Centre for Mental Health

The NHS Long-Term Plan: Response from Centre for Mental Health, August 2018

Centre for Mental Health is an independent charity that drive change in policy and practice. We are pleased to submit our response to NHS England's request for views about the priorities for mental health in the forthcoming long-term plan.

The Centre has also contributed to responses from the Children and Young People's Mental Health Coalition and from the Equally Well collaborative. We have also supported the response from the Forces in Mind Trust, whose Mental Health Research Programme we administer jointly with King's College London.

Our response is based on research the Centre has carried out in recent years, and builds on our report to the Mental Health Taskforce, *Priorities for Mental Health* (Parsonage et al 2016).

1. What are your top three priorities for meeting the mental health needs of people of all ages in England? Over the next five, and ten, years?

Over the next five years, of the many key areas that require attention our priorities would include:

- Building a wider range of evidence-based responses to protecting and promoting **children and young people's mental health** and emotional wellbeing, with a particular focus on reducing inequalities and intervening earlier to prevent emergent problems from escalating into a later crisis
- Developing effective mental health support in **primary care**, particularly for groups of people currently whose needs do not neatly fit into existing systems, eg those with mental and physical health needs (including unexplained physical symptoms), personality disorder traits and complex traumas
- Continuing to extend effective, evidence-based approaches to supporting people's mental health and life chances – for example to ensure **Individual Placement and Support** is available universally within five years for people who would like support with employment

Over ten years, we would also identify the following priorities for achieving longer-term change:

- Focusing on **significantly reducing mental health inequalities**, including inequalities relating to the social and economic determinants of mental health and those relating to access to effective support (eg for people with learning disabilities, people with co-occurring substance misuse, people from BAME communities)
- Creating a **workforce** with the necessary skills, competencies and characteristics to meet people's changing needs and develop according to the evidence of what is most effective

(and cost effective) building on the recommendations of the Centre's report, *The future of the mental health workforce* (Durcan et al 2017)

- **Making prevention a priority** across the board, embedding mental health in all government policies (including social security, housing, criminal justice) and shifting investment into evidence-based approaches to prevention and early intervention

2. What gaps in service provision currently exist, and how do you think the NHS should address them (these can overlap with Q1 but may include a longer list)?

The Five Year Forward View for Mental Health and the Future in Mind programme have both sought to direct investment to closing some of the most significant gaps in service provision for adults and children respectively. This is having a noticeable impact in the areas of greatest focused activity (eg in specialist perinatal mental health services, Early Intervention in Psychosis and Improving Access to Psychological Therapies). It has been evident throughout, however, that this programme marks the beginning of a longer term effort to ensure equal, timely access to effective health and care for people with mental health conditions.

There will remain a number of gaps that the NHS and its partners (most notably in local government) will still need to address following the successful conclusion of these two programmes. Many of them are covered in greater detail in our responses to the other questions in this document. They include:

- Prevention: taking a life-course approach to reducing the risk factors for poor mental health and building up protective factors for good mental wellbeing in line with the evidence for effective interventions and approaches (Khan 2016)
- Primary care: developing effective help in primary care for people whose needs are not met through existing IAPT services or secondary care (eg people with complex mental and physical health problems and people with personality disorders)
- Perinatal mental health: building on the welcome development of specialist community services to ensure that universal services (including primary care, maternity and Health Visiting) are able to identify women experiencing difficulties and refer swiftly to necessary services where appropriate (Stubbs et al 2018)
- Community mental health services: ensuring that all local areas have in place the community-based services that will meet the needs of people with long-term mental health conditions
- Rehabilitation: the Centre, among others, has raised serious concerns about the support offered to people placed in 'locked rehabilitation' inpatient services, particularly those in units that are far from home whose stays extend over a number of years (Wright 2017)
- Substance misuse: we are very concerned about gaps in the availability of effective support for people with co-occurring alcohol and mental health problems (Institute of Alcohol Studies and Centre for Mental Health 2018)
- Criminal justice system: building on the development of Liaison and Diversion services to ensure there are effective community based services to which people can be diverted; improving the quality and comprehensiveness of mental health support in prisons and IRCs; and offering high quality care to people leaving prison, which for many is a time of acute crisis (Durcan 2016)

3. People with physical health problems do not always have their mental health needs addressed; and people with mental health problems do not always have their physical health needs met. How do you think we can improve this?

Addressing these gaps requires action on a number of different fronts:

Improving mental health support for people with physical conditions: this has been a major focus of the IAPT programme under the FYFV-MH for people with the most common long-term conditions such as diabetes. This should be extended further for a wider range of conditions and for people of all ages. But it should also be enhanced by the establishment of collaborative care services for people with the most serious and complex comorbidities, for whom an ongoing approach with proactive care management and holistic support will be necessary (Parsonage et al, 2016). This has been tested more widely in the US and should be piloted and evaluated at scale in England: for example for people with Parkinson's disease, cancer, or stroke, and for those with rare diseases (including in childhood).

Improving physical health support for people with mental health conditions: The widely acknowledged inequality in physical health and life expectancy for people living with a mental illness has been a priority area for the FYFV-MH, with a particular focus on extending access to health checks in mental health services. This is an important step forward, which the Centre is supporting through the creation of the Equally Well UK collaborative. However, the need for further concerted action across the system will remain. It is vital that any smoker living with a mental illness is consistently offered tailored help to quit (Parsonage et al 2016) as part of a comprehensive approach to supporting physical health from the start and throughout life.

Improving support for people with unexplained medical symptoms and complex needs: It is vital that the long-term plan addresses the needs of people whose physical health symptoms have a psychological dimension, and those with the most complex comorbidities. The City and Hackney Primary Care Psychotherapy and Consultation Service is one example of a cost-effective approach to meeting these needs within a primary care setting (Parsonage et al 2016).

4. There are some significant inequalities in how people access and experience care for their mental health needs, and in their outcomes, including but not limited to people who have 'protected characteristics' under the Equality Act 2010. What are your views on what practical steps the NHS should take to address inequalities in the services it provides?

Tackling inequalities in mental health must be a priority for the long-term plan, with concerted action from the start that seeks to address (and where necessary mitigate) the social and economic determinants of mental health inequality; unequal access to effective mental health support; and poorer outcomes from existing services for people experiencing inequalities.

Centre for Mental Health has established a Commission for Equality in Mental Health that will be investigating why inequalities have remained entrenched for so long and identifying policy and practice solutions. We will be pleased to share the emerging findings of this work with NHS England to ensure they can be brought into the long-term plan as it develops. In the meantime, we would strongly advocate:

- Extending the availability of evidence-based parenting programmes to families with the greatest risk factors for childhood mental health difficulties (Parsonage et al 2016)

- Working with African and Caribbean communities to address young men and women's mental health – for example making use of apprenticeship opportunities to create peer mentors for young people at risk of school exclusion (Khan et al 2017)
- Redesigning CAMHS in partnership with marginalised young people who often do not find existing services relevant or helpful (Stubbs et al 2017)
- Building up support for people in or on the edges of the youth justice and criminal justice systems, many of whom have multiple and complex needs and whose experiences of mental health support have been poor (Durcan 2016)
- Reviewing the availability and quality of mental health support for people with learning and developmental disabilities, including autistic spectrum disorders, who have a significantly higher prevalence of poor mental health (Khan 2016)
- Improving data collection in relation to ethnicity and religion in the use of mental health services (and particularly the Mental Health Act)

5. How best can we bridge the gap between children's and adults' mental health services?

The widely acknowledged gaps between children's and adults' mental health services require significant attention over the next 10 years. Young people and young adults face very high levels of distress, feel the stigma of poor mental health especially keenly, and are the least likely age group to seek help from formal, clinical services (Khan 2016). This age group also sees the emergence of some of the most serious adult mental health conditions (including psychosis and personality disorders) and a growth in mental health inequalities, most notably by ethnicity (Khan et al 2017).

For the most vulnerable and marginalised young people in particular, there are numerous transitions that take place during this time, including leaving education, leaving local authority care, and moving from the youth to adult justice systems. It is therefore essential that any approach to bridging the gaps works across the whole system of support for young people and young adults. It needs to be co-designed and co-produced with young people to ensure it meets their needs, feels relevant and speaks their language. And it needs to engage with young people in a way that meets their needs, which may include help with education, employment and money as well as emotional health and wellbeing.

6. How can we recruit, train and retain the workforce to deliver the changes we need, particularly to meet your priorities (Q1 above)?

Building a workforce to meet the needs of the next 10 years will require substantial change to the ways in which people are recruited, trained and enabled to build careers in mental health. Our report on the future of the workforce (Durcan et al 2017) made a number of specific recommendations (listed below) that we believe can be embedded in the long-term plan.

Attracting the workforce

1. Mental health service providers, training bodies and professional associations should reach out to schools and colleges advertising mental health career opportunities to young people when they are thinking about the futures.

Career pathways

2. Professional bodies should join together to develop a range of clear career pathways for mental health professions and professionals.

3. Service providers should develop career pathways that reflect their changing needs. This may mean creating opportunities for careers that go across professional and agency silos, and offering support and training in order for people to move on to different career routes. Career development should also reflect the stage in life each employee is in, for example this might mean roles appropriate to someone reaching retirement as well as support for retirement as they approach it. This all requires recognition from those with a national leadership role around the mental health workforce (including HEE, NHSE, NHSI, CQC and professional bodies).

4. Professional bodies and service providers should create a specific career pathway for inpatient care. This could be linked with crisis care in other settings to give staff a wider range of opportunities and to boost the status and profile of working in inpatient services.

5. Service providers should develop both professional and voluntary opportunities for those with lived experience. They should recognise that some people may wish only to volunteer as part of their own recovery journey, whereas others may have much more to offer long term and to develop careers and take up training in a wide variety of roles at every level of the system.

Supervision and mentoring

6. Mental health service providers should aim to provide the best possible management and clinical supervision and this should have both resource and time invested in it.

7. Service providers should recognise mentoring for students and trainees as a core aspect of work for mental health professionals, with sufficient time scheduled for mentors to perform these duties.

Training

8. Training providers and commissioners should ensure that training in all mental health disciplines equips new staff to develop skills to work flexibly in various settings and in multidisciplinary teams, with recovery and psychological underpinning. Training should focus on and enable practitioners to navigate complex health and care systems and how to manage change.

9. Service providers and training bodies need to ensure that there is a sufficient number and variety of placements available to students and trainees for them to develop necessary skills.

10. Training bodies should ensure that all new training frameworks consider and invest beyond the NHS, including in the voluntary and community sector, in the independent sector, and in health and social care more broadly and beyond.

11. Investment in training needs to directed towards the existing workforce and in helping them in achieving the shifts in focus and expectations.

12. The General Medical Council, Royal College of GPs and education providers should ensure that all general practitioners and other practitioners in primary care have significant and wide-ranging training in mental health.

Competencies

13. Health Education England, the Department of Health and professional bodies should work together to describe the range of competencies that define 'mental health practitioner' and design a number of routes to achieve this or parts of this that go beyond 'traditional professional boundary' thinking, e.g. pharmacists in prescribing roles, peer workers as care coordinators.

14. Education and training providers should develop more post graduate training for mental health service competencies that are open to a wide range of disciplines. An example currently is the University of Bradford post graduate certificate in dementia diagnostics, which is open to a wide range of health professionals.

15. Education and training providers should develop training in consultation skills for mental health professionals. Consultation is an increasingly important means of spreading limited skills more widely.

16. Education and training providers need to develop training for collaborative approaches to service provision. Co-production with service users and carers requires preparation and training for professionals.

17. Education and training providers and service providers should ensure that all mental health practitioners receive significant training in psychological intervention, for instance doing psychological formulations. The mental health service model of the future should be one that gives a greater role to psychological thinking and psychological informedness. This needs to be reflected in the training of all professionals and in the development of mental health practitioner competencies.

Commissioning

18. Commissioners should include consultation in contracts with mental health providers to enable staff to share their expertise, for example with colleagues in primary care, the voluntary and community sector and more widely in schools and general health care and other settings. Consultation within primary care in particular should be a core duty and not an 'add on' for mental health services.

19. Education and training providers should develop specific training and development opportunities for mental health commissioners. Mental health commissioning must be recognised as a skill set in itself that requires specific training and continuing development.

20. Commissioners and providers of mental health services should work long-term to develop needs-led, holistic support services that are embedded in the community, that are coproduced with the people who use them, and that are psychologically informed.

21. Commissioners of mental health services and public health should jointly invest in prevention and engagement (for example with communities, families, schools and workplaces).

Wellbeing

22. Service providers and commissioners should prioritise staff wellbeing in all mental health services. Investing in staff wellbeing will improve productivity, boost retention and encourage more people to develop their careers within 'compassionate organisations'. All mental health service providers should aim to provide comprehensive support for their workforce's wellbeing. Commissioners may wish to seek evidence of this from the organisations they contract for mental health services.

7. Do you think the NHS should be doing more to prevent mental ill-health? If so, what should we do to improve this?

The NHS has an essential role alongside its partners in local government and other public bodies in prevention at every level. As well as supporting action to prevent mental ill health at a population level, NHS organisations can ensure they offer help quickly when difficulties first emerge and people first seek help in order to prevent them from escalating, they can prevent the reoccurrence of mental ill health and they can prevent mental ill health leading to lifelong poor physical health and vice versa. There are opportunities to do this at every life stage, from pregnancy and infancy to later life. Actions the NHS can take to support prevention include:

- Ensuring that GPs and maternity services are equipped to identify women experiencing mental health difficulties (or their partners) during the perinatal period and referring them to the right help without delay (Stubbs et al 2018)
- Establishing clear referral routes for parents seeking advice and help with their children's behaviour, ensuring that GPs in particular are aware of how to refer to evidence-based parenting interventions and working alongside local authority partners to ensure these are available at sufficient levels to meet need locally (Khan 2016)
- Building effective relationships with schools to enable them to promote good mental health, provide targeted help with prevention, and ensure rapid access to specialist help when it is needed
- Working with public health services to establish effective suicide prevention programmes, including offering high quality training to NHS staff in suicide prevention techniques and developing support in and around primary care for people at risk of suicide but not currently diagnosed with a mental health condition
- Supporting the wellbeing of the NHS workforce, providing a mentally healthy environment in which to work, training supervisors and line managers in responding well to staff experiencing difficulties, and creating a welcoming place to work for people with experiences of mental ill health (Durcan et al 2017). Poor mental health at work costs the NHS an estimated £1.3 billion a year (Parsonage and Saini 2017) in reduced productivity, sickness absence and turnover.

8. Do you think the NHS could do more to intervene early for people with mental ill-health? If so, are there any Mental Health problems we should prioritise to provide better early intervention?

The NHS can bring about a significant shift towards earlier intervention in all areas of mental health support during the next 10 years. Internationally, it is estimated that there is an average ten year delay between the first signs of a mental health difficulty and the provision of effective help (Khan 2016), during which time problems can escalate until they reach crisis point. Timely access to help is necessary across all mental health conditions. Steps that can be taken over the next 5-10 years to achieve this include:

- Building mental health literacy, particularly among children, young people and parents, to encourage help-seeking at an early stage when problems are first apparent
- Building the capacity of GPs and the wider NHS and non-NHS workforce (including in schools and other children and family services) to recognise the signs of difficulty, to enquire sensitively about mental health and to respond helpfully when support may be needed
- Developing online resources and tools for individuals, families and professionals to seek help and advice: the *Mentally Healthy Schools* website is a recent example of such a resource (for primary school teachers and staff)
- Redesigning services in partnership with those using them in order to maximise the chances of successful engagement. For the most vulnerable and marginalised, effective services often engage in very different ways to traditional approaches, with less of a focus on diagnosis and a greater attention to people's holistic needs (including with finances, work and education) (Stubbs et al 2017)

9. People with more serious and complex mental health problems do not always receive the care they need. Which groups would you prioritise and what extra help would you like to see developed by the NHS?

It is vital that the long-term plan includes a focus on effective support for people with serious and complex mental health needs that require ongoing help and support from the NHS and others (including social care and housing).

For these groups we need to ensure that effective, holistic help is at hand, including:

Community mental health services: rehabilitation services, building on assertive outreach principles, to provide engaging and holistic support (with links to locally-based specialist inpatient care when it is needed) (Killaspy 2017)

Social care: providing essential help and support with everyday life for people living with mental health conditions and their carers (Woodbridge-Dodd 2018)

Housing support: providing a range of types of help with housing, from supported accommodation and Housing First schemes to support with housing rights and maintaining tenancies (Boardman 2016)

Continuity of care around the criminal justice system: ensuring that people who have been in prison and who have significant mental health needs get effective help and support from community services when they leave (Durcan et al 2018)

Employment support: providing access to IPS services for people who would like to work, not excluding people with complex needs

Crisis care: implementing the Crisp Report's recommendations in full to address concerns about the capacity of acute inpatient services and develop a wider range of alternatives to admission

10. Are there examples of innovative/excellent practice (in mental health care or that could be applied from other areas) that you think could be scaled-up nationally to enhance the quality of care people receive for their mental health, reduce costs and/or improve efficiency of delivery?

We have reviewed, evaluated and analysed a number of innovative services that provide valuable learning for wider implementation. They include:

- City and Hackney Primary Care Psychotherapy and Consultation Service (Parsonage et al 2014)
- Project Future and other MAC-UK projects (Stubbs et al 2017)
- Sheffield Citizens Advice Bureau (Parsonage 2013)
- Up My Street (Khan et al 2017)

The Centre is also currently working with the University of Birmingham to explore models of primary care mental health support for a report we are due to publish later in 2018, and we are working with the NHS Confederation Mental Health Network to evaluate four such models. We hope these reports will provide evidence for the development of effective (and cost effective) models of mental health support in primary care to meet a range of needs.

11. What do you think are the specific challenges that will prevent the NHS from being able to deliver good mental health care, and what should we do to overcome them?

Delivering mental health support that provides anyone who needs it with the right help, close to home at the right time will be a major challenge for the NHS and its partners.

The NHS relies on local government in particular for the provision of effective mental health support, including from adult social care, early years and children's services, public health (including but not limited to substance misuse services, smoking cessation and suicide prevention), housing, community safety and leisure (with particular relevance to physical activity and social prescribing). Together, these services provide a very significant proportion of mental health support and it is vital that the NHS at every level engages with local authorities (district and borough as well as county and unitary) on an equal basis to develop strategies and plan services around their communities' needs and assets.

The NHS also relies increasingly on voluntary and community organisations to provide a range of services to meet the needs of people of all ages with mental health conditions – particularly those least well served by statutory services. Very often, such services rely on short-term, precarious funding, despite offering innovative solutions to otherwise poorly met needs (Durcan et al 2017). The long-term plan can provide a framework to enable NHS organisations to build

more sustainable relationships with the VCS and give staff more opportunities to work in both statutory and voluntary organisations during their careers.

A major challenge for the NHS will be to build a relationship of greater equality with the people who use (or need) its mental health services, especially those whose voices are least well heard (eg children, older people and those from marginalised communities). Mental health services have made significant steps forward by developing peer support roles and establishing Recovery Colleges or equivalents in recent years (Durcan et al 2017). Over the next decade we would hope to see peer support diversify and grow further, with a greater range of roles and opportunities for people with lived experience to provide support to peers in many different settings. We would expect to see commissioners and providers of mental health services working as equal partners with experts by experience to develop strategies, design services and monitor their effectiveness.

Finally, it is essential that the NHS and its national Arm's Length Bodies in particular focus on the 'hard wiring' of the system that has traditionally disadvantaged mental health services. We need to review the systems by which funding flows through the NHS (and between it and its partners) to place mental health on an equal footing to physical health and to encourage more integrated service provision. We need to ensure that mental health services are being asked to collect and share relevant data that helps to improve performance. And we need to develop an accountability structure that places the full range of mental health services on an equal basis: for example to extend the range of clinically appropriate access and waiting time standards.

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