

ALL PARTY-PARLIAMENTARY GROUP ON SOCIAL WORK

**REPORT OF THE INQUIRY INTO ADULT
MENTAL HEALTH SERVICES IN ENGLAND**



Foreword

At the start of this inquiry I was aware of the statistic that one in four people experience mental health difficulties each year. But, as so often with statistics, the numbers mask the reality of the daily impact on hundreds of thousands of people and their families – and on those dedicated to working with them.

As the inquiry progressed, the true scale of the crumbling mental health services in this country was exposed. Despite finding pockets of excellence in practice and encountering many, many examples of immense dedication from those working with people with mental distress, it became clear that the infrastructure, legislation and policies in place are failing those who are so desperately in need of support.

Stigma associated with mental health problems also persists and can lock people into a vicious cycle where they find it impossible to speak out and seek help. Those who do seek help all too often find the service falls short, resulting in crises and worsening mental health.

We have come a long way in the last few decades but it is clear that the prevalence of people experiencing mental health problems is rising. The old models of care are no longer fit for purpose. Shocking statistics show the number of suicides attributed to mental health problems that are too often the fatal consequence of a mental health system that has let people down. Too many deaths could and should be prevented.

The current medical model treats the person as a patient, not an individual, and is overly dependent on budget restraints and workplace targets. Our new vision of a better mental health system is one that is holistic and person centred; a system that recognises the person, not just the diagnosis; a system that offers a continual, seamless support network that stays with the sufferer for as long as they need.

In this report we have made recommendations to the Government to improve prevention, treatment and recovery for patients and to improve workforce morale, structures and integration for all professionals working in mental health. We specifically emphasise the role social work can play in holistic and preventive care and support. It is imperative our recommendations are implemented to turn that hope into reality.

I would like to thank my colleagues on the All-Party Parliamentary Group; BASW and, in particular, Madeline Jennings for her diligent work in compiling this report; but most importantly everyone who came and shared their experiences and stories with us.

**Emma Lewell-Buck,
Member of Parliament for South Shields and
Chair of the All-Party Parliamentary Group on Social Work**

Introduction

This report from the *All-Party Parliamentary Group on Social Work* summarises evidence and recommendations from its four-month inquiry into mental health services in England. Four key points informed lines of questioning from the start:

- In all service planning and delivery, it is crucial to keep the experience of the person who will use the service at the centre of everything
- Commitment to meaningful co-production at every stage of service design is at the heart of successful models for mental health (where ‘co-production’ means developing and delivering services in an equal and reciprocal relationship between professionals, people using services and their families)
- The medical model alone cannot erase stigma, bring about parity of esteem or support recovery for individuals or communities
- Action on mental health must match the rhetoric

We took oral evidence from 30 people and written submissions from 12 others. The evidence covered many aspects of adult mental health. It provided a rich insight into the experience of the mental health system now – from the perspective of people using services, families, professionals from many disciplines, researchers, government officials and politicians. The inquiry sessions brought home the impact of austerity, welfare changes, family pressures, domestic abuse and poverty (and other social determinants) on the quality of people’s lives, on their mental health and on the workloads of services.

The inquiry sessions also revealed passion and clear ideas about action for change, including from people who have used services. We explored how many of the future solutions for better services can come from putting co-production with service users and personalised support at the heart of the mental health system. But current policy rhetoric, commissioning arrangements and service design are not producing sustained and reliable improvement in people’s experiences. Indeed, we took evidence to suggest that service systems are becoming more complex, fragmented and harder to navigate. Demand is growing, including for crisis support. Prevention is talked about but is underdeveloped and specific marginalised and excluded groups remain particularly under-served. The experiences of black and minority ethnic groups continue to be poorer overall.

Funding for mental health services remains inadequate and is not at parity with physical health spending. Investment that does come into mental health has too often been wasted on frequent, complex changes to commissioning and service systems and there is no national framework for mental health provision. Mental health services are also, of course, competing within severely decreasing health and social care budgetary pots. The inquiry contributors spoke of how severe reductions in social care budgets (including the loss of local community and voluntary sector services) are having profound negative impacts across adult mental health and partner services such as the police and other emergency services.

Despite these challenges, our report emphasises optimism for change – from a passionate and dedicated mental health workforce and from the insights and solutions of people with direct experience of using services.

The role of social work

A key approach for improvement explored throughout the inquiry is the benefit (for quality and good use of resources) of promoting more strongly a social model of mental health. This includes ensuring social work is recognised on equal footing with medical and other clinical approaches.

Social workers fulfil a vital role in protecting people’s rights when they are in crisis or where a situation has deteriorated – particularly through their work in safeguarding, as Approved Mental Health Professionals (AMHPs) and Best Interests Assessors (BIAs). These crucial roles are often low profile and lack of workforce planning for AMHPs and BIAs was evident in the inquiry. But social workers are also trained to take a strengths-based approach to prevent and reduce deterioration. They do not treat a person as a ‘patient’ in a diagnostic category; they work holistically and collaboratively with them, their family and social networks. They focus on empowerment and a solution-focused approach to practical as well as emotional, health and legal issues. And they focus on protecting human rights and promoting social justice for individuals, families and communities. These are often the things that people using services say are most important to their recovery.

However, we found that social workers – outside of their AMHP or BIA roles – are often not deployed to use all the professional skills they are trained to use. They are often required to act in more limited roles, as service brokers within local authorities and care coordinators within NHS managed services under the Care Programme Approach (CPA), working from a menu of atomized services and interventions, rather than using all their skills and professional judgement to promote personalised solutions.

Ensuring access to social work support in mental health, and ensuring social workers can practice according to their skills and training to prevent crises and help people make lasting changes, are key recommendations in this report.

An extended report is available online from the www.basw.co.uk website. Full transcripts of the oral evidence sessions are available on request, along with all of the collated written evidence. The main findings in this report are grouped under three section headings, and recommendations are presented in a numerical sequence.

Section 1: Principles for better ways of working and better services

1.1 The case for prevention, early intervention and tackling social determinants of mental distress

Our mental health system should be focused on preventing crises and severe problems in adults – but the inquiry evidence suggested the opposite is often the reality. Rising numbers of referrals to specialist community mental health services and annual increases in detention rates under the Mental Health Act 1983 (MHA) suggest we are still going in the wrong direction. While this inquiry focused on adult mental health, many contributors emphasised that adult distress often has its roots in childhood or adolescence, and according to recent reports child and adolescent mental health is deteriorating nationally. Therefore improving support and services for young people is inextricably linked to improving adult mental health outcomes. This means offering support through transitions across the life span; arbitrary age-related service eligibility criteria should end and the needs of the person, regardless of age, should be the determinant of service availability and the model of care available.

Prevention also means tackling the social determinants of mental distress. Poverty, poor housing, unemployment, poor education, trauma and abuse – these are all directly and indirectly linked to poor mental health and there is growing evidence they are having an increasingly negative impact across the nation.

- 1. The principles of prevention and early-intervention should underpin all mental health service commissioning, provision and services. Outcomes should be evaluated against preventive practice across the whole system.**
- 2. Adult and children’s mental health social care strategies should be integrated with public mental health strategies. The role of social work in promoting public mental health initiatives and prevention should be developed with practitioners alongside people who use services.**
- 3. Crisis resolution and home treatment services should explicitly be required to offer social and family interventions on a par with medical interventions in order to deliver a holistic, evidence-based service.**
- 4. Age-adjusted mental health awareness classes should be a requirement of school education from reception onwards, ideally as part of enhanced Personal Social and Health Education (PSHE) programmes.**
- 5. Transition points within a service user’s engagement with mental health services must be person-centred rather than dictated by bureaucratic frameworks and age related eligibility criteria.**

1.2 The case for personalised assessment and support

Evidence from the inquiry indicates that there is a need and an appetite for the re-emergence of a strong social model of mental health to drive effective personalised assessment and support. This can build on the preventive, early intervention and community focus of the Care Act 2014 and other contemporary policy legal drivers, including the Human Rights Act 1998, and be based on personalised assessments from first access point to mental health services. The inquiry raised some fundamental questions about fitness of current statutory guidance and the legal provisions for assessment and support. This included whether the CPA should be thoroughly re-thought and replaced, in part or whole, by a social model of empowering, self-directed support across the health and social care system. The fitness of the Mental Health Act 1983 was also questioned, particularly in light of its uneasy relationship with the Mental Capacity Act 2005, its assumptions about the role of the police and its lack of fit with current commissioning structures.

6. There should be greater consistency and commitment to a personalised assessment of an individual's needs, strengths and wishes for support as the starting point for access to mental health services.
7. Individuals should be able to define their own priorities throughout care planning, retaining optimal control and say how they want their needs to be met. This should include wider access to personal health budgets.
8. The role of the CPA in national strategy across health and social care should be reviewed formally in light of the potential benefit for service users and families of more personalised, self-directed models, led by social workers and other professionals, within Care Act 2014 principles.
9. Start scoping work within Parliament for a new Mental Health Act that better safeguards people's rights, choice, control and capacity.

1.3 The case for co-production

In the context of the inquiry, co-production was defined as developing and delivering services in an equal and reciprocal relationship between professionals, people using services and their families. Evidence to the All-Party Parliamentary Group (APPG) demonstrated how much people using services want to feel they have involvement, choice and control over the support they get, and to have their contributions to improving mental health services fully recognised. Service users talked to the APPG specifically about the positive potential of the CPA if it were to be co-productive – the CPA would become a dynamic process, being co-produced by the service user with their named care coordinator, using on-going strengths-based practice.

10. Drawing on existing good practice, a national framework of effective, practical co-production and partnership between people using services and professionals should be developed and promoted throughout the NHS, local authorities and other providers.
11. Co-production should be a core skill requirement within all multidisciplinary professional mental health training.

1.4 The case for meeting the needs of carers and families

Building a personalised plan to support an individual's mental health means recognising the person's position within a family and within a community. Mental health professionals and service providers have to recognise that supporting a service user's recovery often requires supporting the family or social network's mental health as well. This means turning the duties in the Care Act 2014 into reality.

12. Ensure every acute and rehabilitation ward and crisis team has a dedicated family liaison social worker.
13. Ensure social workers and multi-professional colleagues in mental health are trained in the requirements and ethos of the Care Act 2014 in respect of carers and families.
14. Ask the Care Quality Commission to consider improvements in how it inspects mental health provider organisations with regard to effective involvement of and support to carers and families.

Section 2: Meeting the needs of diverse and marginalised groups

2.1 The case for developing services for individuals with dual-diagnosis of mental health problems, substance use and/or complex needs (such as homelessness or people within the criminal justice system)

Professionals must be champions in tackling stigma around those with mental distress and who might not conform to societal norms in other ways. Our evidence suggests that many people using services often don't see services and professionals doing this, and feel that services are 'not for them'. They expect to encounter rejection and barriers to getting help just at the point they need it most. Some people face institutionalised disadvantage and discrimination in access to services. More needs to be done to understand and break down these barriers and make sure that access to appropriate help is available to all who need it. This requires a joined up and holistic health and social model.

15. Health and social care commissioners should be required jointly to develop and implement dual and multiple-diagnosis service strategies and operational plans.
16. Providers should ensure inter-professional training and development plans include dual and multiple-diagnoses skills across all services and professions.

17. **Mental health services should be required to take referrals of people with dual diagnosis substance use and mental health problems.**
18. **Instead of relying solely on third sector providers, statutory mental health teams should be empowered, resourced and skilled to conduct outreach to homeless people.**
19. **Local commissioners of offender mental health services should work strategically with local courts to promote non-custodial solutions integrated with local mental health support.**
20. **The right to care coordination and/or personalised and self-directed support plans for mental health should be extended to prisoners, and people in secure care facilities, starting with lower risk offenders, with a view to extending to collaboration with existing services for violent offenders.**

2.2 The case for addressing inequalities amongst different groups of people using mental health services

Despite many notable innovations in outreach to and co-production with black, minority ethnic and other minority communities, many people from such backgrounds or identities never use mental health services because services are not making the effort to reach them or meet their needs appropriately. This can be the case particularly where people experience multiple exclusions – for example where the needs of different disenfranchised or minority groups overlap and create sub-groups within communities (e.g. black lesbian, gay, bisexual and transgender people).

There continues to be particularly low uptake of preventive and primary care services by black and minority ethnic service users. A consequence of this is a consistent over representation of black and minority ethnic people in the most controlling parts of the mental health system, following crises and deterioration of unaddressed problems. It also contributes to overrepresentation of black and minority ethnic community members in mental distress coming into contact with the police and coming into criminal justice and forensic services.

21. **Service access must be co-produced with members of diverse communities to tailor the approach and make it more acceptable and suitable.**
22. **Service strategies to address inequalities should recognise issues of multiple social exclusion and the intersectionality of protected characteristics and identities.**
23. **NHS England and local government bodies should work with relevant service user and lobbying organisations on a national inquiry and action plan to tackle inequalities in the mental health system for people from black and minority ethnic communities. This should include annual ethnicity-related outcome audits across mental health pathways, from primary care to acute and secure settings.**

The issue of specific occupationally-related mental health risks was an area flagged in the inquiry. Army veterans is one occupational group that is historically and currently under-served by our mental health services. Almost three million British Army veterans live and work in the UK with an estimated three to five thousand re-entering civilian life each year. Due to the trauma that may arise from serving in the military, many ex-service personnel will be experiencing mental distress to a lesser or greater degree. Their mental health needs can often have significant social and financial dimensions, including matters such as the integration back into civilian family life and parenting roles. The evidence gathered in the inquiry also suggested that the needs of female veterans have been particularly overlooked.

24. **Ensure that veteran mental health services continue to be supported and ensure plans include social work interventions that deliver preventive and restorative outcomes.**
25. **Establish a government inquiry into the mental health of female veterans with a focus on developing a framework to support them.**

Section 3: Organisational and systems change

3.1 The case for real parity between physical and mental health care services

Policymakers, service users, social workers and allied agencies all express their frustration about the reality of the on-going stigma associated with using mental health services. Yet some politicians in particular talk as if parity is easily achievable simply through the use of the language of parity within law and policy. The case has to be made for real parity of esteem between mental and physical health as well as the case for parity of respect between policymakers and service users in the form of genuine co-production.

26. **Establish a professional and service user-led standing commission to scrutinise and promote progress on parity of esteem for mental health within national and local funding and delivery of social care and health.**
27. **Establish a national, public campaign to highlight the impact that physical ill-health and social problems can have on mental health, and the impact of mental health problems on physical and social wellbeing. This campaign should be co-produced with service users and align with enhanced inter-professional pre and post-qualifying training.**
28. **Pilot and evaluate joint mental health and physical healthcare advocates and navigators within primary and community mental health services.**

3.2 The case for integrating support across the system

Local and national mental health systems of support are complex and involve multiple partners and complicated processes within and beyond health and social care. Service users and professionals still report that from the point of first contact with services there will often be gaps between services and disjointed pathways to help. These cause breaks in support and leave people feeling as if they don't have control and can't sustain relationships with known staff. There is often inadequate support to navigate the system and it is hard for people to know what they should have and expect from mental health services in an increasing postcode lottery of localised commissioning.

The inquiry also took evidence of the difficulties of maintaining complex working relationships across systems over time and under pressure. NHS and local authority partnerships and integrated working are showing considerable strain across the country from pressures such as large cuts to resources, rising demand, churn in service models, new statutory responsibilities (for example the Care Act 2014) and fragmentation of commissioning and provision. NHS management of social work and social care is ending in many areas as local authorities have judged partnership agreements to have marginalised or failed to deliver social work and social care effectively.

29. **Ensure the lessons from mental health integration (for example through partnership agreements) are learnt and applied to emerging innovative integration models across health and social care. These must guarantee sustained delivery of high quality social care and social work within integrated systems, and effective workforce planning for all professions, including AMHPs.**
30. **Replace existing, service-specific processes and service coordination tools, electronic records and administrative processes (for example separate NHS and local authority electronic record systems) with fit-for-purpose ones that enable meaningful integration, partnership and information sharing across whole systems of care. These should be user-led (for example prioritising user-owned records and online portals)**
31. **Introduce a national policy framework to ensure Child and Adolescent Mental Health Services (CAMHS), adult mental health and children's services are required to have local operational collaboration and inter-agency learning protocols.**
32. **Social work outcomes for mental health should be agreed as a sector wide framework for excellent practice by the Department of Health, Association of Directors of Adult Social Services (ADASS) and BASW. These should focus on supporting excellent practice and delivering interventions associated with legislation, statutory and non-statutory roles undertaken by social workers.**

3.3: The case against fragmentation through outsourcing and privatisation

Evidence to the APPG raised many concerns about the risks of more private companies running public mental health services. It is a form of fragmentation that can be highly detrimental to joined-up working when it comes with incentives to deliver only contracted measurables, prioritising the business needs of a single organisation or part of the system over interagency relationships and whole system benefit. Data sharing and experience pooling can be harder to achieve, and service users can experience more silos and lack of professional cohesion.

33. **The APPG considers the contracting out of mental health services to private providers to be risky to the integrity and consistency of services. It should only be permitted after scrutiny through local democratic bodies and when value to service user outcomes *and* whole system effectiveness can be thoroughly demonstrated.**
34. **There needs to be renewed commitment for standardised national pathways of consistent integrated support for every local system that are designed to prevent confusion, fragmentation and new silos.**

3.4 The case for improving how the local mental health economy is designed

Mental health services are underfunded. Constant reorganisation and re-tendering can also waste resources and detract from commissioners and providers meeting core requirements. Fundamental changes in clinical commissioning and to the way policymakers, professionals and the public think about hospital and community services and workforce planning are required in order to maximise the value from every area's mental health economy. Changes should be based on the principal that a social model of support is to be provided on a par with clinical pathways.

- 35. Ensure all Clinical Commissioning Groups (CCGs) work to a comprehensive list of statutory duties with regard to mental health and human rights for which they are legally responsible. This includes, but is not limited to, commissioning secure and safe alternatives to police custody, provision of acute inpatient beds and less restrictive alternatives to admission.**
- 36. Ensure CCGs meet NHS England expectations of investment in mental health; that mental health has parity of focus within NHS Sustainability and Transformation plans, and that the Five Year Forward View for Mental Health commitments are realised.**
- 37. All CCGs, provider trusts and local authorities should be required to produce and implement bed use and detention reduction strategies and demand management plans for inpatient services. These should include recognising the key role of social care, social workers and AMHPs in both responding to, and preventing demand on inpatient services and supporting discharge.**
- 38. Ensure inter-professional training with the police is required within all CCG, local authority, provider trust and third sector organisations' workforce development plans.**

3.5 The case for taking care of the mental health workforce

No service can function well when those responsible for delivering the service are tired, stressed, and themselves at risk of mental distress. All the evidence to the APPG demonstrates that social workers and all professionals working in mental health services are often under duress themselves. The causes of this include not providing mental health professionals with the tools or support to do the job; not providing supervision or debriefing if things go wrong, or simply a chronic shortage of staff to meet the needs of the population.

- 39. All mental health employers and organisations (including the NHS, local authorities, LGA and ADASS) should implement an explicit plan for the mental wellbeing of the workforce. This should be developed with practitioners and should be evaluated for impact and learning.**
- 40. A national mental health and wellbeing helpline and other resources (for example online) should be commissioned by government, specifically for mental health workers.**

About the APPG on Social Work:

The All-Party Parliamentary Group on Social Work is chaired by Emma Lewell-Buck, Member of Parliament for South Shields and a former social worker.

Secretariat support is provided by the British Association of Social Workers (BASW).

The APPG's Mental Health Inquiry Committee is composed of Emma Lewell-Buck MP, Cat Smith MP, Baroness Uddin and Baroness Tyler of Enfield.

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