



All-Party Parliamentary Group on Mental Health

Progress of the Five Year Forward View for Mental Health: On the road to parity

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Foreword

This report of the All-Party Parliamentary Group on Mental Health inquiry into the Five Year Forward View for Mental Health (FyFV-MH) comes at a critical time: halfway through the FyFV-MH and as we await the NHS long-term plan for mental health.



One of the great strengths of the FyFV-MH was that it drew on a range of expertise. It is thanks to everyone who took part in our APPG inquiry—through over 70 written submissions, two oral evidence sessions, a focus group of service users and carers and a visit organised to the Central and North West London NHS Foundation Trust—that in a smaller way we have also been able to draw on the wealth of experience of those who care about mental health.

Passion and determination to make services better shone through all the evidence we received. We weren't just told about problems – we were given clear solutions that could quickly start to make a difference. Underpinning it all was a sense of urgency. Until very recently mental health was forgotten and under-recognised. It is a mark of how far we have come that all political parties are committed to parity of esteem. The message that we heard strongly during this inquiry is that now is the time to redouble our efforts to deliver on that commitment.

During this inquiry we've heard inspiring stories of success where new services have changed people's lives for the better, particularly in perinatal, improving access to psychological therapies (IAPT) and early intervention in psychosis. All these areas have benefited from a significant boost in funding, proving that well-targeted investment works. All those involved should feel proud of the lives changed by improved services. But clearly there is still much more to do. We have identified three key themes, under which we have grouped our 23 recommendations.

Firstly, investment in specialist services has been welcome, but core mental health services for adults severely affected by mental illness, whose needs fall outside specialist services, must now be a priority. Core mental health services, such as community mental health teams, are vital to stop people reaching crisis point. With rising demand, urgent investment is needed in these non-condition specific services.

Secondly, addressing workforce challenges is vital to improve mental health services. The increase in demand since the start of the FyFV-MH means there is a need to re-evaluate and adjust current workforce plans.

Thirdly, there are important improvements to make around oversight and making mental health a collective responsibility across government and arms-length bodies (ALBs). NHS England has demonstrated with its mental health dashboard that better transparency and oversight improve services and accountability, but there is far more to do to make mental health a priority for all the government departments and agencies.

The FyFV-MH never intended to solve every problem in our mental health system, but where it has focused it has made a difference. We know change is possible because we have seen success since 2016. The FyFV-MH was a starting point on the road to parity of esteem. We hope this report will inform the next steps on that journey.

The APPG on Mental Health calls on the Government, with NHS England, to respond to this report and set out how they will address our concerns.

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Executive summary

The ambition of the FyFV-MH

The Five Year Forward View for Mental Health (FyFV-MH) came from the independent task force chaired by Paul Farmer and Jacqui Dyer. It set out an ambitious vision to transform mental health services by 2020/21.

Over 20,000 people with lived experience of mental illness contributed to the FyFV-MH to share what change they wanted to see so they could live fulfilling lives.

The FyFV-MH made 58 recommendations ranging from improving access to mental health services to the interaction between mental illness and justice and ensuring the right protection for specialist supported housing. The FyFV-MH recognised the change needed in health services to take steps to achieve parity of esteem, but also the change needed across wider society to tackle inequality and ensure people have a “decent place to live, a job or good quality relationships”.

What has been achieved so far

Some mental health services such as perinatal, improving access to psychological therapies (IAPT) services and early intervention in psychosis (EIP) were singled out for expansion and received a considerable funding boost. The benefits of this targeted investment for specialist services have been visibly significant.

The FyFV-MH led to new mental health data tracking the proportion of people accessing services covered by the FyFV-MH, and how quickly, by local area. This has transformed the way that the progress of mental health policies can be tracked.

What can we do better

The FyFV-MH was a step in the right direction but it did not cover everything. Core mental health services for adults severely affected by mental illness, mental health treatment for older people and early years support for children under five were notable exclusions.

As we raise awareness, more people rightly ask for professional support. The number of children and young people completing routine eating disorder treatment increased by 12.9% in the first quarter of 2018/19 compared to the same period in 2017/18 alone.¹

There are still racial disparities in access and recovery, problems with mental health provision for people with learning disabilities and autism and a mental health crisis among our children and young people. People with physical health conditions still struggle to get mental health support and people with severe mental illnesses today have the life expectancy of the general population in the 1950s. The FyFV-MH recommendations on housing, welfare and justice have seen little progress compared to those aimed at the health service. We need better collective responsibility for mental illness directed by oversight from the Cabinet Office.

As demand has increased, gaps have been exposed in the strategy. Filling these gaps must be a priority to ensure that what has not yet been achieved, or what was left out of the FyFV-MH, are not forgotten.

¹ NHS England (2018) Children and Young People with an eating disorder – waiting times, Routine Cases Indicator.

The recommendations of the APPG

Based on over 70 pieces of written evidence, two oral evidence sessions and specific focus groups with mental health clinical staff, service users and carers, the APPG is recommending change in three broad areas that were consistently highlighted as needing urgent attention:

Theme 1: Investing in core services for adults severely affected by mental illness

Core services are the 'backbone' of secondary mental health care, supporting adults whose needs fall outside services targeted at specific conditions. We urgently need to invest in core mental health services, such as community mental health teams, for adults severely affected by mental illness and reform thresholds for getting help so that everyone gets timely and effective support regardless of diagnosis. It should be a priority to reduce the number of people reaching crisis point and prevent disparities in accessing services.

Recommendations for core and transformational services:

- NHS England should increase resources (including funding and staffing) for 'core' mental health services, ensuring new services are not developed or expanded at the expense of these existing services. (Chapter 1, Recommendation 1)
- NHS England should implement in full all pathways set out under the FyFV-MH to avoid incentivising a skewed allocation of resources, and revise initial targets after 2021 to make them more ambitious. (Chapter 1, Recommendation 2)
- NHS England and CCGs should ensure appropriate provision and access to the full range of NICE recommended psychological therapies for people who are unable to access IAPT due to the nature or complexity of their mental illness. (Chapter 1, Recommendation 3)
- NHS England should ensure that every STP has a First Response Service or similar model, that directs 111 callers to 24/7 support and mental health crisis response for both adults and children and young people. (Chapter 1, Recommendation 4)
- 100% of acute hospitals should provide access to a Core24 liaison psychiatry service by 2028/29. (Chapter 3, Recommendation 8)

Theme 2: Increasing the mental health workforce

The mental health workforce was raised again and again as being the biggest challenge to delivering the FyFV-MH in full. As it currently stands, the workforce is unable to keep up with increasing demand. One in ten NHS consultant psychiatrist posts are vacant², and there has been a drop of more than 12% in registered nurses working in mental health NHS trusts in England between April 2010 and April 2018.³

Recommendations for workforce

- Health Education England should develop a mental health workforce strategy that takes into account population growth, associated incidence and prevalence of mental illness in the population, and ongoing workforce policy changes. (Chapter 7, Recommendation 17)
- NHS Improvement should set a yearly 4% improvement target in retention rates to be met by all mental health trusts and community and acute trusts where they are providing mental health services. (Chapter 7, Recommendation 18)
- Health Education England should fund a mental health wide recruitment campaign, with focus on recruiting psychology graduates to specific types of therapy in both NHS IAPT and secondary psychological therapy teams to ensure all NICE recommended talking therapies are available. (Chapter 7, Recommendation 19)
- Health Education England should improve development and training of frontline care staff with a specific focus on mental health, learning disability and autism so the existing workforce is supported and equipped to deliver direct care and support to those groups. (Chapter 7, Recommendation 20)
- NHS Employers and DHSC should undertake a review of how trusts encourage applications from people with lived experience of mental illness as a protected characteristic at all levels of a team. (Chapter 7, Recommendation 21)
- Health Education England should review the potential for a new career path designed specifically for people with lived experience to transition from peer work to other roles within a mental health team. (Chapter 7, Recommendation 22)

² Royal College of Psychiatrists (2017) Census 2017: Workforce figures for consultant and specialty doctor psychiatrists.

³ NHS Digital (2018) NHS workforce statistics – June 2018.

Theme 3: Better oversight and collective responsibility for mental health

There has been a failure to make long-lasting changes to areas such as housing and welfare, which are outside the NHS' remit, but nonetheless have a significant impact on a person's mental health.

Recommendations on oversight and collective responsibility:

- NHS England should ensure quarterly publication of the FyFV-MH Dashboard, including Health Education England and NHS Improvement Dashboards to cover (in addition to current indicators) (Chapter 2, Recommendation 5):
 - workforce
 - data on whether funding to implement the FyFV-MH is being spent as outlined in the plan
 - clinical reported outcomes and key targets/operational performance for services not currently covered
 - the annual results of the Care Quality Commission (CQC) community mental health survey with additional data on service user rated quality of care for inpatient services
 - waiting times which accompany the complete list of pathways due to be introduced from the FyFV-MH
 - a Y/N indicator confirming whether co-production is done to the standards of 4Pi⁴
 - a robust data set to track settled accommodation status of adult mental health service users
 - IPS beyond baseline to report at CCG level.
- The Department of Health and Social Care should publish in 2019 a report on the progress of FyFV-MH implementation, including on NHS and cross-government recommendations and commit to an annual publication thereafter. (Chapter 2, Recommendation 6)
- NHS England and Public Health England should ensure premature mortality data is published at STP and local authority levels and local plans set out to meet reduction targets, including rolling out social prescribing in every primary care centre (Chapter 3, Recommendation 7)
- The Department of Health and Social Care should ensure that the Equalities Champion, in collaboration with affected parties, investigates the factors which lead to differences in access to, experiences of and lower recovery rates from secondary mental health care in certain groups to ensure all mental health policies are compliant with the Equalities Act. (Chapter 4, Recommendation 9)
- NHS England should provide additional resources for children and young people's mental health services which support children and young people with complex needs (Chapter 5, Recommendation 10)
- NHS England should continue to hold CCGs to account to ensure that funds going into baselines post 2020/21 are invested in services that have been started as a result of the Five Year Forward View for Mental Health (Chapter 7, Recommendation 23)
- In partnership with the Ministry of Housing, Local Government and Communities and Local Authorities, NHS England should recognise, support and accelerate the work of mental health trusts across the country to address and increase the provision of specialist mental health supported housing. (Chapter 6, Recommendation 14)
- The NHS Long Term Plan should make specific recommendations to improve the impact of the social welfare system on the mental health of those who rely on it, including through reform to assessments for PIP and ESA. (Chapter 6, Recommendation 15)
- The Government should establish a Mental Health Cabinet Committee to ensure collective responsibility for improving the mental health of the nation. (Chapter 6, Recommendation 16)
- NHS England should not approve any STP mental health plan unless it has an ambitious and credible plan for the prevention of mental ill health and delivery of services that best meet the needs of a population. (Chapter 5, Recommendation 11)
- The Green Paper on Adult Social Care should recommend an uplift in social care funding to give it the necessary resources to act in equal partnership with health. (Chapter 5, Recommendation 12)
- NHS England should ensure that every mental health trust has a community rehabilitation and recovery team to work jointly with social care, local accommodation and community support networks for those individuals needing long-term support. (Chapter 5, Recommendation 13)
- NHS England and commissioners should be made accountable for co-production being embedded at all levels from national policy, to commissioning to service provision. NHS England should create incentives such as a CQUIN to hold CCGs to account through the Dashboard and CCG IAF. (Chapter 7, Recommendation 24)

4 NSUN (2013) 4Pi Standards.

Chapter 1: Improving access: getting the help you need, when you need it

What does mental health treatment involve?

Mental health treatment may involve talking therapy, medication or prescribed social activities. The majority of mental health treatment is provided in primary care, usually through a GP.⁵ People with long-term or complex mental health problems will receive care in secondary mental health services with specialist multidisciplinary teams that are designed to meet their needs. Most people in secondary mental health services will receive help through a community mental health team.

Those who are severely unwell may need inpatient treatment in an acute mental health ward or in times of crisis, in A&E departments or at home by a crisis resolution home treatment team. Mental ill health disproportionately affects people in the criminal justice system and treatment is also offered in prisons, secure hospitals and youth offender institutes.

Recognising progress in specialist services for specific conditions

The FyFV-MH has made fantastic progress in services targeted at specific conditions.

The FyFV-MH committed to increased access to specialist perinatal mental health support by 2020/21, enabling 30,000 additional new or expectant mothers to receive evidence-based treatment close to home each year.⁶ Progress in 2017/2018 has exceeded expectations more than three-fold, with 7,000 more women accessing services by March 2018 against a target of 2,000.⁷ Four new mother and baby units are planned in England and NHS England has invited proposals from organisations to develop community perinatal services.

But the Royal College of Psychiatrists' Perinatal Faculty warned that it is "misleading to think that the job is almost done" when suicide remains a leading cause of maternal death in the pregnancy

and the post-natal period. Teenage pregnancies, care beyond the baby's first year and co-morbid substance abuse remain areas lacking in focus and investment.

Commitments are also being met in early intervention in psychosis (EIP) services, with 74% of people starting treatment within two weeks for a first episode of psychosis in the final quarter of 2017/2018 against a target of 50%.⁸ The FyFV-MH recommended that by 2020/21, adult community mental health services should provide improved access to EIP.⁹ NHS England also told us that improvements are underway to ensure service users have access to the full range of treatments advocated by the National Institute for Health and Care Excellence (NICE) which recommends what treatments people with certain conditions should receive.

In the last quarter of 2017/18, 79% of children with an urgent eating disorder were seen within one week and 80% of routine cases were seen within four weeks in line with the FyFV-MH recommended standards.¹⁰ Where targets have been met, we need to raise ambitions to give more people the timeliest treatment possible.

However, in many areas of mental health care there are no targets, creating inequalities among diagnoses.

For example, the inquiry heard that there are no targets for how long adults should have to wait to access eating disorder services. According to the charity BEAT, adults now wait twice as long as children to begin treatment for an eating disorder.¹¹ We were also told by service users and stakeholders, including Rethink Mental Illness, that we are yet to commission a consistent and coherent approach to treating personality disorders.

Areas of mental health that have not been set a target must be considered a priority for the future to prevent skewed allocation of resources. A vital starting point would be to deliver in full the evidence-

5 Gask, L. et al. (Eds.) (2009). Primary Care Mental Health. RCPsych Publications.

6 NHS England (2016) The Five Year Forward View for Mental Health.

7 NHS England (2018) Board Paper: NHS performance and progress on implementation of 'Next Steps on the NHS Five Year Forward View'.

8 NHS England (2018) Mental Health Five Year Forward View Dashboard.

9 NHS England (2016) The Five Year Forward View for Mental Health.

10 NHS England (2018) Mental Health Five Year Forward View Dashboard.

11 Beat (2017) Delaying for years, denied for months.

based referral to treatment pathways outlined in the FyFV-MH for diagnoses such as adult eating disorders, personality disorder and bipolar disorder. There is a lack of transparency over this process, but it is clear that deadlines for introducing some of these pathways have been missed. This is a wasted opportunity. Picking and choosing which parts of the FyFV-MH we implement will cause inequality within mental health care and risks sending the negative message that the quality and speed of the care you receive depends on diagnosis.

1 NHS England should implement in full all pathways set out under the FyFV-MH to avoid incentivising a skewed allocation of resources, and revise initial targets after 2021 to make them more ambitious.

A wider choice of talking therapies for everyone affected by mental illness

NICE states that people seeking mental health treatment for the first time for a mild to moderate condition should be prescribed a ‘talking therapy’.¹² Talking therapies are psychological treatments designed to help people break down their problems into manageable parts.

Almost all respondents to the inquiry named the expansion of the Improving Access to Psychological Therapies (IAPT) programme as one of the biggest successes of the FyFV-MH. IAPT services are designed to quickly provide adults who have mild to moderate cases of depression or anxiety disorders with effective psychological therapies, such as cognitive behavioural therapy (CBT), either face to face, in a group or online. The most recent data shows us that 89% of adults accessed psychological therapy within six weeks of referral.¹³ To have so many people accessing therapy through IAPT in the context of historic underfunding and stigma against mental health is an achievement.

Yet improvements should be made. The British Association for Counselling and Psychotherapy told the inquiry that many IAPT services do not offer the full range of talking therapies, despite the existence

of NICE approved therapies beyond CBT. It is vital that someone seeking mental health treatment is offered the therapy that will be most effective, not just the therapy that is available. We heard specifically about the need to research trauma-informed therapies as most beneficial for someone’s past experiences and future life.

An IAPT service manager told us that IAPT is good at what it does: helping people with mild to moderate cases of anxiety and depression. It was not designed for adults who are severely affected by mental illness, older people or those with addictions and there is too little alternative provision for these groups.

This has created a cohort of would-be service users who could benefit from talking therapy but have nowhere to go. While 50% of younger people are referred to IAPT, this is the case for only 6% of older people.¹⁴

Some of these exclusions have not stood the test of time and should be corrected. IAPT was not designed with older people in mind, but we have been shown evidence that it can be effective for that group. However, we recognise that other groups cannot and should not be seen by IAPT because their needs are better met elsewhere.

“[The IAPT workforce] have no experience or training in psychosis. They may never have seen somebody with bipolar disorder in their career. They aren’t a workforce that you can suddenly have delivering psychological therapies for people with a severe mental illness.”

Service manager

The problem we heard most frequently was that core and community services intended to meet the needs of people severely affected by mental illness are underfunded and under pressure. We have found that those who are the sickest often wait the longest to get help.

¹² NHS England (2018) The Five Year Forward View for Mental Health p36.

¹³ NICE (2018) Depression in adults: Guidance and guidelines.

¹⁴ NHS England (2018) Mental Health Five Year Forward View Dashboard.

¹⁴ Age UK (2016) Hidden in plain sight: the unmet mental health needs of older people.

The inquiry heard that secondary services are too overstretched to offer talking therapies to people severely affected by mental illness who have more complex needs. While IAPT services work to a target of providing therapy within six weeks,¹⁵ there is no equivalent waiting time for accessing therapy in secondary mental health services.

We heard in our meeting with service users and carers that long waits for therapy in secondary care made people feel like they were “hopeless, and like nothing can help”. We heard one extreme example where a service user’s GP told them that if they wanted to access psychological therapy quickly, they should lie to IAPT about having psychosis to avoid being rejected from the service.

“When I asked my GP for help, they said ‘the only thing I can really tell you to do is lie to IAPT [about your history of psychosis].’”

Service user

The inquiry received a lot of evidence highlighting concerns that people with a diagnosis of personality disorder often receive no sort of service at all. In 2013, 154 people with a diagnosis of personality disorder took their own life.¹⁶ Just a quarter of those people had been offered dialectic behavioural therapy (DBT),¹⁷ a well-evidenced, highly effective and low-cost treatment for a diagnosis of personality disorder. Cognitive analytical therapy (CAT) features in NICE guidelines for borderline personality disorder (BPD) and eating disorders.¹⁸ We heard from a service user who was unable to access treatment for her personality disorder and ended up receiving CAT through an eating disorder service, despite not having a primary diagnosis of an eating disorder.

“Cognitive analytical therapy changed everything for me. I’m able to work full-time, and I’m completing a degree. I couldn’t do any of that before. It makes me so angry to think that I first went to my GP with symptoms when I was 10. It shouldn’t have taken this long to get help.”

Service user

Had there been an established pathway for personality disorder there is a good chance she would have accessed the same treatment far sooner – and were it not for her secondary eating disorder diagnosis, she might still be waiting for help today.

The poor availability of certain treatments is partly a workforce problem. We were told by a general adult psychiatrist that when she trained 20 years ago, secondary mental health teams were designed to be multidisciplinary so core services could offer talking therapy or art therapy to people severely affected by mental illness. Paul Farmer from Mind told us that where integrated, multidisciplinary approaches had been retained, the benefits were clear to see.

Yet the inquiry was told by a range of mental health professionals, service users and carers that the resource of community mental health teams to deliver psychological therapies for people severely affected by mental illness is increasingly stretched.

2

NHS England and CCGs should ensure appropriate provision and access to the full range of NICE recommended psychological therapies for people who are unable to access IAPT due to the nature or complexity of their mental illness.

¹⁵ NHS England and NHS Improvement (2018) The Improving Access to Psychological Therapies (IAPT) Pathway for People with Long-term Physical Health Conditions and Medically Unexplained Symptoms.

¹⁶ Appleby et al (2018) The National Confidential Inquiry into Homicides and Suicides by People with Personality Disorder. University of Manchester.

¹⁷ Appleby et al (2018) The National Confidential Inquiry into Homicides and Suicides by People with Personality Disorder. University of Manchester.

¹⁸ ACAT (Undated) Cognitive Analytic Therapy: FAQs for Commissioners.

The need to invest in core services for adults severely affected by mental illness

“The FyFV-MH has some good, carefully selected areas of peripheral vision, but also a large central blind spot over the deteriorating condition of vital core services.”

General Adult Faculty, The Royal College of Psychiatrists

The general consensus of inquiry respondents was that investment in specialist services has been transformational, but that core services are suffering. While some services have improved with additional funding and targets, core services have stood still.

Core services are adult, non-condition specific services which can be found in crisis, inpatient and community settings. Community mental health teams (CMHTs), a core service, provide treatment to the vast majority of those severely affected by mental illness in secondary mental health services.

One consequence of stagnating core services is a rise in inappropriate out-of-area placements (OAPs) which, despite the commitment to end them for adults in the FyFV-MH, remain widespread. At the end of June 2018, there were 645 inappropriate out-of-area bed placements. In June 2018, 38% of OAPs due to an unavailable bed involved travel of distances of over 100km,¹⁹ compared to 25% in June 2017.²⁰

NHS Providers told us that crisis teams had been “crucial” for reducing OAPs by providing intensive support to people experiencing a mental health crisis in their home to avoid the need to be admitted to hospital. Yet the inquiry heard that the work these community-based crisis teams can do is limited without support from CMHTs. It is down to a CMHT to provide ongoing support to people severely affected by mental illness to reduce the risk of a mental health crisis, and the responsibility of a

crisis team to intervene at the point of crisis. Faced with rising demand, both of these core services are struggling on their current resource allocation – leading to more people reaching crisis point, attending A&E or being detained under the Mental Health Act. The interim report of the Independent Review of the Mental Health Act has also highlighted how “people are not receiving the care they need in the community”.²¹

The explanations given for why core services have been less of a priority varied. Some saw these services as less politically appealing and less newsworthy compared to the creation of big ‘new’ specialist services, while others pointed to a less up-to-date evidence research base—though this in itself could be symptomatic of not being at the forefront of policy-making. Some clinicians were emphatic that the quality of care being provided has suffered partly as a result of cost improvement programmes (CIPs) affecting core adult services.

All of these factors have a consequence not just in funding received, but also how attractive core services are as a potential career path for mental health professionals.

“We would welcome a clear strategy for resourcing and investing in core mental health services.”

NHS Providers

Core services, the undisputed backbone of mental health services, must be given resource in the next mental health strategy far beyond what they currently receive.

3 NHS England should increase resources, including funding and staffing, for ‘core’ mental health services, ensuring new services are not developed or expanded at the expense of these existing services.

¹⁹ NHS Digital (2018) Out of Area Placements in Mental Health Services; June 2018.

²⁰ NHS Digital (2017) Out of Area Placements in Mental Health Services; June 2017.

²¹ Independent Review of the Mental Health Act (2018) Interim Report.

Too sick for one service; not sick enough for another – increasing thresholds are a barrier to treatment

We heard that people are being turned away from services, or put down to the bottom of waiting lists, because they are ‘not sick enough’ for secondary mental health services. This risks perverse incentives to do something drastic to get help more quickly. This group must be considered as a priority in the next mental health strategy.

“They referred me to CAMHS, but they said I’d have to wait six months unless I went to A&E, and that way I could access help quicker...you shouldn’t be told [that]. Why should I have to reach that point?”

CAMHS service user

We heard some eating disorder services are only commissioned to provide treatment for people who are below a certain BMI or who binge and purge above a minimum frequency. Some offer no treatment for binge eating disorder, despite its severity and relatively high prevalence.

In many areas the threshold for child and adolescent mental health services (CAMHS) access remains too high, due to high demand and limited resources. Many services will only see high risk children and young people. In a survey of members of the Association of Child Psychotherapists, 72% said that the threshold for access to services has increased in the past five years, leaving children and young people to get worse before being seen.²²

There remain many vulnerable groups who struggle to access CAMHS in the early stages of their mental health difficulties because they do not meet the threshold, resulting in crisis further down the line when problems are more entrenched, more difficult to treat and more costly for services.

A carer who was on the oral evidence panel alongside MPs spoke about her experience of caring for her children with severe mental health needs. She said at times she still felt like she did

not understand what was going on. When a child or young person begins to show signs of mental ill health, it can throw parents into an unfamiliar world where they are unsure how to help. Even the simplest guidance on what to say, or not to say, can go a long way in equipping parents with the knowledge and confidence to support their children to manage their condition in its early stages and prevent the perverse incentive to become ‘sick enough’ to get help.

“One of the things I’m interested in is enabling parents to understand conditions before they develop so there is a role in prevention, so a family with a child suffering from low mood... is not in a situation where they take an overdose before they are heard.”

Mother and carer

The inquiry heard about a scheme at CNWL Mental Health Trust to equip parents whose children are showing signs of disordered eating with the skills to minimise and prevent the onset of an eating disorder. The APPG supports innovative practice to reduce the need for medical intervention. There is understandable anxiety about parents and carers having this role, but there is also clear evidence that with the right support from mental health professionals it is not only possible, but effective. So where appropriate, the APPG believes mental health trusts should deliver evidence-based training to parents whose children display early signs of mental illness on managing and minimising the early symptoms.

Professor Tim Kendall, National Clinical Director for Mental Health at NHS Improvement, accepted that on the whole we needed to do a lot more for carers, including parents, and the APPG would like to hear progress on implementation of the Care Act 2014 to ensure people are receiving the support that they should.

We found it very concerning that some individuals are hit with a ‘double whammy’ of having needs that were considered too high for IAPT, but were not considered ‘unwell enough’ for secondary mental health services. There are serious problems too for

²² Association of Child Psychotherapists (2018) *Silent Catastrophe: Responding to the danger signs of children and young people’s mental health services in trouble.*

those with a dual diagnosis of substance abuse and mental health problems who are too often told they are 'not suitable' for the mental health team due to their substance misuse, but are considered 'too complex' for the drug and alcohol team.

"I'm seeing all these early warning signs and I'd just like a bit of help to cope with it. I've got a job and a relationship at the moment and it just seems like I have to lose those to be 'unwell enough' to get help."

Service user

People should not fall through gaps because their condition does not fit neatly into one particular service, nor be de-prioritised because they can live a reasonably stable life while feeling suicidal or self-harming.

A different response to crisis

A mental health crisis could be described as 'breaking point'. People may experience intense suicidal thoughts, self-harm or try to take their life. Crises also include psychotic episodes, extreme anxiety or panic attacks.

£5.5m of national funding was provided to implement the FyFV-MH recommendation to establish 24/7 community-based mental health crisis response services in all areas across England by 2020/21. These services, such as crisis resolution home treatment teams, do an important job, but are often only available to people who are already in secondary mental health services.

Since 2009/10, the number of attendances at A&E with a recorded primary diagnosis of a psychiatric condition has risen by 94%.²³

Almost everyone at our service user and carer group had attended A&E for their mental health and only two felt they had someone to contact instead of going to A&E. One person told us that when they had called a crisis line they were still told to go to A&E.

"I feel really depressed by all of this because 30 years ago there would've been 30 people who would've said they could call my team [in a mental health crisis]."

Baroness Watkins, former mental health nurse

Despite crisis plans sometimes still recommending going to A&E, we heard in the service user meeting that it is common to be sent home after being seen briefly by a mental health professional.

Psychiatric liaison teams in A&E are skilled in assessing mental health crises and deciding on an appropriate course of treatment. For example, someone attending A&E in a psychotic state could be seen by the liaison team and be admitted to a psychiatric ward. Someone with intense suicidal thoughts may be best discharged to receive ongoing support from a community mental health team or their GP.

The FyFV-MH recommended that by 2020/21, no hospital should be without an all-age liaison service to provide urgent and emergency mental health care and at least half should offer a 24/7 service which meets the NHS England Core24 standards. Initial reports indicate that funding has led to an increase in service provision and there has been good progress towards meeting those targets.

"There is a bit of a narrative...that the liaison psychiatric service is basically a sort of de facto crisis team. Certainly within [my Trust] that's not the case."

Consultant liaison psychiatrist

It is possible to stop people reaching crisis point and attending A&E if community services intervene early enough – but the support across the country is patchy as core services struggle to meet increased demand on static budgets. Anyone attending A&E for a mental health problem is likely to be very unwell, but focusing on emergency departments means the system continues to be geared towards crisis rather than early intervention, ongoing support and recovery.

²³ NHS Digital (2018) Hospital Accident and Emergency Activity.

The APPG believes people reaching crisis point, for example intense suicidal ideation, should be given alternative support that is better suited to their needs. As has been a theme throughout this report, people should not feel that they are only worth help when their situation is the worst it could possibly be.

“I think often people feel like ‘I turn up and get asked to go home’ – you’re told to go [to A&E], other services will tell me to go there, I see someone and I get sent home.”

Service user

NHS England should ensure that every STP has a model to direct 111 callers and mental health 999 calls to a 24/7 support service where experienced psychological well being coaches provide initial assessment over the phone. APPG members have seen in our own constituencies examples where 111 staff do not feel adequately trained in mental health crises. In one area, 111 call handlers did not know which A&E departments had psychiatric liaison services. The 24/7 service should have mental health nurses or social workers as ‘first responders’ to provide face-to-face assessments and crisis management. For this to be rolled out successfully, the workforce must be newly recruited instead of being taken from existing mental health services.

Similar models already exist and these examples of good practice should be adopted as a standard approach to restore the balance between liaison teams providing care for people in a crisis and people with a long-term physical health condition.

4 NHS England should ensure that every STP has a service model that directs 111 callers to 24/7 support and mental health crisis response for both adults and children and young people.

Chapter 2: Building better data to measure the progress we are making

NHS England publishes data in the FyFV-MH dashboard on the proportion of people accessing services covered by the FyFV-MH and how quickly. This allows us to measure how well each CCG is delivering the FyFV-MH. NHS England has made great strides in its reporting of data. A high level of transparency is key to measuring progress and securing long-lasting change in our mental health services – it is how the government and NHS England are held accountable.

Since the first iteration there has been some trial and error in ensuring indicator accuracy. It takes time for data sets to mature, so it is important we stick with the current indicators and continue to report quarterly.

There remain areas where more transparency would make a significant impact. The CQC told us they are undertaking work to strengthen their model to ensure we can assess parity of esteem between mental and physical health across settings. To date, their work has included allocating mental health inspectors with specialist knowledge to acute trust inspections, improving assessment quality, and launching new guidance to ensure more robust inspection of physical health provision within mental health services.

The CQC gave the APPG details of current and planned developments, designed to strengthen the monitoring process, and highlighted helpful brief guides to support services drive improvements.

The mental health investment standard shows whether CCGs are raising their investment in mental health in line with the rise in their overall budget allocation, but the fact remains that there is no definitive confirmation that FyFV-MH funding is reaching the frontline and if it is, whether it is being spent as outlined in the plan.

The physical health sector told the group of their frustrations trying to analyse the indicators most relevant to them. The smoke-free policies and smoking cessation interventions of mental health trusts, for example, are not collected. Diabetes UK said their scrutiny of the national roll out of IAPT for people with long term conditions (LTC) was blocked by the delay of the evaluation publication.

Increased accountability is needed for targets that sit outside NHS England (NHSE), especially those that are delivered by non-health departments and organisations.

“...the cross-government recommendations do not change substantially on a frequent basis, so at this stage we do not feel that a public dashboard would add value.”

Jackie Doyle-Price MP, Parliamentary Under-Secretary of State for Health and Social Care

The settled accommodation indicator has disappeared from the FyFV-MH dashboard despite the FyFV-MH recommending that we monitor employment and settled housing outcomes for people with mental health problems.²⁴ This should be reinstated. New indicators from the non-health side of the FyFV-MH would ensure we achieve what we set out to before we begin to track a new plan. We cannot secure progress without accountability and we cannot have accountability without transparency.

We also need more service user experience data. The cancer dashboard reports survival rate, patient experience and clinical outcomes, showing their equal importance. Currently service user experience is captured by the CQC,²⁵ while the mental health dashboard deals largely with access targets. The APPG believes the dashboard should include a new service user experience indicator, through the inclusion of data from an expanded CQC community mental health survey, which should also capture inpatient experience. It is vital that we transparently take service users views into account about treatment and care received.

In order to get a complete picture, an analyst would have to look at the dashboard, ad-hoc reports such as the Acute Care Commission, local data, and frontline clinical and managerial feedback. This is not easy for dedicated researchers and policy makers, whose job it is to evaluate FyFV-MH progress, and we've been told it is “almost impossible” for busy frontline clinicians. If professional mental health staff and others in the sector are finding it challenging, the APPG has little confidence that service users and carers, unused to health sector terminology

²⁴ NHS England (2016) The Five Year Forward View for Mental Health Recommendation 41.

²⁵ CQC (2017) Community mental health survey 2017.

and processes, will be able to navigate the various accountability mechanisms any easier.

“Our concern is whether your average member of the public knows how to scrutinise the FyFV-MH, and feedback their concerns? If something serious happens there will be a review, but for lower level problems what – if anything – will happen?”

NHS Clinical Commissioners

The APPG therefore recommends that the following indicators are added to the dashboard in addition to the current areas being tracked:

- workforce
- data on whether funding to implement the Forward View for Mental Health is being spent as outlined in the plan
- clinical reported outcomes and key targets/operational performance for services not currently covered
- the annual results of the CQC community mental health survey with additional data on service user rated quality of care for inpatient services
- waiting times which accompany the complete list of pathways due to be introduced from the FyFV-MH
- a Y/N indicator that co-production is happening to the standards of 4Pi
- a robust data set to track settled accommodation status of adult mental health service users
- IPS beyond baseline to report at CCG level.

There has been good progress tracking the delivery of the FyFV-MH, and while there should be continual improvement made to what is tracked, there remain overarching issues of data quality and timeliness. It is unacceptable that the dashboard is routinely late. This must be resolved as a matter of priority.

5 NHS England should ensure quarterly publication of the mental health dashboard, including Health Education England / NHS Improvement dashboards including against the new indicators listed on this page.

6 The Department of Health and Social Care should publish in 2019 a report on the progress of FyFV-MH implementation, including on NHS and cross-government recommendations and commit to an annual publication thereafter.

Chapter 3: The interaction between physical and mental health

Addressing the premature mortality of people with a severe mental health condition

Many respondents to the inquiry argued that more needs to be done to improve the physical health of people with severe mental illnesses (SMI). The life expectancy for someone with a severe mental illness is 15–20 years shorter than the general population largely owing to preventable physical health conditions.²⁶

The FyFV-MH recommended that by 2020/21 at least 280,000 people with SMI should have their physical health needs met.²⁷ We were told by an individual with a diagnosis of schizo-affective disorder how the physical health checks that their psychiatrist had started providing had made a big difference to their life.

However the inquiry heard concerns from stakeholders, including Rethink Mental Illness, that physical health checks in some areas were seen as a ‘tick-box exercise’ and that service users were not aware of available support, such as smoking cessation. The Royal College of GPs told us that they did not believe people with serious and enduring mental health conditions were receiving appropriate physical healthcare. Everyone on the SMI primary care register should receive a physical healthcare check once a year. We must ensure that people with SMI have their physical health complaints listened to properly and not dismissed as ‘part of their mental illness’.

If people with SMI do not engage with their GP, which is not uncommon, it falls to mental health teams to undertake physical health assessments and subsequent follow-ups if any abnormalities are found. We have concerns that mental health teams may not have the resources or training to do this adequately.

Smoking remains the largest contributor to the 10–20 year difference in life expectancy suffered by those with SMI. Action on Smoking Health (ASH) told us that the average smoking rate among people with SMI is over 40% and among people discharged from inpatient psychiatric units over 70% smoke. We were interested to hear about the work occupational

therapists do to deliver lasting behavioural change, replacing habits around smoking, drinking and poor diet with healthier activities such as exercise. People must be given the tools to improve and manage their physical health.

Medication plays a significant role in people with SMI having poorer physical health. Individuals on some antipsychotic medications can experience significant weight gain, which increases the risk of developing cardiovascular disease and type 2 diabetes.

“I have found that the medication route, although reducing my symptoms to a degree, has had a profound effect on my physical health.”

Service user

More needs to be done to ensure that people with mental health conditions are only taking medicines that are clinically appropriate for their condition. We heard about the STOMP pledge to tackle the overmedication of people with a learning disability, autism or both. 30,000 to 35,000 adults with a learning disability are taking psychotropic medicines, when they do not have the health conditions that the medication is for.²⁸

It is vital that healthcare professionals have adequate training, support and resources to ensure prescribing decisions are evidence-based and based on thorough discussions with service users about the benefits and side effects, as well as potential alternatives. No progress has been made on the FyFV-MH recommendation to develop prescribing standards for all health professionals to support informed decision making on taking medication. Implementing that recommendation is key.

Mental health care is not just about medication. Dr Adrian James, a forensic psychiatrist, told the inquiry that social prescribing has progressed from a ‘nice-to-have’ concept to being recognised as an evidence-based way to manage symptoms. We welcome the Government’s recent funding for social prescribing initiatives and hope that this will be available in every primary care centre.

²⁶ Public Health England (2018) People with severe mental illness experience worse physical health.

²⁷ NHS England (2016) Implementing the Five Year Forward View for Mental Health.

²⁸ NHS England (2016) Stopping over medication of people with a learning disability, autism or both (STOMP).

To deliver on the FyFV-MH commitment to prevent poor physical health outcomes for people with severe mental illness, we need a national measure for reducing premature mortality with targets to hold services to account.

7 NHS England and Public Health England should ensure mortality data is published at STP and local authority levels and that local plans set out how to meet reduction targets, including rolling out social prescribing in every primary care centre.

Supporting the mental health of people who have a long-term physical health condition

Having a long term physical health condition (LTC), such as diabetes, increases your risk of mental illness.

Mental health professionals spoke to the inquiry about the cultural shift required to align mental and physical health services. We heard that some physical health clinicians are still not comfortable with recognising potential mental health issues and referring their patients for talking therapy. Training for all healthcare professionals in mental health would go some way to bridging this gap between mental and physical health.

Some mental health conditions are specific to long-term physical health conditions and need to be treated as a specific group. For example, the eating disorder diabulimia is specific to people with type 1 diabetes who deliberately give themselves less insulin than needed, or stop taking insulin entirely, to lose weight. Diabetes UK told us that there are just two specialist centres in the UK for people with diabulimia, despite suggestions that 40% of women and 11% of adolescent boys with Type 1 diabetes may be sufferers.²⁹

A liaison psychiatrist described their specialism as a branch of medicine that is designed specifically to meet the needs of people whose mental illness is secondary to their physical illness, or who have the two alongside one another. The role of liaison in emergency care is crucial, but there needs to be a rebalancing of resources to better support those with long-term conditions by providing appropriate crisis help elsewhere.

The treatment pathway recommended by the FyFV-MH for people with a LTC and mental health needs has been published,³⁰ placing mental health therapists in physical healthcare settings to better meet patients' needs. The APPG hopes this initiative will help to lead the cultural shift to bring the two specialisms together.

NHS England told the inquiry that in 37 communities, pilot projects have successfully provided mental health care to people with diabetes and respiratory illness, leading to a reduction in GP and A&E visits.

It is welcome that people with a LTC and low-level mental health needs will now be able to seek treatment through a specialist IAPT service. However, we must ensure that people with an LTC and severe mental health needs are properly supported. We need to build on the FyFV-MH recommendations and ensure that 100% of acute hospitals can provide access to Core24 liaison psychiatry by 2028/29. This will ensure that people admitted to hospital for a physical condition who require intensive mental health support are able to access it in a timely manner.

8 100% of acute hospitals should provide access to a Core24 liaison psychiatry service by 2028/29.

²⁹ Diabetes UK (2017) Position statement: Diabulimia.

³⁰ National Collaborating Centre for Mental Health (2018) IAPT-LTC Full Implementation Guidance.

Chapter 4: Responding to individual needs

Throughout this inquiry, the APPG has benefited from hearing directly from people with lived experience of mental illness and carers about the challenges they have faced in accessing services and staying well. Everyone's journey through mental health treatment is different, but it seems that at times people feel as if their needs are made to fit a certain box. The APPG firmly believes that responding to a person's individual needs is a vital part of modern mental health services.

We heard from service users about the long and complicated process to get support. It is vital that the confusing nature of accessing mental health services does not cause people to give up asking for help. We heard that there is a lack of information given to service users and carers on how to access services, what to expect during the referral process, and what treatments might be available. This has to change. People should know what they are entitled to and what their rights are as a service user or carer. Mental health treatment is most effective when the person seeking help feels involved and empowered to make decisions about their care so, where possible, service users should also have a say in the type of treatment they receive.

"I've just supported my partner through cancer care and it's really highlighted the difference between severe physical health and severe mental health issues...the cancer pathway was clear, well-organised, and there was always someone to call no matter the time. The mental healthcare system is completely different."

Carer for a family member who has a diagnosis of schizophrenia

Moving towards a single point of access would mean that no matter the condition or who is referring, there is a clear starting point to seeking professional help. This can only work if access to treatment pathways are implemented in full.

There are inequalities within mental health services which must be addressed. Mental health services have fallen short in how they have served people

from Black and minority ethnic backgrounds and deprived communities. LGBTQ+ people still encounter instances of mental health professionals wanting to 'cure them'. People with experience of trauma, such as survivors and victims of domestic, sexual or childhood abuse have a higher prevalence of mental illness.

Black and minority ethnic people face additional inequalities and challenges to their mental health, such as racism and stigma. IAPT data clearly shows that there are worse outcomes for BAME people,³¹ but there is no evidence for why or nationally implemented solutions to change this. If we are to tackle this injustice, we must investigate what causes this gap in recovery from talking therapies and consider solutions. The Independent Review of the Mental Health Act is also looking at BAME inequalities within the mental health sector and the relevance of its findings and recommendations must be tested at each level of mental health care, not just for those under detention.

Claire Murdoch told us in evidence that NHS England is trying to incentivise providers to understand why there are different recovery rates for different groups. We support that work as a first step and hope that this will be fed into future service planning and commissioning.

We heard that people with learning disability or autism (or both) routinely have their referrals to mental health services turned down because some services "do not accept referrals from that group". Mental illness presents very differently in people with a learning disability or autism. As a result, symptoms of mental illness can be wrongly attributed to a person's learning disability or autism meaning that this group does not receive the treatment they need for their mental health problems.

Autistica powerfully described to the inquiry how service design, such as telephone assessments or group therapy, excludes people with autism. Baroness Hollins emphasised throughout the inquiry that services are legally obliged to implement reasonable adjustments so people with learning disability or autism or both can engage with mental health services. This doesn't appear to be happening. We were pleased to hear that the national clinical directors at NHS England for learning disability and

³¹ NHS Digital (2018) Psychological Therapies: Annual report on the use of IAPT services England, further analyses on 2016–17.

mental health are working together over the next 18 months to redesign pathways. We look forward to seeing the outcome of that work.

Addressing inequalities faced by these groups must be a priority for the remaining time of the FyFV-MH through the Equalities Champion. Co-production and peer work should also be a priority to harness the first-hand insights from affected communities to improve services.

9 **The Department of Health and Social Care should ensure that the Equalities Champion, in collaboration with affected parties, investigates the factors which lead to differences in access to, experiences of and lower recovery rates from secondary mental health care in certain groups to ensure all mental health policies are compliant with the Equalities Act.**

Chapter 5: Preventing mental ill health: public health and supporting children and young people

Investing in children and young people's mental health should be part of a preventative approach

The FyFV-MH aims for 35 per cent of children and young people with a diagnosable mental health condition to get NHS-funded community treatment by 2020/21.³² This is a welcome improvement on pre-2015 provision but, even if this is achieved, it leaves 65 per cent of children with mental ill health without help. Half of mental ill health begins before the age of 14. A preventative approach to children's mental health improves chances of recovery, meaning fewer years spent suffering as a young person. NHS England must provide additional resources for child and adolescent mental health services (CAMHS) to support children and young people with complex needs.

"Children's mental health has been the forgotten part of mental health for years...I genuinely believe this is where we need to invest most and reach those kids before it becomes entrenched."

Professor Tim Kendall, National Clinical Director for Mental Health at NHS Improvement

The Royal College of Paediatrics and Child Health told us that public health measures promoting perinatal mental health and the provision of perinatal mental health services will have a significant positive impact on the mental health of the next generation in infancy, adolescence and beyond. The FyFV-MH success in expanding perinatal mental health provision is to be congratulated.

Yet the FyFV-MH made no recommendation on early years provision for children's mental health before the age of five. Parenting support is an intervention which appears to have been effective and the King's Fund called on Public Health England to continue this work.

This is particularly pertinent with the wealth of emerging evidence on adverse childhood experiences (ACEs). There is significant evidence that ACEs can lead to the development of a mental disorder and any new mental health policies for children and young people must take this group into account. Young people affected by ACEs, which develop into unmet mental health needs, also disproportionately come into contact with the criminal justice system.

The Mental Health Policy Commission called for community and family-based approaches to reduce the harm caused by identifiable adverse childhood experiences, such as abuse, domestic violence, bullying or victimisation as a key preventative measure.³³ The APPG echoes this call. Public Health England should explore these approaches in more detail.

Many organisations from the children and young people sector believed that the Green Paper on Children and Young People's Mental Health was right to look at helping children in schools, but expressed concerns that preschool children and children not in school, including at-risk groups such as those in young offender institutes, could miss out.

There was support for the creation of Mental Health Support Teams working in schools to help with pupils' mental health. Professor Tim Kendall told the inquiry that the Green Paper proposals would lead to double the number of mental health professionals working with children. However, organisations remained concerned that in some areas it will take 10 years for Mental Health Support Teams to become accessible. There are also doubts about the level of training and expertise these Mental Health Support Teams will have and the impact this could have on the children they are intended to support.

10 NHS England should provide additional resources for children and young people's (CYP) mental health services which support CYP with complex needs.

32 NHS England (2016) The Five Year Forward View for Mental Health.

33 Mental Health Policy Commission (2018) Investing in a Resilient Generation: Keys to a Mentally Prosperous Nation.

Keeping people well

Overall there should be an approach that focuses on what we can do to keep people well, rather than only on what we can do when they are already sick.

In our service user and carer focus group, we heard that there was inadequate support at times of stress for people with a history of SMI – typically when early warning signs first begin to emerge. They reported that when they flagged these signs of stress to their GP, there was no support available because it was not considered a mental health problem. If these early warning signs develop into severe symptoms, people will likely need to be referred back to secondary mental health services. This is not only at huge cost to the NHS, it is also hugely disruptive to people's lives.

The Prevention Concordat for Better Mental Health is a government initiative that arose out of the FyFV-MH, intended to “promote evidence-based planning and commissioning to increase the impact on reducing health inequalities” as well as representing a “public mental health informed approach to prevention, as outlined in the NHS Five Year Forward View.” The concordat was guided by an expert steering group of national partners who individually pledged to engage in action across the whole system, demonstrating this with a public commitment to delivering specific changes.

Public Health England has been proactive in developing public health guidance and prevention strategies beyond the concordat, for example with its work on supporting all local areas to have suicide prevention plans in place.

However, NHS Clinical Commissioners thought the progress of the concordat had ‘waned’. Moreover, various organisations told the inquiry about their concerns that local government budget cuts were making public health initiatives harder. The Association of Directors of Public Health have said that they “have reached the limit of available efficiencies”. According to Mind, only one to two percent of local authority public health budgets have been devoted to mental health in recent years.³⁴ A robust public health system is essential for a preventative approach that strives for a mentally healthy society.

11 NHS England should not approve any STP mental health plan unless it has an ambitious and credible plan for the prevention of mental ill health and delivery of services that best meet the needs of its population.

³⁴ Mind (2016) Charity reveals ‘shocking’ spend of less than 1 per cent on public mental health.

Chapter 6: Collective responsibility for mental health: looking beyond the NHS

“If we have a mental health plan that just focuses on what the NHS can do for mental health, we will have failed.”

Paul Farmer, Chief Executive of Mind

Around 30,000 people severely affected by mental illness currently live in some form of supported housing.³⁵ If a person needs long-term support for their mental health, supported housing is a stable environment outside of hospital where people severely affected by mental illness can progress to recovery. People’s stays can vary from a few months to several years, depending on their condition.

Housing must be seen as an essential prevention and recovery service, not least to prevent people returning to hospital soon after they have been discharged.

“There is a wealth of evidence that policies can have the unintended consequence of undermining individuals’ progress towards recovery.”

Rethink Mental Illness

The FyFV-MH recommended that the right levels of protection should be in place for people with mental health problems who require specialist supported housing.³⁶ Several respondents expressed concerns about the ongoing government consultation proposing a new funding model for supported housing.³⁷ Since that evidence was submitted, the government has confirmed that housing benefit will be maintained for all supported housing.³⁸ This welcome assurance puts health and housing sectors on a firmer base to work with central and local government to deliver on the housing-related commitments of the FyFV-MH.

The FyFV-MH recommended that the Department of Health and Social Care should work with the Ministry of Housing, Communities and Local Government, NHS England and the Treasury to build an evidence base for specialist supported housing.³⁹ We heard from housing providers that there has been frustratingly little government progress on this, with the only published review of supported housing including insufficient information on the importance and effectiveness of specialist housing support for people with mental illness. Good evidence exists that supported housing works – but we need the government to show leadership in developing and expanding this on a national level. An updated government endorsed evidence-base could lead to increased investment from providers. It is currently estimated that by 2020/21, there will be a shortfall of 35,000 supported housing places.⁴⁰

Supported housing is a less expensive and more settled alternative to a stay in hospital and reduces the number of delayed discharges and out of area placements. According to the Crisp Commission, mental health trusts reported that 39% of delayed discharges were caused by a lack of appropriate housing.⁴¹

Claire Murdoch, the national Mental Health Director at NHS England, suggested that one of the reasons why core mental health services might be struggling was because of their strong ties with supported housing, a vital yet scarce resource.

“You will hear CMHTs saying, ‘It’s harder to find housing for this person,’ or, ‘It’s harder to get social work’s support than perhaps it was’ unless they meet a criteria where the bar’s set very high.”

Claire Murdoch, Director of Mental Health NHS England

35 David Orr, National Housing Federation (February 2017) Strengthening the case for supported housing: the cost consequences

36 NHS England (2016) The Five Year Forward View for Mental Health Recommendation 11.

37 Ministry of Housing, Communities & Local Government and Department for Work and Pensions (2018) Funding for supported housing: Government response to two consultations.

38 Ministry of Housing, Communities & Local Government and Department for Work and Pensions (2018) All supported housing funding to be retained in welfare system.

39 NHS England (2016) The Five Year Forward View for Mental Health.

40 National Housing Federation (2017) Strengthening the case for supported housing: the cost consequences

41 Royal College of Psychiatrists (2016) Old Problems, New Solutions.

The lack of progress in this area so far is a wasted opportunity to reduce the burden on NHS mental health services and improve people's chances of recovery.

Paul Farmer told the inquiry that the scale of transparency around FyFV-MH health data had helped to drive change. Kathy Roberts, Chief Executive of the Association of Mental Health Providers, recommended that the same level of scrutiny should be given to data on the non-health recommendations to ensure a similar level of progress.

Mental health trusts across the country are taking forward a range of different programmes to address housing, such as embedding housing workers in inpatient and community teams. HACT told the inquiry that the new community forensic services which have been co-produced with people with lived experience included housing as a key cornerstone of the new model. The APPG supports these integrated approaches as collective responsibility for the social determinants of health. NHS England should recognise, support and accelerate this type of work integrating health and housing and the Ministry of Housing, Communities and Local Government must ensure the funding is there to make it possible across the board.

Supported housing provision should be integrated with local mental health and social care services, yet funding disparities are undermining this. While we welcome the recent uplift in funding for health, there has been no similar increase for social care.

“We will end up in a very, very difficult position if you have a 3.4% increase for health and nothing else about social care.”

Tim Kendall, Clinical Director at NHS Improvement

Social care reduces the need for people to go to hospital and helps get people out of hospital. Integrated working is not possible if there is an imbalance in resource between the parties involved. Social care must be properly funded if it is to reduce pressure on the NHS – otherwise it will only put pressure back on.

“The mental health plan currently being developed would be much more effective if it was planned and implemented across health and social care, rather than restricted to NHS England.”

Mark Trewin, Mental Health Social Worker

A number of contributors to the inquiry explained how problems in the benefits system are exacerbating mental health problems. There should be an assessment of need, but the process for applying for personal independence payment (PIP) or employment support allowance (ESA) is currently interrogative and traumatising. We need to improve the impact the welfare system has on people with mental illness who rely on the system.

Whilst improving the health and justice pathway was a clear objective of the FyFV-MH, the APPG has serious concerns that plans to divert people away from prison, and treat those with mental health conditions in prison, are failing to be met. The increase in self-harm, use of novel psychoactive substances and assaults on inmates and staff indicate serious challenges to mental health provision in the prison system.

Liaison and diversion (L&D) are teams that identify vulnerable people early on to help improve health and criminal justice outcomes. Coverage of L&D has increased, but we heard concerns that many of these services have inadequate medical input. These services identify those in need of support for a mental health problem, substance abuse issues or a learning disability in the early stages of coming into contact with the criminal justice system. The vast majority of people in prison will eventually return to the community – mental health support is a key part of rehabilitation and reducing the risk of reoffending.

The APPG was pleased to learn that the Department of Health and Social Care and the Ministry of Justice have co-produced five testbed site pilots across England for community sentence treatment requirements (including mental health treatment requirements),⁴² as part of the FyFV-MH commitment to divert offenders with mental health

⁴² Ministry of Justice (2018) Vulnerable offenders steered towards treatment.

conditions away from prison. However, the current testbed sites are based overwhelmingly in primary care, and do not cater for those offenders on the more severe end of the scale. The more we do not cater for this significant minority, the more risk we run of criminalising the mentally ill.

Overall, it is clear that the NHS has shown real commitment and drive in implementing the FyFV-MH. We cannot make long-lasting change to the lives of people affected by mental illness without improved collective responsibility. A key part of this is central oversight. Every department with a responsibility for mental health should be reporting on their progress, as we expect NHS England to. We believe that the cross-department recommendations must be elevated to the Cabinet Office to ensure accountability and real progress. This would be best served by establishing a Mental Health Cabinet Committee that would work to improve the mental health of the nation.

12 The Green Paper on Adult Social Care should recommend an uplift in social care funding to give it the necessary resources to act in equal partnership with health.

13 NHSE should ensure that every mental health trust has a community rehabilitation and recovery team to work jointly with social care, local accommodation and community support networks for those individuals needing long-term support.

14 In partnership with the Ministry of Housing, Local Government, Communities and Local Authorities, NHS England should recognise, support and accelerate the work of mental health trusts across the country to address and increase the provision of specialist mental health supported housing.

15 The NHS Long-Term Plan should make specific recommendations to improve the impact of the social welfare system on the mental health of those who rely on it, including through reform to assessments for PIP and ESA.

16 The Government should establish a Mental Health Cabinet Committee to ensure collective responsibility for improving the mental health of the nation.

Chapter 7: How do we achieve these goals?

We need to grow the NHS mental health workforce

The inquiry has been told repeatedly that securing the right workforce remains the biggest obstacle to delivering the FyFV-MH. The shortage of mental health staff is a deep-rooted problem that NHS England told us they are working hard to resolve. Health Education England (HEE) has set out a plan to employ an extra 19,000 additional people to work in mental health by 2020/21.⁴³

However, serious problems remain. We heard that *Stepping forward to 2020/21: The mental health workforce plan for England* came too late in the planning cycle and there are now significant difficulties in translating this into action at a local level. The British Medical Association also noted the plan lacked the substantial investment in recruitment and retention needed to deliver it.

NHS Providers told the inquiry that they were concerned that national investment in mental health was being used to address FyFV-MH commitments at the expense of other resources – mainly staff for core mental health services.

“...capacity within the service is not increasing and existing staff are expected to add to their current role.”

King’s Fund

There are too few psychiatrists currently working in the NHS. One in ten consultant psychiatrist posts are vacant.⁴⁴ This has consequences not just for service users, but for the quality and quantity of research into improving and discovering treatments for mental illness. Psychiatrists are given clinical research days – but because of the pressure on services, these are increasingly limited. As a result, there has been a reduction in the clinical academic workforce. The consultant academic psychiatry workforce fell by 32% between 2013 (90) and 2017 (61).⁴⁵ Moreover, the vacancy rate climbed from only

2.2% to 11.5% over the same period.⁴⁶ With the added risk of losing EU research funding, the UK risks being left behind in the quality of treatment we can offer in the long term.

“Core services have been a victim of successes of other areas, because general psychiatrists are switching to specialisms that are receiving new funding.”

Dr Adrian James, Registrar of the Royal College of Psychiatrists

Challenges to creating strong multidisciplinary mental health teams are evident. The King’s Fund told us that in some local areas, recommendations from the FyFV-MH such as expanding community-based CAMHS and perinatal services are being achieved by re-training existing staff without adding to the headcount. This robbing Peter to pay Paul approach is not sustainable in the long-term.

As a result, some services – such as those for eating disorders according to BEAT – are operating without the staffing levels and skill mixes recommended in NHS England commissioning guidance.⁴⁷ Specific skill mixes are often a core aspect of access and waiting time standards.

HEE should consider re-evaluating the makeup of the mental health workforce to ensure we have a robust and sustainable workforce fit for the modern culture of the NHS. There is a great deal of interest in mental health among young people in particular. It should be made much easier to work in NHS mental health services for those, for example, graduating with a degree in psychology which was the third most popular undergraduate course for students starting university in 2016.⁴⁸ With their knowledge and expertise, these graduates could have a role, for example, in staffing the 24/7 crisis line proposed by this report.

43 Health Education England (2017) *Stepping forward to 2020/21: The mental health workforce plan for England*, p4.

44 Royal College of Psychiatrists (2017) *Census 2017: Workforce figures for consultant and specialty doctor psychiatrists*.

45 Royal College of Psychiatrists (2017) *Census 2017: Workforce figures for consultant and specialty doctor psychiatrists*.

46 Royal College of Psychiatrists (2017) *Census 2017: Workforce figures for consultant and specialty doctor psychiatrists*.

47 NHS England, NCCMH (2015) *Access and Waiting Time Standard for Children and Young People with an Eating Disorder Commissioning Guide*.

48 HESA (2018) Table 22 – HE student enrolments by subject of study and domicile 2016/17.

“There is a dearth of professionals practising in NICE-approved psychological therapies such as dialectic behavioural therapy and family-based, which are recommended for BPD, bipolar and psychosis.”

Kathy Roberts, Chief Executive of the Association of Mental Health Providers

HEE told the inquiry that they have commissioned a project to map mental health career pathways and particularly those of psychology graduates. Psychologists’ high level of knowledge, skill and experience means they can deliver the most relevant psychological model for each person they see. Recruiting more psychologists for specific therapies such as DBT or CAT would prevent the over reliance on cognitive behavioural therapy (CBT) mentioned earlier in this report.

The losses to the NHS nursing workforce are well publicised. Between April 2010 and April 2018, there was a 12% fall in the number of mental health nurses.⁴⁹ Royal College of Nursing (RCN) research found that London hospitals had 10,000 nursing vacancies and that NHS mental health trusts were among the worst affected by shortages of nurses.⁵⁰ The *Stepping Forward* plan committed an additional 8100 posts for mental health nurses and midwives by 2021.⁵¹ There has been an increase of only 365 mental health nurses in NHS trusts between March 2017 and March 2018, suggesting we need to recruit an additional 7735 more nurses in just three years.⁵²

Respondents to the inquiry also had specific concerns about the government’s plans in the Children and Young People’s Mental Health Green Paper placing further pressure on CAMHS as the newly formed Mental Health Support Teams and the Designated Senior Leads for Mental Health refer more pupils on to specialist services.⁵³ As it stands, there has been no additional resource allocated to CAMHS for supervision of the Mental Health Support Teams and the *Stepping Forward* plan made no plan to increase the number of community child

and adolescent psychiatrists (CAP).⁵⁴ Our concern is that with the current CAMHS workforce it simply will not be possible to deliver the proposals of the Green Paper.

Paul Farmer told the inquiry that HEE should build on the success of the Royal College of Psychiatrists’ Choose Psychiatry recruitment campaign to recruit other specialties that make-up a multidisciplinary mental health team. Progress has been slow in the delivery of HEE’s *Stepping Forward* plan, with 915 additional mental health staff recruited between March 2017 and March 2018.⁵⁵ The APPG believes the government must do all it can to speed up the recruitment process, and recommends funding HEE suitably so that it can undertake a mental health wide recruitment campaign.

HEE told us they have created a dashboard to count training places being commissioned in mental health with a view to counting the number of people in the mental health workforce. It is disappointing that this dashboard has been designed for internal NHS use and they have no intention at this stage to publish it.

Worryingly, despite the big gap between the current workforce and the number of staff needed by 2021, HEE does not appear to have a clear strategy for how this gap will be closed.

17 HEE should develop a mental health workforce strategy that takes into account population growth, associated incidence and prevalence of mental illness in the population, and ongoing workforce policy changes.

18 NHS Improvement should set a yearly 4% improvement target in retention rates to be met by all mental health trusts and community and acute trusts where they are providing mental health services.

49 NHS Digital (2018) NHS Workforce Statistics – April 2018.

50 RCN (2016) London Safe Staffing Review of 2015.

51 Health Education England (2017) *Stepping forward to 2020/21: The mental health workforce plan for England*, p4.

52 NHS Digital (2018), NHS workforce statistics – March 2018

53 Department of Health and Department for Education (2017) *Transforming Children and Young People’s Mental Health Provision : a Green Paper*.

54 Health Education England (2017) *Stepping forward to 2020/21: The mental health workforce plan for England*, p4.

55 <https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2018-09-07/171694/>

19 Health Education England should fund a mental health wide recruitment campaign, with focus on recruiting psychology graduates to specific types of therapy in both NHS IAPT and secondary psychological therapy teams to ensure all NICE recommended talking therapies are available.

All healthcare staff should be trained in mental health, learning disability and autism

We have heard throughout the inquiry that despite greater mental health awareness, there are still a significant number of NHS professionals who do not have a sufficient understanding of mental illness.

“My sister is an experienced A&E staff nurse and I was really shocked by the lack of mental health training she’d received. I said to my sister ‘I can’t believe you’d say to someone who’s come in after a suicide attempt – well why weren’t you thinking about your children?’ And she’s a very senior nurse, in charge of training other nurses.”

Service user

All members of staff need to be aware of their patient’s mental health regardless of whether they are being treated for physical or mental health problems. An undetected mental health problem can have fatal consequences. The BMA, Mind and the Royal College of GPs have made a joint call to extend GP training to four years to allow more focus on mental health. We support that call.

Mental health problems in people with learning disabilities and autism are dangerously under-detected. Training for health professionals in learning disabilities should also be a priority of any future mental health strategy.

20 HEE should improve development and training of frontline care staff with a specific focus on mental health, learning disability and autism so the existing workforce is supported and equipped to deliver direct care and support to those groups.

Peer workers should be offered training and progression into other roles in a mental health team

Peer support is the help and support that people with lived experience of a mental illness are able to give to one another. The peer workforce was part of the additional 8,000 ‘non-traditional’ professionally-regulated mental health workers promised in *Stepping Forward*,⁵⁶ but there has been no strategy on how to achieve this number or guidance on what proportion of the 8,000 should be peer workers.

Service users told us emphatically that the peer workforce was invaluable both in inpatient and community settings, not only to instil a sense of hope by seeing positive role models in meaningful employment, but also to prevent an ‘us/them’ barrier between service user and professional. We heard in written evidence the benefits of peer work for engaging with historically under-served communities and recent research published in the *Lancet* showed that peer supported self-management led to a 9% reduction in readmissions to acute care over one year after discharge.⁵⁷

“On inpatient wards peer workers are invaluable...they have the time, they have the patience, they have the empathy, the knowledge...”

Augusto, service user

Some services, such as some of the new perinatal services created by the FyFV-MH, have budgeted for paid peer workers to be part of the team. This example of good practice should be replicated across all mental health services. Peer work

⁵⁶ Health Education England (2017) *Stepping forward to 2020/21: The mental health workforce plan for England*, p4.

⁵⁷ The Lancet (2018) Peer-supported self-management for people discharged from a mental health crisis team: a randomised controlled trial.

should form a core part of mental health teams with meaningful career progression. Peer work is currently in a low pay band, risking the loss of peer professionals, and their knowledge of a particular service, when they reach the upper limit of their band.

“A big and important innovation is the use and the employment of people with lived experience in your service.”

Claire Murdoch, National Director for Mental Health, NHS England

We should support those peer workers who are interested and capable to progress onto other roles within a mental health team. A career path designed specifically for people to enter the NHS based on their lived experience of mental illness, alongside other key competencies, would allow teams to make full use of personal expertise in a professional setting. Starting as peer workers, these new recruits would receive robust support, training and management from clinical experts to gain qualifications that allow them to work in other mental health roles in a multidisciplinary team such as a care coordinator.

21 NHS Employers and the Department of Health and Social Care should undertake a review of how trusts encourage applications from people with lived experience of mental illness as a protected characteristic at all levels of a team.

22 Health Education England should review the potential for a new career path designed specifically for people with lived experience to transition from peer work to other roles within a mental health team.

Funding the future

Respondents were in near universal agreement that mental health services have historically been underfunded. This has also been recognised by politicians across the political spectrum. The new long-term plan for the NHS is an important opportunity to put this right. More money is not the solution to all problems, but inadequate finances can leave services in perpetual crisis making reform impossible. Mental health must, therefore, receive proportionally more of the new funding for the NHS to redress previous under-investment.

The FyFV-MH came with a headline commitment of over £1bn invested each year in mental health by 2020/21. This has undoubtedly improved the lives of many people. The APPG, however, heard that it is difficult to be certain that funds are reaching the frontline and that historical underfunding means that mental health is still the poor relation in the NHS.

The vast majority of the funding attached to the FyFV-MH was designated for the ‘transformation areas’, with no extra funding for core community services and only £50 million being allocated to other core services nationally.⁵⁸

Some of the evidence to the APPG suggested that even in areas which had allocated funds, such as CYP eating disorders, the resources were insufficient to employ the staff needed. NHS England has provided trusts with ‘workforce calculators’ to assess how many staff are required for their population, but we heard that some trusts felt that they did not have enough money to employ the staff indicated from their calculations.

As many acute trusts are in deficit, there is an incentive for CCGs to divert money earmarked for mental health to plug these gaps. We heard that although mental health trusts are much less likely to be in deficit than other NHS Trusts, this is at least partially because it is easier to ration mental health services.

⁵⁸ The Royal College of Psychiatrists (Undated) MHFYFV National Funding Needed.

The APPG believes transparency is one of the best ways to ensure that funding reaches mental health services. A requirement to regularly publish spending on mental health keeps the pressure on CCGs to match their promises. NHS England's decision to introduce a 'Mental Health Investment Standard' has helped ensure money broadly goes where it is meant to. This rule means that every CCG must increase the amount they spend on mental health in line with the overall increase in health spending. It is important that NHS England stays vigilant on this measure and does not allow CCGs to not "hit the target but miss the point" on the basis that other parts of their services are in deficit.

We were pleased to hear from Claire Murdoch that she expects every CCG will meet this target in 2018/19. It is concerning, however, that the most recently published Mental Health Dashboard showed that in 2017/18 24 CCGs reduced how much they spent on mental health. It was also worrying that NHS England decided that eight CCGs were classed as meeting the mental health investment standard despite the fact they had cut the amount they spent on mental health. We need real transparency around this indicator – it makes a mockery of the investment standard if a CCG can 'meet it' despite cutting investment without extra explanation.

23 NHS England should continue to hold CCGs to account to ensure that funds going into baselines post 2020/21 are invested in ongoing services that have been started as a result of the Five Year Forward View for Mental Health.

Services are better when we involve people who use them

Co-production in mental health is collaborative working on a project between service users, carers and health and social care professionals. The FyFV-MH recommended that this should be a standard approach to service design and commissioning. Yet the April 2018 deadline for NHS England and NHS Improvement to develop an evidence-based approach to co-production in commissioning has been missed. Indeed, evidence received suggests that in practice, very little progress has been made in embedding meaningful co-production across mental health services.

The APPG strongly believes that co-production should be seen as the default for service design and commissioning.

Service users and carers are experts in their own experience. Just as we would value a data analyst's contribution on statistics, meaningful co-production gives full weight to an expert by experience's contribution when considering how service design, commissioning and delivery might affect people with mental illness.

Would-be service users may have reservations about seeking professional help because of a negative experience they or a peer has had in the past. Too often we hear how service users feel alienated within the system. Co-production offers an opportunity to ensure services learn from the experiences of previously marginalised user perspectives, such as the gaps they experienced in their own care, to ensure services are designed from the start to meet a wide-range of needs.

It's important that co-production is meaningful and not a tick-box exercise. We heard that often people are asked to feedback on something that has already been designed by professionals, rather than being equal partners in the design process from the beginning. Done properly, co-production should not just be a feedback forum, but a genuinely collaborative way for people with lived experience to shape the services they use.

Many service users and carers will have other valuable skills, for example critical thinking or community outreach. Some may have another day job. This presents opportunities for co-production from high-level strategic oversight to on the ground implementation, utilising not just people's experiences but their additional skill set that would make them an asset in a variety of projects.

Co-production should be tested against the National Survivor User Network (NSUN) 4Pi principles⁵⁹ as an assurance that service users' contributions are valued equally to that of professionals.

The inquiry heard from Rethink Mental Illness that there is now a 'co-production subgroup' of the FyFV-MH oversight group which will make recommendations to NHSE about steps which should be taken to implement this crucial recommendation. There must be clear accountability for embedding co-production so that the next deadline does not slip past without progress again.

24 NHS England and commissioners should be made accountable for co-production being embedded at all levels from national policy, to commissioning to service provision. NHS England should create incentives such as a commissioning for quality and innovation (CQUIN) to hold CCGs to account through the dashboard and CCG IAF.

59 NSUN (2015) 4Pi National Involvement Standards

Conclusion

The FyFV-MH was a crucial starting point in the journey to transform the lives of people with mental health problems and made 58 recommendations to lay the foundations for parity of esteem by 2020/21. This inquiry sought to establish what progress had been made and where further progress was needed. It is vital that any future mental health plan takes into account recommendations that have been previously made, but not yet achieved.

The wealth of evidence the inquiry received shone a light on many different areas, but the APPG is recommending urgent action for:

Core services

We must give increased investment to the core services that are the bedrock of secondary mental health care, supporting adults severely affected by mental illness. The consequences of leaving core services to stagnate negatively affect both service users and other mental health services that rely on support of core teams to function.

Workforce

The mental health workforce must be increased if we are to achieve the recommendations of the FyFV-MH and beyond. We should make it easier for people with personal experience of mental illness to work in services and ensure that we are harnessing the interest in psychology and mental health among young people to create a modern, diverse workforce.

Oversight and collective responsibility for mental health

There has been frustratingly little progress in areas such as housing and welfare which contribute significantly to mental health. We must ensure that social care is equipped to work as an equal partner to mental health services to prevent a person experiencing poor care due to a failure of whole-systems working. The FyFV-MH made great strides in laying the foundations for improving the lives of people affected by mental illness. We hope that this report will inform the next steps in building true parity of esteem.

Appendix 1: Methodology and terms of reference

Methodology

The inquiry was launched in May 2018 with the final report written between 13th August-3rd October 2018. The APPG received over 70 responses to their request for written evidence, held two oral evidence sessions, a focus group of service users and carers and a visited Central and North West London NHS Foundation Trust. After gathering this evidence, the MPs and Peers of the APPG agreed the key recommendations and findings of the report which was then drafted by staff from Rethink Mental Illness and the Royal College of Psychiatrists.

Consultation

The inquiry's consultation period ran from 10 May 2018 – 15 June 2018. Consultation responses were limited to 1,500 words which respondents could split out over the following three questions however they saw fit:

1. Where has the Five Year Forward View for Mental Health made the biggest impacts and where could they go further?

The Committee would like to know which recommendations have seen improvement, which recommendations need more work and which recommendations have not seen any action.

2. What should any new mental health strategy post 2021 focus on?

The Committee is particularly interested in areas that were missed, such as old age mental health, the mental health of people with intellectual disabilities or psychosis treatment outside of EIP, that could be a focus for any work post 2021 and the future ambition for areas where we have made begun to make progress.

3. How can we better scrutinise the implementation of the Five Year Forward View for Mental Health and what role can the public, Government, policy makers, Arm's Length Bodies (ALBs) and parliamentarians play?

The Committee welcomes thoughts on measuring the progress made by ALBs, data transparency and workforce.

Appendix 2: People who gave evidence to the inquiry

Written submissions

Action on Smoking Health
Agenda
Association of Child Psychotherapists
Association of Directors of Public Health
Association of Mental Health Providers
Autistica
Avon & Wiltshire NHS Mental Health Trust
BEAT
British Association of Counselling and Psychotherapy
British Medical Association
British Psychological Society
Challenging Behaviour Foundation
Chief Pharmacist, College of Mental Health Pharmacy
CQC
Diabetes UK
Dr Elizabeth Cotton, Middlesex University
Dr Tony Rao BSc MBBS MD FRCPsych MSc FRSA
Genetic Alliance
HACT
Health Education England
Janssen
Leicester Royal Infirmary
Look Ahead
MAC-UK
Mark Trewin
Mental Health Foundation
Mind
Money and Mental Health Policy Institute
NHS Clinical Commissioners
NHS Digital
NHS England
NHS Providers
NSUN
One Housing
Opening Doors
Parliamentary Under Secretary of State for Health and Social Care, Jackie Doyle-Price MP
Professor Helen Killaspy
Public Health England
RCPsych Faculty of Academic Psychiatry

RCPsych Faculty of Child and Adolescent Psychiatry
RCPsych Faculty of General Adult Psychiatry
RCPsych Faculty of Intellectual Disability and Autism
RCPsych Faculty of Liaison Psychiatry
RCPsych Faculty of Medical Psychotherapy
RCPsych Faculty of Old Age Psychiatry
RCPsych Faculty of Perinatal Psychiatry
RCPsych Faculty of Rehabilitation and Social Psychiatry
Rethink Mental Illness
Royal Pharmaceutical Society
Samaritans
St Mungo's
The King's Fund
The Labour Campaign for Mental Health
The Lateef Project
The Royal College of GPs
The Royal College of Occupational Therapists
The Royal College of Paediatrics and Child Health
Unite the Union Mental Health Nurses' Association
Unite the Union OPC for Applied Psychologists
YoungMinds

Oral witnesses

Session One | June 2018

Claire Murdoch, National Mental Health Director at NHS England

Tim Kendall, National Clinical Director for Mental Health at NHS Improvement

Session Two | June 2018

Paul Farmer, Chief Executive of Mind

Dr Adrian James, Registrar of the Royal College of Psychiatrists

Kathy Roberts, Chief Executive of Association of Mental Health Providers

Wished to remain anonymous

The APPG also received evidence from service users, carers, clinicians and stakeholders.

The All-Party Parliamentary Group (APPG) on Mental Health exists to inform parliamentarians about all aspects of mental health.

The Secretariat to the All-Party Parliamentary Group on Mental Health is provided by Rethink Mental Illness and the Royal College of Psychiatrists:



With thanks to:

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Dr Kathleen McCurdy, Parliamentary Scholar 2017–18.