Written evidence submitted by MIND (MHS0005)

Evaluation of the Government's commitments in the area of mental health services in England

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About Mind

We're Mind, the mental health charity for England and Wales. We provide advice and support to empower anyone experiencing a mental health problem. We campaign to improve services, raise awareness and promote understanding.

We welcome the opportunity to submit evidence to this important review of government commitments in the area of mental health services in England, at this important time during the course of the NHS Long Term Plan (LTP) and as services seek to recover from and address the consequences of the coronavirus pandemic. A strong continued commitment to mental health services at this time.

Summary

All the commitments assessed in this submission are appropriate and importantly address issues identified in existing service provision. If achieved they will have positive impacts on people with mental ill health.

Many of these commitments have been impacted by the coronavirus pandemic however, both in terms of service disruption and increased scale of need for mental health services. It is therefore vital that existing funding commitments for the Long Term Plan (LTP) and the Mental Health Act Review are met, and additional funding provided for both the backlog of services and increasing provision in light of the pandemic. In particular services will need to address drastically increased need from children and young people and increased acuity experienced by people with existing mental health problems, especially severe mental illness (SMI).

Workforce

Commitment: We are committed to growing the mental health workforce

Was the commitment met / is it on track to be met?

The LTP mental health implementation plan identified 'indicative' workforce growth requirements each year to deliver LTP commitments, with local areas expected to ensure the appropriate

workforce is in place to staff services, which may be different depending on their existing workforce and local availability.

Workforce, however, remains the single biggest risk to the LTP commitments and post-pandemic service delivery. Even prior to the pandemic, workforce projections from Health Education England (HEE), Royal College of Psychiatrists and others had identified the system is well behind the trajectories set out in the mental health implementation plan, and that a further growth in workforce is required on top of this to meet growing need.[1]

The pandemic has put a huge pressure on the workforce and will impact on targets in this area. The pandemic has led to much higher staffing costs through agency spend covering higher staff absences, infection control measures, PPE, testing, remote working and other measures, meaning there has been an increased cost to mental health trusts of an estimated 3.84% and to combined mental health and community trusts of 2.73%. This equates to £472m in additional costs.[2]

Even prior to the pandemic, absences for mental health reasons were increasing for staff across the NHS – total absences for all reasons among clinical staff across the NHS fluctuated between 4% and 5% between 2015 and February 2020, with depression and anxiety being the most cited reasons.[3] Staff burnout during the pandemic will have added to this.

Commitments have also been made to diversify the workforce, which was a key recommendation of the Review of the Mental Health Act. As the system continues to work towards growing the mental health workforce, it is concerning that data around the diversity of the workforce has not been routinely shared, so monitoring this commitment is challenging.

> "I could not identify with a white, middle-class psychiatrist. I couldn't sit down friendly and talk about the issues that were affecting me, my rape, my beating up etc. that I'd gone through. I couldn't sit there and talk to this strange white, middle-class man. For a long time, I couldn't talk to any of them. Maybe one or two of the Black nurses…but they weren't the ones documenting and dealing with my case."[4]

Was the commitment effectively funded (or resourced)?

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[1] Royal College of Psychiatrists (2020) 'Next steps for funding mental health care in England – a comprehensive settlement that invests in infrastructure, prevention, people and technology: www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/policy/next-steps-for-funding-mental-healthcare-in-england-executive-summary---24-9-20.pdf?sfvrsn=76af0ff8_2. Accessed September 2021.
[2] NHS Confederation and NHS Providers (2021) 'A reckoning: the continuing cost of COVID-19': www.nhsconfed.org/sites/default/files/2021-09/A-reckoning-continuing-cost-of-COVID-19.pdf. Accessed September 2021.
[3] Centre for Mental Health (2021) 'Now or never: A systemic investment review of mental health care in England': www.centreformentalhealth.org.uk/publications/now-or-never. Accessed September 2021.
[4] Mind (2019) Mental Health Act Review: Mind's engagement and influence: https://mind.turtl.co/story/5c3f4b11903f285d2e0f30e3/page/6. Accessed September 2021.

The additional £111m in the Recovery Plan for workforce is welcome, but we are still a long way behind on the trajectories set out in the LTP Mental Health Implementation Plan. The Covid-19 mental health and wellbeing recovery action plan also committed to £30m of funding for mental health hubs to support the wellbeing of NHS staff. This level of funding is far below what is needed, at an equivalent of approximately £30 per NHS staff member. A long-term commitment to appropriate funding of these mental health hubs is required. This is essential for the wellbeing and retention of the existing NHS workforce.

The Government should commit to a multi-year settlement for workforce training and education to allow for the growth in the mental health workforce, including via new roles, necessary to deliver the LTP and the recommendations of the Independent Review of the Mental Health Act.

Did the commitment achieve a positive impact for people living with mental ill health?

Growth in the mental health workforce directly impacts on improving the experiences of people with mental ill health. It is also important to note however, that to achieve positive impacts for people with mental ill health will require a focus not just on workforce numbers but on workplace culture. For example, improved staffing levels, skill mix and deployment are an essential part of the systemic change needed to eliminate reliance on force in mental health units, but this will not be enough without open, positive ward cultures. Addressing both staffing numbers and workplace culture is also imperative in programmes aimed at addressing sexual safety.

Ensuring a more diverse and representative workforce, particularly of Black African and Caribbean heritage, has also been identified as vital as part of the Mental Health Act Review alongside culturally appropriate advocacy, in order to better help patients from all ethnic backgrounds voice their individual needs.

Was it an appropriate commitment?

Given how all LTP commitments and other wider commitments rely on growth in the mental health workforce, this was an appropriate and essential commitment. Work in this area, is however, extremely challenging, and more will need to be done to come anywhere close to previous aims. Targets will also need to factor in increased demand because of the coronavirus pandemic.

Previous targets have been indicative to give local areas the flexibility to address local needs and current workforce levels. Given the system is so far behind the trajectories set out in the LTP mental health implementation plan, more specific targets and national levers maybe required to achieve the workforce growth needed.

Children and Young People's (CYP) mental health

Commitment: At least 70,000 additional children and young people each year will receive evidence-based treatment

Was the commitment met / is it on track to be met?

An additional 70,000 children and young people received evidence-based treatment by the end of 2020-21, meeting the Five Year Forward View for Mental Health target. The LTP amended this target to an increase in access to NHS-funded community services to meet the needs of at least 35% of those with diagnosable mental health conditions. Based on the original prevalence rates of diagnosable mental health conditions in children and young people (from 2004), NHS England met this LTP target, with over 420,000 children and young people being treated through NHS-commissioned community services in 2020/21. This is approximately 39.6% of children and young people with a diagnosable mental health condition.

NHS England has however recognised that prevalence of diagnosable mental health conditions in children and young people has been increasing, and this increase escalated during the pandemic. This meant that based on 2020 prevalence rates, only 29.5% of children and young people with a diagnosable mental health condition were seen by community mental health services.[5] Prevalence rates for 2021 have remained stable with 1 in 6 children and young people having a probably mental health disorder.[6]

Importantly, even based on the 2004 prevalence rate, the access rate varied considerably between CCG areas, from a low of 20.6% in Sandwell and West Birmingham CCG[7] to a high of 87.2% in South Tyneside CCG. More than a third of CCGs failed to reach the NHS access target.[8]

Was the commitment effectively funded (or resourced)?

While this target was met using 2004 prevalence figures, the escalation in prevalence of diagnosable mental health conditions since this date, especially since the start of the pandemic, means that more funding is required to (at a minimum) meet the 35% access target.

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[5] NHS England: www.england.nhs.uk/mental-health/cyp/. Accessed September 2021.
[6] NHS Digital (2021) Mental Health of Children and Young People in England 2021 - wave 2 follow up to the 2017 survey: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2021-follow-up-to-the-2017-survey. Accessed October 2021.
[7] Since the data was collected, Sandwell and West Birmingham CCG has formally merged with Dudley, Walsall and Wolverhampton CCGs to form the Black Country & West Birmingham CCG.
[8] NHS Mental Health Dashboard Q4 2020/21: www.england.nhs.uk/publication/nhs-mental-health-dashboard/. Accessed September 2021.

Importantly, Children and Young people's mental health services (CYPMHS) have been very successful in scaling up the number of young people they see. In June 2021 alone, 417,820 were in contact with mental health services - the highest figure to date. The number of young people in contact with mental health services has almost doubled in five years.[9] But with rising need, more funding is needed for CYPMHS. On average, local CCG areas spend less than 1% of their overall budget on children's mental health and 14 times more on adult mental health services than on services for children. Once again, there is huge variability, with eight local areas spending less than £40 per child on mental health services, while 21 areas now spending more than £100 per child.[10]

While the one-off £79 million boost for CYPMHS in March 2021 was essential, it is imperative that the commitment set out in the LTP that funding for CYPMHS will grow faster than both overall NHS funding and total mental health funding, is maintained.[11]

Did the commitment achieve a positive impact for people living with mental ill health?

It has been recognised for many years that dramatic improvements have been required for CYPMHS in England. The treatment gap for the mental health of young people has been far too large for too long, meaning that the majority of children and young people with a diagnosable mental health condition have not received the treatment they need.

In recent years, there has been a greater concerted focus to address this, which will have had a profoundly positive impact on the young people who have been able to access mental health services in a timely and appropriate manner (with the number of young people in contact with mental health services almost doubling in five years).[12] But too many are still not getting the support they need. Over a third (36%) of parents and carers told Mind that thresholds for accessing NHS support is a barrier for young people getting the support they need. Shockingly, 56% of school staff identified that young people who did not receive support experienced self-harm, and more than a third (37%) said young people experienced suicidal thoughts.[13]

"The schools do not have the resources to meet the needs of children with mental health problems and it took nine months to get support via CAMHS and by this time it was too late..." (Parent)[14]

It is also important to understand which children and young people have benefited from an expansion of CYPMHS, and which have not. There is a lack of easily accessible published data on the

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[9] In January 2016 (when data was first published), 211,236 children and young people sought mental health support from services, compared to 417,820 in June 2021 (the most recent data). NHS Digital, Mental Health Services Monthly Statistics: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics Accessed September 2021.

[10] Children's Commissioner (January 2021): The state of children's mental health services 2020/21: www.childrenscommissioner.gov.uk/report/mental-health-services-2020-21/. Accessed September 2021.

[11] NHS England and NHS Improvement. (January 2019). NHS Long Term Plan: www.longtermplan.nhs.uk/. Accessed September 2021.

[12] NHS Digital, Mental Health Services Monthly Statistics: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics Accessed September 2021.

[13] Mind (2021) Not making the grade: why our approach to mental health at secondary school is failing young people: www.mind.org.uk/media/8852/not-making-the-grade.pdf. Accessed September 2021.

[14] Ibid.

ethnicity of 0-18 year olds accessing mental health services to identify any differences in access rates. Lack of scrutiny of this data is highly problematic given we know that there are differences for adults from different ethnicities in relation to accessing mental health services, their experiences of these services and the outcomes they receive. Some research supports that similar patterns are reflected in children and young people, meaning some young people are less likely to access NHS mental health support earlier and more likely to come into contact with services when they have reached crisis point. For instance, one study found that young Black African people were more likely to be referred from secondary health or social/criminal justice services, and were also significantly more likely to be referred to inpatient and emergency services compared to young White British people.[15]

The expansion of CYPMHS has also occurred during the pandemic, when services swiftly had to be delivered remotely to curtail the spread of coronavirus. The change to delivery of services by phone or online has meant mental health services were able to remain open during the pandemic, and for many it was a welcome shift, meaning they were able to access services more easily. However, for many, this was not the case. Mind's research identified that while some preferred remote services, for many it didn't work for them and even made their mental health worse. Some people didn't have the technology, Wi-Fi or ability to use services in this way. But many did, and yet still it wasn't right for them. They had no privacy to talk about intimate issues at home, with fears of being overheard by partners, parents or housemates. Or they felt unable to connect with the person through a computer screen.[16] Importantly, against the assumptions of some, young people from our survey were more likely than adults to want face-to-face support over remote support. 72% of young people who accessed remote mental health support during winter 2020/21 said they would have preferred face-to-face support, compared to 61% of adults. In particular, lack of privacy was an important barrier to young people accessing mental health services remotely.[17]

Importantly, the latest data shows that in June 2021, still only 45% of young people's contacts with mental health services we're face-to-face.[18] This maintenance of high levels of remote delivery of services compared to pre-pandemic levels will mean particular groups of young people will be less likely to get the support they need, as it's not delivered in a way that works for them.

"I found it hard as I couldn't talk to someone face to face and they couldn't see in person how much I was struggling." (young person)[19]

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[15] Chui, Z., et al. (July 2021) 'Inequalities in referral pathways for young people accessing secondary mental health services in south east London.' Eur Child Adolesc Psychiatry. 2021 Jul;30(7):1113-1128. doi: 10.1007/s00787-020-01603-7. Epub 2020 Jul 18. PMID: 32683491; PMCID: PMC8295086:

[16] Mind (2021) 'Trying to Connect: The importance of choice in remote mental health services': www.mind.org.uk/media/8575/mind-20582-trying-to-connect-report-aw2-welsh-recommendations-lr.pdf.

[17] Mind (2021) 'Trying to Connect: Young People data cut': www.mind.org.uk/media/9149/trying-to-connect-yp-briefing-september-2021.pdf

[18] NHS Digital, Mental Health Services Monthly Statistics: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics Accessed September 2021.

[19] Mind (2021) 'Trying to Connect: Young People data cut': www.mind.org.uk/media/9149/trying-to-connect-yp-briefing-september-2021.pdf

Was it an appropriate commitment?

Given the low benchmark with which CYPMHS were starting from, setting a target of 35% access rate for CYPMHS was appropriate, as services had to scale up considerably. However even based on old prevalence rates, this meant that services still only saw less than four in ten young people who required treatment, and with the prevalence increasing (especially during the pandemic) in reality this drops to less than three in ten young people. Leaving seven in ten, the majority, of young people without the NHS support they need.[20] A treatment gap that despite increasing challenges must be addressed.

As we move beyond the target timeframe, a more ambitious target is needed, to ensure it is not accepted that the majority of young people with mental health problems will not get appropriate NHS support. It is there for vital that resources are made available to meet the LTP target of 100% of children and young people who need specialist care being able to access it.[21] Alongside this, consideration needs to be given to ensuring that services are designed to work for young people, and that the current delivery model isn't excluding certain groups of young people.

Commitment: Achieve 2020/21 target of 95% of children and young people with eating disorders accessing treatment within 1 week for urgent cases and 4 weeks for routine cases

Was the commitment met / is it on track to be met?

The target of 95% of children and young people with eating disorders accessing treatment within 1 week for urgent cases and 4 weeks for routine cases by the end of 2020/21 was not achieved. In March 2021, 61% of urgent referrals were seen in one week, and 73% of routine cases were seen in four weeks. This was down from previous months (85% of urgent cases were seen in one week, and 90% of routine cases were seen in four weeks in September 2020).[22]

Referrals for children and young people's eating disorder services have skyrocketed during the pandemic. Mind's research during the pandemic found that nearly 1 in 8 young people (78%) have been over or under-eating to cope with the pandemic.[23] And this is reflected in referrals to services. In quarter one of 2020/21, there were 328 urgent referrals to these services and 1,347 routine referrals. This has more than doubled in a year with 852 urgent referrals and 2,600 routine referrals in quarter one of 2021/22.[24]

"Around October 2020, I started experiencing symptoms of anorexia nervosa. I became preoccupied with food and my days now revolve around eating and exercise." (young person)[25]

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[20] NHS England: www.england.nhs.uk/mental-health/cyp/. Accessed September 2021.
[21] NHS England and NHS Improvement. (January 2019). NHS Long Term Plan: www.longtermplan.nhs.uk/. Accessed September 2021.
[22] NHS England: www.england.nhs.uk/statistics/statistical-work-areas/cyped-waiting-times/. Accessed September 2021.
[23] Mind (2021) 'Coronavirus: the consequences for mental health': www.mind.org.uk/media/8962/the-consequences-of-coronavirus-for-mental-health-final-report.pdf. Accessed September 2021.
[24] NHS England, CYP ED Waiting Times Time Series – Q1 2021-22: www.england.nhs.uk/statistics/statistical-work-areas/cyped-waiting-times/. Accessed September 2021.

In response to this the government provided a one-off £79 million boost for CYPMHS in March 2021 as part of the £500 million for mental health announced at the 2021 to 2022 spending review.[26] Alongside other commitments, this money was earmarked to improve access to eating disorder services for children and young people.

There is high variation between geographical regions in regard to percentage of referrals hitting the one-week and four-week waiting targets. Only 43.3% of urgent referrals in the South West met the one-week target compared to 76.2% in the South East. Likewise, only 65.5% of routine referrals in the South West met the four-week target, compared to 86.1% in the North West.[27]

Was the commitment effectively funded (or resourced)?

Since 2016, additional funding has been given each year to children and young people's community eating disorder services to assist services to meet the access and waiting times standards. Research conducted by the charity Beat on behalf of the All-Party Parliamentary Group on Eating Disorders found that much of this funding has not reached the front line:

- In 2019/20, 90% of the total additional funding for CYP community eating disorders did not reach the services it was pledged to.
- A fifth (21%) of CCGs actually spent less on CYP community eating disorder services in 2019/20 than in 2018/19.
- Spending per capita on CYP community eating disorder services in 2019/20 varied widely across the country.
- Seven CCGs reported a spend of less than £2 per capita. [28]

In response to the large escalation in referrals to CYP eating disorder services during the pandemic, a one off additional funding of £79m for these services was provided in 2021. It's imperative however, given the research conducted by Beat, that this funding reaches frontline services. Furthermore, with escalating need increased funding will be required for these services in future years if these targets are to be met and maintained.

Did the commitment achieve a positive impact for people living with mental ill health?

The waiting time standards for CYP eating disorders are very important for achieving positive impacts for young people struggling with these conditions.

There is underfunding of mental health research across the board, and within this a particular lack of investment into eating disorder research in the UK. Due to serious inequities within eating disorder research, there is a particular lack of evidence around the experiences of some groups of patients,

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[25] Mind (2021) 'Coronavirus: the consequences for mental health': www.mind.org.uk/media/8962/the-consequences-of-coronavirus-for-mental-health-final-report.pdf. Accessed September 2021.
[26] www.gov.uk/government/news/79-million-to-boost-mental-health-support-for-children-and-young-people. Accessed September 2021.
[27] NHS England, CYP ED Waiting Times – Q1 21-22 – National & Regional: www.england.nhs.uk/statistics/statistical-work-areas/cyped-waiting-times/. Accessed September 2021.
[28] APPG on Eating Disorders (May 2021) 'Short-changed: Funding for children and young people's community eating disorder services in England in 2019/20': https://beat.contentfiles.net/media/documents/short-change-report.pdf. Accessed September 2021.

including people with binge eating disorder, people from minority ethnic backgrounds, males, trans people, and autistic people, among others.[29] More needs to be done to see whether the waiting times standards are having a positive impact on all young people, or whether certain groups are being left behind.

The move to online service delivery during the pandemic, was particularly problematic for some young people using eating disorder services. One study found that young people, more than their parents, preferred face-to-face support for most types of interactions (in comparison to their parents who were more likely to prefer virtual support).[30] More needs to be done to understand which groups of young people may have been most negatively affected by the move to more remote delivery of some eating disorder services.

Was it an appropriate commitment?

Given the severe impact eating disorders can have on young people's lives, and that eating disorders have the highest mortality rate among psychiatric disorders[31], it was imperative that a high target was committed to.

Waiting times for children and young people accessing eating disorder services, were some of first waiting time standards for mental health services (the standards being published in 2015 and monitored since 2016) and has been an important driver for making improvements in this area. Between Q1 2016/17 and Q1 2020/21, the percentage of young people starting urgent treatment within one week of referral increased from 65% to 88%. The percentage of routine cases starting treatment within four weeks of referral also increased over time, from 65% in Q1 2016/17 to 90% in Q2 2020/21.[32] This trajectory however was disrupted by the Covid-19 pandemic. It thus essential that a focus on achieving and maintaining this target is built into Covid recovery plans.

Commitment: Ensure there is a CYP crisis response that meets the needs of under 18-year olds

Was the commitment met / is it on track to be met?

The target set out in the LTP, identified that there will be 100% coverage of 24/7 mental health crisis care provision for children and young people which combines crisis assessment, brief response and intensive home treatment functions by 2023/24.

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[29] APPG on Eating Disorders (September 2021) 'Breaking the cycle: An inquiry into eating disorder research funding in the UK': https://beat.contentfiles.net/media/documents/APPG_Research_Funding_inquiry_report.pdf. Accessed October 2021.
[30] Brothwood, P.L et al. (2021) Moving online: young people and parents' experiences of adolescent eating disorder day programme treatment during the COVID-19 pandemic. J Eat Disord 9, 62 (2021).
[31] Arcelus, J., et al. (2011) 'Mortality Rates in Patients with Anorexia Nervosa and Other Eating Disorders: A Meta Analysis of 36 Studies.' Arch Gen Psychiatry 2011, 68: 724-31
[32] Nuffield Trusts (2021) 'Children and young people with an eating disorder waiting times': www.nuffieldtrust.org.uk/public/resource/children-and-young-people-with-an-eating-disorder-waiting-times. Accessed September 2021.

As of 31 March 2020, only approximately a quarter of the country either had full or partial coverage of the four components of a comprehensive crisis service, against a 30% trajectory. Since then, in response to the Covid-19 pandemic, there was a speeded up roll-out of 24/7 all age mental health crisis lines. However, it is unclear if assessments have been completed as to whether these helplines are meeting the needs of under 18 year olds.

Apart from a dip at the beginning of lockdown, the number of people aged under 18 referred for emergency or urgent care has jumped substantially during the pandemic, with numbers currently at their highest yet. The number of new urgent referrals to crisis teams in June 2021 (2,260) was 75% higher than in the same month in 2020 and the number of new emergency referrals (822) was 66% higher than in June 2020.[33]

Importantly, 'full' or 'partial' coverage gives a lot of leeway and having the right model may not equate to the capacity to provide the appropriate level of care to all the children and young people reaching out to a service or being referred. It is important to know how close to full coverage areas are, and to what extent they can meet the needs of the children and young people in their care. The Urgent and Emergency Mental Health Care and Intensive Home Treatment for Children and Young People National Survey Report may contain more detail as may the urgent and emergency care vanguard site reports.

Was the commitment effectively funded (or resourced)?

Funding for children and young people's crisis services comes from overall ringfenced mental health investment. As stated previously however, spending on CYPMHS is low and variable. While the one-off £79 million boost for CYPMHS in March 2021 was essential (including additional funding to support follow-up crisis treatment at home where necessary), it is imperative that the commitment set out in the LTP that funding for CYPMHS will grow faster than both overall NHS funding and total mental health funding, is maintained.

Did the commitment achieve a positive impact for people living with mental ill health?

The changes delivered so far are likely to have achieved a positive impact, but it is difficult to say without more evidence. The Urgent and Emergency Mental Health Care and Intensive Home Treatment for Children and Young People National Survey Report may contain more detail as may the urgent and emergency care vanguard site reports.

We know that children and young people continue to struggle without sufficient support and that the system is being challenged by the impact of the pandemic. However, this only underlines the importance of fulfilling the commitment.

Was it an appropriate commitment?

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[33] NHS Digital, Mental Health Services Monthly Statistics: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics Accessed September 2021.

When children and young people are experiencing mental health crisis it is imperative that there is a timely, effective, and age-appropriate response. This commitment is therefore vital.

An accessible and responsive crisis service should mean that there is less likelihood of the police being involved in crisis situations when they may need to use their Mental Health Act powers to take a person to a place of safety, to be assessed. It should also mean that when police do use these powers, they are able to take the child or young person to a suitable place of safety, not a police station. Use of police stations as places of safety was banned for under 18s in 2017, however the practice has not been completely eliminated, so there can be no room for complacency.

A survey carried out in late 2016 identified only 15 crisis teams for children and young people of which only 46% provided a full 24 hour service including capacity to provide home visits. The authors comment that "in most areas of England, neither children nor adults with dementia can access crisis support from a specialist CRT team. Children's and older adult CRTs are typically less well staffed and less likely to be organised to provide easy-access, 24 h intensive home treatment, compared to adult CRTs." [34]

Lack of appropriate crisis care response for young people, is also contributing to young people being placed on adult wards. In 2019/2020, NHS England data showed that 592 children were placed on adult wards in 2019/20, three times the number in the previous year.[35] In quarter 1 of 2020/21, 83 young people were placed on adult wards, resulting in 1,391 bed days on adult wards.[36]

This commitment is clearly driving improvements, but it's clear much more needs to be done and to understand whether it's working for young people. Importantly the commitment is specific about the required elements of crisis care while allowing some local flexibility.

Adult common mental illness

[34] Lloyd-Evans, B et al. (2018). 'Mental health crisis resolution teams and crisis care systems in England: A national survey.' BJPsych Bulletin, 42(4), 146-151. doi:10.1192/bjb.2018.19.
[35] Article 39 (February 2021) 'Children in hospital (Mental health)': https://article39.org.uk/statistics-briefings/. Accessed October 2021.
[36] NHS Mental Health Dashboard Q4 2020/21: www.england.nhs.uk/publication/nhs-mental-health-dashboard/. Accessed September 2021.

Commitment: All areas commission IAPT-Long term condition services

Was the commitment met / is it on track to be met?

The Five Year Forward View for Mental Health set out that NHS England should invest to increase access to integrated evidence-based psychological therapies for an additional 600,000 adults with anxiety and depression each year by 2020/21 (resulting in at least 350,000 completing treatment), with a focus on people living with long-term physical health conditions.[37] The aim for all areas to have an IAPT Long Term Conditions (IAPT-LTC) service in place from 2018/19 onwards has not been met. The data on the roll out of IAPT-LTC services is not publicly available, making scrutiny of this target harder.

The assurance delivery process by NHS England at the regional level for the IAPT-LTC pathways was temporarily put on hold from March 2020 due to the pandemic. Additionally, the pandemic has seen mental health services being faced with the additional pressure of rising acuity, resulting in more complex presentations, including within IAPT services, leading some IAPT services to provide more sessions per client than previously. This has been coupled with disruptions to physical health pathways and primary care services, all impacting on IAPT-LTC pathways.

Was the commitment effectively funded (or resourced)?

Commissioning of these services come out of the CCG baseline funding for IAPT. This lack of dedicated or ring-fenced funding for the programme may have contributed to the lack of focus on ensuring that there are IAPT-LTC pathways in every CCG area.

In March 2021, £500m was announced by the government as part of a mental health recovery action plan, with £38m for expanding IAPT services to assist the increase in complexity of people's mental health problems as a result of the pandemic, including the mental health of those with long Covid. If increased acuity of mental health problems persists, more funding will be required for all IAPT services for greater training and increasing the numbers of sessions offered.

Did the commitment achieve a positive impact for people living with mental ill health?

Evaluations of IAPT-LTC services and pathways have identified positive impacts for many of the people living with mental ill health who have used them.[38] [39] Research however has also identified there is still much to be done to improve the functioning of LTC pathways in practice and enhance users' experiences.[40]

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[37] Five Year Forward View for Mental Health (2016): www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf. Accessed September 2021.
[38] Royal College of Psychiatrists and UCL (2018) 'IAPT-LTC Early Implementers Programme Report on the implementation and process evaluation of Wave 1 early implementer sites': www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/iapt/iapt-ltc-early-implementers-programme-report.pdf?sfvrsn=2ee7aeac_6. Accessed September 2021.
[39] Panchal, R et al.(2020) 'The successful impact of adapting CBT in IAPT for people with complex long-term physical health conditions.' The Cognitive Behaviour Therapist, 13, E36. doi:10.1017/S1754470X20000306.
[40] Carroll, S et al. (2020) 'Therapists' perceptions of barriers and facilitators to uptake and engagement with therapy in long-term conditions.' Br J Health Psychol. 2021 May;26(2):307-324. doi: 10.1111/bjhp.12475. Epub

"Before transplant, I did see a counsellor. She was a help, but I still struggled. Going to see a counsellor on a certain day when I was poleaxed with kidney failure was impossible at times when I was so cripplingly tired."[41]

Research has also identified that the challenge of living with a long-term condition may be compounded by other issues people face, including poverty, housing or relationship difficulties, racial injustice and discrimination.[42] Subsequently, the IAPT-LTC services should work to assess the current access and experiences of these groups, and to adapt to make improvements as needed.

Was it an appropriate commitment?

The evidence supports the benefits of IAPT for people with physical LTCs, and for the health system as a whole, meaning a commitment in this area is vital. This commitment also assists in efforts for more integration of physical and mental health services throughout the system. More however is needed to focus efforts on this area of work within the overall IAPT programme, and given the nature of people's LTCs, and the challenges of integrating different health systems this requires clear resourcing.

Beyond roll out of the IAPT-LTC pathways in each CCG area, more assessments of these pathways are needed to identify more specific commitments regarding numbers accessing, types of conditions people are accessing with, equity of assess and to improve outcomes and experiences of people using the services.

Adult severe mental illness

Commitment: 280,000 people with SMI will receive a full annual health check

Was the commitment met / is it on track to be met?

The Five Year Forward View for Mental Health made the commitment for 280,000 more people living with severe mental illness (SMI) to have their physical health needs met by increasing early

2020 Oct 11. PMID: 33043530.

[41] National Voices and Centre for Mental Health (2021) 'Ask how I am: Supporting emotional health among people living with long term conditions': www.centreformentalhealth.org.uk/publications/ask-how-i-am. Accessed September 2021.

[42] Ibid.

detection and expanding access to evidence-based physical care assessment by 2020/21.[43] This has equated to a target of 60% of people on the General Practice-SMI register should receive a comprehensive annual physical health-check and follow-up interventions by the end of 2020/21, in all CCG areas.

This target is far from being met, with only 23.4% of people on the SMI register receiving a comprehensive annual health check in the 12 months prior to March 2021, and 27.1% by the end of June 2021. All regions failed to come close to the target. The latest data does however show variation within this, with the South West only providing 18% of people on the SMI register with physical health checks in the previous year, while the North East and Yorkshire managed 35.4%.

The Covid-19 pandemic greatly impacted the delivery of physical health checks during 2020/21, with a reduction in face-to-face contacts and reduced primary care capacity.[44]

Was the commitment effectively funded (or resourced)?

Since 2017, there have been CCG baseline allocations for improving the physical healthcare of people living with a SMI, and other financial incentives for delivery have been provided through the Commissioning for Quality and innovation (CQUIN) framework and the Quality Outcomes Framework (QOF). Physical health checks for people with a SMI have been included in the 2021/22 QOF with an additional £24m direct investment into primary care for this work.

Further funding was provided during the pandemic (winter 2020/21) to develop tailored outreach and engagement activities to support access for people with a SMI to physical health checks, flu vaccinations (where eligible) and COVID-19 vaccinations.

Given that different funding mechanisms have been utilised before with limited progress in this area, it is likely that more funding is required, alongside employing different levers that might assist services to focus on this commitment.

Did the commitment achieve a positive impact for people living with mental ill health?

As the primary tool to reduce the mortality gap experienced by people with a SMI, this commitment has the potential to have a positive impact on both the length and quality of people's lives when living with an SMI. However, this impact will be limited while work in this area has stalled.

More research is also required to understand other intersectionality's that may impact on the physical health of people with an SMI, including race and financial insecurity, to drive improvements in this area.

Was it an appropriate commitment?

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[43] Five Year Forward View for Mental Health (2016): www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf. Accessed September 2021.
[44] NHS England 'Physical Health Checks for people with Severe Mental Illness': www.england.nhs.uk/statistics/statistical-work-areas/serious-mental-illness-smi/.

This commitment is vital given the increased rates of mortality experienced by people with a SMI, and the lack of progress in addressing this. The current target is specific and focused, so more needs to be done to understand what are the barriers that are preventing more progress in this area.

Given the long-standing mortality gap for people with a SMI, it is also important to assess over time, whether improvements in numbers receiving a physical health check are reflected in longer-term improvements in mortality data.

It is likely that given the intersectionality's at play impacting on the poorer physical health of people with an SMI, further targets with a wider scope will be required to drive improvements in this area. For instance addressing the impact of poverty and financial insecurity experienced by people with a SMI which is also driving poorer physical health.

Commitment: New integrated community models for adults with a severe mental illness [delivery date is 2023/24]

Was the commitment met / is it on track to be met?

As part of this commitment the LTP contains several related commitments. This included a commitment to the NHS supporting an additional 35,000 people with SMI where this is a personal goal to find and retain employment by 2023/24, a total of 55,000 people per year. This has been particularly impacted by the pandemic and is well behind the trajectory.

Commitments were also made to Early Intervention in Psychosis (EIP) access standards (60% of referrals seen within two weeks) and 95% of services achieving level 3 NICE accordance. While the access standards are being met, level 3 NICE concordance rates are well below the expectations outlined in the LTP mental health implementation plan.

The Community Mental Health Framework has been an important and welcomed step towards delivery of this commitment. Many local Minds report good involvement of the VCS sector in developing new integrated services, but some areas have progressed less on this. Integrating systems is complex and will be even more challenging in light of increased equity for people with SMI following the pandemic.

Was the commitment effectively funded (or resourced)?

£70 million additional funding was provided to support this ambition to test new models of integrated care and four-week waiting times as part of the Clinically-led Review of NHS Access Standards. Additional baseline funding for CCGs in 2019/20 was provided to bolster core adult community mental health provision.[45]

£87m was also provided by the Covid-19 mental health and wellbeing recovery action plan to provide additional support for those leaving hospital, such as temporary accommodation or care at home.

It is likely given the scale of increased need in light of the pandemic and the complexity of this commitment, more funding will be required.

Did the commitment achieve a positive impact for people living with mental ill health?

While it is too early to judge the impact of changes to delivery of services due to this commitment, we do know that lack of support in the community, for the different aspects of life that can impact on someone's mental health, is often highlighted to us as being a reason why people feel they have hit crisis point.

"If I had had the support promised on discharge I wouldn't have ended up having another crisis three months later during which I self-harmed and attempted suicide."[46]

People tell us that access to 'clinical' support (such as psychological therapies), but also a range of 'social' interventions (such as support for housing or finances) is vital for them to stay well. Our 2017 survey found that the areas of life least likely to be considered in care planning were work, education and training (69 per cent said these were not well considered if at all), social, cultural and spiritual needs (67 per cent), substance misuse (63 per cent), and money and benefits (62 per cent). Despite mental health problems being the reason for admission, half (51 per cent) said the same for managing mental health and self-care; and 42 per cent for mental health treatment.[47]

Was it an appropriate commitment?

This commitment is vital to address a range of issues identified with previous and existing support provided for people with SMI. This includes ensuring more holistic care in the community to prevent people hitting crisis point and needing inpatient care, or after inpatient care has been necessary to be supported when returning home. It is a necessarily ambitious commitment that is central to many other mental health service commitments.

Commitment: The therapeutic offer from inpatient mental health services will be improved by increased investment in interventions and activities, resulting in better patient outcomes and experience in hospital

Was the commitment met / is it on track to be met?

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[45] National Collaborating Central for Mental Health (September 2019) 'The Community Mental Health Framework for Adults and Older Adults': www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf. Accessed October 2021.
[46] Mind (December 2017) 'Leaving hospital: a briefing on discharge from mental health inpatient services': www.mind.org.uk/media-a/4376/leaving-hospital-minds-good-practice-briefing.pdf. Accessed October 2021.
[47] Ibid.

The LTP commitment to improve the therapeutic offer from inpatient mental health services by 2023/24, explicitly built upon the Five Year Forward View for Mental Health's commitment to eliminate Out of Area Placements (OAPs) by 2020/21.[48] It is important to note that the system did not manage to achieve the elimination of OAPs, with 670 active OAPs in March 2021.[49] It is devastating when anyone is sent far from home and their support systems when they are at their most vulnerable, it is therefore vital that there is a concerted focus and effort on getting back on track to eliminating OAPs.

The LTP commitment also identified that improving the therapeutic offer would contribute to a reduction in length of stay for all services to the current national average of 32 days (or fewer) in adult acute inpatient mental health settings. In 2019/20, the average length of stay was 35 days.[50]

Improving the therapeutic offer will have been impacted by the pandemic and the strain this put on services. Important work on discharge was rapidly developed for the winter of 2020 and there is now an expectation of 72 hour rather than 7 day follow-up after discharge. This is very welcome, but it is not the same as providing therapeutic environments and activities and it is still essential that work is done to focus on this.

To a large extent this commitment relies on the delivery of an increased workforce, which is behind trajectories outlined in implementation plans. As highlighted previously however, patient experiences also tell us much more work is also needed to address staff culture, including a shift to focusing on therapeutic activities instead of over-reliance on medication, and trauma informed care.

> "The support you get once you're sectioned – you're observed by someone pulling back a shutter half way through the night to make sure you're asleep, and make sure you're eating, making sure you're taking medication. In terms of any talking therapy, trying to understand, and doing it in a holistic and joined up way, none of that exists."[51]

Similarly, to create therapeutic environments, more needs to be done to improve the mental health estate. As highlighted by the Mental Health Act Review, "Wards become people's home, often for many months, and so should offer a positive community for the patient where they can build new relationships."[52] But mental health wards are still often old, unwelcoming and institutional. Hence, capital investment is also needed if this commitment is to be achieved.

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[48] NHS England (2019) 'NHS Mental Health Implementation Plan 2019/20 – 2023/24': www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/. Accessed September 2021.
[49] NHS Digital (2021) 'Out of Area Placements in Mental Health Services March 2021': https://digital.nhs.uk/data-and-information/publications/statistical/out-of-area-placements-in-mental-health-services/march-2021. Accessed October 2021.
[50] NHS Benchmarking Network (2020): www.nhsbenchmarking.nhs.uk/mental-health-sector#mhld. Accessed October 2021.
[51] Mind (2019) Mental Health Act Review: Mind's engagement and influence: https://mind.turtl.co/story/5c3f4b11903f285d2e0f30e3/page/6. Accessed September 2021.
[52] Independent Review of the Mental Health Act 1983 (2018) 'Modernising the Mental Health Act': https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf. Accessed October 2021.

Was the commitment effectively funded (or resourced)?

It was identified that in 2019/20 preparatory work on this commitment would be done "in advance of additional future funding".[53] It is unclear what funding has got through to services for this since, in light of the pandemic. Likewise, it is unclear when (or if adequate) funding for implementing the Mental Health Act Review will be realised, which would also support this commitment.

Did the commitment achieve a positive impact for people living with mental ill health?

We are repeatedly told through our engagement with people with lived experience, that many patient environments are far from therapeutic and can be detrimental to people's mental health when they are at their most vulnerable. However, the positive impact dedicated, consistent, 1-2-1 interactions with staff to build a trusting therapeutic relationship can be life changing. Providing therapeutic activities, including talking therapies within inpatient wards, have been shown to have a positive impact on the people's wellbeing, reduce use of restraint and serious incidents.[54] Importantly, providing a therapeutic offer which is culturally competent is also vital to ensure that positive outcomes are equitable.

Was it an appropriate commitment?

'Therapeutic' should be the defining characteristic of any inpatient experience, yet the independent review of the Mental Health Act, the implications of the Mental Health Units (Use of Force) Act, and the Care Quality Commission's work on restraint and closed cultures all reinforce what people tell us, that this can be very far from the case.

It is less clear than for some other commitments what the delivery plan is for this area of work, as implementation depended on preparatory work. It should be helpful to update the plan with more specificity.

Commitment: All areas will provide crisis resolution and home treatment (CRHT) functions that are resourced to operate in line with recognised best practice, delivering a 24/7 community-based crisis response and intensive home treatment as an alternative to acute inpatient admission

Was the commitment met / is it on track to be met?

It is hard to assess whether the commitment is on track using publicly available data. No annual survey was completed to collect this data during the pandemic, so assessments of this will be required from NHS England and providers.

Was the commitment effectively funded (or resourced)?

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[53] NHS England (2019) 'NHS Mental Health Implementation Plan 2019/20 – 2023/24': www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/. Accessed September 2021.
[54] Examples of work in this area include: Safe Wards (www.safewards.net), PRMOISE (www.promise.global/how_promise.html), TULIPS (https://sites.manchester.ac.uk/tulips/).

Transformation funding was provided for investment in this area, including Crisis Resolution and Home Treatment teams and crisis alternatives, but it is unclear whether this has been sufficient. Given feedback from services and from people with lived experiences, that the pandemic has led to many with existing mental health problems to have seen their mental health become worse, it will be important that adequate funding reaches crisis services to achieve this commitment.

Did the commitment achieve a positive impact for people living with mental ill health?

It is hard to assess the impact of this specific commitment to date, however we do know that good crisis care services can be lifesaving. Currently, some local Minds are reporting that they have been struggling to get community teams and Crisis Resolution and Home Treatments teams to come out to see people in crisis and they haven't been able to access appropriate statutory services, sometimes with fatal consequences. So, a focus on this area is vital. More is needed to explore and understand people's experiences of trying to access and using these community based crisis response services.

Was it an appropriate commitment?

Crisis Resolution and Home Treatment teams are a core part of mental health care – providing a response to urgent need, enabling people to be cared for at home and facilitating admission to and discharge from hospital. Yet a national survey carried out in 2016 found that few teams adhered fully to national policy guidelines. Most teams (93%) provided a 24 hour telephone response, but just over two-thirds (69%) operated a full 24 hour service, including capacity to make home visits. Only one team was fully adherent. [55] This means that the commitment was appropriate to drive improvements in this area and it is suitably specific if all areas were to have a safe and fully functioning crisis response.

[55] Lloyd-Evans, B et al. (2018). 'Mental health crisis resolution teams and crisis care systems in England: A national survey.' BJPsych Bulletin, 42(4), 146-151. doi:10.1192/bjb.2018.19.