NEXT STEPS FOR FUNDING MENTAL HEALTHCARE IN ENGLAND

Prevention

ROYAL COLLEGE OF PSYCHIATRISTS
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About the Royal College of Psychiatrists

The Royal College of Psychiatrists (RCPsych) is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and for setting and raising standards of psychiatry in the UK. The College aims to improve the outcomes of people with mental illness and the mental health of individuals, their families and communities.

To achieve this, the College: sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; and works with and advocates for patients, carers and their organisations. Nationally and internationally, the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies.

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Executive summary

It has previously been argued that the NHS has not reduced the total demand it originally proposed in the Five Year Forward View because of a lack of concerted effort in public health and prevention, poor resilience in social care and the lack of a parallel five-year budget for workforce growth, education and training.

Public mental health is about community cohesion and drawing on community resources in the widest sense. The COVID-19 pandemic has demonstrated the importance of this and the need to promote healthy lifestyles and prevent poor mental and physical health at the earliest opportunity.

We must increase the funding available to local government and the NHS to enable:

- local authorities to prepare and respond to increasing levels of mental distress and co-morbid physical health problems in the population due to COVID-19 and as a result of lockdown, which has caused anxiety and loneliness, amongst other issues
- mental health providers to prepare for an increase in demand for NHS mental health services (both planned and unplanned) as services deliver the ambitions of the LTP while also addressing a backlog of patients
- local authorities and the NHS to prepare for an increase in demand for drug and alcohol use disorder services given the way in which the pandemic has exacerbated these illnesses, and the reduced availability of some services during the peak, and
- local authorities and the NHS to prepare for an increase in demand for mental health social care support, given the need to discharge patients safely into the community with a package of care in place and for the impact the pandemic is having on children and young people and their families.

This needs to be underpinned by world-leading mental health research to identify preventative interventions, as well as cutting-edge treatments and therapies.

Recommendations

Public health funding

1. At the 2020 CSR, the Government and DHSC to commit to increase the Public Health Grant budget[1] at least in line with the funding uplift for NHS England of an average increase of 3.3% per year in real terms by 2023/24, as part of a multi-year settlement, which will ensure local authorities can continue to provide prevention and public health interventions.
   Specifically, within this budget, local authorities to ring-fence at least 4% for public mental health spending, equating to a rise of 100%, or £70m, compared to 2018/19 figures, as the start of sustained and growing investment in this area.

   This funding should be linked to the Joint Strategic Needs Assessments (JSNAs) for each locality and relevant local strategies. It should also align with the growth in the workforce of public mental health professionals and those working within voluntary, community and social enterprise organisations.

Funding for mental health NHS services

2. DHSC, NHSE/I and Health Education England (HEE), working with colleagues across the mental health sector, to undertake a review to assess whether investment into mental health services detailed in the LTP should be delivered over an accelerated timescale to support them to meet emergent demand. This needs to align with the growth in the mental health workforce.
3. Additionally, the Department for Education (DfE) and NHSE/I to urgently consider whether funding for mental health provision in schools should be delivered over an accelerated timescale, particularly as children and young people are due to return to their education in September 2020.

Funding for drug and alcohol use disorder services

4. At the 2020 CSR, the Government should commit to a real terms increase in the Public Health Grant[2] budget as part of a multi-year settlement, which will ensure local authorities can continue to:
    a. work towards restoring total expenditure for adult substance use disorder services as a proportion of public health expenditure, aiming to get back to at least its 2013/14 levels of 29.9%, equating to a rise of £374m in current prices (based on 2018/19 figures), and
    b. work towards restoring total expenditure for specialist drug and alcohol use disorder services for children and young people back to at least its 2013/14 level (2.4% of public health expenditure), equating to a rise of £43m in current prices (based on 2018/19 figures). This needs to be in line with the growth in addiction psychiatrists and the wider multidisciplinary team.
5. DHSC to allocate £30m of capital funding for drug and alcohol use disorder services by 2024/25.
6. DHSC and the Ministry of Housing, Communities and Local Government (MHCLG) to review the commissioning of addiction services, including potential service models, with consideration of reinstating the NHS as lead commissioners or mandating addiction services within local authority budgets.

Funding for mental health social care support

7. At the 2020 CSR, the Government, MHCLG and DHSC should commit to increase the social care budget for children, young people and adults to at least in line with the funding uplift for NHS England of an average increase of 3.3% per year in real terms by 2023/24.

    Specifically, within this uplift, local authorities should commit to ring-fence funding devoted to early years, aiming to get it back to at least around 8% of the children's social care expenditure, equating to a rise of around £376m in current prices.

Funding for mental health research

8. DHSC to increase the funding for mental health research to 15% of the total UK research budget by 2030, drawing on the Roadmap for Mental Health Research in Europe (ROAMER) priorities and research associated with COVID-19.
9. DHSC to allocate £160m of capital funding to mental health trusts for Research & Development in Mental Health and Dementia including: the prevention agenda, research to improve the productivity and effectiveness of the NHS, and the translation of basic science and support for the life sciences industry by 2024/25. [3]

Strategic planning and leadership[4]

10. Government to establish a Mental Health Cabinet Committee to ensure collective responsibility for improving the mental health of the nation as part of the recovery from COVID-19.
11. Government to lead the development of a long-term, cross-government mental health strategy that runs alongside the NHS LTP. This should be closely aligned to the NHS mental health COVID-19 recovery plan developed by DHSC and reflect the increased mental health need as a direct consequence of COVID-19.
12. Government to extend the mental health representation within the Scientific Advisory Group for Emergencies (SAGE) and/or related sub-groups.
13. Government should ensure all government policies, whether new or existing, are assessed for their impact on mental health and health inequalities.
14. Government to appoint an Equalities Champion for Mental Health, Learning Disabilities and Autism to work across Government, reporting to the Cabinet Office Minister and with dedicated staff and resourcing.

Introduction

Ahead of the publication of the NHS Long Term Plan (LTP) in 2019, we called on the Department of Health and Social Care (DHSC), NHS England & Improvement (NHSE/I), and other arm's-length bodies (ALBs) of the NHS to:

- commit to the biggest expansion in access to mental health services across Europe, empowering the disempowered with a much-needed focus on tackling inequalities, fit for a modern NHS
- enable the NHS to become the safest, most effective, and transparent health system in the world with mental health NHS trusts leading the way
- empower mental health leaders to develop the healthcare services of the future through Integrated Care Systems and Providers (ICS/ICPs)
- build a strong and resilient mental health workforce, and
- invest in mental health services so that spending on mental health by CCGs and NHS England rises from 10.8% in 2017/18 to around 13.1% in 2028/29 of the total estimated NHS England budget.[5]

The LTP, underpinned by a revenue funding settlement of an extra £20.5bn for NHS England by 2023/24 (after inflation), included a commitment that mental health services will grow faster than the overall NHS budget – with a ring-fenced increase in investment worth at least £2.3bn a year by 2023/24. Furthermore, there is an ambition that children and young people's mental health services will grow faster than both overall NHS funding and total mental health spending.[6,7]

An ambitious programme of work is now underway to improve and transform mental health services in England – including a pledge to introduce waiting times standards for children and young people's mental health services, emergency mental health services, and adult and older adult community mental health teams – building on the progress made by the Five Year Forward View for Mental Health.[8,9]

When novel coronavirus (COVID-19) was confirmed to have reached the UK on 29 January 2020, shortly before the World Health Organization declared the situation to be a public health emergency of international concern, NHS services began to prepare for widespread transmission and declared the situation to be a 'Level 4' National Incident.[10,11] One month later, on 28 February, transmission of COVID-19 within the UK was documented and by 1 March 2020, there were cases in England, Wales, Scotland and Northern Ireland.[12]

The pandemic has impacted healthcare provision across the whole of the NHS. For mental health services, some of the expansion programmes have been expedited, such as: establishing 24/7, all-age, open access mental health crisis lines to support people with urgent mental health needs; the creation of mental health A&Es; increased use of digital and remote support technology; and the expansion of children and young people's eating disorder services.[13] At the same time, some mental health services have been required to close or reduce their services (for staff absence or redeployment reasons), and some patients have avoided seeking help for their mental health during the pandemic, particularly via A&E, primary care and in child and adolescent mental health services. Across the health sector, including psychiatry, COVID-19 has also placed major logistical challenges to research and education at a time of pressing need for both.

As the NHS now turns its attention to the restoration and recovery of healthcare services, we have argued, along with other healthcare leaders, for a rapid and forward-looking assessment of how prepared the country would be for a new widespread outbreak of COVID-19. While we acknowledge the future shape of the pandemic is hard to predict, local outbreaks are increasingly likely, and a second wave is a real risk.[14] Ensuring mental health services are prepared to manage patients with COVID-19 (both symptomatic and asymptomatic) while they are receiving treatment for their mental health, as well as prevent nosocomial transmission of the virus, is essential. This is particularly crucial as we approach winter given the pressure that brings to the NHS and social care services.

The third phase of the NHS' response to COVID-19 was outlined on 1 August 2020. As well as downgrading the Incident Alert level from 4 to 3, it included plans to:

- accelerate the return to near-normal levels of non-COVID health services, making full use of the capacity available between now and winter
- prepare for winter demand pressures, alongside continuing vigilance in the light of further probable COVID-19 spikes locally and possibly nationally, and
- doing the above in a way that takes account of lessons learned during the first COVID-19 peak; lock in beneficial changes; and explicitly tackles fundamental challenges including: support for NHS staff, and action on inequalities and prevention.[15]

As well as capital for long-term NHS investments, mental health services need to be underpinned by investment in evidence-based best practice, through research and investment in workforce education and training, as well as local government funding for public mental health, drug and alcohol use disorder services, and mental health social care support. Funding for these services and programmes has been long overdue but is now made even more pressing by the ongoing COVID-19 pandemic.

The Spending Round in 2019 was limited in its one-year settlement for DHSC's departmental budget, committing to a rise of 3.1 per cent in real terms. However, on 21 July 2020, the Chancellor launched the 2020 CSR, which will be published in the autumn and will set out the government's spending plans for the parliament. From this announcement it is now clear that the CSR will set UK Government departments' resource budgets for the years 2021/22 to 2023/24 and capital budgets for the years 2021/22 until 2024/25.[16] This will be critical for NHS trusts, including mental health trusts, to effectively plan for the medium to longer term, as well as deliver national strategies and plans.

Purpose of this briefing

The College has identified four areas that must be fully and sustainably resourced if there is to be the progress in the access to and quality of mental health services that have been promised by government. These include:

- infrastructure
- prevention
- people, and
- technology.

This paper focuses on prevention and is the second in a series covering these four areas. It considers the next steps for funding mental healthcare in England, with a specific focus on the DHSC's total departmental expenditure limits (TDEL) covering both resource (RDEL) and capital spending (CDEL).

We hope this briefing provides a useful steer to Government, DHSC, NHSE/I, other relevant departments and ALBs, and to NHS providers and commissioners ahead of the CSR in autumn 2020. We also hope it is useful for strategic and operational planning for the NHS and local authorities for 2020/21 and beyond, aligned to the mental health related commitments in the NHS Long Term Plan and the recommendations of the Independent Review of the Mental Health Act.[17]

This briefing does not attempt to cover the funding commitments of other government departments (with exception of the relevant mental health services provided by the MHCLG), although we acknowledge that issues surrounding housing, benefits, employment, education and the justice system, for example, are inherently linked to people's mental and physical health. We recognise this is an iterative process and, as such, we might further refine our recommendations over the coming months as the COVID-19 pandemic progresses. As part of Government's commitment to achieve parity of esteem, we urge leaders to implement the recommendations set out in this briefing.

Prevention – protecting our mental healthcare system, ensuring it can cope with increasing demand

It has previously been argued that the NHS has not reduced the total demand it originally proposed in the Five Year Forward View because of a lack of concerted effort in public health and prevention, poor resilience in social care and the lack of a parallel five-year budget for workforce growth, education and training.

In mental health specifically, aside from the impact the ongoing COVID-19 pandemic will have, demand for mental health services will increase naturally as the population grows and services address more unmet need, as per the Five Year Forward View for Mental Health and NHS LTP commitments.

The birth and death rates combined with estimates of migration suggest that between 2018 and 2029 there will be around 4.1 million (+7.4%) more people living in England.[18] Mental illness remains one of the largest single causes of disability in England.[19]

More children and young people in the population suggest capacity will need to be increased for CAMHS, parenting programmes, self-harm, substance use disorder and criminal justice liaison services. Early diagnosis and support will also be needed for children and young people with neurodevelopmental disorders. More people aged 30−45 suggest a greater demand in the future for Improving Access to Psychological Therapies (IAPT), maternal wellbeing, workplace wellbeing and early intervention services.[20]

More older adults, including the very old, means that there will be an increased need for capacity in dementia, old age psychiatry and social care support services. The likely long-term growth in dementia incidence and prevalence across England is also substantial.[21]

The College has previously said that a reduction in the population in their 20s and 50s indicates that resource could be shifted from some adult mental health services to other areas, or invested in prevention and early intervention services, to offset some of the increased demand. As well as cognitive impairment and dementia, another notable growth is expected in common mental health problems/mild non-psychotic disorders and for patients with severe psychotic depression.[22] Our previous briefing considers this in more detail.[23]

While it is clear the delivery of mental health priorities and spending commitments has continued to progress throughout the pandemic, there is consensus that there will be increases in demand for mental health services in the coming months.[24] As such, the need to adequately resource and bolster the mental healthcare system (from promotion, prevention and treatment) to cope with predicted demand is clear. The approach taken should ensure that programmes and services meet demand across the system, quickly and effectively supporting those with mild to moderate mental illness and preventing people from reaching crisis.

Action 1: Local authorities to prepare and respond to increasing levels of mental distress and co-morbid physical health problems in the population due to COVID-19

Public mental health is about community cohesion and drawing on community resources in the widest sense. The COVID-19 pandemic has demonstrated the importance of this and the need to promote healthy lifestyles and prevent poor mental and physical health at the earliest opportunity.

Worsening mental health

The Office for National Statistics (ONS) indicate that the number of people reporting high levels of anxiety has sharply elevated during the COVID-19 pandemic, with loneliness, marital status, sex, disability, whether someone feels safe at home, and work being the factors most strongly associated with high anxiety.[25]

The Centre for Mental Health's analysis of the likely impacts of the COVID-19 pandemic on mental health finds that, if the recession that follows the economic effects of the virus is similar to 2008, about 500,000 more people will experience a mental health difficulty over the next year, according to an estimate by the Institute of Fiscal Studies. But if there is a second wave of COVID-19 and the economy is damaged further, the effects on mental health is expected to be greater still, and last much longer.[26] They recommend that the NHS should prepare for both a V-shaped and a W-shaped recession during the next five years, with resources (financial and human) to respond either to a single, deep recession this year or to a series of economic shocks each of which will create additional need for mental health support. [27]

The Centre for Mental Health also identify those groups at greater risk of poor mental health, including those people who have been bereaved at this time, those who have received intensive hospital treatment for the virus, and staff working in health and care services. [28]

Underpinning all of this is the need for high quality research evidence. This includes information related to COVID-19 for vulnerable groups.[29] Research has shown that the impact of the pandemic and lockdown on the mental health of children and young people to be substantial, particularly for those who are already disadvantaged or have specific needs. There are multiple factors which may be affecting children and young people in different ways including lack of a school environment, family stress, domestic violence, reduced social and healthcare services, and a lack of social and leisure activities.[30,31]

The Centre for Mental Health also note that some groups of people face an especially high risk to their mental health including people facing violence and abuse, people with long-term health conditions, and people from BAME communities. [32]

Worsening physical health

Poor mental health is associated with other priority public health challenges such as obesity[33], lack of regular exercise[34], alcohol use disorders[35] and smoking.[36]

People living with a mental illness are more likely to die prematurely than the general population. Based on data from 2012/13 to 2014/15, the gap in life expectancy in England is 19 years and 16 years respectively for male and female mental health service users when compared with the rest of the population. Prior to this, the gap had only reduced marginally over the preceding 7−8 years.[37] Users of specialist mental health services are more likely to die from any physical health causes than the population who do not require specialist mental health support and management. Many of these 'excessive' deaths could be prevented or delayed by the more widespread use of evidence-based interventions (e.g. health checks and extended lifestyle support, medicine reviews and community falls prevention).

People who are more vulnerable to developing a severe illness and dying with COVID-19 include older people, people living in more deprived areas, those from BAME communities, and people with some physical health conditions.[38] Excess deaths due to COVID-19 have been linked with inequalities, being from a BAME background, obesity and smoking and there is likely to have been preventable deaths from physical health conditions that are overrepresented within people with severe mental illnesses. We should expect therefore, that these groups may also experience some impact on their mental health as a result of the pandemic.

These disparities have reflected broader health inequalities and have highlighted the need to ensure that healthcare, including mental healthcare, meets the needs of all. A particular focus is needed to ensure that support is targeted toward certain groups who are currently disadvantaged within the system.

Funding for public mental health

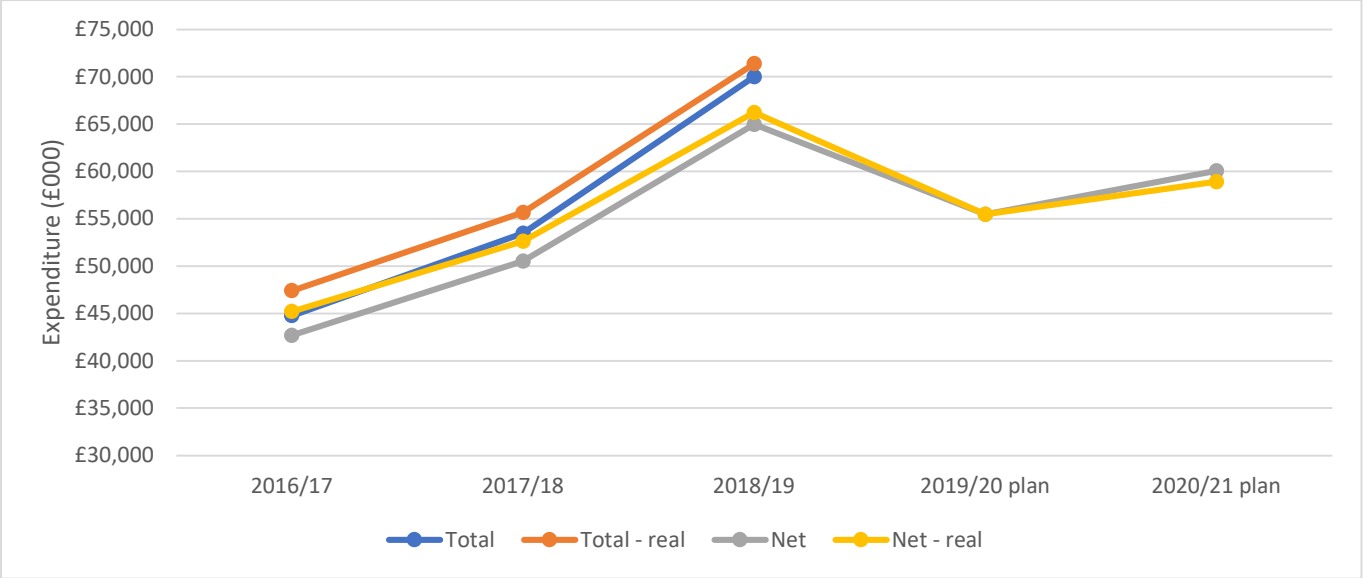
The Spending Round in 2019 confirmed a real-terms increase to the Public Health Grant budget for 2020/21.[39] For public mental health funding specifically, local authorities have only been required to report

public mental health expenditure since the 2016/17 financial year. A Freedom of Information request by Mind determined that the proportion of public health budgets spent on mental health declined year-on-year between 2013/14 and 2015/16, from 1.4% to 0.7%.[40]

The situation has improved since reporting commenced when looking at the outturn total expenditure, with the amount increasing by 50.5% after adjusting for inflation between 2016/17 (£47.423m) and 2018/19 (£71.386m). There are however concerns about subsequent planned net current expenditure figures, which at £58.914m in 2020/21 is 30.3% above that of 2016/17 (£45.214m) but also would be a 11.1% reduction on 2018/19 (£66.235m) if realised in the final figures.

As a percentage of the public health expenditure overall, the percentage of total expenditure has peaked at 2.0% in 2018/19 but in terms of net current expenditure the planned level for 2020/21 would be only 1.8% compared to 2.0% in 2018/19.[41]

Chart 1. Public mental health investment by local authorities in England, total and net current expenditure in cash and real terms (2019/20 prices), 2016/17 to 2020/21



While this briefing does not attempt to cover the funding commitments of other government departments (with exception of the relevant mental health services provided by the MHCLG), we acknowledge that issues surrounding housing, benefits, employment and education, for instance, are inherently linked to people's mental health. Therefore, there needs to be a continued investment in mental health support in schools which can prevent more children and adolescents becoming unwell, good quality housing that can reduce the risks of mental health problems, a roll out of programmes that boost employment, and support for programmes that address systemic inequalities which could reduce the risk of mental illness (to name a few).

Recommendations

Funding

1. At the 2020 CSR, the Government and DHSC to commit to increase the Public Health Grant budget[42] at least in line with the funding uplift for NHS England of an average increase of 3.3% per year in real terms by 2023/24, as part of a multi-year settlement, which will ensure local authorities can continue to provide prevention and public health interventions. Specifically, this should enable local authorities to ring-fence at least 4% for public mental health spending, equating to a rise of 100% or £70m compared to 2018/19 figures as the start of sustained and growing investment in this area.

This funding should be linked to the JSNA for each locality and relevant local strategies. It should also align with the growth in the workforce of public mental health professionals and those within voluntary, community and social enterprise organisations.

The London School of Economics has previously modelled the cost of various public mental health programmes and interventions to prevent mental ill health across the population, which will be useful in understanding where best to invest public mental health funding.[43]

Strategic planning and leadership

As recommended in collaboration with the Mental Health Policy Group[44]:

2. Government to establish a Mental Health Cabinet Committee to ensure collective responsibility for improving the mental health of the nation as part of the recovery from COVID-19.
3. Government to lead the development of a long-term, cross-government mental health strategy that runs alongside the NHS LTP. This should be closely aligned to the NHS mental health COVID-19 recovery plan developed by DHSC and reflect the increased mental health need as a direct consequence of COVID-19.
4. Government to extend the mental health representation within the Scientific Advisory Group for Emergencies (SAGE) and/or related sub-groups.
5. Government should ensure all government policies, whether new or existing, are assessed for their impact on mental health and health inequalities.
6. Government to appoint an Equalities Champion for Mental Health, Learning Disabilities and Autism to work across Government, reporting to the Cabinet Office Minister and with dedicated staff and resourcing.

Prevention and public health measures

As recommended in collaboration with the Mental Health Policy Group[45]:

7. Government to invest in evidence-based interventions to support positive parenting: programmes that have been approved by the National Institute of Health and Care Excellence (NICE) should be made available across the country through a concerted national expansion programme. Local authorities should then ensure that these interventions are well-implemented and appropriately targeted towards families with highest risk factors, and that they acknowledge the impact of COVID-19 in the mental health of children and young people. This also needs to include early years multiagency developmental services for those that may need early diagnosis and support.
8. DfE and DHSC to support all schools to take a 'whole school approach' to mental health, drawing on best quality evidence. In response to the pandemic, greater weight should be placed on mental health and wellbeing within schools and helping children deal with the impact of trauma. The suspension of fines for non-attendance of schools should be extended.
9. Government to ensure that reforms to mental health support in schools prioritise children with multiple risks from a young age, including those impacted by COVID-19. This should include investing in effective classroom-based programmes to boost health behaviour and wellbeing and offering evidence-based support to children and families.
10. Public Health England (PHE) to ensure that trauma and adverse childhood experiences are a priority for public health, by producing clear guidance and support for local authorities to coordinate efforts to improve prevention of and responses to traumas.
11. ONS and PHE to examine the excess mortality rates from COVID-19 among patients already known to services with severe mental illnesses. Once the scale of the problem is known, PHE to work with peer-led projects in Equally Well, other mental health charities and key stakeholders to reduce excess mortality from COVID-19.
12. Government to produce a strategy for reducing race inequality in mental health, including work with schools, the police, youth services and mental health services to improve access and outcomes for

people from BAME communities. This should reflect and respond to findings in PHE's review of COVID-19 deaths in BAME communities.

13. NHSE/I, ICSs, CCGs and mental health providers to develop and monitor data relating to access and outcomes for groups of people with protected characteristics, including by gender, age, sexuality and ethnicity and disability. This should reflect and respond to findings in PHE's review of COVID-19 deaths in BAME communities.
14. PHE to support local authorities to ensure that JSNAs identify mental health inequalities in every local area and that action is taken in local systems to address the biggest gaps. This should also take account of the impact of COVID-19 on different communities.
15. Government and NHSE/I to take forward in full the recommendations of the Women's Mental Health Taskforce with a particular focus on trauma-informed care for victims of domestic abuse. The forthcoming Domestic Abuse Bill should reflect the Taskforce's work and reflect the links between mental health and domestic abuse.

Action 2: Mental health providers to prepare for an increase in demand for NHS mental healthcare services

The mental health consequences of COVID-19 are becoming increasingly evident.

Firstly, there have been reports of increasing referrals to liaison services from acute hospitals for delirium, COVID-related mood & anxiety disorders (including Post Traumatic Stress Disorder (PTSD), non-delirium COVID psychosis and for patients having long hospital stays or who have become deconditioned (loss of functional abilities during a hospital stay).

Secondly, there have been reports of lockdown-specific deteriorations in patients' mental health due to a lack of face to face contact, such as those with psychosis, eating disorders and obsessive compulsive disorder (OCD), as well as for people with depression prolonged by economic hardships and/or loneliness and addictions.

Thirdly, there are people who have had longer durations of untreated psychosis as patients have presented later and sicker. There are also anecdotal reports from our members of people presenting for the first time with depression and psychosis, shortly after attempting suicide.

This corresponds with data from our first membership survey (17 April – 6 May 2020) which indicated concerning reports of decreases in emergency (by 20.3% of respondents) and urgent activity (by 18.4% of respondents) in England. Further disaggregation of these data revealed respondents working in the following specialities were reporting a decrease in workload associated with this activity:

- liaison mental health services (33.8% emergency, 41% urgent)
- child and adolescent mental health services (30.3% emergency, 29.7% urgent), and
- older adult mental health services (22.7% emergency, 18% urgent).

By our second membership survey (corresponding period: 4 May – 26 May 2020), this had improved with 9.7% and 9.2% of all respondents reporting a decrease in emergency and urgent activity respectively, suggesting critical services were being restored.

It now appears that workload associated with emergency and urgent cases across England is increasing. In particular, members working across liaison mental health, addictions, perinatal and general adult services are reporting workload above the England average for emergency appointments/ interventions. For urgent interventions/appointments specifically, liaison mental health, perinatal, addictions, older adult, and general adult services are reporting increases in workload above the England average. For older adult psychiatrists

specifically, they are reporting returning to almost full capacity with higher numbers of older adults with severe depression, anxiety and psychosis.

Meanwhile, in terms of routine activity:

- 36.8% of respondents reported a decrease in work usually conducted within 4 weeks during the first survey; this fell to 24.8% by the second survey
- 39.0% of respondents reported a decrease in work usually conducted within 3 months; this fell to 31.4% by the second survey, and
- 40.4% of respondents reported a decrease in work usually conducted after 3 months; this fell to 35.2% by the second survey.

In general, adult and older adult mental health service users utilise acute emergency services disproportionately – 7% of the adult (over 15) population in England utilise mental health services, but 17% of all A&E attendances and 24% of all non-elective inpatient admissions are for patients who are also mental health service users.[46] Therefore, some of this additional demand is expected to be placed on other medical health services during this time.

This increases the importance of adequately funded liaison mental health services for children and young people, adults and older adults. For children and young people in particular, we asked College members about their views on the availability of liaison services for that age group, with 42% saying availability was 'poor' or 'very poor'.[47]

There also needs to be reciprocal arrangements to manage the physical health of patients receiving treatment for a mental illness. Psychiatrists report relying on goodwill discussions with colleagues from acute hospital or duty junior staff and, without this mutual support, it results in multiple transfers between hospitals that could have been avoided.

NHSE/I have committed to maintain their investment guarantee for mental health, learning disability and autism services during the COVID-19 pandemic.[48] Therefore, funding for the expansion of mental health services should continue as planned. However, it is inevitable that patterns of service use will change during the pandemic, with some experiencing increasing demand, as highlighted within Action 1.

Recommendations

1. DHSC, NHSE/I and HEE, working with colleagues across the mental health sector, to undertake a review to assess whether investment into mental health services detailed in the LTP should be delivered over an accelerated timescale to support mental health services to meet emergent demand. This needs to align with growth in the mental health workforce.
2. DfE and NHSE/I to urgently consider whether funding for mental health provision in schools should be delivered over an accelerated timescale, particularly as children and young people are due to return to their education in September 2020.
3. In line with recommendations of the Commission on Acute Adult Psychiatric Care in England, NHSE/I to establish better ways to monitor and respond to demand and capacity within mental health services.

Action 3: Local authorities and the NHS to prepare for an increase in demand for drug and alcohol use disorder services

The latest Adult Psychiatric Morbidity Survey confirmed that 16.6% of adults drank at hazardous levels (AUDIT scores of 8 to 15), 1.9% were harmful or mildly dependent drinkers (AUDIT scores of 16 to 19) and 1.2% were probably dependent drinkers (AUDIT scores of 20 or more). As with previous years, men

were more likely than women to drink at hazardous levels and above. Most adults drank at lower risk levels (57.5%) or did not drink at all (22.8%).[49]

The survey also identified that 3.1% of adults showed signs of dependence on drugs, including 2.3% who showed signs of dependence on cannabis only and 0.8% with signs of dependence on other drugs (with or without cannabis dependence as well). After increases in the 1990s, the overall rate has remained stable since 2000.[50]

COVID-19 is likely to have a worse effect on the health of people who use alcohol or drugs.[51] People living with an alcohol use disorder are more likely to develop serious complications, such as atypical pneumonia and acute respiratory distress syndrome if they contract COVID-19.[52] Similarly, people who inject drugs are more likely to get certain viral infections and cancers, which weaken their immune system. Recreational drug users are likely to consume drugs in social settings and engage in behaviour which increases their risk of exposure to COVID-19. They can also weaken their immune systems by losing sleep, drinking alcohol and smoking tobacco or cannabis while taking recreational drugs. Drugs such as heroin, methadone and benzodiazepines can make patients more vulnerable to the damage done by COVID-19.[53]

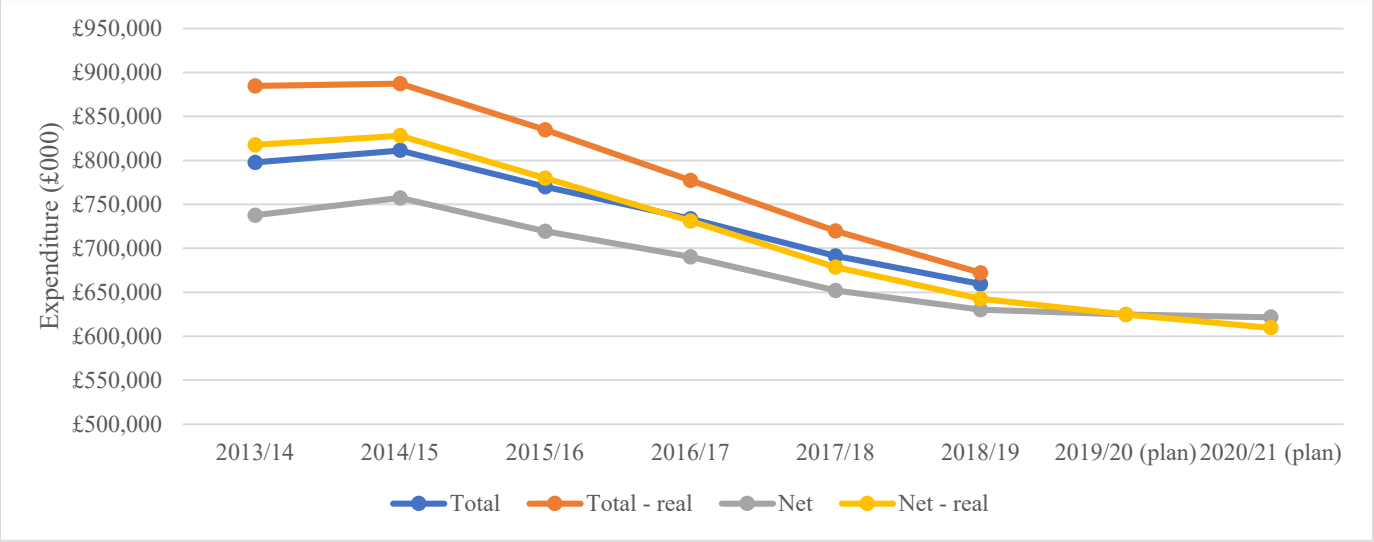
Substance use disorder services – adults

Total expenditure for adult substance use disorder services in 2018/19 (£672.119m) was 24.0% below the level of five years earlier (£884.543m) after adjusting for inflation. Alternatively, if the lens is turned on to net current expenditure the reduction in spending is 25.5% between 2013/14 (£817.892m) and the planned level for 2020/21 (£609.664m).

The spending data for drug and alcohol use disorder services is reported on separately by local authorities but have been combined for this report to reflect that such services tend to be commissioned together. We have also noted the concerns expressed by the Advisory Council on the Misuse of Drugs[54] among others about the consistency and reliability of the reported data, but it does nevertheless still confirm substantial reductions in investment.

These spending cuts have resulted in substance use disorder services for adults receiving a declining proportion of public health expenditure, whether this is based on total expenditure (from 29.9% in 2013/14 to 19.2% in 2018/19) or net current expenditure (from 29.4% in 2013/14 to 18.7% in 2020/21 based on reported planned spend).[55]

Chart 2. Spending by local authorities in England on substance use disorder services for adults, total and net current expenditure in cash and real terms (2019/20 prices), 2013/14 to 2020/21

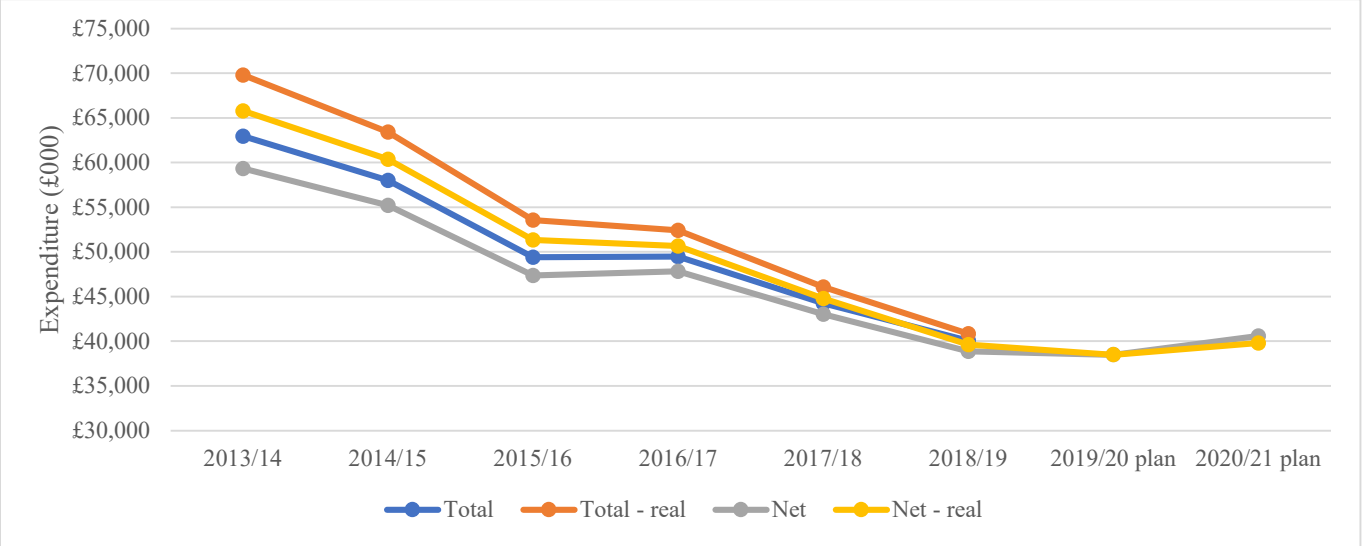


Substance use disorders – specialist services for children and young people

Expenditure is available from 2013/14 onwards following the transfer of public health services to local authorities. Total expenditure in 2018/19 (£40.842m) was down 41.5% compared to the level of five years earlier (£69.792m) after adjusting for inflation. Alternatively, if the comparison is based on net current expenditure the decrease in spending is 39.5% between 2013/14 (£65.786m) and the planned level for 2020/21 (£39.781m).

These spending cuts have resulted in specialist drug and alcohol use disorder services for children and young people receiving a declining proportion of public health expenditure, whether this is based on total expenditure (from 2.4% in 2013/14 to 1.2% in 2018/19) or net current expenditure (from 2.4% in 2013/14 to 1.2% in 2020/21 based on reported planned spend).

Chart 3. Spending by local authorities in England on specialist drug and alcohol use disorder services for children and young people, total and net current expenditure in cash and real terms (2019/20 prices), 2013/14 to 2020/21



It is also worth noting anecdotal reports of increasing numbers of people presenting with behavioural addictions, such as gambling. Specialist face-to-face NHS treatment for gambling addiction was previously only available in London but is now being made available across the country as part of the LTP. As such, funding for NHS gambling services is currently provided by NHSE/I and not by local authorities.

Recommendations

1. At the 2020 CSR, the Government should commit to a real terms increase in the Public Health Grant[56] budget as part of a multi-year settlement, which will ensure local authorities can continue to
    a. work towards restoring total expenditure for adult substance use disorder services as a proportion of public health expenditure, aiming to get back to at least its 2013/14 levels of 29.9%, equating to a rise of £374m in current prices (based on 2018/19 figures), and
    b. work towards restoring total expenditure for specialist drug and alcohol use disorder services for children and young people back to at least its 2013/14 level (2.4% of public health expenditure), equating to a rise of £43m in current prices (based on 2018/19 figures). This needs to be in line with the growth in addiction psychiatrists and the wider multidisciplinary team.
2. DHSC to allocate £30m of capital funding for drug and alcohol use disorder services by 2024/25.
3. DHSC and MHCLG to review the commissioning of addiction services, including potential service models, with consideration of reinstating the NHS as lead commissioners or mandating addiction services within local authority budgets.

Action 4: Local authorities and the NHS to prepare for an increase in demand for mental health social care support

Like many health services, mental health is intrinsically linked to social care. It is an essential element of support, helping recovery and independence and preventing costly crises. Cuts to local authority budgets are limiting the scope of mental health social care, just as they are affecting public health provision. In turn, this is putting extra pressure on individuals, families and the NHS.

The Centre for Mental Health have set out the three main statutory frameworks relevant to mental health for adults.[57] These include:

Mental Health Act:
- Provide section 117 aftercare
- Employ Approved Mental Health Professionals (AMHPs)
- Identify and appoint Nearest Relative
- Provide statutory Independent Mental Health Advocacy (IMHA)

Mental Capacity Act:
- Deprivation of Liberty Standards
- Employ Best Interest Assessors
- Provide statutory advocacy

Care Act:
- Provide social work services and social work counselling
- Assess need and eligibility for community care
- Assess needs of carers
- Arrange personal budgets
- Advocacy

Funding for section 117 aftercare, in particular, is necessary to reduce delayed discharges. Aftercare services are intended to meet a need that arises from or relates to a person's mental health problem and reduces the risk of their mental condition getting worse. It can include healthcare, social care and employment services, supported accommodation and services to meet social, cultural and spiritual needs.[58] This is a major issue that impacts patients, bed availability and budgets.

In the Spending Round in 2019, Government announced an additional £1billion for adult and children's social care. In the past three years, the real terms rise in total adult social care spending has been 1.3%, 1.8% and 2.4%.

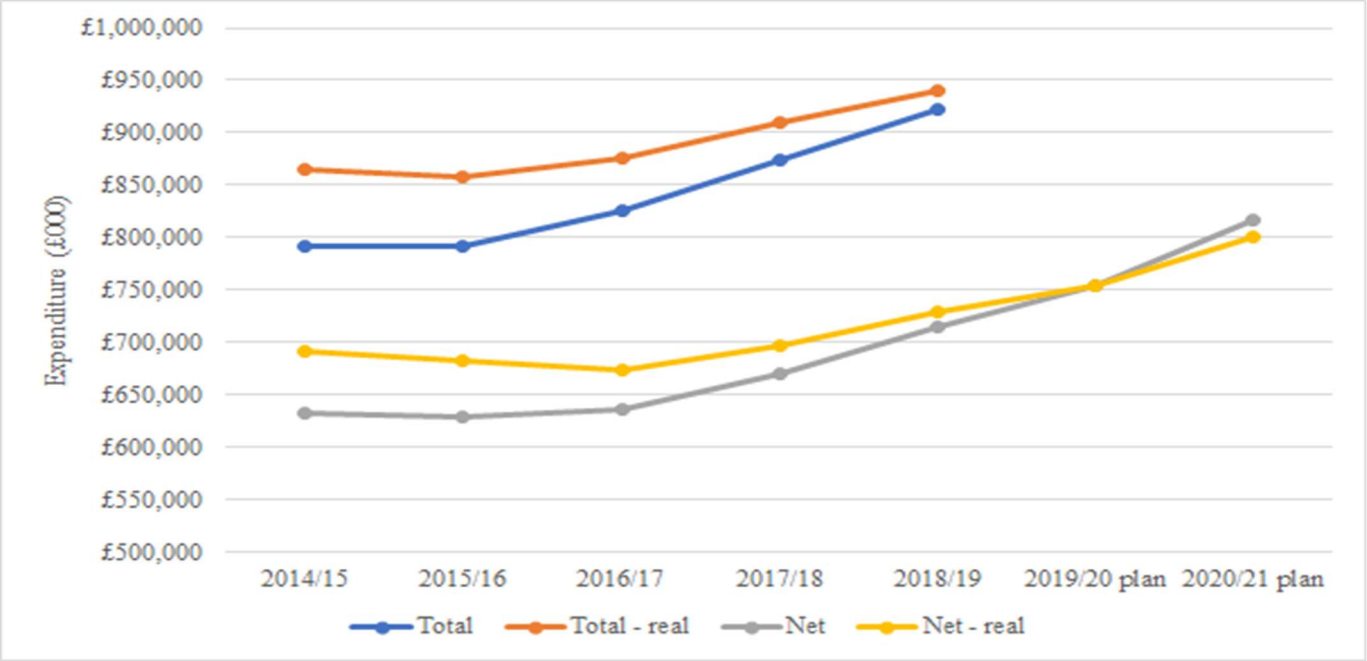
Social care – mental health support for adults (18-64)

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

Across the period of available data, total expenditure peaked in real terms in 2018/19 (the most recent available year, £940.616m) and was 8.7% up on four years earlier after adjusting for inflation (£865.630m). Planned net current expenditure in 2020/21 (£800.637m) was 15.8% above the level of six years earlier (£691.195m) in real terms after a period of relatively flat funding between 2014/15 and 2017/18 inclusive.

Both of these increases are above the real terms increases for adult social care funding overall across the same period – 7.5% for total expenditure between 2014/15 and 2018/19 and 9.5% for net current expenditure between 2014/15 and 2019/20.

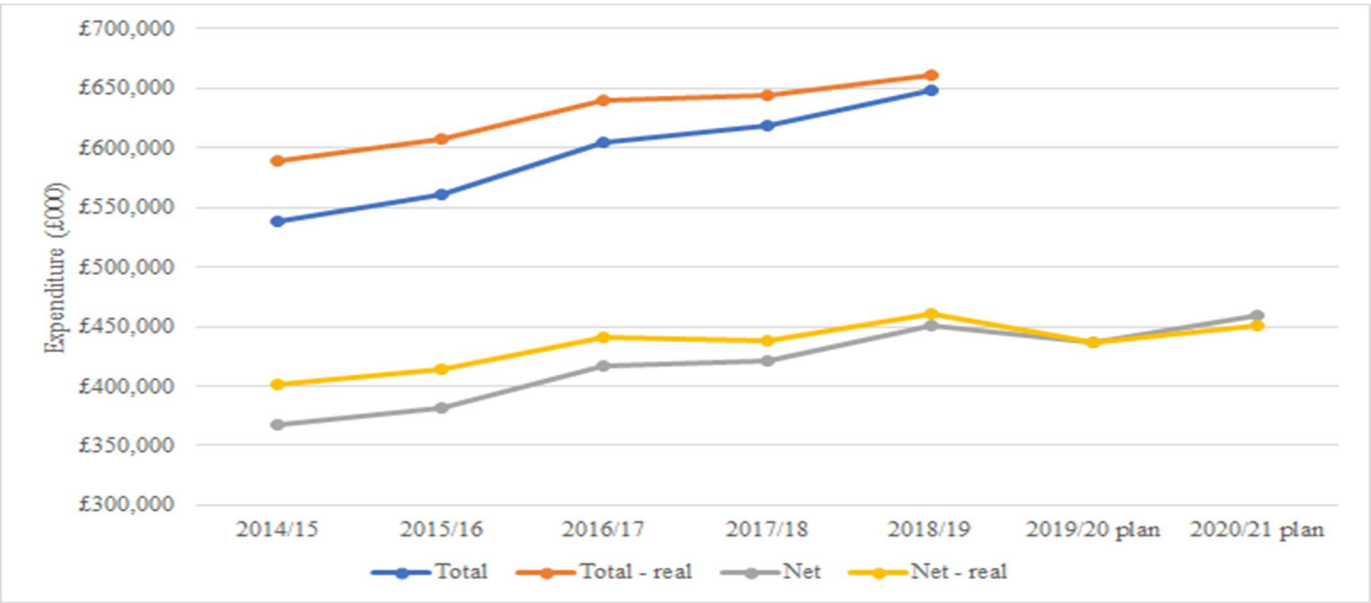
Chart 4. Social care spending by local authorities in England on mental health support for working age adults (18-64 years old), total and net current expenditure in cash and real terms (2019/20 prices), 2014/15 to 2020/21



Social care – mental health support for older adults (65+)

Across the period of available data, total expenditure peaked in real terms in 2018/19 (£661.207m) and was 12.3% up on four years earlier after adjusting for inflation (£589.012m), however growth has substantially slowed in the past two years, amounting to a mere 3.3% (£640.017m). While planned net current expenditure in 2020/21 (£450.636m) was 12.1% above the level of six years earlier (£402.081m) after adjusting for inflation, it should also be noted that the latest amount is also equivalent to a real terms cut of 2.0% on 2018/19 (£460.062m).

Chart 5. Social care spending by local authorities in England on mental health support for older adults (65+ years old), total and net current expenditure in cash and real terms (2019/20 prices), 2014/15 to 2020/21



Social care – mental health support for children and young people

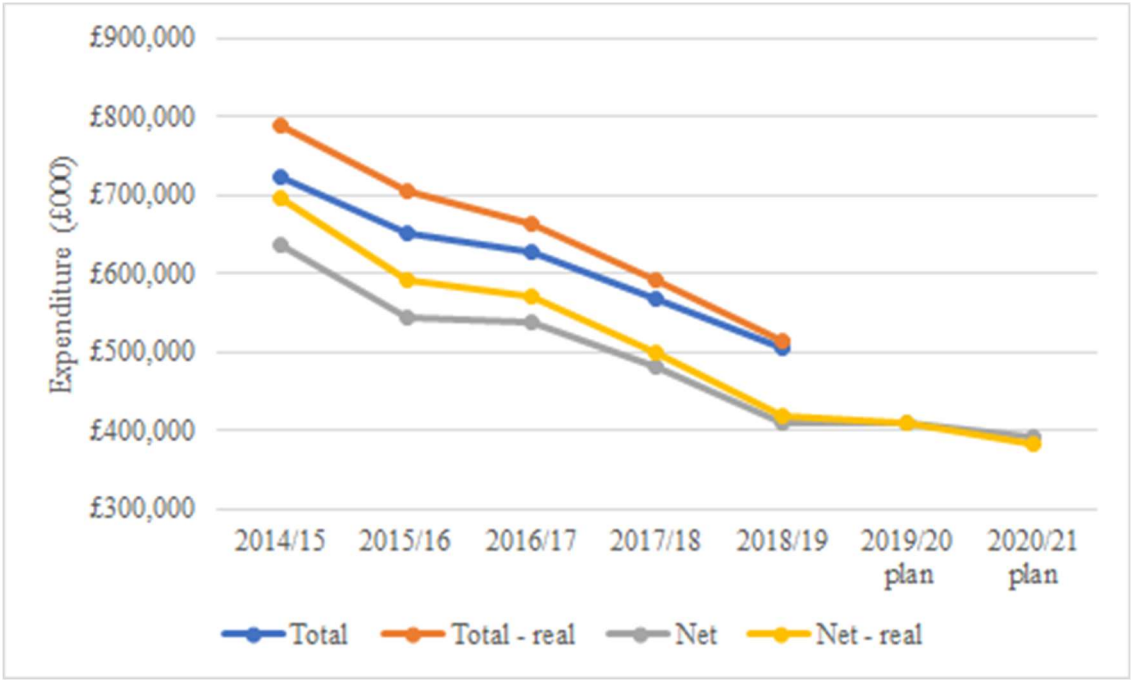
There is a lack of social care support for children and young people. The disinvestment in local authority funded services has led to closures of Sure Start centres, and a lack of support for children and young people with a neuro-disability, which ultimately results in more children and young people presenting to NHS mental health services in crisis. There is also a clear issue with transitions for looked after children in particular as they turn 18 and subsequently lose support. All of these issues contribute to poor mental and physical health.

While data is not collected for mental health spending for children and young people by MHCLG, the disinvestment in crucial services is evident from the charts below.

Spending on Sure Start and early years services has only been reported by MHCLG since 2014/15. Total expenditure has fallen by 34.9% between 2014/15 (£789.526m) and 2018/19 (£513.672m) after adjusting for inflation. Alternatively, if looking at net current expenditure, the decline in real terms has been 44.9% between 2014/15 (£696.843m) and the planned amount for 2020/21 (£383.887m).

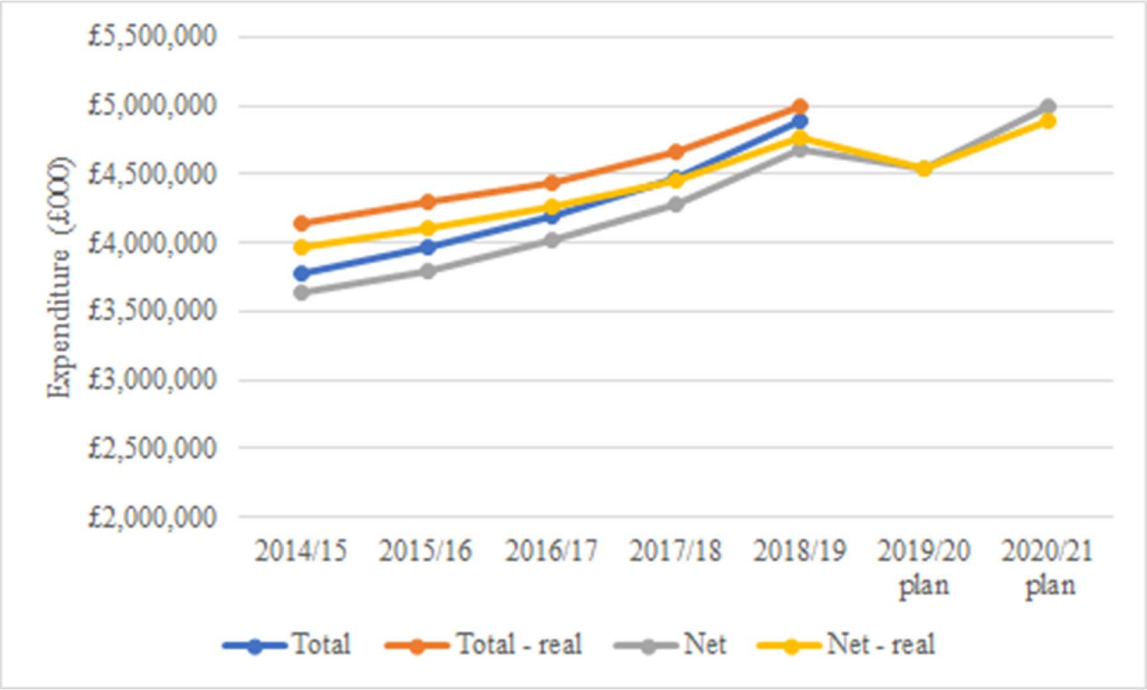
This means the share of children's social care expenditure devoted to these services has declined from 7.9% in 2014/15 to 4.0% in 2020/21 on the current planned net current expenditure. It would require spending to rise by around £376m in current prices to restore investment to that previous share.

Chart 6. Social care spending by local authorities in England on Sure Start centres and early years, total and net current expenditure in cash and real terms (2019/20 prices), 2014/15 to 2020/21



Spending data for looked after children shows that in terms of total expenditure, the amount has grown by 20.7% between 2014/15 (£4.134bn) and 2018/19 (£4.990bn) after adjusting for inflation, however spending growth appears to have slowed in recent years when looking at the planned level of net current expenditure, which has risen by 2.7% in 2020/21 (£4.894bn) compared to two years earlier (£4.768bn), having fallen in 2019/20 (£4.537bn).

Chart 7. Social care spending by local authorities in England on looked after children, total and net current expenditure in cash and real terms (2019/20 prices), 2014/15 to 2020/21



Recommendations

1. At the 2020 CSR, the Government, MHCLG and DHSC should commit to increase the social care budget for children, young people and adults to at least in line with the funding uplift for NHS England of an average increase of 3.3% per year in real terms by 2023/24.

   Specifically, within this uplift, local authorities should commit to ring-fence funding devoted to early years, aiming to get it back to at least around 8% of the children's social care expenditure, equating to a rise of around £376m in current prices.

Action 5: Invest in world-leading mental health research

Mental illness accounts for 23% of the global burden of disease in the UK and should benefit from an equivalent investment into research.[59] In 2018, just 6.1% of the UK's health research budget was spent on mental health, compared to 18.9% on cancer research and this investment has remained flat for a decade.[60]

Spending on research for children and young people and intellectual disabilities is particularly constrained. A lack of clinical drug testing involving older people results in excessive prescribing of off-licence medication to that patient group.

The publication of the Mental Health Research Framework in December 2017, and the Roadmap for Mental Health Research in Europe (ROAMER) project, provides a helpful framework for increasing investment. Prevention across the lifespan is a priority research area in ROAMER report. [61]

At the Spring Budget 2020, the Government announced £30 million of new funding for the National Institute for Health Research to undertake rapid research into COVID-19.[62] COVID-19 is driving increase in mental ill-health and there is consequently a need for research into direct and indirect psychiatric impact of COVID-19 from the short to longer term, and how problems should be treated, managed or mitigated.[63]

At the same time, the way in which certain types of research (e.g. on biological mechanisms and interventional trials) can be pursued has been challenged significantly by the pandemic and adjustments will need to be sustained. Embedding research capacity within plans for infrastructural and service investment will be a productive strategy for best evidence-based practice.

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

Clinical academic psychiatrists, who typically work across both NHS clinical settings and universities medical schools or Higher Education Institutions (HEIs), are essential for leading research and development within clinical services. As leading educators, they are central to the development and delivery of education and clinical training of mental health workforce and inspiring the next generation of doctors specialising in psychiatry. However, academic departments are shrinking and there was a 21.7% decline in number of clinical academic psychiatrists between 2007-2017.[64] Trusts need to actively support academia with time in job plans and research and development infrastructure, otherwise clinical research will disappear and there will be no senior researchers to develop the next generation. There also needs to be greater diversity in academia as it is understood that approximately 80% of European graduates are female but only 20% are professors.

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

Recommendations

Research

1. DHSC to increase the funding for mental health research to 15% of the total UK research budget by 2030, drawing on the ROAMER priorities and research associated with COVID-19.
2. DHSC to allocate £160m of capital funding to mental health trusts for Research & Development in Mental Health and Dementia, including: the prevention agenda, research to improve the productivity and effectiveness of the NHS, and the translation of basic science and support for the life sciences industry by 2024/25.[65]
3. Government to host a Mental Health Research Summit in 2021 that draws on the Grand Challenge and ROAMER programmes.
4. DHSC to commission regular prevalence surveys for adults (with the next report no later than 2023) and for children and young people (with a report no later than 2023).
5. DHSC to fund a follow-up survey to track the outcomes of the care received by the children and young people in the prevalence survey who have given informed consent. This will allow researchers to align findings and track data against better-developed indicators to help the Government better plan for the next ten years. It would also provide necessary information about what happens to children and young people over time.
6. DHSC to ensure that eating disorders are recognised within both prevalence surveys, after being excluded from the most recent iteration of the APMS.
7. NHSD to disaggregate mental health data by an 18-25 age group as it can be challenging to identify this group specifically from the adult datasets.

8. The Medicines and Healthcare products Regulatory Agency (MHRA) to improve drug testing methodologies to include older people with co-morbidities. This might, for example, include ways of getting over issues of capacity by encouraging people to make future wishes statement on this issue whilst they still have the capacity.

Clinical academics

9. Over the next decade, HEE to work with RCPsych and others to reverse the decline in academic psychiatry posts with a 50% increase in Clinical Senior Lecturer posts.
10. Over the next decade, increase clinical academic posts in psychiatry jointly funded by NHS-University/ Medical School to support the educational and training needs of an NHS mental health workforce and to deliver the high-quality clinical and basic research needed to prevent psychiatric morbidity across the lifespan and improve the outcomes and experience of people living with mental disorders.
11. Over the next decade, every medical school should have an academic department of psychiatry with psychiatry being taught effectively to all medical students.
12. NHSE/I, HEE, the National Institute for Health Research (NIHR), the Medical Research Council and the Wellcome Trust to liaise with other interested parties such as RCPsych, the Academy of Medical Royal Colleges, the Academy of Medical Sciences and other relevant stakeholders to provide required funding and support to develop careers of academic psychiatrists.
13. HEE to address significant barriers in clinical academic career pathways in mental health research, and to provide greater support for post-doctoral research fellowships, the transition to academic clinical lecturer and establishment at senior lecturer level. This needs to be done in partnership with NHS trusts so that clinical academia in actively supported with time in job plans and research and development infrastructure.

References and footnotes

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[2] The Public Health Grant can be used for both revenue and capital purposes - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/872798/DHSC_allocations_circular_2020_to_2021.pdf

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