



House of Commons  
Health and Social Care  
Committee

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**The Health and Social  
Care Committee's Expert  
Panel: Evaluation of the  
Government's progress  
against its policy  
commitments in the  
area of mental health  
services in England**

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**Second Special Report of Session  
2021–22**

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## Health and Social Care Committee

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# Report from the Committee's Expert Panel on Mental Health Services

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## The Committee's Expert Panel

1. In 2020, we established and commissioned a panel of experts (known as the Committee's Expert Panel or "Expert Panel") to evaluate—independently of us—progress the Government has made against its own commitments in different areas of healthcare policy. The framework for the Panel's work was set out in our Special Report: Process for independent evaluation of progress on Government commitments (HC 663), published on 5 August 2020. The Expert Panel published its first evaluation of the Government's progress against its policy commitments in the area of maternity services in England on 6 July 2021 (HC 18).

2. The Core members of the Expert Panel are Professor Dame Jane Dacre (Chair), Sir Robert Francis QC, Dr Charlotte Augst, Dr Meerat Kaur, Professor John Appleby, Professor Anita Charlesworth and Professor Stephen Peckham.

3. We asked the Expert Panel to undertake its second evaluation into mental health services in England. For this evaluation, the core Expert Panel members were joined by mental health specialists Dr Ananta Dave, Medical Director, Consultant Child and Adolescent Psychiatrist, Lincolnshire Partnership NHS Foundation Trust, Professor Peter Fonagy OBE, Head of the Division of Psychology and Language Sciences, University College London, Professor Kamaldeep Bhui, Professor of Psychiatry, University of Oxford and Karen Turner, former Director of Mental Health, NHS England.

4. We thank the members of our Expert Panel for their work and the important contribution they have made in support of the Committee's scrutiny of the Department for Health and Social Care.

## The Expert Panel's evaluation

5. With our agreement, the Expert Panel focussed on the following commitments:

- Workforce: Commitment to grow the mental health workforce.
- Children and Young People's (CYP) Mental Health: At least 70,000 additional children and young people each year to receive evidence-based treatment. Achieve 2020/21 target of 95% of children and young people with eating conditions accessing treatment within 1 week for urgent cases and 4 weeks for routine cases. Ensure there is a CYP crisis response that meets the needs of under 18-year-olds.
- Adult Common Mental Illness: All areas commission IAPT-Long term condition services.
- Adult Severe Mental Illness: 280,000 people with SMI will receive a full annual health check. New integrated community models for adults with a severe mental illness by 2023/24. The therapeutic offer from inpatient mental health services to

be improved by increased investment in interventions and activities, resulting in better patient outcomes and experience in hospital. All areas will provide crisis resolution and home treatment (CRHT) functions that are resourced to operate in line with recognised best practice, delivering a 24/7 community-based crisis response and intensive home treatment as an alternative to acute inpatient admission.

6. The Expert Panel's evaluation is appended to this Report. Although its evaluation was undertaken without input from the Committee, we expect the Department to respond to it within the standard two-month period for responses to select Committee reports.



The Health and Social Care Committee's Expert Panel:

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**Evaluation of the Government's progress  
against its policy commitments in the area  
of mental health services in England**

## Introduction

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Governments often make well-publicised policy commitments with good intentions to improve services for the public. While such policy commitments can be made frequently, it is often difficult to evaluate or monitor the extent to which these commitments have been, or are on-track to be, met. For this reason, formal processes of evaluation and review are essential, not only to hold the Government to account, but to allow those responsible for policy implementation to critically appraise their own progress; identify areas for future focus; and to foster a culture of learning and improvement. Such a process can also promote improvement in the quality of commitments made.

Improvement and review are iterative processes during which the impact and success of innovations are identified, modified, and reviewed and this is already in good use within the NHS. The concept has also been used successfully in education, by OFSTED, and in health and social care, by the Care Quality Commission (CQC). To apply this approach to health policy, the House of Commons Health and Social Care Select Committee established a panel of experts to support its constitutional role in scrutinising the work of the Government. The Panel is chaired by Professor Dame Jane Dacre and is responsible for conducting politically impartial evaluations of Government commitments in different areas of healthcare policy.<sup>1</sup> The Panel's evaluations are independent from the work of the Committee.

The Expert Panel produces a report after each evaluation which is sent to the Committee to review. The panel's report is independent but published alongside the Committee's own report. The final report includes rating of the progress the Government has made against achieving its own commitments. This is based on the "Anchor Statements" (see Annex B) set out by the Committee. The intention is to identify instances of successful implementation of Government pledges in health and social care as well as areas where improvement is necessary, and to provide explanation and further context. The overall aim is to use this evidence-based scrutiny to feedback to those making promises so that they can assess whether their commitments are on track to be met and to ensure support for resourcing and implementation were or will be provided to match Government aspirations. It is hoped that this process will promote learning about what makes an effective commitment, identify how commitments are most usefully monitored, and ultimately improve healthcare. Where appropriate, the Panel will revisit and review policy commitments to encourage sustained progress. The Expert Panel's remit is to assess progress against the government's key commitments for the health and care system rather than to make policy recommendations. This is the second report of the Expert Panel and evaluates Government commitments in the area of mental health services in England.

### Members of the Expert Panel

The Expert Panel is chaired by Professor Dame Jane Dacre and is comprised of core members and subject specialists. Core panel members were recruited for their generic expertise in policy, with a broad understanding of qualitative and quantitative research

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<sup>1</sup> The independent expert panel is made up of panel members who remain on it for each evaluation, so called "core members", and of specialist members who are appointed to a specific evaluation depending on their specialism. The core panel members can claim expenses and an honorarium for their work as Specialist Advisers. The specialist panel members can claim expenses for their work as Specialist Advisers. All panel members have to declare their interests, which are shared with the Select Committee and published on its website.



methods, and the evaluation of evidence. Subject specialists were recruited to bring direct experience and expertise to the area under evaluation by the Expert Panel. All Expert Panel members have been officially appointed by the House of Commons Health and Social Care Select Committee.

Core members of the Expert Panel are:

- Professor John Appleby,
- Dr Charlotte Augst,
- Professor Anita Charlesworth CBE,
- Sir Robert Francis QC,
- Dr Meerat Kaur, and
- Professor Stephen Peckham.

Mental Health specialist members of the Expert Panel are:

- Professor Kamaldeep Bhui CBE
- Dr Ananta Dave
- Professor Peter Fonagy OBE
- Karen Turner

Further information on the Expert Panel is set out in the Health & Social Care Committee Special Report: Process for independent evaluation of progress on Government commitments (5 August 2020).

The latest information relating to the Expert Panel can be found here: [The Health and Social Care Committee's Expert Panel \(shorthandstories.com\)](https://www.shorthandstories.com/the-health-and-social-care-committees-expert-panel)

### **Members of the Expert Panel secretariat:**

- Stephen Aldhouse
- Alex Lloyd
- James McQuade
- Sandy Gill
- Siobhan Conway
- Yohanna Sallberg

### **Acknowledgements:**

We would like to thank the Department of Health & Social Care, NHS England & Improvement and Health Education England for their engagement with our evaluation.

We are grateful to those who have supported our work, in particular, the Patient Experience Library and would like to give special thanks to the mental health professionals who took part in our roundtable discussion. We would also like to put on record our gratitude to the various organisations and individuals that submitted evidence to our evaluation for the quality of their submissions. The depth and diligence of the submissions and the considered assessment they offered of a complex set of policy commitments provided an excellent foundation on which we were able to build the evaluation.

## Executive summary

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The Health and Social Care Committee commissioned a review of the evidence for the effective implementation and appropriateness of the Government’s policy commitments relating to mental health services in England. This report has been produced independently of the Committee’s inquiry into children and young people’s mental health and examines a broader remit than the Committee’s inquiry. Our findings and ratings in relation to commitments made to improve services for children and young people do, however, contribute to the Committee’s inquiry on this topic.

The Expert Panel consists of members with recognised expertise in quantitative and qualitative research methods, and policy evaluation. This core group was complemented by experts with a working knowledge and experience of frontline delivery of NHS mental services, clinical research and policy development and implementation.

Evaluations and judgements in this report are summarised by ratings which chart the Government’s progress against specific mental health commitments. While these ratings are in the style used by national bodies such as the Care Quality Commission (CQC), the ratings in this report have been determined by us and do not reflect the opinion of the CQC or any other external agency. The commitments under review are inter-connected allowing an overall rating to be made which forms a combined assessment against all the commitments we evaluated. Separate ratings have also been given to each commitment and its main questions. All ratings are informed by a review process using a combination of established research methods, expert consensus, and consultation with communities (see Annex A for key evidence).

Published data and other sources of evidence, including written submissions from stakeholders, and round table discussions have been used to provide evidence for review by the Expert Panel, which are referenced in footnotes throughout the report.

The Department of Health and Social Care and relevant non-departmental public bodies were invited to contribute to the evaluation.

### Selected Commitments

The Department of Health and Social Care provided the Panel with its main policy commitments in the area of Mental Health Services in England. Using this information and wider policy documentation, we identified nine commitments across four broad policy areas. These included important and measurable ambitions for improvements in health services, reflecting wider NHS and social care systems. The Panel considers these commitments to provide reasonable generalisable evidence of progress against policy aspirations in the broader area of mental health. The Expert Panel evaluated the Government’s progress against these commitments. The commitments we have chosen to examine are:

Policy Area	Government Commitment
Workforce	<ul style="list-style-type: none"> <li>we are committed to growing the mental health workforce</li> </ul>
Children and Young People's (CYP) Mental Health	<ul style="list-style-type: none"> <li>at least 70,000 additional children and young people each year will receive evidence-based treatment ...</li> <li>achieve 2020/21 target of 95% of children and young people with eating conditions accessing treatment within 1 week for urgent cases and 4 weeks for routine cases</li> <li>ensure there is a CYP crisis response that meets the needs of under 18-year-olds</li> </ul>
Adult Common Mental Illness	<ul style="list-style-type: none"> <li>All areas commission IAPT-Long term condition services</li> </ul>
Adult Severe Mental Illness	<ul style="list-style-type: none"> <li>280,000 people with SMI will receive a full annual health check</li> <li>new integrated community models for adults with a severe mental illness [delivery date of 2023/24]</li> <li>the therapeutic offer from inpatient mental health services will be improved by increased investment in interventions and activities, resulting in better patient outcomes and experience in hospital.</li> <li>all areas will provide crisis resolution and home treatment (CRHT) functions that are resourced to operate in line with recognised best practice, delivering a 24/7 community-based crisis response and intensive home treatment as an alternative to acute inpatient admission</li> </ul>

For each commitment under review, the Health and Social Care Committee approved the main questions to guide the Expert Panel's evaluation. The Panel then developed a set of sub-questions relating to specific areas of the commitment. These main questions and sub-questions were incorporated into a final framework referred to as the Panel's planning grid. The planning grid was shared with the Department for Health and Social Care and formed the basis of the Government's formal written response. The Expert Panel used the key questions in the planning grid, as well as its own thematic analysis of 25 written submissions, publicly available data, and transcripts from roundtable events with 24 mental health practitioners as the basis for this evaluation. We invited The Department of Health and Social Care to respond to all main questions and sub-questions in its written response.

The main questions set out in the planning grid are:<sup>2</sup>

- Was the commitment met overall? Or is the commitment on track to be met?
- Was the commitment effectively funded (or resourced)?
- Did the commitment achieve a positive impact for service users?
- Was it an appropriate commitment?

2 First Special Report of Session 2019–21: [Process for independent evaluation of progress on Government commitments](#) (July 2020), p. 3

The ratings for the nine commitments within the four policy areas and main questions were used to inform the Panel’s overall rating for the area of mental health. The ratings for each of the nine commitments in the four policy areas are summarised in the following table.

## Overall rating across all commitments

### Requires Improvement

#### Workforce

Commitment	A. Commitment Met	B. Funding and Resource	C. Impact	D. Appropriate	Overall
Grow the workforce	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement

#### Children and Young People’s Mental Health

Additional treatment	Good	Good	Good	Inadequate	Requires Improvement
95% CYP accessing treatment for eating conditions	Requires Improvement	Good	Requires Improvement	Outstanding	Good
Crisis response	Requires Improvement	Requires Improvement	Requires Improvement	Outstanding	Requires Improvement

#### Adult Common Mental Illness

All areas commission IAPT-Long term condition services	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
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#### Adult Severe Mental Illness

Physical health check	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Integrated community models	Requires Improvement	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement
Improved therapeutic offer	Requires Improvement	Requires Improvement	Requires Improvement	Inadequate	Requires Improvement

Commitment	A. Commitment Met	B. Funding and Resource	C. Impact	D. Appropriate	Overall
Crisis resolution and home treatment	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement

**The overall rating for the nine commitments across the four policy areas evaluated is:**

### ***Requires Improvement***

This rating relates to how the government have progressed overall against nine commitments across the four policy areas based on guidance outlined in the anchor statements (Annex B) set out by the Health and Social Care Committee. While an overall rating of progress against all nine specific commitments is challenging to determine and the ratings of individual commitments are standalone, the evidence we assessed shows that the Government’s progress against its commitments to improve mental health services in England requires improvement. Because of this concern, each of the nine commitments have been rated separately. Although significant efforts have been made across the four main policy areas evaluated (with some notable success), the Panel’s evaluation shows that more progress is required to achieve success in all nine commitments.

We recognise that many, if not all, of the commitment areas have been impacted by the COVID-19 pandemic, which services could not have reasonably prepared for in advance. We have considered factors related to the COVID-19 pandemic throughout our evaluation, acknowledging where commitments were on track to be met prior to the pandemic. As the pandemic has been associated with a rise in mental health conditions,<sup>3</sup> demand for services is greater than when these commitments were made, which could not have been anticipated by services. Therefore, continued and expanded resources for mental health services will be required to ensure the capacity for services increases with the need for mental health support. We recognise the effort by mental health services and frontline workers to support the health of the nation during the COVID-19 pandemic, which have been conducted under unprecedented circumstances.

The rationale to support the ratings and our findings is summarised below.

## **Workforce**

### ***Commitment: Grow the mental health workforce (Requires Improvement)***

- Overall, the mental health workforce has increased by 17,778 FTE staff since 2016, meeting the targets set for 2021.

3 Fancourt, D., Steptoe, A., & Bu, F. (2021). Trajectories of anxiety and depressive symptoms during enforced isolation due to COVID-19 in England: a longitudinal observational study. *The Lancet Psychiatry*, 8(2), 141–149; Saunders, R., Buckman, J. E. J., Fonagy, P., & Fancourt, D. (2021). Understanding different trajectories of mental health across the general population during the COVID-19 pandemic. *Psychological Medicine*, 1–9. doi: 10.1017/S0033291721000957

- However, key staffing groups such as mental health nurses and consultant psychiatrists (and specific sub-specialities relevant to priority policy areas) have not increased in line with targets set in the Stepping forward to 2020/21 and Mental Health Implementation Plans.<sup>4</sup>
- Funding has been allocated to train new staff; however, this funding was designated for overall mental health staff and has not been used to increase staff in specific professional groups. The increase in numbers is only meaningful if they represent appropriately trained and professionally governed individuals. Funding is also insufficient to retain and upskill existing staff.
- Workforce shortages represent the single biggest threat to national ambitions to improve mental healthcare, impacting delivery across all mental health services.

## Children and Young people

### ***Commitment 1: Access to treatment (Requires Improvement)***

- The number of children and young people accessing treatment has increased greatly since this commitment was made, though this has also coincided with a probable increase in the need for services.
- Children and young people who access services have reported significant improvements to their mental health.
- However, the target that only 35% of children and young people should have access to treatment is inadequate and leaves the majority of children and young people who require support for a mental health diagnosis without access to services.

### ***Commitment 2: Eating conditions (Good)***

- The target to ensure 95% of children and young people receive treatment for eating conditions within one week for urgent cases and four weeks for routine cases has not been met.
- Progress on this target has been significantly impacted by the COVID-19 pandemic, which has led to a dramatic increase in the prevalence of eating conditions.
- Given the association between eating conditions and high mortality rates, the ambitious target outlined in this commitment was highly appropriate. The specificity of this commitment meant that services had a clear target to aim towards.

### ***Commitment 3: CYP Crisis Services (Requires Improvement)***

- The provision of 24/7 crisis support lines to provide support, advice and triage has been achieved; a target that has been met in advance of the deadline.

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<sup>4</sup> Health Education England, [Stepping forward to 2020/21: The mental health workforce plan for England](#) (July 2017)

- However, in most regions less progress has been made with other functions of a crisis response service, meaning these services cannot provide treatment for the range of mental health symptoms children and young people present with at these services.
- The absence of functioning crisis response services has led to children and young people being inappropriately placed on adult wards.

## Adult Common Mental Illness

### ***Commitment: All areas commission adult Increasing Access to Psychological Therapies-Long-term condition services (Requires Improvement)***

- Significant work is required before the commitment to establish Increasing Access to Psychological Therapies (IAPT) services for adults with long term conditions across all areas can be met by the 2023/24 deadline.
- The provision of specialist services for adults with a long-term condition has the potential to have positive impact on service users' ability to manage their physical conditions.
- In treating long term conditions through IAPT, savings could be made across the NHS and reduce the burden on these services, but this has not yet been achieved.

## Adult Severe mental Illness

### ***Commitment 1: Annual Physical Health Checks (Requires Improvement)***

- Progress on this commitment has been inadequate, as only approximately half of the target numbers have been achieved as of Q1 2021/22. This commitment was not on track to be achieved prior to the COVID-19 pandemic.
- Recent investment has been made to accelerate progress on this commitment, but we are unable to evaluate the impact of these additional funds as this is reliant on the capacity of general practice to deliver the health checks.
- This is an important commitment as the average lifespan of an individual with a severe mental illness is 15–20 years shorter than the general population.

### ***Commitment 2: Community Models (Requires Improvement)***

- Progress on the commitment to deliver new integrated community models for adults with a severe mental illness requires improvement, as some services continue to rely on inpatient, residential models of care.
- Early implementer sites report positive outcomes from community models, demonstrating the positive potential of this form of care.



- This commitment is not specific enough and requires improvement, as it is unclear which services comprise a community model, or which metrics can be used to evaluate community services.

### ***Commitment 3: Improved therapeutic offer (Requires Improvement)***

- Measures of length of stay in acute services suggest that progress on this commitment has been made, but the quality and scope of activities is not sufficient to provide an improved therapeutic offer. Although it is possible to measure length of stay this does not necessarily reflect improvements in outcomes.
- There is a disparity between the measures used by services and the views of service users, who report the inpatient therapeutic offer to be insufficient.
- The physical estate for mental health services is poor and presents a barrier to achieving this commitment, as service users report a lack of a therapeutic environment.
- The insufficient mix of workforce skills and disciplines within inpatient facilities also constrains progress on this commitment.

### ***Commitment 4: Crisis resolution and home treatment (Requires Improvement)***

- Despite all services providing phone lines, the services are not operational 24/7, limiting their effectiveness.
- Staffing issues, exacerbated by COVID-19, have contributed to difficulties establishing coherent and high-quality crisis services.
- However, commendably, the specification of ideal services is clear, which will support their implementation in services across the country in future.

## **Method of Evaluation**

Our overall approach to evaluation was to review quantitative and qualitative data provided by the Department alongside relevant research evidence to establish causative links, as well as evidence from other sources via a call for written submissions. We triangulated this evidence with secondary data illustrating the experiences of people living with mental illness and commentary from professionals working in mental health services. Our approach was not a formal technical evaluation of the impact of different interventions on the policy aspirations and should not be viewed as a substitute for Government commissioned evaluations via the National Institute for Health Research (NIHR).

We received a formal response to the planning grid from the Department on 6 October 2021. This response, along with information gathered during subsequent meetings, forms the basis for this report.

Evidence was reviewed from several non-governmental sources. Key stakeholders were identified and invited to submit their own written response to the planning grid.

Written submissions were analysed using a framework method for qualitative analysis in health policy research.<sup>5</sup> We also conducted a 90-minute roundtable discussion with Psychologists, Psychiatrists, Nurses, and social care staff that provide services to people living with mental ill health. We employed a realist review approach to the integration of evidence from all sources into the main report.<sup>6</sup>

A full list of evidence is included at the end of the report (see Annex C-D).

### ***Evidence from the Department***

- Additional written information received from the Department
- Meeting with DHSC, NHSE/I and HEE officials

### ***Evidence from stakeholders:***

- 25 written submissions

### ***Evidence from service users:***

- Consultation with the Patient Experience Library
- Secondary evidence through stakeholder submissions and publicly available data

### ***Evidence from clinicians:***

- Roundtable events with 24 mental health professionals

This report provides an analysis of all information provided.

The analysis is structured around the four overall policy areas which covered nine individual commitments, and the main questions (A-D) within each commitment.

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5 Gale, N.K., Heath, G., Cameron, E. et al. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Med Res Methodol* 13, 117 (2013). <https://doi.org/10.1186/1471-2288-13-117>

6 Pawson R, Greenhalgh T, Harvey G, Walshe K. Realist review—a new method of systematic review designed for complex policy interventions. *J Health Serv Res Policy*. 2005;10 Suppl 1:21–34. doi:10.1258/1355819054308530. See also HM Treasury, *Magenta Book Annex A: Analytical methods for use within an evaluation*, March 2020

We selected the commitments to evaluate as these were considered to represent windows into the wider mental health services, and where we felt most attention was needed and where the commitments were clear and measurable. Mental health services cover a wide area of policy which is not possible to fully represent in this report. There were some important commitments we did not select, including those that related to suicide. We recognise that this is a serious issue affecting thousands of individuals and their families. However, suicides often take place outside of mental health care systems and are the result of a complex range of influences that are not always within the scope of mental health services. Effectively tackling suicide requires the coordination of mental health services, social care, public health bodies, schools, employers, and local Government. As a result, we did not feel that we could evaluate progress on this commitment within the scope of this report but recognise the commendable, sustained, and significant work being conducted in health and social care services and by charities.

# 1 Workforce

Commitment	Commitment Met	Funding	Impact	Appropriate	Overall
“We are committed to growing the mental health workforce to achieve the ambitions set out in the NHS Long Term Plan”	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement

In this section, we provide an assessment of Children and Young People’s Crisis Response of the Government’s commitment to grow the mental health workforce, which predominantly focusses on the NHS workforce:

**“We are committed to growing the mental health workforce to achieve the ambitions set out in the NHS Long Term Plan”**

## ***Overall Commitment Rating and Overview for the workforce commitment:***

### ***Requires Improvement***

An adequately staffed workforce is key to the delivery of national ambitions to improve mental healthcare.<sup>7</sup> Our evaluation suggests that progress against the Government’s commitment to increase the mental health workforce requires improvement, as key staffing groups have not increased in line with the targets established in the Stepping Forward to 2021 Plan and the NHS Mental Health Implementation Plan.<sup>8</sup> While we recognise that the overall workforce has increased,<sup>9</sup> professionally regulated staff, for example consultant psychiatrists and mental health nurses, have failed to increase in line with national targets.

The lack of appropriate growth in the mental health workforce has led to negative impacts on both staff and services users.<sup>10</sup> In our evaluation, staff reported unmanageable workloads leading to increased rates of burnout, demoralisation, and exhaustion.<sup>11</sup> These effects have been further compounded by the COVID-19 pandemic and the increased burden on the mental health workforce in circumstances that make the delivery of services challenging. Further, insufficient numbers in the workforce have also impacted the delivery of services, and across the areas of our evaluation detailed in Chapters 2–4, the lack of appropriately qualified staff contributed to reduced access to services for individuals who required mental health support.

7 Royal College of Psychiatrists ([MHS0012](#))

8 Health Education England, [Stepping forward to 2020/21: The mental health workforce plan for England](#) (July 2017); NHS, [NHS Mental Health Implementation Plan 2019/20 – 2023/24](#) (July 2019).

9 Health Education England, [Stepping forward to 2020/21: The mental health workforce plan for England](#) (July 2017)

10 Royal College of Psychiatrists ([MHS0012](#)); NHS Providers ([MHS0013](#)); NHS Confederation ([MHS0018](#))

11 Workforce Roundtable; NHS Providers ([MHS0013](#))

We recognise that funding has been allocated to increase the mental health workforce.<sup>12</sup> However, given the substantial time required to train mental health staff with advanced skills, this investment will only bear fruit when connected to a medium-term strategy of increasing the mental health workforce. Our evaluation highlighted the lack of investment in measures to retain and upskill existing staff, leading to attrition and a scarcity of staff members with advanced skills.<sup>13</sup> Although there has been an influx of newly created professions, their career trajectory is not clear, and they may not remain in mental health services. To support a shorter-term view of increasing the workforce, stakeholders emphasised the need for retention initiatives.<sup>14</sup> These measures are particularly timely in context of the COVID-19 pandemic, which has exacerbated the demand for mental health services.<sup>15</sup>

Our evaluation concluded that it was appropriate to commit to growing the workforce. However, we rated the appropriateness of this commitment as requires improvement because we failed to find evidence to illustrate how the Government or associated NHS bodies calculated the trajectory of growth in the mental health workforce when this commitment was established. Some stakeholders noted that the targets outlined in the Stepping Forward to 2021 and NHS Mental Health Implementation Plan were not sufficient to meet the increasing demand for care.<sup>16</sup> Moreover, stakeholders noted that commitments around the workforce should ensure that staff with the correct competencies were placed in appropriate posts, rather than solely focussing on total workforce figures.<sup>17</sup>

Overall, maintaining a workforce with the right balance of competencies and good local leadership and management is vital to ensure that national ambitions to improve mental healthcare are met. Furthermore, increases to the mental health workforce have not been sufficient to ensure the delivery of services. We recognise work that is currently being conducted to increase training opportunities, though the effects of these measures will not be evident for several years. Therefore, initiatives must be adopted that aim to recruit, train, and retain the right staff, with the right skills, in the right place within the mental health workforce.

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12 The Department of Health and Social Care ([MHS0009](#))

13 Centre for Mental Health, [Now or never: A systemic investment review of mental health care in England](#) (July, 2021)

14 NHS Confederation ([MHS0018](#))

15 NHS Providers ([MHS0013](#))

16 NHS Confederation ([MHS0018](#))

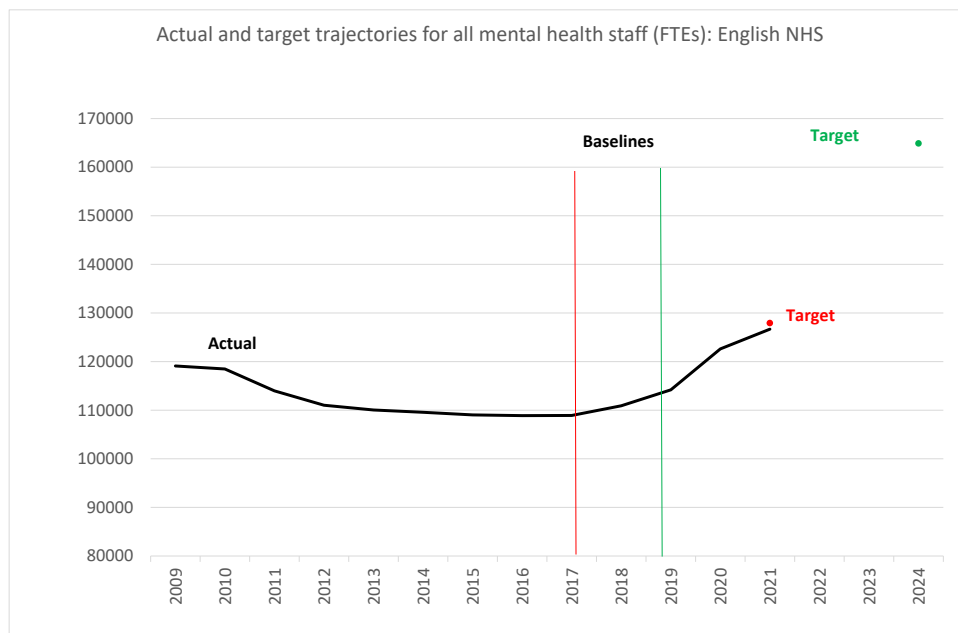
17 NHS Providers ([MHS0013](#))



a significant period of ‘recovery’ from the lows seen in 2017 to the historic levels seen in 2009–2010, which have only recently been exceeded. Further, these figures do not account for the increased need for mental health services in some areas (e.g.,<sup>22</sup>). In our roundtable discussion with mental health professionals, practitioners did not view this growth as sufficient:

*“The overall impression I get is that yes, there’s been a level of investment in more places for nurse training, and a proportion of that has obviously been for mental health—on the good side there has been an increase in the number of applications for people to do undergraduate mental health nursing degrees, but it still appears to be very much a drop in the ocean.” - Mental Health Practitioner.<sup>23</sup>*

**Figure 2: Actual numbers for all mental health staff (FTEs) in NHSE.<sup>24</sup> Red graphics indicate figures outlined in the Stepping Forward to 2020/21 Plan and green graphics indicate figures outlined in the NHS Implementation Plan. Baselines indicate the dates that these plans were published, and coloured dots indicate targets outlined in those plans.**



When these figures were analysed according to staffing group, we found that progress on this commitment was not sufficient for several core professions. These findings informed our conclusion that progress against this commitment requires improvement. In particular, 2021 growth targets for all professionally regulated staff, mental health nurses and consultant psychiatrists have not been met (see Figures 3–6).<sup>25</sup> While we note that there is a deficit of consultant psychiatrists across the workforce (see Figure 5), practitioners who attended our roundtable event highlighted children and young people’s services as an area where there was an acute lack of staff.<sup>26</sup> Recent figures released by

22 Touyz, S., Lacey, H., & Hay, P. (2020). Eating disorders in the time of COVID-19. *Journal of Eating Disorders*, 8 (19), 8–19.

23 Workforce roundtable

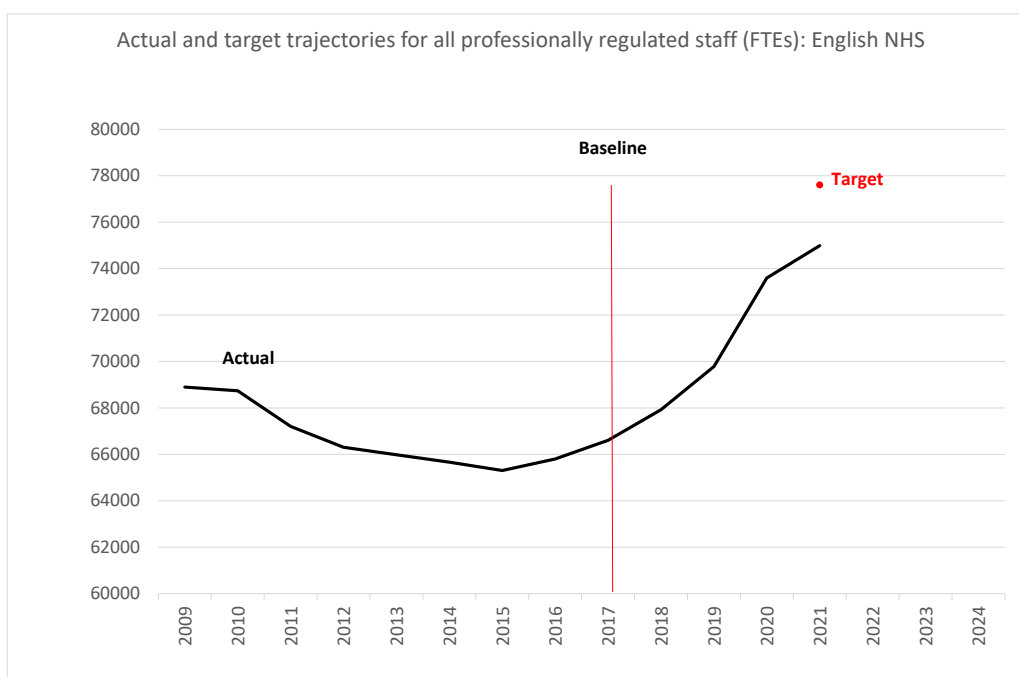
24 [NHS England, NHS Mental Health Dashboard \(2021\)](#); Health Education England, [Stepping forward to 2020/21: The mental health workforce plan for England](#) (July 2017); NHS, [NHS Mental Health Implementation Plan 2019/20 – 2023/24](#) (July 2019)

25 Professionally regulated staff are those registered to one of the nine professional regulatory bodies in the UK.

26 Children and young people’s roundtable

Health Education England indicate that the total number of children and young people’s mental health WTE staff has grown by 39% in 2021 compared to 2019.<sup>27</sup> However, we note that these figures are still lower than the targets outlined in the Stepping Forward to 2020/2021 and Mental Health Implementation Plans for overall number of staff by 3,800.<sup>28</sup> Moreover, the total number of children and young people’s mental health nurses missed the target outlined in these plans by 900 nurses. These recent figures further highlight that certain groups of staff have not increased in line with targets outlined in Stepping Forward to 2020/2021 and Mental Health Implementation Plans.<sup>29</sup> Given the deficits on current targets, significant work will be required to increase the workforce to achieve targets outlined for 2023/2024 and beyond. The unequal distribution of growth in the workforce is illustrated in Table 1.

**Figure 3: Actual growth of professionally regulated staff (FTE) currently employed by NHS England.<sup>30</sup> Red graphics indicate figures outlined in the Stepping Forward to 2020/21 Plan. The baseline indicates the dates that these plans were published, and coloured dot indicates the target outlined in the plan.**



27 Health Education England, [Children and Young People’s Mental Health Services Workforce Report for Health Education England](#) (November, 2021)

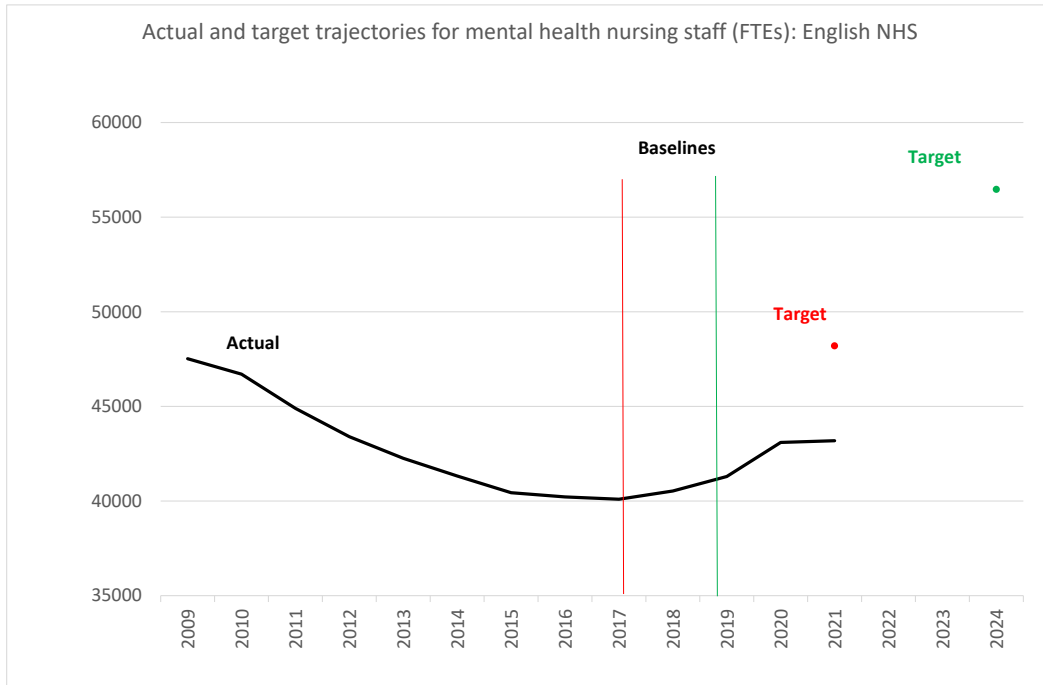
28 Health Education England, [Stepping forward to 2020/21: The mental health workforce plan for England](#) (July 2017); NHS, [NHS Mental Health Implementation Plan 2019/20 – 2023/24](#) (July 2019)

29 Health Education England, [Stepping forward to 2020/21: The mental health workforce plan for England](#) (July 2017); NHS, [NHS Mental Health Implementation Plan 2019/20 – 2023/24](#) (July 2019)

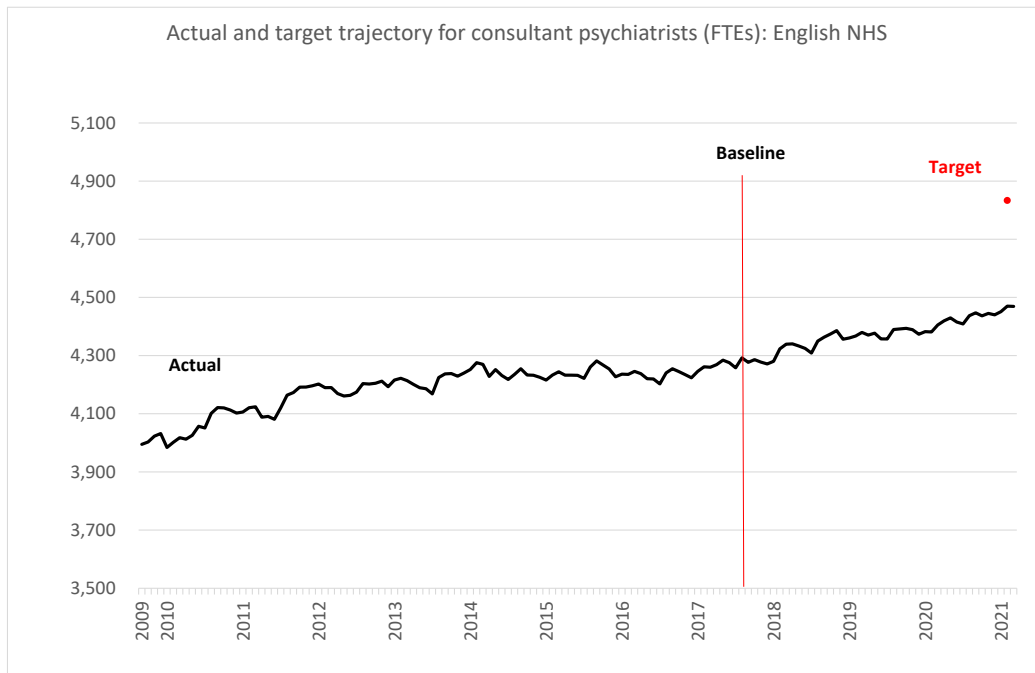
30 NHS England, [NHS Mental Health Dashboard \(2021\)](#); Health Education England, [Stepping forward to 2020/21: The mental health workforce plan for England](#) (July 2017)



**Figure 4: Actual growth of mental health nurses (FTE) currently employed by NHS England.<sup>31</sup> Red graphics indicate figures outlined in the Stepping Forward to 2020/21 Plan and green graphic indicate figures outlined in the NHS Implementation Plan. Baselines indicate the dates that these plans were published and coloured dots indicate targets outlined in those plans.**



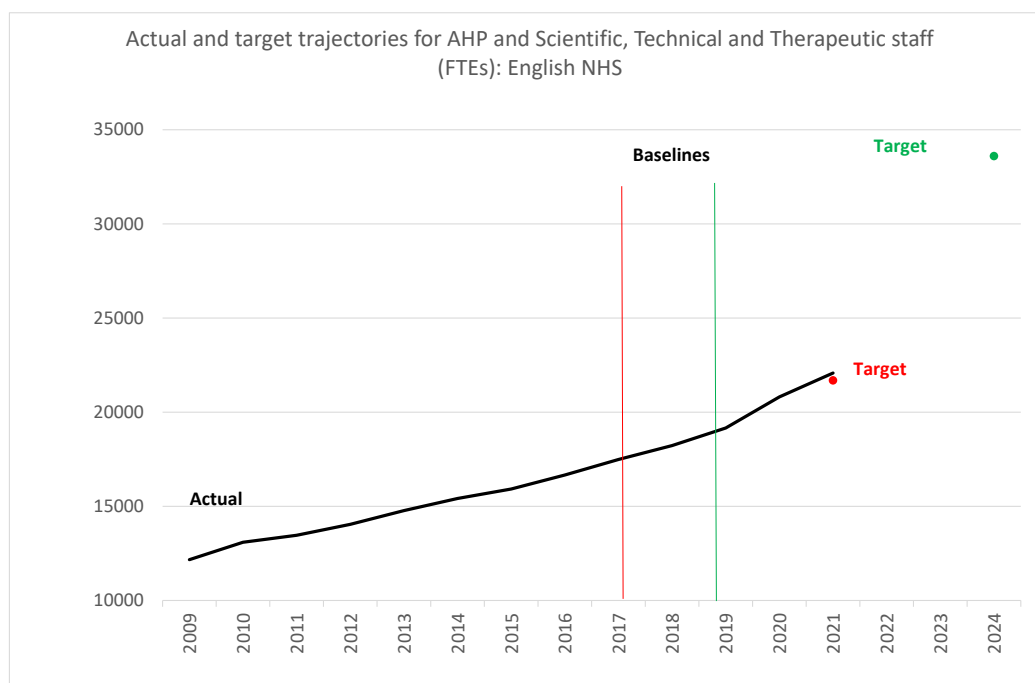
**Figure 5: Actual growth of consultant psychiatrists (FTE) currently employed by NHS England.<sup>32</sup> Red graphics indicate figures outlined in the Stepping Forward to 2020/21 Plan. The baseline indicates the dates that these plans were published and coloured dot indicates the target outlined in the plan.**



31 [NHS England, NHS Mental Health Dashboard \(2021\)](#); Health Education England, [Stepping forward to 2020/21: The mental health workforce plan for England](#) (July 2017); NHS, [NHS Mental Health Implementation Plan 2019/20 – 2023/24](#) (July 2019)

32 [NHS England, NHS Mental Health Dashboard \(2021\)](#); Health Education England, [Stepping forward to 2020/21: The mental health workforce plan for England](#) (July 2017)

**Figure 6: Actual growth of allied health professionals (AHPs) and scientific, technical and therapeutic staff (FTE) currently employed by the NHS in England.<sup>33</sup> Red graphics indicate figures outlined in the Stepping Forward to 2020/21 Plan and green graphic indicate figures outlined in the NHS Implementation Plan. Baselines indicate the dates that these plans were published, and coloured dots indicate targets outlined in those plans.**



**Table 1: Changes in staff numbers, percentage growth and shares of overall staff growth**

Staff group	Change 2016 to 2021		
	Numbers (FTEs)	Percent	Percentage share of change
Doctors	800	9%	4%
Nurses	2,967	7%	17%
Scientific, therapeutic & technical staff	5,418	33%	30%
Support to clinical staff	8,754	22%	49%
Others	-161	-6%	-1%
<b>Total</b>	<b>17,778</b>	<b>16%</b>	

We also note that there has been a particular decline in the number of learning disability nurses (Figure 7). While there has been no quantified target or deadline to increase the numbers of nurses in this staffing group, supporting individuals with a learning disability has been highlighted as an area of priority by the Government since 2014.<sup>34</sup> The decline in learning disability nurses suggests a lack of alignment between Government priorities and workforce planning. Health Education England have recently announced a commitment of £2m to boost the learning disabilities nursing workforce, which is intended to have

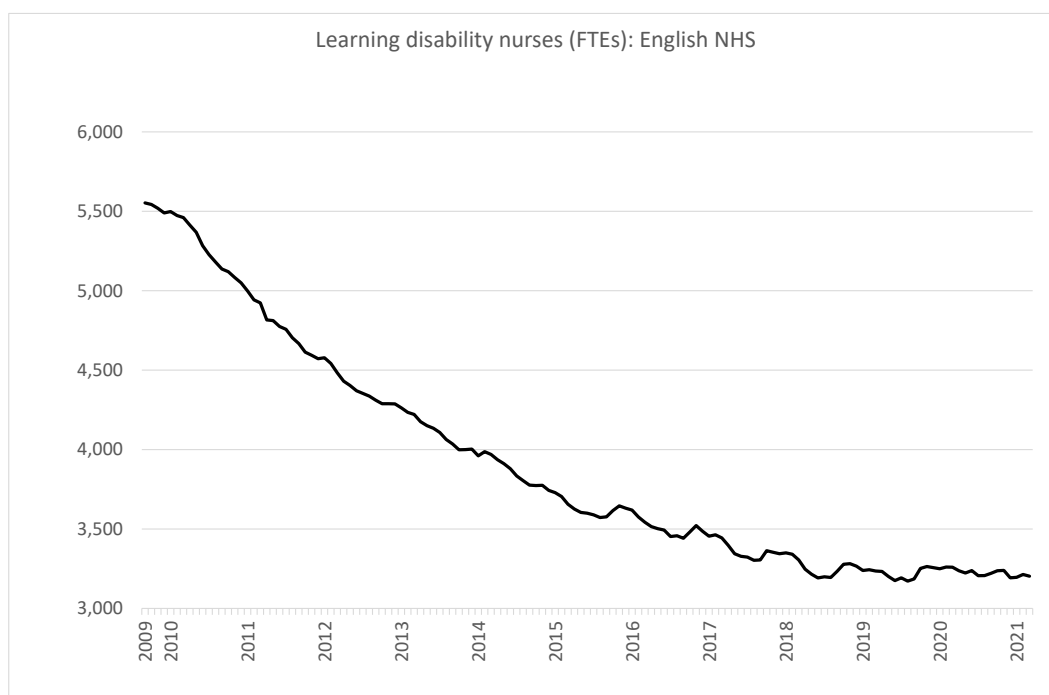
<sup>33</sup> [NHS England, NHS Mental Health Dashboard \(2021\)](#); Health Education England, [Stepping forward to 2020/21: The mental health workforce plan for England](#) (July 2017); NHS, [NHS Mental Health Implementation Plan 2019/20 – 2023/24](#) (July 2019)

<sup>34</sup> Department of Health in partnership with the Modernising Learning Disabilities Nursing UK Implementation Group, [Strengthening the Commitment: One year on](#) (April, 2014)

some impact on numbers in forthcoming years.<sup>35</sup> Nevertheless, we note the decline in this workforce, which will disproportionately affect those who are most vulnerable in society. Indeed, this was reflected by practitioners in this staffing group:

*“What I feel like we’re seeing within learning disability services more broadly is no influx of staffing, as has been needed”*–Learning Disability Practitioner.<sup>36</sup>

**Figure 7: Changes to the number of FTE learning disability nurses since 2009.<sup>37</sup>**



We recognise that progress on this commitment has been impacted by the COVID-19 pandemic. In their response to our evaluation, the Department of Health and Social Care reported that there have been delays due to trainees being unable to complete their training remotely or experiencing difficulties in accessing placements.<sup>38</sup> Stakeholders welcomed the growth in medical school places, which should increase the number of trainees selecting mental health specialisations.<sup>39</sup> However, significant negative impacts on current staff were also reported and exhaustion due to the additional pressures of the pandemic was reported as a concern.<sup>40</sup> Therefore, it is important to consider measures to support existing staff, as well as initiatives to attract new staff to the mental health workforce.

35 The Department of Health and Social Care ([MHS0009](#))

36 Workforce roundtable

37 NHS England, [NHS Mental Health Dashboard \(2021\)](#)

38 The Department of Health and Social Care ([MHS0009](#))

39 NHS Providers ([MHS0013](#))

40 NHS Confederation ([MHS0018](#))

## Was the commitment effectively funded (or resourced)?

### Rating: Requires Improvement

In their response to our evaluation, the Department of Health and Social Care and stakeholders identified several new funding streams that were allocated to increase the mental health workforce:

- £695 million investment into Health Education England’s mental health workforce training and education programme, invested over a five-year period from 2015/16–2020/21. This spend was detailed in the Stepping Forward View to 2020/2021 Plan.<sup>41</sup>
- In the current financial year, an additional £111m that has been allocated to Health Education England to expand specific professions within the mental health workforce.<sup>42</sup>
- £30m of new funding for mental health hubs to support the wellbeing of NHS staff, which was allocated through the COVID-19 mental health and wellbeing recovery action plan.<sup>43</sup>

However, several stakeholders did not view these additional funding sources as adequate and reported that further funds would be required to grow the workforce.<sup>44</sup> NHS Providers, the membership organisation for NHS trusts in England, estimated that an additional £850m a year would be needed to meet the current demand and tackle the backlog of care caused by the pandemic.<sup>45</sup> Moreover, they described concerns about the transparency in the use of funds and said that a fully costed and funded national workforce plan was required to build on existing progress in this area.<sup>46</sup> During our roundtable with practitioners, it was suggested that deficits in the mental health workforce were the result of several factors that disincentivised new trainees:

*“I think we’re reaping what we’ve been sowing really, I think the removal of nursing bursaries and all that kind of stuff, a chronic lack in investment over years, means that we haven’t actually readied a workforce that’s built on any sustainable platform. I think we are all constrained by a lack of long-term investment and proper planning.”*–Mental Health Practitioner.<sup>47</sup>

Indeed, these findings highlight the importance of a long-term view on funding for the mental health workforce. There is a significant time cost associated with training specialist mental health professionals, which can take up to 14 years from the beginning of a practitioner’s medical degree to their qualification as a consultant psychiatrist.<sup>48</sup>

41 Health Education England, [Stepping forward to 2020/21: The mental health workforce plan for England](#) (July 2017)

42 The Department of Health and Social Care ([MHS0009](#))

43 MIND ([MHS0005](#))

44 National Counselling Society ([MHS0003](#)); NHS Providers ([MHS0013](#)); Centre for Mental Health ([MHS0016](#))

45 NHS Providers ([MHS0013](#))

46 NHS Providers ([MHS0013](#))

47 Workforce roundtable

48 Royal College of Psychiatrists, [Be the brightest be the best](#)

Therefore, short-term commitments to increase the workforce will not lead to tangible outcomes for a significant period of time and must be factored into plans to fund the workforce.

With regards to the retention of existing staff, in addition to wellbeing issues, stakeholders also viewed funds as insufficient to encourage them to remain in the workforce.<sup>49</sup> The £30m of funding allocated to the creation of mental health hubs translates to approximately £30 per staff member in the NHS workforce.<sup>50</sup> However, no funds have been allocated to incentivise staff to remain in the workforce, for example through continuing professional development or an established career structure that recognises increased competence. Stakeholders viewed these resources as insufficient and therefore improvement in the amount and allocation of funding is required to increase the mental health workforce.

### ***Did the commitment achieve positive impacts for service users?***

#### ***Rating: Requires improvement***

The failure to make sufficient progress on this commitment has meant that there have been limited positive impacts for service users and staff resulting from increases to the workforce. In evaluating the impact of this commitment, we found two distinct themes: impacts on staff members and impacts on service users. The lack of sufficient growth in key staffing areas within the workforce has led to staff members reporting burnout and increased the likelihood of staff leaving the workforce. Insufficient staffing numbers also meant that some services, such as children and young people’s crisis response services, were struggling to establish an operational crisis response function (see Chapter 2.3. Children and Young People’s Crisis Response Service).

The insufficient growth of the mental health workforce has had negative impacts on staff across all areas of mental healthcare (see Chapters 2, 3 and 4). The NHS Confederation’s Mental Health Network reported workforce issues as one of the biggest issues in mental healthcare.<sup>51</sup> The British Medical Association reported that staff were overworking due to workforce shortages.<sup>52</sup> These working practices are problematic as they increase the likelihood of poor wellbeing amongst staff, which could adversely impact the delivery of treatment.<sup>53</sup> Recruiting highly trained and committed staff is insufficient; local care systems need to ensure both the organisation and the working environment supports staff delivering treatment and that workloads are commensurate with the complex tasks being undertaken and the risk scenarios being managed. Furthermore, in areas of high deprivation and need for services, more complex presentations and service users’ needs require more integration across different specialities and the NHS estates to provide a more seamless service. The importance of equalities legislation is relevant given the learning from COVID-19 crisis management and implication that some staff groups with particular protected characteristics were more vulnerable and more exposed to front line

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49 MIND ([MHS0005](#)); Centre for Mental Health ([MHS0016](#))

50 Ibid

51 NHS Confederation ([MHS0018](#))

52 British Medical Association ([MHS0008](#))

53 NHS Providers, [Children and young people’s mental health survey](#) (May, 2021)

crisis roles (see Chapter 5: Inequalities in Mental Health). Consistent with this account, several stakeholders reported that mental health staff reported exhaustion, demoralization and burnout.<sup>54</sup> This view was shared by practitioners at our roundtable event:

*“It’s how we look after our people, and I think what I’m seeing on the frontline is staff that are burnt out. I’m going to be really blunt: staff that are really exhausted, burnt out. A lot of trusts have put a lot of work through COVID around staff wellbeing and opportunities, but actually for me staff wellbeing is about having a realistic workload and being able to get home on time.”*–Mental Health Practitioner.<sup>55</sup>

Maintaining staff wellbeing is crucial for sustaining the growth of the workforce, as poor wellbeing can culminate in problems with the retention of staff.<sup>56</sup> Without senior staff remaining in-post, there is a skills deficit in management and supervisory roles, which was reported by practitioners in our roundtable event. When referring to mental health services, one practitioner stated:

*“And the other reason they’re not adequately resourced is in terms of staffing, and I don’t just mean the numbers of staff, I also mean the staff with the right levels of expertise and the right seniority within the service.”*–Mental Health Practitioner.<sup>57</sup>

The British Medical Association reported that 4 in 10 of respondents to their member survey planned to retire early,<sup>58</sup> which indicates there is a problem with retaining senior staff that will continue to affect the workforce until initiatives are established to improve retention. Mental Health Practitioners in our roundtable reported similar concerns:

*“That’s something we need to look at: how do we retain the workforce we’ve got because I think there’s a lot of people leaving the NHS as a system, and even more so over the challenging 2 years that we’ve had during COVID. I think that’s something we need to think about: how do we retain staff and what is it making staff want to leave? We may be training them but they’re not staying, and it’s not what they thought it was going to be.”*–Mental Health Practitioner.<sup>59</sup>

Workplace culture was highlighted by MIND, a mental health charity, as an area that could be addressed to increase retention within the mental health workforce. As an example, they said that improving staffing levels, including skills mix and deployment, would be vital in efforts to eliminate the reliance on force, such as the use of physical restraint, in mental health units.<sup>60</sup> It has also been suggested that improving the workplace culture would also support efforts to attract new trainees to mental health services.<sup>61</sup>

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54 British Medical Association ([MHS0008](#)); Care Quality Commission ([MHS0010](#)); Professor Cathy Creswell, University of Oxford ([MHS0014](#)); NHS Confederation ([MHS0018](#))

55 Workforce roundtable

56 NHS Confederation, [Real risk that thousands of NHS staff will leave unless they are allowed to recover](#) (March, 2021)

57 Adult common mental illness roundtable

58 British Medical Association ([MHS0008](#))

59 Workforce roundtable

60 MIND ([MHS0005](#))

61 Nuffield Trust, [Laying foundations](#) (October, 2020)

Insufficient workforce numbers have also impacted the delivery of treatment to service users. The NHS Confederation’s Mental Health Network reported that demand modelling predicts that perhaps as many as 10 million people will need new or additional mental health support as a result of the COVID-19 pandemic, which is 2–3 times the current level of provision.<sup>62</sup> The Care Quality Commission has reported that the decline in mental health nurses since 2009 has reduced the capacity of mental health services, which has resulted in difficulties associated with individuals accessing acute services and increases in waiting times. In our roundtable, Mental Health Practitioners reported that staffing issues were leading to a reduced quality of care for service users and experience of work for practitioners:

*“I think what I’ve seen is, because I think sometimes staff are so challenged by process and volume of activity, I think it is detracting from the interactions they’re having with people. I see a lack of professional curiosity in staff and just taking a moment to reflect and really listen to what’s going on and to think about the dynamic that’s forming. I think we have a workforce sometimes that are so focused on activity, output and process that sometimes they’re losing sight of the person in it. I think that’s the direct result of being overwhelmed sometimes.”*–Mental Health Practitioner.<sup>63</sup>

In summary, the impact of the insufficient growth of the workforce is significant and continues to be the biggest risk to achieving plans to improve mental health.<sup>64</sup> Currently, there exists an issue with attrition of staff with senior qualifications leaving services due to a lack of retention initiatives.<sup>65</sup> The lack of sufficient, suitably qualified practitioners in the workforce is leading to worsening access to support for members of the population who may have a mental illness, and worsening wellbeing for staff members within the NHS who are employed to support individuals with their mental health.

### ***Was it an appropriate commitment?***

#### ***Rating: Requires Improvement***

Growing the mental health workforce is a vital commitment; a view shared by a number of stakeholders who submitted evidence to our evaluation.<sup>66</sup> However, improvement is required against this commitment to ensure that increases to the workforce are aligned to the need for mental health services in the population. The Royal College of Psychiatrists stated that no transparent attempts have been made to compare workforce supply with workforce demand,<sup>67</sup> which is a particularly timely consideration given the increase in mental health needs associated with the COVID-19 pandemic.<sup>68</sup> Moreover, stakeholders reported that the commitment was not ambitious enough in scope. The British Medical

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62 NHS Confederation ([MHS0018](#))

63 Workforce roundtable

64 Centre for Mental Health ([MHS0016](#))

65 Centre for Mental Health, [Now or never: A systemic investment review of mental health care in England](#) (July, 2021)

66 National Counselling Society ([MHS0003](#)); MIND ([MHS0005](#)); British Medical Association ([MHS0008](#))

67 Royal College of Psychiatrists ([MHS0012](#))

68 NHS Confederation ([MHS0018](#))

Association suggested that the commitment neglected the OECD EU country average of 3.7 doctors per 1,000 people, noting that no region in England currently meets this level.<sup>69</sup> These views were shared by the Mental Health Practitioners who attended our roundtable:

*“Looking back over the last 10 years in terms of the total workforce, we’ve got this really significant, almost exponential increase in demand, and that was there pre-pandemic, we know that has been built on massively during the pandemic and we can confidently predict as we see the referral rates now that it’s increasing, and the investment in the mental health nursing workforce being built up is nowhere near enough to meet that demand.”–Mental Health Practitioner<sup>70</sup>*

NHS Providers also felt that the commitment did not recognise the need for the right staff, with the right skills, in the right places and overemphasised the overall workforce numbers.<sup>71</sup> This formed part of a broader theme where stakeholders highlighted the necessity to retain experienced staff members and ensure these practitioners were deployed in services which lacked specialist staff.<sup>72</sup> Therefore, this commitment was not appropriate as it placed disproportionate focus on the number of staff within the workforce, rather than working practices and working culture within mental health services.

In summary, our evaluation of the evidence found that increasing the mental health workforce is an important commitment, but the specification of this commitment was not appropriate as it did not recognise nor address the wider complexities which underpin the development and growth of a qualified and well-supported mental health workforce.

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69 British Medical Association ([MHS0008](#))

70 Workforce roundtable

71 NHS Providers ([MHS0013](#))

72 NHS Providers ([MHS0013](#)); Centre for Mental Health ([MHS0016](#))



## 2 Children and Young People’s Mental Health commitment ratings

Commitment	Commitment Met	Funding	Impact	Appropriate	Overall
“at least 70,000 additional children and young people each year will receive evidence-based treatment—representing an increase in access to NHS-funded community services to meet the needs of at least 35% of those with diagnosable mental health conditions”	Good	Good	Good	Inadequate	Requires Improvement
“Achieve 2020/21 target of 95% of children and young people with eating conditions accessing treatment within 1 week for urgent cases and 4 weeks for routine cases.”	Requires Improvement	Good	Requires Improvement	Outstanding	Good
“ensure there is a CYP crisis response that meets the needs of under 18-year-olds”	Requires Improvement	Requires Improvement	Requires Improvement	Outstanding	Requires Improvement

Overall, our evaluation found a mixed picture with regards to the three commitments assessed within children and young people’s mental health services. We recognise that progress on these commitments has been encouraging overall, as an increasing number of children and young people have access to the services they require. However, to be truly effective at supporting children and young people it is important that the Government sets more ambitious and specific targets, such as those outlined for children and young people’s eating condition services. We recognise that the COVID-19 pandemic has affected progress on these targets but note that the increased need associated with the pandemic further highlights the importance of sustained growth and investment in these services.

## Access to Treatment for Children and Young People

In this section, we provide an assessment of the Government’s commitment that at least 70,000 additional children and young people each year will receive evidence-based treatment, representing 35% of those with a diagnosable mental health condition.

**“[...] at least 70,000 additional children and young people each year will receive evidence-based treatment—representing an increase in access to NHS-funded community services to meet the needs of at least 35% of those with diagnosable mental health conditions”**

### **Overall Commitment Rating and Overview for Children and Young People’s access to evidence-based treatment:**

#### *Requires Improvement*

Most mental health conditions that occur across the lifespan usually present by the age of 18.<sup>73</sup> Therefore, ensuring that children and young people have access to evidence-based treatment to support their mental health needs is an important commitment. Progress against this commitment has been good, as the number of children and young people accessing evidence-based treatment has increased in the past decade. This increase comes from a historic underinvestment in children and young people’s mental health services<sup>74</sup> and therefore we note the improved access this population has to services that support their mental wellbeing. The likely impact of COVID-19 on the mental health of children and young people further highlights that it is imperative investment in these services continues.

However, our evaluation has found that this commitment was not appropriate. In focussing on access rates, rather than treatment outcomes, there is a danger that services are “hitting the target, missing the point”<sup>75</sup> of the purpose of increasing access to treatment for children and young people. This inappropriate focus neglects treatment outcomes for children and young people, which would provide a more robust metric of the success of children and young people’s services. Moreover, the disproportionate focus on the number of children accessing services does not account for the need for these services, which has increased since this commitment was established. In summary, progress on this commitment has been good, yielding positive impacts for children and young people who have been able to access treatment for their mental health. However, our evaluation has found that this commitment was not ambitious enough to start with and scope must be widened to support a greater proportion of children and young people with a mental health diagnosis.

73 Solmi, M., Radua, J., Olivola, M., Croce, E., Soardo, L., de Pablo, G. S., ... & Fusar-Poli, P. (2021). Age at onset of mental disorders worldwide: large-scale meta-analysis of 192 epidemiological studies. *Molecular Psychiatry*, 1–15.

74 NHS Confederation, [Reaching the tipping point: Children and young people’s mental health](#) (August, 2021)

75 CYP Roundtable event

## ***Was the commitment met overall? Is the commitment on track to be met?***

### ***Rating: Good***

The deadline for this commitment to be achieved was 2020/2021, as reported by the Department of Health and Social Care.<sup>76</sup> The data against which this target has been monitored is based on prevalence data collected in 2004, when it was estimated that 1 in 10 children and young people had a probable mental health condition.<sup>77</sup> According to this prevalence estimate in February 2020, 39.6% of children and young people with a diagnosable mental health condition accessed evidence-based treatment. Compared to January 2016, when the data was first published, 211,236 children and young people sought mental health support from services, compared to 417,820 in June 2021.<sup>78</sup> Services have exceeded the target of an additional 70,000 children and young people each year accessing treatment a year early.<sup>79</sup>

However, it is important to recognise that prevalence estimates have been updated since the 2004 data on which this commitment was based. A 2017 survey reported that the prevalence of mental health conditions had increased to 1 in 9 children and young people. Against this prevalence rate, 36.9% of children and young people accessed evidence-based treatment, suggesting this commitment was still met.<sup>80</sup> However, studies conducted during the COVID-19 pandemic reported that the prevalence of mental health conditions in this population has now increased further to 1 in 6.<sup>81</sup> Using these prevalence estimates, only 29.5% of children and young people are accessing evidence-based treatment.<sup>82</sup>

In assessing this commitment, it was important to establish the appropriate prevalence data to compare progress against this commitment. There is evidence that the prevalence of mental health conditions has increased in the child and adolescent population during COVID-19.<sup>83</sup> We note, however, that the measures used to assess whether participants had a probable mental health condition in the 2020 and 2021 studies were collected using online surveys, whereas previous prevalence studies conducted in 2004 and 2017 were collected through interviews.<sup>84</sup> Moreover, the measures used to collect the 2020 and 2021 prevalence estimates are symptom focussed, and do not reflect the full diagnostic criteria of a mental health condition, which stipulates that mental ill health should impact daily functioning.<sup>85</sup> We note this criterion is difficult to assess during COVID-19, where daily functioning was necessarily disrupted by school closures and national lockdowns. Currently, there is a lack of evidence about whether the criteria for clinical cut-off on the instruments used to measure prevalence would apply in the context of the COVID-19 pandemic. In recognition of these issues, we have decided to use prevalence data from 2017 when assessing progress on this commitment, which estimate the prevalence of

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76 The Department of Health and Social Care ([MHS0009](#))

77 Centre for Mental Health, [CYP mental health fact sheet 2021 \(2021\)](#)

78 NHS England, [NHS Mental Health Dashboard \(2021\)](#)

79 The Department of Health and Social Care ([MHS0009](#))

80 Ibid.

81 NHS Digital, [Mental Health of Children and Young People in England](#), prevalence survey (2020)

82 The Department of Health and Social Care ([MHS0009](#))

83 Ibid

84 Centre for Mental Health, [CYP mental health fact sheet 2021 \(2021\)](#)

85 American Psychiatric Association, & American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Arlington, VA.

mental health conditions to be 1 in 9 in the child and adolescent population. On this basis, the data suggests this commitment has been achieved, though some regions have not reached the target of 35% of children and young people accessing services.<sup>86</sup>

Despite progress on this target being good, stakeholders have noted that ensuring children and young people have access to evidence-based treatment has been affected by the COVID-19 pandemic.<sup>87;88</sup> The pandemic has exacerbated existing mental health issues, meaning children and young people are presenting with more complex and more acute symptoms.<sup>89</sup> In our roundtable with Mental Health practitioners, one individual stated that COVID had “magnified” issues with children and young people’s mental health.<sup>90</sup>

### ***Was the commitment effectively funded (or resourced)?***

#### ***Rating: Good***

Specific funding arrangements have been made to expand children and young people’s mental health services and increase access to evidence-based treatment. The NHS Mental Health Implementation Plan 2019/20–2023/24 details yearly spend on children and young people’s mental health services, which includes funds allocated to CCG baselines and central/transformation funding to expand mental health support teams.<sup>91</sup> Moreover, in their response to our evaluation, the Department referred to a recent announcement that £79m would be made available to support the expansion of children and young people’s mental health services including (but not limited to) community services and mental health support teams.<sup>92</sup> We note that these new funding sources to support the expansion of children and young people’s mental health services were welcomed by stakeholders.<sup>93</sup>

However, some stakeholders reported that children and young people’s services had experienced reduced funding in real terms and questioned the sufficiency of the additional funding.<sup>94</sup> Some reports have noted that children and young people’s services have been historically underfunded, and that current investment is not adequate to bring parity of esteem between physical and mental health.<sup>95</sup> Consistent with this, it has been reported that less than 1% of CCGs’ budgets are spent on children and young people’s mental health services.<sup>96</sup> Considering the recent increases in the prevalence and presentation of mental health conditions in children and young people,<sup>97</sup> stakeholders have also said that additional funds will be required to address the increased need for services.<sup>98</sup> However, these views were not shared by practitioners at our roundtable event, who reported that funding was sufficient, but that services did not have the staff required for delivery of treatment (see Chapter 1: Workforce):

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86 Education Policy Institute, [Access and waiting times in children and young people’s mental health services](#) (September, 2017)

87 Samaritans (MHS0001)

88 British Association of Counselling and Psychotherapy (MHS0006)

89 Association of Directors of Children’s Services (MHS00017)

90 CYP Roundtable event

91 NHS Mental Health Implementation Plan 2019/20–2023/24

92 The Department of Health and Social Care (MHS0009)

93 NHS Providers (MHS0013)

94 National Counselling Society (MHS0003)

95 NHS Confederation, [Reaching the tipping point: Children and young people’s mental health](#) (August, 2021)

96 MIND (MHS0005)

97 NHS Digital, [Mental Health of Children and Young People in England](#), prevalence survey (2020)

98 MIND (MHS0005)

*“Has there been sufficient resource and is that resource appropriately targeted is a different question to funding. I know that within most of the trusts, and in my trust, that we cannot use all the finance that’s coming into child and adolescent mental health services, because there are not the staff to be recruited”.*–Mental Health Practitioner.<sup>99</sup>

Indeed, the views shared by practitioners were consistent with some stakeholder submissions, who suggested that the allocation of funds were more problematic than the amount of funds invested. For example, it was suggested by one respondent that funds were not being allocated equally across services but were instead being focussed on those that react to mental illness rather than those aimed to prevent mental health illnesses from emerging. This focus has increased the strain on children’s wellbeing practitioners (CWPs) and education mental health practitioners (EMHPs) to deliver treatment beyond their training and remit.<sup>100</sup> Our evaluation has found that while the amount of funding is good, investment is needed to train, recruit, and retain staff in children and young people’s mental health services (see Chapter 1: Workforce).

Significant regional differences also exist in the allocation of funding for children and young people’s services, leading to a postcode lottery of access.<sup>101;102</sup> For example, 8 areas spend less than £40 per child whereas 21 areas spend more the £100 per child. These differences are important to note, as they likely contribute to disparities in the provision of children and young peoples’ mental health services, which we discuss in the next section below.

### **Did the commitment achieve positive impacts for service users?**

#### **Rating: Good**

When considering the impact of this commitment, it is important to recognise the historically low number of children and young people who were able to access mental health support.<sup>103</sup> Given this context, we suggest that the impact of this commitment has been good, as it has allowed greater numbers of children and young people support for their mental health using evidence-based treatment. Data demonstrates that referrals to mental health services have consistently increased since these figures have been recorded by NHS Digital.<sup>104;105</sup> Those who accessed children and young people’s mental health services reported positive experiences:

*“[CAMHS worker] listened to me. I was given lots of choice and different options. We worked out what was best for me. [CAMHS worker] asked me questions and my mum. It wasn’t one sided. I felt listened to.”* - Young person.<sup>106</sup>

99 CYP Roundtable

100 Professor Cathy Creswell, University of Oxford ([MHS0014](#))

101 Centre for Mental Health ([MHS0016](#))

102 The Children’s Commissioner, [The State of Children’s Mental Health Services 2020/2021](#) (January, 2021)

103 [NHS England, NHS Mental Health Dashboard \(2021\)](#)

104 Ibid

105 National Counselling Society ([MHS0003](#))

106 Care Quality Commission, [Are we listening? Review of children and young people’s mental health services](#) (March 2018)

In addition, parents of service users reported positive experience of the treatment offered by services:

*“I think what they have been done since December is brilliant! They have given me back my son!” –Parent of service user.<sup>107</sup>*

It will be important that the upward trend in numbers of children and young people who are accessing treatment continues as the need for mental health services increases. The NHS Confederation’s Mental Health Network noted in their report ‘Reaching the Tipping Point’ that the COVID-19 pandemic has exacerbated challenges faced by children and young people mental health services.<sup>108</sup> They estimate up to 1.5 million children and young people may need new or additional mental health support as a direct result of measures implemented to mitigate the spread of the COVID-19 pandemic.<sup>109</sup> The increased prevalence of mental illness in children and young people may be the result of a complex range of factors, including but not limited to: social isolation, loneliness, greater exposure to domestic violence, family illness, and financial worries.<sup>110</sup> When questioned about their ability to meet the anticipated level of demand in the next 12–18 months, 78% of trust leaders said they were either extremely or moderately concerned about their ability to provide mental health care for children and young people.<sup>111</sup> As such, it will be important to ensure that services are adequately resourced to meet the increasing number of children and young people who require support for their mental health and deliver good, evidence-based treatment. Currently, the quality of provision in children and young people’s services is good, as noted in a report by the CQC:

*“CAMHS have been really consistent and positive and have always looked to try different options throughout.” - CQC reviewer.<sup>112</sup>*

Nevertheless, there is evidence that there are barriers to accessing services, meaning some children and young people have reduced access to support for their mental health. In 2018, the All-Party Parliamentary Group on Mental Health produced a report detailing progress on the commitments outlined in the NHS Five Year Forward View for Mental Health Plan. It was noted that service users felt that waiting times were too long and the threshold required to be referred for treatment had increased. This view was supported by a survey of child psychotherapists; in a 2018 report by the Association of Child Psychotherapists, 72% of frontline NHS CAMHS staff said that the threshold for gaining access to services had increased in the past 5 years.<sup>113</sup> Service users reported negative attitudes towards current waiting times and thresholds for access:

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107 Ibid

108 NHS Confederation, [Reaching the tipping point: Children and young people’s mental health](#) (August, 2021)

109 Ibid

110 Orben, A., Tomova, L., & Blakemore, S. J. (2020). The effects of social deprivation on adolescent development and mental health. *The Lancet Child & Adolescent Health*, 4(8), 634–640.; Fegert, J. M., Vitiello, B., Plener, P. L., & Clemens, V. (2020). Challenges and burden of the Coronavirus 2019 (COVID-19) pandemic for child and adolescent mental health: a narrative review to highlight clinical and research needs in the acute phase and the long return to normality. *Child and Adolescent Psychiatry and Mental Health*, 14, 1–11.

111 NHS Providers, [Children and young people’s mental health survey \(May, 2021\)](#)

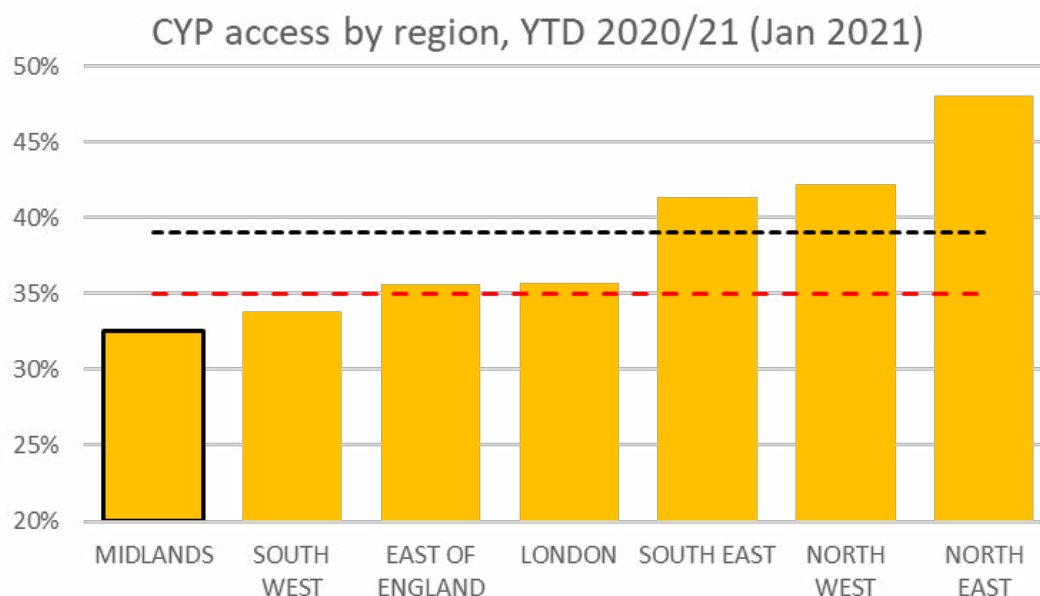
112 Care Quality Commission, [Are we listening? Review of children and young people’s mental health services](#) (March, 2018)

113 Association of Child Psychotherapists, [‘Silent Catastrophe’ – responding to the danger signs of children and young people’s mental health services in trouble](#) (June, 2018)

*“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.<sup>114</sup>*

In addition, there are inequalities in the provision of children and young peoples’ mental health services. Child mental health problems are strongly linked to deprivation.<sup>115</sup> A report by the Children’s Commissioner documented that there are variable waiting times and access rates, with areas higher in deprivation more likely to have longer waiting times, lower spend per child and a greater need for mental health services (see Figure 8).<sup>116</sup> This finding was corroborated by a Green paper jointly published by the Department of Health and Social Care and the Department of Education in 2017, which identified regional differences in referral times ranging from four to 100 weeks.<sup>117</sup>

**Figure 8: Children and young people’s access to evidence-based treatment by region. The red dashed line indicates the target outlined in the commitment whereas the black dashed line indicates the national average based on NHS Digital data from January 2021.<sup>118</sup>**



Moreover, support is not consistent for children and young people from minority ethnic backgrounds. In a report by the Education Policy Institute, an education policy think-tank, children and young people’s services did not engage with faith groups to raise awareness of mental health needs in these communities.<sup>119</sup> Furthermore, support for vulnerable groups, such as refugees, is limited within children and young people’s services. In areas where support has been provided, this is due to staff initiatives rather than dedicated resources:

114 All-Party Parliamentary Group on Mental Health, [Progress of the Five Year Forward View for Mental Health: On the road to parity](#) (2018)

115 Straatmann, V. S., Lai, E., Lange, T., Campbell, M. C., Wickham, S., Andersen, A. M. N., ... & Taylor-Robinson, D. (2019). How do early-life factors explain social inequalities in adolescent mental health? Findings from the UK Millennium Cohort Study. *J Epidemiol Community Health*, 73(11), 1049–1060.

116 The Children’s Commissioner, [The State of Children’s Mental Health Services 2020/2021](#) (January, 2021)

117 The Department of Health and Social Care, [Transforming children and young people’s mental health provision: a green paper](#) (December, 2017)

118 NHS England, [NHS Mental Health Dashboard](#) (2021)

119 Education Policy Institute, [Access to child and adolescent mental health services in 2019](#) (January, 2020)

*“There was also an expectation of good-will from health professionals to run more bespoke services especially when targeting communities less willing to access support. For example, there were a high proportion of traumatised refugees in [this area]. Two staff had an interest in this and so once a month had set up specialist clinics with translators and trauma specialists. There was no ring-fenced money for this service which we were told was a barrier to its success.” - CQC reviewer.<sup>120</sup>*

In summary, the evidence synthesised during the course of our evaluation suggests that the impact of this commitment has been good. However, there is scope for improvement in waiting time and thresholds necessary to access treatment. In addition, our evaluation suggests there are inequalities in the provision of children and young people’s mental health services based on ethnicity and migration status.

### **Was it an appropriate commitment?**

#### **Rating: Inadequate**

Our evaluation found that this commitment was not appropriate. While improvement to access is noted, service users were only required to attend two appointments to be considered to have accessed treatment.<sup>121;122</sup> As such, data cited in support of this commitment did not track whether service users completed a full course of treatment accordance with National Institute for Health and Care Excellence (NICE) guidelines.<sup>123</sup> This view was shared by practitioners at our roundtable event, who noted that there was a lack of outcome measures that could determine whether children and young people were accessing evidence-based treatment.<sup>124</sup>

Stakeholders also reported that the disproportionate focus on the number of children and young people treated, rather than the proportion of the population with a probable mental health condition, had resulted in a false economy when evaluating the success of children and young people’s mental health services.<sup>125</sup> This view was shared by practitioners at our roundtable event, who reported that through focussing on access rates, services were “hitting the target, missing the point”.<sup>126</sup> Mental health practitioners suggested that access targets removed focus from early intervention, which was not an appropriate commitment:

*“[...] we don’t focus enough on early intervention and prevention. Because it’s about hitting an access target, that infers that we’ve already got to a point where we haven’t been able to focus on the early intervention, because we’ve waited until we’ve got to a point where somebody hits a threshold to trigger an access target.” –Practitioner.<sup>127</sup>*

120 Care Quality Commission, [Are we listening? Review of children and young people’s mental health services](#) (March, 2018)

121 [NHS England, NHS Mental Health Dashboard \(2021\)](#)

122 Professor Cathy Creswell, University of Oxford ([MHS0014](#))

123 National Institute for Health and Care Excellence, [Children and young people’s mental health](#)

124 National Institute for Health and Care Excellence, [Children and young people’s mental health](#); Professor Cathy Creswell, University of Oxford ([MHS0014](#)); CYP Roundtable

125 Professor Cathy Creswell, University of Oxford ([MHS0014](#))

126 CYP Roundtable

127 CYP Roundtable



Our evaluation also found that the target to provide access to treatment for 35% of children and young people with a probable mental health condition was not appropriate. To achieve parity of esteem between physical and mental health, more ambitious targets must be set. However, we recognise that this target was set in context of a historic lack of access to children and young people’s mental health services. Overall, the focus of this commitment was inadequate to meet the mental health needs of children and young people.

## Children and Young People’s Eating Condition Services

In this section, we provide an assessment of the Government’s commitment that 95% of children and young people with eating disorders should access treatment within 1 week for urgent cases and 4 weeks for routine cases.

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

### Overall Commitment Rating and Overview for Children and Young People’s Eating Conditions:

#### Good

Eating disorders have a significant impact on the lives of children and young people, and their families. Moreover, eating disorders are associated with high rates of mortality and it has been estimated that providing adequate treatment for eating disorders could avert an average of 70.5 deaths per 100,000 people by age 40.<sup>128,129</sup> In addition, eating disorders have significant impacts on the daily lives of those who experience them and their families. Therefore, ensuring timely access to treatment is a crucial step and the Government’s commitment to improve access to treatment is important and necessary. Prior to the COVID-19 pandemic, the NHS was on track to meet the 2020/2021 target of 95% of children and young people with an eating disorder accessing treatment within 1 week for urgent cases and 4 weeks for routine cases.<sup>130</sup> However, the pandemic has significantly impacted progress against this target, with the prevalence of eating disorders increasing during the pandemic. As such, the latest data suggests that progress on this commitment has not been met by the deadline stipulated in this commitment. We discuss progress against the target and the impact of the pandemic later in this chapter.

Additional funding has been allocated to improve access to eating disorder treatment, though we are not able to evaluate the impact of these funds at this time. Such intervention is timely, as children and young people with eating disorders are presenting later and with more complex symptoms.<sup>131</sup> These delays are leading to negative psychosocial outcomes for children and young people, which have been further exacerbated by the COVID-19

128 Smink, F. R., Van Hoeken, D., & Hoek, H. W. (2012). Epidemiology of eating disorders: incidence, prevalence and mortality rates. *Current Psychiatry Reports*, 14(4), 406–414.

129 Ward, Z. J., Rodriguez, P., Wright, D. R., Austin, S. B., & Long, M. W. (2019). Estimation of eating disorders prevalence by age and associations with mortality in a simulated nationally representative US cohort. *JAMA network open*, 2(10), e1912925-e1912925.

130 The Department of Health and Social Care ([MH50009](#))

131 NHS Providers ([MH50013](#))

pandemic.<sup>132</sup> However, despite the additional pressures on services, we acknowledge the increase in the number of children and young people completing treatment for eating disorders, whilst recognising the further improvement against this commitment required.

### ***Was the commitment met overall? Is the commitment on track to be met?***

#### ***Rating: Requires Improvement***

The deadline for the commitment to reach a target of 95% of children and young people accessing treatment for eating disorders within one week for urgent cases and four weeks for routine cases was by the end of 2020/2021. According to the latest data from NHS Digital, this target has not been met. In Quarter 1 (2021/22), 61.0% (N=520 of 850) of children and young people started treatment within one-week for urgent cases and 72.7% (N=1,889 of 2,600) started treatment within four-weeks for routine cases.<sup>133</sup>

The failure to meet this target should be understood within the context of the impact caused by the COVID-19 pandemic. Prior to the pandemic, data suggested that the NHS was on track to meet this target and in Quarter 4 2019/20, 80.5% (N=284 of 353) of children and young people started treatment within one week for urgent cases and 84.4% (N=1,562 of 1,850) started treatment in four weeks for routine cases.<sup>134</sup> This figure had been steadily increasing from the previous years (see Figure 9). A recent report by the Office of the Children’s Commissioner, a non-departmental body responsible for protecting the rights of children, highlighted that progress against this target may be attributable to the Government’s commitment. Specifically, the Children’s Commissioner’s report noted that services where waiting time targets were introduced, such as eating disorders, have seen improvements in timely access whereas children seeking services without such targets have faced more delayed access to treatment.<sup>135</sup>

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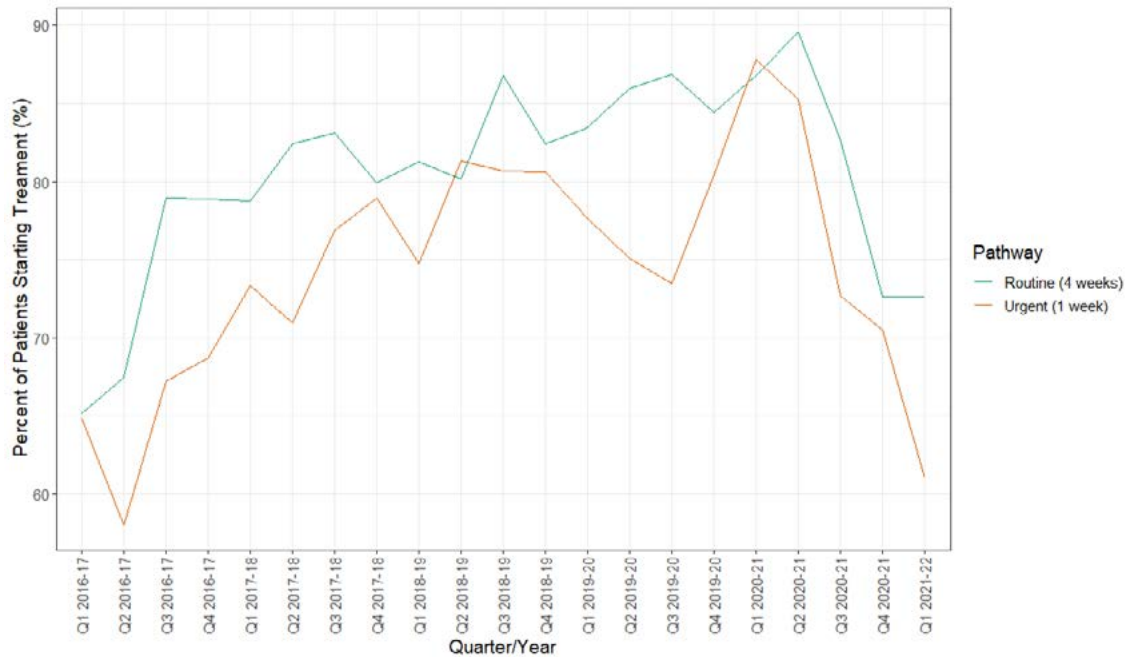
132 MIND ([MHS0005](#))

133 NHS England, [NHS Mental Health Dashboard \(2021\)](#)

134 Ibid

135 The Children’s Commissioner, [The state of children’s mental health services \(2020\)](#)

**Figure 9: Plot demonstrating the percentage of children and young people accessing treatment for eating disorders within 1 week (urgent) and 4 weeks (routine).**



At the onset of the pandemic, the prevalence and acuity of eating disorders increased dramatically, a trend that has been observed internationally.<sup>136</sup> As stated by a practitioner who attended our roundtable event:

*“[...] an exponential rise in young people with eating disorders, and certainly for our trust, we don’t have the capacity in terms of eating condition services for young people, but this is what we’re now seeing.” - Mental Health Practitioner.<sup>137</sup>*

Consequently, demand for support for eating conditions has risen since the onset of the pandemic. The NHS Confederation’s Tipping Point Report found that demand for urgent eating disorder services increased by 141% between Q4 2019/2020 and Q1 2021/2022.<sup>138</sup> A combination of the move to online provision of services and the increased demand at the onset of the pandemic may plausibly have affected progress against this commitment.<sup>139</sup> Therefore, as a consequence of the COVID-19 pandemic, improvements are required to achieve the commitment established by the Government. However, our analysis illustrates that without the pandemic 95% of children and young people accessing services within the established timeframes would have been achieved.

<sup>136</sup> MIND (MHS0005); Touyz, S., Lacey, H., & Hay, P. (2020). Eating disorders in the time of COVID-19. *Journal of Eating Disorders*, 8 (19), 8–19

<sup>137</sup> Adult CMI roundtable.

<sup>138</sup> NHS Confederation, [Reaching the tipping point: Children and young people’s mental health](#) (August 2021)

<sup>139</sup> Ibid

## ***Was the commitment effectively funded (or resourced)?***

### ***Rating: Good***

Specific funding arrangements have been made to resource children and young people’s eating disorder services. The Department referred to several distinct sources of funding in their response to our evaluation:

- Additional funding that has been allocated each year since 2016.
- An additional £53 million a year planned to be allocated to CYP eating disorder services from 2021/22 to 2023/24.
- An additional £79 million extra in 2021/22 Spending Review that was allocated to expand children’s mental health services.<sup>140,141</sup>

This funding is a necessary investment in children and young people’s eating disorder services. We note the funding invested, which stakeholders recognised as appropriate to meet the commitment.<sup>142,143,144</sup> MIND told us that the funding allocated at the 2021/22 spending review was “essential”<sup>145</sup> and the Children and Young People’s Mental Health Coalition with the Centre for Mental Health said funding to support waiting time standards “has been a major step forward”.<sup>146</sup> The investment seen up to 2019/2020 may have contributed to the improvement in waiting times, though there is no available data which allows us to evaluate how funding is allocated for eating condition services beyond national programmes of funding detailed by the Department for Health and Social Care.

We note that additional investment may be necessary to recover levels of access to treatment achieved before the COVID-19 pandemic. In their response to our evaluation, stakeholders recognised that with increasing prevalence, increased financial commitment to eating disorder services will also be necessary.<sup>147</sup> However, it is important to note that any additional funding must be able to be directed towards the appropriate service. In our roundtable, practitioners reported having sufficient funding for delivery, but services lacked the required workforce to facilitate treatment (see Chapter 1, Workforce).

Funding for children and young people’s eating disorders is allocated through Clinical Commissioning Group (CCG) baseline funds.<sup>148</sup> Stakeholders have reported that the absence of ring-fenced funds specifically for eating disorders has led to variability between CCGs with regards to the amount of funds that reach these services.<sup>149,150</sup> The lack of transparency surrounding the allocation of funds is problematic,<sup>151</sup> as a recent report by Beat on behalf of the All Party Parliamentary Group on Eating Conditions found that 41% of CCGs spent less on children and young people’s community eating condition

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140 The Department of Health and Social Care (MH5009)

141 Centre for Mental Health ([MH50016](#))

142 MIND ([MH50005](#))

143 NHS Providers ([MH50013](#))

144 Centre for Mental Health ([MH50016](#))

145 MIND ([MH50005](#))

146 Centre for Mental Health ([MH50016](#))

147 Ibid

148 NHS, [Mental Health Implementation Plan 2019/20–2023/24](#) (January, 2019) p 21

149 MIND ([MH50005](#))

150 Centre for Mental Health ([MH50016](#))

151 Ibid

services in proportion to the amount of additional funding they had received from NHS England in 2019/2020.<sup>152</sup> Despite a statement from NHS England which explained that the funds allocated for eating disorder services should not supplant existing spend or balance reductions elsewhere,<sup>153</sup> only 15% of CCGs increased their spend in line with the additional funds they had received for these services.<sup>154</sup> As such, while adequate funds have been allocated to eating disorder services, these resources have not been utilised for their intended function.

### ***Did the commitment achieve a positive impact for service users?***

#### ***Rating: Requires improvement***

The impact of this commitment is likely to have been good for those children and young people who have been able to access eating disorder services. However, a significant number of individuals have been unable to access timely treatment due to the increased prevalence of eating disorders resulting from the COVID-19 pandemic. The number of urgent cases waiting to access treatment has doubled from 2019/2020 to 2020/2021,<sup>155</sup> leaving children and young people with eating disorders being left without the necessary psychological support during a time where they may be experiencing a psychological crisis.<sup>156</sup> Moreover, without timely access to treatment, children and young people are presenting to mental health services with more acute symptoms,<sup>157</sup> which will increase the burden on children and young people’s acute services. This is pertinent as observational studies have demonstrated that the rate of recovery from eating disorders decreases as chronicity increases.<sup>158</sup> In a report by MIND, one service user reported the extent to which their eating disorder had impacted their day-to-day life:

*“Around October 2020, I started experiencing symptoms of anorexia nervosa. I became preoccupied with food and my days now revolve around eating and exercise.”—Young person.<sup>159</sup>*

The COVID-19 pandemic has had a severe impact on rates of eating disorders. For those with pre-existing eating conditions, access that they may have previously had to services has been disrupted, causing distress.<sup>160</sup> Added to this, there have been a number of new cases that have developed in response to the pandemic.<sup>161</sup> A report by Kooth, a company that provides online counselling services, detailed a significant increase in the number of referrals at the onset of the pandemic.<sup>162</sup> Consistent with this account, a report by MIND

152 All-Party Parliamentary Group on Eating Disorders, [Short-changed: Funding for children and young people’s community eating disorder services in England in 2019/20](#) (May, 2021)

153 NHS England, [Implementing the Five Year Forward View for Mental Health](#) (2017)

154 All-Party Parliamentary Group on Eating Disorders, [Short-changed: Funding for children and young people’s community eating disorder services in England in 2019/20](#) (May, 2021)

155 NHS Confederation, [Reaching the tipping point: Children and young people’s mental health](#) (August, 2021)

156 British Association for Counselling and Psychotherapy ([MHS0006](#))

157 NHS Providers ([MHS0013](#))

158 Austin, A., Flynn, M., Richards, K., Hodson, J., Duarte, T. A., Robinson, P., ... & Schmidt, U. (2021). Duration of untreated eating disorder and relationship to outcomes: A systematic review of the literature. *European Eating Disorders Review*, 29(3), 329–345

159 MIND, [The consequences of coronavirus for mental health](#) (July, 2021)

160 The Department of Health and Social Care ([MHS0009](#))

161 MIND ([MHS0005](#))

162 Kooth, [The state of the nation’s mental health](#) (May, 2021)

found that 78% of young people reported over or under eating to cope with the pandemic.<sup>163</sup> The impact of eating disorders developed during the pandemic can cause severe distress to these individuals, as reported by one of Kooth's service users:

*“I don't know what's going on with me but ever since the start of the pandemic I've developed an eating disorder. I'm in a never-ending cycle of binging and then restricting. I can't control it and it's taken over all aspects of my life. My family can't understand me at all so I don't bother talking to them anymore. All I want to be able to do is eat my food without obsessing over everything. PLEASE HELP.”*—Anonymous service user.<sup>164</sup>

There is evidence that increases in the rates of conditions vary across different regions.<sup>165</sup> In a survey sent to members, the Royal College of Paediatrics and Child Health reported increases in referrals to eating disorder services ranging between 23–250%.<sup>166</sup> These findings indicate that the new funds should be targeted at the services with the highest levels of demand.

We recognise that the delivery of services has been impacted by COVID-19 as clinical sessions with patients were unable to occur face to face,<sup>167</sup> which is the preferred format of support for most adolescents.<sup>168</sup> Stakeholders reported concerns that the inability to meet waiting time targets means that services will find it more challenging to meet the increasing number of referrals that continue to be reported as the response to the COVID-19 pandemic becomes more protracted.<sup>169</sup> Practitioners have highlighted the difficulties in accessing services during the COVID-19 pandemic, for example:

*“CAMHS ... She's not sleeping, she's not eating very well ... COVID hit and the CBT cannot happen face to face and ... CAMHS have now said ... we're going to pause it.”*—SESCO Practitioner<sup>170</sup>

Given the significant negative outcomes that are associated with untreated eating disorders, the impact of progress against this commitment requires improvement to ensure that access to services meets the waiting time standard outlined established by the Government. The failure to meet the waiting time standards outlined in this commitment has led to an increased need for admission for nasogastric tube feeding due to severe loss of body weight over a short period of time.<sup>171</sup> Further, eating disorders and self-harm are often comorbid, which if left untreated can increase the risk of morbidity and mortality.<sup>172</sup> Together, our evaluation highlights the range of negative psychological and social impacts these conditions can have on children and young people without timely treatment.

163 MIND, [The consequences of coronavirus for mental health](#) (July, 2021)

164 Kooth, [The state of the nation's mental health](#) (May, 2021)

165 Royal College of Paediatrics and Child Health, [Paediatricians warn parents to be alert to signs of eating disorders over holidays](#) (December, 2020)

166 Ibid

167 Professor Cathy Creswell, University of Oxford ([MHS0024](#))

168 Brothwood, P.L et al. (2021) Moving online: young people and parents' experiences of adolescent eating disorder day programme treatment during the COVID-19 pandemic. *J Eat Disord* 9, 62

169 British Medical Association ([MHS0008](#))

170 Professor Cathy Creswell, University of Oxford ([MHS0024](#))

171 Huang, H. C. H., & Ougrin, D. (2021). Impact of the COVID-19 pandemic on child and adolescent mental health services. *BJPsych open*, 7(5)

172 van Hoeken, D., & Hoek, H. W. (2020). Review of the burden of eating disorders: mortality, disability, costs, quality of life, and family burden. *Current Opinion in Psychiatry*, 33(6), 521

## Appropriate

### Rating: Outstanding

Eating disorders are persistent and have the highest standardised mortality ratio of all mental health conditions.<sup>173</sup> Due to the significant negative impacts of eating disorders on children and young people, the ambitious target set out in this commitment was an appropriate one. Stakeholders recognised that this was an imperative commitment that had the potential to achieve meaningful outcomes for service users.<sup>174</sup> Setting waiting time standards for eating disorders has led to the expansion of services, though this has been limited by the COVID-19 pandemic. Through providing a metric with which to assess this outcome, progress against this target can be meaningfully measured as has been demonstrated by the monthly reporting by NHS Digital.<sup>175</sup>

There are some minor areas for further improvement on this commitment, specifically around the information recorded during treatment. Collecting data on recovery and relapse rates for those who access eating disorder services is important in providing additional granularity on the effectiveness of treatments. Further, collecting demographic data about those who access treatment would support decision-makers to identify groups of individuals who are not accessing treatment.

## Children and Young People’s Crisis Response

In the following section we evaluate the Government’s commitment to establish a crisis response that meets the needs of children and young people:

**“[...] ensure there is a CYP crisis response that meets the needs of under 18-year-olds”**

### Overall Commitment Rating and Overview for Children and Young People’s Crisis Response:

#### Requires Improvement

A functioning crisis response unit is an essential part of mental healthcare. The Department of Health and Social Care has developed a crisis response service that is comprised of the following four functions:

- (1) 1. A single point of access, including through 111, to crisis support, advice and triage;
- (2) Crisis assessment within the emergency department and in community settings;
- (3) Crisis assessment and brief response within the emergency department and in community settings, with CYP offered brief interventions; and

173 Ibid

174 MIND ([MHS0005](#))

175 NHS England, [NHS Mental Health Dashboard \(2021\)](#)

- (4) Intensive home treatment services aimed at CYP who might otherwise require inpatient care, or intensive support that exceeds the normal capability of a generic CYP mental health community team.<sup>176</sup>

For this service to be considered operational, functions 1–3 must operate 24/7 and function 4 should be available 7 days a week across locally determined hours.<sup>177</sup> Our evaluation showed that progress against this commitment requires improvement. Whilst progress in setting up crisis support lines was accelerated due to the COVID-19 pandemic, the other three functions of this service are not currently operational and there is a lack of evidence to suggest this commitment is on track to be operational by 2023/2024.<sup>178</sup> Stakeholders suggested these services were not adequately funded, which provided a barrier to the provision of these functions.<sup>179</sup>

It is imperative that appropriate crisis response services are operational. Their absence has resulted in some children and young people being sent far from home for treatment and/or placed in adult wards that are inappropriate for their age groups.<sup>180</sup> As noted elsewhere in this report, COVID-19 has exacerbated mental health issues in children and young people,<sup>181</sup> meaning mental health conditions are presenting later and more acutely.<sup>182</sup> As such, crisis response is a vital service that is urgently required by children and young people.

### ***Was the commitment met overall? Is the commitment on track to be met?***

#### ***Rating: Requires Improvement***

The deadline for a fully operational crisis response service for children and young people is 2023/2024, therefore our evaluation assesses whether the Government is on track to meet this deadline. We acknowledge that some progress against this commitment has been made as all-age helplines have been established across the country in response to the COVID-19 pandemic.<sup>183</sup> However, stakeholders reported that the 2019/2020 target to achieve full or partial coverage of the four components of a comprehensive crisis response service in 30% of the country was not met.<sup>184</sup> In their response to our evaluation, the Department noted that according to their latest data, 67% of the country has full or partial coverage of the four components of a comprehensive crisis service, meeting their target for 35% coverage by 2020/21.<sup>185</sup>

Although the development of crisis support lines is encouraging, we note that there is a significant lag in progress on the other three functions of a comprehensive crisis response service.<sup>186</sup> Indeed, the absence of certain functions may reduce the capacity of the crisis response services to provide the appropriate level of care to children and young

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176 The Department of Health and Social Care ([MHS0009](#))

177 Ibid

178 MIND ([MHS0005](#))

179 Royal College of Psychiatrists (MHS0012)

180 MIND ([MHS0005](#))

181 British Association for Counselling and Psychotherapy (MHS00006)

182 MIND ([MHS0005](#))

183 The Department of Health and Social Care ([MHS0009](#))

184 MIND ([MHS0005](#))

185 The Department of Health and Social Care ([MHS0009](#))

186 MIND ([MHS0005](#))



people reaching out to the service.<sup>187</sup> Significant work, therefore, is required before the Government will be on track to deliver an operational crisis response service for children and young people by 2023/2024.

The COVID-19 pandemic has adversely affected progress against this commitment. The pandemic has led to an increased demand for services and in June 2021 the number of new urgent referrals to crisis teams increased to 2,260, a 75% increase on the same month in 2020.<sup>188</sup> The additional burden on services will impede the ability to establish new functions within crisis response services. However, these crisis response services are urgently required to meet the mental health needs of children and young people.

### ***Was the commitment effectively funded (or resourced)?***

#### ***Rating: Requires Improvement***

Funding for children and young people's crisis services comes from overall ring-fenced mental health investment.<sup>189</sup> As such, there are no specific provisions for crisis services, and allocation of funds is determined at CCG level. An additional £79m boost for children and young people's mental health services was announced in March 2021, including crisis services, which was welcomed by stakeholders.<sup>190</sup>

However, stakeholders did not view the funds allocated to support this commitment as sufficient.<sup>191</sup> The Royal College of Psychiatrists said that the requirement for a crisis response service was symptomatic of underinvestment in local authority services for children and young people, meaning a greater number of children and young people were presenting with acute mental health conditions that required crisis care.<sup>192</sup> Stakeholders suggested that early intervention, delivered through local authority services for children and young people, would reduce the burden on crisis care and therefore questioned whether investment in crisis care was sufficient without similar funds allocated to services that could deliver early interventions.<sup>193</sup> Nevertheless, MIND made the case that to ensure that crisis services are adequately funded the commitment to grow funding for mental health services faster than the overall budget for the NHS should be maintained.<sup>194</sup>

### ***Did the commitment achieve positive impacts for service users?***

#### ***Rating: Requires Improvement***

According to the NHS Confederation, there has been a 47% increase in the number of new emergency referrals to crisis care teams in under 18s between December 2019 and April 2021.<sup>195</sup> However, the promise of this commitment has not achieved its full potential due to the absence of a fully operational crisis response service and, therefore, requires

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187 Ibid

188 NHS England, [NHS Mental Health Dashboard \(2021\)](#)

189 MIND ([MHS0005](#))

190 Ibid

191 National Counselling Society ([MHS0003](#))

192 Royal College of Psychiatrists ([MHS0012](#))

193 Ibid

194 MIND ([MHS0005](#))

195 NHS Confederation, [Reaching the tipping point: Children and young people's mental health](#) (August, 2021)

improvement. In a report by Healthwatch Darlington, some service users reported that the response window for crisis response services was too long, with one service user reporting a three day wait for the Mental Health Crisis Team to respond to messages.<sup>196</sup>

The lack of an appropriate crisis care response for young people has contributed to young people being placed on adult wards. In 2019/2020, NHS England data showed that 592 children were placed on adult wards, three times the number in the previous year.<sup>197</sup> In quarter 1 of 2020/21, 83 young people were placed on adult wards, resulting in 1,391 bed days on adult wards.<sup>198</sup> This account was corroborated by the Royal College of Emergency Medicine who reported that the provision for a child in crisis in emergency departments is poor.<sup>199</sup> In a survey sent to members of the Royal College of Emergency Medicine, 54% rated the provision as poor or awful in 2021. Respondents to this survey also reported that only 21% of services were available 24 hours per day, 7 days per week and only 38% available until at least 20:00 every day. Overall, 75% reported services were no better or worse than in 2018.<sup>200</sup>

We note, however, that there are positive examples of best practice where crisis response services have supported children and young people in times of acute mental health. The North East Lincolnshire Crisis and Home Treatment Service for Children and Young People was established in 2013 to support young people with their mental health needs within the community. This service was staffed with a diverse workforce utilising a variety of skills to provide a ‘holistic’ package of care within the service. Service users reported positive experiences with this service. For example, a parent reported:

*“All of the staff dealing with [daughter] have listened and supported [daughter] through a very difficult few years and I would like to thank them and let them know that I really highly appreciate all their support”* – Parent of service user.<sup>201</sup>

Another example of good practice in Gloucester highlighted the importance of co-producing the service with children and young people to agree features of delivery that ensure treatments worked for the individuals using the service. The coproduction of this service resulted in appropriate support for children and young people, which achieved positive impacts for those who approached the service.<sup>202</sup> For example, one service user reported:

*“Before I came to the CYP Haven I was at my lowest, I really struggled with friendships and was often isolated. The CYP Haven supported me through tough times and as a result I have made many friends, some I have met at the CYP Haven. After a few months of visiting the CYP Haven I was signed posted to CAMHS Youth Advisors (CYA). CYA helped me have more of a life*

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196 Healthwatch Darlington, [Children and Young Peoples Mental Health \(Including experiences during the COVID-19 pandemic\)](#) (2020)

197 Article 39, [Children in hospital \(Mental health\)](#) (February, 2021)

198 NHS England, [NHS Mental Health Dashboard](#) (2021)

199 Royal College of Emergency Medicine ([MHS0022](#))

200 Ibid

201 NHS England and NHS Improvement, [Urgent and Emergency Mental Health Care for Children and Young People](#) (2019)

202 Ibid

*and a purpose by letting me join in with projects such as Our Perspective and Recruit Crew. This has helped my confidence and gave me more motivation to live.”–Young person.<sup>203</sup>*

Across both examples of good practice in crisis response services, the clinical team was made up of individuals with a diverse range of expertise and skills. This diversity allowed the service to provide the necessary support for children and young people ‘in-house’ and without reliance on external agencies. However, looking nationwide, several submissions identified problems with recruitment and retention of staff to crisis services as a barrier to achieving positive impacts through these services.<sup>204,205</sup> To achieve the objectives of crisis response it is essential to ensure a sufficient workforce with appropriate skills and qualifications to staff crisis services, along with sufficiently resourced local authority services (see Chapter 1: Workforce).<sup>206</sup> In summary, our analysis suggests that this commitment has the potential to achieve real, positive impact for children and young people. However, progress on this commitment has not been sufficient for this impact to be realised in the majority of services.

### ***Was it an appropriate commitment?***

#### ***Rating: Outstanding***

A comprehensive crisis response service is an essential part of both mental and physical healthcare. Therefore, the commitment to establish a crisis response service to meet the needs of children and young people was appropriate. This view was shared by several stakeholders who submitted evidence to our evaluation.<sup>207</sup> The development of crisis response services is particularly timely in context of the COVID-19 pandemic, which has increased the number of acute referrals seen in children and young people.<sup>208</sup>

The development of this service has the potential to achieve meaningful outcomes for children and young people in acute stages of mental distress. In outlining a clear model for this crisis response service, progress on this commitment can be reliably tracked as the service develops. We note that there are currently problems with data quality, as reported by NHS Digital,<sup>209</sup> which has impeded our ability to evaluate in full whether this commitment is on track to be met by the 2023/24 deadline. As noted by some stakeholders, it is important that partial coverage of crisis response services is not conflated with a fully functional provision, as the absence of functions within crisis response services will impede the ability of teams to provide the appropriate crisis support to children and young people.<sup>210</sup>

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203 Ibid

204 The Department of Health and Social Care ([MHS0009](#))

205 Royal College of Psychiatrists ([MHS0012](#))

206 Royal College of Psychiatrists ([MHS0012](#))

207 MIND ([MHS0005](#))

208 British Association for Counselling and Psychotherapy ([MHS0006](#))

209 NHS England, [NHS Mental Health Dashboard \(2021\)](#)

210 MIND ([MHS0005](#))

### 3 Adult Common Mental Illness

Commitment	Commitment Met	Funding	Impact	Appropriate	Overall
“We are committed to growing the mental health workforce to achieve the ambitions set out in the NHS Long Term Plan”	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement

In this section, we provide an assessment of the Government’s commitment to ensure that all areas commission IAPT services for long term conditions:

“[...] all areas commission IAPT-Long Term Condition (IAPT-LTC) services (including co-location of therapists in primary care)”

#### **Overall Commitment Rating and Overview for Adult Common Mental Illness:**

##### *Requires Improvement*

Approximately 40% of individuals with a mental health diagnosis also have a long-term physical health condition.<sup>211</sup> A co-morbid mental health diagnosis can increase the risk of complications in those with a physical health condition, increasing the cost of care by 45%.<sup>212</sup> It is therefore important to ensure that individuals with a long-term physical health condition have adequate support for their mental wellbeing.

Our analysis suggests that progress on this commitment has not been sufficient to meet the target outlined in the Five Year Forward View for Mental Health (FYFVMH) and significant progress needs to be made for this commitment to be achieved. While we recognise additional funding announced for 2021/2022, this has not been allocated in time for this commitment to be met by the deadline stipulated in the FYFVMH. The positive impact IAPT-LTC services have for individuals with a common mental illness and the potential to create savings across wider health services is self-evident. Given the long-term health implications of Long COVID, establishing these integrated pathways is particularly timely. Therefore, it is important that the roll out of these services is adequately supported.

211 National Collaborating Centre for Mental Health, [The Improving Access Psychological Therapies \(IAPT\) Pathway for People with Long-term Physical Health Conditions and Medically Unexplained Symptoms – Full Implementation Guidance \(2018\)](#)

212 NHS England, [The Five Year Forward View for Mental Health \(2016\)](#)

## ***Was the commitment met overall? Is the commitment on track to be met?***

### ***Rating: Requires Improvement***

The FYFVMH outlined that the expansion of IAPT services should have specific focus on including services for those with long term physical health conditions (LTCs) or medically unexplained symptoms (MUS). The deadline for services to commission IAPT-LTC services, including the co-location of therapists in primary care was the end of 2018/2019. In their submission to our evaluation the Government said this target had not yet been met, for example, only 77% of CCGs having at least one integrated pathway by March 2020.<sup>213</sup> Integrated Care Pathways organise and mobilise cross-sector assets and resources for efficiency and better health outcomes.

Progress on this commitment has been further impacted by the COVID-19 pandemic. NHS England’s assurance delivery process for the delivery of IAPT-LTC services was suspended from March 2020 because of the pandemic, meaning evaluation of this commitment must rely on 2020 data.<sup>214</sup> Assurance by the Department of Health and Social Care that delivery has since recommenced and 2021/2022 figures will be published soon and will provide further insight into progress against this commitment.<sup>215</sup> The pandemic has also resulted in challenges to the integration of physical and mental health care due to reductions in the number of face-to-face contacts in primary care, where therapists are co-located.<sup>216</sup>

Several barriers to progression against this commitment were identified, which have delayed the commissioning of IAPT-LTC services. In our roundtable event with Mental Health Professionals, practitioners highlighted issues around the lack of a common system to store and view patient records. The lack of consistency across recording systems between GPs and IAPT practitioners located in primary care was regarded as a barrier to the implementation of these services. Indeed, this barrier may be a symptom of a wider problem in primary healthcare pathways integrating with IAPT services, as suggested in the Department of Health and Social Care’s response to our evaluation.<sup>217</sup>

## ***Was the commitment effectively funded (or resourced)?***

### ***Rating: Requires Improvement***

Funding for the integration of IAPT-LTC services comes from baseline CCG funding allocated for IAPT services.<sup>218</sup> According to the NHS Mental Health Implementation Plan 2019/20–2023/24 this should result in a total investment of £1.3bn over a four-year period. In March 2021, the Government announced an additional £500m funding for mental health services in the mental health recovery action plan, with £38m of these funds dedicated to expanding IAPT services.<sup>219</sup> We heard from professionals working in Mental Health that new funding streams provide resources to support training and salary costs of qualified practitioners in IAPT services.<sup>220</sup>

213 Department of Health and Social Care ([MHS0009](#))

214 MIND ([MHS0005](#))

215 The Department of Health and Social Care ([MHS0009](#))

216 Royal College of Psychiatrists ([MHS0012](#)).

217 The Department of Health and Social Care ([MHS0009](#))

218 NHS England, [NHS Mental Health Implementation Plan 2019/20 – 2023/24](#) (2019)

219 MIND (MHS005), The Department of Health and Social Care ([MHS0009](#))

220 Adult CMI Roundtable

However, there are important limitations to be considered in the allocation of these funds. Allocation of these resources to commission IAPT-LTC services is determined at CCG level. In their submission to our evaluation, the Department of Health and Social Care noted that commissioning at CCG level has resulted in variability in the level of investment in IAPT-LTC services, which has contributed to delays in progression on this commitment.<sup>221</sup> Practitioners also reported that there was a lack of transparency on the utilisation of resources at CCG level, with a breakdown of funds unavailable. The lack of ring-fenced funds for IAPT-LTC services together with the lack of transparency has impacted the national roll out of this provision which requires improvement to ensure this service is commissioned on a consistent basis throughout England.

Despite these funds being allocated to support the training and salary costs of the IAPT workforce, results of HEE’s Adult IAPT Workforce Census 2020 suggested that available funding has not been sufficient to train and recruit IAPT practitioners to the extent required to meet the objectives of the commitment. Results from the census suggested that in 2020 the vacancy rate was at 11% of total funded WTE posts.<sup>222</sup> As such, we conclude that additional ringfenced funding would be required to recruit, train, and retain sufficient staff for IAPT-LTC services to be commissioned in line with the Government’s commitment.

### **Did the commitment achieve positive impacts for service users?**

#### **Rating: Good**

These services have had a positive impact for those who have accessed IAPT-LTC support. Early evaluations of integrated services reported positive outcomes for service users, who felt better able to manage their physical health conditions.<sup>223</sup> In an evaluation carried out jointly by the Royal College of Psychiatrists and academics at University College London, service users reported positive views about the integration of practitioners with specialist knowledge of their physical and mental health conditions. Service users reported receiving more targeted support, which allowed them to better manage their physical health conditions:

*“The one thing which was brilliant [was the IAPT-LTC practitioner’s] knowledge of [my long-term condition] because it was as good as speaking to a specialist nurse [...] She really got it and really understood the issues and how they were impacting on my life.”<sup>224</sup>*

The use of IAPT-LTC services has led to improvement in measurable outcomes, including symptoms of depression, anxiety, and work and social adjustment.<sup>225</sup> For example, one study led by academics at Imperial College London measured changes to symptoms of depression and anxiety over the course of IAPT-LTC treatment. Their results demonstrated that treatment was associated with a statistically significant decrease of 6.15 points on the

221 The Department of Health and Social Care ([MH50009](#))

222 Health Education England, [Adult IAPT Workforce Census 2020](#) (2020)

223 Clarke, K., Furmaniak, K., & Pilling, S., [IAPT-LTC Early Implementers Programme](#) (2018)

224 *ibid*

225 Toffolutti, V., Stuckler, D., McKee, M., Wolsey, I., Chapman, J., J. Pimm, T., ... & M. Clark, D. (2021). The employment and mental health impact of integrated improving access to psychological therapies services: Evidence on secondary health care utilization from a pragmatic trial in three English counties. *Journal of Health Services Research & Policy*, 1355819621997493.

Patient Health Questionnaire-9, which measures depression, and a statistically significant decrease of 4.83 points on the Generalised Anxiety Condition-7 scale, which measures anxiety.<sup>226</sup> Qualitative evidence suggests that the integration of services for long term conditions into IAPT can support service users' therapeutic journey. For example, one case study reported that accessing support for physical health needs complemented the therapeutic process provided through IAPT, which reduced symptomology:

*“At discharge, Mr D was in recovery with significant reductions in symptoms of depression (PHQ-9 score: 2) and functional impairment (WSAS score: 17). Our work highlighted the importance of clients connecting with physical health teams to access accurate medical information about their condition, which can be processed in therapy to modify inaccurate or unhelpful illness perceptions, as well as to support community integration.”<sup>227</sup>*

In addition to benefits for service users, pilot schemes indicate that IAPT-LTC services can create material savings in physical healthcare services. For example, an evaluation of the Thames Valley early implementer site reported savings of £329 for each person treated over a three-month period.<sup>228</sup> Although smaller, one study found IAPT-LTC services produced a saving of £29 per person over a three-month period in attendance at emergency departments (A&E) services.<sup>229</sup>

The integration of employability services within the IAPT-LTC services was welcomed by stakeholders as an important development, as financial difficulties can exacerbate physical and mental health conditions.<sup>230</sup> Empirical evidence corroborated the view that IAPT-LTC services had a positive impact on adults using these services, as enrolment on IAPT-LTC services was associated with a 37.5% increase in the probability that the individual would transition into employment.<sup>231</sup> However, in our roundtable, practitioners expressed reservations about the efficacy of IAPT-LTC in improving the likelihood that services users would find sustained employment following treatment, as the limited number of sessions would not be sufficient to produce lasting changes to service users' employability prospects.<sup>232</sup> Therefore, the views of mental health practitioners was inconsistent with academic evaluations of pilot IAPT-LTC services.

However, we note that rates of completion of IAPT-LTC treatment are variable, which can impact the efficacy of this service. Notably, stakeholders reported that uptake and completion rates for IAPT-LTC services were lower for individuals from more deprived neighbourhoods.<sup>233</sup> A recent study identified that mobility issues may make it difficult for service users to attend sessions, which may be more difficult for those without access

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226 Ibid

227 Panchal, R., Rich, B., Rowland, C., Ryan, T., & Watts, S. (2020). The successful impact of adapting CBT in IAPT for people with complex long-term physical health conditions. *the Cognitive Behaviour Therapist*, 13.

228 The Department of Health and Social Care ([MHS0009](#))

229 Toffolutti, V., Stuckler, D., McKee, M., Wolsey, I., Chapman, J., J. Pimm, T., ... & M. Clark, D. (2021). The employment and mental health impact of integrated improving access to psychological therapies services: Evidence on secondary health care utilization from a pragmatic trial in three English counties. *Journal of Health Services Research & Policy*, 1355819621997493.

230 Money and Mental Health Policy Institute ([MHS0002](#))

231 Ibid

232 Adult Common Mental Illness roundtable

233 British Medical Association ([MHS0008](#))

to financial resources to attend in-person sessions.<sup>234</sup> Individuals from more deprived neighbourhoods were less likely to see an improvement in their mental health and as such there are inequalities in access and treatment completion of IAPT-LTC services. While it was widely recognised that the impact of this commitment has been positive, there remains significant scope for further improvement.

Highlighting the issue of inequality within this commitment, a report by Healthwatch England found that some IAPT services were inappropriate for individuals from marginalised communities.<sup>235</sup> For example, one practitioner reported:

*“The ICOPE model of counselling via an interpreter if there are language needs is very difficult for our clients. It usually takes a long time for our clients to talk about something that in our culture is not talked about, or accepted, and you tend to keep it secret. So if there is a third person involved - an interpreter from the community - it really interrupts the process of building rapport and trust between client and practitioner.”* - Latin American Women’s Rights Service.<sup>236</sup>

A review published by West Yorkshire Healthcare Partnership which examined how health inequalities for Black, Asian and minority ethnic communities could be tackled, found that within the area completion rates from IAPT-LTC services were lower amongst minority groups:

*“After starting psychological therapies for anxiety conditions and depression, completion rates are lower for people from Black, Asian or minority ethnic backgrounds. For example, in West Yorkshire and Harrogate 46% of White men complete treatment, compared with 39% of Black/Black British men and 38% of men from mixed backgrounds (IAPT 2019/20 figures). Issues raised include a lack of culturally appropriate services, including support in different languages.”*<sup>237</sup>

Whilst progress in this area supports the ‘good’ rating we have awarded there are still difficulties in addressing inequalities in access, treatment and completion of IAPT-LTC services. Stark disparities remain in access for marginalised groups and those from minority ethnic backgrounds. We do not regard these communities as hard to reach but rather seldomly and poorly catered for in many cases. Informal discussion with NHS England assured us that data is being collected to measure outcomes in marginalised communities and examples good practice have been identified. Nevertheless, we are concerned that commitments should be shaped and interpreted in such a way as to encourage commissioning of services for minority and marginalised communities.

234 Carroll, S., Moss-Morris, R., Hulme, K., & Hudson, J. (2021). Therapists’ perceptions of barriers and facilitators to uptake and engagement with therapy in long-term conditions. *British Journal of Health Psychology*, 26(2), 307–324.

235 Healthwatch Islington, [Mental health support services for migrant communities in Islington](#) (April, 2021)

236 Ibid

237 West Yorkshire and Harrogate Health and Care Partnership Review Report, [Tackling health inequalities for Black, Asian and minority ethnic communities and colleagues](#) (October, 2020)



## *Was it an appropriate commitment?*

### *Rating: Requires Improvement*

Given the extent of co-morbidity between physical and mental illness, providing services that integrate treatment and support for long term physical conditions within IAPT is vital to help people with mental and physical comorbidities to manage their health. We recognise that a commitment to improve services for adults with long-term physical health conditions was an appropriate one; a view shared by many stakeholders who submitted evidence to our evaluation<sup>238</sup> and practitioners who attended our roundtable event.<sup>239</sup> However, while it was appropriate for the Government to commit all areas to commissioning IAPT-LTC services, the specification of this commitment could have been better defined to ensure that these services are available across the population and that this commitment led to measurable improvements for service users.

It is important to acknowledge that commitments made in relation to individual aspects of service provision are not, in practice, delivered in isolation and can shape the priorities and practice of NHS Trusts. In their submission to our evaluation NHS Providers expressed concern that a narrow focus on IAPT may have undermined the delivery of other services, reporting that NHS trust senior leaders were uneasy that psychological therapies “could be prioritised at the expense of provision for those with more severe and enduring mental health conditions”.<sup>240</sup> NHS Providers added that their 2018 survey of mental health trust leaders reported that 53% of respondents “said they were able to meet current demand for IAPT services, in stark contrast to community adult mental health services, where only 25% of trust leaders said they could meet current demand”.<sup>241</sup> The additional funding provided by the government to meet its mental health commitments was made available to fund both an expansion in IAPT—including IAPT-LTC and services for those with severe mental illness (see Chapter 4). It is important that funding allocated to CCGs is used to support the expansion of both necessary services.

There were several areas where the appropriateness of this commitment required improvement. The commitment was not wide enough in scope as it did not address access rates or the number of individuals who would be treated through the IAPT-LTC pathway. This improvement is required as our evaluation revealed that there were regional variations in access, uptake, and completion rates of IAPT-LTC services.<sup>242</sup> Moreover, the commitment did not specify outcome measures for the long-term condition treatments that would be used as metrics of success, which makes evaluating progress on this commitment challenging. Several stakeholders noted that the lack of quantifiable data was problematic when evaluating the appropriateness of this commitment.<sup>243</sup>

In our roundtable with professionals working in mental health, practitioners expressed concern about the length of treatment under IAPT-LTC services. IAPT services provide treatments that are completed in 6 to 8 sessions, whereas individuals with long term physical-health conditions may require repeat treatment over longer periods of time to

238 National Counselling Society ([MHS0003](#)), MIND ([MHS0005](#)), NHS Providers ([MHS0013](#)), Centre for Mental Health ([MHS0016](#))

239 Adult CMI roundtable

240 NHS Providers ([MHS0013](#))

241 Ibid

242 British Medical Association ([MHS0008](#))

243 Money and Mental Health Policy Institute ([MHS0002](#)); MIND ([MHS0005](#))

manage their health. Stakeholders noted that many of these physical conditions will have periods of acute presentation, along with periods where symptoms are manageable.<sup>244</sup> It is therefore reasonable to expect that individuals with long term conditions will require more than one course of treatment, however there is limited data to indicate whether IAPT services are currently equipped to deliver more than one course of treatment for adults with long term conditions.

A final concern we heard with regards to this commitment was that there had been insufficient attempts to engage with doctors and clinicians outside of mental health services to highlight the benefit of IAPT-LTC services. Support from staff within physical healthcare services could increase referrals to IAPT-LTC and provide opportunities for these services to have positive impacts for adults with a long-term health condition.<sup>245</sup>

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244 Adult CMI Roundtable

245 Ibid

## 4 Adult Severe Mental Illness

Commitment	Commitment Met	Funding	Impact	Appropriate	Overall
“280,000 people with a severe mental illness will receive a full annual physical health check”	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
[by 2023–2024] “new integrated community models for adults with a severe mental illness (including care for people with eating conditions, mental health rehabilitation needs and a ‘personality condition’ diagnosis) spanning both core community provision and also dedicated services will ensure at least 370,000 adults and older adults per year have greater choice and control over their care, and are supported to live well in their communities”	Requires Improvement	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement

<p>“the therapeutic offer from inpatient mental health services will be improved by increased investment in interventions and activities, resulting in better patient outcomes and experience in hospital. This will contribute to a reduction in length of stay for all services to the current national average of 32 days (or fewer) in adult acute inpatient mental health settings.”</p>	<p>Requires Improvement</p>	<p>Requires Improvement</p>	<p>Requires Improvement</p>	<p>Inadequate</p>	<p>Requires Improvement</p>
<p>“all areas will provide crisis resolution and home treatment (CRHT) functions that are resourced to operate in line with recognised best practice, delivering a 24/7 community-based crisis response and intensive home treatment as an alternative to acute inpatient admission”</p>	<p>Requires Improvement</p>	<p>Good</p>	<p>Requires Improvement</p>	<p>Good</p>	<p>Requires Improvement</p>

Overall, our evaluation of commitments related to adult severe mental illness requires significant improvement to enable these targets to be met. There has been too little funding to improve the physical estate in which services for this population are provided. This has impacted the ability of services to provide an improved therapeutic offer. Furthermore, despite some examples of good practice, integrated community models of care have not been established, and are not on track to meet this target by 2023/24. Our evaluation found that crisis resolution and home teams were similarly behind target, which was

further compounded by staffing issues (Chapter 1: Workforce). In summary, there is significant work required to ensure that adults with severe mental illness have access to the appropriate mental health services in safe and therapeutic environments.

## Physical Health Checks

In this section, we provide an assessment of the Government’s target to ensure that:

**“280,000 people with a severe mental illness will receive a full annual physical health check”**

### *Overall Commitment Rating and Overview for Physical Health Checks:*

#### *Requires Improvement*

The average lifespan of adults with a severe mental illness is approximately 15–20 years shorter than the general population.<sup>246</sup> The completion of physical health checks is vital to reduce the mortality of individuals with a mental illness and, therefore, the commitment to ensure 280,000 adults with a severe mental illness receive annual physical health checks was appropriate. However, the latest data from NHS Digital suggests that this target has not been met.<sup>247</sup> We recognise that progress on this target has been disrupted due to the COVID-19 pandemic,<sup>248</sup> however even prior to the pandemic this target was not on track to be met.

Funding for this commitment requires improvement, as the current level of funding that has been allocated has not been sufficient to meet the targets outlined in this commitment. We recognise that all six aspects of a physical health check have recently been integrated into the Quality and Outcomes Framework (QOF) for GP services, which will incentivise completion of these checks.<sup>249</sup> However, these measures have not been implemented in the timeline stipulated. As progress on this commitment has stalled, there has been limited opportunity for this commitment to produce positive impacts for service users. Overall, while this commitment was appropriate to support individuals with a severe mental illness, significant work must be completed before targets outlined in this commitment are achieved.

### *Was the commitment met overall? Is the commitment on track to be met?*

#### *Progress: Inadequate*

The deadline for 280,000 adults with a severe mental illness (at least 60% of those on the GP adult SMI register) to receive an annual physical health check was Q4 2020/2021. According to NHS Digital, in Q1 2021/2022 140,885 people on GP SMI register had received all six elements of the physical health check in the previous year (see Figure 10),<sup>250</sup> which includes: Weight measurement, exercise and dietary recording, blood pressure,

246 The Department of Health and Social Care (MHS0009); Royal College of Psychiatrists, [Whole-person care: from rhetoric to reality Achieving parity between mental and physical health](#) (March, 2013)

247 NHS England, [NHS Mental Health Dashboard \(2021\)](#)

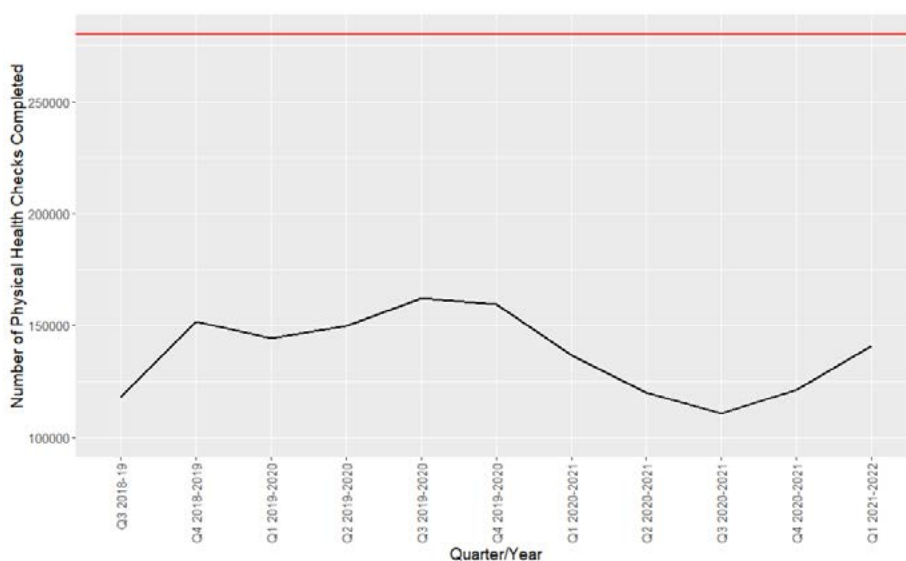
248 The British Medical Association (MHS0008)

249 MIND (MHS0005)

250 NHS England, [NHS Mental Health Dashboard \(2021\)](#)

blood sugar and cholesterol level, liver checks, kidney checks, and ensuring care teams are provided with the results of the physical health check.<sup>251</sup> The 140,885 adults who have received a physical health check reflects 27.1% of people on the GP SMI register, which indicates that the target had not been met. There has been some improvement in Q1 2021/22 from the historic lows reported in Q3 2020/21, which is encouraging.<sup>252</sup> Of the six checks, blood pressure and weight measurement were most commonly completed.<sup>253</sup>

**Figure 10: Total number of adults with a severe mental illness in England who received a full physical health check in the last 12 months. The horizontal red line indicates target of 280,000 of adults who should receive a full physical health check.**



We recognise that progress on this commitment was affected by the COVID-19 pandemic. To reduce the spread of COVID-19, NHS services reduced the number of face-to-face services and temporarily suspended reporting against targets where clinical input was required.<sup>254</sup> According to a report by Rethink Mental Illness, a support charity for individuals experiencing mental health difficulties, individuals with SMI reported difficulty in accessing GP services during lockdown restrictions and were unable to receive regular physical health checks.<sup>255</sup>

However, while lockdown restrictions impacted the provision of face-to-face services, it should be noted that in the 12 months to the end of 2019, only 32.3% of people on the GP SMI register had received a full physical health check in the previous 12-months.<sup>256</sup> These figures were lower than the targets set for this year which indicates that progress against this objective was not on track even prior to the pandemic.<sup>257</sup>

251 National Institute for Health and Care Excellence, [Bipolar disorder: assessment and management](#) (September, 2014)

252 Rethink Mental Illness ([MHS0007](#))

253 NHS England, [Physical Health Checks SMI Statistical Press Notice 2021–22 Q1](#) (August, 2021)

254 NHS England & NHS Improvement, [Managing capacity and demand within inpatient and community mental health, learning disability and Autism services for all ages](#) (March, 2020)

255 Rethink Mental Illness, [The impact of COVID-19 lockdown measures on the physical health of people living with severe mental illness](#) (2020)

256 NHS England, [NHS Mental Health Dashboard](#) (2021)

257 NHS Confederation ([MHS0018](#))

## ***Was the commitment effectively funded (or resourced)?***

### ***Rating: Requires Improvement***

In their response to our evaluation, the Department of Health and Social care have listed several sources of funding to support progress on this commitment:

- £1 billion of funding allocated to CCGs to support the interventions outline in the Five Year Forward View for Mental Health (FYFVMH), which included physical health checks for adults with a severe mental illness.
- An additional £24m in the Quality and Outcomes Framework (QOF) to incentivise the completion of all six elements of the physical health check in primary care.
- £4.5 million in winter 2020/21 and £12 million in 2021/22 allocated to Sustainability and Transformation Partnerships (STPs)/Integrated Care Systems (ICSs) to commission tailored outreach and engagement structures to support people with a severe mental illness to access preventative healthcare.<sup>258</sup>

Funds were allocated to support the completion of physical health checks prior to the 2020/21 deadline, yet this target number of adults accessing this service was not achieved. Stakeholders suggested that the current funding mechanisms used, whereby funding was allocated at CCG level, led to little progress and therefore specific funding for these services would be required.<sup>259</sup> As such, the current level and allocation of funding for this commitment has not produced return on investment in these services. These views were shared by practitioners at our roundtable, who said:

*“There is a massive gap between recognising what we need to be doing and the on the ground implementation of how we do that and whether we have enough funding to do it.”*–Mental Health Practitioner<sup>260</sup>

The targeted funding recently announced to support adults with a severe mental illness to access physical health checks was welcomed by stakeholders.<sup>261</sup> However, it was noted that it would be important to ensure these resources are specifically allocated to achieving progress against this commitment.<sup>262</sup> As the impact of newly targeted funding will not be evident for some time, we were not able, in this evaluation, to assess the appropriateness of these new funding streams.

It was also noted by Rethink Mental Illness that funding for mental health services alone would not be sufficient to ensure physical health checks were completed.<sup>263</sup> Given the reliance on primary care to achieve this commitment, it will be important that both primary and secondary care services are adequately resourced to ensure adults with a severe mental illness have access to annual physical health checks.

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258 The Department of Health and Social Care ([MHS0009](#))

259 MIND ([MHS0005](#))

260 Adult SMI Roundtable

261 MIND ([MHS0005](#)); Rethink Mental Illness ([MHS0007](#))

262 MIND ([MHS0005](#))

263 Rethink Mental Illness ([MHS0007](#))

## **Did the commitment achieve positive impacts for service users?**

### **Rating: Requires Improvement**

Stakeholders reported that this commitment has achieved limited impact while work has stalled.<sup>264</sup> This finding was corroborated by service users, who have reported difficulties accessing GP appointments in order to organise their physical health checks. In a 2019 joint report by the Care Quality Commission and NHS England only 30% of respondents stated they ‘definitely’ received help finding support for physical health needs.<sup>265</sup> In a follow up report in 2020, 36% of respondents stated that had not received support with their physical health needs, though we recognise the difficulty of inferring trends over time from these two surveys due to the COVID-19 pandemic.<sup>266</sup> These quantitative findings were supported by qualitative evidence, exemplified by the views of one service user:

*“I cannot get face-to-face appointments with my GP, so it’s harder to explain my physical health problems”*–Service user.<sup>267</sup>

It was also noted that there are regional variations in the number of physical health checks completed. City and Hackney CCG was one case study highlighted as an example of best practice in the provision of physical health checks for adults with a severe mental illness (though this CCG has since been merged into the North East London CCG in April 2021). City and Hackney CCG developed bespoke approaches to ensuring adults with a severe mental illness received all six elements of physical health check, resulting in this service consistently reaching the 60% target.<sup>268</sup> Indeed, this variation across CCGs and across regions is highlighted by data from NHS Digital, which suggests that a greater number of checks are being completed in London relative to other parts of the country. However, these data do not demonstrate the relative proportion of adults with a severe mental illness receiving annual physical health checks in these areas and therefore we recommend caution when interpreting these findings. Nevertheless, we note across regions the number of people receiving a full physical health check decreased for Q1 and Q2 2020/21, which was likely an impact of the COVID-19 pandemic. These regional differences do highlight that coverage of physical health checks is not consistent across the country, which may exacerbate health inequalities.

## **Was it an appropriate commitment?**

### **Rating: Requires Improvement**

The average lifespan of individuals with a severe mental illness is 15–20 years shorter than the general population.<sup>269</sup> Therefore, the commitment to ensure these individuals receive annual physical health checks is appropriate. This view was shared by stakeholders who in their evidence acknowledged that this was an important commitment to achieve.<sup>270</sup> The timeliness of this commitment was also highlighted in the wake of the COVID-19,

264 MIND ([MHS0005](#))

265 Care Quality Commission, [2019 Community mental health survey Statistical release](#) (November, 2019)

266 Care Quality Commission, [2020 Community mental health survey Statistical release](#) (November, 2020)

267 Rethink Mental Illness, [The impact of COVID-19 lockdown measures on the physical health of people living with severe mental illness](#) (2020)

268 Rethink Mental Illness ([MHS0007](#))

269 The Department of Health and Social Care ([MHS0009](#))

270 MIND ([MHS0005](#)); Rethink Mental Illness ([MHS0007](#)); NHS Confederation ([MHS0018](#))



as empirical evidence has suggested that individuals with a severe mental illness report eating less healthy foods under lockdown conditions, leading to poorer physical health outcomes compared to the general population.<sup>271</sup> The importance of this commitment was also underlined by Mental Health Practitioners who attended our roundtable event:

*“The huge thrust towards physical wellbeing, or addressing the physical health, of people with severe mental illness has been a worthwhile and understandable endeavour, and it absolutely is of importance.”* –Mental Health Practitioner.<sup>272</sup>

The specification of six areas of physical health checks that must be completed has meant that progress on this commitment can be tracked appropriately. However, the completion of physical health checks does not mean that individuals will progress onto further services to improve their physical health (e.g., smoking cessation services), which may limit the potential for this commitment to improve the physical health of adults with a severe mental illness. Moreover, some stakeholders raised concerns about the areas of physical health that were included in this commitment:

*“I just wanted to add about the physical health monitoring, because to my amazement eating disorders are constantly forgotten when we’re talking about physical monitoring of the mentally ill, and this is the highest mortality rate for physical reasons.”* - Mental Health Practitioner.<sup>273</sup>

In addition, some stakeholders felt that the commitment was not wide enough in scope, as it did not account for the intersectional issues that could contribute to poor physical health in those with a severe mental illness.<sup>274</sup> MIND noted that poverty and financial insecurity were other prominent factors that could contribute to poor physical health and should therefore be considered within the scope of the commitment to improve the physical health of those with a severe mental illness.<sup>275</sup>

Finally, some stakeholders reported that the focus on completion of physical health checks neglected capacity issues within primary care that had contributed to targets being unmet.<sup>276</sup> This point is particularly timely, as the Secretary for State for Health and Social Care, the Rt Honourable Sajid Javid, has recently acknowledged that the Government’s 2019 General Election manifesto commitment to increase the number of doctors in Primary Care in England by 6,000 is unlikely to be met.<sup>277</sup> Therefore, the primary care system may not have the required capacity to implement this commitment, which must be addressed to improve access to physical health checks.

## Integrated Community Models for adults with a severe mental illness

In the following section we assess the Government’s commitment to develop new integrated community models for adults with a severe mental illness by 2023/2024:

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271 Rethink Mental Illness ([MHS0007](#))

272 Adult SMI Roundtable

273 Adult SMI roundtable

274 MIND ([MHS0005](#))

275 Ibid

276 Rethink Mental Illness ([MHS0007](#))

277 Health and Social Care Committee Oral evidence: Clearing the backlog caused by the pandemic, HC 599. Q242; The Conservative Party, [https://assets-global.website-files.com/5da42e2cae7ebd3f8bde353c/5dda924905da587992a064ba\\_Conservative%202019%20Manifesto.pdf](https://assets-global.website-files.com/5da42e2cae7ebd3f8bde353c/5dda924905da587992a064ba_Conservative%202019%20Manifesto.pdf) (2019)

**“[by 2023–2024] new integrated community models for adults with a severe mental illness (including care for people with eating conditions, mental health rehabilitation needs and a ‘personality condition’ diagnosis) spanning both core community provision and also dedicated services will ensure at least 370,000 adults and older adults per year have greater choice and control over their care, and are supported to live well in their communities”**

### **Overall Commitment Rating and Overview for Integrated Community Models:**

#### **Requires Improvement**

Establishing integrated community models for adults with a severe mental illness has the potential to lead to positive impacts for people living with mental ill health by supporting them in their local setting and reducing admissions to inpatient settings. Integrated Care Systems are partnerships of health, care and third sector organisations that come together to commission, plan and deliver joined up services and to improve the health of people who live and work in their area. However, progress against this commitment requires improvement as our evaluation found that some services have not taken the transformative, whole system approach that is necessary to implement this model of care.<sup>278</sup> The lack of progress on this commitment may be compounded by inadequate funding, which has meant that services cannot invest sufficiently in the workforce or to prepare estates to house community services.<sup>279</sup>

Due to the stalled progress on this commitment, the potential for these integrated community models to achieve positive impacts for adults living with a severe mental illness has been limited. However, quantitative and qualitative evidence from an early implementer site indicates positive outcomes for service users where it has been implemented. These services would also help reduce the burden on inpatient services. This benefit is particularly timely as there is a scarcity of inpatient beds available.<sup>280</sup> We also note that this commitment lacks specificity, as no information is provided about the services that comprise a ‘community model’. Ensuring that services have clear guidelines to work towards will be important to support progress on this commitment.

#### **Was the commitment met overall? Is the commitment on track to be met?**

#### **Rating: Requires Improvement**

The deadline for this commitment to be met is 2023/2024, therefore our evaluation examines whether this commitment is likely to be met. We recognise that some progress has been made in establishing early implementer sites of a community model, such as the Somerset system which worked in collaboration with Rethink Mental Illness to develop their integrated community mental health service.<sup>281</sup> In their response to our evaluation,

278 Rethink Mental Illness ([MHS0007](#))

279 Royal College of Psychiatrists ([MHS0012](#)); Rethink Mental Illness ([MHS0007](#))

280 The Department of Health and Social Care ([MHS0009](#))

281 The Department of Health and Social Care ([MHS0009](#)); NHS Confederation ([MHS0018](#))

the Department of Health and Social Care noted that these services were currently being rolled out across all STPs/ICSs and 45,700 people were seen through integrated models in Q1 2021/2022.<sup>282</sup>

However, stakeholders said there was still substantial progress to be made against this commitment in other regions and that these objectives were unlikely to be met by 2023/2024.<sup>283</sup> This was attributed to the lack of support for other sectors that are vital to the delivery of integrated community models of care, particularly public health and social care.<sup>284</sup> Without adequate resources for these sectors, progress to achieve this commitment will not be met by 2023/2024.<sup>285</sup> Indeed, the disparity between official targets and progress within services was highlighted by a practitioner who attended our roundtable event:

*“[...] one of the ambitions of the Community Mental Health Framework is to deliver NICE compliant evidence based psychological therapies to everyone with severe mental health problems within secondary care. The gap between that and what my Trust, and my neighbouring trusts, currently do is absolutely staggering ... if you're looking at real fundamental change in what we do as a service then people tend to put their heads in the sand and very little progress is made. I think this movement from community mental health teams that contain people, and assess them and manage their risks, towards community mental health teams that are geared towards actively treating underlying mental health problems is something that people are finding very difficult to process. Progress is glacial at best.”—Mental Health Practitioner.<sup>286</sup>*

We note that progress against this commitment has likely been impacted by the COVID-19 pandemic. Stakeholders noted that some services had paused work on establishing community models due to pressures of the first wave of the pandemic.<sup>287</sup> Moreover, some staff who were originally employed to support these services were redeployed to COVID-19 planning and operations.<sup>288</sup>

### **Was the commitment effectively funded (or resourced)?**

#### **Rating: Inadequate**

In their response to our evaluation, the Department of Health and Social Care referred to several funding streams that had been allocated to support this commitment:

- An additional £1bn by 2023/24 in community mental health care for adults with a severe mental illness under the NHS Long Term Plan,<sup>289</sup> inclusive of a fair-share allocation of £279 million in CCG baseline funding and £121 in Service Development Funding.

282 The Department of Health and Social Care ([MHS0009](#))

283 MIND ([MHS0005](#))

284 NHS Providers ([MHS0013](#))

285 Ibid

286 Adult SMI Roundtable

287 NHS Providers ([MHS0013](#))

288 Rethink Mental Illness ([MHS0007](#))

289 NHS England, [Long Term Plan](#) (January, 2019)

- £500 million as part of the Mental Health Recovery Action Plan in 2021/22. Of this funding £58 million will be invested to bring forward the expansion of integrated primary and secondary care for adults with severe mental illness.<sup>290</sup>

Our evaluation found that this funding has still failed to implement the transformational changes that would be required to provide an integrated community model for adults with a severe mental illness. Several stakeholders reported that these funds would not be sufficient to make adequate progress against this commitment, particularly in context of the backlog created by the COVID-19 pandemic.<sup>291</sup> Rethink Mental Illness reported that it was important to ensure stakeholders who were involved in decisions about how funds were allocated were supportive of the models of mental healthcare.<sup>292</sup> These views were formed on the basis of feedback from their pilot programme. They also noted that for services to be able to provide community models of care, funds must be utilised to transform services to deliver community treatment. Yet, there were regional variations in how funds were being utilised.<sup>293</sup> Indeed, some mental health practitioners reported reservations about the way new funding has been used to implement this commitment:

*“The commitments are very honourable, and we agree with them, but the implementation and the funding around implementation- beyond funding training courses - is something that really needs to be looked at, because there needs to be governance and resources to sustain any of those interventions after the training has been done.”*—Mental Health Practitioner.<sup>294</sup>

### **Did the commitment achieve positive impacts for service users?**

#### **Rating: Requires Improvement**

Due to the limited progress on this commitment, the potential for community models of care to have a positive impact for adults with a severe mental illness has been constrained. This progress is limited despite evidence from pilot sites that community models of care can benefit service users.<sup>295</sup> Initial data from pilot sites indicated that services users were being transferred to appropriate enhanced support, with 54% of those transferred receiving ongoing support of some kind.<sup>296</sup>

To date, reductions in the number of inpatient beds have not been offset by community mental health services.<sup>297</sup> The Department of Health and Social Care noted that adult acute mental health in-patient bed occupancy is currently at critical level, exceeding 93%.<sup>298</sup> In their response to our evaluation, the Department of Health and Social Care recognised that one of the aims of integrated community models was to reduce the reliance on inpatient beds and by extension reliance on inappropriate out of area placements.<sup>299</sup> However, due to a lack of capacity of inpatient beds, the practice of inappropriate out

290 The Department of Health and Social Care ([MHS0009](#))

291 MIND ([MHS0005](#)); Rethink Mental Illness ([MHS0007](#)); NHS Providers ([MHS0013](#))

292 Rethink Mental Illness ([MHS0007](#))

293 Ibid

294 Adult SMI roundtable

295 Rethink Mental Illness, [Learning from Somerset STP as an early CMHS implementor](#)

296 Ibid

297 SANE ([MHS0015](#))

298 The Department of Health and Social Care ([MHS0009](#))

299 Ibid

of area placements has not been eliminated.<sup>300</sup> As such, the impact of this commitment requires improvement. Indeed, the lack of community services meant that few alternatives existed to hospital care for adults with severe mental illness, as reported by one mental health practitioner who attended our roundtable:

*“I think even if you look back over the last 18 months about how patients with SMI have been disproportionately affected through COVID in terms of missing out on services. We weren’t able to provide them with a robust alternative to hospital care, things disappeared so there was an issue with the system there.”*—Mental Health Practitioner.<sup>301</sup>

Some practitioners, however, reported regional variation in the extent to which integrated community models were being adopted, and the extent to which they took a transformative approach to healthcare or focussed on groups of service users:

*“The second point on the transformation agenda with the integrated community models, I think from my understanding that is varied across the different pilot sites. I know locally that has been almost entirely taken as being within the personality condition pathway, called the emotional regulation pathway, that’s where a lot of the transformation bid has focused its attention looking at a specialist service. So the complex emotional needs service that we have locally for kind of the top tier of people meeting that diagnostic criteria and they are then looking at the pathways within the core teams about the NICE evidence interventions around that.”*—Mental Health Practitioner.<sup>302</sup>

One aspect of this commitment was to provide adults with a severe mental illness with the opportunity to have greater control over the care they received. Evidence submitted to our evaluation shows that this has not been achieved. According to a joint report published by the Care Quality Commission and NHS England, half of respondents had come to an agreement about the care they received said they were ‘definitely’ involved as much as they wanted to be in the planning of their care. When asked if they had been provided with the opportunity and time to discuss their needs and treatment, 59% responded ‘yes, definitely’ whilst 13% of respondents reported that they were not given enough time to discuss their needs and treatment.<sup>303</sup> Moreover, data from the Royal College of Psychiatrists’ College Centre for Quality Improvement (CCQI) suggests that 68% of service users were able to review their care plan, suggesting some individuals were not involved in planning their care.<sup>304</sup> Finally, the lack of an operational crisis home treatment function has further impacted the potential for this commitment to achieve positive outcomes for adults with severe mental illness (see Chapter 4.4. Crisis Resolution and Home Treatment Function for adults).<sup>305</sup>

However, in sites where these models were piloted, practitioners and service users reported positive experiences. One service user reported that they no longer felt like they were “bouncing around the system” or “falling through gaps in support.”. These services were also able to address wider determinants of poor mental health, such as housing, benefits,

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300 Ibid

301 Adult SMI roundtable

302 Ibid

303 Care Quality Commission, [2020 Community mental health survey Statistical release](#) (November, 2020)

304 Royal College of Psychiatrists, [Home Treatment Accreditation Scheme National Report 2020](#) (November, 2020)

305 Royal College of Psychiatrists ([MHS0025](#))

and debt.<sup>306</sup> The positive potential these services can have for adults with a severe mental illness evidenced in this preliminary data further highlights the importance that progress is made on this commitment.

### ***Was it an appropriate commitment?***

#### ***Rating: Requires Improvement***

Stakeholders reported that the commitment to provide integrated community models of care for adults with a severe mental illness was appropriate.<sup>307</sup> The timeliness of this commitment is reflected in reports that state 85% of mental health trust leaders felt that they were unable to meet the current demand for community mental health services.<sup>308</sup> Notwithstanding its necessity and timeliness, this commitment lacked specificity as no clear definition of an integrated community model has been provided by the Department of Health and Social Care.<sup>309</sup> Without a defined model of care, steps required to achieve this commitment will be determined at CCG/Integrated Care System (ICS) level, which risks exacerbating localised differences in the implementation of integrated community models of care.<sup>310</sup> Further, there is a need to include outcome measures alongside the development of these services to measure impacts and identify areas of best practice.

Moreover, our evaluation found that the system does not currently have the required infrastructure to implement this commitment. Integrated community models must be built around primary care networks (PCNs) and ICSs, which are currently at various stages of development around the country.<sup>311</sup> There is also a need to include service users in service redesign, which was employed in early implementer sites, though we do not have evidence to evaluate whether this approach will be adopted in other services.<sup>312</sup> Furthermore, stakeholders noted that progress on this commitment required the coordination of mental health services and wider public services, such as drug and alcohol services and social care.<sup>313</sup> However, these services report underfunding and under-resourcing,<sup>314</sup> which will hinder efforts to develop integrated community models for adults with a severe mental illness.

### **Improved Therapeutic Offer**

In this section we provide an evaluation of the Government’s commitment to improve the therapeutic offer within inpatient mental health services:

**“[...] the therapeutic offer from inpatient mental health services will be improved by increased investment in interventions and activities, resulting in better patient outcomes and experience in hospital. This will**

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306 Rethink Mental Illness ([MHS0007](#))

307 MIND ([MHS0005](#)); Rethink Mental illness ([MHS0007](#))

308 NHS Providers, [Mental health services: Addressing the care deficit](#) (March 2019)

309 The Department of Health and Social Care ([MHS0009](#))

310 Rethink Mental Illness ([MHS0007](#)); Adult SMI roundtable

311 NHS Providers ([MHS0013](#))

312 Rethink Mental Illness, [Learning from Somerset STP as an early CMHS implementor](#)

313 Rethink Mental Illness ([MHS0007](#)); NHS Providers ([MHS0013](#))

314 NHS Providers ([MHS0013](#))

**contribute to a reduction in length of stay for all services to the current national average of 32 days (or fewer) in adult acute inpatient mental health settings. “**

### ***Overall Commitment Rating and Overview for Improved Therapeutic offer:***

#### ***Requires improvement***

An improved therapeutic offer should be able to provide an increased range of meaningful activities within inpatient settings, including but not limited to: leisure, exercise, occupational therapy and education, which should be provided on an appropriate Estate.<sup>315</sup> This commitment has the potential to lead to clinically meaningful benefits for service users. Our evaluation found that the mean length of stay in adult acute ward beds has decreased between 2019–2021<sup>316</sup> and is on track to meet the 2023/24 aim of 32 days.<sup>317</sup> However, the impact this has had for service users requires improvement. Qualitative evidence from service users suggests that while progress on this commitment has been made, this has not led to meaningful improvements for individuals within the service,<sup>318</sup> highlighting a disparity between policy targets and lived experience of those within inpatient services.

We recognise that additional funding has been allocated to support progress on this commitment. However, these funds are not adequate to make the substantial changes to the physical estate that are a necessity for a safe and therapeutic environment within these services. Our evaluation found that the specification of this commitment did not give sufficient focus on the preferences, perspectives and experiences of service users.<sup>319</sup> The commitment also lacked specificity, meaning practitioners did not have guidance on what constituted an improved therapeutic offer, or the scale, scope, quality assurance, and models that would deliver for service users.<sup>320</sup> Moreover, this commitment did not recognise the workforce culture and disciplinary mix that is required to improve service user experience.<sup>321</sup>

### ***Was the commitment met overall? Is the commitment on track to be met?***

#### ***Rating: Requires Improvement***

The deadline for the commitment to improve the therapeutic offer from inpatient services by increased investment in interventions and activities is 2023/24. Our evaluation suggested that parts of this commitment are on track to be achieved. For example, the average length of stay in 2020/21 was 35 days, which had decreased from 2019/20, suggesting the commitment to reduce the length of inpatient stay target is on track to be met.<sup>322</sup> However, other aspects of the commitment, such as the improved therapeutic offer within services, are not on track to be achieved. Data from the Royal College of Psychiatrists, who conduct

315 Royal College of Psychiatrists, [Accreditation for Working Age Inpatient Mental Health Services](#) (August, 2020)

316 The Department of Health and Social Care ([MHS0009](#))

317 Rethink Mental Illness ([MHS0007](#))

318 MIND ([MHS0005](#))

319 Ibid

320 Adult SMI roundtable

321 MIND ([MHS0005](#))

322 Ibid

quality evaluations within the College Centre for Quality Improvement (CCQI), suggests that the therapeutic offer has not improved since this commitment was made. The evaluation by the Royal College of Psychiatrists concluded that less than half (42%) of service users have a shared care plan, suggesting these individuals do not have access to therapeutic activities that would support their recovery.<sup>323</sup> This evidence contrasts with evidence submitted by the Department of Health and Social Care, who reported that they were also making sufficient progress to meet the target to improve the therapeutic offer by 2023/24. However, beyond this source, we have no further data to evaluate whether the therapeutic offer will be improved by the 2023/24 deadline.

We also note that progress on this commitment has been impacted by the COVID-19 pandemic. In their submission, Rethink mental illness indicated that access to, and delivery of, services was reduced due to measures that were implemented to mitigate the spread of COVID-19.<sup>324</sup> They also said that the offer within services will take time to return to pre-pandemic levels, which may impact progress on achieving this target by 2023/24. Indeed, practitioners who attended our roundtable reported that they had not observed much progress on this commitment:

*“I don’t think that any progress has been seen in any way within the inpatient therapeutic offer for people on wards. This is especially true of some of the trauma informed ideas or trauma informed environments. Locally, we’ve got a little steering group around it but more nationally I don’t think we’ve seen any particular money or funding or anything like that”*–Mental Health Practitioner.<sup>325</sup>

### **Was the commitment effectively funded (or resourced)?**

#### **Rating: Requires Improvement**

We recognise that additional funding will be made available to support this commitment. In their response to our evaluation, the Department of Health and Social Care said that funding for this commitment commences from 2020/2021, as detailed in the NHS Mental Health Implementation Plan.<sup>326</sup> This Plan outlined a total of £85 million to be spent on improving the therapeutic offer, which is allocated to CCG baselines. However, practitioners questioned how these funding arrangements were determined and whether they were adequate to support frontline workers to deliver evidence-based treatment:

*“I don’t think the Government has ever done a cost analysis of the funding that is needed for the implementation of the NICE guidelines and I think that is something that we’re all struggling with. You are talking about various types of services where psychological intervention is key and to be fair psychological treatment has been progressed in the last 10 years, medication hasn’t really progressed in the last 30 years, so that’s a major gap because there is almost a chasm between what is the guidelines and what is happening on the front*

323 Royal College of Psychiatrists ([MHS0023](#))

324 Rethink Mental Illness ([MHS0007](#))

325 Adult SMI Roundtable

326 NHS, [NHS Mental Health Implementation Plan 2019/20 – 2023/24](#) (July, 2019)



*line. Without actually having that economic analysis it just feels like we are working in unknown parameters with massive demand.”–Mental Health Practitioner.<sup>327</sup>*

We note that the lack of transformation funding to improve the therapeutic offer for inpatient services means that there are insufficient resources to make the necessary changes to the physical environment where these services are offered. Several stakeholders said that the current provision of funding was not adequate to improve the estate which accommodates service users, presenting a barrier to providing a safe and therapeutic environment.<sup>328</sup> These issues have meant that the estate is not suitable to promote individuals’ rehabilitation and recovery.<sup>329</sup> These views were shared by Mental Health Practitioners who attended our roundtable discussion, as one attendee noted:

*“[...] but there’s nothing around them pledging to have rooms where you can see people, or a chair where you can have therapy, or enough staff to meet demand and those are some real basics around provision of a service. Expecting more and more things with not enough people, not enough places, not enough car parking spaces”–Mental Health Practitioner.<sup>330</sup>*

### **Did the commitment achieve positive impacts for service users?**

#### **Rating: Requires Improvement**

Our evaluation found that the impact of the commitment to improve the therapeutic offer from inpatient mental health services requires improvement. In their submission to our evaluation, the Royal College of Psychiatrists noted that only 42% of services users had a personalised therapeutic/recreational timetable of activities, suggesting there is a lack of meaningful activity for these individuals.<sup>331</sup> We note with concern that MIND have reported that the therapeutic environment currently provided by inpatient services can be detrimental to people’s mental health when they are at their most vulnerable.<sup>332</sup> One service user recounted:

*“The support you get once you’re sectioned–you’re observed by someone pulling back a shutter half way through the night to make sure you’re asleep, and make sure you’re eating, making sure you’re taking medication. In terms of any talking therapy, trying to understand, and doing it in a holistic and joined up way, none of that exists.” - Service user.<sup>333</sup>*

The lack of positive outcomes for service users may have been the product of limited involvement of these individuals in the coproduction of treatments within inpatient settings. One academic paper found that patient experience feedback cycle was rarely completed.<sup>334</sup> When improvements were implemented based on feedback, they were

327 Adult SMI roundtable

328 British Medical Association ([MHS0008](#)); NHS Providers ([MHS0013](#))

329 NHS Providers ([MHS0013](#))

330 Adult SMI Roundtable

331 Royal College of Psychiatrists ([MHS0023](#))

332 MIND ([MHS0005](#))

333 MIND, [Mental Health Act Review: Mind’s engagement and influence](#) (2019)

334 Weich, S., Fenton, S. J., Staniszewska, S., Canaway, A., Crepaz-Keay, D., Larkin, M., ... & Griffiths, F. (2020). Using patient experience data to support improvements in inpatient mental health care: the EURIPIDES multimethod study. *Health Services and Delivery Research*, 8(21), 1–338.

largely focussed on superficial features of the physical environmental, rather than changes in working practices that service users felt would be beneficial.<sup>335</sup> Moreover, this same study found that staff felt unable to action change based on patient feedback, which may indicate a lack of adequate resources to implement improvements within services:

*“There’s no point in having all this information if you’re not gonna do anything with it at the end of the day . . . we churn out these reports and the services go, ‘that’s absolutely fantastic. We can use that. Let’s go do this, this and this’, but we as a team don’t, don’t necessarily get that feedback back [about] what [the service has] done with all that information”*—Staff member.<sup>336</sup>

Currently, there is no metric for evaluating the therapeutic offer provided by inpatient services. Practitioners reported that some interventions did not meet the evidence-based standards, which calls in to question their clinical efficacy. Although the interventions provided important pastoral activities for service users, this nevertheless highlights the limited clinical impact of this commitment:

*“The big focus on the therapeutic offer is about activities, and that is literally can we provide an activity in the whole of the morning that we might get one or two people coming to. You know, can we have a coffee morning or something like that. It’s very, very low level, and sometimes that’s necessary, but it’s a far cry from offering evidence-based interventions across the piste.”*—Mental Health Practitioner.<sup>337</sup>

## Was it an appropriate commitment?

### Rating: Inadequate

The commitment to improve the inpatient therapeutic offer and reduce length of stay within these services is important to improve recovery outcomes for service users.<sup>338</sup> However, targets alone are not sufficient to improve outcomes or experiences for service users.<sup>339</sup> Several stakeholders noted that the commitment to improving the therapeutic offer is not the same as providing a therapeutic environment and activities, which require cultural changes within these settings.<sup>340</sup>

Stakeholders welcomed the standards implemented through the CQUIN,<sup>341</sup> which stated that secure services should provide 25 hours of meaningful activity per week.<sup>342</sup> However, it was noted that clear evidence-based standards would need to be established to build confidence that activities offered to service users constitute a therapeutic offer.<sup>343</sup> Without

335 Weich, S., Fenton, S. J., Staniszewska, S., Canaway, A., Crepaz-Keay, D., Larkin, M., ... & Griffiths, F. (2020). Using patient experience data to support improvements in inpatient mental health care: the EURIPIDES multimethod study. *Health Services and Delivery Research*, 8(21), 1–338.

336 Ibid

337 Adult SMI Roundtable

338 Rethink Mental Illness ([MHS0007](#))

339 Ibid

340 Weich, S., Fenton, S. J., Staniszewska, S., Canaway, A., Crepaz-Keay, D., Larkin, M., ... & Griffiths, F. (2020). Using patient experience data to support improvements in inpatient mental health care: the EURIPIDES multimethod study. *Health Services and Delivery Research*, 8(21), 1–338.

341 The Commissioning for Quality and Innovation (CQUIN) is a framework that is used by NHS England to support improvements in the quality and create new systems of care

342 Rethink Mental Illness ([MHS0007](#))

343 Ibid

such standards, it is the responsibility of individual providers to determine what services should be offered, leading to significant regional variation.<sup>344</sup> Indeed, the confusion about services that constituted a ‘therapeutic offer’ was reported by practitioners who attended our roundtable:

*“And I think at times, some of the delay to implementation occurs when things aren’t neatly enough defined by what people mean. I think we’ve seen it here already with commitment three around increased investment in interventions and activities, and as Participant F was saying, that could cover a whole multitudes of things, everything from evidence-based care right the way down to having a cup of tea and a biscuit with someone”*–Mental Health Practitioner.<sup>345</sup>

In our evaluation, we found that the system did not have the systems leadership or systems tools to improve the therapeutic offer for inpatient mental health settings. Specifically, it was highlighted that staff currently in inpatient services required training to deliver therapeutic services that were evidence based.<sup>346</sup> Moreover, to deliver multidisciplinary services, additional staff are required with an appropriate mix of skills.<sup>347</sup> However, some stakeholders noted challenges recruiting and expanding teams with these skills within inpatient services due to a lack of workforce (see Chapter 1: Workforce).<sup>348</sup>

## Crisis Resolution and Home Treatment functions for adults

In this section, we evaluate the Government’s progress on their commitment to provide crisis resolution and home treatment functions that operate in line with best practice:

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

### Overall Commitment Rating and Overview for Crisis Resolution and Home Treatment (CRHT):

#### Requires Improvement

Crisis resolution and home treatment functions have the potential to support individuals with a severe mental illness in the community and reduce the burden on inpatient services. The commitment outlined in the Five Year Forward View for Mental Health outlined three key objectives for adult severe mental illness services:

- that a 24/7 community-based mental health crisis response is available in all areas across England
- that services are adequately resourced to offer intensive home treatment as an alternative to acute inpatient admission

344 Ibid

345 Adult SMI roundtable

346 NHS Providers ([MH50013](#))

347 Royal College of Psychiatrists ([MH50012](#))

348 MIND ([MH50005](#)); Rethink mental illness ([MH50007](#))

- for adults, NHS England should invest to expand CRHTs<sup>349</sup>

Our evaluation found that progress against this commitment requires improvement, as not all services currently meet the full range of expected services.<sup>350</sup> While crisis lines had been established across the country at the beginning of the COVID-19 pandemic, not all services operate these lines on a 24 hours per day, 7 days per week basis.<sup>351</sup> Furthermore, home treatment functions are not provided in all crisis services and therefore significant progress is required to establish these functions in order for these services to provide an alternative to acute inpatient admission.

Funding for this commitment has been good, with £260 million made available to support the development of crisis response and home treatment services.<sup>352</sup> However, as this dedicated funding ended in 2021, stakeholders made the case that further funding would be required in the coming years to ensure that progress on providing these services was sustained.<sup>353</sup> The impact of this commitment has also been good as it has led to measurable decreases in the number of readmissions to forensic inpatient services,<sup>354</sup> though stakeholders did recognise areas where these services could be further improved.<sup>355</sup> We recognise that this is an appropriate commitment, which has a clearly specified model and measurable targets. Ensuring all areas provide crisis resolution and home treatment functions was welcomed as an appropriate commitment by stakeholders who submitted evidence to our evaluation.<sup>356</sup>

### ***Was the commitment met overall? Is the commitment on track to be met?***

#### ***Rating: Requires improvement***

The deadline for all areas to provide crisis resolution and home treatment functions that are resourced to operate in line with recognised best practice was 2020/21. In their response to our evaluation, the Department of Health and Social Care acknowledged this commitment was not achieved in full, as a small percentage of areas have not met the full range of expected services.<sup>357</sup> According to the Department of Health and Social Care, 97% of services offer 24/7 hours of operation and face to face home visits and 95% are open access.<sup>358</sup> In response to the COVID-19 pandemic, progress to establish 24/7 urgent mental health helplines for those with severe needs or in crisis was accelerated ahead of the original 2023/24 target.<sup>359</sup> This progress was recognised by Mental Health Practitioners at our roundtable discussion:

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349 The Department of Health and Social Care ([MHS0009](#))

350 Ibid

351 Royal College of Psychiatrists ([MHS0025](#))

352 The Department of Health and Social Care ([MHS0009](#))

353 NHS Providers ([MHS0013](#))

354 Ibid

355 SANE ([MHS0015](#))

356 MIND ([MHS0005](#)); Rethink Mental illness ([MHS0007](#)); Royal College of Psychiatrists ([MHS0012](#)); SANE ([MHS0015](#))

357 The Department of Health and Social Care ([MHS0009](#))

358 Ibid

359 Ibid

*“with the crisis team, they’re very much operating as usual I don’t think there has been any particular progress around that. But equally we do have a crisis and home treatment team, so I guess that that’s met to some extent.”*–Mental Health Practitioner.<sup>360</sup>

However, an evaluation carried out by the Royal College of Psychiatrists disputes the figures from the Department of Health and Social Care about the proportion of services offering 24/7-hour services. Of the 63 services that were members of the Quality Network for Crisis Resolution and Home Treatment Teams (QNCRHTT), only 37 provided 24-hour provision for both crisis/assessment and home treatment services (though data from 11 services were missing).<sup>361</sup> Working optimistically with the assumption that all 11 missing services also provided 24-hour crisis services, this would mean only 76% of services were operational 24/7, in line with recognised best practice. However, the worst-case scenario is that only 50% were providing crisis care. This latter figure is closer to a survey conducted by SANE, a mental health charity, showing 44% of callers had no support for their mental health whether from a community mental health team, psychiatrist, or crisis line.<sup>362</sup> Therefore, these data demonstrate that progress against this commitment requires improvement.

### **Was the commitment effectively funded (or resourced)?**

#### **Rating: Good**

We recognise that specific funds have been made available to support progress in establishing crisis response and home treatment functions. In their response to our evaluation, the Department of Health and Social Care reported that NHS England and NHS Improvement have recently completed allocation of £261 million of targeted investment in community-based crisis teams.<sup>363</sup> Stakeholders welcomed these funds, however NHS Providers noted that capital funding had yet to be allocated for ambulance vehicles despite an announcement from the Treasury in 2018.<sup>364</sup> They also said that funding would be required beyond 2021 to sustain and spread functions that had been evidenced to work for local populations.<sup>365</sup> Consistent with this view, MIND reported that additional funding may be necessary due to worsening mental health as a result of the COVID-19 pandemic and that it was unclear whether the level of funding had been sufficient to date.<sup>366</sup> The reasons for non-implementation and a lack of 24/7 community care (as opposed to emergency hospital care) are not available from the data submitted to our evaluation.

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360 Adult SMI roundtable

361 Royal College of Psychiatrists ([MHS0025](#))

362 SANE ([MHS0015](#))

363 The Department of Health and Social Care ([MHS0009](#))

364 NHS Providers ([MHS0013](#))

365 Ibid

366 MIND ([MHS0005](#))

## Did the commitment achieve positive impacts for service users?

### Rating: Requires Improvement

The provision of crisis resolution and home treatment services has led to positive impacts for individuals with severe mental health needs or those in crisis. NHS Providers reported that some trusts had been able to reduce the number of readmissions to forensic inpatient services by two-thirds through collaborative local working with crisis resolution team.<sup>367</sup> In our roundtable with Mental Health Practitioners, there were reflections on the strengths and weaknesses of these crisis teams:

*“We’re very good in these crisis teams of getting medication to people when they’re in crisis, but we’re less good at getting evidence-based therapies that would have a similar effect.”*—Mental Health Practitioner.<sup>368</sup>

Yet, some stakeholders reported that there was scope for further improvement on the impact of crisis teams. For example, MIND reported that some local services had not seen crisis response and home treatment teams going to see at-risk individuals and that some individuals struggled to access these services.<sup>369</sup> Consistent with this account, SANE reported that some service users had been discharged from emergency departments after presenting with severe mental health symptoms, having been told they would receive a call from their community mental health team. However, these calls have not been received, further adding to these individuals’ distress.<sup>370</sup> Furthermore, in our roundtable, practitioners reported that these crisis response services had not been sufficiently developed to make a measurable impact on inpatient services:

*“I still think that the burden on beds is huge, and the burden on acute inpatient psychiatry is just incredible due to the diversity of patients, the demands on the staff and I think there is a bit of poverty of attention on that.”*—Mental Health Practitioner.<sup>371</sup>

These findings suggest that while there have been some measurable, positive impacts of crisis resolution and home treatment services, further improvement can be made. One way to increase the effectiveness of these services is to increase awareness about crisis services, as SANE reported that 46% percent of their callers were unaware of their local NHS mental health crisis helpline.<sup>372</sup>

## Was it an appropriate commitment?

### Rating: Good

The commitment to ensure all areas have functional crisis resolution and home resolution functions is appropriate. This view was shared by stakeholders who submitted evidence to our evaluation, who said that these services were important as they form a core part of

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367 NHS Providers ([MHS0013](#))

368 Adult SMI Roundtable

369 MIND ([MHS0005](#))

370 SANE ([MHS0015](#))

371 Adult SMI roundtable

372 SANE ([MHS0015](#))

mental health care.<sup>373</sup> This commitment has the chance to achieve meaningful impacts for service users and the mental healthcare system more broadly, as it can help to reduce the burden on inpatient services.<sup>374</sup> In specifying each component of a crisis response service, there are clear targets with which to measure progress against this commitment.

However, it was noted in several submissions that the system did not have the tools to implement this commitment. It was noted that difficulties in the recruitment and retention of staff had presented a barrier to establishing these services and staffing them to provide a 24/7 service.<sup>375</sup> The Royal College of Emergency Medicine reported that a lack of section 12 doctors and approved mental health professionals had led to delays in crisis resolution and home treatment services providing health assessments.<sup>376</sup>

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373 MIND ([MHS0005](#))

374 Adult SMI roundtable

375 The Department of Health and Social Care ([MHS0009](#))

376 The Royal College of Emergency Services ([MHS0022](#))

## 5 Inequality in Mental Health

In evaluating the Government’s progress on their commitments to mental health, we identified a prominent theme of inequality within mental health services throughout each of the four policy areas. Ensuring equality throughout mental health services is a crucial target for any healthcare system and therefore the existing inequalities in access, provision and outcomes within mental health services reflects a lack of overall progress within the commitments we have evaluated.

Mental ill-health can arise from a complex interaction between biological, psychological, social, and environmental factors.<sup>377</sup> To support people living with mental ill health, it is important that the full range of intersectional factors that can influence mental health are addressed by the healthcare system. We recognise that some services are making progress on this issue. For example, Improving Access to Psychological Therapies (IAPT) services for adults with a long term health condition now include finance and employment services for those with long term conditions (see Chapter 3: Adult Common Mental Illness).<sup>378</sup> However, intersectional approaches are not adopted universally across mental health services and our evaluation found that some areas did not address wider social determinants around mental health, as expressed by one mental health practitioner during our roundtable event:

*“What we are not really seeing is a well-developed, integrated workforce plan that recognises the importance of both clinical and non-clinical tasks in mental health care, and speaks to the social determinants of mental health. There is so much evidence now of a kind-of overwhelming relationship between poverty, deprivation, and mental health”*–Mental Health Practitioner.<sup>379</sup>

Our evaluation found there were regional inequalities in the provision of mental health services across the country. One striking case of regional inequalities was in children and young people’s mental health services. For example, access rates to evidence-based treatments ranged from 6% of all children in some areas (e.g., Durham, South Tyneside, St Helens, Hull and Blackpool), which is approximately half of all children with a clinically diagnosable conditions, to 2% in some areas (e.g., Leeds, South Cheshire, Croydon and Harrow). In areas where only 2% of children access mental health services, this figure is equal to fewer than 1 in 6 children with a clinically diagnosable condition.<sup>380</sup> There were further regional disparities in funding for these services; a quarter of CCGs spent less than £4 per child whereas another quarter spent more than £15 per child.<sup>381</sup> Such differences were also evident in waiting times, as 11 CCGs reported average waiting times of less than 4 weeks, whereas 43 CCGs reported average waiting times of more than 10 weeks.<sup>382</sup> These data suggest that the uneven regional distribution of investment and access to services is still prevalent within mental health services, which disproportionately affects those in more socio-economically deprived areas<sup>383</sup>

377 The Lancet. (2021). Brain health and its social determinants, *The Lancet*, 298 (10305), 18–24.

378 Money and Mental Health Policy Institute ([MHS0002](#))

379 Workforce roundtable

380 The Children’s Commissioner, [The state of children’s mental health services](#) (January, 2020)

381 Ibid

382 Ibid

383 Institute of Health Equity, [Fair Society, Healthy Lives: The Marmot Review](#) (February, 2010)



The COVID-19 pandemic has further exacerbated inequalities in access to mental health services. At the onset of the pandemic, the majority of services moved to an online delivery of care to reduce the spread of the COVID-19.<sup>384</sup> The adoption of digital technologies to provide healthcare is also outlined in the NHS Long-Term Plan, suggesting this approach will continue after measures to reduce the spread of COVID-19 have ended.<sup>385</sup> However, this has raised concern about a growing ‘digital divide’ in access to healthcare. The ‘digital divide’ describes the inequalities between individuals with access to digital technologies, such as computers and internet, and those without.<sup>386</sup> The provision of online health services may create a barrier to accessing treatment for groups who are less likely to own a smartphone, such as older adults and individuals from lower income households.<sup>387</sup> One recent paper highlights that adults with a severe mental illness may be particularly affected by the digital divide.<sup>388</sup> The paper outlines how in some cases, navigating online technologies has posed a particular obstacle to those with a severe mental illness, in gaining access to health-related information that may support their physical health, particularly during the national lockdown. This can further exacerbate health inequalities, such as the reduced life expectancy for those with a severe mental illness, which is 15–20 years shorter than the general population.<sup>389</sup>

We also note disparities in access to mental health services between ethnic groups. Individuals from Black African, Asian and Mixed ethnic groups report greater barriers to engaging with mental health services, which may stem from a lack of culturally appropriate services.<sup>390</sup> Consistent with this account, a recent study found that individuals from Black African, Asian and Mixed ethnic groups were less likely to self-refer to IAPT services relative to White British individuals.<sup>391</sup> Moreover, individuals from Black African, Asian and Mixed ethnic groups who were referred to IAPT services were less likely to receive an assessment compared to White British individuals.<sup>392</sup> A separate study specifically examining young people aged 12–29 from a Black African ethnic background found that these individuals were two times as likely to be referred to a mental health trust through secondary health or social/criminal justice services compared to those from White British backgrounds.<sup>393</sup> These data suggest that there are inequalities in access to mental health services between ethnic groups. There is little evidence of a commitment to reduce ethnic disparities in the inappropriate use of the mental health act, and excess criminal justice and crisis pathways. The Independent Review of the Mental Health Act recognises clinical and systems actions, as well as measures have been implemented to address these issues, but it is too early to judge whether these have been successful.

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384 Parliamentary Office of Science and Technology, [COVID-19 and the digital divide](#) (December, 2020)

385 NHS England, [Digital Transformation](#) (2019)

386 Parliamentary Office of Science and Technology, [COVID-19 and the digital divide](#) (December, 2020)

387 Ofcom, [Technology Tracker](#) (October, 2020)

388 Spanakis, P., Peckham, E., Mathers, A., Shiers, D., & Gilbody, S. (2021). The digital divide: amplifying health inequalities for people with severe mental illness in the time of COVID-19. *The British Journal of Psychiatry*, 1–3.

389 Ibid

390 Centre for Mental Health, [Covid-19: understanding inequalities in mental health during the pandemic](#) (July, 2020)

391 Harwood, H., Rhead, R., Chui, Z., Bakolis, I., Connor, L., Gazard, B., ... & Hatch, S. (2021). Variations by ethnicity in referral and treatment pathways for IAPT service users in South London. *Psychological Medicine*. 1–12. doi:10.1017/S0033291721002518

392 Ibid

393 Chui, Z., Gazard, B., MacCrimmon, S., Harwood, H., Downs, J., Bakolis, I., ... & Hatch, S. L. (2021). Inequalities in referral pathways for young people accessing secondary mental health services in south east London. *European child & adolescent psychiatry*, 30(7), 1113–1128.

While we recognise statements by NHS England and NHS Improvement to tackle racism and health inequality,<sup>394</sup> our evaluation suggests further progress is required to ensure access to services is demonstrably equitable for the commitments in our evaluation. Progress on these commitments should be considered within context of existing inequalities and the intersectional issues that can contribute towards experiences of poor mental health.

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394 NHS England, [Advancing mental health equalities strategy](#) (October, 2020)

## Annex A: Key Evidence and Methodology

Table 1: Key evidence to support the ratings for each commitment

Policy Area	Commitment	Rating	Key Evidence
Workforce	Increase the mental health workforce	Requires improvement	<p>The overall number of mental health staff has increased by 17,778 since 2016 meeting targets</p> <p>2021 targets for mental health nurses and consultant psychiatrists were not met</p> <p>Staff report exhaustion, demoralization and burnout</p> <p>A lack of appropriate staff has resulted in key services being understaffed and unable to provide treatment</p> <p>The number of learning disability nurses has declined since 2010</p>
Children and Young People			
	Additional treatment	Requires improvement	<p>The number of children and young people who have accessed treatment for mental health conditions met the 35% target outlined in this commitment</p> <p>This target was met despite an increase in prevalence between 2007 and 2017</p> <p>Funding has been allocated for this commitment at CCG-level, including baseline funding and central/transformational funding</p> <p>There were several examples of the positive outcomes for children and young people who had accessed services to support their mental health</p> <p>The majority of children and young people with a probable mental health condition did not have access to treatment</p>

Policy Area	Commitment	Rating	Key Evidence
	95% Children and Young People accessing treatment for eating conditions within waiting time targets	Good	<p>In Q1 2021/22 61.0% of children and young people started treatment within 1 week for urgent cases</p> <p>In Q1 2021/22 72.7% of children and young people started treatment within 4 weeks for routine cases</p> <p>There has been a dramatic increase in the prevalence of eating conditions since the beginning of the COVID-19 pandemic</p> <p>Funding has been allocated to expand these services since 2016, with a further £53 million allocated from 2021/22 to 2023/24</p> <p>Establishing waiting time targets has been associated with a significant improvement in access rates since the commitment was made</p>
	Crisis response	Requires improvement	<p>Crisis lines have been established, providing support to children and young people</p> <p>However, other functions of a crisis response are not operational for children and young people</p> <p>A lack of appropriate staff has contributed to the lack of progress on this commitment</p>
Adult Common Mental Illness	All areas commission IAPT services for adults with long term conditions	Requires improvement	<p>77% of areas currently commission IAPT services for adults with a long term condition, suggesting this commitment has not been met</p> <p>Funding for this commitment is allocated at CCG-level and not transparent</p> <p>There are vacancies within IAPT services, which may impact the ability of services to commission IAPT for adults with Long Term Conditions</p> <p>For those who can access the services, IAPT-LTC can lead to clinically meaningful improvements</p> <p>The provision of IAPT-LTC services has not been considered in collaboration with the wider healthcare system</p>
Adult Severe Mental Illness			

Policy Area	Commitment	Rating	Key Evidence
	Physical health check	Requires improvement	<p>140,885 adults on GPs severe mental illness register received all six elements of a physical health check, significantly below the target of 280,000 (50.3%)</p> <p>Targets were not on track to be met before the COVID-19 pandemic</p> <p>Additional funding has been allocated for this commitment through the Quality and Outcomes Framework, however the impact of these resources will not be evident for some time</p> <p>There have been case examples of good practice, but standards are not consistent across the country</p>
	Integrated community models	Requires improvement	<p>Evidence from pilot sites indicates that community models can promote positive outcomes for service users</p> <p>However, reports from stakeholders suggest these models are not on track to be operational by 2023/24</p> <p>Funding is not sufficient to support transformation of primary care services to host mental health services</p> <p>The components of an integrated community model have not been specified</p>
	Improved therapeutic offer	Requires improvement	<p>The length of inpatient stay has decreased between 2019–2021</p> <p>However, many service users do not have a shared care plan</p> <p>Funding has been insufficient to transform the physical estate, which currently does not provide a therapeutic environment</p> <p>Service users report that the therapeutic offer is limited</p> <p>There was no clear definition of 'therapeutic offer' leading to confusion among practitioners</p>

Policy Area	Commitment	Rating	Key Evidence
	Crisis resolution and home treatment	Requires improvement	<p>Data suggests that crisis services, where they exist, are not operational 24/7, in line with best practice</p> <p>Funding has been allocated to support the development of this commitment, but not thought to be enough</p> <p>It was recognised that a fully operational crisis resolution and home treatment function would be a great benefit to service users.</p>

## Annex B: Anchor statements for CQC-style ratings

Rating	Was the commitment met overall/Is the commitment on track to be met?	Was the commitment effectively funded?	Did the commitment achieve a positive impact for patients?	Was it an appropriate commitment?
Outstanding	The commitment was fully met/there is a high degree of confidence that the commitment will be met	The commitment was fully funded with no shortfall	Patients and stakeholders agree that the impact was positive	Evidence confirms appropriateness of the commitment
Good	The commitment was met but there were some minor gaps, or is likely to be met within a short time after the deadline date/it is likely that the commitment will be met, but some outstanding issues will need to be addressed to ensure that is the case	The commitment was effectively funded, with minor shortfalls	The majority of patients and stakeholders agree that the impact was positive	Evidence suggests the commitment was appropriate overall, with some caveats
Requires improvement	The commitment has not been met and substantive additional steps will need to be taken to ensure that it is met within a reasonable time/the commitment will only be met if substantive additional steps are taken	The commitment was ineffectively funded	A minority of patients and stakeholders agree that the impact was positive	Evidence suggests the commitment needs to be modified
Inadequate	The commitment has not been met and very significant additional steps will need to be taken to ensure that it is met within a reasonable time/the commitment will only be met if very significant additional steps are taken	Significant funding shortfalls prevented the commitment being met	Most patients and stakeholders did not agree there was a positive impact for patients	Evidence suggests the commitment was not appropriate

## Annex C: Published written submissions

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The following written submissions were received and can be viewed on the inquiry publications page of the Committee's website.

- 1) Samaritans([MHS0001](#))
- 2) Money and Mental Health Policy institute ([MHS0002](#))
- 3) National Counselling Society ([MHS0003](#))
- 4) MIND ([MHS0005](#))
- 5) British Association for Counselling and Psychotherapy ([MHS0006](#))
- 6) Rethink mental illness ([MHS0007](#))
- 7) British Medical Association ([MHS0008](#))
- 8) The Department of Health and Social Care ([MHS0009](#))
- 9) Care Quality Commission ([MHS0010](#))
- 10) National Confidential Inquiry ([MHS0011](#))
- 11) Royal College of Psychiatrists ([MHS0012](#))
- 12) NHS Providers ([MHS0013](#))
- 13) Professor Cathy Creswell, University of Oxford ([MHS0014](#))
- 14) SANE ([MHS0015](#))
- 15) Centre for Mental Health ([MHS0016](#))
- 16) Association of Directors of Children's Services Ltd ([MHS0017](#))
- 17) NHS Confederation's, Mental Health Network ([MHS0018](#))
- 18) Young People Cornwall ([MHS0020](#))
- 19) YoungMinds ([MHS0021](#))
- 20) Royal College of Emergency Medicine ([MHS0022](#))
- 21) Royal College of Psychiatrists, supplementary submission 1 ([MHS0023](#))
- 22) Professor Cathy Creswell, University of Oxford, supplementary submission 1 ([MHS0024](#))
- 23) Royal College of Psychiatrists, supplementary submission 2 ([MHS0025](#))
- 24) NHS England and NHS Improvement ([MHS0026](#))



## Annex D: Transcripts

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Roundtable with practitioners – Group 1 (Adult mental health workforce) ([MHS0027](#))

Roundtable with practitioners – Group 2 (Child and adolescent mental health) ([MHS0028](#))

Roundtable with practitioners – Group 3 (Adult common mental health) ([MHS0029](#))

Roundtable with practitioners – Group 4 (Adult severe mental health) ([MHS0030](#))

Roundtable with practitioners – feedback session ([MHS0031](#))