Written evidence submitted by the Centre for Mental Health (MHS0016)

About us

Centre for Mental Health is an independent not-for-profit organisation dedicated to eradicating inequalities in mental health. Our research, analysis and evaluation work seeks to inform policy and change practice in pursuit of social justice and equality for mental health.

We are pleased to have been asked to provide evidence to the Committee's Expert Panel about progress made towards the Government's plans for mental health services in England. Our evidence draws on research we have carried out or reviewed.

In relation to children and young people, our evidence is based on information provided by the Children and Young People's Mental Health Coalition, which we host. The Coalition brings together over 200 organisations to campaign and influence policy, with and on behalf of children and young people, in relation to their mental health and wellbeing. The Coalition advocates for the better mental health of all infants, children and young people.

We do not represent any one organisation, approach, or professional group, but come together to provide a strong unified voice speaking out about children and young people's mental health. We are chaired by Sir Norman Lamb.

Summary

Workforce:

NHS England's mental health implementation plan (NHSE, 2019) set out clear and specific targets for the numbers of extra staff who would be needed, across a range of disciplines, to meet the ambitions of the Long Term Plan.

The mental health workforce declined between 2010 and 2017 before rising again, and it has now recovered to the same level as a decade ago (O'Shea, 2021b). This leaves a significant gap which will be exacerbated by rising demand for mental health support as a consequence of the pandemic (O'Shea, 2021a).

Increasing the capacity and diversity of the mental health workforce requires system-wide action (Durcan et al., 2017) including promoting a wide range of mental health careers in schools and colleges; expanding training opportunities, including a wider range of placement options and provision for supervision; and creating a wider range of opportunities for people with lived experience of mental health care to enter and progress within the workforce

Workforce

Mental health workforce capacity

Expanding the mental health care workforce is essential to increase the capacity of the health and care system to meet people's needs. NHS England's mental health implementation plan (NHSE, 2019) set out clear and specific targets for the numbers of extra staff who would be needed, across a range of disciplines, to meet the ambitions of the Long Term Plan. The figures given in the plan were

predicated on the timely achievement of the workforce expansion set out in the previous strategy, *Stepping Forward*.

The mental health workforce declined between 2010 and 2017 before rising again, and it has now recovered to the same level as a decade ago (O'Shea, 2021b). This leaves a significant gap which will be exacerbated by rising demand for mental health support as a consequence of the pandemic (O'Shea, 2021a).

For the children and young people's mental health workforce, workforce expansion and development continue to be the biggest risk in efforts to expand and transform children and young people's mental health services. A report by the National Audit Office found that slow progress on workforce expansion to deliver NHS services was a major risk to delivery of initiatives such as Future in Mind and the Five Year Forward View (National Audit Office, 2018). In evidence to the Public Accounts Committee, NHS England also stated that workforce is the single biggest risk to achieve its Five Year Forward View ambitions (Public Accounts Committee, 2018).

For example, The Stepping Forward programme aimed to increase the children and young people's mental health workforce in England by 4,500 full-time equivalent staff by 2020-21 but data on the progress made in expanding the workforce under this strategy is limited (National Audit Office, 2018). The Health Education England mental health workforce strategy also committed to 100 extra consultant child and adolescent psychiatrists by 2020/21, but it has been noted that they were not on track to hit their target at the time (National Audit Office, 2018).

Increasing the capacity and diversity of the mental health workforce requires system-wide action (Durcan et al., 2017) including:

- Promoting a wide range of mental health careers in schools and colleges
- Expanding training opportunities, including a wider range of placement options and provision for supervision
- Creating a wider range of opportunities for people with lived experience of mental health care to enter and progress within the workforce
- Training mental health professionals in a wider range of psychological interventions, coproduction and consultation skills
- Developing a wider range of career paths and opportunities, including in the VCS and new roles for older workers
- Reviewing and reforming recruitment, training and progression routes for people from racialised communities
- Prioritising the mental wellbeing of mental health workers.

Health and care workforce wellbeing

The pandemic will result in worsening mental health for NHS staff – something which is already being observed in absenteeism figures. There is an absence of strategic planning for how to promote and protect the health of NHS workers, including during and post-pandemic. The Covid-19 mental health and wellbeing recovery action plan only commits to £30m of specific funding – approximately £30 per NHS staff member – on mental health hubs. NHS staff have accessed the health and wellbeing offer 750,000 times but the outcomes of that or the number of contacts per person are unpublished (O'Shea, 2021b).

While there have been some examples of localised good practice in supporting health and care staff wellbeing – such as in Manchester following the Arena bombing – there is no consistent national

strategy. The provision of screening and large-scale clinical treatment for traumatised staff can only be delivered with a clear strategy for investment. A national strategy would detail how it will identify, support and treat the predicted 5,325 ICU staff who will have PTSD, or the estimated 250,000 front line workers who will require treatment for severe depression or anxiety.

The cost of NHS staffing was £47.6bn in 2016/17 (King's Fund, 2019). Preventing a 1% increase in the rate of FTE absence saves £476,000,000 per annum. This is the equivalent of providing a quarter of a million staff with mental health treatment worth approximately £2,000 per person. This is the kind of spending envelope for staff treatment and support that should be under consideration and the levels of funding that a strategy should offer (O'Shea, 2021b).

Children and young people's mental health

Improving access to specialist services

The Five Year Forward View for Mental Health set out plans for improving mental health services so 70,000 more children and young people will access treatment each year by 2020/21. Whilst this was a welcome step to achieving parity of esteem, an inquiry led by the Public Accounts Committee highlighted that the commitment would still leave two-thirds of young people in need without NHS treatment (Public Accounts Committee, 2018).

A review conducted by the National Audit Office (NAO) highlighted concerns in the government's ability to understand real progress towards delivering this ambition due to significant data weaknesses (National Audit Office, 2018). NHS England has since reported that progress against the target has been met, in 2017/18, around 30.5% of children and young people then estimated to have a mental health condition were able to benefit from treatment and support (NHS, 2019).

More recent policy initiatives have since built on this target. The NHS Long Term Plan made a new commitment expanding access to, setting out that by 2023/24, at least an additional 345,000 children and young people aged 0-25 will be able to access support via NHS funded mental health services and Mental Health Support Teams. Over the next decade, the goal is to ensure that 100% of children and young people who need specialist care can access it. However, NHS England have not yet clearly defined this nor have they produced a clear strategy for how they will achieve this.

Whilst targets to improve access to mental health support for children and young people have been welcome, there have been longstanding access issues for children and young people needing specialist and urgent mental health support.

Many of our members cite ongoing issues around high thresholds for support which result in too many children and young people being turned away from support because they are not deemed 'ill enough'. In a recent evidence session to the Health and Social Care Select Committee on children and young people's mental health, it was noted that over half of children and young people with mental health problems are not accessing support from mental health services (Health and Social Care Committee, 2021).

Findings from the Children's Commissioner also show that 4% of children accessed mental health services in 2019/20, equivalent to 1 in 4 (based on the 2020 NHS Digital prevalence data) (Children's Commissioner for England, 2021). While this is concerning, there has been marginal improvements in recent years.

Fragmented commissioning has also contributed to huge variability in what support is available locally which continues to fuel a 'postcode lottery' in provision. Funding levels also appear to vary greatly between local areas. Analysis from the Office of the Children's Commissioner found that eight local areas spend less than £40 per child on mental health services, while 21 areas now spend more than £100 per child (Children's Commissioner for England, 2021).

The Covid-19 pandemic has since placed additional pressure on specialist services. A recent survey by NHS Providers found mental health services for children and young people are under growing pressure and increasingly overstretched, despite significant support and investment. Of those surveyed by the membership body, 100% of mental health trust leaders said that the demand their trust or local systems is experiencing for children and young people's services is significantly (80%) or moderately (20%) increasing compared to six months ago (NHS Providers, 2021).

Referral data also reinforces this. Analysis of NHS data by the Royal College of Psychiatrists has found that 80,226 more children and young people were referred to children and young people's mental health services between April and December in 2020, up by 28% on 2019 (Royal College of Psychiatrists, 2021).

Mental health support teams

Steps have also been taken to expand access to mental health support through the *Transforming Mental Health Provision* green paper. Coalition members have welcomed provisions such as Mental Health Support Teams and the senior lead as welcome additional resource schools and colleges. Mental Health Support Teams are intended to provide early intervention on some mental health and emotional wellbeing issues, such as mild to moderate anxiety, as well as helping staff within a school or college setting to provide a 'whole school approach' to mental health and wellbeing.

Coalition members have highlighted some of the positive work they are seeing being undertaken by MHSTs, including greater partnership working and providing support to those who do not require support from specialist services.

This was echoed in an early evaluation of Mental Health Support Teams, which covered the period from November 2020 to mid-March 2021 (Ellins et al., 2021). The evaluation found there is good progress in implementing the teams, including:

- Improvements reported by education settings included more timely access to support.
- Staff feeling more knowledgeable and comfortable talking to pupils about mental health issues.
- Development of a more proactive and positive culture around mental health and wellbeing in their setting.

However, there have been concerns about implementation and the speed in which all areas of the country will have access to this additional support. When the Green Paper was published, it set out that one third to a quarter of the country will benefit from MHSTs by 2023/24. Data from NHS England shows that there are now over 280 mental health support teams set up or in training – 183 are operational, covering 15% of pupils in England (NHS England, 2021). A further 103 are in development (NHS England, 2021).

The early evaluation also identified particular concerns about a lack of support for children whose needs were not mild to moderate, but also not serious enough to require specialist care. The evaluation shared the view that the 'standard' MHST intervention which Emotional Mental Health Practitioners (EMHPs) had been trained to deliver was less suitable and effective for some groups, including younger children, children who were self-harming, children with SEND, and vulnerable and disadvantaged groups.

Arrangements for early intervention services

Findings from the NAO review demonstrates the need to re-balance current and future investment from late intervention, crisis and urgent care to early intervention provision in local communities (National Audit Office, 2018). The emotional needs of babies, children, young people, and their families can often be effectively met in the community by wider local support services. Many of these services seek to destigmatise mental health difficulties and normalise help-seeking behaviour, identify needs early and provide preventative and low-level mental health support and advice. Services of this kind can help reduce referrals to more costly, specialist services.

However, Coalition members recognise the many barriers that make it difficult for early intervention services to be prioritised. Responsibility for the provision of early support services in the community is shared between the NHS and local authorities. However, there is a significant lack of accountability and transparency across local areas as to who is responsible for ensuring provision is available. As a result, the availability of community services is patchy and there is no standard model for the type of support that should be in place.

This is further confused by a lack of dedicated funding for local areas to provide services of this kind. In their 2019 report on early access to mental health support, the Office of the Children's Commissioner for England estimated that around £226 million was spent on low-level mental health services in the financial year 2018/19 but found that there was wide variation in local areas on the amount spent (Children's Commissioner, 2019).

Eating disorder services

There have been concerns about the increasing numbers of young people experiencing problems with eating disorders. Data from NHS Digital shows the proportion of 11 to 16 year olds with possible eating problems increased from 7% in 2017 to 13% in 2021, whilst the proportion for 17-19 year olds rose from 45% to 58% (NHS Digital, 2021).

There has been growing concern about the rise in demand for eating disorder services, with findings from NHS Confederation showing the number of young people completing an urgent pathway for eating disorders has increased by 141 per cent between quarter four in 2019/20 and quarter one in 2021/22 (NHS Confederation, 2021).

The introduction of an access and waiting time standard for eating disorder services for children and young people has set clear expectations around access to evidence-based treatment within maximum waiting times, and funding to support this has been a major step forward. However, it needs to be ensured that there is comprehensive implementation of the access and waiting time standard across every region, and that additional resources are provided to address this increase in

the need for treatment. Evidence also states that early intervention is crucial to a rapid, sustained, and full recovery.

New care models

One area of significant promise is the development of New Care Models for children and young people's crisis services. Our economic evaluation of this programme (O'Shea, 2020) found that offering community treatment and intensive support instead of acute beds reduced the cost of treatment by £15.3m for a group of just 217 patients – many of whom had been in wards long distances away from home and family.

By investing in local services, each of the sites achieved reductions in overall spending at the same time as a significant expansion of community-based care with comprehensive offers of 24 hour availability of highly skilled teams and innovative models of support.

Each area identified small numbers of young people whose treatment was comparatively expensive. This ranged from 22-49 people with annual, average treatment costs totalling between £7.5m and £13.4m in each site (or £187,351-£513,852 per person).

The programme enabled areas to make significant changes in expenditure. They achieved overall reductions of between £1.1m and £4.1m for 2017/18; a total of £15.3m that can be reinvested in local services. This change was driven by reductions in Out-of-Area Bed Days and Lengths of Stay in hospital, by varying degrees.

Adult common mental illness

The continued expansion of the IAPT programme is an important part of the NHS Long Term Plan. Improving access to psychological therapies should improve outcomes for people with depression and anxiety and end the postcode lottery of timely access to therapy.

Long-term conditions

A major focus of the IAPT programme is to extend access to people living with long-term physical conditions.

Our research with National Voices (Wilton, 2021) finds that people with long-term conditions want timely access to psychological therapy, but this is not enough on its own to meet their mental health needs, and it needs to be part of a whole system approach to supporting mental and physical health. This should include offers of a wider range of psychological interventions than IAPT currently provides, combined with practical help, peer-led support, and emotional support for their families and carers.

The people we spoke to for this research had accessed a range of forms of support for their emotional health, from informal help from friends and family to treatment from health and care services. No one form of support was universally helpful. There is no 'one size fits all' solution. More important than the form of support was whether the person providing it had insight (either from professional training or personal experience) into what it was like to live with a long-term condition (Wilton, 2021).

The report recommends that NHS England should review the IAPT Programme for long-term conditions to determine whether its current approach and structure is able to meet people's needs adequately, how easily accessible it is for people with the full range of long-term conditions, and what modifications may be needed to achieve these aims during the implementation phase of the NHS Long Term Plan.

Addressing inequality

Data from the IAPT programme shows that referrals tend to be highest for people from the most deprived decile of the population and lowest for the least deprived. But treatment entry, completion and recovery rates show the opposite trend, and the available data suggests that at every stage of the IAPT process people living in greater deprivation are disadvantaged (Commission for Equality in Mental Health, 2020). A similar pattern is seen with regard to ethnicity: both completion and recovery rates are consistently lower for people from racialised communities than for white people.

The IAPT programme needs to explore why this happens and what can be done to improve access and outcomes for disadvantaged, marginalised and racialised communities. And this needs as much attention as the continued imperatives to increase the number of people who get access to talking therapies and to improve recovery rates for those who do.

The gap between primary and secondary care

A major current gap in mental health support is the provision of services to people who are regarded as having needs that are too complex for IAPT but who don't meet local thresholds for secondary services. This affects not just a single group but a mixed and varied range of people including those diagnosed with personality disorders or complex trauma symptoms, people with co-occurring drug or alcohol problems and people with persistent physical symptoms (Newbigging et al., 2018). It includes many people who are involved in the criminal justice system, whose needs are multiple and complex but who fall below thresholds for secondary mental health services but whose needs are seen as too complex for IAPT (Durcan, 2021).

The Community Mental Health Framework recognises that the gap between primary and secondary care needs to be closed, and the current investment in primary and community mental health services is intended to address this. It pledges to create a 'whole person, whole population' mental health system. It is currently unclear how far this has been achieved and what models are being employed to deliver this promise.

The recently established Additional Roles Reimbursement Scheme (ARRS) for primary care networks to get funding for dedicated primary care mental health workers is an important opportunity to extend psychological support into GP surgeries and the communities around them (Naylor et al, 2020). We have seen numerous examples of local services that have sought to meet the needs of people who previously fell between primary and secondary care. They include embedding clinical psychologists in GP surgeries (Durcan, 2020) and creating new psychological medicine services (O'Shea, 2019). These need to become a part of the system nationwide, not just an optional add-on in some localities.

Adult severe mental illness

NHS England's plans to improve services for people living with severe mental illness are ambitious. They aim to bring about a significant improvement in both the capacity and quality of community mental health services and in the support people get in a crisis. The vision set out in the Community Mental Health Framework in particular is clear and compelling: achieving it in practice will be a lot harder, and it relies a great deal on the successful expansion of the workforce.

Physical health equality

The Long Term Plan pledges improvements in physical health support for people living with a mental illness. This centres largely on the deployment of annual physical health checks. While current delivery of health checks is low (at less than one quarter of people registered with their GP as having

a severe mental illness), recent changes to the GP contract to incentivise the provision of a full six-part health check are a positive step (Bell, 2021). The Plan also commits the NHS to delivering smoking cessation support to all hospital inpatients, including in mental health services, with an intention to extend this to people using community mental health services over time.

The mixed progress in meeting the physical health needs of people with a mental illness is illustrated by the vaccination programmes for both Covid-19 and influenza. Working age people on GP severe mental illness registers were included within the priority group of those with long-term conditions for the Covid-19 vaccine. This was a positive step for parity, but it raised concerns about the exclusion of people with a range of long-term mental health conditions including personality disorders and eating disorders from this group. And the same group is not currently afforded priority for flu vaccination, despite facing a higher risk of mortality from infectious illness (WHO, 2015; Vai et al, 2021; Nemani et al, 2021).

Mental health equality

A key element of the Long Term Plan is the Advancing Mental Health Equalities programme, and alongside it the Patient and Carer Race Equality Framework (PCREF). These initiatives aim to address ingrained and longstanding inequalities in access to, experiences of and outcomes from mental health services.

Previous attempts to address inequalities, such as the 2005-2009 Delivering Race Equality programme, were hampered by a short-term lifespan and limited engagement outside the NHS. The current programme will need time to make a sustained impact, ongoing resourcing and commitment from senior leaders across the NHS and wider systems of care. It requires professional bodies and education and training providers, for example, to change the ways they recruit, educate and value people, the career pathways they create, and the opportunities they open up to people from diverse communities and backgrounds.

Reform of the Mental Health Act will also be an important element in this process. While changes to the legislation will not directly create equality or address the dramatic disparities in its use, modernising the Act will boost people's rights, reduce the scope for subjective decision-making, and limit the use of coercion both in hospitals and the community.

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Contact us

To discuss any element of this evidence paper, please contact Andy Bell

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