Care not containment: Setting a radical vision for transforming mental health support

Every year we commit vast resources – hundreds of millions of pounds – to the treatment of people within institutional settings. At their best, these stays can represent high quality, targeted interventions in support of recovery – at worst, they can represent long term containment and a denial of human rights.

We have come together to make the case for a rethink of where emphasis is placed and money invested in mental health care. We welcome the recent publication of the Long Term Plan for the NHS and the emphasis which it places upon the importance of investment in mental health. This paper is our constructive contribution to ensure that the NHS makes the most of the resources available by using every penny committed most effectively by providing services in the right place, at the right time, early on.

Alongside extra funding, we call for an approach which focuses on providing preventative and proactive support to aid recovery and independent living in the community, reducing demand and moving emphasis away from the need for more hospital beds.

An enlightened approach focused on care rather than containment will transform the wellbeing of people who experience ill health, uphold their dignity and human rights, and mark a turning point in the mission to end the treatment of people with mental ill health as second class citizens.

Introduction

Over the last ten years, there has been an unprecedented focus on mental health care with the intention of working towards 'parity of esteem' between mental health and physical health services. Policymakers face ever-greater pressure to deliver additional funding, increased capacity, and shorter waiting times for treatment in order to end the historic injustice which has seen people with mental ill health too often treated as second-class citizens. This achievement deserves to be celebrated.

But while there is a consensus that the system needs more resources to deliver these objectives, it is striking that little attention is paid to the important question of how resources in mental health are currently spent. In particular, there is now a real need to initiate a national conversation about how we ensure that the money invested in the mental health system is spent on delivering the most therapeutic, cost-effective interventions that deliver the best outcomes for people.

This paper aims to highlight the deficiencies in the way in which mental health support is currently organised and delivered in many places, and to argue for the implementation of a new approach, focused on the right care at the right time in the right setting, and prioritising people's independence, rights and wellbeing.

We need to make real the laudable policies advocating a population mental health approach, focused on preventing ill health and tackling the social determinants of poor health and mental wellbeing. We must also enhance community services – ensuring that care is delivered as close to home as possible, in partnership with service users and carers, and focused on prevention, early intervention and recovery, and coordinated continuing care for those that need it. This must be part of a whole-systems

approach to modernisation involving non-NHS services such as social care, housing and employment support.

We call for a mental health system which embodies the following core principles:

1. A system which puts the individual at the heart of the system, working with them and their communities early on and throughout their lives rather than waiting until they deteriorate.
2. Enhanced community services addressing the needs of the individual through addressing their social, physical, psychological, medicines and rehabilitation needs using a variety of means – including emotional and psychological support, and 24/7 intensive therapeutic community support teams as an alternative to hospital admissions (commissioned to meet local needs, providing crisis care but also continuing care for those most in need and with complex challenges).
3. Prevention strategies and targeted interventions for high-risk groups, including evidence-based early-years support for children who are at risk of or who have experienced adversity such as trauma, abuse and neglect and also support for those who have been institutionalised in care.
4. Support that is delivered out of hospital and is stepped up and/or down according to need on an ongoing basis. Inpatient care should only be used when effective care can no longer be provided in a community setting, when there is clear therapeutic value to hospital treatment, and when there is an effective plan for the patient's discharge back into the community. It will also continue to be necessary for those whose safety is at risk and who need to be detained under the Mental Health Act
5. Service users and carers as equal partners at all levels of decision-making – including at senior level.

How can we achieve this change?

Critically, investment needs to be targeted at the development of community facing services that embody the changes outlined here. Beyond this, Staff are crucial to the effectiveness of the system. The recent recruitment and retention challenges in mental health services are of grave concern, and staff often feel inadequately trained to meet the demands of rising patient numbers and a challenging working environment. Community Mental Health Teams are under-resourced and there tends to be a shortage of staff trained in evidence-based therapies.

- **Workforce planning is the most critical limiting factor** so plans need to be innovative and ambitious. The workforce needs to reflect the local populations served, affirmatively attracting and nurturing future clinical leaders**.**
- **Addressing the gaps in the skills and competences** among staff will equip them to deliver more effective care without a huge cost to the service. This will in turn result in improved job satisfaction and better outcomes for service users.
- **Supervision underpins the work of practitioners** and will in turn support them to bear the distress and anger of some individuals. Supervision should be prioritised and measured as a key performance indicator.

- **Generic therapeutic skills need to be developed** to enable practitioners to think clearly in situations of high arousal and distress, which is imperative when working with people with more complex problems. A failure to 'care for the people that care for the people' is a huge and enduring problem in the NHS which must be addressed. Staff need to feel hope and optimism if they are to provide the same ambition for their patients.

- **Collective decision making will become more consistent** allowing for the creation of a more balanced system. Practitioners in community and primary care need to be empowered to make decisions together about how to use limited resources more effectively. The demand upon specialist services will reduce as more appropriate and effective interventions are offered at earlier points in the person's journey through services and risk is managed more effectively. Multi agency improvement programmes need to be resourced and NHSI should consider how to rebalance the disproportion in its Improvement programme support to the mental health and community sector

- **Leadership is key in promoting and facilitating change** of this nature. Achieving a philosophical shift in the way we design and deliver services can be challenging and requires individuals in senior positions to show the ambition, drive and leadership needed to implement these changes successfully.

- There must be recognition that **adverse childhood experiences are common** and that there is a compelling body of evidence that demonstrates the increased risk of mental health problems associated with exposure to these events in childhood. Adopting a trauma-informed approach means designing and delivering mental health services that are informed and underpinned by what we know about psychological trauma and that also strive to avoid re-traumatising service users and staff alike. The NHS in England should consider replicating the 'National Trauma Training Framework', which was introduced in Scotland to support trauma-informed practice within the NHS workforce. (likewise Scotland's excellent knife crime and gang initiatives)

Transforming mental health care towards a model centred on resilience-building, positive wellbeing, trauma-informed practice and community-based recovery will have profound consequences for our communities. It will improve mental wellbeing, reduce the social and economic burden of mental ill health, and relieve the strain on specialist NHS services. It will support people who experience mental ill health to live more fulfilling and economically productive lives as full members of their community. It will improve the experience of mental health services for users and staff, while making far better use of resources than existing service models. And above all, it will promote people's independence and human rights, which are too often eroded in long-term institutional care and by inadequate treatment in mental health services.

The case for change

Fortunately, the NHS and social care system has world-class staff delivering high-quality mental health care. Thousands of people benefit from pockets of innovation and best practice in many different parts of the country. However, it is important to address the ways in which the system is not fit-for-purpose.

Mental health funding is inadequate and often not spent in the right way

There is now a broad consensus that mental health services are under-resourced. Even though mental health problems account for 23% of the burden of illness in the UK, mental health spending amounted

to just 10.9% of the total NHS England budget in 2017/18. We know that 75% of mental health problems emerge by the age of 18 (and 50% before the age of 15), but only 9% of all mental health spending goes on children and the Children's Commissioner recently pointed out that local NHS areas spend less than 1% of their budget on children's mental health.

As a consequence of this, an estimated 70% of children with mental health problems do not receive appropriate support. The Education Policy Institute found one in four children referred to specialist mental health services are diverted elsewhere, and these rates have failed to improve substantially over the last five years. High eligibility thresholds are a common reason for referrals being rejected. In some reported instances, children who have self-harmed or experienced abuse have been judged not to meet high access thresholds. NHS Digital's new prevalence survey, which shows that one in eight children and young people aged 5 to 19 had a 'mental disorder', illustrates the scale of the challenge ahead. Of particular concern is the prevalence of mental health problems in young women, many of whom reported having self-harmed or attempted suicide.

The Secretary of State has now announced an extra £2.3bn for mental health services by 2022/23. While additional funding is welcome, this settlement is, in itself, insufficient to correct decades of under-funding. It will make little difference to the overall share of NHS funding going into mental health services.

We strongly support calls for additional funding for mental health care but there needs to be careful thought as to where any additional funding is directed. While inpatient beds and acute services are under pressure across the country, there is a vital need to invest in community services, assertive outreach, crisis services, early intervention and preventative approaches. There is also a need to plan for the growing demand as more referrals come from prisons, custody, Emergency departments, and from people returning from out of area placements. As local authority budgets come under increasing fiscal challenges, increasing numbers of people who are homeless, involved in alcohol and drug misuse and living with the consequences of poverty, means that mental health difficulties rise.

The new Health and Social Care Secretary has identified prevention as one of his key priorities for the health and social care system, alongside technology and the workforce. This must apply equally to the prevention of mental ill health, and bold action will be needed to make up lost ground. Research by the charity Mind has revealed that local authorities spend on average less than 1 percent of their public health budget on public mental health. There is little prospect of this figure improving while local authority budgets continue to be squeezed. Within mental health services, there has been little systematic secondary prevention, reducing avoidable repeat relapses. readmissions, re-detentions.

The Five Year Forward View for Mental Health called for "a far more proactive and preventative approach to reduce the long-term impact for people experiencing mental health problems and for their families, and to reduce costs for the NHS and emergency services". We support this ambition and the Government must set out a robust and properly-funded programme supporting people to stay well in the community.

Length of Stay in a mental health bed in England is higher than most other countries.

Over many years, there has been a concerted effort to move the default setting for mental health care from institutions towards community support. This has enjoyed significant success, as reflected in a steady reduction in the number of inpatient beds in England from approximately 70,000 in 1987 to just 19,000 in 2018 (NHSB data), but the number of independent sector beds is unknown. While it is important to resist the popular assumption that a reduction in bed numbers is, in itself, a cause for concern, the NHS Benchmarking Network's most recent international comparator report found that

England and Wales had the lowest number of beds per capita out of 12 high-income countries. While this was attributed to "a continued move away from institutionalised mental health care with enhanced levels of care available in the community", we believe that within our own mental health services investment in community provision has not often kept pace with the disinvestment in bed provision. In fact, recent benchmarking data suggests disinvestment in community services for those with more complex and severe illnesses, is only in part matched by the expansion of IAPT for primary care common mental health conditions.

One unintended consequence of reducing bed numbers without correspondingly increasing community provision (be it health or care) is that Length of Stay (LoS) increases alongside acuity within inpatient settings, reducing the therapeutic milieu available. Now, too many mental health beds in the NHS are occupied by people who remain in inpatient care for long periods of time. The NHS Benchmarking Network found that the average length of stay (LoS) in a mental health bed in England (36 days) was substantially higher than the international average (27 days).

There is enormous variation domestically as well as internationally. Data obtained by the former Care Minister Norman Lamb from 38 of England's 53 mental health trusts, through a series of Freedom of Information requests, reveals a dramatic variation in both average and longest LoS. Average LoS for patients discharged from adult acute beds in 2017-18 ranged from 17 days to 84 days. The longest LoS varied from 311 to 2,647. Three trusts in total reported patients with a LoS of more than 2,000 days.

The picture is equally stark in children's mental health services. The NHS Benchmarking Network found that England sees children in hospital for an average of 72 days compared to just 10 days in Australia. As well as being the second longest LoS (behind Wales which reported a LoS of 98 days), this is 75% higher than the international average of 41 days. Meanwhile, the FOI data obtained by Norman Lamb showed a three-fold variation in average LoS in CAMHS in 2017-18: ranging from 112 days to just 34 days. The longest inpatient stays varied from 161 days to 982.

It should also be noted that despite good progress in shifting resources in *adult* mental health care from inpatient settings to community services, a substantial and increasing proportion of total investment in CAMHS continues to be tied up in hospital beds. This is reflected in the growing number of CAMHS Tier 4 beds – for highly specialised services – which has increased from 844 in 1999 to 1,449 in 2017. Future development in this area requires a continued increase in the availability of appropriate in-patient beds close to home alongside the development of local community resources to support the therapeutic work required.

The reasons behind the wide variation in LoS are difficult to interpret. Some variation is undoubtedly driven by practice, some by access to local out of hospital supports including community mental health services and access to stable affordable permanent housing, and some by lack of clarity around the technical definitions in use around Length of Stay. As the NHS Benchmarking Network points out, a number of factors can influence Length of Stay including severity of illness, bed availability, rates of involuntary detention, and provision of community care to facilitate a prompt discharge. Furthermore, we sometimes see a risk-averse culture where admitting patients with more complex needs into secure settings is seen as a 'safer' option than working with them in the community, in the absence of continuing care community placements and teams able to deliver effective interventions aimed at promoting recovery.

Delayed discharge due to a lack of enhanced community mental health provision, social care and local authority-commissioned housing are undoubtedly a major factor. Although we should celebrate the community care that currently exists, the reality is that these services too often continue to suffer from under-investment.

Nevertheless, in spite of the variability illustrated, and indeed perhaps because of it, the data offers strong support for the notion that the balance within our own system is not consistently right. We are not consistently delivering the right care and support at the right time in the right place.

There is unquestionably a role for inpatient admission. Safe inpatient stays can be a therapeutic and important part of the overall system. There needs, however, to be a greater focus on the quality of inpatient care so that any admissions are genuinely therapeutic, help to build the individual's strengths and independence, and focused on the goal of discharge and community rehabilitation rather than simply offering physical containment. Modern improvement tools also need to be provided to the mental health sector such as demand capacity modelling tools, factoring in future demand for more rapid transfer from prison and custody, homelessness, substance misuse, complex ASD and mental illnesses.

The human rights of mental health inpatients are not protected

Despite the good care in most NHS mental health facilities, too many people with mental ill health are not treated with dignity and suffer breaches of their human rights.

People with mental health problems are still being sent a long way from home for treatment. While NHS England has committed to eliminating inappropriate `out of area placements` by 2020-21, progress has been slow. The latest figures from NHS Digital show that there were 765 patients in out of area beds at the end of August 2018, compared to 885 twelve months previously.

Recent changes to the Mental Health Act in 2017 has meant that a significant percentage of Mental Health Trusts are struggling to meet the legal requirement for patients detained on a Section 136 either in a Health based place of safety, or among the growing numbers brought to Emergency Departments, to be assessed. Of those referred to the treatment setting considered appropriate, up to 25% may require inpatient admission.

Similarly, a significant percentage of community assessments under the Mental Health Act are having to be cancelled or postponed as there are not enough Approved Mental Health Practitioners, Section 12 approved medics or available police presence to conduct them. Subsequently, there are not enough Inpatient beds available to admit the patient when that outcome is needed. Thus, there are major challenges to meet the legal standards required and this increases risk to patients and families. A recent judgement by a Coroner ruled that it was deemed negligent when a death occurred whilst a patient was assessed under the act as needing admission, but for whom no bed was found.

The evidence shows that being sent many miles away from family and friends during a mental health crisis can exacerbate what is already a traumatic and stressful situation. It is also associated with an increased risk of suicide following discharge. However, we are arguing here that more beds is not the right solution. Investing more in community services would allow the NHS and their Local Authority commissioning partners to provide early and more therapeutic support for people experiencing mental ill health, reduce the need for institutional care, and free up local beds for the most severe cases that truly necessitate a hospital admission.

When inpatient cultures lose their therapeutic quality, through high levels of acuity, excess demand, staff burnout and demoralisation, the risk is that a negative spiral will be established with increasing use of medication and restraint. Figures from 40 mental health trusts, obtained by Norman Lamb, revealed that patients were restrained 59,808 times in 2016-17. This figure has risen every year since 2013 and amounts to a patient being restrained every 10 minutes on average. Face-down (prone)

restraint remains unacceptably common, despite guidance issued by the Department of Health in 2014 which aimed to eliminate this dangerous practice.

Even for people with psychoses who account for the majority of those detained in hospital, The National Audit of Psychosis, 2018 has found disappointing progress, Physical health care has improved, but less psychological therapies, medicines optimisation, recovery care has been provided in either inpatient or community services. In inpatient units with over 100% bed occupancy, the provision of such holistic care becomes problematic.

Most worryingly, there are many people who are stuck in institutions when they have no clinical reason to be there. A major report from the CQC showed that there were 3,500 patients in 'locked rehabilitation wards' last year, many of which were located a long way from the individuals' home. The CQC highlighted concerns that "some of these locked rehabilitation hospitals were in fact long stay wards that risk institutionalising patients, rather than acting as a step on the road back to a more independent life in the person's home community." Their analysis suggests that many of those locked in rehabilitation wards were capable of living with support in the community with supported accommodation and care packages for the person and their family provided by the local authority. This practice of containment is an unacceptable way in which to treat vulnerable people amounting to a serious human rights abuse, and costs the NHS an estimated £700m each year.

Gaps in provision of mental health care in the community

While advances have been made in providing community and primary care-based IAPT common mental health services, gaps exist for those with complex non-psychotic conditions who may be judged ineligible for IAPT services and specialist provision. NHS policies advocating evidence-based practice, person-centred approaches, care closer to home, seamless continuity of care and the use of individuals' strengths along with shared decision-making are to be applauded. Furthermore, focused implementation programmes for early intervention, IAPT for common conditions such as depression and anxiety, perinatal mental health and liaison services in acute care settings, are recognised worldwide as great achievements. However, the low rates of access to specialist mental health care for individuals with a range of complex mental health problems that fall in the GAP between those with less complex anxiety and depression and those with psychosis should be seen as a serious problem.

Such individuals often have symptoms which cross multiple mental health conditions such as OCD, PTSD, personality disorder, substance misuse, Autistic spectrum, adult ADHD and eating disorders and are also often at risk of self-harm. These problems are particularly prevalent in low income areas and within marginalised groups such as those in contact with the criminal justice system and those who are homeless and have been subjected to abuse and trauma.

Non-health and care services have a vital role to play in promoting mental wellbeing

The conversation about how to reduce the prevalence and impact of mental ill health cannot be confined to the NHS. A successful approach to tackling mental illness will involve a wide range of public services and must therefore be an ambition shared across the whole of government. This will include, but should not be limited to:

- Reform of the criminal justice system with an emphasis on rehabilitation and addressing underlying vulnerabilities including mental health problems, substance misuse and childhood adversity. Prisoners who require hospital treatment should also be transferred to hospital

within the recommended 14 day timeframe. Policing levels to promote community safety will also be necessary

- Access to high-quality supported housing and more independent tenancies with personalised care support are needed to create a safe and positive home environment for people with mental ill health.
- Employment services such as Individual Placement & Support, which is internationally recognised as the most effective method of supporting people with severe mental illness into employment.
- Decommissioned drug and alcohol services need to be reinstated to support people with dual diagnosis.
- There needs to be a national plan to commission childhood and adult neurodevelopmental conditions such as ASD and ADHD. Likewise the commissioning of eating disorders need now to meet the growing need, especially in young women.
- Expanding access to parenting interventions and other forms of family support can help to prevent child abuse and neglect. Universal provision and promotion of these services can help to reduce the stigma which prevents some parents from getting support. The Science and Technology Select Committee recently published a report calling for a national strategy for early years' intervention to address childhood adversity. The major disinvestment in family centres in Local authorities needs to be urgently reversed
- Better support for schools, colleges and universities to prioritise the emotional wellbeing of pupils.

A vision for the future

We are calling for a cultural change in the mental health system and a rethink of our priorities for investment. At the heart of this is a renewed focus on safer communities, out-of-hospital care, enabling people to stay well, building on their resilience and supporting them effectively when unwell in the community. We believe that such an approach will deliver the maximal value, in terms of outcomes that matter to people for each pound we are able to spend, emphasising prevention, early intervention and enhanced community support so that people are able to lead good independent lives.

Changing the philosophy/culture of some mental health service providers and wider society will be a challenge. For providers that see inpatient care as a means of minimising risk, it may require a degree of bravery and risk-taking to move towards a positive approach to care which allows individuals to grow and gain confidence in the community. Some private providers also make substantial profits from the provision of long-term institutional care so may be reluctant to change focus. There has been a welcome reduction in stigma in the last 5 years with the 5 Year Forward View but safety, tolerance and community assets are needed in our communities to support more community care.

An effective mental health system which prioritises wellbeing and independence will embody the following core components:

- A departure from the current tendency to see mental health difficulties solely as discrete illnesses, by recognising instead the **complex mix of social, psychological and biological factors** which contribute to each one of our emotional and psychological make ups.
- Individuals of all ages, particularly young people, will be encouraged to recognise distress alongside their psychological strengths. They will be supported to see it as an understandable response to stressors and learn how to **manage their distress by using everyday strategies to promote resilience**.
- Placing the **individual at the centre of the system, working with them early on** and throughout their lives rather than waiting until they deteriorate.
- Enhanced community services **addressing the needs of the individual through a variety of means** which may include personal action, community support, or emotional and psychological work and for the most vulnerable, outreach to their communities is essential to help them access care. Intensive therapeutic community support teams, above and beyond our current models of Home Treatment, should be developed as an alternative to hospital admissions. There should also be an important place for self-help techniques, relapse prevention planning, medicines managment, education, engagement in social activities and social networks, as well as promoting physical health.
- **Prevention strategies and targeted interventions for high-risk groups**, including evidence-based parenting programmes, early-years support for children who have experienced adversity (such as trauma, abuse and neglect) and community programmes to reduce violence.
- All staff involved in the delivery of **primary care** properly trained and supported, including practice nurses, health care assistants, social prescribers, receptionists and volunteers – all of whom are a key interface with people with poor mental health. The development of multi-disciplinary teams in primary care is welcome as are some of the New Models of Care.
- Delivery of mental health support for those with both common mental health problems and more complex problems carried out by **mental health specialists in conjunction with primary care workers and care navigators**, supporting individuals to understand themselves so that they know which community opportunities to access.
- If and when **higher levels of support are required**, these should ideally be delivered out of hospital. In an ideal system, support would simply be stepped up or stepped down in relation to need on an ongoing basis – rather than waiting for people to reach crisis point before they are offered support.
- **Only when community resources are not adequate to address the needs of the individual** close to home should the person be escalated through the system for more specialist interventions. Likewise, if more specialist interventions are required, such as a stay in hospital, this should not exclude individuals from returning to use community resources as appropriate wherever possible. NHS England and the Department of Health and Social Care must show leadership in setting and enforcing strict minimum standards for what 'good' therapeutic hospital care must look like and to ensure that inpatient stays are as optimised for the individual in terms of length of stay. The CQC must ensure it regulates accordingly and strengthen its review of 'effective' domains.

- **Seamless transitions across all parts of the system**, promoting efficient and effective care and a better experience for both service users and staff.
- **User and Carer leadership will be integral to any shift towards more user-centred services**. People with lived experience must be equal partners at all levels of decision-making – including at senior level – to develop a truly collaborative approach to practice improvement. While traditional user engagement has relied on 'feedback' (and decisions made by professionals) and 'representation' (narrowly-defined roles at arms-length from power), a fundamental shift in partnerships is needed which involves true co-production (in design and planning) and co-delivery (e.g. peer support).
- Access to **meaningful work as well as reasonable accommodation and living standards**. Although the Five Year Forward View for Mental Health plans to double access to Individual Placement & Support, this is from a very low base. Specialist employment support should be available to all those who could benefit.
- Integrating mental health support into the **criminal justice and education systems**, rather than being treated as an 'extra'.
- Adequate **funding for social care and public health**.

Beyond this, the Government must offer a firm guarantee that every penny saved through cultural change within mental health services will be reinvested in further mental health care such as prevention and community services.