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Mental health policy in England

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House of Commons Library briefing on mental health policy in England.

Around one in four people in the UK suffer from a mental health problem each year. The NHS has set out that it wants to achieve "parity of esteem" between mental and physical health, in terms of access to services, quality of care and allocation of resources. While the achievement of parity of esteem has been a long term-policy goal, since 2010 this aim has increasingly featured in legislation and in Government and NHS policy statements.

In February 2016 an Independent Mental Health Taskforce published *The Five Year Forward View for Mental Health*. This made a series of recommendations for the NHS and Government to improve outcomes in mental health by 2020/21, including ending the practice of sending people out of their local area for inpatient care and increasing access to talking therapies. The Government and NHS England accepted the Taskforce recommendations, and the Government has committed £1billion by 2020/21 to support their implementation.

In October 2017, the Government commissioned a review of the *Mental Health Act 1983*, in response to concerns about rising rates of detention and the disproportionate use of the Act among people from black and minority ethnic (BAME) groups. An interim report was published in May 2018 and flags several areas for change, such as 'advance planning' decisions so patients' preferences about their care receive suitable consideration. The review is also gathering evidence on the use of the Act among people from BAME groups. The final report is due in autumn 2018.

The briefing also looks at the use of force in mental health units. Current guidance, including the Code of Practice to the Mental Health Act and that published by NICE, provides direction to service providers and healthcare staff about the use of force and restrictive intervention. The Private Members' Bill *Mental Health Units (Use of Force) Bill* is currently awaiting Second Reading in the House of Lords. The Bill would place requirements relating to the use of force on a statutory footing, including requiring mental health units to have a written policy and commit to reducing their use of force.

As health is a devolved matter, the Governments of Scotland, Wales and Northern Ireland are responsible for setting their own policies in this area. Links to policies of the devolved administrations are provided in section 6 of this briefing.

Links to Library briefings on more specific areas of mental health policy, such as children and young people's mental health, suicide prevention, and perinatal mental health, are provided in section 7.

1. Mental health strategies

1.1 Parity of esteem

The Coalition Government's mental health strategy, *No Health without Mental Health: A cross-government mental health outcomes strategy for people of all ages* (February 2011) made explicit its objective to give equal priority to mental and physical health.[1] The strategy also set out the Coalition's plan to improve people's mental health and wellbeing and improve services for those with mental health problems. The Implementation Framework for this strategy (July 2012) described how different bodies, such as schools, employers and local authorities, should work together to support people's mental health.[2]

The *Health and Social Care Act 2012* introduced the first explicit recognition of the Secretary of State for Health's duty towards both physical and mental health.[3] This led to a commitment in the NHS constitution that the NHS is "designed to diagnose, treat and improve both physical and mental health". Similarly, the 2015 Government's *Mandate to NHS England*, states that "NHS England's objective is to put mental health on a par with physical health".

The Government has since set objectives for parity of esteem in successive NHS Mandates – for example the NHS Mandate 2018-19 states that there should be "measurable progress towards the parity of esteem for mental health enshrined in the NHS Constitution, particularly for those in vulnerable situations".[4] Information on NHS England's work to secure parity of esteem is available here: Valuing mental health equally with physical health or "Parity of Esteem"

The *NHS Five Year Forward View*, also committed to achieving parity of esteem by 2020.

Further information on the concept of parity of esteem is available in a Parliamentary Office of Science & Technology (POST) briefing: Parity of esteem for mental health (January 2015).

1.2 NHS Five Year Forward View

The *NHS Five Year Forward View*, published by NHS England and its partners in October 2014, set a commitment to working towards a more equal response across mental and physical health and achieving genuine parity of esteem by 2020. It also set ambitions to expand access and waiting time standards, including to children's services:

> Five Year Ambitions for Mental Health

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1 Department of Health, No Health without Mental Health: A cross-government mental health outcomes strategy for people of all ages, February 2011, page 2

2 Department of Health, No Health without Mental Health: Implementation Framework, July 2012

3 The specific reference to mental health was introduced as an amendment during the legislation's Report stage in the House of Lords. See *Lords Library Note*, LLN 2013/024.

4 Department of Health and Social Care, The Government's mandate to NHS England for 2018-19, March 2018, para 2.14

> Over the next five years the NHS must drive towards an equal response to mental and physical health, and towards the two being treated together. We have already made a start, through the Improving Access to Psychological Therapies Programme – double the number of people got such treatment last year compared with four years ago. Next year, for the first time, there will be waiting standards for mental health. Investment in new beds for young people with the most intensive needs to prevent them being admitted miles away from where they live, or into adult wards, is already under way, along with more money for better case management and early intervention.
>
> This, however, is only a start. We have a much wider ambition to achieve genuine parity of esteem between physical and mental health by 2020. Provided new funding can be made available, by then we want the new waiting time standards to have improved so that 95 rather than 75 per cent of people referred for psychological therapies start treatment within six weeks and those experiencing a first episode of psychosis do so within a fortnight. We also want to expand access standards to cover a comprehensive range of mental health services, including children's services, eating disorders, and those with bipolar conditions. We need new commissioning approaches to help ensure that happens, and extra staff to coordinate such care. Getting there will require further investment.[5]

NHS England's *Forward View into action: planning for 2015-16*, set an expectation that Clinical Commissioning Group (CCG) spending on mental health services in 2015/16 should increase in real terms, and grow by at least as much as each CCG's allocation increase to support the ambition of parity between mental and physical health.[6]

1.3 The Five Year Forward View for Mental Health

The Five Year Forward View for Mental Health, a report from the independent Mental Health Taskforce to NHS England, was published in February 2016. The Taskforce made a series of recommendations for improving outcomes in mental health by 2020/21, encompassing three broad areas:

- Recommendations for the NHS arm's length bodies to achieve parity of esteem between mental and physical health for children, young people, adults and older people;
- Recommendations where wider action is needed - this includes cross-Government action, in areas such as employment, housing and social inclusion; *and*
- Recommendations to tackle inequalities, including the higher incidence of mental health problems among people living in poverty, those who are unemployed and people who already face discrimination. It also addresses inequalities in access to services among certain black and minority ethnic groups, whose first experience of mental health care often comes when they are

[5] NHS England, Five Year Forward View, October 2014, page 26
[6] NHS England, *Forward View into action: planning for 2015-16*, December 2014, page 5

> detained under the *Mental Health Act*, often with police involvement.

The recommendations to be delivered by 2021 include:

- an end to the practice of sending people out of their local area for acute inpatient care
- providing mental health care to 70,000 more children and young people
- supporting 30,000 more new and expectant mothers through maternal mental health services
- new funding to ensure all acute hospitals have mental health services in emergency departments for people of all ages
- increasing access to talking therapies to reach 25% of those who need this support
- a commitment to reducing suicides by 10%

In February 2016 the Government said it welcomed the report's recommendations, and would work with NHS England and other partners to establish a plan for implementing its recommendations.[7] The *Government's Mandate to the NHS 2016-17* also contained a directive for the NHS to implement agreed actions from the Mental Health Taskforce.[8] A Government statement committed to implementing the Taskforce's objectives and an investment of £1 billion by 2020-21:

> […]
>
> We can all agree that the human and financial cost of inadequate care is unacceptable. The Department of Health therefore welcomes the report's publication, and will work with NHS England and other partners to establish a plan for implementing its recommendations. To make those recommendations a reality, we will spend an extra £1 billion by 2020-21 to improve access to mental health services, so that people can receive the right care in the right place when they need it most. That will mean increasing the number of people completing talking therapies by nearly three quarters, from 468,000 to 800,000; more than doubling the number of pregnant women or new mothers receiving mental health support, from 12,000 to 42,000 a year; training about 1,700 new therapists; and helping 29,000 more people to find or stay in work through individual placement support and talking therapies.[9]

The Government's full response to the Taskforce was published in January 2017, accepting its recommendation in full. This response also set out measures to address Taskforce recommendations that apply beyond the NHS, for education, employment and the wider community:

> … the Five Year Forward View for Mental Health set out a programme of reform beyond the NHS, extending across Government departments and Whitehall's arm's length bodies. This document is the formal response to those recommendations

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7 HC Deb 23 February 2016 c153-4
8 Department of Health, The Government's mandate to NHS England for 2016-17, page 18
9 HC Deb 23 February 2016 c153-4

> made to Government. It sets out a far-reaching programme of work to improve mental health services and their links to other public services, and builds mental health prevention and response into the work of Government departments to improve the nation's mental health and reduce the impacts of mental illness.[10]

Additionally, in July 2017 then Health Secretary Jeremy Hunt launched a workforce strategy for implementation of the Five Year Forward View for Mental Health, which sets out plans for 21,000 new posts across England by April 2021 (the Government had previously pledged to an increase of 10,000 posts by this date). The plan was developed by partners including Health Education England (HEE), NHS Improvement, NHS England, and the Royal College of Psychiatrists.

NHS England's Implementation Plan (July 2016) details how it will deliver the Taskforce's recommendations. It focuses on the role of the NHS in delivering its commitments and is directed at commissioners and providers to support and influence their own local plans.

[10] DH, *Five Year Forward View for Mental Health: government response*, 9 January 2017

2. Reform of the Mental Health Act 1983

In October 2017, the former Health Secretary announced that the Government has commissioned an independent review of the *Mental Health Act 1983* (the Act).[11]

This followed concerns about high rates of detention under the Act and the disproportionate use of the Act among people from black and minority ethnic groups. The *Five Year Forward View for Mental Health* recommended that there should be action to substantially reduce *Mental Health Act* detentions and targeted work should be undertaken to reduce the current significant overrepresentation of BAME and any other disadvantaged groups within detention rates.[12]

The terms of reference asks the review to make recommendations for improvement in the following areas:

- rising rates of detention under the act
- the disproportionate number of people from black and minority ethnicities detained under the act
- stakeholder concerns that some processes relating to the act are out of step with a modern mental health system, including but not limited to:
  - the balance of safeguards available to patients, such as tribunals, second opinions, and requirements for consent
  - the ability of the detained person to determine which family or carers have a say in their care, and of families to find appropriate information about their loved one
  - that detention may in some cases be used to detain rather than treat
  - questions about the effectiveness of community treatment orders, and the difficulties in getting discharged
  - the time required to take decisions and arrange transfers for patients subject to criminal proceedings.[13]

An interim report was published in May 2018 summarising the review's work so far and the priority issues that have emerged.

The report highlights concerns about high rates of detention for people from black Caribbean, black African and mixed black ethnicity, and has collated evidence on the reasons behind this – such as discrimination, poverty and social exclusion, as well as higher rates of mental illness

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11 Written Statement HCWS143, Independent Review of the Mental Health Act, 9 October 2017

12 The Five Year Forward View for Mental Health, A report from the independent Mental Health Taskforce to the NHS in England, February 2016, recommendation 22

13 Department of Health and Social Care, Terms of Reference – Independent Review of the Mental Health Act 1983, 4 October 2017

among some ethnic groups. The review will further consider how behaviours of staff that section and admit people affect the likelihood of detention, alternatives to compulsory detention and barriers to uptake of earlier interventions.[14]

The Review also flags areas for change such as the role of the 'nearest relative' who can make certain decisions about a person's care. At present, the nearest relative is automatically appointed from a set list prescribed in the *Mental Health Act*. The review says that this can result in inappropriate people automatically being selected as the nearest relative, and that in practice family and friends who are not eligible to be the nearest relative can struggle to engage in the care of the person they support.[15]

The review will also further consider provisions for advance planning, as the review heard evidence that people's attempts to set out what they did or did not want did not receive adequate attention.[16]

The report also stresses that any changes to legislation must be underpinned by improvements to mental health services.

The final report is expected in autumn 2018.

[14] The independent review of the Mental Health Act, Interim Report, 1 May 2018, para 7.13
[15] The independent review of the Mental Health Act, Interim Report, 1 May 2018, para 7.10
[16] The independent review of the Mental Health Act, Interim Report, 1 May 2018, para 7.6

3. Use of force in mental health settings

3.1 Current policy

Mental Health Act 1983

The *Mental Health Act 1983: Code of Practice* (the Code) provides statutory guidance on restrictive interventions for people receiving treatment for a mental disorder in a hospital, which are defined as follows:

> Restrictive interventions are deliberate acts on the part of other person(s) that restrict a patient's movement, liberty and/or freedom to act independently in order to:
>
> 1. take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, and
> 2. end or reduce significantly the danger to the patient or others.[17]

The guidance applies to all people receiving treatment for a mental disorder, whether or not they are detained under the *Mental Health Act*.

The Code states that when restrictive interventions are required, they should:

> 3. be used for no longer than necessary to prevent harm to the person or to others
> 4. be a proportionate response to that harm, and
> 5. be the least restrictive option.[18]

It also states that service providers should have programmes in place to reduce the use of restrictive interventions.

The Code requires that all hospitals should have a policy on training for staff who may be exposed to violence or aggression in their work or who may need to be involved in the application of a restrictive intervention.[19]

The Code's section on physical restraint says that if physical restraint is necessary, patients should not be deliberately restrained in a way that impacts on their airway, breathing or circulation. Full account should also be taken of their physical health, and staff should constantly monitor their airway and physical health throughout the intervention.[20]

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17 Department of Health, *Mental Health Act 1983* Code of Practice, January 2015, para 26.36
18 *Ibid.*, para 26.37
19 *Ibid.*, para 26.175
20 *Ibid.*, para 26.71

The Code also states that where physical restraint has been used, staff should record the decision and the reasons for it, including details about how the intervention was implemented and the patient's response.[21]

Positive and Safe programme

In April 2014 the Department of Health launched the *Positive and Safe* programme, which aims to reduce use of restrictive interventions across all health and adult social care.

As part of this, the Department published new guidelines on ending the deliberate use of face-down restraint for people receiving care. *Positive and Proactive care: Reducing the need for restrictive interventions,* provides non-statutory guidance for adult health and social care staff to develop a culture where restrictive interventions are only ever used as a last resort, and only then for the shortest possible time.

It also identified key actions that aim to better meet people's needs and enhance their quality of life, reducing the need for restrictive interventions:

- Staff must not deliberately restrain people in a way that impacts on their airway, breathing or circulation, such as face down restraint on any surface, not just on the floor.
- If restrictive intervention is used it must not include the deliberate application of pain.
- If a restrictive intervention has to be used, it must always represent the least restrictive option to meet the immediate need.
- Staff must not use seclusion other than for people detained under the Mental Health Act 1983.
- People who use services, families and carers must be involved in planning, reviewing and evaluating all aspects of care and support.
- Individualised support plans, incorporating behaviour support plans, must be implemented for all people who use services who are known to be at risk of being exposed to restrictive interventions.

The guidance specifically states that face-down (prone) restraint should not be used:

> People must not be deliberately restrained in a way that impacts on their airway, breathing or circulation. The mouth and/or nose must never be covered and techniques should not incur pressure to the neck region, rib cage and/or abdomen. There must be no planned or intentional restraint of a person in a prone/face down position on any surface, not just the floor.[22]

Positive and proactive care also introduced new monitoring and governance mechanisms to hold services to account for making these

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21 *Ibid.*, para 26.72

22 Department of Health, Positive and Proactive Care: reducing the need for restrictive interventions, April 2014, para 70

improvements. It was accompanied by an investment of £1.2 million in staff training to help avoid the use of restrictive interventions.[23]

In February 2017, the then Health Minister Nicola Blackwood gave an update on the implementation of Positive and Safe:

> Since the Coalition Government published Positive and Proactive Care: reducing the need for restrictive interventions in April 2014, the Department, with its partners, has taken a number of steps to implement its recommendations.
>
> These include the development of the Positive and Safe Champions Network to promote good practice in the reduction of restrictive interventions; the inclusion of information about the number and type of restraints in the Mental Health Services Dataset and the development of core standards for the training of staff in techniques of prevention and management of violence and aggression.
>
> The Department of Health and the Department for Education are working to produce, for consultation, new guidance on minimising the use of restraint on children and young people who have autism, learning disabilities or mental health issues, and whose behaviour challenges, in health and care settings and in special schools.
>
> Positive and Proactive Care introduced a requirement that services develop Restrictive Intervention Reduction Plans. These plans along with organisations' relative use of restraint in comparison with other organisations, form a key focus of the Care Quality Commission's (CQC) inspections. We expect the CQC to use its regulatory powers to ensure that services minimise the use of restraint and other restrictive interventions, including face down restraint.[24]

The Government is also consulting on draft guidance on reducing the need for restraint and restrictive intervention for children and young people with learning disabilities, autistic spectrum disorder and mental health needs.

NICE guidance

The National Institute of Health and Care Excellence (NICE) guidelines on *Violence and aggression: short-term management in mental health, health and community settings* (May 2015) recommend ways to reduce the use of restrictive interventions, such as through staff training and de-escalation techniques. NICE guidelines are not mandatory but provide evidence-based recommendations for commissioners and providers of healthcare.

The guidelines state that a restrictive intervention should only be used if de-escalation techniques and other preventative strategies have failed and there is a risk of harm to the service user or other people if no action is taken. They also state that sufficient numbers of trained staff,

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23 Department of Health, New drive to end deliberate face down restraint, 3 April 2014
24 PQ 63005 [on mental health services: restraint techniques], 10 February 2017

including a doctor trained in resuscitation, should be immediately available.[25]

The NICE guidelines advise against face-down restraint, but do say it can be used if necessary, unlike the Department of Health's *Positive and Proactive Care* guidance.

The NICE quality standard on *Violent and aggressive behaviours in people with mental health problems* (June 2017) also states that restrictive interventions should only be used if other preventive strategies have failed. They should be used for no longer than necessary and de-escalation should continuously be attempted.

The quality standard also recommends that people who use mental health services who have been violent or aggressive should be supported to identify successful de-escalation techniques and make advance statements about the use of restrictive interventions. If a restrictive intervention is used, the patient's physical health should be monitored during and after physical restraint.

Patient ethnicity

Concerns have been raised in Parliament and among stakeholder groups about the disproportionate use of physical restraint on people from certain minority ethnic groups, particularly from black African and Caribbean communities.

In October 2017, the Cabinet Office published the Race Disparity Audit, which found that black Caribbean adults were the most likely to have been detained under the *Mental Health Act*[26], but did not make specific reference to the use of force in mental health settings.

The Home Affairs Select Committee published a report on *Policing and mental health* in February 2015. The report highlighted concerns that the black community more commonly reported the use of force:

> There are real concerns that black and ethnic minority people are disproportionately detained under s. 136 (of the *Mental Health Act 1983*). Matilda MacAttram of Black Mental Health UK said there was still a feeling in the black community that the young black men are presumed to be dangerous based on their physical appearance, and this perception determines how they are labelled and the treatment they receive. At events organised by the Centre for Mental Health to hear views on experiences of detention under s. 136, black people more commonly reported the use of force and that force was used at an earlier stage during contact with the police. Deborah Coles of INQUEST, agreed that there was a prevailing assumption that people with mental health illness would be dangerous, and that is doubled if the person is from the African Caribbean community. She said the answer was largely to do with training.[27]

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25 NICE guideline, Violence and aggression: short-term management in mental health, health and community settings, p30-31, 28 May 2015

26 Cabinet Office, Race Disparity Audit, October 2017, page 49

27 Home Affairs Select Committee, *Policing and Mental Health*, 6 February 2015, HC 202 2013-14, para 71

The charity INQUEST, which focuses on state-related deaths and their investigation, published a report in 2015 which stated:

> The lack of publicly-available data is particularly concerning in relation to ethnicity where…there have been significant questions raised about an over-representation of black people in mental health settings and the coercive use of force that features in some of their deaths.[28]

3.2 The Mental Health Units (Use of Force) Bill

The *Mental Health Units (Use of Force) Bill* is currently in the House of Lords, having finished its journey through the House of Commons in July 2018.

The Bill makes provision about the oversight and management of use of force in relation to patients in mental health units and similar settings. It applies to England only.

The Bill would introduce statutory requirements in relation to the use of force in mental health units; and require service providers to keep a record of any use of force, have a written policy for the use of force, commit to a reduction in the use of force, and provide patients with information about their rights in relation to the use of force.

In the case of death or serious injuries following the use of force, the Bill would require mental health units to have regard to all relevant NHS and Care Quality Commission (CQC) guidance. This would have the effect of putting NHS England's Serious Incident Framework on a statutory footing.

The Bill also places a new duty on the Secretary of State to produce an annual report on the use of force at mental health units. At present, data on this is not routinely published.

In addition to provisions on the use of force in mental health units, the Bill also includes provisions on the use of body cameras worn by police officers who attend mental health units for any reason.

Detailed information on the Bill is available in the Library briefing: Mental Health Units (Use of Force) Bill 2017-19: Committee Stage Report (17 May 2018)

28 Inquest, Deaths in mental health detention, February 2015

4. Mental health crisis care

The Government's Mandate to the NHS 2018-19 sets objectives for the NHS to achieve seven day services, including 24/7 access to mental health crisis care in both community and A&E settings.[29]

In May 2018, the Government announced £15 million of funding for community services, such as clinics and crisis cafes, to prevent people reaching crisis point. The *Beyond Places of Safety* scheme will fund 51 projects across the country.[30]

In January 2016, the Government announced funding for mental health crisis care interventions, including £247 million to provide mental health support in emergency departments, and £400 million for community crisis resolution teams:

> **£247 million to place mental health services in every hospital emergency department**
>
> People with mental health problems are 3 times more likely to turn up at A&E than those without. Yet not every hospital in the country has the services needed to support them. Every hospital in the country should have liaison mental health services, which will mean specialist staff, with training in mental health, will be on hand to make sure that patients get the right care for them, and are referred for further support if needed.
>
> Today, the Prime Minister will announce £247 million will be deployed over the next 5 years to make sure that every emergency department has mental health support and, as a global leading effort, will make sure that these services are available 24 hours a day, 365 days a year in at least half of England's acute hospitals by 2020. This new money will not only improve the care of those with mental illness in A&E but will also generate important savings for these hospitals – through fewer admissions and reduced lengths of stay, for example.
>
> **Over £400 million for crisis home resolution teams to deliver 24/7 treatment in communities and homes as a safe and effective alternative to hospitals**
>
> Crisis resolution and home treatment teams have been introduced throughout England as part of a transformation of the community mental healthcare system. They aim to assess all patients being considered for acute hospital admission, to offer intensive home treatment rather than hospital admission if feasible, and to facilitate early discharge from hospital. Key features include 24-hour availability and intensive contact in the community, with visits twice daily if needed.
>
> The new investment in this integrated, multidisciplinary approach will ensure more complete coverage around the country.[31]

In February 2014, the Department of Health and signatories published the *Mental Health Crisis Care Concordat* - a national agreement

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29 Department for Health and Social Care, The Government's mandate to NHS England for 2018-19, March 2018, para 1.9

30 Department of Health and Social Care, £15 million boost for local mental health crisis services,15 May 2018

31 Gov.uk, Prime Minister pledges a revolution in mental health treatment, 11 January 2016

between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

It focuses on four main areas:

- Access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
- Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment.
- Recovery and staying well – preventing future crises by making sure people are referred to appropriate services.

The Crisis Care Concordat also contained an objective to ensure that mental health emergencies are treated with the same urgency as physical health emergencies.

4.1 Places of safety

Sections 135 and 136 of the *Mental Health Act 1983* give the police powers to detain and remove persons who appear to be suffering from a mental disorder and take them to a designated "place of safety" until an assessment can take place and appropriate treatment arranged.

The *Policing and Crime Act 2017* (the Act) includes measures to reduce instances where people experiencing a mental health crisis are held in a police cell as a place of safety whilst waiting an assessment.

The Act introduces restrictions on places that may be used as places of safety. It makes it unlawful to use a police station as a place of safety for anyone under the age of 18 in any circumstances. A police station may now only be used as a place of safety for a person aged 18 and over in the specific circumstances set out in *The Mental Health Act 1983 (Places of Safety) Regulations 2017*, namely, where:

- (the behaviour of the person poses an imminent risk of serious injury or death to themselves or another person;
- because of that risk, no other place of safety in the relevant police area can reasonably be expected to detain them, and
- so far as reasonably practicable, a healthcare professional will be present at the police station and available to them[32]

The Act also introduces a requirement for police officers to consult one of a list of specified healthcare professionals, where it is practicable to do so, before deciding whether or not to keep a person at, or remove a person to, a place of safety.

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[32] Department of Health, Home Office, Guidance for the implementation of changes to police powers and places of safety provisions in the mental health act 1983, October 2017, page 12

The *Policing and Crime Act* also decreases from 72 to 24 hours the length of time a person can be detained in a place of safety whilst waiting for an assessment. This may only be increased by 12 hours with the authorisation of a medical practitioner and, if the place of safety is a police station, a police officer of the rank of superintendent or above must also approve the extension.

5. Waiting time standards

In October 2014, the Government announced the first waiting time standards for mental health services, to bring waiting times for mental health in line with those for physical health. From 1 April 2015 (to be fully implemented by April 2016), the new waiting time standards are as follows:

- 75% of people referred for psychological therapies for treatment of common mental health problems like depression and anxiety will start their treatment within 6 weeks and 95% will start within 18 weeks;
- At least 50% of people going through their first episode of psychosis will get help within 2 weeks of being referred.[33]

For psychological therapies, annual data for 2016-17 shows that 87.5 per cent of patients waited less than 6 weeks and 98.2 per cent waited less than 18 weeks to enter treatment.[34]

For early intervention in psychosis, the most recent data shows that in June 2018 76.5 per cent of patients started treatment within two weeks.[35]

In 2016 the Government introduced waiting time standards to improve access to eating disorders services for children and young people. The target is that by 2020/21, 95 per cent of children and young people with an eating disorder will receive treatment within one week for urgent cases and within four weeks for routine cases. The Government has said that it is on track to meet the standard.[36] The most recent data from NHS England shows that for Q1 2018-19, 74.7 per cent of children and young people started urgent treatment within one week and 81.2 per cent started routine treatment within four weeks.[37]

The Government has said that their ambition is for access and waiting time standards to be implemented for all mental health services by 2020.[38]

33 Gov.uk, First ever NHS waiting time standards for mental health announced, 8 October 2014
34 NHS Digital, Psychological Therapies, Annual report on the use of IAPT services - England, 2016-17
35 NHS England, Early Intervention in Psychosis Waiting Times June 2018
36 PQ 165025 [on eating disorders], 25 July 2018
37 NHS England, Children and Young People with an Eating Disorder Waiting Times Q1 2018-19, 2 August 2018
38 PQ 217112 [on mental health services: children], 10 December 2014

6. Scotland, Wales and Northern Ireland

Scotland

In March 2017 the Scottish Government announced a new ten-year Mental Health Strategy, focused on improving access to services and supporting earlier intervention. The 40 actions in the strategy include increasing the mental health workforce in A&E, GP practices, police station custody suites and prisons – supported by £35 million additional investment over the next five years for 800 extra workers.[39]

The *Mental Health Strategy 2012-15* set out the Scottish Government's priorities and commitments to improve mental health services and to promote mental wellbeing and prevent mental illness. The strategy identifies seven key themes:

- Working more effectively with families and carers
- Embedding more peer to peer work and support
- Increasing the support for self-management and self help approaches
- Extending the anti-stigma agenda forward to include further work on discrimination
- Focusing on the rights of those with mental illness
- Developing the outcomes approach to include personal, social and clinical outcomes
- Ensuring that we use new technology effectively as a mechanism for providing information and delivering evidence based services[40]

The *Mental Health (Scotland) Bill* was introduced in the Scottish Parliament on 19 June 2014 by the Cabinet Secretary for Health and Wellbeing. The overarching objective of the Bill is to help people with a mental disorder access effective treatment quickly and easily. The Scottish Parliament has produced a research briefing on the Bill: Mental Health (Scotland) Bill. The Bill received Royal Assent on 4 August 2015.

The Scottish Government published its Suicide Prevention action plan: Every life matters in August 2018, which sets a target to further reduce the rate of suicide by 20% by 2022.

The plan sets key actions to achieve this target, such as the creation of a National Suicide Prevention Leadership Group, that will support the delivery of local prevention plans, backed by £3 million funding over the course of the current Parliament.

The Scottish Government will also fund the creation and implementation of refreshed mental health and suicide prevention training by May 2019, and develop a Scottish Crisis Care Agreement.

The Scottish Parliament's research service has published a briefing on Mental Health in Scotland (2014).

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39 Scottish Government press release, New Mental Health Strategy (30 March 2017)
40 Scottish Government, Mental Health Strategy 2012-15

Wales

In October 2012, the Welsh Government published *Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales*. This is a 10-year strategy for improving the lives of people using mental health services, their carers and their families.

The main themes of Together for Mental Health are:

- promoting mental wellbeing and, where possible, preventing mental health problems developing,
- establishing a new partnership with the public, centred on:
  - Improving information on mental health
  - Increasing service user and carer involvement in decisions around their care
  - Changing attitudes to mental health by tackling stigma and discrimination
- delivering a well designed, fully integrated network of care. This will be based on the recovery and enablement of service users in order to live as fulfilled and independent a life as possible,
- addressing the range of factors in people's lives which can affect mental health and wellbeing through Care and Treatment Planning and joint-working across sectors,
- identifying how the Government will implement the Strategy.

A new national Mental Health Partnership Board will oversee delivery of the Strategy.

At the heart of the strategy is the *Mental Health (Wales) Measure 2010*, which places legal duties on health boards and local authorities to improve support for people with mental ill-health.

In October 2016 the Welsh Government published the 2016-19 delivery plan, which sets out the actions to ensure the strategy is implemented.

Northern Ireland

The *Regional Mental Health Care Pathway: You in Mind*, launched in October 2014, commits health and social care services to deliver care which is more personalised and improves the experience of people with mental health problems, and adopts an evidence based/recovery oriented approach to care across the system.

In September 2015, Health Minister Simon Hamilton tasked officials to create an innovative service which will meet the needs of those suffering from mental trauma. The 2015 report, *Towards A Better Future: The Trans-generational Impact of the Troubles on Mental Health* (March 2015) found that over 213,000 people in Northern Ireland are experiencing significant mental health problems as a result of the Troubles. The Stormont House Agreement made a commitment to implement the Commission for Victims and Survivors' recommendation for a comprehensive Mental Trauma Service, to operate within the Health Service, but working closely with the Victims and Survivors

Service (VSS), and other organisations and groups who work directly with victims and survivors.[41]

The Northern Ireland Government's *Draft Programme for 2016-2021* and the Health Minister's most recent policy direction, *Health and Wellbeing 2026*, highlight the importance of mental health and related services in Northern Ireland.

Northern Ireland's Department of Health is currently consulting on a new draft suicide prevention strategy – Protect Life 2. Its key objectives are to reduce the rate of suicide and reduce the differential in suicide rate between the most and least deprived areas.

The strategy proposes various specific actions with regard to health services in order to:

- Reduce the risk of suicides among those in contact with mental health services, and improving patient safety;
- Reduce repeat self-harm by using presentation at hospital emergency departments due to self-harm as an opportunity to act quickly and link those at risk with services;
- Raise awareness of self-harm and suicide prevention services, and engagement with these services by people who need them, particularly mental health services; and
- Improve the initial response to people experiencing suicidal behaviour and who are self-harming by training those who provide their first point of contact.

The Northern Ireland Assembly Research and Information Service have published a briefing on Mental Health in Northern Ireland (2017).

[41] Northern Ireland Executive, Health Minister, Simon Hamilton, today reiterated his commitment to establishing a comprehensive Mental Trauma Service in Northern Ireland, 24 November 2015

7. Further reading

The Government provides information on current mental health policy on its page on mental health service reform.

NHS England provides information on its work to improve mental health services - see mental health.

House of Commons Library briefings

- Suicide Prevention: Policy and Strategy (September 2018)
- Children and young people's mental health – policy, CAMHS services, funding and education (August 2018)
- Perinatal mental illness (July 2018)
- Mental health problems: statistics on prevalence and services (April 2018)
- NHS Key Statistics: England (May 2018)
- Access and waiting time standards for early intervention in psychosis (March 2018)
- Social care: Announcement delaying introduction of funding reform (including the cap) and other changes until April 2020 (England) (February 2018)
- NHS maximum waiting times and patient choice policies (May 2016)

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