



Birmingham and Solihull Mental Health,
Learning Disabilities and Autism
Provider Collaborative

Birmingham and Solihull Mental Health Needs Assessment (2025)



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Executive Summary

Why have we undertaken this needs assessment?

The purpose of this needs assessment is to understand the mental health needs of the population of Birmingham and Solihull. This will be used to inform our plans to meet those needs as effectively as we can.

Key areas of focus have included:

- Evaluating how effectively services cater to diverse communities and groups of Birmingham and Solihull.
- Identifying disparities in access, experience and outcomes that exist for different groups and based on where people live.
- Highlighting areas where there are gaps in existing provision and pathways of care.
- Outlining initiatives which are aiming to improve service provision and better meet population needs.
- Analysing trends in prevalence and projections of future needs.
- Considering mental health needs across the life course.
- Gathering perspectives from communities and people who access mental health services on current provision and opportunities to make improvements.
- Suggesting areas for further research, service development, and strategic priorities for the Mental Health, Learning Disabilities and Autism Provider Collaborative's upcoming 5-year strategy.



What were our key findings and recommendations?

National trends in prevalence

Surveys in England have shown that in recent years there has been:

- An increase in the proportion of working age adults with common mental health conditions rising to a prevalence of 22.6% of 16- to 64-year-olds in 2023/24.
- An increase in the proportion of children and young people aged 8 to 25 years with a probable mental disorder with a prevalence of 1 in 5 children and young people in 2023.

Local trends in prevalence

Data on the prevalence of mental health conditions in Birmingham and Solihull show:

- Depression prevalence has increased in both Birmingham and Solihull over the last decade in line with national trends rising to 12% of the population in both areas in 2022/23.
- In Birmingham the prevalence of SMI (serious mental illness) has consistently been above the national average rising from 1.1% to 1.2% of the population (17,476 people) in 2022/23.
- In Solihull the prevalence of SMI has consistently been below the national average although this increased over the last decade from 0.7% to 0.9% of the population (2,078 people) in 2022/23.
- It was estimated in 2019 that there were 134,755 Birmingham adults aged 18-64 with a common mental health condition representing 18% of the age group population, with this number projected to increase by 5% by 2030.
- There are an estimated 24,000 working-age adults with common mental health conditions¹ in Solihull, with higher prevalence in deprived communities.

¹ Refer to the [Mental Health Needs Assessment glossary](#) for definition

Mental health condition in adults

1 in 5 adults currently have a mental health condition.
By 2030 it's predicted to be 1 in 4 adults.



1 in 5
currently



1 in 4
by 2030

Collectively this data points to the worsening mental health of the population and increasing levels of need for mental health support. The increasing proportion of children and young people with mental health conditions is significant given the high proportion of the Birmingham and Solihull population aged under 25 years and that Birmingham is the youngest core city in the UK. There are gaps in our understanding of the prevalence of anxiety in the local population and this is an area where we could build our understanding to inform future service planning and commissioning of services.

Recommendation: The Provider Collaborative should work with NHS partners, local authorities, and other stakeholders to produce a clearer, data-driven picture of future population health needs, using mental health prevalence data and population change forecasts.

Demand for mental health services in Birmingham and Solihull

Multiple sources of information indicate that there has been growth in the demand for mental health services in Birmingham and Solihull and that services are experiencing challenges keeping pace with rising demand:

- For NHS Talking Therapies a total of 51,595 referrals were received in 2024, an 80% increase from 2020.
- For Secondary Mental Health Services², a total of 179,908 referrals were received in 2024, a 58% increase from 2020.
- The number of unique³ patients in contact with mental health services increased by 42% from 2020 to 2024.
- In-patient bed occupancy was 95% at Birmingham and Solihull Mental Health Foundation Trust at the end of quarter 4 of 2024/25 which is above the national average of 90% and above the recommended occupancy level of 85%.
- Figures on the average length of stay and long length of stay for adult acute mental health beds show that Birmingham and Solihull is in the quartile with longest length of stay. Length of stay is higher than both the national average and recommended peers.
- Data on discharges from mental health inpatient beds between July 2023 and June 2024 shows that 33% of Birmingham and Solihull patients were readmitted within six months. For patients in adult learning disability inpatient beds, the readmission rate rises sharply to 99%.

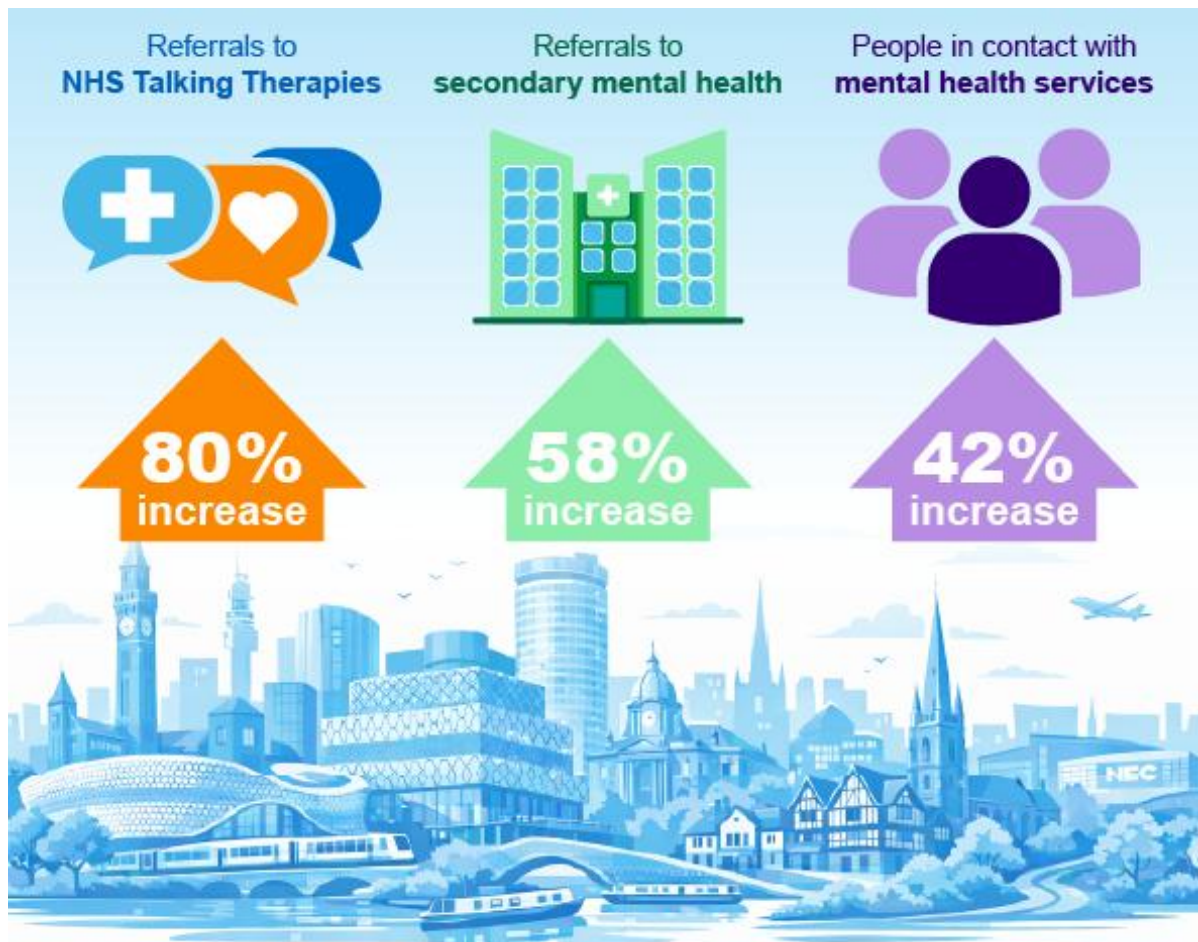
Recommendation: The Provider Collaborative and partners to ensure delivery of the 3-year inpatient bed strategy with a sustained focus on:

- Reducing length of stay for adult inpatients
- Reducing adult inpatient bed occupancy
- Reducing the proportion of delayed discharges from adult inpatient beds
- Reducing the percentage of discharges from learning disability beds which results in readmission within 6 months

² Refer to the [Mental Health Needs Assessment glossary](#) for definition

³ Refer to the [Mental Health Needs Assessment glossary](#) for definition

Mental health services in Birmingham and Solihull 2020–2024



Mental health needs across the life course

The needs assessment has considered mental health needs across the following stages of the life course: perinatal and infant mental health, children and young people's mental health, the mental health of working age adults and the mental health of older adults.

Perinatal and infant mental health – key messages

Critical window: The first 1,001 days of life are crucial for early intervention and prevention. Perinatal mental illness can affect the parent-infant relationship, impacting the baby's ability to form secure attachments, which is key for future emotional wellbeing. Evidence shows that the return on investment is greatest at this stage of the life course.

High prevalence and unmet need: Birmingham and Solihull have the second highest rates of perinatal mental health conditions in the country. [The assessment of need in Birmingham](#)⁴ identified gaps in mental health support for 0–2-year-olds even where services had a remit from birth.

Findings from the assessment of need in Birmingham: The assessment of need in Birmingham recommended that capacity for specialised parent-infant support should be expanded. Work should also continue to build on internal and external links with staff to offer consultation, training and increase service capacity for 0–2s so they can benefit from specialised support.

Assessment of need in Solihull: A needs assessment of parent-infant relationship help and support in Solihull will soon be published, outlining gaps in provision and unmet needs.

Recommendations: The Provider Collaborative to review the findings from both the Birmingham and Solihull needs assessments with consideration of how to build a cohesive Birmingham and Solihull offer which addresses unmet needs as part of service transformation.



Birmingham and Solihull have the second highest rates of perinatal mental health conditions in the country.

⁴ <https://parentinfantfoundation.org.uk/wp-content/uploads/2022/11/Nurturing-our-future.pdf>

Children and young people's mental health – key messages

The level of child poverty in Birmingham is a significant risk factor for poor mental health. It is well established that poverty is linked to a higher risk of [adverse children experiences](#)⁵ leading to greater risk of poor mental wellbeing and mental ill health. Latest figures indicate that [nearly 1 in 2 children in Birmingham are growing up in poverty](#).⁶



The under 25 population in Birmingham is extremely diverse with the Asian ethnic group accounting for 37% of the population. This is significant as evidence shows that South Asian ethnic groups are under-represented within children and young people's mental health services in Birmingham and Solihull. Feedback from communities also highlights concerns regarding the lack of cultural competency of services and difficulties navigating and accessing

support. Whilst Solihull is less diverse than Birmingham, diversity is greatest in the under 25 age group with 28% of children in Solihull schools from ethnic minority groups.

Effective interventions: There is strong evidence that parenting programmes, anti-bullying initiatives, school-based interventions for anxiety and depression, targeted suicide prevention, and universal school-based suicide prevention programmes all offer good return on investment.

Neurodevelopmental pathway challenges: There are significant issues with long waits for first appointments, assessments, and diagnostic decisions for neurodevelopmental conditions in Birmingham and Solihull. Average waiting times for initial assessments in Birmingham and Solihull exceed 50 weeks for autism and 37 weeks for ADHD.

Vulnerable groups: Care experienced children and young people, and those in contact with the criminal justice system, have heightened vulnerabilities and higher prevalence of mental health conditions, encounter multiple barriers to accessing services and may benefit from targeted support.

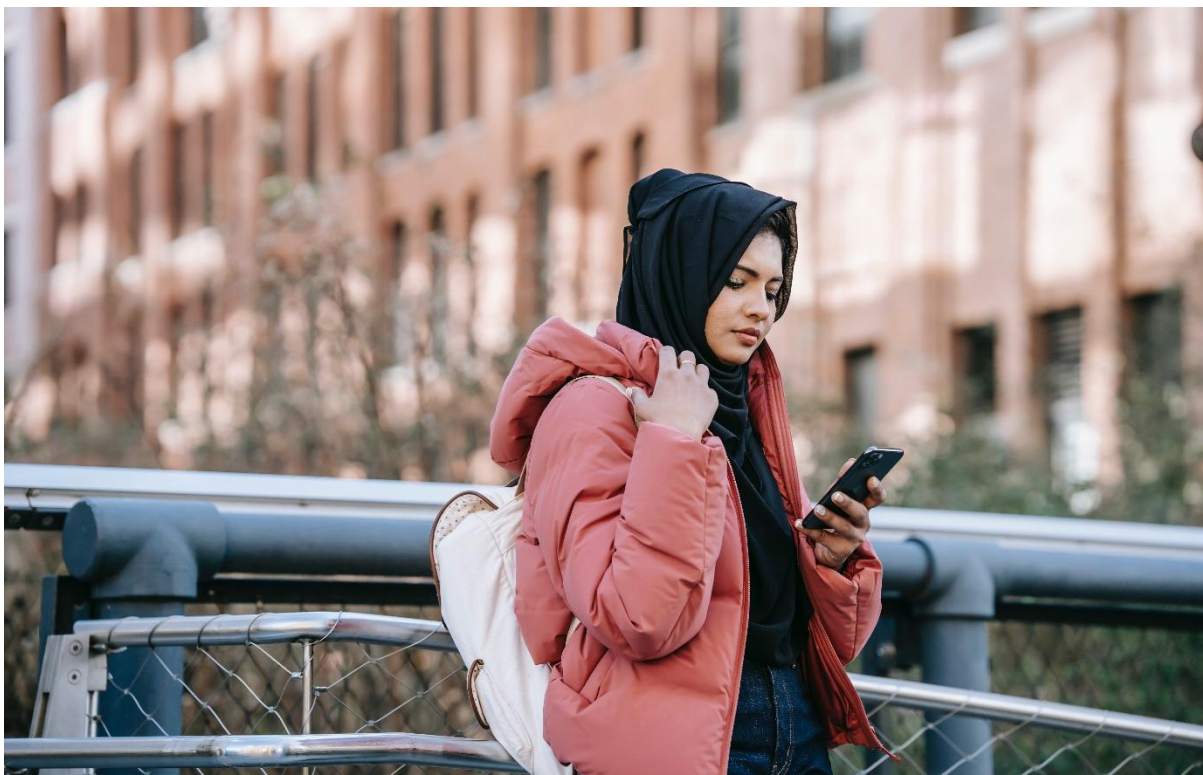
⁵ <https://safeguarding-guide.nhs.uk/context-of-NHS-safeguarding/s2-06/>

⁶ <https://www.resolutionfoundation.org/publications/uneven-ground/>

Service access and wait times: There are major challenges with waiting times and access to mental health services, including variations in rates of access by parliamentary constituency, long wait times for first contact, and a high proportion of referrals discharged without contact.

Recommendation: Local plans to transform children and young people's mental health services to include details regarding:

- How they will incorporate interventions which have robust evidence of effectiveness and potential for good return on investment
- Provision of targeted mental health support for vulnerable groups who encounter significant barriers accessing support such as care experienced children and children and young people in contact with the criminal justice system
- How waiting times for support from children and young people's mental health services can be reduced
- How the broader system offers for those who do not meet the thresholds of children and young people's mental health services can be strengthened
- How delays in the neurodevelopmental diagnostic pathway can be addressed to decrease the time taken from referral to diagnosis and post-diagnostic support improved
- How barriers to accessing support can be reduced for communities who are under-represented within children and young people's mental health services



Working age adults – key messages

Material disadvantage and unemployment: Material disadvantage and unemployment are strong factors affecting mental health and wellbeing in working age adults. Birmingham has higher rates of unemployment and a lower proportion of the population who are economically active compared to the national average whilst the reverse is true in Solihull.

The mental health of the working age population: Nationally, there has been an increase in the proportion of the working age population who report mental health conditions with non-work-limiting conditions increasing twelve-fold over the past 20 years.

Employment support for adults with severe mental illness (SMI): The individual placement and support (IPS) model supports people with severe mental illness (SMI) into employment, and in Birmingham and Solihull, more than 1,500 people with SMI have entered and sustained employment with IPS support during 2024/25.

Recommendation: Given the challenged picture in Birmingham and the importance of employment and material disadvantage to mental wellbeing it is recommended that the Provider Collaborative strategy and commissioning plans consider how employment support for people with mental health conditions can be strengthened further.



Older adults – key messages

Prevalence of mental health conditions: It was estimated that in 2020 that 4,132 older people in Birmingham had severe depression which represented nearly 3% of the population aged 65 years and above. By 2040, this number is predicted to rise to 5,393 people.

Multiple long-term conditions: An ageing population with an increasing prevalence of multiple long-term conditions has significant impacts upon the mental health of older adults. The close relationship between physical and mental health means that treatment for older people needs to be integrated, rather than condition specific.

Vulnerable groups: Prevalence of mental health conditions are higher among specific groups of older people. For example, national research shows that 40% of older people who are living in care homes have depression; 30% of older carers experience depression at some point; and older people going through a bereavement are up to four times more likely to experience depression than older people who haven't been bereaved.

Older carers: The impact of caring responsibilities can have a significant impact on the mental health of older adults. It is estimated that nationally there will be 1.8 million older carers by 2030 and nearly half of carers aged 85 or over who are providing 20 or more hours of care a week say that they feel anxious or depressed. In Solihull, 23% of carers are aged over 65. In Birmingham, the figure is 34%.

Dementia can trigger mental health problems, with estimates suggesting that 20-40% of people living with dementia are depressed, it can also make treatment of mental health conditions more challenging. There are currently an estimated 13,000 people living with dementia in Birmingham and Solihull. **It is estimated there will be over 17,000 people living with Dementia in Birmingham and Solihull by 2040.**

Barriers to help seeking include perceiving poor mental health as an inevitable part of ageing, fear of being a burden, and concern about being judged or stigmatised as well as lack of awareness of potential symptoms of mental health conditions.

The rate of prescribing of anti-depressants in Birmingham and Solihull is highest in the population aged over 50 years with highest rates of prescribing in those aged 60 to 69 years and those aged 80 to 89 years. National research indicates that older people with mental health problems are more likely to be prescribed anti-depressants and less likely to be referred for talking therapies than younger adults.

NHS Talking Therapies: Older adults are under-represented in NHS talking therapy services in Birmingham and Solihull. **Rates of access for talking therapies are lowest in the over 65 age group, however, recovery rates are highest in the over 65s.** This suggests that there is potential significant benefit in increasing the proportion of over 65s accessing talking therapies.



Recommendation: It is recommended that the mental health needs of older adults is an explicit focus within Provider Collaborative strategy and implementation plans with consideration of:

- How integrated rather than condition specific support can be developed to meet the needs of older adults with multiple long-term conditions and mental health needs
- How mental health support can be strengthened for older adults who have heightened risk of mental health difficulties including older carers
- How stigma in relation to mental health can be reduced and rates of access of NHS talking therapies for over 65s can be increased

Health inequalities

Key findings from the needs assessment in relation to health inequalities include:

Barriers to accessing mental health support

Community engagement and feedback from multiple sources has highlighted consistent themes across a range of communities in Birmingham and Solihull:

- **Cultural awareness:** Mental health services often lack understanding of cultural needs.
- **Cultural stigma:** Stigma around mental health in various cultures hinders discussions and help-seeking.
- **Access to support:** Challenges exist in knowing what support is available and how to access it.
- **Language barriers:** Lack of translation services reduces accessibility.

Inclusion health groups

Inclusion health groups typically have worse health outcomes due to experiences of overlapping risk factors for poor mental health such as poverty, violence and complex trauma. This includes groups such as care experienced children and young people, people in contact with the criminal justice system, people who are homeless, people with addictions to substances and refugees and asylum seekers.

Identified gaps in mental health service provision for inclusion health groups in Birmingham and Solihull include:

- People with co-current substance misuse and mental health conditions (dual diagnosis) are often excluded from services and do not receive holistic care.
- There are gaps in access to counselling and trauma informed mental health support for victims of domestic abuse.

- Significant unmet mental health needs for sex workers as highlighted in the [Sex Worker Analysis of Health Needs \(SWAN\)](#)⁷ report produced by Birmingham City Council.

Disparities based on ethnicity and where people live

Disparities and variations by ethnic group and where people live in Birmingham and Solihull include:

- The Black Caribbean, Black Other, and Mixed – White and Black Caribbean ethnic groups have high rates of detention under the Mental Health Act in Birmingham and Solihull. Rates of detention were greater than 200 per 100,000 population compared to the average of all ethnic groups of 101 per 100,000.
- People of Black Caribbean, Black Other and Mixed – White and Black Caribbean ethnicity have the highest rates of accessing services for Severe Mental Illness (SMI) and Crisis services.
- The White Irish ethnic group has the higher rates of anti-psychotic and anti-depressant prescriptions of all ethnic groups in Birmingham and Solihull and the third highest rate of accessing Crisis services.
- The Chinese ethnic group has the lowest rate of detention under the Mental Health Act, the lowest rate of being prescribed anti-depressants and anti-psychotic medication and lowest rate of access Crisis and SMI services.
- Access to children and young people's mental health services varies significantly by constituency, with lower access in deprived areas like Ladywood and Hodge Hill.
- Prescribing rates for anti-psychotic medications vary considerably across Birmingham and Solihull, ranging from 1,308 per 100,000 in Sutton Coldfield to 2,087 per 100,000 in Erdington.

Recommendation: Provider Collaborative strategy and implementation plans to ensure there is a focus on the following areas:

- Developing targeted support and provision where evidence and research indicate gaps and unmet need for inclusion health groups, for example sex workers and victims of domestic abuse.
- Contributing to existing initiatives and plans to address inequalities such as the development and implementation of the dual diagnosis working protocol
- Improving the cultural competency of services and reducing barriers to access for under-represented groups and communities.
- The collection and analysis of data regarding protected characteristics⁸ and development and oversight of plans to address health inequalities.

⁷⁷ https://www.birmingham.gov.uk/info/50342/public_health_reports/2955/inclusion_health/2

⁸ <https://www.equalityhumanrights.com/equality/equality-act-2010/protected-characteristics>

Initiatives to improve services and better meet needs

There are a variety of initiatives and plans for Birmingham and Solihull to improve the accessibility of mental health support and better meet population needs.

These include:

- The 24/7 pilot in East Birmingham (pictured right) which aims to provide an integrated service offer including crisis care, home treatment, early intervention, community, rehabilitation with plans to include inpatient care as part of future development of the service. The service is focused on looking after the whole person, considering the physical health and social needs alongside their mental health.
- Initiatives to improve access to mental health support in the community as part of community transformation such as neighbourhood mental health teams, intensive community rehabilitation teams, the older adult connector and peer support pilot and services developed as part of the health inequalities workstream.
- A transformation programme for children and young people's service to develop a consistent Birmingham and Solihull service, tailored to localities.



Recommendation: The Provider Collaborative oversees rigorous evaluation of these projects and initiatives to ensure they are meeting stated aims and objectives and identifying opportunities to scale up areas of good practice.

Perspectives of communities and service users

The experience of care campaign was commissioned by the Mental Health, Learning Disabilities and Autism Provider Collaborative to gather detailed feedback on people's experiences with NHS mental health services in Birmingham and Solihull. It included a desktop review of existing publications and evidence, focus groups and interviews and an online survey.

Key themes which were highlighted were:

- **Long wait times:** There is a significant negative impact of long wait times and difficulties accessing support.
- **Lack of support:** Insufficient support is available for service users and their families while waiting for services.
- **Awareness and information:** There is a lack of awareness and information about available community support.
- **System navigation:** People encounter difficulties navigating the complexities of the mental health support system.
- **Communication issues:** Problems with communication, such as difficulty reaching teams and delays in receiving appointment letters impacted upon accessibility of support.
- **Continuity of care:** The lack of continuity in care leads to information having to be repeated to multiple professionals.
- **Tailored services:** Services are not adequately tailored to the needs of individuals with autism.
- **Stigma and shame:** Stigma and shame related to mental health in various communities.
- **Community assets:** It was recognised there is a need to strengthen community assets and peer support.
- **Service integration:** It was recognised there is a need for better coordination and integration of services.
- **Survey findings:** 245 responses were received to the online survey. Findings included:
 - Referral processes: Varied difficulty in referral processes, with some services being more challenging to access than others.
 - Wait times: Long wait times and difficulties accessing support were frequently cited.
 - Support while waiting: 64% felt they did not receive timely support.
 - Satisfaction scores: Average satisfaction score was 2.82 out of 5, with the lowest for children and young people's services (1.96) and the highest for inpatient services (2.86).



“I can't complain about the support I got. It was a long wait to see someone; it would be good to have someone to check in with me more often.”

Priorities for improvement identified via the campaign were:

- **Community engagement:** Strengthen community engagement and leverage lived experience expertise.
- **Trust building:** Repair relationships and build trust with communities.
- **Support while waiting:** Improve support available while waiting for NHS services.
- **Shared vision:** Co-produce a shared vision for Provider Collaborative with community and stakeholder engagement.
- **Focus on outcomes:** Set key priorities and ensure focus on outcomes and accountability.
- **Evaluation framework:** Develop a framework to measure and evaluate progress against Provider Collaborative strategy commitments.

Recommendation: The Provider Collaborative 5-year strategy draws on key themes from the experience of care campaign when setting out future vision and ambitions for the development of mental health services in Birmingham and Solihull.



“

“Eventually, I got a professional who sat and listened to us after years and this was amazing! It made a huge difference, and we now have a good support team.”

Glossary of key terms

There are a variety of different key terms, acronyms and other terminology used throughout the report. Where possible these are explained within the text or links are provided to external websites which provide further information and definition. However, there are some key concepts which are used throughout the report which are also summarised here below to help aid understanding.

Adverse childhood experiences: Adverse childhood experiences (ACEs) are traditionally understood as a set of 10 traumatic events or circumstances occurring before the age of 18 that have been shown through research to increase the risk of adult mental health problems and debilitating diseases. Five ACE categories are forms of child abuse and neglect, which are known to harm children and are punishable by law, and five represent forms of family dysfunction that increase children's exposure to trauma. Further information on adverse childhood experiences is available here:

<https://www.eif.org.uk/report/adverse-childhood-experiences-what-we-know-what-we-dont-know-and-what-should-happen-next>

Attention Deficit Hyperactivity Disorder (ADHD): ADHD is a developmental disorder characterized by an ongoing pattern of one or more of the following types of symptoms:

- Inattention, such as having difficulty paying attention, keeping on task, or staying organized
- Hyperactivity, such as often moving around (including during inappropriate times), feeling restless, or talking excessively
- Impulsivity, such as interrupting, intruding on others, or having trouble waiting one's turn

It is common for people to show these behaviours some of the time. However, for people with ADHD, the behaviours are frequent and occur across multiple situations, such as at school, at home, at work, or with family and friends. Further information on ADHD is available here:

<https://www.nimh.nih.gov/health/topics/attention-deficit-hyperactivity-disorder-adhd>

Common mental health conditions: Common mental health conditions (CMHCs), also referred to as common mental disorders (CMDs) comprise different types of depression and anxiety. They cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. Although usually less disabling than major psychiatric disorders, their higher prevalence means the cumulative cost of CMHCs to society is great (Stansfeld, et al., 2016).

Health inequalities or health inequities: Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. They include differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age. Further detail regarding health inequalities is available here:

<https://www.kingsfund.org.uk/insight-and-analysis/long-reads/what-are-health-inequalities>

Index of Multiple Deprivation: The [Index of Multiple Deprivation \(IMD\)](#) is the official measure of relative deprivation for small areas in England. It is based on 39 separate indicators across seven domains of deprivation, and areas are ranked from most deprived to least deprived.

<https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019>

Integrated Care Boards: [The role of the Integrated Care Board \(ICB\)](#) is to allocate the NHS budget and commission services for the population, taking over the functions previously held by NHS Clinical Commissioning Groups (CCGs) and some of the direct commissioning functions of NHS England. The ICB is directly [accountable](#) to NHS England for NHS spend and performance. Integrated care boards (ICBs) replaced Clinical Commissioning Groups (CCGs) in the NHS in England from 1 July 2022.

<https://www.kingsfund.org.uk/insight-and-analysis/animations/how-does-nhs-england-work>

<https://www.kingsfund.org.uk/insight-and-analysis/long-reads/understanding-accountabilities-structures-health-care>

Integrated Care System: [Integrated care systems \(ICSs\)](#) are local partnerships that bring health and care organisations together to develop shared plans and joined-up services. They aim to improve outcomes, tackle inequalities, enhance productivity and support social and economic development. Following the passage of the [2022 Health and Care Act](#), ICSs were formalised as legal entities with statutory powers and responsibilities. There is a [single ICS for Birmingham and Solihull](#).

<https://www.england.nhs.uk/integratedcare/what-is-integrated-care/>

<https://www.kingsfund.org.uk/insight-and-analysis/long-reads/health-and-care-act-key-questions>

<https://www.birminghamsolihullics.org.uk/>

Life course approach: A [life course approach](#) considers the critical stages, transitions and settings where large differences can be made in promoting or restoring health and wellbeing. Adopting the life course approach means identifying key opportunities for minimising risk factors and enhancing protective factors through evidence-based interventions at key life stages, from preconception to early years and adolescence, working age, and into older age.

<https://www.gov.uk/government/publications/health-matters-life-course-approach-to-prevention/health-matters-prevention-a-life-course-approach>

Mental health: Mental health is a state of mental wellbeing that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It is an integral component of health and wellbeing that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in (World Health Organization, 2022).

Mental Health, Learning Disabilities and Autism Provider Collaborative:

The Provider Collaborative is a partnership of NHS providers of mental health services and the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector which works closely with wider system partners including local authorities and is responsible for commissioning mental health services in Birmingham and Solihull. The responsibility for commissioning has been delegated from the ICB who retain formal accountability and provide oversight of the Provider Collaborative.

Mental Health Services Data Set (MHSDS): [The Mental Health Services Data Set \(MHSDS\)](#) is a national data collection in England for patients in contact with mental health, learning disabilities, and autism services. It aims to provide robust, consistent, and comparable data for these services. The MHSDS is a secondary uses dataset, meaning it collects data from patient records for purposes beyond direct patient care, such as research, service planning, and commissioning.

<https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/about>

Post-traumatic stress disorder: Post-traumatic stress disorder (PTSD) is a mental health condition that can be caused when someone is exposed to a traumatic event. The [International Classification of Diseases 11th revision \(ICD-11\)](#) describes a major traumatic event as “a stressful event or situation of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone.”

The [Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition \(DSM-5\)](#) describes a major traumatic event as “exposure to actual or threatened death, serious injury, or sexual violence.” [Symptoms of experiencing PTSD](#) include re-experiencing the event, avoiding reminders of the event and experiencing symptoms of heightened arousal that cause significant distress, and interfere with daily activities and family, social, school or working life.

<https://icd.who.int/en/>

<https://www.psychiatryonline.org/dsm>

<https://www.who.int/news-room/fact-sheets/detail/post-traumatic-stress-disorder>

Prevalence: Prevalence is the proportion of a population who have a specific characteristic in a given time period. In the context of this report, prevalence is discussed in relation to the proportion of the population nationally or within Birmingham and Solihull who have mental health conditions. Prevalence may be reported as a percentage (5%, or 5 people out of 100), or as the number of cases per 10,000 or 100,000 people. Further detail regarding the definition of prevalence is available here:

<https://www.nimh.nih.gov/health/statistics/what-is-prevalence>

Provider Collaborative: See ‘Mental Health, Learning Disabilities and Autism Provider Collaborative’.

Secondary mental health services: Secondary mental health services provide specialized care for individuals with more severe or complex mental health conditions than those typically addressed in primary care. These services are often accessed through referral from a general practitioner (GP) or another healthcare professional. Secondary services may include community mental health teams, crisis resolution and home treatment teams, assertive outreach teams, and inpatient mental health wards.

Severe mental illness (SMI): Severe mental illness (SMI) has been defined as “a mental, behavioural, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities” (The National Institute of Mental Health, 2024). It is an umbrella term for chronic psychiatric disorders, such as schizophrenia and schizoaffective, delusional, major depressive, and [bipolar disorders](#).

<https://www.sciencedirect.com/topics/psychology/bipolar-disorder>

Social determinants of health: The [social determinants of health](#) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of influences shaping the conditions of daily life. These include economic policies and systems, development agendas, social norms, social policies and political systems.

https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

The Mental Health Act: [The Mental Health Act \(1983\)](#) provides the legal framework to detain and treat people in a mental health crisis, who are at risk of harm to themselves or others. The purpose of the Act is to make sure that patients get the vital treatment they need in a place that is safe for both them and others.

If a patient is well enough to leave hospital but still needs extra support, the Act also gives clinicians the power to arrange a [Community Treatment Order](#). This is where patients are required to meet certain conditions set by their clinician and receive supervised care in their community.

<https://www.legislation.gov.uk/ukpga/1983/20/contents>

<https://www.mind.org.uk/information-support/legal-rights/community-treatment-orders-ctos/overview/>

Trauma and trauma informed practice: Trauma is when people experience very stressful, frightening or distressing events that are difficult to cope with or out of their control. It could be one incident, or an ongoing event that happens over a long period of time.

[Trauma informed practice](#) is an approach to health and care interventions which is grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development. Trauma-informed practice aims to increase practitioners' awareness of how trauma can negatively impact on individuals and communities, and their ability to feel safe or develop trusting relationships with health and care services and their staff.

More detail regarding trauma informed practice, including its 6 key principles is available here:

<https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice>

Voluntary, Community, Faith and Social Enterprise (VCFSE) sector:

The voluntary, community, faith and social enterprise (VCFSE) sector is an important partner for statutory health and social care agencies and plays a key role in improving health, wellbeing and care outcomes. The VCFSE sector is a key part of the Provider Collaborative governance and decision-making.

1. Background and Context

This section sets out key contextual information for the mental health needs assessment including the national and local strategy and policy context, information regarding the establishment of the provider collaborative, the purpose and scope of the needs assessment and a brief overview of the social determinants of health and how they impact upon mental health.

1.1. National Policy and Strategy

Key areas of national strategic direction and policy for NHS mental health services in England include the NHS Long Term Plan, national guidance and policy regarding reducing health inequalities and the NHS 10 year plan published in July 2025. These are discussed in turn below.

1.2. The NHS Long Term Plan

The NHS Long Term Plan, which was published in 2019, set out commitments to:

- Increase funding for mental health services at a faster rate than the overall NHS budget and by at least £2.3bn a year by 2023/24.
- Improve access to mental health crisis care, mental healthcare for mothers during and after pregnancy, and increase mental health support available for children and young people including in schools and college.
- Deliver care closer to home and improve access and quality of care for adults and older adults with severe mental illnesses. This includes developing integrated models of care, including primary and community mental health services, and ensuring that at least 370,000 individuals are supported by 2023/24.
- Continue to develop services in the community and hospitals, including talking therapies and mental health liaison teams, to provide the right level of care for hundreds of thousands more people with common or severe mental illnesses.

1.3. Health Inequalities

National plans and initiatives to tackle health inequalities include:

- **Advancing Mental Health Equalities Strategy (2020):** Focus on reducing health outcome gaps through policy development, co-production with experts, and regional capacity building.
- **Core20PLUS5:** Targets the most deprived 20% of the population and specific at-risk groups, focusing on five clinical areas, including severe mental illness.
- **Patient Carer Race Equality Framework (PCREF, 2023):** Aims to reduce racial inequalities in mental health services through leadership, data transparency, and feedback mechanisms.

1.4. Lord Darzi's Investigation

Following the election of the Labour government in 2024 Lord Ara Darzi was asked to undertake an independent investigation into the NHS. In September 2024 Lord Darzi published the [report from his investigation](#); key points from the investigation regarding mental health include:

- The prevalence of mental health conditions in England has increased and there is rising demand on services, with long waits for mental healthcare having become normalised.
- Funding and resources need to be shifted to the community and the NHS needs to embrace multidisciplinary models of care that bring together primary, community and mental health services.
- There has been a lack of capital investment in the NHS and some mental health units are in poor condition.

Lord Darzi also discussed inequalities in access to mental health services and mental health outcomes. In particular, he highlighted the impacts of poverty and homelessness on mental health, as well as the disproportionate use of the Mental Health Act to detain Black or Black British people.

1.5. The NHS 10 year plan

Published in July 2025, the NHS 10 year plan set out strategic priorities to modernize and transform the NHS over the next decade. The overarching principles set out within the plan include 3 shifts:

- **Hospital to Community:** This shift aims to move more care from hospitals to community settings, such as GP clinics, pharmacies, and local health centres. The goal is to provide care closer to home, which can help reduce hospital admissions and improve patient outcomes. The plan commits to the share of expenditure on hospital care falling, with proportionally greater investment in out-of-hospital care.
- **Analogue to Digital:** This involves leveraging digital technology to enhance healthcare services. Examples include using electronic health records, telemedicine, and Artificial Intelligence tools to improve diagnosis and treatment. This shift aims to make healthcare more efficient and accessible.
- **Sickness to Prevention:** The focus here is on preventing illness rather than just treating it. This includes initiatives to promote healthier lifestyles and early detection of diseases, which can help reduce the burden on healthcare services and improve overall public health.

Key planned developments in relation to meeting the mental health needs of the population include:

- **Investment in Mental Health Emergency Departments (MHEDs):** Up to £120 million will be invested to develop around 85 MHEDs, providing fast, same-day access to specialist support. These units will provide walk-in access, receive patients conveyed by ambulance, or referred by the police or 111 and undertake

rapid assessment typically within 4 hours, alongside short-term support and safe discharge or onward referral.

- **Neighbourhood healthcare:** The ten year plans commits to establishing a neighbourhood health centre (NHC) in every community, beginning with places where healthy life expectancy is lowest. NHCs will co-locate NHS, local authority and voluntary sector services, to help create an offer that meets population need holistically. NHC's will bring historically hospital-based services such as diagnostics, post-operative care and rehabilitation into the community and will also offer services like debt advice and employment support.
- **Employment support:** Individual placement support for people with severe mental illness (SMI) will be expanded. Subject to the outcomes of trials of [Health and Growth accelerators](#) in South Yorkshire, North East and North Cumbria, and West Yorkshire, outcome targets will be set for integrated care boards (ICB's) to reduce economic inactivity and unemployment.
- **Assertive Outreach Care:** The plan commits to ensuring 100% national coverage of [assertive outreach](#) mental health care in the next decade, with a focus on narrowing mental health inequalities.
- **Mental Health Support Teams (MHSTs) and Young Futures Hubs:** The plan commits to the expansion of Mental Health Support Teams (MHSTs) in schools and colleges to achieve full national coverage by 2029-2030 and provide additional support for children and young people's mental health through Young Futures Hubs.
- **Workforce:** The plan commits to recruit 8,500 mental health staff to reduce long waits and improve support for complex needs.
- **Use of technology:** Possible developments include virtual therapists providing 24/7 support for mild or moderate need. For people with more severe illness, remote monitoring will help support a proactive response in crisis. Using the NHS app patients will be able to self-refer to talking therapies for anxiety and depression. It is intended that new digital tools, digitised therapies and real-time suicide surveillance will improve mental health and reduce suicide rates

1.6. Local Strategies

1.6.1. Health and Wellbeing Strategies

Health and wellbeing boards are a formal committee of the local authority charged with promoting greater integration and partnership between bodies from the NHS, public health and local government. In line with [statutory guidance](#), health and wellbeing boards must produce joint local health and wellbeing strategies which sets out the priorities for improving the health and wellbeing of the local population and how the identified needs will be addressed.

The aims of the Birmingham and Solihull health and wellbeing strategies in relation to mental health are summarised below.

Birmingham Joint Health and Wellbeing Strategy (2022-2030)	Solihull Joint Health and Wellbeing Strategy (2024-2032)
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<ul style="list-style-type: none"> • Reduce adult depression and anxiety prevalence to less than 12% by 2030. • Lower suicide rates and emergency self-harm admissions to be among the lowest in England. • Reduce smoking prevalence in adults with long-term mental health conditions to the national average by 2027. • Close the employment gap for people with long-term health conditions. • Achieve Triple Zero: zero deaths or overdoses linked to alcohol or drugs by 2030. 	<ul style="list-style-type: none"> • Reduce isolation and improve access to primary care. • Decrease wait times for specialist services and the number of people in crisis. • Lower suicide rates and enhance recovery.
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The [Birmingham Triple Zero Strategy, 2022 – 2032](#) referenced above aims to reduce deaths and overdoses linked to drug and alcohol misuse. It identifies opportunities to:

- Strengthen the collaboration between homelessness, mental health and substance misuse services
- Embed service user voice in treatment planning, evaluation and service design between homelessness, mental health and substance misuse services.
- Deliver targeted training and awareness to support engagement and referral for people accessing mental health or housing services
- Create/enhance pathways between substance misuse services and other services such as the secondary mental health services, criminal justice services and primary care.

In addition to the above strategies, Birmingham and Solihull Integrated Care System (ICS) developed a 10-year strategy for health and care which was published in 2023. The overarching aim of the strategy is to increase life expectancy for the people of Birmingham and Solihull and mental health is identified as one of five priority clinical condition areas. Specific mental health related objectives included in the strategy are to support the provision of timely and culturally sensitive support to the LGBTQ+ community and to reduce smoking prevalence in those with severe mental illness.

1.6.2. Health Inequalities Strategies

Key publications which focus on Birmingham, Solihull and the West Midlands region which aim to reduce health inequalities are set out in the below table.

Title	Ambitions and priorities
Towards Mental Health	This report aims to address mental health

Equality: West Midlands Mental Health Commission (2023)	disparities through 13 evidence-based recommendations. These include enhancing mental health support in education, promoting the living wage, increasing NHS workforce diversity, and improving community-led infrastructure and physical activity opportunities.
Birmingham and Solihull ICS Health Inequalities Strategy (2022-2027)	This strategy aims to reduce the gap in healthy life expectancy for citizens of Birmingham and Solihull and includes a focusing addressing the association between Severe Mental Illness (SMI) and reduced life expectancy.
Tackling Health Inequalities: A Blueprint for Solihull (2022-2025)	This strategy sets out six principles to reduce health inequalities, including routinely and systematically considering all four dimensions of health inequalities, systematic self-assessment by partners to ensure health inequalities are addressed as a core activity and investing in prevention and early intervention.

Forthcoming strategies which will address mental health include the provider collaborative 5-Year Strategy and Creating a Mentally Healthy City Strategy (Birmingham City Council) both are due for publication in 2025.

1.7. The Mental Health Learning Disability and Autism Provider Collaborative

1.7.1. Overview

On 1st April 2023 the provider collaborative was established taking on responsibilities for the commissioning of mental health services for Birmingham and Solihull. On 1st June 2024, the provider collaborative expanded to include commissioning responsibilities for learning disability and autism services. The collaborative brings together NHS providers, the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector, and local councils to improve quality, efficiency, and outcomes, and to address inequalities in access and experience.

This mental health needs assessment (MHNA) in order to support the development of the provider collaborative 5 year strategy due for publication during 2025.

1.7.2. Purpose of the Mental Health Needs Assessment (MHNA)

The MHNA aims to:

- Provide an evidence-based picture of local mental health needs.
- Assess the equity of service provision for diverse communities.
- Identify disparities in access, experience, and outcomes.
- Highlight gaps in provision and unmet needs.
- Identify good practices and projects to build upon.
- Outline community perspectives on mental health.
- Make recommendations for further enquiry, service development, and strategic priorities.

1.7.3. Scope of the MHNA

The MHNA takes a life course approach, focusing on NHS-funded services provided by NHS Trusts and the VCFSE sector. It aims to inform the provider collaborative's 5-year strategy and future commissioning of mental health services based on population health needs.

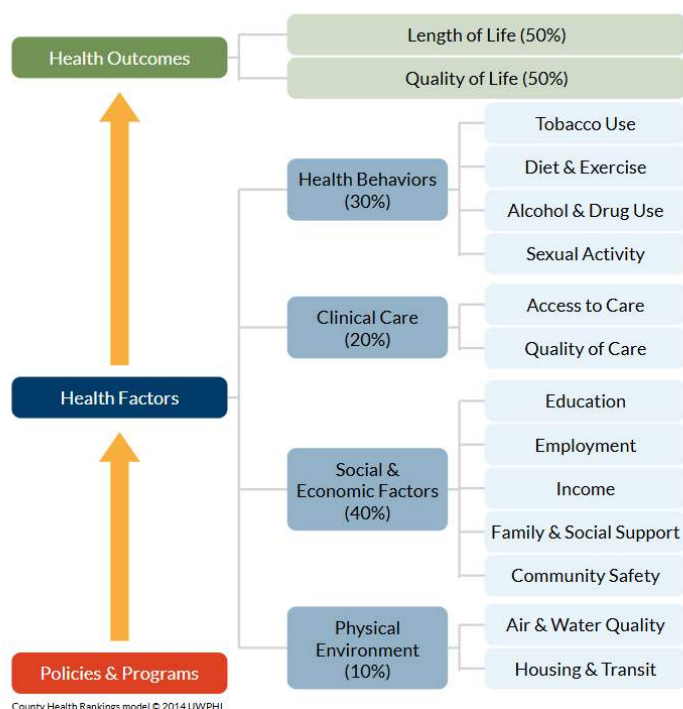
1.8. The Social Determinants of Health

The social determinants of health are non-medical factors influencing health outcomes, including the conditions in which people are born, grow, work, live, and age. These determinants shape daily life and include:

- Income
- Education
- Unemployment and job insecurity
- Working conditions
- Food insecurity
- Housing and environment
- Early childhood development
- Social inclusion and non-discrimination
- Access to quality health services

The [County Health Rankings' model of health](#) illustrates that only 20% of health outcomes are determined by access to care and the quality of care received with 50% of health outcomes being determined by social and economic factors and the physical environment, see figure 1.

Figure 1 -County Health Rankings' model of health



Source: [County Health Rankings & Roadmaps](#)

Key Points of note regarding the social determinants of health are:

- **Impact on Mental Health:** Social determinants significantly influence mental health and inequalities. Poor quality housing, deprivation, and adverse childhood experiences increase the risk of mental disorders.
- **Life Course Approach:** Disadvantage accumulates throughout life, necessitating actions to improve conditions from birth through old age. This approach helps prevent mental disorders and promotes mental health.
- **Health Outcomes:** Only 20% of health outcomes are determined by healthcare access and quality, while 50% are influenced by social and economic factors and the physical environment.
- **Addressing Inequalities:** Actions to improve everyday life conditions can enhance population mental health and reduce the risk of mental disorders associated with social inequalities.

While the needs assessment does not explicitly focus on addressing the social determinants of health, it is crucial to consider their impact when discussing mental wellbeing and demand for mental health services in Birmingham and Solihull. Initiatives which address factors like poverty, deprivation, housing, and homelessness can have a significant positive impact on the mental health of the population.

2. National Context

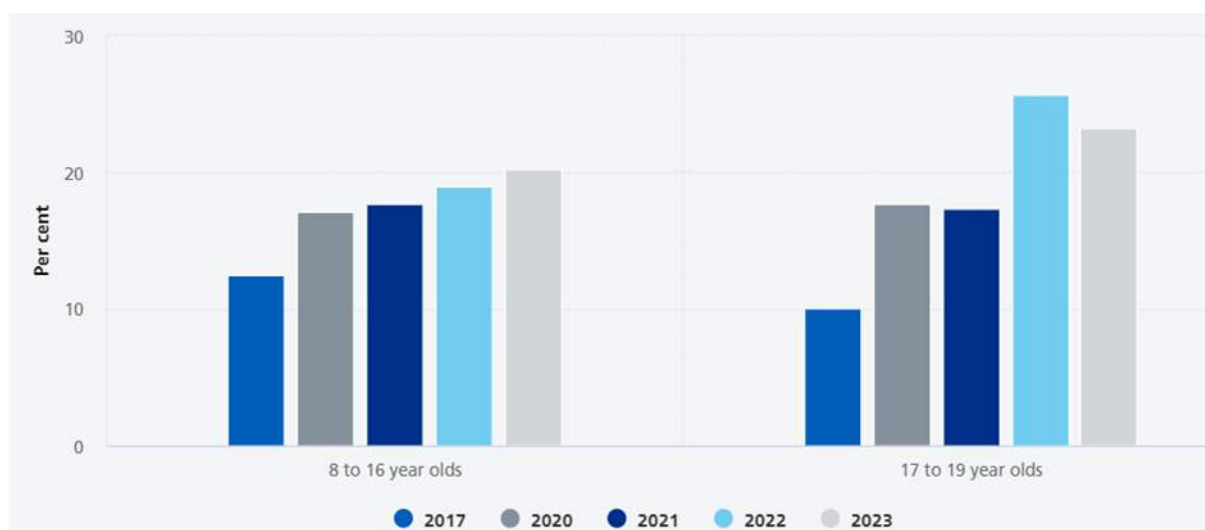
2.1. Prevalence of Mental Health Conditions

Prevalence data needs to be considered within the context and the timing of when it was collected, as many types of mental illness are partly a response to external and societal stresses, prevalence at a population level can also mask differences between groups. Two main sources of prevalence data are considered in this section, [the Mental Health of Children and Young People Survey](#) and the [Adult Psychiatric Morbidity Survey](#).

2.1.1. The Children and Young People's Survey

This national survey provides data on the prevalence of mental disorders, tracks changes over time and examines factors related to mental health, such as household circumstances, education, employment, and access to services. The most recent version of the survey was published in November 2023. The below chart shows the percentage of children and young people with a probable mental disorder from 2017 to 2023.

Figure 2 - Percentage of children and young people with a probable mental disorder



Source: [Children and Young People's Mental Health Survey – wave 4 follow up to the 2017 survey](#)

Key points of note from the survey are:

- In 2023, about 1 in 5 children and young people aged 8 to 25 years had a probable mental disorder. This was 20.3% of 8 to 16 year olds, 23.3% of 17 to 19 year olds and 21.7% of 20 to 25 year olds.
- After a rise in prevalence between 2017 and 2020, rates of probable mental disorder remained stable in all age groups between 2022 and 2023.

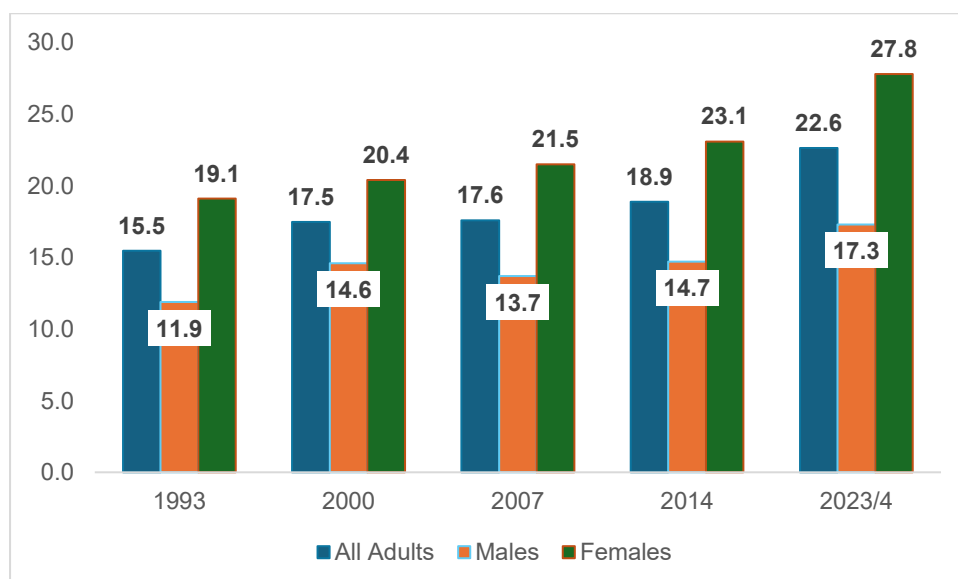
The data also highlights inequalities in the prevalence of mental health difficulties. Children and young people whose families face financial difficulties had markedly higher rates of mental health difficulties: for example, almost 27% of 8-16 year olds whose parents could not afford for them to take part in activities outside school had a mental health difficulty, compared with just 10% of those who could. Children with a mental health difficulty were less likely than those without to feel safe (56% vs 85%), to be themselves (49% vs 84%) and to enjoy learning (35% vs 70%) at school (Marcheselli, Mandalia, Ryder-Dalton, & McManus, 2023).

2.1.2. The Adult Psychiatric Morbidity Survey

The [Adult Psychiatric Morbidity Survey \(APMS\)](#) provides comprehensive data on the prevalence of both treated and untreated psychiatric disorders among adults in England, highlighting demographic variations and the impact of societal factors on mental health. Part 1 findings from the 2023/24 survey were published in June 2025 (Morris, Hill, Brugha, & McManus, 2025) with part 2 findings due for publication later in the 2025 calendar year. The survey findings reveal that:

- There has been a significant increase in the proportion of people in England aged 16-64 years with common mental health conditions, rising from 18.6% in 2014 to 22.6% in 2023/24.
- A higher proportion of women have common mental health conditions than men, 27.8% of women in 2023/24 compared to 17.3% of men. This has been consistent finding at every point data has been collected from 1993 to 2023/24.

Figure 3: Prevalence of common mental health conditions in people aged 16-64 years in England, 1993 to 2023/24



Source: [Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/4: Data tables - NHS England Digital](#)

Other key findings from the 2023/24 survey include:

- Lifetime non-suicidal self-harm was reported by 10.3% of 16- to 74-year-olds in 2023/24, an increase from 6.4% in 2014 and 3.8% in 2007.
- The proportion of adults screening positive for ADHD increased from 8.2% in 2007 and 9.7% in 2014, to 13.9% in 2023/24.
- The proportion of young adults (aged 16 to 24), with a common mental health condition, rose from 17.5% in 2007 to 25.8% in 2023/4.
- Younger adults were also more likely to report lifetime non-suicidal self-harm and to screen positive for Post-Traumatic Stress Disorder (PTSD) and ADHD than older age groups.
- Adults with problem debt and those who were not in employment were more likely to have a common mental health condition, report lifetime non-suicidal self-harm and to screen positive for PTSD.
- Living in the most deprived fifth of areas was associated with increased prevalence of common mental health conditions, suicide attempts and PTSD.
- People with a doctor diagnosed physical health condition, that limited their activities, were more likely to have a common mental health condition, report non-suicidal self-harm and screen positive for PTSD.
- The proportion of 16- to 74-year-olds, with common mental health condition symptoms, reporting receipt of treatment rose from 24.4% in 2007 and 39.4% in 2014, to 47.7% in 2023/4.
- Receipt of psychological therapies, among those with symptoms, rose from 10.4% in 2007 to 17.9% in 2023/4; and receipt of medication rose from 19.6% in 2007 to 38.4% in 2023/4.

2.2. Impact of the Covid-19 Pandemic

Initial forecasts of the pandemic on mental health of the population predicted significant mental health impacts, including depression, anxiety, post-traumatic stress disorder (PTSD), and sleep deprivation, similar to previous epidemics (Durcan, O'Shea, & Allwood, 2020).

In October 2020, modelling by the Centre for Mental Health predicted that the equivalent of 10 million people would need new or additional mental health support, with 1.5 million being children and young people under 18. About two-thirds of the people who would need support would be those with existing mental health problems, including severe mental illness (O'Shea, Covid-19 and the nation's mental health, 2020). High-risk groups which were identified include Covid-19 survivors, healthcare workers, economically impacted individuals, and the bereaved.

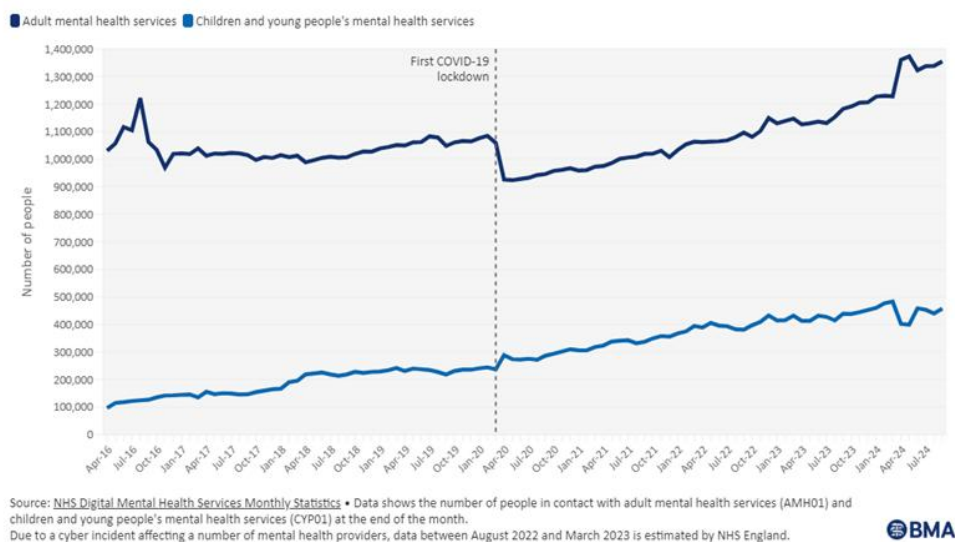
2.3. Demand for Mental Health Services

It is important to note that referrals to mental health services had been steadily rising in the years prior to the pandemic. Following a dramatic fall in referrals during the first few months of the pandemic, referrals rose sharply and resumed an upward trajectory. Referrals increased in England from 4.4 million a year in 2016/17 to 6.4

million in 2021/22 (National Audit Office, 2023). By June 2022, 1.2 million people were estimated to be on a waiting list for community-based mental health support, and an estimated 8 million people in England had unmet mental health needs (National Audit Office, 2023). Subsequent estimates of the numbers on a waiting list for mental health care are closer to 1.6 million (Rethink Mental Illness, 2025).

As shown in figure 4 below, the number of people in contact with mental health services has been steadily rising (British Medical Association, 2025). As discussed above, the Adult Psychiatric Morbidity Survey (APMS) also shows an increase in the proportion of people with common mental health conditions accessing treatment. The percentage of adults aged 16-74 with a common mental health disorder, who report accessing treatment has increased from 39.4% in 2014 to 47.7% in 2023/24.

Figure 4 - The number of people in contact with mental health services, April 2016 - September 2024



Source: The British Medical Association - [Mental health pressures data analysis](#)

For children and young people's mental health services, evidence indicates that whilst there has been an increase in the number of people in contact with services, services have struggled to keep pace with demand as the number of open referrals have also reach a record high level (The Health Foundation, 2022).

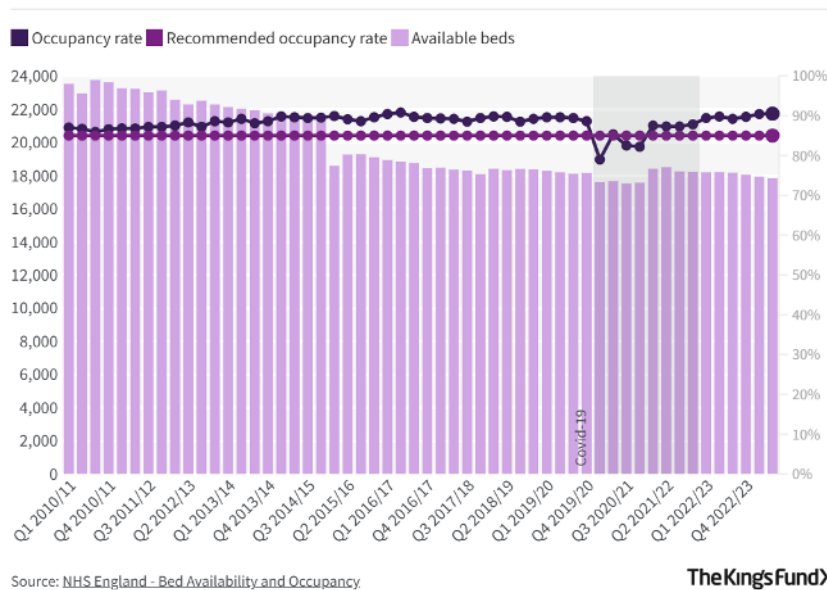
2.4. Inpatient Bed Occupancy and Length of Stay

Bed occupancy levels are an important indicator of pressure and capacity within mental health and other connected services. The maximum level of occupancy advised by the Royal College of Psychiatrists is 85%. The national average has consistently been above this level for several years except for a brief period during the covid-19 pandemic, as shown in the below chart.

The below chart also shows that the [numbers of mental health beds \(17,836\)](#) are at

their lowest level since data collection began in 2010/11 (excluding the period during the pandemic) which means people who need to be admitted can face [considerable delays in accident and emergency \(A&E\)](#) while they wait for an available bed, or may be cared for in [inappropriate environments](#), such as being admitted to a ward in an acute trust (Gilbert & Mallorie, Mental health 360: acute mental health care for adults, 2024).

Figure 5 - Occupancy rate and available beds, Q1 10-11 to Q2 23-24



Source: [Mental Health 360 | Acute Care For Adults | The King's Fund](#)

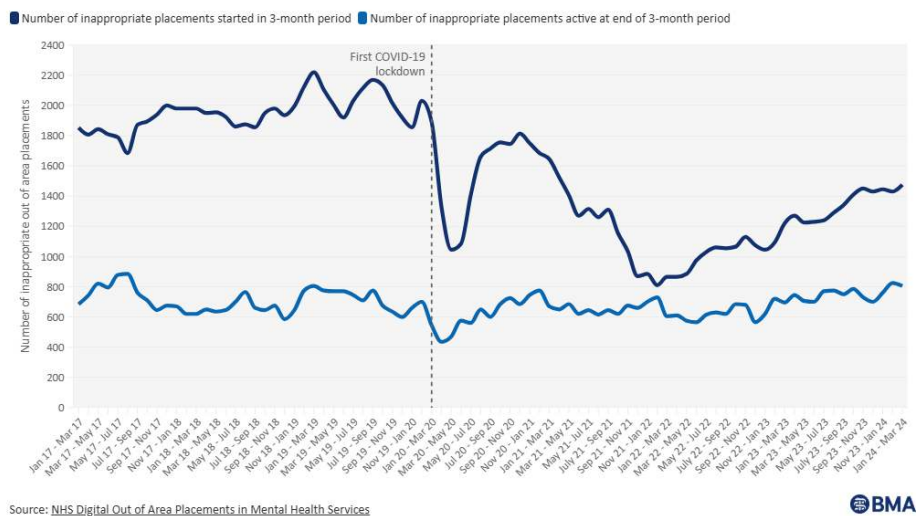
The NHS Benchmarking survey of mental health providers found that the average length of stay in an adult acute mental health bed had increased (from [32 days in 2014](#) to [39 days in 2023](#)). National data also shows that the number of patients with a stay of more than 60 days increased by 22% between June 2021 and November 2023. This places increased pressure on available beds, and may indicate either [missed opportunities to provide effective support earlier](#) in the care pathway or delays in access to appropriate support post-discharge (Gilbert & Mallorie, Mental health 360: acute mental health care for adults, 2024).

2.5. Out of Area Placements

Sending patients out of area for inpatient mental health care is both worse for health outcomes and costly for the NHS. Ease of access for family and friends is an important part of a patient's recovery, and, especially for someone experiencing mental distress, being removed from their support system can hinder recovery. This, in turn, can lead to delayed discharge, and reduced capacity for others also requiring help. Unfortunately, this type of placement is sometimes the last option for doctors and patients for whom a local bed cannot be found (the criteria in place which defines this type of placement as 'inappropriate'). Nationally, there is a drive to reduce out of area placement but there remains significant challenges with meeting

this ambition (see figure 6 below).

Figure 6 - Inappropriate out of area mental health placements - England, January 2017 - March 2024



Source: British Medical Association - [Mental health pressures data analysis](#)

In October 2023, of those people in out-of-area placements, [59% had to travel 100km or more](#) from their home. [An analysis of acute mental health care pathways](#) found no correlation between local bed numbers and use of out-of-area placements. This means that out-of-area bed use is unlikely to be due simply to a lack of beds but instead relates to flow issues across the whole system. These include available community capacity and the provision of appropriate alternatives to admission, both of which can reduce the demand for local beds (Gilbert & Mallorie, Mental health 360: acute mental health care for adults, 2024).

Furthermore, the Care Quality Commission (CQC) report [Monitoring the Mental Health Act in 2023/24](#) has highlighted issues regarding bed availability, staffing shortages, re-admission to inpatient care and racial disparities in access to care (Care Quality Commission, 2024). Issues reported by the CQC include:

- Lack of bed availability has led to people being placed far from home. For example, one mother who was detained was placed 5 hours from home and because of this she didn't receive any visitors during her time in hospital.
- There are not enough staff to support all patients, which is affecting people's access to care and leading to people being restricted from going outside as there is nobody to supervise them, or in the most extreme cases, people being inappropriately confined.
- In nearly half of cases where a child or young person was detained, they had to be re-admitted within a year.
- People from the most deprived areas are attending A&E services for their mental health at 3.5 times the rate of people from the least deprived areas.

- Lack of suitable community resources continues to lead to inappropriate hospitalisation of people with a learning disability and autistic people

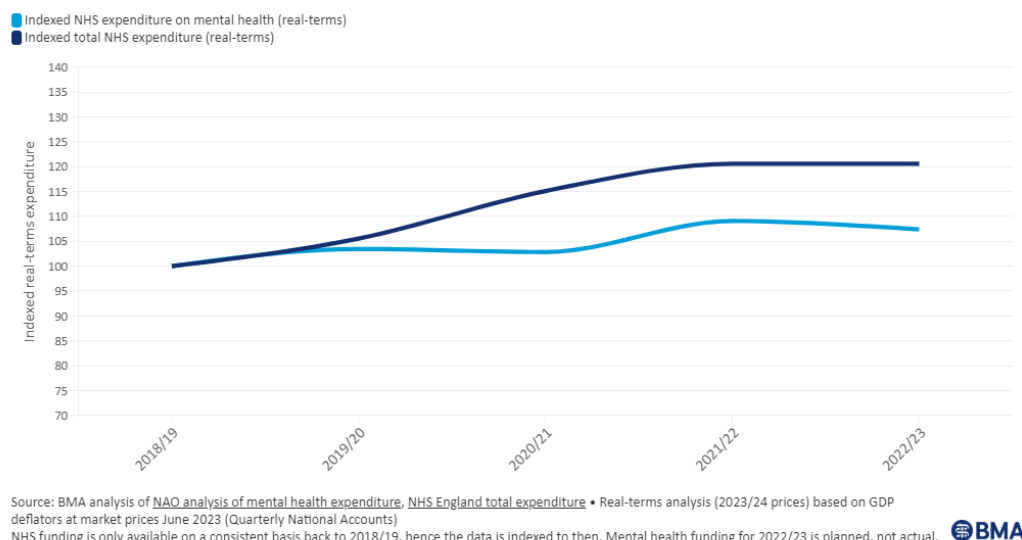
2.6. Funding of mental health services

NHS funding for mental health services has historically been insufficient relative to population needs and in the extent to which mental illness contributes to the global burden of disease (Gilburt & Mallorie, Mental health 360: funding and costs, 2024).

Recognising the need to invest in mental health services, the [Mental Health Investment Standard \(MHIS\)](#) requires ICBs to increase their investment in mental health services at a rate that is at least in line with their overall funding growth. It is expected that this standard was met by all ICBs in England in 2023/24 (House of Commons Library, 2024), and this remains a requirement in the NHS's Planning Guidance for 2025/26.

Despite the MHIS, the overall share of NHS spend on mental health services fell in 2024/25 to below 9%. In a recent statement to Parliament, [the Secretary of State for Health revealed that mental health services spent £14.9bn in 2024/25, representing 8.78% of the total](#). Projected spending for 2025/26 was £15.6bn, representing a further decrease in share of spend (8.71%). The declining proportion of NHS expenditure on mental health is illustrated by [analysis undertaken by the British Medical Association \(BMA\)](#) of indexed NHS expenditure on mental health in England in comparison to total NHS England expenditure (see figure 7).

Figure 7 - Indexed NHS expenditure on mental health compared to total NHS expenditure, 2018/19 - 2022/23



Source: British Medical Association - [Mental health pressures data analysis](#)

In addition to the above, the mental health estate is some of [oldest in the NHS](#), with 18% constructed before the NHS was formed and multiple sites classified as ‘not functionally suitable’. The [Independent Review of the Mental Health Act](#) and the [Care Quality Commission](#) (CQC) also found that many mental health wards are unsafe for staff and patients, and provide poor-quality care in unsuitable buildings (Gilbert & Mallorie, Mental health 360: funding and costs, 2024).

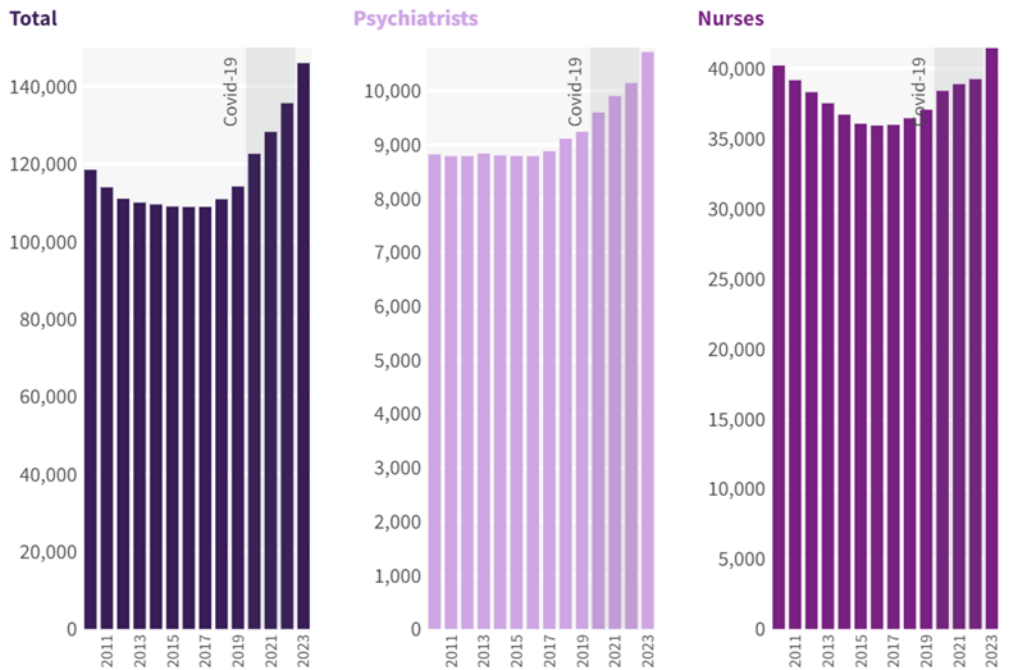
National programmes of [capital investment for mental health services](#) focus on replacing dormitories with single en-suite rooms, and improving urgent and emergency care settings (including avoiding using police cells for temporary detention of people experiencing a mental health crisis). In addition, systems are expected to prioritise patient safety projects, such as removing ligature points, and to ensure sufficient inpatient capacity for children and young people. However, even with this investment, [current trends](#) indicate that the gap between spending and what is needed for basic maintenance of the estate is widening (Gilbert & Mallorie, Mental health 360: funding and costs, 2024).

2.7. The mental health workforce

Between 2010 and 2023, the NHS mental health workforce grew by 23% (full time equivalent), with therapists and support staff increasing by 45%, but nurses only by 3% (Gilbert & Mallorie, Mental health 360: workforce, 2024).

Figure 8 - Increase in the NHS mental health workforce, 2010 - 2023

The mental health workforce is increasing



Source: NHS Digital - NHS Workforce Statistics

Total figures are for September each year, psychiatrists and nurses are for October each year.

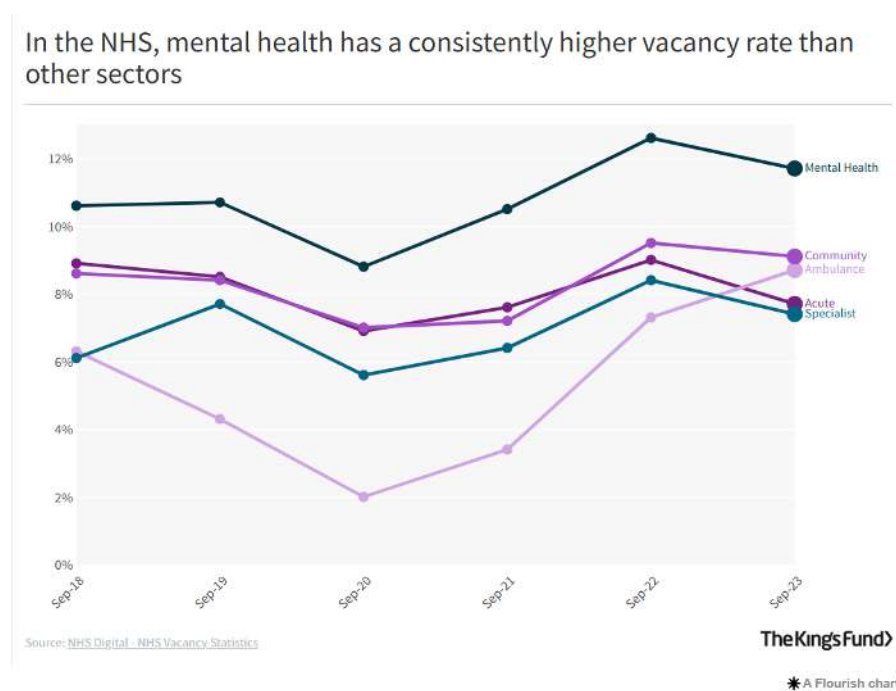
TheKingsFund

Source: [Mental Health 360 | Workforce | The King's Fund](#)

Additionally, the workforce is less experienced as a higher proportion of psychiatrists are in more junior positions in 2022 (27%) compared to 2010 (15%) (Gilbert & Mallorie, Mental health 360: workforce, 2024). The challenges that come with staffing shortages paired with increased demand for mental health care has been identified as a major barrier to delivering and fulfilling NHS plans for service expansions and improvement (National Audit Office, 2023).

One of the greatest challenges for the mental health sector is the long-standing issues around workforce retention and staffing shortages, with NHS data showing that 1 in 5 mental health nursing posts left vacant in the first 3 months of 2022/23 (Care Quality Commission, 2024). When vacancy rates for different sectors within the NHS are compared, mental health consistently has the highest vacancy rate of all sectors (see figure 14 below which shows data from 2018 to 2023). The lack of doctors and nursing staff, paired with the increased use of agency staff to temporarily fill vacancies has made a negative impact on the quality and safety of inpatient care.

Figure 9 - vacancy rate by NHS sector, September 2018 to September 2023



Source: [Staff Shortages | The King's Fund](#)

The impact of workforce shortages on the quality and safety of patient care has been highlighted in the [Care Quality Commission \(CQC\) reporting on Monitoring the Mental Health Act in 2022/23](#) (Care Quality Commission, 2024). The [Health Services Safety Investigation Body \(HSSIB\) investigation into acute mental health inpatient settings for adults](#) also highlights the negative impact of challenges with workforce shortages, recruitment and retention and makes safety recommendations to national bodies to address these issues including updates to the NHS Long Term Workforce Plan (Health Services Safety Investigation Body, 2025) .

Not only does the issue of staffing shortages impact the quality and safety of care for patients, but there is evidence to demonstrate the negative impact this has on the mental health and wellbeing of permanent staff members. Findings from the 2023 NHS Staff Survey (NHS, 2024) revealed that 2 in 5 (41.7%) staff members reported feeling unwell due to work-related stress (although it is worth noting that this measure has improved by approximately 3% since 2022). In addition, similar to previous years, less than half (46.7%) felt that they were able to meet all conflicting demands during work hours, and less than a third (32.4%) agreed that there are enough staff at their organisation for them to do their job properly (NHS, 2024).

In 2023, NHS England and the Department of Health and Social Care published the NHS Long Term Workforce Plan, the first comprehensive plan to grow and strengthen the workforce over a 15-year period (NHS England, 2023).

The Plan highlights that demand for mental health and learning disabilities services is expected to increase at a faster rate than other areas of healthcare, growing by

4.4% annually. Without intervention, this could result in a shortfall of approximately 17,000 mental health nurses by 2036/37. To address this, the plan outlines the need for substantial investment in the mental health workforce, including recruitment, training, and retention strategies.

The Government's election manifesto included a pledge to expand the mental health care workforce by 8,500 over the course of the Parliament. It is unclear yet if this is additional to the expansion already set out in the NHS Long Term Workforce Plan. It would, however, represent a significant slowing down in the rate of increase of the mental health workforce compared with recent years.

3. Birmingham and Solihull Context

3.1. Population Characteristics

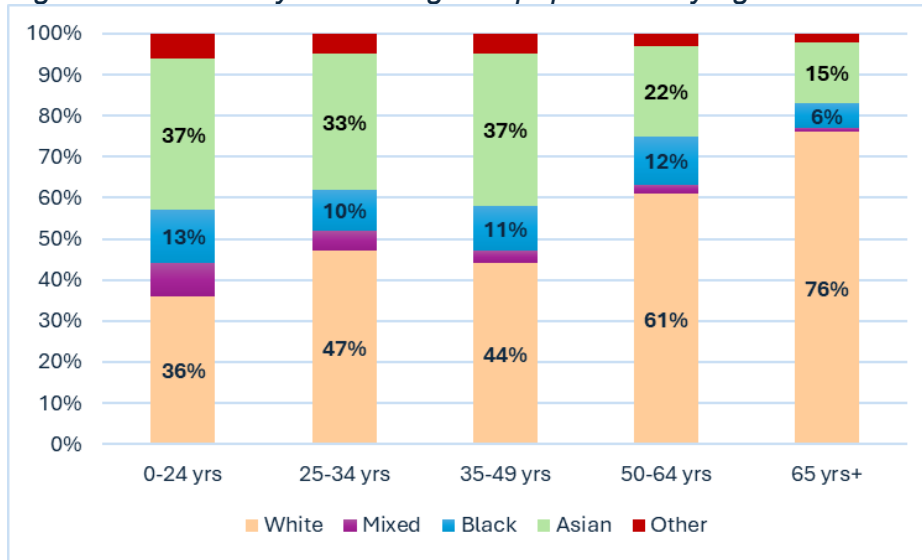
The demography of Birmingham and Solihull is varied encompassing a combined population of over 1.3 million people based on [2022 mid-year estimates](#) from the Office of National Statistics (ONS). Birmingham has a higher population density than Solihull and is predominantly urban whereas approximately 10% of the population in Solihull live in rural areas.

Birmingham is the second largest city in the United Kingdom with a population of over 1.1 million and is ['super diverse'](#) with over 50% of the population belonging to ethnic minority groups. Diversity is greatest within the under 25 age group where ethnic minority groups collectively make up 64% of the population with the Asian / Asian British ethnic group being the largest ethnic group, accounting for 37% of under 25-year-olds as shown in figure 10 below.

Birmingham is also one of the youngest cities in Europe with 36% of the population below 25 years of age compared to a national average of 29% and a median⁹ age of 34 years compared to 40 years for the West Midlands region and 40.5 years for England (Birmingham City Council, 2024).

⁹ The median value in a set of data is the middle value when the data is sorted from smallest to largest, it separates the top half of the values from the bottom half and is a measure of central tendency.

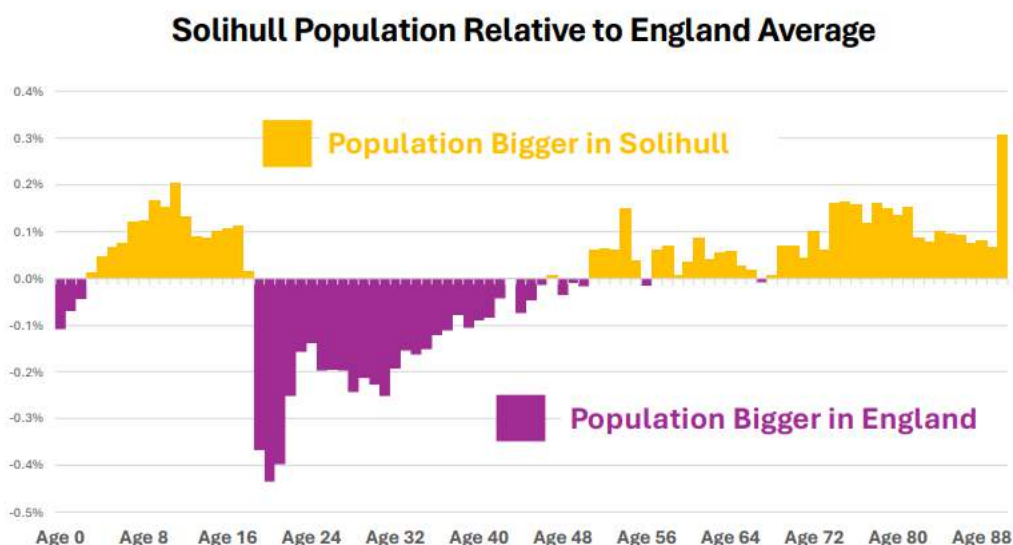
Figure 10 - Ethnicity of Birmingham population by age band



Source: [Nomis - Query Tool - RM032 - Ethnic group by sex by age](#)

Solihull, home to over 200,000 residents, has an older population profile compared to the national average, with a median age of 43. Notably, 21.3% of its population is aged 65 and over—higher than both the England and West Midlands averages. While the proportion of children aged 0–15 exceeds the national average and matches the regional figure, the borough has fewer residents under the age of 3 and between 19 and 50. This is particularly evident among students aged 19–22 and adults aged 28–31. In contrast, Solihull has a higher-than-average number of residents aged 51 and above, especially those between 72 and 81 years old (Solihull Metropolitan Borough Council, 2023). This is illustrated in the chart below.

Figure 11 - Solihull population relative to England average by single year



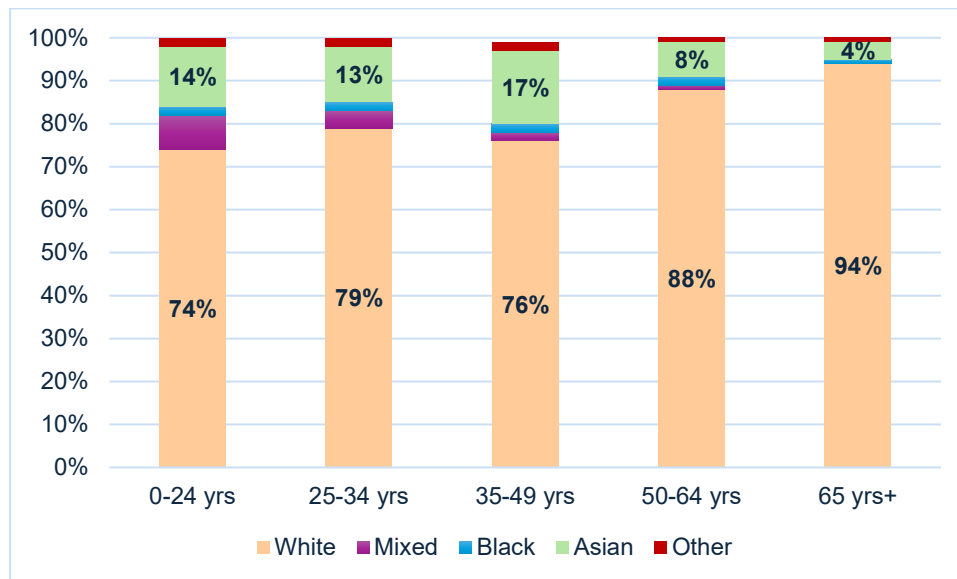
Source: [Solihull Population Estimate 2023](#)

In contrast to Birmingham, the population in Solihull is less diverse, in the 2021

census 82.2% of people in Solihull identified their ethnic group within the "White" category. However, the proportion of the population who identify as [Asian / Asian British](#) increased from 6.6% in 2011 to 11% in 2021.

Similarly to Birmingham there is greater diversity in the youngest age groups as shown in figure 12 below with 26% of people aged under 25 belonging to an ethnic minority group compared to 18% in the population as a whole.

Figure 12 - Ethnicity of Solihull population by age band



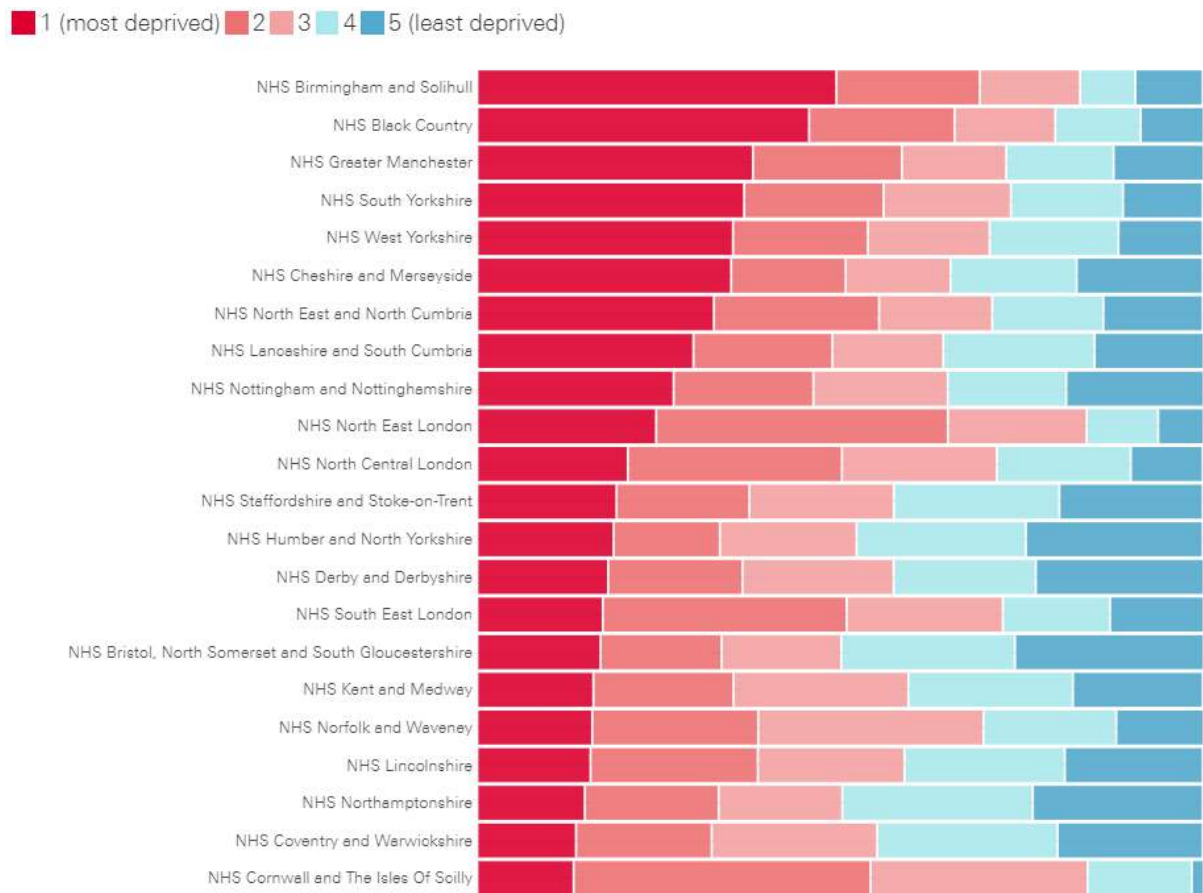
- Source: [Nomis - Query Tool - RM032 - Ethnic group by sex by age](#)

3.2. Poverty and Deprivation

There are significant challenges with poverty and deprivation across Birmingham and Solihull. Of 42 Integrated Care System areas in England, Birmingham and Solihull has the highest percentage of neighbourhoods in the most deprived quintile¹⁰ (The Health Foundation, 2022).

¹⁰ A quintile is representative of 20% of a given population, dividing it into five equally sized groups.

Figure 13 - The percentage of neighbourhoods in each deprivation quintile in each ICS

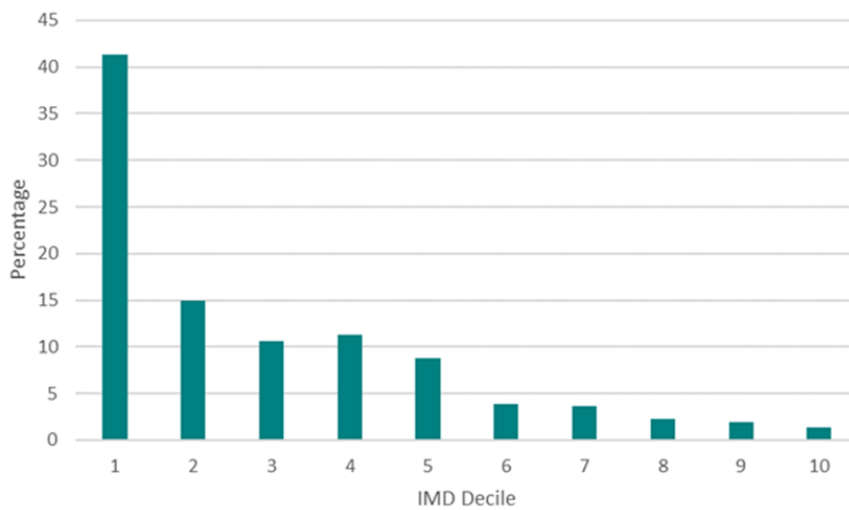


Source: [Integrated care systems: what do they look like? | The Health Foundation](#)

Furthermore, analysis of 2019 Index of Multiple Deprivation data finds that over 60% of the population in Birmingham live in the 3 most deprived Index of Multiple Deprivation deciles¹¹ and [41% in the most deprived decile](#) (Zorrilla, 2024).

¹¹ A decile is a quantitative method of splitting up a set of ranked data into 10 equally large subsections each representing 10%

Figure 14 - IMD deciles distribution for Birmingham



Source: [Birmingham and the Index of Multiple Deprivation – City-REDI Blog](#)

When looking at deprivation across Birmingham and Solihull, analysis of census data shows that Hodge Hill, Perry Barr, Erdington, Ladywood, Yardley, and Hall Green all have over 80% of households which exhibit at least one indicator of deprivation, see figure 15.

Figure 15 - Households with one or more indicators of deprivation



Source: Map produced by Centre for Mental Health using Office for National Statistics data from the 2021 Census

Whilst large parts of Solihull rank among the least deprived in England, over half of the population in North Solihull live in the most deprived 10% of neighbourhoods in

England (Solihull Metropolitan Borough Council, 2019).

Child poverty is a significant challenge within Birmingham; a [2024 briefing by the Resolution Foundation](#) reports that nearly 1 in 2 children (48%) in Birmingham are growing up in poverty (McCurdy, 2024).

Important considerations in relation to child poverty and mental health include:

- Children in the least well-off 20% of households are four times more likely to experience serious mental health difficulties by age 11 compared to those from the wealthiest 20% (Centre for Mental Health; Save The Children; Children and Young People's Mental Health Coalition, 2024).
- Research finds that [a 1% increase in child poverty in the UK was associated with an additional five children entering care](#), mainly due to abuse and neglect, per 100,000 children (Bennett, et al., 2022).

3.3. Prevalence of Mental Health Conditions

3.3.1. Depression

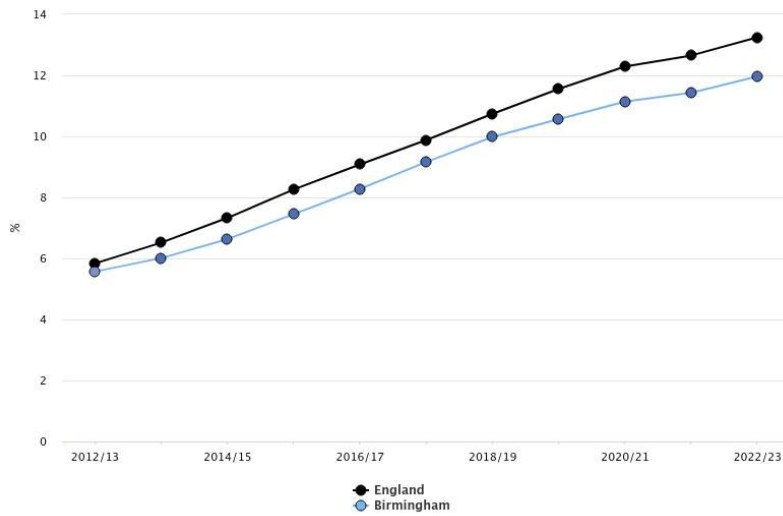
Depression is one of the most common mental health disorders. According to the World Health Organization 280 million people were living with depression across the world, this includes 23 million children and adolescents (World Health Organization, 2022).

Symptoms of depression include feeling hopeless, losing interest in activities once enjoyed, changes in appetite, sleep, and energy, and sometimes suicidal ideation or attempts (American Psychiatric Association, 2013). Depression is more common in younger adults with typical onset during late teenage years to mid-20s (American Psychiatric Association, 2013). A significant risk factor for depression is continuous exposure to poverty (American Psychiatric Association, 2013).

Data on the local prevalence of depression based on the proportion of the population aged 18 or above recorded as having symptoms of depression on GP practice disease registers is shown below.

3.3.1.1. Trend of depression prevalence: Birmingham

Figure 16 - Trend of depression prevalence in Birmingham and England

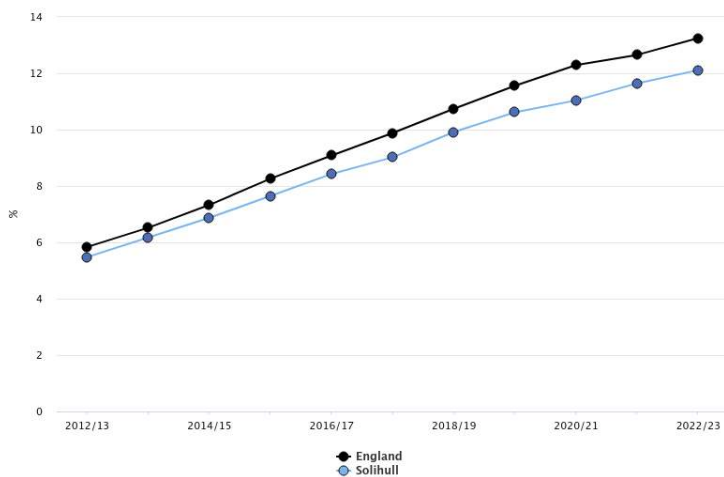


Source: [Mental Health and Wellbeing JSNA | Fingertips | Department of Health and Social Care](#)

Depression prevalence rose from 5.6% (50,754 people) in 2012/13 to 12.0% (125,374 people) in 2022/23, below the national average of 13.2% but higher than the average of Birmingham’s statistical neighbours¹².

3.3.1.2. Trend of depression prevalence: Solihull

Figure 17 - Trend of depression prevalence in Solihull and England



Source: [Mental Health and Wellbeing JSNA | Fingertips | Department of Health and Social Care](#)

¹² For each local authority (LA), statistical neighbour models designate several other LAs deemed to have similar characteristics to enable benchmarking. These designated LAs are known as statistical neighbours.

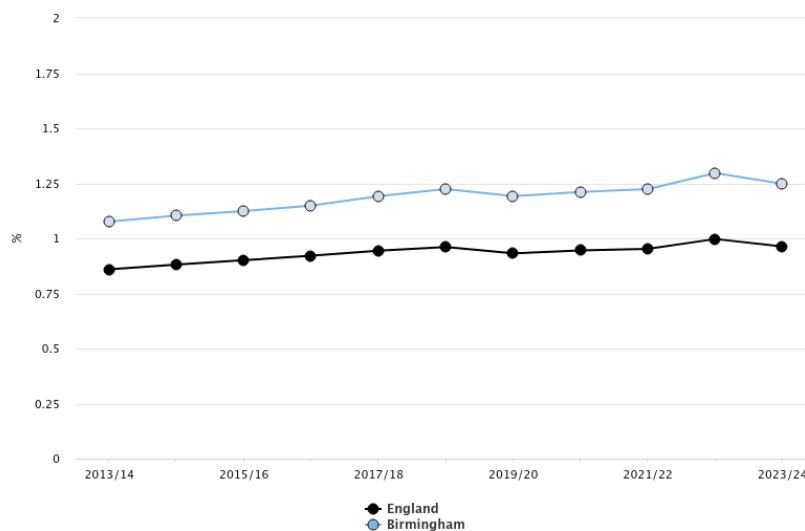
Depression prevalence increased from 5.5% (9,476 people) in 2012/13 to 12.1% (22,373 people) in 2022/23, also below the national average and lower than the average of Solihull's statistical neighbours.

3.3.2. Severe Mental Illness (SMI)

The phrase Severe Mental Illness (SMI) refers to people with psychological problems that are often so debilitating that their ability to engage in functional and occupational activities is severely impaired. Schizophrenia and bipolar disorder are often referred to as an SMI. General Practices record data regarding the number of patients on practice disease registers with schizophrenia, bipolar affective disorder and other psychoses and this is presented below for Birmingham and Solihull.

3.3.2.1. Trend of SMI prevalence: Birmingham

Figure 18 - Trends in SMI prevalence in Birmingham and England

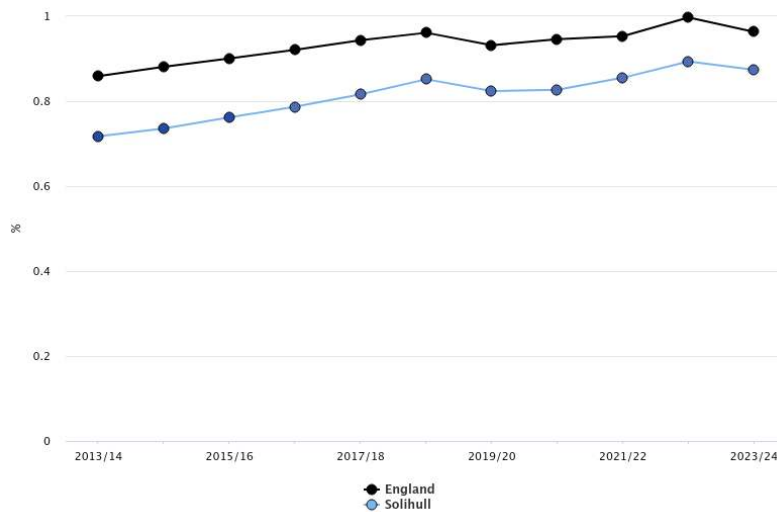


Source: [Mental Health and Wellbeing JSNA | Fingertips | Department of Health and Social Care](#)

The proportion of the population on GP practice disease registers with SMI has increased from 1.1% (13,160 people) in 2013/14 to 1.2% (17,476 people) in 2023/24. The prevalence of SMI in Birmingham has consistently been above the national average during the years 2013/14 and 2023/24 and is above the average of statistical neighbours and is one of four areas within the statistical neighbour group where prevalence is increasing.

3.3.2.2. Trend of SMI prevalence: Solihull

Figure 19 - Trends in SMI prevalence in Solihull and England



Source: [Mental Health and Wellbeing JSNA | Fingertips | Department of Health and Social Care](#)

The proportion of people on GP practice disease registers with SMI has increased from 0.7% (1,583 people) in 2013/14 to 0.9% (2,078 people) in 2023/24. The prevalence of SMI in Solihull has consistently been below the national average during the years 2013/14 and 2023/24 and is slightly above the average of statistical neighbours (0.8%).

3.3.3. Prescribing of Antidepressants

Antidepressants are licensed to treat depression, anxiety disorders, phobias, bulimia, and some physical conditions like long-term pain. Data on the number of people prescribed antidepressants in Birmingham and Solihull, and the associated costs, were recorded between the 1st of April 2023 and the 31st of March 2024. The data includes Birmingham and Solihull patients who were dispensed any drug under the British National Formulary (which provides key information on the selection, prescribing, dispensing and administration of medicines) chapter 4.3 (antidepressant drugs).

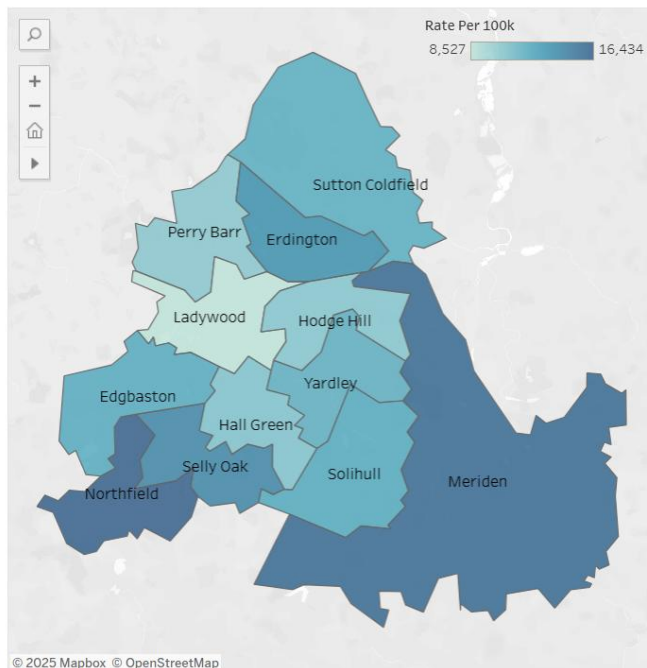
As noted above, antidepressant drugs are also used as a pain medication and to treat people living with bulimia and so a proportion of the prescriptions identified as anti-depressant will be for pain management and bulimia. Therefore, final figures on prescriptions for depression are indicative and not authoritative.

Between the 1st of April 2023 and the 31st of March 2024, 11.8% of the population in Birmingham and 14.1% of the population in Solihull were prescribed antidepressant medication, costing £3,263,380 in Birmingham and £699,420 in Solihull.

The following are key points of note when it comes to variations in prescribing rates for Birmingham and Solihull and by parliamentary constituency:

- The overall prescribing rates are 11,997 per 100,000 for Birmingham and 14,191 per 100,000 for Solihull.
- Rates of prescribing per 100,000 ranged from 16,434 in Northfield (Birmingham) to 8,527 in Ladywood (Birmingham). This is shown in the map below.

Figure 20 - Patients prescribed antidepressant medications in Birmingham and Solihull, rate per 100,000, February 2024 to January 2025

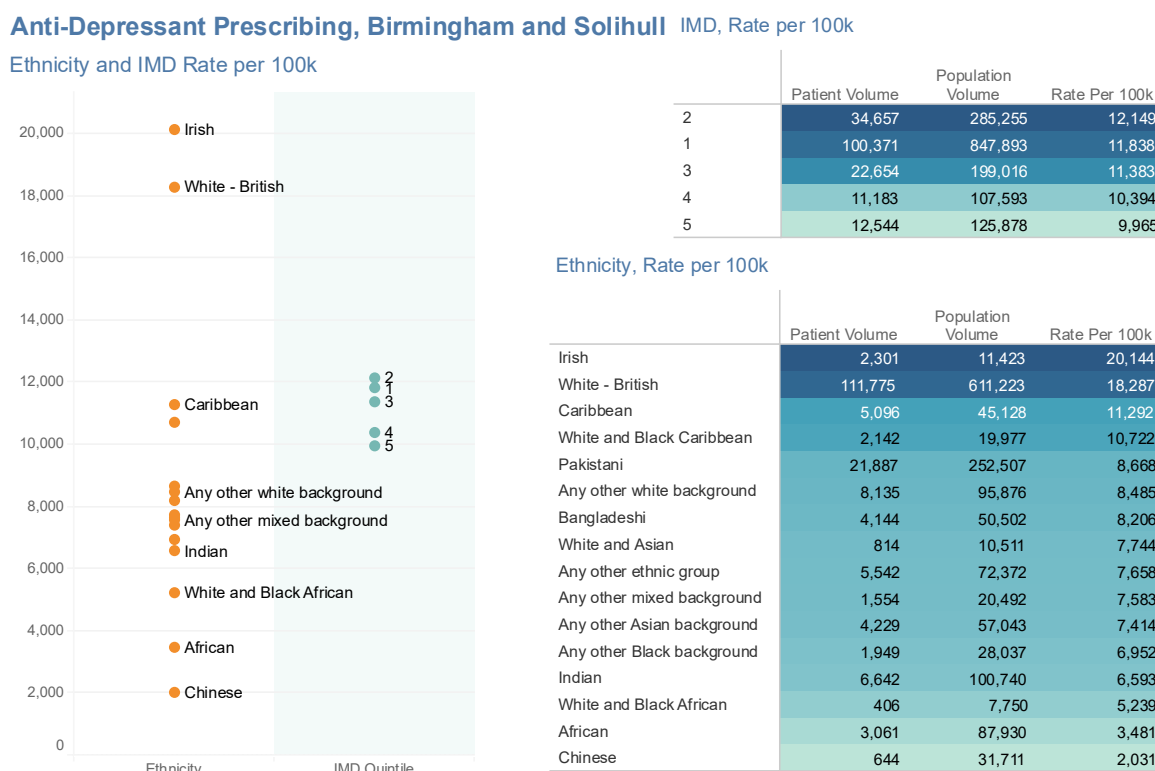


• Source: Business Intelligence, Midlands and Lancashire CSU

When it comes to variation in rates of prescribing by ethnic group and IMD decile:

- The highest rates of prescribing by ethnic group are for White Irish (20,144 per 100,000) and White British (18,287 per 100,000) and the lowest rate is for the Chinese ethnic group (2,031 per 100,000).
- There are higher prescribing rates in more deprived quintiles (2, 1, and 3) compared to the least deprived quintile (5).

Figure 21 - Rate of prescribing of antidepressant medication per 100,000 by ethnic group and IMD quintile (where 1 is most deprived and 5 least deprived)



Source: Business Intelligence, Midlands and Lancashire CSU

3.3.4. Prescribing of Antipsychotic medications

Antipsychotic medication is used to treat psychosis and other mental illnesses with psychotic symptoms such as schizophrenia, schizoaffective disorder, bipolar, severe depression, and personality disorder and are therefore a useful indicator of severe mental illness.

Data on the number of people prescribed antipsychotic medication in Birmingham and Solihull, and the associated costs, were recorded between the 1st of April 2023 and the 31st of March 2024. The data includes Birmingham and Solihull patients who were dispensed any drug under the British National Formulary chapter 4.2 (antipsychotic drugs).

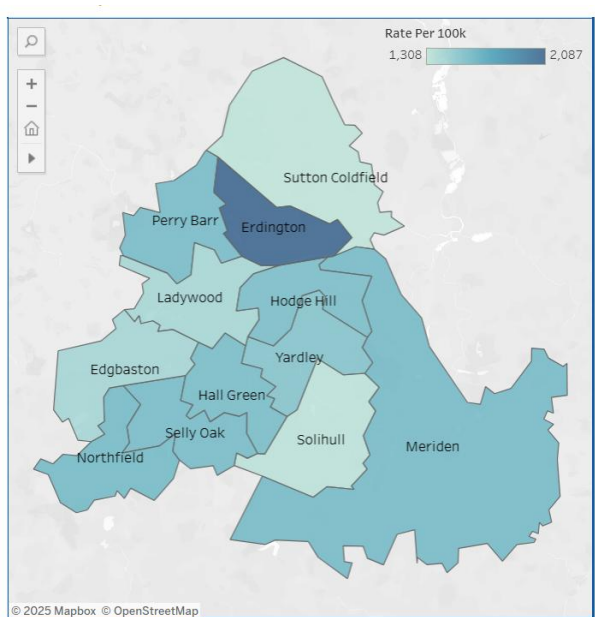
It should be noted that antipsychotic drugs are also used in sedation, for example olanzapine which may be used to stop an individual becoming agitated and so a proportion of the prescriptions identified as antipsychotic will be sedative medication. Therefore, final figures on prescriptions for severe mental illness are indicative and not authoritative.

Between the 1st of April 2023 and the 31st of March 2024, 1.6% of the population in Birmingham and 1.4% of the population in Solihull were prescribed antipsychotic medication, costing £3,010,810 in Birmingham and £450,420 in Solihull.

The following are key points of note when it comes to variations in prescribing rates for Birmingham and Solihull and by parliamentary constituency:

- The overall prescribing rates are 1,558 per 100,000 for Birmingham and 1,459 for Solihull.
- Rates of prescribing per 100,000 ranged from 1,308 in Sutton Coldfield (the least deprived parliamentary constituency in Birmingham) to 2,087 in Erdington (one of the most deprived parliamentary constituencies in Birmingham). This is shown in the map below.

Figure 22 - Patients prescribed antipsychotic medications in Birmingham and Solihull, rate per 100,000, February 2024 to January 2025



Source: Business Intelligence, Midlands and Lancashire CSU

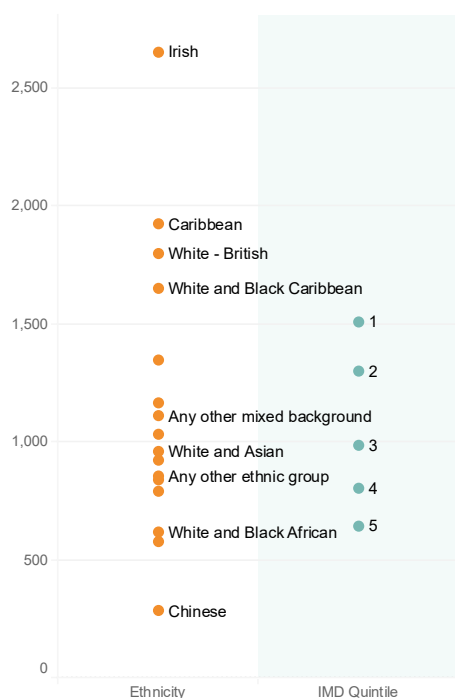
When it comes to variation in rates of prescribing by ethnic group and IMD decile:

- The White Irish ethnic group have the highest rate at 2,653 per 100,000.
- The Black Caribbean ethnic group have the second highest rate at 1,926 per 100,000.
- The Chinese ethnic group have the lowest rate at 287 per 100,000.
- There is correlation between level of deprivation and prescribing of anti-psychotic medication with rates of prescribing increasing in line with IMD quintiles progressing from least to most deprived.

Figure 23 - Rates of prescribing of antipsychotic medication per 100,000 by ethnic group

Anti-Psychotic Prescribing, Birmingham and Solihull IMD, Rate per 100k

Ethnicity and IMD Rate per 100k



	Patient Volume	Population Volume	Rate Per 100k
1	12,799	847,893	1,510
2	3,712	285,255	1,301
3	1,964	199,016	987
4	866	107,593	805
5	811	125,878	644

Ethnicity, Rate per 100k

	Patient Volume	Population Volume	Rate Per 100k
Irish	303	11,423	2,653
Caribbean	869	45,128	1,926
White - British	10,999	611,223	1,800
White and Black Caribbean	330	19,977	1,652
Any other Black background	378	28,037	1,348
Pakistani	2,946	252,507	1,167
Any other mixed background	228	20,492	1,113
Bangladeshi	522	50,502	1,034
White and Asian	101	10,511	961
Any other Asian background	527	57,043	924
Any other ethnic group	620	72,372	857
Any other white background	806	95,876	841
Indian	798	100,740	792
White and Black African	48	7,750	619
African	509	87,930	579
Chinese	91	31,711	287

Source: Business Intelligence, Midlands and Lancashire CSU

3.4. Self-Harm and Suicide

Self-harm is when somebody intentionally damages or injures their body, and is a common way of responding to or expressing overwhelming emotional distress. Early identification, accurate diagnosis and effective treatment of mental health conditions can prevent self-harm and suicide in children and young people.

Accuracy of epidemiological data concerning self-harm are hampered by under-reporting. UK data suggest 60% of adults and 90% of young people aged 12-17 do not contact medical or psychological services after self-harming (Knipe, Padmanathan, Newton-Howes, Chan, & Kapur, 2022). Alternative estimations suggest only 1 in 28 young men and 1 in 18 young women will seek professional help (Fenton & Kingsley, 2023). Hospital admission rates are a useful measure of intentional self-harm, and an indicator of how well we are preventing these mental health crises from occurring (The Nuffield Trust, 2024).

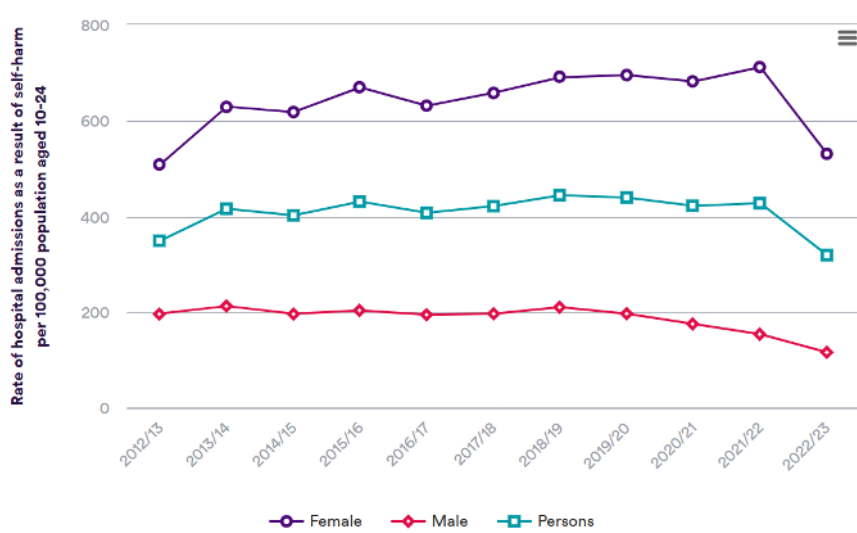
3.4.1. Hospital admissions as a result of self-harm in children and young people

The national trend in hospital admission for children and young people aged 10-24 years is shown in figure 24 below. It shows that:

- A higher proportion of females are admitted for self-harm in this age group compared to males

- A significant drop in hospital admissions due to self-harm across genders in 2022/23. However, this may be due to changes in NHS England’s reporting methodology, which reclassified Same Day Emergency Care (SDEC) cases, leading to fewer admissions being recorded under the Admitted Patient Care data set.

Figure 24 – National rate of hospital admissions due to self-harm per 100,000 population aged 10-24 years

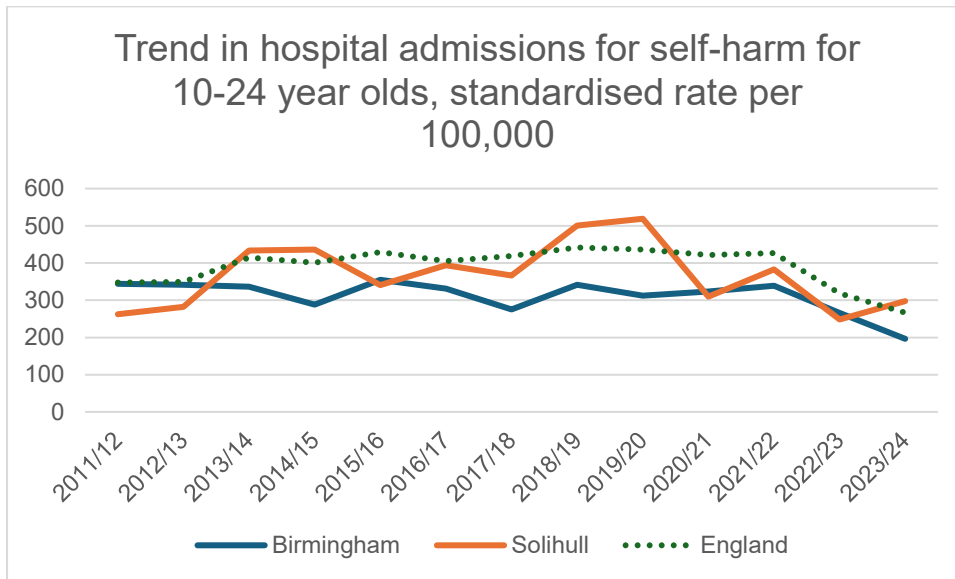


Source: [Hospital admissions as a result of self-harm in children and young people | Nuffield Trust](#)

The trend in hospital admissions due to self-harm for people aged 10-24 years in Birmingham and Solihull is shown in figure 40 below. This shows that:

- The rate of admissions in Birmingham has remained below the national average during this period.
- The rate of admissions in Solihull has fluctuated above and below the national average and was above the national average for the financial year 2023/24.

Figure 25 – Rate of hospital admissions due to self-harm per 100,000 population aged 10-24 years, Birmingham and Solihull compared to England average



Source: [Mental Health and Wellbeing JSNA | Fingertips | Department of Health and Social Care](#)

Data on rates of hospital admissions per 100,000 for Birmingham and Solihull population for all-age groups due to self-harm for the 12-month period March 2024 to February 2025 (figure 41) shows that:

- Rates of admission were significantly higher in the 10-19 years age group
- Rates of admission were significantly higher for females compared to males
- The ethnic groups with highest rates of admission were Mixed White and Black Caribbean and White British, the lowest rate of admission was in the Chinese ethnic group.
- Rates of admission by index of multiple deprivation quintiles show that there are higher rates of admission for people who live in the more deprived areas of Birmingham and Solihull.

Figure 26 – Demographic characteristics of people admitted to hospital due to self-harm in Birmingham and Solihull: rate per 100,000, March 2024 to February 2025

Inpatient Admissions for Self-Harm, Birmingham and Solihull

Demographic Equalities, Rate per 100k

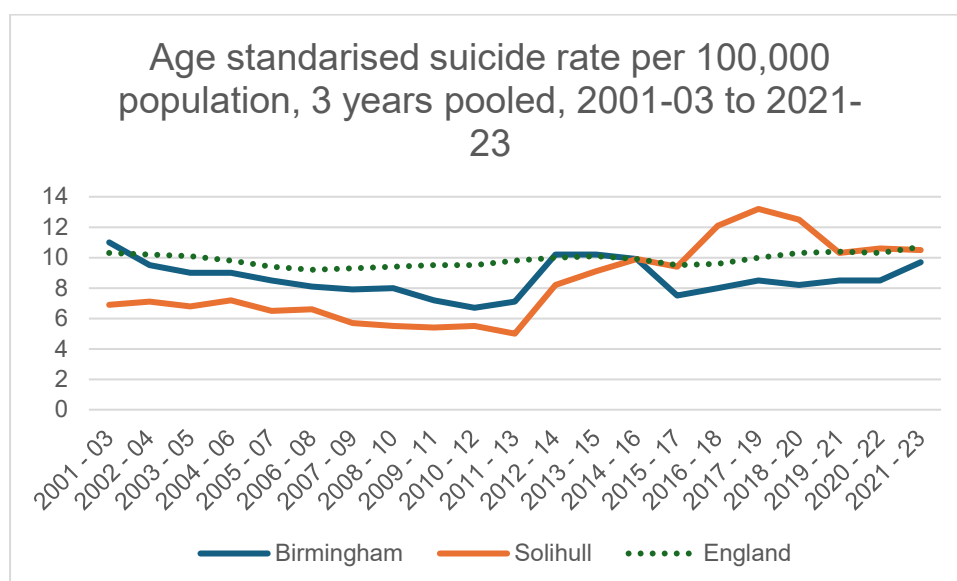


Source: Business Intelligence, Midlands and Lancashire CSU

3.4.2. Suicide in Birmingham and Solihull

The suicide rates for Birmingham and Solihull in comparison to the England average are shown in figure 27 below.

Figure 27 – Age standardised suicide rate, 3 years pooled



Source: [Suicide Prevention | Fingertips | Department of Health and Social Care](#)

The above chart shows that:

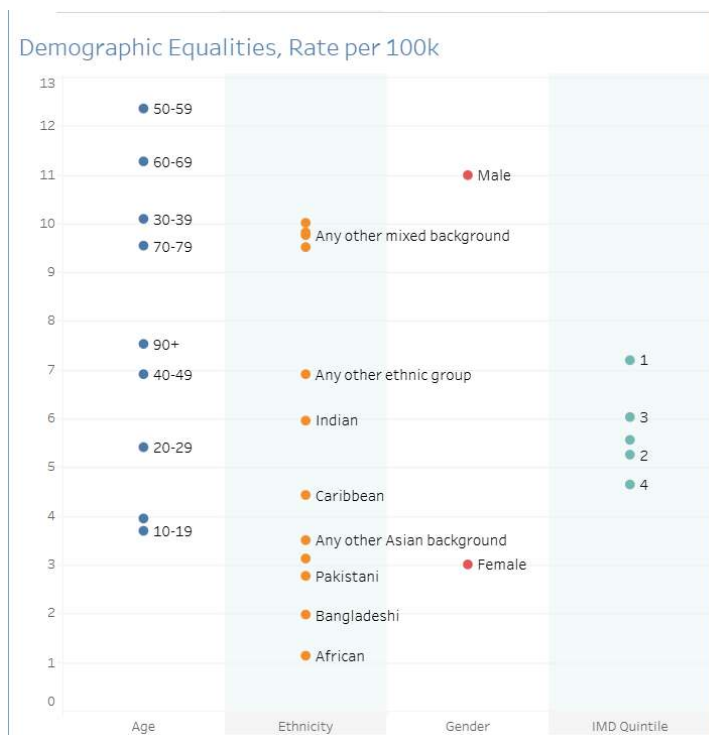
- Prior to 2014-16 the suicide rate in Solihull was lower than Birmingham and the national average, however, from 2015-17 onwards the suicide rate in Solihull has consistently been higher than Birmingham and was above the national average during the period 2016-18 to 2018-20.
- The suicide rate in Birmingham has been lower than both the rate in Solihull and the national average since 2015-17.

The demographic characteristics of people who died by suicide in Birmingham and Solihull during the period February 2024 to February 2025 are shown in figure 28 below.

The below chart shows that:

- The suicide rate over the period was highest in the 50-59 years and 60-69 years age group
- The suicide rate was highest amongst people of Mixed ethnicity with highest rates in the Mixed White and Black Caribbean, Mixed White and Asian and any other Mixed background.
- The suicide rate was lowest in the Black African ethnic group.
- The suicide rate was significantly higher for men compared to women.
- The suicide rate was highest for people in the most deprived IMD quintile, meaning the rate of suicide was highest for those living in areas of Birmingham and Solihull which are in the most deprived 20%.

Figure 28 - Demographic characteristics of people who resident in Birmingham and Solihull who died by suicide: rate per 100,000, February 2024 to February 2025



Source: Midlands and Lancashire CSU

3.4.3. Suicide Prevention Strategies

A national [5 year suicide prevention strategy for England](#) was published in 2023 which sets out national priorities and ambitions for suicide prevention. Alongside the national strategy there are strategies in place at a local level for Birmingham and Solihull which set out priorities for suicide prevention and these are summarised below:

Title	Ambitions and Priorities
Birmingham Suicide Prevention Strategy, 2019-2024	<p>The strategy outlines six priorities to reduce deaths through suicide.</p> <ul style="list-style-type: none"> - Priority one is to reduce risk in high-risk groups. - Priority two is to improve the mental health of vulnerable groups and those who experience problems with access to services. - Priority three is to reduce access to the means of suicide - Priority four is to provide better information and support to those bereaved or affected by suicide - Priority five is to support the media in delivering sensitive approaches to suicide and suicidal behaviour. <p>Priority six is to support research, data collection and</p>

	monitoring.
Title	Ambitions and Priorities
Solihull Suicide Prevention Strategy 2023-2026	<p>The Solihull suicide prevention strategy sets out four priorities to support achievement of the ambition to reduce the number of suicides and to prevent loss of life to suicide in Solihull. The priorities are:</p> <ul style="list-style-type: none"> - Maintain focus on becoming a safer suicide community to reduced stigma associated with talking about suicide, including someone who has died by suicide or who has attempted to do so - To provide better support and care for those at the highest risk of dying by suicide - Working together to prevent suicide - Learning from those who have died by suicide including implementation of a real time surveillance system

Review of progress against the Birmingham suicide prevention strategy for 2019-2024 has demonstrated that there has been progress in delivery of the suicide prevention training scheme and coronial audit but limited progress in other areas. An updated strategy for 2025-35 is due to go for public consultation during 2025 and plans to cover:

- Improving data and evidence
- Providing support to people who self-harm
- Tailored, targeted support to priority groups
- Increasing training and skills
- Providing effective crisis support
- Reducing access to means and methods of suicide
- Providing effective bereavement support
- Making suicide prevention everyone’s business.

Publication of the revised strategy for Birmingham is expected in Autumn 2025. The Solihull Suicide Prevention strategy will be reviewed at the end of 2025, to inform a strategy refresh in 2026.

3.5. Detention under the Mental Health Act

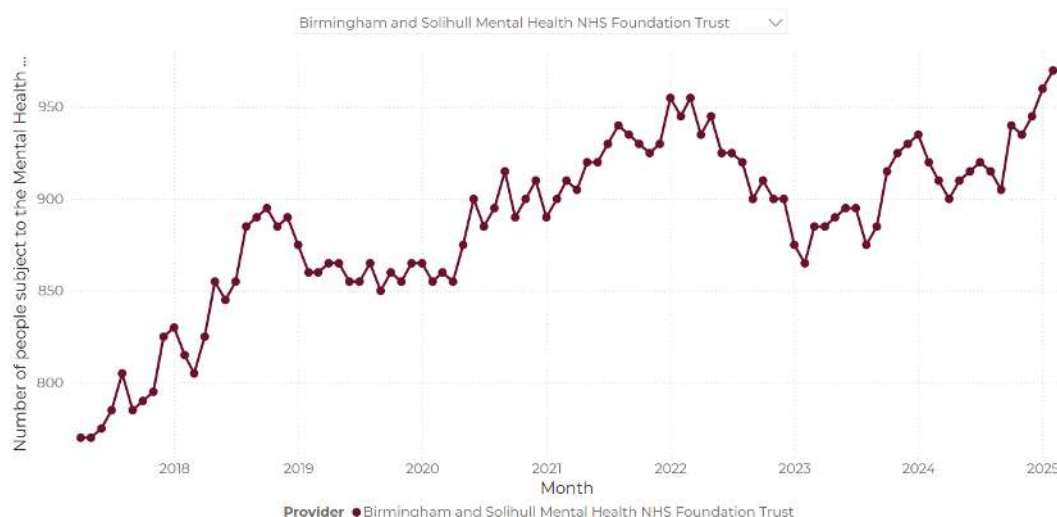
The [Mental Health Act \(1983\)](#) provides the legal framework for detaining individuals who have a mental disorder and a pose a risk to themselves or others. Detention under the Mental Health Act (MHA) is often referred to as "sectioning," as it involves applying specific sections of the Mental Health Act. This includes:

- In an emergency situation where someone seems to be at serious risk of harming themselves and they are in a public space the police can take someone to a place of safety (usually a hospital or sometimes the police station) and detain them under section 136 of the MHA in order for a mental health assessment to be undertaken by a doctor and an approved mental health professional.
- In non-emergency situations people can be assessed by a doctor and an approved mental health professional which can result in detention in hospital for up to 28 days under section 2 of the MHA or for up to 6 months under section 3 of the MHA, with further renewals.

People who have been treated in hospital under the Mental Health Act and are being discharged or allowed out of the hospital on short-term leave, may be put under a Community Treatment Order (CTO). Generally, a CTO means people can go home under certain conditions that they have to meet, and they can be readmitted to hospital if they break the terms of the CTO.

The number of people detained under the MHA at Birmingham and Solihull Mental Health Foundation Trust increased by 26% from April 2017 (770) to February 2025 (970). Nationally, there was a 17% increase over the same period. See figure 29 below.

Figure 29 – Number of people subject to the Mental Health Act 1983 for Birmingham and Solihull Mental Health NHS Foundation Trust, April 2017 to February 2025



Source: [Number of people subject to the Mental Health Act 1983 | Mental Health Watch](#)

Based on the data recorded in the mental health services dataset (MHSDS) during a period of mental health care, for the 12 month period from March 2024 to February 2025 the rate of detention under the MHA per 100,000 population was 69 per 100,000 in Solihull and 107 per 100,000 in Birmingham.

Key points of note regarding differences in rates of detention by ethnic group include:

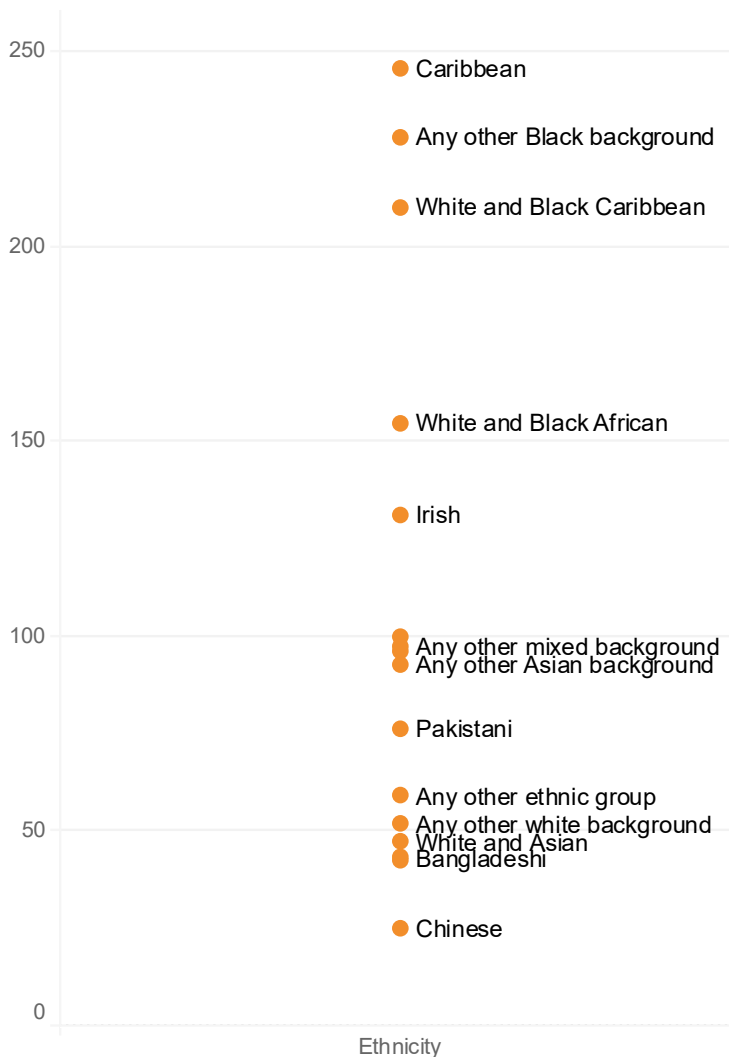
- Detention rates are highest in the Black Caribbean, Black Other and Mixed – White and Black Caribbean ethnic groups (all above 200 per 100,000).
- The lowest detention rate is in the Chinese ethnic group (25 per 100,000).
- The average rate for all ethnic groups is 101 per 100,000.

This above is illustrated in figure 30 (below).

Figure 30 – Detentions under the MHA by ethnic group, March 2024 – February 2025

Patients sectioned under the MH Act, BSOL

Demographic Equalities, Rate per 100k



Source: Business Intelligence, Midlands and Lancashire CSU

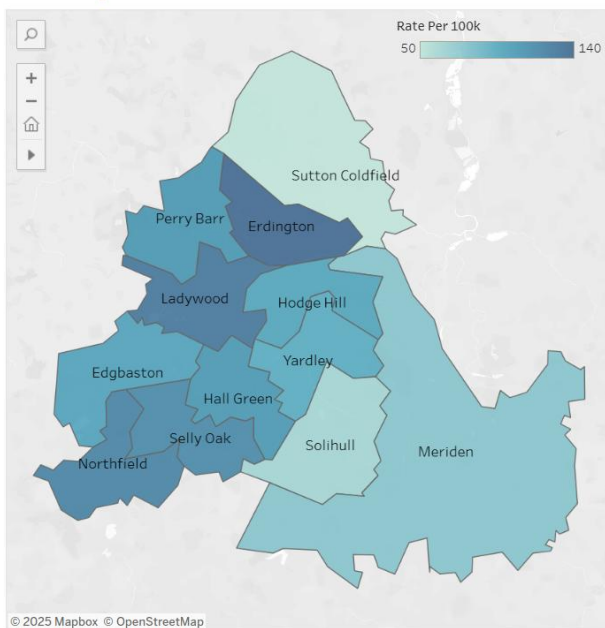
When it comes to detention under the MHA by parliamentary constituency:

- The parliamentary constituencies with the highest rates of detention under the MHA are Erdington (140 per 100,000), Ladywood (130 per 100,000) and Northfield (122 per 100,000).

- The parliamentary constituencies with the highest rates of detention under the MHA are Sutton Coldfield (50 per 100,000), Solihull (62 per 100,000) and Meriden (75 per 100,000).

This is illustrated in figure 31 below.

Figure 31– Detentions under the MHA by parliamentary constituency, March 2024 – February 2025



Source: Business Intelligence, Midlands and Lancashire CSU

3.6. Mental health service provision

3.6.1. Overview

Mental health service provision in Birmingham and Solihull includes a range of services delivered by the NHS, Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations and the independent and private sector. The primary focus in this needs assessment is on NHS-funded services which are commissioned by the provider collaborative.

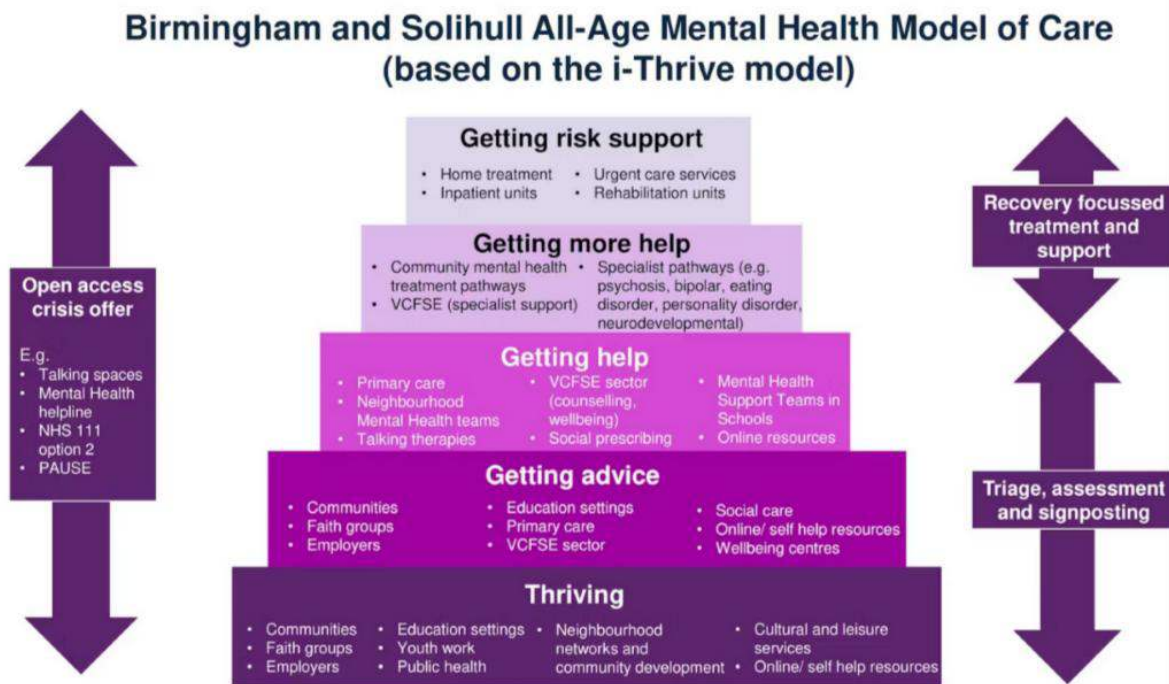
NHS-funded services in Birmingham and Solihull include:

- Services provided by [Birmingham and Solihull Mental Health NHS Foundation Trust \(BSMHFT\)](#): These include inpatient, community, and specialist services for those aged 16 years and above in Birmingham and all ages in Solihull.
- Services provided by [Forward Thinking Birmingham \(FTB\)](#) which provides mental health services for the 0-25 age group in Birmingham, although some services such as [Early Intervention in Psychosis](#) are delivered to people aged up to 35. FTB services were previously part of Birmingham Women’s and Children’s NHS Foundation Trust and transferred to BSMHFT in July 2025.

- VCFSE sector services which includes talking therapies delivered by the [Living Well Consortium](#), the [Birmingham Mind mental health helpline](#) and [talking spaces](#), the [Solihull Oasis Crisis Café](#), and [Rethink Redwoods](#) residential care home.

The below diagram summarises the overall nature of mental health provision.

Figure 32 - The All-Age Mental Health Model of Care



Source: Diagram of all-age mental health model care produced for draft provider collaborative 5 year strategy

3.6.2. Demand for services

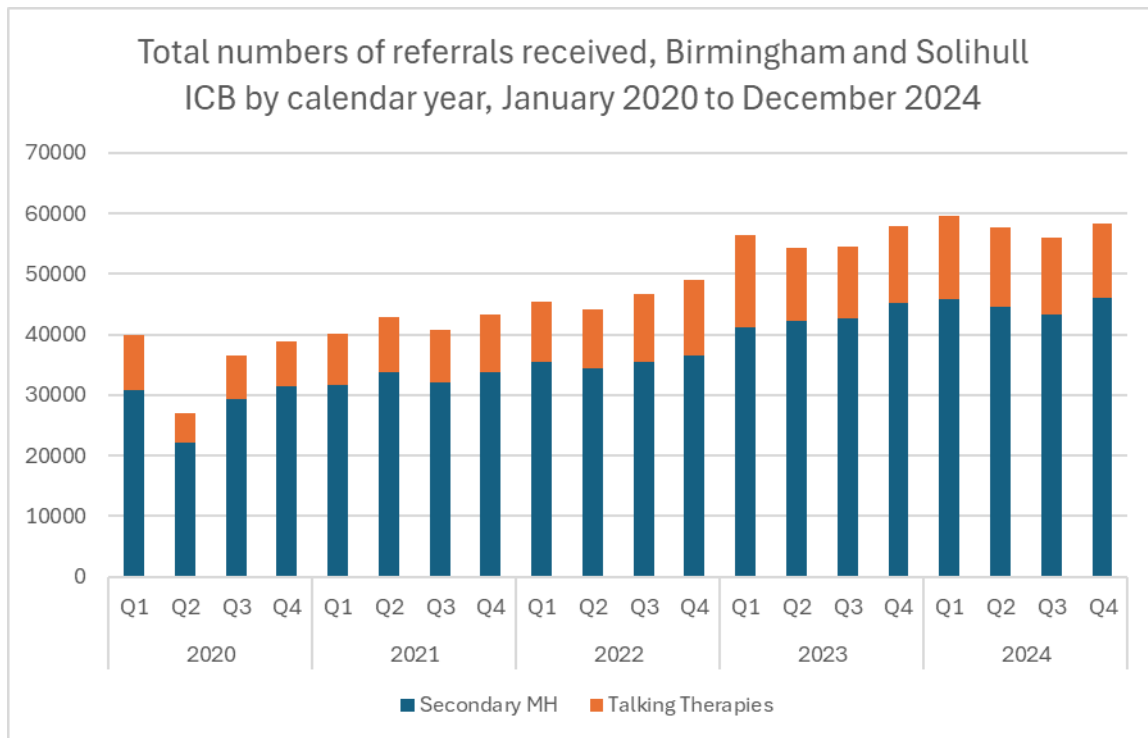
From 2020 to 2024, Birmingham and Solihull saw significant increases in both the numbers of referrals to NHS mental health services and the number of people in contact¹³ with mental health services. This is illustrated in the figures below.

The below chart shows that:

- For NHS Talking Therapies a total of 51,595 referrals were received in 2024, an 80% increase from 2020.
- For Secondary Mental Health Services, a total of 179,908 referrals were received in 2024, a 58% increase from 2020.
- In total 231,503 referrals were received in 2024, a 63% increase from 2020.

¹³ Contact with services has been defined as a distinct count of patients with an attended care contact (excluding asynchronous email and text) in the reporting month.

Figure 33 - Total number of referrals received for secondary mental health services and NHS Talking Therapies, Birmingham and Solihull ICB, January 2020 - December 2024



Source: Business Intelligence, Midlands and Lancashire CSU

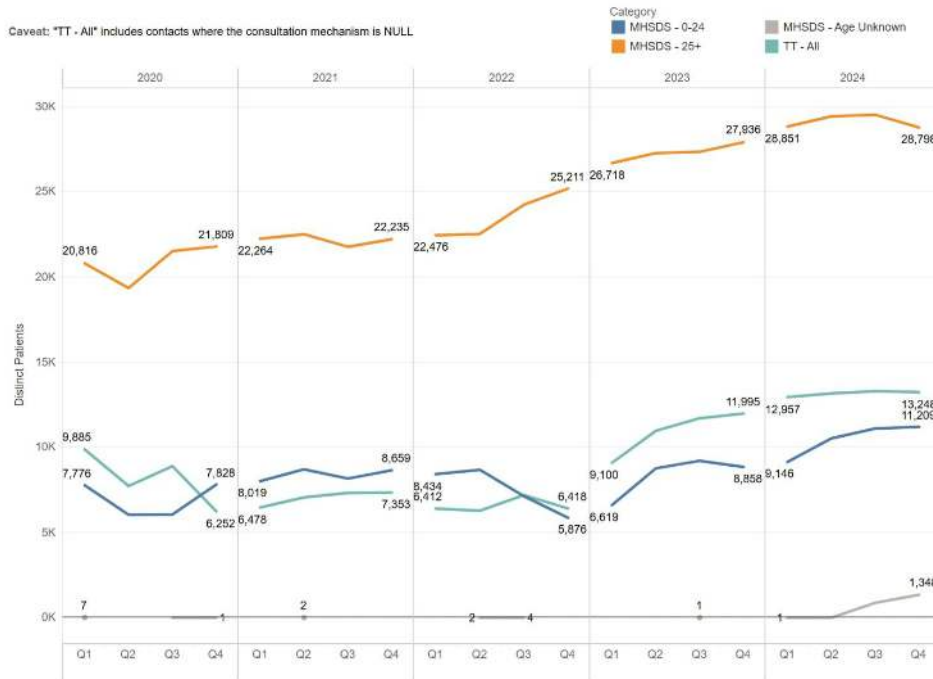
The below chart shows that from quarter 1 of the 2020 calendar year to quarter 4 of the 2024 calendar year there was:

- A 38% increase in people aged 25 years or older in contact with secondary mental health services.
- A 34% increase in the numbers of people in contact with NHS talking therapies.
- An overall 44% increase in the numbers of people in contact with mental health services.

Figure 34 - Number of unique patients in contact with mental health services per quarter, January 2020 – December 2024

Number of unique patients in contact with MH services, BSOL ICB

Source: MHSDS Commissioner Extracts, Talking Therapies Dataset



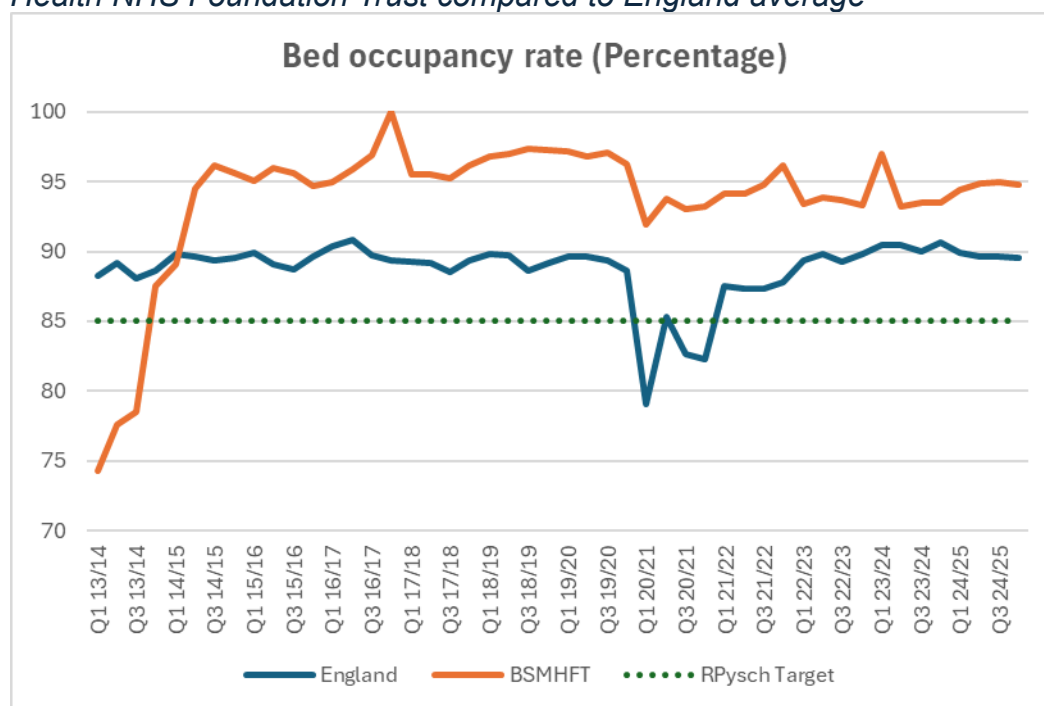
Source: Business Intelligence, Midlands and Lancashire CSU

3.6.3. Mental health inpatient services

There a variety of challenges and pressures relating to mental health inpatient services in Birmingham and Solihull which are illustrated by:

High levels of bed occupancy: BSMHFT have consistently exceeded the recommended 85% bed occupancy level and national average ever since quarter 2 of 2014/15, see figure 35 below.

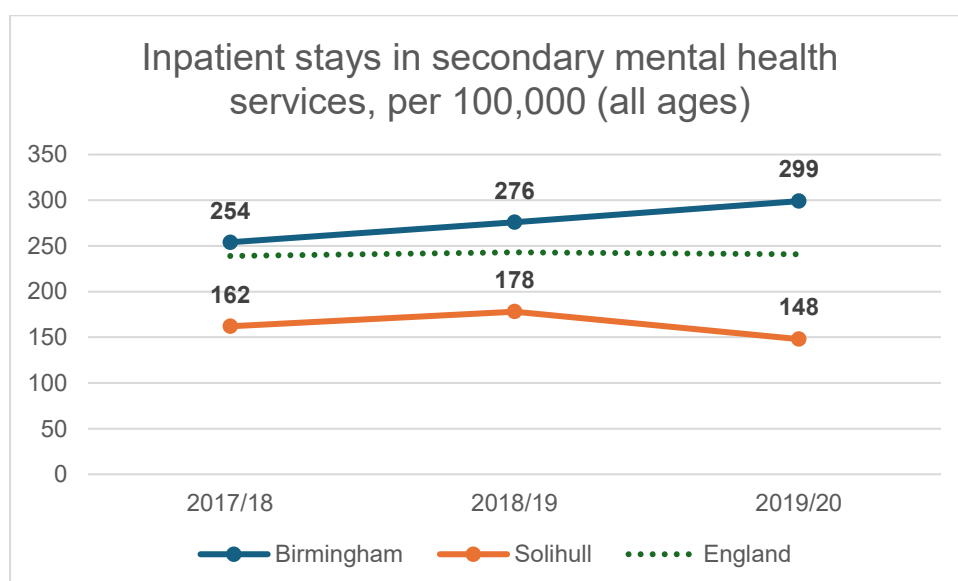
Figure 35– Mental health inpatient bed occupancy, Birmingham and Solihull Mental Health NHS Foundation Trust compared to England average



Source: [Bed occupancy across mental health trusts | Mental Health Watch](#)

Rate of inpatient stays per 100,000 population: The rate of mental health inpatient stays in Birmingham has increased from 254 (2017/18) to 299 (2019/20) and is above the national average whilst in Solihull the rate has decreased from 162 (2017/18) to 148 (2019/20) and is below the national average.

Figure 36 – In-patient stays in secondary mental health services, rate per 100,000 (all ages)

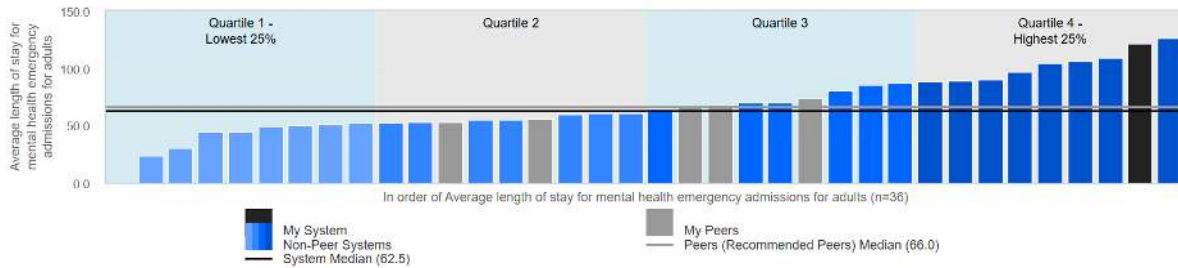


Source: [Fingertips | Department of Health and Social Care](#)

Length of stay for emergency admissions: According to data from the [Model](#)

Health System for May 2025, Birmingham and Solihull ICB recorded the second highest average length of stay for adult mental health emergency admissions nationally at 121.2 days. This is also the highest within its peer group, where the median value is 66.0 days.

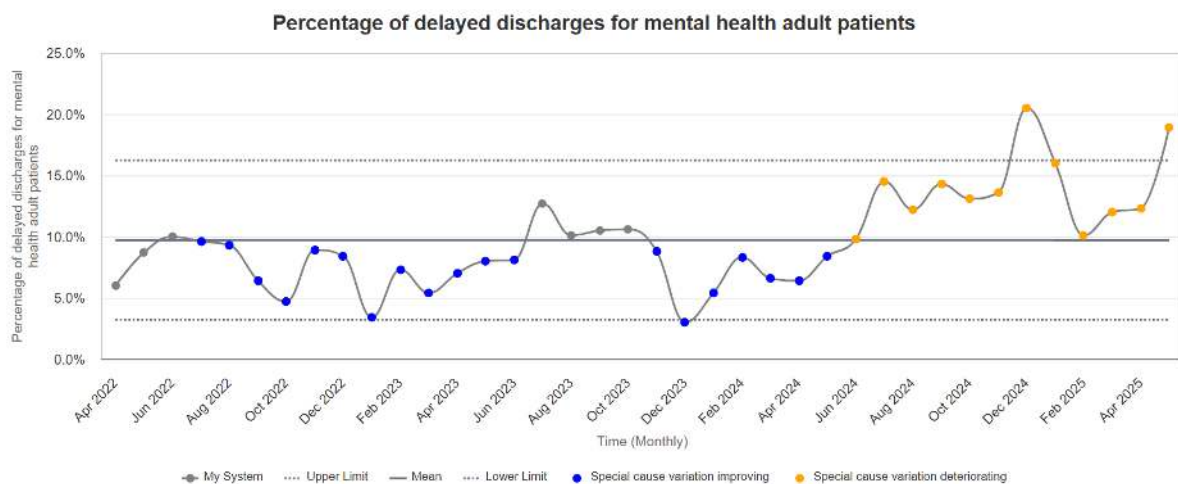
Figure 37 – Average length of stay for mental health emergency admissions for adults, national distribution



Source: Average length of stay for mental health emergency admissions for adults - Model Health System

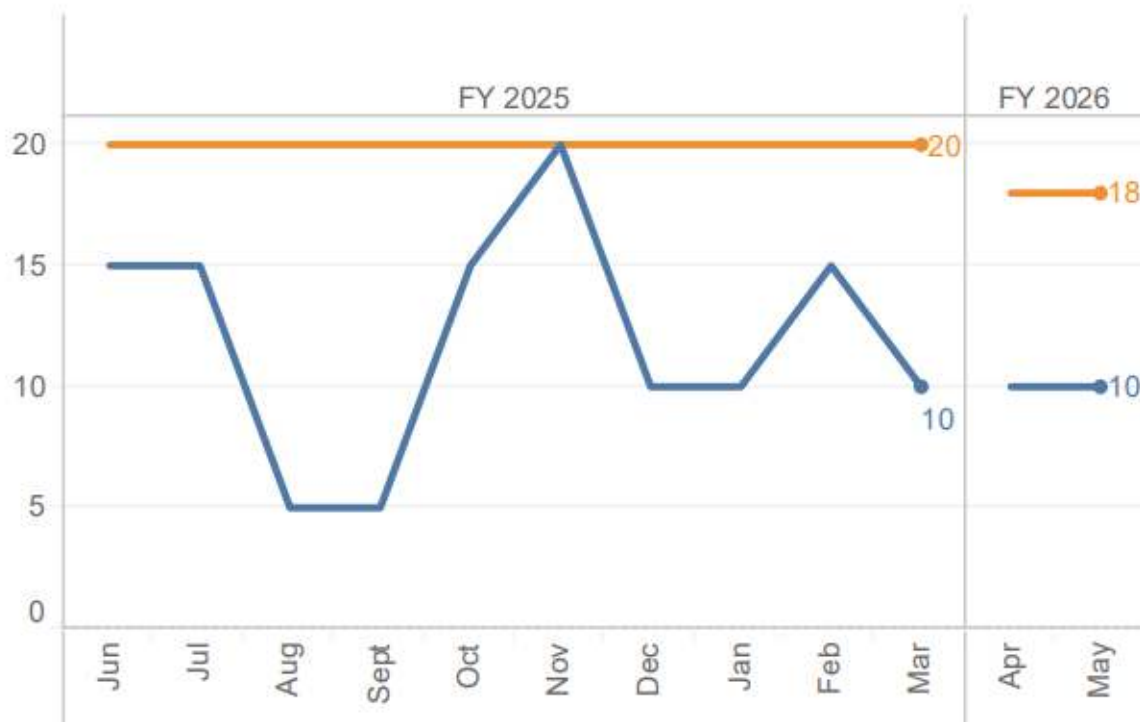
Delayed discharges: The percentage of delayed discharges for mental health adult patients in Birmingham and Solihull has shown a deteriorating trend from June 2024 with 18.9% of discharges delayed in May 2025.

Figure 38 – Percentage of delayed discharges for mental health adult patients, Birmingham and Solihull ICB, April 2022 to May 2025



Out of area placements: For the 12-month period from June 2024 to May 2025 the number of out of area placements has remained below the locally agreed target of 20 for 2024-25 and 18 for 2025-26, see below. The national ambition is to reduce out of area placements to zero.

Figure 39 - Number of out of area placements in adult acute beds



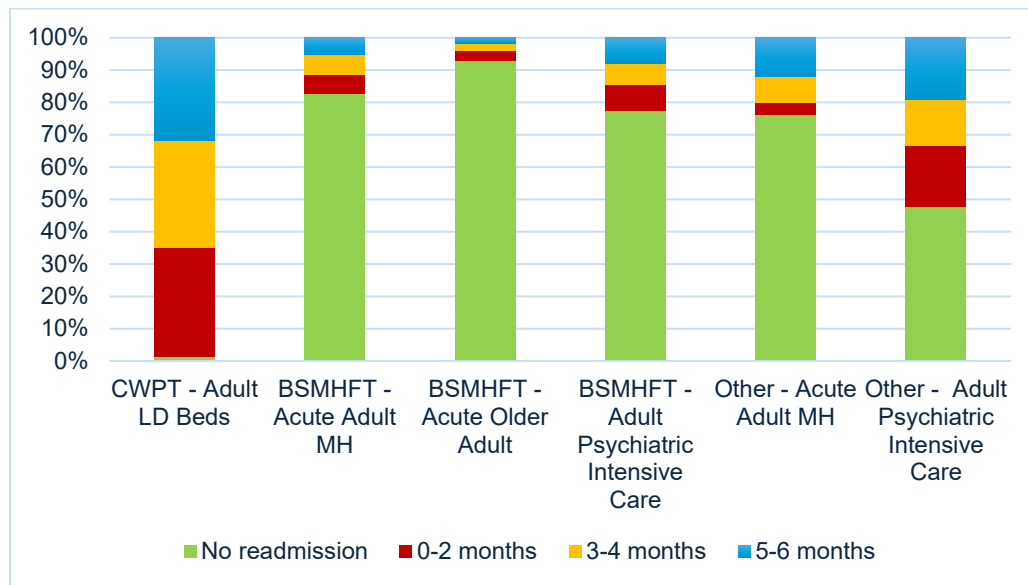
Source: NHSE MHSDS monthly statistics

Readmissions to inpatient care: Data on readmissions by provider and bed type for patients discharged between July 2023 and June 2024 where Birmingham and Solihull ICB is the commissioning organisation shows that:

- The highest rates of readmissions are in adult learning disability beds at Coventry and Warwickshire NHS Partnership Trust with only 1% of those discharged not being readmitted within 6 months of discharge.
- The second highest rates of readmissions are in psychiatric intensive care beds by providers categorised as other which encompasses a range of independent and NHS provider organisations¹⁴.
- The lowest rate of readmissions is in acute older adult beds at BSMHFT where 7% of those discharged were readmitted within 6 months of discharge.

¹⁴ Providers included under other are Active Care Group, Black Country Healthcare NHS Foundation Trust, Cygnet Healthcare Limited, Midlands Partnership NHS Foundation Trust, Partnerships in Care Limited, Priory Group Limited, South West Yorkshire NHS Partnership Trust, St Andrews Healthcare

Figure 40 – Readmissions by provider and bed type, patients discharged between July 2023 and June 2024



Source: Business Intelligence, Midlands and Lancashire CSU

Overall, for mental health inpatient services 33% of those discharged between July 2023 and June 2024 were readmitted within 6 months.

Figure 41 – Readmissions to inpatient care within 6 months, Birmingham and Solihull

Mental Health Re-admissions

Source: MHSDS (Mental Health Services Dataset) Commissioner Extract

Methodology: BSOL ICB Commissioned patients. Re-admissions within 6 months of the initial discharge date, for discharges occurring between July 2023 and June 2024.

Re-admission Category
 0-2 months
 3-4 months
 5-6 months
 No Re-admission

Proportion of Re-admissions by Re-admission Category



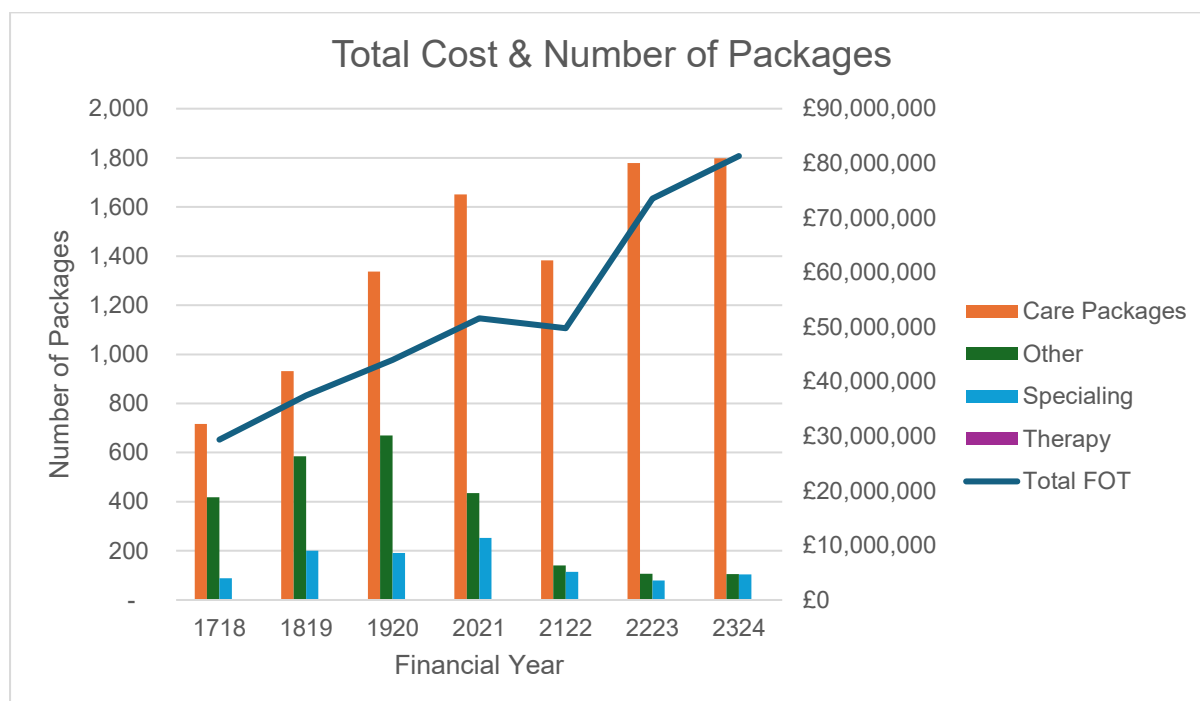
Source: Business Intelligence, Midlands and Lancashire CSU

3.6.4. Section 117 aftercare

Under [section 117 of the Mental Health Act 1983](#) people who have been detained in hospital under [section 3 of the Mental Health Act 1983](#), sentenced by a criminal court to detention in a psychiatric hospital or transferred to psychiatric hospital from prison are eligible for aftercare. Aftercare can include healthcare, including medication, help with specialised accommodation, social care support, day centre facilities and recreational activities.

In Birmingham and Solihull, the number and cost of section 117 packages has grown at a significant rate with the total number of care packages increasing by 151% from 2017-18 to 2023-24 and the total cost of packages increasing by 177% from c. £29M in 2017-18 to c. £81M in 2023-24 (see figure 42 below).

Figure 42 – Total Cost and Number of S117 Aftercare and Specialist Placement Packages, 2017-18 to 2023-24



Source: Broadcare System held by Birmingham and Solihull Mental Health NHS Foundation Trust

In response to this unsustainable trajectory, a transformation priority for the provider collaborative is to redesign the pathway and processes in conjunction with partners, the aims of the project are to:

- Improve the s117 care pathway to ensure timely and cost-effective delivery of health and social care services for better patient outcomes and experience.
- Improve the timeliness of the pathway from both a health and social care perspective and to improve the level of integration, reduce duplication and resource utilisation across the pathway.
- Identify opportunities to increase the utilisation of universal commissioned mental health and learning disabilities and autism services to meet s117 aftercare needs.

Initial stakeholder workshops were held to support these aims during September 2024 and a transformation project group to oversee the redesign of pathways and processes has been established and will be taking the project forward during 2025.

3.6.5. Service developments and transformation initiatives

3.6.5.1. The community transformation programme

Guided by the [Community MH Framework for Adults and Older Adults](#) the Birmingham and Solihull community transformation programme has sought to better support people with serious mental illness or complex mental health conditions in the

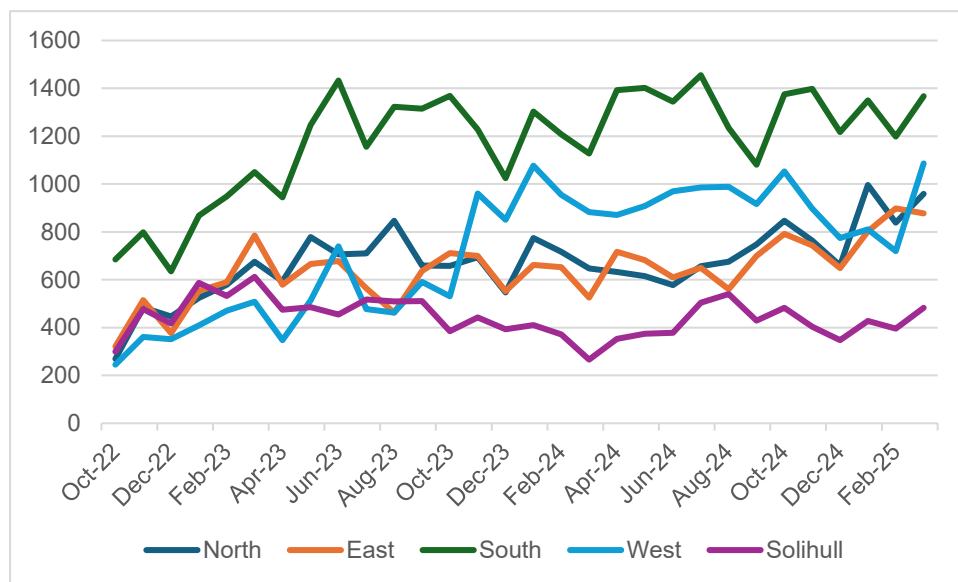
community. Key initiatives have included the development of neighbourhood mental health teams and intensive community rehabilitation teams.

3.6.5.1.1. Neighbourhood mental health teams

Neighbourhood mental health teams (NHMT's) seek to bridge the gap between GP-only mental health care and secondary mental health services. The aims of NHMT's include providing earlier support, more holistic care and support and signposting as part of joint working with the VCFSE sector.

For the period October 2022 to March 2025, NHMT's have received over 48,000 referrals, had over 118,000 contacts with service users and discharged over 44,000 service users of which 4.5% required referral to secondary mental health services.

Figure 43 - Neighbourhood Mental Health Teams, service user contacts, Oct-22 to Mar-25



Source: Birmingham and Solihull Mental Health NHS Foundation Trust

The community transformation programme has also identified areas where there are gaps in existing provision and pathways and is developing provision to better meet needs. For example, work led by consultant clinical psychologists has led to the development of a Psychological Service Index which identified existing provision for trauma in primary care was not meeting the level of need.

This has led to the piloting of a dialectical behaviour therapy skills 8-week course within the NMHTs which commenced in June 2025.

3.6.5.1.2. The intensive community rehabilitation team

The ICRT was established in 2023 to provide community-based rehabilitation as an alternative to inpatient care. The ICRT has a multi-disciplinary team including nurses, occupational therapists, psychologists, peer support workers, recovery navigators, and consultants.

The goals of the ICRT are to:

- Reduce reliance on out-of-area placements.
- Improve recovery outcomes by focusing on community-based support.
- Facilitate earlier discharges from rehabilitation beds.

Achievements of the ICRT include:

- Supported 55 individuals with complex needs to live independently.
- Reduced demand for rehabilitation beds and generated cost savings.

3.6.5.2. The 24/7 pilot

Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) was named in August 2024 as one of six providers across the country who are leading the development of a 24/7 mental health service pilot.

The pilot has involved the phased opening of a neighbourhood centre in the east of Birmingham, providing day and night support to local people aged 18 and over with Serious Mental Illness (SMI). The centre is run by BSMHFT, in partnership with a range of local colleagues across health and social care including GPs, Voluntary Community Faith and Social Enterprise (VCFSE) organisations and those with lived experience.

This centre covers the neighbourhoods of Small Heath, Bordesley Green and Heartlands – based in the east of Birmingham serving a population of approximately 40,000 people.

The service is offering an open access drop-in service bringing together all aspects of community mental health specialist care in the area. The integrated service offer includes crisis care, home treatment, early intervention, community, rehabilitation with plans to include inpatient care as part of future development of the service. The service is focused on looking after the whole person, considering the physical health and social needs alongside their mental health.

Funded by NHS England over two years, the pilot will adopt a successful model of mental health care used in other countries which is recognised by the World Health Organization.

3.7. The experience of care campaign

Rethink Mental Illness led on an experience of care campaign which involved gathering views from a wide variety of service users, groups and communities of interest during January 2024 to July 2024. Feedback was gathered via an online survey which received 245 responses, 15 focus groups with 122 participants and 14 one to one interviews. A desktop review was also undertaken of existing intelligence, reports and information regarding people's experiences of mental health services in Birmingham and Solihull.

Overarching themes from the campaign were:

- **Long wait times:** Significant delays in accessing mental health services, leading to deterioration in mental health. Of those responding to the survey, 64% of stated they did not receive timely support from mental health services when required.
- **Difficult referral processes:** Lengthy and challenging referral pathways, with variations in ease depending on the service type.
- **Lack of support whilst waiting:** Insufficient support for service users and their families while waiting for services, exacerbating mental health issues.
- **Complex system:** Difficulties navigating the mental health support system, leading to frustration and delays.
- **Lack of awareness of support available:** Lack of awareness and information about available community support, including voluntary, community, faith, and social enterprise sectors.
- **Communication issues:** Problems with getting through to teams, delays in receiving appointment letters, and the need to repeat information due to lack of continuity in care.
- **Lack of tailored services:** Services not adequately tailored to the needs of individuals with autism.
- **Cultural competence:** Inadequate cultural competence among professionals, particularly affecting children and young people's services, community mental health teams, and crisis teams.
- **Stigma and shame:** Persistent stigma and shame associated with mental health within various communities.
- **Need for integration:** A strong need for better-coordinated, more joined-up, and integrated services to reduce duplication and improve resource utilization.
- **Community assets and peer support:** The necessity to strengthen existing community assets and peer support networks.
- **Low satisfaction:** Respondents to the survey were asked to score their satisfaction with services received on a scale of 1 to 5 (where 5 is best). The average score was 2.82 with the lowest levels of satisfaction being recorded for children and young people's mental health services (1.96) and the highest for inpatient services (2.86).

Barriers to accessing mental health support which were identified included:

- **Cultural and physical barriers:** Cultural taboos, stigma, non-sensory friendly environments, and physical ill health.
- **Financial impact:** The financial burden of attending appointments.
- **Referral and communication issues:** Non-fluid referral processes, lack of communication, and the need to chase updates, often leading to further delays.

These themes underscore the need for systemic improvements in mental health services, focusing on reducing wait times, enhancing support during waiting periods, improving system navigation and communication, tailoring services to individual

needs, increasing cultural competence, addressing stigma, and better integrating services to provide holistic and effective care.

4. Mental health needs across the life course

4.1. Perinatal and Infant Mental Health

4.1.1. Introduction

Perinatal mental health (PMH) refers to parents' mental health and emotional wellbeing from preconception until their child is 2 (Institute of Health Visiting, n.d.). Perinatal mental health conditions are defined as mental illnesses that affect females during the perinatal period. This includes common mental health conditions (CMHCs), severe mental illness (SMI), eating disorders and personality disorders.

If left untreated, mental health issues can have significant and long-lasting effects on the woman, the child, and the wider family. Specialist PMH services provide care and treatment for women with complex mental health needs and support the developing relationship between parent and baby. They also offer women with mental health needs advice for planning a pregnancy.

The Office of Health Improvement and Disparities (OHID), part of the Department of Health and Social Care (DHSC), developed local modelled prevalence estimates for perinatal mental health (PMH) conditions in England using a cohort of females who had a birth event in 2016. The results were produced for 2016 and then applied to 2016 and 2019 maternities data to produce prevalence estimates. Estimates were not produced beyond 2019 because the data to measure the impact of the COVID-19 pandemic was not yet available. Locally the prevalence estimates are 28.0 % for Birmingham and 24.8% for Solihull (Office for Health Improvement and Disparities, 2025).

However, it is important to note that PMH need may be underestimated in areas with a higher proportion of females from ethnic minorities who give birth and PMH need is higher in areas with younger populations and higher levels of deprivation (Office for Health Improvement and Disparities, 2025). This is particularly relevant to Birmingham given the diverse population, high levels of deprivation and youthful age profile of the city.

The following service developments were identified as part of the [NHS Long Term Plan](#) and associated [Mental Health Implementation plan](#):

- Increasing the availability of specialist PMH community care for women who need ongoing support from 12 months after birth to 24 months.
- Improving access to evidence-based psychological therapies for women and their partners.

- Mental health checks for partners of those accessing specialist PMH community services and signposting to support as required.

[Infant mental health](#) describes the social and emotional wellbeing and development of children in the earliest years of life. During the first 1001 days of life, from conception to a child's second birthday, the brain is more plastic and is developing faster than at any other point in life. [Early development](#) is shaped by a dynamic interaction between a baby's biological make-up and their experience: the quality of the parent-infant relationship impacts how neuronal connections are built, emotions and behaviour become regulated, and attachment styles (how individuals interact with and attach to the people closest to them) are developed.

Severe and persistent problems in early relationships and emotional development can have pervasive and lifelong negative impacts on a range of outcomes. However, infant mental health care that supports babies having responsive, nurturing relationships with consistent, sensitive caregivers can provide the foundation of positive infant mental health that has benefits across the lifespan. The [2022 Birmingham Assessment of Need](#) describes a growing body of research that demonstrates how early relationships and emotional wellbeing and development can predict later wellbeing in multiple domains: the first 1001 days of life offer a critical window of opportunity for early intervention and prevention that can support inter-generational physical, mental and economic wellbeing at both a personal and population level (Birmingham Women's and Children's NHS Foundation Trust, 2022).

Figure 44 – Benefits of a secure parent-infant relationship



Source: [Commissioning Toolkit - Parent-Infant Foundation](#)

The [Parent-Infant Foundation](#) advises that services designed to meet the needs of pre- birth and the first few years of life need to be tailored to particular needs of this cohort, and vary from systems traditionally associated with children and young people’s mental health services. The Parent-Infant Foundation promotes the model of a [multi-disciplinary specialised parent-infant relationship team](#) that helps parents to overcome difficulties, build on existing parenting strengths, and develop new capacity to provide the sensitive, responsive, and appropriate care that their babies need to thrive (Parent-Infant Foundation, n.d.).

4.1.2. The relationship between Perinatal and Infant mental health

Children of parents with perinatal mental illness are at increased risk of a range of poorer outcomes, especially in relation to their cognitive, social, and emotional development (Goodman, 2019). Perinatal mental illness can affect the parent-infant relationship and impact on the baby’s ability to form a secure attachment which is key for their future emotional wellbeing and development (Centre for Early

Childhood, 2021). It has been estimated that nearly 75% of the £8 billion a year costs associated with perinatal mental health are due to the long-term impact on children (Bauer, Parsonage, Knapp, Lemmi, & Adelaja, 2014).

Whilst specialist perinatal mental health services may provide Parent-Infant relationship (PAIR) support as is the case in Birmingham and Solihull, there are a group of children under the age of two who may not be able to access this support. These infants include:

- Infants experiencing, or at risk of, neglect or abuse where mother/parent does not meet perinatal mental health service access criteria.
- Infants of mothers with mild to moderate mental health difficulties who do not meet perinatal mental health service access criteria.
- Infants of mothers diagnosed with complex trauma and/or personality disorder who do not meet perinatal mental health service access criteria.
- Infants of mothers experiencing alcohol or substance misuse difficulties or domestic abuse, who may be signposted to specialist treatment or intervention services that don't offer PAIR work.
- Infants of young mothers aged under the age of acceptance to perinatal mental health services – these young mothers may be eligible for a children and young people's mental health service but this is unlikely to include parent-infant work.
- Infants of fathers/other carers who wish to access parent-infant work independently from the mother (assuming parent-infant services work with a non-resident parent/carer).
- Adoptive or foster parents who need help to form a secure relationship with their new child under the age of two.
- Infants for whom the transition to parenthood has activated something painful or adverse in their parent's own childhood that is interfering with the emerging parent-infant relationship, but who do not have perinatal mental health difficulties.
- Infants in families affected by previous baby loss/bereavement/complicated conception, where service support, if available, doesn't include PAIR support.
- Infants of mothers in prison or refuges, who are asylum seekers, or part of other marginalised groups who will not be eligible for, or face barriers accessing, perinatal mental health support.

4.1.3. The Birmingham and Solihull context

According to latest figures, Birmingham and Solihull ICB have the second highest prevalence rates for perinatal mental health across the country (see table below).

Figure 45 – Prevalence of perinatal mental health conditions across Integrated Care Board areas

ICB	Number of females with birth event	Estimated prevalence %	95% CrIs	Estimated number of females affected	Range of estimated number of females affected
NHS Black Country	14,637	28.2	27.8 to 28.6	4,129	4,069 to 4,190
NHS South Yorkshire	14,712	27.6	27.3 to 28.0	4,065	4,013 to 4,119
NHS Birmingham and Solihull	17,515	27.6	27.1 to 28.0	4,826	4,754 to 4,900
NHS North East and North Cumbria	28,194	27.5	27.1 to 27.8	7,741	7,645 to 7,839

Source: [Estimated prevalence of perinatal mental health conditions in England, 2016 and 2019 - GOV.UK](#)

In Solihull:

- 2022 population estimates show that 6,524 children aged 0-2 years live in the borough, 1,151 (17.6%) of which live within the 10% most deprived areas.
- In comparison with the rest of England, Solihull has poorer outcomes for several measures of maternal health and infant health such as neonatal mortality and low birth weight, although the proportion of low-birth-weight babies and overall infant mortality have stabilised as shown in the most recently published data.
- Solihull has higher rates of children in care and emergency hospital admissions amongst 0–4-year-olds than the national average.

The [2022 Birmingham Assessment of Need](#) (Birmingham Women's and Children's NHS Foundation Trust, 2022) reported that:

- In 2020, an estimated 49.6% of children in Birmingham aged two and under lived in the most deprived 10% of neighbourhoods in England.
- In comparison with the rest of England, Birmingham has poorer outcomes for several measures of maternal health and infant health such as maternal mortality, stillbirth, low birth weight, very low birth weight, and infant mortality.
- Birmingham has higher indications of deprivation than other parts of England on relevant measures such as poverty including child poverty, children in care, teenage pregnancy, and unemployment.
- Data from the Childhood Local Data on Risks and Needs dataset shows that Birmingham is in the worst 5% of England local authorities for modelled prevalence of children aged 0-2 in households with all three of the so called

'toxic trio' (domestic abuse, severe mental health problem and substance misuse).

- Birmingham has the largest proportion of children aged 0-5 years of any local authority in England and the ethnic diversity of this population increases with every cohort of children born.

The [2022 Birmingham Assessment of Need](#) reported modelled estimates suggesting that 2,420 families per year in Birmingham most at risk of long-term difficulties, would both require *and* access specialised parent-infant relationship support. These families were in *addition* to families estimated to be most at risk and in need of support but not predicted to access it, *and* the families most at risk who would be eligible to receive parent-infant relationship support through moderate to severe perinatal mental health provision. *A workforce of 47 whole time equivalent staff was estimated to be needed to meet the needs of these 2,420 families.*

4.1.4. Early intervention and prevention

The [2022 Birmingham Assessment of Need](#) summarises the evidence on the economic case for early investment:

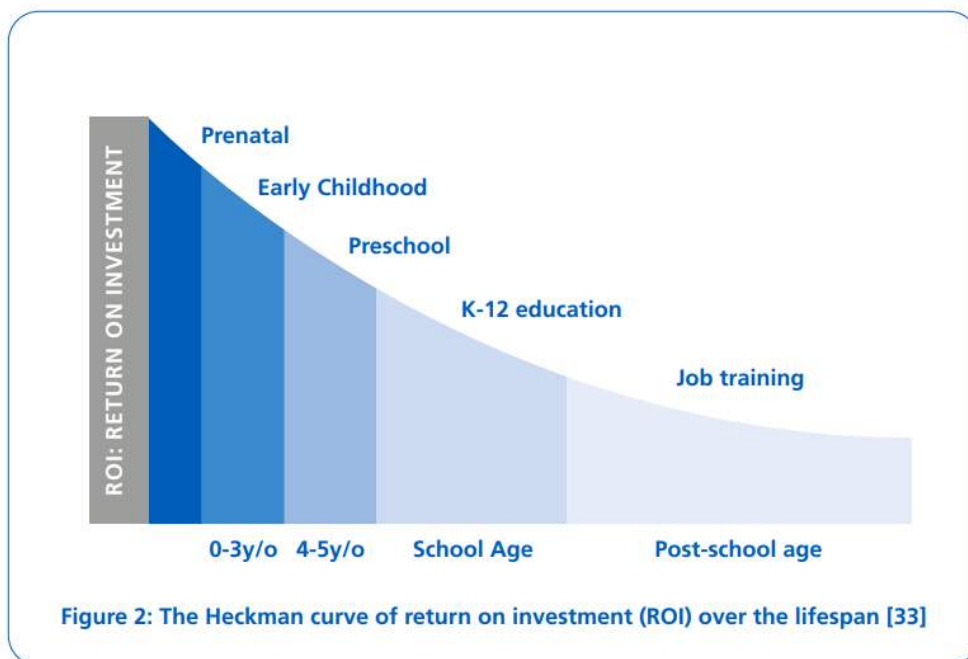
The evidence clearly shows that well designed and implemented early years programmes can have significant benefits in terms of life-long health, educational attainment, social, emotional and economic wellbeing and reduced involvement in crime that far outweigh their costs.

The needs assessment states:

This is because early years interventions can (a) prevent difficulties arising and therefore reduce the need for remedial spending on complex interventions and multiple layers of support later in life, and (b) ensure that where children do develop difficulties these are likely to be less serious and more responsive to less intensive interventions. The most economically efficient time to invest in developing children's skills and social abilities is in the very early years.

The below figure taken from the needs assessment represents the Heckman curve of return on investment over the lifespan which shows the highest return on investment during the prenatal period:

Figure 46 – The Heckman curve of return on investment (ROI) over the lifespan



Source: [Nurturing-our-future.pdf](#)

4.1.5. Service provision: Perinatal mental health

Birmingham and Solihull has a commissioned specialised perinatal community mental health service offered by [BSMHFT](#). The service is commissioned to work with parents aged 18 and above, and to provide care to parents aged 16-18 in partnership with Forward Thinking Birmingham (FTB) and [Solar](#), who are responsible for providing perinatal mental health care for parents under the age of 16.

To support the delivery of care to patients aged 16-25 with a Birmingham GP, a comprehensive Joint Working Framework has been developed in collaboration between BSMHFT and FTB. This will be operationalised with the support of a newly developed Perinatal Clinical Specialist post, being piloted from May 2025 and jointly funded by FTB and BSMHFT.

Additional mild to moderate perinatal mental health support is offered to Birmingham parents via Perinatal Talking Therapies, as well as VCFSE services such as Acacia, and Approachable Parenting. Funding from the [Government Family Hubs & Start for Life programme](#) has been used to enhance perinatal and parent-infant relationship support more widely across Birmingham, with workforce training, enhanced VCFSE peer support, and an enhanced maternity offer aimed to reduce health inequalities and a small pilot PAIR service (see below).

The Start for Life programme aimed to create test and learn service opportunities that, if successful, could become part of mainstream commissioning. Programme funding has recently been extended to March 2026 to support consolidation and embedding of pilot.

Solihull Healthy Child Programme Service (0-19 years) incorporates Health Visiting, Infant Feeding and Family Nurse Partnership teams provide by South Warwickshire University NHS Foundation Trust. The Health Visiting team offer a range of interventions to support perinatal and infant mental health, including a package of emotional wellbeing visits underpinned by evidence-based research. The team also has two practitioners fully accredited in [Video Interaction Guidance \(VIG\)](#) and practitioners trained in the [Parent Infant Interaction Observation Scale \(PIIOS\)](#).

VIG provides a bedrock of support for attunement between parents and infants and clients include neurodiverse parents and children to help support communication and create a reciprocal relationship which positively impacts on child development, to improve health outcomes. Solar also delivers Video Interaction Guidance (VIG) for parents/carers with attachment difficulties in parallel to the offer from Health Visiting. This is an important service to address attachment issues using a strengths-based approach to promote secure and attuned parent-infant relationships.

The Health Visiting team also offers Solihull Approach postnatal parenting groups, and the Parent and Baby Outcomes Star is used with all parents antenatally and postnatally and focuses on perinatal mental health and wellbeing and the New Mum and Dad Star is used in VIG work. In addition, the team offers DadPad along with ChatHealth (a text messaging advice and support service).

Solihull also has a specialist infant feeding team who support parents/carers with breastfeeding and responsive parenting and the Family Nurse Partnership team support young parents from early pregnancy up until the child is 2 years old, with a key focus on secure parent-infant attachment for parent/carers aged 19 and under (and 21 years and under with experience of the care system).

4.1.6. Service provision: Infant mental health

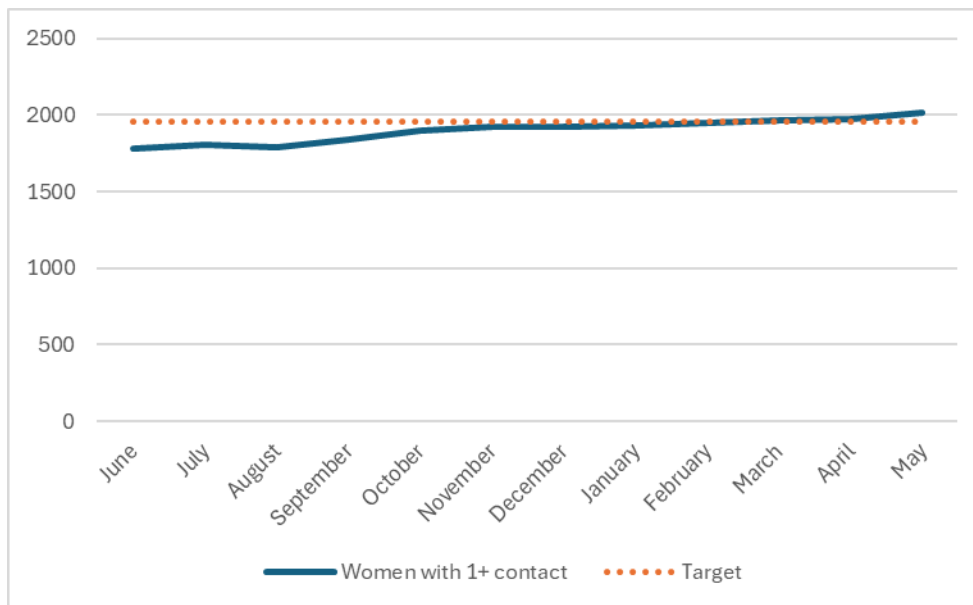
The [2022 Birmingham assessment of need](#) describes the range of services across Birmingham that are supporting infant mental health via a focus on the PAIR. Non-specialised services mainly support by reducing the risk factors for difficulties in the parent-infant relationship or strengthening protective factors as part of wider service aims. Highly specialised infant mental health provision is primarily offered via the PAIR pathway in the [BSMHFT Perinatal Mental Health service](#), although only 12% of families most at risk of developing serious PAIR related difficulties are estimated to meet the moderate-severe mental health access criteria for this service.

Forward Thinking Birmingham (FTB) offers a 0-25 mental health service to families with a Birmingham GP. Historically, the service has received very few referrals for Under 2s, and this informed the creation, in 2021, of a [new consultant post](#) focused on infant mental health delivery. Since April 2022, Government Family Hubs & Start for Life funding has enabled the piloting of a small pilot PAIR resource in Birmingham, aligned with the recommendation of the 2022 needs assessment to create a specialised PAIR service. This has provided an additional 2.8 whole time equivalent dedicated infant mental health clinical capacity within FTB and early work

has supported community engagement and staff consultation, with a small amount of direct work to families. With extended funding anticipated for delivery in 2025-26, priorities are expected to be widening access to families, developing a new parent-infant psychotherapy offer, online group support for families, and creating locally informed training for community staff. However, funding for this resource, which constitutes just under 6% of the workforce estimated to meet need in Birmingham, is only currently available to March 2026.

4.1.7. Access targets

Figure 47 – Perinatal and Maternal Mental Health performance against access target, June 2024 to May 2025



Source: Mental Health System Performance Report, BSOL ICB produced by Business Intelligence, Midlands and Lancashire CSU

Within the NHS Long Term Plan, there is an ambition to increase access to Perinatal Mental health services, locally this translates to 1,953 women in Birmingham and Solihull having at least one contact and performance against this target over the rolling period June 2024 to May 2025 for Birmingham and Solihull is shown above. The trajectory shown above shows the target was reached at the end of March 2025 achieving 1,965 contacts against the target of 1,953. This trajectory is based on the 10% of the birthrate (2015) estimated to experience moderate to severe mental health problems during pregnancy in the post-natal period.

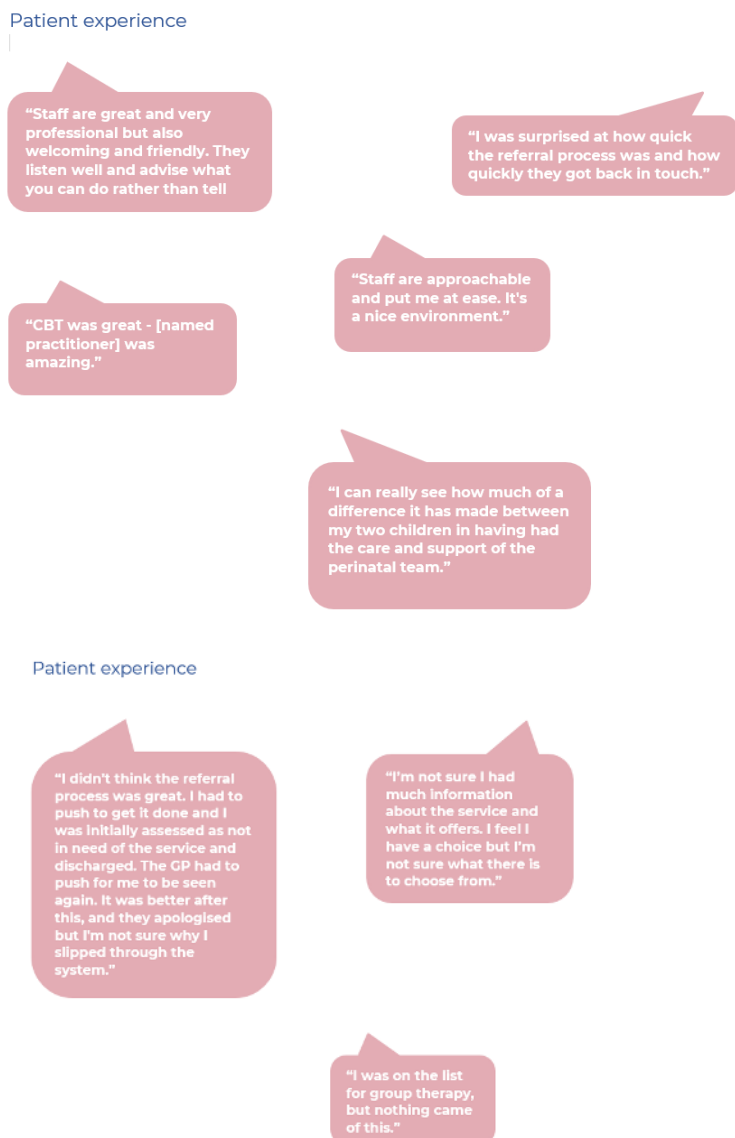
4.1.8. Service user experience

A peer review of the Solihull Perinatal Service against the Perinatal Quality Network (PQN) Community Standards – Sixth Edition (CCQI, 2022) took place in January 2025.

Service user experience captured as part of the review process is highlighted below, this includes some challenges in relation to routes into the service as well as positive feedback on experiences of support received and positive feedback regarding staff

working within the service.

Figure 48 - Extracts from peer review of Solihull perinatal mental health service



Source: Perinatal Quality Network Peer Review of Solihull Perinatal Service, Birmingham and Solihull Mental Health NHS Foundation Trust

4.1.9. Potential unmet needs and gaps in provision

Whilst children's futures are not determined by the age of two, the neuroplasticity of this period and the breadth and longevity of the impacts of effective parent-infant relationship interventions across the lifespan, make the first 1001 days of life a time of unique vulnerability and opportunity. This period offers a crucial window of opportunity for early intervention and prevention that can (a) prevent difficulties arising and therefore reduce the need for remedial spending on complex interventions and multiple layers of support later in life, and (b) ensure that where children do develop difficulties these are likely to be less serious and more responsive to less intensive interventions. In this way, infant mental health

interventions that support and enhance parent-infant relationships constitute an investment in inter-generational physical, mental and economic wellbeing at both a personal and population level.

The [2022 needs assessment of parent-infant relationship help and support in Birmingham](#) identified gaps in mental health support for 0-2 year olds even where services had a remit from birth. This ‘baby blindspot’ is a [national challenge](#). The assessment of need recommended that FTB should expand capacity for specialised parent-infant support and continue to build on internal and external links with staff to offer consultation and training and increasing service capacity to manage a larger caseload of 0-2s who would benefit from specialised support.

Under the leadership of the provider collaborative, work is underway to establish a Birmingham and Solihull-wide multidisciplinary group focused on parent–infant relationships and perinatal mental health. This group will develop a unified strategy aligned with Family Hubs and Start for Life expectations, helping to identify and address unmet needs and service gaps in Perinatal and Infant Mental Health.

It also of note that an assessment of need has recently been completed in Solihull replicating the format used in Birmingham with additional Solihull specific information which involved:

- Gathering a wide range of local, national and international data to understand the need for parent-infant relationship support from conception to age two in Solihull.
- Interviewing 19 practitioners and service managers, gathering service data and consulting with senior leads to map current parent-infant relationship support from conception to age two across Solihull.
- Asking 27 local practitioners and managers about current strengths and future training needs and researching the likely workforce requirements for improving parent-infant relationships.
- Gathering the views of 12 local parents on a range of questions connected to parent-infant relationship support.

Once published, this will also provide a picture of potential gaps in provision and unmet need in Solihull.

4.2. Children and Young People’s Mental Health

4.2.1. Introduction

The early years and childhood lay the foundations for good wellbeing (physical and mental) through to adulthood. It is well documented that disadvantage can start even before a child is born and can accumulate over time and impact on future generations. Children and young people who face multiple risks have an increased risk of multiple and sustained childhood mental health difficulties (Public Health

England, 2018).

Poverty is associated with an increased risk of experiencing multiple adverse childhood experiences (including neglect, abuse, bereavement, and having a parent/carer with a substance misuse issue or severe mental illness) leading to increased risk of mental ill health.

Successive studies in the UK countries have reported that a child in the most deprived decile (10%) of small neighbourhoods is over ten times more likely to be on a child protection plan (CPP) or in out of home care than a child in the least deprived decile, both of which are markers of childhood abuse and neglect (Bywaters, Skinner, Cooper, Kennedy, & Malik, 2022). Similarly, a UK study (Marryat & Frank, 2019) found that children from the most deprived 20% were 12 times more likely to experience three or more adverse childhood experiences by the age of eight than children from the least deprived 20%. Children's exposure to poverty creates and compounds adversity, driving poor health and social outcomes in later life.

Research suggests a causal relationship between poverty and adverse childhood experiences, such as exposure to violence. One study (Haushofer & Fehr, 2014) has indicated that cash transfers to households can reduce intimate partner violence.

There is a great deal of high-quality scientific evidence demonstrating that adverse childhood experiences lead to a substantially higher risk of poor wellbeing, mental ill health, and other negative outcomes during the whole lifetime of the person affected (Lippard & Nemeroff, 2020). For example, analysis shows that 46% of individuals with depression (Nelson, Klumpp, Doebler, & Ehring, 2017) and 57% of people diagnosed with bipolar disorder (Post, et al., 2013) report high levels of childhood maltreatment.

Most (75%) lifetime mental health difficulties first occur before the age of 24, and 50% before the age of 14 (Kessler, et al., 2005). There is considerable evidence that giving every child the best possible start will generate the greatest societal and mental wellbeing benefits. Early intervention increases the prospects of good mental health in later life – but delayed or inadequate intervention decreases these chances. Action needs to be universal, across the whole of society and proportionate to need in order to level the social gradient in health outcomes.

4.2.2. Early Intervention and Prevention

There is strong evidence that much poor mental health could be avoided by investment in prevention and early intervention measures. This includes actions that address the social and economic circumstances that influence mental health, such as reducing poverty and providing safe green spaces. It can also include measures aimed at the family and individual levels, such as interventions to support parenting and families' coping strategies.

Parenting programmes is a term used to describe a range of interventions for parents, which are often delivered to a group. They aim to support parents to

strengthen their relationships with their children and foster their child's emotional and social skills development. There is good evidence parenting programmes can help promote positive mental health and reduce the risk of poor emotional development for children. [A report by the London School of Economics and The Mental Health Foundation](#) references a growing number of studies that show the cost-effectiveness of parenting programmes, reporting up to £15.80 can be saved on spending in the long-term for every £1 spent on delivering the programme (McDaid, et al., 2022).

There is also strong evidence that measures targeted at all pupils within a school can reduce bullying and have positive benefits for mental health. Based on the effectiveness of an anti-bullying programme delivered in Finland researchers have estimated what the effects of a similar programme might be in the UK and found that between the ages of 7 and 11, an additional four in every 100 children could avoid sustained bullying, saving £1.58 for every £1 spent over those four years (McDaid, et al., 2022). When the costs associated with bullying up to the age of 50 were considered, long-term saving increases to £7.52 per £1 spent (McDaid, et al., 2022).

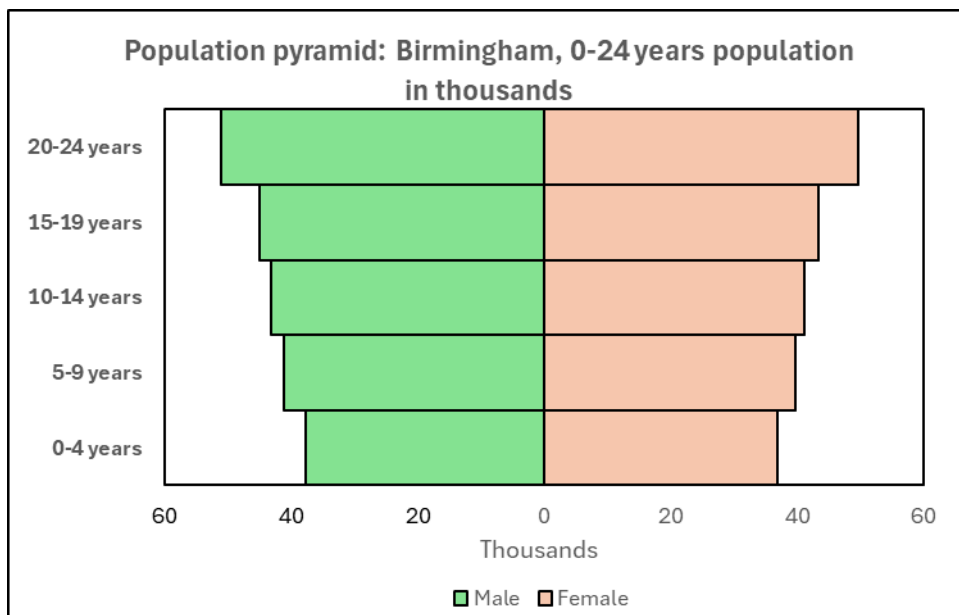
Other research finds that interventions to prevent and treat many mental disorders among adolescents have lifelong health and economic benefits, and that a range of interventions to prevent and treat mental disorders amongst adolescents can deliver significant return on investment (Stelmach, et al., 2022). The study which considered the case for interventions across a range of low-income, middle-income and high-income countries found across all 36 countries included in the model, the Return on Investment (ROI) for the package of interventions was 23.6 over 80 years. This ROI means that for every \$1 invested in the interventions, it is expected that \$23.6 of health and economic benefits would be returned to the economy (Stelmach, et al., 2022). Interventions which demonstrated high return on investments include school-based intervention for anxiety and depression, targeted suicide prevention intervention for adolescents treated for self-harm and universal and school-based suicide prevention programmes (Stelmach, et al., 2022).

Similarly, the United Nations Children's Fund (UNICEF) have provided evidence that the economic benefits of investing in mental health and psychosocial support across the mental health continuum strongly outweigh the cost of implementation. This includes evidence that parenting programmes and interventions are a scalable and cost-effective way to support parents and caregivers and prevent abuse, neglect and adversity in childhood, contributing to good mental health and well-being for children and reducing risk-taking behaviours throughout their lives (UNICEF, 2024).

4.2.3. Children and young people in Birmingham and Solihull

Based on 2023 estimates of the under 25 resident population, there are 428,772 people aged under 25 living in Birmingham and 62,966 people aged under 25 living in Solihull. The under 25 population represents 36.8% of the total population of Birmingham and 28.8% of the total population of Solihull. In Birmingham, the proportion of the population aged under 25 years increases by 5-year age band with the 20-24 year age group being the biggest, see figure below.

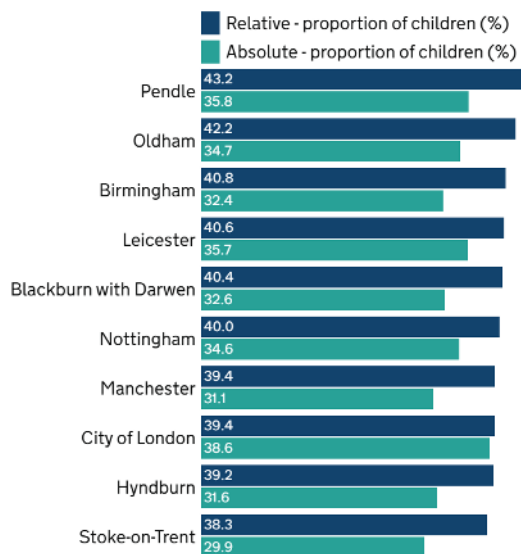
Figure 49: Under 25 population in Birmingham based on 2023 estimates



Source: [Local Authority Health Profiles - Data | Fingertips | Department of Health and Social Care](#)

As well as having the youngest population of the core cities, Birmingham is also among the local authorities in England that have the highest proportions of children aged under 16 living in low-income families. As shown in figure 62 below, for the financial year ending 2023, 40.8% of children aged under 16 were living in relative low-income families and 32.4% of children aged under 16 were living in absolute low-income families.

Figure 50: The local authorities with the highest proportions of children aged under 16 in Relative and Absolute low-income families, England, financial year ending 2023

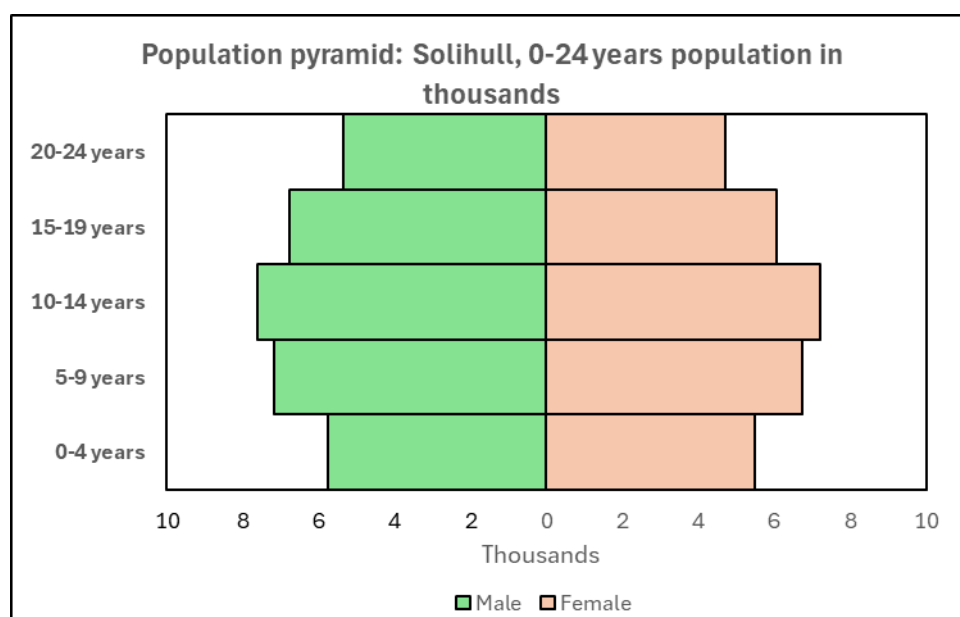


Source: [DWP Stat-Xplore, Children in Low Income Families, local authority by age](#) and [ONS Nomis, Population Estimates, local authority by age](#)

Source: [Children in low income families: local area statistics, financial year ending 2023 - GOV.UK](#)

In Solihull, the 10-14 years age group is the largest in the under 25 population and the 20-24 years age group is the smallest, as shown in figure 51 below. The three wards in the North of Solihull have a notably younger population than the rest of Solihull with 24% of the population aged 0-15 in Chelmsley Wood, Kinghurst and Footbridge and Smith’s Wood. This compares to 18% for the rest of Solihull borough and 19% in England as a whole (Solihull Metropolitan Borough Council, 2023).

Figure 51: Under 25 population in Solihull based on 2023 estimates



Source: [Local Authority Health Profiles - Data | Fingertips | Department of Health and Social Care](#)

4.2.4. Special Educational Needs and Disabilities (SEND)

Special educational needs and disabilities (SEND) is a term used to describe learning difficulties or disabilities that make it harder for a child or young person to learn compared to children of the same age. A child of compulsory school age or a young person has a learning difficulty or disability if he or she has a significantly greater difficulty in learning than the majority of others of the same age, or, has a disability which prevents or hinders them from making use of facilities of a kind generally provided for others of the same age in mainstream schools or mainstream post-16 institutions.

The government's [SEND code of practice](#) describes four key areas of need for children with SEND:

- **Social, emotional and mental health.** This category includes children who are struggling with any social or emotional problems that are impacting their ability to learn. This could include mental health problems like anxiety.
- **Cognition and learning.** These children might find it harder to learn things like reading and writing, for example. This category includes learning difficulties like dyslexia and dyscalculia.
- **Communication and interaction.** Autistic children, for example, may face difficulties interacting with others in the classroom.
- **Physical and sensory needs.** This category includes sensory impairments like [D/deafness](#) and [blindness](#) or [deafblindness](#), mobility issues and other medical needs.

Research has identified an increased prevalence of mental health difficulties for

children and young people with SEND although this may be in large part due to socio-economic disadvantage (Emerson & Hatton, 2007) (Emerson, Einfeld, & Stancliffe, 2010). Recognising the elevated risk of developing mental health conditions that children and young people with SEND face, it has been highlighted that child and adolescent mental health services need to ensure that services and interventions are effective for children with [intellectual disabilities](#), and especially those living in poverty (Emerson, Einfeld, & Stancliffe, 2010).

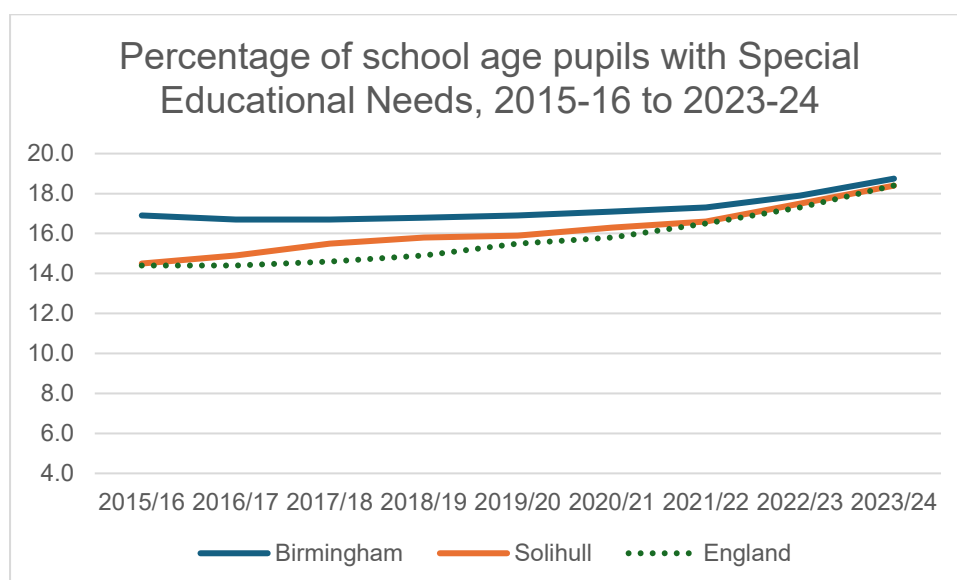
4.2.4.1. Children with SEND in Birmingham and Solihull

Data on fingertips Public Health profiles for Birmingham and Solihull for the period 2014/15 to 2023/24 illustrate the following:

- The percentage of school pupils in England who have a special educational need was 18.4% in 2023/24.
- The figure for Birmingham was 18.7% and for Solihull it was 18.4%.
- Both areas saw an increase in the proportion of school pupils with special educational needs during the period 2015/16 to 2023/24 with a larger increase in Solihull.
- In both areas the proportion of children with special educational needs was similar to the England average in 2023/24 which also increased during the period 2015/16 to 2023/24.

The trend for both Birmingham and Solihull is illustrated in the chart below.

Figure 52 – The percentage of school age pupils with Special Educational Needs



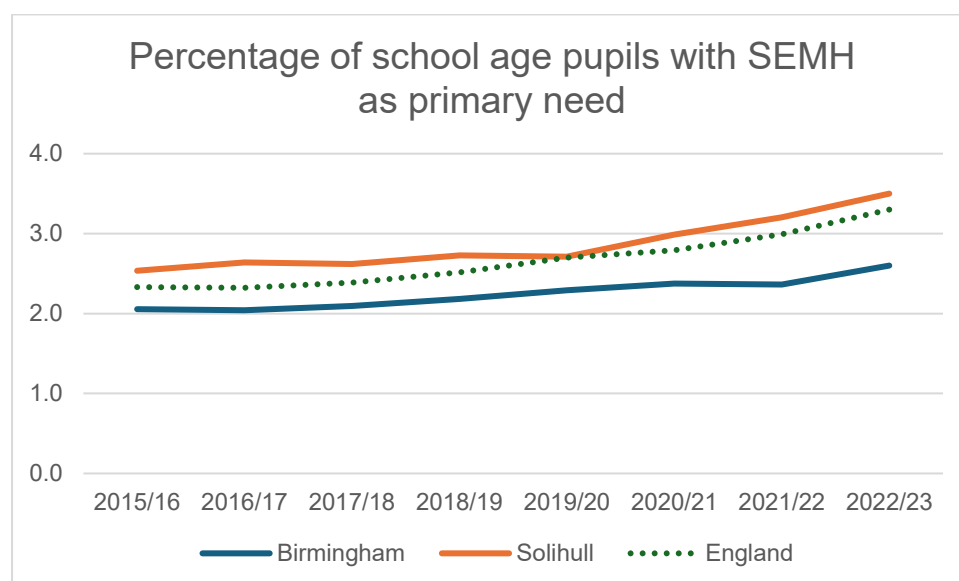
Source: [Children and Young People's Mental Health and Wellbeing | Fingertips | Department of Health and Social Care](#)

4.2.4.2. Social, emotional and mental health as primary need

The proportion of school aged children in Birmingham and Solihull who with Special Education Needs (SEN) who are identified as having social, emotional and mental health as the primary type of need is displayed below. The charts cover the period 2014/15 to 2022/23, observations of note include:

- Nationally, the percentage of school age children with SEN who social, emotional and mental health as the primary need increased from 2.3% to 3.3% during 2015/16 to 2022/23.
- The percentage of school age children in Birmingham with SEN who had social, emotional and mental health as their primary need increased from 2.1% to 2.6% during 2015/16 to 2022/23 but remained below the national average during this period.
- The percentage of school age children in Solihull with SEN who had social, emotional and mental health as their primary need increased from 2.5% to 3.5% during 2015/16 to 2022/23 which was above the national average during this period.

Figure 53: Percentage of school age pupils with social, emotional and mental health as primary need



Source: [Children and Young People's Mental Health and Wellbeing | Fingertips | Department of Health and Social Care](#)

4.2.5. Neurodevelopmental diagnostic pathway

Neurodevelopmental conditions affect brain development and function, often manifesting in childhood and impacting various aspects of a person's functioning, including cognitive, social, and motor skills.

In 2012 the estimated prevalence of neurodevelopmental impairments and

conditions was around 3–4% of children in England (Blackburn, Read, & Spencer, 2012). [Attention deficit hyperactivity disorder \(ADHD\)](#) is the most common neurodevelopmental condition in the UK; in 2012 it was estimated to affect 1–2% of children and young people and [autism](#) was thought to occur in at least 1% of children and young people in the UK (Blackburn, Read, & Spencer, 2012). More recent studies estimate global prevalence of attention deficit hyperactivity disorder (ADHD) in children be around 5%, while studies based on US populations (where rates of diagnosis and treatment tend to be highest) estimate the rate at between 8% and 10% (NICE, 2025).

The European Society of Child and Adolescent Psychiatry (ESCAP) practice guidance states that the worldwide prevalence estimates for autism have increased from 0.04% in the 1970s to 1–2% (Fuentes, Hervas, & Howlin, 2021). Factors which may account for this increase include increased general awareness, broadening of diagnostic criteria, and improved access to specialist referral pathways (Hyman, Levy, & Myers, 2020).

The identification of Autism (ASD) and / or ADHD through diagnostic assessment can be important in order that children and young people can understand themselves and others around them can make adjustments as needed in relation to the neurodiversity. In recent years the number of both children and adults referred for assessment of a neurodevelopmental conditions has grown significantly leading to long waits for assessment.

At a national level a [2024 report from the Children's Commissioner](#) highlighted that not only are children facing considerable waits for their first appointment with community and mental health services, but they then face subsequent waits for their neurodevelopmental condition to be assessed, and for a diagnostic decision. Waits are particularly long in community health services (The Children's Commissioner, 2024).

Analysis by the Children's Commissioner found that for children diagnosed with a neurodevelopmental condition by NHS community health services in 2022-23 and 2023-24:

- The mean average wait from referral to diagnosis was 2 years and 3 months (810 days).
- Those with ADHD or autism spectrum disorder (ASD) waited a mean average of 2 years and 5 months (880 days) and 2 years and 2 months (791 days) respectively.

There were also lengthy wait times for ASD and ADHD diagnoses in children and young people's mental health services with a mean average waiting time from referral to diagnosis of 527 days for autism and 570 days for ADHD (The Children's Commissioner, 2024).

In Birmingham and Solihull, community assessment services for

neurodevelopmental conditions are delivered by Birmingham Community Healthcare NHS Foundation Trust for those aged 0-16 years and University Hospitals Birmingham in Solihull for those aged 0-18 years. Forward Thinking Birmingham also provide an assessment and treatment service for ADHD for those between the ages of 16 and 25, and ASD assessments for children and young people who have not yet been diagnosed and are experiencing mental health issues.

There are high numbers of children and young people are waiting for a neurodevelopmental diagnostic assessment, with average waiting times exceeding 50 weeks for Autism and 37 weeks for ADHD (Birmingham Community Healthcare; University Hospitals Birmingham; Birmingham and Solihull ICB, 2025), see figure below.

Figure 54 – Number of children waiting for a neurodevelopmental diagnostic assessment, January 2025

Numbers of children waiting (at end January 2025)

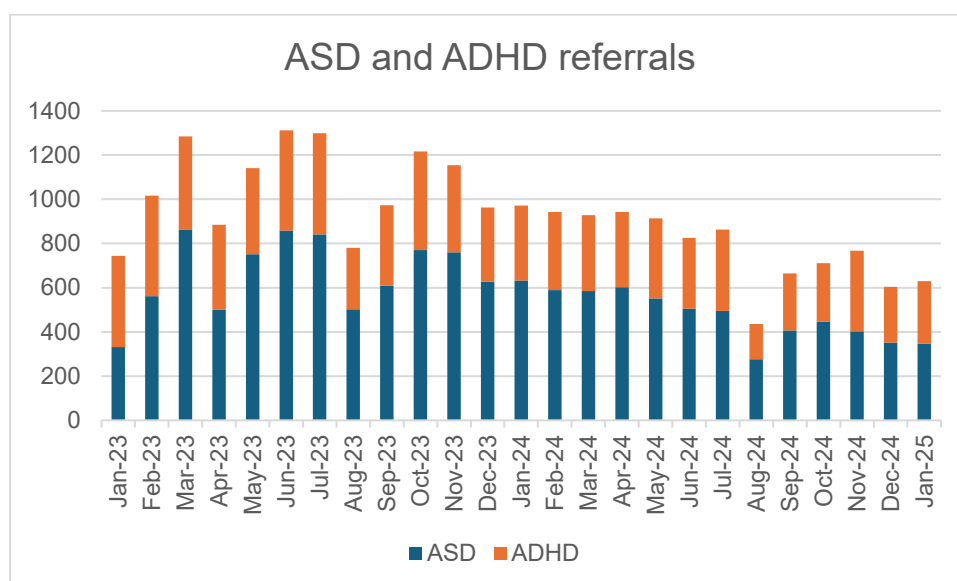
Place	Condition	Number of children waiting for assessment	Average time children have been waiting (weeks)
Birmingham	ADHD	3,630,	60.9
	Autism	11,765	92

Place	Condition	Number of children waiting for Initial Assessment	Average time children have been waiting (weeks)
Solihull	ADHD	564	37
	Autism	1,184	51

Source: [Update on Neurodevelopmental Assessment Pathways for Children and Young People in Birmingham and Solihull | Reported presented to Joint Health Overview and Scrutiny Committee, April 2025](#)

The numbers of referrals in Birmingham for ASD and ADHD assessments are shown below, where “steady state” service capacity for Autism in 2023 was assessed as c. 160 referrals a month based on experience to the end of 2022. Since then, there has been a significant increase in referrals and for both ASD and ADHD referrals demand outstrips capacity (Birmingham Community Healthcare; University Hospitals Birmingham; Birmingham and Solihull ICB, 2025).

Figure 55 – ASD and ADHD referrals received, January 2023 to January 2025



Source: [Update on Neurodevelopmental Assessment Pathways for Children and Young People in Birmingham and Solihull | Reported presented to Joint Health Overview and Scrutiny Committee, April 2025](#)

In addition to the above, in July 2024 Healthwatch Birmingham undertook an investigation into the [Experiences of the neurodevelopmental assessment and diagnostic pathway for children and young people in Birmingham](#) (Healthwatch Birmingham, 2024).

They identified the following issues with the diagnostic pathway:

- Length of wait for the referral and professional support.
- Professionals not submitting documents on time and referrals being missed, further delaying the assessment and diagnostic process.
- Restrictive criteria and thresholds.
- Professionals’ knowledge of the referral pathway – how, when and who to refer to.
- Focusing on parenting style and child’s behaviour rather than the child’s symptoms.
- Poor communication and partnership working with families.
- Lack of support for families before and after diagnosis.

People told Healthwatch Birmingham they want to see the following improvements:

- Support families, children and young people to ‘wait well’.
- Increase training and support for professionals referring children and young people for assessment.
- Improve the assessment and diagnosis process.

The challenges in relation to the diagnostic pathway require a system response and Birmingham Community Healthcare NHS Foundation Trust, Birmingham and Solihull ICB and University Hospitals Birmingham have set out intentions to work with system partners to make improvements (Birmingham Community Healthcare; University

Hospitals Birmingham; Birmingham and Solihull ICB, 2025), these include the following actions:

- Set out a model which integrates NHS assessment pathways with existing graduated pathways in line with ordinarily available guidance across universal, targeted and specialist tiers of care.
- Enable children and young people (up to 18 years old) to access appropriate support and assessment in a timely manner.
- Make the assessment process as efficient as possible drawing on the work that professionals have already done with children and young people to inform diagnosis.
- Improve access to pre and post diagnostic support.
- Improve transition where children move into adult services.
- Reduce the waiting lists for assessment to manageable levels.

4.2.6. Children and young people in contact with the youth justice system

In England and Wales, the youth justice system (YJS) deals with children and young people aged 10-17 who may have committed a crime, with 10 being the age of criminal responsibility. Factors associated with child and young offenders who encounter the criminal justice system (CJS) include lower levels of educational attainment, persistent absence during schooling, and vulnerability during childhood (Rowe & Law, 2024). Research has also found that a disproportionate number of CYP who come into contact with the CJS are from minority ethnic group backgrounds, have grown up in care or disadvantaged families, and are often the victims of crime themselves (Ministry of Justice, 2016; McAra & McVie, 2010).

Children in the youth justice system have been found to have a higher prevalence of mental health needs than the general population of adolescents. Of those children sentenced in the year ending March 2020 with a completed [AssetPlus](#) assessment¹⁵, there were concerns in relation to mental health in 72 per cent of cases (HM Inspectorate of Probation, 2023).

There is also an over-representation of people with neurodivergent conditions in the criminal justice system. For example, a meta-analysis found that compared with published general population prevalence, there is a fivefold increase in prevalence of ADHD in youth prison populations (30.1%) and a 10-fold increase in adult prison populations (26.2%) (Young, Moss, Sedgwick, & Hodgkins, 2015).

Despite high levels of need, many justice-involved children struggle to access appropriate mental health support. Their needs often go unrecognised or untreated due to limited screening and resources. In addition to long waits and high thresholds

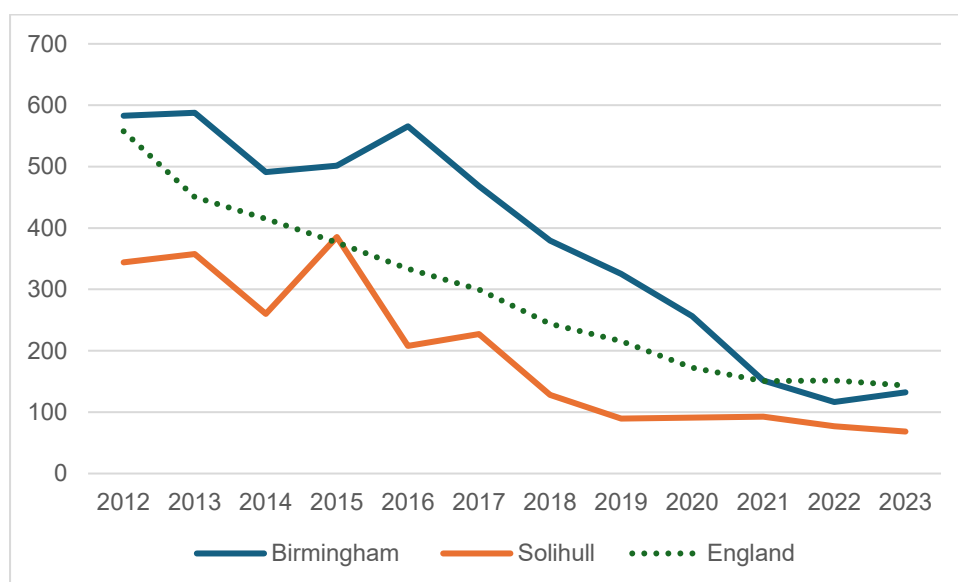
¹⁵ These assessment does not include the cohort of children and young people who receive an [out of court disposal](#)

faced by all young people, these children may also face stigma—viewed as offenders before being seen as children in need. As a result, support is often only provided once a crisis occurs (HM Inspectorate of Probation, 2023).

4.2.6.1. CYP in contact with the CJS in Birmingham

The rate of first-time entrants to the youth justice system in Birmingham and Solihull is shown below with reference to the national average. In 2023 the rate in Birmingham was 132.5 per 100,000 which is below the national average and represents a 77% decrease from 2012.

Figure 56 – First time entrants to the youth justice system, crude rate per 100,000 of the 0 – 17 population



Source: [Fingertips | Department of Health and Social Care](#)

For the reporting period October to December 2024, the Birmingham Youth Justice Service worked with 568 children, of whom 484 had a completed assessment. Of those who had a completed assessment, 177 (36.5%) assessments identified children with a mental health issue and of these 151 had an appropriate referral to a specialist service (Birmingham Children's Trust, 2024).

Discussions with professionals involved in provision of mental health support to this cohort as part of this needs assessment have highlighted several challenges, including:

- Fragmented nature of assessments which do not fully consider differential diagnosis and create potential for under-diagnosis or over-diagnosis of neurodevelopmental conditions such as ADHD.
- Lack of pre- and post-diagnostic support for possible neurodevelopmental conditions.

- Lack of continuity for children and young people who move out of area or spend short periods of time in different places.
- Lack of models of care and pathways that can offer culturally sensitive support.
- Externalised behaviours (e.g. aggression) are often misread, delaying intervention.
- Lack of physical health support to address physical health needs which are closely related to mental health conditions.
- Limited assertive outreach capacity to improve engagement with mental health services.
- Underutilisation of [NICE recommended interventions](#) such as group work, multi-system intervention and evidence-based parenting intervention.
- Fragmented nature of commissioning and contracting arrangements which include differing clinical standards and governance structures and limited expectation for joint working protocols, processes and or service ethos, e.g. trauma informed.

Strengths which were acknowledged within existing models of provision were that:

- Strong partnership between the Youth Justice team and dedicated Forward Thinking Birmingham (FTB) resource enables integrated working.
- Joint investment in the clinical team (part-funded by BCT) supports strategic service delivery and enhances trauma-informed, psychologically led practice across the workforce.
- Flexible, creative engagement helps reach children who struggle to access services—e.g. no rigid DNA policies, meeting young people in comfortable settings, and collaborative work with multi-agency partners through consultation and outreach.

Given the over-representation of people with neurodivergent conditions in the criminal justice system, early screening for neurodivergent conditions is crucial in preventing unnecessary involvement with the CJS and ensuring provision of appropriate support. Birmingham YJS are pursuing conversations related to neurodevelopmental pathways, and connections have been made with Clinical leads for both ADHD and Autism pathway and an interaction map with YJS has been drafted to be piloted with the leads.

4.2.6.2. CYP in contact with the CJS in Solihull

As per figure 56 above, in 2023 in Solihull the rate of first-time entrants to the youth justice system was 68.4 per 100,000 which is below the national average and represents an 80% decrease from 2012.

The Solihull Youth Justice Service was last fully inspected by HMIP in 2023 and was found to be “requiring improvement.” During this time, it was noted that 62 per cent of children on the caseload had a learning disability, a learning difficulty or an education, health and care plan. It also identified that the offer of support for health, specifically speech, language and communication outcomes for Children, needs to

improve.

A review of data of the caseload from the 2024-25 year demonstrates that

- 61% of children on the caseload had needs identified regarding emotional development and mental health
- 61% had physical health & development issues
- 64% had Speech, Language, Communication & Neuro-disability
- 62% had substance misuse

The review found limited reduction in symptomology in 96% of children at the time of closure. This demonstrates the need for specialist health provision to support this highly vulnerable group during the time that they have a multi-agency team already in place around them.

4.2.7. Substance misuse and the mental health of CYP

There is a strong bi-directional relationship between mental health and substance misuse in children and young people. Young people with mental health issues such as anxiety, depression, or trauma may use substances like alcohol or cannabis to cope as a form of self-medication. Conversely, frequent substance use can trigger or worsen mental health conditions, including psychosis, depression, and anxiety.

Binge drinking in adolescence is linked to other health risk behaviours such as self-harm and thoughts of suicide (McCloud, Barnaby, Omu, Drummond, & Aboud, 2004) and frequent cannabis use in young people can be associated with negative mental health experiences such as depression, anxiety and even psychosis (Patton, et al., 2002).

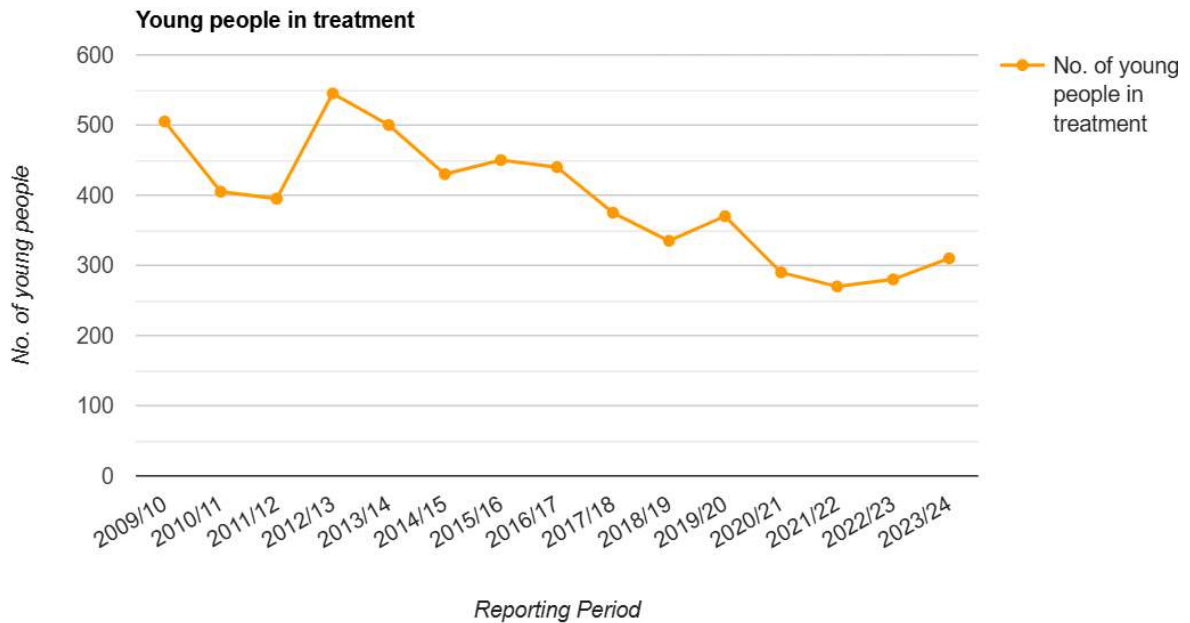
Substance misuse is also strongly linked to exploitation, including county lines¹⁶, gang affiliation, and sexual exploitation (West Midlands Police and Crime Commissioner, 2017). In the West Midlands, 85% of children assessed by Youth Offending Teams were recorded as misusing substances. Over half were regular cannabis users, nearly a quarter regularly used alcohol, and a smaller proportion used Class A drugs or multiple substances. These findings highlight the strong link between substance misuse and youth offending in the region (West Midlands Combined Authority, 2021).

[A 2025 report by the Royal College of Psychiatrists](#) warns that young people with both substance use and mental health disorders are often excluded from care due to fragmented services (Royal College of Psychiatrists, 2025). The report calls for integrated, trauma-informed approaches that address both needs together.

¹⁶ **County lines** is a term used in the UK to describe a form of criminal exploitation where gangs and organized crime networks transport illegal drugs from urban areas into smaller towns and rural communities, often across police and local authority boundaries.

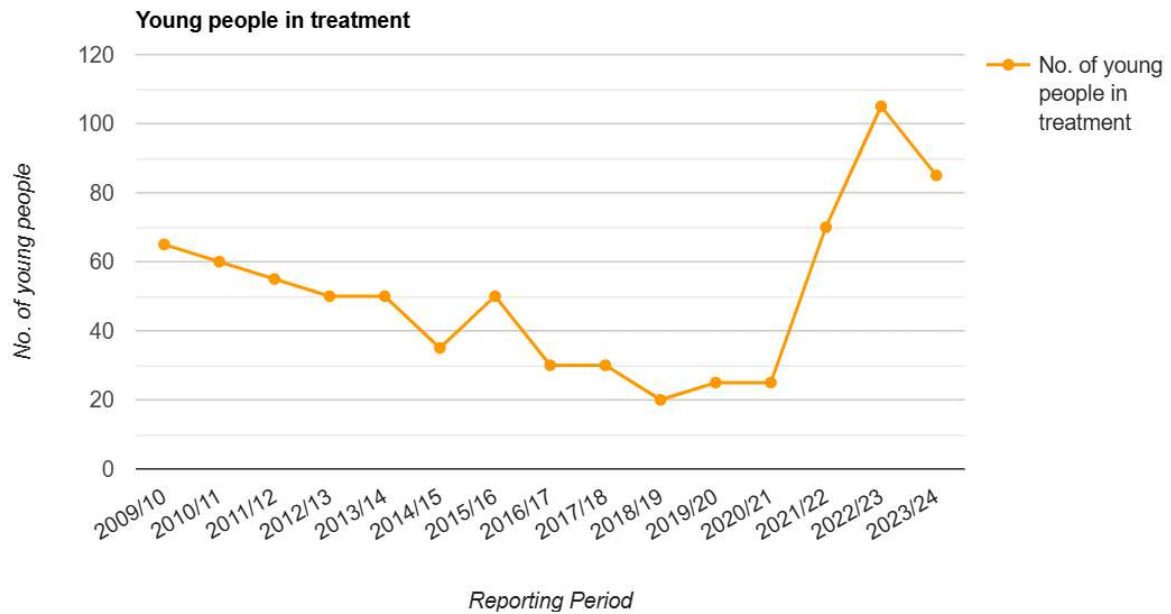
In Birmingham and Solihull, data from the [National Drug Treatment Monitoring System \(NDTMS\)](#) on young people in contact with alcohol and drug services shows there were 310 young people in treatment in Birmingham in 2023/24 for and 85 in Solihull.

Figure 57 – Number of young people aged under 18 years in treatment via drug and alcohol services in Birmingham, 2009/10 to 2023/24



Source: [NDTMS - ViewIt - Young People](#)

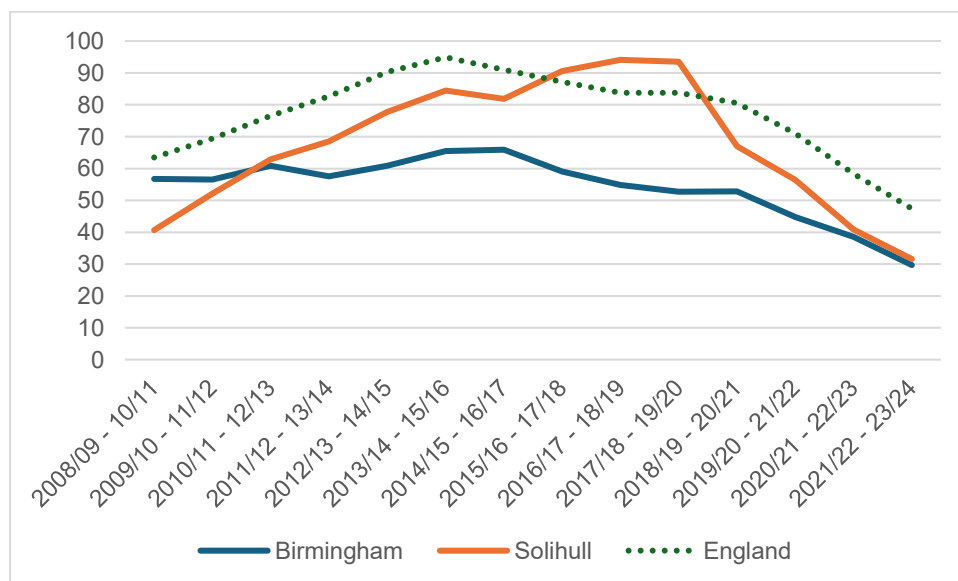
Figure 58 Number of young people aged under 18 years in treatment via drug and alcohol services in Solihull, 2009/10 to 2023/24



NDTMS - ViewIt - Young People

Another indicator of the level of substance misuse within the local population is the rate of hospital admissions due to substance misuse for 15-24 year olds. The rate has declined in both Birmingham and Solihull in recent years and in both areas the rate was below the national average in 2023/24.

Figure 59: Hospital admissions due to substance misuse (15-24 years), standardised rate per 100,000



Source: [Fingertips | Department of Health and Social Care](#)

4.2.8. Access to mental health support for CYP

Nationally, there are significant challenges with access to children and young people's mental health services as highlighted in the [2024 Children's Commissioner report](#) (The Children's Commissioner, 2024). Key findings from the Children's Commissioner report based on data for the 2022-23 financial year include:

- There were 949,200 children and young people who had active referrals to Children and Young People's Mental Health Services (CYPMHS) at any point within the 2022-23 financial year. This is 8% of the 11.9 million children in England. Of these children and young people:
 - Almost 305,000 (32%) entered treatment¹⁷;
 - 270,300 (28%) were still waiting at the end of the year;
 - 372,800 (39%) had their referrals closed before accessing CYPMHS¹⁸.
- Of the 1.4 million children estimated to have a probable mental health condition, less than half received at least 1 contact with CYPMHS during the year (49%), broadly the same as the previous year (48%).
- For the 305,000 children and young people (32% of those referred) who entered treatment within the year, they waited an average of 35 days (median) or 108 days (mean).¹⁹
- Some children experience particularly long wait times before they entered treatment. In 2022-23, there were 6,300 children and young people who waited over 2 years (104 weeks) before entering treatment, for whom the average wait was over three years (median 1,128 days, mean 1,399 days).
- For the 270,300 children and young people recorded as still waiting at the end of the year for their 2nd contact, they waited on average 142 days (median) or 359 days (mean).
- Of this group, 32,200 children had been waiting for over 2 years. These children had been waiting on average 1,361 days (median) or 1,704 days (mean).

The report includes benchmarking data by [Integrated Care Board \(ICB\)](#) which shows that Birmingham and Solihull spent £1,168 per child with an active referral and 1.37% of total expenditure on CYPMS both of which are above the average for ICB's nationally. The median wait in days from referral to second contact for Birmingham and Solihull ICB was 32 days which is lower than the national average, however, the percentage of referrals closed before the child or young person had entered treatment (defined as receiving 2 contacts) was 59% which was the joint highest nationally.

¹⁷ The Children's Commissioner has defined entering treatment as receiving at least 2 contacts from children and young people's mental health services

¹⁸ The Children's Commissioner has defined a referral being closed before accessing children and young people's mental health services as referrals closed without at least 2 contacts

¹⁹ This is the wait time from referral to second contact with services. The significant difference between the median and mean average reflects a small number of very long waits which make the mean value larger than the median.

Similarly, the Care Quality Commission's [annual assessment of the state of health and social care in England for 2023/24](#) highlights particular concerns about children and young people's mental health services and notes that whilst the mental health workforce has grown, there are challenges with staffing and skill mix. Services face challenges in recruiting staff including nurses, psychologists, occupational therapists, and consultant psychiatrists – all of which are having an impact on capacity, and therefore on the availability and regularity of appointments (Care Quality Commission, 2024).

Research commissioned by CQC into attendances at urgent and emergency care settings by people with a mental health issue also found that those aged 18 to 21 consistently have the highest rates of presentation for mental health issues at both emergency departments and urgent care centres (Care Quality Commission, 2024). Not getting the right help at the right time can lead to people's symptoms to deteriorate and they can then end up in crisis and/or inappropriate environments, such as urgent and emergency care.

4.2.8.1. Variations in access rates

When it comes to accessing mental health services in Birmingham and Solihull, there are variations in rates of access based on where people live, their ethnicity and age. The figure below illustrates the proportion of 5- to 25-year-olds in Birmingham and Solihull who are likely to have a mental health condition²⁰ who are accessing support²¹ from children and young people's mental health services.

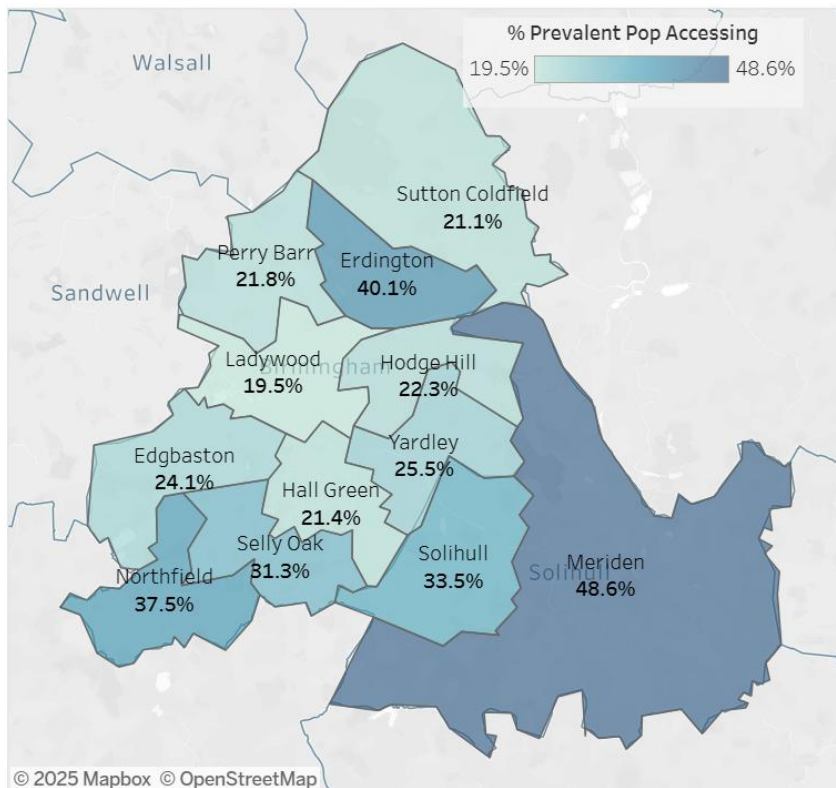
The map illustrates how there is significant variation in rates of access to mental health support with some parliamentary constituencies with high levels of deprivation showing low levels of access. For example, Hodge Hill ([the most deprived constituency in Birmingham based on 2019 IMD data](#)) has an access rate of 22.3% and Ladywood (the second most deprived constituency) has an access rate of 19.5% whilst other constituencies such as Meriden in Solihull and Erdington have access rates above 40%.

²⁰ This is based on prevalence data for Birmingham and Solihull for the population aged 5-25 years taken from the [2017 Children and Young People's Survey](#) and [Fingertips Public Health Profile on Common Mental Disorders](#). Analyses shown in this report displaying the proportion of the population with likely mental health conditions accessing services assume a uniform prevalence of mental health conditions across local authority areas, however it is likely that rates will vary with greater prevalence of mental health conditions in the more deprived wards and constituencies in Birmingham and Solihull.

²¹ This is defined as a count of patients having one or more care contacts in the most recent 12 months of available data.

Figure 60 – Proportion of the 0-25 population with likely mental health conditions accessing support from Children and Young People’s Mental Health Services

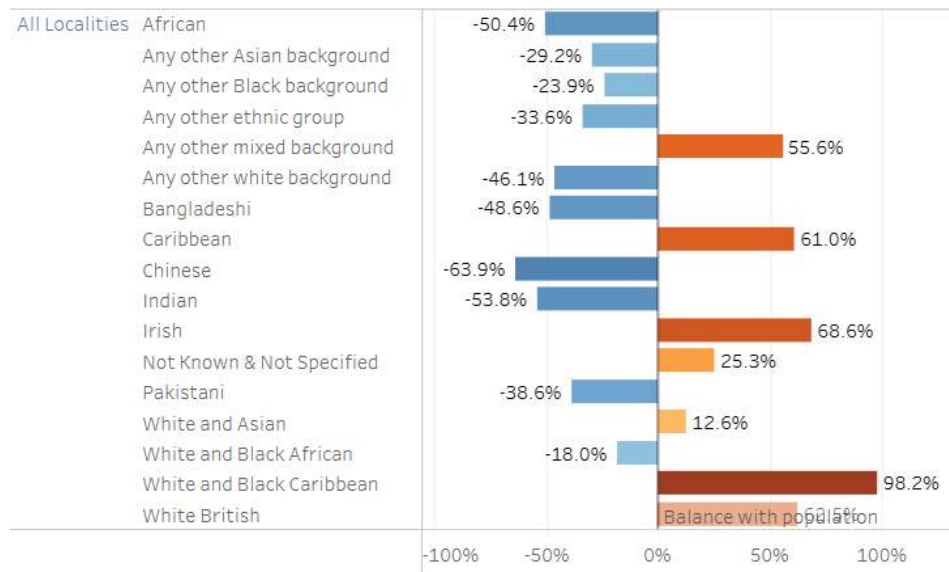
Parliamentary Constituency



Source: Produced by NHS Midlands and Lancashire CSU Business Intelligence Team using data from MHSDS Commissioner Extracts

When the ethnicity of patients accessing mental health support from Children and Young People’s Mental Health Services is compared to the wider Birmingham and Solihull population it shows that certain ethnic groups are over and under-represented. For example, the mixed White and Black Caribbean, White Irish, White British and Black Caribbean ethnic groups are over-represented and the Chinese, Indian, Black African, Bangladeshi and Pakistani ethnic groups are under-represented. This is based on comparing the proportion of service users from ethnic groups with the proportion of people from that ethnic group in the population as a whole.

Figure 61 – Characteristics of CYPMHS patients compared to local population



Source: Children and Young People’s Mental Health and Equalities Dashboard produced by NHS Midlands and Lancashire CSU using data from MHSDS Commissioner Extracts

4.2.8.2. Referral outcomes

Outcomes from referrals which were discharged during the 12-month period from April 2024 to March 2025 show that:

- 4,933 referrals were discharged by Forward Thinking Birmingham of which 1,333 (27%) were discharged without contact and 3,600 (73%) were discharged following 1 or more contacts with the service.
- 1,456 referrals were discharged by Solar of which 610 (42%) were discharged without contact and 846 (58%) were discharged following 1 or more contacts with the service.
- 12,706 referrals were discharged by other service providers of which 3,936 (31%) were discharged without contact and 8,770 (69%) were discharged following 1 or more contacts with the service.

Figure 62 – Children and Young People’s Mental Health Referral Outcomes, April 2024 to March 2025

Children and Young People (0-24) Referral Outcomes

Source: MHSDS Commissioner Extracts

Caveat: If a single referral is made to multiple teams and the patient has attended at least one team, the referral is considered attended.
Team Type "Single Point of Access" is excluded

Outcome

- Referrals discharged without a contact
- Referrals discharged with 1+ contact

		FY 2025												Grand Total
		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
FTB		73.0%											27.0%	
Solar		58.1%											41.9%	
Other		69.0%											31.0%	
FTB	Referrals discharged with 1+ contact	51	150	179	198	202	249	337	310	391	428	488	617	3,600
	Referrals discharged without a contact	97	113	118	129	101	95	106	65	67	110	141	191	1,333
	Total Discharged	148	263	297	327	303	344	443	375	458	538	629	808	4,933
Solar	Referrals discharged with 1+ contact	21	55	53	88	47	57	103	78	80	87	86	91	846
	Referrals discharged without a contact	40	43	32	42	35	40	65	55	53	63	55	87	610
	Total Discharged	61	98	85	130	82	97	168	133	133	150	141	178	1,456
Other	Referrals discharged with 1+ contact	365	536	605	631	638	703	843	831	793	941	883	1,001	8,770
	Referrals discharged without a contact	177	275	254	259	329	316	353	451	333	399	369	421	3,936
	Total Discharged	542	811	859	890	967	1,019	1,196	1,282	1,126	1,340	1,252	1,422	12,706
Grand Total	Referrals discharged with 1+ contact	437	741	837	917	887	1,009	1,283	1,219	1,264	1,456	1,457	1,709	13,216
	Referrals discharged without a contact	314	431	404	430	465	451	524	571	453	572	565	699	5,879
	Total Discharged	751	1,172	1,241	1,347	1,352	1,460	1,807	1,790	1,717	2,028	2,022	2,408	19,095

Source: Business Intelligence, Midlands and Lancashire CSU

These referral outcomes are broken down further to show the proportion by different mental health types in figure 63 below.

Figure 63 – Children and Young People’s Mental Health Referral Outcomes, April 2024 to March 2025

Children and Young People (0-24) Attendance Outcomes by Team Type Category

Source: MHSDS Commissioner Extracts
Data coverage: Apr 24 to Mar 25
Total values less than 10 have been removed
Team Type "Single Point of Access" is excluded

Outcome

- % without a contact
- % with 1+ contact

		Referrals discharged with 1+ contact	% with 1+ contact	Referrals discharged without a contact	% without a contact	Total	
Liaison Psychiatry		91%				9%	
24/7 Helpline		86%				14%	
Mental Health In Education		83%				17%	
Eating Disorder		79%				21%	
Severe Mental Illness		72%				28%	
Crisis: Community and Acute		68%				32%	
Social MH service		62%				38%	
Mood and Depression		58%				42%	
Forensic / Criminal Justice		47%				53%	
Other		46%				54%	
Neurodevelopmental / LD		41%				59%	
Perinatal and Maternal		33%				67%	
24/7 Helpline	Other	574	86%	95	14%	669	
Crisis: Community and Acute	FTB	1,974	76%	637	24%	2,611	
	Solar	345	97%	11	3%	356	
Eating Disorder	Other	339	36%	602	64%	941	
	FTB	120	88%	17	12%	137	
Forensic / Criminal Justice	Solar	66	68%	31	32%	97	
	FTB	33	72%	13	28%	46	
Liaison Psychiatry	Other	406	46%	480	54%	886	
	FTB	3,218	91%	311	9%	3,529	
Mental Health In Education	Other	466	86%	74	14%	540	
	FTB	1,715	82%	383	18%	2,098	
Mood and Depression	Other	734	66%	383	34%	1,117	
	FTB	418	43%	553	57%	971	
Neurodevelopmental / LD	Other	1,985	60%	1,350	40%	3,335	
	FTB	92	57%	70	43%	162	
Other	Other	104	33%	211	67%	315	
	FTB	30	59%	21	41%	51	
Perinatal and Maternal	Other	142	44%	183	56%	325	
	FTB	111	33%	222	67%	333	
Severe Mental Illness	Other	63	69%	28	31%	91	
	FTB	143	74%	51	26%	194	
Social MH service	FTB	8	62%	5	38%	13	
Grand Total		13,086	70%	5,731	30%	18,817	

Source: Business Intelligence, Midlands and Lancashire CSU

4.2.8.3. Wait times

Data is presented below which shows the trend in waiting times for BSMHFT (SOLAR) and Birmingham Women’s and Children’s (Forward Thinking Birmingham) over the period September 2024 to May 2025 for children and young people aged 0-17 years.

The data shows the trend lines for median waits which represent the middle value in a dataset when values are sorted from smallest to largest. It also shows the 90th percentile trend line—meaning 90% of people waited less than this time, while 10% waited longer.

Two types of waiting time data are presented: one for individuals who received their first contact with services during the reporting period, measured from referral to first contact; and another for those with an open referral who were still waiting for contact during the reporting period.

Wait times from referral to first contact: Forward Thinking Birmingham

The chart below shows that for Forward Thinking Birmingham the median wait time in days from referral to first contact for those receiving first contact in the three-month rolling period was 6 days in May 2025. The 90th percentile wait time was 85 days meaning 10% of those receiving contact during the reporting period waited more than 85 days from referral to first contact. The trend for 90th percentile waits also evidences a reduction in the longest waits over the 12 months from 171 days in Sept 2024 to 85 days in May 2025.

Figure 64 – Median and 90th percentile waiting time, three month rolling figures for Forward Thinking Birmingham, September 2024 to May 2025



Source: MHSDS Published Metrics via BSOL ICB Business Intelligence

Wait times from referral to first contact: SOLAR

The chart below shows that for SOLAR the median wait time in days from referral to first contact for those receiving first contact in the three-month rolling period was 4 days in May 2025. The 90th percentile wait time was 101 days meaning 10% of those receiving contact during the reporting period waited more than 101 days from referral to first contact.

Figure 65 – Median and 90th percentile waiting time from referral to first contact, three month rolling figures for SOLAR, September 2024 to May 2025

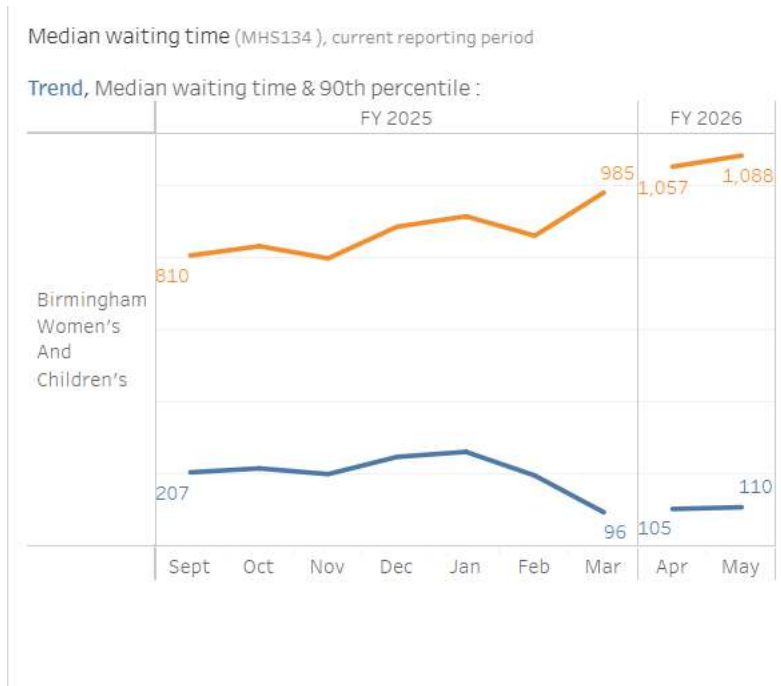


Source: MHSDS Published Metrics via BSOL ICB Business Intelligence

Wait times – awaiting first contact: Forward Thinking Birmingham

The chart below shows that for Forward Thinking Birmingham the median wait time in days waiting for open referrals awaiting a first contact during the three-month rolling period was 110 days in May 2025. The 90th percentile wait time was 1,088 days meaning 10% of those waiting for a first contact during the reporting period have been waiting for more than 1,088 days (approximately 3 years) from referral for a first contact.

Figure 66 Median and 90th percentile waiting time for open referrals awaiting first contact, three month rolling figures for FTB, September 2024 to May 2025

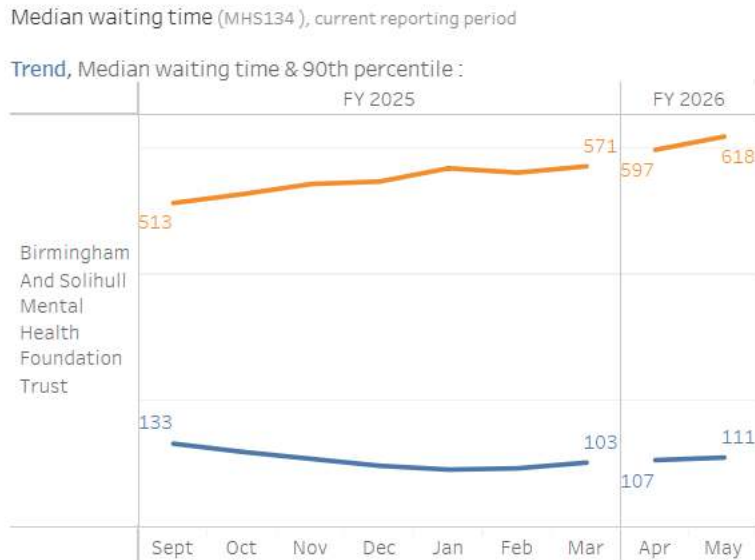


Source: MHSDS Published Metrics via BSOL ICB Business Intelligence

Wait times – awaiting first contact: SOLAR

The chart below shows that for SOLAR the median wait time in days waiting for open referrals awaiting a first contact during the three month rolling period was 111 days in May 2025. The 90th percentile wait time was 618 days meaning 10% of those waiting for a first contact during the reporting period have been waiting for more than 618 days (approximately 1 year and 8 months) from referral for a first contact.

Figure 67 Median and 90th percentile waiting time for open referrals awaiting first contact, three month rolling figures for SOLAR, September 2024 to May 2025



Source: MHSDS Published Metrics via BSOL ICB Business Intelligence

The above illustrates some very long waits for first contact and extremely lengthy waits at the 90th percentile, especially for FTB (1,088 days or approximately 3 years). This warrants further investigation to determine underlying reasons including exploration of any data quality issues impacting upon the figures.

4.2.9. Mental Health Support Teams in Schools

Following the 2017 [Green Paper for Transforming children and young people's mental health](#) NHS England and partner organisations led on the development and rollout of [mental health support teams in schools \(MHSTs\)](#).

MHSTs have three core functions:

- to deliver evidence-based interventions for mild-to-moderate mental health issues;
- support the [senior mental health lead](#) (where established) in each school or college to introduce or develop [whole school or college approach](#) and;
- give timely advice to school and college staff and liaise with external specialist service to help children and young people to get the right support and stay in education.

The rollout of MHSTs has happened in successive waves starting with initial trailblazers in 2018/19 and then subsequent waves in financial years that have followed.

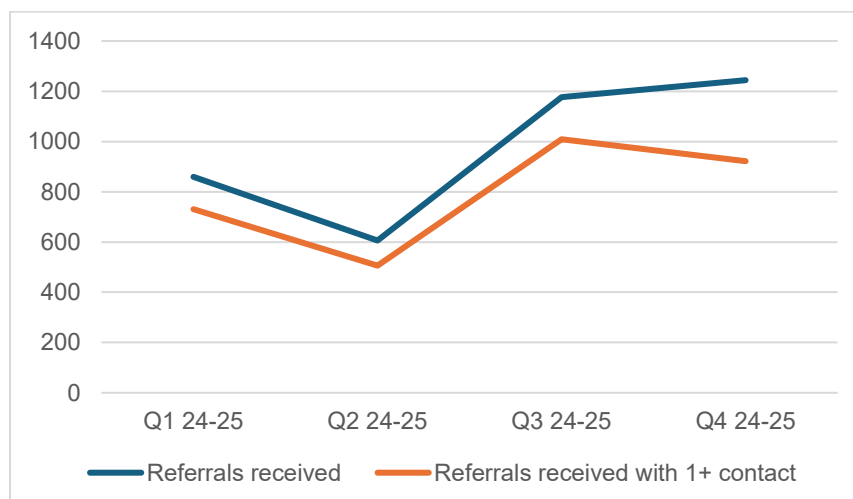
4.2.9.1. Delivery of MHSTs in Birmingham and Solihull

Birmingham and Solihull has 22 MHST's delivered in partnership with VCSFE and NHS providers:

- Solihull has 6 teams that are delivered by Barnardo's covering 96% of schools in Solihull (79 schools).
- Birmingham has 16 teams, 2 teams are delivered by the NHS, 10 teams are delivered by Compass covering 64% of schools in Birmingham (238 schools).

Activity data for MHST's for the 2024-25 financial year shows an increase in referrals and of the 1244 referrals received at the end of quarter 4, 922 had received 1 or more contacts with MHST professionals.

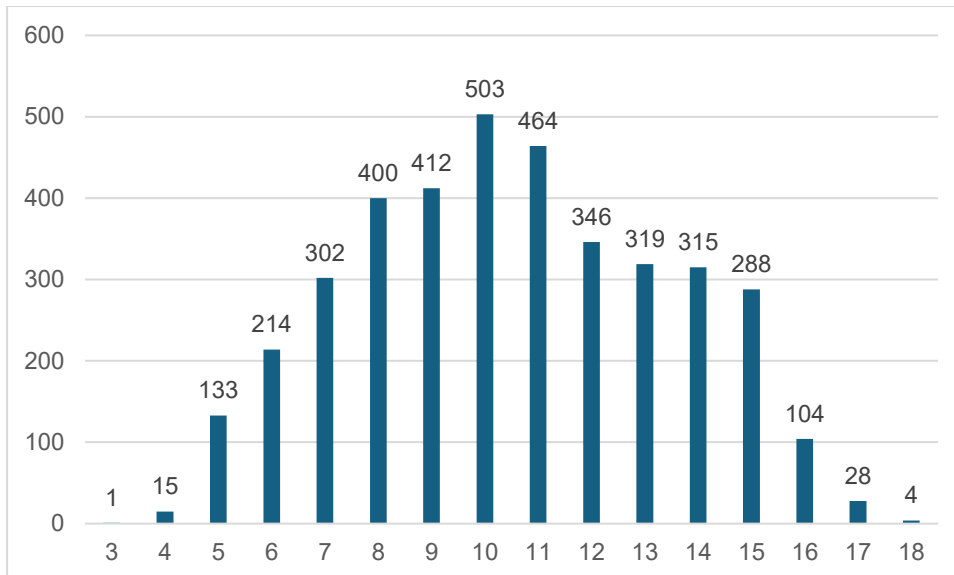
Figure 68: Mental Health Support Teams in Birmingham and Solihull: referrals received and referrals with 1 or more contacts



Source: Business Intelligence, Midlands and Lancashire CSU

There is spread across the age range in terms of which children and young people are accessing support from MHSTs with access highest for those aged 10 and 11 years of age.

Figure 69: Referrals with 1 or more contacts from 3rd May 2019 to 31st May 2025 by age in years



Source: Business Intelligence, Midlands and Lancashire CSU

There are significant gaps in the recording of the ethnicity of those accessing MHST's with ethnicity not recorded for 42% of cases with 1 or more contacts with the service. Where ethnicity has been recorded the White ethnic group accounts for 54% of those accessing the service with 1 or more contacts, Asian / Asian British for 21%, Mixed ethnicity for 11% and Black / Black British for 6%.

The gender split of those accessing MHST's shows 29% female and 26% male with gender not being recorded in 45% of cases. The primary reasons for referral to MHST which have been recorded show the top 3 categories are anxiety (45.4%), conduct disorders (37.4%) and depression (10.5%) with self-harm the primary reason for 1.6% of referrals received.

4.2.10. Service User Experience

As noted elsewhere in this report, Rethink Mental Illness undertook a project to gather information on service user experience and part of this process involved a desktop review of existing information and intelligence. This desktop review considered the following sources of information relating to the experiences of children and young people:

- Birmingham and Solihull Mental Health Foundation Trust and Forward Thinking Birmingham reports on [Patient Advice and Liaison \(PALS\)](#) contacts, [complaints](#) and [Friends and Family Test \(FFT\)](#) responses.

- [Healthwatch](#) quarterly reports from their online feedback centre and signposting line
- Healthwatch investigations regarding [children and young people's mental health services in Birmingham](#) and [children and young people's mental health services in Solihull](#)
- A Birmingham City Council [Overview and Scrutiny report](#) regarding the extent to which services are meeting young people's mental health needs in Birmingham
- Families and workforce consultation on digital transformation carried out by Forward Thinking Birmingham
- Surveys and focus groups with 18–25-year-olds in Solihull
- Solihull SEND community event 2023
- Solihull Parent Carer Voice survey

The broad themes which emerged from this review regarding the experiences and views of children, young people and families were:

- **Communication:** there is limited communication and support whilst waiting for appointments, getting through to teams on the telephone can be difficult, more information, support and resources on what a diagnosis means and how parents can support their children is needed, more information on what other support is available would be beneficial.
- **Access and waiting times:** wait times are too long and there is a lack of support whilst waiting, the referral process is clunky with limited information on what is happening, children, young people and families would like to be able to access a better range of information, support and resources (including online resources).
- **Continuity of care and transition:** transition between children and young people's and adult services is poor, services are not sufficiently connected or joined up, there are frequent changes in the workforce and children and young people have to re-tell their stories which can be re-traumatising.
- **Support in educational settings:** there are gaps in mental health support available in schools, there is a lack of clarity regarding how schools fit into the support offer as part of SEND, there needs to be a whole system approach involving children and young people's mental health services, Mental Health Support Teams (MHST's), schools and the VCFSE sector.
- **ADHD and Autism:** Wait times for diagnosis are too long and services are not tailored to the sensory needs of children and young people who are neurodivergent.

The improvements which children, young people and families would like to see are:

- Reduction in wait times and more support whilst waiting
- More information / resources on: - what conditions mean – what support is available – what other services they can access.
- More connected / joined up services with better transition between services.
- A more stable workforce with fewer changes in staff

- A more cohesive joined up system offer within schools
- Services that are more tailored towards the needs of CYP with autism and other neurodevelopmental conditions.
- Up to date websites that are user friendly, contain a range of useful resources and support ease of access to services

4.2.11. Service User Outcomes

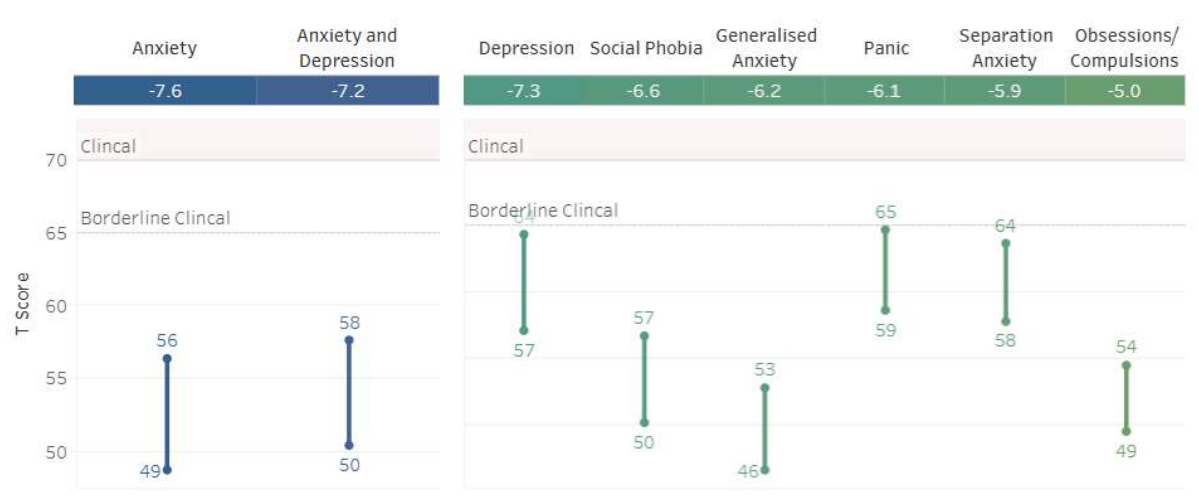
Service user outcomes for children and young people’s mental health services are discussed below in relation to three outcome measures:

- The [revised child anxiety and depression scale \(RCADS\)](#) which is a 47-item self-report tool assessing anxiety and depression in children aged 5-18 years.
- The [DIALOG+](#) assessment tool which measures satisfaction across 13 life domains including areas such as mental health, relationships, personal safety and physical health.
- Self-rated reliable improvement based on paired outcome scores for 0-17 year olds who have been discharged from services.

4.2.11.1. Revised Child Anxiety and Depression Scale (RCADS)

The RCADS data for 5- to 18-year-olds with discharged referrals with a first contact in the 24 months to May 2025 shows improvement in anxiety and anxiety and depression including across a range of sub-scales. The data presented below shows the average score change with a reduction in the score from first to last improvement representing an improvement.

Figure 70: Average T Score Change, First to Last Assessment

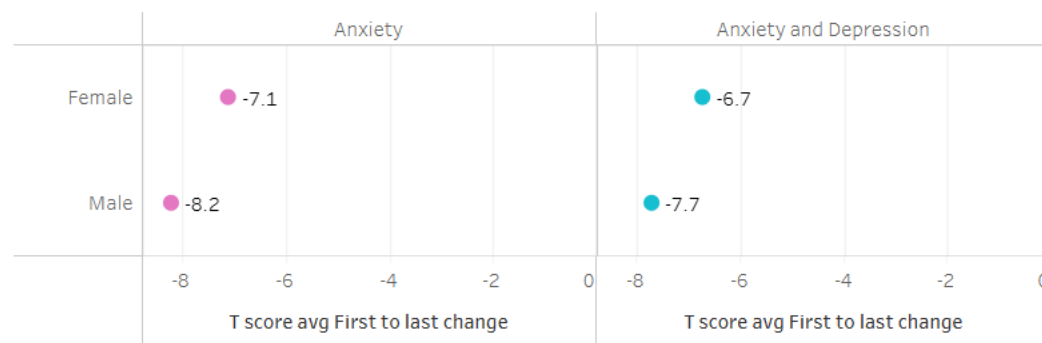


Source: Business Intelligence, Midlands and Lancashire CSU

When looking at T score changes by gender, on average, there is a greater improvement in scores for boys compared to girls, see figure 71 below.

Figure 71: Average T Score Change by Gender

Demographic Segmentation: Average T Score Change by Gender

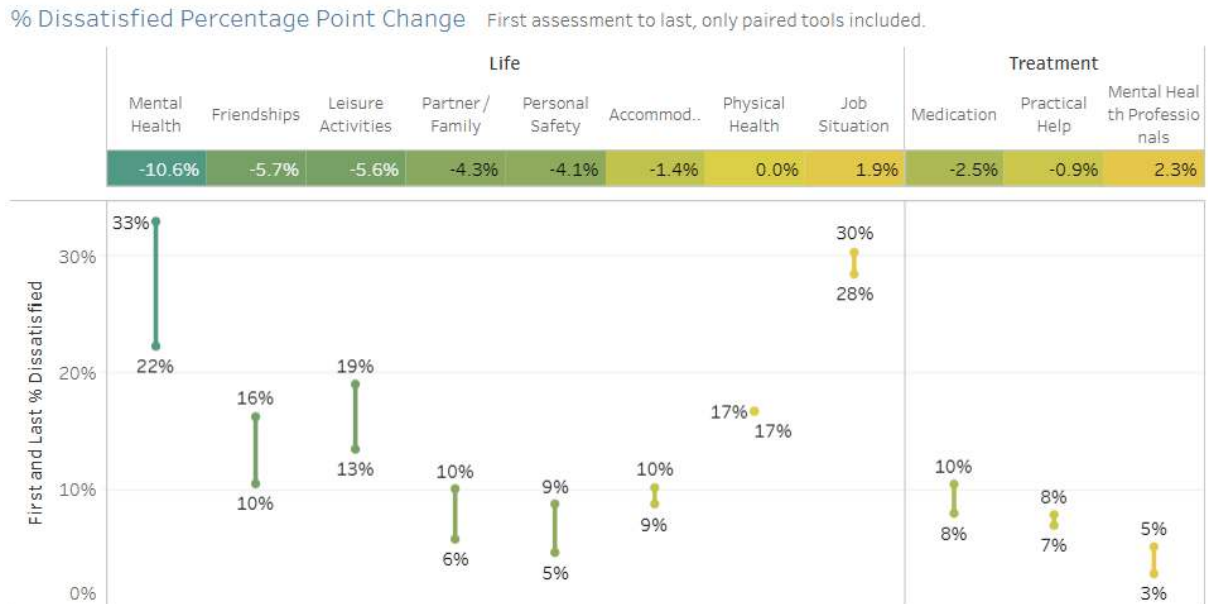


Source: Business Intelligence, Midlands and Lancashire CSU

4.2.11.2. DIALOG+

The data presented below shows the average changes in first and last scores for children and young people aged 8 to 25 years at first contact, where there is a paired score for referrals with a first contact in the 24 months to May 2025. A negative score indicates an improvement with fewer patients being explicitly dissatisfied at their last appointment compared to their first, a positive score indicates an increase in dissatisfaction. It is of note that currently there is a small proportion of paired scores for DIALOG+ so data below represents early indications and may not be fully representative.

Figure 72 – Dissatisfied percentage point change – first assessment to last, only paired scores included



Source: Business Intelligence, Midlands and Lancashire CSU

The data shows that:

- The greatest areas of improvement in the life domain were in relation to mental health, friendships and leisure activities.
- Less improvement was noted in relation to accommodation and physical health and there were worsening scores for job situation and mental health professionals, although the overall percentage explicitly dissatisfied with mental health professionals was low at 5% and worsened slightly from 3%.

4.2.11.3. Self-rated reliable improvement

Self-rated reliable improvement following support from children and young people’s mental health services is reported on a monthly basis. Figures shown are for closed referrals for children and young people aged 0-17 with at least two contacts and a self-rated paired score. Based on this measure, 55% reported a reliable improvement in May 2025 (green line), 37% reported no change (grey line) and 8% a reliable deterioration (red score). The trend over the 12-month period from June 2024 to May 2025 is shown in the figure below.

Figure 73 – Reliable improvement for closed referrals with at least 2 contacts and a self-rated paired score



Source: Business Intelligence, Midlands and Lancashire CSU

4.2.12. Transition to Adult Mental Health Services

The transition from Children and Young People’s Mental Health Services (CYPMHS) to Adult Mental Health Services (AMHS) is a critical period for young people with mental health needs. It is a widely recognised that there are several significant challenges that impact on continuity of care, engagement and outcomes:

- **Discontinuity of care:** differences in service models and eligibility criteria between CYPMHS and AMHS often lead to abrupt breaks in care. Young people may lose access to support despite ongoing needs (Hendrickx, et al., 2020).
- **Developmental and situational transitions:** Adolescents face simultaneous life changes (e.g., education, independence) alongside service transitions. These overlapping transitions can exacerbate mental health issues (Hendrickx, et al., 2020).
- **Service misalignment and gaps:** AMHS often have stricter eligibility criteria, leaving some without support. Inconsistent age boundaries (e.g., transition at 16 vs. 18) complicate planning. (Royal College of Psychiatrists, 2022).
- **Lack of Developmentally Appropriate Services:** Few services are tailored for the 16–25 age group, who have distinct needs. This age group often falls between child and adult service models (Royal College of Psychiatrists, 2022)
- **System complexity and stigma:** Navigating adult services can be confusing and discouraging. Stigma around mental illness may prevent help-seeking during this vulnerable time (Royal College of Psychiatrists, 2022).

Children and young people with special educational needs and disabilities face additional challenges during the transition from children’s to adult mental health care:

- **Loss of Continuity and Trusted Relationships:** Young people with SEND often lose long-standing relationships with professionals, which can be distressing (Care Quality Commission, 2014).

- **Eligibility Gaps and Service Thresholds:** Adult services may not accept young people with autism, ADHD, or learning disabilities if they don't meet clinical thresholds (NHS England, 2023).
- **Inadequate Preparation and Planning:** Transitions are often poorly coordinated, with limited involvement of young people and families. Families often have to coordinate care themselves due to lack of system support (Care Quality Commission, 2014).
- **Differences in Service Models:** CYPMHS is holistic and family-centred, while AMHS expects more independence (Stolper, van Doesum, & Steketee, 2022), this can be overwhelming for young people with SEND.
- **Increased Risk of Disengagement:** These barriers can lead to disengagement from services, worsening mental health at a time of other life transitions (Care Quality Commission, 2014)

Actions recommended by the Royal College of Psychiatry to address the challenges associated with transition include:

- Developing coordinated services that bridge CYPMHS and AMHS.
- Establishing structured pathways and early planning for transitions.
- Training professionals in both CYPMHS and AMHS to support transition-age youth.
- Extending CYMHS to age 25 or creating dedicated services for 18–25-year-olds.
- Promoting mental health awareness through education and public campaigns.

The Birmingham and Solihull CYP transformation programme has a core objective of developing a more cohesive system offer which reduces challenges associated with transition points and strengthens mental health support across the life course.

4.3. The mental health of working age adults

4.3.1. Trends in the mental health of the working age population

For working age adults, low educational attainment, material disadvantage and unemployment are particularly strong factors affecting mental health and wellbeing (World Health Organization and Calouste Gulbenkian Foundation, 2014). Becoming newly unemployed or moving below the poverty line has a clear negative impact on mental health, and reversing the situations where they occur could improve population mental health (Kromydas, Thomson, Pulford, Green, & Katikireddi, 2021).

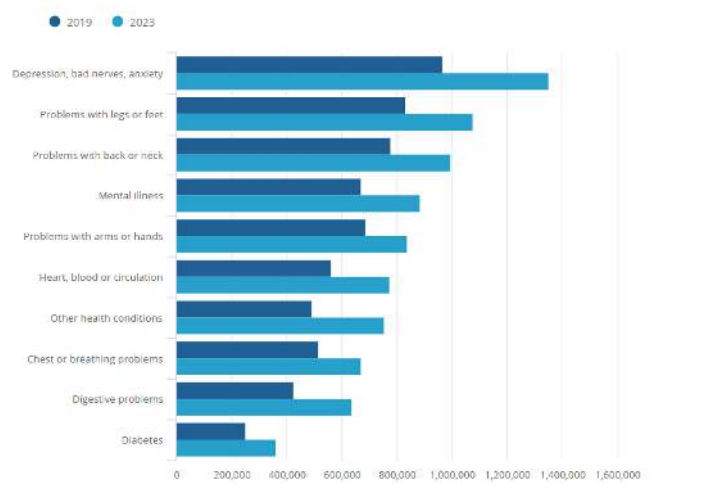
Poor quality employment, such as employment with no or short-term contracts, and jobs with low reward and control at work, have significant harmful impacts on mental health. Conversely, job security and a sense of control at work are protective of good mental health (World Health Organization and Calouste Gulbenkian Foundation, 2014).

Statistics regarding mental health at work which have been collated by [the Mental Health Foundation](#) include:

- In the United Kingdom in 2022, mental health was the 5th most common reason given for sickness absence, accounting for 7.9% of occurrences (Office for National Statistics, 2023).
- Mental ill health is now the most common cause of work-limiting conditions among those aged 44 years and younger (Atwell, Vriend, Rocks, Finch, & Farrington-Douglas, 2023).
- Over the past decade, the number of workers aged 16–34 years who reported that their mental health limits the type or amount of work they can do has more than quadrupled. (Atwell, Vriend, Rocks, Finch, & Farrington-Douglas, 2023).

[Analysis by the Office for National Statistics \(ONS\)](#) (Office of National Statistics, 2023) shows that from January to March 2019 to January to March 2023 the most prevalent health condition amongst those economically inactive because of long-term sickness was depression, bad nerves or anxiety:

Figure 74: Top 10 types of health conditions of people aged 16 to 64 years who are economically inactive because of long-term sickness, UK, January 2019 to March 2023

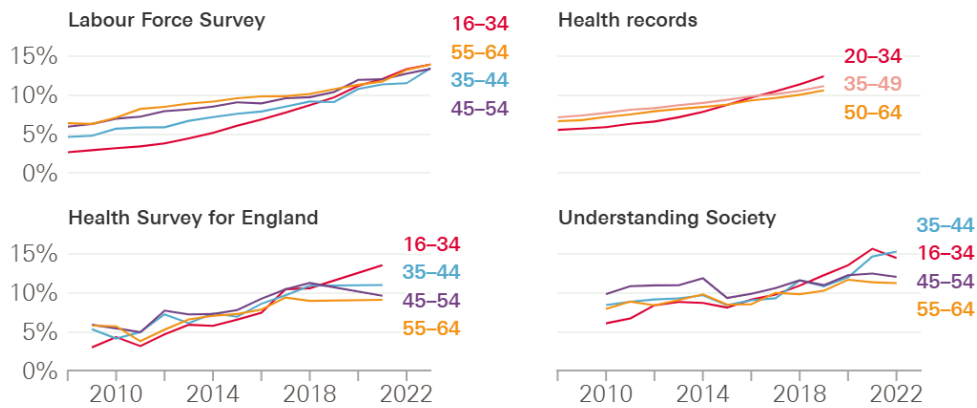


Source: [Rising ill-health and economic inactivity because of long-term sickness, UK - Office for National Statistics](#)

Furthermore, [analysis by the Health Foundation](#) (Vriend, Rocks, & Finch, 2025) also finds that the mental health of the working-age population appears to be getting worse. Over 10% of working-age people report signs of poor mental health across a range of data sources, including self-reported survey measures, screening tools and clinical diagnoses. While this rise is seen across people of all ages, the greatest increase has been for people of younger ages (16–34 years). Multiple data sources

indicate that rates have at least doubled over the past decade. This is illustrated below. These trends likely reflect a combination of rising prevalence, higher reporting and evolving definitions.

Figure 75 – Proportion of population reporting mental health conditions, by data source and age group, UK and England, 2008-2023



 **The Health Foundation**
© 2025

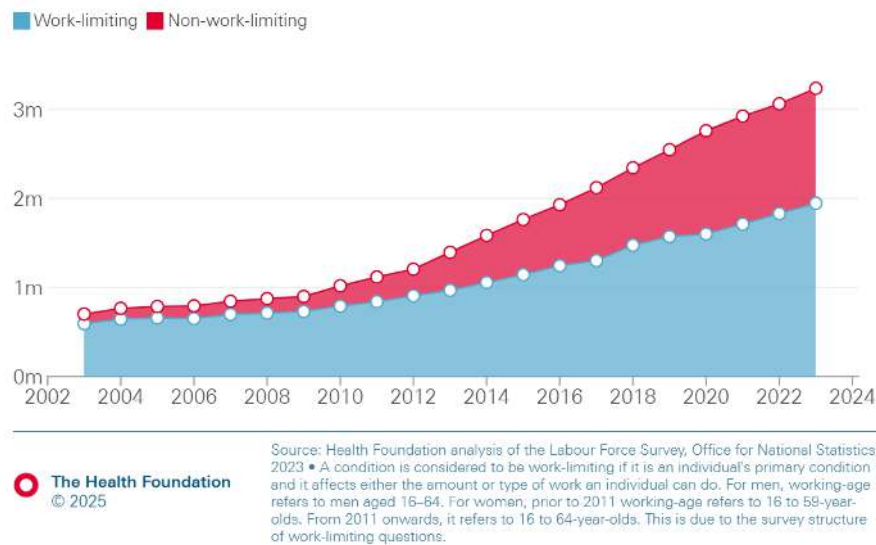
Source: Health Foundation analysis of Office for National Statistics, Labour Force Survey, 2023; Clinical Practice Research Datalink (CPRD); NHS Digital, Health Survey for England, 2023; University of Essex – Institute for Social and Economic Research, Understanding Society, UK, 2010–2022 • Health Survey for England data on mental health conditions is not available for 2019 and 2020. Understanding Society data identifies people as having a mental health condition if they have a GHQ score greater than 20 on a scale of 0-36. Health record data is based on the CPRD. Regulatory approvals to use CPRD data for this analysis were granted by the CPRD Independent Scientific advisory Committee (ISAC protocol number 20-000096).

Source: [Mental health trends among working-age people - The Health Foundation](#)

The Health Foundation analysis also finds that people with lower-level qualifications, those outside the labour market and people living in Scotland and northern England are more likely to report mental health conditions. Regions in the north of England also tend to have the greatest proportion of the population receiving benefit payments due to mental health.

Behind these trends, the data also show the varying nature and severity of mental health conditions. While 60% of mental health conditions are work-limiting, the greatest rise over the past two decades has been in non-work-limiting mental health conditions, which have risen 12-fold. See below.

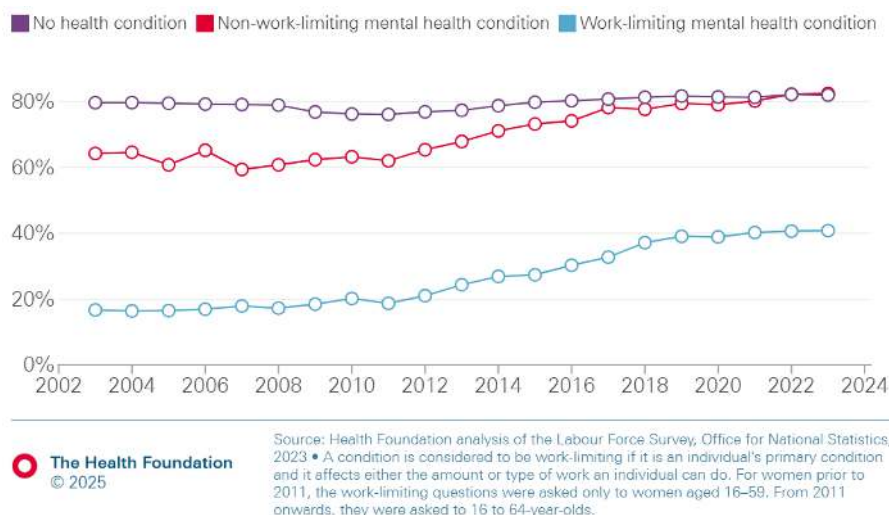
Figure 76 – Number of working-age people reporting work-limiting and non-working-limiting mental health condition as main condition (millions), UK, 2003-2023



Source: [Mental health trends among working-age people - The Health Foundation](#)

People with work-limiting mental health conditions are half as likely to be in work compared with people with no health conditions, see figure 77 below, although higher qualifications can reduce this gap. While people with non-work-limiting mental health conditions have higher employment rates that match those of people with no health conditions, they are more likely to have lower pay once in work.

Figure 77 – Employment rate for people reporting mental health conditions as main health condition, by work-limiting status, UK, 2003-2023



Source: [Mental health trends among working-age people - The Health Foundation](#)

4.3.2. Prevalence of mental health conditions

The Birmingham [Working Age Adults Joint Strategic Needs Assessment \(JSNA\)](#) (Birmingham City Council, 2021) includes the following statistics regarding the

prevalence of mental illness in Birmingham for working age adults:

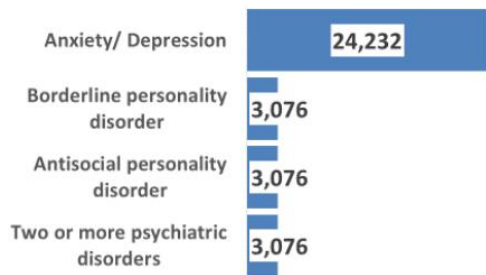
- It was estimated that in 2019 there were nearly 134,755 Birmingham adults aged 18-64 with a common mental health condition (CMHC), representing 18% of the age group population. CMHCs include depression, generalised anxiety disorder, panic disorder, phobias, social anxiety disorder, obsessive-compulsive disorder and post-traumatic stress disorder.
- The Lesbian, Gay, Bisexual and Transgender (LGBT) community have a higher-than-average rate of mental health issues. This was reflected in the Out & About Birmingham survey that reported 31% of those who took part had mood (affective) disorders, 19.5% anxiety disorders, 9.7% adjustment disorders and 5.5% eating disorders.

• The Working Age Adults JSNA also projects that the number of adults with a CMHC in Birmingham is predicted to increase by 5% between 2019 and 2030 (6,884 individuals, which is higher with Office for National Statistics (ONS) population projections). This is also reflected in ONS projections, which estimate there are currently just over 51,000 persons aged 18-64 in Birmingham with two or more psychiatric disorders. This is expected to increase to 55,000 by 2035 (Birmingham City Council, 2021).

For Solihull, national prevalence suggests 24,000 Solihull working age adults have a CMHC such as anxiety or depression, with prevalence rates higher in deprived communities and individuals subject to personal risk factors such as substance misuse, adverse childhood experiences physical ill health/disability, homelessness and caring responsibilities (Solihull Metropolitan Borough Council, 2020).

The estimated numbers of adults with mental ill health by condition type is set out in [the Story of Solihull](#) and this is displayed in figure 78 below.

Figure 78 - Estimated Number of Solihull Adults with Mental Ill Health



Source: Projecting Adult Needs & Service Information (PANSI), IPC and Oxford Brookes

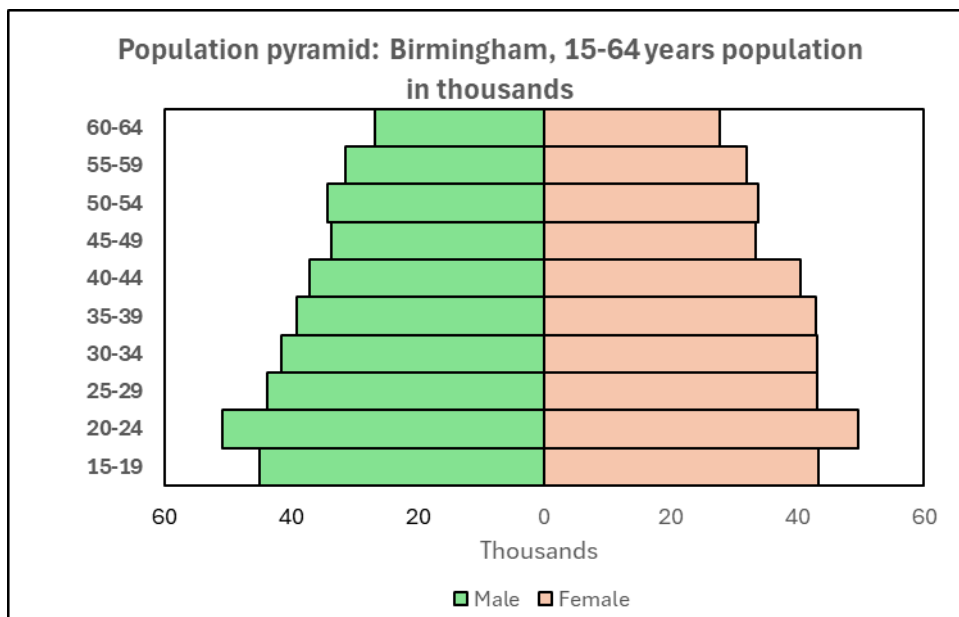
Source:

https://www.solihull.gov.uk/sites/default/files/migrated/InfoandIntelligence_The-Story-of-Solihull-2020.pdf

4.3.3. The working age population in Birmingham and Solihull

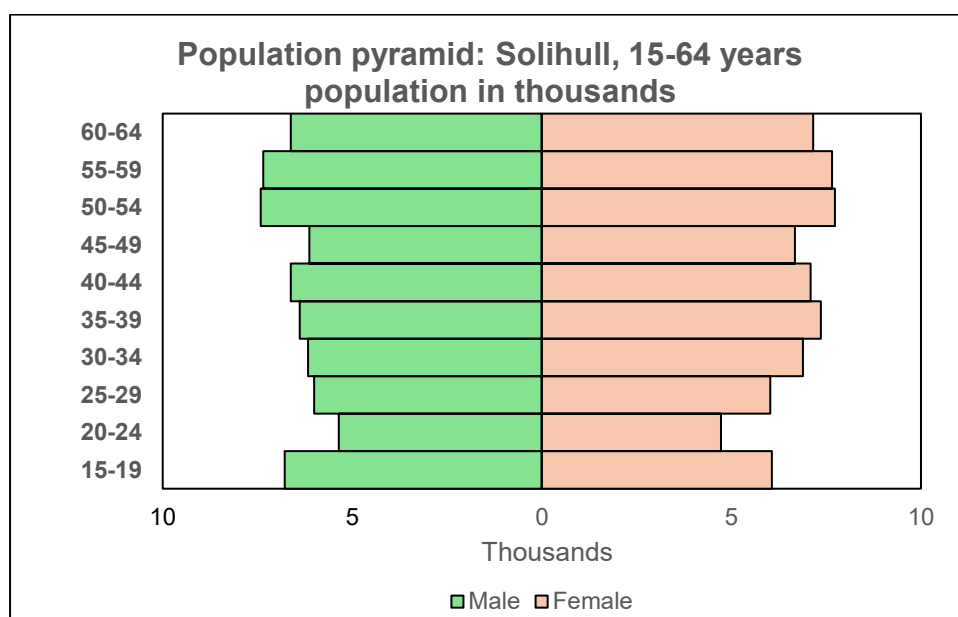
Based on 2023 estimates of the under 25 resident population, there are 773,528 people aged between 15 and 64 years living in Birmingham and 132,223 people aged between 15 and 64 in Solihull. The 15-64 years population represents 66.3% of the total population of Birmingham and 60.4% of the total population of Solihull. The below population pyramids show the distribution of the population by 5-year age band and sex in Birmingham and Solihull.

Figure 79: Population aged 15-64 years in Birmingham by age band and sex



Source: [Local Authority Health Profiles - Data | Fingertips | Department of Health and Social Care](#)

Figure 80: Population aged 15-64 years in Solihull by age band and sex



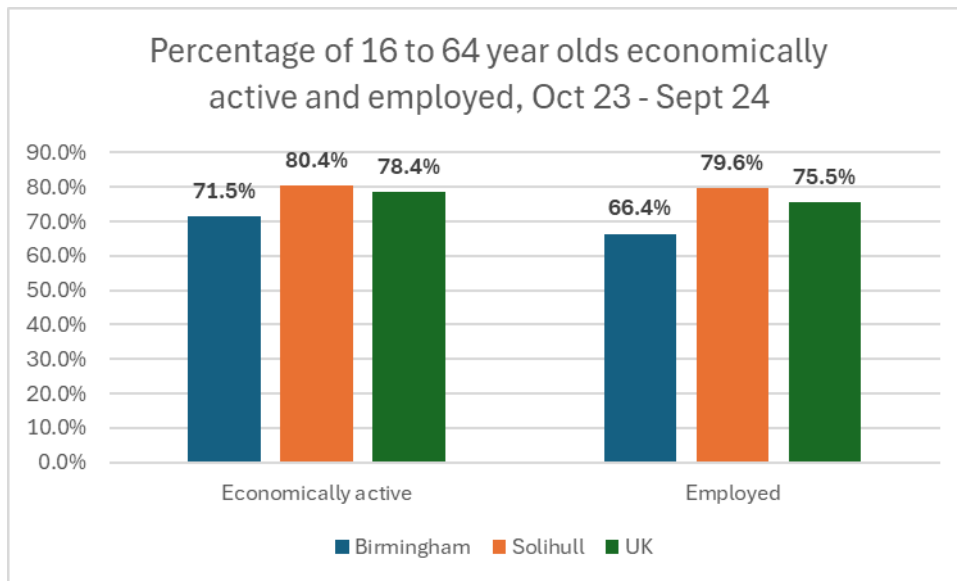
Source: [Local Authority Health Profiles - Data | Fingertips | Department of Health and Social Care](#)

4.3.4. Economically active population and employment

Research by the Office for National Statistics (Office for National Statistics, 2022) has found that prevalence of moderate to severe depressive symptoms was higher among adults who were economically inactive because of long-term sickness (59%), unpaid carers for 35 or more hours a week (37%), disabled adults (35%), adults in the most deprived areas of England (25%), young adults aged 16 to 29 years (28%) and women (19%).

The percentage of 16- to 64-year-olds who are economically active and who are employed varies between Birmingham and Solihull. Solihull has higher levels of economic activity and employment than both Birmingham and the national average and this is shown in the figure below.

Figure 81 – Proportion of population who are economically active and employed



Source: [Labour Market Profile - Nomis - Official Census and Labour Market Statistics](#)

Reasons for economic inactivity in Birmingham vary across the life course; the most common reasons being studying for 16–24-year-olds, looking after home or family for 25–50-year-olds and long-term sickness and disability for 50-64 year olds (Birmingham City Council, 2024). In Birmingham 42,000 of the working age population are economically inactive due to long term sickness or disability (Birmingham City Council, 2024).

Data on the [fingertips Public Health profiles](#) shows the rate of long-term claimants of job-seekers allowance in Birmingham was 3.1 per 1,000 in 2023 which is higher than both the national and regional average and higher than any of the local authority areas in the West Midlands region. By contrast, Solihull's rate of 0.5 per 1,000 is below both the regional and national average. This is shown in figure 82 below.

Figure 82 – Crude rate of long-term claimants of jobseeker’s allowance, 2023

Long term claimants of Jobseeker's Allowance 2023

Crude rate - per 1,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	31,751	0.9	0.9	0.9
West Midlands region (statistical)	↓	5,670	1.5	1.5	1.5
Birmingham	↓	2,350	3.1	3.0	3.2
Dudley	↓	569	2.9	2.6	3.1
Sandwell	↓	532	2.4	2.2	2.6
Wolverhampton	↓	338	2.0	1.8	2.2
Stoke-on-Trent	↓	315	1.9	1.7	2.1
Walsall	↓	297	1.7	1.5	1.9
Coventry	↓	278	1.2	1.0	1.3
Nuneaton and Bedworth	↓	70	0.8	0.6	1.0
Newcastle-under-Lyme	↓	64	0.8	0.6	1.0
Staffordshire Moorlands	↓	43	0.8	0.6	1.0
Bromsgrove	↓	45	0.8	0.6	1.0
Wychavon	↓	60	0.8	0.6	1.0
Malvern Hills	↓	33	0.7	0.5	1.0
Worcester	↓	47	0.7	0.5	0.9
Shropshire	↓	129	0.7	0.6	0.8
Redditch	↓	35	0.6	0.4	0.9
South Staffordshire	↓	40	0.6	0.4	0.8
Tamworth	↓	25	0.5	0.3	0.8
Wyre Forest	↓	30	0.5	0.3	0.7
Warwick	↓	49	0.5	0.4	0.7
Telford and Wrekin	↓	60	0.5	0.4	0.6
Solihull	↓	63	0.5	0.4	0.6
Stafford	↓	41	0.5	0.4	0.7
Cannock Chase	↓	28	0.4	0.3	0.6
Herefordshire	↓	44	0.4	0.3	0.5
Lichfield	↓	24	0.4	0.2	0.5
North Warwickshire	↓	14	0.3	0.2	0.6
East Staffordshire	↓	27	0.3	0.2	0.5
Rugby	→	11	0.2	0.1	0.3
Stratford-on-Avon	→	11	0.1	0.1	0.2

Source: [Fingertips | Department of Health and Social Care](#)

The contrast between Birmingham and Solihull is further illustrated by the high proportion of the Solihull working age population who are employed (78% compared to the national average of 76%), with the rate above average for men, women, ethnic minority groups and among all age groups (Solihull Metropolitan Borough Council, 2020). Furthermore, 58% of economically active residents in Solihull are in a good job, defined by conditions, wages and hours, this is above the UK average and one of the highest rates outside London and the South East of England (Solihull Metropolitan Borough Council, 2020).

4.3.5. Individual placement and support

Individual placement and support (IPS) is an evidence-based model of supported employment for people with Severe Mental Illness (SMI). It has been rigorously trialled and has consistently outperformed all other tested forms of support for job seekers with severe and enduring mental health problems (NHS England, 2023). The implementation of IPS has been part of the NHS Long Term Plan and preceding

strategies for national mental health improvement for over 8 years and is a fundamental part of the ongoing transformation of community mental health (CMH) services (NHS England, 2023).

Individual Placement and Support (IPS) Services in Birmingham and Solihull are delivered by [the Shaw Trust](#) and as part of this service offer:

- IPS workers are integrated into community mental health services within Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) and Forward-Thinking Birmingham (FTB) hubs, Early Intervention in Psychosis (EIP) teams, and within primary care through the community transformation programme.
- The service provides career and accurate benefits advice to enable people to make informed decisions.
- IPS workers provide employment advice to care coordinators, employers, and other interested stakeholders. They also act as a key link or 'bridge' between mental health services and employers.
- The service delivers an accredited full-fidelity IPS support model, an evidence-based model promoted by the Centre for Mental Health, which has these eight key principles:
 - Competitive Employment is the primary goal.
 - Everyone who wants it is eligible for employment support.
 - Job search is consistent with individual preferences.
 - Job search is rapid, beginning within one month, followed by extended in-work support.
 - Employment specialists are embedded in clinical mental health teams, with service users receiving employment advice alongside ongoing mental health support.
 - Employment specialists and clinical teams are located together.
 - Employment specialists develop relationships with employers based on a person's work preferences.
 - Support is time-unlimited and individualised to both the employer and the employee.

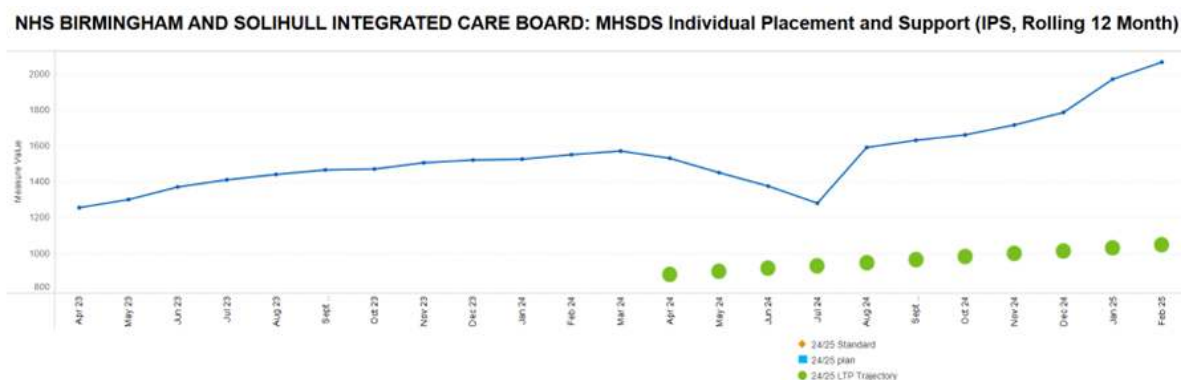
In Birmingham and Solihull, over 1,500 people living with SMI had contact with the IPS service delivered by Shaw Trust during 2024/25. Of these:

- 1,300 people started a vocational profile
- 454 successfully entered paid employment with one-one support from a Shaw Trust IPS employment specialist
- 247 people sustained employment for 13 weeks
- 185 people sustained employment for 26 weeks

The below chart shows the rolling 12-month figure for people accessing SMI services for Birmingham and Solihull ICB with the number of people accessing significantly exceeding the NHS Long Term Plan target figure with the rolling 12-month figure for

February 2025 being 2,065 against a target of 1,051.

Figure 83: IPS, rolling 12-month access figure, Birmingham and Solihull ICB



Source: [Mental Health Core Data Pack](#)

4.3.6. Mental health service provision for working age adults

NHS adult mental health services for adults are provided in a range of settings including:

- Primary care services, such as GPs and NHS talking therapies for anxiety and depression.
- Services for people in acute need, such as crisis teams and A&E psychiatric liaison.
- Community services, such as generic community mental health teams, and teams aimed at specific groups or disorders (for example, perinatal mental health teams and early intervention in psychosis teams).
- Mental health wards and units and longer-stay rehabilitation units.
- Specialised services such as forensic mental health services.

These secondary mental health services are part of a broader service offer for working age adults that includes services provided by the Voluntary, Community, Faith and Social Enterprise sector. NHS funded mental health provision delivered by the VCFSE sector for working age adults includes a variety of service offers relating to crisis care, rehabilitation and community support such as recovery centres, community development workers, community navigator roles and peer support workers.

In addition to these services, there are ongoing service developments to strengthen the service offer for adults in Birmingham and Solihull via the community transformation programme and initiatives such as the 24/7 community pilot both of which are discussed were previously discussed in section 3.6.5.

4.4. The mental health of older adults

There is an ageing population in England; between the years 2018 and 2028, the number of people 75–84 years is projected to increase by a third, and those aged 85 years and older by more than a fifth (Health Foundation, 2023). It is also projected that the number of people living with major illness is projected to increase by 37% – over a third – by 2040, nine times the rate at which the working age population (20–69-year-olds) is expected to grow (4%) (Health Foundation, 2023).

As part of these trends, there has been a rise in the number of older adults living with multiple long-term conditions. This includes 80% of people over 65 having been diagnosed with more than one long-term health condition and the majority of people aged 80 and over living with three or more (Age UK, 2019). Living with multiple long-term conditions can lead to chronic pain, impaired functioning, reduced independence and social isolation which can all impact upon the mental health of older adults. The close relationship between physical and mental health means that treatment for older people needs to be integrated, rather than condition specific (Age UK, 2019).

Other important considerations when considering the mental health of older adults include:

- Globally, around 14% of adults aged 60 and over live with a mental disorder (World Health Organization, 2023). According to the Global Health Estimates (GHE) 2019, these conditions account for 10.6% of the total disability (in disability adjusted life years, DALYs) among older adults. The most common mental health conditions for older adults are depression and anxiety (World Health Organization, 2023).
- Prevalence of mental health conditions are higher among specific groups of older people. For example, 40% of older people who are living in care homes have depression; 30% of older carers experience depression at some point; and older people going through a bereavement are up to four times more likely to experience depression than older people who haven't been bereaved (Age UK, 2019).
- The impact of caring responsibilities can have a significant impact on the mental health of older adults. It is estimated there will be 1.8 million older carers by 2030 and nearly half of carers aged 85 or over who are providing 20 or more hours of care a week say that they feel anxious or depressed (Age UK, 2019). Older people caring for someone with dementia report feeling helpless, sad, and guilty, and require support to cope with their emotions (Age UK, 2019).
- Not only can dementia trigger mental health problems, with estimates suggesting that 20-40% of people living with dementia are depressed (Age UK, 2019), but it can also make treatment of mental health conditions more challenging. Symptoms of dementia can be similar to those of other mental health conditions, such as depression and anxiety, making accurate diagnoses harder. Older people

living with dementia may struggle to express how they are feeling which also increases the difficulty of diagnosis (Age UK, 2019).

- There are multiple barriers to older adults seeking help when they are struggling with their mental health; these include perceiving poor mental health as an inevitable part of ageing, fear of being a burden, and concern about being judged or stigmatised as well as lack of awareness of potential symptoms of mental health conditions (Age UK, 2019).
- Older people with mental health problems are more likely to be prescribed anti-depressants and less likely to be referred for talking therapies than younger adults (Centre for Ageing Better, 2023). Older people are a fifth as likely as younger age groups to have access to talking therapies, but six times more likely to be on tranquillisers (Age UK, 2019).

Furthermore, evidence summarised by Age UK (Age UK, 2019) shows many health professionals:

- Are reluctant to talk about mental health with older people, especially older males, as they presume it will make older people feel uncomfortable.
- Perceive mental health conditions as an inevitable part of ageing so do not refer people to support. This is particularly true regarding bereavement.
- Believe that talking therapies are not effective for older people or that older people will not engage with the process, so opt to prescribe medications instead.

Evidence shows that these presumptions are unfounded and in reality, older people are more likely to engage with and benefit from mental health treatment when it is offered to them than their working age counterparts (Age UK, 2019).

In addition to the above, Centre for Mental Health undertook a review on behalf of Age UK to explore evidence relating to mental health in later life. They reviewed research regarding the mental health of people in later life in England, what types of mental health support are available to older people currently, and what policies exist to improve the support people are offered (Iskander-Reynolds, 2024).

Key findings from the review were:

- The mental health of people in later life has been overshadowed by systemic and interpersonal ageism: older people's mental health needs have too often been disregarded, at both an individual level and in the development of health and care systems. This is discriminatory and carries a heavy cost for individuals, families, communities and public services.
- There is no national strategy or blueprint to help public services to prevent mental ill health in later life, to intervene quickly and effectively to stop problems from escalating, or to meet the needs of people with mental health problems in later life effectively and holistically.
- The UK population is ageing, and people are living with physical and neurodegenerative conditions for longer. The mental health of this population is

therefore going to be increasingly important for health and care services to address effectively.

- There is a pressing need to tackle ageist assumptions and expectations about mental health in later life. There is a pervasive sense of pessimism and inevitability that normalises poor mental health and prevents both help-seeking and offers of support.
- Older people with caring responsibilities face an extra strain on their mental health. This continues beyond the loss of the person they care for, with complex grief affecting the mental health of carers more often than for the wider population.
- Mental and physical health problems have complex interactions among older people: having one increases the risks of the other, and poor mental health exacerbates physical health problems. This is compounded for those with neurodegenerative conditions, or those who are misdiagnosed (for example with dementia instead of depression, or vice versa).
- Person-centred and holistic approaches to mental health in later life need to be promoted so that no one's needs are overlooked or inadequately met. There is no one-size-fits-all for mental health in later life.
- Having meaningful roles and opportunities is beneficial for both mental and physical health among older adults. Positive social connections, including face to face time and safe and supportive networks, can help to boost people's mental health in later life. This may be especially important for those who are unable to engage with services or communities through digital technology.

The review explored what data is available about mental health in later life in the UK and found:

- Three quarters (75%) of people aged above 65 years in the UK say they have experienced significant anxiety or low mood at least once since turning 65, with 10% feeling this frequently or all the time (Seaman, Stapleton, & Mawhinney, 2020).
- Depression affects 22% of men and 28% of women aged above 65 years, 40% of men and 43% of women aged above 85 years, and 40% of older people in care homes (Faculty of Old Age Psychiatry and Royal College of Psychiatrists, 2018).
- Nearly 1 in 10 people aged above 75 yrs could have clinical depression (Frost, Beattie, Bhanu, Walters, & Ben-Shlomo, 2019).
- Hospital admissions of older adults from drug and alcohol misuse have increased, accounting for around 30% of total admissions (Faculty of Old Age Psychiatry and Royal College of Psychiatrists, 2018).

There is evidence that some groups of people in later life have a higher risk of mental health difficulties than others, including:

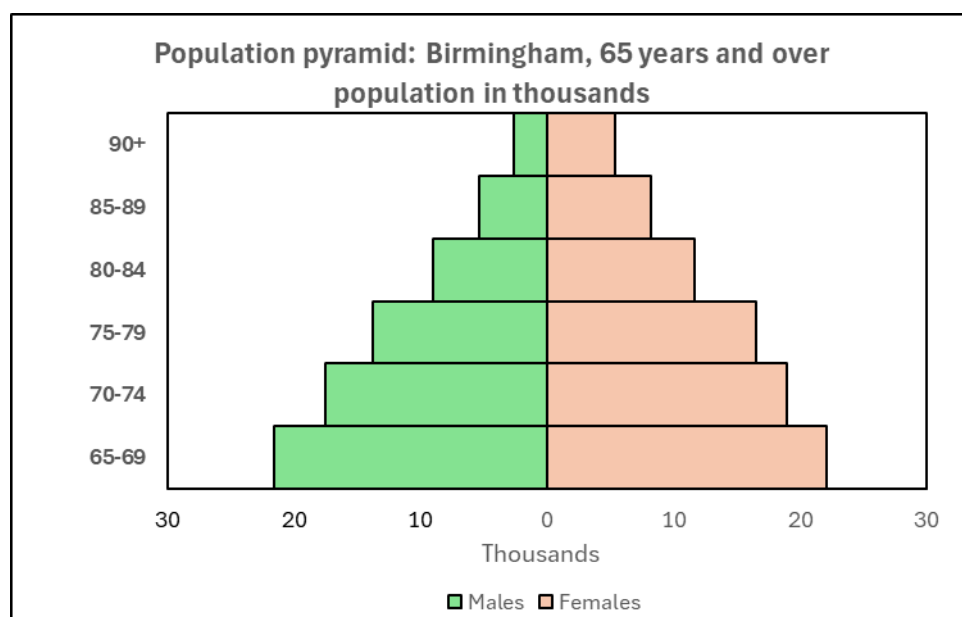
- Those in nursing homes and other residential aged care facilities (Creighton, Davison, & Kissane, 2015; Seitz, Purandare, & Conn, 2010)

- Those living with long-term physical conditions and disabilities (Bishop-Fitzpatrick & Rubenstein, 2019; Cooper, et al., 2015)
- Those living with dementia and neurodegenerative diseases (Wolitzky-Taylor, Castriotta, Lenze, & Craske, 2010)
- Those living in poverty (Weich & Lewis, 1998)
- Carers (Carers UK, 2019)
- Those from ethnic minority groups and immigrants (Devonport, et al., 2023).

4.4.1. The older adult population in Birmingham and Solihull

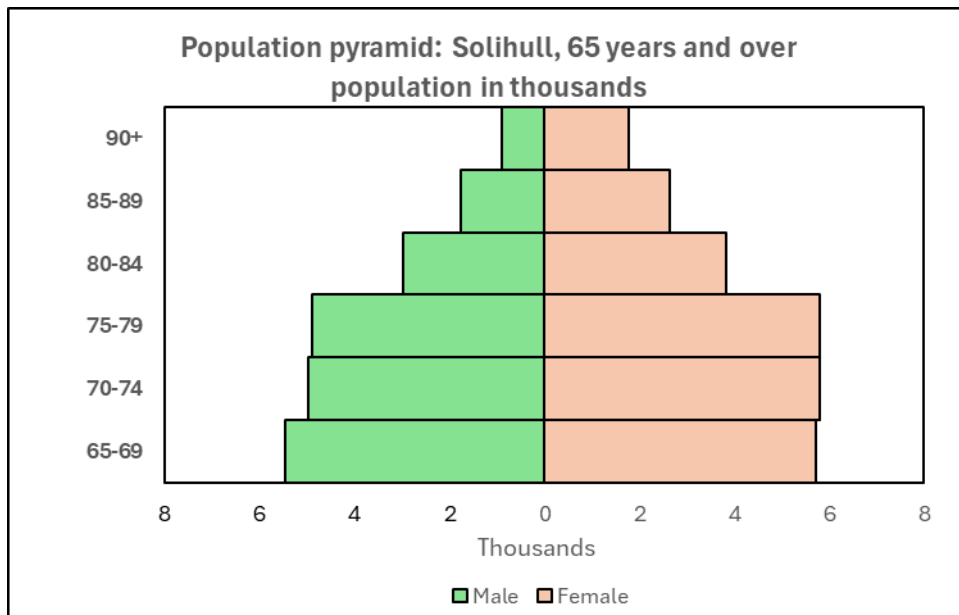
Based on 2023 estimates of the under 25 resident population, there are 773,528 people aged between 15 and 64 years living in Birmingham and 132,223 people aged between 15 and 64 in Solihull. The 15-64 years population represents 66.3% of the total population of Birmingham and 60.4% of the total population of Solihull. The below population pyramids show the distribution of the population by 5 year age band and sex in Birmingham and Solihull.

Figure 84: Population aged over 65 years in Birmingham based on 2023 estimates



Source: [Local Authority Health Profiles - Data | Fingertips | Department of Health and Social Care](#)

Figure 85: Population aged over 65 years in Solihull based on 2023 estimates



Source: [Local Authority Health Profiles - Data | Fingertips | Department of Health and Social Care](#)

For Birmingham, by 2040, the population of older people is predicted to rise to over 194,000. Life-limiting long-term illness and disability also becomes more common with age, by 2040 affecting 75% of the population aged 85 and over (Birmingham City Council, 2021).

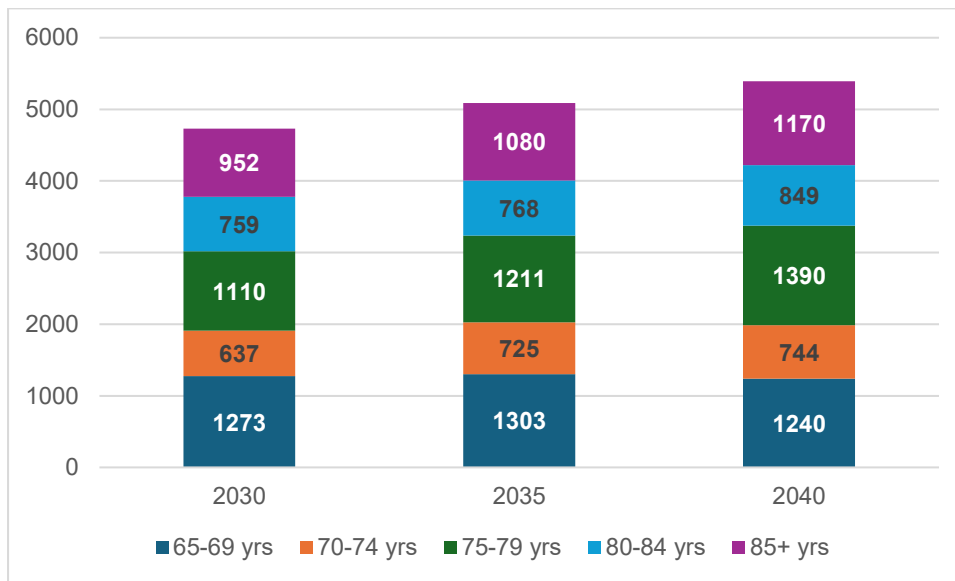
As noted in section 3, there is less diversity in the older adult population in both Birmingham and Solihull compared to younger age groups. Ethnic minority groups account for 24% of people aged 65 years and above in Birmingham and 6% in Solihull. However, in Birmingham there is considerable variation in the ethnicity of the older adult population across the city. For example, 70% of the older adult population in Small Heath, Sparkhill and Alum Rock are of Asian and Asian British ethnicity, whilst in Newtown nearly 50% are of Black or Black British ethnicity (Birmingham City Council, 2025).

4.4.2. Prevalence of mental health conditions in older adults

Data from the Projecting Older People Population Information (POPPI) system provides projected figures on the number of older adults in Birmingham and Solihull with severe depression. This is illustrated in the charts below and shows the following predicted percentage increases and decreases in severe depression prevalence by age group in Birmingham:

- A 25% increase in the 75 to 79 years age group.
- A 23% increase in the over 85 years age group.
- A 17% increase in the 70 to 74 years age group.
- A 12% increase in the 80 to 84 years age group.
- A 3% decrease in the 65 to 69 years age group.

Figure 86 – Numbers of older adult predicted to have severe depression in Birmingham

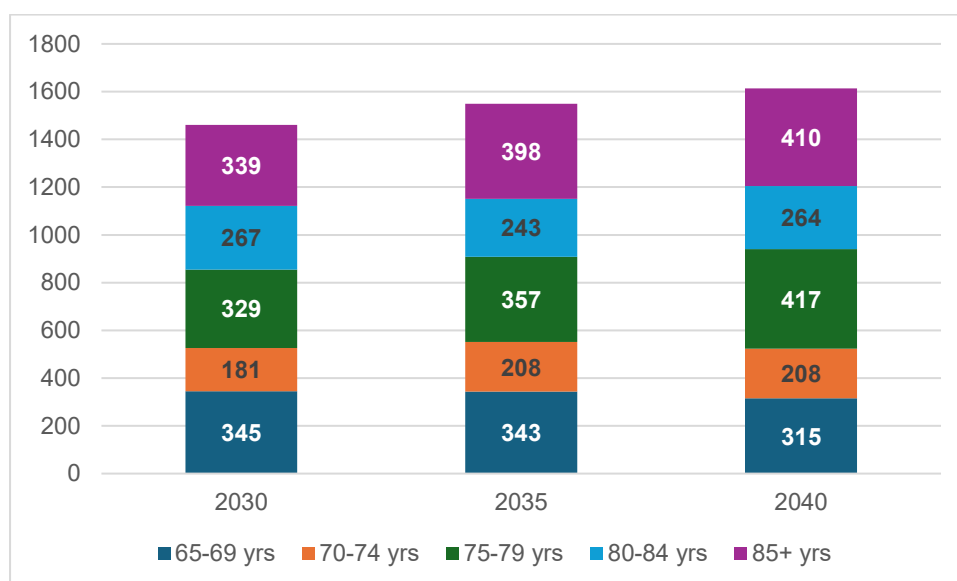


Source: [Projecting Older People Population Information System](#)

The equivalent data for Solihull over the 10 year period from 2030 to 2040 shows the following predicted increases and decreases in severe depression prevalence by age group:

- A 27% increase in the 75 to 79 years age group.
- A 21% increase in the over 85 years age group.
- A 15% increase in the 70 to 74 years age group.
- A 1% decrease in the 80 to 84 years age group.
- A 9% decrease in the 65 to 69 years age group.

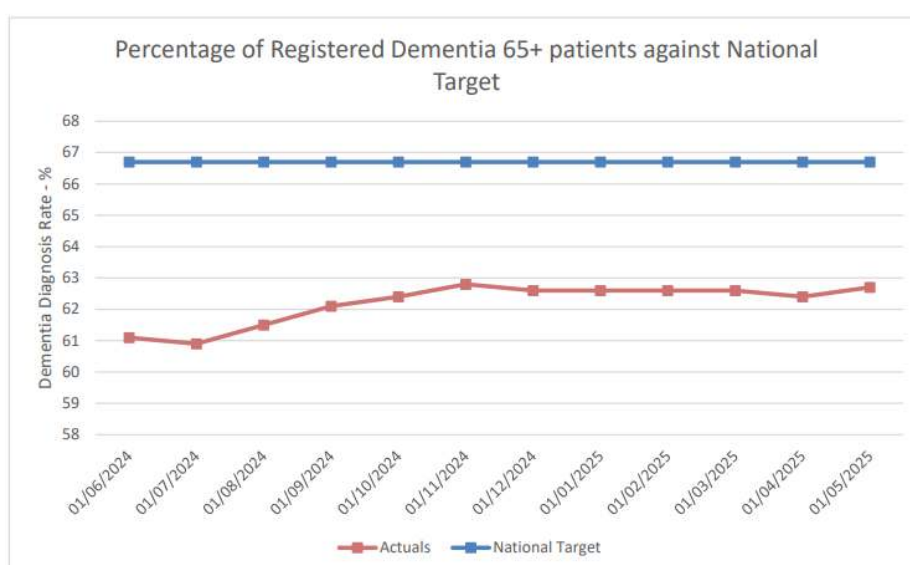
Figure 87 – Numbers of older adult predicted to have severe depression in Solihull



Source: [Projecting Older People Population Information System](#)

In 2019, there were 7,387 people on dementia registers in Birmingham GP practices. By 2040, this is predicted to increase to 14,716. The incidence of dementia increases with age and estimated prevalence among those aged over 80 is around 17% compared to 3% in those aged 65- 79 (based on 2020 estimates) (Birmingham City Council, 2021). Nationally, there is an NHS target for the dementia diagnosis rate which is set at 66.7%. Diagnosis rates are calculated by comparing recorded diagnoses to estimated dementia prevalence. Performance against this target for Birmingham and Solihull is shown below.

Figure 88: Performance against dementia diagnosis rate target



Source: Primary care dementia data, NHS England

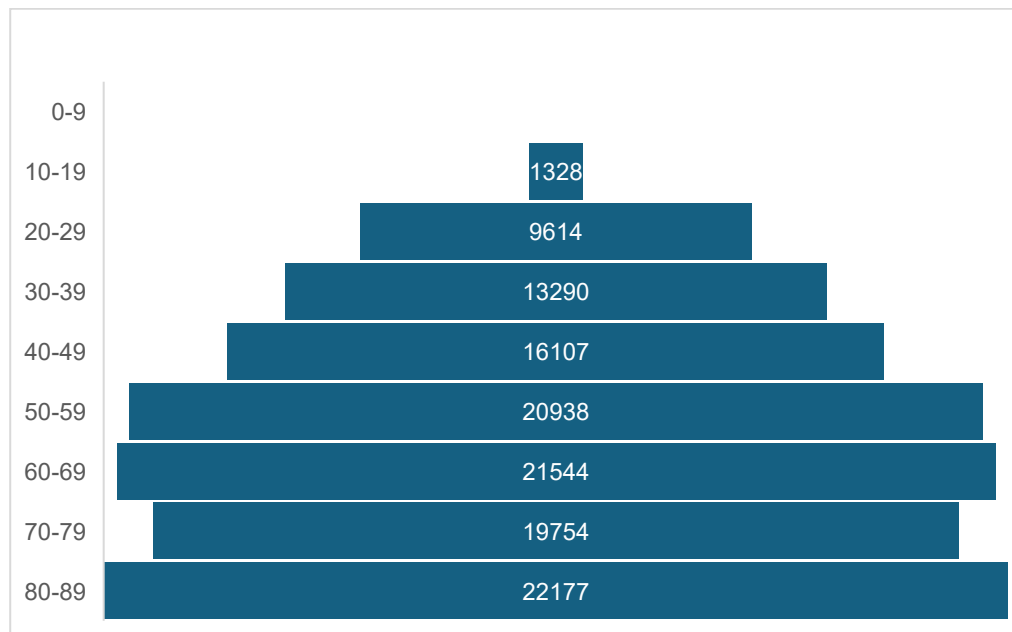
The Birmingham and Solihull Dementia Strategy for 2023 to 2028 states that there

are currently an estimated 13,000 people living with dementia in Birmingham and Solihull. It is estimated there will be over 17,000 people living with Dementia in Birmingham and Solihull by 2040 (Birmingham and Solihull ICS, 2023).

4.4.3. Prescribing of anti-depressants

Data on the prescribing of anti-depressant medications in Birmingham and Solihull shows that rates of prescribing are highest in the population aged 50 years and above and highest in the 80-89 years age band. See figure 89 below.

Figure 89: Rate of prescribing of anti-depressants in Birmingham and Solihull per 100,000 population by age band, April 2024 to March 2025

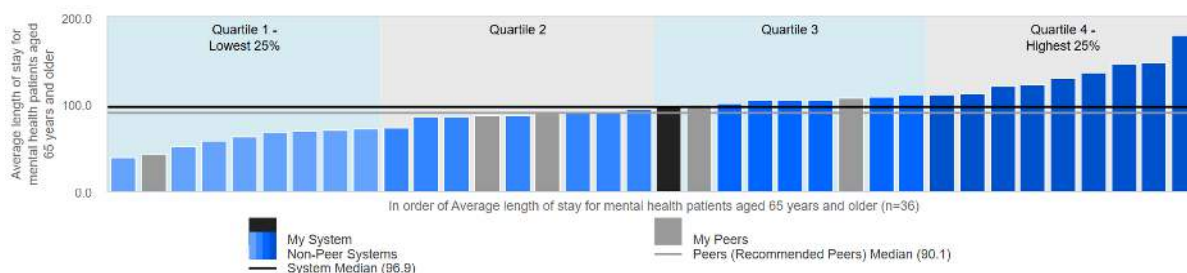


Source: Business Intelligence, Midlands and Lancashire CSU

4.4.4. Length of stay in inpatient settings

The mean average length of stay for adults aged 65 years and above in mental health inpatient settings was 98.9 days for Birmingham and Solihull ICB in May 2025. This places Birmingham and Solihull in the third quartile of the national distribution and is higher than the national median (96.9 days) and above the median value of the Birmingham and Solihull ICB peer group (90.1 days) as shown below.

Figure 90 – Average length of stay for mental health inpatients aged 65 years and older, national distribution with Birmingham and Solihull ICB highlighted black



Source: [Average length of stay for mental health patients aged 65 years and older - Model Health System](#)

4.4.5. Mental health service provision for older adults

Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) deliver a range of inpatient services and community-based services for older adults.

Community based services include:

- [Admiral nursing services](#) which provide dementia nursing support to family carers with multiple and complex care needs.
- [Community enablement and recovery teams \(CERT\)](#) which work in collaboration with community mental health teams and inpatient units to treat and support service users with primarily complex needs and their carers in their local communities to avoid admission to hospital and, where admission is unavoidable, to reduce the duration of stay.
- [Older people's community mental health team](#) which provides multidisciplinary, multi-agency support.
- [Older Peoples Intervention Programme \(OPIP\)](#) which provides hub based intensive patient assessment (day attendance), supports the psychologically informed therapies and interventions programme (in all settings) and community engagement with patients.
- The [care home liaison service](#) is a multidisciplinary team of nurses and occupational therapists. The team helps care staff develop strategies and build competence and confidence to support residents with mental health needs. Each care home has a designated community mental health nurse who works directly with the residents (as clinically appropriate) if they are a current service user of the Trust.
- The [Memory Assessment Service \(MAS\)](#) also provides assessment and diagnosis for users suspected of developing dementia, when all other causes have been ruled out, including physical, mental health and alcohol.

Inpatient services are provided to older adults with mental health issues at the [Juniper Centre](#), Moseley and [Ashcroft Unit](#) in Hockley. All units offer 24-hour

specialist mental health care for service users with an acute organic (such as dementia) or functional (such as depression or psychosis) ongoing mental health issue.

4.4.6. Older adults and NHS Talking Therapies

In line with the national picture, in Birmingham and Solihull a low proportion of those accessing NHS Talking Therapies for anxiety and depression are aged 65 years and above. This is shown in figure 91 below.

Figure 91: Percentage of clients entering Talking Therapies treatment who are aged 65 years and over



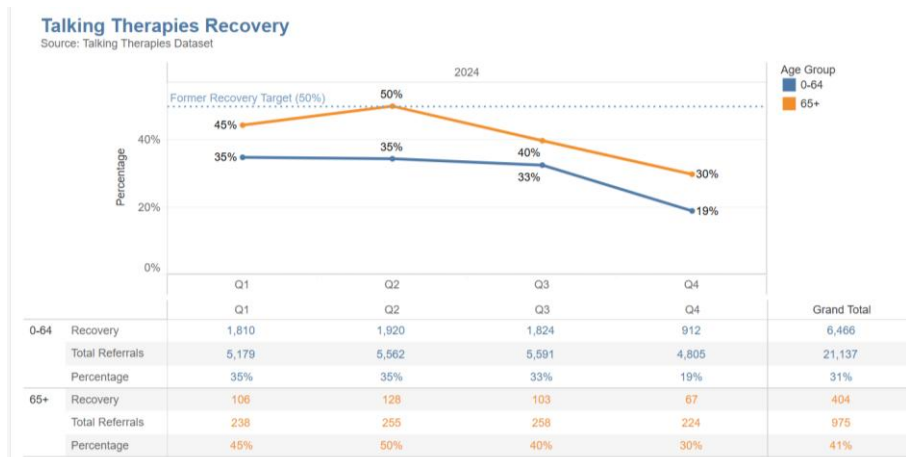
Data Source: NHS Digital IAPT Quarterly, Patients Entering First Treatment

Source: NHS England Talking Therapies quarterly statistics

The above shows that the percentage of those entering first treatment aged 65 years and above has fluctuated between 4.6% and 5.4% over the last 4 quarters for which data is available. This compares to the proportion of the Birmingham and Solihull population who are aged over 65 years compared to Office for National Statistics population projections which is 17.6%.

Recovery rates for older adults compare favourably to other age groups indicating NHS talking therapies is most effective with older adults out of all age groups, this suggests there should be greater emphasis given to promoting uptake of talking therapies with older adults given the relatively low uptake within this age group and better outcomes following completion of treatment. The recovery rates for the 65 years plus population are illustrated in the charts below which show the percentages achieving recovery and reliable recovery for the 2024 calendar year.

Figure 92: NHS Talking Therapies Recovery Rates, by quarter of 2024 calendar year



Source: Business Intelligence, Midlands and Lancashire CSU

5. Inclusion health groups

Inclusion health is a term used in the UK to describe efforts aimed at addressing the extreme health and social inequalities experienced by people who are socially excluded. These individuals often face multiple, overlapping risk factors for poor health, such as:

- Poverty
- Violence
- Complex trauma
- Stigma and discrimination
- Limited access to healthcare services

Inclusion health groups often:

- Have much worse health outcomes than the general population
- Die at a younger average age
- Face barriers to accessing care, such as lack of documentation, language barriers, or fear of discrimination
- Are underrepresented in health data systems, making it harder to plan services effectively

The below summary considers a range of inclusion health groups with reference to barriers to vulnerabilities in relation to their mental health, barriers to accessing mental health support and potential unmet needs and gaps in provision.

5.1. People with learning disabilities

The UK Department of Health and Social Care (DHSC) provides the below definition of learning disability (Department of Health and Social Care, 2001):

A significantly reduced ability to understand new or complex information, to

learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood.

Learning disability is distinct from learning difficulties which has been defined as follows (Public Health England, 2023):

A reduced intellectual ability for a specific form of learning and includes conditions such as dyslexia (reading), dyspraxia (affecting physical co-ordination) and attention deficit hyperactivity disorder (ADHD)

There are many possible causes of learning disability. These can range from common, well-recognised conditions such as Down syndrome to less well-known genetic causes, trauma during birth or severe infection. Many people are never able to pinpoint a single cause for their learning disability (National Centre for Mental Health, n.d.).

Public Health England (PHE) estimates there are about 1.3 million people with a learning disability in England, including over 950,000 adults aged 18 years or over. The number of people with learning disabilities recorded in health and welfare systems is much lower (Public Health England, 2023).

Evidence suggest that mental health problems are more common in people with a learning disability than in those without a learning disability. Some studies suggest the rate of mental health problems in people with a learning disability is double that of the general population. The estimated prevalence of mental health disorders ranges from 15-52%, depending on the diagnostic criteria used (Mencap, n.d.). Children with learning disabilities are four and a half times more likely to have a mental health problem than children without a learning disability (Mental Health Foundation, n.d.).

Mental health problems among people with a learning disability are often overlooked, underdiagnosed and left untreated due to poor understanding, awareness, evidence in this area and symptoms mistakenly attributed to the person's learning disability (Mental Health Foundation, n.d.). The lifetime prevalence of suicide attempts is significantly greater in individuals with learning disabilities (11.1%) than without (2.7%) (Birmingham City Council, 2024).

[Research by the Children and Young People's Mental Health Coalition](#) has highlighted a significant gap in evidence-based psychological support for children with learning disabilities who also experience mental health challenges. It also found that young people with learning disabilities and their families often lack confidence in the system's ability to meet their mental health needs, feeling overlooked and misunderstood.

Furthermore, they report that children, young people and their families often do not know what support is available to them and what they are entitled to. There is also great variation across the country with regards to what mental health services young

people have access to. While pathways to care for young people with learning disabilities do exist in some areas, they are not always effectively implemented (Children and Young People's Mental Health Coalition, 2019).

5.1.1. People with learning disabilities in Birmingham and Solihull

During 2021-22, a total 10,835 people in Birmingham were on GP practices Quality Outcomes Framework (QOF) register as having a learning disability. However, it has been estimated that only 23% of the estimated 1.1 million people with a learning disability are on their GP's learning disability register. Part of this discrepancy is due to the GP register only accounting for patients aged 14 years and above, and that GP registers only account for the citizens where their learning disability is diagnosed and known to their GP (Birmingham City Council, 2024).

5.1.2. Experience of mental health services

The Experience of Care Campaign led by Rethink Mental Illness in Birmingham and Solihull sought to engage with people with learning disabilities, autism, Special Educational Needs and Disabilities (SEND), and Attention Deficit Hyperactivity Disorder (ADHD) to understand their experiences of accessing mental health services locally. They facilitated 4 focus group sessions, 3 groups in Birmingham and 1 in Solihull and also attended the Autism and ADHD summit. They identified the following themes from their engagement (Rethink Mental Illness, 2024):

- Long waits to access to access support.
- Lack of multi-agency support/communication.
- Lack of response in crisis situations – resulting in Ambulance/Police/A&E. - Communication - often the way information is communicated is too complex, full of jargon.
- It is evident from the focus groups that local community support/groups are vital and a key element in their life for those who attend.

5.1.3. Mental health inpatients

The national Care Quality Commission Report [Monitoring the Mental Health Act in 2022/23](#) (Care Quality Commission, 2024) states that:

- *The lack of suitable accommodation within the community has led to people, particularly autistic people and people with a learning disability, being unnecessarily detained in hospital, while a significant number of patients are being placed far from home, some for years at a time.*

The issue of long-term inpatients is also discussed within the Learning Disability Deep Dive (Birmingham City Council, 2024) where it is reported that:

In October 2021, there were 3,490 people with learning disabilities and/or autistic spectrum disorders (LDA) in hospital within England, representing

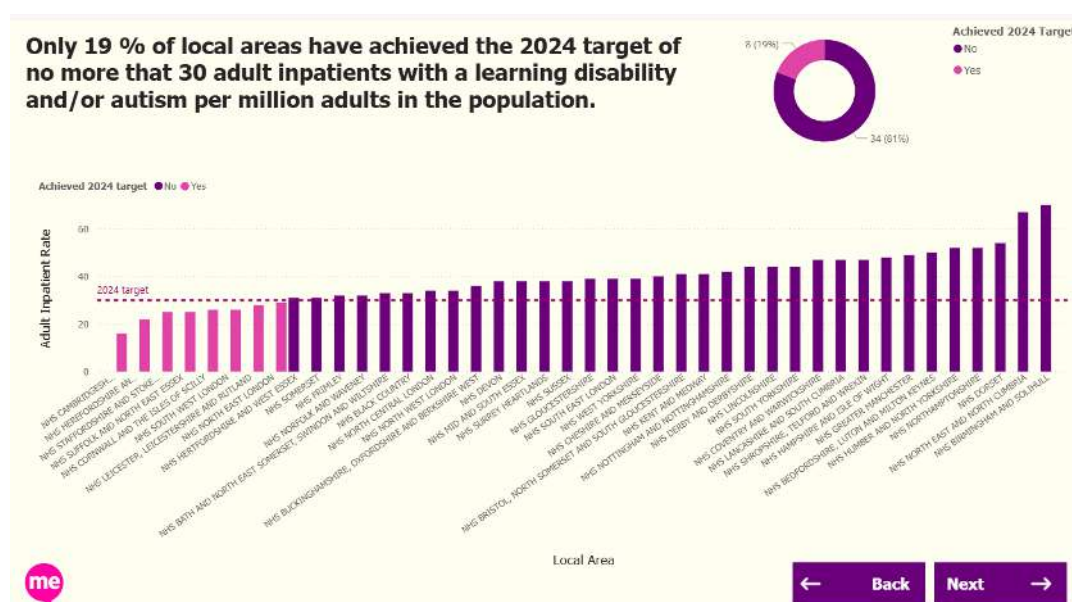
those with 'a bed' designated for mental illness treatment or care, who have been diagnosed or are understood to have a learning disability and/or autistic spectrum disorder. In this sample, a third of inpatients (32%) with a planned discharge date experienced an overdue discharge, with common reasons including awaiting care home placements or support accommodation availability. Over half of the 3,490 inpatients had been admitted for over a year.

[National statistics published by NHS England](#) show that there were 2,025 learning disabilities and/or autism inpatients in England at the end of March 2025 and that of these:

- 1,020 (50%) have had a total length of stay of over 2 years. This includes 315 who have been in hospital for more than 10 years.
- 855 (42%) inpatients are in a secure ward.
- The largest number of inpatients (610, 30%) were aged between 25-34, and the lowest number (40, 2%) were aged 65 and over.
- 440 inpatients (22%) have a date planned for them to leave hospital.

Benchmarking data presented by Mencap shows that the adult inpatient rate in Birmingham and Solihull (78) is the highest in the country, far exceeding the national target of 30 adult inpatients with a learning disability/ autism per 1 million population.

Figure 93: Adult Inpatient Rate, National distribution by Integrated Care Board



Source: [Mencap Interactive Heatmap](#)

Further to the above, information presented in section 3.6.3 shows the high rates of readmission to inpatient care for learning disability beds occurring between July 2023 and June 2024 with 99% of discharges from learning disability beds at Coventry and Warwickshire NHS Partnership Trust resulting in readmission within 6 months.

5.2. Autistic people

The term autism describes a pattern of 'qualitative differences and impairments in reciprocal social interaction and social communication, combined with restricted interests and rigid and repetitive behaviours, often with a lifelong impact'. The term 'autism spectrum disorder' is a broad, heterogeneous neurodevelopmental disorder which is behaviourally defined, with different levels of severity, that encompasses autism, Asperger's syndrome²², and atypical autism. The precise cause is not known, but several different genetic, neurobiological, and environmental factors are thought to be involved (NICE, 2023).

Clinical Knowledge Summaries (CKS) produced by the National Institute for Health and Care Excellence (NICE) (NICE, 2023; NICE, 2024) present the following evidence regarding the prevalence of autism:

²² It should be noted that 'Asperger syndrome' (often shortened to Asperger's) is no longer used as a diagnostic term for autism and is considered controversial due to the history of Hans Asperger: [Asperger syndrome \(Asperger's\)](#)

- Autism spectrum disorder (ASD) is one of the most common childhood-onset neurodevelopmental disorders. In the UK, the estimated prevalence in adults is about 1.1%, with relative consistency across studies
- The proportion of males to females diagnosed with ASD varies across studies but always shows a greater proportion of males to females, mostly ranging from 3:1 to 5:1.
- This gender split is largely thought to be because of females being better at camouflaging their difficulties and ‘fitting in’ with society’s expectations. It is also thought that ASD traits in girls are under-reported and hence under-diagnosed.
- Comparing this estimated prevalence of ASD in adults with that of children (1-2%) suggests that ASD is underdiagnosed among adults.
- Studies of autism in adults have shown that up to 80% of people have experienced a difficulty in obtaining a diagnosis, and many adults will not have received a formal diagnosis.

It is estimated that there are around 700,000 people in the UK, including one in 100 children, with a diagnosis of ASD (autism spectrum disorder), although recent research based on under-diagnosis has estimated there could be more than 1.2 million autistic people in England alone (Brugha, et al., 2012; O’Nions, et al., 2023).

A 2022 [review of published UK and international literature on autism population health needs](#) (NHS Midlands and Lancashire Commissioning Support Unit, 2022) found that:

- Access to mental health services appropriately tailored to autistic peoples’ needs is a major area of concern for both children and young people and adults.
- There are substantial disparities in access to health and care services (particularly for mental health services), and a lack of support after diagnosis.
- Themes around a lack of access to mental healthcare, the ability of mental health services to tailor to autism needs, and a lack of post-diagnostic support services were consistent across published academic and grey literature.
- Several common barriers to access to health and care services (including diagnostic services) were identified, including: sensory sensitivities; communication difficulties; lack of autism knowledge; waiting times.
- Particularly concerning is the considerable burden of mental health conditions faced by autistic people, and high rates of suicide relative to the general population

5.2.1. The autistic population in Birmingham and Solihull

The [Birmingham and Solihull Integrated Care System \(ICS\) Strategic Vision for Autism, 2023 - 2028](#) states that there are approximately 16,020 people across Birmingham and Solihull who have been diagnosed with autism by the NHS, just over half of these are under 18 years old. In addition to this, there will be others who have received a private diagnosis or have not sought a diagnosis (Birmingham and Solihull ICS, 2023).

5.2.2. Experience of mental health services

Nationally, the [2023 CQC community mental health survey](#) reported that groups more likely to report worse experiences across multiple questions were people aged 16-35, autistic people, and people who access services over the telephone (Care Quality Commission, 2025).

Locally, the [Healthwatch Investigation: Community Mental Health Services in South and East Birmingham](#) reported that improvements people wanted to see included improved understanding of mental health by healthcare professionals, including GPs and a better understanding of autism (Healthwatch, 2024).

Focus groups held with children and young people as part of the [Birmingham scrutiny inquiry](#) identified long waits for autism and ADHD diagnoses as a significant issue and the [Healthwatch Investigation Access to mental health services for children and young people in Birmingham](#) identified inadequate support for conditions such as autism within children and young people's mental health services (Birmingham City Council, 2024; Healthwatch, 2021).

Issues with the diagnostic pathway and delays in people receiving an autism diagnosis are a significant issue nationally. The [National Autistic Society](#) reported that as of September 2024, 204,876 people were waiting for an autism assessment in England, according to [NHS data](#). This is a 25% increase in the number of people waiting in just one year, and a 96% increase from this point two years ago (National Autistic Society, 2024).

Guidance from the National Institute for Health and Care Excellence (NICE) states that, no-one should wait longer than 13 weeks. However, NHS data shows that of those waiting for an assessment, 89% (183,200) have been waiting longer than the recommended 13 weeks (NHS Digital, 2024).

Within Birmingham, Healthwatch have undertaken an investigation into the [Experiences of the neurodevelopmental assessment and diagnostic pathway for children and young people in Birmingham](#). Concerns were raised regarding criteria, thresholds and wait times and lack of support following diagnosis (Healthwatch, 2024), the findings of this are discussed in further detail in section 4.2.5 of the children and young people section of this report.

5.2.3. Mental health inpatients

As noted in the section below regarding learning disabilities, there are major challenges with regards to meeting the ambitions of the [Transforming Care programme](#) to reduce the numbers of people in Birmingham and Solihull who have autism or learning disabilities and remain in mental health inpatient care.

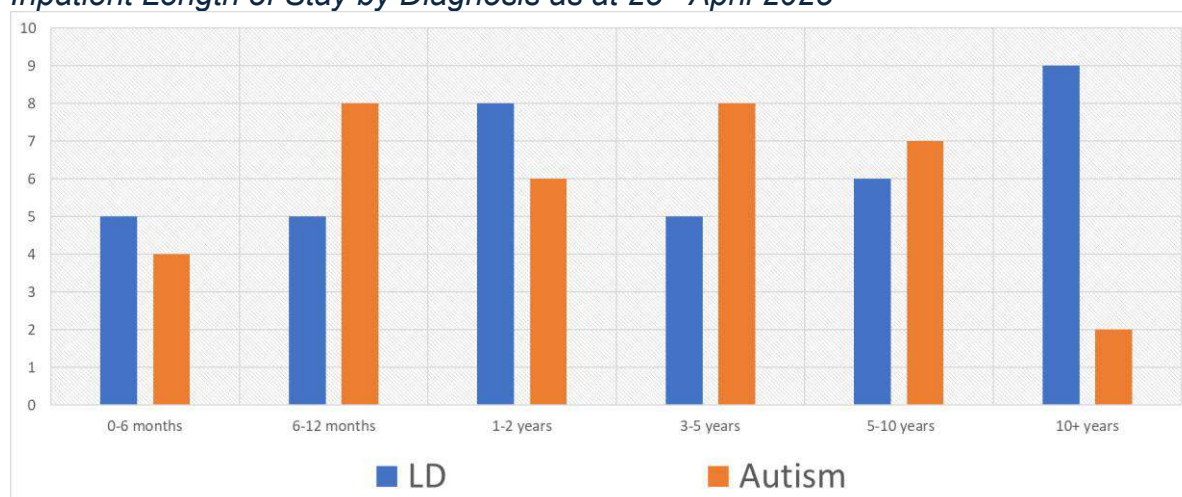
The [National Autistic Society](#) reports that for autistic people who are inpatients in mental health hospitals in England the average length of stay is around 4.9 years (National Autistic Society, 2025), they also cite statistics from the [Assuring](#)

[Transformation NHS Digital data](#) for February 2025 which report that there were 2,055 autistic people and people with a learning disability are in inpatient mental health hospitals in England. It is stated that of these:

- 1,460 (71%) are autistic
- There are 215 under 18s in inpatient units that are autistic or have a learning disability. Of these, 96% are autistic.

A snapshot of the Birmingham and Solihull Learning Disability and Autism inpatient cohort at the end of April 2025 shows that 35 patients are autistic and 38 have learning disabilities, and that out of this cohort 33% had been mental health inpatients for 5 years or longer, see below.

Figure 94 – Birmingham and Solihull Learning Disability and Autism – Mental Health Inpatient Length of Stay by Diagnosis as at 25th April 2025



Source: Learning Disabilities & Autism Current Adult Inpatient Cohort Report, April 2025

5.3. Care experienced children and young people

“Care experienced” is an umbrella term that encompasses children and young people who are currently or have previously been [looked after by the local authority](#). This includes children and young people who have been adopted from local authority care, children and young people who are subject to a [special guardianship order](#) and children currently in foster care or residential care as well as [care leavers](#).

A [2020 evidence summary](#) (Sanders, 2020) produced by [The Institute for Research and Innovation in Social Services \(Iriss\)](#) outlines the mental health difficulties that care experienced children and young people face, these include:

- Care experienced children and young people are approximately four times more likely to have a mental disorder than children living in their birth families.
- Almost half (rising to three quarters in residential homes) meet the criteria for a psychiatric disorder compared to 10% of general population.

- Barnardo's surveyed care leavers and found that 46% were identified as having mental health needs, with 65% of them not receiving any form of statutory support and are between four and five times more likely than their peers to attempt suicide.

Adopted children in the UK can face enduring mental health and behavioural problems. The likelihood of emotional and behavioural problems is increased where the number of adverse childhood experiences is greater (Paine, Fahey, Anthony, & Shelton, 2021). Most adopted children in the UK are taken into care because of maltreatment by their birth parents. They are more likely to have experienced adversity at an early stage of life (including abuse, neglect, and unstable living arrangements) than the general population. Moreover, an evaluation of adopted children accessing therapeutic support via the Adoption Support Fund showed adopted children had *“substantially higher levels of emotional, behavioural and developmental needs than both the general population and looked after children and showed very high levels of predicted psychiatric disorder”* (Department for Education, 2019).

Research undertaken by [What Works for Children's Social Care](#) (now named [Foundations](#)) highlights that care experienced children and young people face compounding vulnerability to their mental health, including their experiences of trauma, transitions between carers and difficulties accessing support (Ott, Wills, & Taylor, 2023). Furthermore with a transition out of care, typically at 18, young people have found that much of the support system changes and often they are no longer eligible for support from young person mental health services, despite research showing a deterioration in mental health in their first year of leaving care (Ott, Wills, & Taylor, 2023).

Research undertaken by the Nuffield Foundation discusses the consistently worse mental health of children in care compared to the general population, the challenges associated with transition to adulthood for care experienced children and young people and recommends that there should be regular 'mental health MOTs' for care leavers throughout their adult lives (Sacker, Murray, Lacey, & Maughan, 2021). The [2022 Independent Review of Children's Social Care](#) also recommends that ongoing mental health support should be part of the lifelong commitment that local authorities make to their community of care experienced adults (MacAlister, 2022). The review includes the following quote from a care experienced young person:

“Whenever a child is at risk of going into care, emergency care, they should automatically see mental health advisers and workers. And that shouldn't stop when you leave care. The trauma of that is like grief. In post-18 there should be a special service for mental health support, where specialists are trained in trauma, and that is open for entrants to care. I have complex PTSD and the best treatment for that is EMDR [Eye Movement Desensitisation and Reprocessing], and that service is not easily accessible. If it was integrated in that mental health services, it would help decrease rates in homelessness and prison and integrate in the community.”

The review also calls for more trauma informed care in line with [the definition of complex trauma set out by UK Trauma Council](#).

5.3.1. Children in care in Birmingham and Solihull

The following charts and figures provide contextual information regarding care experienced children and young people in Birmingham and Solihull. However, these figures do not capture the number of children in care living in Birmingham or Solihull who have been placed by other local authorities. Therefore, the number of care experienced children in Birmingham and Solihull are likely to be higher than indicated below.

Figure 95: Children in care: crude rate per 10,000 population, Birmingham and statistical neighbours, 2023/24

Area	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	-	83,630	70	69	70
Neighbours average	-	-	-	-	-
Derby	7	598	100	92	108
Manchester	5	1,303	100	95	106
Nottingham	2	674	100	92	108
Sandwell	12	812	94	87	100
Leeds	6	1,549	89	85	94
Coventry	1	674	84	78	90
Birmingham	-	2,300	79	76	83
Leicester	3	599	68	62	73
Luton	8	374	62	56	69
Sheffield	4	646	57	52	61
Croydon	14	509	56	51	61
Enfield	11	414	51	47	57
Hillingdon	9	317	43	38	48
Hounslow	15	285	42	37	47
Brent	10	307	42	37	47
Ealing	13	301	37	33	42

Source: [Child and Maternal Health - Data | Fingertips | Department of Health and Social Care](#)

With 79 children in care per 10,000, Birmingham is seventh of 16 statistical neighbours and above the England average for 2023/24.

Figure 96: Children in care: crude rate per 10,000 population, Solihull and statistical neighbours, 2023/24

Area	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	-	83,630	70	69	70
Neighbours average	-	-	-	-	-
Solihull	-	554	114	105	124
Worcestershire	10	1,044	87	82	93
Calderdale	8	363	81	73	89
Warrington	9	354	80	72	89
Bury	6	344	78	70	87
Stockport	2	495	77	71	84
Trafford	3	377	67	61	75
Swindon	11	320	60	54	67
Central Bedfordshire	12	365	54	48	60
Bracknell Forest	4	140	49	41	58
Bromley	5	350	48	43	53
Havering	13	284	46	41	52
Buckinghamshire UA	7	523	41	38	45
Windsor and Maidenhead	1	140	41	34	48
Hertfordshire	14	971	36	33	38
South Gloucestershire	15	214	35	30	40

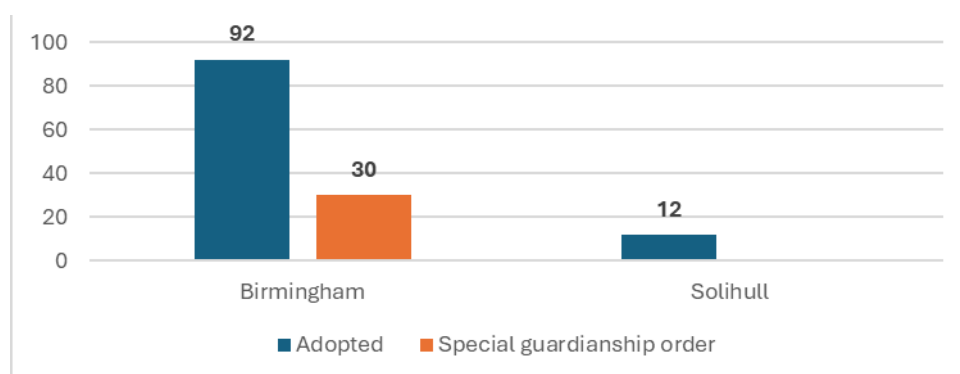
Source: [Child and Maternal Health - Data | Fingertips | Department of Health and Social Care](#)

With 114 children in care per 10,000, Solihull ranks first among its 16 statistical neighbours and is significantly above the England average for 2023/24.

5.3.2. Children adopted from local authority care or subject to Special Guardianship Order

The below chart for the year ending 31st March 2024 shows that 92 children were adopted from local authority care in Birmingham and 12 children were adopted from local authority care in Solihull. In Birmingham, 30 children ceased to be looked after due to special guardianship, the numbers for Solihull have been suppressed due to small volume. However, these numbers do not include children who have been adopted or subject to a Special Guardianship Order (SGO) who have been placed in Birmingham or Solihull by other local authorities. Local authorities have a statutory responsibility to provide assessments of support needs for the first 3 years post adoption / Special Guardianship order. After that, support needs become the responsibility of the local authority in which the child lives.

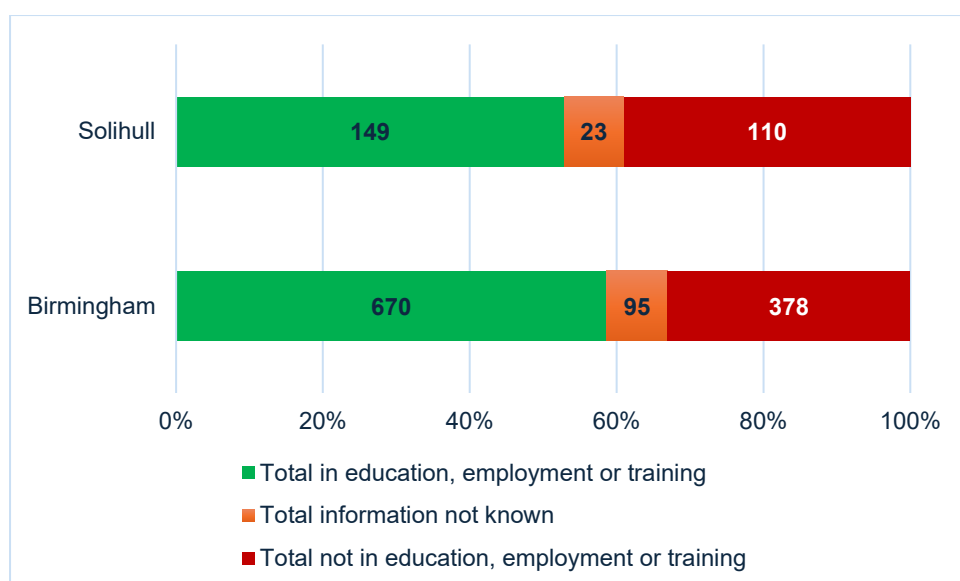
Figure 97 – Children adopted from local authority care and children who became subject to Special Guardianship Order, year ending 31st March 2024



Source: [Statistics: looked-after children - GOV.UK](https://www.gov.uk/statistics/looked-after-children)

5.3.3. Care leavers in education, employment or training

Figure 98 - care leavers aged 17 to 21 years by leaver activity for year ending 31st March 2024



Source: [Statistics: looked-after children - GOV.UK](https://www.gov.uk/statistics/looked-after-children)

For care leavers aged 17 to 21 years, 59% were in education, employment or training in Birmingham and 53% in Solihull.

5.3.4. Emotional wellbeing and mental health support

Dedicated emotional wellbeing mental health support for care experienced children and young people in Birmingham and Solihull includes:

- Emotional wellbeing support for children in care and care leavers via the [Therapeutic Emotional Support Service \(TESS\)](#) at [Birmingham Children’s Trust \(BCT\)](#) for children and young people which BCT hold [corporate parenting](#) responsibility for.

- A specialist team at Forward Thinking Birmingham who provide support to professionals, external agencies and local networks supporting care experienced children and young people.
- A specialist team at SOLAR who provide emotional and mental health support to all Children in Care and Care Leavers up to the age of 19 residing in Solihull.
- Therapeutic support available via the application from local authorities to the national [Adoption and Special Guardianship Support Fund \(ASGSF\)](#).

Further detail regarding each of the above is provided below.

5.3.4.1. Therapeutic and Emotional Support Service (TESS)

[Therapeutic Emotional Support Service \(TESS\)](#) in Birmingham provides emotional wellbeing support for children in care and care leavers under the responsibility of [Birmingham Children's Trust \(BCT\)](#). TESS focuses on early help for children with low to moderate emotional wellbeing needs, using relationship-based and strengths-based approaches. The service collaborates with BCT social workers to build resilience, promote secure attachments, support placement stability, and offer trauma-informed interventions.

The service is for children and young people (0-18 years) on an [Interim Care Order](#), or in local authority care under [Section 20 of the Children Act](#). It also supports care leavers up to the age of 25 and [unaccompanied asylum-seeking children](#) under BCT care. The service is not able to support children who do not fall under the [corporate parenting responsibility](#) of BCT, children on [Special Guardianship Orders \(SGO\)](#) or placed for adoption.

TESS is not a mental health service and does not provide diagnostic or specialist mental health support and therefore not equipped to support children and young people with mental health risks like self-harm and suicidal ideation. TESS is staffed predominantly social workers with additional training. Of the staff, 54% have introductory/intermediate training in therapeutic models (e.g., VIG, DDP, systemic practice) and 38% have formal therapeutic training with professional registration (e.g., BAPT, AFT, BACP), 8% are clinical psychologists.

5.3.4.2. FTB Children in Care and Care Leavers Team

Forward Thinking Birmingham (FTB) Specialist Team for children in care and care leavers consists of 3.2 WTE qualified staff (Clinical Psychology, Nursing, and Occupational Therapy) experienced in complex mental health settings. Their service offer includes:

- **Specialist Trauma-Informed Assessments and Interventions:** Collaborating with FTB teams to bring a trauma-informed and care-experience perspective to assessments, formulations, and intervention planning.

- **Direct Work with Carers:** Supporting foster carers and residential care homes with understanding complex clinical presentations, providing specialist advice, and assisting with safety planning and mental health risk management.
- **Carer Support Groups:** Running regular groups to help carers understand the impact of early life trauma and better support their young people.
- **Network Collaboration:** Working with various networks to support assessments, presenting to Urgent Care teams, and attending network meetings to offer a specialist mental health perspective.
- **Training and Development:** Leading trauma competency development across the mental health division of Birmingham Women's and Children's NHS Foundation Trust, providing regular training and case discussions.
- **Consultations:** Offering regular consultations to multi-agency partners, including Children in Care nurses, unaccompanied asylum seeking children (UASC) nurses, paediatricians, BCT colleagues, and residential care home staff for a coordinated approach to care.

5.3.4.3. SOLAR – LATCH

The focus of the Looked After Children's Team for Children's Health (LATCH) team is providing mental health and emotional wellbeing care, to children who are looked after in Solihull. The service offer in Solihull is currently under review at the time of writing but the below provides examples of the type of support currently provided by the LATCH team:

- Attachment training to foster carers
- DDP ([Dyadic Developmental Psychotherapy](#)) informed therapy
- Support to solar practitioners working with children who are looked after
- [Eye movement desensitisation and reprocessing](#) (EMDR)
- Counselling and psychological support
- Consultation to social workers and professional networks supporting young people who are looked after

5.3.4.4. The Adoption and Special Guardianship Support Fund (ASGSF)

The ASGSF provides funding for therapeutic support in England for adopted children and those with Special Guardianship (SGO) or Child Arrangement Orders. Local authorities apply to the Fund based on assessments showing a child's need for therapeutic support.

Key Findings from a 3-Year Evaluation:

Findings from a 3 year evaluation of the ASGSF (Department for Education, 2022) identified the following:

- **Children's Mental Health:** Children aged 5-15 receiving ASF-funded support had significantly greater mental health needs compared to the general population.

- **Parent and Carer Wellbeing:** Emotional health and wellbeing of parents and carers were significantly worse at the point of accessing ASF support than the overall adult population.
- **Improvement in Mental Health:** School-aged children showed small but statistically significant improvements in mental health difficulties after receiving ASF-funded support.
- **Longitudinal Survey:** Children with higher-level difficulties at the start tended to worsen, while those with lower-level difficulties improved over the study period.
- **Complex Needs:** Some interviewees felt their child's needs were too complex for the level of support provided by the ASF.

Adopt Birmingham supports families to access FTB when needs exceed what ASGSF can provide. A 2020 audit showed 32% of referrals to FTB resulted in no service, highlighting the need for improved care pathways.

Changes to the ASGSF for 2025/26 include:

- **Funding Limits:** The annual therapy cost limit is reduced from £5,000 to £3,000.
- **Match Funding:** ASGSF will no longer match fund more expensive support packages.
- **Assessment Allowance:** The separate £2,500 allowance for specialist assessments is removed; assessments must be funded within the £3,000 limit.
- **Completion Deadline:** All therapy packages or assessments funded in 2025-26 must be completed by 31 March 2026.

5.3.5. Possible gaps in provision and pathways

There are potential gaps in accessibility to timely and responsive mental health support for care experienced children and young people who:

- Present risks which exceed the scope of the TESS service and for which timely access to alternative mental health support is not available.
- Have needs that are too complex for the level of support that can be provided by the ASGSF but who do not meet criteria or thresholds for support from Forward Thinking Birmingham or SOLAR.

5.4. Carers

A carer, [as defined in NHS guidance](#), is anyone, including children and adults who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid.

5.4.1. The mental health of carers

A variety of published research consistently shows a strong link between caring responsibilities and negative impacts on mental health. This includes carers being

significantly more likely to experience mental health problems such as emotional stress, depressive symptoms, or clinical depression compared to the general population (Shah, Wadoo, & Latoo, 2010). [Research by Carers UK](#) highlights the adverse impact of caring responsibilities on the mental health of carers and that those experiencing financial difficulties reported worse mental health (Carers UK, 2023). Key findings from the Carers UK national survey include:

- 27% of carers said their mental health was bad or very bad.
- Carers who were struggling to make ends meet were much more likely to say their mental health was bad or very bad (45%).
- 88% of carers whose mental health was bad or very bad said they were experiencing increased tiredness, and 87% said they were having difficulty sleeping.
- 84% of carers whose mental health was bad or very bad said they had continuous low mood, 82% had feelings of hopelessness and 71% regularly felt tearful.
- Over a third of carers (36%) whose mental health was bad or very bad said they had thoughts related to self-harm or suicide.
- 39% of carers whose mental health was bad or very bad said they were not receiving any support with their mental health, with the most commonly reported barrier for this group being too busy caring (50%).
- Nearly three quarters (73%) of carers whose mental health was bad or very bad said that they continued providing care even though they felt they were at breaking point.

Recent research has also highlighted that ‘sandwich carers’ who are simultaneously caring for children and older family members suffer from deterioration in both their mental and physical health over time, especially for those who spent more than 20 hours per week caring for a family member (Xue, Lacey, Gessa, & McMunn, 2024).

Those caring for people with mental illnesses face a well-documented set of challenges; these include increased risk of suffering physically, psychologically and socially as well as social isolation, financial difficulties and occupational restrictions. They also may experience negative emotions such as anger, aggression, frustration, low self-esteem, constant worry and feelings of helplessness (Phillips, Durkin, Engward, Cable, & Iancu, 2023).

Parents and carers of young people with mental health needs have a key role in supporting young people through both crisis and recovery. However, they are often in distress themselves, feel isolated, and struggle to be heard by the mental health system. There is generally a lack of support for parents and carers in the current child and adolescent mental health system (Association for Young People's Health, 2021).

Research has consistently shown that children and young people who are caring for parents with mental illness are a hidden and vulnerable group and face adverse outcomes in terms of their own physical and mental health, educational attainment, social network and transition into adulthood (Blake-Holmes & Cook, 2024). Studies from several countries have found that children of parents with a mental illness were at a greater risk of poorer outcomes than their peers, with higher rates of mental illness and poorer development in behavioural, and academic domains (Dharampal & Ani, 2019).

Research published in the [International Journal of Caring and Care](#), has shown 28% of adolescent young carers in the UK think about self-harming. Furthermore, 56% of young carers surveyed in the UK reported that their health had deteriorated as a result of their caring responsibilities (Lewis, et al., 2022). It has also been argued that younger carers can sometimes overcome the effects of extreme adversity with information, recognition of their role, and inclusion in their parent's treatment plan (Dharampal & Ani, 2019).

Whilst caregiving can have a negative impact on the physical and mental wellbeing of the carer, specific sociodemographic, personal and situational factors can work as a buffer and support tailored to individual needs, taking into consideration personality, particular circumstances, along with cultural and personal beliefs can balance the negative effects of caregiving (Phillips, Durkin, Engward, Cable, & Iancu, 2023).

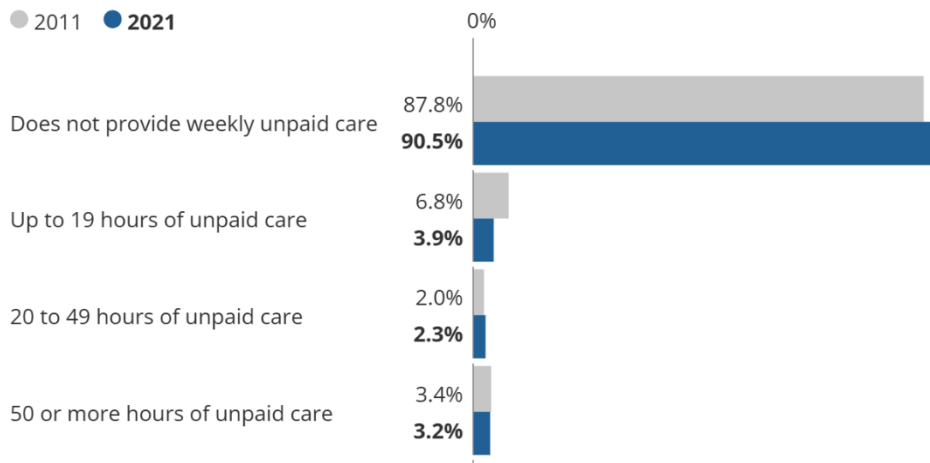
5.4.2. Carers in Birmingham

Comparing findings from the 2011 and 2021 census shows that the proportion of the population both in Birmingham and Solihull providing weekly unpaid care decreased. However, the 2021 census was undertaken during the coronavirus (COVID-19) pandemic. This may have influenced how people perceived and managed their provision of unpaid care and therefore may have affected how people chose to respond. Caution should also be taken when making comparisons between 2011 and 2021 because of changes in question wording and response options.

The proportion of Birmingham residents provided unpaid care are shown in the chart below.

Figure 99: Hours per week of unpaid care provision by usual residents of Birmingham

Age-standardised proportion of usual residents (aged five years and over) by hours per week of unpaid care provision, **Birmingham**



Source: Office for National Statistics – 2011 Census and Census 2021

Source: [How life has changed in Birmingham: Census 2021](#)

The above chart shows that:

- In 2021, 3.9% of Birmingham residents (aged five years and over) reported providing up to 19 hours of unpaid care each week. This figure decreased from 6.8% in 2011.
- In 2021, just under 1 in 40 people (2.3%) reported providing between 20 and 49 hours of unpaid care each week, compared with 2.0% in 2011.
- The proportion of Birmingham residents (aged five years and over) that provided at least 50 hours of weekly unpaid care decreased from 3.4% to 3.2%.

Information provided by Forward Carers in Birmingham and within the [Birmingham Carers Partnership Strategy, 2024-2029](#) shows that:

- There are approximately 91,500 carers in Birmingham, of which 27,192 have registered with [Birmingham Carers Hub](#).
- A third of carers in Birmingham provide more than 50 hours of care per week
- Of these registered carers, 32% report health conditions with mental illness being the second most common health issue, with around 6% of carers reporting their own mental illness.
- Women are more likely to be carers than men and 50% of male carers are aged 75 years and above.
- 30% of carers in Birmingham are aged 50-64 years and this is the peak age for caring nationally.

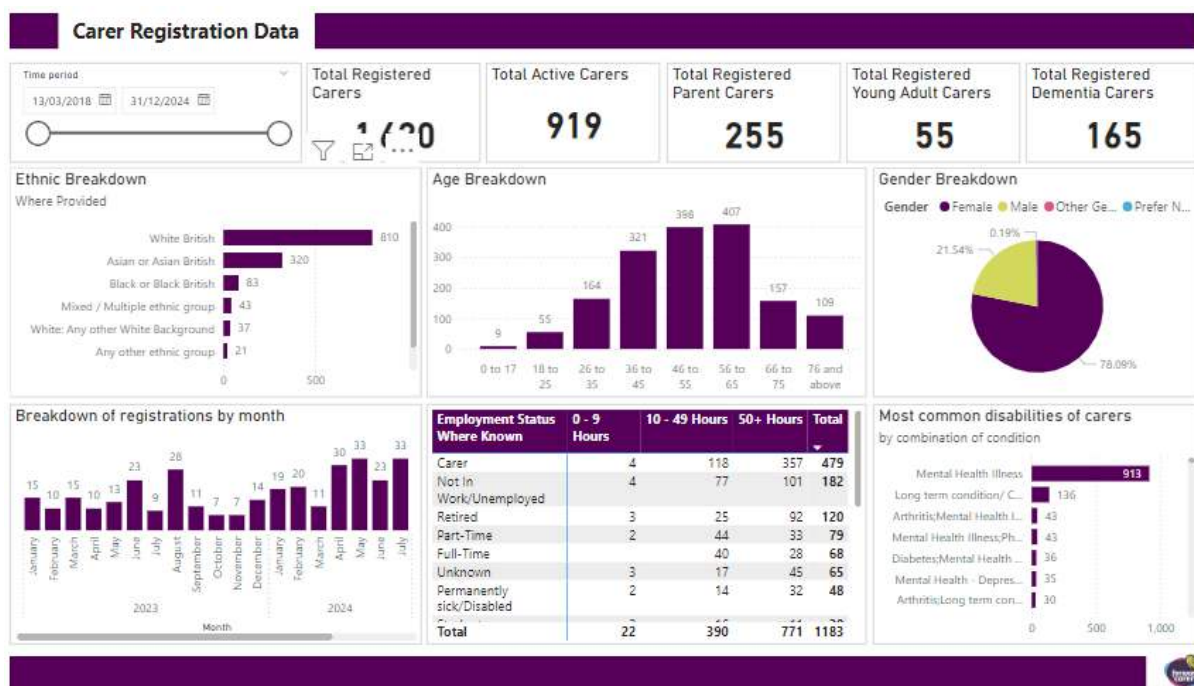
Although 6% of registered Birmingham carers have recorded themselves as having

mental health issues this is likely an under-representation as feedback from focus groups run by Forward Carers has indicated:

- Some carers believe that they need to have a diagnosed or recognised mental health issue to flag concerns in relation to their mental health.
- Some carers are concerned that reporting challenges with their mental health may lead to a perception that they are unfit to carry out their caring role.

The below image provides a breakdown of the ethnicity, gender, age ranges and employment status of carers who report mental health issues and are registered with Birmingham Carers Hub:

Figure 100: Carer Registration Data held by Forward Carers



Source: Forward Carers data dashboard

The below responses taken from a recent survey by Forward Carers show feedback given by carers regarding their emotional wellbeing and mental health:

“Due to self-neglect my physical and mental health have declined. My focus has been on my cared for person. I don’t want to let them down.”

“I worry about the future for my mother as her mental faculties worsen and she needs more support, especially the financial implications.”

“The stress and anxiety of caring has made me attempt suicide. I have no support and fear how am I going to get better.”

“More support is needed for carers who themselves have complex needs like mental health issues or language barriers. Support needs to be in person and physical such

as helping complete forms and helping move forward in one way or another. There are forums and other types of group sessions available for Carers but how are Carers with complex needs as mentioned above able to attend these forums?"

"I appreciate the services offered by Birmingham Carers Hub, and some activities, like therapy and yoga, have been helpful in reducing stress. However, there are gaps in support that make it challenging to address my most urgent needs."

In addition to the above, the [Personal Social Services Survey of Adult Carers in England, 2023-24](#) found that 25% of carers in Birmingham were caring for someone with a mental health problem, and 46% caring for someone with dementia. It also found that as a result of caring:

- 80% of carers reported feeling tired
- 65% of carers reported feeling stressed
- 65% of carers reported disturbed sleep
- 50% of carers reported feeling depressed
- 44% of carers reported feeling short tempered / irritable

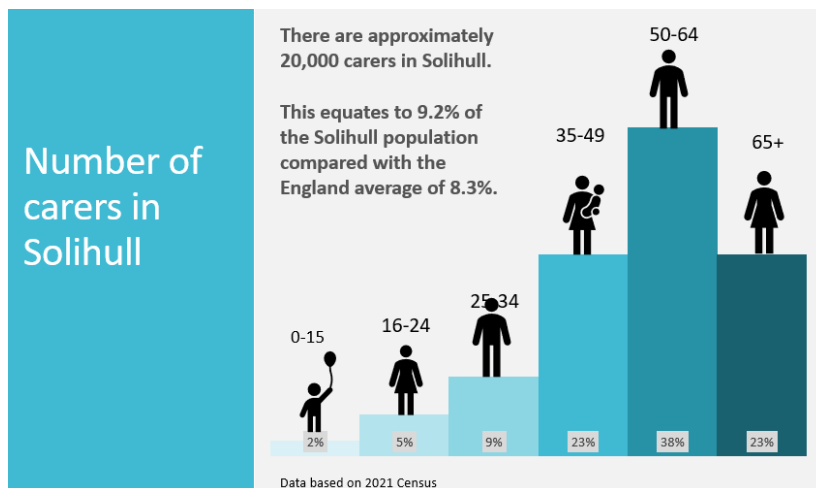
Birmingham Carers Hub also recently engaged with delivery partners regarding their perceptions of the impacts of caring on the mental health of carers, the below quote from one of the partners illustrates the challenges that carers can often face with their emotional wellbeing and mental health:

"We often speak to carers at risk of carer burn out, depression, lacking a sense of moving on in life and being stuck in a rut. Many of which cannot leave the cared-for so they do not get any time out nor do they get adequate support from social services, family or friends to allow them some time for themselves. "

5.4.3. Carers in Solihull

The draft 2025 update to the [Solihull Carers Strategy 2022-2027](#) reports that there are approximately 20,000 carers in Solihull with a higher proportion of the population having a caring role than the national average (9.2% compared to the England average of 8.3%). When looking at the age ranges of those providing care those aged 50-64 years represent the biggest group with 38% of carers in Solihull belonging to this age range, see figure 106 below.

Figure 101: Number of carers in Solihull



Source: Draft 2025 update to the Solihull Carers Strategy, 2022-27

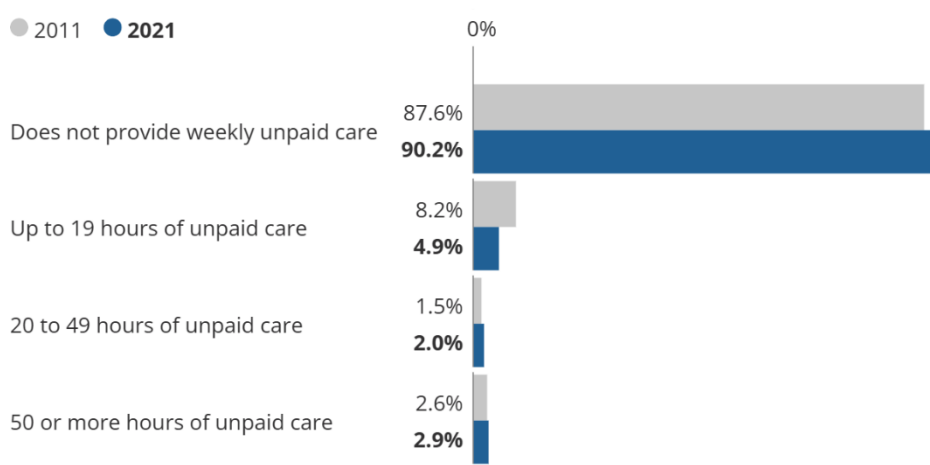
Other points of note regarding the profile of carers in Solihull include:

- A higher proportion of women are carers, with 60% of carers being women and 40% being men.
- 26% of carers in Solihull aged 5 years and older are disabled under the Equality Act compared to 17% of the population who are not carers.
- 26% of carers in Solihull report that they are not in good health.
- A disproportionate number of carers providing more than 50 hours of care a week live in the most deprived areas of Solihull.
- Fewer people from ethnic minorities report themselves as carers (7%) compared to the general population in Solihull (10%). This may be due to under-reporting and has been identified as an area for further enquiry.

Comparing findings from the 2011 census with the 2021 census shows a decline in the proportion of people in Solihull providing unpaid care in line with regional trends, see figure 102 below.

Figure 102: Hours per week of unpaid care provision by usual residents of Solihull

Age-standardised proportion of usual residents (aged five years and over) by hours per week of unpaid care provision, **Solihull**



Source: Office for National Statistics – 2011 Census and Census 2021

Source: [How life has changed in Solihull: Census 2021](#)

In relation to changes in the proportion of people providing unpaid care in Solihull:

- Solihull saw the West Midlands' joint second-largest percentage-point fall (alongside [Stratford-on-Avon](#) and [Wychavon](#)) in the proportion of people (aged five years and over) providing up to 19 hours of weekly unpaid care (from 8.2% in 2011 to 4.9% in 2021).
- Across the region, only [Malvern Hills](#) saw a greater fall in the proportion of people (aged five years and over) providing up to 19 hours of weekly unpaid care (from 8.7% to 5.1%).
- Every local authority area across the West Midlands saw a fall in the proportion of people (aged five years and over) providing up to 19 hours of weekly unpaid care, as the regional proportion fell from 7.4% to 4.5%.

The [Personal Social Services Survey of Adult Carers in England, 2023-24](#) found that 28% of carers in Solihull were caring for someone with a mental health problem, and 35% caring for someone with dementia. It also found that as a result of caring:

- 81% of carers reported feeling tired
- 67% of carers reported feeling stressed
- 66% of carers reported disturbed sleep
- 47% of carers reported feeling depressed
- 46% of carers reported feeling short tempered / irritable

It is projected that the Solihull population aged 65+ who will need help with a domestic task will increase by 27% from around 13,700 to 17,300 between 2020 and 2040. Similar increases in a range of needs are projected including a 39% rise in the

number suffering from dementia from 3,444 to 4,777. This is likely to mean there will be many older carers, who are likely to have their own health issues.

For younger and parent carers, people with learning disabilities and physical disabilities are now living longer, thanks to advances in health care, therefore it is expected that the number of young and parent carers will increase in line with the population. It is also expected that there will be an increase due to improved awareness and more parents identifying themselves as carers.

5.4.4. Mental health support for carers in Birmingham and Solihull

Support for carers in Birmingham delivered by Birmingham Carers Hub includes:

- Support from the RESET Health Group - a 12-week mixed therapeutic, somatic and movement programme for Carers experiencing poor wellbeing - <https://theresethealthgroup.com/carers>
- Access to specialist counselling support, such as for bereaved Carers or those supporting someone with an acquired brain injury.
- A range of mindfulness, relaxation and yoga sessions.
- Support to carers experiencing financial difficulties to maximise their welfare entitlements
- Peer support groups for those experiencing loneliness and isolation.

Support for carers in Solihull is delivered by [Carers Trust Solihull](#) which includes peer support and bereavement support with referral pathways to NHS Talking Therapies and secondary mental health services.

5.5. Domestic abuse

5.5.1. Prevalence of domestic abuse in Birmingham and Solihull

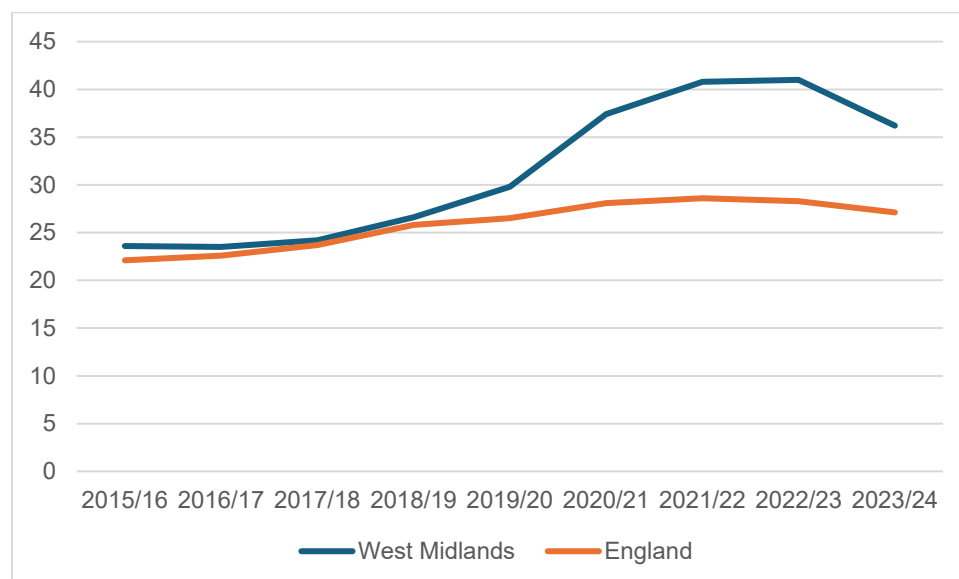
Domestic abuse often goes unreported because of stigma, shame, fear, and other factors, including doubts about whether reporting will enhance the victim's safety. As a result, domestic abuse is often concealed and challenging to measure accurately.

Women consulted as part of the [domestic abuse needs assessment completed in Birmingham in 2022](#) who came from Asian, Black and marginalised ethnic groups (and particularly Black women), reported fears about calling the Police. They expressed mistrust in how they and their partner/ex-partner would be dealt with by the Police. The potential effect being that a perceived fear of racism may prevent the reporting of domestic abuse to the Police in some communities (Birmingham Voluntary Sector Council, 2022).

Data from the fingertips public health profile on the domestic abuse related incidents and crimes recorded by the police per 1,000 population for the years 2015/16 to

2023/24 shows that the rate in the West Midlands increased sharply in 2020/21 financial year and has remained above the national average since with a rate of 36.2 per 1,000 in 2023/24 (see figure 103 below).

Figure 103: Domestic abuse related incidents and crimes recorded by the police per 1,000 population



Source: [Fingertips | Department of Health and Social Care](#)

5.5.2. Domestic abuse and mental health

Needs assessments relating to domestic abuse were completed separately in [Birmingham in 2022](#) and [Solihull in 2021](#) (Birmingham Voluntary Sector Council, 2022; Solihull Metropolitan Borough Council, 2021). The following research findings were presented in the Solihull needs assessment regarding mental health:

- Women subjected to domestic abuse are more likely to experience a mental health problem, while women with mental health problems are more likely to be domestically abused, with 30- 60% of women with a mental health problem having been subjected to domestic violence.
- Domestic violence is associated with depression, anxiety, [Post-Traumatic Stress Disorder \(PTSD\)](#) and substance abuse in the general population.
- Exposure to domestic violence has a significant impact on children's mental health. Many studies have found strong links with poorer educational outcomes and higher levels of mental health problems.
- Mental ill health is also a risk factor for abuse perpetration.

Key findings from these needs assessments which are specific to Birmingham and Solihull are summarised in the below table.

Birmingham	Solihull
<p>A survey of survivors of domestic abuse identifies lack of support for the mental health of children who are adversely impacted by domestic abuse.</p> <p>More broadly, long wait times and difficulties accessing counselling are identified as an area of challenge. The report identifies additional access to counselling and trauma informed support would support better outcomes for those adversely affected by domestic abuse.</p>	<p>The mental health and emotional wellbeing needs of domestic abuse victims (adults and children) were frequently cited as a cause for concern amongst practitioners who were interviewed.</p> <p>Reports from practitioners frequently referred to the waiting times to get women and children with complex mental health needs seen by mental health services. This is referred to in the Pathfinder Project, which recommends that “victims have priority and timely access to specialist mental health support services, which are adequately and consistently funded”.</p> <p>The needs assessment recommends the pathway for domestic abuse victims into mental health services should be reviewed.</p>

5.6. Ethnic minority groups

5.6.1. Ethnic minorities and mental health

Ethnic inequalities in mental healthcare in the United Kingdom are well documented, this includes under-representation of ethnic minority groups in primary care mental health service provision and over-representation in crisis pathways and detention (Race Equality Foundation, 2020; Bansal, et al., 2022).

Birmingham City Council have produced a suite of [community health profiles](#) which include information in relation to ethnic groups and mental health based on desktop analysis of published evidence, grey literature and population survey data. Building on these profiles a set of deep engagement partners have been selected who will undertake engagement with local communities in Birmingham to bring insight regarding their experiences, needs and perspectives in relation to emotional wellbeing and mental health. Whilst this work is ongoing at the time of writing, some emerging findings from this work are included in the discussion below.

Additionally, engagement sessions with communities of focus for the health inequalities strand of the community transformation programme (described in brief below) has also generated insights regarding community perspectives on mental health needs, barriers to accessing support and type and nature of mental health support needed in future. This is also included in the discussion below.

5.6.2. Community transformation engagement sessions

The health inequalities workstream of the Birmingham and Solihull community transformation programme is working with a variety of communities of focus to explore opportunities to:

- Co-commission and co-design culturally tailored services.
- Invest in grassroots organisations who can be responsive to the needs of local communities.
- Recruit peer support and lived experience roles from communities and provide support, training and fair remuneration.

Communities were identified based on groups that are under-represented within community provision and / or over-represented within crisis and urgent care pathways and this included the following ethnic minority groups: Black African and Black Caribbean, Chinese, Gypsy, Roma and Traveller and South Asian. As part of the workstream engagement sessions have been held with members of these communities and feedback from these sessions is included within the below summary.

5.6.3. South Asian population

5.6.3.1. Community Health Profiles

The [Pakistani community health profile report](#) references a published study on migration, ethnicity and mental health which used outcome data for over 10,000 women at 9-months and over 8,000 women at 5-years after migration. Compared with White British women, Indian and Pakistani women had a two-fold increase in odds of distress. At the 5-year mark compared with White British women, odds of psychological distress remained statistically significantly increased for Indian women and Pakistani women (Moore, Jayaweera, Redshaw, & Quigley).

The [Bangladeshi community health profile](#) references evidence that Bangladeshis cite biological factors less frequently as causes for mental illness, and social causes more frequently than White British (such as interpersonal problems, stress, and negative childhood events). Bangladeshis also cited supernatural causes more frequently and either wanted alternative forms of treatment such as religious activities or no treatment at all (McCabe & Priebe, 2004).

5.6.3.2. South Asian community health inequalities focus groups

A focus group with members of the South Asian community in Birmingham as part of

the community transformation health inequalities workstream identified the following themes:

Theme	Points of note
Barriers to accessing mental health support	<p>Identified barriers to accessing support were:</p> <ul style="list-style-type: none"> • Language barriers. • Cultural stigma in the community and wider family. • Lack of understanding of mental health and its connection to poor physical health. • Previous negative experiences of accessing support • Not knowing where to go to for help when GP appointments are not available for up to 2-3 weeks.
Experiences of accessing mental health support	<p>Key points identified were:</p> <ul style="list-style-type: none"> • There is a lack of continuity in the medical/clinical team providing support. • Medication is not always reviewed in a timely manner. • Grassroots organisations provide support and help to explain the processes in community languages. •
Identified gaps in provision, pathways or unmet needs	<p>The following key points were highlighted:</p> <ul style="list-style-type: none"> • More information is required on mental health, such as what are the signs and symptoms of mental ill health? Is there provision which can provide support before a GP is needed to make a referral? • Support is required to better understand the education system and where to go to for help where there are worries and concerns about children's mental health. • It was identified that the following resources / support would be valuable: <ul style="list-style-type: none"> ○ Befriending service to tackle feelings of isolation or loneliness ○ Safe spaces to talk where the community can drop-in without appointments
Initiatives / plans to improve access, experience and outcomes of mental health service provision	<p>Proposed initiatives include:</p> <ul style="list-style-type: none"> • Setting up safe spaces for people to come together to share experiences, offering support to help identify what else can be offered in community. • Working with community mental health teams and neighbourhood mental health teams to identify spaces in community to hold clinical appointments, it is hoped that is will foster a positive working relationship and lead to possible MH drop-in clinics for low level support. •

Theme	Points of note
Initiatives / plans to improve access, experience and outcomes of mental health service provision (continued)	<ul style="list-style-type: none"> • Facilitating the partnership between grassroots organisations to ensure a wider and more accessible offer across communities. • Identification of Peer Support workers – there are several organisations who have community volunteers, it would be beneficial to support the setting up of a more robust infrastructure to utilise the skills of the community volunteers.

5.6.3.3. *Perspectives of Muslim women in Birmingham*

A focus group with Muslim women in Birmingham regarding emotional wellbeing and mental health took place during February 2025 led by [Ashiana Community Project](#) with funding from Birmingham City Council. Key findings are summarised below:

Theme	Points of note
Mental health challenges	<ul style="list-style-type: none"> • Depression and Anxiety: Exacerbated by societal pressures, family expectations, and lack of emotional support. • Cultural Stigma and Shame: Fear of judgment prevents seeking professional help. • Gender Expectations and Workload: Burden of managing household responsibilities, child-rearing, and work. • Childhood Trauma: Contributes to long-term mental health struggles. • Domestic Abuse: Both physical and emotional abuse are prevalent. • Lack of Support and Resources: Limited culturally appropriate mental health services. • Pressure from Family, Culture, and Religion: Impacts self-esteem. • Isolation and Lack of Confidence: Especially among immigrant women. • Mental Health Issues from Difficult Pregnancies and Miscarriages: A recurrent theme.
Coping strategies	<ul style="list-style-type: none"> • Faith and Prayer: Important remedies. • Physical Activities: Walking, gardening, exercising. • Self-Care Activities: Bathing, dressing up, maintaining a clean space. • Keeping Busy: Engaging in tasks that provide a sense of control. • Music and Creative Outlets: Listening to music, arts, writing. • Physical Touch and Emotional Connection: Seeking comfort through close relationships.

Theme	Points of note
Coping strategies (continued)	<ul style="list-style-type: none"> • Seeking Professional Help: Consulting GPs or mental health professionals. • Family and Social Support: Relying on family and friends. • Technology: Video calls and social media.
Experience of mental health services	<ul style="list-style-type: none"> • Lack of Awareness: Unawareness of where to seek help. • Negative Experiences with NHS Services: Mixed reviews, some find services uncaring. • Language Barriers: Difficulty in being understood. • Limited Services Integrating Islam and Mental Health Support.
Recommendations	<ul style="list-style-type: none"> • Increase Mental Health Awareness & Reduce Stigma: Workshops and faith-based counselling. • Create Safe Spaces for Support: Support groups and online platforms. • Improve Access to Mental Health Services: Train culturally competent therapists and offer community clinics. • Address Gender Expectations & Domestic Pressures: Educate families on shared responsibilities and promote self-care. • Tackle Domestic Abuse: Awareness campaigns and confidential support networks. • Address Body Shaming & Societal Pressures: Promote body positivity and challenge unrealistic beauty standards. • Break Generational Patterns: Parenting classes and empower the younger generation. • Provide More Social Support & Reduce Isolation: Mentorship programs and inclusive social events.

5.6.3.4. **The Pakistani report**

The [Pakistani report](#) identifies issues of cultural taboo in relation to mental health in the Pakistani community in Birmingham as well as variable levels of understanding in relation to recognising, responding and appropriately signposting for mental health needs (Birmingham Pakistani Report, 2023). It includes the following quotes from Theiba Khan - Lead Clinical Educator/ Team Manager at Birmingham and Solihull Mental Health NHS Foundation Trust:

“Diabetes is fine: acceptable. We accept it because it is a physical condition.”
“But when it comes to the mind, [one typical response is] how can you have a mental health condition? It is because you are not close to your Creator.”

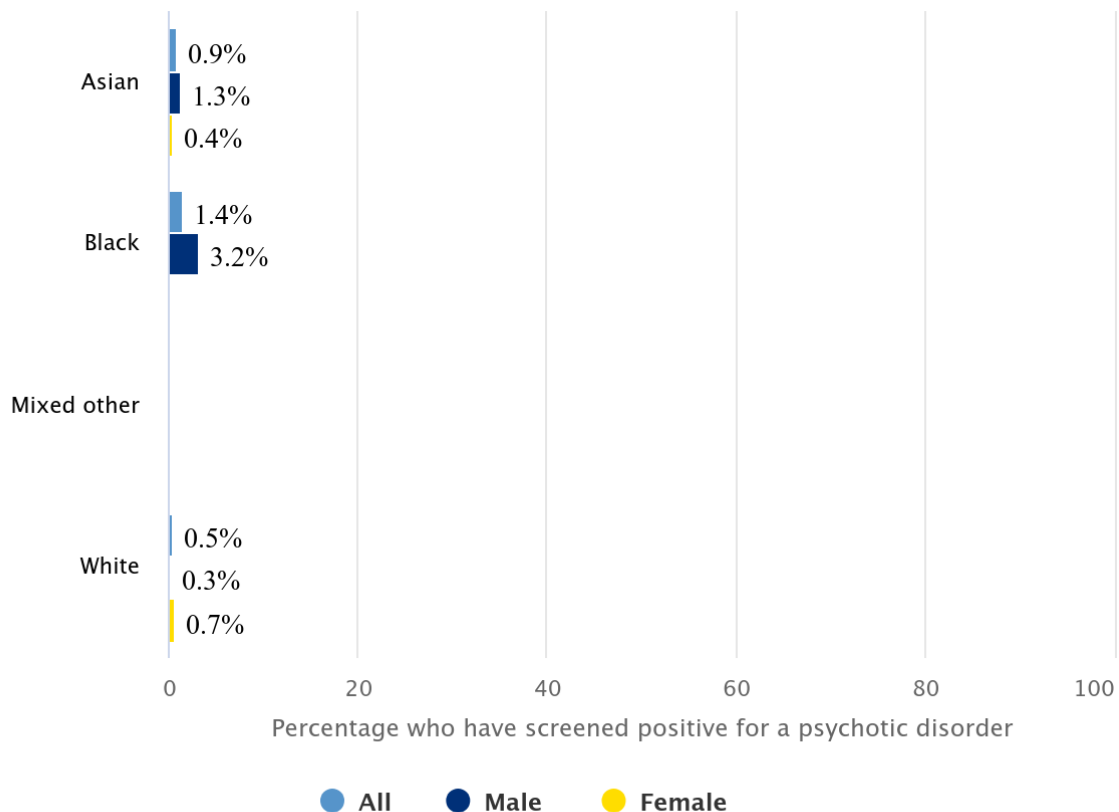
“Spiritual support has always been there, and actually the understanding of mental health issues has got better. Where there are gaps is the local mosques, which are small...those local mosques may not have the resources to deal with mental health issues, but they need mental health awareness,

and they can then signpost to the bigger mosques for support”.

5.6.4. Black African and Black Caribbean population

The [Caribbean community health profile](#) identifies that there is an elevated risk of psychosis for the Black African and Black Caribbean population. It states that the increased risk is of the order of five to twelve times greater than for White people. Data from the adult psychiatric morbidity survey from 2007 and 2014 shows higher rates of psychotic disorder among people of Black ethnicity when compared to White and Asian ethnic groups (see figure 104 below). More up to date information will be forthcoming when chapter 12 on psychotic disorder of the Adult Psychiatric Morbidity Survey 2023/24 is published later this year.

Figure 104: Percentage of people aged 16 and over who screened positive for a psychotic disorder in the past year by ethnicity and sex, England, 2007 and 2014 (combined)



Source: [Psychotic disorders - GOV.UK Ethnicity facts and figures](#)

Additionally, as detailed elsewhere in this report, in the year to March 2023, Black people were 3.5 times as likely as white people to be detained under the Mental Health Act – 228 detentions for every 100,000 black people, compared with 64 for every 100,000 White people (NHS Digital, 2024). Detention under the Mental Health Act is discussed in further detail in section 3.5.

5.6.4.1. BLACHIR

The [Birmingham and Lewisham African and Caribbean Health Inequalities Review \(BLACHIR\)](#) describes how stigma, shame and cultural factors and lack of cultural awareness and understanding from mental health services provide barriers to people accessing and receiving the support they need (Birmingham City Council; Lewisham Council, 2022).

The BLACHIR report includes the following quotes from members of the community:

“There are still strong religious connections and thoughts about mental health and these needs changing and tackling as does the perception [of mental health] within the community and shame in the family.”

“Racism, stigma and culture play a role in the way our communities view mental health services. Sometimes, they cause more harm than good.”

“There is a lack of or limited understanding of cultural needs and backgrounds with different Black communities. Health professionals must develop better cultural understanding in mental health services when caring for Black African and Black Caribbean patients.”

5.6.4.2. Representation within SMI and Crisis Services

Data on the ethnicity of people accessing services for severe mental illness²³ and crisis services²⁴ in Birmingham and Solihull shows that:

- The Black Caribbean, Mixed – White and Black Caribbean and Black African ethnic groups all have higher than average rates of accessing services for Severe Mental Illness in Birmingham and Solihull, see figure 105 below.
- The Mixed – White and Black Caribbean, Black Caribbean and Black Other ethnic groups have higher than average rates of accessing crisis services, see figure 105 below.

Additionally, the rates of prescribing of anti-psychotic medication discussed in section 3.3.4 shows that the Black Caribbean ethnic group has the second highest rate of being prescribed anti-psychotics after the White Irish population with a higher-than-average rate for the Black Caribbean population in Birmingham and Solihull.

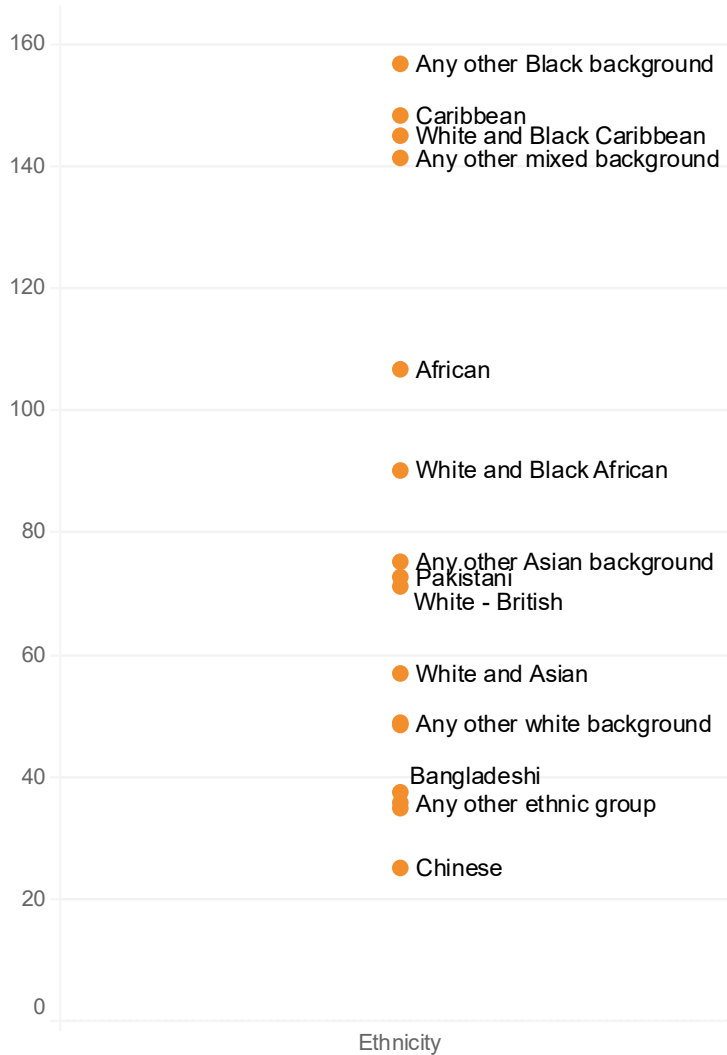
²³ This includes Assertive Outreach, Community Rehabilitation, Early Intervention in Psychosis, Personality Disorder Service, Individual Placement and Support Services

²⁴ This covers a variety of services including Crisis Resolution and Home Treatment, Psychiatric Liaison, Psychiatric Decisions Unit, Crisis Cafes, the Crisis House and the Health Based Place of Safety

Figure 105: Ethnic groups accessing SMI services, rate per 100,000, March 2024 to February 2025

Patients in Severe Mental Illness Services, BSOL

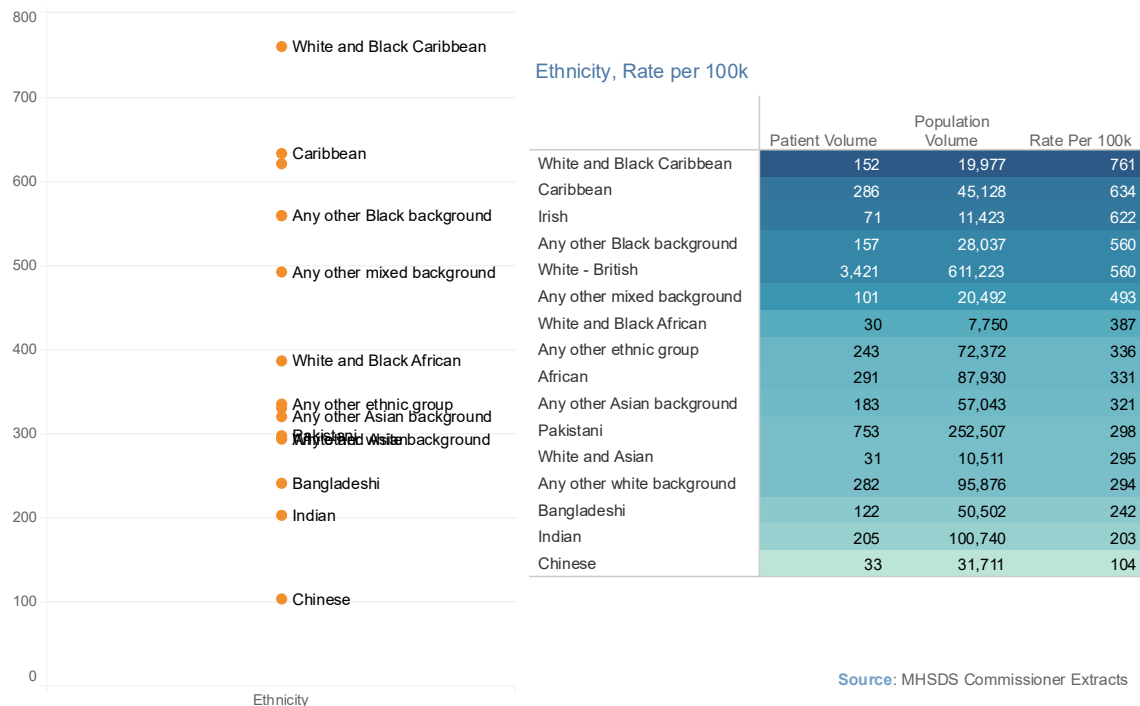
Demographic Equalities, Rate per 100k



Source: Produced by Business Intelligence, Midlands and Lancashire CSU using MHSDS commissioner extracts

Figure 106: Ethnic groups accessing Crisis services, rate per 100,000, March 2024 to February 2025

Patients in Crisis Services, BSOL
Demographic Equalities, Rate per 100k



Source: MHSDS Commissioner Extracts

Source: Business Intelligence, Midlands and Lancashire CSU

5.6.4.3. Experiences of the Somali community

A Healthwatch investigation into [Somali people's experiences of health and social care services in Birmingham](#) highlights distrust and detachment from health and social care services within the community, the negative impact of stigma and the opportunities for health services to link up with organisations that are connected to the community (Healthwatch, 2020).

The following issues are highlighted with regards to distrust and detachment:

- lack of dignity and respect
- poor diagnosis and referral to specialist treatment
- cultural and language difficulties
- stigma and discrimination

In relation to mental health the following quote from a member of the community is included within the report:

“There is the issue of mental health in the Somali community. They do not address it or treat it. The Somali family would rather keep the mental health issue within the family and it gets bigger and bigger. There is a stigma attached to mental health in the Somali community. There is something that healthcare can do to support the Somali community with mental health issues.

At the moment there is a mental health Somali organisation in Birmingham led by a certified psychotherapist and it would be useful for healthcare to link up with such organisation that are led by other Somalis. They understand the community and the issues affecting them.”

5.6.4.4. Somali community health inequalities focus group

The below table summarises themes which have emerged from engagement with the Somalian community as part of the community transformation health inequalities workstream:

Theme	Points of note
Barriers to accessing mental health support	<ul style="list-style-type: none"> • Language – no words to describe mental health but also interpreting services are not easily available. • Service information is inaccessible – there is a feeling of being passed from person to person. • Stigma – mental health isn’t spoken about openly within the community. • There is unmet need in relation to trauma and grief particularly for elders.
Experiences of accessing mental health support	<ul style="list-style-type: none"> • When there is a crisis that needs mental health professionals’ attention people are not accepted into the service because they are deemed to not meet the criteria – but the criteria aren’t made clear, there are strong feelings that there is unmet need. • Lack of trust has built up over several years – promises have been made about easier access to services which has not materialised. • Peer support is seen as beacon of hope, this group provide mutual support to each other, and they recognise the power /strength that lies in peer support.
Identified gaps in provision, pathways or unmet needs	<p>Identified key challenges include:</p> <ul style="list-style-type: none"> • Teenagers / safety / hate crime / knife crime. • Isolated and excluded parts of the community • How to stay well. • How to find relevant and accessible resources. • How to manage and support mental health difficulties/ challenges/ problems. • How to recognise when people are unwell – where to seek help and when from services.
Plans to improve access, experience and outcomes of mental health service provision	<p>Following delivery of four peer insight workshops a six point action plan has been created with the East Neighbourhood Mental Health Team with feedback on progress being shared and discussed during 2025/26.</p>

5.6.5. Central and East European communities

Nationally, the majority of Central and Eastern European (CEE) nationals resident in the UK come from the EU countries of the CEE region, with the largest numbers from Poland, Romania and Lithuania. The biggest non-EU CEE community are currently the Ukrainians.

In Birmingham, the 'White Other' group, which includes CEE populations, constitutes around 4% of the population. According to the 2021 Census, there were approximately 37,000 Central and Eastern European nationals living in Birmingham, constituting 3.2% of the population. The majority were Polish (8,583), followed closely by Romanians (8,516), with much smaller numbers representing other CEE nationalities (2,445).

Since the 2021 Census, there has been a considerable increase in numbers of Ukrainian refugees settling in Birmingham following the Russian invasion of Ukraine in February 2022. Exact data on numbers is not publicly available. However, Refugee Action in Birmingham have supported almost 700 guests in the Homes for Ukraine Scheme (Refugee Action, 2023).

A study into mental health support for Central and Eastern European communities in Birmingham was carried out between June and November 2024, it was commissioned by Birmingham City Council Public Health and conducted by [Centrala Space](#). The study identified critical gaps in service provision and made recommendations to address them (Trevena, 2025). These key findings are summarised below:

5.6.5.1. *Mental Health Challenges*

CEE migrants in Birmingham face significant mental health issues, including depression, anxiety, loneliness, and elevated risk of suicide, particularly among young men. These challenges are compounded by:

- **Migration Stressors:** Language barriers, precarious employment, social isolation, loneliness, and experiences of discrimination contribute to poor mental health.
- **Cultural Stigma:** Mental health issues are often perceived as weakness, discouraging individuals from seeking help.
- **Systemic Barriers:** NHS services often fail to accommodate the cultural and linguistic needs of CEE migrants, leading to difficulties in accessing appropriate care.

5.6.5.2. *Barriers to Accessing Support*

Although entitled to free mental health care under the NHS, CEE migrants encounter numerous obstacles:

- **Lack of Awareness:** Many are unaware of available services or how to access them.

- **Language and Cultural Differences:** Limited access to interpreters and a lack of culturally tailored approaches hinder effective communication and care.
- **Practical Constraints:** Long NHS waiting times, rigid appointment schedules, and work-related constraints prevent many from accessing support.
- **Negative Experiences:** Past negative experiences, including feeling dismissed or misunderstood by healthcare professionals, discourage further help-seeking.

5.6.5.3. Experiences of Mental Health Support

- **Unmet needs:** Mental health support offered by the NHS is difficult to access, inflexible in approach and inadequate.
- **Language Barriers in Therapy:** Even migrants fluent in English struggle to express complex emotions, making therapy less effective.
- **Resorting to private therapy:** Due to unmet needs, many CEE nationals are pushed into seeking support privately. Private support offers options for receiving therapy in person and/or in native languages. However, cost is a major barrier.

5.6.5.4. Recommendations

To address these issues, the report recommends the following actions:

- **Raise Awareness:** Develop multilingual campaigns and distribute information in community spaces, ethnic shops, and online platforms.
- **Improve NHS Services:** Enhance cultural sensitivity training for staff, increase language support, and offer flexible appointment times and therapy support.
- **Expand Community Support:** Establish a network of mental health champions, peer-led groups, mental health workshops, and youth programmes to reduce isolation and improve wellbeing.
- **Make Private Therapy More Accessible:** Subsidise private therapy options to bridge the gap left by NHS services and provide support options in native languages.
- **Reduce Stigma:** Launch awareness campaigns and partner with community organisations to encourage open conversations about mental health and help reduce mental health stigma.
- **Improve NHS data:** Introduce CEE-specific ethnicity categories in NHS data collection to better track service use and outcomes.

5.6.6. Chinese population

Studies suggest that Chinese people may not contact mental health services when they first develop problems; many only utilise these services during a crisis. This pattern is represented within data from the Care Quality Commission which showed that Chinese people in the UK were less likely to seek help from primary care services for psychological distress but are more likely to face compulsory admission than the national average (Yeung, Ng, & Tsang, 2017; Tang, 2019). National data on the number of people per 100,000 using NHS mental health, learning disability and autism services, by ethnicity for the period April 2018 to March 2023 shows that the Chinese had the lowest rate of all ethnic groups with 1,883 compared to the figure of

4,756 for all ethnic groups (NHS Digital, 2024).

Data presented elsewhere in this report identifies that the Chinese population in Birmingham and Solihull have the lowest rate of detention under the Mental Health Act, are least likely to be prescribed anti-depressants and least likely to be prescribed anti-psychotic medication. Figures 105 and 106 above also show that for the Chinese ethnic group the number of people per 100,000 accessing crisis and SMI services is the lowest of all ethnic groups.

5.6.6.1. Chinese community health inequalities focus group

The below table summarises themes which have emerged from engagement with the Chinese community as part of the community transformation health inequalities workstream:

Theme	Points of note
Barriers to accessing mental health support	<ul style="list-style-type: none"> • Language – no words to describe mental health. • Language barriers with a variety of languages spoken within the community e.g. Mandarin, Cantonese. • The Chinese community is very diverse one approach will not meet the needs of all. • High levels of stigma associated with mental health. • Lack of trust in mental health services and professionals.
Experiences of accessing mental health support	<ul style="list-style-type: none"> • Lack of accessible information. • Elders will ask family members to translate. • Difficulty accessing services at point of crisis. • Lack of trust built up over the years because of the language and cultural barriers and a “helicopter” experience of help and support swooping in and leaving when systems and services change priorities. • Important to find ways of talking with the community e.g. what do good days feel like, what makes you happy. • These were identified by the community as important: <ul style="list-style-type: none"> ○ Info and awareness raising ○ Consistent Access to services ○ Mental health first aid training ○ Activities / social and wellbeing activities ○ Diet, and wellbeing advice ○ Domestic Violence training and Support ○ Suicide Prevention training & Support ○ Gambling support and support in other addictions mainly alcohol • •

	<ul style="list-style-type: none"> •
Theme	Points of note
Identified gaps in provision, pathways or unmet needs	As identified above, barriers to accessing mental health support are contributing towards mental health needs not being met. It is also recognised that the cultural competency of services can be strengthened with mental health professionals receiving training on cultural awareness to ensure inclusion across the services.
Initiatives / plans to improve access, experience and outcomes of mental health service provision	<ul style="list-style-type: none"> • Facilitating insight workshops with activity and wellbeing as a focal point. • Working with community groups to provide information about services available. • Exploring access to mental health first aid training.

5.6.7. Gypsy, Roma and Traveller population

Factors contributing to poor mental health among Gypsy, Roma and Traveller populations in the UK include: prison, poverty, poor employment prospects, unpaid caring responsibilities, insecure and inappropriate accommodation, experiences of racism and discrimination, destructive coping mechanisms for unresolved grief, loss of freedom linked to an inability to travel and the high prevalence of negative stereotypes (Parry, et al., 2004; Friends, Families and Travellers, 2022; Van Cleemput, 2018; Cemlyn, Greenfields, Burnett, Matthews, & Whitwell, 2009; Leeds City Council, 2019; Millan & Smith, 2019; Thompson, Stone, & Tyson, 2022; McKey, Quirke, Fitzpatrick, Kelleher, & Malone, 2022).

5.6.7.1. *Gypsy, Roma and Traveller health inequalities focus group*

The below table summarises themes which have emerged from engagement with the Gypsy, Roma and Traveller community as part of the community transformation health inequalities workstream:

Theme	Points of note
Barriers to accessing mental health support	<ul style="list-style-type: none"> • The term Mental Health has a negative connotation so community tend to refer to it as “nerves or bad nerves” – this can be misunderstood by professionals, there are no direct translations for mental health conditions. • In the Roma community there is not always access to an interpreter for medical appointments and letters are not written in the community language. • High level of stigma. • Often families are not registered with a GP or have no permanent home address so cannot access services.

	These results in them taking a cheap flight back home to see a Dr or picking up medication from a local community store that has been exported.
Theme	Points of note
Barriers to accessing mental health support (continued)	<ul style="list-style-type: none"> • Professional do not know anything or enough about the ways/ traditions etc of the GRT community. • Huge unmet need around trauma and grief. • Not having a permanent place of residence can also lead to groups being marginalised. • Being able to connect with MH and health professionals who “look like them” builds trust.
Initiatives / plans to improve access, experience and outcomes of mental health service provision	<ul style="list-style-type: none"> • Working with PeopleforPeople to explore co production, • The ability to celebrate cultures and identities by use of story telling • Working with community groups to provide information about services available • Support the further development of drop-in sessions, currently offer drop in for housing, benefits etc, would like to extend this to MH

5.7. Homeless people and rough sleepers

5.7.1. Homelessness, housing and mental health

Having a decent, affordable, secure home is fundamental to mental health, with insecure and overcrowded housing associated with stress and anxiety. Noisy, crowded or uncomfortable housing (and feeling stressed or anxious about housing) can also affect sleep quality, and poor sleep can lead to mental health problems or make existing problems harder to cope with (Walker, 2017) and cold homes can increase the risk of severe mental illness (Clair & Baker, 2022).

5.7.2. Homelessness in Birmingham and Solihull

Data from the [mental health and wellbeing joint strategic needs assessment \(JSNA\) profile](#) on the Fingertips public health profiles shows that in 2020/21

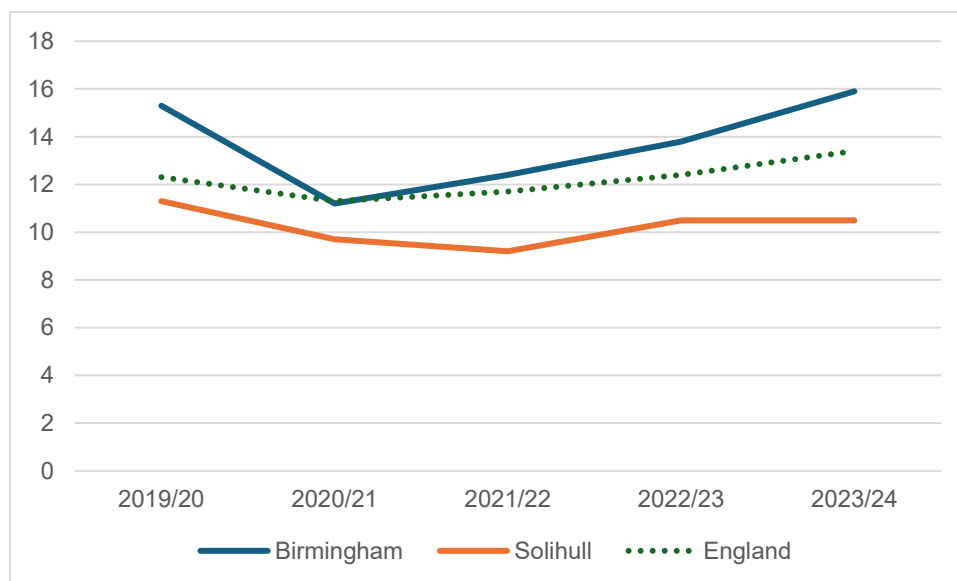
- 42% of adults in contact with secondary mental health services in Birmingham live in stable and appropriate accommodation.
- 39% of adults in contact with secondary mental health services in Solihull live in stable and appropriate accommodation.

Nationally, the average proportion of people in contact with secondary mental health services who live in stable and appropriate accommodation is 58%. Data presented by Shelter shows that one in 71 people in Birmingham is homeless (the 18th highest proportion out of 154 upper-tier councils in England) whilst one in 353 people in

Solihull is homeless (Shelter, 2023).

The scale of the challenge in Birmingham is further illustrated by data on the rate per 1,000 of households owed a duty under the Homelessness Reduction Act and the rate per 1,000 of households in temporary accommodation. The figures are 15.9 per 1,000 and 19.7 per 1,000 respectively and the trend from 2019/20 to 2023/24 is illustrated below showing Birmingham is consistently above the national average. Solihull, by contrast, is consistently below the national average for both measures.

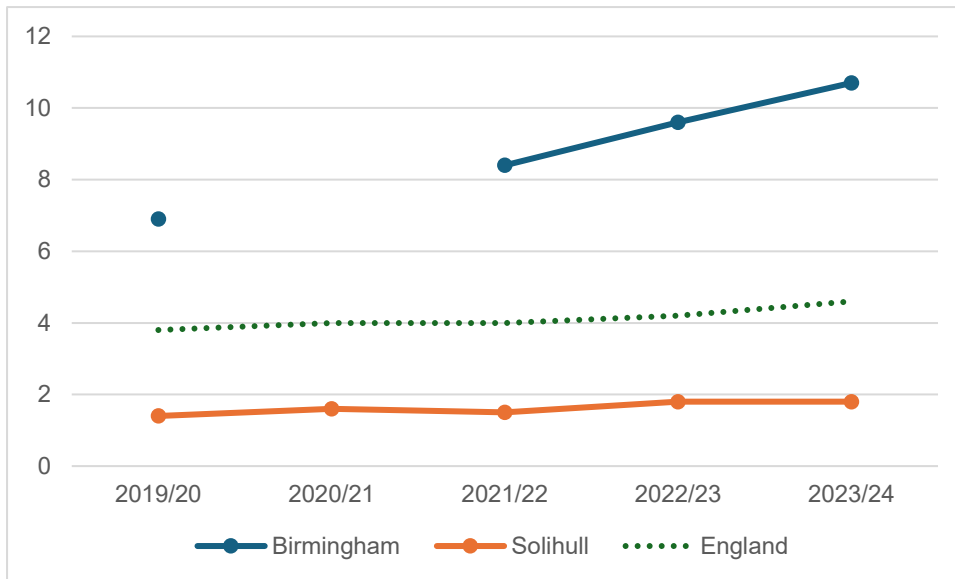
Figure 107: Households owed a duty under the Homelessness Reduction Act, Crude rate per 1,000



Source: [Fingertips | Department of Health and Social Care](#)

Figure 108: Homelessness: households in temporary accommodation²⁵

²⁵ Data for 2020/21 for Birmingham is suppressed on Fingertips due to gaps in completeness.



Source: [Fingertips | Department of Health and Social Care](#)

5.7.3. Barriers to accessing mental health support

Research by the charity Groundswell has identified multiple challenges that people who are homeless face when they require mental health support [\(Groundswell, 2022\)](#). These include:

- People who are homeless and rough sleepers have a lack of trust in mental health services and mental health professionals. People reported not being listened to, especially in relation to treatment options and diagnosis. People have greater trust in voluntary and community sector organisations and peers.
- Many people experiencing homelessness do not know where to go when they need mental health support. Where people experiencing homelessness reached out to their GP, this often led to dissatisfaction. A significant proportion of people need support from a case or support worker to navigate the complexities of the system.
- Several people told Groundswell their only experiences of interacting with services were through primary care or emergency care. For some, despite ongoing mental ill health, a mental health crisis was the first time they were able to receive support. Support is often only available when a person's mental health had significantly deteriorated.
- When people were able to access mental health services, they told Groundswell that transitions between different services and localities often meant they had to re-tell their story, re-refer themselves or begin the process of accessing help entirely.
- Key suggestions participants identified that would improve the mental health and wellbeing for people experiencing homelessness included: access to safe, suitable and settled accommodation, earlier intervention and faster response from services, flexibility in service delivery and alternative types of support and, crucially, the involvement of peers

5.7.4. Mental health support in Birmingham and Solihull

Examples of mental health service provision for homeless people in Birmingham and Solihull are described below.

5.7.4.1. The homeless community mental health team (CMHT)

The homeless CMHT provides mental health support to those who are homeless or in unstable accommodations. This could range from people who are sofa surfing, in housing of multiple occupancies (HMOs) and hostels if the length of stay is for less than 6 months.

The team consists of two community psychiatric nurses, a clinical lead, manager, psychiatrist and administrative support. The service considers the holistic needs of individuals accessing care and provision includes medication administration, risk management, care planning and assessment with service users reviewed every 6 months by a psychiatrist or sooner if required.

5.7.4.2. Rough Sleeper Outreach Team

The Rough Sleeper Outreach Team was commissioned in 2020 and funded by NHS England. The team supports those individuals who are street homeless or sleeping in cars, or other outdoor spaces. They work in partnership with other homeless organisations such as Trident Housing and offer mental health support and assessments to help those individuals secure housing where possible with a multi-disciplinary approach.

The team is made up of 3 community psychiatric nurses, a clinical lead, manager, psychiatrist and psychotherapist. The psychotherapist focuses on reflective work with partner agency staff so that they can support the rough sleeper population and manage their own wellbeing.

5.7.4.3. Homeless Health Exchange

The homeless health exchange is a GP practice for homeless people. The team is made up of GP's, nurses, outreach nurses, mental health nurses, therapist, support worker, administrative staff a clinical lead and manager. The service offer appointment slots to see the nurses and GP's as well as a daily nurse drop in, a weekly mental health drop in and support in the community. The service links in with partners to provide holistic support such as [Change Grow Live \(CGL\)](#) and housing.

5.8. People in contact with the criminal justice system

[Centre for Mental Health](#) have produced the below evidence summary on behalf of the provider collaborative in relation to the mental health needs of people in contact with the criminal justice system. It sets out key messages and summary information regarding prevalence and needs, risk factors, mental health care in prisons, pathways between prison and community, alternatives to custody and national priorities for improvement.

5.8.1.Key Messages

The following key messages were identified from publications reviewed by Centre for Mental Health:

- People at every stage of the criminal justice system, in all settings, have very high rates of mental ill health.
- Adversity, and especially childhood adversity, are common among people in the justice system, and are often linked to both mental ill health and offending.
- Rates of mental distress are higher among women and girls in the justice system than men.
- Current mental health care provision is patchy, and poor connections between health and justice services make it harder to deliver effective support.
- Prison mental health care does not provide an equivalent service to that which is available in the community.
- Improved continuity of care is vital, for example to divert people from custody, to provide support through transition points, and to offer effective help to those leaving prison.

5.8.2.Prevalence and Needs

In terms of the prevalence of mental ill health:

- Prisoners have very high levels of mental ill health: for example 12% have current psychosis (Bebbington, et al., 2017) and 16.7% have [complex post-traumatic stress disorder \(PTSD\)](#) (Facer-Irwin, Karatzias, Bird, Blackwood, & MacManus, 2022).
- Comorbidities (of multiple mental health conditions) are present in at least half of prisoners (Singleton, Meltzer, & Gatward, 1998).
- High levels of mental ill health are also present in police custody detainees: about one-third have a current mental health need and one in five are assessed as having a significant risk of suicide (Samele, et al., 2021). The most common unmet need among detainees is for support with accommodation.
- Former prisoners continue to have high levels of mental ill health: difficulties are complex and enduring, and linked to reoffending (Bebbington, McManus, Coid, Garside, & Brugha, 2021).
- Approximately 38% of people on probation caseloads have a current mental health need (Brooker & Glyn, 2021).
- Young women in the youth justice system have higher rates of childhood adversity than young men and a greater prevalence of mental ill health (Khan, Harris, & Sinclair, 2021). Young women also have very much higher rates of serious self-harm than young men (Khan, Harris, & Sinclair, 2021).

5.8.3.Risk factors and previous experiences

Risk factors for mental ill health among people in contact with the criminal justice system include:

- Adverse childhood experiences are the norm among prisoners: 84% of men had at least one, and 45% had four or more, implying very high levels of adversity (K, Bellis, Hughes, Barton, & Newbury, 2020).
- People who experienced traumatic events during childhood have higher rates of mental ill health, self-harm and attempted suicide when they are in prison, compared with those who did not (Liu, Li, Liang, & Hou, 2021).
- A quarter of prisoners had been in contact with mental health services in the year prior to entering custody (Bebbington, et al., 2017) – implying a serious shortcoming in current diversion arrangements.
- Within the justice system, transition points are high risk times for people’s mental health and for suicide (Lennox, Angell, & Dean, 2023). These include being remanded, being transferred (e.g. between prisons, or to hospital or back to prison) and being released.
- Suicide risk factors within the prison population include having a mental illness, having a history of suicide attempts, being in a single cell, a lack of social visits, being on remand, having a life sentence, or having committed a violent (Zhong, et al., 2021).

5.8.4. Mental health care in prisons

- Around 14% of prisoners (and 27% of women in prison) are on the caseloads of prison mental health services (Durcan, 2023).
- Mental health disorders are significantly more prevalent in the prison population than in the general population, with rates 4.5 – 5 times higher. The elevated rates of unmet need detected suggest that many individuals in prison experiencing current mental health issues either go unidentified or are unable to access treatment (Tyler, Miles, Karadag, & Rigers, 2019).
- Limited resources mean services either limit themselves to supporting those with the most serious needs (leaving those with less complex needs unsupported) or provide basic levels of support (e.g. medication) but don’t offer the level of holistic care and treatment people need (Durcan, 2023).
- The best performing prison mental health services are those that have multi-disciplinary input, good communication and relationships, and a balance between care and security considerations (Durcan, 2023).
- Staffing levels and disciplines vary widely between establishments and regions within England – there is no consistency, and the range of interventions varies from prison to prison (Durcan, 2023).
- A quarter of transfers from prison to hospital (under the Mental Health Act) are delayed (Durcan, 2023). Some prisons have adopted interim arrangements for people waiting transfer to hospital, but they have not shown evidence of effectiveness (Dyer, et al., 2021).

5.8.5. Pathways between prison and community

With regards to pathways between prison and community:

- Continuity of care for people leaving prisons is poor, despite very high levels of need. Lack of continuity either means support provided in prison suddenly stops (especially in cases of early release) or people are forced to tell their stories repeatedly to different services (Durcan, The future of prison mental health care in England, 2021).
- The RECONNECT service has been set up by NHS England to provide people leaving prison with mental health support in the community (Durcan, The future of prison mental health care in England, 2021). This aims to improve continuity of care.

5.8.6. Alternatives to custody

When it comes to alternatives to custody:

- Community sentence treatment requirements (CSTRs) are slowly being used more frequently, and there is good evidence about the benefits of the Mental Health Treatment Requirement (MHTR) especially, including on rates of reoffending (Ministry of Justice, 2024).
- There is a lot of variation in the timeliness and quality of pre-sentence reports which means opportunities for diversion are too often missed. Early identification of mental health needs is critical in the justice pathway when decisions (e.g. about charging and remand) are made quickly. At present, this is lacking due to a lack of agreed definitions, poor or slow assessments and record-keeping, and poor communication between health and justice agencies (which Liaison & Diversion services are unable to bridge as well as they might) (Criminal Justice Joint Inspectorates, 2021).
- Inadequate provision of (mainstream) community mental health services limits the scope for diversion from custody (Criminal Justice Joint Inspectorates, 2021).

5.8.7. National improvement priorities

Based on their evidence scan, Centre for Mental Health have outlined 5 areas for improvement nationally.

1. A need for better and stronger liaison between mental health and criminal justice services, including to enable diversion to take place for people with severe mental illness to keep them out of custody. Improved opportunities for diversion can be achieved through greater use of the Mental Health Treatment Requirement and the provision of effective community mental health care for offenders who do not need to be in custody.
2. More consistency is needed in the provision of mental health care within prisons, including multi-disciplinary inputs, to provide a range of interventions that would be equivalent to what is offered in the community. This will require significant additional resources and a workforce that is sufficient to meet the population's complex needs.
3. All prisons should become trauma-informed environments, adopting trauma-informed approaches. This approach is better developed in the women's prison

estate than in men's prisons. This will require significant changes to the ways in which they function, and a significant improvement in staff training and supervision. It should be assumed that adversity and trauma are the norm among the justice population, not the exception.

4. Transfers from prison to hospital should be improved, with clear accountability for completing the process within 28 days. This requires systemic reform to reduce blockages in the secure care system – for example delayed discharges due to a lack of housing and community support.
5. Leaving prison should be regarded as a time of crisis for an individual with a mental health difficulty. Continuity of care is essential – for example ensuring that anyone who has been on a prison mental health service caseload is supported through the gates by community services. And support must be holistic, including help with money, accommodation and work. Integrated care boards and provider collaboratives must take responsibility for ensuring they have arrangements in place to support people through these transitions.

5.8.8. Perspectives of people in contact with the criminal justice system

The West Midlands Probation Service carried out 3 focus groups regarding emotional wellbeing and mental health during March 2025 at the following locations:

- Crowley House: a female probation approved premises for people on probation, it is based in Birmingham, residents usually stay for up to 26 weeks unless there are extenuating circumstances.
- Elliot House: a probation approved premises in Birmingham for people on probation with diagnosed mental health conditions where they can have access to a forensic psychiatrist from Reaside hospital. Residents can reside there for up to 26 weeks.
- Carpenter House: a probation approved premises based in Birmingham, residents tend to stay for up to 26 weeks, those with high interest or concern can stay for up to 12 months.

Participants were asked questions in relation to:

- Experience of mental health services, either past or present.
- When and how they first accessed support from mental health services.
- Their views on the nature of support that was provided in terms of impact and effectiveness.
- Whether the process of accessing help was straightforward.

In total 17 participants shared their views and the broad themes from these discussions are summarised below:

Focus Group	Summary
Crowley House (8 participants)	<ul style="list-style-type: none"> • The overall view given from the group was that the length of time spent waiting for an appointment with mental health services and for medication, particularly following release from custody, is not acceptable. • Challenges were outlined regarding constantly having to repeat and relive trauma to different services, not being seen by the same GP or other healthcare professionals and having to go through it all again which can be extremely distressing. • Any therapeutic work that had taken place in custody was not followed up in the community, meaning people were left to cope alone, having shared their traumas.
Elliot House (4 participants)	<ul style="list-style-type: none"> • All participants accessed mental health support whilst in a crisis • There are long wait for mental health appointments and when you do get them, they are often cancelled at the last minute leaving individuals feeling vulnerable. • There are challenges regarding continuity of access to medication when transitioning from custody to community. • Participants wanted broader treatment not just to be given medication. • Focus group members would like to see more activities as part of the wellbeing package such as arts & crafts, acupuncture, talking therapies, activities to use your mind and consider your future. • More education is needed for staff to enable better understanding and empathy with those in the prison environment. • When released from prison participants would like more information on how to access services and what that may entail.
Carpenter House (5 participants)	<ul style="list-style-type: none"> • Most participants had experienced mental health issues from an early age. • A key theme related to waiting for mental health appointments which are then cancelled at the last minute. • Another key theme was not feeling listened to by professionals. • Participants would like holistic response to addressing their wellbeing rather than just being given medication. • Participants feel there is a pecking order for accessing support and they are lower down due to them being involved in the criminal justice system. • It was stated there was a poor experience of the service offered for veterans, however, it was not disclosed what this may relate to. • It was stated there is a lack of empathy and understanding by staff in the custodial environment.

Alongside these focus groups, West Midlands Probation service practitioners completed a survey with clients during March 2025 to gather information regarding the accessibility and effectiveness of mental health support as well as any gaps in

provision or support. A total of 12 responses were recorded on behalf of 10 male clients and 2 female clients who were aged between 18 and 65 years of age. Of these 12 clients, 6 were in receipt of support for mental health services or had accessed support previously, for these 6 people:

- None had found the process of accessing mental health support straightforward with barriers to accessing support including:
 - Difficulties accessing medication following release from custody.
 - Distrust of professionals associated with childhood trauma.
 - Difficulties accessing appointments and not feeling listened to.
 - Unanswered phone calls, delayed responses to e-mails and lack of appointments.
 - Long waiting lists.
- All felt the nature of mental health provided could be improved, and suggestions for this included:
 - Ensuring provision of medication for at least 7 days following release from prison, especially where depot injections are required.
 - Support to access therapeutic care and face to face assessments is needed.
 - There needs to be focus on supporting people which relies less on medication.
 - There needs to be easier referral processes with better communication from mental health services.
 - Reducing wait times.
 - Providing support where people feel listened to.

Of the 6 clients who had not previously accessed mental health support comments were received that the referral process should be easier with more support from primary care to enable those with unmet mental health needs to access services.

In addition to the above, feedback was sought from practitioners at the [Birmingham Mind Community Development Worker \(CDW\) service](#) regarding the mental health needs and challenges that people who have been in contact with the criminal justice system face. The feedback from the CDW service was that:

- The lack of continuity in care and support systems often results in a revolving door of reoffending and crisis.
- Where services are available, they are not always effectively promoted so there is limited awareness.
- Prison leavers with neurodiverse conditions can often feel abandoned by healthcare services and struggle to express their emotional needs.
- Prison leavers face difficulty accessing GPs, especially as services are increasingly online.

- Homelessness complicates access to healthcare and benefits, further impacting mental health.
- Delays in receiving mental health appointments worsen conditions, increasing the likelihood of reoffending due to lack of timely intervention. Continuity of care post-release is crucial, but disruptions in this area have been highlighted by prison leavers.
- People of colour face additional systemic discrimination, stigma, and mistreatment, which compounds mental health challenges. This is often exacerbated by issues with medication access.
- Individuals with low literacy skills experience anxiety and frustration when navigating housing, benefits, and job applications.
- Difficulty in navigating the internet to access appointments is a significant barrier.
- Individuals face homelessness after release, preventing them from accessing benefits or medications, which exacerbates mental and physical health issues.

5.8.9. Mental health support in Birmingham and Solihull

In Birmingham, initiatives such as the Community Sentence Treatment Requirement (CSTR) pilot have demonstrated success in diverting individuals with mental health and substance misuse issues away from custodial sentences and into community-based support, thereby promoting long-term stability and community safety (West Midlands Combined Authority, 2022).

5.9. People with alcohol and drug dependence

It is very common for people to experience problems with their mental health and alcohol/drug use (co-occurring conditions) at the same time. Research shows that mental health problems are experienced by the majority of drug (70%) and alcohol (86%) of alcohol users in community substance misuse treatment. Death by suicide is also common, with a history of alcohol or drug use being recorded in 54% of all suicides in people experiencing mental health problems. Other evidence highlights that people with co-occurring conditions have a heightened risk of other health problems and early death. We also know that despite the shared responsibility that NHS and local authority commissioners have to provide treatment, care and support, people with co-occurring conditions are often excluded from services (Public Health England, 2017).

5.9.1. Substance misuse needs assessments

Needs assessments relating to substance misuse were completed separately in [Birmingham](#) and [Solihull](#) in 2021 and 2023 respectively (Birmingham City Council, 2021; Thomas, Lardner, & Rowson, 2023). Research cited in the Birmingham needs assessment highlighted that the co-occurrence of a substance use disorder, and a mental health disorder is known as dual diagnosis and it is often under-diagnosed, underestimated and poorly treated throughout the world. It also stated that evidence suggests that around 10-20% of the homeless population would fulfil the criteria for

dual diagnosis and they are nearly five times more likely to die than the equivalent age group in the general population (Birmingham City Council, 2021).

Key findings from these needs assessments which are specific to Birmingham and Solihull are summarised in the below table.

Birmingham	Solihull
<ul style="list-style-type: none"> • Nearly one-third of people starting treatment for opiate use in Birmingham have housing needs. • Half of those entering treatment also have a mental health need. • In 2016/17: <ul style="list-style-type: none"> ○ 47% of adults in specialist alcohol treatment were also in contact with mental health services. ○ 39.5% of adults in drug treatment had concurrent mental health service contact. ○ These rates are significantly higher than both regional and national averages. <p>Service user feedback highlights:</p> <ul style="list-style-type: none"> • Unmet mental health needs often drive substance use, leading to use of substances like spice and mamba, and increasing the risk of homelessness. • Mental health services should not deny support due to substance use but instead address the underlying mental health issues. • There is a need for integrated, specialist services that treat both mental health and substance use issues seriously and simultaneously. 	<ul style="list-style-type: none"> • In 2020–21, 42% of clients entering treatment in Solihull had a mental health treatment need, lower than the England average of 63%. • Of the 119 adults in drug treatment with a mental health need: <ul style="list-style-type: none"> ○ 82% (98 people) were receiving mental health treatment. ○ This is higher than the England average of 71%, but 18% (21 people) were not receiving the treatment they needed. • Mental health needs vary by substance group: <ul style="list-style-type: none"> ○ 43% of alcohol and non-opiate clients in Solihull had a mental health need, compared to 71% nationally. ○ 36% of alcohol-only clients in Solihull had a mental health need, compared to 64% in England. • Overall, Solihull has a lower proportion of clients with mental health needs in substance misuse services than the national average. • Further research is needed to determine whether this reflects a less complex client mix or under-identification of mental health needs.

5.9.2. Dual diagnosis deep dive

In 2025 Birmingham City Council published a [deep dive into Co-Occurring Mental Health Problems and Substance Misuse in Birmingham](#). Co-occurring mental health problems and substance misuse is also referred to as ‘dual diagnosis’. The deep dive reports that 67.6% of those in substance misuse treatment in Birmingham have a known mental health need. There are also an estimated 14,587 citizens living in

Birmingham with dual diagnosis with an unmet need, equating to 2.6% of citizens aged 15 years and over (Birmingham City Council, 2025).²⁶

The deep dive reported 5 key findings:

- Key Finding 1: There is demand for system leadership, partnership working and co-ordination of key services for citizens living with dual diagnosis.
- Key Finding 2: There is currently insufficient data to allow a full understanding of dual diagnosis prevalence in Birmingham and the associated health and wellbeing needs.
- Key Finding 3: There are opportunities to further understand training needs and embed specific dual diagnosis training opportunities.
- Key Finding 4: There are opportunities to improve holistic and person-centred support for citizens living with dual diagnosis.
- Key Finding 5: There is a need for more research to take place to build the evidence base around health inequalities for citizens living with dual diagnosis.

Detailed recommendations and proposed actions are set out within the report which includes the formation of a Dual Diagnosis Steering Group tasked with developing Birmingham's Dual Diagnosis Joint Working Protocol to enhance patient-centred support for these groups.

5.10. Refugees and Asylum Seekers

5.10.1. Refugees and asylum seekers and mental health

The [1951 United Nations \(UN\) Convention Relating to the Status of Refugees](#) defines a refugee as someone who is “unable or is unwilling to return to their country of origin owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion.”

In the United Kingdom, a person is only recognised as a refugee by law if the UK government has issued them with refugee status documentation. An [asylum seeker](#) is a person who is seeking international protection and has applied for refugee status under the convention but whose claim has not yet been determined.

Asylum seekers and refugees can experience multiple forms of trauma which lead to a heightened risk of developing mental health conditions. Traumatic events in their country of origin can include torture, war, imprisonment, physical assault, sexual assault, loss of livelihood and losing close family or friends. Asylum seekers and refugees can also experience trauma during the journeys they make, or after they

²⁶ This estimate is based upon data regarding drugs misuse in 15-64 year olds and alcohol misuse in over 18s.

arrive in the UK (Mental Health Foundation, 2024).

Research consistently demonstrates that the risk of experiencing poor mental health and developing mental health problems is increased where people experience poverty, financial insecurity, unemployment, lack of adequate housing, social isolation, loneliness, prejudice, and discrimination. The post-migration conditions that asylum seekers and refugees face often put them at risk of experiencing these challenges which can adversely impact upon their mental health (Mental Health Foundation, 2024).

Furthermore, complex legal procedures required to claim asylum, obtain permission to reside within the country, and enduring the claim consideration process can cause significant additional stress (Pollard & Howard, 2021).

According to data from [World Mental Health Surveys](#), the lifetime prevalence for [Post Traumatic Stress Disorder \(PTSD\)](#) in the general population is 3.9%, and 12% for any depressive disorder (Mental Health Foundation, 2024). In contrast, an international systematic review found that among adult asylum seekers and refugees, the prevalence of PTSD was 31.46%, and the prevalence of depression was 31.5% (Mental Health Foundation, 2024).

Research has also found prevalence of depression up to 31% and anxiety up to 11% amongst asylum seekers and refugees, with anxiety particularly increased soon after migration (Pollard & Howard, 2021). The World Health Organization's (WHO) review of 129 studies in 39 countries showed that among people who have experienced war or other conflict in the previous 10 years, one in five people (22%) will have depression, anxiety, post-traumatic stress disorder, bipolar disorder or schizophrenia (Charlson, et al., 2019).

While all refugees may experience challenges such as separation from their families, security risks, and exposure to violence, women are at particular risk of violence and exploitation (Mental Health Foundation, 2024). The high prevalence of PTSD in refugee women has been associated with experiences of sexual abuse (Mental Health Foundation, 2024).

5.10.2. Refugees and asylum seekers in Birmingham and Solihull

Between 2014 and 2023 there were 1,038 asylum seekers resettled in Birmingham, this equates to 9 persons per 10,000 population, this is higher than the West Midlands and UK where the rate is 7 persons per 10,000 population (Birmingham City Council, 2024).

Figures from the Home Office at the year ending March 2025 show the numbers of

asylum seekers in receipt of local authority support²⁷ were 2,504 in Birmingham and 259 in Solihull (Home Office and Ministry of Housing, Communities and Local Government, 2025). In addition to this there were 1,258 arrivals in Birmingham and 304 arrivals in Solihull under the Homes for Ukraine scheme and a further 605 people supported in Birmingham and 10 people supported in Solihull under the Afghan resettlement programme. Collectively these figures represent 0.37% of the population of Birmingham and 0.26% of the population of Solihull.

5.10.3. Barriers to accessing mental health support

There are multiple factors that present challenges for refugees and asylum seekers who require support with their mental health. These include confusion over NHS structures and how to access healthcare or arrange appointments and limited knowledge about the health system and entitlements to healthcare, language barriers including availability and quality of interpretation services, the need to disclose sensitive information, lack of trust, fear and stigma as well as lack of cultural competence of service providers (Kang & Farrington, 2019; Pollard & Howard, 2021). Furthermore, mental health and counselling support are Western concepts and current UK practices are not generally aligned to non-Western cultural experiences (Pollard & Howard, 2021).

Research has indicated that positive experiences of services may help reduce some of these barriers with potential approaches included cultural competence, explicit consideration of therapeutic boundaries, and psychotherapeutic support for trauma (Pollard & Howard, 2021).

5.10.4. Access to support and mental health needs for asylum seekers in Birmingham and Solihull

Focus groups undertaken by Migration Policy and Practice on behalf of Birmingham City Council with 45 asylum seekers residing in temporary hotel accommodation sought to understand the mental health needs and service access among asylum seekers in Birmingham. Participants were from South Asia (42%), Africa (33%), and the Middle East (24%) and the following key themes were identified and recommendations made:

Living Conditions

²⁷The types of support include different provisions under sections of the Immigration and Asylum Act 1999: - Section 95 provides support for asylum seekers who have an asylum claim or appeal outstanding, and failed asylum seekers who had children in their household when their appeal rights were exhausted.

- Section 98 is the temporary provision of accommodation for asylum seekers who would otherwise be destitute and who are:

a) Awaiting a verdict on their section 95 support application

b) Receiving section 95 support, but are waiting to be allocated their dispersal accommodation.

- Section 4 support is available when an asylum claim has been finally determined as refused but they are destitute and there are reasons that temporarily prevent them from leaving the UK.

- Frequent relocations causing stress and depression.
- Poor living conditions: overcrowding, lack of basic amenities.
- Specific issues like inadequate food quality and lack of facilities for personal grooming.

Daily Life

- Limited activities leading to feelings of isolation and depression.
- Positive impact of visits from charity organizations.
- Frustration over monotonous routines and uncertainty about asylum application status.

Language Barriers

- Difficulties in accessing services and communicating with healthcare providers.
- Insufficient language classes and fear of ridicule.
- Misinterpretation by translators affecting asylum applications.

Future Status and Uncertainty

- Anxiety and depression due to uncertainties about asylum status.
- Impact of riots and hostility towards asylum seekers.
- Concerns about safety and security.

Access to Education and Employment

- Mixed views on education opportunities; some appreciated free learning, others frustrated by inability to work.
- Desire for orientation sessions about available courses and employment opportunities.

Emotional Wellbeing

- Struggles with past traumas and constant pressure due to fears of deportation.
- Importance of emotional support and counselling services.
- Specific challenges faced by pregnant women and domestic violence survivors.

Sense of Safety and Security

- Concerns about safety after riots.
- Need for more secure housing and community support.
- Positive impact of security measures in accommodations.

Future Aspirations

- Hopes for building stable lives and contributing to society.
- Stress and uncertainty about asylum applications affecting mental health.

Cultural Variations in Coping Mechanisms

- Diverse definitions of mental health and coping strategies.
- Importance of culturally sensitive approaches to mental health services.

Factors Influencing Mental Health

- Educational level, age, and gender influencing coping mechanisms.
- Higher stress among educated participants and those aged 30-45.
- Gender differences in willingness to discuss mental health issues.

Recommendations made by Migration Policy and Practice are summarised below:

Mental Health and Well-being

- Expand culturally sensitive mental health services, including multilingual therapy and peer support groups.
- Provide trauma-informed care, especially for those with past experiences of violence or persecution.
- Increase awareness and accessibility of mental health services.

Legal and Administrative Support

- Simplify and improve communication on the asylum process.
- Establish dedicated caseworkers to help navigate appointments, legal processes, and essential services.

Living Conditions and Nutrition

- Improve accommodation standards, especially for families and pregnant women.
- Allow greater autonomy in food choices by providing cooking facilities or financial assistance for groceries.

Employment and Education Opportunities

- Lift work restrictions or provide structured volunteering and training programs.
- Offer tailored English language courses.

Safety and Community Integration

- Strengthen anti-racism and community engagement initiatives.
- Improve security measures in accommodations while fostering a welcoming environment.

5.11. Sex Workers

5.11.1. Sex workers and mental health

There is a well-established relationship between poor health and sex work, which includes high levels of mental ill-health. The [Sex Worker Health Needs Analysis](#) (SWAN report) finds that after adjusting for age, sex, ethnicity and deprivation, sex

work was associated with an increased risk of the following health-related outcomes in primary care: mental health disorders (up to 20 times), sexually transmitted infections (up to 20 times), chronic kidney disease (3 times), self-harm (7 times), falls (3 times), and death (5 times) (Birmingham City Council; University of Birmingham, 2024).

Other research finds that depression is the most common mental health amongst sex workers, but sex workers also experience high rates of other psychological problems including anxiety, substance abuse and suicidal ideation (Martín-Romo, Sanmartín, & Velasco, 2023). Despite the high prevalence of mental health problems, sex workers often encounter significant barriers to accessing healthcare services including stigma, concerns about safety and potential legal ramifications of disclosing their occupation (Martín-Romo, Sanmartín, & Velasco, 2023; Birmingham City Council; University of Birmingham, 2024).

5.11.2. Sex workers in Birmingham and Solihull

Data taken from the Genito-Urinary Medicine Clinic Activity Dataset (GUMCAD) which was reviewed in the [SWAN report](#) indicated that the prevalence of sex work increased between 2017 and 2021 from 0.03% to 0.08% in the West Midlands, and from 0.01% to 0.26% in Birmingham (Birmingham City Council; University of Birmingham, 2024, p. 14).

Data from the [Clinical Practice Research Datalink](#) (CPRD) linked [Hospital Episode Statistics](#) (HES) shows that most sex workers were White, female, and from the most deprived backgrounds. The Unlinked Anonymous Monitoring (UAM) Survey of people who inject drugs (PWID) found that among participants recruited in the West Midlands between 2019 and 2021, 7% of PWID reported engaging in sex work in the last year and 13% ever engaging in sex work. The proportion reporting sex work increased between 2019 and 2020/21. PWID engaging in sex work were more likely to be women, younger in age, inject cocaine, have higher sexual partner numbers, and be homeless compared to PWID who were not sex workers (Birmingham City Council; University of Birmingham, 2024, p. 17).

5.11.3. Mental health support

The [SWAN report](#) includes findings that sex workers frequently identified that they needed mental health support which was challenging to access. These needs were multi-faceted and varied for different sex workers. Some felt that they needed mental health support to manage their struggles with self-esteem in relation to the occupation. Others wanted support for sexual assaults and abuses which they had experienced during their sex work but felt that because of the occupation these assaults and abuses were not taken seriously.

Some had underlying mental health issues in relation to adverse childhood or adolescent experiences, these ranged from sexual abuse, parental death, or family alienation due to their sexual orientation. Furthermore, the intersectional nature of

many participants characteristics was felt to be misunderstood by practitioners in mental health support and health more generally, where sex workers felt they were seen as the dregs of society, being not just sex workers, but Black, or Asian sex workers, and 'even worse' Black or Asian gay sex workers.

The [SWAN report](#) includes findings from three participants who took part in six one hour-long sessions using a semi-structured discussion guide. The participants were: a white heterosexual female with experience of off-street sex work (i.e., from a premises); a South Asian homosexual male offering services as a transsexual, also off-street; and a white heterosexual female with experience of on street sex work.

These three participants spoke extensively and with strong feelings about the barriers to access they encountered when looking for support from mental and emotional health services. All three wanted – but could not get – 'holistic' therapy. That is, therapy to address past and current adversities and covering all aspects of their lives (not just one incident e.g., a rape). They described therapists as: being judgemental; being unrealistic in expecting them to disclose 'everything' immediately, and offering far too few sessions; the latter also reflecting the unhelpful idea that the therapy sessions would deal with 'one' issue; also reflected in the therapists' not being confident or competent to help them with the 'complexity' of their issues (and in making this statement, giving the sex worker the message that they were in the 'too difficult' box) (Birmingham City Council; University of Birmingham, 2024, p. 191).

The SWAN report also includes the following quote taken from external research regarding barriers to seeking support:

I would be too afraid to talk to a mental health service as I wouldn't want my profession in sex work to be kept on file and used against me. (Birmingham City Council; University of Birmingham, 2024, p. 62)

5.11.4. Service provision, potential unmet needs and gaps

Gaps in provision of mental health support for sex workers are highlighted throughout the [SWAN report](#). This includes the findings that the level of need outstrips the current levels of provision and wider mental health services do not understand the nuances of the sex worker population to offer appropriate support. These nuances do not only relate to sex work itself but also the fact that many sex workers themselves have multiple marginalised characteristics such as sexuality, gender, and ethnicity, as well as their occupation (Birmingham City Council; University of Birmingham, 2024). Holistic services are required that encompass statutory health care alongside mental health support delivered by trained lay or peer staff who are nonjudgemental and have insight into the complexities surrounding sex work.

The most cited gap highlighted by focus groups held with staff working in services who had been providing support services for sex workers within Birmingham was gap in provision of mental health support. This included services not having a specific pathway for further referrals to specialist services and how 'safe' services are to meet the specific needs of sex workers (Birmingham City Council; University of Birmingham, 2024, p. 160).

One key recommendation made within the report is to develop mental health and substance use services to cater to the needs of sex workers:

The additional health risks associated with sex work and substance misuse identified in this review, as well as the disproportionate mental health burden on sex workers, particularly for those who identify as a sexual/gender minority, means that specialist mental health and substance use services aimed at sex workers should be a priority. (Birmingham City Council; University of Birmingham, 2024, p. 12)

Feedback gathered from [Dr Christine Christie](#) who led the interviews with sex workers as part of the SWAN report emphasised the need for more trauma informed care:

The degree of trauma (reflecting life history and current circumstances rather than a mental health problem or disorder), is not understood and consequently systematically downplayed by professionals – and following from that, also by the sex workers themselves.

So ideally, we would have a specific 'trauma' service/pathway offering an initial, not time-limited, space to unpick and get a perspective on, past and present traumatic events (not a talking-therapy/solution focused service). The service aim would be to provide a) relationship (because relationship is the critical prerequisite for trauma recovery); b) a trauma-informed understanding/perspective on their past & current experiences; c) support/confidence for making their own decisions about how to move forward.

5.12. The Lesbian, Gay, Bisexual and Transgender Community

5.12.1. The LGBT community and mental health

A review published in the European Journal of Public Health in 2019 (Zeeman, et al., 2019) found the following inequalities for Lesbian, Gay, Bisexual and Transgender (LGBT) people in relation to mental health:

- LGBT people are twice to three time more likely to report enduring psychological or emotional problems compared to the general population.
- Suicide attempts, suicidal ideation, depression and anxiety disorders were 1.5 times higher for LGB people compared to heterosexual peers with alcohol related

substance dependence over the previous 12 months being 1.5 times more common in LGB people.

- Disparities related to mental distress were most pronounced for LGB people under the age of 35, and people over the age of 55.
- Intersex people showed a raised incidence of suicide attempts at 19%, with 60% having considered suicide compared to 3% in mainstream populations.
- Bisexual and trans people showed even greater disparities in mental health compared to lesbian and gay counterparts, increasing the need for specialist mental health services and counselling support.

Similarly, other recent research finds a higher risk for mental disorders for lesbian/gay people and bisexual people than heterosexuals for all invested diagnostic categories, as well as higher risk for depression and suicidality in bisexual people compared to lesbian/gay people (Wittgens, et al., 2022).

Key points of note from the Birmingham City Council community health profiles for the [lesbian](#), [gay man](#), [transgender](#) and [bisexual communities](#) include:

- The reasons for poorer mental health in the LGBT community have been well documented, e.g., due to homophobia and biphobia (and their internalisation), minority stress, rejection from friends and family, substance abuse, body image, barriers to accessing healthcare and discrimination.
- Roughly 60% of LGBT young people had deliberately harmed themselves at some point in their life and more than one in five LGBT young people had attempted to take their own life.
- Studies with gay men and other men who have sex with men (MSM) report that poorer mental health is associated with younger age (18 to 24 years), lower income, being from a minority ethnic background, being disabled, being single, being born abroad, sexual attraction to both men and women, substance abuse, not being out and homophobic discrimination and bullying at school, and internalised homophobia.
- The importance and appeal placed on attaining an ideal body image and a high level of body dissatisfaction, which within the gay community may translate to seeking both a lean and muscular body, has been posited as an important reason for the high prevalence of eating disorders in gay men and for gay men being underweight.
- The [Stonewall School Report](#) presents 2017 data from a survey of 3,713 young people aged 11 to 19. Of those surveyed:
 - half of LGBT boys (51%) had deliberately harmed themselves compared with 71% of LGBT girls
 - 71% of LGBT boys had thought about taking their own life compared with an estimated 25% of young people in general.
 - Just over a fifth (22%) of LGBT students had attempted to take their own life compared with an estimated 5% to 13% of 16 to 24-year-olds in the general population.

- A higher percentage of disabled LGBT students (48%), LGBT students on free school meals (40%) and LGBT students who had been bullied (37%) had attempted to take their own life compared with their LGBT peers.
- Statistical analysis of the Stonewall survey by Jadva et al. reported that trans adolescents were 2-3 times more likely to self-harm, report suicidal thoughts and attempt suicide than non-trans LGB respondents (Jadva, Guasp, Bradlow, Bower-Brown, & Foley, 2023). There is also an indication that the high levels of bullying faced by trans students in school contribute to the high levels of self-harming and mental health problems experienced by trans children. However, methodological drawbacks with the Stonewall survey, such as a nonrepresentative sample and lack of validated measures, require these findings to be treated with caution.
- In their review of the primary studies undertaken in the UK, the Netherlands, Belgium and Switzerland, de Graaf et al. reported that adolescents with gender dysphoria from the UK had higher levels of emotional, behavioural and peer relationship problems and a high level of internalising and externalising problems compared with their counterparts in other European countries (de Graff, et al., 2022).
- Evidence shows a high prevalence of self-reported self-harm, suicidal thoughts and attempted suicide amongst trans adults, and significantly higher rates compared with [cisgender](#) LGBT respondents and the general population.
- Survey findings show that trans people who have undergone conversion therapy
- are more likely to report severe mental health problems than trans people who have not, with marked increases in self-harming thoughts and behaviours.

In relation to health inequalities and barriers to accessing healthcare more broadly, the [2019 Older Adults Joint Strategic Needs Assessment](#) produced by Birmingham City Council identifies health inequalities and barriers to accessing healthcare which Lesbian, gay, bisexual and transgender (LGBT) older adults face:

- Poorer health outcomes due to lifestyle behaviour especially relating to drugs and alcohol
- Difficulties accessing health care
- Professionals' denial of service user's sexuality and identity in health and social care settings
- Increased risk of requiring formal care
- Increased difficulty during end-of-life care and during bereavement
- Challenges creating new social networks and a higher risk of mental health issues; Experiences of homophobia, aggression and violence.

5.12.2. The LGBT community in Birmingham and Solihull

Based on the 2021 census, in Birmingham there are:

- 11,258 people identified as bisexual (1.3% of the total population)

- 7,711 men identified as 'gay or lesbian' (0.9% of the total population)
- 4,257 women identified as 'gay or lesbian' (0.5% of the total population)
- 7,826 people identified that their gender identity was different from their sex registered at birth (0.85% of the total population)

For Solihull, 2021 census data shows that:

- 3,289 people in Solihull identified as a sexual orientation other than heterosexual when the census was carried out in March 2021 – 1.9% of respondents.
- Of these 1.9% of respondents, the most common LGBTQ+ sexualities were gay or lesbian (53.7% of those who did not identify as heterosexual) and bisexual (38%).

The [Lesbian community health profile](#) reports that the prevalence of mental health problems in a West Midlands lesbian population was 31%-35%, and suicide attempts were between 20%-31%.

5.12.3. Disparities in access, experience and outcomes

In relation to the experiences and outcomes of the LGBT population when accessing mental health support, the community health profiles report the following:

- The main barrier to accessing mental health services for the trans community reported in the [Government Equalities Office \(2018\) National LGBT Survey](#) was the long wait time (74%), followed by respondents' feelings of anxiety, embarrassment or worry (39%). Around a fifth of respondents (20-22%) said that their GP was not supportive, their GP did not know where to refer them or they were unable to attend at a convenient time.
- With an average wait time of 4 years from referral to initial appointment, the role of long waiting lists to access gender identity services has been highlighted as an important contributor to the mental health problems experienced by trans people. Most surveys and published studies report that long waiting times for gender dysphoria clinics are a risk factor for depression, anxiety, and self-harm in the trans population.
- Lesbian women reported the following barriers to accessing mental healthcare services: wait was too long (47%), worried, anxious or embarrassed (22%), GP not supportive (14%), no convenient time (12%), GP did not know where to refer (8%) and services not close enough (7%).
- 2 in 5 lesbians reported experiencing negative or mixed reactions from mental healthcare professionals.
- The most common difficulties that gay men faced in accessing mental health services were having to wait too long (70%), feeling worried, anxious or embarrassed (31%), not knowing where to go (19%), not being able to go at a convenient time (19%) and having an unsupportive GP (18%).

- The National LGBT survey found that the most common difficulties that bisexual people faced in accessing mental services included waiting too long (75%), feeling worried, anxious or embarrassed (41%), having an unsupportive GP (25%) and not being able to go at a convenient time (21%).
- A greater percentage of bisexual people (23%) reported having a negative experience of using mental health services compared with gay and lesbian people (18%), and a greater percentage of bisexual women (24%) reported this than bisexual men (19%).

Differences in treatment outcomes based on sexual orientation have been observed for NHS talking therapies with lesbian and bisexual women having higher final session severity for depression and anxiety, and functional impairment and increased risk of not attaining reliable recovery or reliable improvement when compared to heterosexual women. Similarly, bisexual men had higher final-session severity for depression, anxiety and functioning and increased risk of not attaining reliable recovery or reliable improvement when compared to heterosexual and gay men (Rimes, Ion, Wingrove, & Carter, 2019).

5.12.4. Potential unmet needs and gaps

The [Birmingham Women’s Health Needs report](#) published in 2024 recommended actions for the Birmingham and Solihull Mental Health Learning Disability and Autism Provider Collaborative to improve timely access to appropriate mental health support for women including the lesbian population. Specifically, it was recommended that the provider collaborative work with the local LGBT+ organisations and the lesbian communities develop accessible wellbeing resources to address low level mental health needs and promote pathways to addressing more complex needs around self-harm, suicide and eating disorders within these communities.

Additionally, the [Birmingham and Solihull Integrated Care System 10 year strategy](#) contain a priority commitment to “*Ensure LGBT+ people with common mental health issues receive timely and culturally sensitive support through IAPT and specialist services.*”

Focus groups with the LGBTQ+ community were held in February 2025 with 13 participants as part of Birmingham City Council funded ‘deep engagement’ sessions. Participants included trans and non-binary individuals and LGBTQ+ individuals with mental health diagnoses. Themes which were explored included mental health and wellbeing, self-help and community support and key messages to the NHS, public health and local authority. These are summarised below.

Theme	Key points
Mental health and wellbeing	<p>The requirements to be mentally healthy are:</p> <ul style="list-style-type: none"> • Community based support system • Good coping mechanisms

	<ul style="list-style-type: none"> • Achieving a stable level of happiness <p>Community support whilst waiting for gender-affirming care is crucial. Those providing therapy often lack trans-specific training.</p> <p>Barriers to accessing support include inaccessible spaces and refusal of service due to being trans, anxiety about accessing services due to autism, expectation of judgment and misunderstanding and having to explain sexuality and/or gender identity.</p> <p>Good support is affordable, high-quality, easy to navigate and provides holistic care and respectful treatment and enables people to feel understood without having to explain sexuality, gender identity, or neurodiversity.</p>
Self-help and community support	<p>Accessible communication and peer networks are important when it comes to self-help and community support.</p> <p>Resources and tools which have helped provide support include cognitive behavioural therapy (CBT), relaxation techniques, support via telephone helplines such as the Birmingham Mind helpline and NHS 111, talking spaces and peer support groups like Café Queer.</p>
Messages to NHS, public health and local authorities	<ul style="list-style-type: none"> • Establish a Gender Identity Clinic (GIC) in Birmingham. • Train NHS staff in Trans and LGBT awareness. • Develop empathy and understanding for trans people. • Inclusive services that recognize and respect LGBTQ+ identities.

Example quotes from participants in the focus groups are shown below:

“Birmingham has the largest trans community that doesn’t have its own GIC – can we have one please?”

“Any kind of mental health intervention felt like a sticking plaster because I knew what the root cause was – I wasn’t getting the GAC [gender-affirming care] I needed.”

“No Community Mental Health services should ever say ‘we can’t see you because you’re trans’. Shouldn’t happen. Does happen. Not supposed to.”

“Living with mental illness and autism – behind the mask, my behaviour patterns are hard. I have a psychiatrist but people can’t do anything for me. Tried CBT and relaxation, doesn’t work. Feel trapped and stuck.”

“Thinking about the safety: sometimes I struggle with when I’m in a crisis, I don’t know what to do. There isn’t a number I can call, I don’t have a massive support system around me.”

“Only when you say you’re thinking about suicide, do you get any response from crisis teams, helplines etc.”

“For me, because I’m autistic, I have anxiety about accessing services because I feel I have to behave in a certain way to get the service, otherwise people will misunderstand me.”

5.13. Veterans

[Centre for Mental Health](#) have produced the below evidence summary on behalf of the provider collaborative in relation to the mental health needs of military veterans. It draws on a variety of publications and sets out key messages and summary information regarding prevalence and needs, mental health support for veterans and national priorities for improvement.

5.13.1. Key messages

The following key messages in relation to the mental health of military veterans were identified:

- Military veterans have higher levels of mental ill health than the general population, and poorer outcomes from mental health services.
- Complexity of need is more common in veteran populations, meaning that holistic approaches are important to meet needs comprehensively.
- Help-seeking among veterans is more likely to be delayed than in the general population, but the gap is narrowing.
- A mixture of veteran-specific and veteran-friendly mainstream provision is necessary to ensure people’s needs are met effectively.

5.13.2. Needs, risk factors and prevalence

Post-traumatic stress disorder (PTSD) is more common among veterans than the general population. Groups of veterans with higher risks of PTSD include those from the lower military ranks, unmarried, those with lower educational attainment, those who experienced childhood adversity, and those who experienced traumatic events during their service (Iversen, et al., 2008).

Veterans with mental health problems are twice as likely to have experienced multiple adverse childhood events than the general military population (Williamson, Baumann, & Murphy, 2022). Early service leavers (defined as those who leave service within 4 years of joining) are more likely to experience a range of mental health needs. Being an early service leaver is associated with living in a more deprived area of the UK, which is also associated with a greater likelihood of needing mental health support and longer delays in help-seeking (Murphy, Palmer, & Ashwick, 2017).

Having strong social networks and relationships is protective against common mental health problems among serving personnel and veterans. Those with poorer social networks, during and after service, are likely to be at greater risk (Hatch, et al., 2013).

Veterans seeking urgent mental health have more complex needs than others in this situation: including both a wider range of mental health problems and more social needs (Campbell, Weijers, Barker, & Murphy, 2023).

5.13.3. Mental health support for veterans

PTSD is the most common reason for veterans to seek mental health support, but it is often only part of their need. Veterans are less likely than the general population to disclose mental health difficulties to civilian clinicians (in primary care or mental health services) (Busuttil, 2022). Spouses and children of veterans are also more likely to miss out on the support they need from mainstream mental health services (Busuttil, 2022).

Veteran-specific mental health services can be useful to offer effective and acceptable care, but it is still important to provide veteran-friendly services in the mainstream. Many veteran-led services show promise of good outcomes but need more robust evaluation, and availability varies across the country (Johnstone, 2024)

Stereotypes in society about veterans' mental health (based on widely-held beliefs that veterans who have been traumatised in combat are 'mad, bad, and sad') can delay help-seeking until people reach crisis point (Johnstone, 2024).

Delays in help-seeking may, however, be falling: Combat Stress, a charity providing specialist mental health support to veterans, has reported that between 1994 and 2014 the number of people seeking support for their services rose fourfold, and the average length of time it took them to reach out for help halved between those dates (Murphy, Weijers, Palmer, & Busuttil, 2015).

5.13.4. National priority areas for improvement

The following national priority areas for improvement have been identified by Centre for Mental Health

1. Providing effective support to those experiencing traumatic events and other major risk factors during service may protect against later mental health difficulties.
2. Mainstream primary care and mental health service clinicians need to be educated about how to identify and respond to the mental health needs of veterans (including the importance of trauma-informed approaches).
3. Mental health support for veterans (and their families) needs to be holistic, using formulation-based approaches and addressing the full range of a person's needs and not just their presenting problem.
4. Stereotypes about veterans' mental health need to be addressed in order to provide more effective support and to promote speedier help-seeking.

5.13.5. Veterans in Birmingham and Solihull

Birmingham City Council undertook a [deep dive into health and wellbeing inequalities affecting veterans in Birmingham](#) in 2021. The deep dive provided an estimate of the veteran population in Birmingham of 31,866 people accounting for 8% of 16 to 64 year olds and 9.2% of those aged over 65 (Birmingham City Council, 2021).

Data taken from the 2021 census and presented in the [Story of Solihull 2023](#) states that there are almost 6,000 veterans in Solihull accounting for 3.4% of the Solihull population (Solihull Metropolitan Borough Council, 2023).

5.13.6. Mental health support in Birmingham and Solihull

Mental health support for veterans in Birmingham and Solihull is available via [Op COURAGE](#) which is partnership of eight specialist organisations that provide an integrated service across the whole Midlands region.

Op COURAGE is an NHS mental health specialist service designed to help serving personnel due to leave the military, reservists, veterans and their families.

It brings together three services previously known as:

- Veterans Mental Health Transition, Intervention and Liaison Service (TILS)
- Veterans Mental Health Complex Treatment Service (CTS)
- Veterans Mental Health High Intensity Service (HIS)

It supports people of any age who have served in any of the armed forces at any time, for any duration. Op COURAGE supports people with common problems like anxiety, depression and substance misuse, as well as more advanced mental health conditions and psychological trauma. It can also help address other issues that may be affecting wellbeing, such as housing, finances and relationships, and can provide support to family members. Key functions of the service include:

- Helping veterans recognise and treat early signs of mental health problems, as well as more advanced mental health conditions and psychological trauma.
- Providing support and treatment for substance misuse and addictions.
- Liaising with charities and local organisations to support wider health and wellbeing, such as help with housing, relationships, finances and employment.
- Making referrals to other NHS services, where needed.
- Recognising that family members may also need help and care and supporting them to access this.

6. Key findings and recommendations

The following key points emerge from this needs assessment as areas where there are opportunities to take action to improve the mental health and wellbeing of people in Birmingham and Solihull.

Key finding 1	Review of information from national and local data sources regarding the prevalence of common mental health conditions has highlighted gaps in data regarding the prevalence of anxiety within the population of Birmingham and Solihull.
Opportunity for action	Working with public health colleagues, informatics teams and other stakeholders we can explore opportunities to build a more detailed picture of the prevalence of anxiety in Birmingham and Solihull and projected future trends.
Recommendation	The Provider Collaborative should work with NHS partners, local authorities, and other stakeholders to produce a clearer, data-driven picture of future population health needs, using mental-health prevalence data and population-change forecasts.
Intended outcome	This insight will help inform future planning and commissioning of services.

Key finding 2	Multiple sources of information highlight significant challenges regarding capacity, flow and underutilisation of community alternatives regarding mental health inpatient services in Birmingham and Solihull. Too many people are also being cared for out of area which is not in the best interests of patients
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	and is costly to the NHS.
Opportunity for action	Strengthened community provision which reduces the likelihood of hospital admissions and improvements in flow to reduce delayed discharges and length of stay will deliver multiple benefits to service users and the NHS.
Recommendation	The provider collaborative and partners to ensure delivery of the 3-year inpatient bed strategy with a sustained focus on: <ul style="list-style-type: none"> • Reducing length of stay for adult inpatients • Reducing adult inpatient bed occupancy • Reducing the proportion of delayed discharges from adult inpatient beds • Reducing the percentage of discharges from learning disability beds which results in readmission within 6 months
Intended outcome	Delivery of these objectives will improve service user experience and outcomes and support financial sustainability of the provider collaborative.

Key finding 3	Findings from the experience of care campaign outlined several areas where there are needs for systemic improvements
Opportunity for action	The strategic direction for the provider collaborative as set out in the forthcoming 5 year strategy provides an opportunity to set out ambitions to drive system improvement
Recommendation	The provider collaborative 5 year strategy draws on key themes from the experience of care campaign when setting out future vision and ambitions for the development of mental health services in Birmingham and Solihull.
Intended outcome	The provider collaborative 5 year strategy and associated implementation plans set out and deliver plans to improve mental health services in a way which will improve access, experience and outcomes for people in Birmingham and Solihull.

Key finding 4	<p>There are significant challenges in Birmingham with regards to perinatal and infant mental health need given:</p> <ul style="list-style-type: none"> - The diversity and age profile of the population - The prevalence of mental health need - Current service capacity
Opportunity for action	<p>A rigorous assessment of need has been undertaken in Birmingham in 2022 and a similar assessment for Solihull is due for publication in 2025. The findings from these documents provide an opportunity for development of targeted work to improve service provision in line with local need.</p>
Recommendation	<p>The provider collaborative to review the findings from both the Birmingham and Solihull needs assessments with consideration of how to build a cohesive Birmingham and Solihull offer which addresses unmet needs as part of service transformation</p>
Intended outcome	<p>Plans which are developed and implemented support the expansion of service provision to more effectively meet local need.</p>

Key finding 5	<p>Children and young people's mental health services emerge as an area in need of significant attention due to:</p> <ul style="list-style-type: none"> - Long wait times and high thresholds - Disparities in rates of access by ethnic group and area of residence - Poor service user experience
Opportunity for action	<p>The transformation of children and young people's services in Birmingham and Solihull is an existing priority area for Birmingham and Solihull and the transfer of FTB services to BSMHFT provide an opportunity to develop a more cohesive system offer across Birmingham and Solihull.</p>
Recommendation	<p>Local plans to transform children and young people's mental health services to include details regarding:</p> <ul style="list-style-type: none"> • How they will incorporate interventions which have robust evidence of effectiveness and potential for good return on investment.

	<ul style="list-style-type: none"> • Provision of targeted mental health support for vulnerable groups who encounter significant barriers accessing support such as care experienced children and children and young people in contact with the criminal justice system. • How waiting times for support from children and young people's mental health services can be reduced. • How the broader system offer for those who do not meet the thresholds of children and young people's mental health services can be strengthened. • How delays in the neurodevelopmental diagnostic pathway can be addressed to decrease the time taken from referral to diagnosis and post-diagnostic support improved. • How barriers to accessing support can be reduced for communities who are under-represented within children and young people's mental health services.
Intended outcome	The achievement of transformation priorities which encompass the recommendations above would improve service user access, experience and outcomes

Key finding 6	Material disadvantage and unemployment has a significant impact upon the emotional wellbeing and mental health of the working age population. Interventions which can improve employment opportunities and material circumstances can have a significant positive impact upon people with mental health conditions.
Opportunity for action	To scale up and enhance services which provide employment support for people with mental health conditions.
Recommendation	The provider collaborative strategy and commissioning plans consider how employment support for people with mental health conditions can be strengthened further.
Intended outcome	Improved access to employment opportunities and an increase in sustained employment for people with mental health conditions will support improvement in the mental health of the working age population.

Key finding 7	The ageing population, increasing proportion of older adults with multiple long-term conditions and projected future needs indicate a requirement for more integrated rather than condition specific support. Additionally, whilst older adults are less likely than other age groups to access NHS talking therapies those aged over 65 years demonstrate the best recovery rates.
Opportunity for action	Developing the principle of integrated rather than condition specific care provides an opportunity to deliver more holistic support for older people. Increasing uptake of NHS talking therapies in the over 65 age group offers opportunities to improve the mental wellbeing of older adults in Birmingham and Solihull.
Recommendation	<p>It is recommended that the mental health needs of older adults is an explicit focus within provider collaborative strategy and implementation plans with consideration of:</p> <ul style="list-style-type: none"> • How integrated rather than condition specific support can be developed to meet the needs of older adults with multiple long-term conditions and mental health needs. • How mental health support can be strengthened for older adults who have heightened risk of mental health difficulties including older carers. • How stigma in relation to mental health can be reduced and rates of access of NHS talking therapies for over 65s can be increased.
Intended outcome	More holistic care for older adults will support a variety of their needs being met with positive impacts upon their mental wellbeing. Increased uptake of NHS talking therapies may also lead to positive impacts upon the mental wellbeing of older adults in Birmingham and Solihull.

Key finding 8	There are multiple inclusion health groups who have heightened vulnerability to developing mental health conditions, face barriers to accessing services and support, and evidence indicates there are gaps in local pathways and provision. It also a common finding across multiple ethnic minority groups that services lack cultural competency which creates a further
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	<p>barrier to accessing support alongside cultural stigma relating to mental health.</p> <p>The needs assessment also identified areas where further analysis and investigation would be beneficial to understand opportunities to enhance and strengthen pathways for vulnerable groups.</p>
Opportunity for action	<p>Developing plans which address identified gaps, contributing to initiatives intended to address gaps, improving the cultural competency of services and tackling stigma and further analysis and continued focus on health inequalities provides an opportunity to improve the accessibility, experience and outcomes of services for inclusion health groups.</p>
Recommendation	<p>Provider collaborative strategy and implementation plans to ensure there is a focus on the following areas:</p> <ul style="list-style-type: none"> • Developing targeted support and provision where evidence and research indicates gaps and unmet need for inclusion health groups, for example sex workers and victims of domestic abuse. • Contributing to existing initiatives and plans to address inequalities such as the development and implementation of the dual diagnosis working protocol • Improving the cultural competency of services and reducing barriers to access for under-represented groups and communities. • The collection and analysis of data regarding protected characteristics and development and oversight of plans to address health inequalities. • Further investigation of pathways and provision for inclusion health groups to identify areas where existing support can be improved to better meet needs.
Intended outcome	<p>Taking actions to address health inequalities as a key area of focus within provider collaborative strategy and implementation plans can lead to improvements in the accessibility, experience and outcomes of services for inclusion health groups.</p>

Key finding 9	Service transformation initiatives are taking place in relation to 24/7 care in East Birmingham and via community transformation initiatives which have the potential to bring significant positive benefits for people with mental health needs in Birmingham and Solihull.
Opportunity for action	Understanding the effectiveness of services which are being piloted provides an opportunity to recognise where there are areas of good practice which can be scaled up and replicated as well as the identification of learning points for future service transformation initiatives.
Recommendation	The provider collaborative oversees rigorous evaluation of these projects and initiatives to ensure they are meeting stated aims and objectives and identifying opportunities to scale up areas of good practice.
Intended outcome	Robust evaluation of these transformation initiatives informs the future development of services to better meet population health needs in Birmingham and Solihull.

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