** There is no dedicated psychiatric time to support community mental health nurses.

Service	Description	Provided by	Commissioned by	Available to	Engagement route	value	Comments
Adult Mental Health Day Services (Walsall)	a range of activities to promote recovery, social inclusion and independent living, including: Anxiety Management, Depression Management, Assertion Training, Life Skills, Hearing voices, New Horizons (bipolar), Anger Management - Groups support to assist people to build on their existing self-help skills as well as developing new coping strategies.	DWMPT	Walsall CCG	Adults recovering from, or living with, mental health problems	The service is accessed by referral from a health care professional or GP.	Circa £988k	Following assessments it provides same day assessment for all urgent referrals and an assessment within 15 working days for priority referrals (non-urgent).
Early Access Service	The service acts as a single point of entry for all adult secondary care referrals and provides mental health screening and assessment of all referrals. The service manages urgent and routine referrals and during opening times directs all crisis calls to the CRHT team out of hours access is via the crisis Following assessments it provides same day assessment for all urgent referrals and an assessment within 15 working days for priority referrals (non-urgent).teams.	DWMPT	Walsall CCG	All adult 17 + who meet the criteria for secondary care	GP heath and other professional.	Circa £953k	Brings together all aspects of assessment for secondary care services into one team for functional illness The team will provide a multi disciplinary approach to the whole assessment process, matching needs of service users. The service is meant to **Gap** Providing signposting (advice and guidance) to the referrer, should the criteria for secondary mental health care not be met; Delays in referrals and accessibility to other services.
Early Intervention in Psychosis	Provide assessment and care for individuals experiencing a first onset of psychosis, usually under the age of 35. Focus is on	DWMHPT	WCCG	individuals experiencing a first onset of psychosis18 -35 years with common mental	Operates an integrated referral system to specialist mental health services via a	Circa £859k	The maximum case capacity of the team when fully staffed is 120 cases - 137 new referrals per annum. The CRHT utilise a range of interventions

Service	Description	Provided by	Commissioned by	Available to	Engagement route	value	Comments
Service (EIPS)	optimising medical control of psychotic symptoms, providing a range of psychological and family interventions and assisting in the personal adjustments necessarily arising from an individual's illness.			health problems (including depression and/or anxiety)	single point of entry. Referrals accepted from all secondary mental health services within the borough.		depending on the presenting need. Psychosocial interventions e.g. Brief Solution focused therapy to assist the service user/carers to understand their experience and develop future coping strategies and medication.
Community Recovery Service	The service provides support people with severe and persistent mental health problems requiring ongoing treatment and interventions. Including those who have substantial or critical social care needs directly associated with their mental illness. The service aims to improve independence and access to community care, and increase stability in the lives of service users and their carers.	DWMPT	Walsall CCG	people with severe and persistent mental health problems requiring ongoing treatment and support	GP referral to Early Access Service who will identify the most appropriate service and can refer you to the Community Recovery Service	Circa £3.4m	There are two Community and Recovery Teams in Walsall. Delivering service from a variety of community settings across Walsall.
Adult Outpatients Community Health Care Assessments	Outpatient services cover all the one-to-one services offered to adults of a working age outside of the community teams and in-patient settings. E.g. Review of treatment, medication and plans.	DWMPT	Walsall CCG	People with severe and persistent mental health problems requiring ongoing treatment and support	GP referral to Early Access Service who will identify the most appropriate service and can refer you to the Community Recovery Service	Circa £889k	

Service	Description	Provided by	Commissioned by	Available to	Engagement route	value	Comments
Assertive Outreach and Community Rehabilitation Service	Intensive support for severely mentally ill people who are difficult to engage in more traditional services. Some have a forensic history and a dual diagnosis. Care and support is offered in their homes or other community settings at times suited to them.	DWMPT	Walsall CCG	people aged 17 years and above dependant on functionality support , with a severe and enduring mental illness and have not engaged effectively with traditional services	Adult Community Mental Health Teams or Consultant Psychiatrists.	Included within CRS above	Teams are multi-disciplinary and focus on the needs of people with long-term serious mental illness
Mental Health Crisis Resolution and Home Treatment Service	The service provides an alternative to hospital admission for people in a crisis. It provides short term immediate multi-disciplinary, community based treatment 24 hours a day, 7 days a week in a range of settings as an alternative to inpatient care. The Team aim to achieve a crisis response to all accepted referrals within 4 hours.	DWMPT	Walsall CCG	Adults 16 + with serious mental illness experiencing acute difficulties for whom home treatment would be appropriate	heath and other professional via referral from secondary mental health services and is accessible	Circa £2.4m	The duration of the intervention is based on the needs of the service user last which on average should last 4 weeks**.** **Gaps** This service is unable to meet the demands of those presenting in crisis in the current service design due to staffing structure and service specification. This is particularly the situation for those in crisis during the night.
Adult Inpatient Dorothy Pattison	The service offers treatment and assessment to service users who have mental health needs. The service assist individuals, their families, carers to understand the nature of their mental health difficulties by providing information and education along with practical and emotional	DWMPT	Walsall CCG	The service assists adults below the age of 65 old and supports individuals, their families, carers	Via the Mental Health Crisis Resolution and Home Treatment service.	Circa £4.7m	Inpatient wards located at Dorothy Pattison Hospital, Walsall. Waiting time -No waiting times accessible as and when required. Exclusion - Outpatients and children **Gaps**-People stay longer than may be required which prevents others using the service and therefore increases demand on external beds. Psychiatric

Service	Description	Provided by	Commissioned by	Available to	Engagement route	value	Comments
	support to achieve optimum recovery						Intensive Care Unit (PICU) is not currently provided within this resource. This creates demand in the independent sector and financial pressures on commissioners.
Challenging behaviour Placements	User is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities. Providers include (but not limited); Parklands Court The Lakes Alma Court Darwin Court The Coach House Willowbrook	A number of in and out of area providers	Walsall CCG	Anyone meeting Walsall council or CCG funding criteria	Care coordinator referral	Circa £5m in CCG and LA	Challenging behaviour can be described as culturally abnormal behaviour(s) of such intensity, frequency or duration that the physical safety of the person or others Providers includes Walsall has a shortage of nursing EMI and challenging behavioural facilities. Therefore we utilise available provision on our borders in Staffordshire, Birmingham and Wolverhampton.

Service	Description	Provided by	Commissioned by	Available to	Engagement route	value	Comments
Locked Rehabilitation	*Locked rehabilitation* services provide safe and nurturing environments for males and females with complex and often enduring mental illness for both detained and informal patients. Specialist providers with the NHS & Independent sector include (but not limited to);	A number of out of area provides		Anyone meeting Walsall CCG funding criteria	Care coordinator referral	Circa £5m	Providers include: Partnerships in Care Cambian Healthcare Barchester Healthcare John Munroe Ludlow Healthcare The Priory Group St, Andrews Healthcare Huntercombe
Triage Car	The mental health triage scheme, is a team of West Midlands Police officers psychiatric nurses and paramedics to answer calls to people believed to be experiencing mental ill health to ensure appropriate support of people with mental health to reduce the number of people detain under the Mental Health Act	MDT partnership lead by police	black country investment	Adults across Walsall	Referral from Social worker,		Service works across the black country therefore the distribution of access s not clearly balanced. 1339 hours covered across the black country between (01/04/2015 to 31/01/2016) 326 contact of which 247 contacts for mental health. **Gap** - there are limited facts data of success. Clinicians can't refer to it.
Memory Assessment Services	The Memory Service offers assessment and diagnosis to patients for whom memory problems are the primary symptom. The service offers pre- and post-diagnostic counselling, advice, education, guidance, signposting and medication monitoring.	DWMHPT	Walsall CCG	Patients who are diagnosed with dementia	Via general practice and also via existing mental health services. Referrals are also accepted from the Community Mental Health Teams and Acute Hospital Services where the GP is informed.	Circa £1.1m	This service is available across Walsall and is provided via home visits and within clinics. **Gap** more capacity required to undertake home visits

Service	Description	Provided by	Commissioned by	Available to	Engagement route	value	Comments
Eating Disorders Service	This is a specialist service addressing eating disorders		Walsall CC	To adults with an eating disorder. The service is unable to provide support to clients suffering with obesity.	Via referral from a General Practitioner.	Circa £84k	The service is provided at the nearest Local Mental Health Units, via Primary Mental Health or CAMHS home visits where appropriate. The team is based at: Canal side Abbotts Street, Bloxwich, Walsall, WS3 3AZ
Primary Mental Health Service	The service treats service users experiencing mild to moderate mental health problems. These include depression and anxiety disorders such as Post Traumatic Stress, Obsessive Compulsive Disorder, Phobias, and Social Anxiety etc. The service offers many kinds of treatments including; Cognitive Behavioural Therapy, Eye Movement Desensitisation Reprocessing, Guided Self-Help and our series of six, weekly courses to help manage your mood and overcome anxiety.	DWMPT	Walsall CCG	The service supports people aged 17 and over. People with common mental health problems including; Depression, OCD, PTSD, GAD, Panic, health anxiety, phobia	The first point of contact for the client is via the Primary Care Mental Health Nurse (PCMHN) based in GP surgeries or local community health centre No referral is needed	Circa £1.9m (combined cost with IAPT)	The service is unable to offer a service to the following Clients: who present as a significant risk to themselves or others, with a diagnosis of a severe mental health problem such as schizophrenia or bipolar disorder, with a diagnosis of Personality Disorder (as brief interventions are contra-indicated for the client group

Service	Description	Provided by	Commissioned by	Available to	Engagement route	value	Comments
Improving Access to Psychological Therapies (IAPT)	A community based service offering a range of evidence based psychological interventions to those with a wide spectrum of common mental health problems. It will employ a bio psychosocial model of care. It takes an integrated approach to service delivery.	DWMHPT	WCCG	Individuals 17+with common mental health problems (including depression and/or anxiety)	Access via a GP referral, by other or self referral.		IPCMHS is suppose to make its services entirely accessible encourages take-up by hard to reach groups and facilitate the reduction in waiting times across the whole stepped care pathway. 8am-8pm Monday – Saturday
Psychiatric Liaison Service for Older people	The Psychiatric Liaison Service for Older people is provided by Walsall Health Care Trust. The service is dedicated to assessing people who attend Walsall Manor Hospital following a self-harm/suicide attempt, or who have symptoms that suggests they are suffering from a mental illness. The team is comprised of a clinical nurse specialist and a senior mental health nurse	WHT	Walsall CCG	The service is for individuals over the age of 65 with complex mental health needs and is also accessible to younger clients with cognitive impairment.	Referrals to the service are made on admittance to Walsall Manor Hospital.	£1092541 per annum - Day services for older people (Bloxwich Hospital) £233607	This service is provided at Walsall Manor Hospital.

Service	Description	Provided by	Commissioned by	Available to	Engagement route	value	Comments
Midwifery	Identification of maternal mental health issues at appointments. Referral when required to DWMHT or WHT lifestyle services	NHS	CCG NHS	All pregnant women	Midwifery appointments	As part of maternity contract	
Health visiting	Assessment of women's emotional health and wellbeing via validated tools. Support offered for transition to parenthood, maternal mental health support and parenting which impact on maternal MH	NHS	WMBC	All Women 28 weeks to 5 years post deliver	HV appointments Referral when required to DWMHT or WHT lifestyle services.	As part of larger 0-5 contract	Adhere to HV MH pathway
Dementia Cafe	A range of dementia support provision which include: Dementia Cafes, Dementia support workers and Dementia friendly communities. The cafés are hosted each month for two hours at a time, covering a range of days and times including evenings. Dedicated dementia café coordinators are available at each venue as well as guest speakers,	Pathways 4 Life in partnership with Age UK	Walsall CCG	Patients with dementia and their carers	self referral and professional referral	£50,000 per year. At approximately £12 per head per session per person, the programme has capacity to support 4,167	The cafés are hosted each month for two hours at a time, covering a range of days and times including evenings. Dedicated dementia café coordinators are available at each venue as well as guest speakers, activities and free refreshments. - • Link line dementia cafe (working to commissioned Specification) Forget me not support group for dementia an informal cafe

Service	Description	Provided by	Commissioned by	Available to	Engagement route	value	Comments
	activities and free refreshments.					individual attendances.	

Service	Description	Provided by	Commissioned by	Available to	Engagement route	value	Comments
Dementia support workers	Raise awareness of dementia - Screening for dementia where people have struggled to access services - Raise awareness of healthy lifestyles	Pathways for life	Walsall CCG	Hard to reach groups including Urdu if required-Screening and support- Care homes and Endo of life, based at manor hospital	self referral and professional referral		Work with GPs to screen people for potential dementia. Provides ongoing support for post diagnosis-Care home support and end of life- Work within care homes providing ongoing support for homes and people in care homes.
Personal Assistant in dementia	Six Personal Assistants -provide diagnosis support for people soon after a diagnosis of dementia, for a period of up to 3 months from diagnosis.	CCG	Accord Group	Older people with dementia their family who may or may not be carers,	self or professional referral		New service which takes a community engagement approach
Dementia friendly communities	A programme which encourages organisations and businesses to adapt their provision to improve the experience of people with dementia and their carers. Receive support shopping experience for carers of dementia – with window stickers	Pathways for life and Alzheimer's society	jointly funded by the CCG and Walsall Council	It is accessible for all and free to businesses	Open access	£10,000 per year	Dementia awareness- Communication skills - Environmental action plan - Developing dementia champion. Organisations and business reaching the required standards receive an approved council and CCG verified certificate from the mayor. There are two providers of this initiative:

Service	Description	Provided by	Commissioned by	Available to	Engagement route	value	Comments
Advocacy Matters	Independent Advocacy service provides issue-based Information, advice and support for older people. Independent advocacy exists to support people to have their voice heard and rights respected		jointly funded by the CCG and Walsall Council	support people who use services and family carers	self referral and professional referral		Service available to support older people to have a voice **Gap** Not widely known
Mind matters cafe	Cafe provides activities support information – profession guest speakers chosen by the attendees.		External funded not by the CCG and Walsall Council	Older people who have experienced a mental health problem	self referral and professional referral		The service operates to the CCG designed specifications **Gap** Only one service
Link Line	The Link Line is a voluntary project work to support older people to receive the best care possible to tackle social isolation and improve older people wellbeing.	**Link Line**	CCG and external funding	Older people cares, people who are lonely and or isolated and dementia suffers	Professional or self referral.	NA	**Gap** low staffing levels compared to need based on funding, heavily reliant on volunteers.
Walsall CAB support to	Provides advice, information and advocacy/representation for clients who are experiencing mental	CAB	WBMC	Individuals 16+	Referrals are made by staff based at the hospital, from	###	Service support people with mental ill health who have financial and or legal issues to prevent exculpation

Service	Description	Provided by	Commissioned by	Available to	Engagement route	value	Comments
Mental Health Service Users	health issues. The focus is on income maximisation with particular emphasis on welfare benefit and tax credit entitlement, debt, housing and employment advice. The service covers information, advice, and help with form filling and other practical assistance				community based services and by self referral from former clients		into crisis. **Gap** Enough provision available to support people at risk across all tiers **Recommendation** Invest in provision across all service provision
Emotional Health & Wellbeing Service	The Emotional Health & Wellbeing Service support individuals to make lifestyle changes to improve their emotional health and wellbeing. The service offers psycho-education and guided self-help using Cognitive Behavioural Approaches with individuals on a one to one basis with a focus on improving emotional wellbeing. Also provides up to eight sessions of structured guided self-help	WHT lifestyle service	WBMC	People 18 years or over presenting with low or no risk	Professional or self referral.	£88k	This service is going through transition and is to be integrated into the lifestyle service in coming months **Gap** training will not be included. **Recommendation** Commission specific additional training element
Wellbeing service	The service provides support to those struggling to cope with daily life. Wellbeing Service provides varying levels of support tailored to the individual needs and keep connected. For adults who want to stay livings in their own home but need some support.	WHG	WHG	Any Adults 16+ including older people living within Walsall who want to stay living in their own home but need a bit of support.	Professional or self referral.	NA	Support available to residents and not residents **Gap**s not widely known access with a charge **recommendation** service to be free to service users at point of access

Service	Description	Provided by	Commissioned by	Available to	Engagement route	value	Comments
The Community Enablement Service	Community based service which provides a range of services to enable recovery for people experiencing poor mental wellbeing and/or mental health issues by use of the 5 ways to wellbeing tool, and the mental health recovery star outcomes based support planning process.	Rethink	CCG	Adults 17+	Professional or self referral.	Circa £131k	This is a newly commissioned service
Samaritans help line	The Samaritans is a registered charity aimed at providing emotional support to anyone in emotional distress, struggling to cope, or at risk of suicide through a confidential telephone helpline.	Samaritans	NA	All adults	direct telephone call	NA	The service is available 24 hours a day in which people about anything that the individual is struggling with. Has built in referral for local support path way to Rethink. **Gap** No data recording received due to the anonymous nature of service Recommendation Closer working with local provision
Walsall Service Users Empowerment (SUE)	An independent group. A user-led organisation representing the interests of Walsall residents that use Walsall's health and social care services to help people start to regain control of their lives	SUE	0	Anyone using health or social care services	self referral		**Gap** Capacity to support the population of Walsall limited and finance a challenge **Recommendation** development support

Service	Description	Provided by	Commissioned by	Available to	Engagement route	value	Comments
BME Mental Health & Wellbeing Service	Local organisations involved to promote useful services. Events are open to the public with an aim to aid community cohesion. The events are often a part of awareness raising. Also providing subsidised Day trips that are accessible for the whole community	**WBSC**	External funding	All residents in Walsall experiencing mental ill health Individuals Family units Carer's	• Self • Family & friends • GP • Social Worker CPN or any other health professional	NA	**Gap** ability to undertake Community development and engagement work within BME communities, Not clearly integrated into the mental health pathway **Recommendation** review and integrate
Floating Housing Support	**Outreach -**Completing visits to residents in Walsall and providing support by assessments, care planning, form filling, housing related support, advocacy, signposting and a befriending service. **Consultation** – Consultation through group and one to one discussions on community needs and how to address them. **Advocacy –** Empowering individuals and their carers to speak out about concerns they have about their needs with the help of our support service.	WBSC	External funding	All residents in Walsall Individuals Family units Carer's	• Self • Family & friends • GP • Social Worker • CPN or any other health professional	NA	**Gap** ability to undertake Community development and engagement work within BME communities **,** Not clearly integrated into the mental health pathway **Recommendation** review and integrate

Service	Description	Provided by	Commissioned by	Available to	Engagement route	value	Comments
WPH counselling Services	The Service offers a range of Counselling and Education Services. The service also offers free pregnancy testing free pregnancy testing. The education programme address sexual health and teenage pregnancy	WPH Counselling and Education Services	Walsall CCG	Available for all individuals in need	Via "Drop In" Sessions Midwives Hospitals GP referrals Community psychiatric nurses Teenage Pregnancy Team Social services Youth Services / Education Voluntary Sector		The service makes available interpreters and offers a teenage programme. It provides an emergency out of hours helpline.
Women's Refuge	The service provides 24 units of accommodation, 10 floating support units, children and young people's worker and court IDVA	Accord Housing	Walsall CCG	Provision of a women's refuge to support women & their children who are escaping domestic abuse.	£275k	11/12: Service utilisation £101.16% (86% target) Service Throughput 240.63% (100- 120% target) Planned moves 93.47% (Target 82%) Outcomes are articulated in the annual performance	**Gap -** mental health support not provided as core support.

Service	Description	Provided by	Commissioned by	Available to	Engagement route	value	Comments
Independent Domestic Violence Advisors (IDVA)	Outreach Worker to support victims of domestic abuse with additional complex needs i.e. mental health, substance misuse or frailty issues. This role also includes liaison with the Hospital A&E to identify victims of domestic abuse and offer early help to avoid escalation or repeat victimisation.		Walsall CCG	Victims of domestic abuse	professional referral	NA	**Gap** There are insufficient support services available for victims of DV&A, with particular gaps earlier in the pathway (to prevent escalation), for key groups and longer term support for individuals and high risk.
Crisis Point	Offers psychotherapy, counselling and support to victims and survivors of sexual crime. Independent sexual assaults advocate (ISVA). voluntary organisation			victims of domestic abuse	Via Adult Community Mental Health Teams or Consultant Psychiatrists.	NA	**Gap** Not clearly integrated into the mental health pathway

Dudley and Walsall Mental Health Partnership NHS Trust (DWMPHT) Activity

DWMPHT is the main provider of mental health services for the registered population of Walsall. The services are provided in Walsall via two main hospital sites – Dorothy Pattison for Adults and Bloxwich for Older Adults, along with a range of sites providing Community and Primary Care mental health services.

The number of referrals made to the Trust increased from 11,250 to 12,447 between 2012/13 and 2014/15 (Table 16) which represents an 11% increase. Based on the current analysis, it is not possible to say whether this increase is above the increase in population and prevalence. External referrals to DWMPHT showed an increase of 8.4%. Emergency referrals are those coming via Psychiatric Liaison and Street Triage teams. The Trust is working on improving the coding of the data and improvements can be seen in the significant reduction in the referrals coded as 'Other'.

Table 16: Referrals to DWMPHT (Walsall Registered population), 2012/13 - 2014/15

Referral Type	2012/13	2013/14	2014/15
EMERGENCY	49	127	221
EXTERNAL	5038	5179	5459
INTERNAL	4262	5201	6162
Other	1901	1176	605
Grand Total	**11250**	**11683**	**12447**

Source: DWMPHT

Note: Accepted Referrals = At least one seen Face to Face Contact and excludes primary care.

The vast majority of accepted referrals were for Acute services, followed by Older Adults (Appendix on page 182). The data shows a trend of increased referrals for these two services with a reduction in the Community and Recovery Services and Early Intervention services (Table 17 and Figure 55).

Table 17: DWMPHT Accepted Referrals by service area, 2012/13 - 2014/15

Service	2012/13	2013/14	2014/15
Acute Services	3,686	4,445	4,208
Community and Recovery Services	1,629	1,402	1,422
Early Intervention Services	129	94	85
Medical Outpatients (Adults only)	533	474	465
Older Adults	2,164	2,250	2,601
Accepted Referrals by DWMPHT (Walsall only)	**8,372**	**8,685**	**8,782**
Unique number of patients	**4,164**	**4,177**	**4,463**

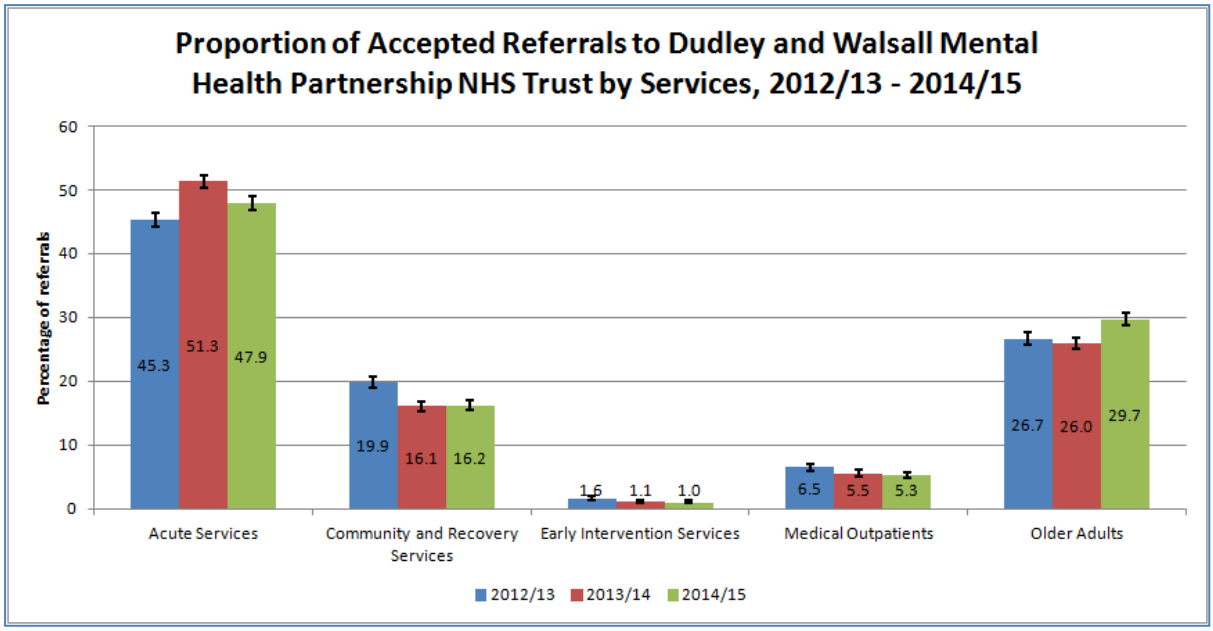
Source: DWMPHT

Note: Accepted Referrals = At least one seen Face to Face Contact and excludes primary care.

The increase in Acute services referrals is considered to be due to the introduction of the Early Access Service (EAS) and the increase in referrals via Psychiatric Liaison service. This has potentially affected the downward trend in referrals to the community and recovery services as all adult referrals predominately go through EAS first.

With 8,782 accepted referrals for 4,463 patients, this represents nearly 2 referrals per patient. This could most likely be due to patient being referred to different services within the period, or referred back into the service after being discharged. A high proportion of the latter will be of concern but can only be ascertained by more detailed analysis outside the scope of this NA.

Figure 55: DWMPHT Referrals by Service Areas, 2012/13 - 2014/15

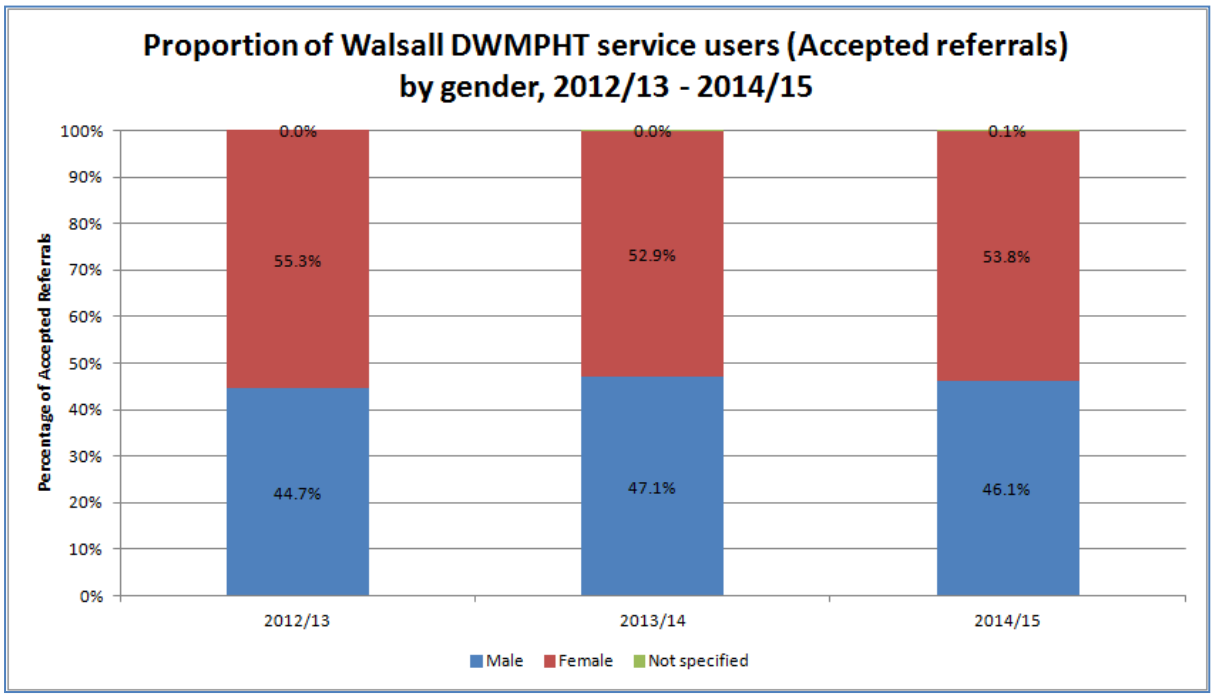


Source: DWMPHT, informatics service.

Service User Demographics

Over the last three years more female service users were referred to DWMPHT (approximately 54% in 2014/15) and this trend seems to be consistent for each year (Figure 56). However the proportion of accepted referrals for men has increased since 2012/13 which could be positive given that men are known to not engage as well with health services compared to women or this could indicate a real increase in mental health illness in men.

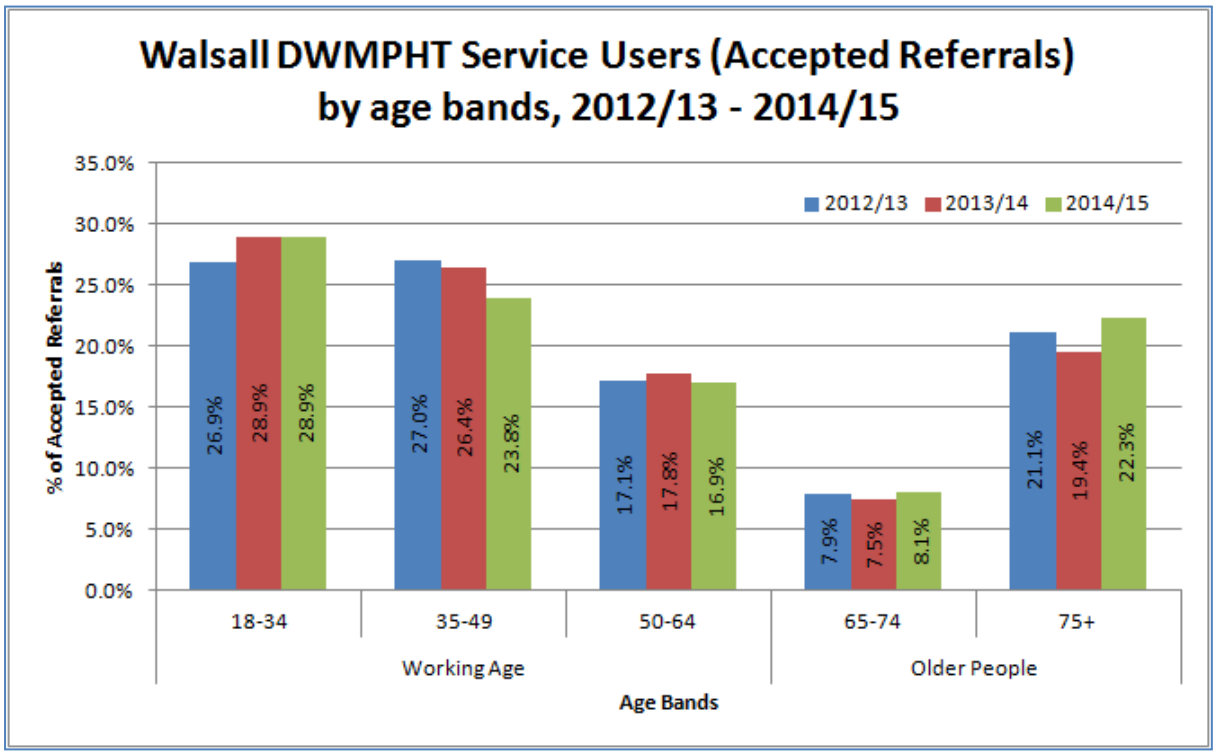
Figure 56: Walsall DWMPHT service users by gender, 2012/13 - 2014/15



Source: DWMPHT

The largest proportion of service users with accepted referral was from the working age cohort and specifically 18-34 age bands in the last two years (Figure 57). There seems to be trend increase observed in 18-34 age group within working age cohort and decrease in 35-49 age group over the last three years. Within the older people cohort, the 75+ age group had the highest proportion of referrals which can be attributed to high proportion of memory service patients(53%).

Figure 57: Walsall DWMPHT service users by age band, 2012/13 - 2014/15



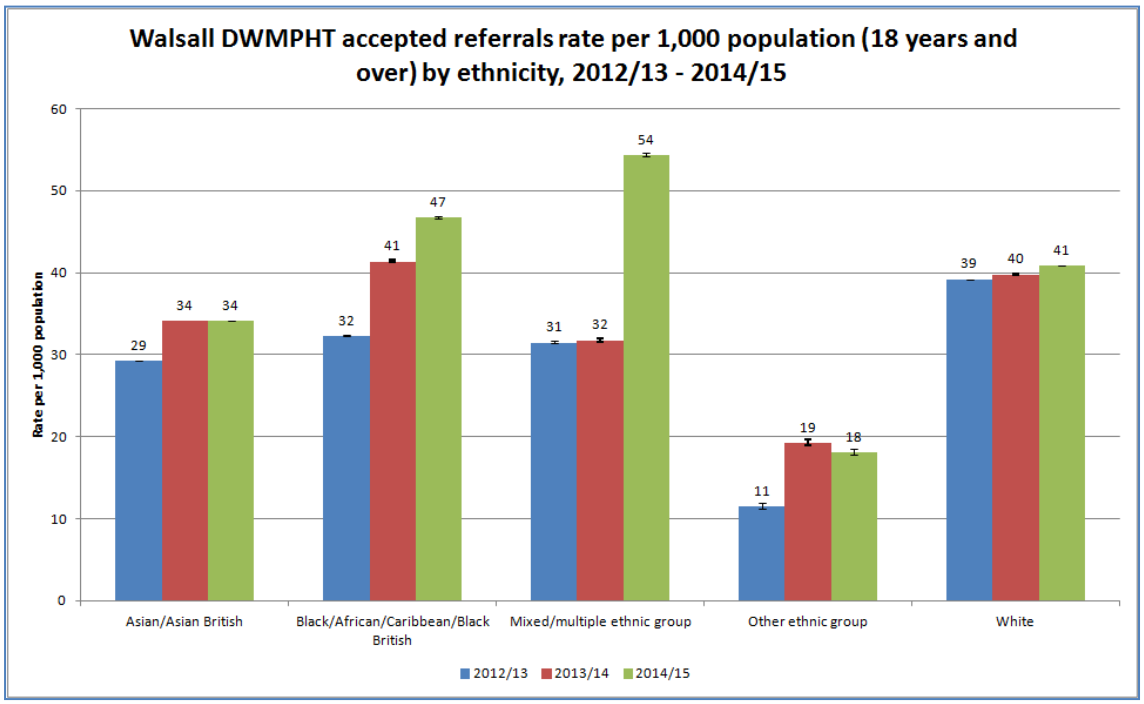
Source: DWMPHT

The vast majority of Walsall DWMPHT accepted referrals were white ethnic group (20,253) with 8% (3,709) from minority ethnic group over the last three years[††††].

The highest rates of Walsall adult DWMPHT service users is seen in the Mixed/Multiple ethnic group , followed by the Black Ethnic group in 2014/15 (Figure 58). The lowest rate was observed in Other ethnic group followed by Asian ethnic group which have shown little variation over time. The Black ethnic group has seen an increase in rates between 2012/13 and 2014/15, though the most marked increase is seen in the mixed/multiple ethnic group.

[††††] Those accepted referrals which had ethnic group recorded as Not stated/Not Recorded/Unknown were removed from calculations but represented 8% of total number of accepted referrals between 2012/13 and 2014/15.

Figure 58: Walsall DWMPHT accepted rate per 1,000 by ethnicity, 2012/13 - 2014/15



Source: DWMPHT

Note: Accepted referrals: At least one face to face contact.

The top five reasons for referral were Mood disorders, Organic mental disorders, Schizophrenia and delusional disorders, Personality disorders and Neurotic disorders (Table 18). For Mood (Affective) disorders (33% of all referrals), under half of these were bipolar affective disorders (44%) followed by depressive disorders (40%). Organic, including symptomatic mental disorders account for a further 31% of accepted referrals mainly related to Dementia. The increase in diagnosis over the last 3 years is largely contributed to better coding practices.

Table 18: Accepted Referrals to DWMPHT by top 10 diagnoses.

Accepted Referrals Diagnosis (ICD10 Block)	ICD10 Codes	2012/13	2013/14	2014/15
Mood [affective] disorders	F30 - F39	1471	1857	3648
Organic, including symptomatic, mental disorders	F00 - F09	776	1066	2116
Schizophrenia, schizotypal and delusional disorders	F20 - F29	853	1022	1951
Disorders of adult personality and behaviour	F60 - F69	505	472	1152
Neurotic, stress-related and somatoform disorders	F40 - F48	308	501	1069
Mental and behavioural disorders due to psychoactive substance use	F10 - F19	286	422	696
Symptoms and signs involving cognition, perception, emotional state and behaviour	R40 - R46	35	70	111
Persons encountering health services for specific procedures and health care	Z40 - Z54	54	44	31
Behavioural syndromes associated with physiological disturbances and physical factors	F50 - F59	24	45	44
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	F90 - F98	10	29	64
Persons encountering health services for examination and investigation	Z00 - Z13	27	36	27
Mental retardation	F70 - F79	8	17	49
Persons with potential health hazards related to family and personal history and certain conditions influencing health status	Z80 - Z99	11	16	30
Persons with potential health hazards related to socioeconomic and psychosocial circumstances	Z55 - Z65	33	6	17
Episodic and paroxysmal disorders	G40 - G47	13	13	16
All other diagnosis aggregated due small numbers		31	29	38
Total Number of diagnosis		**4,445**	**5,645**	**11,059**
Total Number of Accepted Referrals		**8,372**	**8,685**	**8,782**
Total Number of Unique Service Users		**4,164**	**4,177**	**4,463**

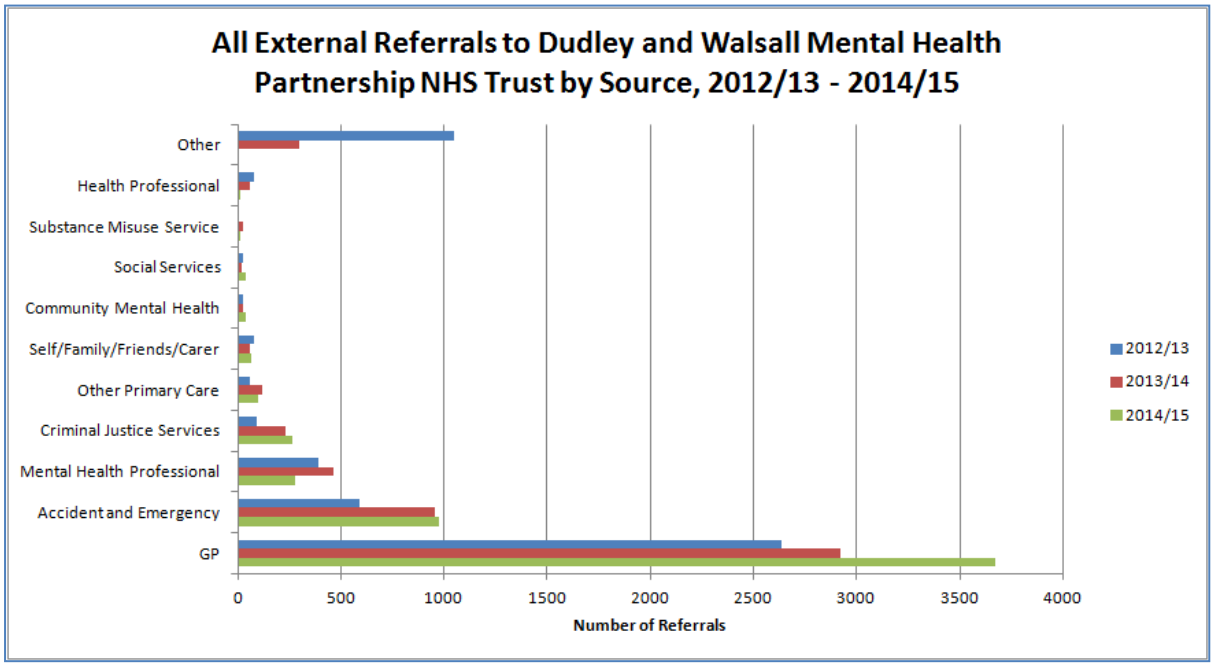
Source: DWMPHT

Note: Accepted referrals at least one face to face contact and primary and secondary diagnosis based on ICD10 codes and each admission may have multiple diagnoses

Mental Health Service Referral Source

Over half (59%) of all external referrals received by DWMPHT came from general practitioners in the last three years (Figure 59), followed by referrals from accident and emergency(see Figure 60). It is not possible to comment whether the increase is for appropriate referrals. The increase in referral from A&E could be positive down to cases being picked up by Psychiatric Liaison team, or represent insuffient management of cases in the community to prevent crisis.

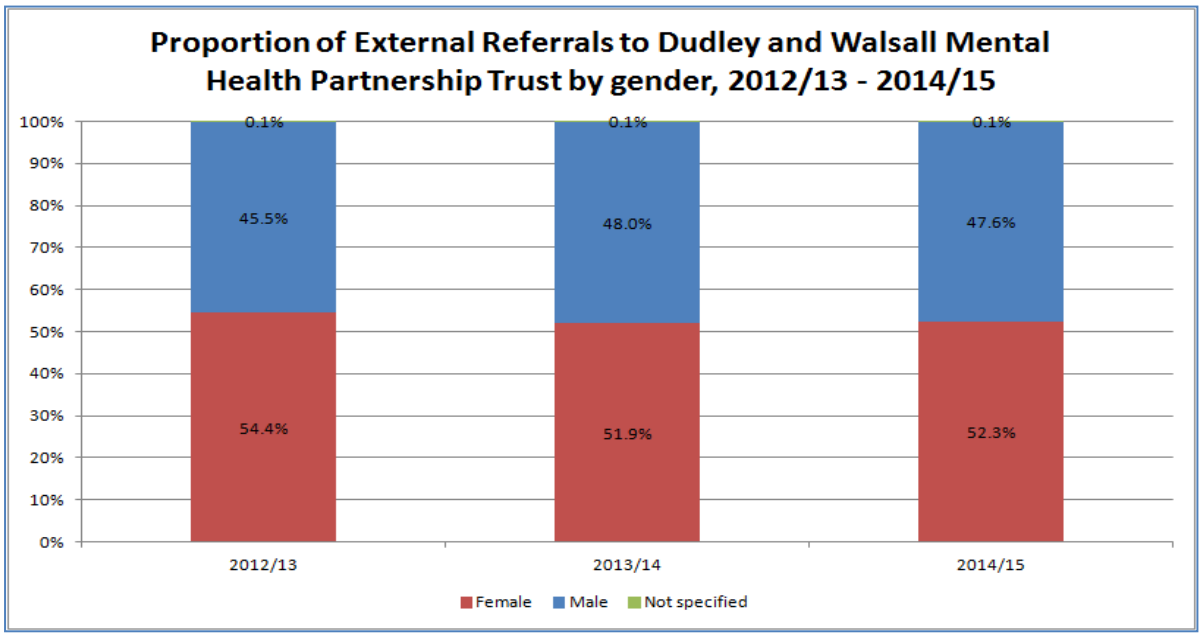
Figure 59: Mental Health Trust External Referrals by Source, 2012/13 - 2014/15



Source: DWMPHT

Note: The data above represents all external referrals received by DWMPHT.

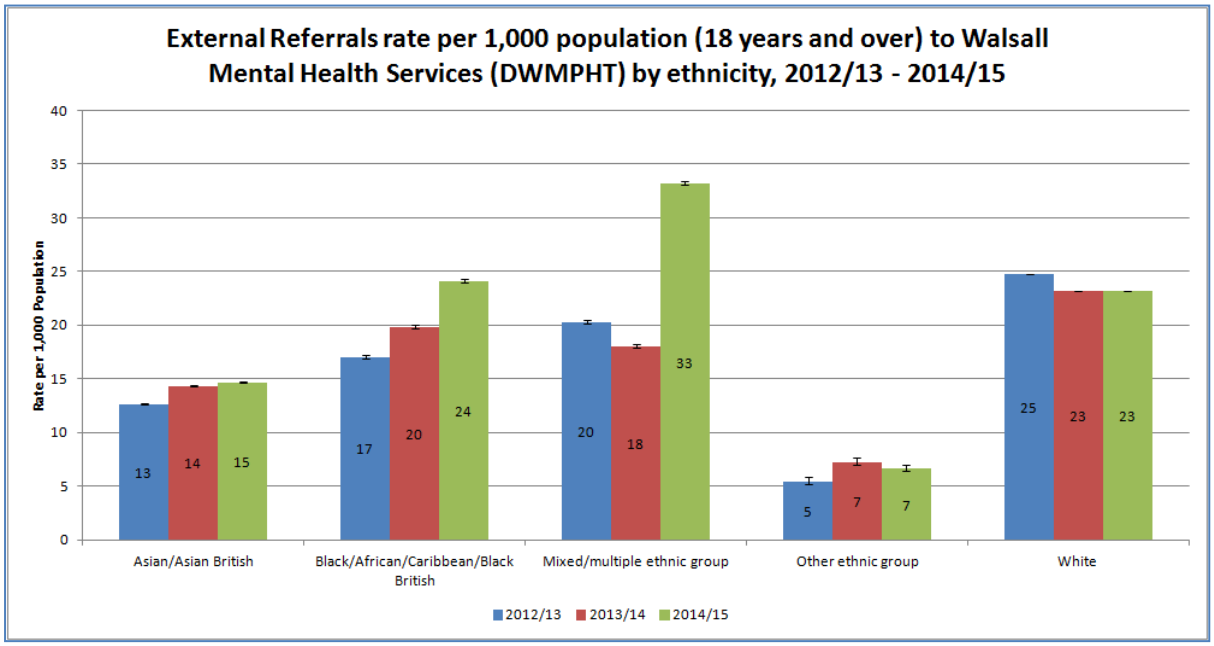
Figure 60: External Referrals to DWMPHT by gender, 2012/13 - 2014/15



Source: DWMPHT

The vast majority of external referrals were patients from White ethnic group (87.6%) consistently for each of last three years with 12.4% from ethnic minority group. A comparison of rate of referrals by ethnic groups indicates the highest rates are attributed to patients from the Mixed/multiple ethnic group (33 per 1,000) followed by Black ethnic group (24 per 1,000) with most groups showing an upward trend except White and other ethnic groups (see Figure 61).

Figure 61: External Referrals rate per 1,000 by ethnicity, 2012/13 - 2014/15



Source: DWMPHT

Note: 12.5% of external referrals did not have ethnicity recorded and they have been removed from the above rate calculation.

Waiting times for Mental Health Services

The waiting times for DWMPHT are based on front door services and are very much dependent on the service area. It can range from no waiting lists for crisis and psychiatric liaison services to 1 week on average for Early Access Service and over 2 weeks for Older Adults community mental health teams (Table 19).

Table 19: Waiting times for DWMPHT (Weeks), March 2016

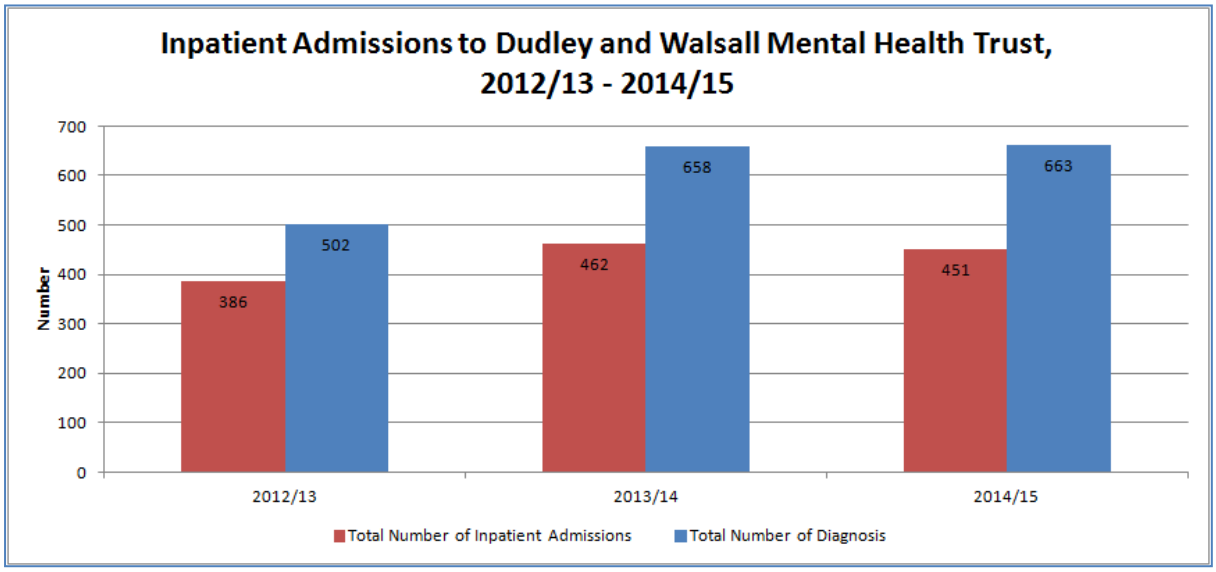
Team	Waiting Times (Weeks) – as at 27th June 2016
Early Access Service	1.0
Older Adults CMHT	2.2
Memory Service	1.8

Source: DWMPHT

Inpatient services

There were 451 service users (Adults and Older Adults) admitted to inpatient services in 2014/15 which shows a slight decrease on previous year, though over the three years there has been an upward trend in admissions.

Figure 62: Inpatient Admissions to DWMPHT, 2012/13 - 2014/15

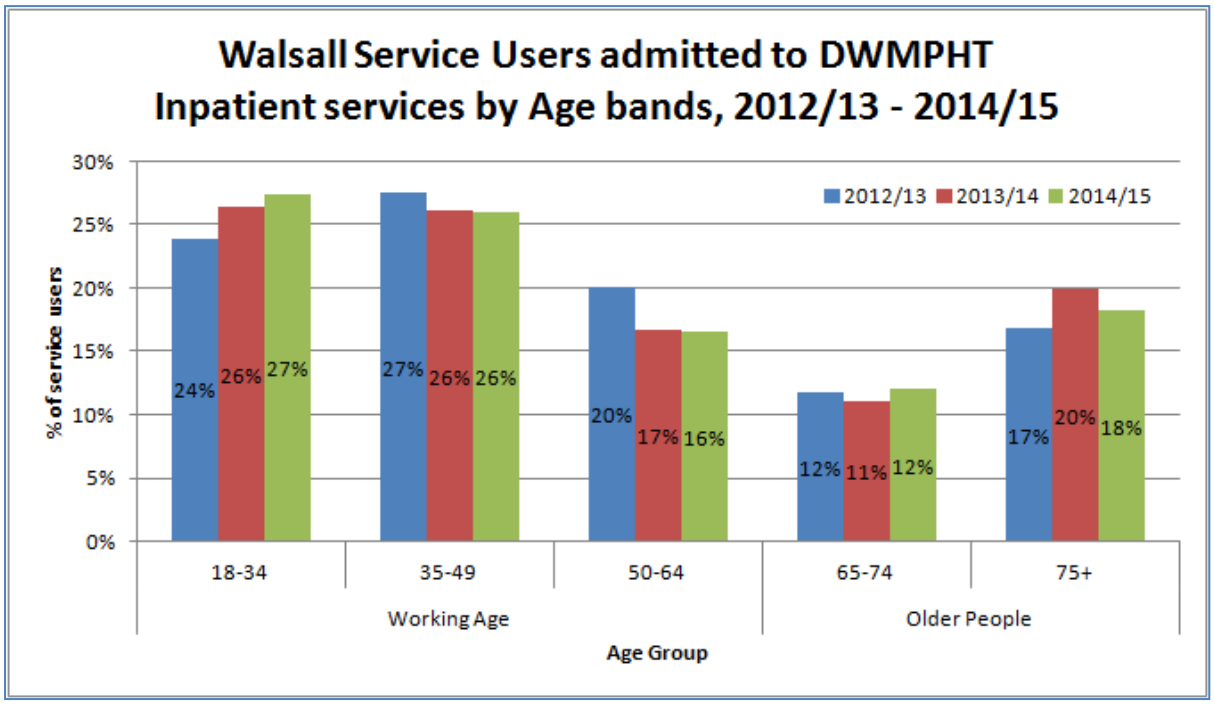


Source: DWMPHT

Mirroring the trend in referrals, a higher proportion of females to males (51%:49%) on average were admitted over the last three years, and the 18-49 age range accounted for

over half (52%) of the patients admitted to inpatient services between 2012/13 and 2014/15 (see Figure 63).

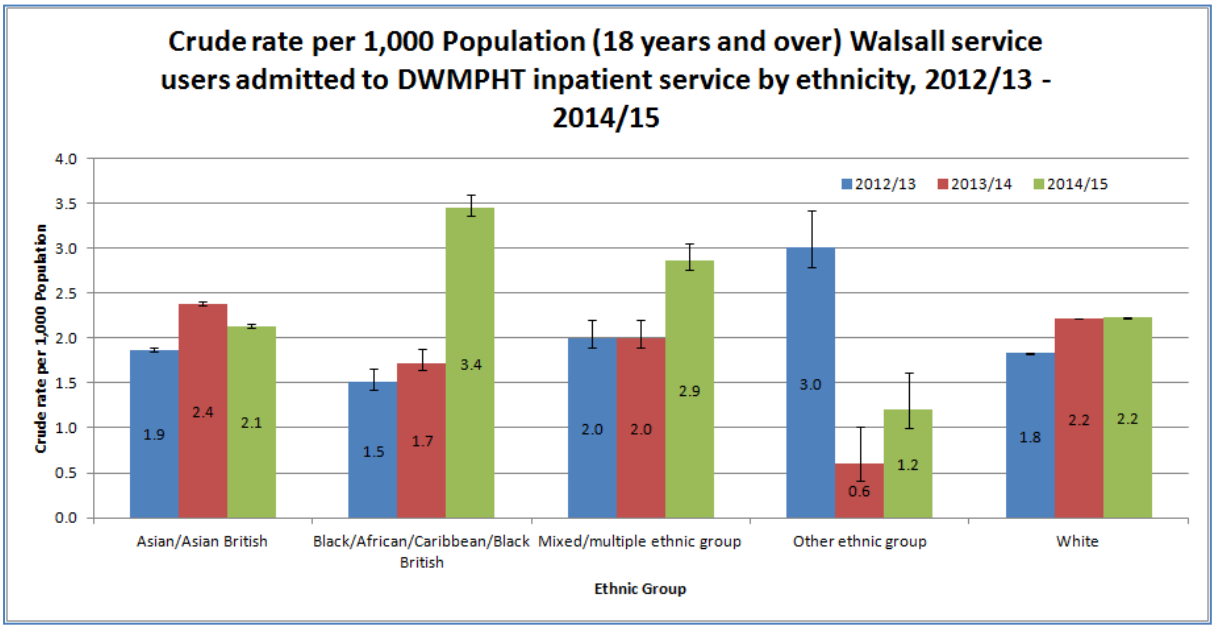
Figure 63: Inpatient Admissions by Age band, 2012/13 - 2014/15



Source: DWMPHT

The highest rate of inpatients was for individuals from the Black ethnic group (3.4 per 1,000) followed by Mixed/multiple ethnic group (2.9 per 1,000) in 2014/15. Overall the rates of inpatient admission have seen a significant increase in these two ethnic group; Black ethnicity group 2.3 times higher in 2014/15 than 2012/13 and 1.5 times higher for Mixed ethnic group during the same period (see Figure 64).

Figure 64: Rate per 1,000 Population Admitted to Inpatient service by ethnicity, 2012/13 - 2014/15



Source: DWMPHT

The top five diagnosis for inpatients mirrors those for referrals to the Trust, except for Organic mental disorders, and instead Disorders due to Psychoactive substance use was the third highest diagnosis. Affective (Mood) disorders are the most common cause (37%) – under half of these were bipolar affective disorders (44%) followed by depressive disorders (40%). Schizophrenia and related disorders account for a further 31% of admissions. Walsall inpatients diagnosis ratio (admissions compared with diagnosis) has increased over 3 years which has been attributed to better coding practices (Table 20).

Table 20: Inpatient admissions to DWMPHT by diagnosis, 2014/15

Diagnosis (ICD10 Block)	2012/13	2013/14	2014/15
Mood [affective] disorders	218	241	242
Schizophrenia, schizotypal and delusional disorders	87	125	142
Mental and behavioural disorders due to psychoactive substance use	50	70	79
Neurotic, stress-related and somatoform disorders	41	66	65
Disorders of adult personality and behaviour	33	54	58
Other degenerative diseases of the nervous system	*	*	19
Organic, including symptomatic, mental disorders	31	36	16
Persons encountering health services for examination and investigation	6	12	9
Persons with potential health hazards related to family and personal history and certain conditions influencing health status	*	5	8
Episodic and paroxysmal disorders	5	*	6
Symptoms and signs involving cognition, perception, emotional state and behaviour	*	13	5
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	6	5	*
Persons encountering health services in other circumstances	7	6	*
Other Diagnosis	14	17	7
Total Number of Diagnosis	**502**	**658**	**663**
Total Number of Inpatient Admissions	**386**	**462**	**451**
Ratio of diagnosis: Admissions	**1.3**	**1.4**	**1.5**

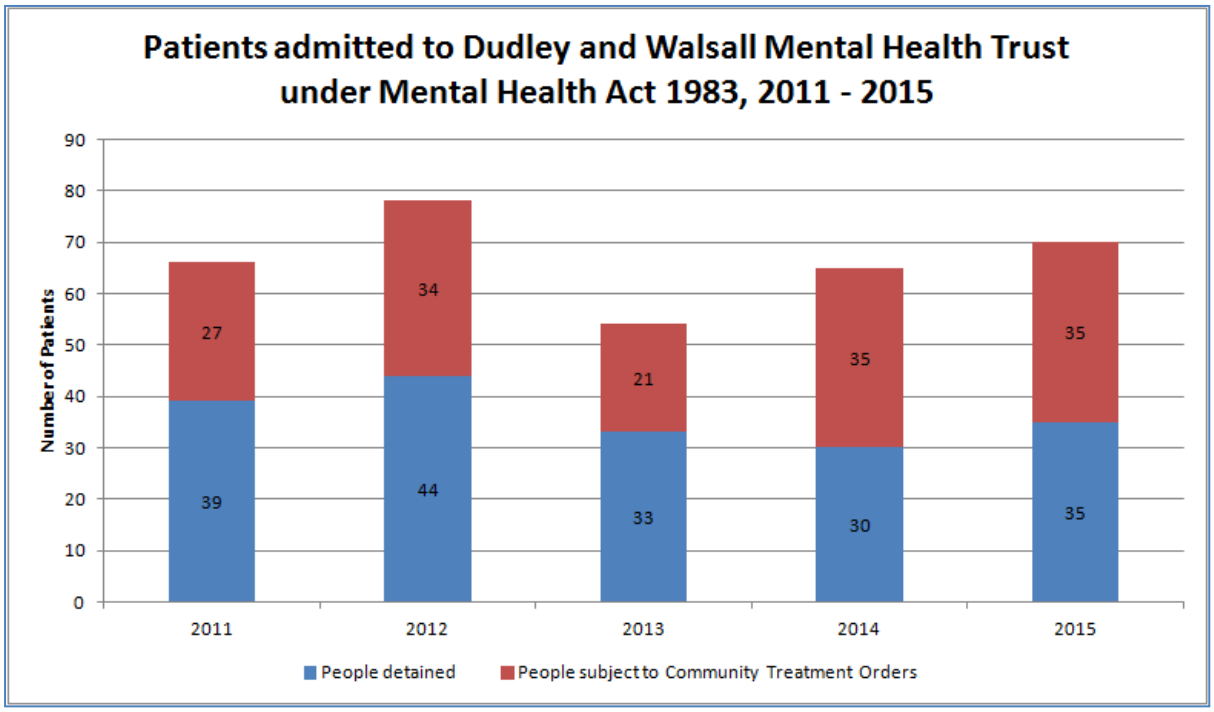
Source: DWMPHT

Notes: Primary diagnosis based on ICD10 codes and each admission may have multiple diagnoses

There were a total of 70 people subject to the Mental Health Act 1983 in 2015. Of these, 35 were detained in Dudley and Walsall Mental Health Trust and 35 were being treated under

Community Treatment Orders (CTOs). There has been a steady increase in detentions since 2013, though numbers have remained below the peak seen in 2012. However the numbers are for all patients detained, and not just Walsall patients. The increased detentions could indicate a real increase in need with insufficient provision to prevent significant deterioration or a crisis (Figure 65).

Figure 65: Inpatients formally detained in Dudley and Walsall Mental Health Trust, 2011-2015



Source: Health and Social Care Information Centre (HSCIC)

http://www.hscic.gov.uk/searchcatalogue?productid=19118&q=title%3a%22Inpatients+formally+detained+in+hospitals+under+the+Mental+Health+Act%22+&sort=Most+recent&size=10&page=1#top

Caveat: Not all these patients will be Walsall residents or Walsall GP registrations.

Mental Health Act (MHA) 136 Sections

The police can use section 136 of the mental health act to take an individual to a place of safety when they are in a public place. They can be kept under the section for up to 72 hours and the person requires a mental health act assessment by qualified and approved mental health professionals.

DWMHPT report that 155 patients used the 136 suite over the last two years with higher proportion of men (66%). There has been a reduction of people using the 136 suite from 100 individuals in 2013/14 to 55 in 2014/15.

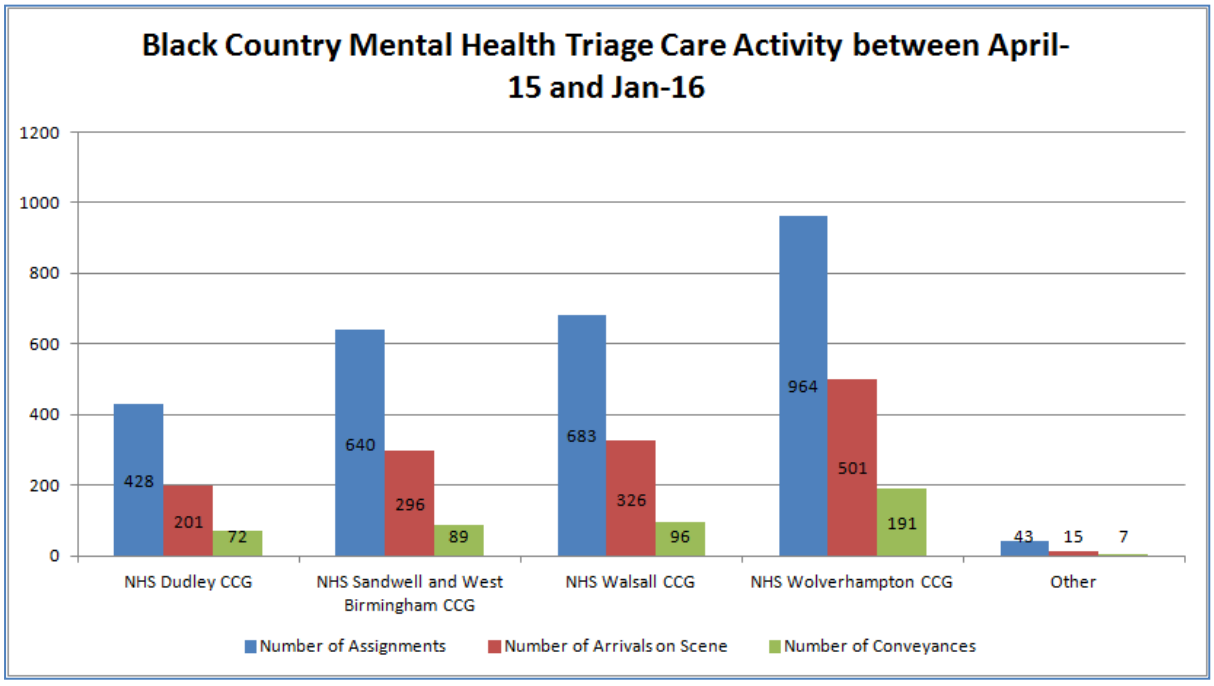
Triage Car

The Triage Team is a multi-agency approach to dealing with individuals in Mental Health Crisis comprising of police, paramedic and a community psychiatric nurse. The triage team operate in a marked paramedic vehicle and respond to calls generated by police/ ambulance control (including 111 calls) and will provide rapid assessment of patients.

The Black Country Mental Health Triage Car attended 683 assignments for NHS Walsall CCG, with 326 arrivals on scene and 96 conveyances between April 2015 and Jan 2016 (29% of all incidents attended by triage car). For 252 arrivals on scene, the chief complaint related to a mental health incident‡‡‡‡ for Walsall, which represented three quarters of all those arrivalsl (77%) in that period.

The Triage car was involved in 51 MHA 136 sections between April-15 and Jan-16 in Walsall, with around 73 cases prevented from the application of the section. Across the Black Country, only Wolverhampton CCG had more assignments than Walsall CCG (Figure 66).

Figure 66: Mental Health Triage Car Activity between April-15 and Jan-16



Source: West Midlands Ambulance Service NHS Trust

Improving Access to Psychological Therapies

Improving access to psychological therapies (IAPT) was developed to support the frontline NHS in implementing National Institute for Health and Clinical Excellence (NICE) for people suffering from depression and anxiety disorders[139].

‡‡‡‡ Mental health (including Running calls mental health team), Overdose, Psychiatric or Suicide, Psychiatric problems, Suicide and section 136.

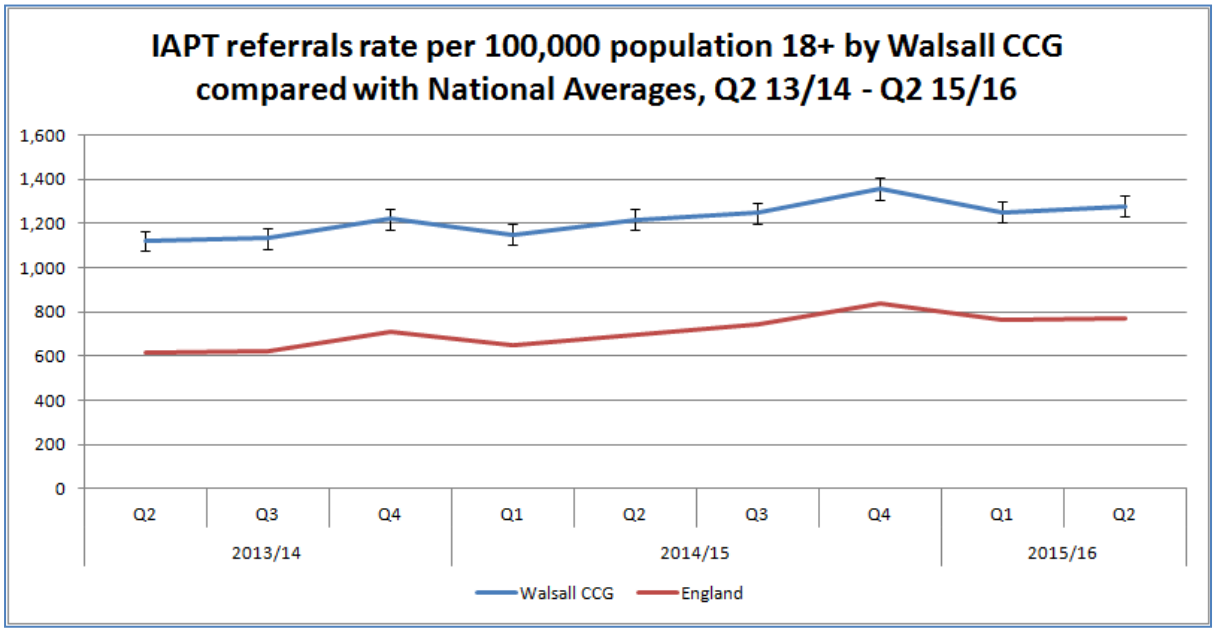
The IAPT provision in Walsall is delivered by Dudley and Walsall Mental Health Trust (Talking Therapies). The quarterly referral rate in Q2, 2015/16 showed that Walsall achieved a rate of 1,279 per 100,000 population aged 18+; compared to 773 per 100,00 for England.

Between 1 April 2014 and 31st March 2015, 10,340 referrals were received by IAPT service. 6,470 referrals entered treatment for which 7.7 days was the average waiting time between the referral and the first treatment appointment[140].

2,320 referrals finished a course of treatment. 1,485 (63.9%) started treatment at caseness[§§§§] of which 960 (43.8%) moved to recovery and 940 (42.8%) showed reliable recovery.

Waiting times for IAPT (referral to first treatment) is monitored in terms of waiting more than 28 days. The percentage of referrals in 2014/15 waiting more than 28 days was 7%. This is lower than the England average of 33%.

Figure 67: IAPT Referral Rate for Walsall CCG, Q2 2013/14 - Q2 2015/16

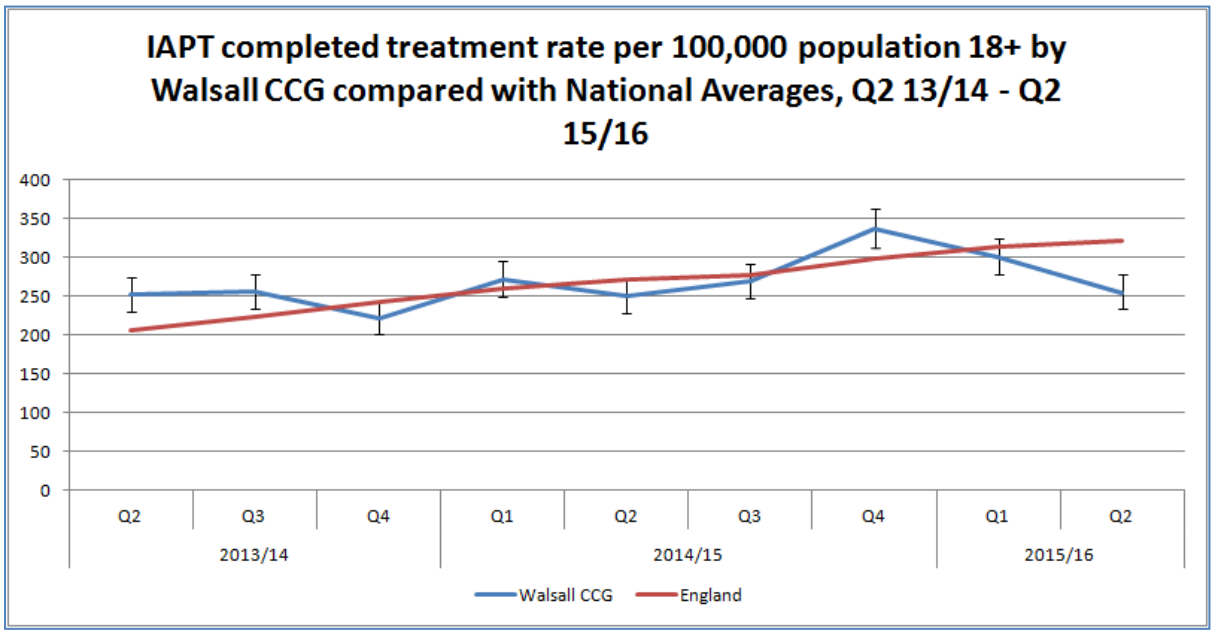


Source: HSCIC

Benchmarking completion of treatment shows that Walsall CCG as of quarter 2 2015/16 had lower than average completion rate compared with England. The last three quarters have shown a downward trend in contrast to national upward trend (see Figure 68).

[§§§§] Caseness is the threshold

Figure 68: IAPT treatment completion rate for Walsall CCG, Q2 2013/14 - Q2 2015/16



Source: HSCIC

Dudley and Walsall Mental Health Trust reported that approximately 10,449 referrals in 2014/15 slightly higher than reported by health and social care information centre which may be due to criteria used and validation by information centre. The table below shows the source of the referrals to IAPT service with GPs (62%) being highest referrers followed by self-referrals by patients (36%).

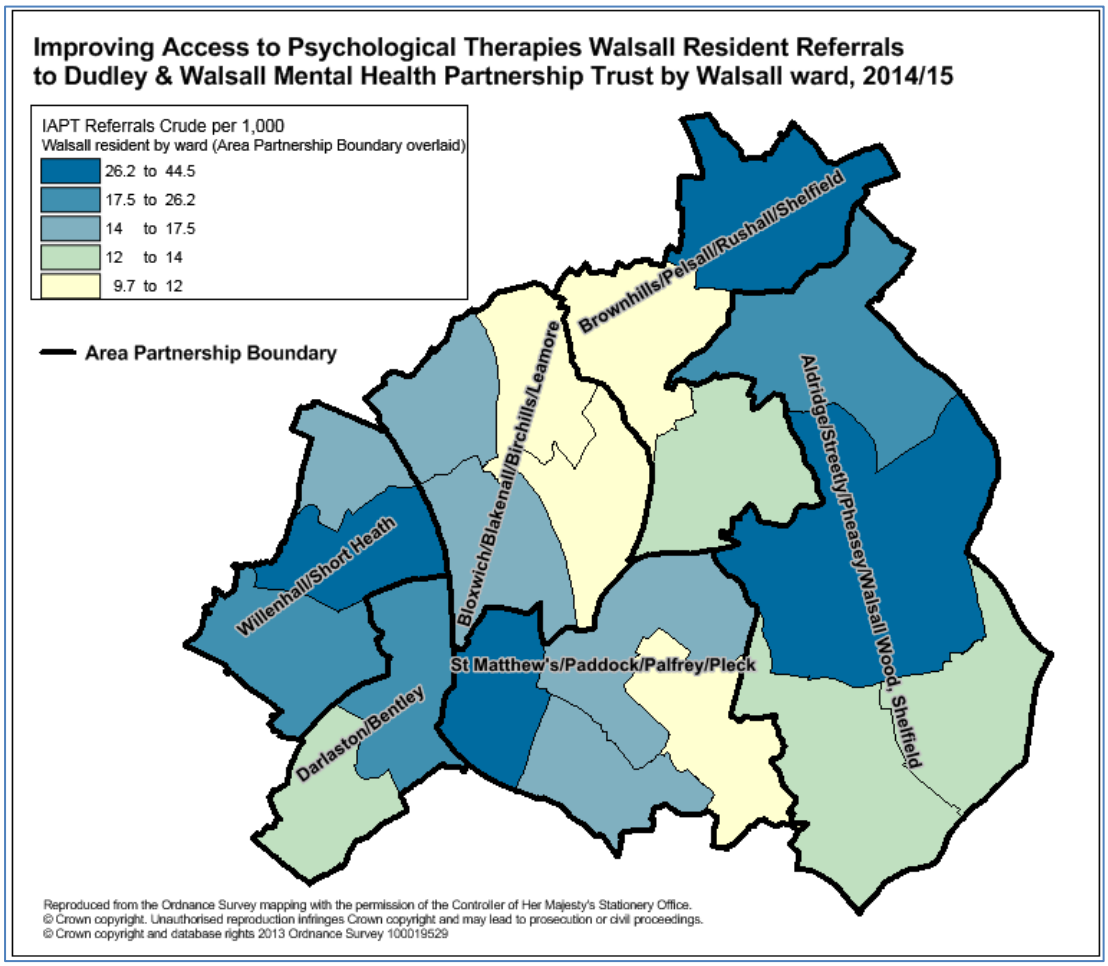
Figure 69: Source of Referrals to IAPT, 2014/15

Referral Source	Number of Referrals	Percentage
GP	6,456	62%
Self-Referral	3,800	36%
Other	184	2%

Source: DWMPHT

The highest rate of IAPT referrals come from residents living mainly in east side of the borough (Brownhills 44.7 per 1,000 and Aldridge Central & South 38.1 per 1,000), however there are wards in central and west part of the borough that also have high rate of IAPT referrals such as Willenhall/Short Heath (Figure 70).

Figure 70: IAPT Referrals per 1,000 populations (18 and over) by Walsall Wards

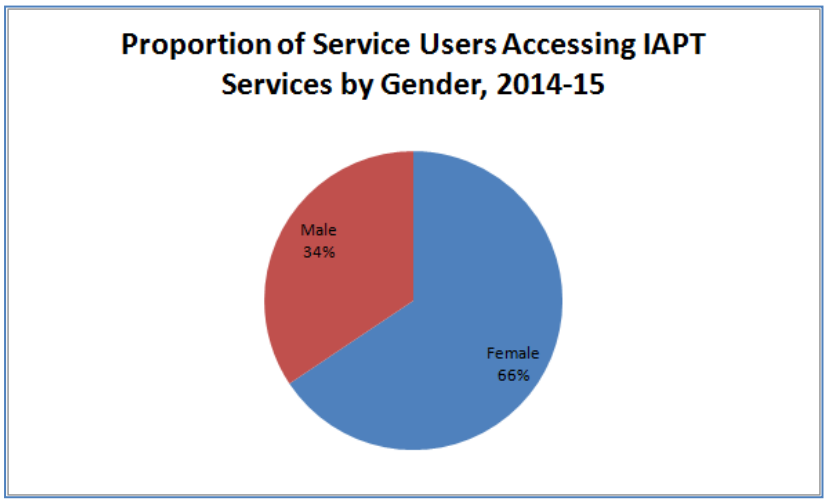


Source: DWMPHT

http://www.hscic.gov.uk/catalogue/PUB19098

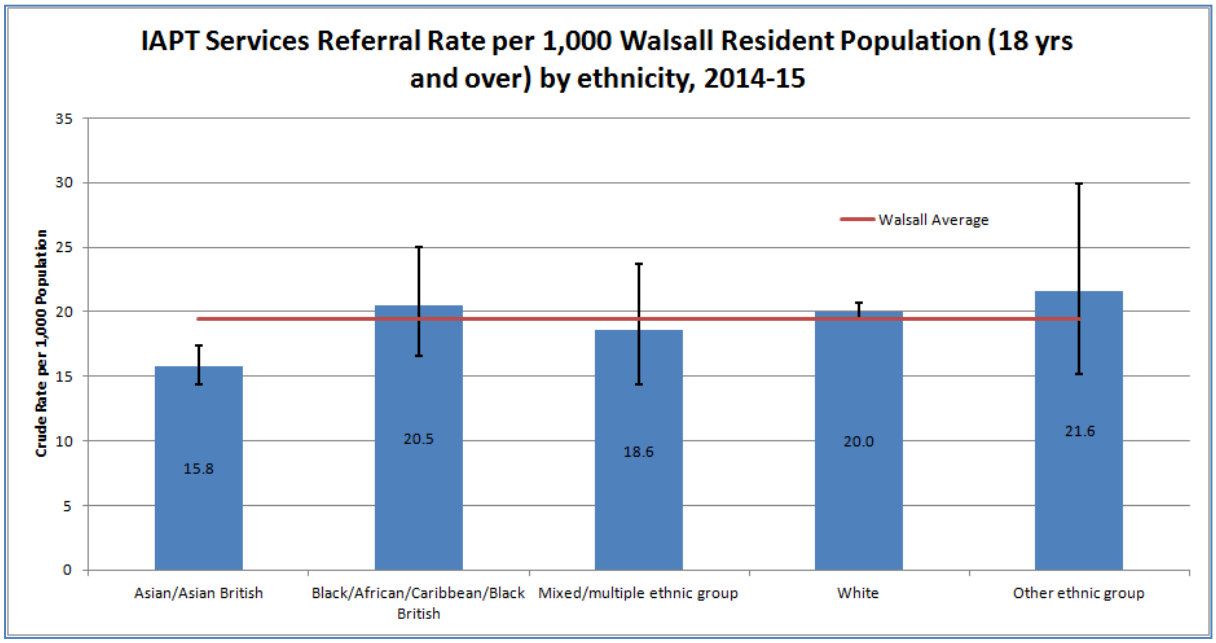
Two thirds of IAPT referrals were females (66%) and 15.7% of all referrals were from BAME community. Asian ethnic group (15.8 per 1,000) had significantly lower rate compared with other groups and the Walsall average of 19.5 per 1,000 (see Figure 72). Intelligence is not available on the use if IAPT service by some of the vulnerable groups eg pregnant/post natal women, or by those with a Long term condition.

Figure 71: IAPT Service Users by Gender, 2014-15



Source: DWMPHT

Figure 72: IAPT Referral rate per 1,000 by ethnicity, 2014-15



Source: DWMPHT

Note: Not recorded or not stated status of service users were excluded from data, which represented only 0.03%.

Primary care

Primary care is the first point of contact for most people and is delivered by a wide range of independent contractors, including GPs, dentists, pharmacists and optometrists, as well as NHS walk-in centres and the NHS 111 telephone service[141].

GP

For majority of patients the GP is the first point of call when faced with a mental health and wellbeing issue. The majority of common mental health conditions are diagnosed and managed in primary care. Up to half of people with a serious mental illness are seen only in a primary care setting. A range of QOF indicators incentivise GPs for the provision of quality care for those suffering from depression, dementia and severe mental illness. Walsall CCG's performance was higher than national for all these indicators in 2014/15 (Appendix on page 183). However there is some variation across the practices for all indicators, and is more marked for 'The percentage of patients with a new diagnosis of depression who have had a bio-psychosocial assessment by the point of diagnosis'.

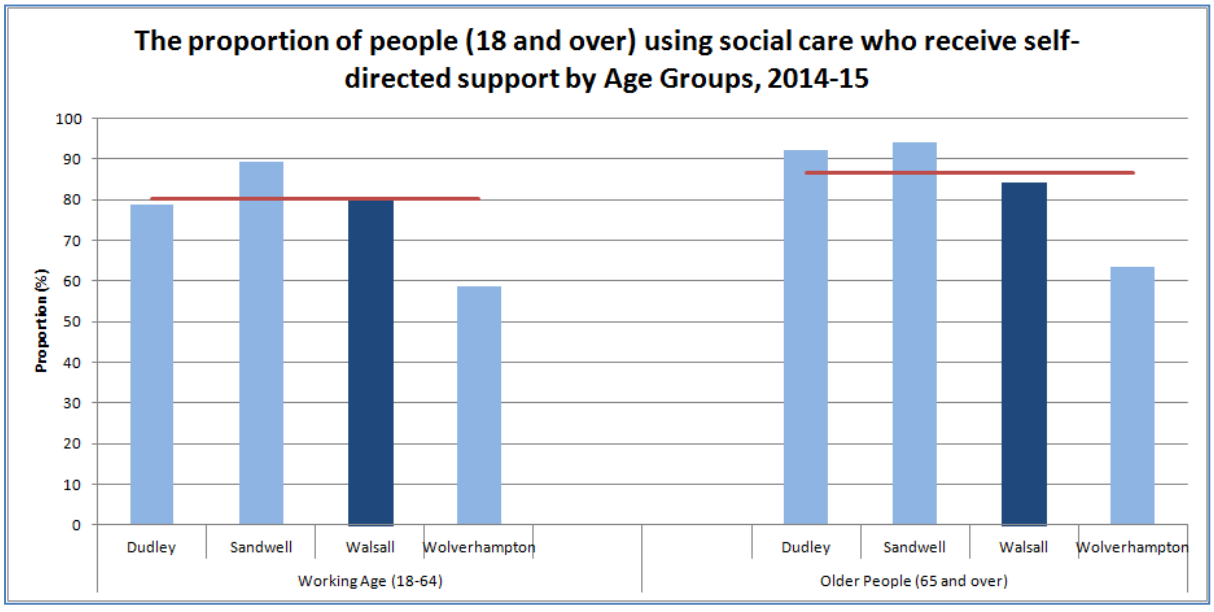
Link to GP Practice Profiles

Adult Social Care Services

In 2013/14 120 people with mental health illness were receiving support from Adult Social Care which represents a rate of 75 per 100,000. This is statistically significantly lower than the regional (256 per 100,000) and national averages (391 per 100,000)[142].

The proportion of people in Walsall using community-based social care services and who receive self-directed support, such as personal budget, is presented (Figure 73). Self-directed support gives people more choice over how their care and support works. A higher score is better. The proportion of those receiving self-directed support is similar to national average at 80.8 per cent for working age (18-64) and 84.1% for older people (65 and over) and other Black Country local authorities.

Figure 73: People using social care who receive self-directed support, 2014/15



Source: Adult Social Care Outcomes Framework, HSCIC

The tables below show the number of Walsall residents that received social care related supported by Walsall council.

Figure 74: Number of individuals diagnosed with Dementia and receiving a range of Social Care support

Dementia	2014/15	2015/16
Community (Supported) Living	*	*
Direct Payments	50	61
Daycare	8	*
Homecare	15	14

*suppression of numbers smaller than five.

Figure 75: Number of individuals with a non-Dementia diagnosis and receiving a range of Social Care support

Non-Dementia	2014/15	2015/16
Community (Supported) Living	34	40
Direct Payments	35	31
Daycare	7	5
Homecare	31	36

Source: Walsall Council, Adult Social Care.

There was an increase in the number of people with Dementia receiving Direct Payments, and those without Dementia getting support with Community Living and HomeCare, over the two year period. This is however a very small snaphot of the social care provision and no conclusions are drawn from it. The breakdown by type of stay for Adults and Older Adults for 2015-16 is presented (Table 21). A previous analysis of variance by the CCG indicated that there was a reduction in numbers for each category from 2011/12 to 2013/14; 42% change (residential and nursing) for Adults (from 60 to 35) and 17% for Older Adults (126 to 105). The total residential and nursing home count for Adults in 2015/16 is slightly higher (43) than the total in 2013/14 (35); whereas for Older Adults there is a slight reduction (101 vs 105).

Table 21: Local Authority support of residential and nursing placements

Age profile	TypeOfStay	Tot al Number of Clients
<65	Nursing	23
	Residential	20
>65	Nursing	42
	Residential	59
Grand Total		**144**

Source: Walsall Council, Adult Social Care.

Commissioning for mental health

CCG Budget

In 2015-16, the CCG funding for commissioning of Mental Health (MH) services was £35.269 million, of which approx £3.8 million was earmarked for Child and Adolescent Mental Health services, £23.9 million for Adult services and £7.6 million for Older Adult services.

Table 22: Programme budgeting details-components of Mental Health spend, 2015-16

	CAMHS	Adult	Older People	Total	%	LD
	£000	£000	£000	£000		£000
NHS Contracts	3,339	18,786	6,832	28,957	82	2
Other contracts	408	476	218	1,102	3	
Non NHS Placements		4,091	593	4,683	13	
Non Contracted Activity		527		527	1	
TOTAL	**3,747**	**23,880**	**7,642**	**35,269**	**100**	**2**

Source: Walsall CCG

Of this total, approximately £29 million is for care commissioned from NHS providers (equivalent to 82%), through a combination of NHS block and cost and volume contracts. A further £4.9 million was committed with independent sector providers for long term packages of care in nursing homes and community settings, and approx £0.7 million was contracted with voluntary and small providers for Adult and Older Adult services. Over the last 3 financial years, there have been significant cost pressures for MH services, predominantly in care package costs with the independent sector, and the CCG has had to find funding in excess of £2 million to meet existing commitments. In addition, the contract with the main NHS provider has seen increases in activity for both inpatient and community services. Prior to 2016-17, Mental Health services had not been required to deliver any savings under the CCG QIPP programme, but given the size of the CCG QIPP targets for 2016-17 (around £22 million), MH services have been allocated a cash releasing savings target of approx. £2.7 million to be delivered by year end. This represents approximately 7% of 2016-17 base funding and is obviously a significant challenge for commissioners. However, it is hoped that it will be achieved following implementation of the strategy for Older Peoples services, by expanding the community infrastructure to allow a reduction of inpatient beds, together with redesign for Rehabilitation services, supporting patients in the community as opposed to admission into nursing home care. It is hoped that the needs assessment will also support the QIPP agenda, allowing the review of current commissioning arrangements and moving commissioned care to the areas of higher need.

SPOT Analysis

The SPOT analysis looks at the spend and outcomes for directorates such as Public Health, Adult Social Care in Local authorities and for programmes such as Cancer, Cardiovascualr

disease in clinical commissioning groups. The latest profile for Walsall (2015) shows that mental health programme ranks 2nd in total spend for Walsall CCG and the expenditure per head (£164) is higher than regional (£152) and national (£153) comparators (Figure 76). Whilst the expenditure per head is slightly higher, the outcomes are better than regional and national performance particularly for proportion of those with MH with a care plan, (higher than national) and higher level of access to IAPT services (23%) than regional and national levels.

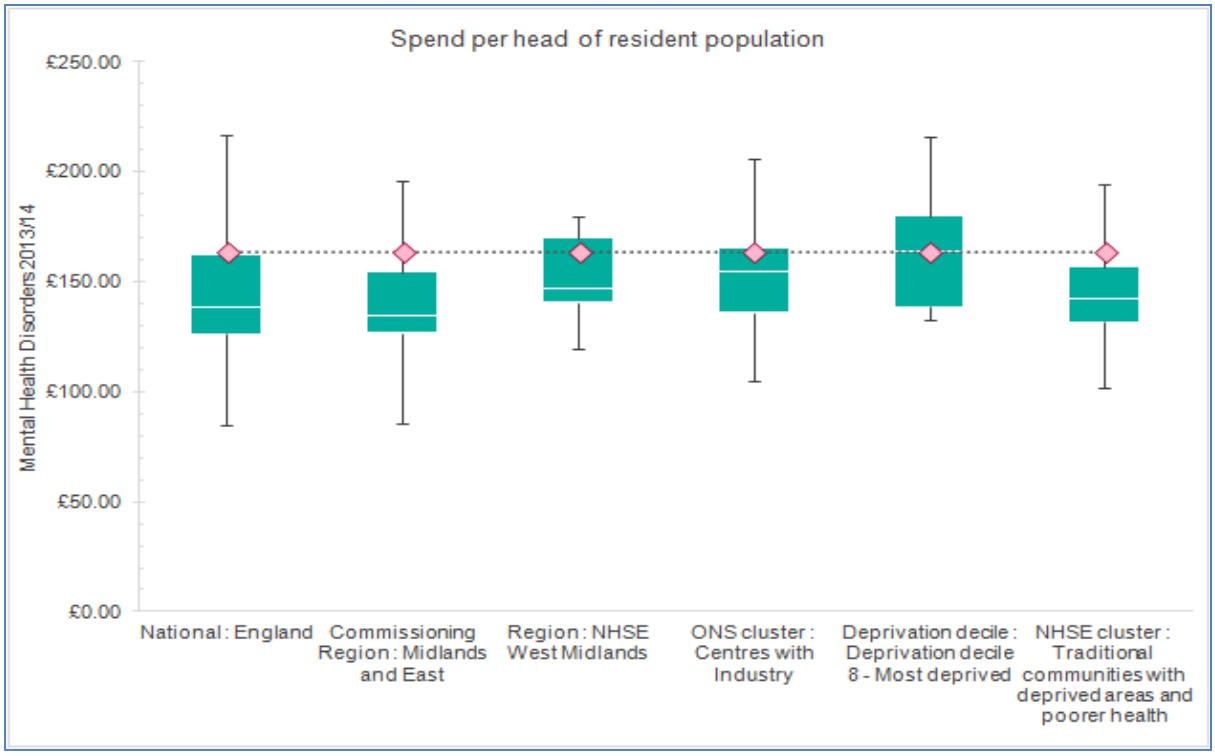
The access to psychological service for Asian patients is reported to be above the comparator areas including regional and national averages.

Figure 76: Mental Health related Spot analysis indicator for Walsall CCG, 2015

Selected measures for Walsall	Local value	Z score (-3 -2 -1 0 1 2 3)	National	Region	ONS cluster	Deprivation decile
Mental Health						
Mental Health Disorders	£164		£145	£152	£153	£161
% MH with comprehensive care plan (MH002 / MH10)	91%		86%	88%	87%	87%
% dementia whose care has been reviewed (DEM002 / DEM02)	82%		84%	84%	85%	85%
Access to IAPT services	23%		13%	14%	12%	11%

Source: PHE

Figure 77: Walsall resident population mental health spend per head against comparators



Source: PHE

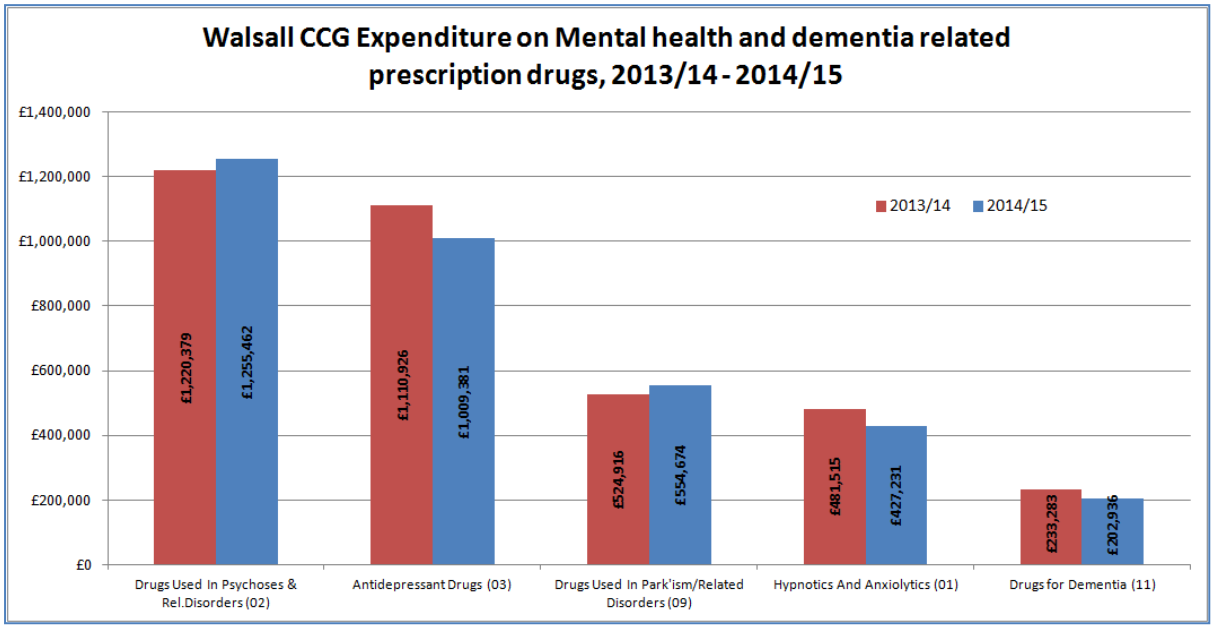
Local authority budget

Walsall Borough Council's annual budget on mental health related services is £5,538,711 and current forecast for 2015/16 indicates it will increase to £6,166,667. The major expenditure related to supporting residential and nursing costs, home care and support staff working in partnership with Dudley and Walsall Mental Health partnership trust (Social workers/Support workers/ Management and admin).

Medicine Management

Walsall CCG spent £47,512,956 on all prescriptions within primary care, of which 7.3% (£3,449,682) was related to Mental Health And Dementia(MHAD) treatments[*****]. The highest spend of MHADs was Drugs Used in Psychoses & Related disorders (£1,255,462) followed by Antidepressant drugs (£1,009,381) (Figure 78).

Figure 78: Walsall CCG Expenditure on Mental Health and Dementia related drugs, 2013/14 - 2014/15



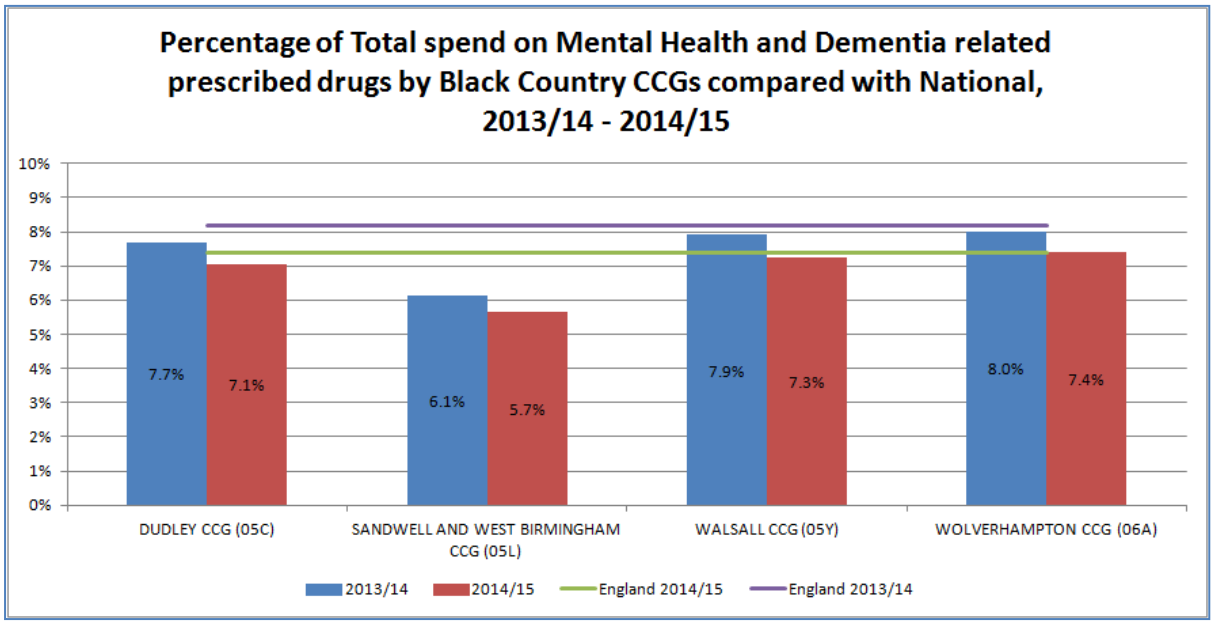
Source: HSCIC

Note: Within iView the British National Formulary sections the following listed have been used to identify mental health and dementia related prescriptions - Drug Used In Psychoses & Rel. Disorders, Antidepressant Drugs, Drugs Used In Park'ism/Related Disorders, Hypnotics And Anxiolytics and Drugs for Dementia.

[*****] Mental Health and Dementia Drugs: British National Formulary - Drug Used In Psychoses & Rel. Disorders, Antidepressant Drugs, Drugs Used In Park'ism/Related Disorders, Hypnotics And Anxiolytics and Drugs for Dementia.

Overall there was reduction in Walsall of 0.6% on the proportion of total prescribing spend on MHAD between last two years (2013/14 and 2014/15) (Figure 79). This mirrors the national and local Black Country comparator CCGs.

Figure 79: Proportion of total prescribing spend on mental health and dementia related drugs by Black Country CCGs, 2014/15



Source: HSCIC

Note: Within iView the British National Formulary sections the following listed have been used to identify mental health and dementia related prescriptions - Drug Used In Psychoses & Rel. Disorders, Antidepressant Drugs, Drugs Used In Park'ism/Related Disorders, Hypnotics And Anxiolytics and Drugs for Dementia.

Mental Health and Vulnerable groups

Maternal Mental Health

Depression and anxiety are the most common mental health problems during pregnancy, with around 12% of women experiencing depression and 13% experiencing anxiety at some point; many women will experience both. Depression and anxiety also affect 15-20% of women in the first year after childbirth[143].Teenage mothers have three times the rate of post-natal depression of older mothers and a higher risk of poor mental health for three years after the birth[144]. In 2013, there were 192 teenage conceptions (under 18) in Walsall with the rates of conceptions higher in Walsall (36.8 per 1,000) compared with national averages (24.3 per 1,000). Overall the teenage conception rate has fallen from 46.9 per 1,000 in 2012, however it still remains above regional and national averages[145].

The Joint Commissioning Panel for Mental Health (JCPMH) has suggested that rates of perinatal mental illness (PMI) can range from 2 to 300 per 1,000 maternities depending on the severity of PMI. An estimate of the numbers of women in Walsall that may fall into the different PMI categories using national rates is presented (Table 23).

Table 23: Estimated Prevalence of women affected by perinatal mental illness

		Number of women affected	
Perinatal mental illness	**Rate per 1,000 maternities**	**England**	**Walsall estimate***
Postpartum psychosis	2 per 1,000	1380	7
Chronic serious mental illness	2 per 1,000	1380	7
Severe depressive illness	30 per 1,000	20640	112
Post traumatic stress disorder (PTSD)	30 per 1,000	20640	112
Mild - Moderate depressive illness and anxiety states	100-150 per 1,000	86020	375-562
Adjustment disorders and distress	150-300 per 1,000	154830	562-1124

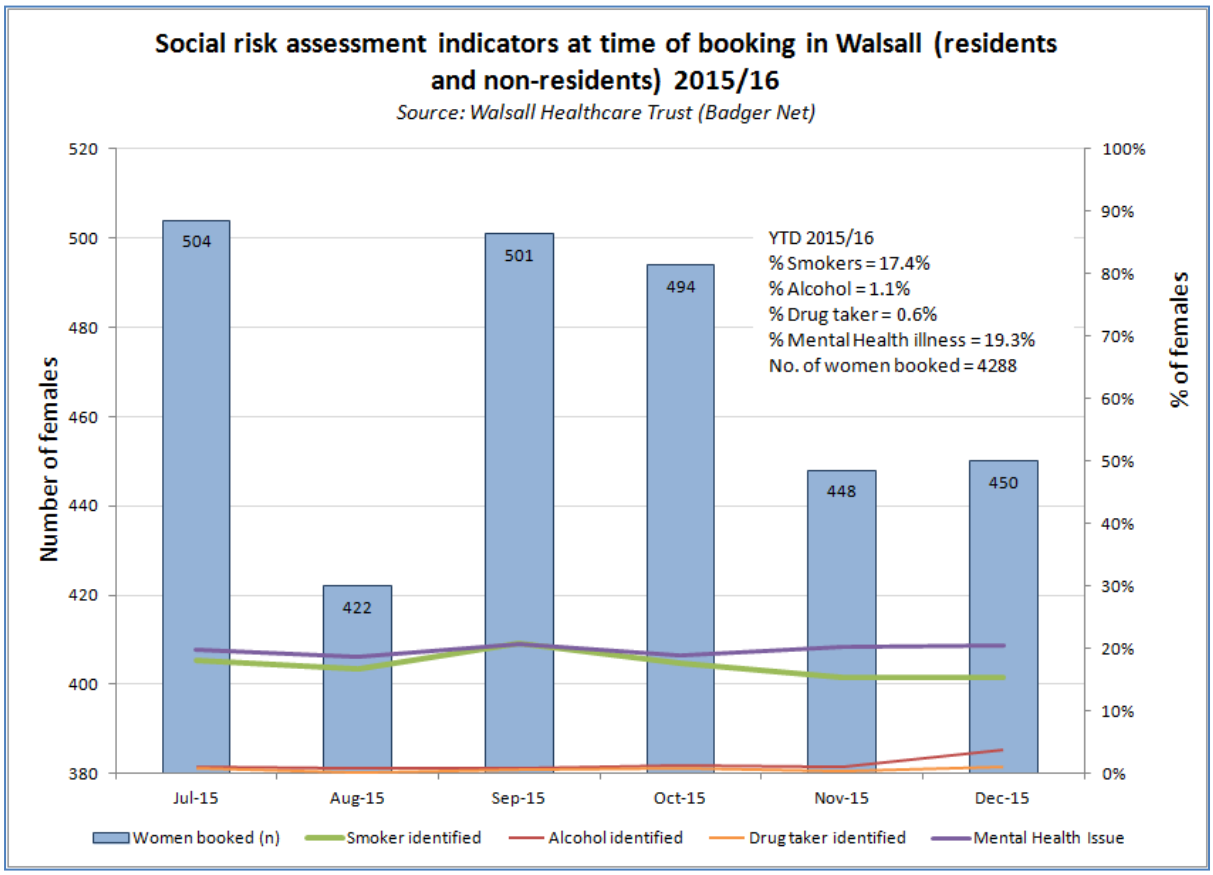
Source: Estimated using prevalence figures in guidance produced by the Joint Commissioning Panel for Mental Health in 2012 and ONS data on live births in England in 2011.

Caveat: There may be some women who experience more than one of these conditions

The midwifery service at Walsall Healthcare NHS Trust screen pregnant women for social risks indicators including identifying those with mental health conditions. 829 pregnant women were identified with mental health conditions by the midwifery service, ranging from low-moderate and severe, which was 19.3% of all pregnant women seen by WHNT between April-15 and Dec-15(Figure 80). This suggests that around one in five pregnant women were identified with mental health concern by midwifery service at the WHNT.

Using the current maternity data, the projection for the whole year (2015/16) indicates that around 1,114 women could be identified with mental health issues. This figure is less than the lower end of the estimated prevalence (1175) and is likely to be down to the diagnosis used and thresholds (Table 15).

Figure 80: Social risk assessment indicators, Apr/15 - Dec/15



Source: WNHT, Badger Net

Links with emotional wellbeing and mental health

Maternal mental health during pregnancy and after birth can have lasting effects on not only the mother but the emotional health and development of the child. Young mothers are at an even greater risk. They can face social isolation, increased levels of poverty and are more likely to become lone parents. Young mothers need support throughout pregnancy and afterwards to help improve the outcomes for themselves and their children.

The infant mortality rate for babies born to teenage mothers is 60% higher than for babies born to older mothers; children born to teenage mothers have higher mortality rates under 8 years and are more likely to have more accidents and behavioural problems[146].

NICE recommends the screening of post-natal depression as part of routine care, and the use of psychosocial interventions and psychological therapy for women depending on the severity of depressive symptoms. However, research suggests that in practice a significant proportion of women with post-natal depression are missed in primary care[19].In 2015 the Department of Health found that the lack of support for mothers with mental health disorders contributes to a long term cost to society and to their children, of about £8.1 billion for each one-year cohort of births in the UK. Nearly three-quarters of this cost (72%) relates to adverse impacts on the child rather than the mother[147].

Service Provision

The midwifery service assesses women for mental health issues when women attend their booking appointment and will also note issues that might cause additional stress such as experiencing domestic abuse. If a referral is required, they will refer the woman to her GP.

DWMHT offer a service called Primary Mental Health and Talking Therapies that the women can self refer into or request a referral from her GP if she is feeling low.

Health Visitors assess women for mental health issues when they visit at 28 weeks and after birth and are able to offer low level support. If a referral is required, they will refer the woman to her GP for onward referral.

Learning Disabilities & Mental Health

People with learning disabilities demonstrate the complete spectrum of mental health problems, with higher prevalence than found in those without learning disabilities[148].

Prevalence

The latest QOF prevalence of Learning Disabilities in Walsall was 0.42% (1,167 adults), which was lower than regional (0.48%) and national average (0.44%). During 2014-15, there were 580 adults (18-64) with learning disabilities recieving long term support by Walsall LA. The Walsall rate of 3.61 per 1,000 was higher than regional average (3.50 per 1,000) and lower than national average (3.73 per 1,000).

National estimates of the prevalence of mental health problems in those with learning disabilities ranges between 30% and 50%. Table 24 shows for specific conditions the estimate numbers for Walsall LD population (based on QOF 2014/15 figures)[149,150,151].

Table 24: Estimate prevalence rates from population-based studies of adults with learning disability

Disorder	Rate	Estimated numbers Walsall LD Adults
Schizophrenia	3%	35
Bipolar affective disorder	1.50%	18
Depression	4%	47
Generalised anxiety disorder	6%	70
Specific phobia	6%	70
Agoraphobia	1.50%	18
Obsessive-compulsive disorder	2.50%	29
Dementia at age 65 years and over	20%	233
Autism	7%	82
Severe problem behaviour	10-15%	117-175

Source: Smiley E. Epidemiology of mental health problems in adults with a learning disability: an update. QOF 2014/15 Learning disability prevalence.

Link to Emotional Wellbeing and Mental Health

The prevalence of dementia is much higher amongst older adults with learning disabilities compared to the general population (21.6% vs. 5.7% aged 65+). People with Down's syndrome are at particularly high risk of developing dementia, with an age of onset 30-40 years younger than the general population[152].

Reported prevalence rates for anxiety and depression amongst people with learning disabilities vary widely, but are generally reported to be at least as prevalent as the general population[153] , and higher amongst people with Down's syndrome[154] (also refer Table 24).

Challenging behaviours (aggression, destruction, self-injury and others) are shown by 10%-15% of people with learning disabilities, with age-specific prevalence peaking between ages 20 and 49[155].

Service Provision

There is no dedicated service currently in Walsall to meet the mental health and wellbeing needs of those with a Learning Disability. This has been identified as a significant gap in the stakeholder consultation.

Attention Deficit Hyperactivity Disorder & Mental Health

The definitions of Attention Deficit Hyperactivity Disorder (ADHD) are based on high levels of impulsivity, hyperactivity and inattention[156]. ADHD can overlap with symptoms of other related disorders; common coexisting conditions in adults include personality disorder, bipolar disorder, obsessive-compulsive disorder and substance misuse.

Prevalence

The prevalence of ADHD in adults is estimated between 2% and 4%. Follow-up studies of children have found that by age 25 only 15% retained the full diagnosis and 65% fulfilled criteria for ADHD or in partial remission[157]. Applying these prevalence estimates to Walsall population would suggest that about 3,712-7,425[†††††] of adults (25 years and over) may have a partial or fully diagnosed ADHD.

Link to Emotional Wellbeing and Mental Health

Maternal smoking, substance misuse and alcohol consumption during pregnancy, low birth weight, fetal hypoxia and brain injury, poor family relationships are all considered risk factors for ADHD. Self-harm, a predisposition to road traffic and other accidents, substance misuse, delinquency and academic underachievement are some of the associated problems seen in those with ADHD[158]. The association between ADHD and crime is becoming

[†††††] ONS 2014 Mid-year population estimates

increasingly recognised. Studies show that the rate of young people and adults with ADHD in the prison population far exceeds that in the general population. NICE recommends that ADHD is a factor that should be considered in the delivery of treatment services for offenders, starting with early intervention programmes and going on to rehabilitation and supervision of adult offenders.

Service provision

Walsall does not have a commissioned Attention Deficit Hyperactivity Disorder (ADHD) service. Dudley and Walsall Mental Health Partnership trust have developed a new a Consultant led adult Neurodevelopment service delivered from Dorothy Pattison hospital. They offer an assessment and advice on pharmacological treatments for patients suspected of, or who have a diagnosis of ADHD. It is offered on a spot purchase basis.

The service accepts referrals for individuals aged 16 years and over but does not accept referrals for adults with moderate to severe learning difficulties. Referrals are accepted from a number of agencies including GPs, local authorities, CCGs and other NHS providers. Access can be only gained on agreement by the relevant CCG.

Autism & Mental Health

Autistic spectrum disorder (ASD) is a condition that affects social interaction, communication, interest and behaviour. It includes Asperger syndrome and childhood autism[159]. The way that autism is expressed in individuals differs at different stages of life, in response to interventions and coexisting conditions such as learning difficulties. A significant proportion of adults with autism across the whole autistic spectrum experience social and economic exclusions. They are more likely to have coexisting mental and physical disorders, and other development discords[160].

Prevalence

The epidemiological data on adult prevalence of autism is limited and where information is available there is element of selection bias or extrapolation from childhood studies[161]. However a case-finding population survey in England found prevalence between 1-1.1%[162]. Applying this prevalence estimate to Walsall population could estimate that 2,096 – 2,306 people in Walsall are likely to have autism in adulthood.

Link to emotional welling and mental health

The prevalence of depression among people with higher-functioning autism, including Asperger syndrome, could be between 30-40%[163]. Autism can co-exist with other mental health diagnoses eg depression, social anxiety, obsessive-compulsive disorder, ADHD, eating disorders, personality disorder and psychosis. Around 70% of people with autism meet diagnostic criteria for at least 1 other psychiatric disorder that can further impair psychosocial functioning, especially when mentalhealth condition is unrecognised[164].

An increased prevalence was reported in groups from disadvantaged socioeconomic background or migrant factors that contribute to greater prevalence in an African-Caribbean population[165,166,167].

Service provision

Walsall does not have a commissioned Autistic Spectrum Disorder(ASD). Dudley and Walsall Mental Health Partnership trust have developed a new a Consultant led adult Neurodevelopment service delivered from Dorothy Pattison hospital. The service provides an Autism spectrum disorder assessment for adults and management of people with neurodevelopment disorders. It is offered on a spot purchase basis.

The service accepts referrals for individuals aged 16 years and over but does not accept referrals for adults with moderate to severe learning difficulties. Referrals are accepted from a number of agencies including GPs, local authorities, CCGs and other NHS providers. Access can be only gained on agreement by the relevant CCG.

Older people

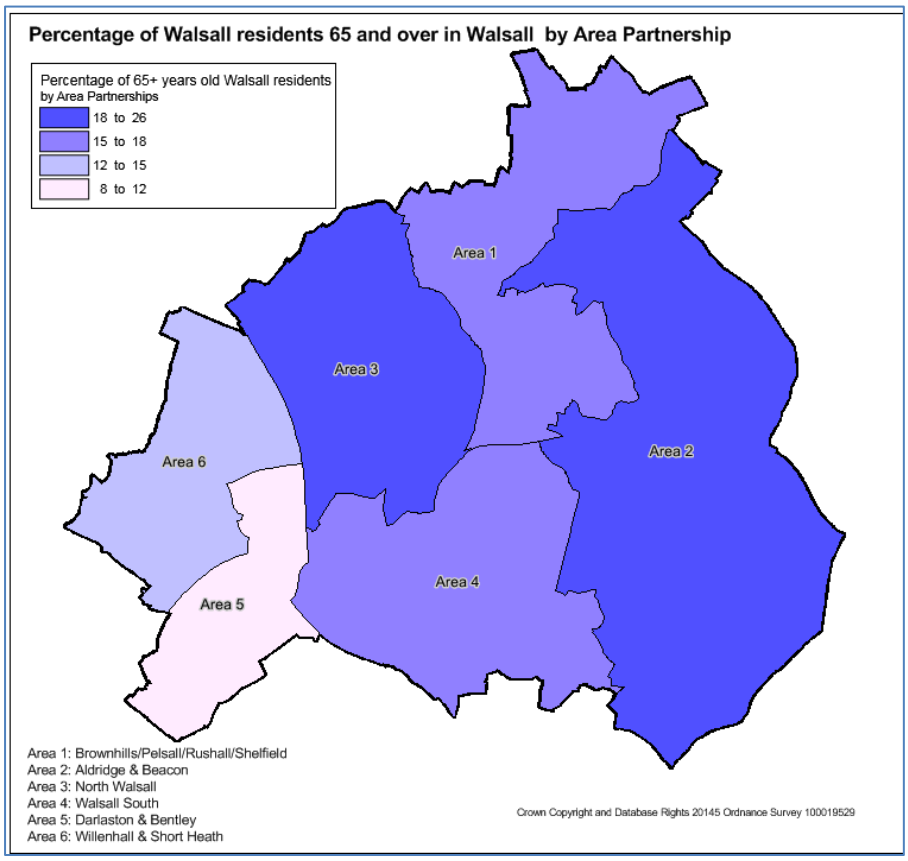
This section is based on the definition of an older person being someone that is 65 years and over and a resident of the borough. Add in increase care, increase drug, loneliness, reduced services and care

An Older People's Needs Assessment is currently being finalised by Walsall Public Health.

Demographics

There are 47,940 older people in Walsall (Figure 81) representing 23% of the population (further details in section 19). Figure 82 shows the numbers of older people in Walsall by different age groups and social status (employment and housing).

Figure 81: Older people across Walsall by area partnership



Source: ONS

Figure 82: Summary counts of older people in Walsall

Indicator	Count	Source and date
All aged 65+	48,753	ONS 2014 mid-year estimates
Aged 65-69	14,006	ONS 2014 mid-year estimates
Aged 70-74	11,778	ONS 2014 mid-year estimates
Aged 75-79	9,943	ONS 2014 mid-year estimates
Aged 80-84	7,018	ONS 2014 mid-year estimates
Aged 85-89	3,884	ONS 2014 mid-year estimates
Aged 90+	2,124	ONS 2014 mid-year estimates
Job Seeker Allowance claimants aged 60+	140	ONS 2015 (Nomis)
Pension Credit Claimants aged 65+	24,580	ONS 2015 (Nomis)
Living in rented property: Aged 65+	21,630	ONS Census 2011
Living in own property - social Aged 65+	7,070	ONS Census 2011
Living in rented property - private Aged 65+	1,526	ONS Census 2011

Link with emotional wellbeing and mental health

Mental health problems in this group are under-identified by health-care professionals and by older people themselves, and the stigma surrounding mental illness makes people reluctant to seek help[168]. Symptoms of depression in older adults are often overlooked and untreated because they coincide with other late life problems. Older adults with depressive symptoms have poorer functioning compared to those with chronic medical conditions such as lung disease, hypertension or diabetes. Depression also increases the perception of poor health, the utilization of medical services and health care costs.[168] Depression affects 1 in 5 people over the age of 65 living in the community and 2 in 5 living in care homes[169]. We know that those with a long term condition are more likely to suffer from depression nd anxiety. An estimated 70% of new cases of depression in older people are related to poor physical health[170,171].

Older people are less likely to have a neurotic disorder (or common mental health problem) than other sections of the British population. 10.2% of those aged 65-69 and 9.4% of those aged 70-74 have a neurotic disorder compared with 16.4% of the general population[172].

Service Provision

There are a range of older peoples' services across Walsall addressing psychosocial needs and supporting older people to improve and maintain their health and wellbeing. Provision includes prevention, early intervention, community support, hospital and acute care (see mapping).

Refugees

The definition of a refugee as stated by United Nations is "A person who owing to well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion is living outside of the country of his nationality". In the UK the classification is someone who has applied for refugee status and is still waiting for decision on that application, so incorporates asylum seekers and refugees[173].

Demographic

As of 31st December 2015, there were 279 asylum seekers (including singles and families) in Walsall[174]. Table 25 shows that currently Walsall is accommodating 22% against capacity (cluster limit 1268).

Table 25: Asylum seekers in Walsall, December 2015

Walsall				
S95		S4		Total
Singles	Family	Singles	Family	
72	171	11	25	279
Cluster Limit				1268
Capacity percentage				22%

Source: Walsall Council, Resources Directorate (Supported Housing).

Links with emotional wellbeing and mental health

Asylum seekers, refugees and their families are known to be at high risk of mental health problems (Ehntholt & Yule, 2006)[175]. Within the refugee community cultural differences, language barriers and mental health stigma play a huge role in poor access to services, for both adults and children.

Mental illness is more prevalent amongst this group than general population due to detrimental experiences in country of origin, the journey to UK and the process of claiming asylum and placement within communities[176]. The most frequently diagnosed conditions are trauma, psychological distress, depression and anxiety[177]. Services and support for these groups need to be flexible and responsive to the different cultural understandings of and ways of managing mental health issues (Montgomery & Foldspang, 2005).

Service Provision

Refugee and Migrant Centre of the Black Country

The Refugee and Migrant Centre of the Black Country assists asylum seekers, refugees and new migrants, and also people from the more established BAME communities. The service offers free advice and guidance on issues which can have an impact on mental health such as citizenship, access to Education, Employment Support, Family support, access to Healthcare and Housing.

Travellers

The definition of traveller community is a collective term used to describe a wide variety of cultural and ethnic groups (Gypsy, Roma and Traveller). Defining a person as a Gypsy, Roma or Traveller is a matter of self-ascription and does not exclude those who are living in houses[178]. Gypsy or Irish travellers are recognised under the Equality Act 2010 and are widely considered by government (national and local) and charities to be vulnerable marginalised group who suffer from poor outcomes[179].

Demographic

The 2011 census reports that 0.11% of the Walsall adult (18+ years) population were from the Gypsy, Roma and Traveller (GRT) community (221).

Links with emotional wellbeing and mental health

Traveller communities have one of the lowest life expectancies and the highest child mortality rates in England[180].

Service Provision

There is currently no specific service in Walsall addressing the mental health needs of travelling communities

Lesbian, Gay, Bisexual and Transgender Community

Lesbian, gay, bisexual and transgender (LGBT) people experience a number of health inequalities which are often unrecognised in health and social care setting. In the area of

mental health and wellbeing data collection in these settings, the sexual orientation information is not always captured to identify this community[181].

Demographics

A national survey (Table 26) estimated that 2% of 16+ years identified themselves as Gay/Lesbian, bisexual or other. Using these estimates, there could be potentially around 4,344 people who belong to the LGBT community in Walsall.

Table 26: Sexual identity prevalence result from integrated household survey by age group, UK 2013.

Age groups	16-24	25-34	35-49	50-64	65+	Total
Heterosexual / Straight	89.3	91.6	92.4	94.2	94.6	92.7
Gay / Lesbian	1.6	1.8	1.5	0.9	0.3	1.2
Bisexual	1.1	0.6	0.4	0.3	0.2	0.5
Other	0.2	0.2	0.2	0.3	0.3	0.3
Don't know / Refusal	4.4	4.1	3.9	3.2	4.1	3.9
No response[2]	3.4	1.7	1.5	1.1	0.4	1.5

Source: ONS Integrated Household Survey: 2013.

Caveat: In 2013 there were 178,820 eligible respondents (aged 16 and over) to the sexual identity questions and 169,102 valid responses.

Links with emotional wellbeing and mental health

The National Institute for Mental Health in England (NIMHE) carried out a review that showed that suicide is four times more likely in gay and bisexual men and the risk of depression and anxiety is one and half times higher in LGBT people[182]. Studies suggest that LBGT people have higher rates of alcohol and/or drug abuse and eating disorders[183]. Lesbian and bisexual women are twice as likely to self-harm as the general population.

Service Provision

There is currently no specific service in Walsall targeted to the mental health needs LGBT people.

Carers and Mental health

A carer is defined as someone who provides unpaid help and support to a relative, friend or neighbour who could not manage without that help due to frailty, long-term illness, disability or addiction[184].

Prevalence

Carers of working age are by far the biggest group of carers overall in England and Wales, with about 4.3million carers aged 19-64 years and 1.3million aged 65 and above[185]. The number of older carers has grown by 35% as compared to 11% across all age groups, according to 2011 census. In the UK, there are estimated about 1.5 million people caring for a relative or friend with mental health problems. One in four carers are mental health carers and 1 in every 40 people is a mental health carer[186].

The majority of the carers provide 1-19 hours of unpaid care(Table 27). However, the proportion of carers providing over 20 hours of unpaid care is higher in Walsall, as compared to West Midlands and England. This represents approximately 30,632 of Walsall residents providing unpaid care with Aldridge & Beacon (12.7%) and Brownhills (12.5%) Area Partnership having the highest percentage of carers. The available data on unpaid care work doesn't allow breakdown by physical and mental health carers, and the higher proportions in Walsall may suggest a gap in the provision of Social Care support.

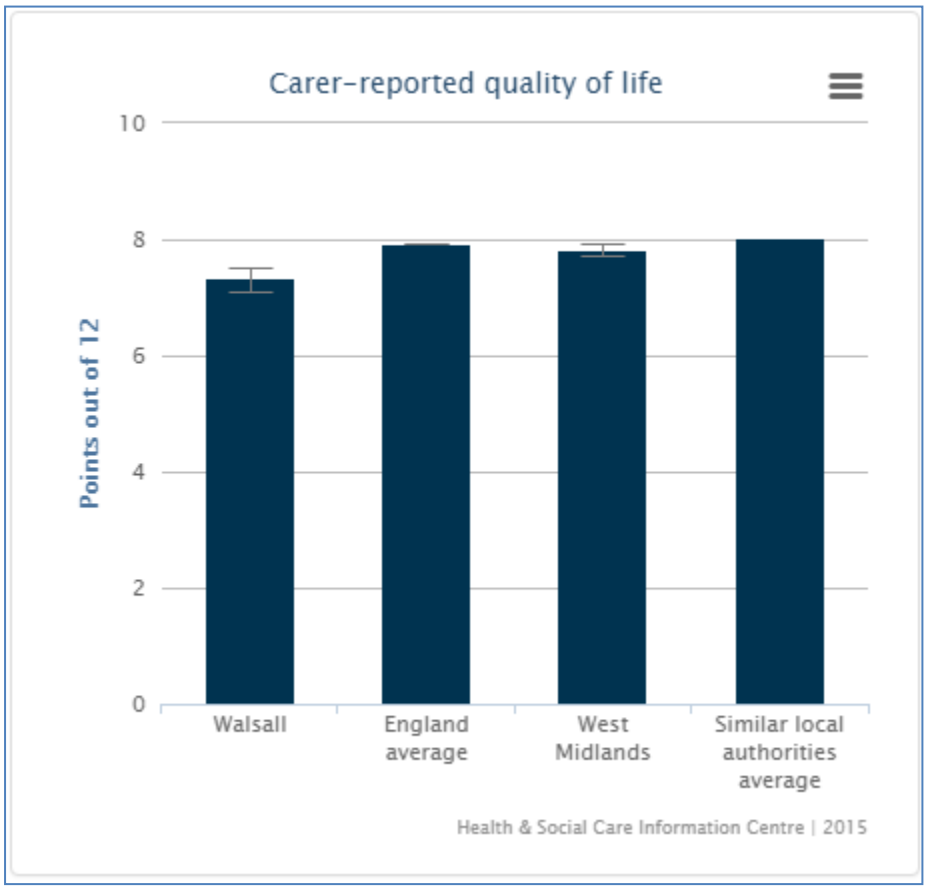
Table 27: Percentage of Walsall residents providing unpaid care, 2011

	% Providing Unpaid Care (Hours)		
	1-19	20-49	50+
Brownhills	7	1.9	3.6
Aldridge & Beacon	8.1	1.5	3.1
North Walsall	5.1	1.9	3.7
Walsall South	6.0	1.9	2.6
Darlaston & Bentley	5.2	1.8	3.9
Willenhall & Short Heath	6.3	1.8	3.1
Walsall	**6.3**	**1.8**	**3.3**
West Midlands	**6.8**	**1.5**	**2.7**
England	**6.5**	**1.4**	**2.4**

Source: ONS Census 2011

The carer's survey measured different outcomes related to overall quality of life for carers where a higher score was better (out of 12 points). Walsall respondents reported a significantly lower than regional and national average quality of life (Figure 83). The survey was only a sample of carers within each authority but it does provide an indication that this area may need to explored further.

Figure 83: Carer-reported quality of life, 2014-15



Source: Health and social care information centre

Link to emotional wellbeing and mental health

Carers are twice as likely to suffer mental health problems as non-carers[187]. The negative health effects of caring are primarily psychological and often present as symptoms of anxiety, depression and social dysfunction[188]. The same study also showed that carers who provide at least 20 hours care per week are often at greatest risk of poor health and adverse health changes because of their caring responsibilities, with women and those caring for a partner/spouse facing greater risk of psychological distress. The Prince's Royal Trust's carers' health survey in 2004 identified that 38% carers reported suffering stress/nervous tension, 28% reported suffering from depression and 27% reported suffering from anxiety[189]

Some of the key issues facing mental health carers includes risk of suicide of the person cared for, unpredictability of caring for someone with mental health problem, stigma of mental illness due to common prejudices and misunderstandings around mental health and lack of specialised respite.

Service Provision

There are a number of services in Walsall to support different aspects of carers needs (see mapping).

Offenders

Research has demonstrated that the health of offenders is in general significantly worse than that of general population as a whole, particularly in terms of mental health problems, addictions and blood borne virus diseases. About 20% of people who come into contact with police have mental health problems. As many as 90% of the prison population has a mental health problem.

Offenders and ex-offenders generally experience greater health inequalities and social exclusions. As the number of people who come into contact with Criminal Justice sector increases, there will be an increasing number of ex-offenders in the communities[190].

Prevalence

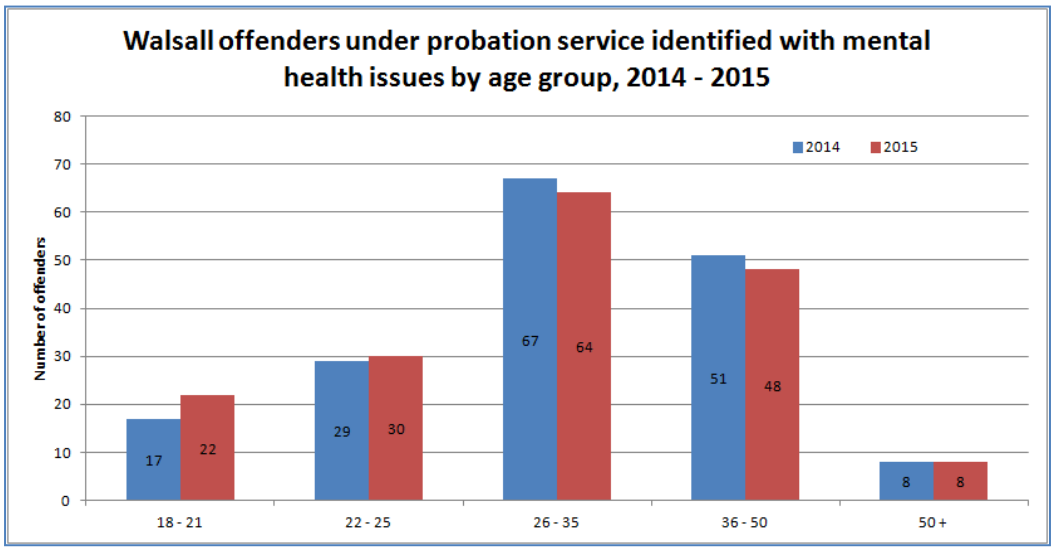
In 2014/15 there were 5,026 arrestees who passed through Walsall Local Policing Unit (LPU) custody. Anecdotally, a significant proportion of those who are taken to police custody present with mental health issues, more so in those who are repeat offenders. A system is in place for the screening of their mental health and further signposting and referrals, via the Walsall Partnerships Officer, West Midlands Police. Data on the number of offenders identified as having a MH need and outcome was not available at the time of writing this needs assessment.

There are two services working with offender population between judicial custody and community settings, Community Rehabilitation Company working with 913 (as of April 2016) and National Probation service working with circa 500 offenders again in both settings.

The has been a slight reduction in the number of Walsall residents under the probation service over the last two years, with 775 in 2014 down to 759 in 2015. Just under a quarter (22.2-22.6%) of these offenders were identified with mental health issues[‡‡‡‡‡]. Around three quarters of offenders with a MH need were men (74%). The highest proportion was for those aged between 26-35 years followed by 36-50 years (Figure 84). Majority came from the White ethnic group (85.5%) and those from the BAME group had shown an increase from 8.1% (2014) to 14.5% (2015).

[‡‡‡‡‡] Mental health issues defined as suicide/self harm, mental health issues, mentally disordered offender register in Delius or answering Yes to any questions in Section 11 'Emotional wellbeing' of OASys.

Figure 84: Walsall Offenders identified with mental health issues by age group, 2014-2015



Source: Staffordshire and West Midlands Community Rehabilitation Company

Caveat: 'Mental Health Issues Y/N' derived from either a current 'Suicide/Self Harm', 'Mental Health Issues', 'Mentally Disordered Offender' register in Delius or answering Yes to any questions in Section 11 'Emotional Wellbeing' of OASys.

Link to emotional wellbeing and mental health

The Health & Justice report 2014 highlighted the mental health needs among those in criminal justice system are often complex with comorbidity.

Table below shows that there was significantly higher rates of mental health disorders within the offender population in comparison to general public indicating that health inequalities and lack of services available to this cohort:

Mental Health Condition	Prisoner Population	General Population
Personality Disorders	55%	Less than 10%
Anxiety	20%	10%
Depression	40%	12%
Psychotic	10%	1%

Source: PHE – Health & Justice Report 2014 and NICE QS88 (June 2015)

The suicide rate in prisons is almost 15 times higher than in the general population: in 2002 the rate was 143 per 100,000 compared to 9 per 100,000 in the general population[191]. The mental health of those in prison needs to be reflected on in context as people are entering a stressful environment and without their usual social and family support as well as certain vulnerabilities.

A survey of prisoner population found that more than 70% of the prison population has two or more mental health disorders[192,193]. Male prisoners are 14 times more likely to have two or more disorders than men in general, and female prisoners are 35 times more likely than women in general[194].

Service Provision

Walsall has a Criminal Justice provision which is a pathway into mental health services for the offender client group.

The Criminal Justice provision provides a pathway into mental health services for offender client group. This support is (usually) available for up to 12 weeks and is available through Criminal Justice agencies such as probation and the police. The service screens, triages and acts as an interface between other mental health services. (See mapping).

Liaison and Diversion pilot scheme

Dudley and Walsall Mental Health Partnership NHS Trust have teamed up with Black Country Partnership NHS Foundation Trust to help deliver the government's Liaison and Diversion pilot scheme.

The new service, part of an £800,000 investment across Dudley, Sandwell, Walsall and Wolverhampton, has been in operation since April. It sees more mental health personnel based at police stations and courts to ensure people of all ages with mental health issues, a learning disability, substance misuse problems or other vulnerabilities are identified and assessed as early as possible as they pass through the criminal justice system.

Jacky O'Sullivan, Clinical Development Director for Dudley and Walsall Mental Health Partnership NHS Trust explained: "We put together a joint bid with the Black Country to enhance our links with the community and to develop a service that aims to improve access to healthcare for those people who come into contact with the criminal justice system."

This pilot is part of the second wave of trials commissioned by NHS England. The success of the scheme will be evaluated and, if HM Treasury approves the full business case, extended to the rest of the country by 2017.

Domestic Abuse

The cross-government definition of domestic violence and abuse is[195]:

"any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality".

The abuse can encompass, but is not limited to psychological, physical, sexual, financial and emotional.

Violence between adult partners occurs in all social classes, all ethnic groups and cultures, all age groups, in those with disability as well as the able bodied, and in both homosexual and heterosexual relationships. Women are usually the most frequent victims[196,197].

A Domestic Violence Needs Assessment has recently been completed and readers are advised to refer to it for more details: http://www.walsallintelligence.org.uk/WI/publications/Walsall%20Domestic%20Abuse%20Needs%20Assessment%202015%20final%20version.pdf

Demographics

A Domestic Abuse Profile for Walsall has been provided by West Midlands Police for the Domestic Violence needs assessment and the key points were:

- Domestic Abuse Committed Crimes decreased from 2007-early 2014 (average of 105/month July 13-Apr14) but showed a sharp increase in April 2014. This effect was seen across the West Midlands Police Force area and was not specific to Walsall. These higher levels have been maintained (average of 149/month May14-June15). This increase may be due to improved data quality and the launch of Operation Sentinel (long running initiative aimed at enhancing the service provided by West Midlands police and its partners to vulnerable victims across the area)
- Assault accounts for over 50% of Domestic Abuse crimes
- 24% of Domestic Abuse crimes were classified as high risk, 76% as medium or standard
- The highest intensity of crimes occurred within Caldmore and Chuckery, there is also high intensity within Blakenall Heath
- 78% of offences relate to dwellings.
- The majority of victims were female (84%), white-skinned European (80%), peak age range 21-30 (38%) and unemployed (57% where data were available)
- The majority of offenders were male (91%), white-skinned European (79%), peak age range 20-29 (41%) and unemployed (66% where data were available)
- Between July 2013 and June 2015 there were 2329 arrests for domestic abuse where the offender was taken to a Walsall custody station. 32% were charged but 60% were “no further action”.

Data supplied by the Walsall Domestic Violence Forum (WDVF) were used to show the number of referrals by financial year. Figure 85 indicates a gradual annual increase since 2012/13; however Domestic Abuse Referral Team(DART) referrals seem to be falling when observed on quarterly basis since April 2014.

Figure 85: Walsall DART Annual Referrals, 2008/09 - 2014/15

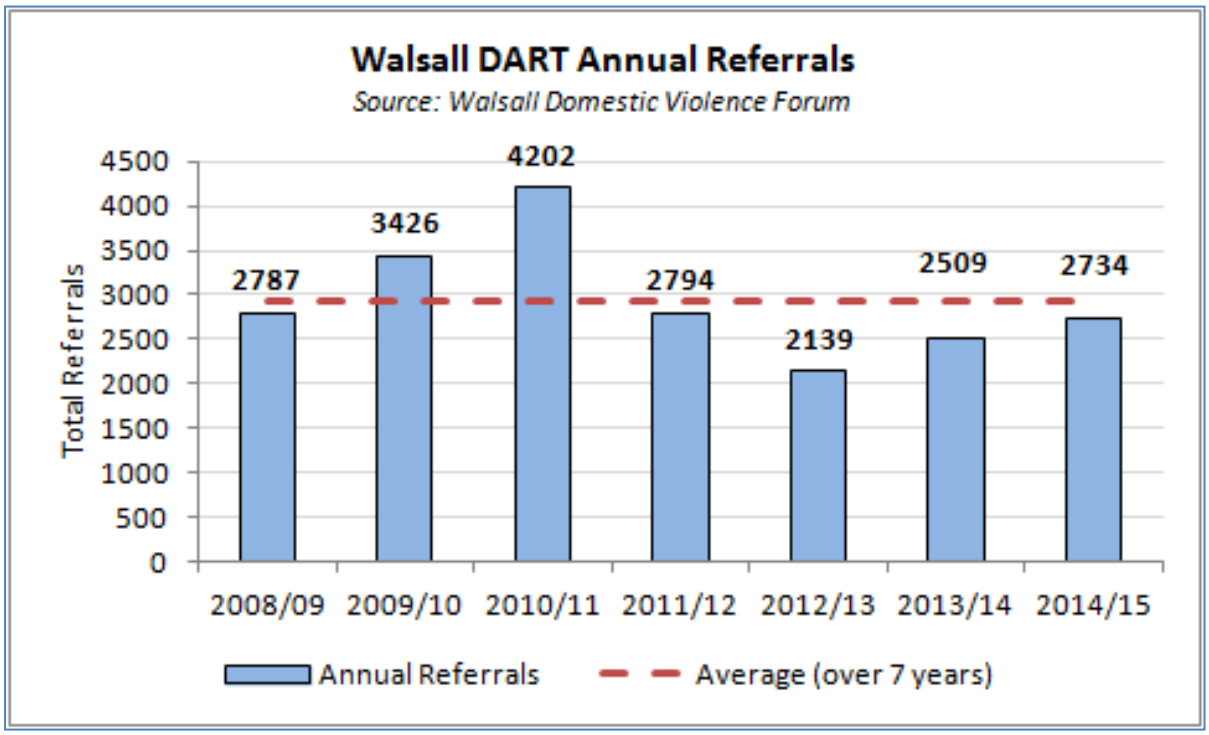
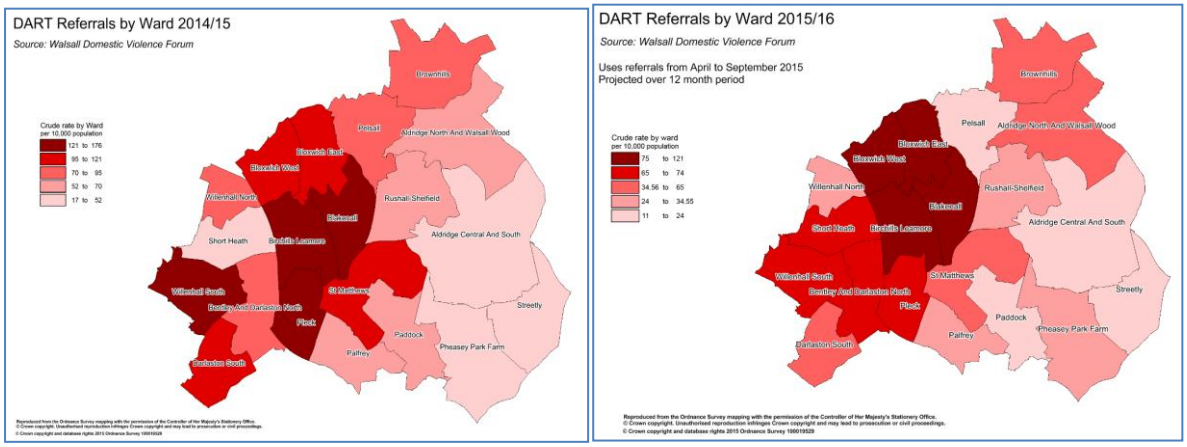


Figure 86 shows DART referrals across the Borough (Wards). The highest rate of DART referrals in 2014/15 occurred within Birchills Leamore, Blakenall, Pleck and Willenhall South wards (121-176 per 10,000 populations).

Figure 86: DART Referrals by Ward, 2014/15 - 2015/16



Source: Walsall Domestic Violence Forum

Note: 201/15 Referrals = April to September 2015, Projected over 12 month period.

Link to emotional wellbeing and Mental Health

There is clear evidence that mental health is impacted by domestic abuse and it has been reported that[198]:

- 40% of high-risk victims report having mental health issues
- 16% of victims report that they have considered or attempted suicide as a result of the abuse, and 13% report self-harming
- Domestic abuse has significant psychological consequences for victims, including anxiety, depression, suicidal behaviour, low self-esteem, inability to trust others, flashbacks, sleep disturbances and emotional detachment
- Domestic abuse victims are at risk of post-traumatic stress disorder (PTSD) – as many as two-thirds of victims of abuse (64%) developed PTSD in one study
- Between 30 and 60% of psychiatric in-patients had experienced severe domestic abuse.

Service Provision

Walsall provides women's refuge and support for women experiencing domestic violence. There is no specific service targeted to addressing the mental health needs of women suffering from domestic violence.

Service Personnel

According to most recent figures the total strength of the UK Armed Forces was 180,000 personnel in October 2012, of which 166,000 (92.2%) were trained and 13,860 were untrained. The ex-service population has been estimated to be around 3.8 million and will grow over the next two years as a result of The Strategic Defence and Security Review (2010), which recommended a reduction in the size of the UK armed forces.

The 2011 census reported that 196 Walsall residents were employed by armed forces and were eligible to complete the census which represent about 0.11% of working population[§§§§§].

Prevalence

The prevalence figures for mental health conditions within the armed forces vary slightly across the different study cohorts depending on samples and measures used, however the overall prevalence of mental health problems have remained fairly stable between 2003 - 2009[199]. The structured diagnostic instrument, the Patient Health Questionnaire (PHQ) found that the prevalence of someof the conditions as following (based on 821 randomly sampled personnel)[200]:

- Common mental disorders 27.2%
- PTSD 4.8%
- Alcohol abuse 18%
- Neurotic disorders 13.5%[201]

[§§§§§] A person aged 16 and over and in employment in the week before the census is a member of the armed forces if they have an occupation code 'Officers in Armed forces' or 'NCOs and other ranks'. This means that civilians working for the armed forces are not classified as a member of the armed forces.

There are lower suicide rates among UK serving personnel than in the general population. However around 2-3 times higher risk of suicide in men aged 24 or under has been observed, especially for those who have left the Armed forces compared with general population and those serving[202].

Less than 10 mental health veterans were in the DWMHT services as of March 2016. The IAPT service received 110 referrals from veterans (referrals where ex-British armed forces indicator completed including dependents) between 2014/15 with 73% (80 veterans) entering into treatment resulting in 19% completing the course[203].

Link to emotional wellbeing and mental health

Barriers to mental health care in military populations has been well documented. Stigma concerning mental health problems is particularly problematic in men within the general population and more so in armed forces as there is self perceived expectation to be physically and psychologically resilient during times of adversity[204,205,206].

Service Provision

There is currently no specific service in Walsall addressing the mental health needs of the armed forces and those who previously served as military personnel.

Homelessness and mental health

The term homelessness spans a continuum of housing needs, from insecurely housed to literally roof-less (so called "rough sleepers")[207].

Homeless households refers to a family or individual who has applied for LA housing support and been judged to be homeless, whereas Homeless families are those with dependent children. A household is legally homeless if they do not have accommodation that they are entitled to occupy, which is accessible and physically available to them[208].

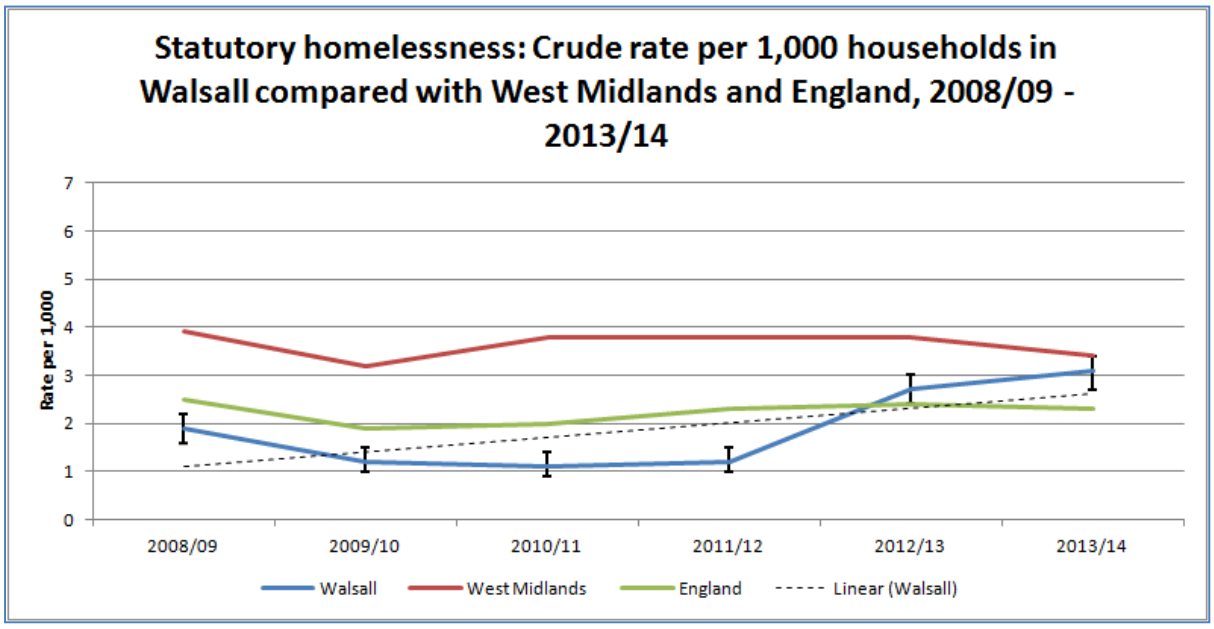
Demographics and Prevalence

There were 103 families which were known to local authority under the homeless legislation statutory return (P1E) in 2014/15 [******].

Up until 2011-12, the homelessness rate in Walsall has been well below the England and West Midlands averages(Figure 87) . A trend increase in Walsall is evident after that and in the last three years (2011/12-2013/14) the average Walsall rate has risen sharply and has gone above the England average while the gap with regional average has narrowed. There has been a 71% increase in the number of households in Walsall classified as homeless (194 to 332) over a six year period (includes families and individuals).

[******] Walsall Council Housing Department

Figure 87: Estimated rate of statutory homelessness, 2008/09 - 2013/14



Source: Department of Communities and Local Government

Note: Numerator – count of households who are eligible, unintentionally homeless and in priority need for Local authority under part VII of housing act 1996 or part III housing act 1985.
Denominator- 2008 mid-years population estimates.

Link to emotional wellbeing and mental health

Homelessness Link's National Health Audit found that eight- in-ten have one or more physical health needs, and seven-in-ten have at least one mental health problem. Being homeless means people are more likely to suffer from mental and physical ill-health and at the same time unable to access the health services you need[209].

Prevalence of serious illness such as schizophrenia and psychoses can be up to 25%-30%[210], with higher rates among women, young people and the long term homeless[211].Substance misuse and mental health illness are high within this community with a range of 10-20% reported by studies[212].

There is higher rate of self harm and suicides in the homeless community with people likely to be male, have a history of mental illness and a substance use problem[213].

Service Provision

There is currently no specific service in Walsall addressing the mental health needs of those who are homeless.

Young people (Transition from CAMHS to AMHS)

The transition phase is between the ages of 16 to 18 up to age 24 when specific needs have been identified. These are young people who may have been involved with CAMHS and still need support or who have newly emerging mental problems. In 2015, a children and young people emotional wellbeing and mental health (EWMH) needs assessment was completed in Walsall, in which it was recognised that nationally and locally there was a gap in support provided to young people.

One group within this that needs consideration are the ***Care Leavers***. About half of the children in care have clinical-level mental health problems, a rate that is four to five times higher than in children in the general population. The mental health needs of care leavers is an even greater challenge to address, who often become ineligible for support from statutory services just at the time they need it most, facing complex psychological challenges. While most young people make a gradual transition to independence, supported by their family, care leavers often experience multiple, overlapping changes in their living circumstances all at once[214].

The Children (Leaving Care) Act 2000 specifically stated that Local Authorities would need to keep in touch with care leavers until they were at least 21, and they should continue to provide assistance with education, employment and training as they were regarded as a vulnerable group. There were 165 young people (18-24 years) known to Walsall Children Services and eligible under the care leavers classification (as of 30th June 2015) (from Children and Young People EWMH Needs Assessment).

The EWMH strategy 2015 recommended the following areas to address the issue:

- Develop a transition service for young people based upon the expressed needs of young people; explore the feasibility of developing a 16-25 service.
- Set joint protocols in place so that young people within the transition age group are managed by both CAMHS and AMHS, so they can both provide joint assessment and services to young people with depression and other needs.
- Set a robust transition pathway into place for young people moving into AMHS

Link to Children and Young People Emotional Wellbeing and Mental Health:
http://www.walsallintelligence.org.uk/WI/publications/Emotional%20Wellbeing%20and%20Mental%20Health%20Needs%20Assessment%20v1.0.pdf

What does the evidence say?

A review of existing literature was conducted to explore the evidence base for primary prevention interventions for mental health in adults and older people, maternal mental health and workplace based interventions.
Secondary interventions or treatments for people who are already known to have a mental illness were not considered. The review aimed to identify high-level evidence from systematic reviews, meta-analyses and health economic studies that could be used to inform the delivery and targeting of interventions to groups at higher risk of mental ill health in Walsall borough. The review also draws on recommended interventions as identified from the recently published 'Better Mental Health for All'.

Population based interventions for promoting wellbeing and preventing mental health illness

Most interventions focus on treating existing mental illness rather than primary prevention of mental health issues or promoting mental wellbeing, however the evidence base is slowly growing.
The promotion of mental well being and prevention of mental ill health can be delivered at two levels:

Universal –targeting the whole population, groups or settings where there is an opportunity to improve mental health such as schools or workplaces.

Targeted – for people in groups or communities with higher prevalence of mental health problems; people with early detectable signs of mental health stress or distress; targeting people at the highest risk of mental health problems.

A range of Interventions for Adults that have been shown to be effective are presented below.

Universal

- Mindfulness has a rapidly expanding evidence base and is increasingly popular in both people with mental health problems and risk factors and in general populations. It is explained as knowing directly what is going on inside and outside ourselves, moment by moment, and reconnecting with our bodies and the sensations they experience.
- There is a small evidendce base for effectiveness of activities that both exercise and still the mind like Yoga and Tai Chi.
- Walking and exercise on prescription schemes, books on prescription schemes, social prescribing and wellbeing pledge programmes in primary care.
- Use of volunteering as a way of linking local people who share their time and skills, and enabling them to live well, improve their health and wellbeing, and link them to their community. Volunteering can help lower the number of GP visits by removing the kind of visits that do not require medical attention.

- Mental health literacy training to frontline housing and advice workers can help individuals and families to secure and sustain appropriate accommodation, manage debt and maximise their incomes.
- Implementation of accessible financial services can help tackle poverty, empower people (particularly women) and communities, and assist with reducing poor physical and mental health among the most disadvantaged[215]
- The use of social media and other avenues is vital to disseminate universal public mental health messages such as those promoted in 5 Ways 2 Wellbeing

Targeted

- Increasing people's capacity to use psychological treatment methods can prevent the development of mental health problems, particularly if used during periods of transition and pressure, such as redundancy, after birth or after bereavement. Simple interventions and promoting available services such as cognitive behavioural therapy, bereavement counselling and relationship support have been successful in this way, particularly with those at increased risk of mental health problems, such as those with long term conditions and those who are isolated.
- Psychologically Informed Environment (PIE) is seen as a promising approach. PIEs – whether physical or social environments are conscious of the mental health needs of the people that inhabit them. PIEs have been piloted in housing, homelessness, social care and criminal justice settings in England. Provision of social along with clinical psychological support was shown to have more impact than social support only. In one study, of the 274 people receiving housing support who were also offered psychotherapy sessions, the attendance rate was 76%, which was considered high. At the end of the sessions, 42% of clients were in employment, education, voluntary placement or training as compared to 21% of those who did not receive psychotherapy[216]
- Supporting unemployed working age adults into high quality work is critical , while ensuring those who are unable to work have access to a reasonable standard of resources and are supported to lead fulfilling lives, moving towards employment as appropriate.
- Low mental health literacy limits opportunities for vulnerable groups to be actively involved in decisions about their health and increases delays in help-seeking and access to appropriate treatment. Therefore it is important to increase mental health literacy especially for people with limited financial and social resources, including older people, people with long term health conditions, refugees, people from Black and Minority Ethnic communities and people living with disabilities.

Mentally healthy communities and neighbourhoods

Asset based community development (ABCD) is an emerging approach to developing flourishing communities and enhancing population wellbeing. The ABCD approach seeks to identify and build upon existing strengths that enable communities to flourish, instead of focusing solely on problems and deficits in communities. People are viewed as active citizens and co-producers with something to offer, rather than passive clients and service users. The emphasis is on empowering and enabling people to take control of their lives and supporting them to do more for themselves[217]. This is similar in principle to the recovery model of support for mental health problems, which aims to lessen the long-term impact of mental ill-health and strengthen the individual's participation within their community. The ABCD approach is becoming increasingly valuable in preserving or further developing communities and services, especially as funding across the NHS and public sector is declining.

Creating and protecting green spaces within neighbourhoods is vital in order to generate better physical and mental health outcomes for individuals and communities. Marmot review refers to evidence that well designed green and open spaces can benefit communities – increasing social contact and social integration, particularly in underprivileged neighbourhoods[218] The aesthetic experience of looking at or being in green spaces can have a positive "psychosomatic" effect on people by reducing stress, lowering blood pressure, and alleviating cognitive disorders and attention deficit disorder. The potential not only to relax, but also to exercise outdoors in green areas, contributes to better mental health and well-being. Several recent literature reviews have concluded that green spaces have the potential to benefit people's mental health and well-being[219].

The economic benefits of mental wellbeing are broad, deep reaching and societal, but as yet few studies have addressed this.
A range of public mental health interventions have been shown to give excellent returns on investment within one to two years. The benefits of such studies are calculated in terms of the mental health problems they prevent, and are possibly underestimates as they do not include the added value from increasing mental wellbeing.

Figure 88:Total Returns on Investment: economic pay offs per £1 expenditure

Economic pay-offs per £1 investment	NHS	Other public sectors	Non public sector	Total
Early identification and intervention as soon as mental disorder arises				
Early intervention for depression in diabetes	1.08	1.78	5.03	7.80
Health visitor interventions to reduce postnatal depression	0.40	–	0.40	0.80
Early intervention for depression in diabetes	0.19	0	0.14	0.80
Early intervention for medically unexplained symptoms	1.01	0	0.74	1.75
Early diagnosis and treatment of depression at work	0.51	–	4.52	5.03
Early detection of psychosis	2.62	0.79	6.85	10.27
Screening for alcohol misuse	2.24	0.93	8.57	11.75
Suicide training courses provided to all GPs	0.08	0.05	43.86	43.99
Suicide prevention through bridge safety barriers	1.75	1.31	51.39	54.45
Promotion of mental health and prevention of mental disorder				
Prevention of conduct disorder through social and emotional learning programmes	9.42	17.02	57.29	83.73
School-based interventions to reduce bullying	0	0	14.35	14.35
Workplace health promotion programmes	–	–	9.69	9.69
Addressing social determinants and consequence of mental disorder				
Debt advice services	0.34	0.58	2.36	3.55
Befriending for older adults	0.44	–	–	0.44

Source:Better Mental Health For All, 2016. Faculty of Public Health

Older Adults

Universal

- Community approaches to reduce isolation in older people that have been found to be effective include:
    - Befriending and mentoring. Befriending initiatives, often delivered by volunteers, provide an 'upstream' intervention that is potentially of value both to the person being befriended and the 'befriender'. For those receiving the intervention, it promotes social inclusion and reduces loneliness; for the befriender, there is the personal satisfaction of contributing to the local community by offering support and skills. Specific potential benefits include the improved mental well-being of the person receiving the intervention, a reduced risk of anxiety and depression, at least in the short term[220].
    - Group interventions were more likely to be beneficial compared with one-to-one interventions. Social group schemes which incorporate self-help support and peer involvement are effective ways to reduce social

isolation, such as the 'Standing Together' peer support service delivered by the Mental Health Foundation[221]

- There is some evidence that supports developing technical skills may prove to help loneliness. A programme recruiting volunteers aged 50 years and older to support 144 beneficiaries aged 65 years and older go online found that volunteer help to go online seemed to result in increased social contacts, reduced loneliness, and improved mental well-being and was valued quite highly by beneficiaries[222].

Targeted

- Identifying and supporting carers with a focus on carers aged eighty five and over. Health and social care agencies should work together on this.
- Dementia Friendly Communities enables the creation of dementia-friendly communities across the UK and ensures everyone understands that they have a shared responsibility for ensuring people with dementia feel understood, valued and able to contribute to their community. An extension of this is the Dementia Friends initiative which aims to change people's perceptions of dementia and to change the way the nation thinks, talks and acts about the condition.
- Peer support groups for people with early stage dementia living in extra care, retirement housing and their families have had promising outcomes in the areas of wellbeing, social support and practical coping strategies, with improvements in communication abilities, managing memory and managing lives all linked to peer support.
- Reminiscence therapy for older people has a range of therapeutic and preventative effects, including reduction in symptoms of depression and improved feelings of self-esteem[223].
- NICE recommendations include a range of activities including support sessions to assist with daily routines and self-care, community based physical activity programmes, walking schemes and training for practitioners.

Maternal mental health

Health visiting and reducing post-natal depression

Health visitors are well placed to identify mothers suffering from postnatal depression and to provide preventative screening and early interventions. Trials with interventions provided by health visitors have shown positive outcomes: women were more likely to recover fully after 3 months[224]; targeted ante-natal intervention with high-risk groups was shown to reduce the average time mothers spent in a depressed state; and a combination of screening and psychologically informed sessions with health visitors was clinically effective 6

and 12 months after childbirth[225]. The biggest direct costs of the interventions were associated with training (estimated at £1,400 per health visitor), plus the additional time spent by health visitors with mothers for screening and counselling[226].
When quality of life benefits to women are incorporated, the health visiting intervention provides a positive net benefit with an incremental cost-effectiveness ratio (ICER) of around £4,500 per quality-adjusted life year (QALY).

Peer-based telephone support has also been shown to reduce the risk of post natal depression Strong evidence was lacking for a range of other interventions including, antenatal and postnatal classes, post-partum lay-based home visits, early post-partum follow-up, continuity of care models, in-hospital psychological debriefing and cognitive behavioural therapy[227].

Workplace

There are valid empirically supported interventions that workplaces can use to aid in the prevention of common mental illness as well as facilitating the recovery of employees diagnosed with depression and/or anxiety.

Workplace screening for depression and anxiety disorders

The use of a workplace based screening questionnaire, followed by care management for those found to be suffering from, or at risk of developing, depression and/or anxiety disorders has been shown in a number of studies to be effective in tackling depression and reducing productivity losses in various workplaces. Those identified as being at risk of depression or anxiety disorders were offered a course of cognitive behavioural therapy (CBT) delivered in six sessions over 12 weeks. In a similar approach in Australia, productivity improvements outweighed the costs of the intervention. The results showed that from a business perspective the intervention appears cost-saving (Figure 89).
Benefits are gained through both a reduction in the level of absenteeism and improved levels of workplace productivity through a reduction in presenteeism. The impact may differ across industries; the case may be less strong where staff turnover is high and skill requirements low. From a health and social services perspective the model is cost-saving, assuming the costs of the programme are indeed borne by the enterprise.

Figure 89: Total net costs/pay offs from business and societal perspectives for a company with 500 employees (2009 prices)

	Year 1 (£)	Year 2 (£)
Intervention cost	20,676	0
Health (including social care)	0	-10,522
Absenteeism (productivity losses)	-17,508	-23,006
Presenteeism (productivity losses)	-22,868	-30,050
Total	-19,700	-63,578

Source:LSE, 2011. Mental Health promotion and Prevention: the Economic case

Promoting well-being in the workplace

Systematic reviews suggest that employers that promote actions such as greater job control, task-restructuring and decreased demand, can positively influence mental health through reducing stress, anxiety and depression, and increasing self-esteem, job satisfaction and productivity. Offering flexible working arrangements, career progression opportunities, ergonomics and environment, stress audits, and improved recognition of risk factors for poor mental health by line managers are some of the approaches that employers can adopt to promote mental health in the workplace.

Other measures targeted at improving physical activity levels and healthy eating can include access to gyms, exercise and sports opportunities and changes to the food available on office premises. Scottish health care workers who were helped to adopt more active commuting habits showed significantly improved mental health.

An evaluation of a multi-component health promotion intervention consisting of personalised health and well-being information and advice, a health risk appraisal questionnaire, access to a tailored health improvement web portal, wellness literature, and workshops focused on identified wellness issues, has reported significantly reduced stress levels, reduced absenteeism and reduced presenteeism, compared with a control group[228] . The cost of a multi-component intervention is estimated at £80 per employee per year. The model appears cost saving compared to taking no action (Figure 90). In year 1, the initial costs of £40,000 for the programme are outweighed by gains arising from reduced presenteeism and absenteeism of £387,722. This represents a substantial annual return on investment of more than 9 to 1. In addition there are likely to be benefits to the health system from reduced physical and mental health problems as a result of the intervention not quantified here.

Figure 90: Total net costs/pay offs from business perspectives for a company with 500 employees (2009 prices)

	Year 1 (£)
Intervention cost	40,000
Absenteeism (productivity losses)	-110,527
Presenteeism (productivity losses)	-277,195
Total	-347,722

Source: LSE, 2011. Mental Health promotion and Prevention: the Economic case

Public Engagement and User Involvement

Background

Walsall MBC's Public Health team commissioned a public consultation exercise on mental health and emotional wellbeing. The primary focus was towards those who have not used services.

Methodology

Residents from across the Borough of Walsall were consulted using a mixed-methodology approach in two phases;

Phase 1: Quantitative telephone survey

500 short ten-minute telephone interviews were conducted across Walsall using randomly created telephone numbers; these are generated using a method known as Random Digit Dialling, or RDD for short to gather the public's understanding of the following:

- Where do people go to for support when feeling low or fed up
- Isolation/ loneliness – impact loneliness and isolation has on mental health and wellbeing
- Information – Where people obtain information re mental health
- Knowledge of mental health services
- Access of services – where people would go if they were worried about their mental health
- Attitudes to mental health
- Stigma of mental health.

Phase 2: 7 focus groups

The secondary phase of qualitative research was conducted between 9th and 16th February 2016 and each lasted between 1 and 1½ hours. There were a total of 50 participants across the following 7 targeted focus groups;

- Carers
- The unemployed (use Job Centre)
- Young men
- Older people
- Asian men & women
- African & Caribbean men & women

- Mental health service users

Understanding mental health and wellbeing and risk factors

Respondents were asked what proportion of people in the UK they thought might have a mental health condition at some point in their lives; three in ten stated they thought the figure was one in ten, 28% indicating 1 in 4 and 24% believed it was 1 in 50.

Participants in the focus groups were asked what 'mental health and emotional wellbeing' means to them. Asian women, the unemployed and the Afro-Caribbean participants most typically struggled to articulate an answer. Older people and Carers were more able to provide an answer.

When asked whether they knew anyone close to them that had been diagnosed with a mental health condition, just over half (51%) of survey respondents indicated they did. At least one participant in each of the focus groups knew of someone or was actually living with a condition themselves.

Focus group participants felt that mental health conditions could affect anyone; young or old, rich or poor, from any walk of life and across communities.

Help seeking behaviour

Those most at risk, being least likely to seek help, was felt to be men and certain ethnic groups – this was partially linked to socio-cultural and religious reasons.

83% of survey respondents claimed they would be likely to go to their GP for help if they had a mental health concern. The majority of participants in the focus groups also felt that their GP would be the first port of call – others would talk to close friends or family members.

Support from general practice

For participants in the focus groups, many had experience of using or trying to use their GP, either themselves or when trying to support family members with 'depression' being the most common condition highlighted. Most do not report particularly positive experiences. This is mainly due to;

- barriers accessing appointments
- the limited time available to GPs
- the generalist rather than specialist approach
- what appeared to be a typical approach to simply prescribing medication

Perceptions inequalities in care

BME participants in particular believed the prescription of tablets to treat mental health conditions by GPs was a cultural and racial bias, and therefore discriminatory. There was a

feeling that those from White backgrounds were more likely to be offered other or additional support services, such as counselling.

Exploring stigma of mental ill health

Stigma remains a huge barrier, both for the public at large and for those dealing with mental health conditions and symptoms.

When asked about how comfortable they thought they would be in talking about being diagnosed with a mental health condition, 63% of survey respondents indicated they would be comfortable (very or slightly) discussing this with family or close friends. This drops to just 27% if they needed to talk to employers. This suggests that stigma is still attached to the topic, particularly when approaching the subject to non-family or close friends.

Participants in the focus groups agreed with this negative view point, both from a personal view that most sufferers seem to internalise problems (rather than seek help), and that the wider public continue to stigmatise those with mental health conditions. It was felt the media perpetuates this stigmatism through the negative portrayal in news stories.

Awareness of local services

Just 39% of survey respondents indicated they were aware of services available locally that could support them with mental health, stress and anxiety issues. There was also limited awareness from non-mental health service users and Carers of local support services (aside from their GP).

Participant who were most aware of local services were those that have either accessed services or those that work within the local community. It was claimed that, even where awareness was relatively high, little information was available on the breadth of services or on the referral pathways for accessing services.

Raising awareness of mental health

Positive publicity on what mental health and wellbeing is and why it is important should be made more widely available. TV was felt to be the most appropriate media for disseminating information to the widest audience.

Locally, awareness could be raised through posters and leaflets, for example, in surgeries and health centres, as well as posters and billboards more widely spread across the borough.

Supporting people with mental ill health

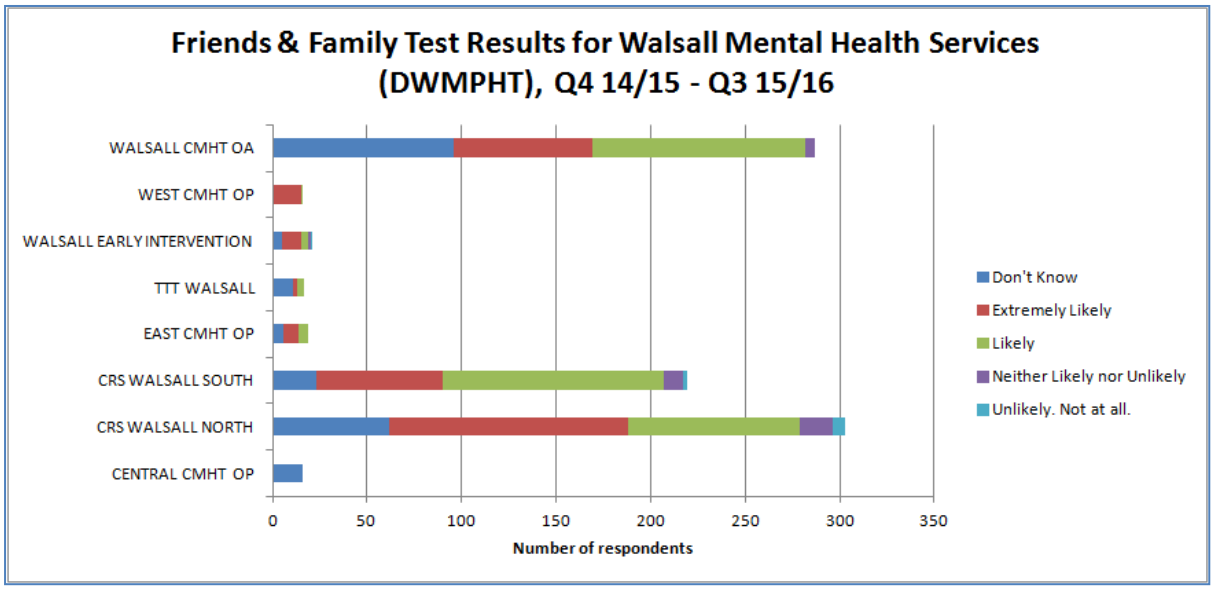
Services that provided group support were the most valued as these tended to counter the issue of isolation, loneliness and feelings that sufferers had to deal with conditions on their own.

Participants in the focus groups also felt that a walk-in centre style approach for people showing signs of mental health conditions might be a suitable way of supporting these vulnerable people. A hub approach, that brought numerous agencies and support services together, was felt to be an appropriate solution.

Friends and Family Test

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.
The latest FFT data (Q4 14/15 – Q3 15/16) for DWMPHT shows that 72% of participates reported that they were likely or extreme likely to recommend the service to friends and family. There was variation in the teams (of care coordinators) ranging from 35% to 100% (see
Figure 91).

Figure 91: Friends & Family Test Results for Walsall MH service, Q4 14/15 - Q3 15/16



Source: DWMPHT

Care Quality Commission National survey

National surveys were used to find out about the experiences of people who receive care and treatment. At the start of 2015, a questionnaire was sent to 850 people who received community mental health services, of which 266 people at Dudley and Walsall Mental Health Partnership NHS Trust responded. This will include both Dudley and Walsall resident patients.

The results show that for all the domains (appendix on page 181), DWMHT rated About the Same as other Trusts with overall experience result of 7.1/10.

The latest DWMPHT Care Quality Commission (CQC) inspection was carried out on 19th May 2016 and the overall finding was "Requires improvement". Table 28 shows the CQC ratings for each area within DWMPHT organisation with the following areas identified as "Requiring improvement": Provider, Acute and PICU and Crisis and Places of Safety (Overall opinion, safe, effective) and Children and Young People for safe.

Table 28: CQC inspection ratings for Dudley and Walsall Mental Health Partnership Trust, 2016

	PROVIDER	Acute and PICU	Adult Community	Older People Community	Crisis and Places of Safety	Children and Younger People	Older Adults Wards
OVERALL OPINION	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Good	Good
SAFE	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Good
EFFECTIVE	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Good	Good
CARING	Good	Good	Good	Good	Good	Good	Good
RESPONSIVE	Good	Good	Good	Good	Good	Good	Good
WELL LED	Good	Good	Good	Good	Good	Good	Good

Source: CQC

Consultation with Key Stakeholders

Aim

The purpose of the Consultation was to understand the views of the wide ranging stakeholders on current services, where there might be gaps or recurrent issues and where there might be strengths and opportunities for further improvement. Their involvement and input was considered significant to help shape the recommendations for the evolution of mental health services in Walsall.

Stakeholders consulted include:

- General Practitioners and Practice nurses
- DWMPHT
- Midwives at Walsall Manor
- Health Visitors
- Police
- Third sector providers

Methodology

Questionnaires were distributed to all stakeholders via email, which was followed by reminder emails. Questionnaires for GPs were also shared at the locality meetings to discuss the reasons behind the survey, generate interest and ensure a high return rate.

The questionnaires explored similar themes for all stakeholders, but were amended to account for the differences in the services provided by the different groups.
A face to face meeting was held with Psychiatric Liaison service, Crisis and Home Care Team, Bloxwich hospital, Community Mental Health Older People team and with colleagues in Police.

A Stakeholder event was hosted in April 2016, where the preliminary findings of the Needs Assesment and Recommendations were shared. The event offered another opportunity for stakeholders to feedback. A report of the event is available from the PH department on request, as are the details of the questionnaire responses received.

Results

A total of 75 individual survey responses were received of which the largest proportion was from General Practitioners and Practice nurses (31). Amongst the DWMHT respondents (18), teams that responses came from were CRS, EAS, Inpatient and Outpatients – Adults and Older Adults, Assertive Outreach, IAPT, CRHT. The range of professionals who responded were Consultant Psychiatrist, management and admin, clinical psychologist, high intensity practitioner, primary MH nurse, CPN, Clinical lead, CBT Practitioner. Despite numerous requests, we have not been able to receive responses from Social Workers.
Of the total maternal health questionnaire respondents (14), the majority were Health Visitors, a few midwives and for some the role was not stated.
The police (7) and third sector (5) responses provided valuable views on how the impact of current mental health services was being felt by the partners.

Main themes

The questions were based around

- confidence in assessing potential mental health problems adults and older people
- onward referral for more support and views on referral processes
- views on the services provided and available in the borough
- strengths, weaknesses and opportunities in the current service provision

Summary of findings from stakeholder consultation

(Caveat – despite repeated effort to engage with a representative sample of stakeholders, the response rates from the different service groups was relatively low, except for GPs and practice nurses.)

Identification and assessment of mental health and emotional wellbeing (MH& EWB) problems

Majority of GP and practice nurse respondents said that they felt confident in assessing the emotional well being and mental health needs of Adults (58%) and Older Adults (45%), with the confidence for the assessment of Older Adults' needs lower than that for Adults. 35% of respondents said they felt 'somewhat confident' or 'don't feel confident' for assessing Older Adults, as compared to 23% for Adults.

Lack of time was stated as the biggest reason (87%) that affects ability to carry out a MH&EWB assessment followed by awareness of interventions and services (45%), skills and training (42%), availability of validated tools (23%) and other priorities (19%). Respondents were more likely ('Always' and 'Most times') to inquire about the MH&EWB of a carer (84%) as compared to a pregnant women (76%) or someone with a LTC (74%).

For assessing and identifying maternal MH&EWB needs, majority respondents (71%) stated they were confident or very confident. Lack of time was reported as the biggest barrier to assessing MH needs, followed by awareness of interventions and services, other priorities and skills and training.

Assessment of wider determinants and lifestyle factors

GP and practice nurse respondents were more likely to inquire (Always and Most times) about the smoking status of the patients (94%), followed by employment status (84%), substance misuse (77%) and levels of physical activity (68%).

Amongst the DWMPHT respondents, substance misuse (90%) and impact on employment (90%) were mostly likely to be inquired about, followed by levels of physical activity (80%), smoking status (70%), benefits (70%), peer support (70%) and housing advice (60%).

Awareness of services and signposting

Lack of signposting for residents and a lack of awareness of available services e.g. WPH amongst clinicians was raised as an issue by the 3rd sector respondents. There was no mention of any community or voluntary sector services which GPs signpost patients to, except for WPH and Age UK mentioned by a very small number of respondents.

Onward referrals and referral processes

Appropriate referrals, criteria and feedback

71% respondents from DWMPHT stated that the referrals they received were 'mostly' appropriate. 41% said they were only sometimes filled with complete information and only 29% said they were mostly completely filled. A small number of respondents complained of insufficient information provided by GPs on referral forms.

For maternal mental health, majority of respondents stated they would refer women to their GP (13/14). A small number mentioned talking therapies, Lifestyle emotional well being service, On line support, CPN, Walsall Pregnancy help service, Home start and health trainer. Almost all respondents stated they had no feedback on their referral but this could be due to majority referrals made by phone call or advising women to self refer.

Amongst the GP and practice nurse respondents, EAS had the maximum positive response with 59% saying they got feedback, followed by IAPT (56%) and less than half i.e. 44% said they got feedback from Older Peoples' service. An equal proportion of respondents felt that referral criteria to EAS was clear (45%) as opposed to somewhat clear or not clear at all (42%). However a larger proportion felt that criteria for Older peoples' services(42%) and IAPT (45%)was somewhat clear or not clear as opposed to 32% stating it was clear for Older Peoples' service and 26% for IAPT.

Waiting Times

Long waiting times for counselling services, funding delays and placement costs were raised in the Trust responses. 93% of GP and practice nurse respondents stated that the waiting time for IAPT was not appropriate, followed by 85% for Older Peoples' service and 68% for EAS.

Discharge arrangements

The majority respondents (47%) from the Trust felt that the community care arrangements made at the time of discharge were adequate only 'some of the time'. Issues raised included lack of communication to care coordinators and between agencies, discharge letters not received by GPs, lack of housing support and lack of local places including day care and local support groups.

Amongst GP and practice nurse respondents, there was greater satisfaction with information received on discharge from Primary Care mental health teams (71% felt it was adequate), followed by Secondary Care Adults (65% felt it was adequate) and Secondary Care Older Adults (52%). Adequacy of community care arrangements available on discharge follow the same trend with 68% of respondents stating they were adequate for those discharged from Primary Care mental health teams, 48% for Secondary Care (Adults) and 44% for Secondary Care Older Adults.

Service Gaps

The absence of specific services was identified across the respondents, along with gaps in the seamless and integrated working between services across domains of care.

Figure 92: Service Gaps identified from Consultation

Lack of specific services	Gaps in integrated working
For those with Learning difficulties, autism, ADHD	Transfer from CAHMS to Adults, especially services for those aged 16-18 years
Personality Disorder service	Transfer from Adults to Older adults
Specialist perinatal service	Transfer from Primary to Secondary care – often patients not appropriate for primary care but not considered eligible for secondary care
Insufficient rehab services	Not enough psychology support and counselling service in secondary care
Insufficient day care and respite services	No review panel for discussing cases of repeat offenders/callers to agree a plan of care
Lack of preventative and early intervention approaches	Not enough support in the community for offenders with mental health needs
	Lack of dedicated pathway for troubled families

Community based services

The lack of support groups, low level intervention and therapy (exercise and socialisation rather than medication for mild to moderate depression) was raised as a concern.

Insufficient preventative and early intervention services in the borough along with inappropriate management of high risk patients in acute settings, for e.g. patients left alone for too long, was stated as leading to high offender numbers due to deterioration of mental health needs, and a high demand on police time and resources for managing repeat callers and missing persons.

The management of those with dual diagnosis, especially when having an acute episode of drugs or alcohol intake, is seen as causing a significant problem.

Third sector respondents identified the need to utilise community spaces or 'hubs'; locations for potential local community groups to take place and provide the public with a point of access for information giving and sharing.

Crisis service

There was consistent criticism across all stakeholders of the current crisis service in the borough, deemed as being understaffed and sufficient to meet the needs of those facing a mental health crisis.

The triage car was mostly seen as a positive addition. However the duration of time needed for the police to spend with a patient brought to 136 suites at Dorothy Pattison hospital was seen as a big demand on police time. The AMP provision at Dorothy Pattisons was felt to be understaffed resulting in lengthy waiting times.

Older peoples' services

Concerns were raised with regards to the current older peoples' services in the borough. The needs of the elderly cohort were felt to be neglected, with problems such as loneliness and social isolation possibly contributing to worsening underlying mental health conditions, as well as acting as a precipitating factor in the development of typical conditions e.g. anxiety, depression. The limited GP time was considered insufficient to meet the emotional well being needs of elderly patients.

It was reported that older people who commit offences driven by mental health issues appear to be on the rise and this could be due to patchy and insufficient services to meet their needs.

GPs reported poorer feedback from Older peoples' services, along with lack of clarity of referral criteria.

Support for vulnerable groups – carers and ethnic minorities

Respondents felt that carers of those living with dementia as well as other mental health conditions could benefit from greater resources and information to aid their work and allow for an improved understanding and higher quality of care.

It was felt that there is greater scope for work to be carried out with ethnic minority groups, e.g. BME, South Asian community, hard to reach groups e.g. homeless people and refugees. There is a great burden of mental health disease in these groups and greater work with them may act as a force for tackling these issues.

Strengths, weaknesses and opportunities

Lack of information sharing amongst agencies was raised as an issue in all stakeholder groups, contributing to a lack of co-ordinated and collaborative approach.

Things that work well in mental health services were reported as the availability of talking therapies which patients could self-refer into, current support groups e.g. Mind Matter cafes, the availability of CPNs in GP practice and that once a patient was in the service they were considered to be well supported.

The weaknesses raised were a reflection of the issues discussed above, and the opportunities stated as the need to address these issues while considering the following:

- Improved communication and information sharing
- More community based services that are open for longer duration over evenings and weekends, and with better signposting
- To facilitate a partnership approach to addressing mental health across health, social care and community partners
- Single point of access to all services
- Increasing dementia and mental health awareness

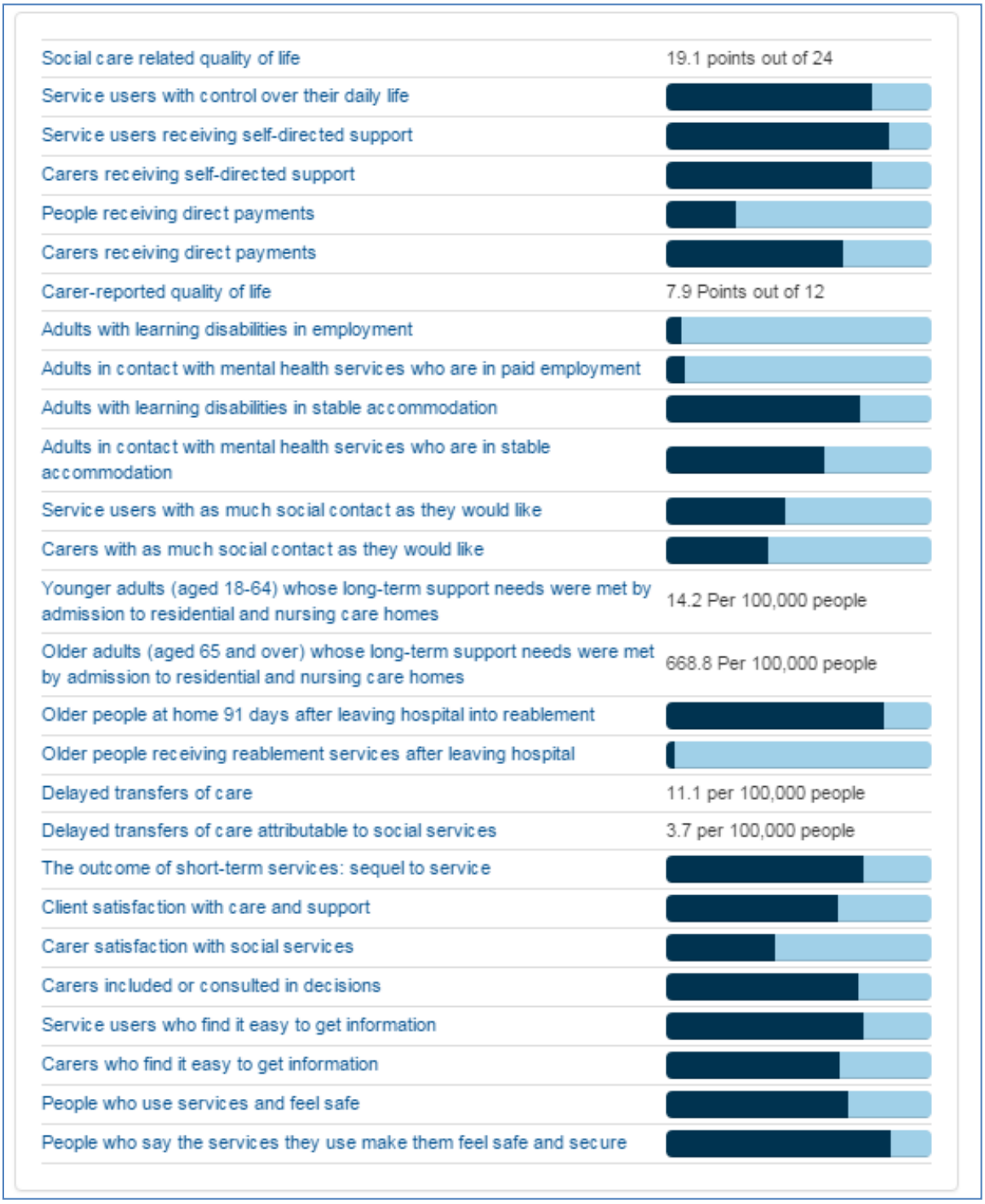
Glossary

ABCD	Asset Based Community Development
ADHD	Attention Deficit Hyperactivity Disorder
AF	Atrial Fibrillation
AMHS	Adult Mental Health Services
AP	Area Partnership
APMS	Adult Psychiatric Morbidity Survey
ASD	Autistic Spectrum Disorder
ASPD	Antisocial Personality Disorder
BAME	Black and Asian Minority Ethnic
BME	Black and Minority Ethnic
BMI	Body Mass Index
BN	Bulimia Nervosa
BPD	Borderline Personality Disorder
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CIN	Children In Need
CJS	Criminal Justice System
CPA	Care Programme Approach
CPN	Community Psychatric Nurse
CPP	Child Protection Plan
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRHT	
CRS	Community and Recovery Service
CSSA	Community Safety Strategic Assessment
CTO	Community Treatment Orders
CYP	Children and Young People
DART	Domestic Assault Response Team
DCLG	Department of Communities and Local Government
DfE	Department of Education
DoH	Department of Health
DV	Domestic Violence
DWMPHT	Dudley and Walsall Mental Partnership Health Trust
DWP	Department of Work and Pensions
EAP	Employer Assistance Programs
EAS	Early Access Service
ED	Eating Disorders
EHC	Education Health And Care Plan
ELSA	English Longitudinal Study of Ageing
ESA	Employment Support Allowance
EU	European Union
FFT	Friends and Family Test

FSM	Free School Meals
GCSE	General Certificate of Secondary Education
GP	General Practitioner
HES	Hospital Episdode Statistics
HiAP	Health in all Policies
HMRC	Her Majesty's Revenue and Customs
HSCIC	Health and Social Care Information Centre
IAPT	Improving Access to Psychological Therapies
IB	Incapacity Benefit
ICD10	International Classification of Disease and Related Health Problems
IMD	Index of Multiple Deprivation
JCPMH	Joint Commissioning Panel for Mental Health
KS2	Key Stage 2
KS4	Key Stage 4
LA	Local Authority
LAC	Looked
LAPE	Local Alcohol Profiles for England
LBG	Lesbian, Gay, Bisexual
LCI	Lower Confidence Interval
LD	Learning Disability
LGBT	Lesbian, Gay, Bisexual or Transgender
LSOA	Lower Super Output Area
MECC	Make Every Contact Count
MH	Mental Health
MINI	Mental Health Illness Index
MOJ	Ministry of Justice
NCHOD	National Centre for Health Outcome Development
NCMP	National Child Measurement Programme
NDTMS	National Drug Treatment Monitoring System
NEET	Not In Education Employment or Training
NHS	National Health Service
NICE	National Institute For Clinical Excellence
NIMHE	National Institute For Mental Health in England
NSF	National Service Framework
OCD	Obsessive Compulsive Disorder
ONS	Office of National Statistics
PANSI	Projecting Adult Needs and Service Information
PD	Personality Disorders
PDI	Physical Disability
PH	Public Health
PHMF	Public Health Mortality File
PHQ	Patient Health Questionnaire
PIE	Psychologically Informed Environment
PMI	Perinatal Mental Illness

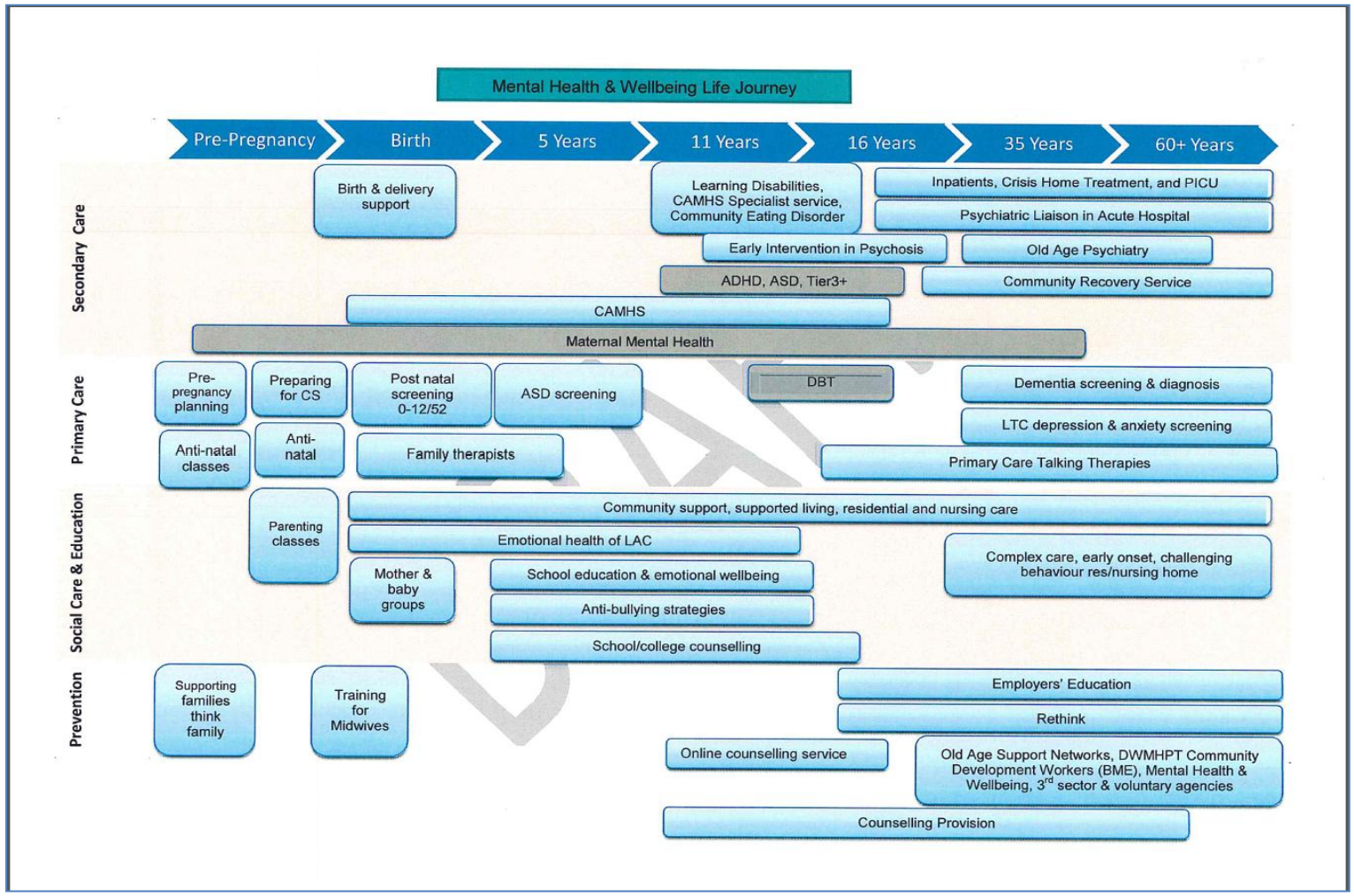
PTSD	Post Traumatic Stress Disorder
QALY	Quality Adjusted Life Year
QIPP	
QOF	Quality Outcome Framework
RDD	Random Digit Dialling
SDA	Severe Disablement Allowance
SDQ	Strengths and Difficulties Questionnaire
SEN	Special Educational Needs
SMR	Standardised Mortality Ratio
SMS	Substance Misuse Service
SUS	Secondary Use Service
TA	Teacher Assessment
TCRU	Thomas Coram Research Unit
UCI	Upper Confidence Interval
UCL	University of Central London
WCCS	Walsall Council Children Services
WHG	Walsall Housing Group
WHNT	Walsall Healthcare NHS Trust
WM	West Midlands
WRAG	Work Related Activity Group
YOW	Youth of Walsall

Appendix 1: Adult Social Care Framework

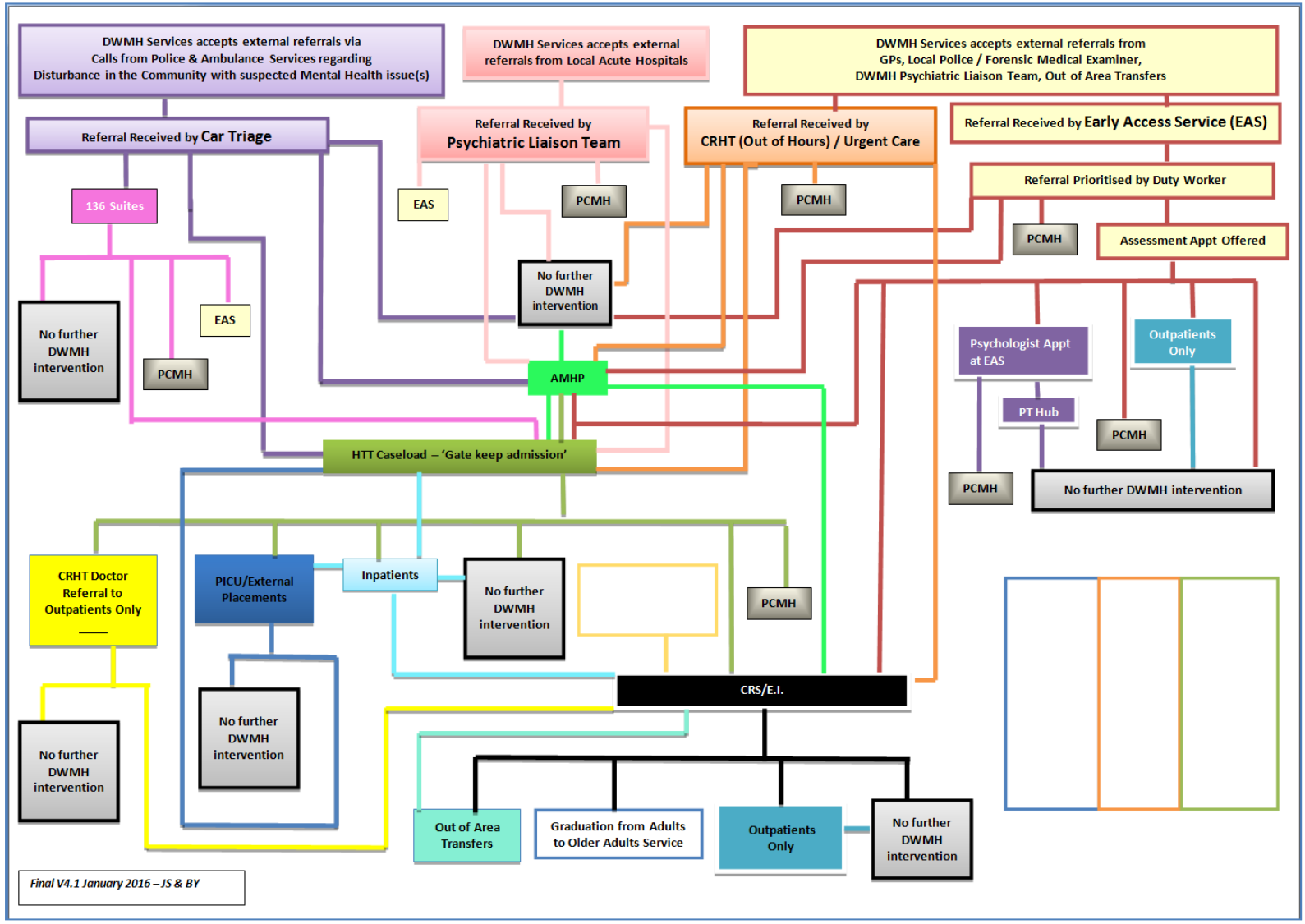


Source: Health and Social Care, 2015

Appendix 2: Current description of Mental Health & Wellbeing Services in Walsall across the Life Course



Appendix 3: Adult Pathway Dudley & Walsall Mental Health Trust



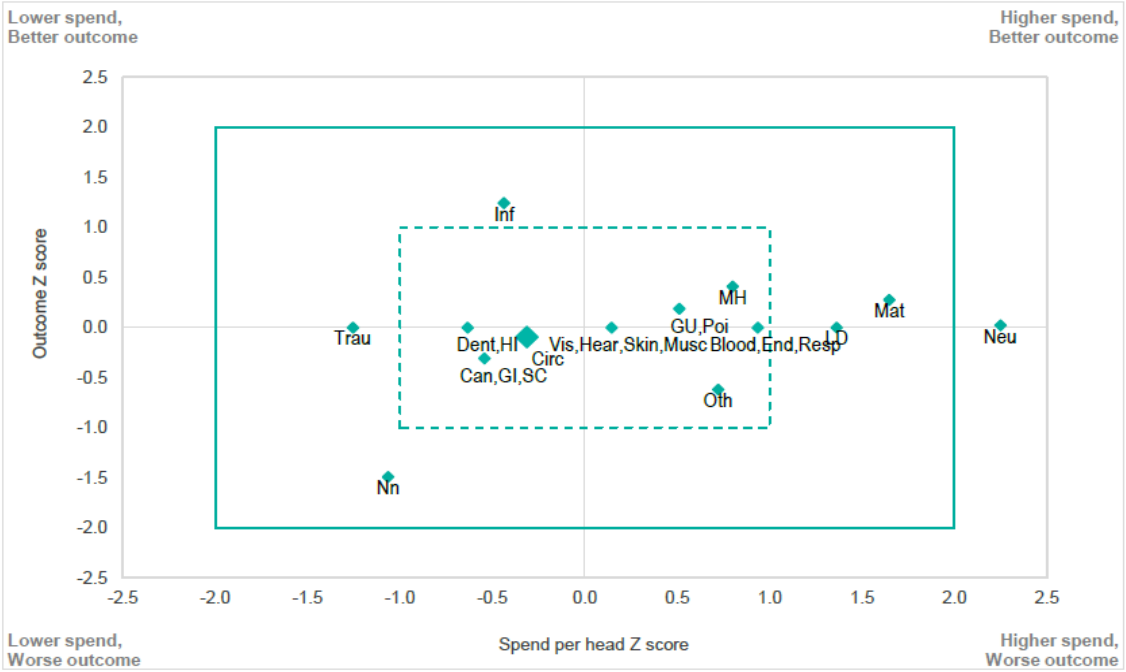
Appendix 4: Spotlight Analysis for Walsall CCG

Public Health England

Spend and outcome tool: Quadrant chart

Organisation	Walsall	Type	CCG
		Period	2015

(●) Weighted ( ) Unweighted outcomes



Interpreting the chart:

Each dot represents a programme budget category. The outcome measures on the chart have been chosen because they are reasonably representative of the programme as a whole. This means that for Other and Total programmes no outcome data is available. The source data for the outcome measures shown on the chart can be found in the Spend and Outcome Tool.

A programme lying outside the solid +/- 2 z scores box, may indicate the need to investigate further. If the programme lies to the left or right of the box, the spend may need reviewing, and if it lies outside the top or bottom of the box, the outcome may need reviewing. Programmes outside the box at the corners may need a review of both spend and outcome. Programmes lying outside the dotted/thin +/- 1 z score box may also warrant further exploration.

Details of the specific spend and outcome measured used are available in the Reference tab.

Z score:
A z score essentially measures the distance of a value from the mean (average) in units of standard deviations. A positive z score indicates that the value is above the mean, whereas a negative z score indicates that the value is below the mean. A z score below -2 or above +2 may indicate the need to investigate further. Each dot represents a programme budget category.

CCG chart quadrant key

Inf	Infection	GI	Gastro Intestinal
Can	Cancers	Skin	Skin
Blood	Blood	Musc	Musculo Skeletal
End	Endocrine	Trau	Trauma and Inj.
MH	Mental Health	GU	Genito Urinary
LD	Learning Dis.	Mat	Maternity
Neu	Neurological	Nn	Neonates
Vis	Vision	Poi	Poisoning…
Hear	Hearing	HI	Healthy Individ.
Circ	Circulation	SC	Social Care
Resp	Respiratory Sys.	Oth	Other
Dent	Dental		

SPOT v3.6.321.xlsb Quadrant 25/09/2015

Appendix 5: CQC Summary for Dudley and Walsall Mental Health Trust

Patient survey	Patient response	Compared with other trusts
Health and social care workers	7.8/10	About the same
Organising care	8.8/10	About the same
Planning care	7.3/10	About the same
Reviewing Care	7.8/10	About the same
Changes in who people see	6.4/10	About the same
Crisis care	6.2/10	About the same
Treatments	7.4/10	About the same
Other areas of life	5.2/10	About the same
Overall views and experiences	7.5/10	About the same
Overall experience	7.1/10	About the same

Appendix 6: DWMPHT Service Line and teams/service mapping.

Service Line	Teams/Services
Acute Services	Early Access Services (EAS) Teams Adult Inpatients CRHT Psychiatric Liaison Street Triage Urgent Care
Community and Recovery Services	Community and Recovery Service (CRS) Teams Psychological Therapies Hub Employment/Vocational Service Criminal Justice
Early Intervention Services	Eating Disorder Early Intervention Services Primary Care/IAPT – provided on a separate report
Medical Outpatients	Adult and Older Adults Outpatients only – excludes CAMHS, CRHT, EI dedicated medical team.
Older Adults	OA CMHTs OA Inpatients Memory Service Day Care

Appendix 7: GP Practice Profile (Mental Health)

Indicator	Period	Practice Count	Practice Value	CCG Value	England Value	England Lowest	England Range	England Highest
Mental Health: QOF prevalence (all ages)	2014/15	34	n/a	0.88%	0.88%	0.06%		15.57%
Exception rate for MH indicators (2014/15 indicators)	2014/15	6	n/a	5.4%	11.1%	0.0%		76.7%
Dementia: QOF prevalence (all ages)	2014/15	40	n/a	0.8%	0.7%	0.0%		59.2%
% reporting Alzheimer's disease or dementia	2014/15	1	n/a	1.0%	1.0%	0.3%		25.0%
Exception rate for dementia indicators	2014/15	1	n/a	5.8%	8.3%	0.0%		100%
Depression: QOF incidence (18+) - new diagnosis	2014/15	35	n/a	1.4%	1.2%	0.0%		18.2%
Depression: QOF prevalence (18+)	2014/15	212	n/a	7.9%	7.3%	0.0%		33.0%
Exception rate for depression indicator (2014/15 indicators)	2014/15	8	n/a	22.5%	24.5%	0.0%		100%
% reporting a long-term mental health problem	2014/15	4	n/a	5.8%	5.1%	0.4%		60.1%
MH002: comprehensive care plan (den. incl. exc.)	2014/15	29	n/a	86.8%	77.2%	0.0%		100%
MH007: record of alcohol consumption for patients on the MH register (last 12 mnths), den. incl. exc.	2014/15	29	n/a	90.5%	80.3%	0.0%		100%
MH006: record of BMI for patients on the MH register in preceding 12 months (den.incl.exc.) - retired	2013/14	27	n/a	87.9%	78.8%	0.0%		100%
MH003: record of blood pressure check in preceding 12 months for patients on the MH register (den.incl.exc.)	2014/15	28	n/a	87.7%	81.5%	0.0%		100%
MH008: Female patients (25-64 yrs) on the MH register who had cervical screening test in preceding 5 years (den. incl. exc.)	2014/15	5	n/a	75.5%	71.6%	0.0%		100%
MH009: Patients on lithium therapy with record of serum creatinine and TSH in the preceding 9 months (den.incl.exc.)	2014/15	5	n/a	96.5%	93.4%	0.0%		100%
MH010: Patients on lithium therapy with levels in therapeutic range in preceding 4 months (den.incl.exc.)	2014/15	5	n/a	90.1%	82.6%	0.0%		100%
MH004: Patients on MH register with cholesterol check in preceding 12 months (den.incl.exc.) - retired	2013/14	9	n/a	78.0%	68.0%	0.0%		100%
MH005: Patients on the MH register with blood glucose or HbA1c check in preceding 12 months (den.incl.exc.) - retired	2013/14	13	n/a	84.4%	74.9%	0.0%		100%
DEP001: Newly diagnosed patients w. depression who had a bio-psychosocial assessment on diagnosis (current FY, aged 18+) (den.incl.exc.) - retired	2013/14	13	n/a	76.7%	75.8%	0.0%		100%
DEP003: Newly diagnosed patients with depression who had a review 10-56 days after diagnosis (den.incl.exc.)	2014/15	26	n/a	67.9%	63.8%	0.0%		100%
DEM002: Dementia care has been reviewed last 12mths (den.incl.exc.)	2014/15	28	n/a	79.1%	77.0%	0.0%		100%
DEM003: Blood tests recorded (den.incl.exc.)	2014/15	5	n/a	85.8%	74.7%	0.0%		100%

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