A WORLD-LEADING MENTAL HEALTHCARE SYSTEM BY 2035: COMMITMENTS FOR A CROSS-GOVERNMENT MENTAL HEALTH AND WELLBEING PLAN

Royal College of Psychiatrists

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About the Royal College of Psychiatrists

We are the professional medical body responsible for supporting psychiatrists throughout their careers from training through to retirement, and in setting and raising standards of psychiatry in the United Kingdom.

We work to secure the best outcomes for people with mental illness, intellectual disabilities and developmental disorders by promoting excellent mental health services, supporting the prevention of mental illness, training outstanding psychiatrists, promoting quality and research, setting standards and being the voice of psychiatry.

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1. Executive summary

The government's commitment to level up and address unequal outcomes and life chances across the country has never been more pressing.[1] Improving the mental health and wellbeing of the nation is integral to this commitment, particularly for people who experience worse outcomes than the general population.

We welcomed the former Secretary of State for Health and Social Care's commitment to ensuring the NHS is set up properly for success, levelling up across the NHS and social care, pursuing personalisation, as well as using emerging technologies and data. The Government's mental health and wellbeing plan will be central to delivering this commitment and we commend it to the new Secretary of State and urge them to take this agenda forward.

Mental illness remains one of the largest single causes of disability in England[2] with up to one in five mothers suffering from depression, anxiety, or psychosis during pregnancy or in the first year after childbirth[3], one in six children and young people aged 6−19 having a probable mental disorder[4], 1−2% of adults having a severe mental illness (SMI)[5] and one in 30 adults living with drug dependence.[6]

Mental illness also disproportionately affects people living in poverty, those who are unemployed, and those who face racial discrimination.[7]

Yet, we know that only a minority of people in England with a mental illness, including substance/alcohol use, receive any form of treatment. The only exception to this is for people experiencing psychosis. [8]

The government's last cross-government mental health strategy only achieved half of its objectives in full, and only two have been partially achieved. The ambition for more people to have good mental health, more people with mental illness to have good physical health, and more people to have a positive experience of care and support has not been achieved.

Within the NHS, the Long Term Plan (LTP) is making good progress to transform mental health services across the country, building on the foundations of the Five Year Forward View for Mental Health (FYFVMH). However, as with the FYFVMH, major barriers to delivery remain. Many of these were apparent before the COVID-19 pandemic but have undoubtedly been exacerbated by recent events.

Firstly, a clear, ambitious mental health workforce is lacking. Secondly, sustained increased investment at a local level has been variable. Thirdly, we remain behind in the ambition to improve the quality and flow of data, particularly for older adult services, and children and young people's services. The capacity and capability of NHS Digital (NHSD) (now subsumed within NHSE) to meet the recommendations for a data revolution should be enhanced. Fourth, there has not always been sufficiently joined-up leadership and governance at a senior level across Government departments and with NHSE. This Plan is an opportunity to further align these processes more strategically. Fifth, there is a tendency for health strategies and plans to be produced in silos without enough thought to the relevant interdependencies.

The Chief Executive of NHS England (NHSE), Amanda Pritchard, recently set out her top priorities for the NHS: recovery, reform, resilience, and respect. Achieving these ambitions will mean recovering from the inevitable impact of the pandemic on the nation's mental health, reforming and improving mental healthcare for the future, ensuring mental health services are resilient to future shocks, and respecting all staff and patients with much greater attention paid to equality, diversity, and inclusion (EDI).

As NHS leaders implement their plans for 2022/23 and beyond, we are pleased to see a continued commitment to improve mental health services and services for people with learning disabilities and/or autistic people through continued growth in mental health investment to transform and expand community health services and improve access.[9]

We have made progress since the introduction of the FYFVMH and the current NHS LTP, but the treatment gap remains substantial. The scale of the challenge in mental health is so great that demand continues to outstrip capacity. With mental health referrals at record levels of 4.3 million last year and a backlog of at least 1.5 million people still waiting to start treatment, pressure on the NHS is likely to reach unprecedented levels.[10]

Clearly, NHS treatment cannot be the only answer to our national mental health challenge. Investing in public mental health through evidence-based health promotion, prevention and early intervention initiatives is the only way to reduce the prevalence of mental illness in the population and consequently the burden of mental illness in the long-term. The current cost of living crisis makes this situation more urgent. Food insecurity, fuel poverty, debt and loneliness are a reality for millions of people.

But there is far less coverage of interventions to prevent associated impacts of mental illness, such as premature mortality, and negligible coverage of interventions to prevent mental illness from arising or to promote mental wellbeing and resilience. This implementation failure results in preventable population scale suffering, broad impacts and associated economic costs. Furthermore, it breaches the right to health and the Equality Act, and the implementation gap has further widened during the pandemic.

The United Nations Sustainable Developmental agenda set 17 ambitious and transformational goals for people and for the planet in January 2016, with the aim that all will be achieved by 2030.[11] Goal three seeks to ensure healthy lives and promote well-being for all, at all ages. The target of achieving universal coverage by 2030 applies to the treatment of mental disorder, prevention of mental disorder and promotion of mental wellbeing.[12] The Government has committed to achieving the UN Sustainable Development Goals (SDGs) by 2030 but this will require a collaborative, planned approach over the next eight years.

Sustainable development for people and the planet is defined as development that meets the needs of the present without compromising the ability of future generations to meet their own needs. The interlinkages and integrated nature of the SDGs balance the three dimensions of sustainable development: economic, social, and environmental. This cross-government mental health and wellbeing plan must be seen in the context of achieving this goal.

Our vision for the Plan: 2025-2035

To drive progress over the next decade, the Government must build on the foundations set by No Health Without Mental Health,[13] Future in Mind[14], the FYFVMH, and the NHS LTP[15]. It must also align with other global and national calls to action.

Our vision for 2035 is to create a world-leading mental healthcare system in England; one that is designed to promote good health and wellbeing, prevent mental ill health, intervene at the earliest opportunity, and to provide universal and timely access to high-quality treatment and support for those who need it.

We recommend the Department of Health and Social Care (DHSC), other Governmental departments, the NHS and its arm's-length bodies, local government, and key partners commit to ambitious and targeted action so that collectively:

1. by 2035, the prevalence of mental disorders in the English population has been reduced by five percentage points, and disparities in prevalence across population groups have been reduced
2. by 2030, we have achieved the UN SDG target of delivering universal health coverage for the treatment of mental disorders, prevention of mental disorders and promotion of mental wellbeing in England
3. by 2030, we have achieved the UN SDG target of reducing premature mortality from mental disorders and illness (through prevention and treatment, and promoting mental health and wellbeing) by one-third in England
4. by 2030, we have achieved the UN SDG target of providing universal access to quality essential health care services so that everyone who needs mental health treatment and support in England will be able to access it at the right place and at the right time, including through NHS primary care, urgent and emergency care, and secondary and specialist mental health services
5. by 2030, we have improved the quality, safety and effectiveness of treatment and care for those needing services for their mental health, measured through patient experience, effectiveness, safety, and patient outcomes (that matter most to patients)
6. by 2030, we have achieved the UN SDG target of strengthening the prevention and treatment of substance abuse and harmful use of alcohol in England
7. by 2030, we have built a strong and resilient mental health workforce with mental health leaders empowered to develop the healthcare services of the future through Integrated Care Systems (ICSs), Partnerships (ICPs) and Boards (ICBs)
8. by 2030, we have set up local systems to invest in mental health services and integrated pathways of care in an equitable and sustainable way that reflect significant historic underinvestment, and
9. by 2035, there is equitable funding for world-class mental health research, giving us a greater knowledge and understanding of effective treatments and service models that contribute to better patient experiences, recovery, and long-term outcomes around the world.

Our principles for the Plan

The development of the Plan should be underpinned by a set of values and principles drawn from the responses to the consultation. This will help clarify what the strategy is to achieve and how this will be achieved.

- It must be ambitious, realistic and measurable
- It must be co-produced
- It must be joined-up
- It must be transparent
- It must have prevention and early intervention front and centre
- It must be underpinned by cross-cutting commitments to reduce inequalities across the board
- It must have an accompanying Implementation Plan with comprehensive workforce and funding projections and commitments
- It must be future proof

About our response

We believe this consultation, alongside the forthcoming update of the NHS LTP, is an opportunity to develop a world-leading mental healthcare system by 2035. Preventing poor mental and physical health must be front and centre of the levelling up mission if we are to protect the NHS and enable more people to live longer, healthier, and happier lives. For those who need treatment and support, we must reduce the treatment gap and reduce disparities in access, quality of care, safety, experience, and outcomes. We welcome the opportunity to share our recommendations with the government to support the development of a new cross-government, 10-year plan for mental health and wellbeing, and a refreshed suicide prevention plan for England.

Summary of recommendations

	Actions	Responsible organisation
HOW CAN WE PROMOTE POSITIVE MENTAL WELLBEING AND PREVENT THE ONSET OF MENTAL ILL-HEALTH?		
Reduce socio-economic inequalities, deprivation, and poverty	The Department for Levelling Up, Housing and Communities (DLUHC) to develop a National Strategy on Inequalities led by the Prime Minister to reduce widening social, economic, environmental and health inequalities.[16]	DLUHC
	DLUHC to set a target to reduce levels of child poverty to 10%, putting it on par with the lowest rates in Europe.[17]	DLUHC
	DLUHC to put health and mental health equity and wellbeing at the heart of local, regional, and national economic planning and strategy. [18]	DLUHC
	DHSC to fund Public Health at a level of 0.5% of GDP with spending focused proportionately across the social gradient. [19]	DHSC
	The Office for Health Improvement and Disparities (OHID) and DHSC to ensure Public Health develops capacity and expands its focus on social determinants of health. [20]	OHID and DHSC
	OHID to develop social determinants of health interventions to improve healthy behaviours. [21] [22]	OHID
	DLUHC to increase the deprivation weighting in the local government funding formula, and invest in the development of economic, social, and cultural resources in the most deprived communities. [23]	DLUHC
	DLUHC to invest in the development of economic, social, and cultural resources in the most deprived communities. [24]	DLUHC
	DLUHC to invest in the resilience of areas that were damaged and weakened before and during the pandemic. [25]	DLUHC
	DLUHC to tackle domestic and gender violence and abuse.	DLUHC
	DWP to ensure that all workers receive at least the national living wage as a step towards achieving the long-term goal of preventing in-work poverty. [26]	DWP
	DWP to make the social safety net sufficient for people not in full-time work to receive a minimum income for healthy living. [27]	DWP
	DWP to review the taxation and benefits system to ensure they achieve greater equity and are not regressive. [28]	DWP

	DWP to make permanent the £1,000-a-year increase in the standard allowance for Universal Credit. [29]	DWP
	DWP to end the five-week wait for Universal Credit and provide cash grants for low-income households. [30]	DWP
	DWP to remove sanctions and reduce conditionalities in benefit payments, eradicating benefit caps and lifting the two-child limits. [31]	DWP
	DWP to provide tapering levels of benefits to avoid cliff edges. [32]	DWP
	DWP to increase child benefit for lower-income families to reduce child and food poverty. [33]	DWP
	DLUHC to eradicate food poverty permanently and remove reliance on food charities. [34]	DLUHC
	DLUHC to extend free school meal provision for all children in households in receipt of Universal Credit. [35]	DLUHC
	DLUHC to give sufficient support to food aid providers and charities. [36]	DLUHC
Take action on climate change, pollution, and biodiversity loss	The Department for Environment and Rural Affairs (Defra) to prioritise a unified approach with sufficient resources to tackle the climate and ecological crisis across all aspects of government.	Defra
	Defra to follow the UK Health Alliance on Climate Change (UKHACC) principles for a healthy and green recovery to place environmental and health factors at the heart of any economic recovery following the COVID-19 pandemic.	Defra
	Defra to base decisions on changes to land and water usage on tools which include assessment of prospective impacts to mental and physical health.	Defra
	All research organisations to: ▪ ensure that future research in planetary health includes multidisciplinary studies examining how the mental health of different vulnerable groups are affected by climate-related hazards, pollution and biodiversity loss, and ▪ establish and quantify the co-benefits to mental health of taking action against climate change, biodiversity loss and pollution.	Research organisations
	The Medical School Council to: ▪ ensure the impact of the climate and ecological emergency, and the role medical professionals can play in preventing and mitigating this, are a core part of the curriculum, and ▪ work with medical schools to ensure students are taught about the overuse of tests and interventions.	Medical School Council
	All organisations responsible for postgraduate and continuing medical education to ensure that practicing doctors receive similar updates to undergraduates.	All organisations responsible for

		postgraduate and continuing medical education
Put health at the heart of urban and community planning	DLUHC to ensure all new housing developments include within their plans a priority to promote good mental health and wellbeing of their population and improve access to health services for people of all ages with mental ill health. Dementia-friendly communities should be a fundamental part of the design. New housing development sites can learn lessons from 'Healthy New Towns' demonstrator sites, including: ▪ developing health services that help people to stay well ▪ strengthening and integrating 'out-of-hospital' care ▪ developing the future workforce ▪ linking health services to wider community assets ▪ supporting self-management ▪ using digital technology to support care ▪ creating integrated health and wellbeing centres ▪ maximising the benefits of integrated health and wellbeing centres ▪ strategic estates planning ▪ developing a schedule of accommodation, and ▪ options for project funding.	DLUHC and local authorities
	DLUHC to build more good-quality homes that are affordable and environmentally sustainable. [37]	DLUHC and local authorities
	DLUHC to ensure 100% of new housing is carbon-neutral by 2030, with an increased proportion being either affordable or in the social housing sector. [38]	DLUHC and local authorities
	DLUHC to reduce sources of air pollution from road traffic in more deprived areas. [39]	DLUHC and local authorities
	DLUHC to increase support for those who live in the private rented sector by increasing the local housing allowance to cover 50% of market rates. [40]	DLUHC and local authorities
	DLUHC to remove the cap on council tax. [41]	DLUHC and local authorities
	DLUHC to urgently reduce homelessness and extend and make watertight the protections against eviction. [42]	DLUHC and local authorities
	DLUHC to implement recommendations from the Royal Society for Public Health report, *Health on the High Street*, including:	DLUHC and local authorities

	○ local authorities nationwide to introduce A5 planning restrictions within 400 metres of primary and secondary schools ○ DLUHC to provide local authorities with the power and support to restrict the opening of new betting shops and other unhealthy outlets where there are already clusters ○ vape shops to ensure all customers who smoke are aware of their local stop smoking service ○ industry and all businesses selling food on the high street – cafés, pubs, fast food outlets, convenience stores, leisure centres – to reduce the calories in their products ○ Facebook and Google to provide discounted advertising opportunities to local, independent health-promoting businesses ○ local authorities to support meaningful use of shops by making records on vacant commercial properties publicly accessible ○ councils to set differential rent classes for tenants based on how health-promoting their business offer is, and ○ business rates relief for businesses that try to improve the public's health.	
	Local authorities to substantially invest in the infrastructure to support walking, cycling, leisure activity, sport and active travel, and neighbourhood walkability with well-designed neighbourhoods.	Local authorities
	DLUHC and OHID to tackle obesogenic environments on high streets by: • addressing the junk food offer around schools by banning unhealthy fast-food outlets from within a five-minute walk of school gates • ending discounts targeted at school children • ending app-based food delivery services to school gates • building better places to go, including better quality parks with the use of young people in mind, and physical signage outside schools directing young people to their nearest park, and • limiting the reach of junk food adverts, including banning the advertising of unhealthy food products across all council-owned advertising sites.	DLUHC and OHID
Put mental health at the heart of ICS population management	ICSs to adopt population health management approaches that focus on public mental health and wellbeing. This should include work on perinatal mental health, children, and young people (where some of the greatest opportunities for prevention lie), and on wider services such as addiction, homelessness or housing services and employment support.	ICSs

	ICSs to invest in school-based programmes, including bullying and violence prevention, interventions to promote adolescent social-emotional functioning and developmental trajectories, universal resilience-focused interventions, school-based promotion of self-regulation, school based mindfulness programmes, youth mentoring programmes, psychosocial interventions delivered by teachers, prevention of smoking, alcohol, and drug use.[43]	ICSs
	ICSs to ensure that population health management approaches allow for an understanding of the health inequalities and health service utilisation by creating a linked dataset with patient-level information from acute services, primary care, primary care prescribing, mental health, community services, continuing healthcare, social care, public health, and specialised commissioning. Using these data can help clinicians to review pathways and services, and to understand the quality, strategic and financial opportunities, and risks.	ICSs
	NHSE to provide local ICSs with guidance and examples of good practice, demonstrating how population health approaches can help address mental health issues as well as wider public health problems.	NHSE
Reduce stigma and discrimination	DHSC should fund an anti-stigma campaign to help end the stigma and discrimination often experienced by people with mental health problems.	DHSC
	DHSC and DfE should continue to fund MindEd so they can continue to provide free educational resource on children, young people, adults, and older people's mental health.	DHSC and DfE
Promote self-help	DHSC to commit to fully fund both adult and children and young people's Every Mind Matters platforms, taking into consideration the needs of people across demographics.	DHSC
Reduce social isolation and loneliness and invest in community assets	OHID and NHSE to develop a preventative strategy with initiatives to reduce the incidence of loneliness along with other factors that are known to reduce the risk of mental illness in older people.	OHID and NHSE
	Local authorities should offer interventions that promote social interaction through volunteering opportunities, community engagement, social skills training, and befriending, for example. The NHS might not be well placed to lead on this but could provide infrastructure, evaluations, input to the communities (by invitation), teaching or physical health checks.	Local authorities
	Primary Care Networks (PCN's) to map assets and resources within the community, with due consideration of mental health and wellbeing resources. The ease in which patients can access these resources (with a particular focus on excluded groups), and the ease in which primary care professionals can refer to them, should be regularly reviewed.	PCNs

	NHSE and PCNs to expand the roll out of social prescribing in primary care in line with the ambitions and recommendations of the College's Position Statement on this important intervention.[44]	NHSE and PCNs
Improve perinatal and parental outcomes	HM Treasury and Department for Education (DfE) to increase levels of spending on the early years and (as a minimum) meet the OECD average and ensure allocation of funding is proportionately higher for more deprived areas. [45]	HM Treasury and DfE
	DfE and DHSC to increase the availability and quality of early years services, including Children's Centres, in all regions of England and to reduce inequalities in early years development. [46]	DfE and DHSC
	DHSC and DfE to expand perinatal and early years mental health services within Universal Services (maternity services, health visiting, Sure Start centres and primary care).	DHSC
	OHID and NHSE to reverse the decline in the health visiting and school nursing workforce through a demand-driven, well-resourced national workforce strategy and plan.	OHID and NHSE
	DHSC to fund local authorities to enable them to provide health visiting and school nursing services at a level that delivers everything that Government and the National Institute for Health and Care Excellence (NICE) guidance expect of them.	DHSC
	NHSE and OHID should ensure antenatal classes universally include information about mental health and wellbeing, as well as parenting and parenting programmes.	NHSE and OHID
	NHSE and OHID to invest in interventions to address perinatal outcomes including targeting parent tobacco, alcohol, and substance use during pregnancy and interventions targeting birth outcomes such as low birth weight, preterm birth, prenatal infection, and poor maternal nutrition, and breastfeeding support.[47]	NHSE and OHID
	NHSE and OHID to expand the existing package of measures aimed at parents, including parenting programmes and promotion of child/parent attachment. [48]	NHSE and OHID
Improve outcomes in childhood and adolescence	DHSC to reverse declines in the mental health of children and young people and improve levels of wellbeing from the present low rankings internationally. [49]	DHSC
	OHID to ensure that trauma and adverse childhood experiences are a priority for public health. It should produce clear guidance and support for local authorities to coordinate efforts to improve the prevention of, and responses to, trauma. [50]	OHID
	DHSC, DfE and DLUHC to increase resources for preventing abuse and identifying and supporting children experiencing abuse. [51]	DHSC, DfE and DLUHC
	DHSC to implement the recommendations of the Independent Review of Children's Social Care in full, swiftly and with appropriate resourcing.	DHSC

	DHSC to invest in services for Looked after children through foster parent training improved parenting practices and reduced child disruptive behaviour. [52]	DHSC
	DfE to increase attainment to match the best in Europe by reducing inequalities. [53]	DfE
	DfE to invest in school-based programmes, including bullying and violence prevention, interventions to promote adolescent social-emotional functioning and developmental trajectories, universal resilience-focused interventions, school-based promotion of self-regulation, school based mindfulness programmes, youth mentoring programmes, psychosocial interventions delivered by teachers, prevention of smoking, alcohol, and drug use.[54]	DfE
	DfE to ensure that all young people are engaged in education, employment or training up to the age of 21. [55]	DfE
	DfE to increase the number of post-school apprenticeships and support in-work training throughout the life course. [56]	DfE
	DfE to develop and fund additional training schemes for school leavers and unemployed young people. [57]	DfE
	DfE to restore the per-student funding for secondary schools and especially sixth form, at least in line with 2010 levels and up to the level of London (excluding London weighting). [58]	DfE
	DfE to further support young people's training, education, and employment schemes to reduce the numbers who are NEET, and urgently address gaps in access to apprenticeships. [59]	DfE
	DfE to raise minimum wage for apprentices and further incentivise employers to offer such schemes. [60]	DfE
	DfE to invest in Special Educational Needs services to deliver behavioural and educational interventions that improve children's inclusion and participation in school, cognitive development, interventions to support reading for children with intellectual disability in schools, and parenting programmes. [61]	DfE
	DfE to give excluded students additional support and enrol those who need it into Pupil Referral Units. [62]	DfE
	DfE to prioritise funding for youth services. [63]	DfE
	DfE and DHSC to promote interventions to increase physical activity in children and young people. [64]	DfE
Protect children and young people from online harm	The Department for Culture, Media and Sport (DCMS) and the Regulator to urgently review and establish a protocol for the sharing of data from social media companies with universities for research into benefits and harms on children and young people.	DCMS and Regulator

	Urgent review of the ethical framework for using digital data – the same standards need to apply as in other areas of research.	DCMS and Regulator
	DCMS and NHSE to fund a follow-up of the NHSD (now within NHSE) prevalence study to examine the impact of social media on vulnerable children and young people over time.	DCMS and NHSE
	To instruct the regulator to establish a levy on tech companies proportionate to their worldwide turnover. This would be used to fund independent research and training packages for clinicians, teachers and others working with children and young people. As with the gambling industry and social responsibility measures, the gaming and social media industry should be required to increase social responsibility measures similarly, such as emulate the gambling industry's duty of care practices (e.g., personalised behavioural feedback, stop messages) in gaming/social media platforms.	DCMS and Regulator
	Enable the regulator to undertake a joint review with the UK Gambling Commission to review regulation regarding loot boxes in line with other countries which have recognized loot boxes as a form of gambling.	DCMS and Regulator
	Undertake a consultation in 2020 on a yellow card warning system similar to that used for medicines, in order for professionals and potentially parents/carers/young people to report harms of social media and gaming companies.	DCMS and Regulator
	Prioritise the strictest enforcement of Data Protection law and in particular, UK DPA 2018 "Age-appropriate design" to services targeting and / or popular with children, including a requirement that services should default to assuming users need child protection until explicit action is taken to opt-out.	DCMS and Regulator
	Mitigate the harm to children caused by habit-forming features of the service by consideration and analysis of how processes (including algorithmic serving of content, the display of other users' approval of posts and notifications) contribute to development of habit-forming behaviour.	Technology companies
	Social media platforms should flag up engagement with risky content and operate and offer a free direct hotline for at-risk or vulnerable individuals.	Technology companies
	Social media companies should provide user configurable controls (not in the cloud) that can block incoming content of the young person's choosing (by default 'full safety measures on') and provide feedback on content they are planning to send (e.g., BBC Own It app for an example).	Technology companies
	Social media companies should promote and contribute to mental health charities in home countries to support any vulnerable individuals.	Technology companies

	Gaming companies and social media platforms should regularly fund research related to their products, to be conducted by independent external bodies and provide on a regular basis user data for research purposes to academic institutions.	Technology companies
	Funding of media literacy awareness campaigns.	Technology companies
	Teachers have a key role to play in terms of education about online safety.	Education professionals
	Schools and colleges should have policies relating to device use and a digital code of conduct. Good practice should be sought out and shared. A multi-stakeholder engagement of peers, parents and school staff should be encouraged to support, inform, and update school policies.	Education professionals
	If teachers are concerned about the level of technology used by children and young people and the possible impact on their health and well-being, they should seek guidance from resources such as the MindEd modules and discuss the issue with their mental health leads within schools, as well as sharing concerns with parents.	Education professionals
	The Personal, Social and Health Education Association syllabuses should be developed further to include online safety, and further resource development should be prioritised.	Education professionals
	Opportunities for group working away from screens should be encouraged whenever possible.	Education professionals
	Questions around technology use should become a core part of biopsychosocial assessments and formulations; the online world can be just as important to young people as their offline world. It is helpful to ask children and young people about any areas that worry them in their digital lives, whilst keeping a check on their use and its disruption of healthy or necessary activities.	Healthcare professionals
	Psychiatrists should be mindful of the possible impact of technology use when children and young people report difficulties in areas such as sleeping, academic performance, mood, behaviour or eating.	Healthcare professionals
	Mental health conditions such as depression and behavioural problems may make children more vulnerable to problematic technology use; clinicians should be aware of the impact of technology.	Healthcare professionals
	Clinicians must be aware of the additional needs of vulnerable parents, such as those suffering from depression, who may struggle to support their child around problematic technology use. If problematic technology use is identified: ▪ the assessing clinician will seek to understand the impact of all presenting difficulties including potential problematic use on family relationships, educational performance	Healthcare professionals

	and social interactions. In this context, the clinician will start to understand the potential level of problematic technology use ▪ it has not yet been fully elucidated whether conditions such as depression and anxiety are contributing factors to problematic internet use or gaming or are a result of the condition. It is recommended that, where more than one condition is present, the clinician documents the duration of all conditions, and ▪ clinicians should be aware of the safeguarding implications of online content and contact.	
	Services should deliver training in the concept of technology addiction. Online resources such as minded.org are useful training resources and should be further developed as knowledge increases in this area.	People involved in training and service development
	Pathways to specialist services also need to be developed. There are models for other specialist pathways, such as eating disorders, where locality services treat children and young people whose symptoms are less severe. This enables locality teams to maintain expertise and recognise conditions, ensuring that children and young people can be treated as soon as possible. Where symptoms are more severe, children and young people will need specialist care. As treatment for technology addiction is still developing, this may involve travelling to specialist clinics, however as more awareness of the condition develops, the level of expertise will increase. Local protocols will need to be developed based on the diagnostic criteria available. What must be acknowledged is that children and young people with technology addiction are more likely to experience additional mental health needs such as depression, anxiety, developmental conditions such as ADHD and eating disorders.	People involved in training and service development
	Embedding the use of device-collected screen time and internet usage-type data in ongoing (or commencing) large-scale cohort studies examining other variables including health outcomes is essential to allow for: ▪ longitudinal research studies with children and young people at different developmental stages, examining whether technology causes harmful outcomes as well as potential benefits ▪ examining different types of screen use, as well as content, and exploring a variety of health-related outcomes. Screen time use data cannot rely purely on self-report ▪ determining the effects of extensive online media usage on cognitive development. ▪ there is a need for qualitative studies exploring children's and young people's perspectives, including gender differences	Researchers

	▪ research is needed that focuses on potentially vulnerable groups such as those with mental health and neurodevelopmental disorders, looked-after children, LGBTQIA+ young people and very young children ▪ websites that normalise or promote concepts such as self-harm, suicide and anorexia should be studied and their impact on young people understood. Additionally, when limitations are proactively placed on sites by technology companies, the impact of these limitations on the health and well-being of children and young people should be studied ▪ research needs to elucidate the possible concepts of technology addiction and examine the potential for addiction, including further development of screening tools and treatment programmes ▪ research is needed into the incidence of problematic technology use across the UK, and ▪ the development of further brain neuroimaging studies is needed that will examine the posited affected areas, not only for overuse but also to examine tolerance and withdrawal effects.	
	Research is needed to understand how young people with mental health needs are using the internet and what support could be put in place.	Researchers
	Research is also needed to understand the possible benefits of programmes that can help people manage their digital technology use, for example, apps that can block the use of other apps and the use of time restrictions. Personalised programmes for media addiction, for example, including specialised Cognitive Behavioural Therapy (CBT) and systemic family therapy, need to be developed and evaluated. Programmes need to take into account heterogeneity around potential causes (e.g., severe mental illness, low self-esteem, loneliness, ADHD, individual's predisposition to addiction) and engagement with specific internet content or transactions (e.g., social media, online gaming or gambling).	Researchers
	Therapeutic trials should have integrated mediation analyses as a core aspect of trial design in order to determine which psychological and/or neurological changes predict and accompany successful treatment outcomes.	Researchers
	Further research into the use of social media platforms for support, for example, in relation to suicide prevention.	Researchers
Prevent depression, eating disorders and dementia	DHSC and other government departments to prevent depression through good quality employment, physical activity, reduction in social isolation and loneliness, early access to psychological and educational interventions.	DHSC and OGDs

	DHSC and other government departments to invest in lifestyle modification and dissonance-based prevention programs to prevent eating disorders.	DHSC and OGDs
	DHSC and other government departments to invest in interventions that address the twelve modifiable risk factors which could prevent or delay 40% of dementia include treatment of hypertension, reduction of obesity and associated diabetes, physical activity. limiting alcohol use, avoiding smoking, prevention of air pollution and head injury, addressing insomnia, and use of hearing aids for hearing loss.	DHSC and OGDs
Reduce employee stress and increase wellbeing	DWP to implement the recommendations of the Stevenson/Farmer review on mental health and employers in full and oversee its implementation.	DWP
	Employers to invest in workplace interventions to reduce employee stress and increase wellbeing through: ▪ strategic approaches to improve mental wellbeing in the workplace taking account workplace culture, workload, job quality, autonomy and employee concerns about mental health including stigma ▪ supportive work environment ▪ external sources of support ▪ organisation-wide approaches ▪ training and support for managers ▪ individual-level approaches ▪ approaches for employees who have or are at risk of poor mental health ▪ organisational-level approaches for high-risk populations, and ▪ engaging with employees and their representatives.	Employers
	Employers to invest in workplace interventions to promote mental wellbeing and prevent mental disorder including[65]: ▪ workplace resources which can improve employee wellbeing and organisational performance ▪ increasing employee control via flexible working ▪ resilience promotion programmes which were more effective for those at higher risk of stress ▪ workplace-based physical activity promotion o mindfulness and yoga o protective labour and social policies which modified association between work stress and mental disorder	Employers

	○ procedural justice and relational justice in the workplace which were associated with reduced depression ○ interventions to prevent employment related stress and mental disorder ○ interventions to address work-related stress and promote wellbeing, and ▪ online interventions to reduce workplace stress or improve mindfulness through online mindfulness interventions reduced employee stress symptoms. Targeted online stress management interventions led to small reductions in stress, though the strength of associations varied among the interventions.	
HOW CAN WE INTERVENE EARLIER WHEN PEOPLE NEED SUPPORT WITH THEIR MENTAL HEALTH?		
Invest in a whole system response to children and young people's mental health	Local authorities to commission and fund health visiting services that are able to offer a high-quality service to all those who need them, in line with the Healthy Child Programme.	Local authorities
	DHSC to fund the roll-out of early support hubs for children and young people aged 11 – 25.	DHSC
	NHSE to provide additional funding to enable the full implementation of the Mental Health Support Teams (MHST) review recommendations, with a focus on strengthening provision for children with greater and more complex needs. Providing recommendations are implemented, support the furthering of the roll out of MHST beyond 2023/24 to ensure access for 100% of pupils.	NHSE
	NHSE to ensure staff in MHST have received training so that they feel equipped to identify the mental health needs of vulnerable groups of children and young people, including young people not in education, employment or training (NEETs), children with neurodevelopmental problems (including Attention Deficit Hyperactivity Disorder [ADHD], autism spectrum disorders [ASD] and intellectual disabilities), children with long-term health conditions, children with behavioural difficulties, looked-after children, young carers, refugees and migrant children, children with a first language other than English, children in the criminal justice system, abused children, LGBTQIA+ young people, and to refer them appropriately when required.	NHSE
	DHSC to work with DfE to implement the forthcoming recommendations of the children's social care review, particularly where these relate to meeting the needs of children with mental illnesses and prioritise this agenda as part of the new cross-Government mental health strategy.	DHSC and DfE

	DHSC and NHSE to identify pressure points and provide targeted investment to scale services and recover performance including children and young people's eating disorder services and acute care.	DHSC and NHSE
	DHSC to review the evidence for rolling out Mental Health First Aid to those who work in youth clubs, sports clubs and other recreational groups, Churches, and other religious organisations.	DHSC
Ensure mental health support is a central component of enhanced models of primary care	NHSE and PCNs to implement the recommendations of the Fuller Stocktake report[66], and specifically relevant to mental health: ▪ enable all PCNs to evolve into integrated neighbourhood teams, supporting better continuity and preventive healthcare as well as access, with a blended generalist and specialist workforce drawn from all sectors. Secondary care consultants – including psychiatrists, geriatricians, respiratory consultants, paediatricians – should be aligned to neighbourhood teams with commitments reflected in job plans, along with members of community and mental health teams. With teams collocated within neighbourhoods, to extend models of personalised care, embed enhanced health in care homes and develop a consistent set of diagnostic tests. At place level, bring together teams on admissions avoidance, discharge and flow – including urgent community response, virtual wards and community mental health crisis teams. Focus on community engagement and outreach, across the life course. Proactively identify and target individuals who can benefit from interventions in neighbourhoods, committing to delivering neighbourhood teams first for Core20PLUS5 populations. Co-ordinate vaccinations, screening and health checks at place level, in accordance with national standards, and ▪ create a clear development plan to support the sustainability of primary care and translate the framework provided by Next steps for integrated primary care into reality, across all neighbourhoods. Ensure a particular focus on unwarranted variation in access, experience and outcomes. Ensure understanding of current spending distribution across primary care, compared with the system allocation and health inequalities. Support primary care where it wants to work with other providers at scale, by establishing or joining provider collaboratives, GP federations, supra-PCNs or working with or as part of community mental health and acute providers. Tackle gaps in provision, including where appropriate, commissioning new providers in particular for the least well-served communities.	NHSE and PCNs

	NHSE to ensure there is adequate access to information across the interfaces between primary, acute, and mental health care.	NHSE and ICSs
	NHSE to explore the potential for community pharmacists to perform medication reviews for people on longer-term psychotropic medication prescriptions.	NHSE
	PCNs to accept dual GP registrations for students and work to be able to manage care in a more coordinated way.	PCNs
Increase access to IAPT services	NHSE and ICSs to ensure everyone with common mental disorders can access psychological therapies each year.	NHSE and ICSs
	NHSE and ICSs to expand the choice of therapies available in the Increasing Access to Psychological Therapies (IAPT) programme for all mental health diagnoses.	NHSE and ICSs
	NHSE to review the current exclusion criteria for accessing IAPT services and consider the factors affecting the number of people who do not complete treatment.	NHSE
	NHSE to develop a strategy to reduce the gap in access between older adults, Black, Asian and minority ethnic groups, students and any other group not currently served well by IAPT services.	NHSE
	NHSE and ICSs to ensure parity of access to IAPT services for older people (who are significantly less able to access psychological therapies by dint of frailty and multimorbidity) and people with an intellectual disability. Services need to comply with equality legislation by making a reasonable adjustment to their services to facilitate people with intellectual disabilities using IAPT services.	NHSE and ICSs
	NHSE and ICSs to significantly expand IAPT services for people with long-term conditions.	NHSE and ICSs
	NHSE and ICSs to ensure the quality and people's experience of IAPT services continually improves. Improving the numbers of people who recover, reducing geographic variation between services, and reducing inequalities in access and outcomes for particular population groups are all important aspects of the development of IAPT services.	NHSE and ICSs
Invest in healthcare roles that support integrated care	NHSE and ICSs to invest in new roles that supported integrated mental and physical healthcare. This should include ensuring that at least 10% of the 1,000 Physician Associates being trained each year work in mental health.	NHSE and ICSs
	NHSE to ensure investment in new roles includes funding for the increases required in psychiatric capacity to train and supervise new roles.	NHSE

HOW CAN WE IMPROVE THE QUALITY AND EFFECTIVENESS OF TREATMENT FOR MENTAL HEALTH CONDITIONS?		
Reduce inequalities in access, experience, and outcomes in mental health provision	NHSE and ICSs to ensure everyone who uses mental health services has equitable access to effective early interventions and equitable experiences of care and outcomes, regardless of age or ethnicity.	NHSE and ICSs
	NHSE and ICSs to ensure there is a year-on-year reduction in the disparities between people from Black, Asian and minority ethnic groups and the rest of the population, in terms of both numbers of people detained under the Mental Health Act 1983 and the range of appropriate treatments offered including alternatives to detention.	NHSE and ICSs
	NHSE and ICSs should expand LGBTQIA+ services as well as outreach services to deprived children, young people and families, hard-to-reach groups, and those from Black, Asian and minority ethnic communities.	NHSE and ICSs
	NHSE and ICSs should ensure people at risk of discrimination, and protected groups under the Equalities Act subject to the Mental Health Act have access to an advocate with specialist knowledge of legislation to advocate appropriately for them.	NHSE and ICSs
	MoJ should ensure mental health tribunal panels better reflect the communities they work with.	MoJ
	DHSC to produce a strategy for reducing race inequality in mental health, building on the Race Disparity Audit, including work with schools, the police, youth and community services and mental health services to improve access, outcomes, and experiences for people from Black, Asian and minority ethnic communities.	DHSC
	NHSE, ICSs and mental health providers must develop and monitor data relating to access and outcomes for groups of people with protected characteristics, including by gender, age, sexuality and ethnicity and disability.	NHSE, ICSs and mental health providers
	DHSC and NHSE to take forward in full the recommendations of the Women's Mental Health Taskforce.	DHSC and NHSE
	NHSE and ICSs should take steps to improve access and outcomes for LGBTQIA+ communities and set an expectation that commissioners will recognise the value of specialist LGBTQIA+ services, commissioning them to meet local needs.	NHSE and ICSs
	Government to legislate to extend the definition of disability in the Equality Act to protect people with fluctuating mental health problems.	Government
	ICSs to commission services that use population health data to identify health inequality and have an explicit plan to address this.	ICSs

	Regular training for all Home Office and healthcare staff on early indicators of mental health conditions and the circumstances in which capacity assessments should be triggered. This should be linked to safeguarding training along with the development of a screening tool for assessment of capacity for all detainees and robust pathways including the provision (in keeping with the conclusions of the Mental Welfare Commission for Scotland, 2018) of appropriate advocacy services for those found to lack mental capacity to make relevant decisions.[67]	Home Office
	The Home Office to ensure that refugees and migrants with existing mental illness are only be detained in very exceptional circumstances.	Home Office
Improve people's experience of care when transitioning between services	NHSE and ICSs to ensure that strategic, operational, and clinical leaders need to be given protected time to undertake the work required to expand and harmonise services to better meet the needs of young adults, which must include proactive efforts to develop a common language to describe services and bridge cultural differences across children and young people's and adult services.	NHSE and ICSs
	ICSs to ensure that young people and their parents/carers should be at the centre of their individual transition planning between specialist mental health services and have a role in the wider service development and delivery.	ICSs
	ICSs to support joint working between leaders of child and adolescent mental health services (CAMHS), adult mental health services (AMHS), local authority services and third sector organisations to improve the experience for young people of transition between mental health services. Additional funding is likely to be required to meet increased demand and for additional staff to support carefully planned transitions, which should feel virtually seamless for the young person themselves.	ICSs
	ICSs to ensure that training needs are identified for staff working within CAMHS and AMHS to support developmentally appropriate clinical care for young people. The RCPsych should develop training programmes for psychiatrists to work with 0-5's, under 18's and 18-25's when this is not part of their specialist training.	ICSs
Make mental health services safer	NHSE, ICSs and mental health providers to ensure the average NHS trust score for 'organising care' in the Care Quality Commission's (CQC) community mental health survey improves year-on-year, with no trust posting a decline.	NHSE, ICSs and mental health providers
	NHSE to re-design what is meant by aftercare, including reforming eligibility criteria to improve equity of access, resolving some of the complex arrangements across health and social care, especially regarding funding.	NHSE
	Mental health trusts to ensure all patients in contact with mental health services have a simple goal-orientated care plan as well as a personalised safety plan including an agreed	Mental health trusts

	set of activities, strategies, people, and organisations to contact for support if they become suicidal.	
Learn from deaths	All NHS trusts to identify deaths that warrant an investigation and put in place a process to learn from them in cases where a patient had been receiving treatment and support for their mental illness, with a particular focus on people 'at risk' such as those who are from a Black, Asian and minority ethnic groups.	NHS trusts
	NHSE and ICSs to roll-out the 'Learning from Deaths' tool produced by the College's Centre for Quality Improvement (CCQI)[68], which support trusts to respond to concerns about any aspect of their care; and provides trusts with guidance on using individual reviews to consolidate learning identified using the tool.	NHSE and ICSs
	NHSE to commission annual thematic reviews to support the implementation of the Tool and learning.	NHSE
Focus on quality improvement and reduce unwarranted variation	NHSE to introduce a new quality commitment to ensure availability of appropriate, safe, and high-quality mental health, learning disability and autism inpatient care (and alternatives to inpatient care) in every system for adults, children, and young people.	NHSE
	NHSE and ICSs to work with Royal Colleges and partners to review and decommission models of inpatient provision which are incompatible with safe, high-quality care and therapeutic outcomes.	NHSE, ICSs, Royal Colleges, and partners
	ICSs to address the inequalities in access to local community support which results in marginalised groups being overrepresented in the most restrictive settings and reduce variation in access, experience & outcomes.	ICSs
	CQC and NHSE to significantly increase and enhance the quality improvement support available to mental health trusts to enhance their safety and quality.	CQC and NHSE
	NHSE to expand the Getting it right first time (GIRFT) programme to cover other mental health services, such as community services for adults and older adults; personality disorders; as well as intellectual disability services.	NHSE
	CQC to reintroduce an annual national survey of the experiences of mental health inpatient services.	CQC
	NHSE to develop a repository of best practice in mental healthcare for ICSs.	NHSE
	NHSE to commission national clinical audits focused on mental health (to achieve parity with physical health services). These could focus on services for infants and their parents or primary caregivers, children and young people, working-age adults, older adults, and groups who report worse experiences and outcomes from NHS mental health services.	NHSE
	All mental health services to comply with national quality standards, e.g., via RCPsych quality networks.	Mental health providers

	NHSE to improve the quality and completeness of routine data (e.g., mental health services dataset (MHSDS)) for use in national clinical audits, to reduce audit burden.	NHSE
	NHSE to improve completeness and quality of MHSDS and other basic information on service provision.	NHSE
	NHSE to reduce unwarranted variation in mental health service provision across the country and utilise quality networks to support this ambition.	NHSE
Choose interventions wisely and safe prescribing	NHS healthcare leaders to embed a culture in which patients and clinicians regularly discuss the clinical value and effectiveness of proposed treatments or interventions with the explicit aim of reducing the amount of inappropriate clinical activity.	NHS leaders
	NHSE to promote the implementation of safe prescribing and withdrawal management for medicines associated with dependence or withdrawal.	NHSE
	NHSE to further promote the Stopping over medication of people with a learning disability, autism or both (STOMP) and Supporting Treatment and Appropriate Medication in Paediatrics (STAMP) initiatives across the NHS.	NHSE
Measure and collect patient outcomes data	NHSE and ICSs to prioritise the collection and recording of routine outcomes measures for: ▪ perinatal mental health care ▪ children and young people's mental health care ▪ community mental health care ▪ adult crisis and acute mental health care ▪ integrated IAPT service ▪ adult eating disorder services, and ▪ tailored outreach and engagement for flu/COVID-19 vaccination and physical health checks.	NHSE and ICSs
	ICSs to work with system partners to develop and collect outcome measures in mental health aligned with the College's report.	ICSs
Make mental health services greener	NHSE to ensure the NHS reaches carbon net-zero by 2040 and 2045 and this target is central to the commitments in the NHS LTP Refresh.	NHSE
	DHSC and ICSs to replace ageing buildings across the mental health estate.	DHSC and ICSs
	Every NHS health organisation, commissioner, and provider to produce a Green Plan and regularly review this.	NHS health organisation, commissioners, and providers

	NHS providers to develop and implement a biodiversity action plan which examines 'greening (incorporating more environmentally friendly systems) of estates, buildings, and care pathways, and establishes links with green care providers.	NHS providers
	NHS providers to establish a natural services network to map all sites in their local area that provide opportunities for sustainable interaction with nature and/or activities that preserve the natural environment and promote these to mental health services.	NHS providers
	NHS providers to incorporate the goals of *Choosing Wisely* into daily practice, including: ▪ encouraging doctors to provide patients with resources that increase their understanding about potential environmental harms of biomedical/ pharmaceutical interventions and help them understand that doing nothing or fewer interventions can sometimes be the best approach. ▪ encouraging and empowering patients to ask questions such as, "Do I really need this test or procedure? What are the risks? Are there simpler safer options? What happens if I do nothing?"	NHS providers
	ICSs to appoint a social prescribing Lead to oversee all community teams developing a social prescribing function to identify local opportunities for complementary health-improving activities.	ICSs
	ICSs to expand the NHS sustainability awards. Continue recognising sustainable clinical work across the NHS with consideration towards developing an additional award for the work of mental health services in achieving a high standard of sustainable practice.	ICSs
	Governing NHS bodies across the UK to jointly develop a minimum set of standards for providers in developing sustainable services and ▪ ICSs to include these minimum standards in their contracts, and ▪ ICSs to develop a sustainable mental health service toolset: provide a working set of standards by which mental health services can develop effective sustainable development plans which reflect the need for estates and clinical staff to work collaboratively when developing and delivering sustainable mental health services.	CQC and other governing bodies across the UK
Invest in the health and wellbeing of NHS and social care staff	NHSE to further expand staff mental health and wellbeing hubs.	NHSE
	NHSE and NHS employers to make the protection and promotion of staff wellbeing central to the culture of the NHS, through embedding reflective spaces within ICSs and NHS organisations to enable staff to recover from the impact of the pandemic and to make routine emotional and psychological support for staff moving forward.	NHSE and NHS employers
	NHSE and NHS employers to review and reduce mandatory training to ensure it is personalised and meaningful. Other activities and policies that do not treat staff as	NHSE and NHS employers

	individuals should also be identified and rolled back to relieve them of commitments that are irrelevant to their day-to-day job.	
HOW CAN WE SUPPORT PEOPLE LIVING WITH MENTAL HEALTH CONDITIONS TO LIVE WELL?		
Improve the physical health of people with severe mental illnesses and/or intellectual disabilities and autistic people	NHSE and OHID to reduce premature mortality for those with a mental illness/disorder and those with intellectual disabilities (through prevention and treatment and promote mental health and well-being) by one-third by 2030.	NHSE and OHID
	NHSE to ensure people on the SMI primary care register and the Learning Disability register receive comprehensive physical health checks and reduce disparities in access between different population groups.	NHSE
	OHID and NHSE introduce a new Tobacco Control Plan focused on tackling smoking in all people with a mental health condition, through targeted investment and effective data monitoring systems, underpinned by targets for reduced smoking prevalence in this population.	OHID and NHSE
	OHID and NHSE to promote interventions to prevent smoking uptake and support cessation including: ▪ interventions to prevent smoking tobacco control programmes which include legislative smoking bans, plain packaging and mass media campaigns ▪ interventions to support smoking cessation and reduction through pharmacological and non-pharmacological interventions, and ▪ the implementation of "No smoking" policies in mental health secondary care settings to reduce smoking rates.[69]	OHID and NHSE
	NHSE to ensure IAPT services include support for smokers to quit, to improve both mental and physical health outcomes.	NHSE
	OHID and NHSE to ensure national communications activity on promoting positive mental health should include messages about the benefits of stopping smoking and avoiding starting. Similarly, national 'stop smoking' communications should include information on the benefits to mental health.	OHID and NHSE
	ICSs to ensure co-production with service users locally should be supported to resource peer support workers using quality improvement methodology, to maximise signposting to help and quit rates.	ICSs
	OHID and NHSE to address major gaps in the data to monitor smoking rates across all populations with a mental health condition, to measure the provision of evidence-based support and the outcome of treatment.	OHID and NHSE

	DHSC to introduce public policies that restrict alcohol availability and/or raise taxes on alcohol to reduce drinking.	DHSC
	NHSE to invest in brief and digital interventions to reduce harmful alcohol consumption through primary care-based brief interventions so that we can reduce alcohol consumption in hazardous and harmful drinkers.	NHSE
	NHSE to invest in targeted alcohol interventions for people with mental disorder through brief interventions including digital approaches.	NHSE
	NHSE to invest in digitally delivered interventions to reduce the use of cannabis.	NHSE
	NHSE to invest in inventions to prevent drug use among people with a mental disorder and comorbid substance misuse.	NHSE
	NHSE and OHID to promote physical activity to improved symptoms and outcomes of mental disorders.	NHSE and OHID
	NHSE to invest in weight management interventions.	NHSE
	NHSE to ensure the COVID-19 vaccination programmes considers those with a mental disorder and/or intellectual disability.	NHSE
Integrate and personalise mental health care for people with long-term conditions	NHSE to develop robust integrated pathways of care for long-term conditions that address psychosocial needs, including the management of co-morbid mental illness. Psychiatric expertise (particularly Old Age psychiatrists) is required for the assessment and management of complex cases and should be built into the pathway.	NHSE
	NICE to reconsider its current strategy, which separates physical and mental health recommendations in their guidance.	NICE
	NHSE to rapidly expand the roll out of integrated psychological therapy services for people with medically unexplained symptoms and long-term physical health conditions as set out in the NHS LTP.	NHSE
	Healthcare professionals to ensure screen everyone admitted with acute complications of diabetes whose aetiology is unclear or not medically explained for mental illness. Staff need to be appropriately trained to do this.	Healthcare professionals
	Healthcare professionals to screen all patients prescribed second-generation antipsychotics for diabetes.	Healthcare professionals
	All mental health providers to create a diabetes register, with immediate priority given to units where individuals may have prolonged inpatient admissions, such as secure hospitals.	Mental health providers
	All mental health providers to audit current practices in diabetes care and consider:	Mental health providers

	▪ the implementation of diabetes-related competencies as part of mandatory training with a particular focus on managing and avoiding hypoglycaemia and safe use of insulin ▪ basic skills for staff in the management of diabetes and mental health that are in keeping with their job role to care for patients with comorbidity ▪ awareness of local pathways and policies for contacting diabetes or mental health services, and ▪ if best practice tariff criteria are met for diabetes ketoacidosis and hypoglycaemia and for children and young people with diabetes.	
	NHSE to ensure people with dementia receive a timely diagnosis.	NHSE
	NHSE to ensure people with dementia are offered post-diagnostic treatment and support, which should be NICE-recommended, and the support needs should be outlined in the initial care plan. This care plan should be reviewed within at least 12 months of being agreed, then reviewed every 12 months in accordance with changes in the person's needs. Revisions should be jointly developed and agreed with the person (and, if applicable, their carer).	NHSE
	NHSE to ensure carers for people with dementia should also be offered post-diagnostic support and/ or a carer's needs assessment.	NHSE
	ICSs should assess the different levels of risk of developing dementia as well as specific needs, such as those with early-onset dementia, people from Black, Asian and minority ethnic backgrounds and people with intellectual disabilities and capture this within their Joint Strategic Needs Assessment and local Dementia Needs Assessment.	ICSs
	NHSE to consider new models to support older people with dementia and mental health issues in the community, moving beyond the model that depends on memory clinics. This might incorporate a model whereby patients remain under the care of an Old Age psychiatrist from diagnosis until death, rather than being discharged back to a GP. This should involve regular check-ups and brief interventions when problems are identified. This aims to improve the quality of care provided, reduce hospital admissions and GP caseloads.	NHSE
	NHSE to ensure the commissioning of any new cardiovascular or respiratory disease service must specifically consider the psychological needs of that population from the outset and ensure that appropriately skilled mental health professionals are integrated and supported to function within that service.	NHSE

	NHSE to ensure all patients on a cancer treatment pathway are referred to psychological and mental health support in the community, in a timely manner.	NHSE
	NHSE to ensure the commissioning of any new cancer service must specifically consider the psychological needs of that population from the outset and that appropriately skilled mental health professionals are integrated and supported to function within that service.	NHSE
	NHSE to develop robust integrated care pathways for patients with cancer that meet their psychosocial needs, including the management of co-morbid mental illness.	NHSE
	NHSE to recommend the widespread commissioning of integrated cancer psychological support services in acute trusts and cancer centres, consisting of a stepped-care approach to managing psychological distress as per NICE guidance (access to counselling, psychology, and liaison psychiatry).	NHSE
	NHSE to ensure that all GPs are able to refer patients on a cancer treatment pathway to psychological and mental health support in the community, in a timely manner.	NHSE
	NHSE to commission services which should include primary care advice lines and prescriber support to GPs, led by psychiatrists with cancer care experience.	NHSE
	NHSE to recommend commissioning of inpatient cancer liaison psychiatry services consisting of at least some dedicated medical and nursing resource, in line with demand.	NHSE
	NHSE, National Institute for Health Research (NIHR), the Medical Research Council and the Wellcome Trust to liaise with other interested parties such as RCPsych, the Academy of Medical Royal Colleges, the Academy of Medical Sciences to significantly improve funding and support to integrated education and research involving cancer and mental health.	NHSE, NIHR, the Medical Research Council and the Wellcome Trust and partners
	NHSE should consider integrated training opportunities and enhanced generalist skills. This should include mental health competencies for 'non-mental health professionals' including nurses, doctors, staff working in acute settings, GPs, advanced care practitioners, pharmacists, and voluntary, community and social enterprise (VCSE) staff. It should also include physical health competencies for mental health staff, including psychiatrists, psychologists, and social care staff. NHSE should also consider integrated training opportunities, such as the management of common chronic physical and mental comorbidities such as alcohol and mood disorders and diabetes and depression.	NHSE
Increase support for carers	DHSC to invest in interventions for carers through support, psychoeducation, intent-based interventions, internet based information and education alongside professional support. It is also important to specifically consider the needs of young carers.	DHSC

Support people to find and retain meaningful employment	DWP to work with employers to ensure they support the wellbeing of their staff, including fully implementing the Thriving at Work report. Public sector organisations should be at the forefront of change and make use of their economic power (for example supply chains) to encourage wider uptake. This should take into account the changing nature of work and the recommendations of the Taylor Review.	DWP
	DHSC and the DWP to work together to give a guarantee that anyone with a serious mental illness who wants help with employment is able to access IPS.	DHSC and DWP
	DHSC to invest in interventions with a specific focus on work, such as exposure therapy and CBT-based and problem-focused return-to-work programmes.	DHSC
	DHSC to invest in work-directed intervention to clinical support, telephone or online cognitive behavioural therapy, and structured telephone outreach and care management programmes.	DHSC
	DWP and DHSC to give workers with mental health problems early access to occupationally focused healthcare, which should include helping them to obtain, remain in, or return to, appropriate work.	DWP and DHSC
	DWP and DHSC to expand vocational support services in both NHS and community settings for patients with mental health problems to help them remain in, or return to, work.	DWP and DHSC
	DWP to improve access to flexible benefits and sick leave for patients with chronic fluctuating health conditions to help patients remain in, or return to, work.	DWP
	DWP to ensure that all employers (including the NHS) recognise the benefits of ensuring that all supervisors, from the most junior upwards, feel confident to identify potential mental health difficulties in their staff and to speak with them about such difficulties using an approach to wellness that focuses on health rather than disease.	DWP
	NHS employers should ensure all healthcare staff understand the close links between someone's state of mental health and their ability to work, which is especially important when providing care for people who work in safety-critical occupations (e.g., vehicle operators, emergency services etc.).	NHS employers
	NHS employers to ensure all healthcare staff provide care in a way that helps patients stay in, or return to, appropriate work.	NHS employers
	NHS employers to ensure all NHS staff understand the key role that occupational health services have in helping to support patients staying in, or returning to, appropriate work.	NHS employers
	NHS employers to ensure, as a priority, that all NHS supervisors, from the most junior upwards, feel confident enough to identify potential mental health difficulties in their staff	NHS employers

	and to speak with them about such difficulties using an approach to wellness that focuses on health rather than disease.	
	Mental healthcare professionals to routinely explore a patient's employment history – including their current employment status – to understand what role it may have played in contributing to their state of mental health.	Mental health professionals
	Mental healthcare professionals to view it as an important treatment outcome to help patients to obtain, remain in, or return to, appropriate work.	Mental health professionals
	Mental healthcare professionals to encourage healthcare colleagues to recognise the mental health benefits of being in work and to consider work as a key treatment outcome for any care provided.	Mental health professionals
	Mental healthcare professionals to advocate for their patients by appropriately communicating with employers and occupational health providers to challenge any discrimination or stigma that exists about mental health, with the aim of helping their patients remain in, or return to, appropriate work.	Mental health professionals
	All employers to ensure that those in supervisory positions, from the most junior upwards, feel confident enough to identify potential mental health difficulties in their staff and to speak with them about such difficulties using an approach to wellness that focuses on health rather than disease.	Employers
	All employers to adopt policies and practices which support people who develop mental health conditions to remain in, or return to, appropriate full- or part-time work.	Employers
	All employers to recognise the value of occupationally focused mental healthcare in helping their staff remain in, or return to, appropriate work.	Employers
Improve the welfare system	DWP to ensure Universal Credit is rolled out in a way that enables and supports anyone with a mental illness and publish transparent data to demonstrate this.	DWP
Support people with problem debt	NHSE and ICSs to consider how best they can identify and support people with mental illness experiencing financial difficulty, and wherever possible ensure people have access to high-quality housing, debt, and financial advice.	NHSE and ICSs
Support people to access safe housing	DHSC and NHSE to develop a long-term plan for ICSs and local authorities to prioritise step down housing with adequate funding for people who require transitional accommodation and support to live independently.	DHSC and NHSE
	DHSC and DLUHC to reform the social housing system so that it better meets the needs of people with a mental illness and adopt a sustainable funding model for supported housing to ensure everyone who needs supported housing is able to access it.	DHSC and DLUHC

	HM Treasury, DHSC and DLUHC to agree a new long-term funding settlement for social care to complement improvements in mental health services support.	HM Treasury, DHSC and DLUHC
HOW CAN WE IMPROVE SUPPORT FOR PEOPLE IN CRISIS?		
Expand access to mental health services	NHSE and ICSs to increase access to Infant Mental Health Services.	NHSE and ICSs
	NHSE and ICSs to increase access to Community Perinatal Mental Health Services for women in the perinatal period and increase the paternal mental health support available.	NHSE and ICSs
	NHSE and ICSs to increase access to evidence-based specialist mental health care for women with a severe mental illness during the perinatal period.	NHSE and ICSs
	NHSE and ICSs to ensure Community Perinatal Mental Health Services include access to psychological therapies and the right range of specialist community or inpatient care so that comprehensive, high-quality services are in place across England.	NHSE and ICSs
	NHSE and ICSs to increase access to integrated treatment and support, through IAPT, Mental Health Support Teams in schools, and CAMHS with appropriate waiting times for children and young people.	NHSE and ICSs
	NHSE and ICSs to develop an equivalent model for Crisis Resolution and Home Treatment Teams for children and young people, which should be multi-agency (including social workers) and adapted to meet the needs of children and young people.	NHSE and ICSs
	NHSE and ICSs to introduce a 4−6 week waiting time standard for access to specialist NHS children and young people's mental health services, building on the expansion of specialist NHS services already underway.	NHSE and ICSs
	NHSE and ICSs to ensure there are developmentally informed services for children and young people up until the age of 25 years, and this should be appropriately resourced between child and adolescent and adult mental health services.	NHSE and ICSs
	Primary care providers to roll out suicide skills training for primary care professionals, such as STORM training.	Primary care providers
	NHSE and ICSs to empower and support primary care leaders to collaborate with mental health leaders involved in the design and implementation of the Community Mental Health Framework.	NHSE and ICSs
	PCNs, ICSs and NHSE to make pathways to primary mental health care fairer for groups of people who face additional barriers and/or struggle to access services through the traditional primary care route.	PCNs, ICSs and NHSE
	All primary care providers to have a specific mental health care pathway that covers the lifespan of people with intellectual disabilities, autistic people, or both.	Primary care providers

	All primary care providers to hold registers for people with intellectual disability and autistic people.	Primary care providers
	NHSE and ICSs to ensure that information resources about various care pathways are accessible for those with Intellectual Disabilities so that patients can understand and participate in their treatment pathway.	NHSE and ICSs
	NHSE and ICSs to ensure community mental health services meet a defined set of recommended NICE guidelines and more staff are able to give continuity of support to a larger number of patients with SMI to prevent relapse, hospitalisation and the use of the Mental Health Act 1983.	NHSE and ICSs
	NHSE and ICSs to ensure community Rehabilitation and Recovery teams are available in every mental health trust with an appropriate number of inpatient beds to avoid the use of 'locked rehab' units.	NHSE and ICSs
	NHSE and ICSs to ensure all settings in which older people with a mental illness are resident have easy access to a mental health support team that includes the services of a specialist in old age psychiatry.	NHSE and ICSs
	NHSE and ICSs to increase the number of people who can benefit from a personal health budget.	NHSE and ICSs
	NHSE and ICSs to significantly reduce the reliance on inpatient services for people with an intellectual disability and/or autistic people.	NHSE and ICSs
	NHSE and ICSs to significantly enhance community services for adults and children with an intellectual disability and/or autistic people.	NHSE and ICSs
	NHSE and ICSs to ensure that people experiencing a first episode of psychosis start treatment with a NICE-recommended package of care with a specialist Early Intervention in Psychosis (EIP) service within two weeks of referral.	NHSE and ICSs
	NHSE and ICSs to ensure that all specialist EIP provision is graded at level 4, in line with NICE recommendations.	NHSE and ICSs
	NHSE and ICSs to ensure 24/7 crisis and liaison pathways for all ages are implemented. Crisis resolution and home treatment teams should incorporate a model specifically to meet the different needs and risks of older adults (particularly in relation to co-morbid physical health issues). These teams should also be adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission.	NHSE and ICSs
	ICSs should monitor and respond to demand and capacity within mental health services.	ICSs
	NHSE and ICSs to introduce a new standard so that patients should expect to wait a maximum of four hours for admission to an acute psychiatric ward or acceptance for home-based treatment following assessment, for those who need it.	NHSE and ICSs

	NHSE and ICSs to ensure that 85% bed occupancy rates in mental health trusts are consistently achieved.	NHSE and ICSs
	NHSE and ICSs to reduce delayed discharges/delayed transfers of care for patients in mental health inpatient settings.	NHSE and ICSs
	NHSE and ICSs to invest in supported housing and other accommodation-based support.	NHSE and ICSs
	NHSE and ICSs to ensure that NHS mental health trusts eliminate both inappropriate external and internal (within the home provider) out-of-area placements.	NHSE and ICSs
	NHSE and ICSs to invest, in the short-term, in additional adult acute inpatient beds for areas with consistently high rates of inappropriate out-of-area placements and/or persistently high bed occupancy rates.	NHSE and ICSs
	DHSC, NHSE and ICSs to fund and procure age-appropriate alternative forms of mental health crisis provision. This should be extended to include children and young people and older adults and should not be limited to care homes in the case of the latter.	DHSC, NHSE and ICSs
	NHSE and ICSs to collect data on the availability of crisis alternatives, including activity, workforce, finance, and outcome metrics.	NHSE and ICSs
	NHSE and ICSs to work with local authorities and partners to provide better support for people in crisis that is not deemed to be a mental health crisis. This needs to be a non-clinical response to meet people's needs, which might be related to housing, addiction, or relationship difficulties, to name but a few. An example of this support is Distress Brief Intervention (DBI) in Scotland. DBI consists of two parts, with part one seeing trained frontline health, police, paramedic, and primary care staff help ease any individual. They then ask the person if they would like further support and, if they agree, they are referred to the DBI service with a promise of contact within the next 24 hours to start providing further face-to-face support. Part two is provided by commissioned and trained third sector staff who contact the person within 24 hours of referral and provide community-based problem-solving support, wellness, and distress management planning, supported connections and signposting.	NHSE and ICSs
	NHSE and ICSs to substantially increase the availability of psychological therapies accessible in secondary, tertiary care and specialist settings. For children and young people with more complex issues, they should access more specialised therapies if first and second line IAPT treatments have failed.	NHSE and ICSs
	NHSE and ICSs to ensure that adults with an eating disorder who require urgent treatment start this within one week. For adults with an eating disorder requiring routine treatment, this should start within four weeks.	NHSE and ICSs

	NHSE and ICSs to ensure that there is a dedicated community eating disorders service, which is integrated with medical care and supports a seamless transition from children and young people's services to adult care and from inpatient care to reduce the length of stay.	NHSE and ICSs
	NHSE to provide targeted funding to support provider collaboratives in developing and trialling integrated specialist pathways which offer more personalised care for patients who are acutely unwell.	NHSE
	NHSE and ICSs to promote the implementation of the Medical Emergencies in Eating Disorders (MEED) guidelines.	NHSE and ICSs
	NHSE and ICSs to ensure that people with complex mental health problems, including personality disorders, have greater access to a range of evidence-based psychotherapies tailored to their needs.	NHSE and ICSs
	NHSE and ICSs to ensure that the principles of reflective, psychologically minded practice and enabling environments underpin training of professionals and delivery of integrated models of care in community and inpatient settings across physical, mental health and social care.	NHSE and ICSs
	NHSE to ensure that every ICS has NHS specialist addictions services led by appropriately trained and experienced addiction psychiatrists. This should include adequate provision for children and young people and older adults experiencing addictions.	NHSE and ICSs
	NHSE to ensure that more veterans are able to access NHS mental health services (Transition, Intervention and Liaison Service (TILS) and Complex Treatment Service (CTS)) with an initial face-to-face assessment within 2 weeks and a first clinical appointment, where appropriate, two weeks thereafter. There should also be a greater focus on increasing services available to female veterans.	NHSE
	NHSE and ICSs to ensure that there is an explicit provision in each locality for those with autism. This should extend beyond the diagnostic process, to provide services for the treatment of their co-occurring mental and physical disorders and include the coherent involvement of the wide range of agencies and services that can benefit the individual.	NHSE and ICSs
	NHSE and ICSs to ensure that Liaison and Diversion services provide a multi-agency assessment and referral service within police custody and the courts across England hold cases in the short-term to prevent people from falling through the net.	NHSE and ICSs
	NHSE and ICSs to ensure that solitary confinement (defined as more than 22 hours in segregation without meaningful human contact) is banned immediately for children and young people in the youth justice system.	NHSE and ICSs

	NHSE and ICSs to ensure that Community Sentence Treatment Requirements is significantly expanded as proposed in the Government White Paper on a Smarter Approach to Sentencing. This will allow for those with more severe mental illnesses to benefit from community sentences.	NHSE and ICSs
	NHSE and ICSs to ensure that adults receive dedicated mental health screening within 24−48 hours after entering prison and 70% of people who need treatment or support are followed up within a month.	NHSE and ICSs
	NHSE and ICSs to ensure that there is a minimum ratio of prison officers to prisoners to increase basic safety, protect from dangerous, mind-altering drugs and increase access to mental health services in prison. NHSE and ICSs should also conduct an urgent assessment of how to better attract and retain a prison mental health workforce, including forensic psychiatrists, to deliver mental health care.	NHSE and ICSs
	NHSE and ICSs to ensure that all young people identified as 'in need' by youth justice liaison and diversion workers have an appropriate service they can be referred to.	NHSE and ICSs
	DHSC and the Ministry of Justice (MoJ) to reform the criminal justice system to make prisons safer and divert more people to community options.	DHSC and MoJ
	MoJ to conduct a detailed assessment on the impact of changes to Legal Aid on people with mental health problems and ensure improved and fair access to adequate legal advice and support.	MoJ
Introduce new waiting time standards in mental health	NHSE to develop a clear implementation plan for new mental health access standards (developed through the Clinically-led Review of NHS Standards), which is ambitious but achievable, and provide specific funding to enable specialist eating disorder services to meet these new targets.	NHSE
	NHSE to introduce new waiting time standards for other areas of mental health provision, including: ▪ perinatal mental health services ▪ children and young people's mental health services (not including eating disorders) ▪ adult crisis and acute mental health care ▪ adults who receive mental health treatment following a referral for mental health support from learning disability and autism services ▪ children and young people who receive mental health treatment following a referral for mental health support from learning disability and autism services ▪ adult eating disorder services, and ▪ integrated IAPT services.	NHSE

Improve the urgent and emergency care pathway for those with a mental illness	NHSE and ICSs to expedite work already underway to connect Integrated Urgent Care services to 24/7 mental health crisis services in each locality.	NHSE and ICSs
	NHSE and ICSs to increase the number of mental health specialists working in the 111 service and ensure call handlers are trained so that they are better able to triage and direct patients to the appropriate 24/7 urgent NHS mental health telephone support services for their area.	NHSE and ICSs
	NHSE and ICSs to routinely collect standardised data on mental health-related calls handled by the 111 service, including age and gender, and the outcome.	NHSE and ICSs
	NHSE and ICSs to review the implementation of NHS mental health telephone support, advice, and triage services and expedite the further improvements needed identified through this exercise. Any review should consider the extent to which: ▪ the service has integrated with Integrated Urgent Care Services and NHS 111 successfully ▪ the full crisis pathway has been mapped in each local area ▪ the services are providing an age-appropriate response ▪ the services are ensuring equity in access to those with mental health needs and co-occurring conditions such as learning disability or autism, and ▪ other agencies such as police, ambulance and local authorities can access advice and support.	NHSE and ICSs
	NHSE and ICSs to invest in bespoke mental health crisis vehicles to reduce inappropriate ambulance or police conveyance to A&E. This will reduce pressure on ambulance fleets and provide a safe and appropriate alternative to full-size ambulance vehicles.	NHSE and ICSs
	NHSE and ICSs to create new joined-up functions between mental health services, ambulance services and other urgent and emergency care services, and significantly expand the education and mental health training of the paramedic and wider ambulance workforce.	NHSE and ICSs
	NHSE and ICSs to expedite plans already in place to put mental health professionals in ambulance and police control rooms and to be deployed to provide 'on-the-scene' responses.	NHSE and ICSs
	ICSs to work in partnership with young people to design services they find welcoming, non-stigmatising and helpful.	ICSs
	NHSE to ensure the forthcoming urgent and emergency care strategy includes mental health.	NHSE

	NHSE and ICSs to ensure that acute hospitals and/or paediatric departments provide access to a Core24 liaison psychiatry service for everyone who needs it. These teams should include psychiatrists with expertise in older adults.	NHSE and ICSs
	NHSE and ICSs to ensure that integrated inpatient and outpatient services include liaison psychiatry to meet the needs of patients with more complex problems.	NHSE and ICSs
	DHSC to invest capital funding to develop age-appropriate assessment spaces in A&E and acute hospitals for people with mental health/learning disability needs.	DHSC
	DHSC to ensure that, within the existing Health Infrastructure Plan or where investment is being made for a new or upgraded acute hospital, plans include sufficient space for integrated mental and physical healthcare (liaison mental health services) to be delivered.	DHSC
Implement the Mental Health Act Reform Bill	DHSC, OGDs and NHSE to implement the Mental Health Act Reform Bill, supported by adequate revenue and capital investment, including in workforce training and development.	DHSC, OGDs and NHSE
	DHSC to ensure that investment is accompanied by a workforce plan to ensure the required workforce is in place at the time of implementation. Without requisite investment in the workforce, we would recommend that the timeframes for implementation be revised.	DHSC
	Invest capital funding to improve digital technology within mental health trusts including the digitisation of the MHA.	DHSC
Commit to preventing suicides and provide better information and support to those bereaved or affected by suicide	NHSE and ICSs to provide better information, resources, and support to those bereaved or affected by suicide as over 20% of the Coroners Preventing Future Deaths reports each year are about poor communication with families.	NHSE and ICSs
	All healthcare providers to employ Family Liaison officers (FLO).	Healthcare providers
	All healthcare providers to have training on working with families (e.g., making families count).	Healthcare providers
	NHSE and ICSs to support family bereavement services in all areas of the country.	NHSE and ICSs
	NHSE and ICSs to ensure that every mental health provider has a pastoral Suicide Lead.	NHSE and ICSs
	NHSE and ICSs to ensure that every healthcare provider enables reflective practice for all staff in all health organisations, including specific groups to process the impact of patient suicide.	NHSE and ICSs
	NHSE and ICSs to ensure that every healthcare provider provides resources and support for patients bereaved by peer suicide.	NHSE and ICSs
	NHSE and ICSs to ensure that every healthcare provider improves learning systems after a death.	NHSE and ICSs

	NHSE and ICSs to ensure that healthcare providers move away from Risk Assessment tools, as they are ineffective and not recommended by NICE and the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). As it is not possible to accurately predict the suicide of a given person at a particular point in time, healthcare professionals should offer a compassionate and therapeutic assessment, undertake a personalised risk assessment (to identify risks, not to predict suicide but to intervene), identify needs and collaboratively develop a risk mitigation plan, and coproduce a Safety Plan.	NHSE and ICSs
	NHSE and ICSs to prioritise reducing rates of self-harm as a key indicator of suicide risk drawing on the examples of tailored services providing intervention after presentation e.g., ASSIST, Distress Brief Intervention, and brief interventions in repeated self-harm (BIRSH).	NHSE and ICSs
	NHSE and ICSs to move away from culture of inclusion and exclusion as many statutory services specifically exclude people from care based on being high-risk or complex.	NHSE and ICSs
	NHS providers to develop spaces to reflect on inequality and prejudice that will lead to action.	NHS providers
	Healthcare professionals to be aware of the impact of stigma and negative attitudes that, although often unconscious, are detrimental to patients and their carers.	Healthcare professionals
	NHS providers to support research, data collection and monitoring and ensure real-time data collection is supported by adequate funding for academics to analyse it to gain a greater insight into the aetiological factors of suicide.	NHS providers
	NHSE to extend rapid surveillance data which is gathered about child deaths to move to above 18 years, to capture university students and extend OHID funding to cover all ages.	NHSE
	OHID and OGDs to reduce access to the means of suicide as a public health intervention.	OHID and OGDs
	DCMS to ensure the media maximises its role in prevention by reporting suicide responsibly.	DCMS
	DHSC and Defra to review and act on the recommendations of the forthcoming report from the EFRA Select Committee inquiry into rural mental health and suicide.	DHSC and Defra
	DHSC to expand suicide training for all frontline staff who look after children and young people, such as teachers and GPs. et	DHSC
	DHSC and NHSE to expand the Learning Disability Mortality Review (LeDeR) program to include autistic people who do not have a learning disability.	DHSC and NHSE
	DHSC and NHSE to support the timely adoption of MBBRACE report recommendations across the country.	DHSC and NHSE

CROSS-CUTTING ENABLERS		
Implement the NHS LTP in full by 2028/29 with the restoration of all existing service trajectories	NHSE and DHSC to commit to the restoration of services to trajectories as outlined in the NHSE Mental Health Implementation Plan by 2023/24-2024/25.	NHSE and DHSC
	NHSE and DHSC to review the continuing demand for mental health services arising from COVID-19 pandemic and allocate sufficient funding for recovery that is equitable to the elective recovery programme.	NHSE and DHSC
	NHSE and DHSC to publish interim in-year targets for the NHS LTP mental health programme so the public can see that ICSs are on track to deliver.	NHSE and DHSC
Ensure ICSs are setup to improve the mental health and wellbeing of their population	ICSs to have Mental Health reflected as a top priority with the full programme delivery supported and tracked at ICS board level.	ICSs
	ICSs to have a credible workforce plan to demonstrate how it will be meeting the mental health priorities of the local population.	ICSs
	ICSs to ensure that senior mental health leadership will be a core component of all place-based planning.	ICSs
	ICSs to ensure that Integrated Care Strategies drive a coordinated public mental health approach across all parts of the system. Guidance should be clear on how the system itself can be designed to prevent poor mental health and support good mental health.	ICSs
	ICS leaders to develop a system-wide outcomes framework, including mental health and wellbeing outcomes, which defines the partners' collective ambition for improving outcomes for people living in the area, which should be then used to monitor performance against the outcomes framework annually.	ICSs
	Mental health leadership at ICS level must always include people who use services.	ICSs
	ICSs exceeding core expectations should work with those who are struggling through a peer-learning approach.	ICSs
	NHSE should systematically capture and share learning from areas that are furthest ahead.	NHSE
	NHSE to review each ICBs five-year systems plan annually to be assured that: ▪ it meets the ambition set out by their ICS ▪ has a clear plan to improve mental health and wellbeing outcomes in population health and healthcare ▪ tackles inequalities in mental health and wellbeing outcomes, experience and access to care and support ▪ reflects the national priorities and ambitions of the NHS LTP for Mental Health and the forthcoming cross-government mental health and wellbeing plan	NHSE

	▪ sufficiently takes account of how they will commission specialist mental health services previously commissioned by NHSE, and ▪ aligns clearly with the national mental health workforce plan and is realistic and deliverable locally.	
	NHSE to use the findings from these annual assessments to provide tailored support and guidance to ICBs.	NHSE
Strengthen leadership and increase transparency and accountability	The Cabinet Office to establish a Mental Health Cabinet Committee to ensure collective responsibility for improving the mental health and wellbeing of the nation.	Cabinet Office
	The Cabinet Office to ensure that the Mental Health Policy Tool is implemented by all departments, and utilised and completed in a transparent way for all policy development. This tool has been developed to assist government departments with considering mental health in their policy development. This has been in development for some time, with colleagues from across government and stakeholders working together.	Cabinet Office
	NHSE to provide the requisite funding, support, and resourcing so NHS providers can deliver on the recommendations from the NHS Leadership by General Sir Gordon Messenger in full, including: ▪ targeted interventions on collaborative leadership and organisational values ▪ positive equality, diversity and inclusion (EDI) action ▪ consistent management standards delivered through accredited training ▪ a simplified, standard appraisal system for the NHS ▪ a new career and talent management function for managers ▪ effective recruitment and development of non-executive directors (NEDs), and encouraging top talent into challenged parts of the system.	NHSE
	Every local authority should appoint a ‘member champion’ for mental health as part of the Mental Health Challenge for Local Authorities in order to lead the way in their local areas.	Local authorities
	NHSE to commit to publishing the Mental Health Dashboard every quarter and include trust-level data and workforce data to create a more comprehensive picture of opportunities and challenges at the commissioner, provider, and ICS levels.	NHSE
	NHSE to make routine data available so that there is transparency about how local areas commission services that account for age, gender, ethnicity, disability, and sexuality.	NHSE
	DHSC to publish an annual report on the implementation of the NHS LTP and this cross-government mental health and wellbeing plan.	DHSC
	Secretary of State for Health and Social Care to report:	DHSC

	▪ whether there will be an increase in the amount of spending from NHSE and ICBs on mental health and if there will be an increase in the proportion of spending on mental health spending compared with total expenditure in the previous year ▪ how much is being spent on mental health (in total and as a proportion of overall healthcare spending) in the current year by NHS and ICBs and as a proportion of total spending, and how much each ICB has spent on mental health for the year and the proportion of its total spending it represents.	
Increase funding for NHS mental health services	DHSC and NHSE to ensure a long-term commitment to the Mental Health Investment Standard (MHIS) beyond 2024/25 for NHS-funded mental health services. The MHIS should be strengthened along the lines suggested by NHSE[70] prior to the pandemic to include the following elements: ▪ ICBs must increase investment by at least their overall allocation growth plus a further 'percentage increment to reflect…additional funding included in... allocations' ▪ The shares of this resource spent with mental health providers and invested in children's and young people's mental health services specifically must increase, and ▪ ICB investment plans should be subject to local review at the system level, including by a nominated lead provider of mental health services. This should ensure the plans are 'credible' to deliver the necessary workforce and activity commitments.	DHSC and NHSE
	NHSE to strengthen the way the MHIS operates (as set out by the HFMA)[71] by, ▪ allowing systems to agree the assessment of investment over a longer period of time to enable ICSs to invest where needed without being penalised for improving mental health services more quickly ▪ ensuring additional non-recurrent mental health spending due to COVID-19 is excluded when assessing baseline expenditure ▪ ensuring the achievement of the MHIS is assessed at system level with ICB and ICP sign off ▪ ensuring quality and outcome measures are included in the assessment of the MHIS ▪ revising MHIS categories so that they are consistent with the NHS LTP, and ▪ ensuring the primary measure of the MHIS excludes continuing healthcare/packages of care and prescribing.	NHSE and DHSC
	NHSE to ensure the additional £1.5bn allocated to deal with the rising costs of energy and fuel, as well as wider inflation, is fairly apportioned to mental health trusts. We know that	NHSE

	around £350m more investment is now needed by 2023/24 to fulfil the NHS LTP commitments because of the impact of inflation, using the latest GDP deflators.[72]	
	NHSE to update the NHS Mental Health dashboard based on the recent recategorisation exercise to allow for trend analysis.	NHSE
Invest in the NHS mental health estate	At the next CSR, HM Treasury, DHSC and NHSE to provide ring-fenced investment for mental health NHS trusts as part of a multi-year capital settlement. This additional capital funding uplift should be in addition to trusts' day-to-day capital budgets and should include: ▪ a new Health Infrastructure Plan (HIP) for Mental Health. Within this, o commit to a new £1bn building and redevelopment programme for Mental Health to enable 12 major building and redevelopment schemes to be awarded to mental health NHS trusts by 2030. o improve the therapeutic environment of mental health and learning disability/autism inpatient settings by: • eliminating mixed sex accommodation • procuring en-suite facilities for all existing single rooms • minimising the risks of harm through innovative safety improvement projects, and making the estate more suitable for people with disabilities • reaffirm the commitment to complete the elimination of dormitory provision and replace with single en-suite rooms • invest in new building and redevelopment schemes for community mental health facilities, including clinical and office space, and the essential improvements to digital infrastructure, and • new building and redevelopment schemes for crisis mental health facilities, including the procurement of sufficient mental health ambulances/ transport vehicles; creating age-appropriate mental health assessment spaces in A&Es (or alternative) and acute hospitals; and procuring age-appropriate alternative forms of mental health crisis provision.	HM Treasury, DHSC and NHSE

	▪ eradicate significant and moderate risk maintenance backlog in mental health and learning disability sites/estates.	
	DHSC to allow mental health trusts to spend their planned capital budgets in full each year given the historic underinvestment. This should enable trusts to address ongoing backlog maintenance issues, maintain safe services and minimise risks across their estate.	DHSC
	Within the existing HIP programme or where investment is being made for a new or upgraded acute hospital, DHSC, NHSE and local leaders to review whether plans include sufficient space for integrated mental health and physical healthcare (liaison mental health services) to be delivered. This needs to be built into service design from the outset.	DHSC and NHSE
Ensure public mental health budgets have a growing share of public health spending	At the next Comprehensive Spending Review (CSR), HM Treasury and DHSC to commit to increase the Public Health Grant budget as part of a multi-year settlement, which will ensure local authorities can continue to provide prevention and public health interventions.	HM Treasury and DHSC
	Local authorities to ring-fence at least 4% of total public health expenditure for public mental health spending as the start of sustained and growing investment in this area. This funding should be linked to the JSNA for each locality and relevant local strategies. It should also align with the growth in the public mental health workforce and those within voluntary, community and social enterprise organisations.	Local authorities
Increase funding for drug and alcohol use disorder service	DHSC and MoJ to commit the investment advocated by Dame Carol Black in her recent independent report on drugs to restore funding for substance use disorders to a comparable share of public health spending to that of 2013/14.	DHSC and MoJ
	DHSC and DLUHC to review the commissioning of addiction services, including potential service models, in light of the independent review of drugs by Dame Carol Black. The College endorses Dame Carol's call to improve commissioning standards and move towards integrated commissioning.	DHSC and DLUHC
	DHSC to prioritise rebuilding the workforce as set out in the government's 10-year drug strategy.	DHSC
Increase funding for mental health social care	At the next CSR, HM Treasury, DLUHC and DHSC to commit to increase the social care budget for babies, children, young people, and adults. Specifically, within a funding uplift, local authorities should commit to ring-fence funding devoted to early years, aiming to get it back to at least around 8% of the children's social care expenditure.	HM Treasury, DLUHC and DHSC
	NHSE to develop a 10-year data plan for mental health, including how data will be used to promote patient choice, efficiency, access, and quality in DHSC mental health care, as well as ensuring that all NHS-commissioned mental health data are transparent (including	NHSE

	where data quality is poor/in early stages of development or collection) to drive improvements in services.	
	DHSC to set up a new Mental Health Innovation Fund.	DHSC
	NHSE to develop a strategic delivery plan for how digital can support the enhanced delivery of mental health services and care for the benefit of patients and staff.	NHSE
	NHSE to strengthen the commitment to deliver shared-care records and the programmes to achieve this funded, especially in rural areas without a large tertiary centre or urban council that can fund these programmes at risk.	NHSE
	NHSE to invest in greater digital technology to improve the efficiency of collecting outcome measures and empower patients to play a role in their own care.	NHSE
	NHSE to encourage greater working between digital suppliers and clinicians to help improve the interface between outcome measures and EPRs.	NHSE
	NHSE to provide clear information for patients on data use and assurances, without jargon to help people understand GDPR and what this means for them personally.	NHSE
	NHSE to co-create digital inclusion strategies with charities such as Citizens online.	NHSE
Invest in digital technology Increase funding for research	DHSC to increase the funding for mental health research to 15% of the total UK health research budget by 2030.	DHSC
	Working alongside funders, academics, clinicians, and people with lived experience, DHSC to meet the Mental Health Research Goals collectively developed by the sector by 2030. This includes: ▪ research to half the number of children and young people experiencing persistent mental health problems by; o increasing knowledge of the aetiology, development (including risk and protective factors) and progression of mental health problems at key transition points across the life-course o increasing research on effective mental health promotion, prevention, treatment and support in children and young people in education, community and health, including specialist mental health, settings, and, o increasing research on implementation of effective interventions in a range of settings to optimise outcomes. This includes research on service delivery and organisational factors influencing outcomes. ▪ research to improve understanding of the links between physical and mental health, and eliminate the mortality gap by;	DHSC, academics, clinicians, and people with lived experience

	▪ strengthening our understanding of the co-morbidity of both mental and physical health problems. This research should address clusters of health problems, underlying mechanisms and progression, and societal and individual risk and protective factors and in addition, the implications for treatment and support ▪ conducting research to improve the efficacy and effectiveness of interventions for prevention and increase maintenance of good physical health for people with mental health problems, or at risk of developing mental health problems. The aim is to reduce morbidity and excess mortality ▪ research to develop new and improved treatments, interventions and support for mental health problems by; o conducting research to investigate the mechanisms underlying mental wellbeing, mental health problems and related behaviours through use of markers from basic biological, psychological and social science to understand how to improve treatments, interventions and support. o developing and implementing new and improved treatments, interventions and support, including medical, social and psychological approaches to increase patient choice and greater personalisation. o developing and evaluating effectiveness of digital interventions that complement and supplement face to face interventions for prevention, support and recovery. ▪ research to improve choice of, and access to, mental health care, treatment and support in hospital and community settings by; o conducting research to understand the barriers to help-seeking and service access, and the delivery of mental health services and other support in diverse settings and across different communities, including Black, Asian and minority ethnic group and those from LGBTQIA+, to address stigma, discrimination, and social exclusion o Conducting research to accelerate the implementation of existing best evidence at the population and individual level. In addition,	

	implement evidence on how patient choice and joint decision-making make a difference to outcomes in routine care and, ▪ increasing research to inform strategies for tackling social and health inequalities to improve public mental health.	
	DHSC to fund large-scale epidemiological studies on autism prevalence, prevalence of co-occurring mental health disorders, and service use needs, in order to be more precise and more informative to policy development.	DHSC
	DHSC to fund research into the most effective treatments for co-occurring mental health conditions in autism (both pharmacological and non-pharmacological).	DHSC
	DHSC to allocate capital funding to mental health trusts for Research & Development in Mental Health and Dementia, including: the prevention agenda, research to improve the productivity and effectiveness of the NHS, and the translation of basic science and support for the life sciences industry.	DHSC
	DHSC to continue to commission regular prevalence surveys for adults and for children and young people.	DHSC
	DHSC to fund a follow-up survey to track the outcomes of the care received by the children and young people in the prevalence survey who have given informed consent. This will allow researchers to align findings and track data against better-developed indicators helping the Government better plan for the next ten years. It would also provide necessary information about what happens to children and young people over time.	DHSC
	DHSC to ensure that eating disorders are recognised within both prevalence surveys, after being excluded from the previous iterations of the APMS.	DHSC
	DHSC and other partners to reverse the decline in academic psychiatry posts.	DHSC
	Every medical school will have an academic department of psychiatry, with psychiatry being taught effectively to all medical students.	Medical schools
	DHSC to liaise with other interested parties such as RCPsych, the Academy of Medical Royal Colleges, the Academy of Medical Sciences, and other relevant stakeholders, to provide required funding and support to develop the careers of academic psychiatrists.	DHSC
	DHSC to address significant barriers in clinical academic career pathways in mental health research, and to provide greater support for post-doctoral research fellowships, the transition to academic clinical lecturer and establishment at senior lecturer level.	DHSC
	DHSC to commit to increase the number of medical school places in England to 15,000 by 2028/29 in order to deliver the NHS LTP and allocate those places to schools that have	DHSC

Build a strong and resilient mental health workforce	a clear plan to encourage more students to choose a shortage specialty, including psychiatry.	
	DHSC and NHSE to continue the expansion of core psychiatry posts and ensure provision for further expansion to facilitate long-term sustainability and growth in consultant psychiatrist posts for 2035. The additional core training posts made available from August 2021 onwards must be fully funded through the core training pathway, with sufficient provision also made for an expansion in higher training capacity.	DHSC and NHSE
	DHSC and NHSE out plans to publish a comprehensive NHS workforce strategy following publication of Health Education England's (HEE) strategic framework (now subsumed into NHSE). This should be accompanied by 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 NHS LTP, proposed standards from the Clinically-led Review of NHS Standards, and the proposed Mental Health Act reforms. The settlement must take into account that funding for postgraduate medical education and training has been essentially flat in real terms between 2013/14 (£2.111bn) and 2020/21 (£2.080bn).	DHSC and NHSE
	DHSC to ensure funding is allocated to deliver the requisite workforce for the Mental Health Act reforms. This includes the additional 494 FTE psychiatrists needed by 2033/34, as identified in the independent research commissioned by the College, as well as the non-medical workforce identified by HEE-commissioned research.	DHSC
	DHSC and NHSE to provide the necessary investment in workforce to deliver the autism diagnostic pathway and reduce waiting times. Funding is required for both new posts and education and training, while also supporting retention and development among existing staff in these services.	DHSC and NHSE
	DHSC and NHSE to maintain the NHS Staff Support Offer, with £50m funding each year over the three years.	DHSC and NHSE
	DHSC and NHSE to ensure that, from 2022/23 onwards, at least 10% of the 1,000 PAs being trained each year work in mental health (including liaison services and GP practices).	DHSC and NHSE
	DHSC and NHSE to ensure that the implementation of the provision within the Health and Care Act 2022 to provide mandatory training about learning disability and autism for Health and Social Care staff is supported by sufficient resources.	DHSC and NHSE

2. Introduction

The government's commitment to level up and address unequal outcomes and life chances across the country has never been more pressing.[73] Improving the mental health and wellbeing of the nation is integral to this commitment, particularly for people who experience worse outcomes than the general population.

We welcomed the former Secretary of State for Health and Social Care's commitment to ensuring the NHS is set up properly for success, levelling up across the NHS and social care, pursuing personalisation, as well as using emerging technologies and data. The Government's mental health and wellbeing plan will be central to delivering this and we commend it to the new Secretary of State and urge them to take this agenda forward.

Mental illness remains one of the largest single causes of disability in England[74] with:

- up to one in five mothers suffering from depression, anxiety or psychosis during pregnancy or in the first year after childbirth[75]
- one in eight children and young people aged 5-19 having at least one mental disorder (when assessed in 2017)[76]
- one in six children and young people aged 6−19 having a probable mental disorder (when assessed in 2021) [77]
- 13% of young people aged between 11–16 years and 58.2% of those aged 17-19 years having possible eating problems (when assessed in 2021)[78]
- one in six adults having a common mental disorder[79]
- 1−2% of adults having a severe mental illness (SMI)[80]
- one in 30 adults living with a drug dependence[81]
- one in five older people in the community, and two in five within care homes, affected by depression which is often triggered by, and worsening the outcomes for, comorbidities[82]
- there is an estimated prevalence of 781,000 people in England with dementia as of 2018[83], and
- evidence suggests the prevalence of all mental disorders s higher in people with intellectual disabilities than in the general population[84].

Mental illness also disproportionately affects people living in poverty, those who are unemployed, and those who face racial discrimination[85]. The mental health impact of caring for someone with these illnesses is considerable.

Ahead of the publication of the NHS Long Term Plan (LTP), we commissioned an analysis that found that the birth and death rates combined with estimates of migration between 2018 and 2029 there will be around 4.1 million (+7.4%) more people living in the country.[86] Invariably, this will lead to greater demand across public, independent and third sector services and therefore the requirement for additional funding to support that growth.

We argued that more children and young people in the population suggest capacity will need to be increased for child and adolescent mental health services (CAMHS), parenting programmes, self-harm, substance misuse and Criminal Justice liaison services. Early diagnosis and support will also be needed for children and young people with neurodevelopmental disorders.[87]

More people aged 30−45 suggest a greater demand in the future for Improving Access to Psychological Therapies (IAPT), maternal wellbeing, workplace wellbeing and early intervention services. Furthermore, people with intellectual disabilities are living longer than before, and children born prematurely are surviving, which will have an impact on services in the future.[88]

More older adults, including the very old, means that there will be an increased need for capacity in dementia, old age psychiatry and social care support services. There are clear demographic and economic imperatives to focus much more rigorously on the mental health of older people. The increase in numbers of older people also highlights the lack of research in the treatment and management of depression and other functional illnesses in older adults.[89]

Yet, we know that only a minority of people in England with a mental illness, including substance/alcohol use, receive any form of treatment. The only exception to this is for people experiencing psychosis. [90]

Looking back

Cross-Government plans

The Mental Health Policy Group has reviewed the progress made by *No health without mental health* cross-government mental health strategy since its launch in 2011.[91] The Group found that of the six main desired outcomes, half have not been achieved and two have only been partially achieved.

- **OBJECTIVE 1: More people will have good mental health – this has not been achieved.**

A record 4.3 million people were referred to clinical mental health services last year. Even before the COVID-19 pandemic, mental illness prevalence had increased substantially, and wellbeing scores were down.[92]

- **OBJECTIVE 2: More people with mental health problems will recover – this has been partially achieved.**

Significant investment and targets for increasing access to psychological therapies have meant the 50% recovery target is being met or nearly met for common mental health disorders. Perinatal mental health services are also achieving better outcomes. There is a more mixed picture for serious mental illness – the lesson is that investment, minimum waiting times and standards are necessary to drive improvement.[93]

- **OBJECTIVE 3: More people with mental health problems will have good physical health – this has not been achieved.**

The premature mortality of people with serious mental illness has significantly worsened – and had done so even before the COVID-19 pandemic.[94]

- **OBJECTIVE 4: More people will have a positive experience of care and support – this has not been achieved.**

Care Quality Commission (CQC) surveys show that, across many areas of care, the experience of using mental health services is at its lowest point throughout the eight-year period (2014 to 2021 inclusive).[95]

- **OBJECTIVE 5: Fewer people will suffer avoidable harm – partially achieved.**

There has been a worrying increase in the use of the Mental Health Act since 2011 but the Use of Force Act is a positive innovation.

- **OBJECTIVE 6: Fewer people will experience stigma and discrimination – this has been achieved.**

Time to Change appeared to galvanise a significant shift in public attitudes to mental health but this is no longer being funded.

Alongside the MHPG, we are calling for the government to learn the lessons of *No health without mental health* and its implementation. We consider the key lessons to be that:

- there was no real implementation plan or delivery mechanism with buy-in from across the government
- although some clinical services benefitted from extra investment, targets and focus, many supporting services, like those commissioned and provided by public health and local government more widely, had their funding dramatically reduced, with the heaviest cuts falling in areas of greatest deprivation and therefore greatest mental health need
- austerity also meant that deprivation and income inequality, which drive mental ill health prevalence, actually got worse.

NHS plans

Within the NHS, the LTP for Mental Health is making good progress to transform mental health services across the country, building on the foundations of the Five Year Forward View for Mental Health (FYFVMH). However, as with the FYFVMH, major barriers to delivery remain. Many of these were apparent prior to the COVID-19 pandemic but have undoubtedly been exacerbated by recent events.

Firstly, a clear, ambitious mental health workforce is lacking. The inability of the NHS to substantially grow and retain the mental health workforce – predominantly in mental health nursing – is having the most significant impact on the delivery of the mental health programme.

Secondly, sustained increased investment at a local level has been variable. The Mental Health Investment Standard (MHIS) has been successful in driving growth in mental health spending overall but there remain challenges with local areas investing the full allocation given additional pressures across the wider system.

Thirdly, we remain behind in the ambition to improve the quality and flow of data, particularly for older adult services and children and young people's services. The capacity and capability of NHS Digital (NHSD) (now subsumed within NHS England (NHSE)) to meet the recommendations for a data revolution should be enhanced.

Fourth, there has not always been sufficiently joined-up leadership and governance at a senior level across Government departments and with NHSE. This Plan is an opportunity to further align these processes more strategically.

Fifth, there is a tendency for health strategies and plans to be produced in silos without enough thought to the relevant interdependencies. There is more work needed to address the needs of specific groups, including older adults with functional and organic mental illnesses, those living with substance use disorders, those with neurodevelopmental disorders, those with complex needs such as personality disorder/emerging personality disorder, and those with intellectual disabilities and autism, and to integrate those recommendations into a wider cross-government plan.

Global plans

Globally, public mental health policies have become increasingly prominent in the World Health Organisation, the World Psychiatric Association, and the United Nations. Yet we know barriers to implementation remain. It has been argued that the reasons for this are:

- insufficient public mental health knowledge
- insufficient mental health policy or policy implementation
- insufficient resources
- insufficient political will
- political nature of some public mental health activities such as poverty, and

- insufficient appreciation of cultural differences. [96]

Looking ahead

The Chief Executive of NHS England (NHSE), Amanda Pritchard, recently set out her top priorities for the NHS: recovery, reform, resilience, and respect. Achieving these ambitions will mean recovering from the inevitable impact of the pandemic on the nation's mental health, reforming and improving mental healthcare for the future, ensuring mental health services are resilient to future shocks, and respecting all staff and patients with much greater attention paid to equality, diversity, and inclusion.

As NHS leaders implement their plans for 2022/23 and beyond, we are pleased to see a continued commitment to improve mental health services and services for people with a learning disability and/or autistic people – maintaining continued growth in mental health investment to transform and expand community health services and improve access.[97]

NHS recovery following the COVID-19 pandemic is complex and multifaceted, but if we are to improve health outcomes for all patients, their mental health needs to be considered as well as the way people interface between different services and sectors. There is often a bi-directional relationship between the performance of mental health services and other sectors, including the responsiveness of urgent and emergency care, timely access to primary care, and elective care, across local health economies.

The whole NHS shares the same challenges around investing in our workforce with more people, new ways of working, and embedding a compassionate and inclusive culture needed to deliver outstanding care; responding to COVID-19 ever more effectively whether it be through the vaccination programme or meeting the needs of patients with COVID-19 in mental health settings; harnessing the potential of digital technologies and working collaboratively with providers, local authorities and other partners across ICSs to develop a five-year strategic plan for their system and places.

We have made progress since the introduction of the FYFVMH and the current LTP, but the treatment gap remains substantial. The scale of the challenge in mental health is so great that demand continues to outstrip capacity. With mental health referrals at record levels of 4.3 million last year and a backlog of at least 1.5 million people still waiting to start treatment, pressure on the NHS is likely to reach unprecedented levels.[98]

Clearly, NHS treatment cannot be the only answer to our national mental health challenge. Investing in public mental health through evidence-based health promotion, prevention and early intervention initiatives is the only way to reduce the prevalence of mental illness in the population and consequently the burden of mental illness in the long-term. The current cost of living crisis makes this situation more urgent. Food insecurity, fuel poverty, debt and loneliness are a reality for millions of people.

But there is far less coverage of interventions to prevent associated impacts of mental illness, such as premature mortality, and negligible coverage of interventions to prevent mental illness from arising or to promote mental wellbeing and resilience. This implementation failure results in preventable population scale suffering, broad impacts and associated economic costs. Furthermore, it breaches the right to health and the Equality Act, and the implementation gap has further widened during the pandemic.

The United Nations Sustainable Developmental agenda set 17 ambitious and transformational goals for people and for the planet in January 2016, with the aim that all will be achieved by 2030.[99] Goal three seeks to ensure healthy lives and promote well-being for all, at all ages. The target of achieving

universal coverage by 2030 applies to treatment of mental disorder, prevention of mental disorder and promotion of mental wellbeing.[100] The UK government has committed to achieving the UN Sustainable Development Goals (SDGs) by 2030 but this will require a collaborative, planned approach over the next eight years.

Sustainable development for people and planet is defined as development that meets the needs of the present without compromising the ability of future generations to meet their own needs. The interlinkages and integrated nature of the SDGs balance the three dimensions of sustainable development: economic, social, and environmental. This cross-government mental health and wellbeing plan must be seen in the context of achieving this goal.

Our vision for the Plan: 2025-2035

To drive progress over the next decade, the Government must build on the foundations set by *No Health Without Mental Health*,[101] *Future in Mind*[102], the *FYFVMH*, and the *NHS LTP*[103]. It must also align with other global and national calls to action.

Our vision for 2035 is to create a world-leading mental healthcare system in England; one that is designed to promote good health and wellbeing, prevent mental ill health, intervene at the earliest opportunity and to provide universal and timely access to high-quality treatment and support for those who need it.

We recommend the Department of Health and Social Care (DHSC), other Governmental departments (OGDs), the NHS and its arm's-length bodies, local government and key partners commit to ambitious and targeted action so that collectively:

1. by 2035, the prevalence of mental disorders in the English population has been reduced by five percentage points, and disparities in prevalence across population groups have been reduced
2. by 2030, we have achieved the UN SDG target of delivering universal health coverage for the treatment of mental disorders, prevention of mental disorders and promotion of mental wellbeing in England
3. by 2030, we have achieved the UN SDG target of reducing premature mortality from mental disorders and illness (through prevention and treatment, and promoting mental health and wellbeing) by one-third in England
4. by 2030, we have achieved the UN SDG target of providing universal access to quality essential health care services so that everyone who needs mental health treatment and support in England will be able to access it at the right place and at the right time, including through NHS primary care, urgent and emergency care, and secondary and specialist mental health services
5. by 2030, we have improved the quality, safety and effectiveness of treatment and care for those needing services for their mental health, measured through patient experience, effectiveness, safety, and patient outcomes (that matter most to patients)
6. by 2030, we have achieved the UN SDG target of strengthening the prevention and treatment of substance abuse and harmful use of alcohol in England
7. by 2030, we have built a strong and resilient mental health workforce with mental health leaders empowered to develop the healthcare services of the future through Integrated Care Systems (ICSs), Partnerships (ICPs) and Boards (ICBs)
8. by 2030, we have set up local systems to invest in mental health services and integrated pathways of care in an equitable and sustainable way that reflect significant historic underinvestment, and
9. by 2035, there is equitable funding for world-class mental health research, giving us a greater knowledge and understanding of effective treatments and service models that contribute to better patient experiences, recovery, and long-term outcomes around the world.

Globally, it is estimated that the broad impacts of mental disorders and poor mental wellbeing will reach US$6046 billion by 2030.[104] As this Government pursues the levelling up agenda, there is an opportunity for our country to be at the forefront of solving this social, economic and environmental crisis that impacts significantly on the nation's mental health.

Our principles for the Plan

The development of the Plan should be underpinned by a set of values and principles drawn from the responses to the consultation. This will help clarify what the strategy is to achieve and how this will be achieved.

- **It must be ambitious, realistic, and measurable**

By 2035, we must see real parity of esteem between mental and physical health delivered. This will mean that thousands more people of all ages living with a mental illness, disorder or condition will have access to high-quality treatment and support. It must mean that mental health services cater to the different mental health needs of people across the life course, from pre-conception to old age, and appreciating the intergenerational nature of mental health problems.

These ambitions need to be focused, based on evidence and realistic – translating into measurable outcomes that matter most to people.

Through this work, there needs to be an agreed definition between the government and the public of what parity of esteem between mental and physical health will look like by 2035.

- **It must be co-produced**

There needs to be meaningful consultation and engagement with the public, patients, carers, families and health and care professionals throughout – both in terms of its development, implementation, and monitoring.

- **It must be joined-up**

While being led by DHSC, the plan should also be co-produced by other government departments to align initiatives that promote and support good health, such as housing, schools, communities, criminal justice, addictions, welfare, social care, and public health.

There has been a tendency for stand-alone strategies to be produced, such as for learning disability services, for instance, and for those strategies to not have the necessary crossover with national strategies and plans. This results in silo strategy development and difficulties with implementation.

Within the NHS, we need a mental health service that is flexible and responsive to the needs of a changing population. The plan should recognise the interdependencies with other NHS programmes and that improvements in mental health care can alleviate some of the pressures in other parts of the healthcare system, such as primary care as set out in the Fuller Stocktake, and urgent and emergency care.

- **It must be transparent**

There must be an open and transparent process for developing the plan and allocating funding, and a similarly transparent governance process for its monitoring, implementation, and evaluation.

- **It must have prevention and early intervention front and centre**

This plan must effectively tackle the wider social determinants of poor mental health and enable all of us to enjoy mentally healthy lives from cradle to grave. This must include a commitment to invest in

public mental health initiatives and social care, and should bring about changes in education, welfare, addictions, criminal justice, and other public services to better support lifelong mental health.

In addition to significant investment in mental health services themselves, there are other priorities in the plan that will play a key role in improving support for people with mental health problems and tackling the factors which can cause or exacerbate these. This includes priority areas such as primary care, children and young people's health services and support for people with multiple long-term conditions. All NHS services have a role in protecting and promoting mental health, not just the services that deal with diagnosable mental illness.

- **It must be underpinned by cross-cutting commitments to reduce inequalities across the board**

The plan should recognise the effect of negative life experiences, such as racism, sexism, homophobia, and transphobia, which contribute to mental illness in a major way. The plan should continue to address this both in general society, in education, and in the healthcare profession.

It should also recognise the effect of institutional racism and other forms of discrimination on mental health and support an anti-racist approach across government and within the NHS.

Without this, the ambitions will simply not be achievable.

- **It must have an accompanying Implementation Plan with comprehensive workforce and funding projections and commitments**

The Implementation Plan should be published alongside the plan, or soon after, and set out how Government will deliver on the existing and new commitments. It should also specify how it will align with other interdependencies, such as the NHS LTP Refresh, the Health Disparities White Paper, and the Dame Carol Black Review, for example.

The first three years of a strategy are often most pivotal as unless it starts to yield results in this time period, it is at risk of being shelved. An ambitious strategy that sets out to achieve real and concrete change needs funding to do so. There must be an accompanying funding settlement for the commitments outlined in the Plan agreed upon at the next comprehensive spending review in 2024/25.

The plan should be underpinned by the need to recruit and retain a mental health workforce that enables the delivery of high-quality care for patients sustainably in the long-term. It should also ensure clear alignment between training, workforce planning and service provision.

This is absolutely key, and the plan risks being severely compromised if this were not to be included.

- **It must be future proof**

The Plan must include commitments that can withstand the changing political landscape as well as the changing system architecture through the formation of ICSs, ICBs and ICPs. It must also build in commitments that are resilient to the economic and health-related shocks to society.

About our response

We believe this consultation, alongside the forthcoming update of the NHS LTP, is an opportunity to develop a world-leading mental healthcare system by 2035. Preventing poor mental and physical health must be front and centre of the levelling up mission if we are to protect the NHS and enable more people to live longer, healthier, and happier lives. For those who need treatment and support, we must reduce the treatment gap and reduce disparities in access, quality of care, safety, experience, and outcomes.

We welcome the opportunity to share our recommendations with government to support in the development of a new cross-government, 10-year plan for mental health and wellbeing, and a refreshed suicide prevention plan for England.

This document has been produced in response to the DHSC's discussion paper and call for evidence. Throughout our response, we outline ways the government can take a population approach to improve coverage of mental health services, improve mental health and wellbeing outcomes that matter most to people, integrate and coordinate services across health and care to prevent mental disorder from arising, prevent the associated impacts and inequalities, promote mental wellbeing and resilience, and support the delivery of effective interventions to treat mental disorder.

Our response has been produced in collaboration with our members and patient and carer representatives. We also draw extensively on the recommendations made by the College's Public Mental Health Implementation Centre (PMHIC), which has produced a comprehensive summary of the evidence on public mental health interventions.[105]

We are likely to update this document as further discussions take place over the summer/autumn, allowing us to build on our recommendations.

We have also contributed to a joint response with the Mental Health Policy Group. As a group we represent providers, professionals, the voluntary and community sector, and hundreds of thousands of people who use the NHS and services in the wider community that support their mental health.

The devolved nations of the UK have their own mental health strategies and plans. We would encourage learning to be shared across the nations, to co-ordinate best practice and ensure the participation of UK government departments whose remit covers the whole of the UK, such as the Department for Work and Pensions (DWP) and Home Office immigration and asylum policy.

In chapters 3-7, we outline our recommendations for each question in the consultation. Chapter 8 focuses on the cross-cutting enablers to make this happen. Here, we cover revenue and capital investment across the NHS, public health grants and social care, the role of ICSs, leadership, governance and accountability, the workforce, and investing in digital technology.

3. How can we promote positive mental wellbeing and prevent the onset of mental ill-health?

The Marmot Review in 2020, *Build Back Fairer*, identified that the levels of social, environmental, and economic inequality in society are damaging the nation's health and wellbeing. The report highlights that over the past decade, there has been a stagnation of health improvement – the second worst in Europe – and widening health inequalities.[106]

Professor Sir Michael Marmot argues that as we emerge from the COVID-19 pandemic, it would be a catastrophic mistake to re-establish the status quo; we have an opportunity to build back a fairer society.[107]

The Government's White Paper on Levelling Up the United Kingdom included an ambition to improve wellbeing in every area of the UK, with the gap between top performing and other areas closing, by 2030.[108]

More needs to be done to promote mental wellbeing across whole populations, with more progressively targeted interventions to address specific needs among more vulnerable and at-risk groups, such as children and older adults. Many of our recommendations to the Government are drawn from the College's PMHIC, which aims to support the improved implementation of evidence-based interventions to treat mental disorder, prevent associated impacts, prevent mental disorders, and promote mental wellbeing and resilience. This will result in the sustainable and equitable reduction of the impacts of mental disorder and promotion of population mental wellbeing locally, nationally, and internationally.[109]

Reduce socio-economic inequalities, deprivation, and poverty

Health is significantly influenced by the social, economic, and environmental conditions around us. In the UK, people living in the poorest areas die earlier than those in richer areas. All risk factors for premature mortality – smoking, poor diet, and harmful alcohol use – are impacted by these socioeconomic factors.[110] For instance, childhood obesity is rising and the gap in prevalence is widening between the least and most deprived areas in England;[111] 31% of households with someone who smokes fall below the poverty line;[112] and high-risk drinking prevalence rose by 64% in the lower socioeconomic groups during the first lockdown of the COVID-19 pandemic.[113]

The Marmot Review argues that years of austerity and stagnating wages had resulted in many households, particularly those with children, being in poverty and suffering from ill health as a result. Regional inequalities in wealth had widened and many people from Black, Asian and minority ethnic backgrounds and lower waged households are struggling.[114] Increases in in-work poverty, one of the clearest signs of a society that is not meeting the needs of its population, are damaging the health and prospects of working age adults and of children. [115]

The Child Poverty Action Group has identified that while child poverty was down overall in the UK in 2020/21, this is likely to be a temporary improvement related to the additional support provided to low-income families during the COVID-19 pandemic. Child poverty has continued to increase in the North East and Wales, and the North East has now overtaken London to have the highest child poverty rate in the UK.[116]

The Government's White Paper on Levelling Up included an ambition for the government to improve healthy life expectancy by 5 years by 2035, but the Health Foundation has estimated that it would take 192 years to achieve this at the current rate.[117]

The government must keep their commitment to increase Healthy Life Expectancy by 5 years by 2035 by tackling the root causes of ill health including poverty, housing and structural inequalities based on demographic factors such as ethnicity.

Recommendations

Strategic focus

- The Department for Levelling Up, Housing and Communities (DLUHC) to develop a National Strategy on Inequalities led by the Prime Minister to reduce widening social, economic, environmental and health inequalities.[118]
- DLUHC to set a target to reduce levels of child poverty to 10%, putting it on par with the lowest rates in Europe.[119]
- DLUHC to put health and mental health equity and wellbeing at the heart of local, regional and national economic planning and strategy. [120]

Enhance the Public Health system

- DHSC to fund Public Health at a level of 0.5% of GDP with spending focused proportionately across the social gradient. [121]
- The Office for Heath Improvement and Disparities (OHID) and DHSC to ensure Public Health develops capacity and expands its focus on social determinants of health. [122]
- OHID to develop social determinants of health interventions to improve healthy behaviours.[123] [124]
- DLUHC to increase the deprivation weighting in the local government funding formula, and invest in the development of economic, social, and cultural resources in the most deprived communities.[125]
- DLUHC to invest in the development of economic, social, and cultural resources in the most deprived communities. [126]
- DLUHC to invest in the resilience of areas that were damaged and weakened before and during the pandemic. [127]
- DLUHC to tackle domestic and gender violence and abuse.

Improve financial security

- DWP to ensure that all workers receive at least the national living wage as a step towards achieving the long-term goal of preventing in-work poverty. [128]
- DWP to make the social safety net sufficient for people not in full-time work to receive a minimum income for healthy living. [129]
- DWP to review the taxation and benefits system to ensure they achieve greater equity and are not regressive. [130]
- DWP to make permanent the £1,000-a-year increase in the standard allowance for Universal Credit. [131]
- DWP to end the five-week wait for Universal Credit and provide cash grants for low-income households. [132]
- DWP to remove sanctions and reduce conditionalities in benefit payments eradicating benefit caps and lift the two-child limits. [133]
- DWP to provide tapering levels of benefits to avoid cliff edges. [134]
- DWP to increase child benefit for lower-income families to reduce child and food poverty. [135]
- DLUHC to eradicate food poverty permanently and remove reliance on food charities. [136]
- DLUHC to extend free school meal provision for all children in households in receipt of Universal Credit. [137]
- DLUHC to give sufficient support to food aid providers and charities. [138]

Take action on climate change, pollution, and biodiversity loss

Climate change, pollution and biodiversity loss have created a health crisis. Our actions and our impacts will be inherited for generations to come, and we need to ensure there is a sustainable and positive vision for mental health services.

There are interconnected factors that individually and collectively have a profoundly destructive impact on human and planetary health.

There are particular implications for the nation's mental health, and this is likely to disproportionately affect vulnerable groups, including people with pre-existing mental illness and children. [139]

A tremendous effort by national and international organisations to tackle the dual threats of climate change and ecological degradation is already under way. UK, global and international frameworks of action, including the UK Government's Climate Change Act; the United Nations' Sustainable Development Goals; Conference of Parties (COP); Convention on Biological Diversity; United Kingdom Health Alliance on Climate Change (UKHACC) and NHS plan for delivering a net-zero NHS. However, without concerted collective pressure and effort, these organisations and frameworks will not achieve their goals.

Recommendations

- The Department for Environment and Rural Affairs (Defra) to prioritise a unified approach with sufficient resources to tackle the climate and ecological crisis across all aspects of government.
- Defra to follow the UK Health Alliance on Climate Change (UKHACC) principles for a healthy and green recovery to place environmental and health factors at the heart of any economic recovery following the COVID-19 pandemic.
- Defra to base decisions on changes to land and water usage on tools which include assessment of prospective impacts to mental and physical health.
- All research organisations to:
    - ensure that future research in planetary health includes multidisciplinary studies examining how the mental health of different vulnerable groups are affected by climate-related hazards, pollution and biodiversity loss, and
    - establish and quantify the co-benefits to mental health of taking action against climate change, biodiversity loss and pollution.
- The Medical School Council to:
    - ensure the impact of the climate and ecological emergency, and the role medical professionals can play in preventing and mitigating this, are a core part of the curriculum, and
    - work with medical schools to ensure students are taught about the overuse of tests and interventions.
- All organisations responsible for postgraduate and continuing medical education to ensure that practicing doctors receive similar updates to undergraduates.

Put health at the heart of urban and community planning

Local authorities manage assets vital to the public's mental health, such as housing and planning functions, elements of education, children's and adult social care services, the maintenance of parks and open spaces, provision of libraries, children's centres, and youth services. All of these have the potential either to enhance and protect people's mental health or – including in their absence - to diminish and harm it. Yet their important role in public mental health is under great pressure following too many years of austerity cuts.

A report published by the Royal Society for Public Health looked at many high street outlets, including those determined bad for health – payday lenders, bookmakers, tanning salons, and fast food outlets – and those that were good for health – pubs and bars, libraries, pharmacies, dentists, opticians and leisure centres.[140]

The physical, economic, and social characteristics of housing, places and communities have an important influence on people's physical and mental health and wellbeing, and inequalities in these are related to inequalities in health.

Recommendations

Housing

- DLUHC to ensure all new housing developments include within their plans a priority to promote good mental health and wellbeing of their population and improve access to health services for people of all ages with mental ill health. Dementia-friendly communities should be a fundamental part of the design. New housing development sites can learn lessons from 'Healthy New Towns' demonstrator sites, including:
    - developing health services that help people to stay well
    - strengthening and integrating 'out-of-hospital' care
    - developing the future workforce
    - linking health services to wider community assets
    - supporting self-management
    - using digital technology to support care
    - creating integrated health and wellbeing centres
    - maximising the benefits of integrated health and wellbeing centres
    - strategic estates planning
    - developing a schedule of accommodation, and
    - options for project funding.
- DLUHC to build more good-quality homes that are affordable and environmentally sustainable.[141]
- DLUHC to ensure 100% of new housing is carbon-neutral by 2030, with an increased proportion being either affordable or in the social housing sector. [142]
- DLUHC to reduce sources of air pollution from road traffic in more deprived areas. [143]
- DLUHC to increase support for those who live in the private rented sector by increasing the local housing allowance to cover 50% of market rates. [144]
- DLUHC to remove the cap on council tax. [145]
- DLUHC to urgently reduce homelessness and extend and make watertight the protections against eviction. [146]

High streets

- DLUHC to implement recommendations from the Royal Society for Public Health report, *Health on the High Street*, including:
    - local authorities nationwide to introduce A5 planning restrictions within 400 metres of primary and secondary schools
    - DLUHC to provide local authorities with the power and support to restrict the opening of new betting shops and other unhealthy outlets where there are already clusters
    - vape shops to ensure all customers who smoke are aware of their local stop smoking service
    - industry and all businesses selling food on the high street – cafés, pubs, fast food outlets, convenience stores, leisure centres – to reduce the calories in their products
    - Facebook and Google to provide discounted advertising opportunities to local, independent health-promoting businesses

    - local authorities to support meaningful use of shops by making records on vacant commercial properties publicly accessible
    - councils to set differential rent classes for tenants based on how health-promoting their business offer is, and
    - business rates relief for businesses that try to improve the public's health.
- Local authorities to substantially invest in the infrastructure to support walking, cycling, leisure activity, sport and active travel, and neighbourhood walkability with well-designed neighbourhoods.
- DLUHC and OHID to tackle obesogenic environments on high streets by:
    - addressing the junk food offer around schools by banning unhealthy fast-food outlets from within a five-minute walk of school gates
    - ending discounts targeted at school children
    - ending app-based food delivery services to school gates
    - building better places to go, including better quality parks with the use of young people in mind, and physical signage outside schools directing young people to their nearest park, and
    - limiting the reach of junk food adverts, including banning the advertising of unhealthy food products across all council-owned advertising sites.

Put mental health at the heart of ICS population management

Population health refers to the health outcomes of a group of individuals, including how these outcomes are distributed within the group. It is an approach that combines patterns of health determinants, health outcomes, and policies and interventions that link the two.

Population health management aims to improve physical and mental health outcomes, promote wellbeing, and reduce health inequalities by focusing on the wider determinants of health and the role of people and communities.

The King's Fund framework for population health centres on four pillars:

- the wider determinants of health
- health behaviours and lifestyles
- the places and communities we live in, and
- an integrated health and care system.[147]

The role of ICSs in the first three of these pillars needs to acknowledge that the reach of the NHS does not extend easily to all these areas – ICSs need to strengthen the way NHS organisations work with local authorities and the voluntary sector in implementing effective action in this area, based on best practice.

The fourth pillar is a central component for ICS development, supported by population health management techniques that use big data to drive planning and delivery of care. With quality data, this can involve identifying local 'at risk' groups through segmentation and risk-stratification. Interventions then can be targeted at preventing ill-health, improving care and support for people with ongoing health conditions and reducing unwarranted variations in outcomes.

The College's Advancing Mental Health Equality (AMHE) resource lays out how we can better use data and existing resources to identify inequalities within local populations. ICSs can use population health data to identify health inequality and develop plans to address this.

Recommendations

- ICSs to adopt population health management approaches that focus on public mental health and wellbeing. This should include work on perinatal mental health, children and young people (where some of the greatest opportunities for prevention lie), and on wider services such as addiction, homelessness or housing services and employment support.
- ICSs to invest in school-based programmes, including bullying and violence prevention, interventions to promote adolescent social-emotional functioning and developmental trajectories, universal resilience-focused interventions, school-based promotion of self-regulation, school-based mindfulness programmes, youth mentoring programmes, psychosocial interventions delivered by teachers, prevention of smoking, alcohol and drug use.[148]
- ICSs to ensure that population health management approaches allow for an understanding of the health inequalities and health service utilisation by creating a linked dataset with patient-level information from acute services, primary care, primary care prescribing, mental health, community services, continuing healthcare, social care, public health and specialised commissioning. Using these data can help clinicians to review pathways and services, and to understand the quality, strategic and financial opportunities and risks.
- NHSE to provide local ICSs with guidance and examples of good practice, demonstrating how population health approaches can help address mental health issues as well as wider public health problems.

Reduce stigma and discrimination

There are many negative life experiences, such as racism, sexism, homophobia, and transphobia, which contribute to mental illness in a major way. It is important we continue to address stigma both in general society, education and in the healthcare profession.

Mental health professionals should understand the link between these adverse experiences and mental health and try to help prevent these at a population level.

Recommendations

- DHSC should fund an anti-stigma campaign to help end the stigma and discrimination often experienced by people with mental health problems.
- DHSC and the Department for Education (DfE) should continue to fund MindEd so they can continue to provide free educational resource on children, young people, adults and older people's mental health.

Promote self-help

As part of a drive to preventing rather than curing, more needs to be done to help people help themselves. Understanding the evidence base around apps and self-help platforms for basic mental health/wellbeing support (sleep, diet, activity, and stress management) will help us to advance their use and people’s personal agency in wellbeing. Digital platforms can also identify opportunities for local employers, education settings and communities to support one another in voluntary community service.

Every Mind Matters is an important tool to allow people – including children and young people - to manage their mental wellbeing.[149]

The use of online platforms must be clear and accessible for people across demographics (e.g., intellectual disability) to minimise digital exclusion as we know that it is often those in most need of support and advice who are least likely to have access to these forms of information.

Recommendation

- DHSC to commit to fully fund both adult and children and young people's Every Mind Matters platforms, taking into consideration the needs of people across demographics.

Reduce social isolation and loneliness and invest in community assets

Someone who is socially isolated isn't necessarily lonely, nor is a lonely person necessarily socially isolated. Both can have a significant impact on mental health and wellbeing.[150]

There has been a growing interest across the country in the use of social prescribing and related approaches to connect people with resources in their local community aimed at improving health and wellbeing. Evaluations have reported positive results in terms of patient outcomes and service use allowing healthcare professionals to refer people to a range of non-clinical services to address their needs in a holistic way and often focuses on improving mental health and wellbeing.

While used predominantly for adults and older adults, children and young people can also significantly benefit from this, particularly during times of transition in their lives (such as leaving home) as lack of activities, isolation and loneliness can cause and exacerbate mental health problems. Similarly, people with an intellectual disability can benefit from this in order to reduce social isolation and promote inclusion.

Wellbeing coordinators, care navigators and/or Wellbeing Hubs are another way to help connect people with local voluntary and community sector services – particularly people who are at risk of social isolation and need some extra support, or who are known to be experiencing emotional distress. The intention is to prevent the development of mental health problems and to support the recovery of those with existing mental health problems. The aspiration should be to widen the wellbeing offer in primary care over time, with the addition of peer-coaches, self-management courses and (potentially) other resources such as dementia care navigators.

Recommendations

- OHID and NHSE to develop a preventative strategy with initiatives to reduce the incidence of loneliness along with other factors that are known to reduce the risk of mental illness in older people.
- Local authorities should offer interventions that promote social interaction through volunteering opportunities, community engagement, social skills training, and befriending, for example. The NHS might not be well placed to lead on this but could provide infrastructure, evaluations, input to the communities (by invitation), teaching or physical health checks.
- Primary Care Networks (PCNs) to map assets and resources within the community, with due consideration of mental health and wellbeing resources. The ease in which patients can access these resources (with a particular focus on excluded groups), and the ease in which primary care professionals can refer to them, should be regularly reviewed.
- NHSE and PCNs to expand the roll out of social prescribing in primary care in line with the ambitions and recommendations of the College's Position Statement on this important intervention.[151]

Improve perinatal and parental outcomes

It is well understood that the first 1001 days of babies and toddlers' lives is critical to future development. If parents do not have the physical or emotional capacity to provide nurturing care, this

can have a potentially significant and lasting impact on babies' development, with knock-on impacts on later learning, earning, mental and physical health.

Recommendations

- HM Treasury and DfE to increase levels of spending on the early years and (as a minimum) meet the OECD average and ensure allocation of funding is proportionately higher for more deprived areas.[152]
- DfE and DHSC to increase the availability and quality of early years services, including Children's Centres, in all regions of England and to reduce inequalities in early years development.[153]
- DHSC to expand perinatal and early years mental health services within Universal Services (maternity services, health visiting, Sure Start centres and primary care).
- OHID and NHSE to reverse the decline in the health visiting and school nursing workforce through a demand-driven, well-resourced national workforce strategy and plan.
- DHSC to fund local authorities to enable them to provide health visiting and school nursing services at a level that delivers everything that Government and the National Institute for Health and Care Excellence (NICE) guidance expect of them.
- NHSE and OHID should ensure antenatal classes universally include information about mental health and wellbeing, as well as parenting and parenting programmes.
- NHSE and OHID to invest in interventions to address perinatal outcomes including targeting parent tobacco, alcohol, and substance use during pregnancy and interventions targeting birth outcomes such as low birth weight, preterm birth, prenatal infection, and poor maternal nutrition, and breastfeeding support.[154]
- NHSE and OHID to expand the existing package of measures aimed at parents, including parenting programmes and promotion of child/parent attachment. [155]

Improve outcomes in childhood and adolescence

Children's mental health does not exist in a vacuum, and the biggest risk factors are social – in particular, exposure to cumulative adversities such as poverty, domestic violence, victimisation, community breakdown and inadequate schooling. For the most vulnerable, not least children under the age of 5 and those with neurodevelopmental conditions, these experiences can have life-long implications for their development and wellbeing.

The Marmot Review *10 Years On* found worrying trends in some of the critical drivers of children's early years development and education. This followed the widespread closure of Children's Centres and early years services, with the greatest impact in more deprived areas. [156]

Recommendations

- DHSC to reverse declines in the mental health of children and young people and improve levels of wellbeing from the present low rankings internationally.[157]
- OHID to ensure that trauma and adverse childhood experiences are a priority for public health. It should produce clear guidance and support for local authorities to coordinate efforts to improve the prevention of, and responses to, trauma.[158]
- DHSC, DfE and DLUHC to increase resources for preventing abuse and identifying and supporting children experiencing abuse.[159]
- DHSC to implement the recommendations of the Independent Review of Children's Social Care in full, swiftly and with appropriate resourcing.
- DHSC to invest in services for Looked after children through foster parent training improved parenting practices and reduced child disruptive behaviour.[160]

- DfE to increase attainment to match the best in Europe by reducing inequalities. [161]
- DfE to invest in school-based programmes, including bullying and violence prevention, interventions to promote adolescent social-emotional functioning and developmental trajectories, universal resilience-focused interventions, school-based promotion of self-regulation, school-based mindfulness programmes, youth mentoring programmes, psychosocial interventions delivered by teachers, prevention of smoking, alcohol and drug use.[162]
- DfE to ensure that all young people are engaged in education, employment or training up to the age of 21. [163]
- DfE to increase the number of post-school apprenticeships and support in-work training throughout the life course. [164]
- DfE to develop and fund additional training schemes for school leavers and unemployed young people. [165]
- DfE to restore the per-student funding for secondary schools and especially sixth form, at least in line with 2010 levels and up to the level of London (excluding London weighting). [166]
- DfE to further support young people's training, education and employment schemes to reduce the numbers who are NEET, and urgently address gaps in access to apprenticeships. [167]
- DfE to raise minimum wage for apprentices and further incentivise employers to offer such schemes. [168]
- DfE to invest in Special Educational Needs services to deliver behavioural and educational interventions that improve children's inclusion and participation in school, cognitive development, interventions to support reading for children with intellectual disability in schools, and parenting programmes. [169]
- DfE to give excluded students additional support and enroll those who need it into Pupil Referral Units. [170]
- DfE to prioritise funding for youth services. [171]
- DfE and DHSC to promote interventions to increase physical activity in children and young people. [172]

Protect children and young people from online harm

The use of social media and internet technology by children and young is now integral to their lives. There are many positive benefits from the use of the internet but there is also evidence to suggest that digital technology may impact adversely on children and young people's development, education, and attention. There is a connection between screen use and obesity, difficulties with sleep and mental health issues including self-harm, depression and eating distress. Children and young people may also encounter distressing material online and may be vulnerable to online harms e.g., sexual exploitation and cyberbullying. Gaming disorder has recently been recognised and the concept of internet addiction is emerging. [173]

The role of persuasive technology has been documented with regards to compulsive use, and is manifest, for example, in notifications that a post has been 'liked', or a tweet re-tweeted, which can also impact on a young person's self-esteem. Although most children and young people will be able to harness the benefits of technology without negative effects, some may be vulnerable to compulsive use and potential harm.[174]

Recommendations

For regulators[175]

- The Department for Culture, Media and Sport (DCMS) and the Regulator to urgently review and establish a protocol for the sharing of data from social media companies with universities for research into benefits and harms on children and young people.

- DCMS and Regulator to urgently review the ethical framework for using digital data – the same standards need to apply as in other areas of research.
- DCMS and NHSE to fund a follow-up of the NHSD (now within NHSE) prevalence study to examine the impact of social media on vulnerable children and young people over time.
- DCMS to instruct the Regulator to establish a levy on tech companies proportionate to their worldwide turnover. This would be used to fund independent research and training packages for clinicians, teachers and others working with children and young people. As with the gambling industry and social responsibility measures, the gaming and social media industry should be required to increase social responsibility measures similarly, such as emulate the gambling industry's duty of care practices (e.g., personalised behavioural feedback, stop messages) in gaming/social media platforms.
- DCMS to enable the Regulator to undertake a joint review with the UK Gambling Commission to review regulation regarding loot boxes in line with other countries which have recognised loot boxes as a form of gambling.
- DCMS and the Regulator to undertake a consultation in 2020 on a yellow card warning system similar to that used for medicines, in order for professionals and potentially parents/carers/young people to report harms of social media and gaming companies.
- DCMS and the Regulator to prioritise the strictest enforcement of Data Protection law and in particular, UK DPA 2018 "Age-appropriate design" to services targeting and / or popular with children, including a requirement that services should default to assuming users need child protection until explicit action is taken to opt-out.

For technology companies[176]

- Mitigate the harm to children caused by habit-forming features of the service by consideration and analysis of how processes (including algorithmic serving of content, the display of other users' approval of posts and notifications) contribute to the development of habit-forming behaviour.
- Social media platforms should flag up engagement with risky content and operate and offer a free direct hotline for at-risk or vulnerable individuals.
- Social media companies should provide user configurable controls (not in the cloud) that can block incoming content of the young person's choosing (by default 'full safety measures on') and provide feedback on content they are planning to send (e.g., BBC Own It app for an example).
- Social media companies should promote and contribute to mental health charities in home countries to support any vulnerable individuals.
- Gaming companies and social media platforms should regularly fund research related to their products, to be conducted by independent external bodies and provide on a regular basis user data for research purposes to academic institutions.
- Funding of media literacy awareness campaigns.

For education[177]

- Schools and colleges should have policies relating to device use and a digital code of conduct. Good practice should be sought out and shared. A multi-stakeholder engagement of peers, parents and school staff should be encouraged to support, inform and update school policies.
- If teachers are concerned about the level of technology used by children and young people and the possible impact on their health and well-being, they should seek guidance from resources such as the MindEd modules and discuss the issue with their mental health leads within schools, as well as sharing concerns with parents.
- The Personal, Social and Health Education Association syllabuses should be developed further to include online safety, and further resource development should be prioritised.
- Opportunities for group working away from screens should be encouraged whenever possible.

For healthcare professionals[178]

- Questions around technology use should become a core part of biopsychosocial assessments and formulations; the online world can be just as important to young people as their offline world. It is helpful to ask children and young people about any areas that worry them in their digital lives, whilst keeping a check on their use and its disruption of healthy or necessary activities.
- Psychiatrists should be mindful of the possible impact of technology use when children and young people report difficulties in areas such as sleeping, academic performance, mood, behaviour or eating.
- Mental health conditions such as depression and behavioural problems may make children more vulnerable to problematic technology use; clinicians should be aware of the impact of technology.
- Clinicians must be aware of the additional needs of vulnerable parents, such as those suffering from depression, who may struggle to support their child around problematic technology use. If problematic technology use is identified:
    - the assessing clinician will seek to understand the impact of all presenting difficulties including potential problematic use on family relationships, educational performance and social interactions. In this context, the clinician will start to understand the potential level of problematic technology use
    - it has not yet been fully elucidated whether conditions such as depression and anxiety are contributing factors to problematic internet use or gaming or are a result of the condition. It is recommended that, where more than one condition is present, the clinician documents the duration of all conditions, and
    - clinicians should be aware of the safeguarding implications of online content and contact.

For training and service development[179]

- Services should deliver training in the concept of technology addiction. Online resources such as minded.org are useful training resources and should be further developed as knowledge increases in this area.
- Pathways to specialist services also need to be developed. There are models for other specialist pathways, such as eating disorders, where locality services treat children and young people whose symptoms are less severe. This enables locality teams to maintain expertise and recognise conditions, ensuring that children and young people can be treated as soon as possible. Where symptoms are more severe, children and young people will need specialist care. As treatment for technology addiction is still developing, this may involve travelling to specialist clinics, however as more awareness of the condition develops, the level of expertise will increase. Local protocols will need to be developed based on the diagnostic criteria available. It must be acknowledged that children and young people with technology addiction are more likely to experience additional mental health needs such as depression, anxiety, developmental conditions such as ADHD and eating disorders.

For research[180]

- Embedding the use of device-collected screen time and internet usage-type data in ongoing (or commencing) large-scale cohort studies examining other variables including health outcomes is essential to allow for:
    - longitudinal research studies with children and young people at different developmental stages, examining whether technology causes harmful outcomes as well as potential benefits
    - examining different types of screen use, as well as content, and exploring a variety of health-related outcomes. Screen time use data cannot rely purely on self-report
    - determining the effects of extensive online media usage on cognitive development

    - there is a need for qualitative studies exploring children's and young people's perspectives, including gender differences
    - research is needed that focuses on potentially vulnerable groups such as those with mental health and neurodevelopmental disorders, looked-after children, LGBTQIA+ young people and very young children
    - websites that normalise or promote concepts such as self-harm, suicide and anorexia should be studied and their impact on young people understood. Additionally, when limitations are proactively placed on sites by technology companies, the impact of these limitations on the health and well-being of children and young people should be studied.
    - research needs to elucidate the possible concepts of technology addiction and examine the potential for addiction, including further development of screening tools and treatment programmes
    - research is needed into the incidence of problematic technology use across the UK, and
    - the development of further brain neuroimaging studies is needed that will examine the posited affected areas, not only for overuse but also to examine tolerance and withdrawal effects.
- Research is needed to understand how young people with mental health needs are using the internet and what support could be put in place.
- Research is also needed to understand the possible benefits of programmes that can help people manage their digital technology use, for example, apps which can block the use of other apps and the use of time restrictions. Personalised programmes for media addiction, for example, including specialised Cognitive Behavioural Therapy (CBT) and systemic family therapy, need to be developed and evaluated. Programmes need to take into account heterogeneity around potential causes (e.g., severe mental illness, low self-esteem, loneliness, ADHD, individual's predisposition to addiction) and engagement with specific internet content or transactions (e.g., social media, online gaming or gambling).
- Therapeutic trials should have integrated mediation analyses as a core aspect of trial design in order to determine which psychological and/or neurological changes predict and accompany successful treatment outcomes.
- Further research into the use of social media platforms for support, for example, in relation to suicide prevention.

Prevent depression, eating disorders and dementia

For depression, eating disorders and dementia, there is good evidence that interventions can prevent the onset of these illnesses.[181]

Recommendations

- DHSC and other government departments to prevent depression through good quality employment, physical activity, reduction in social isolation and loneliness, early access to psychological and educational interventions.
- DHSC and other government departments to invest in lifestyle modification and dissonance-based prevention programs to prevent eating disorders.
- DHSC and other government departments to invest in interventions that address the twelve modifiable risk factors which could prevent or delay 40% of dementia include treatment of hypertension, reduction of obesity and associated diabetes, physical activity. limiting alcohol use, avoiding smoking, prevention of air pollution and head injury, addressing insomnia, and use of hearing aids for hearing loss.

Reduce employee stress and increase wellbeing

As almost one in four adults in England experience at least one mental disorder each year,[182] workplace interventions can have population-level impact in promoting mental wellbeing, preventing mental disorder, and supporting recovery. The independent Farmer/Stevenson report, *Thriving at Work*, made important recommendations about how all employers can improve mental health at work and called on the public sector to lead the way.[183]

In the NHS, there is several years of experience of applying quality improvement to the topic of wellbeing, experience, and joy in the workforce. Several NHS provider organisations, such as East London NHS Foundation Trust, have been applying this approach for the last 5 years, with demonstrable results. The RCPsych ran a programme which supported 40 teams across different contexts to use quality improvement to understand what contributes to wellbeing and experience and give teams autonomy to test ideas to change the way they work in order to improve people's experience and wellbeing. This has resulted in reduced burnout and improved experience at work over a year-long programme.

Recommendations

- DWP to implement the recommendations of the Stevenson/Farmer review on mental health and employers in full and oversee its implementation.
- Employers to invest in workplace interventions to reduce employee stress and increase wellbeing through:
    - strategic approaches to improve mental wellbeing in the workplace taking into account workplace culture, workload, job quality, autonomy and employee concerns about mental health including stigma
    - supportive work environment
    - external sources of support
    - organisation-wide approaches
    - training and support for managers
    - individual-level approaches
    - approaches for employees who have or are at risk of poor mental health
    - organisational-level approaches for high-risk populations, and
    - engaging with employees and their representatives.
- Employers to invest in workplace interventions to promote mental wellbeing and prevent mental disorder including:[184]
    - workplace resources which can improve employee wellbeing and organisational performance
    - increasing employee control via flexible working
    - resilience promotion programmes which were more effective for those at higher risk of stress
    - workplace-based physical activity promotion
        - mindfulness and yoga
        - protective labour and social policies which modified association between work stress and mental disorder
        - procedural justice and relational justice in the workplace which were associated with reduced depression
        - interventions to prevent employment related stress and mental disorder
        - interventions to address work related stress and promote wellbeing, and
    - online interventions to reduce workplace stress or improve mindfulness through online mindfulness interventions Targeted online stress management interventions led to small reductions in stress, though the strength of associations varied among the interventions.

4. How can we intervene earlier when people need support with their mental health?

Invest in a whole system response to children and young people's mental health

The mental health impact of the pandemic has been felt most acutely by those children and young people who already faced multiple disadvantages. Experiences of poverty, neglect, homelessness, and abuse have been heightened for many young people, with a significant impact on their mental health. Ensuring developmentally appropriate services has become a significant priority for children's (and adult) mental health services, and it is critical that approaches to early intervention and prevention take the same approach.

Health visiting teams have an ever more important role in supporting infants, toddlers, and their caregivers, and identifying those at risk. It is therefore concerning that after peaking in October 2015, the number of health visitors in NHS community health services has rapidly declined.

Schools also offer an excellent ground for early intervention and prevention, helping children stay mentally well. The roll-out of Mental Health Support Teams (MHSTs) has continued at pace since 2018. An initial evaluation of trailblazer sites identified significant opportunities for strengthening the programme, including offering further career development and progression opportunities for MHST staff.

A school-based offer is not suitable for all children and young people, particularly older children, and some with more complex needs. For many young people who leave education, mental health problems continue to hamper their ability to successfully navigate the transition into adulthood.

Within CAMHS, our members are telling us about an increasing number of patients being referred to specialist mental health services. But pressure points have emerged over the course of the pandemic, with some specialist services facing much more significant demand than others. Children and young people's eating disorder services are one particular area of concern.

There is also a greater number of children with mental health needs are also presenting to Emergency Departments and being admitted to paediatric wards, with mental health needs that have become so acute as to manifest in physical health emergencies (incl. eating disorders, self-harm, etc.). More children and young people are facing being admitted hundreds of miles away from home because no bed is available for them locally.

There is currently a dire shortage of adequate social care provision to meet these ever-increasing needs, most notably to provide early intervention to vulnerable families. The absence of adequate and secure family support and, where appropriate, social care leads to increasing numbers of children and young people referred to mental health services without any other support mechanisms. This sets unrealistic expectations of what might be achieved through therapy and medication and/or inpatient admission alone, and places even greater pressure on already-stretched mental health services.

Consequently, many children and young people get caught in a 'revolving door' – successfully treated in CAMHS but discharged into an environment which made them unwell. Action should be taken to ensure the various needs of children are met through a whole system response to children and young people's needs, including appropriate specialist provision. By supporting closer collaboration across CAMHS, social care, and education, specialist services can work together to personalise care and support children and young people to recover quickly and sustainably.

Recommendations

- Local authorities to commission and fund health visiting services that are able to offer a high-quality service to all those who need them, in line with the Healthy Child Programme.
- DHSC to fund the roll-out of early support hubs for children and young people aged 11 – 25.
- NHSE to provide additional funding to enable the full implementation of the MHST review recommendations, with a focus on strengthening provision for children with greater and more complex needs. Providing recommendations are implemented, support the furthering of the roll out of MHST beyond 2023/24 to ensure access for 100% of pupils.
- NHSE to ensure staff in MHST have received training so that they feel equipped to identify the mental health needs of vulnerable groups of children and young people, including young people not in education, employment or training (NEETs), children with neurodevelopmental problems (including Attention Deficit Hyperactivity Disorder [ADHD], autism spectrum disorders [ASD] and intellectual disabilities), children with long-term health conditions, children with behavioural difficulties, looked-after children, young carers, refugees and migrant children, children with a first language other than English, children in the criminal justice system, abused children, LGBTQIA+ young people, and to refer them appropriately when required.
- DHSC to work with DfE to implement the forthcoming recommendations of the children's social care review, particularly where these relate to meeting the needs of children with mental illnesses and prioritise this agenda as part of the new cross-Government mental health strategy.
- DHSC and NHSE to identify pressure points and provide targeted investment to scale services and recover performance including children and young people's eating disorder services and acute care.
- DHSC to review the evidence for rolling out Mental Health First Aid to those who work in youth clubs, sports clubs and other recreational groups, Churches, and other religious organisations.

Ensure mental health support is a central component of enhanced models of primary care

We need to promote early recognition of poor mental health and help-seeking in the community. This doesn't mean medicalising issues, but it does mean supporting and helping people who are in distress. We must encourage wider conversations in the community about the difference between well-being interventions and mental health/illness.

Primary care teams have an important role to play, and wellbeing services can meet the needs of underserved groups. Evidence-based interventions exist for common mental health problems. However, many people are unable to access effective care because it is not available to them or because interactions with caregivers do not address their needs. Current policy initiatives focus on supply-side factors, with less consideration of demand. It is important to work at all three levels: community, primary care, and well-being services.

The key issues faced in primary care include recognition of mental health problems co-occurring with physical illness; housing; reform of the care system; support for families that are experiencing problems; and reform of the benefits system so that it does not cause as much distress to those with long term health problems – particularly, too frequent reassessment and sanctioning.

The interface between primary and secondary care also remains difficult to negotiate. These problems must be given more attention – there is evidence for models that work more efficiently but they don't get implemented because they require a change in professional roles. The Community Mental Health Framework will help if it is implemented in partnership with primary care, but we are concerned about the roll-out in many places. There needs to be better collaborative working between primary care, mental health services, and the third sector.

We also need to invest in new forms of mental health support as a central component of enhanced models of primary care, so that primary care teams are better equipped to address the wide range of mental health needs in general practice (including among people presenting primarily with physical symptoms), and to address the physical health needs of people with mental health problems. This will need to be done in a way that is aligned with wider efforts to transform primary care to ensure that it is sustainable.

Local integrated care teams can make full use of mental health expertise in supporting people with complex and ongoing care needs, with mental health staff (community psychiatric nurses, nurse therapists and psychologists), including those with expertise in older people's mental health, enabled to input proactively into all case discussions and offer advice and training to the wider team.

We should also recognise that primary and specialist medical and mental care need to work together to provide better primary care to those with mental health problems, which may mean employing GPs within mental health trusts.

There also needs to be more attention paid to how supervision is being provided and clarity over the issue of 'shared care' and 'medical responsibility' which becomes a barrier to collaborative working.

Much of this is about allowing staff time to develop relationships between sectors, organisations, professionals with improved local leadership. The COVID-19 pandemic has placed massive pressure on services and effected rapid change. While much of this is positive, services might need some time and space to take stock, reconnect with the community and staff and aim for excellence again, but this is difficult to do that with high demand.

Recommendations

- NHSE and PCNs to implement the recommendations of the Fuller Stocktake report[185], and specifically relevant to mental health:
    - enable all PCNs to evolve into integrated neighbourhood teams, supporting better continuity and preventive healthcare as well as access, with a blended generalist and specialist workforce drawn from all sectors. Secondary care consultants – including psychiatrists, geriatricians, respiratory consultants, paediatricians – should be aligned to neighbourhood teams with commitments reflected in job plans, along with members of community and mental health teams. With teams collocated within neighbourhoods, to extend models of personalised care, embed enhanced health in care homes and develop a consistent set of diagnostic tests. At place-level, bring together teams on admissions avoidance, discharge and flow – including urgent community response, virtual wards and community mental health crisis teams. Focus on community engagement and outreach, across the life course. Proactively identify and target individuals who can benefit from interventions in neighbourhoods, committing to delivering neighbourhood teams first for Core20PLUS5 populations. Co-ordinate vaccinations, screening and health checks at place level, in accordance with national standards, and
    - create a clear development plan to support the sustainability of primary care and translate the framework provided by *Next steps for integrated primary care* into reality, across all neighbourhoods. Ensure a particular focus on unwarranted variation in access, experience and outcomes. Ensure understanding of current spending distribution across primary care, compared with the system allocation and health inequalities. Support primary care where it wants to work with other providers at scale, by establishing or joining provider collaboratives, GP federations, supra-PCNs or working with or as part of community mental health and acute providers. Tackle gaps in provision, including where appropriate, commissioning new providers in particular for the least well-served communities.

- NHSE and ICSs to ensure there is adequate access to information across the interfaces between primary, acute and mental health care.
- NHSE to explore the potential for community pharmacists to perform medication reviews for people on longer-term psychotropic medication prescriptions.
- PCNs to accept dual GP registrations for students and work to be able to manage care in a more coordinated way.

Increase access to IAPT services

The IAPT programme continues to expand access for people requiring treatment for anxiety disorders and depression in England.

The NHS LTP includes a target to reach 1.9 million people with anxiety disorders or depression by 2023/24. IAPT services are characterised by:

- evidenced-based psychological therapies: with the therapy delivered by fully trained and accredited practitioners, matched to the mental health problem and its intensity and duration designed to optimise outcomes
- routine outcome monitoring, and
- regular and outcomes-focused supervision so practitioners are supported to continuously improve and deliver high-quality care.

Recommendations

- NHSE and ICSs to ensure everyone with common mental disorders can access psychological therapies each year.
- NHSE and ICSs to expand the choice of therapies available in the IAPT programme for all mental health diagnoses.
- NHSE to review the current exclusion criteria for accessing IAPT services and consider the factors affecting the number of people who do not complete treatment.
- NHSE to develop a strategy to reduce the gap in access between older adults, Black, Asian and minority ethnic groups, students and any other group not currently served well by IAPT services.
- NHSE and ICSs to ensure parity of access to IAPT services for older people (who are significantly less able to access psychological therapies by dint of frailty and multimorbidity) and people with an intellectual disability. Services need to comply with equality legislation by making a reasonable adjustment to their services to facilitate people with intellectual disabilities using IAPT services.
- NHSE and ICSs to significantly expand IAPT services for people with long term conditions.
- NHSE and ICSs to ensure the quality and people's experience of IAPT services continually improves. Improving the numbers of people who recover, reducing geographic variation between services, and reducing inequalities in access and outcomes for particular population groups are all important aspects of the development of IAPT services.

Invest in healthcare roles that support integrated care

There are several roles that benefit the delivery of integrated care, including community connectors, non-medical prescribers, advanced care practitioners, primary mental health care workers, social workers, local authority representatives, mental health practitioners, nurses, healthcare assistants and peer support workers. These types of roles can support holistic patient care, early intervention and enable the right skill mix, ensuring that psychiatrists only see those who need intensive support.

To provide personalised and integrated care to people with mental and physical multimorbidity, roles with skills to detect issues and effectively treat patients across the primary/secondary care interface are required. For example, primary care roles within specialist mental health units, such as physician associates, can provide support with the physical healthcare of mental health patients. We have also heard positive examples of physical health nurses working in EIP teams and social prescribers within community and inpatient mental healthcare.

Recommendations

- NHSE and ICSs to invest in new roles that supported integrated mental and physical healthcare. This should include ensuring that at least 10% of the 1,000 Physician Associates being trained each year work in mental health.
- NHSE to ensure investment in new roles includes funding for the increases required in psychiatric capacity to train and supervise new roles.

5. How can we improve the quality and effectiveness of treatment for mental health conditions?

Reduce inequalities in access, experience, and outcomes in mental health provision

Identifying and reducing inequalities in access, experience and outcomes are essential to the delivery of high-quality mental health care.

Mental health problems disproportionately affect people living in poverty, those who are unemployed, and who already face discrimination. Across England, there are persistent and wide-ranging inequalities for people from Black, Asian and minority ethnic backgrounds, increasing their likelihood of being disadvantaged across all aspects of society compared to those from other backgrounds. As the Equality and Human Rights Commission highlighted, someone from a Black, Asian and minority ethnic background is more likely to experience poverty, have poorer educational outcomes, be unemployed, and come into contact with the criminal justice system.[186] These, in turn, are risk factors for developing a mental illness.[187] These individuals are also less likely to receive care and support when they need it.

Racism and racial discrimination are one of many factors which can have a significant, negative impact on a person's life chances and mental health. The College is particularly concerned about the disproportionate impact on people from Black, Asian and minority ethnic communities, notably those of Black African and Caribbean heritage.

As the College has previously recognised, patients in the NHS may experience racism and racial discrimination.[188] [189] This has also been recognised as a problem in international healthcare systems.[190] It can lead to substantial disparity in access to and experiences of various areas of psychiatric care, including crisis care[191], admissions[192], detentions[193], pathways into care[194], readmission[195] and use of seclusion.[196] The 2014 Adult Psychiatric Morbidity Survey[197] showed that, although Black British adults had the highest mean score for severity of mental health symptoms, they were the least likely to receive treatment for mental illness. Where they do come into contact with services, it is disproportionately based on a detention order requiring them to stay in hospital.[198]

Efforts to tackle this should be urgently prioritised by the Government, non-governmental organisations, and professional bodies.

Within the NHS, the AMHE resource is to ensure that all mental health care, and mental health promotion, is responsive to the strengths and needs of each individual and community's identity and culture.[199] Not only are there moral, legal, and economic imperatives for advancing equality, but learning and collaborating with all sections of society provides a valuable opportunity to innovate and enhance the way we provide care. Similarly, the Patient and Carer Race Equality Framework (PCREF) plays a vital role in improving access, experience, and outcomes for ethnic minorities. ICSs will play a vital role as driver and facilitator of Advancing Mental Health Equality.[200]

Furthermore, ageism and age discrimination are commonplace. Due to unconscious bias and perceptions, older adults can experience discrimination leading to less accurate diagnosis and treatment, which in turn causes harmful consequences. Older people with mental health problems in England often do not receive the same level or quality of mental health care as those of working age, and these services have been excluded from new investment.

Recommendations

- NHSE and ICSs to ensure everyone who uses mental health services has equitable access to effective early interventions and equitable experiences of care and outcomes, regardless of age or ethnicity.
- NHSE and ICSs to ensure there is a year-on-year reduction in the disparities between people from Black, Asian and minority ethnic groups and the rest of the population, in terms of both numbers of people detained under the Mental Health Act 1983 and the range of appropriate treatments offered including alternatives to detention.
- NHSE and ICSs should expand LGBTQIA+ services as well as outreach services to deprived children, young people and families, hard-to-reach groups and those from Black, Asian and minority ethnic communities.
- NHSE and ICSs should ensure people at risk of discrimination, and protected groups under the Equalities Act subject to the Mental Health Act have access to an advocate with specialist knowledge of legislation to advocate appropriately for them.
- MoJ should ensure mental health tribunal panels better reflect the communities they work with.
- DHSC to produce a strategy for reducing race inequality in mental health, building on the Race Disparity Audit, including work with schools, the police, youth and community services and mental health services to improve access, outcomes and experiences for people from Black, Asian and minority ethnic communities.
- NHSE, ICSs and mental health providers must develop and monitor data relating to access and outcomes for groups of people with protected characteristics, including gender, age, sexuality and ethnicity and disability.
- DHSC and NHSE to take forward in full the recommendations of the Women's Mental Health Taskforce.
- NHSE and ICSs should take steps to improve access and outcomes for LGBTQIA+ communities and set an expectation that commissioners will recognise the value of specialist LGBTQIA+ services, commissioning them to meet local needs.
- Government to legislate to extend the definition of disability in the Equality Act to protect people with fluctuating mental health problems.
- ICSs to commission services that use population health data to identify health inequality and have an explicit plan to address this.
- Regular training for all Home Office and healthcare staff on early indicators of mental health conditions and the circumstances in which capacity assessments should be triggered. This should be linked to safeguarding training along with the development of a screening tool for assessment of capacity for all detainees and robust pathways including the provision (in keeping with the conclusions of the Mental Welfare Commission for Scotland, 2018) of appropriate advocacy services for those found to lack mental capacity to make relevant decisions.[201]
- The Home Office to ensure that refugees and migrants with existing mental illness are only be detained in very exceptional circumstances.

Improve people's experience of care when transitioning between services

The NHS LTP included a commitment to a new approach to young adult mental health services for people aged 18-25. Given that between the ages of 16-18, young people are more susceptible to mental illness, it is critical that mental health services create a seamless transition from children and young people's mental health services to appropriate support including adult mental health services and does not create a gap.

The NHS LTP commitment is for service models to create a comprehensive offer for 0–25-year-olds that reaches across mental health services for children, young people, and adults. The new model will

deliver an integrated approach across health, social care, education, and the voluntary sector, such as the evidenced-based 'iThrive' operating model which currently covers around 47% of the 0-18 population and can be expanded to 25-year-olds.[202]

It is essential that any development is joined up with improvements to services for infants and children. Increased investment in mental health services will be critical to delivering on the ambitions of the NHS LTP, and system leaders will need to keep a close watch to respond to changes in demand as services are adapted and expanded.

In addition, NHS England is working closely with Universities UK via the Mental Health in Higher Education programme to build the capability and capacity of universities to improve student welfare services and improve access to mental health services for the student population, including focusing on suicide reduction, improving access to psychological therapies and groups of students with particular vulnerabilities.

Recommendations

- NHSE and ICSs to ensure that strategic, operational, and clinical leaders need to be given protected time to undertake the work required to expand and harmonise services to better meet the needs of young adults, which must include proactive efforts to develop a common language to describe services and bridge cultural differences across children and young people's and adult services.
- ICSs to ensure that young people and their parents/carers should be at the centre of their transition planning between specialist mental health services and have a role in the wider service development and delivery.
- ICSs to support joint working between leaders of CAMHS, adult mental health services (AMHS), local authority services and third sector organisations to improve the experience for young people of transition between mental health services. Additional funding is likely to be required to meet increased demand and for additional staff to support carefully planned transitions, which should feel virtually seamless for the young person.
- ICSs to ensure that training needs are identified for staff working within CAMHS and AMHS to support developmentally appropriate clinical care for young people. The RCPsych should develop training programmes for psychiatrists to work with 0-5's, under 18's and 18-25's when this is not part of their specialist training.

Make mental health services safer

The Independent Review of the Mental Health Act found that patients in mental health facilities are often placed in some of the worst places in the NHS estate. The Review found that badly designed, dilapidated buildings and poor facilities are not a safe place for staff to work and for patients can contribute to a sense of containment atmosphere and make it hard for effective engagement in therapeutic activities.[203]

The CQC's State of Care report on mental health found that many mental health wards are unsafe and provide poor quality care in old and unsuitable buildings. The CQC argues that the design of many of these buildings does not permit staff to observe all areas easily and many wards contained fixtures and fittings that people who are at risk of suicide could use as ligature anchor points.[204]

NHS Providers' analysis also showed the continued under-prioritisation of investment in the mental health estate is having a demonstrable impact on patients.

The 2019 NHS staff survey (the most recent iteration that included this question) showed that more than one in five workers in mental health trusts witnessed an error, near miss, or incident that could

have hurt a member of staff in the last month. Safety concerns raised by RCPsych members have included a lack of safe places for clinical assessments, a lack of a proper alarm system and unsafe procedures/protections for handling toxic or dangerous products such as used needles.

The CQC also found that sexual safety incidents are common on mental health wards and affect not only service users, but also staff and visitors. Following a review of incident reports on NHS mental health wards over a 3-month period in 2017, they found that 1.6% were related to sexual safety. The National Collaborating Centre for Mental Health (NCCMH) developed standards and guidance on improving sexual safety in inpatient environments as part of a Collaborative. Through their work, they identified that mixed-sex accommodation still exists across the country and significant investment and assurances to prevent out-of-area admissions would be required for these to be completely eliminated.[205]

There are currently many examples of good and outstanding care in mental health settings – but also too much poor care, and variation in quality and access across different services. Of the 50 mental health trusts rated by the CQC as of July 2022, only 40.0% are rated as good on safety (none as outstanding), which is better than the non-specialist acute sector at 23.9%, but also remains well below community trusts (66.7%). [206] The biggest concerns relate to the poor physical environment, restrictive interventions, sexual safety, safe medicines management and low staffing levels. A mere 30.2% of all trusts with acute wards for working-age adults and psychiatric intensive care have secured good or outstanding ratings for the safety of those facilities. Despite this, currently, 80.0% of mental health trusts are rated as good or outstanding for being well-led and 2.0% are rated as inadequate. This compares to the non-specialist acute sector where 61.5% are good or outstanding and 4.1% are rated as inadequate. [207] Building on this foundation, the Government should aim to make mental health services in England among the safest in the world.

Recommendations

- NHSE, ICSs and mental health providers to ensure the average NHS trust score for 'organising care' in the CQC's community mental health survey improves year-on-year, with no trust posting a decline.
- NHSE to re-design what is meant by aftercare, including reforming eligibility criteria to improve equity of access and resolving some of the complex arrangements across health and social care, especially regarding funding.
- Mental health trusts to ensure all patients in contact with mental health services have a simple goal-orientated care plan as well as a personalised safety plan including an agreed set of activities, strategies, people and organisations to contact for support if they become suicidal.

Learn from deaths

Learning from deaths is an essential part of quality improvement work for organisations. Since 2017, all trusts in England have been required to have a process in place for mortality reviews. This must mean that all deaths are appropriately reviewed to assess if there is potential for organisational learning, the deaths selected for further review have a structured judgment review completed, and the review of deaths is undertaken in the spirit of openness and transparency and organisational learning rather than blame, and the review of deaths will involve families and those close to the deceased where possible. [208]

Recommendations

- All NHS trusts to identify deaths that warrant an investigation and put in place a process to learn from them in cases where a patient had been receiving treatment and support for their mental

illness, with a particular focus on people 'at risk' such as those who are from a Black, Asian and minority ethnic groups.

- NHSE and ICSs to roll out the 'Learning from Deaths' tool produced by the College's Centre for Quality Improvement (CCQI)[209], which support trusts to respond to concerns about any aspect of their care; and provides trusts with guidance on using individual reviews to consolidate learning identified using the tool.
- NHSE to commission annual thematic reviews to support implementation of the Tool and learning.

Focus on quality improvement and reduce unwarranted variation

We should utilise quality improvement much more broadly as a mechanism to improve outcomes. The evidence from this approach over recent years is that we have managed to achieve improvements in complex safety issues such as restrictive practice, which would not have been achievable through other routes.

The Getting It Right First Time (GIRFT) programme aims to improve the quality of care within the NHS by reducing unwarranted variations, bringing efficiencies, and improving patient outcomes. In mental health, the GIRFT programme is currently looking at adult acute and urgent and emergency care, children and young people's acute and emergency care, and adult rehabilitation and complex care. [210]

CCQI [211]also works with mental health services to improve the standard of care that people with mental health needs receive. They work with more than 90% of mental health service providers in the UK. One of their main activities is developing service standards and reviewing services against them to help them improve the quality of care they offer. They also accredit services that can demonstrate high levels of compliance with our standards.

They currently run 22 of these projects working with various types of mental health services and over 1,500 services participate. Membership of some of these projects (e.g., forensic, inpatient CAMHS and perinatal) is a requirement of NHSE's commissioning contracts.

We need to utilise the learning from the large-scale quality improvement programmes of recent years to bring together teams across sectors to collaborate and test ideas to improve quality of life.

Areas for future exploration could include the AMHE Collaborative. NCCMH has recently launched a ground-breaking quality collaborative that aims to support mental health providers to advance mental health equality in their local areas, supporting the implementation of the AMHE resource.[212]

Recommendations

- NHSE to introduce a new quality commitment to ensure the availability of appropriate, safe and high-quality mental health, learning disability and autism inpatient care (and alternatives to inpatient care) in every system for adults, children and young people.
- NHSE and ICSs to work with Royal Colleges and partners to review and decommission models of inpatient provision which are incompatible with safe, high-quality care and therapeutic outcomes.
- ICSs to address the inequalities in access to local community support which results in marginalised groups being overrepresented in the most restrictive settings and reduce variation in access, experience & outcomes.
- CQC and NHSE to significantly increase and enhance the quality improvement support available to mental health trusts to enhance their safety and quality.

- NHSE to expand the GIRFT programme to cover other mental health services, such as community services for adults and older adults; personality disorders; as well as intellectual disability services.
- CQC to reintroduce an annual national survey of the experiences of mental health inpatient services.
- NHSE to develop a repository of best practice in mental healthcare for ICSs.
- NHSE to commission national clinical audits focused on mental health (to achieve parity with physical health services). These could focus on services for infants and their parents or primary caregivers, children and young people, working-age adults, older adults, and groups who report worse experiences and outcomes from NHS mental health services.
- All mental health services to comply with national quality standards, e.g., via RCPsych quality networks.
- NHSE to improve the quality and completeness of routine data (e.g., mental health services dataset (MHSDS)) for use in national clinical audits, to reduce audit burden.
- NHSE to improve completeness and quality of MHSDS and other basic information on service provision.
- NHSE to reduce unwarranted variation in mental health service provision across the country and utilise quality networks to support this ambition.

Choose interventions wisely and safe prescribing

The Choosing Wisely campaign aims to promote conversations between doctors and patients by helping patients choose care that is supported by evidence, not duplicative of other tests or procedures already received, free from harm and truly necessary.[213]

The use of medicines for conditions such as anxiety and depression is supported by safe prescribing guidelines that help balance the favourable benefits of lasting symptom management with any side effects and the risk of withdrawal symptoms.

Health Education England (HEE), NHS England and NHS Improvement (now subsumed into one organisation: NHSE), experts by experience and MindEd launched a collection of new co-produced online learning sessions to stop the over-medication of people with learning disability and/or autistic people (STOMP).

The STOMP and STAMP initiatives support people with a learning disability and who are autistic to stay well and have a good quality of life. They aim to promote opportunities for patients, families, and carers to speak up if they feel someone in their care is receiving inappropriate medication.[214]

Recommendations

- NHS healthcare leaders to embed a culture in which patients and clinicians regularly discuss the clinical value and effectiveness of proposed treatments or interventions with the explicit aim of reducing the amount of inappropriate clinical activity.
- NHSE to promote the implementation of safe prescribing and withdrawal management for medicines associated with dependence or withdrawal.
- NHSE to further promote the Stopping over medication of people with a learning disability, autism or both (STOMP) and Supporting Treatment and Appropriate Medication in Paediatrics (STAMP) initiatives across the NHS.

Measure and collect patient outcomes data

The NHS faces a major challenge of delivering good care through the cost-effective use of resources; reducing unwarranted variation in outcomes, quality, and safety; and working to prevent disease. Achieving this 'triple aim' is dependent on breaking the traditional divide between primary care, community services, social care, mental health services and hospitals, and taking full accountability for population health outcomes.[215] As well as NHS organisations, local authorities and the voluntary sector have a key role in promoting wellbeing and improving mental health in their communities.

A central function of ICSs is to develop an approach to population health management, prevent ill health and address health inequalities. Much of this work will need to be done by using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities.

The College's forthcoming report consolidates a set of outcomes from all specialties in psychiatry. It recommends that the development of outcome measures should[216]:

- focus on what is important to patients and carers
- include measures that are relevant to patients and clinicians
- include measures that are simple and easy to use
- include measures that are clear and unambiguous
- include measures that allow comparisons between teams and services
- include measures that can be validated for the purpose for which they are used
- include IT support that simplifies the data collection and analysis, and ensures maximum use of data already collected
- include data that is checked for reliability
- include data that can be used at the clinical, team and organisational level, and
- give immediate feedback on the data to patients, carers and clinicians so that outcomes can influence the treatment process.

Recommendations

- NHSE and ICSs to prioritise the collection and recording of routine outcomes measures for:
    - perinatal mental health care
    - children and young people's mental health care
    - community mental health care
    - adult crisis and acute mental health care
    - integrated IAPT service
    - adult eating disorder services, and
    - tailored outreach and engagement for flu/COVID-19 vaccination and physical health checks.
- ICSs to work with system partners to develop and collect outcome measures in mental health aligned with the College's report.

Make mental health services greener

A sustainable and positive vision of mental health services will require a greater understanding, adoption and integration of preventative principles and interventions. This preventative ethos must be placed at the heart of healthcare.[217]

Detecting and treating illnesses early to halt or slow their progress can reduce relapses and prevent patients deteriorating to the point of needing hospitalisation. This is not only better for people but also more efficient and sustainable.

The NHS is a major contributor to carbon emissions. In England, it accounts for 4–5% of the total[218]. Improving NHS sustainability cannot be achieved merely through rationalising estates, it must involve a more holistic approach to health creation, health protection, and a model of healthcare where prevention is prioritised by services.

The NHS has a target to reach Net Zero by 2045. The NHS LTP set out several environmental and sustainability targets, which are outlined below:

- by 2025, the NHS will reduce our carbon footprint by 51% against 2007 levels, by greening our estates and facilities, including phasing out coal and oil fuel as the primary heating
- by 2023/24, the NHS will cut business mileages and fleet air pollutant emissions by 20%, and
- the NHS will deliver reductions in single-use plastics throughout the NHS supply chain.

NHSE has asked every trust in the country to develop their own roadmap to tackle climate change and meet the NHS's net zero commitments.[219]

Replacing ageing buildings across mental health trusts will help meet these commitments.

Increasing access to green space and trees on NHS sites also provides an opportunity for supporting mental health, improving air quality and social prescribing.

There is also an opportunity for mental health trusts to embed nature within service design, which will have a positive impact on mental and physical health. For instance, the NHS Children's Woodland Retreat in a tree-house style mental health unit for 13–18-year-olds in Bury.[220]

Following the UK hosting the 26th UN Climate Change Conference of the Parties (COP26) it is essential that green design, and green estates are prioritised, contributing simultaneously to climate change limitation, and nature-informed approaches to healing and wellbeing.

Recommendations

- NHSE to ensure the NHS reaches carbon net-zero by 2040 and 2045 and this target is central to the commitments in the NHS LTP Refresh.
- DHSC and ICSs to replace ageing buildings across the mental health estate.
- Every NHS health organisation, commissioner and provider to produce a Green Plan and regularly review this.
- NHS providers to develop and implement a biodiversity action plan which examines 'greening (incorporating more environmentally friendly systems) of estates, buildings and care pathways, and establishes links with green care providers.
- NHS providers to establish a natural services network to map all sites in their local area that provide opportunities for sustainable interaction with nature and/or activities that preserve the natural environment and promote these to mental health services.
- NHS providers to incorporate the goals of Choosing Wisely into daily practice, including:
    - encouraging doctors to provide patients with resources that increase their understanding about potential environmental harms of biomedical/ pharmaceutical interventions and help them understand that doing nothing or fewer interventions can sometimes be the best approach.
    - encouraging and empowering patients to ask questions such as, "Do I really need this test or procedure? What are the risks? Are there simpler safer options? What happens if I do nothing?"
- ICSs to appoint a social prescribing Lead to oversee all community teams developing a social prescribing function to identify local opportunities for complementary health-improving activities.

- ICSs to expand the NHS sustainability awards. Continue recognising sustainable clinical work across the NHS with consideration towards developing an additional award for the work of mental health services in achieving a high standard of sustainable practice.
- Governing NHS bodies across the UK to jointly develop a minimum set of standards for providers in developing sustainable services and
    - ICSs to include these minimum standards in their contracts, and
    - ICSs to develop a sustainable mental health service toolset: provide a working set of standards by which mental health services can develop effective sustainable development plans which reflect the need for estates and clinical staff to work collaboratively when developing and delivering sustainable mental health services.

Invest in the health and wellbeing of NHS and social care staff

At present, members report high workloads, poor work-life balance, and pressures on CPD. This means that older consultants are more likely to retire early due to work-related stress, which has been exacerbated by the pandemic. Across the sector, there has been an increase in the number of doctors taking early retirement, with NHS figures showing that the numbers have tripled in the past decade.[221]The Royal College of Psychiatrists 2021 workforce census shows a total of 193 consultants were reported to have retired in England 2020/21, signalling a 49.6% increase from 2016/17[222].

There needs to be significant investment in retention and in mental health support for health and care staff, particularly after the strain put on them during the pandemic. This is needed both as a duty of care towards staff, but also to mitigate the impacts of mental health-related absence, which has consistently been the most reported reason for sickness absence.

Staff are dealing with heavy and unsustainable workloads and face an elevated risk of burnout. Members have reported increased staff absences due to sickness, stress, and low morale. Sustainable recovery planning from the pandemic is essential, as it will not only impact retention but also recruitment. Without further interventions, such as reflective spaces, to support staff, there will be an ongoing impact on workforce supply.

The Royal College of Psychiatrists member survey from September 2020 showed that across the UK, 52.6% of members confirmed their wellbeing had ‘significantly suffered’ (12.3%) or ‘suffered’ (40.3%) as a result of COVID-19 and the lockdown, while a mere 11.1% confirmed that it had ‘significantly improved (2.9%) or ‘improved’ (8.2%). These headline percentages compare to 48.6% and 13.1% respectively in our second survey (in the field from 1-6 May) and 54.4% and 10.2% respectively in our third survey (in the field from 18-26 May).[223]

In addition, every quarter, the Royal College of Psychiatrists survey Research Panel members about waiting times, quality, and leadership. Members are also asked how they would rate morale across their multidisciplinary team in the last three months. In March 2022, just 10.1% of panel members in England confirmed that morale had got ‘better’, meanwhile 20.8% stated it had got ‘much worse’ and 40.9% ‘worse’.[224]

The NHS has a package of health and wellbeing support in place for NHS staff which includes access to a 24hr text service, free self-help apps, as well as training, coaching and guidance for teams and leaders and 40 staff mental health and wellbeing hubs in every region of England:

Staff mental health and wellbeing hubs have been set up across the country to provide health and social care colleagues rapid access to assessment and local evidence-based mental health services and support where needed. The hub offer is confidential and free of charge for all health and social care staff in England.

The COVID-19 Mental Health and Wellbeing Recovery Action Plan committed to £30m of funding for mental health hubs, which is equivalent to approximately £30 per NHS staff member. NHS staff have accessed the health and wellbeing offer 750,000 times, which shows that there is demand for these services. A long-term commitment to funding these mental health hubs is required.

Recommendations

- NHSE to further expand staff mental health and wellbeing hubs.
- NHSE and NHS employers to make the protection and promotion of staff wellbeing central to the culture of the NHS, through embedding reflective spaces within ICSs and NHS organisations to enable staff to recover from the impact of the pandemic and to make routine emotional and psychological support for staff moving forward.
- NHSE and NHS employers to review and reduce mandatory training to ensure it is personalised and meaningful. Other activities and policies that do not treat staff as individuals should also be identified and rolled back to relieve them of commitments that are irrelevant to their day-to-day job.

6. How can we support people living with mental health conditions to live well?

Improve the physical health of people with severe mental illnesses and/or intellectual disabilities and autistic people

Improving the physical health of people living with mental illness, intellectual disability and/or autistic people should be an urgent priority.

Poor mental health is associated with other priority public health challenges such as obesity, lack of regular exercise, alcohol and substance use disorders and smoking.[225]

People with severe mental illnesses often develop chronic physical health conditions at a younger age than people without SMI – obesity, asthma, diabetes, chronic obstructive pulmonary disease, coronary heart disease, stroke, heart failure and liver disease. They are also much less likely than the wider population to receive an early diagnosis or timely treatment pathway to address these physical health conditions.

Based on data from 2016 to 2018, in England, people with SMI are 4.5 times more likely to die prematurely than those who do not have SMI. This inequality exists across genders but is greater for females. Females with SMI are 4.7 times more likely to die prematurely than females without SMI. There is also significant geographical variation in excess premature mortality with a range between 2.7 to 7 times more likely to die before the age of 75 than adults without SMI. [226]

However, SMI is rarely recorded as an underlying cause of death and indeed, is often not recorded on death certificates even as a contributory cause. It is estimated that for people with SMI, 2 out of 3 deaths are from physical illnesses that can be prevented. [227]

Many of these 'excess' deaths could be prevented or delayed by the more widespread use of evidence-based interventions (e.g., health checks and extended lifestyle support, medicine reviews and community falls prevention).

People who are more vulnerable to developing a severe illness and dying from COVID-19 include older people, people living in more deprived areas, those from Black, Asian and minority ethnic communities, and people with some physical health conditions.

The NHS LTP established a commitment for 390,000 people to receive a full annual Physical Health Check, with an expectation for 60% of people on GP Practice SMI registers to receive one. However, in March 2020, the percentage of people who had received a check in the preceding year stood at 36%. This number has fallen further during the COVID-19 pandemic and there needs to be immediate action to address this as part of the NHS recovery plan and then beyond that through this Strategy..

Recommendations

Physical health monitoring and intervention

- NHSE and OHID to reduce premature mortality for those with a mental illness/disorder and for those with intellectual disabilities (through prevention and treatment and promote mental health and well-being) by one-third by 2030.
- NHSE to ensure people on the SMI primary care register and the Learning Disability register receive comprehensive physical health checks and reduce disparities in access between different population groups.

Smoking cessation

A new review conducted by researchers at the University of Bristol has found a causal relationship between smoking and mental illness, particularly schizophrenia. The researchers found that smoking increases the risk of developing schizophrenia by between 53% and 127% and of developing depression by 54% to 132%.

As outlined in the report by ASH and the Royal College of Psychiatrists' PMHIC, we recommend:

- OHID and NHSE to introduce a new Tobacco Control Plan focused on tackling smoking in all people with a mental illness, through targeted investment and effective data monitoring systems, underpinned by targets for reduced smoking prevalence in this population
- OHID and NHSE to promote interventions to prevent smoking uptake and support cessation including:
    - interventions to prevent smoking tobacco control programmes which include legislative smoking bans, plain packaging and mass media campaigns
    - interventions to support smoking cessation and reduction through pharmacological and non-pharmacological interventions
    - Implementation of "No smoking" policies in mental health secondary care settings to reduce smoking rates.[228]
- NHSE to ensure IAPT services include support for smokers to quit, to improve both mental and physical health outcomes.
- OHID and NHSE to ensure national communications activity on promoting positive mental health should include messages about the benefits of stopping smoking and avoiding starting. Similarly, national 'stop smoking' communications should include information on the benefits to mental health.
- ICSs to ensure coproduction with service users locally should be supported to resource peer support workers using quality improvement methodology, to maximise signposting to help and quit rates.
- OHID and NHSE to address major gaps in the data to monitor smoking rates across all populations with a mental health condition, to measure the provision of evidence-based support and the outcome of treatment.

Interventions to reduce alcohol misuse and harmful drinking

- DHSC to introduce public policies that restrict alcohol availability and/or raise taxes on alcohol to reduce drinking.
- NHSE to invest in brief and digital interventions to reduce harmful alcohol consumption through primary care-based brief interventions so that we can reduce alcohol consumption in hazardous and harmful drinkers.
- NHSE to invest in targeted alcohol interventions for people with mental disorder through brief interventions including digital approaches.

Interventions targeting drug misuse

- NHSE to invest in digitally delivered interventions to reduce the use of cannabis.
- NHSE to invest in inventions to prevent drug use among people with a mental disorder and comorbid substance misuse.

Promoting physical activity

- NHSE and OHID to promote physical activity to improved symptoms and outcomes of mental disorders.
- NHSE to invest in weight management interventions.

Prevention of COVID-19 infection and associated mortality

- NHSE to ensure the COVID-19 vaccination programmes considers those with a mental disorder and/or intellectual disability.

Integrate and personalise mental health care for people with long-term conditions

Millions of people in England have at least one long-term condition and the population with multi-morbidities is increasing. Adults and older adults who have multi-morbidities are often not served well by the current healthcare system. This includes those living with substance use disorders, personality disorders, intellectual disabilities, neurodevelopmental disorders, and those in contact with the criminal justice system.

People are also at increased risk of poor mental health when attending physical healthcare providers with symptoms that are never satisfactorily explained by any organic cause, known as medically unexplained symptoms.

NICE guidelines for those conditions (and other physical health problems) include little mention of the provision of psychosocial care and psychiatric input in particular. Instead, NICE tends to simply refer to separate guidance on depression in physical illness. Therefore, there is a risk that the need for adequate psychosocial care is overlooked by commissioners.

In recent years, there has also been a tendency to commission 'one-size fits all' IAPT services that cannot manage people with complex needs and, therefore, to address this, IAPT should be commissioned in conjunction with liaison mental health services.

Whilst there is increasing availability of liaison psychiatry services for emergency departments and for the acute care pathway, the harms described above remain largely unaddressed. Training for all clinicians, plus comprehensive integrated psychological medicine in all clinical pathways, for outpatients and inpatients, in secondary and primary care, could, in time, eliminate these from our clinical landscape.

Providing support to meet the mental health needs of carers (who are often older carers) is especially important for long-term conditions, as well as cancer and cardiovascular and respiratory diseases.

Recommendations

General

- NHSE to develop robust integrated pathways of care for long-term conditions that address psychosocial needs, including the management of co-morbid mental illness. Psychiatric expertise (particularly Old Age psychiatrists) is required for the assessment and management of complex cases and should be built into the pathway.
- NICE to reconsider its current strategy, which separates physical and mental health recommendations in their guidance.

Diabetes

- NHSE to rapidly expand the roll out of integrated psychological therapy services for people with medically unexplained symptoms and long-term physical health conditions as set out in the NHS LTP.
- Healthcare professionals to ensure they screen everyone admitted with acute complications of diabetes whose aetiology is unclear or not medically explained for mental illness. Staff need to be appropriately trained to do this.

- Healthcare professionals to screen all patients prescribed second-generation antipsychotics for diabetes.
- All mental health providers to create a diabetes register, with immediate priority given to units where individuals may have prolonged inpatient admissions, such as secure hospitals.
- All mental health providers to audit current practices in diabetes care and consider:
    - the implementation of diabetes-related competencies as part of mandatory training with a particular focus on managing and avoiding hypoglycaemia and safe use of insulin
    - basic skills for staff in the management of diabetes and mental health that are in keeping with their job role to care for patients with comorbidity
    - awareness of local pathways and policies for contacting diabetes or mental health services, and
    - if best practice tariff criteria are met for diabetes ketoacidosis and hypoglycaemia and for children and young people with diabetes.

Dementia care

- NHSE to ensure people with dementia receive a timely diagnosis.
- NHSE to ensure people with dementia are offered post-diagnostic treatment and support, which should be NICE-recommended, and the support needs should be outlined in the initial care plan. This care plan should be reviewed within at least 12 months of being agreed upon, then reviewed every 12 months in accordance with changes in the person's needs. Revisions should be jointly developed and agreed upon with the person (and, if applicable, their carer).
- NHSE to ensure carers for people with dementia should also be offered post-diagnostic support and/ or a carer's needs assessment.
- ICSs should assess the different levels of risk of developing dementia as well as specific needs, such as those with early-onset dementia, people from Black, Asian and minority ethnic backgrounds and people with intellectual disabilities and capture this within their Joint Strategic Needs Assessment and local Dementia Needs Assessment.
- NHSE to consider new models to support older people with dementia and mental health issues in the community, moving beyond the model that depends on memory clinics. This might incorporate a model whereby patients remain under the care of an Old Age psychiatrist from diagnosis until death, rather than being discharged back to a GP. This should involve regular check-ups and brief interventions when problems are identified. This aims to improve the quality of care provided, reduce hospital admissions and GP caseloads.

Cardiovascular and respiratory diseases

- NHSE to ensure the commissioning of any new cardiovascular or respiratory disease service must specifically consider the psychological needs of that population from the outset and ensure that appropriately skilled mental health professionals are integrated and supported to function within that service.

Cancer

- NHSE to ensure all patients on a cancer treatment pathway are referred to psychological and mental health support in the community, in a timely manner.
- NHSE to ensure the commissioning of any new cancer service must specifically consider the psychological needs of that population from the outset and that appropriately skilled mental health professionals are integrated and supported to function within that service.
- NHSE to develop robust integrated care pathways for patients with cancer that meet their psychosocial needs, including the management of co-morbid mental illness.
- NHSE to recommend the widespread commissioning of integrated cancer psychological support services in acute trusts and cancer centres, consisting of a stepped-care approach to managing

psychological distress as per NICE guidance (access to counselling, psychology and liaison psychiatry).
- NHSE to ensure that all GPs are able to refer patients on a cancer treatment pathway to psychological and mental health support in the community, in a timely manner.
- NHSE to commission services which should include primary care advice lines and prescriber support to GPs, led by psychiatrists with cancer care experience.
- NHSE to recommend commissioning of inpatient cancer liaison psychiatry services consisting of at least some dedicated medical and nursing resource, in line with demand.
- NHSE, the National Institute for Health Research (NIHR), the Medical Research Council and the Wellcome Trust to liaise with other interested parties such as RCPsych, the Academy of Medical Royal Colleges, the Academy of Medical Sciences to significantly improve funding and support to integrated education and research involving cancer and mental health.

Workforce

- NHSE should consider integrated training opportunities and enhanced generalist skills. This should include mental health competencies for 'non-mental health professionals' including nurses, doctors, staff working in acute settings, GPs, advanced care practitioners, pharmacists, and voluntary, community and social enterprise staff (VCSE) staff. It should also include physical health competencies for mental health staff, including psychiatrists, psychologists, and social care staff. NHSE should also consider integrated training opportunities, such as the management of common chronic physical and mental comorbidities such as alcohol and mood disorders and diabetes and depression.

Increase support for carers

Carers can have an important role in supporting a person living with a mental illness and may have mental health problems of their own, such as depression. However, carers can feel excluded by mental health services and poorly supported in their role.

Future strategies need to recognise and value the role of carers and ensure they are fully engaged. The Triangle of Care65 approach has shown considerable promise in ensuring that carers are appropriately involved in decision-making, supported in caring and given help for their wellbeing.

Recommendations

- DHSC to invest in interventions for carers through support, psychoeducation, intent-based interventions, internet-based information and education alongside professional support. It is also important to specifically consider the needs of young carers.

Support people to find and retain meaningful employment

Currently, 300,000 people living with long-term mental health problems lose their jobs each year. This is unacceptable for the patient, carers, and families as well as wider society who no longer can benefit from the productive employment many of these people can undertake. We need to act on this, to support people who can remain in work to continue. The Thriving at Work recommendations need to be implemented as an urgent priority. The proportion of people using specialist mental health services who are in paid work remains small. Many more people would like support with employment.

Addressing patients' occupational, educational, and psychosocial needs is an essential aspect of mental health care. Supporting individuals to work, wherever possible, can positively contribute to the recovery of individuals who have mental health conditions. Therefore, all mental health professionals

should formally consider whether employment is a precipitating and/or maintaining factor in someone's mental health condition and should view being in appropriate work as a key treatment outcome.

Programmes that support people into employment when they want this, on their own terms, should be expanded, and we welcome the commitment in the NHS LTP to increase access to Individual Placement and Support (IPS).

We also need to look beyond secondary mental health services and extend the principles of IPS to mainstream employment service provision. There are pilot projects in some local areas extending and adapting IPS to IAPT and primary care, to addiction services, to armed forces veterans and to people leaving prison.[229]

Recommendations

- DWP to work with employers to ensure they support the wellbeing of their staff, including fully implementing the Thriving at Work report. Public sector organisations should be at the forefront of change and make use of their economic power (for example supply chains) to encourage wider uptake. This should take into account the changing nature of work and the recommendations of the Taylor Review.
- DHSC and the DWP to work together to give a guarantee that anyone with a serious mental illness who wants help with employment is able to access IPS.
- DHSC to invest in interventions with a specific focus on work, such as exposure therapy and CBT-based and problem-focused return-to-work programmes.
- DHSC to invest in work-directed intervention to clinical support, telephone or online cognitive behavioural therapy, and structured telephone outreach and care management programmes.
- DWP and DHSC to give workers with mental health problems early access to occupationally focused healthcare, which should include helping them to obtain, remain in, or return to, appropriate work.
- DWP and DHSC to expand vocational support services in both NHS and community settings for patients with mental health problems to help them remain in, or return to, work.
- DWP to improve access to flexible benefits and sick leave for patients with chronic fluctuating health conditions to help patients remain in, or return to, work.
- DWP to ensure that all employers (including the NHS) recognise the benefits of ensuring that all supervisors, from the most junior upwards, feel confident to identify potential mental health difficulties in their staff and to speak with them about such difficulties using an approach to wellness that focuses on health rather than disease.
- NHS employers should ensure all healthcare staff understand the close links between someone's state of mental health and their ability to work, which is especially important when providing care for people who work in safety-critical occupations (e.g., vehicle operators, emergency services etc.).
- NHS employers to ensure all healthcare staff provide care in a way that helps patients stay in, or return to, appropriate work.
- NHS employers to ensure all NHS staff understand the key role that occupational health services have in helping to support patients staying in, or returning to, appropriate work.
- NHS employers to ensure, as a priority, that all NHS supervisors, from the most junior upwards, feel confident enough to identify potential mental health difficulties in their staff and to speak with them about such difficulties using an approach to wellness that focuses on health rather than disease.
- Mental healthcare professionals to routinely explore a patient's employment history – including their current employment status – to understand what role it may have played in contributing to their state of mental health.

- Mental healthcare professionals to view it as an important treatment outcome to help patients to obtain, remain in, or return to, appropriate work.
- Mental healthcare professionals to encourage healthcare colleagues to recognise the mental health benefits of being in work and to consider work as a key treatment outcome for any care provided.
- Mental healthcare professionals to advocate for their patients by appropriately communicating with employers and occupational health providers to challenge any discrimination or stigma that exists about mental health, with the aim of helping their patients remain in, or return to, appropriate work.
- All employers to ensure that those in supervisory positions, from the most junior upwards, feel confident enough to identify potential mental health difficulties in their staff and to speak with them about such difficulties using an approach to wellness that focuses on health rather than disease.
- All employers to adopt policies and practices which support people who develop mental health conditions to remain in, or return to, appropriate full- or part-time work.
- All employers to recognise the value of occupationally focused mental healthcare in helping their staff remain in, or return to, appropriate work.

Improve the welfare system

Social security benefits play an important role in enabling people with a range of mental health problems to live well. For many, these entitlements provide an important safety net during times of ill health and offset the extra costs of living with a disability. Yet we know that people with mental health problems struggle to receive the benefits they are entitled to and have poor experiences of the system, including the inappropriate use of sanctions. This inevitably creates a significant barrier to their recovery.

The system for assessing benefit entitlements must ensure that people are accurately and honestly assessed. It must also ensure the impact of individual health problems is understood and that assessments achieve the right results the first time, without needing to be reviewed.

Recommendation

- DWP to ensure Universal Credit is rolled out in a way that enables and supports anyone with a mental health problem and publish transparent data to demonstrate this.

Support people with problem debt

Problem debt is closely associated with poor mental health. Difficulties managing personal finances can trigger relapses in people with mental health problems. For some people having a mental health problem can lead to financial difficulty.

People with problematic debts have half the recovery rates in IAPT of those without.[230] Routine screening for financial difficulty and high-quality advice on debt, finance and associated issues is likely to be highly cost-effective for the NHS and could significantly reduce the risk of homelessness among people with mental health problems.

Recommendations

- NHSE and ICSs to consider how best they can identify and support service users experiencing financial difficulty, and wherever possible ensure people have access to high-quality housing, debt and financial advice.

Support people to access safe housing

Having somewhere safe, stable, and secure to live is essential for good mental and physical health. For too many people, housing insecurity and poor mental health reinforce one another. Insecure tenancies, the risk or experience of homelessness and poor-quality housing, can all affect mental health.

Securing the housing rights of people with mental health problems is an essential cornerstone of a fair society. It can also increase the efficiency of mental health services and reduce the use of inappropriate out-of-area placements.

Recommendations

- DHSC and NHSE to develop a long-term plan for ICSs and local authorities to prioritise step-down housing with adequate funding for people who require transitional accommodation and support to live independently.
- DHSC and DLUHC to reform the social housing system so that it better meets the needs of people with mental health problems and adopt a sustainable funding model for supported housing to ensure everyone who needs supported housing is able to access it.
- HM Treasury, DHSC and DLUHC to agree a new long-term funding settlement for social care to complement improvements in mental health services support.

7. How can we improve support for people in crisis?

Expand access to mental health services

If the UK is to meet the UN SDG target of achieving universal coverage, we must significantly increase access to mental health services.

Recommendations

Increase access to perinatal and infant mental health services

- NHSE and ICSs to increase access to Infant Mental Health Services.
- NHSE and ICSs to increase access to Community Perinatal Mental Health Services for women in the perinatal period and increase the paternal mental health support available.
- NHSE and ICSs to increase access to evidence-based specialist mental health care for women with a severe mental illness during the perinatal period.
- NHSE and ICSs to ensure Community Perinatal Mental Health Services include access to psychological therapies and the right range of specialist community or inpatient care so that comprehensive, high-quality services are in place across England.

Increase access to children and young people's mental health services

- NHSE and ICSs to increase access to integrated treatment and support, through IAPT, Mental Health Support Teams in schools, and CAMHS with appropriate waiting times for children and young people.
- NHSE and ICSs to develop an equivalent model for Crisis Resolution and Home Treatment Teams for children and young people, which should be multi-agency (including social workers) and adapted to meet the needs of children and young people.
- NHSE and ICSs to introduce a 4−6 week waiting time standard for access to specialist NHS children and young people's mental health services, building on the expansion of specialist NHS services already underway.
- NHSE and ICSs to ensure there are developmentally informed services for children and young people up until the age of 25 years, and this should be appropriately resourced between child and adolescent and adult mental health services.

Increase access to primary mental health care services

- Primary care providers to roll out suicide skills training for primary care professionals, such as STORM training.
- NHSE and ICSs to empower and support primary care leaders to collaborate with mental health leaders involved in the design and implementation of the Community Mental Health Framework.
- PCNs, ICSs and NHSE to make pathways to primary mental health care fairer for groups of people who face additional barriers and/or struggle to access services through the traditional primary care route.
- All primary care providers to have a specific mental health care pathway that covers the lifespan of people with intellectual disabilities, autistic people, or both.
- All primary care providers to hold registers for people with intellectual disability and autistic people.
- NHSE and ICSs to ensure that information resources about various care pathways are accessible for those with Intellectual Disabilities so that patients can understand and participate in their treatment pathway.

Increase access to community mental health services for adults and older adults

- NHSE and ICSs to ensure community mental health services meet a defined set of recommended NICE guidelines and more staff are able to give continuity of support to a larger number of patients with SMI to prevent relapse, hospitalisation and the use of the Mental Health Act 1983.
- NHSE and ICSs to ensure community Rehabilitation and Recovery teams are available in every mental health trust with an appropriate number of inpatient beds to avoid the use of 'locked rehab' units.
- NHSE and ICSs to ensure all settings in which older people with a mental illness are resident have easy access to a mental health support team that includes the services of a specialist in old age psychiatry.
- NHSE and ICSs to increase the number of people who can benefit from a personal health budget.

Increase access to community services for children and adults with an intellectual disability and/or autistic people

- NHSE and ICSs to significantly reduce the reliance on inpatient services for people with an intellectual disability and/or autistic people.
- NHSE and ICSs to significantly enhance community services for adults and children with an intellectual disability and/or autistic people.

Increase access to mental health crisis services

- NHSE and ICSs to ensure that people experiencing a first episode of psychosis start treatment with a NICE-recommended package of care with a specialist Early Intervention in Psychosis (EIP) service within two weeks of referral.
- NHSE and ICSs to ensure that all specialist EIP provision is graded at level 4, in line with NICE recommendations.
- NHSE and ICSs to ensure 24/7 crisis and liaison pathways for all ages are implemented. Crisis resolution and home treatment teams should incorporate a model specifically to meet the different needs and risks of older adults (particularly in relation to co-morbid physical health issues). These teams should also be adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission.
- ICSs should monitor and respond to demand and capacity within mental health services.

Increase access to mental health inpatient services and alternatives

- NHSE and ICSs to introduce a new standard so that patients should expect to wait a maximum of four hours for admission to an acute psychiatric ward or acceptance for home-based treatment following assessment, for those who need it.
- NHSE and ICSs to ensure that 85% bed occupancy rates in mental health trusts are consistently achieved.
- NHSE and ICSs to reduce delayed discharges/delayed transfers of care for patients in mental health inpatient settings.
- NHSE and ICSs to invest in supported housing and other accommodation-based support.
- NHSE and ICSs to ensure that NHS mental health trusts eliminate both inappropriate external and internal (within the home provider) out-of-area placements.
- NHSE and ICSs to invest, in the short-term, in additional adult acute inpatient beds for areas with consistently high rates of inappropriate out-of-area placements and/or persistently high bed occupancy rates.
- DHSC, NHSE and ICSs to fund and procure age-appropriate alternative forms of mental health crisis provision. This should be extended to include children and young people and older adults and should not be limited to care homes in the case of the latter.
- NHSE and ICSs to collect data on the availability of crisis alternatives, including activity, workforce, finance, and outcome metrics.

- NHSE and ICSs to work with local authorities and partners to provide better support for people in crisis that is not deemed to be a mental health crisis. This needs to be a non-clinical response to meet people's needs, which might be related to housing, addiction, or relationship difficulties, to name but a few. An example of this support is Distress Brief Intervention (DBI) in Scotland. DBI consists of two parts, with part one seeing trained frontline health, police, paramedic and primary care staff help ease any individual. They then ask the person if they would like further support and, if they agree, they are referred to the DBI service with a promise of contact within the next 24 hours to start providing further face-to-face support. Part two is provided by commissioned and trained third sector staff who contact the person within 24 hours of referral and provide community-based problem-solving support, wellness and distress management planning, supported connections and signposting.
- NHSE and ICSs to substantially increase the availability of psychological therapies accessible in secondary, tertiary care and specialist settings. For children and young people with more complex issues, they should access more specialised therapies if first and second line IAPT treatments have failed.

Increase access to specialist mental health teams

- NHSE and ICSs to ensure that adults with an eating disorder who require urgent treatment start this within one week. For adults with an eating disorder requiring routine treatment, this should start within four weeks.
- NHSE and ICSs to ensure that there is a dedicated community eating disorders service, which is integrated with medical care and supports a seamless transition from children and young people's services to adult care and from inpatient care to reduce the length of stay.
- NHSE to provide targeted funding to support provider collaboratives in developing and trialling integrated specialist pathways which offer more personalised care for patients who are acutely unwell.
- NHSE and ICSs to promote the implementation of the Medical Emergencies in Eating Disorders (MEED) guidelines.
- NHSE and ICSs to ensure that people with complex mental health problems, including personality disorders, have greater access to a range of evidence-based psychotherapies tailored to their needs.
- NHSE and ICSs to ensure that the principles of reflective, psychologically minded practice and enabling environments underpin training of professionals and delivery of integrated models of care in community and inpatient settings across physical, mental health and social care.
- NHSE to ensure that every ICS has NHS specialist addictions services led by appropriately trained and experienced addiction psychiatrists. This should include adequate provision for children and young people and older adults experiencing addictions.
- NHSE to ensure that more veterans are able to access NHS mental health services (Transition, Intervention and Liaison Service (TILS) and Complex Treatment Service (CTS)) with an initial face-to-face assessment within 2 weeks and a first clinical appointment, where appropriate, two weeks thereafter. There should also be a greater focus on increasing services available to female veterans.
- NHSE and ICSs to ensure that there is an explicit provision in each locality for those with autism. This should extend beyond the diagnostic process, to provide services for the treatment of their co-occurring mental and physical disorders and include the coherent involvement of the wide range of agencies and services that can benefit the individual.

Increase access to secure services and offender healthcare

- NHSE and ICSs to ensure that Liaison and Diversion services provide a multi-agency assessment and referral service within police custody and the courts across England hold cases in the short-term to prevent people from falling through the net.

- NHSE and ICSs to ensure that solitary confinement (defined as more than 22 hours in segregation without meaningful human contact) is banned immediately for children and young people in the youth justice system.
- NHSE and ICSs to ensure that Community Sentence Treatment Requirements is significantly expanded as proposed in the Government White Paper on a Smarter Approach to Sentencing. This will allow for those with more severe mental illnesses to benefit from community sentences.
- NHSE and ICSs to ensure that adults receive dedicated mental health screening within 24−48 hours after entering prison and 70% of people who need treatment or support are followed up within a month.
- NHSE and ICSs to ensure that there is a minimum ratio of prison officers to prisoners to increase basic safety, protect from dangerous, mind-altering drugs and increase access to mental health services in prison. NHSE and ICSs should also conduct an urgent assessment of how to better attract and retain a prison mental health workforce, including forensic psychiatrists, to deliver mental health care.
- NHSE and ICSs to ensure that all young people identified as 'in need' by youth justice liaison and diversion workers have an appropriate service they can be referred to.
- DHSC and the Ministry of Justice (MoJ) to reform the criminal justice system to make prisons safer and divert more people to community options.
- MoJ to conduct a detailed assessment on the impact of changes to Legal Aid on people with mental health problems and ensure improved and fair access to adequate legal advice and support.

Introduce new waiting time standards in mental health

It is widely recognised that having clear standards can facilitate service improvement through enhancing patient experience and driving up health outcomes. For example, standards introduced in 2015 set out waiting times for children and young people's eating disorder services and have proven to be an essential tool to drive service improvements. However, similar standards have been lacking in relation to adult services.

Under the new waiting time standards which are to be introduced by NHSE, subject to agreement of funding and an implementation plan with DHSC, it is intended that patients presenting to community-based mental health services – including those with eating disorders – will start to receive help within four weeks of referral. Given what we know about the importance of early intervention in improving long term outcomes in people with eating disorders, this standard is welcome.

While the proposed introduction of new access standards in mental health is a welcome step towards parity of esteem, they will not in and of themselves be able to drive dramatic improvements in performance. There are obvious deliverability concerns, particularly in relation to the workforce being in place to implement such drastic service improvements within clear timeframes. A long-term plan for growing the workforce is a necessary prerequisite to implementation of the new standards.

In light of the disproportionate impact of the pandemic on eating disorder presentations, we also know that the current NHS LTP funding profile will be insufficient to drive the kind of service improvements that patients need. Moreover, given that there has been no cost estimate for implementing the NICE eating disorder guidance, there is a significant risk that this will continue not to be implemented in full, given resource constraints.

Experience from the implementation of the children and young people's eating disorder standards and pathway guidance highlights the importance of ambitious but achievable targets, and effective and transparent data collection. Perhaps most importantly, however, the 2014 commitment to invest an additional £30 million (that has been increased to £52 million) in recurrent funding supercharged performance of children and young people's eating disorder services in England. Additional, targeted

investment would almost certainly prove transformative and ensure adult eating disorder services are able to mirror improvements seen in under-19s services prior to the pandemic.

Recommendation

- NHSE to develop a clear implementation plan for new mental health access standards (developed through the Clinically-led Review of NHS Standards), which is ambitious but achievable, and provide specific funding to enable specialist eating disorder services to meet these new targets.
- NHSE to introduce new waiting time standards for other areas of mental health provision, including:
    - perinatal mental health services
    - children and young people's mental health services (not including eating disorders)
    - adult crisis and acute mental health care
    - adults who receive mental health treatment following a referral for mental health support from learning disability and autism services
    - children and young people who receive mental health treatment following a referral for mental health support from learning disability and autism services
    - adult eating disorder services, and
    - integrated IAPT services.

Improve the urgent and emergency care pathway for those with a mental illness

NHS 111 and the 999 services have traditionally not served people with a mental illness very well, with many being told to go to A&E as call handlers did not know what else to advise. There is much greater local variation in mental health care than there is for any other part of the healthcare system. NHS 111 handlers did not have a good working knowledge of how every local area's mental health services operate and the different pathways in crisis, community, and acute care.

At the time of the COVID-19 pandemic, more than half of mental health trusts did not have a public-facing 24/7 telephone number for access to urgent mental health support. Of those that did, some had a number that was difficult for the public to find, and several websites were directing people to A&E and 999 as the local default option for urgent mental health support.

NHS 111

The NHS LTP sets out plans to ensure that by 2023/24, anyone seeking urgent mental health support should be able to do so via 111. In most areas, it is expected that a patient with a primary mental health need will be put through to a mental health nurse or straight through to the mental health crisis line commissioned by their local area.

The Clinical Assessment Service is a central component of this, offering patients access to clinicians – both experienced generalists and specialists. When a call is routed directly to a dedicated resource, if the call is not answered, the call must be routed back into the NHS 111 service.

The 111 service no longer reports data relating to mental illness. Therefore, it is unclear how well it serves this population and whether it maximises the opportunity to intervene at the earliest point. We do not know how many people are calling 111 with a mental health problem, or how many calls are routed to a local crisis line (or, of those, how many are successfully transferred and how many people get through to a mental health nurse).

24/7 urgent NHS mental health telephone support, advice, and triage services

In May 2020, NHSE reported mental health telephone support, advice and triage services had been set up in every part of the country. These services have been a lifeline for many patients, but they are not

always well linked with the NHS 111 service. They are also not yet operating the full service envisaged in the NHS LTP.

999 service

When a person is experiencing a mental health crisis, they or their family, friends or a member of the public might seek help via 999. Depending on the circumstances, this can lead to a response from the police or ambulance service.

The Independent Review of the Mental Health Act found that a large proportion of first-line responses to people in mental health crisis come from police officers, who were often found to act with kindness and compassion. However, if the police detain a person under section 136, they may be taken to hospital in a police vehicle. The Review heard from many service users how demeaning and distressing this can be. There is clear guidance in the Code of Practice that ambulance vehicles are the preferred method of conveyance and should be made available in a timely manner when it is needed. But given the existing constraints on ambulance services, a timely response is not always possible.

There are a limited number of mental health transport vehicles, which leads to delays in the safe and timely transport of patients between acute and mental health hospital sites. This has been highlighted further during the pandemic with the establishment of many standalone 'mental health A&Es' and new diversion pathways.

Mental health professionals are also needed in ambulance and police control rooms and to be deployed to provide an 'on-the-scene' response. This is part of the commitments in the NHS LTP to be achieved by 2023/24. However, we understand this work has been delayed because of the pandemic, and the complex ambulance commissioning structures appear to be a barrier to implementation. The 999 service also needs to be properly linked with the new crisis lines for every area, allowing 999 call handlers to transfer patient calls to the local crisis line where appropriate. Call handlers on the crisis line also need to be able to access the new mental health transport vehicles.

Liaison mental health services

It is crucial that when people attend A&E, it is equipped to meet their mental as well as physical needs.

Recommendations

- NHSE and ICSs to expedite work already underway to connect Integrated Urgent Care services to 24/7 mental health crisis services in each locality.
- NHSE and ICSs to increase the number of mental health specialists working in the 111 service and ensure call handlers are trained so that they are better able to triage and direct patients to the appropriate 24/7 urgent NHS mental health telephone support services for their area.
- NHSE and ICSs to routinely collect standardised data on mental health-related calls handled by the 111 service, including age and gender, and the outcome.
- NHSE and ICSs to review the implementation of NHS mental health telephone support, advice, and triage services and expedite the further improvements needed identified through this exercise. Any review should consider the extent to which:
    - the service has integrated with Integrated Urgent Care Services and NHS 111 successfully
    - the full crisis pathway has been mapped in each local area
    - the services are providing an age-appropriate response
    - the services are ensuring equity in access to those with mental health needs and co-occurring conditions such as learning disability or autism, and
    - other agencies such as police, ambulance and local authorities can access advice and support.

- NHSE and ICSs to invest in bespoke mental health crisis vehicles to reduce inappropriate ambulance or police conveyance to A&E. This will reduce pressure on ambulance fleets and provide a safe and appropriate alternative to full-size ambulance vehicles.
- NHSE and ICSs to create new joined-up functions between mental health services, ambulance services and other urgent and emergency care services, and significantly expand the education and mental health training of the paramedic and wider ambulance workforce.
- NHSE and ICSs to expedite plans already in place to put mental health professionals in ambulance and police control rooms and to be deployed to provide 'on-the-scene' responses.
- ICSs to work in partnership with young people to design services they find welcoming, non-stigmatising and helpful.
- NHSE to ensure the forthcoming urgent and emergency care strategy includes mental health.
- NHSE and ICSs to ensure that acute hospitals and/or paediatric departments provide access to a Core24 liaison psychiatry service for everyone who needs it. These teams should include psychiatrists with expertise in older adults.
- NHSE and ICSs to ensure that integrated inpatient and outpatient services include liaison psychiatry to meet the needs of patients with more complex problems.
- DHSC to invest capital funding to develop age-appropriate assessment spaces in A&E and acute hospitals for people with mental health/learning disability needs.
- DHSC to ensure that, within the existing Health Infrastructure Plan or where investment is being made for a new or upgraded acute hospital, plans include sufficient space for integrated mental and physical healthcare (liaison mental health services) to be delivered.

Implement the Mental Health Act Reform Bill

In July 2022, the Government published the Draft Mental Health Act Bill which set out proposed changes to reform the Act[231]. The College broadly welcomes the proposed reforms. They provide an opportunity to modernise mental health law, tackle racial disparities, and improve support for people in a mental health crisis. However, the proposed reforms will result in significant changes to the way psychiatrists work and will place more demands on their time.

Key changes include:

- removing Learning Disability and Autism from the civil parts of the Act, retaining them for criminal patients
- placing Care (Education) and Treatment Reviews on a statutory footing and risk register to help manage this transition
- detention criteria amended in the civil parts of the Act so people can only be detained if "serious harm may be caused to the health or safety of the patient or of another person" and secondly that the decision maker must consider "the nature, degree and likelihood of the harm, and how soon it would occur"
- detention criteria amended in both civil and criminal parts of the Act so that treatment provides a therapeutic benefit
- additional safeguards around the administration of urgent electro-convulsive therapy.
- the replacement of Nearest Relative with a Nominated Person
- shortening of periods for automatic referrals to tribunals
- introduction of Conditional Discharge where restricted patients can be subject to conditions when discharged by the Mental Health Tribunal (MHT) or the Secretary of State if they no longer require detention for treatment in hospital, but there are continuing risks that cannot otherwise be safely managed in the community

- introduction of a statutory 28-day time limit within which individuals with a severe mental health need must be transferred from prison to hospital for treatment under the Act.
- changes to Advocacy in England to extend the right to Independent Mental Health Advocate (IMHA) services to voluntary patients in England, which is already the case in Wales.
- extension of MHT's power to recommend to the local social services authority and ICS that they make plans for the provision of after-care services for the patient.
- removal of police stations and prisons as places of safety, and
- advance Choice Documents are to be introduced, but due to legal reasonings in connection to the Mental Capacity Act reforms, they have not been included in the Draft Bill.

Due to workforce shortages and slower than needed increases in particular parts of the psychiatric workforce, many of these changes to the MHA cannot be absorbed within the existing workforce.

In light of these concerns, and to support policy makers prepare for successful implementation of the reforms, the College commissioned The Strategy Unit to provide an independent assessment of the impact of the proposed changes on the psychiatric workforce.

This was with the aim of better understanding how many additional psychiatrists would be required to deliver the reforms in the proposed year of implementation, and 10 years later.

The research found:

- By 2023/24, an additional 333 Full-Time Equivalent psychiatrists will be needed, costing £40m per year by 2023/24.
- By 2033/34, a further 161 Full-Time Equivalent psychiatrists will be needed, costing £60m per year by 2033/34, at current prices (including £40m cited to 2023/24).

These numbers relate only to the impact of the proposed reforms from the White Paper, and the amended draft Bill and different timeframes mean these numbers will differ.

It is imperative that any numbers are interpreted as being in addition to those required to deliver NHS LTP commitments, meet increased demand for mental health services, fill existing vacancies within services, and replace those leaving the profession.

Recommendations

- DHSC, OGDs and NHSE to implement the Mental Health Act Reform Bill, supported by adequate revenue and capital investment, including in workforce training and development.
- DHSC to ensure that investment is accompanied by a workforce plan to ensure the required workforce is in place at the time of implementation. Without requisite investment in the workforce, we would recommend that the timeframes for implementation be revised.
- Invest capital funding to improve digital technology within mental health trusts including the digitisation of the MHA.

Commit to preventing suicide and provide better information and support to those bereaved or affected by suicide

There were 4,912 registrations of people who took their own life in England in 2020, a 7.6% reduction compared to 2019. The standardised rate also declined by 7.4% (from 10.8 to 10.0 per 100,000) in comparison to the previous year. Around three-quarters of all suicides registered in 2020 in England were male.[232]

In 2017, DHSC, Public Health England (PHE) and NHSE asked all local areas to have multi-agency suicide prevention plans in place by 2017, contributing to a 10% reduction in suicide nationally. These plans set out targeted actions in line with the National Suicide Prevention Strategy and new evidence around suicide and include a strong focus on primary care and substance use disorders.

However, even now, there is limited evidence on intervention to reduce national suicide rates, except for reducing access to means of suicide, and the emphasis on this can increases stress and a sense of failure. It is, therefore, essential that we focus on deepening our understanding through research and data collection, trying to get to grips with the nature of suicide, and reducing distress in high-risk groups, including those left behind. Suicide is acting out distress that cannot be put into words.

Our 2020 College report on self-harm and suicide in adults highlights studies that show there seems to be an association between suicidal ideation/action and accessing relevant content online, particularly for young people.[233] There are some suggestions that it may be associated with more violent methods of self-harm.

We know that maternal suicide remains the leading cause of direct deaths occurring within a year after the end of pregnancy[234]. Identification, assessment, and support for mothers' mental health are critically important in preventing suicide. The MBBRACE reports have made important recommendations that can help to reduce maternal suicide.[235]

Recommendations

- NHSE and ICSs to provide better information, resources, and support to those bereaved or affected by suicide as over 20% of the Coroners Preventing Future Deaths reports each year are about poor communication with families.
- All healthcare providers to employ Family Liaison officers (FLO).
- All healthcare providers to have training on working with families (e.g., making families count).
- NHSE and ICSs to support family bereavement services in all areas of the country.
- NHSE and ICSs to ensure that every mental health provider has a pastoral Suicide Lead.
- NHSE and ICSs to ensure that every healthcare provider enables reflective practice for all staff in all health organisations, including specific groups to process the impact of patient suicide.
- NHSE and ICSs to ensure that every healthcare provider provides resources and support for patients bereaved by peer suicide.
- NHSE and ICSs to ensure that every healthcare provider improves learning systems after a death.
- NHSE and ICSs to ensure that healthcare providers move away from Risk Assessment tools, as they are ineffective and not recommended by NICE and the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). As it is not possible to accurately predict the suicide of a given person at a particular point in time, healthcare professionals should offer a compassionate and therapeutic assessment, undertake a personalised risk assessment (to identify risks, not to predict suicide but to intervene), identify needs and collaboratively develop a risk mitigation plan, and coproduce a Safety Plan.
- NHSE and ICSs to prioritise reducing rates of self-harm as a key indicator of suicide risk drawing on the examples of tailored services providing intervention after presentation e.g., ASSIST, Distress Brief Intervention, and brief interventions in repeated self-harm (BIRSH).
- NHSE and ICSs to move away from culture of inclusion and exclusion as many statutory services specifically exclude people from care based on being high-risk or complex.
- NHS providers to develop spaces to reflect on inequality and prejudice that will lead to action.
- Healthcare professionals to be aware of the impact of stigma and negative attitudes that, although often unconscious, are detrimental to patients and their carers.
- NHS providers to support research, data collection and monitoring and ensure real-time data collection is supported by adequate funding for academics to analyse it to gain a greater insight into the aetiological factors of suicide.

- NHSE to extend rapid surveillance data which is gathered about child deaths to move to above 18 years, to capture university students and extend OHID funding to cover all ages.
- OHID and OGDs to reduce access to the means of suicide as a public health intervention.
- The Department for Culture, Media, and Sport (DCMS) to ensure the media maximises its role in prevention by reporting suicide responsibly.
- DHSC and Defra to review and act on the recommendations of the forthcoming report from the EFRA Select Committee inquiry into rural mental health and suicide.
- DHSC to expand suicide training for all frontline staff who look after children and young people, such as teachers and GPs. et
- DHSC and NHSE to expand the Learning Disability Mortality Review (LeDeR) program to include autistic people who do not have a learning disability.
- DHSC and NHSE to support the timely adoption of MBBRACE report recommendations across the country.

8. Cross-cutting enablers

a. Implement the NHS LTP in full by 2028/29 with the restoration of all existing service trajectories

The mental health consequences of COVID-19 are widely acknowledged and reflected in service level data. We are facing not just a backlog of existing patients who did not access care during the peak of the pandemic, but also an increase in the number of patients requiring care. Both groups are now presenting with greater acuity and complexity.

Eating disorder services for children and young people have seen particularly significant rises. Access and waiting time standards for children and young people's eating disorder services state that 95% of children and young people who are referred should receive NICE-approved treatment within 1 week for urgent and 4 weeks for non-urgent cases. There has been a marked decline in performance against this target during the pandemic. In the period between April and June 2021, only 61.0% of urgent cases commenced treatment within one week, compared with 87.8% in the corresponding period in 2020/21 when performance was at its best level to date.[236]

After briefly returning to closer to pre-pandemic levels in January and February of this year, referrals to children and young people's mental health services (0–18-year-olds) have once again seen very significant increases in April (85% up on April 2019), May (99% up on May 2019) and June (102% up on June 2019). Over the last six months of 2020/21, there were 59% more such referrals compared to same period in 2019/20 (332,293 compared to 209,291).[237] Due to the huge rise in referrals, a reduced proportion of children and young people are starting treatment, and more are on waiting lists.

In relation to adult secondary mental health services, 153,000 over-18s are estimated to have missed out on referral to adult secondary mental health treatment in 2020/21 (based on year-on-year trends) without even taking into account the likely increase in need because of the pandemic.

Unmet need in one part of the mental health system is undoubtedly going to put pressure on other areas. In the forthcoming NHS LTP Refresh publication, we would expect to see the majority of access and waiting time trajectories remaining deliverable within the existing timeline. For any targets that are unachievable within the current timeframes, we want to emphasise the importance of ICSs continuing to invest and prioritise mental health spending despite wider system pressures.

Recommendations

- NHSE and DHSC to commit to restoration of services to trajectories as outlined in the NHSE Mental Health Implementation Plan by 2023/24-2024/25.
- NHSE and DHSC to review the continuing demand for mental health services arising from COVID-19 pandemic and allocate sufficient funding for recovery that is equitable to the elective recovery programme.
- NHSE and DHSC to publish interim in-year targets for the NHS LTP mental health programme so the public can see that ICSs are on track to deliver.

b. Ensure ICSs are setup to improve the mental health and wellbeing of their population

From July 2022 ICSs became the new intermediate tier for the health system in England with four broad aims:

- improving the outcomes in population health and health care
- tackling inequalities in outcomes, experiences and accessing services
- enhancing productivity and value for money, and
- helping the NHS support broader social and economic development.

Each ICS includes an Integrated Care Board (ICB), responsible for developing a plan for meeting the health needs of the population. For ICS/ICBs to be truly successful, they need to embrace the key elements of partnership working, including openness and shared goals and values between all parties involved.

Many ICBs are further developing the Mental Health Provider Collaborative model locally, which supports transformation at scale on behalf of the ICB. It is great to see such innovative developments taking place locally, especially the increased focus on Third Sector partners, patients and families and Local Authorities.

ICSs need to drive a coordinated public mental health approach across all parts of the system, many of which incur the costs and consequences of poor mental health, correcting the current tendency to let mental health problems develop before treating them, with the human and financial costs this entails. Part of delivering a public mental health approach will also be making sure that systems understand their place in the wider community. ICSs will exist within a wider and more complicated ecosystem of political, social, and commercial entities. Systems need to understand how they can take their place in the communities they serve, involving partners who may be entirely outside the health system in order to improve their populations' mental health.

The biggest challenge to maximising the role of the health and care workforce in providing integrated care is inadequate workforce supply. While it is welcome that ICBs are being given more responsibility to develop system-wide plans to address current and future workforce supply locally, and to undertake supply/demand planning based on population health needs, ICBs do not have access to the levers that government has and are required to take action to fill staffing gaps, such as increasing training places or changing immigration policies. ICBs alone cannot ensure the delivery of effective national workforce planning.

Furthermore, integration and increased working across boundaries have the potential to impact on workforce supply by increasing career mobility and in theory, could see increased workforce supplies in certain areas of the healthcare system to the detriment of areas already struggling. Integration will, therefore, require action to combat variation in the availability of resources and ensure all local areas have a sufficient workforce to deliver high-quality care. At a regional level, there are differences in the numbers of psychiatrists working at various grades, with some members reporting that in some locations we are already below the number of psychiatrists required to run safe services. While it is positive that the role of workforce planning at ICS and local levels is being strengthened, we consider it imperative to strengthen the role of workforce planning at a national level to tackle historical and persistent speciality and geographical shortages.

In addition to workforce system thinking, clear pathways of care need to be established with a well-defined understanding of who delivers what and how this can be maximised to ensure effective delivery of services and therefore support all, especially people in crisis. The formation of ICS/ ICB allows the pathway to be place-based – i.e., no firm boundaries – and ensures a pathway of care that is meaningful to the local people. For individuals with mental health needs, learning disabilities and

autistic people, this offers an opportunity for care and support to be more joined-up where partnerships between the NHS, Local Authorities, Third Sector and patients and families are strengthened.

Recommendations

- ICSs to have Mental Health reflected as a top priority with the full programme delivery supported and tracked at ICS board level.
- ICSs to have a credible workforce plan to demonstrate how they will be meeting the mental health priorities of the local population.
- ICSs to ensure that senior mental health leadership will be a core component of all place-based planning.
- ICSs to ensure that Integrated Care Strategies drive a coordinated public mental health approach across all parts of the system. Guidance should be clear on how the system itself can be designed to prevent poor mental health and support good mental health.
- ICS leaders to develop a system-wide outcomes framework, including mental health and wellbeing outcomes, which defines the partners' collective ambition for improving outcomes for people living in the area, which should be then used to monitor performance against the outcomes framework annually.
- Mental health leadership at ICS level must always include people who use services.
- ICSs exceeding core expectations should work with those who are struggling through a peer-learning approach.
- NHSE should systematically capture and share learning from areas that are furthest ahead.
- NHSE to review each ICBs five-year systems plan annually to be assured that:
    - it meets the ambition set out by their ICS
    - has a clear plan to improve mental health and wellbeing outcomes in population health and healthcare
    - tackles inequalities in mental health and wellbeing outcomes, experience and access to care and support
    - reflects the national priorities and ambitions of the NHS LTP for Mental Health and the forthcoming cross-government mental health and wellbeing plan
    - sufficiently takes account of how they will commission specialist mental health services previously commissioned by NHSE, and
    - aligns clearly with the national mental health workforce plan and is realistic and deliverable locally.
- NHSE to use the findings from these annual assessments to provide tailored support and guidance to ICBs.

c. Strengthen leadership and increase transparency and accountability

On 1 July, NHSE and NHS Improvement, HEE and NHSD came together as one organisation. This presents an important opportunity to provide joined-up leadership and strategic planning on mental health.

There has not always been sufficient joined-up leadership and governance at a senior level across Government departments and with NHSE. This Plan is an opportunity to further align these processes more strategically, such as better integrating workforce planning and service expansion policies.

For leadership within the NHS services, we are supportive of the seven transformative recommendations set out in the recent publication of the independent review of health and adult social care leadership, led by General Sir Gordon Messenger and Dame Linda Pollard.[238] The

recommendations seek to ensure services can deliver the best possible care, tackle the COVID-19 backlog and address the disparities the pandemic has exposed across the country.

Recommendations

Leadership and oversight

- The Cabinet Office to establish a Mental Health Cabinet Committee to ensure collective responsibility for improving the mental health and wellbeing of the nation.
- The Cabinet Office to ensure that the Mental Health Policy Tool is implemented by all departments, and utilised and completed in a transparent way for all policy development. This tool has been developed to assist government departments with considering mental health in their policy development. This has been in development for some time, with colleagues from across government and stakeholders working together.
- NHSE to provide the requisite funding, support and resourcing so NHS providers can deliver on the recommendations from the NHS Leadership review by General Sir Gordon Messenger in full, including;
    - targeted interventions on collaborative leadership and organisational values
    - positive equality, diversity and inclusion (EDI) action
    - consistent management standards delivered through accredited training
    - a simplified, standard appraisal system for the NHS
    - a new career and talent management function for managers
    - effective recruitment and development of non-executive directors (NEDs), and
    - encouraging top talent into challenged parts of the system.
- Every local authority should appoint a 'member champion' for mental health as part of the Mental Health Challenge for Local Authorities in order to lead the way in their local areas.

Transparency

- NHSE to commit to publishing the Mental Health Dashboard every quarter and include trust-level data and workforce data to create a more comprehensive picture of opportunities and challenges at the commissioner, provider and ICS levels.
- NHSE to make routine data available so that there is transparency about how local areas commission services that account for age, gender, ethnicity, disability and sexuality.

Accountability

- DHSC to publish an annual report on the implementation of the NHS LTP and this cross-government mental health and wellbeing plan.
- Secretary of State for Health and Social Care to report:
    - whether there will be an increase in the amount of spending from NHSE and ICBs on mental health and if there will be an increase in the proportion of spending on mental health spending compared with total expenditure in the previous year
    - how much is being spent on mental health (in total and as a proportion of overall healthcare spending) in the current year by NHS and ICBs and as a proportion of total spending, and
    - how much each ICB has spent on mental health for the year and the proportion of its total spending it represents.

d. Increase funding for NHS mental health services

The NHS LTP included a commitment that mental health services would grow faster than the overall NHS budget – with a ring-fenced increase in investment worth at least £2.3bn a year by 2023/24.[239] Prior to the pandemic, an ambitious programme of work had got underway to improve and transform mental health services in England. While there was a long way to go to achieve parity of esteem

between mental health, learning disability and autism services and physical health services, investment had started to make a tangible difference.

The Government committed £500m in March 2021, as part of the Mental Health Recovery Action Plan. This provided an injection of emergency funding across a wide range of services and programme areas. This additional funding was critical and widely welcomed. Spending per head for 2020/21 in England was also 6.7% higher than the previous year, averaging £202.21.[240]

We need to ensure that programmes and services meet demand across the system, quickly and effectively supporting those with mild to moderate mental illness and preventing people from reaching crisis.

Recommendations

- DHSC and NHSE to ensure a long-term commitment to the Mental Health Investment Standard (MHIS) beyond 2024/25 for NHS-funded mental health services. The MHIS should be strengthened along the lines suggested by NHSE prior to the pandemic to include the following elements:
    - ICBs must increase investment by at least their overall allocation growth plus a further 'percentage increment to reflect…additional funding included in... allocations'
    - the shares of this resource spent with mental health providers and invested in children's and young people's mental health services specifically must increase, and
    - ICB investment plans should be subject to local review at the system level, including by a nominated lead provider of mental health services. This should ensure the plans are 'credible' to deliver the necessary workforce and activity commitments.
- NHSE and DHSC to strengthen the way the MHIS operates (as set out by the HFMA)[241] by;
    - allowing systems to agree on the assessment of investment over a longer period of time to enable ICSs to invest where needed without being penalised for improving mental health services more quickly
    - ensuring additional non-recurrent mental health spending due to COVID-19 is excluded when assessing baseline expenditure
    - ensuring the achievement of the MHIS is assessed at system-level with ICB and ICP sign off
    - ensuring quality and outcome measures are included in the assessment of the MHIS
    - revising MHIS categories so that they are consistent with the NHS LTP, and
    - ensuring the primary measure of the MHIS excludes continuing healthcare/packages of care and prescribing.
- NHSE to ensure the additional £1.5bn allocated to deal with the rising costs of energy and fuel, as well as wider inflation, is fairly apportioned to mental health trusts. We know that around £350m more investment is now needed by 2023/24 to fulfil the NHS LTP commitments because of the impact of inflation, using the latest GDP deflators.[242]
- NHSE to update the NHS Mental Health dashboard based on the recent recategorisation exercise to allow for trend analysis.

e. Invest in the NHS mental health estate

When the NHS was founded in 1948 its estate was made up of around 3,000 hospitals, many of which required urgent improvement and reorganisation. After just two major injections of capital funding in the 1960s and 2000s, the Naylor Review in 2017 sought to identify opportunities to rebuild NHS infrastructure to meet modern standards of service delivery fit for the future. The Review concluded that without investment in the NHS estate, the Five Year Forward View could not be delivered, and the estate would remain unfit for purpose and continue to deteriorate.[243]

Across the 50 NHS mental health trusts in England, much of the estate still meets that description, posing serious challenges to those who receive treatment and care and to those who work in those facilities.[244] These challenges are not merely confined to those around health and safety, but also relate to the estate being therapeutically poor in many areas and adversely impacting upon the wellbeing of the workforce.

Similarly, the way mental health care is provided in acute hospitals can put people at risk of poorer mental health outcomes. Developing more delirium and dementia-friendly environments in acute hospitals will reduce the risk of developing delirium, a medical emergency that itself is a risk factor for the development of dementia – a condition that carries a huge individual and carer mental health burden and has wide-ranging social and economic implications.[245]

The Health Infrastructure Plan (HIP) is a five-year rolling programme of investment in NHS infrastructure taking a strategic approach to improve hospitals, primary and community care estates and health infrastructure, with waves of investment in new infrastructure initiatives.[246] The programme is supported by the Government's new national construction framework, ProCure 2020, which is working with new hospital building projects up until 2030.[247]

We understand the existing HIP capital projects were selected by looking at priorities within ICSs; looking at those parts of the estate which are the oldest and most operational issues; and those that were most advanced in the scoping and planning process. A mere two of the 40 schemes confirmed in October 2020 were for mental health trusts.[248] There were 205 other proposals across Sustainability and Transformation Partnerships (STPs) outside of HIP1 (2020-2025) and HIP2 (2025-2030), but between July 2017 and June 2020, just 11 mental health trusts received STP full business case approval for 16 infrastructure projects, totalling £68.6m Public Dividend Capital allocations. [249] The ongoing next phase of HIP33, inviting trusts to compete for investment in a further eight projects, must therefore afford sufficient priority to mental health facilities. We have made the case previously for a Mental Health Infrastructure Plan that would ultimately fund 12 hospitals/schemes over the period to 2030. [250]

However, a recent survey by NHS Providers found that half of the members part of the new building programme are not confident the funding they have been allocated will be sufficient to deliver the project. Almost two in five hospitals (39%) have their completion date behind schedule and from these, 62% said the delays affected their trust's ability to deliver safe and effective patient care and one third said it affected it to a great extent. Almost all (96%) trusts strongly agreed or agreed that, if appropriately funded, their scheme will improve patient-centred care and experience, improve clinical outcomes, and enable them to increase productivity.

Furthermore, almost all (96%) trusts strongly agreed or agreed that the government should confirm the funding envelope for the New Hospital Programme beyond the current spending review period (2022/23-2024/25).

Recommendations

- At the next CSR, HM Treasury, DHSC and NHSE to provide ring-fenced investment for mental health NHS trusts as part of a multi-year capital settlement. This additional capital funding uplift should be in addition to trusts' day-to-day capital budgets and should include:
    - a new Health Infrastructure Plan (HIP) for Mental Health. Within this,
        - commit to a new £1bn building and redevelopment programme for Mental Health to enable 12 major building and redevelopment schemes to be awarded to mental health NHS trusts by 2030.
        - improve the therapeutic environment of mental health and learning disability/autism inpatient settings by:

        - eliminating mixed sex accommodation
        - procuring en-suite facilities for all existing single rooms
        - minimising the risks of harm through innovative safety improvement projects, and making the estate more suitable for people with disabilities
        - reaffirm the commitment to complete the elimination of dormitory provision and replace with single en-suite rooms
        - invest in new building and redevelopment schemes for community mental health facilities, including clinical and office space, and the essential improvements to digital infrastructure, and
        - new building and redevelopment schemes for crisis mental health facilities, including the procurement of sufficient mental health ambulances/ transport vehicles; creating age-appropriate mental health assessment spaces in A&Es (or alternative) and acute hospitals; and procuring age-appropriate alternative forms of mental health crisis provision.
    - eradicate significant and moderate risk maintenance backlog in mental health and learning disability sites/estates.
- DHSC to allow mental health trusts to spend their planned capital budgets in full each year given the historic underinvestment. This should enable trusts to address ongoing backlog maintenance issues, maintain safe services and minimise risks across their estate.
- Within the existing HIP programme or where investment is being made for a new or upgraded acute hospital, DHSC, NHSE and local leaders to review whether plans include sufficient space for integrated mental health and physical healthcare (liaison mental health services) to be delivered. This needs to be built into service design from the outset.

f. Ensure public mental health budgets have a growing share of public health spending

A successful future for public health will require improved and sustained investment. A commitment to a national plan for public mental health must be supported by guaranteed funding that matches the rate of budget increase of the NHS, with a proportion earmarked for public mental health. At a local level, the Public Health Grant to local authorities is vital for achieving good mental health, but without adequate funding, local authorities are being held back from fulfilling their potential to protect the public's mental health.

In February 2022, it was confirmed that the Public Health Grant for 2022/23 would increase by only £93m in cash terms compared to the previous year.[251] For public mental health funding specifically, local authorities have only been required to report public mental health expenditure since the 2016/17 financial year. The situation has been improving since reporting commenced when looking at the outturn total expenditure, with the amount increasing by 50.8% after adjusting for inflation (2021/22 prices) between 2016/17 (£50.063m) and 2018/19 (£75.499m) and then continuing to rise by 2020/21 (£80.689m, 61.2% up on 2016/17).

There are however concerns about subsequent planned net current expenditure figures, which at £69.271m in 2021/22 after adjusting for inflation would be 1.1% below the investment in 2018/19 (£70.050m) if realised in the final figures. As a percentage of the public health expenditure overall, the percentage of total expenditure has peaked at 2.1% in 2019/20 or 2.0% in terms of net current expenditure in 2019/20 and again in the planned spending in 2021/22 (after COVID-related expenditure is excluded for purposes of direct comparison).[252]

Recommendations

- At the next Comprehensive Spending Review (CSR), HM Treasury and DHSC to commit to increase the Public Health Grant budget as part of a multi-year settlement, which will ensure local authorities can continue to provide prevention and public health interventions.
- Local authorities to ring-fence at least 4% of total public health expenditure for public mental health spending as the start of sustained and growing investment in this area. This funding should be linked to the JSNA for each locality and relevant local strategies. It should also align with the growth in the public mental health workforce and those within voluntary, community and social enterprise organisations.

g. Increase funding for drug and alcohol use disorder service

The latest Adult Psychiatric Morbidity Survey (APMS) confirmed that 16.6% of adults drank at hazardous levels (AUDIT scores of 8 to 15), 1.9% were harmful or mildly dependent drinkers (AUDIT scores of 16 to 19) and 1.2% were probably dependent drinkers (AUDIT scores of 20 or more). As in previous years, men were more likely than women to drink at hazardous levels and above. Most adults drank at lower risk levels (57.5%) or did not drink at all (22.8%).[253]

The survey also identified that 3.1% of adults showed signs of dependence on drugs, including 2.3% who showed signs of dependence on cannabis only and 0.8% with signs of dependence on other drugs (with or without cannabis dependence as well). After increases in the 1990s, the overall rate has remained stable since 2000.[254]

The recently published Dame Carol Black independent review of drugs: phase two report sets out a way forward for drug treatment and recovery, providing 32 recommendations. The report starkly makes the case that the "Government faces an unavoidable choice: invest in tackling the problem or keep paying for the consequences."[255] We welcomed this report and its call to increase investment in addiction services by an additional £552m ringfenced funding per year, to begin to undo the decade of cuts, to enable local communities to improve the quality and access to addiction treatment and support. The College welcomed the action to support the treatment of addiction as a long-term illness in the government's ten-year drug strategy, as well as the additional £780m investment which will help significantly expand access and strengthen drug treatment services which have experienced years of cuts.

Also, it is important to note the decline in specialist clinicians leading addictions services. The College's 2020 addictions workforce report found a 58% fall in the number of higher trainee places, with five regions in England having no opportunities for such training to drive up the quality of treatment offered, as well as train the wider health and social workforce to ensure people with addictions are offered the help they need.[256] Fewer trainees now will result in fewer specialists in the future. Unless urgent action is taken, addiction psychiatry is at a very real risk of being wiped out in a decade.

Action is required to improve the provision of physical healthcare to people with drug dependence, including better training of the workforce to respond to co-existing problems.[257] Another barrier within this area is the location of substance misuse services outside of the NHS, which leads to detachment from NHS professional training and development structures. If the future sees more psychiatrists based in VCSE organisations due to integrated working, it will be important to provide training posts for trainees within those settings to ensure a sustainable pipeline for the future.

Recommendations

- DHSC and MoJ to commit the investment advocated by Dame Carol Black in her recent independent report on drugs to restore funding for substance use disorders to a comparable share of public health spending to that of 2013/14.
- DHSC and DLUHC to review the commissioning of addiction services, including potential service models, in light of the independent review of drugs by Dame Carol Black. The College endorses Dame Carol's call to improve commissioning standards and move towards integrated commissioning.
- DHSC to prioritise rebuilding the workforce as set out in the government's 10-year drug strategy.

h. Increase funding for mental health social care

Like many health services, mental health is intrinsically linked to social care. It is an essential element of support, helping recovery and independence and preventing costly crises.

In September 2021, the Government announced a reform of social care, based on recommendations put forward by the Dilnot Commission in 2011.[258] The reform – and accompanying funding package - introduces a cap on total lifetime care costs from 2023, and an increased asset threshold for help with the costs of care. It will apply to people of all ages, including those living with severe mental illness.

However, some of the problems with the current social care system remain.

Without investment in mental health social care services, estimated at £1.1bn per annum by 2030/31[259], significant pressure will continue to be placed on NHS services, and delivery of some of the Community Mental Health Framework (CMHF) could be jeopardised.

Increase spending on mental health support for adults (18-64)

The reporting of expenditure on social care services fundamentally changed from 2014/15 onwards so previous data is not comparable (total expenditure by local authorities on 'adults aged under 65 with mental health needs' amounted to £1,336m in 2013/14).

Across the period of available data, the total expenditure peaked in real terms in 2020/21 (the most recent available year, £1,086,262m) and was 19.3% up on six years earlier after adjusting for inflation (£910.474m). Planned net current expenditure in 2021/22 (£866.217m) was 16.4% above the level of seven years earlier (£727.003m) in real terms after a period of relatively flat funding between 2014/15 and 2017/18 inclusive, however the net current expenditure in 2020/21 was also lower than the previous year after adjusting for inflation.[260] .

Both increases are above the real terms increases for adult social care funding overall across the same period – 17.8% for total expenditure between 2014/15 and 2020/21 and 11.7% for net current expenditure between 2014/15 and 2021/22.

Increase spending on mental health support for older adults (65+)

Across the period of available data, total expenditure peaked in real terms in 2019/20 (£731.203m), however in 2020/21 the total expenditure in real terms (£677.699m) was lower in each of the previous three years. While planned net current expenditure in 2021/22 (£489.418m) is 4.1% above the level of spend for 2020/21 after inflation, it should also be noted that the latest amount is also equivalent to a real terms cut of 3.8% on 2019/20 (£508.659m).

Increase spending on mental health support for children and young people

The disinvestment in local authority funded services has led to closures of Sure Start centres, and a lack of support for children and young people with a neuro-disability, which ultimately results in more children and young people presenting to NHS mental health services in crisis. There is also a

clear issue with transitions for looked after children as they turn 18 and subsequently lose support. All of these issues contribute to poor mental and physical health.

Spending on Sure Start and early years services has only been reported by the DLUHC and its forerunner departments since 2014/15. Total expenditure has fallen by 43.8% between 2014/15 (£830.428m) and 2020/21 (£466.623m) after adjusting for inflation. Alternatively, if looking at net current expenditure, the decline in real terms has been 47.2% between 2014/15 (£732.943m) and the planned amount for 2021/22 (£387.014m).

This means the share of children's social care expenditure devoted to these services has declined from 7.9% in 2014/15 to 3.7% in 2021/22 on the current planned net current expenditure. It would require spending to rise by around £430m in current prices to restore investment to that previous share.

Increase funding for social care to support the first 1001 days of life

The first 1001 days of life – from conception to age two, are critical for a child's future cognitive and emotional development. Moreover, while over £3bn has been spent on mitigating the impact of the pandemic on older children, nothing has been spent on mitigating impacts on under 2s, despite the considerable potential for preventive interventions that dramatically improve outcomes and reduce pressure on health and social care services in the long term.

Recommendations

- At the next CSR, HM Treasury, DLUHC and DHSC to commit to increase the social care budget for babies, children, young people and adults. Specifically, within a funding uplift, local authorities should commit to ring-fence funding devoted to early years, aiming to get it back to at least around 8% of the children's social care expenditure.

i. Invest in digital technology

Investment in technology can improve care, increase productivity, and release staff time. The COVID-19 pandemic rapidly accelerated the use of technology in healthcare provision, with remote working and consultations becoming increasingly widespread across mental health services. The 2020 Spending Review committed £559m to support the modernisation of technology across the health and care system.

As we emerge from the pandemic, and look to the next decade, action will be needed to evaluate and embed progress to date. Further investment will also be needed to maintain progress and address ongoing issues that affect patient care, such as issues with IT system interoperability.

Electronic patient records and interoperability

Mental health services have been at the forefront of using electronic patient record (EPR) systems for many years. However, the potential benefits of modern software, apps and clinical informatics are not being realised. Currently available EPRs make recording overly time-consuming and difficult to use, with patients' stories and important clinical information often unrecognisably fragmented across multiple fields. Moreover, there is a need for greater interoperability between different recording systems. At present, if a patient moves residence to another (ICS) area or is transferred from a mental health trust to an acute trust, there is generally no direct transfer of patient records – with obvious implications for interruptions in their care.

The programme to introduce shared care records across the country has not met the goal of universal coverage by October 2021 but has galvanised the plans of most areas to deliver widespread coverage. Mental health, learning disability and autism services are at risk of being marginalised,

especially where there are multiple smaller providers, or non-NHS providers (e.g., drug and alcohol services).

Furthermore, interoperability must be achieved if the proposed Mental Health Act reforms are to be realised. At present most Mental Health Act related activity is still carried out using paper-based systems, including forms for assessment, medication or leave. This means that information is often incomplete or inaccessible to patients and staff, so there is a greater risk of mistakes being made because of human error, and patients and carers are provided with less information. The Independent Review of the Mental Health Act found that digital enablers could provide patients with a modern and consistent way to access information about the Act, their rights, safeguards, and treatment processes[261].

There is also an important opportunity to improve patient centred care/empower patients through improving patient access to their records, where appropriate. At present, patients are put at a disadvantage by current outdated record systems which constrain their access to their own records, thereby hampering their ability to contribute to their care and care planning. This is despite mental health services being at the forefront of shared decision-making.

Clinical information systems

Clinical information systems are also inadequate for clinicians' needs, resulting in considerable time in entering information and limited ability to extract the relevant information needed to monitor and manage the quality of care. Dashboards that provide clinicians with benchmarkable information about their caseload would be invaluable. Clinical interpretation of data not only benefits patients, but also enables clinicians to benchmark against their peers which helps to drive up quality. Yet, there is a lack of access for mental health services to other services' information systems, preventing access to needed information such as CT scan imaging to clarify diagnoses.

Clinical administrative work has become a significant burden and focus for all mental health staff which significantly and negatively impacts on clinical quality, safety, and productivity. This has been recognised by the CQC and Lord Carter's review into mental health productivity, which shows that community clinicians are spending over 33% of their time on documentation and reporting, more than face-to-face patient care[262]. The potential for modern software to support reliable care pathway management, evidence-based interventions, outcome measurement and clinical interpretation of data to benefit patients and populations is not being realised.

Against this context, the What Good Looks Like programme of work, which will see Trusts and other NHS Organisations assessed against guidance to identify gaps and prioritise areas for investment and improvement, is promising.[263] In addition to considering technology, this will look at the culture, the people, the skills, and the processes that are required to support good digital and data transformation. The accompanying programme of work from 2021 to 2023 and onwards aims to fix many of the problems outlined above. This must be sufficiently funded and have the oversight and governance procedures needed to achieve its ambitions.

Ensuring services have the digital capabilities they need to optimise care

In 2021, NHSX launched a new digital playbook on mental health to help clinical teams reimagine and redesign how patients receive care[264]. It is one of a set of playbooks that look at how technology is being used to solve common challenges in delivering care across the NHS, ensuring that patients can benefit from the latest digital developments in their treatment. The playbook incorporates: the role and benefits of digital technology in delivering better mental health pathways; experiences of those who have implemented digital into mental health services and the successes and challenges, and links to the wide range of trusted digital tools available to clinicians.

The playbooks aim to support the NHS's commitment, set out in the NHS LTP, to reduce face-to-face outpatient appointments by up to a third over the next five years and make digitally enabled primary and outpatient care mainstream across the NHS.

Another area of innovation has been the Global Digital Exemplars (GDE) programme which included seven digitally advanced mental health trusts delivering exceptional care efficiently, using world-class digital technology and information, being supported to become GDEs[265].

The Digital Aspirant programme is targeted at supporting those providers outside the GDE network to get the core digital capabilities they need to deliver safe, high-quality, and efficient care, providing substantial funding for full participants, and seed funding for others[266]. 23 trusts were selected in the first wave of the Digital Aspirant programme, with £28 million of funding for their first year. In March 2021 an additional 32 trusts joined the programme. Seven of these will also receive up to £6m over the next three years, while the remaining 25 are receiving funding of just £250,000 to develop their digital strategy and business case.

Eight Mental Health Trusts were selected as Digital Aspirants, out of a total of 59 chosen to participate. Mental Health Trusts therefore make up just 13.5% of participating trusts, whereas they make up 23% of all Trusts (50 Mental Health Trusts out of 213 acute non-specialist, acute specialist, community, and ambulance Trusts). Mental Health Trusts are, therefore, underrepresented in the Digital Aspirant Programme. Blueprints have subsequently been developed to help other NHS Trusts deliver digital capabilities more quickly and cost effectively than was possible in the past.

The Innovation and Technology Payment (ITP) programme supports the NHS to adopt innovations by removing some of the financial and procurement barriers to introducing new technologies[267]. It is a competitive process for innovations and technologies that have already proved their clinical effectiveness and are ready to be rolled out nationally. Amongst the theme's receiving support is one on mental health: Digital apps to support emergency/crisis mental health assessments, receiving funding via the Evidence Generation Fund.

A new Mental Health Innovation Fund

Alongside the established national programmes to encourage and enhance digital provision of mental health services, the College is advocating for the establishment of a Mental Health Innovation Fund that would enable industrial innovators to work with NHS clinicians on the development and implementation of a diverse range of solutions. It is envisioned that funds would be allocated on a competitive basis in two phases for each project, with the initial phase facilitating research and assessment of technical feasibility and further funding then awarded for a smaller number of innovators in the second phase to develop and evaluate prototype solutions with their NHS partners. Successful initiatives would be made freely available to the NHS with the successful innovators then allowed to sell their developed solutions to other healthcare systems. On the basis of each competitive process costing around £400,000 (with an assumption that 5-7 bids would be successful for the initial £10,000 funding in the first phase and then two would proceed to receive around £150-175,000 in the second phase), an annual fund of £12m would enable around 30 competitions to take place each year.

Digital literacy and exclusion

Growing digital literacy among patients and digital capability in services has enabled more routine use of remote consultation – a new way for patients to engage with services and speak to clinicians. Remote consultations can involve the use of internet video platforms as a tool to undertake psychiatric interviews or follow-up interviews, audio consultations over the internet, or telephone consultations. This trend was significantly accelerated during the pandemic. While digital consultations can improve the accessibility of care for those with mobility/transport difficulties or practical concerns, they can also help to reduce costs. However, remote consultations should be an adjunct to, rather than a substitution for, face-to-face consultation and patients should always have the choice of a face-to-face

consultation. Both the therapeutic relationship and clinical appropriateness mean that digital appointments are sometimes inappropriate and should not be the only option available to access care.

It is also important to acknowledge the significant risk of digital exclusion among patients, and how technology is not always accessible to all or designed with the users at its centre. It is important that people with dementia, people who lack digital literacy or find technology challenging, people who have cognitive impairment, people with an intellectual disability and people who do not have access to digital platforms are not disadvantaged. This should be reflected in the training curriculum, with part of the research funding advocated for in this submission also potentially utilised to evaluate patient experience of digital consultations among these patient groups in particular.

Similarly, we need to provide clear information on data use and assurances, without jargon to help people understand GDPR and what this means for them personally.

Recommendations

- NHSE to develop a 10-year data plan for mental health, including how data will be used to promote patient choice, efficiency, access and quality in DHSC mental health care, as well as ensuring that all NHS-commissioned mental health data are transparent (including where data quality is poor/in early stages of development or collection) to drive improvements in services.
- DHSC to set up a new Mental Health Innovation Fund.
- NHSE to develop a strategic delivery plan for how digital can support the enhanced delivery of mental health services and care for the benefit of patients and staff.
- NHSE to strengthen the commitment to deliver shared-care records and the programmes to achieve this funded, especially in rural areas without a large tertiary centre or urban council that can fund these programmes at risk.
- NHSE to invest in greater digital technology to improve the efficiency of collecting outcome measures and empower patients to play a role in their own care.
- NHSE to encourage greater working between digital suppliers and clinicians to help improve the interface between outcome measures and EPRs.
- NHSE to provide clear information for patients on data use and assurances, without jargon to help people understand GDPR and what this means for them personally.
- NHSE to co-create digital inclusion strategies with charities such as Citizens online.

j. Increase funding for research

Mental illness accounts for 23% of the global burden of disease in the UK, but for many years, received only 6.1% of the UK's health research budget. Over the past few years, funding has been increasing. NIHR funding for mental health research was £109.5m in 2020/21[268] compared to £80.3m[269] in 2017/18 but this historic underinvestment requires continued focus.

Spending on research on children and young people and intellectual disabilities is particularly constrained. Similarly, a lack of clinical drug testing involving older people results in excessive prescribing of off-licence medication.

A clinical research culture improves patient outcomes, workforce satisfaction and retention alongside a significant contribution to the UK economy. To ensure research influences policy and clinical practice at the earliest opportunity, researchers need easier access to existing datasets. For example, there was a long delay in transferring the latest Adult Psychiatric Morbidity Survey (APMS) data to the UK data archive, and there is a risk-averse process in place for allowing researchers to access it. This means researchers devote much of their funding to accessing the data rather than on actual research. Moreover, it is time for parity in research opportunities for all trusts, to enable the NHS to be a leading research sponsor.

Clinical academic psychiatrists, who typically work across both NHS clinical settings and universities medical schools or Higher Education Institutions (HEIs), are essential for leading research and development within clinical services. As leading educators, they are central to the development and delivery of education and clinical training of mental health workforce and inspiring the next generation of doctors specialising in psychiatry. However, academic departments are shrinking and there was a 21.7% decline in number of clinical academic psychiatrists between 2007-2016[270]. Trusts need to actively support academia with time in job plans and research and development infrastructure, otherwise clinical research will disappear and there will be no senior researchers to develop the next generation. There also needs to be greater diversity in academia as it is understood that approximately 80% of European graduates are female but only 20% are professors.

Without addressing this situation, improvements and innovations in NHS healthcare will stagnate and fall behind. Patients will not have access to the best care possible through a motivated and up-skilled workforce. The urgent need to correct disparity in mental health research investments need to be supported by proportionate investment into clinical academic careers and posts.

Recommendations

- DHSC to increase the funding for mental health research to 15% of the total UK health research budget by 2030.
- Working alongside funders, academics, clinicians and people with lived experience, DHSC to meet the Mental Health Research Goals collectively developed by the sector by 2030. This includes:
    - research to half the number of children and young people experiencing persistent mental health problems by;
        - increasing knowledge of the aetiology, development (including risk and protective factors) and progression of mental health problems at key transition points across the life-course
        - increasing research on effective mental health promotion, prevention, treatment and support in children and young people in education, community and health, including specialist mental health, settings, and;
        - increasing research on the implementation of effective interventions in a range of settings to optimise outcomes. This includes research on service delivery and organisational factors influencing outcomes.
    - research to improve understanding of the links between physical and mental health, and eliminate the mortality gap by;
        - strengthening our understanding of the co-morbidity of both mental and physical health problems. This research should address clusters of health problems, underlying mechanisms and progression, and societal and individual risk and protective factors and in addition, the implications for treatment and support.
        - conducting research to improve the efficacy and effectiveness of interventions for prevention and increase maintenance of good physical health for people with mental health problems, or at risk of developing mental health problems. The aim is to reduce morbidity and excess mortality.
    - research to develop new and improved treatments, interventions and support for mental health problems by;
        - conducting research to investigate the mechanisms underlying mental wellbeing, mental health problems and related behaviours through use of markers from basic biological, psychological and social science to understand how to improve treatments, interventions and support.

        - developing and implementing new and improved treatments, interventions and support, including medical, social and psychological approaches to increase patient choice and greater personalisation.
        - developing and evaluating the effectiveness of digital interventions that complement and supplement face to face interventions for prevention, support and recovery.
    - research to improve choice of, and access to, mental health care, treatment and support in hospital and community settings by;
        - conducting research to understand the barriers to help-seeking and service access, and the delivery of mental health services and other support in diverse settings and across different communities, including Black, Asian and minority ethnic group and those from LGBTQIA+, to address stigma, discrimination, and social exclusion
        - Conducting research to accelerate the implementation of existing best evidence at the population and individual level. In addition, implement evidence on how patient choice and joint decision-making make a difference to outcomes in routine care and,
        - increasing research to inform strategies for tackling social and health inequalities to improve public mental health.
- DHSC to fund large-scale epidemiological studies on autism prevalence, prevalence of co-occurring mental health disorders, and service use needs, in order to be more precise and more informative to policy development.
- DHSC to fund research into the most effective treatments for co-occurring mental health conditions in autism (both pharmacological and non-pharmacological)
- DHSC to allocate capital funding to mental health trusts for Research & Development in Mental Health and Dementia, including: the prevention agenda, research to improve the productivity and effectiveness of the NHS, and the translation of basic science and support for the life sciences industry.
- DHSC to continue to commission regular prevalence surveys for adults and for children and young people.
- DHSC to fund a follow-up survey to track the outcomes of the care received by the children and young people in the prevalence survey who have given informed consent. This will allow researchers to align findings and track data against better-developed indicators helping the Government better plan for the next ten years. It would also provide necessary information about what happens to children and young people over time.
- DHSC to ensure that eating disorders are recognised within both prevalence surveys, after being excluded from the previous iterations of the APMS.
- DHSC and other partners to reverse the decline in academic psychiatry posts.
- Every medical school will have an academic department of psychiatry, with psychiatry being taught effectively to all medical students.
- DHSC to liaise with other interested parties such as RCPsych, the Academy of Medical Royal Colleges, the Academy of Medical Sciences and other relevant stakeholders, to provide required funding and support to develop the careers of academic psychiatrists.
- DHSC to address significant barriers in clinical academic career pathways in mental health research, and to provide greater support for post-doctoral research fellowships, the transition to academic clinical lecturer and establishment at senior lecturer level.

k. Build a strong and resilient mental health workforce

A new 10-year national mental health plan needs to recognise the increased prevalence of mental illness. With challenges meeting existing demand and an already unacceptable treatment gap – two-thirds of

people who would benefit from evidence-based treatment do not receive it[271] – there is a pressing case to address the demand and supply issues within the mental health workforce to meet increased future demand, particularly due to COVID-19.

In the mental health sector, recruiting enough skilled staff to meet the needs of patients was already an urgent and substantial challenge before the pandemic. Papers from NHSE and Improvement's November board meeting described workforce as '*the single biggest risk and opportunity for the Mental Health Programme'*, with workforce expansion *'critical to delivering the NHS LTP and coping with additional post-pandemic pressures'.*[272]

There have been several plans to try to remedy the workforce challenges surrounding the Five Year Forward View for Mental Health (for the period ending 2020/21) and NHS LTP, but workforce remains widely recognised as one of the biggest challenges to their delivery.

While there has been welcome growth in the mental health workforce overall, this has not been sufficient in the areas in which it is most needed. For example, Stepping Forward to 2020/21 set the intention to add 570 consultants and 8,100 nurses to the mental health workforce. Since March 2017 (the government's baseline date), data from January 2022[273] shows only 212 (37.2%) consultants and 3,221 (39.8%) mental health nurses have been added to the workforce. When considering both sets of targets outlined in *Stepping Forward*[274] and the *NHS Mental Health Implementation Plan*[275] for the NHS LTP, data from January 2022 shows that the system is around 500 consultant psychiatrists behind the target for 2021/22, and, therefore, on course to miss the target by 2023/24.

A shortage of substantive psychiatrists has an impact on the continuity of care and stability of services and ultimately increases reliance on locums. While some locums may be every bit as invested in improving local services, others may have chosen not to commit to a single employer and may be more transient, less experienced and if employed via a locum agency, usually more expensive. While expenditure on locums is inevitable during transitions and to cover planned and unplanned absences, the locum psychiatric consultant workforce in England is at its highest reported level of 768 (15.1%), compared to 686 in 2019 and 536 in 2017[276]. This represents a 43.3% increase since 2017. According to the NHS Benchmarking Network, mental health trusts across the UK spent an average of £8.1 million on bank and agency staff for adult inpatient services and £3.5 million for adult community services in 2020/21.

The RCPsych 2021 Workforce Census shows increasing numbers of vacant or unfilled consultant posts. Vacant posts reference an unmet need, where work is likely reallocated within a medical team, potentially leading to burnout and low morale or gaps in service provision. Since 2017, there has been a 30.1% increase in the number of vacant or unfilled consultant posts in England[277]. The specialities with the highest number of vacancies were child and adolescent psychiatry, eating disorder psychiatry and addiction psychiatry. There are also certain geographical areas across England that face persistent challenges around workforce numbers.

The RCPsych 2021 Workforce Census also shows a 49.6% increase in consultant retirements since 2017[278]. As of April 2022, there were 2,924 (37.4%) registered psychiatrists with a licence aged 55 and over working for the NHS in England[279]. Issues impacting on workforce retention need to be addressed for new supply to have an impact. This includes improving the retire and return offer.

Mental health services have been under intense pressure for many years, and it only stands to get worse as the full impact of the pandemic is beginning to be seen in services. The CQC's annual report, Monitoring the Mental Health Act in 2020/21, notes that '*staff are now exhausted, with high levels of anxiety, stress and burnout, and the workforce is experiencing high levels of vacancies'.* The report goes on to add that '*working under this sustained pressure poses a challenge to the safe, effective and caring management of inpatient services and to the delivery of care in a way that maintains people's human rights'.*[280]

Responding to people who need care and support due to the pandemic will lead to increased demand for more staff working in the mental health workforce, new skills to support the wider workforce to identify and support people with mental health conditions, new roles to enable psychiatrists to work to the top of their skill set to see the most complex patients, and new ways of working to ensure psychiatric input is embedded within Long-covid services.

Workforce expansion

It will also be critical to build a sustainable pipeline for the future. As of June 2022, 47.62% of psychiatrists on the medical register in England had qualified abroad.[281] Recruiting from overseas is crucial for fulfilling workforce commitments required in the NHS LTP. Indeed, overseas doctors have long had crucial roles in delivering excellent patient care and we need to continue to support international medical graduates more than ever. However, it would be both unsustainable and unethical to over-rely on international recruitment to get the workforce that we need. We must train more doctors here in the UK. Since 2018 the government has funded an additional 1,500 medical training places per year. This was a welcome step to increase the number of home-grown doctors and increase supply over the long-term, however it did not go far enough to put long-term workforce planning on a sustainable footing. COVID-19 has created an unforeseen growth in medical school places because of an unexpectedly high number of students qualifying for an offer to study medicine in 2021. In response, the government decided to provide extra funding to medical and dental schools across England and to increase the number of available places to 9,000. This is a positive development for the future psychiatric workforce and the uplift should be retained and expanded year on year towards reaching 15,000 in 2028/29. This should be accompanied by assertive action over the longer term to ensure medical students become trainees in under resourced specialties, including psychiatry. This is necessary to deliver a sustainable supply of psychiatrists for the long-term.

The expansion in medical school places needs to be followed by a similar expansion in the number of training places at Core and Higher levels. A further expansion of Core posts is required to deliver the NHS LTP and Mental Health Act reforms, as well as meet heightened demand due to COVID-19. Trainees are delivering services from day one, so an expansion of Core posts has a direct impact on service delivery. Additional Core trainee places, distributed strategically, could also help overcome geographical and specialty shortages if they are allocated in the right way.

Such an expansion needs to be coupled with a focus on retention of trainees. More core training places are also required to mitigate against the increasing diversity of training pathways. Research from UCL showed that psychiatry trainees overwhelmingly did not progress directly through training within six years, with only 14.7% completing training without delays, and 11 years being the average time taken to progress. It also found that trainees desired training arrangements to both support their progression and work-life balance, including allowing time out and Less Than Full Time (LTFT) hours.181 Increased flexibility can increase the longevity of the workforce, but more psychiatry training places are required to support the gaps and reduce the burden on full time staff.

Workforce expansion is particularly pertinent due to the upcoming reforms to the Mental Health Act (MHA). Independent research commissioned by the Royal College of Psychiatrists estimates the number of psychiatrists needed to deliver the reforms. Using the DHSC's own estimates on changing numbers of detentions[282], the research finds that by 2023/24 an additional 333 FTE psychiatrists will be needed, and by 2033/34 a further 161 will be needed[283]. The required expansion is solely based on the impact of the reforms, and therefore must be viewed as being additional to increases required to deliver the NHS LTP and meet increased demand for services. The success of the reforms will be dependent on investment to increase and train the additional workforce needed.

Another area contributing to mounting workforce pressures is the cross-government all-age autism strategy for 2021-2026. This contains laudable objectives including improvements to the diagnostic pathway and reducing waiting times.175 Delays in diagnosis and misdiagnosis reduce the chances of individuals receiving appropriate support and increase the risk of mental health crisis and hospital admissions. Successful delivery of the strategy will undoubtedly require investment into a substantial

number of new posts, including consultant psychiatrists and associated spending on education and training, staff retention and development. We understand that a fully costed set of proposals has been submitted by NHS England and Improvement to that end and urge serious consideration of this bid to ensure the strategy can be placed on a strong footing. Furthermore, the Clinically-led Review of NHS Standards is expected to introduce new waiting time guarantees across both emergency and community-based mental health services, which are equitable to physical healthcare standards. While this is essential to achieve parity of esteem and ensure that those accessing them get the mental health support they need and deserve, we are concerned that the workforce requirements have not been considered.

Furthermore, while welcome progress has been made on workforce expansion through the Government's COVID-19 mental health and wellbeing recovery action plan, it is imperative that work is undertaken now to build a sustainable pipeline for the future.

Upskilling/new ways of working

Workforce expansion is not the only tool that should be used to tackle mounting demand. Given increasing prevalence, there is a need to upskill other doctors and allied health professionals on mental health. Currently, doctors feel unable to deal with mental health issues in their specialties yet are required to care for people with mental illness. For example, a 2018 survey of more than 1,000 GPs revealed rising demand for mental health support in primary care, with GPs saying that 40% of their appointments involve mental health.[284] This signals demand for new skills, or potentially new roles, in primary care to deliver the right care to patients.

There is a particular need for mental health skills in paediatric units and emergency departments. This is even more important due to recent concern about the number and severity of children and young people presenting with mental ill health in emergency departments and being admitted on paediatric wards. Paediatricians feel ill-equipped and trained to manage the mental health needs of these patients and have inadequate access to specialist support. Mental health leads within paediatric units and emergency departments could seek to shift the culture and upskill staff.

Credentialling is also a good way to offer training and/or upskilling where there is not currently a pathway in place. The Royal College of Psychiatrists has been working hard on developing credentials in liaison psychiatry and eating disorders which offer opportunities to improve standards of care through enabling staff to develop specialised skills and knowledge. For more staff to undertake these certificated courses, central funding could be provided to Trusts to enable them to release staff.

Over the next ten years, progress on tackling health inequalities is vital. It is important that all healthcare professionals have appropriate skills and training to minimise health inequalities, and possess the competences to deliver fair, non-judgmental, and least restrictive care.[285] The growing prevalence of health inequalities, as well as unmet need in excluded or overlooked patient groups, creates demand for an increased mental health workforce in areas with high proportions of people from the different population groups that are most affected – an approach that will require detailed demographic and geographical surveys. It also creates demand for new skills and new ways of working to identify mental health problems across different groups of the population, reduce the treatment gap, and work to eliminate inequitable access, outcomes and experience. One way to do this could be through the development of tailored services such as mental health services for people who identify as LGBTQIA+, similar to the targeted STD and HIV specialist services.

The integration agenda presents opportunities for mental health services to be integrated more comprehensively into the wider health system and to give better, more joined up care to people with mental illness. Clinicians and healthcare staff are increasingly developing a more personalised approach to providing care, including looking at both physical and mental health needs, and where relevant considering other social or economic needs or factors. To maximise the role of the workforce, it is important to think about integration beyond health and social care, including housing, policing

and beyond. However, to maximise the role of the workforce in providing integrated care, action will be required to ensure the workforce is equipped with the right skills. For example, team working, leadership, digital clinical skills, consultation and liaison skills, cultural competence, and the ability to work closely with primary care and other interfaces will all be important.

Delivering the right care at the right time in the right place, with a more focused role on health promotion and prevention, will require consideration of integrated training opportunities and enhanced generalist skills. This should include mental health competencies for 'non-mental health professionals' including nurses, doctors, staff working in acute settings, GPs, advanced care practitioners, pharmacists, and VCSE staff. It also includes physical health competencies for mental health staff, including psychiatrists, psychologists, and social care staff. Integrated care presents opportunities to better care for people with mental and physical healthcare needs. Training should, therefore, look at management of common chronic physical and mental comorbidities such as alcohol and mood disorders and diabetes and depression.

Recommendations

- DHSC to commit to increase the number of medical school places in England to 15,000 by 2028/29 in order to deliver the NHS LTP and allocate those places to schools that have a clear plan to encourage more students to choose a shortage specialty, including psychiatry.
- DHSC and NHSE to continue the expansion of core psychiatry posts and ensure provision for further expansion to facilitate long-term sustainability and growth in consultant psychiatrist posts for 2035. The additional core training posts made available from August 2021 onwards must be fully funded through the core training pathway, with sufficient provision also made for an expansion in higher training capacity.
- DHSC and NHSE to lay out plans to publish a comprehensive NHS workforce strategy following the publication of HEE's strategic framework. This should be accompanied by 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 NHS LTP, proposed standards from the Clinically-led Review of NHS Standards, and the proposed Mental Health Act reforms. The settlement must take into account that funding for postgraduate medical education and training has been essentially flat in real terms between 2013/14 (£2.111bn) and 2020/21 (£2.080bn).
- DHSC to ensure funding is allocated to deliver the requisite workforce for the Mental Health Act reforms. This includes the additional 494 FTE psychiatrists needed by 2033/34, as identified in the independent research commissioned by the College, as well as the non-medical workforce identified by HEE-commissioned research.
- DHSC and NHSE to provide the necessary investment in workforce to deliver the autism diagnostic pathway and reduce waiting times. Funding is required for both new posts and education and training, while also supporting retention and development among existing staff in these services.
- DHSC and NHSE to maintain the NHS Staff Support Offer, with £50m funding each year over the three years.
- DHSC and NHSE to ensure that, from 2022/23 onwards, at least 10% of the 1,000 PAs being trained each year work in mental health (including liaison services and GP practices).
- DHSC and NHSE to ensure that the implementation of the provision within the Health and Care Act 2022 to provide mandatory training about learning disability and autism for Health and Social Care staff is supported by sufficient resources.

9. References

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Contact

The College would be happy to provide further detail on any of the information contained within this paper and would welcome feedback on these proposals. We recognise this is an iterative process and, as such, we will be building on our recommendations over the coming months. You can find the version number and date on the front cover of this briefing.

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